00 Redaction Log

Location	Redacted Item
A. Transmittal (Cover) Letter	Transmittal (Cover) Letter
H. Financial Information - Financial Statements	1. Humana Medical Plan, Inc. 2014 Audited Financial Statement
H. Financial Information - Financial Statements	2. Humana Medical Plan, Inc. 2015 Audited Financial Statement
H. Financial Information - Financial Statements	3. Humana Medical Plan, Inc. 2016 Audited Financial Statement
H. Financial Information - Financial Statements	4. Humana Medical Plan, Inc. 2014 NAIC Health Statement
H. Financial Information - Financial Statements	5. Humana Medical Plan, Inc. 2015 NAIC Health Statement
H. Financial Information - Financial Statements	6. Humana Medical Plan, Inc. 2016 NAIC Health Statement
I. Financial Information - Pro Forma Financial Statements	1. Assets
I. Financial Information - Pro Forma Financial Statements	2. Liabilities, Capital, and Surplus
I. Financial Information - Pro Forma Financial Statements	3. Summary of Operations – Total
I. Financial Information - Pro Forma Financial Statements	4. Cash Flows
I. Financial Information - Pro Forma Financial Statements	5. Summary of Operations
I. Financial Information - Pro Forma Financial Statements	6. Assumptions
J. Financial Information - Surplus	Surplus
K. Financial Information - Insolvency Protection Account	Insolvency Protection Account
L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	SRC # 10- Additional Expanded Benefits
L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	SRC # 15- Provider Engagement Model
L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	SRC # 33- Disaster Recovery Requirements
L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	MMA SRC # 7- MMA Physician Incentive Program
L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	MMA SRC # 10- Transitions of Care
L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	MMA SRC # 13- Value Based Purchasing
L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	LTC SRC # 3- Transitions of Care
L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	LTC SRC # 5- Transition from Nursing Facility to Community

00 Redaction Log

L. Exhibit A-4-a, General Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits	LTC SRC # 8- Home and Community-Based Services (HCBS) Performance and Credentialing
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T. Attachment C, Cost Proposal and Instructions, including applicable exhibits	2. Exhibit 1: Summary of MMA RY 18/19 Capitation Rates by Region and Rate Group
T. Attachment C, Cost Proposal and Instructions, including applicable exhibits	3. Exhibit 2: Summary of MMA RY 18/19 Maternity Kick Payment by Region
T. Attachment C, Cost Proposal and Instructions, including applicable exhibits	4. Exhibit 3: Summary of Results of Sensitivity Testing
T. Attachment C, Cost Proposal and Instructions, including applicable exhibits	6. LTC Actuarial Memorandum
T. Attachment C, Cost Proposal and Instructions, including applicable exhibits	7. Exhibit 1: Summary of LTC RY 18/19 Capitation Rates by Region and Rate Group
T. Attachment C, Cost Proposal and Instructions, including applicable exhibits	8. Exhibit 2: Summary of Results of Sensitivity Testing
T. Attachment C, Cost Proposal and Instructions, including applicable exhibits	10. Exhibit C-1– Florida SMMC ITN – Capitated Plan Cost Proposal Template

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4. Exhibit 3: Summary of Results of Sensitivity Testing
5. Exhibit 4: MMA Actuarial Certification
6. LTC Actuarial Memorandum
7. Exhibit 1: Summary of LTC RY 18/19 Capitation Rates by Region and Rate Group
8. Exhibit 2: Summary of Results of Sensitivity Testing
9. Exhibit 3: LTC Actuarial Certification
10. Exhibit C-1– Florida SMMC ITN – Capitated Plan Cost Proposal Template

*Page Number does not include Introduction page for Exhibit A-5

Humana.

October 6, 2017

Jennifer Barrett
Agency for Health Care Administration
Building 2, Suite 203, Mail Stop 15
2727 Mahan Drive
Tallahassee, Florida 32308-5403

RE: AHCA ITN 001-17/18 – Region 1

Dear Ms. Barrett:

Humana Medical Plan, Inc. (Humana) is pleased to submit the enclosed response to the Agency's ITN 001-17/18 – Region 1 for the Statewide Medicaid Managed Care program. As required by Section 2 (Attachment A, page 12 of 41) of the ITN, Humana includes the following information in accordance with the Transmittal Letter requirements:

- **Respondent's name**: Humana Medical Plan, Inc.
- **Respondent's address**: 3501 SW 160th Avenue, Miramar, FL 33027
- **Respondent's Federal Employer Identification Number**: The information on this page is exempt from disclosure pursuant to Section 119.071(5)

- **The names of the respondent's official contact person and an alternate who have the authority to bind the respondent to a Contract, along with both individuals' title, address, telephone number, email address, and official signature.**

  Please see below for the information requested for Humana's official contact person:

  Name: John Edward Barger III
  Title: Vice President of Dual Eligible and Medicaid Programs
  Address: 4030 Boy Scout Boulevard, Tampa, FL 33607
  Telephone: The information on this page is exempt from disclosure pursuant to Section 119.071(5)
  E-mail Add

  Please see below for the information requested for Humana's alternate contact person:

  Name: Alan Wheatley
  Title: President, Retail Segment
  Address: 500 West Main Street, Louisville, KY 40202
  Telephone: The information on this page is exempt from disclosure pursuant to Section 119.071(5)
  E-mail Add

- **A statement authorizing release of the redacted version of the response in the event the Agency receives a public records request**

  In the event the Agency receives a public records request, Humana Medical Plan, Inc. authorizes the release of the redacted version of our proposal response to ITN 001-17/18 – Region 1.

Sincerely,

John Edward Barger III
Vice President of Dual Eligible and Medicaid Programs
Humana Medical Plan, Inc.

Alan Wheatley
President, Retail Segment
Humana Medical Plan, Inc.

EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

RESPONDENT NAME: **HUMANA MEDICAL PLAN, INC.**

1. IDENTIFICATION OF PLAN TYPES

I hereby certify that my company is submitting a response to AHCA ITN 001-17/18 to operate as one of the following plan types in Region 1:

☒ Comprehensive Plan

OR

☐ Long-Term Care Plus Plan

OR

☐ Managed Medical Assistance Plan

OR

☐ Specialty Plan

2. QUALIFICATION OF PLAN ELIGIBILITY

I hereby certify my company currently operates as one (1) of the following:

☒ HMO Health Maintenance Organization and possess a current Florida Certificate of Authority and Health Care Provider Certificate in at least one (1) Florida county.

OR

☐ PSN that possesses a Florida Third Party Administrator License or a subcontract/letter of agreement with a Florida-licensed Third Party Administrator. A copy of the Third Party Administrator license, or subcontract/letter of agreement, must be submitted with the solicitation response.

In addition, the respondent shall complete **Exhibit A-2-b,** Provider Service Network Certification of Ownership and Controlling Interest.

OR

☐ Exclusive Provider Organization that meets the licensure requirements of Section 627.6472, Florida Statutes.

EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

OR

☐ Accountable Care Organization authorized under federal law.

Signature below indicates the respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

Humana Medical Plan, Inc.
Respondent Name

John E Barger — 10/8/2017
Authorized Official Signature **Date**

John E. Barger III
Authorized Official Printed Name

VP of Dual Eligible and Medicaid Programs
Authorized Official Title

Failure to submit, Exhibit A-2-a, Qualification of Plan Eligibility, signed by an authorized official may result in the rejection of response.

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Exhibit A-2-b, PSN Certification of Ownership and Controlling Interest

Exhibit A-2-b, **Provider Service Network Certification of Ownership and Controlling Interest** is not applicable to Humana. Humana operates as an HMO (Health Maintenance Organization).

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

RESPONDENT NAME: Humana Medical Plan, Inc.

1. ACCEPTANCE OF SOLICITATION REQUIREMENTS

I hereby certify that I understand and agree that my organization has read all requirements and Agency specifications provided in this solicitation, accepts said requirements, and that this response is made in accordance with the provisions of such requirements and specifications. By my written signature below, I guarantee and certify that all items included in this response shall meet or exceed any and all such requirements and Agency specifications. I further agree, if awarded a Contract resulting from this solicitation, to deliver services that meet or exceed the requirements and specifications provided in this solicitation.

AND

2. ACCEPTANCE OF CONTRACT TERMS AND CONDITIONS

I hereby certify that should my organization be awarded a Contract resulting from this solicitation, it will comply with all terms and conditions as specified in this solicitation and in the Agency Standard Contract (**Exhibit A-8, including Attachments II - V**).

AND

3. STATEMENT OF NO-INVOLVEMENT

I hereby certify that neither my organization nor any person with an interest in the organization had any prior involvement in performing a feasibility study of the implementation of the subject Contract, in drafting of this solicitation or in developing the subject program.

AND

4. PROHIBITION OF GRATUITIES

I hereby certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from such my organization's response or subsequent Contract in violation of the provisions of Chapter 112, Florida Statutes. I understand that any Contract issued as a result of this solicitation may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

AND

5. NON-COLLUSION CERTIFICATION

I hereby certify that all persons, companies, or parties interested in the response as principals are named therein, that the response is made without collusion with any other person, persons, organization, or parties submitting a response; that it is in all respects made in good faith; and as the signer of the response, I have full authority to legally bind the prospective respondent to the provisions of this solicitation.

AND

6. PERFORMANCE OF SERVICES

I hereby certify my organization shall ensure all services, provided directly or indirectly under the Contract resulting from this solicitation, will be performed within the borders of the United States and its territories and protectorates.

AND

7. ORGANIZATIONAL CONFLICT OF INTEREST CERTIFICATION

The standards on organizational conflicts of interest in Title 48, Code of Federal Regulations, Subpart 9.5 – Organizational and Consultant Conflicts of Interest and Section 287.057(17), Florida Statutes, apply to this solicitation. A respondent with an actual or potential organizational conflict of interest shall disclose the conflict. If the respondent believes the conflict of interest can be mitigated, neutralized or avoided, the respondent shall submit a Conflict of Interest Mitigation Plan with its response, that shall, at a minimum:

a) Identify any relationship, financial interest or other activity which may create an actual or potential organizational conflict of interest.
b) Describe the actions the respondent intends to take to mitigate, neutralize, or avoid the identified organizational conflicts of interest.
c) Identify the official within the respondent's organization responsible for making conflict of interest determinations.

The Conflict of Interest Mitigation Plan will be evaluated as acceptable or not acceptable. The Agency reserves the right to request additional information from the respondent or other sources, as deemed necessary, to determine whether or not the plan adequately neutralizes, mitigates, or avoids the identified conflicts.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

Pursuant to the aforementioned requirements, I hereby certify that, to the best of my knowledge, my organization (including its subcontractors, subsidiaries and partners):

Please check the applicable paragraph below. Do not check more than one of the paragraphs below.

☒ Has no existing relationship, financial interest or other activity which creates any actual or potential organizational conflicts of interest relating to the award of a Contract resulting from this solicitation.

☐ Has included information in its response to this solicitation detailing the existence of actual or potential organizational conflicts of interest and has provided a "Conflict of Interest Mitigation Plan", as outlined above.

AND

8. RESPONDENT ATTESTATION FOR EXHIBIT A-4

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria, including **Exhibits A-4-a, A-4-b, A-4-c and A-4-d,** including all exhibits/attachments, as applicable.

I understand the Agency may not consider supplemental response narrative for evaluation which is not contained within the Response Sections contained in **Exhibit A-4,** Submission Requirements and Evaluation Criteria.

AND

9. RESPONDENT ATTESTATION FOR ATTACHMENT C, COST PROPOSAL INSTRUCTIONS AND RATE METHODOLOGY NARRATIVE

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Attachment C, Cost Proposal Instructions and Rate Methodology Narrative, including all applicable exhibits.**

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

AND

10. RESPONDENT ATTESTATION REGARDING SCRUTINIZED COMPANIES LIST

I hereby certify that my company is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes. Pursuant to Section 287.135(5), Florida Statutes, the respondent agrees the Agency may immediately terminate the resulting Contract for cause if the respondent is found to have submitted a false certification or if the respondent is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the resulting Contract.

AND

11. NAMES OF OPERATION

I hereby certify the following is a list of all names under which my organization has operated during the past five (5) years (since July 14, 2012).

Florida Comfort Choice

Florida Senior's Choice

Humana Family

Miramar Health and Fitness Center

AND

12. BUSINESS RELATIONSHIP

The respondent shall disclose any business relationship (as defined in Section 409.966(3)(e), Florida Statutes) with any other eligible Managed Care Plan that is a potential respondent to this solicitation. Such disclosure shall include identifying information for each Managed Care Plan, the nature of the business relationship, the current service area of each Managed Care Plan (by line of business), and the signature of the authorized representative for each Managed Care Plan.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

The respondent must disclose any business relationship(s) in the space provided below:

Not Applicable

AND

13. COMPLETE MEDICAID PROVIDER ENROLLMENT PACKAGE SUBMISSION

I hereby certify my organization, if awarded a Contract, shall provide the Agency with an accurate and complete Medicaid Provider Enrollment Application, including all ownership and principal fingerprint cards and processing fees, within thirty (30) days after the Contract award is complete.

AND

14. REQUIRED PLAN READINESS DOCUMENTATION

I hereby certify my organization, if awarded a Contract, shall submit to the Agency all required Plan Readiness documentation within established timeframes as required in **Attachment A**, Instructions and Special Conditions, **Section E.**, Contract Implementation.

AND

15. CERTIFICATION REGARDING TERMINATED CONTRACTS

I hereby certify that my organization (including its subsidiaries and affiliates) has not unilaterally or willfully terminated any previous contract prior to the end of the contract with a State or the Federal government and has not had a contract terminated by a State or the Federal government for cause, prior to the end of the contract, within the past five (5) years (since July 14, 2012), other than those listed on **Page 6** of this Exhibit.

AND

16. LIST OF TERMINATED CONTRACTS

List the terminated contracts in chronological order and provide a brief description (half-page or less) of the reason(s) for the termination. Additional

pages may be submitted; however, no more than five (5) additional pages should be submitted in total.

The Agency is not responsible for confirming the accuracy of the information provided.

The Agency reserves the right within its sole discretion, to determine the respondent to be an non-responsible vendor based on any or all of the listed contracts and therefore may reject the respondent's reply.

Respondent Name:Not Applicable

Client's Name:Not Applicable

Term of Terminated Contract: Not Applicable

Description of Services: Not Applicable

Brief Summary of Reason(s) for Contract Termination: Not Applicable

Respondent Name:Not Applicable

Client's Name:Not Applicable

Term of Terminated Contract: Not Applicable

Description of Services: Not Applicable

Brief Summary of Reason(s) for Contract Termination: Not Applicable

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

Signature below indicates the respondent's full acknowledgement of; understanding of; and agreement with all of the certifications and statements identified above in Items 1 through 16 as written and without caveat.

Humana Medical Plan, Inc.
Respondent Name

E Barger, III — 10/8/17

Authorized Official Signature **Date**

John E. Barger III
Authorized Official Printed Name

VP of Dual Eligible and Medicaid Programs
Authorized Official Title

Failure to submit, Exhibit A-2-c, Additional Required Certifications and Statements, signed by an authorized official may result in the rejection of response.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

RESPONDENT NAME: Humana Medical Plan, Inc.

The Agency for Health Care Administration ("Agency" or "AHCA") "must avoid, neutralize, or mitigate significant potential organizational conflicts of interest (OCI) before a Contract is awarded. If the Agency elects to mitigate the significant potential organizational conflict or conflicts of interest, an adequate mitigation plan, including organizational, physical, and electronic barriers, shall be developed. [Section 287.057(17)(a)(1), Florida Statutes]

The Agency has determined that in order to evaluate proposals and negotiate a Contract that is in the best interests of the State, it is necessary to use the services of Milliman, Inc. ("Milliman") to act as an actuary and advisor throughout all stages of the "Statewide Medicaid Managed Care Program" competitive solicitation. The Agency reasonably anticipates one or more prospective respondents may also use Milliman. The Agency has determined that all reasonably anticipated OCIs relating to Milliman may be mitigated by the following mitigation plan, which has been agreed to by Milliman:

I. Milliman

a. All Milliman personnel who will perform services under the "Statewide Medicaid Managed Care Program" competitive solicitation shall be part of a separate internal Milliman working group (the "Milliman AHCA Group") with its own internal electronic and hard folders.

b. All documents or communications received or generated by the Milliman AHCA Group that relate in any way to this solicitation shall be placed only in this Group's separate files.

c. Each member of the Milliman AHCA Group shall submit **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit indicating they will provide actuarial services to the Agency.

d. No Milliman personnel, other than the Milliman AHCA Group personnel shall have access to the Milliman AHCA's Groups files.

e. The above-listed personnel shall not discuss any information relating to the SMMC ITN Services with any other Milliman personnel.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

II. Respondents

a. Any actual or prospective respondent who is using Milliman for this procurement must disclose this fact in its initial reply to the solicitation. Specifically, a respondent wishing to use Milliman must:

i. Identify itself and its intent to use Milliman;
ii. Identify the specific Milliman personnel that will be assisting the respondent in the procurement;
iii. Submit **Exhibit A-3-b, Milliman Employee Organizational Conflict of Interest Affidavit** forms, completed by each identified Milliman personnel.

b. All replies submitted in response to this solicitation must include the completed declaration in **Section IV.** of this Exhibit, signed by the authorized official who signed the reply on behalf of the respondent.

c. Any actual or prospective respondent who learns there is a reasonable basis to believe there has or may have been a violation of the Milliman OCI Mitigation Plan shall, within seventy-two (72) hours, notify the Agency of the facts and circumstances of the possible violation.

III. Protests

a. **Actual or prospective respondents are advised they have a burden to diligently investigate and challenge potential OCIs relating to Milliman**.

b. All challenges to the Milliman OCI Mitigation Plan must be timely filed as a challenge to the specifications of this solicitation. Similarly, challenges to amendments to the Milliman OCI Mitigation Plan must be timely filed as specifications challenges.

c. All challenges to Milliman-related information provided by actual or prospective respondents and posted by the Agency must be timely filed as specifications challenges.

d. **All protests filed after a Notice of Intent to Award has been posted which allege a Milliman-related OCI shall be limited to alleged violations of the Milliman OCI Mitigation Plan**.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

IV. Declaration

Declaration of John E. Barger III
Authorized Official Printed Name

Pursuant to Section 92.525, Florida Statutes, John E. Barger III
Authorized Official Printed Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that Humana Medical Plan, Inc.
Respondent Name

   will directly and indirectly fully comply with the Milliman Organizational Conflict of Interest Mitigation Plan through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 8 day of October 2017.

J E Barger III
Authorized Official Signature

John E. Barger III
Authorized Official Printed Name

Failure to submit, Exhibit A-3-a, Milliman Organizational Conflict of Interest Mitigation Plan, certified by an authorized official may result in the rejection of response.

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EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT

Declaration of Steven Buehler
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, Steven Buehler
Milliman Employee Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I am an employee of Milliman at Milliman's business office located in Indianapolis, IN and have been assigned to provide actuarial services to Humana, Inc.
Respondent Name

3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 4th day of August 2017.

Steven Buehler
Signature

Steven Buehler
Printed Name

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EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT

Declaration of Shannon Sizemore
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, Shannon Sizemore
Milliman Employee Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I am an employee of Milliman at Milliman's business office located in Indianapolis, IN and have been assigned to provide actuarial services to Humana, Inc.
Respondent Name

3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 4th day of August 2017.

Signature

Shannon Sizemore
Printed Name

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EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT

Declaration of Nick Barratt
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, Nick Barratt
Milliman Employee Name
declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I am an employee of Milliman at Milliman's business office located in Indianapolis, IN and have been assigned to provide actuarial services to Humana, Inc
Respondent Name

3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 4th day of August 2017.

Signature

Nick Barratt
Printed Name

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EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT

Declaration of Jeremy Palmer
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, Jeremy Palmer
Milliman Employee Name

declares that:

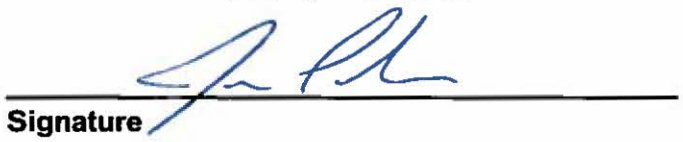
1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I am an employee of Milliman at Milliman's business office located in Indianapolis, IN and have been assigned to provide actuarial services to Humana, Inc.
Respondent Name

3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 4th day of August 2017.



Signature

Jeremy Palmer
Printed Name

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EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT

Declaration of Amy Coleman
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, Amy Coleman
Milliman Employee Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I am an employee of Milliman at Milliman's business office located in Indianapolis, IN and have been assigned to provide actuarial services to Humana, Inc.
Respondent Name

3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 4th day of August 2017.

Amy B. Coleman
Signature

Amy Coleman
Printed Name

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EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT

Declaration of Marlene Howard
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, Marlene Howard
Milliman Employee Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I am an employee of Milliman at Milliman's business office located in Indianapolis, IN and have been assigned to provide actuarial services to Humana, Inc.
Respondent Name

3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 4th day of August 2017.

Marlene Howard
Signature

Marlene Howard
Printed Name

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EXHIBIT A-3-b
MILLIMAN EMPLOYEE
ORGANIZATIONAL CONFLICT OF INTEREST AFFIDAVIT

Declaration of Teresa Wilder
Milliman Employee Name

Pursuant to Section 92.525, Florida Statutes, Teresa Wilder
Milliman Employee Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I am an employee of Milliman at Milliman's business office located in Indianapolis, IN and have been assigned to provide actuarial services to Humana, Inc.
Respondent Name

3. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that I will fully comply with it through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 4th day of August 2017.

Teresa Wilder
Signature

Teresa Wilder
Printed Name

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BID BOND

Travelers Casualty and Surety Company of America
Hartford, CT 06183

KNOWN ALL BY THESE PRESENTS, That we, Humana Medical Plan, Inc., as Principal, and Travelers Casualty and Surety Company of America, as Surety, are held and firmly bound unto State of Florida, Agency for Healthcare Administration, as Obligee, in the sum of one million & 00/$100 Dollars ($1,000,000.00) for the payment of which we bind ourselves, and our successors and assigns, jointly and severally, as provided herein.

WHEREAS, Principal has submitted or is about to submit a bid to the Obligee on a contract for Florida Medicaid Managed Care Program Solicitation Number: AHCA ITN 001-17/18 Region 1 ("Project").

NOW, THEREFORE, the condition of this bond is that if Obligee accepts Principal's bid, and Principal enters into a contract with Obligee in conformance with the terms of the bid and provides such bond or bonds as may be specified in the bidding or contract documents, then this obligation shall be void; otherwise Principal and Surety will pay to Obligee the difference between the amount of Principal's bid and the amount for which Obligee shall in good faith contract with another person or entity to perform the work covered by Principal's bid, but in no event shall Surety's and Principal's liability exceed the penal sum of this bond.

Signed this 15th day of August, 2017.

Humana Medical Plan, Inc.
(Principal)

By: _____ V.P.

Travelers Casualty and Surety Company of America

By: _____
Jeffrey B Hollon, Attorney-in-Fact

WARNING: THIS POWER OF ATTORNEY IS INVALID WITHOUT THE RED BORDER

TRAVELERS

POWER OF ATTORNEY

Farmington Casualty Company
Fidelity and Guaranty Insurance Company
Fidelity and Guaranty Insurance Underwriters, Inc.
St. Paul Fire and Marine Insurance Company
St. Paul Guardian Insurance Company

St. Paul Mercury Insurance Company
Travelers Casualty and Surety Company
Travelers Casualty and Surety Company of America
United States Fidelity and Guaranty Company

Attorney-In Fact No. 227259 **Certificate No.** 007233433

KNOW ALL MEN BY THESE PRESENTS: That Farmington Casualty Company, St. Paul Fire and Marine Insurance Company, St. Paul Guardian Insurance Company, St. Paul Mercury Insurance Company, Travelers Casualty and Surety Company, Travelers Casualty and Surety Company of America, and United States Fidelity and Guaranty Company are corporations duly organized under the laws of the State of Connecticut, that Fidelity and Guaranty Insurance Company is a corporation duly organized under the laws of the State of Iowa, and that Fidelity and Guaranty Insurance Underwriters, Inc., is a corporation duly organized under the laws of the State of Wisconsin (herein collectively called the "Companies"), and that the Companies do hereby make, constitute and appoint

Judy B. Hertel, Jeffrey B. Hollon, Donna Ferry, Clinton Glasscock, Robin Fisher, Tina Terry, Virginia Blackburn, John C Couch, and Brandon Egan

of the City of Louisville, State of Kentucky, their true and lawful Attorney(s)-in-Fact, each in their separate capacity if more than one is named above, to sign, execute, seal and acknowledge any and all bonds, recognizances, conditional undertakings and other writings obligatory in the nature thereof on behalf of the Companies in their business of guaranteeing the fidelity of persons, guaranteeing the performance of contracts and executing or guaranteeing bonds and undertakings required or permitted in any actions or proceedings allowed by law.

IN WITNESS WHEREOF, the Companies have caused this instrument to be signed and their corporate seals to be hereto affixed, this 22nd day of May, 2017.

Farmington Casualty Company
Fidelity and Guaranty Insurance Company
Fidelity and Guaranty Insurance Underwriters, Inc.
St. Paul Fire and Marine Insurance Company
St. Paul Guardian Insurance Company

St. Paul Mercury Insurance Company
Travelers Casualty and Surety Company
Travelers Casualty and Surety Company of America
United States Fidelity and Guaranty Company

State of Connecticut
City of Hartford ss.

By: _____
Robert L. Raney, Senior Vice President

On this the 22nd day of May, 2017, before me personally appeared Robert L. Raney, who acknowledged himself to be the Senior Vice President of Farmington Casualty Company, Fidelity and Guaranty Insurance Company, Fidelity and Guaranty Insurance Underwriters, Inc., St. Paul Fire and Marine Insurance Company, St. Paul Guardian Insurance Company, St. Paul Mercury Insurance Company, Travelers Casualty and Surety Company, Travelers Casualty and Surety Company of America, and United States Fidelity and Guaranty Company, and that he, as such, being authorized so to do, executed the foregoing instrument for the purposes therein contained by signing on behalf of the corporations by himself as a duly authorized officer.

In Witness Whereof, I hereunto set my hand and official seal.
My Commission expires the 30th day of June, 2021.

MARIE C. TETREAULT NOTARY PUBLIC CONNECTICUT

Marie C. Tetreault
Marie C. Tetreault, Notary Public

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WARNING: THIS POWER OF ATTORNEY IS INVALID WITHOUT THE RED BORDER

Financial Information: Introduction to Financial Statements

Introduction to Financial Statements

Humana has included its most recent audited financial statements for the past three (3) years as described in Table 2, Financial Statement Requirements. Humana has included the financial statements requested for an entity with at least three (3) years of financials.

The following financial statements are included within Section H, Financial Information – Financial Statements, of our proposal:

		Page Numbers
1.	Humana Medical Plan, Inc. 2014 Audited Financial Statement	1-56a
2.	Humana Medical Plan, Inc. 2015 Audited Financial Statement	57-118
3.	Humana Medical Plan, Inc. 2016 Audited Financial Statement	119-186
4.	Humana Medical Plan, Inc. 2014 NAIC Health Statement	187-312
5.	Humana Medical Plan, Inc. 2015 NAIC Health Statement	313-444
6.	Humana Medical Plan, Inc. 2016 NAIC Health Statement	445-578
7.	Humana Inc. 2014 Audited Financial Statement	579-624
8.	Humana Inc. 2015 Audited Financial Statement	625-675
9.	Humana Inc. 2016 Audited Financial Statement	676-730

Note: The financial statements included within this section contain their original page numbers. To maintain consistent page numbering across all financial statements within this section, we have added additional page numbers to the lower right-hand corner of each page.

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March 30, 2015

Audit Committee of the Board of Directors
Humana Medical Plan, Inc.
500 West Main Street
Louisville, Kentucky 40202

In planning and performing our audit of the statutory-basis financial statements of Humana Medical Plan, Inc. (the "Company") as of and for the year ended December 31, 2014, in accordance with auditing standards generally accepted in the United States of America, we considered its internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the statutory-basis financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we do not express an opinion on the effectiveness of the Company's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

A material weakness is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control was for the limited purpose described in the first paragraph and would not necessarily identify all deficiencies in internal control that might be material weaknesses and therefore, there can be no assurance that all deficiencies or material weaknesses have been identified. We did not identify any deficiencies in internal control that we consider to be material weaknesses, as defined above, as of December 31, 2014.

This communication is intended solely for the information and use of the audit committee, board of directors, management, others within the organization, and state insurance departments to whose jurisdiction the Company is subject and is not intended to be and should not be used by anyone other than these specified parties.

Very truly yours,

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP

March 30, 2015

To the Board of Directors of
Humana Medical Plan, Inc.:

We have audited, in accordance with generally accepted auditing standards, the statutory basis financial statements of Humana Medical Plan, Inc. (the "Company") for the years ended December 31, 2014 and 2013, and have issued our report thereon dated March 30, 2015. In connection therewith, we advise you as follows:

a. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the Code of Professional Conduct and pronouncements of the American Institute of Certified Public Accountants, and the Rules of Professional Conduct of the Alabama, Florida, Kentucky, and New York Boards of Public Accountancy.

b. The engagement partner and engagement manager, who are certified public accountants, have 25 years and 9 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 85 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

c. We understand that the Company intends to file its audited statutory basis financial statements and our reports thereon with the Insurance Department of the State of Florida and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory financial condition of the Company.

While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with generally accepted auditing standards is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flow in conformity with accounting practices prescribed or permitted by the Insurance Department of the State of Florida. Consequently, under generally accepted auditing standards, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance about whether the statutory basis financial statements are free of material misstatement, whether caused by error or fraud, and to exercise due professional care in the conduct of the audit. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility

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that material errors or misstatements caused by fraud may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit means that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Insurance Department of the State of Florida.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory financial position of insurers and should not rely solely upon the independent auditor's report.

d. We will retain all documents (including those kept in a hard copy or electronic medium) created or received or received by us that are necessary or appropriate to document the Firm's professional work product, for seven years from the date that we grant permission to use our report in connection with the issuance of the company's financial statements (report release date), unless a longer period of time is required by law. After notification to the Company we will make the workpapers available for review by the Insurance Department of the State of Florida at the offices of the insurer, at our offices, at the Insurance Department or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Insurance Department of the State of Florida, photocopies of pertinent audit workpapers may be made (under the control of the accountant) and such copies may be retained by the Insurance Department of the State of Florida.

e. The engagement partner has served in that capacity with respect to the Company since 2010, is licensed by the Alabama, Florida, Kentucky, and New York Boards of Public Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

f. To the best of our knowledge and belief, we are in compliance with the requirements of Section 7 of the NAIC's *Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the board of directors and management of the Company and the Insurance Department of the State of Florida and other state insurance departments and is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

Humana Medical Plan, Inc.

(A wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2014 and 2013

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Humana Medical Plan, Inc.
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Statutory Basis of Accounting
December 31, 2014 and 2013

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March 30, 2016

Audit Committee of the Board of Directors
Humana Medical Plan, Inc.
500 West Main Street
Louisville, KY 40202

In planning and performing our audit of the statutory-basis financial statements of Humana Medical Plan, Inc. (the "Company") as of and for the year ended December 31, 2015, in accordance with auditing standards generally accepted in the United States of America, we considered its internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the statutory-basis financial statements, but not for the purpose of expressing an opinion on the Company's internal control over financial reporting. Accordingly, we do not express an opinion on the Company's internal control over financial reporting.

AICPA AU-C 265, *Communicating Internal Control Related Matters Identified in an Audit*, of the AICPA Professional Standards includes the following definitions of a deficiency, a significant deficiency and a material weakness:

> Deficiency - a deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis.
>
> Significant deficiency - a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.
>
> Material weakness - a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses and therefore, material weaknesses may exist that were not identified. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above, as of December 31, 2015.

This letter is intended solely for the information and use of the audit committee, board of directors, management, others within the organization, and state insurance departments to whose jurisdiction the Company is subject and is not intended to be, and should not be, used by anyone other than these specified parties.

Very truly yours,

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP

March 30, 2016

To the Board of Directors of
Humana Medical Plan, Inc.:

We have audited, in accordance with generally accepted auditing standards, the statutory basis financial statements of Humana Medical Plan, Inc. (the "Company") for the years ended December 31, 2015 and 2014, and have issued our report thereon dated March 30, 2016. In connection therewith, we advise you as follows:

a. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the Code of Professional Conduct and pronouncements of the American Institute of Certified Public Accountants, and the Rules of Professional Conduct of the Alabama, Florida, Georgia, Kentucky, and Tennessee Boards of Public Accountancy.

b. The engagement partner and engagement manager, who are certified public accountants, have 27 years and 9 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 68 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

c. We understand that the Company intends to file its audited statutory basis financial statements and our reports thereon with the Insurance Department of Florida and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory financial condition of the Company.

   While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with generally accepted auditing standards is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flow in conformity with accounting practices prescribed or permitted by the Insurance Department of Florida. Consequently, under generally accepted auditing standards, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance about whether the statutory basis financial statements are free of material misstatement, whether caused by error or fraud, and to exercise due professional care in the conduct of the audit. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud.

Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material errors or misstatements caused by fraud may occur in the future. Also, our use of professional judgment and the assessment of materiality for the purpose of our audit means that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Insurance Department of Florida.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory financial position of insurers and should not rely solely upon the independent auditor's report.

d. We will retain audit working papers (including those kept in a hard copy or electronic medium) prepared in compliance with professional standards for seven years from the date that we grant permission to use our report in connection with the issuance of the Company's financial statements (report release date), unless a longer period of time is required by law. After notification to the Company we will make the workpapers available for review by the Insurance Department of Florida at the offices of the insurer, at our offices, at the Insurance Department or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Insurance Department of Florida, photocopies of pertinent audit workpapers may be made (under the control of the accountant) and such copies may be retained by the Insurance Department of Florida. In addition, to the extent requested, we may provide the Insurance Department of Florida with copies of certain of our audit working papers (such as unlocked electronic copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by the Insurance Department of Florida or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Insurance Department of Florida and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance or outcome of your regulatory examination.

e. The engagement partner has served in that capacity with respect to the Company since 2015, is licensed by the Alabama, Florida, Georgia, Kentucky, and Tennessee Boards of Public Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

f. To the best of our knowledge and belief, we are in compliance with the requirements of Section 7 of the NAIC's *Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the board of directors and management of the Company and the Insurance Department of Florida and other state insurance departments and is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

Humana Medical Plan, Inc.
9 5 2 7 0 2 0 1 5 2 2 0 0 0 1 0 0
Audited Financial Report

Humana Medical Plan, Inc.

(a wholly owned subsidiary of Humana Inc.)

Financial Statements and Supplemental Schedules
Statutory Basis of Accounting
December 31, 2015 and 2014

pwc

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Statutory Basis of Accounting
December 31, 2015 and 2014

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March 30, 2017

Audit Committee of the Board of Directors
Humana Medical Plan, Inc.
500 West Main Street
Louisville, KY 40202

In planning and performing our audit of the statutory-basis financial statements of Humana Medical Plan, Inc. (the "Company") as of and for the year ended December 31, 2016, in accordance with auditing standards generally accepted in the United States of America, we considered its internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the statutory-basis financial statements, but not for the purpose of expressing an opinion on the Company's internal control over financial reporting. Accordingly, we do not express an opinion on the Company's internal control over financial reporting.

AICPA AU-C 265, *Communicating Internal Control Related Matters Identified in an Audit*, of the AICPA Professional Standards includes the following definitions of a deficiency, a significant deficiency and a material weakness:

> Deficiency - a deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis.
>
> Significant deficiency - a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.
>
> Material weakness - a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses and therefore, material weaknesses may exist that were not identified. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above, as of December 31, 2016.

This letter is intended solely for the information and use of the audit committee, board of directors, management, others within the organization, and state insurance departments to whose jurisdiction the Company is subject and is not intended to be, and should not be, used by anyone other than these specified parties.

Very truly yours,

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP

March 30, 2017

To the Board of Directors of Humana Medical Plan, Inc.:

We have audited, in accordance with generally accepted auditing standards, the statutory basis financial statements of Humana Medical Plan, Inc. (the "Company") for the years ended December 31, 2016 and 2015, and have issued our report thereon dated March 30, 2017. In connection therewith, we advise you as follows:

a. We are independent certified public accountants with respect to the Company and conform to the standards of the accounting profession as contained in the Code of Professional Conduct and pronouncements of the American Institute of Certified Public Accountants, and the Rules of Professional Conduct of the Alabama, Florida, Georgia, Kentucky, and Tennessee Boards of Public Accountancy.

b. The engagement partner and engagement manager, who are certified public accountants, have 28 years and 11 years, respectively, of experience in public accounting and are experienced in auditing insurance enterprises. Members of the engagement team, most of whom have had experience in auditing insurance enterprises and 70 percent of whom are certified public accountants, were assigned to perform tasks commensurate with their training and experience.

c. We understand that the Company intends to file its audited statutory basis financial statements and our reports thereon with the Insurance Department of Florida and other state insurance departments in states in which the Company is licensed and that the insurance commissioners of those states will be relying on that information in monitoring and regulating the statutory financial condition of the Company.

   While we understand that an objective of issuing a report on the statutory basis financial statements is to satisfy regulatory requirements, our audit was not planned to satisfy all objectives or responsibilities of insurance regulators. In this context, the Company and insurance commissioners should understand that the objective of an audit of statutory basis financial statements in accordance with generally accepted auditing standards is to form an opinion and issue a report on whether the statutory basis financial statements present fairly, in all material respects, the admitted assets, liabilities, and capital and surplus, results of operations and cash flow in conformity with accounting practices prescribed or permitted by the Insurance Department of Florida. Consequently, under generally accepted auditing standards, we have the responsibility, within the inherent limitations of the auditing process, to plan and perform our audit to obtain reasonable assurance about whether the statutory basis financial statements are free of material misstatement, whether caused by error or fraud, and to exercise due professional care in the conduct of the audit. The concept of selective testing of the data being audited, which involves judgment both as to the number of transactions to be audited and the areas to be tested, has been generally accepted as a valid and sufficient basis for an auditor to express an opinion on financial statements. Audit procedures that are effective for detecting errors, if they exist, may be ineffective for detecting misstatements resulting from fraud. Because of the characteristics of fraud, particularly those involving concealment and falsified documentation (including forgery), a properly planned and performed audit may not detect a material misstatement resulting from fraud. In addition, an audit does not address the possibility that material errors or misstatements caused by fraud may occur in the future. Also, our use of professional

judgment and the assessment of materiality for the purpose of our audit means that matters may exist that would have been assessed differently by insurance commissioners.

It is the responsibility of the management of the Company to adopt sound accounting policies, to maintain an adequate and effective system of accounts, and to establish and maintain internal control that will, among other things, provide reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorized use or disposition and that transactions are executed in accordance with management's authorization and recorded properly to permit the preparation of financial statements in conformity with accounting practices prescribed or permitted by the Insurance Department of Florida.

The Insurance Commissioner should exercise due diligence to obtain whatever other information that may be necessary for the purpose of monitoring and regulating the statutory financial position of insurers and should not rely solely upon the independent auditor's report.

d. We will retain audit working papers (including those kept in a hard copy or electronic medium) prepared in compliance with professional standards for seven years from the date that we grant permission to use our report in connection with the issuance of the Company's financial statements (report release date), unless a longer period of time is required by law. After notification to the Company we will make the workpapers available for review by the Insurance Department of Florida at the offices of the insurer, at our offices, at the Insurance Department or at any other reasonable place designated by the Insurance Commissioner. Furthermore, in the conduct of the aforementioned periodic review by the Insurance Department of Florida, photocopies of pertinent audit workpapers may be made (under the control of the accountant) and such copies may be retained by the Insurance Department of Florida. In addition, to the extent requested, we may provide the Insurance Department of Florida with copies of certain of our audit working papers (such as unlocked electronic copies of Excel spreadsheets that do not contain password protection or encryption). As such, these audit working papers will be subject to potential modification by the Insurance Department of Florida or by others. We are not responsible for any modifications made to the copies, electronic or otherwise, after they are provided to the Insurance Department of Florida and we are likewise not responsible for any effect that any such modifications, whether intentional or not, might have on the process, substance or outcome of your regulatory examination.

e. The engagement partner has served in that capacity with respect to the Company since 2015, is licensed by the Alabama, Florida, Georgia, Kentucky, and Tennessee Boards of Public Accountancy, and is a member in good standing of the American Institute of Certified Public Accountants.

f. To the best of our knowledge and belief, we are in compliance with the requirements of Section 7 of the NAIC's *Model Rule (Regulation) Requiring Annual Audited Financial Reports* regarding qualifications of independent certified public accountants.

This letter is intended solely for the information and use of the board of directors and management of the Company and the Insurance Department of Florida and other state insurance departments and is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

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HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2014
OF THE CONDITION AND AFFAIRS OF THE

Humana Medical Plan, Inc.

NAIC Group Code 0119 (Current) 0119 (Prior) NAIC Company Code 95270 Employer's ID Number [redacted] The information on this page is exempt from

Organized under the Laws of Florida, State of Domicile or Port of Entry FL

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes [X] No [ ]

Incorporated/Organized 08/12/1986 Commenced Business 06/01/1987

Statutory Home Office 3501 SW 160th Avenue, Miramar , FL, US 33027
(Street and Number) (City or Town, State, Country and Zip Code)

Main Administrative Office 3501 SW 160th Avenue
(Street and Number)
Miramar , FL, US 33027, 305-626-5616
(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Mail Address P.O. Box 740036, Louisville , KY, US 40201-7436
(Street and Number or P.O. Box) (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 3501 SW 160th Avenue
(Street and Number)
Miramar , FL, US 33027, 305-626-5616
(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Internet Website Address www.humana.com

Statutory Statement Contact Jeremy Denny, 502-580-8298
(Name) (Area Code) (Telephone Number)
DOIINQUIRIES@humana.com, 502-580-2099
(E-mail Address) (FAX Number)

OFFICERS

President & CEO Bruce Dale Broussard
Sr. VP & CFO Brian Andrew Kane #
VP & Corporate Secretary Joan Olliges Lenahan
VP & Appointed Actuary Jonathan Albert Canine

OTHER

Alan James Bailey # VP & Treasurer
John Gregory Catron VP & Chief Compliance Officer
Mark Sobhi El-Tawil # VP & Division Leader-Western Division
Gerald Lawrence Ganoni # President & VP, Small Business & Large Group
Brian Phillip LeClaire Sr VP & Chief Info Officer
Kevin Ross Meriwether # VP & Division Leader-SE Division
Richard Donald Remmers VP, Employer Group Segment
Debra Anne Smith VP-Sr. Prod Strategy & Prod Dev
Joseph Christopher Ventura Assistant Corporate Secretary

John Edward Barger, III Reg Pres-Sr. Prod/Central Florida
Michael Lester Cotton # Vice President
Jeffrey Carl Fernandez # Segment VP, Medicare: West
Roy Goldman Ph.D VP & Chief Actuary
Heidi Suzanne Margulis Sr. Vice President
William Mark Preston # VP-Investment Management
George Renaudin Seg. VP, Medicare: East
Jill Michelle Sumfest M.D. Market Vice President
Timothy Alan Wheatley President-Retail Segment

Elizabeth Diane Bierbower Pres, Employer Group Segment
Steven James DeRaleau President, HumanaOne
Deborah Maureen Galloway Vice President
Charles Frederic Lambert, III Vice President
Steven Edward McCulley # SVP, Medicare Operations
Tamara Lynn Quiram # COO, Small Business & Large Group
Donald Hank Robinson # Vice President-Tax
Fernando Jose Valverde M.D. # Reg. Pres-Sr. Prod/S. Florida
Ralph Martin Wilson Vice President

DIRECTORS OR TRUSTEES

Roy Ainsworth Beveridge M.D. #
Bruce Dale Broussard
James Elmer Murray

State of Kentucky
County of Jefferson SS:

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Bruce Dale Broussard
President & CEO

Joan Olliges Lenahan
VP & Corporate Secretary

Alan James Bailey
VP & Treasurer #

Subscribed and sworn to before me this 20th day of February 2015

Michele Sizemore
Notary Public
January 3, 2019

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number.....
2. Date filed .....
3. Number of pages attached.....

Michele H. Sizemore
State at Large
Kentucky
My Commission Expires Jan. 3, 2019

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HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2015
OF THE CONDITION AND AFFAIRS OF THE

Humana Medical Plan, Inc.

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NAIC Group Code 0119 (Current) 0119 (Prior) NAIC Company Code 95270 Employer's ID Number

Organized under the Laws of Florida, State of Domicile or Port of Entry FL

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes [X] No [ ]

Incorporated/Organized 08/12/1986 Commenced Business 06/01/1987

Statutory Home Office 3501 SW 160th Avenue (Street and Number), Miramar , FL, US 33027 (City or Town, State, Country and Zip Code)

Main Administrative Office 3501 SW 160th Avenue (Street and Number)
Miramar , FL, US 33027 (City or Town, State, Country and Zip Code), 305-626-5616 (Area Code) (Telephone Number)

Mail Address P.O. Box 740036 (Street and Number or P.O. Box), Louisville , KY, US 40201-7436 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 3501 SW 160th Avenue (Street and Number)
Miramar , FL, US 33027 (City or Town, State, Country and Zip Code), 305-626-5616 (Area Code) (Telephone Number)

Internet Website Address www.humana.com

Statutory Statement Contact Jeremy Denny (Name), 502-580-8298 (Area Code) (Telephone Number)
DOIINQUIRIES@humana.com (E-mail Address), 502-580-2099 (FAX Number)

OFFICERS

President & CEO Bruce Dale Broussard
Sr. VP & CFO Brian Andrew Kane
VP & Corporate Secretary Joan Olliges Lenahan
VP & Chief Actuary Kenny Waitem Kan #

OTHER

Stephen Michael Arnhold #, Vice President
Alan James Bailey, VP & Treasurer
John Edward Barger, III, VP of Dual Eligible & Medicaid Programs
Elizabeth Diane Bierbower, Pres, Group Segment
Renee Jacqueline Buckingham, VP & Div. Leader - Eastern Division
Jonathan Albert Canine, VP & Appointed Actuary
John Gregory Catron, VP & Chief Compliance Officer
Steven James DeRaleau, President, HumanaOne
Mark Sobhi El-Tawil, VP & Division Leader-Western Division
Jeffrey Carl Fernandez, Segment VP, Medicare: West
Louis Manuel Fernandez M.D. #, VP & Chief Medical Officer
Deborah Maureen Galloway, Reg. Pres.-Sr. Products/Central Florida
James Burnett Laughlin III #, Reg. Pres-Sr. Products/Southeast Region
Brian Phillip LeClaire, Sr VP & Chief Info Officer
Heidi Suzanne Margulis, Sr. Vice President
Steven Edward McCulley, SVP, Medicare Operations
Kevin Ross Meriwether, VP & Division Leader-Southeastern Div.
William Mark Preston, VP-Investment Management
Tamara Lynn Quiram, Seg. VP & Pres., Small Business & Large Group
Richard Donald Remmers, VP, Group Segment
George Renaudin, Seg. VP, Medicare: East
Donald Hank Robinson, Vice President-Tax
Fernando Jose Valverde M.D., Reg. Pres-Sr. Products/South Florida
Joseph Christopher Ventura, Assistant Corporate Secretary
Timothy Alan Wheatley, President-Retail Segment
Ralph Martin Wilson, Vice President
Cynthia Hillebrand Zipperle #, VP & Chief Accounting Officer

DIRECTORS OR TRUSTEES

Bruce Dale Broussard
Brian Andrew Kane #
James Elmer Murray

State of Kentucky
County of Jefferson SS:

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Bruce Dale Broussard
President & CEO

Joan Olliges Lenahan
VP & Corporate Secretary

Alan James Bailey
VP & Treasurer

Subscribed and sworn to before me this 22nd day of February, 2016

Michele Sizemore
Notary Public
January 3, 2019

Michele H. Sizemore
Notary Public at Large
Kentucky
My Commission Expires Jan. 3, 2019

a. Is this an original filing? ..... Yes [X] No [ ]
b. If no,
1. State the amendment number.....
2. Date filed .....
3. Number of pages attached.....

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FOR THE YEAR ENDED DECEMBER 31, 2016
OF THE CONDITION AND AFFAIRS OF THE

Humana Medical Plan, Inc.

NAIC Group Code 0119 (Current) 0119 (Prior) NAIC Company Code 95270 Employer's ID Number [redacted]

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Internet Website Address www.humana.com

Statutory Statement Contact Jeremy Denny (Name), 502-580-8298 (Area Code) (Telephone Number)
DOIINQUIRIES@humana.com (E-mail Address), 502-580-2099 (FAX Number)

OFFICERS

President & CEO	Bruce Dale Broussard	Sr. VP & CFO	Brian Andrew Kane
VP & Corporate Secretary	Joan Olliges Lenahan	VP & Chief Actuary	Kenny Waitem Kan

OTHER

Stephen Michael Arnhold, Vice President	Alan James Bailey, VP & Treasurer	John Edward Barger, III, VP of Dual Eligible & Medicaid Programs
Elizabeth Diane Bierbower, Pres, Group Segment	Renee Jacqueline Buckingham, VP & Div. Leader - Eastern Division	Jonathan Albert Canine, VP & Appointed Actuary
John Gregory Catron, VP & Chief Compliance Officer	Douglas Edwards #, Vice President	Mark Sobhi El-Tawil, VP & Division Leader-Western Division
Jeffrey Carl Fernandez, Segment VP, Medicare: West	Louis Manuel Fernandez M.D., VP & Chief Medical Officer	Deborah Maureen Galloway, Reg. Pres.-Sr. Products/Central Florida
James Burnett Laughlin III, Reg. Pres-Sr. Products/Southeast Region	Brian Phillip LeClaire, Ph.D., Sr VP & Chief Info Officer	Heidi Suzanne Margulis, Sr. Vice President
Steven Edward McCulley, SVP, Medicare Operations	Kevin Ross Meriwether, VP & Division Leader-Southeastern Div.	William Mark Preston, VP-Investment Management
Tamara Lynn Quiram, Seg. VP & Pres., Small Business & Large Group	Richard Donald Remmers, VP, Group Segment	George Renaudin II, Seg. VP, Medicare: East
Donald Hank Robinson, Vice President-Tax	Fernando Jose Valverde M.D., Reg. Pres-Sr. Products/South Florida	Joseph Christopher Ventura, Vice President and Assistant Corporate Secretary
Timothy Alan Wheatley, President-Retail Segment	Ralph Martin Wilson, Vice President	Tod James Zacharias #, Vice President
Cynthia Hillebrand Zipperle, VP & Chief Accounting Officer		

DIRECTORS OR TRUSTEES

Bruce Dale Broussard	Brian Andrew Kane	James Elmer Murray

State of Kentucky
County of Jefferson SS:

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2014 Annual Report

Closing the gap between people and care

Humana®

GCHJ7KTEN 0215

Humana Inc. Financial Highlights

(dollars in millions, except per common share results)

	2014	2013	2012	2011	2010
Operating Results					
Revenues	$48,500	$41,313	$39,126	$36,832	$33,596
Net income	$1,147	$1,231	$1,222	$1,419	$1,099
Diluted earnings per common share	$7.36	$7.73	$7.47	$8.46	$6.47
Financial Position					
Total assets	$23,466	$20,735	$19,979	$17,708	$16,103
Total liabilities	$13,820	$11,419	$11,132	$9,645	$9,179
Total shareholder equity	$9,646	$9,316	$8,847	$8,063	$6,924
Cash Flow from Operations	$1,618	$1,716	$1,923	$2,079	$2,242
Membership by Segment (in thousands)					
Retail Segment					
Medical membership	7,882.3	6,026.0	5,553.8	4,795.0	3,681.9
Specialty membership	1,165.8	1,042.5	948.7	782.5	510.0
Employer Group Segment					
Medical membership	2,834.0	2,833.1	2,852.4	2,794.9	3,009.5
Specialty membership	6,502.7	6,780.8	7,136.2	6,532.6	6,517.5
Other Businesses					
Medical membership	3,125.4	3,125.2	3,682.6	3,594.7	3,595.2
Consolidated					
Medical membership	13,841.7	11,984.3	12,088.8	11,184.6	10,286.6
Specialty membership	7,668.5	7,823.3	8,084.9	7,315.1	7,027.5

Top awards and recognition in 2014

Easiest health care company for providers to do business with

#1 overall performance

#1 speed of paying health care providers

Athenahealth PayerView rankings 2013 and 2014

Awards for hiring and supporting veterans

Secretary of Defense Freedom Award

Top 10 Best for Vets Employer
- Military Times

Most Valuable Employer for Military
- CivilianJobs.com

Outstanding Veteran Employer
- VetJobs.com

Fit-Friendly Worksite

Platinum Award, 2014

American Heart Association

Corporate responsibility

One of the Best 100 Corporate Citizens

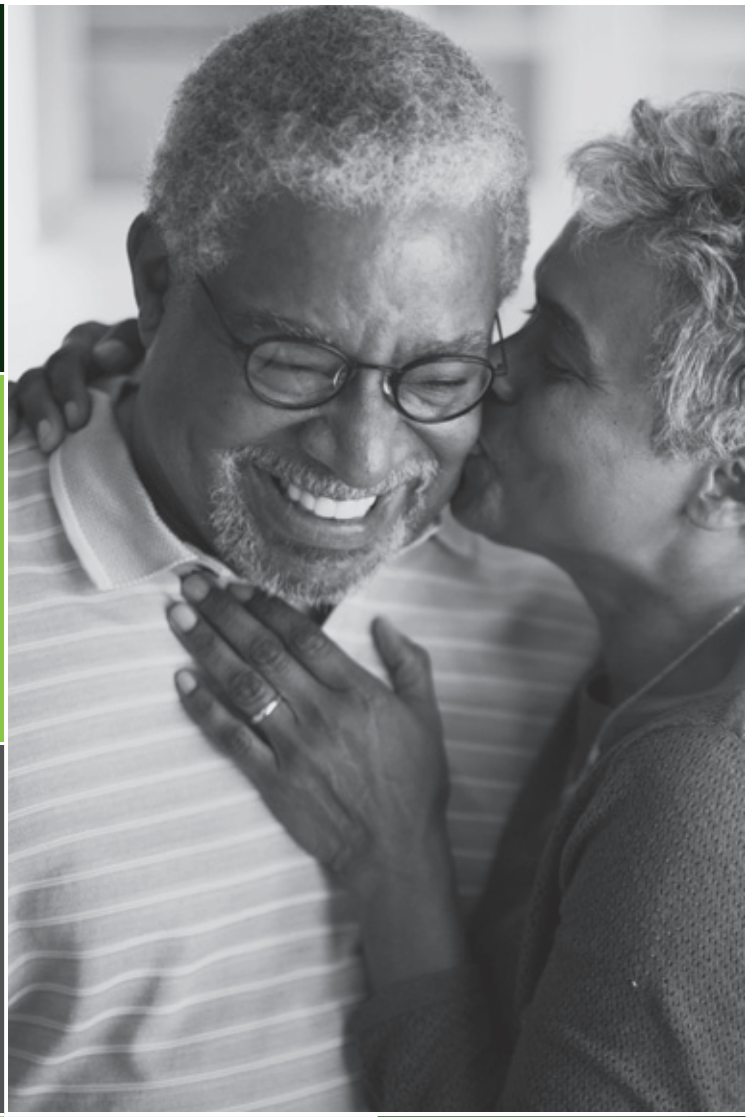
Environment, human rights, philanthropy, employee relations

CR Magazine, 2014

Accolades for diversity

Human Rights Campaign's Corporate Equity Index

DiversityInc's Top 25 Noteworthy Companies



Best Employers for Healthy Lifestyles

Platinum, 2014

National Business Group on Health

Recognized 8 years in a row for sustainability

Dow Jones Sustainability Indices

RobecoSAM Gold Class Distinction

Carbon Disclosure Project

FTSE4Good Index

Newsweek Green Rankings

Best U.S. Healthcare Company to Work for

Diversity, inclusion, military-friendly, health coaching, financial policies and more

Global Healthcare Magazine, 2014

2013 Finalist, GBCHealth Award

For TeamUp4Health, a program that showed how small groups of committed individuals can impact the health of their community

Bruce Broussard, Director, President and Chief Executive Officer and Kurt Hilzinger, Chairman of the Board of Directors

Dear fellow stockholders,

In an environment of rapid change, Humana continued in 2014 to refine and enhance our integrated care delivery model. Specifically, we made significant progress in: 1) building trusting relationships with our members through improving the customer experience, 2) engaging our members in clinical programs based on these trusting relationships, and 3) offering assistance to providers in transitioning from fee-for-service to value-based reimbursement. This was accomplished by putting our nearly 14 million medical members at the center of the healthcare equation and surrounding them with up-to-the-minute technology, data analytics, and vibrant partnerships with thousands of Humana-affiliated physicians and other health professionals who are dedicated to a single goal – making it easy for people to achieve their best health.

Why easy? One of the many curious aspects of healthcare in the U.S. is that, despite all the attention paid to the obesity epidemic and the growing prevalence of preventable diseases, as a society and as an industry we've made achieving and maintaining health hard. The fact is, if you want to eat right and live a healthy lifestyle, you have to work at it. And if you need help in improving your health or managing an illness, the complexity and countless other barriers presented by the health industry can often be nearly impossible to navigate and overcome.

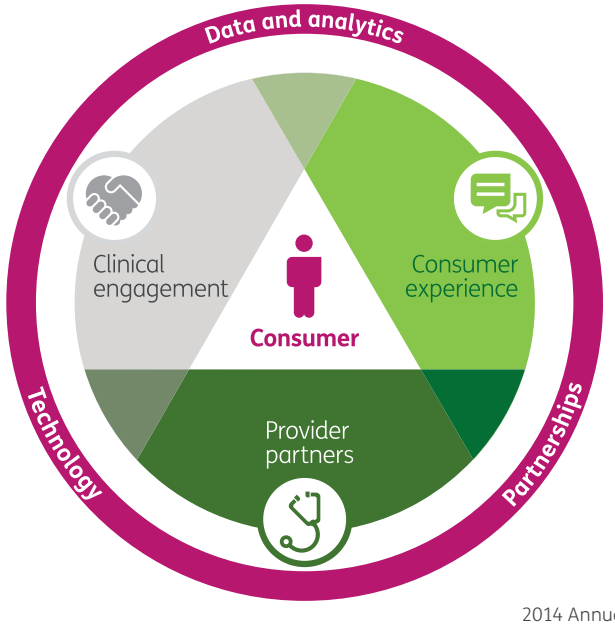
It doesn't have to be this way. Health should be easy to achieve, not hard. The good news is that we're gradually realigning a health system that's vastly out of balance. For example, according to the Bipartisan Policy Center, 50 percent of what ***makes*** us healthy is our own behaviors. But what we ***spend*** on healthy behaviors is only 4 percent of the nation's total healthcare bill each year.

Our commitment

This disconnect is the gap between people and the rational, evidence-based, and simple medical care they deserve. In fact, at Humana we are dedicated to "closing the gap between people and care." To keep us on track and accountable, we've committed to improving the health of the communities we serve by making it easy for people to achieve their best health.

Integrated care makes it easy for people to achieve their best health

Our Integrated Care Delivery Model



Total Medicare Advantage membership **increased**

18%

to 2.9 million members

Total Medicare stand-alone Prescription Drug Plan membership **increased**

22%

to 4.0 million members

HumanaOne membership more than doubled to approximately

1 million members

State-based contract membership growth more than tripled to approximately

300,000 members

This transformative work is consistent with Humana's own ongoing transformation. From a traditional health insurer with an episodic, claims-based relationship with our customers, we're becoming a health company dedicated to co-creating improved health with our members through a closer relationship with them. We're working to better understand the challenges of managing chronic conditions – such as diabetes and congestive heart failure – to help people modify their lifestyles and improve their lives. Additionally, we're putting technologically driven tools at our members' disposal – and in the hands of our hundreds of thousands of physician-partners – along with sophisticated data analytics to help them achieve their best health.

At the center of this new clinical model is not the health plan, but the person. To that end, Humana is committed to becoming a consumer-focused health company, providing integrated care that makes it easy for people to achieve their best health through outstanding clinical capabilities and a personalized consumer experience.

Results so far

How are we doing, in light of our commitment? Humana's consumer-focused strategy and integrated care delivery model facilitated a number of accomplishments this past year, while we simultaneously invested in new growth areas. These accomplishments included:

Wellness and prevention

- 62 percent of our new Medicare Advantage members for 2014 had wellness screenings via a Health Risk Assessment
- 1.3 million of our medical members received their preventive care on schedule

Primary care engagement

- We continued to make meaningful progress in improving our Star quality ratings, with 92 percent of individual Medicare Advantage members in 4 Star or greater rated plans, up from 60 percent in the previous year
- We increased the number of primary care providers in value-based relationships by 26 percent to over 42,000 at the end of 2014

Home health

- We grew the number of our members engaged in the Humana Chronic Care Program by 50 percent, significantly outpacing our total Medicare Advantage membership growth of 18 percent
- Our Chronic Care Program enabled newly-managed members to have 496,000 more days at home by reducing hospitalizations

Associate engagement and health

- We achieved world-class associate engagement for the first time, with results in the 91st percentile
- Forty percent of our associates have improved their health profile since 2012, reducing their modifiable health risks such as high body mass index (BMI), blood pressure, and glucose levels, and losing an aggregate of 97 tons

The beneficial effect of these and other consumer-focused components of our strategy allowed us to maintain stable member benefits and premiums for many of our members across the nation. At the same time, we entered into two new areas of growth for 2014 and the future: healthcare exchanges and state-based contracts. Because of these initiatives, medical membership grew substantially and our financial metrics improved.

Membership growth

- Total Medicare Advantage membership increased 18 percent to 2.9 million members
- Total Medicare stand-alone Prescription Drug Plan membership increased 22 percent to 4.0 million members
- HumanaOne membership more than doubled to approximately 1 million members
- State-based contract membership growth more than tripled to approximately 300,000 members

Financial results

- Healthcare Services segment revenues grew 26 percent to $20 billion
- Consolidated pretax earnings increased 13 percent though net income was challenged by a dramatic rise in our income tax rate due to the non-deductibility of the health insurance industry fee
- We rededicated ourselves to focusing on return on invested capital (ROIC) across all our lines of business, enhancing our alignment with the interests of our investors

The future

In conclusion, we believe the elements we've described come together to form a powerful investment thesis for shareholders:

- Continued robust organic membership and revenue growth,
- Proven superior clinical operating performance, and
- Disciplined capital allocation, which all lead to
- A sustainable competitive advantage.

We continue to be pleased with Humana's prospects as we further develop and implement our strategy. The engagement of our associates and focus on the consumer through our Integrated Care Delivery Model have never been stronger. Humana believes it's not enough just to try to close the gap between people and care. We believe in the accountability that comes from "a dream with a deadline." But we also know we can't do it alone. We eagerly invite partnerships from all like-minded groups and individuals in the communities we serve, to make a positive, enduring difference in people's health and lives.

Sincerely,

Kurt J. Hilzinger
Chairman of the Board and Stockholder

Bruce D. Broussard
Director, President and Chief Executive Officer and Stockholder

Diluted Earnings per Common Share

** Includes $0.99 per share of benefits expense for our closed block long-term care insurance policies reserve strengthening.*

***Includes $0.15 per share of expense related to early retirement of debt.*

73%
Humana Chronic Care Program (HCCP) engagement rate

496k **more days at home**
for our newly managed HCCP members

Back row left to right: James J. O'Brien, Frank A. D'Amelio, David A. Jones, Jr., William E. Mitchell, David B. Nash, M.D., Kurt J. Hilzinger. Front row left to right: W. Roy Dunbar, Bruce D. Broussard, William J. McDonald, Marissa T. Peterson

Board of Directors

Kurt J. Hilzinger
Chairman of the Board
Humana Inc.
Partner
Court Square Capital Partners, LP

Bruce D. Broussard
President and Chief Executive Officer
Humana Inc.

Frank A. D'Amelio
Executive Vice President,
Business Operations and
Chief Financial Officer
Pfizer Inc.

W. Roy Dunbar
Former Chairman of the Board
NetworkSolutions

David A. Jones, Jr.
Chairman
Chrysalis Ventures, LLC

William J. McDonald
Managing Partner
Wild Irishman Advisory, LLC

William E. Mitchell
Managing Partner
Sequel Capital Management, LLC

David B. Nash, M.D.
Founding Dean
Jefferson School of Population Health
Thomas Jefferson University

James J. O'Brien
Former Chairman of the Board and
Chief Executive Officer
Ashland Inc.

Marissa T. Peterson
President and Chief Executive Officer
Mission Peak Executive Coaching

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2014
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number 1-5975

HUMANA INC.
(Exact name of registrant as specified in its charter)

Delaware	**61-0647538**
(State of incorporation)	**(I.R.S. Employer Identification Number)**
500 West Main Street Louisville, Kentucky	**40202**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (502) 580-1000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of exchange on which registered**
Common stock, $0.16 2/3 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2014 was $19,712,008,342 calculated using the average price on June 30, 2014 of $128.11.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2015 was 149,607,897.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 16, 2015.

HUMANA INC.
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For the Year Ended December 31, 2014

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Forward-Looking Statements

Some of the statements under "Business," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere in this report may contain forward-looking statements which reflect our current views with respect to future events and financial performance. These forward-looking statements are made within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, or the Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including the information discussed under the section entitled "Risk Factors" in this report. In making these statements, we are not undertaking to address or update them in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Humana," is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. As of December 31, 2014, we had approximately 13.8 million members in our medical benefit plans, as well as approximately 7.7 million members in our specialty products. During 2014, 73% of our total premiums and services revenue were derived from contracts with the federal government, including 15% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 542,400 members as of December 31, 2014.

Humana Inc. was organized as a Delaware corporation in 1964. Our principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202, the telephone number at that address is (502) 580-1000, and our website address is www.humana.com. We have made available free of charge through the Investor Relations section of our web site our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

This Annual Report on Form 10-K, or 2014 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2014 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Implementation dates of the Health Care Reform Law began in September 2010 and will continue through 2018, and many aspects of the Health Care Reform Law are already effective and have been implemented by us. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, an annual insurance industry premium-based assessment, and a three-year commercial reinsurance fee. The

Health Care Reform Law is discussed more fully in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Care Reform."

Business Segments

On January 1, 2014, we reclassified certain of our businesses from our Healthcare Services segment to our Employer Group segment to correspond with internal management reporting changes. Our reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. See Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for segment financial information.

We manage our business with three reportable segments: Retail, Employer Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, generally require a referral from the member's primary care provider before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. However PPOs generally require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy, provider, home based, and integrated wellness services. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2014:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 25,941	53.9%
Medicare stand-alone PDP	3,396	7.1%
Total Retail Medicare	29,337	61.0%
Individual commercial	3,265	6.8%
State-based Medicaid	1,096	2.3%
Individual specialty	256	0.4%
Total premiums	33,954	70.5%
Services	39	0.1%
Total premiums and services revenue	$ 33,993	70.6%

Individual Medicare

We have participated in the Medicare program for private health plans for over 30 years and have established a national presence, offering at least one type of Medicare plan in all 50 states. We have a geographically diverse membership base that we believe provides us with greater ability to expand our network of PPO and HMO providers. We employ strategies including health assessments and clinical guidance programs such as lifestyle and fitness programs for seniors to guide Medicare beneficiaries in making cost-effective decisions with respect to their health care. We believe these strategies result in cost savings that occur from making positive behavior changes.

Medicare is a federal program that provides persons age 65 and over and some disabled persons under the age of 65 certain hospital and medical insurance benefits. CMS, an agency of the United States Department of Health and Human Services, administers the Medicare program. Hospitalization benefits are provided under Part A, without the payment of any premium, for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Eligible beneficiaries are required to pay an annually adjusted premium to the federal government to be eligible for physician care and other services under Part B. Beneficiaries eligible for Part A and Part B coverage under traditional fee-for-service Medicare are still required to pay out-of-pocket deductibles and coinsurance. Throughout this document this program is referred to as Medicare FFS. As an alternative to Medicare FFS, in geographic areas where a managed care organization has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a Medicare Advantage organization under Medicare Part C. Pursuant to Medicare Part C, Medicare Advantage organizations contract with CMS to offer Medicare Advantage plans to provide benefits at least comparable to those offered under Medicare FFS. Our Medicare Advantage plans are discussed more fully below. Prescription drug benefits are provided under Part D.

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, and Private Fee-For-Service, or PFFS, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data analysis techniques to help identify member needs, complex case management, tools to guide

members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

Our Medicare HMO and PPO plans, which cover Medicare-eligible individuals residing in certain counties, may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations or as specified by the plan, most HMO plans provide no out-of-network benefits. PPO plans carry an out-of network benefit that is subject to higher member cost-sharing. In some cases, these beneficiaries are required to pay a monthly premium to the HMO or PPO plan in addition to the monthly Part B premium they are required to pay the Medicare program.

Most of our Medicare PFFS plans are network-based products with in and out of network benefits due to a requirement that Medicare Advantage organizations establish adequate provider networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. In these areas, we offer Medicare PFFS plans that have no preferred network. Individuals in these plans pay us a monthly premium to receive typical Medicare Advantage benefits along with the freedom to choose any health care provider that accepts individuals at rates equivalent to Medicare FFS payment rates.

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits and Improvement Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines.

At December 31, 2014, we provided health insurance coverage under CMS contracts to approximately 2,446,200 individual Medicare Advantage members, including approximately 542,400 members in Florida. These Florida contracts accounted for premiums revenue of approximately $7.2 billion, which represented approximately 27.8% of our individual Medicare Advantage premiums revenue, or 15.0% of our consolidated premiums and services revenue for the year ended December 31, 2014.

Our HMO, PPO, and PFFS products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2015, and all of our product offerings filed with CMS for 2015 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP plan co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Medicare Part D Provisions." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2015, and all of our product offerings filed with CMS for 2015 have been approved.

We have administered CMS's Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program since 2010. This program allows individuals who receive Medicare's low-income subsidy to also receive immediate prescription drug coverage at the point of sale if they are not already enrolled in a Medicare Part D plan. CMS temporarily enrolls newly identified individuals with both Medicare and Medicaid into the LI-NET prescription drug plan program, and subsequently transitions each member into a Medicare Part D plan that may or may not be a Humana Medicare plan.

Medicare and Medicaid Dual Eligible and Long-Term Care Support Services

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. There were approximately 9.6 million dual eligible individuals in the United States in 2014, trending upward due to Medicaid eligibility expansions and individuals aging into the Medicare program. These dual eligibles may enroll in a privately-offered Medicare Advantage product, but may also receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. The dual eligible population is a strategic area of focus for us and we are leveraging the capabilities of our integrated care delivery model, including care management programs particularly as they relate to chronic conditions, to expand our services to this population. As of December 31, 2014, we served approximately 404,000 dual eligible members in our Medicare Advantage plans and approximately 992,000 dual eligible members in our stand-alone prescription drug plans.

Since the enactment of the Health Care Reform Law, states are pursuing stand-alone dual eligible CMS demonstration programs in which Medicare, Medicaid, and Long-Term Care Support Services (LTSS) benefits are more tightly integrated. Eligibility for participation in these stand-alone dual eligible demonstration programs may require state-based contractual relationships in existing Medicaid programs. We were successful in our bids for state-based contracts in Florida and Virginia in 2013 and in Ohio, Illinois, and Kentucky in 2012. Ohio, Illinois, and Virginia are contracts for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the state-based Medicaid program. We began serving members in Illinois in the first quarter of 2014 and in Virginia in the second quarter of 2014. We partner with organizations, including CareSource Management Group Company, to serve individuals in certain states. We began serving members in Kentucky and certain LTSS regions in Florida at various effective dates ranging from the second half of 2013 through the first quarter of 2014.

LTSS eligible beneficiaries heavily overlap with the dual eligible population. On September 6, 2013, we acquired American Eldercare Inc., or American Eldercare, the largest provider of nursing home diversion services in the state of Florida, serving frail and elderly individuals in home and community-based settings. American Eldercare complements our core capabilities and strength in serving seniors and disabled individuals with a unique focus on individualized and integrated care, and has contracts to provide Medicaid long-term support services across the entire state of Florida. The enrollment effective dates for the various regions ranged from August 2013 to March 2014.

Individual Commercial Coverage

Our individual health plans are marketed under the HumanaOne® brand. We offer products both on and off of the public exchange, including exchange offerings in certain metropolitan areas in 15 states. We offer products on exchanges where we can achieve an affordable cost of care, including HMO offerings and select networks in most markets. Our off-exchange products offered in 22 states are primarily PPO and POS offerings, including plans issued prior to 2014 that were previously underwritten. Policies issued prior to the enactment of the Health Care Reform Law on March 23, 2010 are grandfathered policies. Grandfathered policies are exempt from most of the requirements of the Health Care Reform Law, including mandated benefits. However, our grandfathered plans include provisions that guarantee renewal of coverage for as long as the individual chooses. Policies issued between March 23, 2010 and December 31, 2013 are required to conform to the Health Care Reform Law, including mandated benefits, upon renewal in 2014, 2015 or 2016, depending on the state.

Prior to 2014, our HumanaOne® plans primarily were offered as PPO plans in 27 states where we could generally underwrite risk and utilize our existing networks and distribution channels. As indicated above, this individual product included provisions mandated by law to guarantee renewal of coverage for as long as the individual chooses.

Rewards-based wellness programs are included with many individual products. We also offer optional benefits such as dental, vision, life, and a portfolio of financial protection products.

Employer Group Segment Products

This segment is comprised of products sold to employer groups including medical and supplemental benefit plans as well as health and wellness products as described in the discussion that follows. The following table presents our premiums and services revenue for the Employer Group segment by product for the year ended December 31, 2014:

	Employer Group Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Group Medicare Advantage	$ 5,490	11.4%
Group Medicare stand-alone PDP	8	—%
Total group Medicare	5,498	11.4%
Fully-insured commercial group	5,339	11.1%
Group specialty	1,098	2.3%
Total premiums	11,935	24.8%
Services	362	0.8%
Total premiums and services revenue	$ 12,297	25.6%
Intersegment services revenue:		
Wellness	$ 78	n/a
Total intersegment services revenue	$ 78	

n/a – not applicable

Employer Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts. We participate in the Federal Employee Health Benefits

Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government's health insurance program for Federal employees, retirees, former employees, family members, and spouses. As with our individual commercial products, the employer group offerings include HumanaVitality®, our wellness and loyalty reward program.

Our administrative services only, or ASO, products are offered to employers who self-insure their employee health plans. We receive fees to provide administrative services which generally include the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded employers. These products may include all of the same benefit and product design characteristics of our fully-insured HMO, PPO, or POS products described previously. Under ASO contracts, self-funded employers generally retain the risk of financing substantially all of the cost of health benefits. However, more than half of our ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

As with individual commercial policies, employers can customize their offerings with optional benefits such as dental, vision, life, and a portfolio of voluntary benefit products.

Group Medicare Advantage and Medicare stand-alone PDP

We offer products that enable employers that provide post-retirement health care benefits to replace Medicare wrap or Medicare supplement products with Medicare Advantage or stand-alone PDPs from Humana. These products offer the same types of benefits and services available to members in our individual Medicare plans discussed previously and can be tailored to closely match an employer's post-retirement benefit structure.

Wellness

We offer wellness solutions including our Humana Vitality® wellness and loyalty rewards program, health coaching, and clinical programs. These programs, when offered collectively to employer customers as our Total Health product, turn any standard plan of the employer's choosing into an integrated health and well-being solution that encourages participation in these programs.

Our Humana Vitality® program provides our members with access to a science-based, actuarially driven wellness and loyalty program that features a wide range of well-being tools and rewards that are customized to an individual's needs and wants. A key element of the program includes a sophisticated health-behavior-change model supported by an incentive program.

We also provide employee assistance programs and coaching services including a comprehensive turn-key coaching program, an enhancement to a medically based coaching protocol and a platform that makes coaching programs more efficient.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, home based services, integrated behavioral health services, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2014:

	Healthcare Services Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 16,905	n/a
Provider services	1,110	n/a
Home based services	585	n/a
Integrated behavioral health services	133	n/a
Total intersegment revenue	$ 18,733	
External services revenue:		
Provider services	$ 1,076	2.3%
Home based services	107	0.2%
Pharmacy solutions	99	0.2%
Integrated behavioral health services	—	—%
Total external services revenue	$ 1,282	2.7%

n/a – not applicable

Pharmacy solutions

Humana Pharmacy Solutions®, or HPS, manages traditional prescription drug coverage for both individuals and employer groups in addition to providing a broad array of pharmacy solutions. HPS also operates prescription mail order services for brand, generic, and specialty drugs and diabetic supplies through RightSourceRx®, as well as research services.

Provider services

Our subsidiary, Concentra Inc.®, acquired in 2010, delivers occupational medicine, urgent care, physical therapy, and wellness services to employees and the general public through its operation of medical centers and worksite medical facilities.

Our CAC Medical Centers, or CAC, in South Florida operate full-service, multi-specialty medical centers staffed by primary care providers and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry.

Our subsidiary, Metropolitan Health Networks, Inc., or Metropolitan, and our noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, both acquired in 2012, are Medical Services Organizations, or MSOs, that coordinate medical care for Medicare Advantage beneficiaries and Medicaid recipients, primarily in Florida and Texas. These MSOs represent key components of our integrated care delivery model which we believe is scalable to new markets.

Home based services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Home based services include the operations of Humana At Home, Inc., or Humana At Home® (formerly known as SeniorBridge Family Companies, Inc.), acquired in 2012. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies, such as Florida, with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home® is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility.

Integrated behavioral health services

Corphealth, Inc. (d/b/a LifeSynch®), a Humana subsidiary, offers care management, behavioral health services and wellness programs.

Other Businesses

Products and services offered by our Other Businesses are described in the discussion that follows. The following table presents our premiums and services revenue for our Other Businesses for the year ended December 31, 2014:

	Other Businesses Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Military services	$ 19	—%
Closed-block long-term care insurance policies	51	0.1%
Total premiums	70	0.1%
Services	481	1.0%
Total premiums and services revenue	$ 551	1.1%

Military Services

Under our TRICARE South Region contract with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. On April 1, 2012, we began delivering services under our current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. Under the current contract, we provide administrative services while the federal government retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement.

Closed Block of Long-Term Care Insurance Policies

We have a non-strategic closed block of approximately 32,700 long-term care insurance policies associated with our acquisition of KMG America Corporation in 2007. Long-term care insurance policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block and we are evaluating strategic alternatives for this business.

Informatics

Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We believe that technology represents a significant opportunity in health care that positively impacts our members. We have enhanced our health information technology capabilities enabling us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews millions of clinical data points each day to provide members, providers, and payers real-time clinical insights and gaps-in-care data to improve health outcomes, as well as technology that allows disparate electronic health record systems and Humana to share data that gives providers a comprehensive view of the patient and enables the exchange of essential health information in real-time. As we have integrated these and related assets into our operations over the past few years, we have enhanced our ability to leverage predictive modeling capabilities that enable us to anticipate, rather than react to, our members' health needs. To that end, we have accelerated our process for identifying and reaching out to members in need of clinical intervention. At December 31, 2014, we had approximately 420,700 members with complex chronic conditions in the Humana Chronic Care Program,

a 50.1% increase compared with approximately 280,200 members at December 31, 2013, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Membership

The following table summarizes our total medical membership at December 31, 2014, by market and product:

	Retail Segment				Employer Group Segment					
	(in thousands)									
	Individual Medicare Advantage	Individual Medicare stand-alone PDP	Individual Commercial	State-based contracts	Fully-insured commercial Group	Group Medicare Advantage and stand-alone PDP	ASO	Other Businesses	Total	Percent of Total
Florida	542.4	300.6	252.7	293.7	189.7	22.6	28.3	—	1,630.0	11.8%
Texas	184.0	258.5	181.6	—	238.6	63.2	118.2	—	1,044.1	7.5%
Kentucky	74.5	185.6	27.3	—	101.8	81.0	472.1	—	942.3	6.8%
Georgia	92.8	90.3	286.4	—	140.8	2.4	15.8	—	628.5	4.5%
Ohio	81.3	121.1	21.9	—	48.6	151.0	139.0	—	562.9	4.1%
Illinois	83.9	126.1	28.8	4.8	108.1	11.6	90.3	—	453.6	3.3%
California	38.4	378.9	9.6	—	0.1	0.1	—	—	427.1	3.1%
Wisconsin	51.5	80.2	11.7	—	89.4	14.2	113.3	—	360.3	2.6%
Missouri/Kansas	82.2	175.6	14.3	—	53.3	5.0	6.9	—	337.3	2.4%
Tennessee	119.6	87.6	27.8	—	50.5	2.2	39.5	—	327.2	2.4%
Louisiana	127.9	50.1	22.7	—	63.1	10.5	30.4	—	304.7	2.2%
North Carolina	79.6	139.9	5.9	—	—	37.4	—	—	262.8	1.9%
Virginia	131.6	104.8	7.7	—	—	3.9	—	—	248.0	1.8%
Indiana	71.9	99.6	14.3	—	22.0	3.9	19.5	—	231.2	1.7%
Michigan	49.1	113.3	34.1	—	8.8	13.8	3.7	—	222.8	1.6%
Colorado	31.2	75.3	35.1	—	24.3	7.3	0.4	—	173.6	1.3%
Arizona	56.2	65.2	18.6	—	29.4	1.5	1.5	—	172.4	1.2%
Military services	—	—	—	—	—	—	—	3,090.4	3,090.4	22.3%
Others	548.1	1,536.8	147.6	—	67.0	62.6	25.4	35.0	2,422.5	17.5%
Totals	2,446.2	3,989.5	1,148.1	298.5	1,235.5	494.2	1,104.3	3,125.4	13,841.7	100.0%

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers whom we employ or with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care providers, specialist physicians, dentists, and providers of ancillary health care services and facilities. These ancillary services and facilities include laboratories, ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

We use a variety of techniques to provide access to effective and efficient use of health care services for our members. These techniques include the coordination of care for our members, product and benefit designs, hospital inpatient management systems, the use of sophisticated analytics, and enrolling members into various care management programs. The focal point for health care services in many of our HMO networks is the primary care provider who, under contract with us, provides services to our members, and may control utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. Some physicians may have arrangements under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met.

We have available care management programs related to complex chronic conditions such as congestive heart failure and coronary artery disease. We also have programs for prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate or diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

Our contracts with physicians typically are renewed automatically each year, unless either party gives written notice, generally ranging from 90 to 120 days, to the other party of its intent to terminate the arrangement. Most of the physicians in our PPO networks and some of our physicians in our HMO networks are reimbursed based upon a fixed fee schedule, which typically provides for reimbursement based upon a percentage of the standard Medicare allowable fee schedule.

The terms of our contracts with hospitals and physicians may also vary between Medicare and commercial business. A significant portion of our Medicare network contracts, including those with both hospitals and physicians, are tied to Medicare reimbursement levels and methodologies.

Automatic reductions to the federal budget, known as sequestration, took effect on April 1, 2013, including aggregate reductions to Medicare payments to providers of up to 2% per fiscal year. Due to the uncertainty around the application of these reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs. See "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Capitation

We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. For some of our medical membership, we share risk with providers under capitation contracts where physicians and hospitals accept varying levels of financial risk for a defined set of membership, primarily HMO membership. Under the typical capitation arrangement, we prepay these providers a monthly fixed-fee per member, known as a capitation (per capita) payment, to cover all or a defined portion of the benefits provided to the capitated member.

We believe these risk-based models represent a key element of our integrated care delivery model at the core of our strategy. Our health plan subsidiaries may enter into these risk-based contracts with third party providers or our owned provider subsidiaries.

At December 31, 2014, approximately 883,000 members, or 6.4% of our medical membership, were covered under risk-based contracts, including 709,000 individual Medicare Advantage members, or 29.0% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and monitor the financial performance and solvency of our capitated providers. However, we delegated claim processing functions under capitation arrangements covering approximately 141,200 HMO members, including 113,200 individual Medicare Advantage members, or 16.0% of the 709,000 individual Medicare Advantage members covered under risk-based contracts at December 31, 2014, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the

underlying claims experience was approximately $833 million, or 2.2% of total benefits expense, for the year ended December 31, 2014. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Sets, or HEDIS, which is used by employers, government purchasers and the National Committee for Quality Assurance, or NCQA, to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Providers participating in our networks must satisfy specific criteria, including licensing, patient access, office standards, after-hours coverage, and other factors. Most participating hospitals also meet accreditation criteria established by CMS and/or the Joint Commission on Accreditation of Healthcare Organizations.

Recredentialing of participating providers occurs every two to three years, depending on applicable state laws. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee, composed of a peer group of providers, reviews the applications of providers being considered for credentialing and recredentialing.

We request accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care, and URAC. Accreditation or external review by an approved organization is mandatory in the states of Florida and Kansas for licensure as an HMO. Additionally, all products sold on the federal and state marketplaces are required to be accredited. Certain commercial businesses, like those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, credentialing, utilization management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in most of our commercial, Medicare and Medicaid HMO/POS markets with enough history and membership, except Puerto Rico, and for many of our PPO markets.

Sales and Marketing

We use various methods to market our products, including television, radio, the Internet, telemarketing, and direct mailings.

At December 31, 2014, we employed approximately 1,700 sales representatives, as well as approximately 1,200 telemarketing representatives who assisted in the marketing of individual Medicare and individual commercial health insurance and specialty products in our Retail segment, including making appointments for sales representatives with prospective members. We also market our individual Medicare products via a strategic alliance with Wal-Mart Stores, Inc., or Wal-Mart. This alliance includes stationing Humana representatives in certain Wal-Mart stores, SAM'S CLUB locations, and Neighborhood Markets across the country which provides an opportunity to enroll Medicare eligible individuals in person. In addition, we market our individual Medicare and individual commercial health insurance and specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual commercial health insurance and specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Employer Group segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. In addition, we have begun to offer plans to employer groups through private exchanges. Employers can give their employees a set amount of money and then direct them to a private exchange. There, employees can shop for a health plan and other benefits based on what the employer has selected as options. We also sell group Medicare Advantage products through large employers. We use licensed independent brokers, independent agents, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our individual commercial health insurance and specialty products.

Underwriting

Beginning in 2014, the Health Care Reform Law requires all individual and group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, newly issued individual and group health plans are not subject to underwriting in 2014 and beyond. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history.

Prior to 2014, through the use of internally developed underwriting criteria, we determined the risk we were willing to assume and the amount of premium to charge for our commercial products. In most instances, employer and other groups had to meet our underwriting standards in order to qualify to contract with us for coverage.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have larger memberships and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2014 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system.

Our management works proactively to ensure compliance with all governmental laws and regulations affecting our business. We are unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting our businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on our results of operations, financial position, or cash flows.

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2014 Form 10-K.

Certain Other Services

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers' compensation, and officer and director errors and omissions risks. Professional and general liability risks may include, for example, medical malpractice claims and disputes with members regarding benefit coverage. We retain certain of these risks through our wholly-owned, captive insurance subsidiary. We reduce exposure to these risks by insuring levels of coverage for losses in excess of our retained limits with a number of third-party insurance companies. We remain liable in the event these insurance companies are unable to pay their portion of the losses.

Centralized Management Services

We provide centralized management services to each of our health plans and to our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, billing/enrollment, and customer service.

Employees

As of December 31, 2014, we had approximately 57,000 employees and approximately 2,700 additional medical professionals working under management agreements primarily between Concentra and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. These estimates, however involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services;
- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, including new technologies;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- changes in our pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g. hurricanes and earthquakes);
- medical cost inflation; and
- government mandated benefits or other regulatory changes, including any that result from the Health Care Reform Law.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

In addition, we also estimate costs associated with long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental insurance policies sold to individuals for which some

of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these future policy benefit reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. Our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies, and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. However, to the extent premium rate increases or loss experience vary from the assumptions we have locked in, additional future adjustments to reserves could be required.

While we proactively attempt to effectively manage our operating expenses, increases or decreases in staff-related expenses, additional investment in new products (including our opportunities in the Medicare programs, state-based contracts, participation in health insurance exchanges, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well-being product offerings, acquisitions, new taxes and assessments (including the non-deductible health insurance industry fee and other assessments under the Health Care Reform Law), and implementation of regulatory requirements may increase our operating expenses.

Failure to adequately price our products or estimate sufficient benefits payable or future policy benefits payable, or effectively manage our operating expenses, may result in a material adverse effect on our results of operations, financial position, and cash flows.

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We may also face increased competition due to participation by other insurers in the health insurance exchanges implemented under the Health Care Reform Law. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

The policies and decisions of the federal and state governments regarding the Medicare, military, Medicaid and health insurance exchange programs in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the premiums or other revenues to us under the programs, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, health care services, and other costs associated with these programs. Legislative or regulatory actions, such as those resulting in a reduction in premium payments to us, an increase in our cost of administrative and health care services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract.

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable

medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives, our state-based contracts strategy, and our participation in the new health insurance exchanges, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in these products.

Our future performance depends in large part upon our ability to execute our strategy, including opportunities created by the expansion of our Medicare programs, the successful implementation of our integrated care delivery model, our strategy with respect to state-based contracts, including those covering members dually eligible for the Medicare and Medicaid programs, and our participation in health insurance exchanges.

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. Over the last few years we have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 72% of our total premiums and services revenue for the year ended December 31, 2014 generated from our Medicare products, in particular our contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

The recently implemented Health Care Reform Law created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state demonstration projects to experiment with better coordination of care between Medicare and Medicaid. Depending upon the results of those demonstration projects, CMS may change the way in which dual eligibles are serviced. If we are unable to implement our strategic initiatives to address the dual eligibles opportunity, including our participation in state-based contracts, or if our initiatives are not successful at attracting or retaining dual eligible members, our business may be materially adversely affected.

Additionally, our strategy includes the growth of our commercial products, including participation in the new health insurance exchanges, introduction of new products and benefit designs, including HumanaVitality and other wellness products, growth of our specialty products such as dental, vision and other supplemental products, the adoption of new technologies, development of adjacent businesses, and the integration of acquired businesses and contracts.

There can be no assurance that we will be able to successfully implement our operational and strategic initiatives, including implementing our integrated care delivery model, that are intended to position us for future growth or that the products we design will be accepted or adopted in the time periods assumed. Failure to implement this strategy may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we fail to properly maintain the integrity of our data, to strategically implement new information systems, or to protect our proprietary rights to our systems, our business may be materially adversely affected.

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional information systems. We have reduced the number of systems we operate, have

upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. Our information systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory or other legal problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results.

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

There can be no assurance that our information technology, or IT, process will successfully improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, defend against cybersecurity attacks, or improve service levels. In addition, there can be no assurance that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data, or to defend against cybersecurity attacks, may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we are unable to defend our information technology security systems against cybersecurity attacks or prevent other privacy or data security incidents that result in security breaches that disrupt our operations or in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could be exposed to significant regulatory fines or penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows.

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders.

The costs to eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our members' private information and result in the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

Our business may be materially adversely impacted by the adoption of a new coding set for diagnoses.

Federal regulations related to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), contain minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. ICD-9, the current system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States, was scheduled to be replaced by ICD-10 code sets on October 1, 2014. However, on April 1, 2014, The Protecting Access to Medicare Act of 2014 was signed into law, delaying implementation of ICD-10 until at least October 1, 2015. For dates of service on or after the date of final implementation, health plans and providers will be required to use ICD-10 codes for such diagnoses and procedures. While we have prepared for the transition to ICD-10, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after the final implementation date, including providers in our network who are employees, we will have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. If we do not adequately implement the new ICD-10 coding set, or if providers in our network do not adequately transition to the new ICD-10 coding set, our results of operations, financial position and cash flows may be materially adversely affected.

We are involved in various legal actions and governmental and internal investigations, any of which, if resolved unfavorably to us, could result in substantial monetary damages or changes in our business practices. Increased litigation and negative publicity could increase our cost of doing business.

We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment and employment discrimination-related suits, employee benefit claims, securities laws claims, and tort claims.

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management, and offering of products and services. These include and could include in the future:

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice;
- claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation or non-acceptance or termination of provider contracts or provider contract disputes relating to rate adjustments resulting from the Balance Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as "sequestration");
- disputes related to ASO business, including actions alleging claim administration errors;
- qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model;
- claims related to the failure to disclose some business practices;
- claims relating to customer audits and contract performance;

- claims relating to dispensing of drugs associated with our in-house mail-order pharmacy; and
- professional liability claims arising out of the delivery of healthcare and related services to the public.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act and other statutes may be sought.

While we currently have insurance coverage for some of these potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation, and governmental review of industry practices. These factors may materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, may increase the regulatory burdens under which we operate, and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows.

See "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty.

As a government contractor, we are exposed to risks that may materially adversely affect our business or our willingness or ability to participate in government health care programs.

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 76% of our total premiums and services revenue for the year ended December 31, 2014. These programs involve various risks, as described further below.

- At December 31, 2014, under our contracts with CMS we provided health insurance coverage to approximately 542,400 individual Medicare Advantage members in Florida. These contracts accounted for approximately 15% of our total premiums and services revenue for the year ended December 31, 2014. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.
- At December 31, 2014, our military services business primarily consisted of the TRICARE South Region contract which covers approximately 3,090,400 beneficiaries. For the year ended December 31, 2014, premiums and services revenue associated with the TRICARE South Region contract accounted for approximately 1% of our total premiums and services revenue. On April 1, 2012, we began delivering services under the current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On January 27, 2015, we received notice from the DHA of its intent to exercise its option to extend the TRICARE South Region contract through March 31, 2016. The loss of the TRICARE South Region contract, should it occur, may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the

performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.

- CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process that bases our prospective payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews, as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

  CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. These audits are referred to herein as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

  In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the Medicare FFS benchmark audit is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

  The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to the current round of RADV contract level audits being conducted on 2011 premium payments. Selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year. We have been notified that certain of our Medicare Advantage contracts have been selected for audit for contract year 2011.

  Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For-Service business which we used to represent a proxy of the benchmark audit data in Medicare FFS which has not yet been released. We based our accrual of estimated audit settlements for contract years 2011 (the first year that application of extrapolated audit results is applicable) through 2014 on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However,

as indicated, we are awaiting additional guidance from CMS regarding the benchmark audit data in Medicare FFS. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' recent comments in formalized guidance regarding "overpayments" to Medicare Advantage plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that Medicare Advantage plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which if not implemented correctly, could have material adverse effect on our results of operations, financial position, or cash flows.

- Our CMS contracts which cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net receivable of $69 million at December 31, 2014.

  Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS's portion of claims costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year.

  Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS's claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS's claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low-income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS's share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

- The Budget Control Act of 2011, enacted on August 2, 2011, increased the United States debt ceiling conditioned on deficit reductions to be achieved over the next ten years. The Budget Control Act of 2011 also established a twelve-member joint committee of Congress known as the Joint Select Committee on Deficit Reduction to propose legislation to reduce the United States federal deficit by $1.5 trillion for fiscal years 2012-2021. The failure of the Joint Select Committee on Deficit Reduction to achieve a targeted deficit reduction by December 23, 2011 triggered an automatic reduction, including aggregate reductions to Medicare payments to providers of up to 2 percent per fiscal year. These reductions took effect on April 1, 2013, and the Bipartisan Budget Act of 2013, enacted on December 26, 2013, extended the reductions for

two years. We expect a corresponding substantial reduction in our obligations to providers. Due to the uncertainty around the application of any such reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs applied by the Budget Control Act of 2011.

- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations are also conducted by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 could have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with a non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. The provisions of the Health Care Reform Law include, among others, imposing a significant new non-deductible health insurance industry fee and other assessments on health insurers, limiting Medicare Advantage payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products, additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). In addition, the Health Care Reform Law has increased and will continue to increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms will come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. Implementation dates of the provisions of the Health Care Reform Law began in September 2010 and continue through 2018. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. For additional information, please refer to the section entitled, "Health Care Reform" in "Item 7 - Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing in this annual report.

Our participation in the new federal and state health insurance exchanges, which entail uncertainties associated with mix, volume of business and the operation of premium stabilization programs, which are subject to federal administrative action, could adversely affect our results of operations, financial position, and cash flows.

The Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products. In addition, regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law may have an adverse effect on our pool of participants in the health insurance exchange. All of these factors may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

Our business activities are subject to substantial government regulation. New laws or regulations, or changes in existing laws or regulations or their manner of application, including reductions in Medicare Advantage payment rates, could increase our cost of doing business and may adversely affect our business, profitability, financial condition, and cash flows.

In addition to the Health Care Reform Law, the health care industry in general and health insurance are subject to substantial federal and state government regulation:

Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent.

These regulations set standards for the security of electronic health information. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. On January 17, 2013, HHS issued the omnibus final rule on HIPAA privacy, security, breach notification requirements and enforcement requirements under the HITECH Act, and a final regulation for required changes to the HIPAA Privacy Rule for the Genetic Information Nondiscrimination Act, or GINA. The omnibus final rule became effective on March 26, 2013, with a compliance date of September 23, 2013. Among other requirements, the HITECH Act and Omnibus final rule mandates individual notification in the event of a breach of unsecured, individually identifiable health information, provides enhanced penalties for HIPAA violations, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort.

American Recovery and Reinvestment Act of 2009 (ARRA)

On February 17, 2009, the American Recovery and Reinvestment Act of 2009, or ARRA, was enacted into law. In addition to including a temporary subsidy for health care continuation coverage issued pursuant to the Consolidated Omnibus Budget Reconciliation Act, or COBRA, ARRA also expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other things, ARRA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to the U.S. Department of Health and Human Services in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. ARRA also requires business associates to comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires the U.S. Department of Health and Human Services to issue regulations implementing its privacy and security enhancements.

Corporate Practice of Medicine and Other Laws

As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows.

Anti-Kickback, Physician Self-Referral, and Other Fraud and Abuse Laws

A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease, or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services

to a total of 11 categories of health services. The professional groups with which we are affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

Environmental

We are subject to various federal, state, and local laws and regulations relating to the protection of human health and the environment. If an environmental regulatory agency finds any of our facilities to be in violation of environmental laws, penalties and fines may be imposed for each day of violation and the affected facility could be forced to cease operations. We could also incur other significant costs, such as cleanup costs or claims by third parties, as a result of violations of, or liabilities under, environmental laws. Although we believe that our environmental practices, including waste handling and disposal practices, are in material compliance with applicable laws, future claims or violations, or changes in environmental laws, could have a material adverse effect on our results of operations, financial position or cash flows.

State Regulation of Insurance-Related Products

Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance-related services regulate our operations including: licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re-entry into a state or market, rate increases, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance-related products we offer are sold under licenses issued by the applicable insurance regulators.

Our licensed insurance subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports.

Any failure by us to manage acquisitions, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition

strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives. Among the businesses that we are currently evaluating is our closed block of long-term care insurance policies business. While no decision has been made with respect to any course of action, if we were to divest this business it is reasonably likely that we would have to recognize a material loss that will have a material adverse effect on our results of operations. The divestiture of certain other businesses could also result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations. There can be no assurance that we will be able to complete any such divestitures on terms favorable to us.

If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business may be adversely affected.

We employ or contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. A key component of our integrated care delivery strategy is to increase the number of providers who share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner.

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

In some situations, we have contracts with individual or groups of primary care providers for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. This type of contract is referred to as a "capitation" contract. The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows.

Our pharmacy business is highly competitive and subjects us to regulations in addition to those we face with our core health benefits businesses.

Our pharmacy mail order business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, Internet companies and other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally

regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state's board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, and the application of state laws related to the operation of internet and mail-order pharmacies. The failure to adhere to these laws and regulations may expose us to civil and criminal penalties.

Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance.

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as "AWP," average selling price, which is referred to as "ASP," and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our mail-order pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we do not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, our gross margins may decline.

We have contractual relationships with pharmaceutical manufacturers or wholesalers that provide us with purchase discounts and volume rebates on certain prescription drugs dispensed through our mail-order and specialty pharmacies. These discounts and volume rebates are generally passed on to clients in the form of steeper price discounts. Changes in existing federal or state laws or regulations or in their interpretation by courts and agencies or the adoption of new laws or regulations relating to patent term extensions, and purchase discount and volume rebate arrangements with pharmaceutical manufacturers, may reduce the discounts or volume rebates we receive and materially adversely impact our results of operations, financial position, and cash flows.

Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of

statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Dividends from our non-insurance companies such as in our Healthcare Services segment are generally not restricted by Departments of Insurance. In the event that we are unable to provide sufficient capital to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected.

Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers. In addition, our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under regulatory and public scrutiny over the ratings assigned to various fixed-income products. As a result, rating agencies may (i) become more conservative in their methodology and criteria, (ii) increase the frequency or scope of their credit reviews, (iii) request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected.

The securities and credit markets may experience volatility and disruption, which may adversely affect our business.

Volatility or disruption in the securities and credit markets could impact our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairments are considered using variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the possibility that customers or lenders could develop a negative perception of our long or short-term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2014:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	14	125	—	94	233
Texas	4	56	2	44	106
California	—	28	—	18	46
Georgia	1	21	—	15	37
Kentucky	2	10	11	11	34
Arizona	1	20	—	9	30
Illinois	—	17	—	12	29
Colorado	—	20	—	9	29
Michigan	—	23	—	3	26
Ohio	—	10	—	16	26
Pennsylvania		16		8	24
Tennessee	—	11	—	13	24
New Jersey	—	14	—	9	23
Louisiana	—	11	—	11	22
Virginia	—	14	—	8	22
New York	—	4	—	13	17
North Carolina	—	6	—	10	16
Missouri	—	12	—	3	15
Nevada		10		5	15
Wisconsin	—	8	1	6	15
Connecticut	—	10	—	3	13
Indiana	—	7	—	6	13
South Carolina	—	2	4	7	13
Maryland	—	10	—	2	12
Oklahoma	—	7	—	5	12
Mississippi	—	—	—	10	10
Puerto Rico	—	—	—	9	9
Others	—	47	—	41	88
Total	22	519	18	400	959

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists, urgent care facilities, and worksite medical facilities. Of the medical centers included in the table above, approximately 54 of these facilities are leased or subleased to our providers to operate.

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to the headquarters in Louisville, Kentucky, we maintain other principal operating facilities used for customer service, enrollment, and/or claims processing and certain other corporate functions in Louisville, Kentucky; Green Bay, Wisconsin; Tampa, Florida; Cincinnati, Ohio; San Antonio, Texas; and San Juan, Puerto Rico.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2014 and 2013:

	High	Low
Year Ended December 31, 2014		
First quarter	$ 118.78	$ 95.59
Second quarter	$ 128.95	$ 104.74
Third quarter	$ 135.51	$ 115.97
Fourth quarter	$ 149.07	$ 124.17
Year Ended December 31, 2013		
First quarter	$ 81.52	$ 66.01
Second quarter	$ 85.17	$ 72.10
Third quarter	$ 99.60	$ 82.93
Fourth quarter	$ 105.25	$ 91.21

Holders of our Capital Stock

As of January 31, 2015, there were approximately 3,300 holders of record of our common stock and approximately 40,250 beneficial holders of our common stock.

Dividends

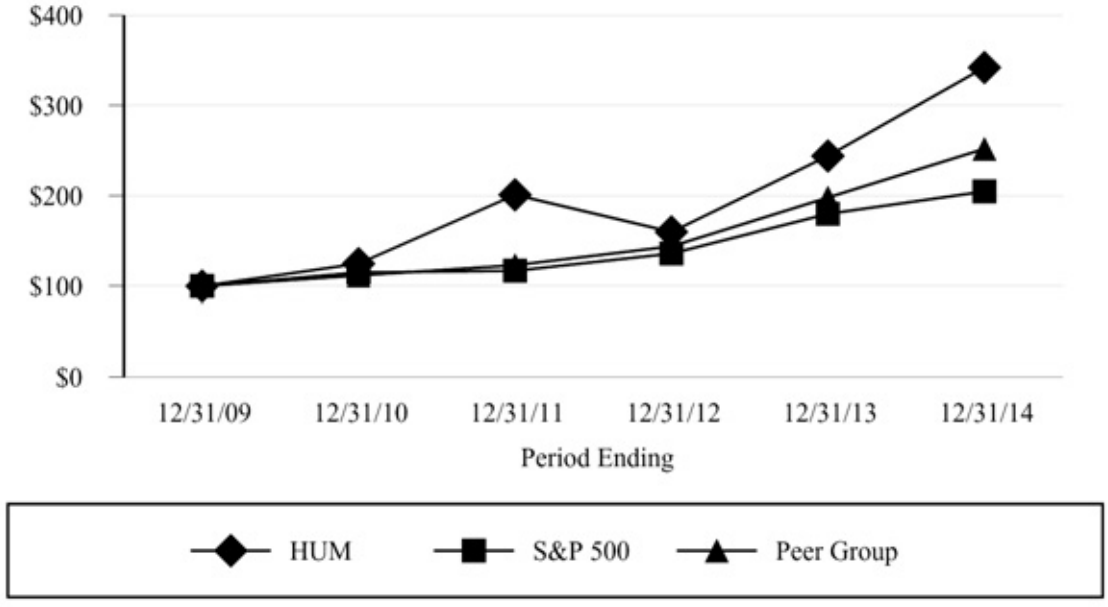
The following table provides details of dividend payments, excluding dividend equivalent rights, in 2013 and 2014:

Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2013 payments			
12/31/2012	1/25/2013	$0.26	$42
3/28/2013	4/26/2013	$0.26	$41
6/28/2013	7/26/2013	$0.27	$42
9/30/2013	10/25/2013	$0.27	$42
2014 payments			
12/31/2013	1/31/2014	$0.27	$42
3/31/2014	4/25/2014	$0.27	$42
6/30/2014	7/25/2014	$0.28	$43
9/30/2014	10/31/2014	$0.28	$43

In October 2014, the Board of Directors declared a cash dividend of $0.28 per share that was paid on January 30, 2015 to stockholders of record as of the close of business on December 31, 2014, for an aggregate amount of $42 million. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2014. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2009, and that dividends were reinvested when paid.



	12/31/2009	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014
HUM	$ 100	$ 125	$ 201	$ 160	$ 244	$ 342
S&P 500	$ 100	$ 115	$ 117	$ 136	$ 180	$ 205
Peer Group	$ 100	$ 112	$ 123	$ 144	$ 198	$ 252

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2014 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1)
October 2014	592,852	$ 128.37	592,852	$ 1,889,450,517
November 2014	3,236,801	130.97	3,236,801	1,365,543,163
December 2014	0	0	0	1,365,543,163
Total	3,829,653	$ 130.56	3,829,653	

(1) In September 2014, the Board of Directors replaced a previous share repurchase authorization of up to $1 billion with a current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Under the current share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment bankers), subject to certain regulatory restrictions on volume, pricing, and timing. As of February 18, 2015, the remaining authorized amount under the current authorization totaled approximately $1.37 billion, which includes $100 million of stock held back as part of an accelerated share repurchase agreement as more fully described under "Stock Repurchases" in Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(2) Excludes 0.02 million shares repurchased in connection with employee stock plans.

ITEM 6. SELECTED FINANCIAL DATA

	2014 (a)	2013 (b)	2012 (c)	2011	2010 (d)
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$ 45,959	$ 38,829	$ 37,009	$ 35,106	$ 32,712
Services	2,164	2,109	1,726	1,360	555
Investment income	377	375	391	366	329
Total revenues	48,500	41,313	39,126	36,832	33,596
Operating expenses:					
Benefits	38,166	32,564	30,985	28,823	27,117
Operating costs	7,639	6,355	5,830	5,395	4,380
Depreciation and amortization	333	333	295	270	245
Total operating expenses	46,138	39,252	37,110	34,488	31,742
Income from operations	2,362	2,061	2,016	2,344	1,854
Interest expense	192	140	105	109	105
Income before income taxes	2,170	1,921	1,911	2,235	1,749
Provision for income taxes	1,023	690	689	816	650
Net income	$ 1,147	$ 1,231	$ 1,222	$ 1,419	$ 1,099
Basic earnings per common share	$ 7.44	$ 7.81	$ 7.56	$ 8.58	$ 6.55
Diluted earnings per common share	$ 7.36	$ 7.73	$ 7.47	$ 8.46	$ 6.47
Dividends declared per common share	$ 1.11	$ 1.07	$ 1.03	$ 0.75	$ —
Financial Position:					
Cash and investments	$ 11,482	$ 10,938	$ 11,153	$ 10,830	$ 10,046
Total assets	23,466	20,735	19,979	17,708	16,103
Benefits payable	4,475	3,893	3,779	3,754	3,469
Debt	3,825	2,600	2,611	1,659	1,669
Stockholders' equity	9,646	9,316	8,847	8,063	6,924
Cash flows from operations	$ 1,618	$ 1,716	$ 1,923	$ 2,079	$ 2,242
Key Financial Indicators:					
Benefit ratio	83.0%	83.9%	83.7%	82.1%	82.9%
Operating cost ratio	15.9%	15.5%	15.1%	14.8%	13.2%
Membership by Segment:					
Retail segment:					
Medical membership	7,882,300	6,026,000	5,553,800	4,795,000	3,681,900
Specialty membership	1,165,800	1,042,500	948,700	782,500	510,000
Employer Group segment:					
Medical membership	2,834,000	2,833,100	2,852,400	2,794,900	3,009,500
Specialty membership	6,502,700	6,780,800	7,136,200	6,532,600	6,517,500
Other Businesses:					
Medical membership	3,125,400	3,125,200	3,682,600	3,594,700	3,595,200
Consolidated:					
Total medical membership	13,841,700	11,984,300	12,088,800	11,184,600	10,286,600
Total specialty membership	7,668,500	7,823,300	8,084,900	7,315,100	7,027,500

(a) Includes loss on extinguishment of debt of $37 million ($23 million after tax, or $0.15 per diluted common share) for the redemption of senior notes.

(b) Includes benefits expense of $243 million ($154 million after tax, or $0.99 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies.

(c) Includes the acquired operations of Arcadian Management Services, Inc. from March 31, 2012, SeniorBridge Family Companies, Inc. from July 6, 2012, and Metropolitan Health Networks, Inc. from December 21, 2012.

(d) Includes the acquired operations of Concentra Inc. from December 21, 2010. Also includes operating costs of $147 million ($93 million after tax, or $0.55 per diluted common share) for the write-down of deferred acquisition costs associated with our individual commercial medical policies and benefits expense of $139 million ($88 million after tax, or $0.52 per diluted common share) associated with reserve strengthening for our non-strategic closed block of long-term care insurance policies.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Executive Overview

General

Humana Inc., headquartered in Louisville, Ky., is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefits expense as a percentage of premiums revenue, represents a statistic used to measure underwriting profitability. The operating cost ratio, which is computed by taking total operating costs, which excludes depreciation and amortization, as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

Business Segments

On January 1, 2014, we reclassified certain of our businesses from our Healthcare Services segment to our Employer Group segment to correspond with internal management reporting changes. Our reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. This is further described in Note 2 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

We manage our business with three reportable segments: Retail, Employer Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, marketed directly to individuals, and includes our contract with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Employer Group segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary benefit products, as well as administrative services only, or ASO, products and our health and wellness products primarily marketed to employer groups. The Healthcare Services segment includes services offered to our health plan members as well as to third parties including pharmacy solutions, provider services, home based services, integrated behavioral health services, and predictive modeling and informatics services. The Other Businesses category consists of our military services, primarily our TRICARE South Region contract, Puerto Rico Medicaid, and closed-block long-term care insurance policies.

The results of each segment are measured by income before income taxes. Transactions between reportable segments consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, home based, and behavioral health, to our Retail and Employer Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often utilize the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent.

We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest

expense on corporate debt, and certain other corporate expenses. These items are managed at the corporate level. These corporate amounts are reported separately from our reportable segments and included with intersegment eliminations.

Seasonality

One of the product offerings of our Retail segment is Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. Our quarterly Retail segment earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D benefit design results in coverage that varies as a member's cumulative out-of-pocket costs pass through successive stages of a member's plan period, which begins annually on January 1 for renewals. These plan designs generally result in us sharing a greater portion of the responsibility for total prescription drug costs in the early stages and less in the latter stages. As a result, the PDP benefit ratio generally decreases as the year progresses. In addition, the number of low-income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

Our Employer Group segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Employer Group's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses. Similarly, certain of our fully-insured individual commercial medical products in our Retail segment experience seasonality in the benefit ratio akin to the Employer Group segment, including the effect of existing members transitioning to policies compliant with the Health Care Reform Law.

In addition, the Retail segment also experiences seasonality in the operating cost ratio as a result of costs incurred in the second half of the year associated with the Medicare and individual health care exchange marketing seasons.

2014 Highlights

Consolidated

- Our 2014 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. A core element of the model is to offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. At December 31, 2014, approximately 709,000 members, or 29.0%, of our individual Medicare Advantage membership were in risk arrangements under our integrated care delivery model, as compared to 561,500 members, or 27.1%, at December 31, 2013.

- Year-over-year comparisons of our results were impacted by investments in health care exchanges and state-based contracts as well as higher specialty prescription drug costs associated with a new treatment for Hepatitis C, partially offset by membership growth in our Medicare Advantage, Medicare stand-alone PDP, and individual commercial medical offerings as well as increased membership in our clinical programs.

- In September 2014, we paid the federal government $562 million for the annual health insurance industry fee. This fee is not deductible for tax purposes, which has significantly increased our effective income tax rate in 2014. Year-over-year comparisons of the operating cost ratio are negatively impacted by this and other fees mandated by the Health Care Reform Law beginning in 2014. Likewise, year-over-year comparisons of the benefit ratio reflect the inclusion of these mandated fees in the pricing of our products for 2014. In 2015, the health insurance industry fee increases by 41% for the industry taken as a whole. Accordingly, absent changes in market share, we would expect a 41% increase in our fee in 2015. The health insurance industry fee is further described below under the section titled "Health Care Reform."

- Year-over-year comparisons of diluted earnings per common share are favorably impacted by a lower number of shares used to compute diluted earnings per common share reflecting the impact of share repurchases.

- Our operating cash flow of $1.6 billion for the year ended December 31, 2014 compared to operating cash flow of $1.7 billion for the year ended December 31, 2013. For 2014, the effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law impacted the timing of our operating cash flows, as we built a receivable of $679 million in 2014 that is expected to be collected in 2015.

- Our 2014 financing cash flows have been negatively impacted by the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies for which we do not assume risk. Claims payments were $945 million higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk during 2014. We are experiencing higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which is resulting in higher reinsurance subsidy receivable balances in 2014 that will be settled in 2015 under the terms of our contracts with CMS.

- We continue to focus on disciplined capital allocation. In 2014, we issued senior notes and received net proceeds of $1.7 billion, redeemed our $500 million 6.45% senior notes for cash totaling approximately $560 million, repurchased 5.7 million shares of our common stock for $730 million in open market transactions (which excludes another $100 million of stock held back pursuant to an accelerated share repurchase program), and paid dividends to stockholders of $172 million.

Retail Segment

- On April 7, 2014, CMS announced final 2015 Medicare benchmark payment rates and related technical factors impacting the bid benchmark premiums, which we refer to as the Final Rate Notice. We believe the Final Rate Notices together with the impact of payment cuts associated with the Health Care Reform Law, quality bonuses, sunset of the Star quality CMS demonstration in 2015, risk coding modifications, the impact of the health insurance industry fee, and other funding formula changes, indicate 2015 Medicare Advantage funding cuts of approximately 2%. We believe we have effectively designed Medicare Advantage products based upon these levels of rate reduction while continuing to remain competitive compared to both the combination of Medicare FFS with a supplement policy as well as Medicare Advantage products offered by our competitors. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.

- Medicare Advantage premiums are tied to the achievement of certain quality performance measures (Star Ratings). Beginning in 2015, plans must have a Star Rating of four or higher to qualify for bonus money. Star Ratings issued by CMS in October 2014 indicated that plans covering 92% of our Medicare Advantage membership for the 2015 plan year achieved a Star Rating of 4.0 or higher. We have 23 Medicare Advantage plans that achieved a rating of four or more stars, an increase from 18 the previous year. We are offering one Medicare Advantage plan that achieved a 5.0 Star Rating, our CarePlus Health Plans, Inc. HMO plan in Florida, as well as five Medicare Advantage plans that achieved a 4.5 Star Rating. Plans that earn an overall Star Rating of five become eligible to enroll members year round.

- As discussed in the detailed Retail segment results of operations discussion that follows, for the year ended December 31, 2014, our Retail segment pretax income declined by 14.4% primarily due to the same factors discussed above for our consolidated results.

- Individual Medicare Advantage membership increased 377,500 members, or 18.2%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, particularly for our HMO offerings, for the 2014 plan year as well as dual eligible members from state-based contracts in Virginia and Illinois. January 1, 2015 individual Medicare Advantage membership increased approximately 257,000 members, or 10.5%, from December 31, 2014 reflecting net membership additions for the 2015 enrollment season, primarily in our HMO offerings.

- Medicare stand-alone PDP membership increased 717,800 members, or 21.9%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2014 plan year. January 1, 2015 Medicare stand-alone PDP membership, excluding the LI-NET prescription drug plan program, increased approximately 230,500 members, or 5.8%, from December 31, 2014 reflecting net membership additions for the 2015 enrollment season.

- Our state-based Medicaid membership as of December 31, 2014 increased 213,000 members from December 31, 2013, primarily due to the addition of members under our Florida Medicaid and Florida Long-Term Support Services contracts.

- Individual commercial medical membership of 1,148,100 at December 31, 2014 increased 548,000 members, or 91.3%, from December 31, 2013 primarily reflecting new sales, both on-exchange and off-exchange, of plans compliant with the Health Care Reform Law. At December 31, 2014, individual commercial medical membership in plans compliant with the Health Care Reform Law, both on-exchange and off-exchange, was 686,300 members. In addition, federal and state regulatory changes in December 2013 allowed certain individuals to remain in their existing underwritten health plans that are not compliant with the Health Care Reform Law, which has led to much higher than previously expected retention of our existing underwritten health plans. We believe that this is occurring at other health insurance issuers as well and will result in an overall deterioration of the risk pool in plans compliant with the Health Care Reform Law, as more previously underwritten members remain with their current health plans rather than enter the exchanges. However, we expect that the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law will mitigate this deterioration to some extent.

Employer Group Segment

- As discussed in the detailed Employer Group segment results of operations discussion that follows, the Employer Group segment pretax income declined 10.3% for the year ended December 31, 2014 primarily reflecting higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes which allowed individuals to remain in plans not compliant with the Health Care Reform Law.

- Fully-insured group Medicare Advantage membership of 489,700 at December 31, 2014 increased 60,600 members, or 14.1%, from 429,100 at December 31, 2013 primarily due to the January 2014 addition of a new large group account.

- Membership in HumanaVitality®, our wellness and loyalty rewards program, rose 36.2% to 3,856,800 at December 31, 2014 from 2,831,000 at December 31, 2013 primarily due to the addition of group Medicare members as well as individual Medicare Advantage and fully-insured individual commercial medical membership growth.

Healthcare Services Segment

- As discussed in the detailed Healthcare Services segment results of operations discussion that follows, our Healthcare Services segment pretax income improved 41.8% for the year ended December 31, 2014 primarily due to a decline in the operating cost ratio in 2014 on a revenue base that reflects growth from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.

- Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We have accelerated our process for identifying and reaching out to members in need of clinical intervention. At December 31, 2014, we had approximately 420,700 members with complex chronic conditions in the Humana Chronic Care Program, a 50.1% increase compared with approximately 280,200 members at December 31, 2013, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Other Businesses

- Year-over-year comparisons within Other Businesses are impacted by the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 and a reduction in benefits expense in 2013 related to a favorable settlement of contract claims with the United States Department of Defense, or DoD, associated with previously disclosed litigation. In addition, as discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, during 2013, we recorded net benefits expense of $243 million ($154 million after-tax, or $0.99 per diluted common share) for reserve strengthening related to our non-strategic closed-block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Implementation dates of the Health Care Reform Law began in September 2010 and will continue through 2018, and many aspects of the Health Care Reform Law are already effective and have been implemented by us. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, an annual insurance industry premium-based assessment, and a three-year commercial reinsurance fee. Certain provisions of the Health Care Reform Law became effective in 2014, including:

- All individual and group health plans must guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments;
- The elimination of annual limits on coverage on certain benefits;
- The establishment of federally-facilitated, federal-state partnerships or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers;
- The introduction of plan designs based on set actuarial values;
- The establishment of a minimum benefit ratio of 85% for Medicare Advantage plans with penalties up to and including termination of Medicare Advantage contracts for continued failure to meet the minimum; and
- Insurance industry assessments, including an annual health insurance industry fee and a three-year $25 billion industry wide commercial reinsurance fee. The annual health insurance industry fee levied on the insurance industry is $8 billion in 2014 with increasing annual amounts thereafter, growing to $14 billion by 2017, and is not deductible for income tax purposes, which significantly increased our effective income tax rate in 2014 to approximately 47.2%. In 2014, we paid the federal government $562 million for the annual health insurance industry fee. In 2015, the health insurance industry fee increases by 41% for the industry taken as a whole. Accordingly, absent changes in market share, we would expect a 41% increase in our fee in 2015. In addition, statutory accounting for the health insurance industry fee required us to restrict surplus in the year preceding payment of the health insurance industry fee beginning in 2014. Accordingly, in addition to recording the full-year 2014 assessment in the first quarter of 2014, we were required to restrict surplus for the 2015 assessment ratably in 2014.

The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). In addition, the Health Care Reform Law has increased and will continue to increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms comes, in part, from material additional fees and taxes on us (as discussed above) and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described in this report.

As discussed above, it is reasonably possible that the Health Care Reform Law and related regulations, as well as future legislative changes, including legislative restrictions on our ability to manage our provider network or otherwise operate our business, or regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with the non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows (including the receipt of amounts due under the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law in 2015 related to claims paid in 2014, which payments may be subject to federal administrative action).

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and behavioral health services, to our Retail and Employer Group customers and are described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Comparison of Results of Operations for 2014 and 2013

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2014 and 2013:

Consolidated

	2014	2013	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 33,954	$ 27,204	$ 6,750	24.8 %
Employer Group	11,935	10,930	1,005	9.2 %
Other Businesses	70	695	(625)	(89.9)%
Total premiums	45,959	38,829	7,130	18.4 %
Services:				
Retail	39	16	23	143.8 %
Employer Group	362	359	3	0.8 %
Healthcare Services	1,282	1,280	2	0.2 %
Other Businesses	481	454	27	5.9 %
Total services	2,164	2,109	55	2.6 %
Investment income	377	375	2	0.5 %
Total revenues	48,500	41,313	7,187	17.4 %
Operating expenses:				
Benefits	38,166	32,564	5,602	17.2 %
Operating costs	7,639	6,355	1,284	20.2 %
Depreciation and amortization	333	333	—	— %
Total operating expenses	46,138	39,252	6,886	17.5 %
Income from operations	2,362	2,061	301	14.6 %
Interest expense	192	140	52	37.1 %
Income before income taxes	2,170	1,921	249	13.0 %
Provision for income taxes	1,023	690	333	48.3 %
Net income	$ 1,147	$ 1,231	$ (84)	(6.8)%
Diluted earnings per common share	$ 7.36	$ 7.73	$ (0.37)	(4.8)%
Benefit ratio (a)	83.0%	83.9%		(0.9)%
Operating cost ratio (b)	15.9%	15.5%		0.4 %
Effective tax rate	47.2%	35.9%		11.3 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs as a percentage of total revenues less investment income.

Summary

Net income was $1.1 billion, or $7.36 per diluted common share, in 2014 compared to $1.2 billion, or $7.73 per diluted common share, in 2013. Net income for 2014 includes expenses of $0.15 per diluted common share associated with a loss on extinguishment of debt for the redemption of certain senior notes in 2014 and net income for 2013

includes benefits expense of $0.99 per diluted common share for reserve strengthening associated with our closed-block of long-term care insurance policies included with Other Businesses as discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data as well as the benefit of a reduction in benefits expense in 2013 related to a favorable settlement of contract claims with the DoD. Excluding these items, the increase in net income primarily resulted from higher pretax income in our Healthcare Services segment substantially offset by lower pretax income in our Retail and Employer Group segments. In addition, 2014 was favorably impacted by a lower number of shares used to compute diluted earnings per common share reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $7.1 billion, or 18.4%, from 2013 to $46.0 billion for 2014 primarily due to increases in both Retail and Employer Group segment premiums mainly driven by higher average individual and group Medicare Advantage membership as well as higher individual commercial medical membership. In addition, year-over-year comparisons to the 2013 were negatively impacted by sequestration which became effective April 1, 2013. Premiums revenue for our Other Businesses declined primarily due to the loss of our Puerto Rico Medicaid contracts effective September 30, 2013. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per member premiums. Items impacting average per member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Services Revenue

Consolidated services revenue increased $55 million, or 2.6%, from 2013 to $2.2 billion for 2014 primarily due to an increase in services revenue in our Retail segment due to the acquisition of American Eldercare in September 2013.

Investment Income

Investment income totaled $377 million for 2014, an increase of $2 million from 2013, as higher average invested balances were partially offset by lower interest rates.

Benefits Expense

Consolidated benefits expense was $38.2 billion for 2014, an increase of $5.6 billion, or 17.2%, from 2013 primarily due to increases in both the Retail and Employer Group segments mainly driven by higher average individual and group Medicare Advantage membership as well as higher individual commercial medical membership. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $518 million in 2014 and $474 million in 2013. These increases in favorable medical claims reserve development primarily resulted from increased membership and better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

The consolidated benefit ratio for 2014 was 83.0%, a decrease of 90 basis points from 2013 primarily due to reserve strengthening in 2013 associated with our closed-block of long-term care insurance policies included with Other Businesses as discussed above, as well as the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 which more than offset higher ratios year-over-year in the Retail and Employer Group segments.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs increased $1,284 million, or 20.2%, in 2014 compared to 2013 primarily due to costs mandated by the Health Care Reform Law, including the non-deductible health insurance industry fee, and investments in health care exchanges and state-based contracts, partially offset by operating cost efficiencies.

The consolidated operating cost ratio for 2014 was 15.9%, increasing 40 basis points from 2013 primarily due to increases in the operating cost ratios in our Retail and Employer Group segments due to the same factors impacting consolidated operating costs as described above.

Depreciation and Amortization

Depreciation and amortization for 2014 totaled $333 million, unchanged from 2013.

Interest Expense

Interest expense was $192 million for 2014 compared to $140 million for 2013, an increase of $52 million, or 37.1%. In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date. We recognized a loss on extinguishment of debt, included in interest expense, of approximately $37 million in connection with the redemption of these notes.

Income Taxes

Our effective tax rate during 2014 was 47.2% compared to the effective tax rate of 35.9% in 2013. The non-deductible nature of the health insurance industry fee levied on the insurance industry beginning in 2014 as mandated by the Health Care Reform Law increased our effective tax rate by approximately 9.4 percentage points for 2014. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

	2014	2013	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,446,200	2,068,700	377,500	18.2%
Medicare stand-alone PDP	3,989,500	3,271,700	717,800	21.9%
Total Retail Medicare	6,435,700	5,340,400	1,095,300	20.5%
Individual commercial (a)	1,148,100	600,100	548,000	91.3%
State-based Medicaid	298,500	85,500	213,000	249.1%
Total Retail medical members	7,882,300	6,026,000	1,856,300	30.8%
Individual specialty membership (b)	1,165,800	1,042,500	123,300	11.8%

(a) Individual commercial medical membership includes Medicare Supplement members.

(b) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2014	2013	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 25,941	$ 22,481	$ 3,460	15.4 %
Medicare stand-alone PDP	3,396	3,025	371	12.3 %
Total Retail Medicare	29,337	25,506	3,831	15.0 %
Individual commercial	3,265	1,160	2,105	181.5 %
State-based Medicaid	1,096	328	768	234.1 %
Individual specialty	256	210	46	21.9 %
Total premiums	33,954	27,204	6,750	24.8 %
Services	39	16	23	143.8 %
Total premiums and services revenue	$ 33,993	$ 27,220	$ 6,773	24.9 %
Income before income taxes	$ 1,098	$ 1,283	$ (185)	(14.4)%
Benefit ratio	84.3%	84.2%		0.1 %
Operating cost ratio	12.4%	10.9%		1.5 %

Pretax Results

- Retail segment pretax income was $1.1 billion in 2014, a decrease of $185 million, or 14.4%, compared to 2013 primarily driven by investment spending for health care exchanges and state-based contracts and higher specialty prescription drug costs associated with a new treatment for Hepatitis C, partially offset by Medicare Advantage and individual commercial medical membership growth as well as increased membership in our clinical programs.

Enrollment

- Individual Medicare Advantage membership increased 377,500 members, or 18.2%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, particularly for our HMO offerings, for the 2014

plan year as well as dual eligible members from state-based contracts in Virginia and Illinois. Individual Medicare Advantage membership at December 31, 2014 includes 18,300 dual eligible members from state-based contracts.

- Medicare stand-alone PDP membership increased 717,800 members, or 21.9%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2014 plan year.

- Individual commercial medical membership increased 548,000 members, or 91.3%, from December 31, 2013 to December 31, 2014 primarily reflecting new sales, both on-exchange and off-exchange, of plans compliant with the Health Care Reform Law.

- State-based Medicaid membership increased 213,000 members, or 249.1%, from December 31, 2013 to December 31, 2014 primarily driven by the addition of members under our Florida Medicaid and Florida Long-Term Support Services contracts.

- Individual specialty membership increased 123,300 members, or 11.8%, from December 31, 2013 to December 31, 2014 primarily driven by increased membership in dental and vision offerings.

Premiums revenue

- Retail segment premiums increased $6.8 billion, or 24.8%, from 2013 to 2014 primarily due to membership growth across all lines of business, particularly for our individual Medicare Advantage, individual commercial medical, primarily on the health care exchanges, and state-based Medicaid businesses. Individual Medicare Advantage average membership increased 17.0% in 2014. Individual Medicare Advantage per member premiums decreased approximately 1.4% in 2014 compared to 2013, primarily due to Medicare rate reductions and the impact of sequestration which became effective on April 1, 2013.

Benefits expense

- The Retail segment benefit ratio of 84.3% for 2014 increased 10 basis points from 2013 primarily due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, higher planned clinical investment spending, and higher benefit ratios associated with members from state-based contracts, partially offset by increased membership in our clinical programs and the inclusion of the health insurance industry fee in the pricing of our products.

- The Retail segment's benefits expense for 2014 included the beneficial effect of $385 million in favorable prior-year medical claims reserve development versus $332 million in 2013. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 110 basis points in 2014 versus approximately 120 basis points in 2013.

Operating costs

- The Retail segment operating cost ratio of 12.4% for 2014 increased 150 basis points from 2013 primarily due to the non-deductible health insurance industry fee mandated by the Health Care Reform Law and investment spending for health care exchanges and state-based contracts, partially offset by scale efficiencies from Medicare and individual commercial medical membership growth.

Employer Group Segment

	2014	2013	Change Members	Change Percentage
Membership:				
Medical membership:				
Group Medicare Advantage	489,700	429,100	60,600	14.1 %
Group Medicare stand-alone PDP	4,500	4,200	300	7.1 %
Total group Medicare	494,200	433,300	60,900	14.1 %
Fully-insured commercial group	1,235,500	1,237,000	(1,500)	(0.1)%
ASO	1,104,300	1,162,800	(58,500)	(5.0)%
Total group medical members	2,834,000	2,833,100	900	— %
Group specialty membership (a)	6,502,700	6,780,800	(278,100)	(4.1)%

(a) Specialty products include dental, vision, and other supplemental health and voluntary benefit products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2014	2013	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Group Medicare Advantage	$ 5,490	$ 4,710	$ 780	16.6 %
Group Medicare stand-alone PDP	8	8	—	— %
Total group Medicare	5,498	4,718	780	16.5 %
Fully-insured commercial group	5,339	5,117	222	4.3 %
Group specialty	1,098	1,095	3	0.3 %
Total premiums	11,935	10,930	1,005	9.2 %
Services	362	359	3	0.8 %
Total premiums and services revenue	$ 12,297	$ 11,289	$ 1,008	8.9 %
Income before income taxes	$ 314	$ 350	$ (36)	(10.3)%
Benefit ratio	83.9%	83.5%		0.4 %
Operating cost ratio	16.1%	15.9%		0.2 %

Pretax Results

- Employer Group segment pretax income decreased $36 million, or 10.3%, to $314 million in 2014 primarily reflecting higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes which allowed individuals to remain in plans not compliant with the Health Care Reform Law.

Enrollment

- Fully-insured group Medicare Advantage membership increased 60,600 members, or 14.1%, from December 31, 2013 to December 31, 2014 primarily due to the addition of a new large group account.

- Fully-insured commercial group medical membership decreased 1,500 members, or 0.1% from December 31, 2013 as an increase in small group business membership was generally offset by lower membership in large

group accounts. Approximately 65% of our fully-insured commercial group medical membership was in small group accounts at December 31, 2014 compared to 61% at December 31, 2013.

- Group ASO commercial medical membership decreased 58,500 members, or 5.0%, from December 31, 2013 to December 31, 2014 primarily due to continued pricing discipline in a highly competitive environment for self-funded accounts. We expect our group ASO commercial medical membership to decline by approximately 400,000 to 425,000 members January 1, 2015 primarily due to the loss of a few large group accounts.

- Group specialty membership decreased 278,100 members, or 4.1%, from December 31, 2013 to December 31, 2014 primarily due to declines in dental and vision membership related to our planned discontinuance of certain unprofitable product distribution partnerships.

Premiums revenue

- Employer Group segment premiums increased $1.0 billion, or 9.2%, from 2013 to 2014 primarily due to higher average group Medicare Advantage membership as well as an increase in fully-insured commercial group medical premiums per member that more than offset a slight decline in total membership for this segment.

Benefits expense

- The Employer Group segment benefit ratio increased 40 basis points from 83.5% in 2013 to 83.9% in 2014 primarily due to higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes, partially offset by the inclusion of the health insurance industry fee and other fees mandated by the Health Care Reform Law in our pricing.

- The Employer Group segment's benefits expense included the beneficial effect of $132 million in favorable prior-year medical claims reserve development versus $138 million in 2013. This favorable prior-year medical claims reserve development decreased the Employer Group segment benefit ratio by approximately110 basis points in 2014 versus approximately 130 basis points in 2013.

Operating costs

- The Employer Group segment operating cost ratio of 16.1% increased 20 basis points from 2013. This increase primarily reflects the impact of the non-deductible health insurance industry fee and other fees mandated by the Health Care Reform Law as well as a higher percentage of small group commercial business which carries a higher operating cost ratio than large group business. These increases were partially offset by an increase in group Medicare Advantage membership which generally carries a lower operating cost ratio than our commercial group medical membership as well as operating cost efficiencies.

Healthcare Services Segment

	2014	2013	Change	
			Dollars	Percentage
		(in millions)		
Revenues:				
Services:				
Provider services	$ 1,076	$ 1,125	$ (49)	(4.4)%
Home based services	107	94	13	13.8 %
Pharmacy solutions	99	59	40	67.8 %
Integrated behavioral health services	—	2	(2)	(100.0)%
Total services revenues	1,282	1,280	2	0.2 %
Intersegment revenues:				
Pharmacy solutions	16,905	13,079	3,826	29.3 %
Provider services	1,110	1,080	30	2.8 %
Home based services	585	326	259	79.4 %
Integrated behavioral health services	133	126	7	5.6 %
Total intersegment revenues	18,733	14,611	4,122	28.2 %
Total services and intersegment revenues	$ 20,015	$ 15,891	$ 4,124	26.0 %
Income before income taxes	$ 739	$ 521	$ 218	41.8 %
Operating cost ratio	95.5%	95.8%		(0.3)%

Pretax results

- Healthcare Services segment pretax income of $739 million for 2014 increased $218 million from 2013. The increase is primarily due to a decline in the operating cost ratio in 2014 on a revenue base that reflects growth from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Employer Group segment membership increased to approximately 329 million in 2014, up 20% versus scripts of approximately 274 million in 2013. The increase primarily reflects growth associated with higher average medical membership for 2014 than in 2013.

Services revenue

- Services revenue for 2014 were relatively unchanged from 2013, increasing $2 million, or 0.2% , to $1.3 billion for 2014.

Intersegment revenues

- Intersegment revenues increased $4.1 billion, or 28.2%, from 2013 to $18.7 billion for 2014 primarily due to growth in our Medicare membership which resulted in higher utilization of our pharmacy solutions and home based services businesses.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.5% for 2014 decreased 30 basis points from 95.8% for 2013 primarily due to an improvement in the ratio for our pharmacy solutions business partially offset by our investment in home based services and other businesses across the segment.

Other Businesses

Our Other Businesses pretax income of $78 million for 2014 compared to a pretax loss of $193 million for 2013. The pretax loss in 2013 included net expense of $243 million for reserve strengthening for our closed-block of long-term care insurance policies further discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives. Among the businesses that we are currently evaluating is our closed block of long-term care insurance policies business. While no decision has been made with respect to any course of action, if we were to divest this business it is reasonably likely that we would have to recognize a material loss that will have a material adverse effect on our results of operations. Year-over-year comparisons also reflect the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 as well as a reduction in benefits expense in 2013 related to a favorable settlement of contract claims with the DoD associated with previously disclosed litigation.

Comparison of Results of Operations for 2013 and 2012

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2013 and 2012:

Consolidated

	2013	2012	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 27,204	$ 25,001	$ 2,203	8.8 %
Employer Group	10,930	10,138	792	7.8 %
Other Businesses	695	1,870	(1,175)	(62.8)%
Total premiums	38,829	37,009	1,820	4.9 %
Services:				
Retail	16	24	(8)	(33.3)%
Employer Group	359	371	(12)	(3.2)%
Healthcare Services	1,280	1,023	257	25.1 %
Other Businesses	454	308	146	47.4 %
Total services	2,109	1,726	383	22.2 %
Investment income	375	391	(16)	(4.1)%
Total revenues	41,313	39,126	2,187	5.6 %
Operating expenses:				
Benefits	32,564	30,985	1,579	5.1 %
Operating costs	6,355	5,830	525	9.0 %
Depreciation and amortization	333	295	38	12.9 %
Total operating expenses	39,252	37,110	2,142	5.8 %
Income from operations	2,061	2,016	45	2.2 %
Interest expense	140	105	35	33.3 %
Income before income taxes	1,921	1,911	10	0.5 %
Provision for income taxes	690	689	1	0.1 %
Net income	$ 1,231	$ 1,222	$ 9	0.7 %
Diluted earnings per common share	$ 7.73	$ 7.47	$ 0.26	3.5 %
Benefit ratio (a)	83.9%	83.7%		0.2 %
Operating cost ratio (b)	15.5%	15.1%		0.4 %
Effective tax rate	35.9%	36.1%		(0.2)%

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs as a percentage of total revenues less investment income.

Summary

Net income was $1.2 billion, or $7.73 per diluted common share, in 2013 compared to $1.2 billion, or $7.47 per diluted common share, in 2012. The increase in net income primarily was driven by improved operating performance across most of our major business lines, including Medicare Advantage membership growth in our Retail and Employer

group segments. These increases were partially offset by benefits expense of $0.99 per diluted common share in 2013 for reserve strengthening associated with our closed-block of long-term care insurance policies included with Other Businesses as discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. Year-over-year comparisons of diluted earnings per common share are favorably impacted by a lower number of shares used to compute diluted earnings per common share in 2013 reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $1.8 billion, or 4.9%, from 2012 to $38.8 billion for 2013 primarily due to increases in both Retail and Employer Group segment premiums mainly driven by higher average individual and group Medicare Advantage membership, partially offset by the impact of sequestration which became effective April 1, 2013 as well as a decline in premiums for Other Businesses. The decline in premiums for Other Businesses primarily reflects the transition to the current TRICARE South Region contract effective April 1, 2012, and the termination of the Puerto Rico Medicaid contracts effective September 30, 2013. As discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, on April 1, 2012, we began delivering services under the current TRICARE South Region contract that the DHA awarded to us on February 25, 2011. We account for revenues under the current contract net of estimated healthcare costs similar to an administrative services fee only agreement, and as such there are no premiums recognized under the current contract. Our previous contract was accounted for similar to our fully-insured products and as such we recognized premiums under the previous contract.

Services Revenue

Consolidated services revenue increased $383 million, or 22.2%, from 2012 to $2.1 billion for 2013 primarily due to an increase in services revenue in our Healthcare Services segment and an increase in services revenue for our Other Businesses due to the transition to the current TRICARE South Region contract on April 1, 2012. The increase in services revenue in our Healthcare Services segment primarily resulted from the acquisitions of Metropolitan on December 21, 2012 and SeniorBridge on July 6, 2012, and growth in our provider services operations.

Investment Income

Investment income totaled $375 million for 2013, a decrease of $16 million from 2012, as higher average invested balances were more than offset by lower interest rates and lower net realized capital gains year-over-year.

Benefits Expense

Consolidated benefits expense was $32.6 billion for 2013, an increase of $1.6 billion, or 5.1%, from 2012 primarily due to a year-over-year increase in the Retail and Employer Group segments benefits expense, mainly driven by an increase in the average number of Medicare members, partially offset by a decrease in benefits expense for Other Businesses in 2013. The decrease in benefits expense for Other Businesses primarily was due to the transition to the current administrative services only TRICARE South Region contract on April 1, 2012 and the termination of the Puerto Rico Medicaid contracts effective September 30, 2013. We do not record benefits expense under the current TRICARE South Region contract. Our previous contract was accounted for similarly to our fully-insured products and as such we recorded benefits expense under the previous contract. Retail segment benefits expense increased $1.9 billion, or 8.9%, from 2012 to 2013 primarily due to membership growth. As more fully described herein under the section entitled "Benefits Expense Recognition", actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $474 million in 2013 and $257 million in 2012. These increases in favorable medical claims reserve development primarily resulted from claims trend for the prior year ultimately developing more favorably than originally expected across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope.

The consolidated benefit ratio for 2013 was 83.9%, an increase of 20 basis points from 2012 primarily due to reserve strengthening associated with our closed-block of long-term care insurance policies included with Other

Businesses as discussed above, partially offset by the increase in favorable prior-year medical claims reserve development of $217 million from 2012 to 2013.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs increased $525 million, or 9.0%, in 2013 compared to 2012 primarily due to an increase in operating costs in our Retail and Healthcare Services segments. The increase in the Retail segment primarily reflects investment spending for exchanges under the Health Care Reform Law and new state-based contracts as well as increased marketing spending for Medicare.

The consolidated operating cost ratio for 2013 was 15.5%, increasing 40 basis points from 2012. The impact of the current TRICARE South Region contract being accounted for as an administrative services fee only arrangement beginning April 1, 2012 was partially offset by improved operating leverage in our Retail and Employer Group segments.

Depreciation and Amortization

Depreciation and amortization for 2013 totaled $333 million, an increase of $38 million, or 12.9%, from 2012 primarily due to capital expenditures and depreciation and amortization associated with 2012 and 2013 acquisitions.

Interest Expense

Interest expense was $140 million for 2013 compared to $105 million for 2012, an increase of $35 million, or 33.3%. In December 2012, we issued $600 million of 3.15% senior notes due December 1, 2022 and $400 million of 4.625% senior notes due December 1, 2042.

Income Taxes

Our effective tax rate during 2013 was 35.9% compared to the effective tax rate of 36.1% in 2012. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

			Change	
	2013	2012	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,068,700	1,927,600	141,100	7.3%
Medicare stand-alone PDP	3,271,700	3,052,700	219,000	7.2%
Total Retail Medicare	5,340,400	4,980,300	360,100	7.2%
Individual commercial	600,100	521,400	78,700	15.1%
State-based Medicaid	85,500	52,100	33,400	64.1%
Total Retail medical members	6,026,000	5,553,800	472,200	8.5%
Individual specialty membership (a)	1,042,500	948,700	93,800	9.9%

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2013	2012	Change	
			Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 22,481	$ 20,788	$ 1,693	8.1 %
Medicare stand-alone PDP	3,025	2,853	172	6.0 %
Total Retail Medicare	25,506	23,641	1,865	7.9 %
Individual commercial	1,160	1,004	156	15.5 %
State-based Medicaid	328	185	143	77.3 %
Individual specialty	210	171	39	22.8 %
Total premiums	27,204	25,001	2,203	8.8 %
Services	16	24	(8)	(33.3)%
Total premiums and services revenue	$ 27,220	$ 25,025	$ 2,195	8.8 %
Income before income taxes	$ 1,283	$ 1,161	$ 122	10.5 %
Benefit ratio	84.2%	84.2%		— %
Operating cost ratio	10.9%	11.1%		(0.2)%

Pretax Results

- Retail segment pretax income was $1.3 billion in 2013, an increase of $122 million, or 10.5%, compared to 2012 primarily reflecting improved operating performance over the prior year. The improved operating performance primarily was driven by membership growth as well as a decrease in the operating cost ratio.

Enrollment

- Individual Medicare Advantage membership increased 141,100 members, or 7.3%, from December 31, 2012 to December 31, 2013 reflecting net membership additions for the 2013 enrollment season and sales to newly-eligible Medicare beneficiaries throughout the year. Effective January 1, 2013, we divested approximately 12,600 members acquired with Arcadian Management Services, Inc. in accordance with our previously disclosed agreement with the United States Department of Justice.

- Medicare stand-alone PDP membership increased 219,000 members, or 7.2%, from December 31, 2012 to December 31, 2013 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2013 enrollment season.

- Individual commercial medical membership increased 78,700 members, or 15.1%, from December 31, 2012 to December 31, 2013 primarily reflecting net new sales in 2013. On October 1, 2013, the initial open enrollment period began for plans effective January 1, 2014 offered through federally facilitated, federal-state partnerships or state-based exchanges for individuals and small employers (with up to 100 employees), including certain metropolitan areas in the 14 states where Humana has public exchange offerings.

- State-based Medicaid membership increased 33,400 members, or 64.1%, from December 31, 2012 to December 31, 2013, primarily driven by the addition of our Kentucky Medicaid contract and Florida Long-Term Support Services contracts, including American Eldercare.

- Individual specialty membership increased 93,800 members, or 9.9%, from December 31, 2012 to December 31, 2013 primarily driven by increased membership in dental and vision offerings.

Premiums revenue

- Retail segment premiums increased $2.2 billion, or 8.8%, from 2012 to 2013 primarily due to a 7.6% increase in average individual Medicare Advantage membership in 2013. Individual Medicare Advantage per member

premiums increased approximately 0.5% in 2013 compared to 2012, primarily reflecting the impact of sequestration which became effective on April 1, 2013.

Benefits expense

- The Retail segment benefit ratio of 84.2% for 2013 was comparable to that of 2012. The Retail segment's benefits expense for 2013 included the beneficial effect of $332 million in favorable prior-year medical claims reserve development versus $192 million in 2012. This change in favorable prior-year medical claims reserve development primarily was driven by claims trend for the prior year ultimately developing more favorably than originally expected and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 130 basis points in 2013 versus approximately 80 basis points in 2012.

Operating costs

- The Retail segment operating cost ratio of 10.9% for 2013 decreased 20 basis points from 2012. This decrease reflects scale efficiencies associated with servicing higher year-over-year membership together with our continued focus on operating cost efficiencies, partially offset by investment spending for exchanges under the Health Care Reform Law and new state-based contracts as well as increased Medicare marketing spending.

Employer Group Segment

			Change	
	2013	2012	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,237,000	1,211,800	25,200	2.1 %
ASO	1,162,800	1,237,700	(74,900)	(6.1)%
Group Medicare Advantage	429,100	370,800	58,300	15.7 %
Medicare Advantage ASO	—	27,700	(27,700)	(100.0)%
Total group Medicare Advantage	429,100	398,500	30,600	7.7 %
Group Medicare stand-alone PDP	4,200	4,400	(200)	(4.5)%
Total group Medicare	433,300	402,900	30,400	7.5 %
Total group medical members	2,833,100	2,852,400	(19,300)	(0.7)%
Group specialty membership (a)	6,780,800	7,136,200	(355,400)	(5.0)%

(a) Specialty products include dental, vision, and other supplemental health and voluntary benefit products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2013	2012	Change	
			Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,117	$ 4,996	$ 121	2.4 %
Group Medicare Advantage	4,710	4,064	646	15.9 %
Group Medicare stand-alone PDP	8	8	—	— %
Total group Medicare	4,718	4,072	646	15.9 %
Group specialty	1,095	1,070	25	2.3 %
Total premiums	10,930	10,138	792	7.8 %
Services	359	371	(12)	(3.2)%
Total premiums and services revenue	$ 11,289	$ 10,509	$ 780	7.4 %
Income before income taxes	$ 350	$ 312	$ 38	12.2 %
Benefit ratio	83.5%	83.6%		(0.1)%
Operating cost ratio	15.9%	16.2%		(0.3)%

Pretax Results

- Employer Group segment pretax income increased $38 million, or 12.2%, to $350 million in 2013 reflecting improved operating performance primarily due to group Medicare Advantage membership growth and lower benefit and operating cost ratios, as described below.

Enrollment

- Fully-insured commercial group medical membership increased 25,200 members, or 2.1% from December 31, 2012 as higher small group business membership was partially offset by lower membership in large group accounts. Approximately 61% of our fully-insured commercial group medical membership was in small group accounts at December 31, 2013 compared to 59% at December 31, 2012.

- Fully-insured group Medicare Advantage membership increased 58,300 members, or 15.7%, from December 31, 2012 to December 31, 2013 primarily due to the January 2013 addition of a new large group retirement account.

- Effective January 1, 2013 we lost our sole group Medicare Advantage ASO account which had 27,700 members at December 31, 2012.

- Group ASO commercial medical membership decreased 74,900 members, or 6.1%, from December 31, 2012 to December 31, 2013 primarily due to continued pricing discipline in a highly competitive environment for self-funded accounts.

- Group specialty membership decreased 355,400 members, or 5.0%, from December 31, 2012 to December 31, 2013 primarily due to a decline in vision membership related to our planned discontinuance of certain unprofitable product distribution partnerships.

Premiums revenue

- Employer Group segment premiums increased $792 million, or 7.8%, from 2012 to 2013 primarily due to higher average group Medicare Advantage medical membership.

Benefits expense

- The Employer Group segment benefit ratio decreased 10 basis points from 83.6% in 2012 to 83.5% in 2013 primarily due to higher favorable prior-year medical claims reserve development, partially offset by growth

in our group Medicare Advantage products which generally carry a higher benefit ratio than our fully-insured commercial group products. The Employer Group segment's benefits expense included the beneficial effect of $138 million in favorable prior-year medical claims reserve development versus $48 million in 2012. The change in favorable prior-year medical claims reserve development from 2012 to 2013 primarily was driven by claims trend for the prior year ultimately developing more favorably than originally expected and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. This favorable prior-year medical claims reserve development decreased the Employer Group segment benefit ratio by approximately 130 basis points in 2013 versus approximately 50 basis points in 2012.

Operating costs

- The Employer Group segment operating cost ratio of 15.9% decreased 30 basis points from 2012. This decrease primarily reflects continued savings as a result of our operating cost reduction initiatives and growth in our group Medicare Advantage products which generally carry a lower operating cost ratio than our fully-insured commercial group products, partially offset by investment spending in technology capabilities.

Healthcare Services Segment

	2013	2012	Change	
			Dollars	Percentage
		(in millions)		
Revenues:				
Services:				
Provider services	$ 1,125	$ 966	$ 159	16.5 %
Home based services	94	40	54	135.0 %
Pharmacy solutions	59	16	43	268.8 %
Integrated behavioral health services	2	1	1	100.0 %
Total services revenues	1,280	1,023	257	25.1 %
Intersegment revenues:				
Pharmacy solutions	13,079	11,352	1,727	15.2 %
Provider services	1,080	370	710	191.9 %
Home based services	326	167	159	95.2 %
Integrated behavioral health services	126	133	(7)	(5.3)%
Total intersegment revenues	14,611	12,022	2,589	21.5 %
Total services and intersegment revenues	$ 15,891	$ 13,045	$ 2,846	21.8 %
Income before income taxes	$ 521	$ 428	$ 93	21.7 %
Operating cost ratio	95.8%	96.1%		(0.3)%

Pretax results

- Healthcare Services segment pretax income of $521 million for 2013 increased $93 million from 2012 as revenue growth and the pretax income contribution from our home based services and pharmacy solutions businesses, as well as the acquisition of Metropolitan, were partially offset by previously-planned investment spending associated with the integration and build-out of provider practices. The growth in pretax income associated with our home based services business reflects the increase in home health services provided to our Medicare Advantage members.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Employer Group segment membership increased to approximately 274 million in 2013, up 15% versus scripts of approximately 238 million in 2012.

The increase primarily reflects growth associated with higher average medical membership for 2013 than in 2012.

Services revenue

- Services revenue increased $257 million or 25.1% from 2012 to $1.3 billion for 2013 primarily due to the acquisitions of Metropolitan and SeniorBridge as well as growth in our provider services operations.

Intersegment revenues

- Intersegment revenues increased $2.6 billion, or 21.5%, from 2012 to $14.6 billion for 2013 primarily due to growth in our pharmacy solutions business as it serves our growing membership, particularly Medicare stand-alone PDP, and the acquisition of Metropolitan in the fourth quarter of 2012.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.8% for 2013 decreased 30 basis points from 96.1% for 2012 primarily due to scale efficiencies associated with growth in our pharmacy solutions business.

Other Businesses

Our Other Businesses pretax loss of $193 million for 2013 compared to a pretax loss of $18 million for 2012. The pretax losses in 2013 and 2012 included net expense of $243 million and $29 million, respectively, for reserve strengthening for our closed-block of long-term care insurance policies further discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. In addition, 2013 reflects the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 offset by the beneficial effect of a favorable settlement of contract claims with the DoD primarily associated with litigation settled in 2012.

Liquidity

Our primary sources of cash include receipts of premiums, services revenue, and investment and other income, as well as proceeds from the sale or maturity of our investment securities and borrowings. Our primary uses of cash include disbursements for claims payments, operating costs, interest on borrowings, taxes, purchases of investment securities, acquisitions, capital expenditures, repayments on borrowings, dividends, and share repurchases. Because premiums generally are collected in advance of claim payments by a period of up to several months, our business normally should produce positive cash flows during periods of increasing premiums and enrollment. Conversely, cash flows would be negatively impacted during periods of decreasing premiums and enrollment. From period to period, our cash flows may also be affected by the timing of working capital items including taxes and assessments. The use of operating cash flows may be limited by regulatory requirements which require, among other items, that our regulated subsidiaries maintain minimum levels of capital and seek approval before paying dividends from the subsidiaries to the parent. Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by Departments of Insurance.

For 2014, the effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law, commonly referred to as the 3Rs, impacted the timing of our operating cash flows, as we built a receivable in 2014 that is expected to be collected in 2015. The net receivable balance associated with the 3Rs was $679 million at December 31, 2014. In addition, our 2014 financing cash flows have been negatively impacted by the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies for which we do not assume risk. We are experiencing higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which resulted in higher reinsurance subsidy receivables balances in 2014 that will be settled in 2015 under the terms of our contracts with CMS. Any amounts receivable or payable associated with these risk limiting programs and CMS subsidies may have an impact on regulated subsidiary liquidity, with any temporary shortfalls funded by the parent company.

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2014 Form 10-K.

Cash and cash equivalents increased to $1.9 billion at December 31, 2014 from $1.1 billion at December 31, 2013. The change in cash and cash equivalents for the years ended December 31, 2014, 2013 and 2012 is summarized as follows:

	2014	2013	2012
		(in millions)	
Net cash provided by operating activities	$ 1,618	$ 1,716	$ 1,923
Net cash used in investing activities	(63)	(1,182)	(1,965)
Net cash used in financing activities	(758)	(702)	(29)
Increase (decrease) in cash and cash equivalents	$ 797	$ (168)	$ (71)

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in earnings, enrollment activity, and the timing of working capital items as discussed below. Cash flows were positively impacted by annual Medicare enrollment gains because premiums generally are collected in advance of claim payments by a period of up to several months. In addition, 2014 operating cash flows were impacted by lower earnings and increased receivables associated with the 3Rs, partially offset by an increase in benefits payable from growth in membership.

Comparisons of our operating cash flows also are impacted by other changes in our working capital. The most significant drivers of changes in our working capital are typically the timing of receipts for premiums and payments of benefits expense. We illustrate these changes with the following summaries of receivables and benefits payable.

The detail of total net receivables was as follows at December 31, 2014, 2013 and 2012:

				Change		
	2014	2013	2012	2014	2013	2012
			(in millions)			
Medicare	$ 664	$ 576	$ 422	$ 88	$ 154	$ 86
Commercial and other	535	405	346	130	59	31
Military services	106	87	59	19	28	(409)
Allowance for doubtful accounts	(137)	(118)	(94)	(19)	(24)	(9)
Total net receivables	$ 1,168	$ 950	$ 733	218	217	(301)
Reconciliation to cash flow statement:						
Provision for doubtful accounts				32	37	26
Receivables from disposition (acquisition)				14	(3)	(51)
Change in receivables per cash flow statement resulting in cash from operations				$ 264	$ 251	$ (326)

Medicare receivables are impacted by revenue growth associated with growth in individual and group Medicare membership and the timing of accruals and related collections associated with the CMS risk-adjustment model.

The increases in commercial and other receivables in 2014 and 2013 primarily are due to growth in the business. In addition, the increase in commercial and other receivables in 2014 is primarily due to the commercial risk adjustment provision of the Health Care Reform Law which became effective in 2014.

Military services receivables at December 31, 2014 and 2013 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our current TRICARE South Region contract. The $409 million decrease in military services receivables from December 31, 2011 to December 31, 2012 primarily resulted from the transition to our current TRICARE South Region contract which we account for similar to

an administrative services fee only agreement. As such, beginning April 1, 2012, payments of the federal government's claims and related reimbursements for the current TRICARE South Region contract are classified with receipts (withdrawals) from contract deposits as a financing item in our consolidated statements of cash flows.

The detail of benefits payable was as follows at December 31, 2014, 2013 and 2012:

				Change		
	2014	2013	2012	2014	2013	2012
			(in millions)			
IBNR (1)	$ 3,254	$ 2,586	$ 2,552	$ 668	$ 34	$ 496
Reported claims in process (2)	475	381	315	94	66	(61)
Military services benefits payable (3)	—	—	4	—	(4)	(335)
Other benefits payable (4)	746	926	908	(180)	18	(75)
Total benefits payable	$ 4,475	$ 3,893	$ 3,779	582	114	25
Payables from acquisition				—	(5)	(66)
Change in benefits payable per cash flow statement resulting in cash from operations				$ 582	$ 109	$ (41)

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) and claims received but not processed at the balance sheet date. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).

(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling, as well as amounts owed to our pharmacy benefit administrator which fluctuate due to bi-weekly payments and the month-end cutoff.

(3) Military services benefits payable primarily represents the run-out of the claims liability associated with our previous TRICARE South Region contract that expired on March 31, 2012. A corresponding receivable for reimbursement by the federal government is included in the military services receivable in the previous receivables table.

(4) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The increase in benefits payable in 2014 primarily was due to an increase in IBNR, primarily as a result of Medicare Advantage and individual commercial membership growth, and an increase in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuate due to month-end cutoff. These items were partially offset by a decrease in amounts owed to providers under capitated and risk sharing arrangements primarily related to the disbursement of a portion of our Medicare risk adjustment collections under our contractual obligations associated with our risk sharing arrangements. The increase in benefits payable in 2013 primarily was due to an increase in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuate due to month-end cutoff, and an increase in IBNR, primarily as a result of Medicare Advantage membership growth. The increase in benefits payable in 2012 primarily was due to an increase in IBNR, primarily as a result of Medicare Advantage membership growth, partially offset by a $335 million decrease in the military services benefits payable due to the run-out of claims under the previous TRICARE South Region contract that expired on March 31, 2012, a decrease in the amounts owed to providers under capitated and risk sharing arrangements, and a decrease in the amounts due to our pharmacy benefit administrator which fluctuate due to month-end cutoff. Under the current TRICARE South Region contract effective April 1, 2012, the federal government retains the risk of the cost of health benefits and related benefit obligation as further described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. As discussed previously, the timing of payments and receipts associated with these provisions impacted our operating cash

flows as we built a receivable in 2014 that is expected to be collected in 2015. The net receivable balance associated with the 3Rs was approximately $679 million at December 31, 2014, including certain amounts recorded in receivables as noted above. In September 2014, we paid the federal government $562 million for the annual health insurance industry fee.

In addition to the timing of receipts for premiums and services revenues, payments of benefits expense, and amounts due under the risk limiting and health insurance industry fee provisions of the Health Care Reform Law, other working capital items impacting operating cash flows primarily resulted from the timing of payments for the Medicare Part D risk corridor provisions of our contracts with CMS and changes in the timing of the collection of pharmacy rebates.

Cash Flow from Investing Activities

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $528 million in 2014, $441 million in 2013, and $410 million in 2012. Excluding acquisitions, we expect total capital expenditures in 2015 to be in a range of approximately $575 million to $625 million primarily reflecting increased spending associated with growth in our provider services and pharmacy businesses in our Healthcare Services segment.

Proceeds from sales and maturities of investment securities exceeded purchases by $411 million in 2014. These net proceeds were used to fund normal working capital needs due to an increase in receivables in 2014 that will be collected in 2015 associated with the 3Rs in addition to the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies, as discussed below. We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $592 million in 2013 and $320 million in 2012.

Cash consideration paid for acquisitions, net of cash acquired, was $18 million in 2014, $187 million in 2013, and $1.2 billion in 2012. Acquisitions in 2014 included health and wellness related acquisitions. Cash paid for acquisitions in 2013 primarily related to the American Eldercare and other health and wellness related acquisitions. In 2012, acquisitions included Metropolitan, Arcadian, SeniorBridge and other health and wellness and technology related acquisitions.

Cash Flow from Financing Activities

Claims payments were $945 million higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk during 2014, $155 million higher during 2013, and $341 million higher during 2012. As discussed previously, our 2014 financing cash flows have been negatively impacted by the timing of payments to and receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. We experienced higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which is resulting in higher subsidy receivable balances in 2014 that will be settled in 2015 under the terms of our contracts with CMS. Our net receivable for CMS subsidies and brand name prescription drug discounts was $1.7 billion at December 31, 2014 compared to $713 million at December 31, 2013. Refer to Note 6 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Under our current administrative services only TRICARE South Region contract that began April 1, 2012, reimbursements from the federal government equaled health care cost payments for which we do not assume risk in 2014. Health care cost payments were less than reimbursements by $5 million in 2013 and exceeded reimbursements by $56 million in 2012 due to the timing of such receipts. Receipts from HHS associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were $26 million higher than claims payments for the year ended 2014. See Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for further description.

We repurchased 5.7 million shares for $730 million in 2014, which excludes another $100 million of stock held back pending final settlement of an accelerated stock repurchase plan, 5.8 million shares for $502 million in 2013, and

6.3 million shares for $460 million in 2012 under share repurchase plans authorized by the Board of Directors. We also acquired common shares in connection with employee stock plans for an aggregate cost of $42 million in 2014, $29 million in 2013, and $58 million in 2012.

As discussed further below, we paid dividends to stockholders of $172 million in 2014, $168 million in 2013, and $165 million in 2012.

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem our $500 million 6.45% senior unsecured notes.

In December 2012, we issued $600 million of 3.15% senior notes due December 1, 2022 and $400 million of 4.625% senior notes due December 1, 2042. Our net proceeds, reduced for the discount and cost of the offering, were $990 million. We used the proceeds from the offering primarily to finance the acquisition of Metropolitan, including the retirement of Metropolitan’s indebtedness, and to pay related fees and expenses.

In March 2012, we repaid, without penalty, junior subordinated long-term debt of $36 million.

The remainder of the cash used in or provided by financing activities in 2014, 2013, and 2012 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2012, 2013, and 2014 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2012	$1.02	$ 165
2013	$1.06	$ 167
2014	$1.10	$ 170

In October 2014, the Board declared a cash dividend of $0.28 per share that was paid on January 30, 2015 to stockholders of record on December 31, 2014, for an aggregate amount of $42 million. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

Stock Repurchase Authorization

In September 2014, the Board of Directors replaced its previously approved share repurchase authorization of up to $1 billion (of which $816 million remained unused) with the current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Under the current share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions (including pursuant to an accelerated share repurchase agreement with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. As of February 18, 2015, the remaining authorized amount under the current authorization totaled approximately $1.37 billion, after giving effect to the $500 million accelerated share repurchase program we entered into in November 2014 with Goldman, Sachs & Co.

Senior Notes

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds,

reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem the $500 million 6.45% senior unsecured notes as discussed below.

In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $560 million. We recognized a loss on extinguishment of debt, included in interest expense, of approximately $37 million in connection with the redemption of these notes.

Credit Agreement

Our 5-year $1.0 billion unsecured revolving credit agreement expires July 2018. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110 basis points, varies depending on our credit ratings ranging from 90 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 10 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $7.8 billion at December 31, 2014 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $9.6 billion and actual leverage ratio of 1.4:1, as measured in accordance with the credit agreement as of December 31, 2014. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2014, we had no borrowings outstanding under the credit agreement. We have outstanding letters of credit of $4 million issued under the credit agreement at December 31, 2014. No amounts have been drawn on these letters of credit. Accordingly, as of December 31, 2014, we had $996 million of remaining borrowing capacity under the credit agreement, none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

In October 2014, we entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time, with the aggregate face or principal amounts outstanding under the program at any time not to exceed $1 billion. The net proceeds of issuances have been and are expected to be used for general corporate purposes, including to repurchase shares of our common stock. The maximum principal amount of commercial paper borrowings outstanding at any one time during the year ended December 31, 2014 was $175 million. There were no outstanding borrowings at December 31, 2014.

Liquidity Requirements

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement and our commercial paper program or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares.

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2014 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $750 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis

points, or annual interest expense by $2 million, up to a maximum 100 basis points, or annual interest expense by $8 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, certain of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated insurance subsidiaries. Cash, cash equivalents, and short-term investments at the parent company increased to $1.4 billion at December 31, 2014 from $508 million at December 31, 2013 primarily due to net proceeds of $1.73 billion from the September 2014 issuance of senior notes, offset by the $560 million senior note redemption discussed above and share repurchases. Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by Departments of Insurance. Our subsidiaries paid dividends to the parent of $927 million in 2014, $967 million in 2013, and $1.2 billion in 2012. The declines in dividends to the parent in 2013 and 2014 primarily were a result of higher surplus requirements associated with premium growth. Refer to our parent company financial statements and accompanying notes in Schedule I – Parent Company Financial Information. Regulatory requirements, including subsidiary dividends to the parent, are discussed in more detail in the following section. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2015 is approximately $800 million in the aggregate.

In September 2014, we paid the federal government $562 million for the annual health insurance industry fee attributed to calendar year 2014, in accordance with the Health Care Reform Law. In 2015, the health insurance industry fee increases by 41% for the industry taken as a whole. Accordingly, absent changes in market share, we would expect a 41% increase in our fee in 2015.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to the parent, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2014 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
			(in millions)		
Debt	$ 3,800	$ —	$ —	$ 1,200	$ 2,600
Interest (1)	2,753	187	369	294	1,903
Operating leases (2)	1,145	232	361	188	364
Purchase obligations (3)	175	95	64	16	—
Future policy benefits payable and other long-term liabilities (4)	2,708	78	398	231	2,001
Total	$ 10,581	$ 592	$ 1,192	$ 1,929	$ 6,868

(1) Interest includes the estimated contractual interest payments under our debt agreements.

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2027. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. An operating lease is a type of off-balance sheet arrangement. Assuming we acquired the asset, rather than leased such asset, we would have recognized a liability for the financing of these assets. See also Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(3) Purchase obligations include agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty.

(4) Includes future policy benefits payable ceded to third parties through 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We expect the assuming reinsurance carriers to fund these obligations and reflected these amounts as reinsurance recoverables included in other long-term assets on our consolidated balance sheet. Amounts payable in less than one year are included in trade accounts payable and accrued expenses in the consolidated balance sheet.

Off-Balance Sheet Arrangements

As of December 31, 2014, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion off-balance sheet arrangements, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion our guarantees and indemnifications, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Critical Accounting Policies and Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements and accompanying notes, which have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements and accompanying notes requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We continuously evaluate our estimates and those critical accounting policies related primarily to benefits expense and revenue recognition as well as accounting for impairments related to our investment securities, goodwill, and long-lived assets. These estimates are based on knowledge of current events and anticipated future events and, accordingly, actual results ultimately may differ from those estimates. We believe the following critical accounting policies involve the most significant judgments and estimates used in the preparation of our consolidated financial statements.

Benefits Expense Recognition

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. IBNR represents a substantial portion of our benefits payable as follows:

	December 31, 2014	Percentage of Total	December 31, 2013	Percentage of Total
	(dollars in millions)			
IBNR	$ 3,254	72.7%	$ 2,586	66.4%
Reported claims in process	475	10.6%	381	9.8%
Other benefits payable	746	16.7%	926	23.8%
Total benefits payable	$ 4,475	100.0%	$ 3,893	100.0%

Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent three months, the key assumption used in estimating our IBNR is that the completion factor pattern remains consistent over a rolling 12-month period after adjusting for known changes in claim inventory levels and known changes in claim payment processes. Completion factors result from the calculation of the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. For the most recent three months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and weekday seasonality.

The completion factor method is used for the months of incurred claims prior to the most recent three months because the historical percentage of claims processed for those months is at a level sufficient to produce a consistently reliable result. Conversely, for the most recent three months of incurred claims, the volume of claims processed historically is not at a level sufficient to produce a reliable result, which therefore requires us to examine historical trend patterns as the primary method of evaluation. Changes in claim processes, including recoveries of overpayments, receipt cycle times, claim inventory levels, outsourcing, system conversions, and processing disruptions due to weather or other events affect views regarding the reasonable choice of completion factors. Claim payments to providers for services rendered are often net of overpayment recoveries for claims paid previously, as contractually allowed. Claim overpayment recoveries can result from many different factors, including retroactive enrollment activity, audits of provider billings, and/or payment errors. Changes in patterns of claim overpayment recoveries can be unpredictable and result in completion factor volatility, as they often impact older dates of service. The receipt cycle time measures the average length of time between when a medical claim was initially incurred and when the claim form was received. Increases in electronic claim submissions from providers decrease the receipt cycle time. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claim may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required.

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of

each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, and epidemics also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent three months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent three months. Each of these factors requires significant judgment by management.

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent three months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderate adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2014 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
1.40%	$(357)	(4.00)%	$(381)
1.20%	$(306)	(3.50)%	$(333)
1.00%	$(255)	(3.00)%	$(286)
0.80%	$(204)	(2.50)%	$(238)
0.60%	$(153)	(2.25)%	$(214)
0.40%	$(102)	(2.00)%	$(190)
0.20%	$(51)	(1.50)%	$(143)

(a) Reflects estimated potential changes in benefits payable at December 31, 2014 caused by changes in completion factors for incurred months prior to the most recent three months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2014 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent three months.

(c) The factor change indicated represents the percentage point change.

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals.

	2014	2013	2012
		(in millions)	
Balances at January 1	$ 3,893	$ 3,775	$ 3,415
Acquisitions	—	5	66
Incurred related to:			
Current year	38,641	32,711	30,198
Prior years	(518)	(474)	(257)
Total incurred	38,123	32,237	29,941
Paid related to:			
Current year	(34,357)	(29,103)	(26,738)
Prior years	(3,262)	(3,021)	(2,909)
Total paid	(37,619)	(32,124)	(29,647)
Reinsurance recoverable	78	—	—
Balances at December 31	$ 4,475	$ 3,893	$ 3,775

The following table summarizes the changes in estimate for incurred claims related to prior years attributable to our key assumptions. As previously described, our key assumptions consist of trend and completion factors estimated using an assumption of moderately adverse conditions. The amounts below represent the difference between our original estimates and the actual benefits expense ultimately incurred as determined from subsequent claim payments.

	Favorable Development by Changes in Key Assumptions					
	2014		2013		2012	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
			(dollars in millions)			
Trend factors	$ (266)	(3.7)%	$ (233)	(3.4)%	$ (138)	(2.4)%
Completion factors	(252)	1.2 %	(241)	1.2 %	(119)	0.7 %
Total	$ (518)		$ (474)		$ (257)	

(a) The factor change indicated represents the percentage point change.

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $518 million in 2014, $474 million in 2013, and $257 million in 2012. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2014, 2013, and 2012.

	Favorable Medical Claims Reserve Development			Change	
	2014	2013	2012	2014	2013
			(in millions)		
Retail Segment	$ (385)	$ (332)	$ (192)	$ (53)	$ (140)
Employer Group Segment	(132)	(138)	(48)	6	(90)
Other Businesses	(1)	(4)	(17)	3	13
Total	$ (518)	$ (474)	$ (257)	$ (44)	$ (217)

The favorable medical claims reserve development for 2014, 2013, and 2012 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. In addition, the favorable medical claims reserve development during 2014 and 2013 reflects increased membership and better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2014 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense associated with military services and provisions associated with future policy benefits excluded from the previous table was as follows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
		(in millions)	
Military services	$ 11	$ (27)	$ 908
Future policy benefits	32	354	136
Total	$ 43	$ 327	$ 1,044

Due to the transition to the current TRICARE South Region contract on April 1, 2012, which is accounted for as an administrative services only contract as more fully described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, there was no military services benefits payable at December 31, 2014 or 2013. This transition is also the primary reason for the decline in military services benefits expense from 2012 to 2013.

Future policy benefits payable of $2.3 billion and $2.2 billion at December 31, 2014 and 2013, respectively, represent liabilities for long-duration insurance policies including long-term care insurance, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs.

Future policy benefits payable include $1.5 billion at December 31, 2014 and $1.4 billion at December 31, 2013 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Approximately 32,700 policies remain in force as of December 31, 2014. No new policies have been written since 2005 under this closed block. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was $123 million of additional liability at December 31, 2014 and no additional

liability at December 31, 2013. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. A prolonged period during which interest rates remain at levels lower than those anticipated in our reserving would result in shortfalls in investment income on assets supporting our obligation under long term care policies because the long duration of the policy obligations exceeds the duration of the supporting investment assets. Further, we monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases and/or loss experience vary from our loss recognition date assumptions, future adjustments to reserves could be required.

During 2013, we recorded a loss for a premium deficiency with respect to our closed block of long-term care insurance policies. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2010 loss recognition date, particularly as they related to emerging experience due to an increase in life expectancies and utilization of home health care services. Based on this deterioration, and combined with lower interest rates, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed-block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2013 we recorded $243 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $350 million partially offset by a related reinsurance recoverable of $107 million included in other long-term assets.

During 2012, we recorded a change in estimate associated with future policy benefits payable for our closed-block of long-term care insurance policies resulting in additional benefits expense of $29 million and a corresponding increase in future policy benefits payable. This change in estimate was based on current claim experience demonstrating an increase in the length of the time policyholders already in payment status remained in such status. Future policy benefits payable was increased to cover future payments to policyholders currently in payment status.

For our closed block of long-term care policies, actuarial assumptions used to estimate reserves are inherently uncertain due to the potential changes in trends in mortality, morbidity, persistency (the percentage of policies remaining in-force) and interest rates. As a result, our long term care reserves may be subject to material increases if these trends develop adversely to our expectations. The estimated increase in reserves and additional benefit expense from hypothetically modeling adverse variations in our actuarial assumptions, in the aggregate, could be up to $300 million, net of reinsurance. Although such hypothetical revisions are not currently appropriate, we believe they could occur based on past variances in experience and our expectation of the ranges of future experience that could reasonably occur. Generally accepted accounting principles do not allow us to unlock our assumptions for favorable items. This hypothetical modeling does not contemplate a divestiture situation. We are evaluating alternatives related to our closed block of long term care policies. While no decision has been made with respect to any course of action, if we were to divest this business, it is reasonably likely that we would have to recognize a material loss and that loss could exceed the amount provided above.

In addition, future policy benefits payable includes amounts of $210 million at December 31, 2014, $215 million at December 31, 2013, and $220 million at December 31, 2012 which are subject to 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, and as such are offset by a related reinsurance recoverable included in other long-term assets.

Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Our commercial contracts establish rates on a per employee basis for each month of coverage based on the type of coverage purchased (single to family coverage options). Our Medicare and Medicaid contracts also establish monthly rates per member. However, our Medicare contracts also have additional provisions as outlined in the following separate section.

Premiums revenue and administrative services only, or ASO, fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. In addition, we adjust revenues for estimated changes in an employer's enrollment and individuals that ultimately may fail to pay, and for estimated rebates under the minimum benefit ratios required under the Health Care Reform Law. . Enrollment changes not yet processed or not yet reported by an employer group or the government, also known as retroactive membership adjustments, are estimated based on available data and historical trends. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in the current period's revenue.

We bill and collect premium remittances from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from CMS for our Medicare products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are recognized when the amounts become determinable and the collectibility is reasonably assured.

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to Medicare Advantage plans. Rates paid to Medicare Advantage plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model is more fully described in Item 1. – Business under the section titled "Individual Medicare."

Investment Securities

Investment securities totaled $9.5 billion, or 41% of total assets at December 31, 2014, and $9.8 billion, or 47% of total assets at December 31, 2013. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2014 and 2013. The fair value of debt securities were as follows at December 31, 2014 and 2013:

	December 31, 2014	Percentage of Total	December 31, 2013	Percentage of Total
		(dollars in millions)		
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 374	3.9%	$ 584	6.0%
Mortgage-backed securities	1,498	15.7%	1,820	18.6%
Tax-exempt municipal securities	3,068	32.1%	2,971	30.3%
Mortgage-backed securities:				
Residential	17	0.2%	22	0.2%
Commercial	843	8.8%	673	6.9%
Asset-backed securities	29	0.3%	63	0.6%
Corporate debt securities	3,718	39.0%	3,667	37.4%
Total debt securities	$ 9,547	100.0%	$ 9,800	100.0%

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2014. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $199 million at December 31, 2014 and $222 million at December 31, 2013. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.0 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for $1.8 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 11%. In addition, certain monoline insurers guarantee the timely repayment of bond principal and interest when a bond issuer defaults and generally provide credit enhancement for bond issues related to our tax-exempt municipal securities. We have no direct exposure to these monoline insurers. We owned $484 million and $548 million at December 31, 2014 and 2013, respectively, of tax-exempt securities guaranteed by monoline insurers. The equivalent weighted average S&P credit rating of these tax-exempt securities without the guarantee from the monoline insurer was AA.

Our direct exposure to subprime mortgage lending is limited to investment in residential mortgage-backed securities and asset-backed securities backed by home equity loans. The fair value of securities backed by Alt-A and subprime loans was $1 million at December 31, 2014 and 2013. There are no collateralized debt obligations or structured investment vehicles in our investment portfolio. The percentage of corporate securities associated with the financial services industry was 21% at December 31, 2014 and 23% at December 31, 2013.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2014:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2014						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 79	$ —	$ 80	$ (1)	$ 159	$ (1)
Mortgage-backed securities	22	—	320	(5)	342	(5)
Tax-exempt municipal securities	131	(1)	118	(2)	249	(3)
Mortgage-backed securities:						
Residential	1	—	4	—	5	—
Commercial	31	(1)	267	(18)	298	(19)
Asset-backed securities	13	—	—	—	13	—
Corporate debt securities	219	(6)	128	(7)	347	(13)
Total debt securities	$ 496	$ (8)	$ 917	$ (33)	$ 1,413	$ (41)

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an investment is other than temporary requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2014 primarily were composed of senior tranches having high

credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2014.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2014 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2014, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2014. There were no material other-than-temporary impairments in 2014, 2013, or 2012.

Goodwill and Long-lived Assets

At December 31, 2014, goodwill and other long-lived assets represented 24% of total assets and 59% of total stockholders' equity, compared to 27% and 61%, respectively, at December 31, 2013.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition. The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2014 segment change discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk, including those resulting from changes in interest rates.

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. Prior to 2009, under interest rate swap agreements, we exchanged the fixed interest rate under all of our senior notes for a variable interest rate based on LIBOR using interest rate swap agreements. We terminated all of our interest rate swap agreements in 2008. We may re-enter into interest rate swap agreements in the future depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $1.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2014 or December 31, 2013.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA- at December 31, 2014. Our net unrealized position increased $225 million from a net unrealized gain position of $250 million at December 31, 2013 to a net unrealized gain position of $475 million at December 31, 2014. At December 31, 2014, we had gross unrealized losses of $41 million on our investment portfolio primarily due to an increase in market interest rates in the current markets than when the securities were purchased, and as such, there were no material other-than-temporary impairments during 2014. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 4.1 years as of December 31, 2014 and 4.3 years as of December 31, 2013. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $466 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2014 and 2013. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have exceeded 300 basis points once, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points three times, and have changed by less than 100 basis points six times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2014						
Investment income (a)	$ (20)	$ (15)	$ (9)	$ 42	$ 85	$ 128
Interest expense (b)	—	—	—	—	—	—
Pretax	$ (20)	$ (15)	$ (9)	$ 42	$ 85	$ 128
As of December 31, 2013						
Investment income (a)	$ (24)	$ (16)	$ (8)	$ 26	$ 52	$ 79
Interest expense (b)	—	—	—	—	—	—
Pretax	$ (24)	$ (16)	$ (8)	$ 26	$ 52	$ 79

(a) As of December 31, 2014 and 2013, some of our investments had interest rates below 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2014 or December 31, 2013 or under our commercial paper program (commenced in October 2014) at December 31, 2014.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2014	2013
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,935	$ 1,138
Investment securities	7,598	8,090
Receivables, less allowance for doubtful accounts of $137 in 2014 and $118 in 2013	1,168	950
Other current assets	4,011	2,122
Total current assets	14,712	12,300
Property and equipment, net	1,419	1,218
Long-term investment securities	1,949	1,710
Goodwill	3,711	3,733
Other long-term assets	1,675	1,774
Total assets	$ 23,466	$ 20,735
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 4,475	$ 3,893
Trade accounts payable and accrued expenses	2,185	1,821
Book overdraft	334	403
Unearned revenues	361	206
Total current liabilities	7,355	6,323
Long-term debt	3,825	2,600
Future policy benefits payable	2,349	2,207
Other long-term liabilities	291	289
Total liabilities	13,820	11,419
Commitments and contingencies (Note 16)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 197,951,551 shares issued at December 31, 2014 and 196,275,506 shares issued at December 31, 2013	33	33
Capital in excess of par value	2,330	2,267
Retained earnings	9,916	8,942
Accumulated other comprehensive income	223	158
Treasury stock, at cost, 48,347,541 shares at December 31, 2014 and 42,245,097 shares at December 31, 2013	(2,856)	(2,084)
Total stockholders' equity	9,646	9,316
Total liabilities and stockholders' equity	$ 23,466	$ 20,735

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2014	2013	2012
	(in millions, except per share results)		
Revenues:			
Premiums	$ 45,959	$ 38,829	$ 37,009
Services	2,164	2,109	1,726
Investment income	377	375	391
Total revenues	48,500	41,313	39,126
Operating expenses:			
Benefits	38,166	32,564	30,985
Operating costs	7,639	6,355	5,830
Depreciation and amortization	333	333	295
Total operating expenses	46,138	39,252	37,110
Income from operations	2,362	2,061	2,016
Interest expense	192	140	105
Income before income taxes	2,170	1,921	1,911
Provision for income taxes	1,023	690	689
Net income	$ 1,147	$ 1,231	$ 1,222
Basic earnings per common share	$ 7.44	$ 7.81	$ 7.56
Diluted earnings per common share	$ 7.36	$ 7.73	$ 7.47
Dividends declared per common share	$ 1.11	$ 1.07	$ 1.03

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2014	2013	2012
	(in millions)		
Net income	$ 1,147	$ 1,231	$ 1,222
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	122	(338)	164
Effect of income taxes	(44)	124	(60)
Total change in unrealized investment gains/losses, net of tax	78	(214)	104
Reclassification adjustment for net realized gains included in investment income	(20)	(22)	(33)
Effect of income taxes	7	8	12
Total reclassification adjustment, net of tax	(13)	(14)	(21)
Other comprehensive income (loss), net of tax	65	(228)	83
Comprehensive income	$ 1,212	$ 1,003	$ 1,305

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2012	193,230	$ 32	$ 1,938	$ 6,825	$ 303	$ (1,035)	$ 8,063
Net income				1,222			1,222
Other comprehensive income					83		83
Common stock repurchases						(518)	(518)
Dividends and dividend equivalents			—	(166)			(166)
Stock-based compensation			82				82
Restricted stock grants and restricted stock unit vesting	15	—					—
Restricted stock forfeitures	(1)	—	—				—
Stock option exercises	1,227	—	60				60
Stock option and restricted stock tax benefit			21				21
Balances, December 31, 2012	194,471	32	2,101	7,881	386	(1,553)	8,847
Net income				1,231			1,231
Other comprehensive loss					(228)		(228)
Common stock repurchases						(531)	(531)
Dividends and dividend equivalents			—	(170)			(170)
Stock-based compensation			92				92
Restricted stock unit vesting	563	—					—
Stock option exercises	1,242	1	66				67
Stock option and restricted stock tax benefit			8				8
Balances, December 31, 2013	196,276	33	2,267	8,942	158	(2,084)	9,316
Net income				1,147			1,147
Other comprehensive income					65		65
Common stock repurchases			(100)			(772)	(872)
Dividends and dividend equivalents			—	(173)			(173)
Stock-based compensation			98				98
Restricted stock unit vesting	966	—					—
Stock option exercises	710	—	52				52
Stock option and restricted stock tax benefit			13				13
Balances, December 31, 2014	197,952	$ 33	$ 2,330	$ 9,916	$ 223	$ (2,856)	$ 9,646

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2014	2013	2012
		(in millions)	
Cash flows from operating activities			
Net income	$ 1,147	$ 1,231	$ 1,222
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	449	426	338
Stock-based compensation	98	92	82
Net realized capital gains	(20)	(22)	(33)
(Benefit) provision for deferred income taxes	(64)	42	(80)
Provision for doubtful accounts	32	37	26
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(264)	(251)	326
Other assets	(952)	(330)	(253)
Benefits payable	582	109	(41)
Other liabilities	413	313	300
Unearned revenues	155	(24)	(43)
Other	42	93	79
Net cash provided by operating activities	1,618	1,716	1,923
Cash flows from investing activities			
Acquisitions, net of cash acquired	(18)	(187)	(1,235)
Proceeds from sale of business	72	34	—
Purchases of property and equipment	(528)	(441)	(410)
Proceeds from sales of property and equipment	—	4	—
Purchases of investment securities	(2,883)	(3,261)	(3,221)
Maturities of investment securities	885	1,077	1,497
Proceeds from sales of investment securities	2,409	1,592	1,404
Net cash used in investing activities	(63)	(1,182)	(1,965)
Cash flows from financing activities			
Receipts (withdrawals) from contract deposits, net	(919)	(150)	(397)
Proceeds from issuance of senior notes, net	1,733	—	990
Repayment of long-term debt	(500)	—	(36)
Common stock repurchases	(872)	(531)	(518)
Dividends paid	(172)	(168)	(165)
Excess tax benefit from stock-based compensation	12	8	22
Change in book overdraft	(69)	79	18
Proceeds from stock option exercises and other, net	29	60	57
Net cash used in financing activities	(758)	(702)	(29)
Increase (decrease) in cash and cash equivalents	797	(168)	(71)
Cash and cash equivalents at beginning of year	1,138	1,306	1,377
Cash and cash equivalents at end of year	$ 1,935	$ 1,138	$ 1,306
Supplemental cash flow disclosures:			
Interest payments	$ 143	$ 146	$ 110
Income tax payments, net	$ 1,030	$ 734	$ 745
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 18	$ 196	$ 1,535
Less: Fair value of liabilities assumed	—	(9)	(300)
Cash paid for acquired businesses, net of cash acquired	$ 18	$ 187	$ 1,235

The accompanying notes are an integral part of the consolidated financial statements.

Humana, Inc.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. The company's strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 73% of our total premiums and services revenue from contracts with the federal government in 2014, including 15% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

Our financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America. Our consolidated financial statements include the accounts of Humana Inc. and subsidiaries that the Company controls, including variable interest entities associated with medical practices for which we are the primary beneficiary. We do not own many of our medical practices but instead enter into exclusive long-term management agreements with the affiliated Professional Associations, or P.A.s, that operate these medical practices. Based upon the provisions of these agreements, these affiliated P.A.s are variable interest entities and we are the primary beneficiary, and accordingly we consolidated the affiliated P.A.s. All significant intercompany balances and transactions have been eliminated.

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, future policy benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

Business Segment Reclassifications

On January 1, 2014, we reclassified certain of our businesses from our Healthcare Services segment to our Employer Group segment to correspond with internal management reporting changes. Our reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation. See Note 17 for segment financial information.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges coupled with three premium stabilization programs, as described more fully below.

The Health Care Reform Law imposes an annual premium-based fee on health insurers for each calendar year beginning on or after January 1, 2014 which is not deductible for tax purposes. We are required to estimate a liability for the health insurer fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurer fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurer fee in September of each year. In September 2014, we paid the federal government $562 million for the annual health insurance industry fee attributed to calendar year 2014, in accordance with the Health Care Reform Law.

The Health Care Reform Law also establishes risk spreading premium stabilization programs effective January 1, 2014. The risk spreading programs are applicable to certain of our commercial medical insurance products. In the aggregate, our commercial medical insurance products represented approximately 18% of our total premiums and services revenue for the year ended December 31, 2014. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs are for years 2014 through 2016, with potential for additional reinsurance recoveries through 2018 to the extent funds are available. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the Health Care Reform Law to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the Health Care Reform Law.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans (except certain exempt and grandfathered plans as discussed above) operating both inside and outside of the health insurance exchanges established under the Health Care Reform Law. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. We generally rely on providers, including certain network providers who are our employees, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for our risk scores under the program. Our estimate of amounts receivable and/or payable under the risk adjustment program is based on our estimate of both our own and the state average risk scores. Assumptions used in these estimates include but are not limited to geographic considerations including our historical experience in markets we have participated in over a long period of time, member demographics (including age and gender for our members and other health insurance issuers), our pricing model, sales data for each metal tier (different metal tiers yield different risk scores), the mix of previously underwritten membership as compared to new members in plans compliant with the Health Care Reform Law, published third party studies, and other publicly available data including regulatory plan filings. We expect to refine our estimates as new information becomes available, including additional data released by the Department of Health and Human Services, or HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS, however, there will be no payments associated with these audits for 2014 or 2015, the first two years of the program.

The temporary risk corridor program applies to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including our small group health plans, will not be subject to the risk corridor program. The risk corridor provisions limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS

making additional payments to us or require us to refund HHS a portion of the premiums we received. HHS guidance provides that risk corridor collections over the life of the three year program will first be applied to any shortfalls from previous benefit years before application to current year obligations.

We estimate and recognize adjustments to premiums revenue for the risk adjustment and risk corridor provisions by projecting our ultimate premium for the calendar year separately for individual and group plans by state and legal entity. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. We record receivables or payables at the individual or group level within each state and legal entity and classify the amounts as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

The transitional reinsurance program requires us to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the Health Care Reform Law in the individual commercial market will be eligible for recoveries if individual claims exceed a specified threshold. Accordingly, we account for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in our consolidated statements of income. We account for contributions made by individual commercial plans compliant with the Health Care Reform Law, which are subject to recoveries, as ceded premiums (a reduction of premiums) and similarly we account for any recoveries as ceded benefits (a reduction of benefits expense) in our consolidated statements of income.

We are required to remit payment for our per member reinsurance contribution, exclusive of the portion payable to the U.S. Treasury, by January 15 of the year following the benefit year, or January 15, 2015 for the 2014 benefit year. The portion of the reinsurance contribution due to the U.S. Treasury must be paid by November 15 of the year following the benefit year, or November 15, 2015 for the 2014 benefit year. Risk adjustment calculations will be completed and HHS will notify us of recoveries due or payments owed to/from us under the risk adjustment and reinsurance programs by June 30 of the year following the benefit year. Following this notification, risk corridor calculations are then due by July 31 of the year following the benefit year. Payments due to HHS under the risk adjustment and risk corridor programs must be remitted within 30 days of notification for each program and will be collected prior to the distribution of recoveries by HHS under each program. Payment and recovery amounts will be settled with HHS annually in the second half of the year following the benefit year. Accordingly, for the 2014 benefit year, we expect to receive recoveries and/or pay amounts due under these programs in the second half of 2015.

In addition to the provisions discussed above, beginning in 2014, HHS pays us a portion of the health care costs for low-income individual members for which we assume no risk in accordance with the Health Care Reform Law. We account for these subsidies as a deposit in our consolidated balance sheets and as a financing activity in our consolidated statements of cash flows. We do not recognize premiums revenue or benefits expense for these subsidies. Receipt and payment activity is accumulated at the state and legal entity level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the state and legal entity balance at the end of the reporting period. We will be notified of final settlement amounts by June 30 of the year following the benefit year. Receipts from HHS associated with cost sharing subsidies for which we do not assume risk were approximately $281 million, exceeding payments of $255 million by $26 million for the year ended December 31, 2014. See Note 7 for detail regarding amounts recorded to the consolidated balance sheets related to the 3Rs.

Cash and Cash Equivalents

Cash and cash equivalents include cash, time deposits, money market funds, commercial paper, other money market instruments, and certain U.S. Government securities with an original maturity of three months or less. Carrying value approximates fair value due to the short-term maturity of the investments.

Investment Securities

Investment securities, which consist entirely of debt securities, have been categorized as available for sale and, as a result, are stated at fair value. Investment securities available for current operations are classified as current assets.

Investment securities available for our long-term insurance products and professional liability funding requirements, as well as restricted statutory deposits, are classified as long-term assets. For the purpose of determining gross realized gains and losses, which are included as a component of investment income in the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or other-than-temporary impairment.

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase.

Receivables and Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions. Individual polices are subject to the requirements of the Health Care Reform Law as discussed previously.

Premiums Revenue

We bill and collect premium remittances from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from CMS for our Medicare products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are recognized when the amounts become determinable and the collectibility is reasonably assured.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the individual, small group, and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Beginning in 2014, Medicare Advantage products were also subject to minimum benefit ratio requirements under the Health Care Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic

conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

We cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments we receive monthly from CMS and members, which are determined from our annual bid, represent amounts for providing prescription drug insurance coverage. We recognize premiums revenue for providing this insurance coverage ratably over the term of our annual contract. Our CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which we are not at risk.

The risk corridor provisions compare costs targeted in our bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. As risk corridor provisions are considered in our overall annual bid process, we estimate and recognize an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2014, subsidy and discount payments of $6.7 billion exceeded reimbursements of $5.8 billion by $945 million. For 2013, subsidy and discount payments of $4.8 billion exceeded reimbursements of $4.6 billion by $154 million. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 6 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS.

Military Services

On April 1, 2012, we began delivering services under our current TRICARE South Region contract with the DoD. Under the terms of the current TRICARE South Region contract, the federal government retains all of the risk of the cost of health benefits and we do not record premiums revenue or benefits expense in our consolidated statements of income related to these health care costs and related reimbursements. Instead, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement as discussed further under our description of services revenue that follows. Our previous TRICARE South Region contract that expired on March 31, 2012 provided a financial interest in the underlying health care cost; therefore, we reported revenues on a

gross basis. We shared the risk with the federal government for the cost of health benefits incurred under our previous contract, earning more revenue or incurring additional cost based on the variance of actual health care costs from an annually negotiated target health care cost. TRICARE revenues under the previous contract consisted generally of (1) an insurance premium for assuming underwriting risk for the cost of civilian health care services delivered to eligible beneficiaries; (2) health care services provided to beneficiaries which were in turn reimbursed by the federal government; and (3) administrative services fees related to claim processing, customer service, enrollment, and other services. We recognized the insurance premium as revenue ratably over the period coverage was provided. Health care services reimbursements were recognized as revenue in the period health services were provided. Administrative services fees were recognized as revenue in the period services were performed. We deferred the recognition of any contingent revenues for favorable variances until the end of the contract period when the amount was determinable and the collectibility was reasonably assured. We estimated and recognized contingent benefits expense for unfavorable variances currently in our results of operations.

Services Revenue

Patient services revenue

Patient services include injury and illness care and related services as well as other healthcare services related to employer needs or as required by law. Patient services revenues are recognized in the period services are provided to the customer when the sales price is fixed or determinable, and are net of contractual allowances.

Administrative services fees

Administrative services fees cover the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded groups. Revenues from providing administration services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs. Accordingly, we have recorded premiums revenue and benefits expense related to these stop loss insurance contracts. We routinely monitor the collectibility of specific accounts, the aging of receivables, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. ASO fees received prior to the service period are recorded as unearned revenues.

On April 1, 2012, we began delivering services under our current TRICARE South Region contract with the DoD. Under the current contract, we provide administrative services, including offering access to our provider networks and clinical programs, claim processing, customer service, enrollment, and other services, while the federal government retains all of the risk of the cost of health benefits. We account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. The current contract includes fixed administrative services fees and incentive fees and penalties. Administrative services fees are recognized as services are performed.

Our TRICARE members are served by both in-network and out-of-network providers in accordance with the current contract. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2014, health care cost reimbursements and payments were each approximately $3.2 billion for the year. For 2013, health care cost reimbursements were $3.2 billion, exceeding payments of $3.2 billion by $5 million. For the first nine months of the current contract, April 1, 2012 to December 31, 2012, health care cost payments were $2.1 billion, exceeding reimbursements of $2.0 billion by $56 million.

Receivables

Receivables, including premium receivables, patient services revenue receivables, and ASO fee receivables, are shown net of allowances for estimated uncollectible accounts, retroactive membership adjustments, and contractual allowances.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be cancelled upon 30 days notice by the employer group.

Life insurance, annuities, and certain health and other supplemental policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 18.

Beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model and accordingly policy acquisition costs are expensed as incurred because premiums received in the current year are intended to pay anticipated benefits in that year.

Long-Lived Assets

Property and equipment is recorded at cost. Gains and losses on sales or disposals of property and equipment are included in operating costs. Certain costs related to the development or purchase of internal-use software are capitalized. Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years for equipment, 3 to 7 years for computer software, and 20 to 40 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

We periodically review long-lived assets, including property and equipment and other intangible assets, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in our operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. We recognize an impairment loss based on the excess of the carrying value over the fair value of the asset. A long-lived asset held for sale is reported at the lower of the carrying amount or fair value less costs to sell. Depreciation expense is not recognized on assets held for sale. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Goodwill and Other Intangible Assets

Goodwill represents the unamortized excess of cost over the fair value of the net tangible and other intangible assets acquired. We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an

evaluation of future discounted cash flows to determine fair value of our reporting units. Impairment tests completed for 2014, 2013, and 2012 did not result in an impairment loss.

Other intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Other intangible assets are amortized over the useful life, based upon the pattern of future cash flows attributable to the asset. This sometimes results in an accelerated method of amortization for customer contracts because the asset tends to dissipate at a more rapid rate in earlier periods. Other than customer contracts, other intangible assets generally are amortized using the straight-line method. We review other finite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in other current assets in our consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health and financial protection products.

We estimate the costs of our benefits expense payments using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors, and record benefit reserves for future payments. We continually review estimates of future payments relating to claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency liability in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we do not anticipate recording a material premium deficiency liability, except when unanticipated adverse events or changes in circumstances indicate otherwise.

We believe our benefits payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs. We adjust future policy benefits payable for the additional liability that would have been recorded if investment securities backing the

liability had been sold at their stated aggregate fair value and the proceeds reinvested at current yields. We include the impact of this adjustment, if any, net of applicable deferred taxes, with the change in unrealized investment gain (loss) in accumulated other comprehensive income in stockholders' equity. As discussed above, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model under which policy reserves are not established because premiums received in the current year are intended to pay anticipated benefits in that year.

Book Overdraft

Under our cash management system, checks issued but not yet presented to banks that would result in negative bank balances when presented are classified as a current liability in the consolidated balance sheets. Changes in book overdrafts from period to period are reported in the consolidated statement of cash flows as a financing activity.

Income Taxes

We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets or liabilities and their reported amounts in the consolidated financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. We also recognize the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. A valuation allowance is provided against these deferred tax assets if it is more likely than not that some portion or all of the deferred tax assets will not be realized. Future years' tax expense may be increased or decreased by adjustments to the valuation allowance or to the estimated accrual for income taxes.

We record tax benefits when it is more likely than not that the tax return position taken with respect to a particular transaction will be sustained. A liability, if recorded, is not considered resolved until the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired, or the tax position is ultimately settled through examination, negotiation, or litigation. We classify interest and penalties associated with uncertain tax positions in our provision for income taxes.

Derivative Financial Instruments

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, a privately held Medical Services Organization, or MSO, headquartered in Miami, Florida that coordinates medical care for Medicare Advantage and Medicaid beneficiaries primarily in Florida and Texas. Our agreement with MCCI includes a put option that would allow the controlling interest holder to put their interest to us after a specified date as well as a call option that would allow us to purchase the controlling interest after a specified date. Accordingly, we recorded, at fair value, a liability and an asset associated with the put and call, respectively. Changes in the fair value of the liability and asset during the years ended December 31, 2014, 2013, and 2012 were not material to our results of operations, financial condition, or cash flows.

At times, we may use interest-rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as adjustments to interest expense in the consolidated statements of income. We were not party to any interest-rate swap agreements in 2014, 2013, or 2012.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). However, for awards granted to retirement eligible employees, the compensation expense is recognized on a straight-line basis over the shorter of the requisite service period or the period from the date of grant to an employee's eligible retirement date. We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model. In addition, we report certain tax effects of stock-based compensation as a financing activity rather than an operating activity in the consolidated statement of cash flows. Additional detail regarding our stock-based compensation plans is included in Note 13.

Earnings Per Common Share

We compute basic earnings per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted earnings per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding employee stock options and restricted shares, or units, using the treasury stock method.

Fair Value

Assets and liabilities measured at fair value are categorized into a fair value hierarchy based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from independent sources, while unobservable inputs reflect our own assumptions about the assumptions market participants would use. The fair value hierarchy includes three levels of inputs that may be used to measure fair value as described below.

Level 1 – Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt securities that are traded in an active exchange market.

Level 2 – Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting our own assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. We obtain at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates, and prepayment speeds. We are responsible for the determination of fair value and as such we perform analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by our third party investment advisor. In addition, on a quarterly basis we examine the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations.

Fair value of privately held debt securities, as well as auction rate securities, are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows. Auction rate securities are debt instruments with interest rates that reset through periodic short-term auctions. From time to time, liquidity issues in the credit markets have led to failed auctions. Given the liquidity issues, fair value could not be estimated based on observable market prices, and as such, unobservable inputs were used. For auction

rate securities, valuation methodologies include consideration of the quality of the sector and issuer, underlying collateral, underlying final maturity dates, and liquidity.

Recently Issued Accounting Pronouncements

In April 2014, the Financial Accounting Standards Board, or FASB, issued new guidance related to discontinued operations which changes the criteria for determining which disposals can be presented as discontinued operations and modifies related disclosure requirements. The new guidance is effective for us beginning with annual and interim periods in 2015 with early adoption permitted under certain circumstances. Based upon existing facts and circumstances, the adoption of the new guidance is not expected to have a material impact on our results of operations, financial condition, or cash flows.

In May 2014, the FASB issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not in the scope of this new guidance. The new guidance is effective for us beginning with annual and interim periods in 2017. We are currently evaluating the impact on our results of operations, financial condition, and cash flows.

There are no other recently issued accounting standards that apply to us or that are expected to have a material impact on our results of operations, financial condition, or cash flows.

3. ACQUISITIONS

On September 6, 2013, we acquired American Eldercare Inc., or American Eldercare, the largest provider of nursing home diversion services in the state of Florida, serving frail and elderly individuals in home and community-based settings. American Eldercare complements our core capabilities and strength in serving seniors and disabled individuals with a unique focus on individualized and integrated care, and has contracts to provide Medicaid long-term support services across the entire state of Florida. The enrollment effective dates for the various regions ranged from August 2013 to March 2014. The allocation of the purchase price resulted in goodwill of $76 million and other intangible assets of $75 million. The goodwill was assigned to the Retail segment. The other intangible assets, which primarily consist of customer contracts and technology, have a weighted average useful life of 9.3 years. Goodwill and other intangible assets are amortizable as deductible expenses for tax purposes.

On December 21, 2012, we acquired Metropolitan Health Networks, Inc., or Metropolitan, an MSO that coordinates medical care for Medicare Advantage beneficiaries and Medicaid recipients, primarily in Florida. We acquired all of the outstanding shares of Metropolitan and repaid all outstanding debt of Metropolitan for a transaction value of $851 million, plus transaction expenses. The total consideration of $851 million exceeded our estimated fair value of the net tangible assets acquired by approximately $827 million, of which we allocated $263 million to other intangible assets and $564 million to goodwill. A majority of the goodwill was assigned to the Healthcare Services segment and a portion to our Retail segment. Goodwill and other intangible assets are not amortizable as deductible expenses for tax purposes. The other intangible assets, which primarily consist of customer contracts and trade names, have a weighted average useful life of 8.4 years.

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI, a privately held MSO headquartered in Miami, Florida that coordinates medical care for Medicare Advantage and Medicaid beneficiaries primarily in Florida and Texas.

The Metropolitan and MCCI transactions provide us with components of a successful integrated care delivery model that has demonstrated scalability to new markets. A substantial portion of the revenues for both Metropolitan and MCCI are derived from services provided to Humana Medicare Advantage members under capitation contracts with our health plans. In addition, Metropolitan and MCCI provide services to Medicare Advantage and Medicaid members under capitation contracts with third party health plans. Under these capitation agreements with Humana and third party health plans, Metropolitan and MCCI assume financial risk associated with these Medicare Advantage and Medicaid members.

On July 6, 2012, we acquired Humana At Home, Inc. (formerly known as SeniorBridge Family Companies, Inc.), or Humana At Home, a chronic-care provider of in-home care for seniors, expanding our existing clinical and home health capabilities and strengthening our offerings for members with complex chronic-care needs. The allocation of the purchase price resulted in goodwill of $99 million and other intangible assets of $14 million. The goodwill was assigned to the Healthcare Services segment. Goodwill and other intangible assets are not amortizable as deductible expenses for tax purposes. The other intangible assets, which primarily consist of customer contracts, trade name, and technology, have a weighted average useful life of 5.2 years.

Effective March 31, 2012, we acquired Arcadian Management Services, Inc., or Arcadian, a Medicare Advantage health maintenance organization (HMO) serving members in 15 U.S. states, increasing Medicare membership and expanding our Medicare footprint and future growth opportunities in these areas. The allocation of the purchase price resulted in goodwill of $44 million and other intangible assets of $38 million. The goodwill was assigned to the Retail segment. Goodwill and other intangible assets are not amortizable as deductible expenses for tax purposes. The other intangible assets, which primarily consist of customer contracts and provider contracts, have a weighted average useful life of 9.7 years.

The results of operations and financial condition of American Eldercare, Metropolitan, Humana At Home, and Arcadian have been included in our consolidated statements of income and consolidated balance sheets from the acquisition dates. In addition, during 2014, 2013 and 2012, we acquired other health and wellness and technology related businesses which, individually or in the aggregate, have not had, or are not expected to have, a material impact on our results of operations, financial condition, or cash flows. Acquisition-related costs recognized in each of 2014, 2013, and 2012 were not material to our results of operations. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the current year were not material for disclosure purposes.

4. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2014 and 2013, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2014				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 365	$ 10	$ (1)	$ 374
Mortgage-backed securities	1,453	50	(5)	1,498
Tax-exempt municipal securities	2,931	140	(3)	3,068
Mortgage-backed securities:				
Residential	17	—	—	17
Commercial	846	16	(19)	843
Asset-backed securities	28	1	—	29
Corporate debt securities	3,432	299	(13)	3,718
Total debt securities	$ 9,072	$ 516	$ (41)	$ 9,547
December 31, 2013				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 584	$ 6	$ (6)	$ 584
Mortgage-backed securities	1,834	34	(48)	1,820
Tax-exempt municipal securities	2,911	93	(33)	2,971
Mortgage-backed securities:				
Residential	22	—	—	22
Commercial	662	20	(9)	673
Asset-backed securities	63	1	(1)	63
Corporate debt securities	3,474	223	(30)	3,667
Total debt securities	$ 9,550	$ 377	$ (127)	$ 9,800

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2014 and 2013, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2014						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 79	$ —	$ 80	$ (1)	$ 159	$ (1)
Mortgage-backed securities	22	—	320	(5)	342	(5)
Tax-exempt municipal securities	131	(1)	118	(2)	249	(3)
Mortgage-backed securities:						
Residential	1	—	4	—	5	—
Commercial	31	(1)	267	(18)	298	(19)
Asset-backed securities	13	—	—	—	13	—
Corporate debt securities	219	(6)	128	(7)	347	(13)
Total debt securities	$ 496	$ (8)	$ 917	$ (33)	$ 1,413	$ (41)
December 31, 2013						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 231	$ (6)	$ 5	$ —	$ 236	$ (6)
Mortgage-backed securities	1,076	(47)	21	(1)	1,097	(48)
Tax-exempt municipal securities	693	(28)	57	(5)	750	(33)
Mortgage-backed securities:						
Residential	6	—	1	—	7	—
Commercial	270	(8)	40	(1)	310	(9)
Asset-backed securities	35	(1)	—	—	35	(1)
Corporate debt securities	594	(28)	17	(2)	611	(30)
Total debt securities	$ 2,905	$ (118)	$ 141	$ (9)	$ 3,046	$ (127)

Approximately 96% of our debt securities were investment-grade quality, with a weighted average credit rating of AA- by S&P at December 31, 2014. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. At December 31, 2014, 7% of our tax-exempt municipal securities were pre-refunded, generally with U.S. government and agency securities. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for 36% of the tax-exempt municipals that were not pre-refunded in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for the remaining 64% of these municipals. Our general obligation bonds are diversified across the United States with no individual state exceeding 11%. In addition, 16% of our tax-exempt securities were insured by bond insurers and had an equivalent weighted average S&P credit rating of AA exclusive of the bond insurers' guarantee. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2014 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2014.

The percentage of corporate securities associated with the financial services industry was 21% at December 31, 2014 and 23% at December 31, 2013.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2014 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2014, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2014.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2014, 2013, and 2012:

	2014	2013	2012
		(in millions)	
Gross realized gains	$ 29	$ 33	$ 38
Gross realized losses	(9)	(11)	(5)
Net realized capital gains	$ 20	$ 22	$ 33

There were no material other-than-temporary impairments in 2014, 2013, or 2012.

The contractual maturities of debt securities available for sale at December 31, 2014, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 530	$ 534
Due after one year through five years	2,060	2,164
Due after five years through ten years	2,036	2,145
Due after ten years	2,102	2,317
Mortgage and asset-backed securities	2,344	2,387
Total debt securities	$ 9,072	$ 9,547

5. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2014 and 2013, respectively, for financial assets measured at fair value on a recurring basis:

	Fair Value	Fair Value Measurements Using		
		Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2014				
Cash equivalents	$ 1,712	$ 1,712	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	374	—	374	—
Mortgage-backed securities	1,498	—	1,498	—
Tax-exempt municipal securities	3,068	—	3,060	8
Mortgage-backed securities:				
Residential	17	—	17	—
Commercial	843	—	843	—
Asset-backed securities	29	—	28	1
Corporate debt securities	3,718	—	3,695	23
Total debt securities	9,547	—	9,515	32
Total invested assets	$ 11,259	$ 1,712	$ 9,515	$ 32
December 31, 2013				
Cash equivalents	$ 876	$ 876	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	584	—	584	—
Mortgage-backed securities	1,820	—	1,820	—
Tax-exempt municipal securities	2,971	—	2,958	13
Mortgage-backed securities:				
Residential	22	—	22	—
Commercial	673	—	673	—
Asset-backed securities	63	—	62	1
Corporate debt securities	3,667	—	3,644	23
Total debt securities	9,800	—	9,763	37
Total invested assets	$ 10,676	$ 876	$ 9,763	$ 37

There were no material transfers between Level 1 and Level 2 during 2014 or 2013.

Our Level 3 assets had a fair value of $32 million at December 31, 2014, or 0.3% of our total invested assets. During the years ended December 31, 2014, 2013, and 2012, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the years ended December 31,								
	2014			2013			2012		
	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total
	(in millions)								
Beginning balance at January 1	$ 24	$ 13	$ 37	$ 25	$ 13	$ 38	$ 25	$ 16	$ 41
Total gains or losses:									
Realized in earnings	—	—	—	—	—	—	—	—	—
Unrealized in other comprehensive income	—	—	—	—	—	—	—	—	—
Purchases	—	—	—	—	—	—	—	—	—
Sales	—	(5)	(5)	—	—	—	—	(3)	(3)
Settlements	—	—	—	(1)	—	(1)	—	—	—
Balance at December 31	$ 24	$ 8	$ 32	$ 24	$ 13	$ 37	$ 25	$ 13	$ 38

Financial Liabilities

Our long-term debt, recorded at carrying value in our consolidated balance sheets, was $3,825 million at December 31, 2014 and $2,600 million at December 31, 2013. The fair value of our long-term debt was $4,102 million at December 31, 2014 and $2,751 million at December 31, 2013. The fair value of our long-term debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we completed our acquisitions of American Eldercare, Metropolitan, SeniorBridge, Arcadian, and other companies during 2014, 2013, and 2012. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the related tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected cash flows and discount rates in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no assets or liabilities measured at fair value on a nonrecurring basis during 2014, 2013, or 2012.

6. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2014 and 2013:

	2014		2013	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 105	$ 1,690	$ 45	$ 743
Trade accounts payable and accrued expenses	(36)	(32)	(71)	(30)
Net current asset (liability)	$ 69	$ 1,658	$ (26)	$ 713

7. COMMERCIAL 3Rs

The accompanying consolidated balance sheets include the following amounts associated with the 3Rs at December 31, 2014. No such amounts were recorded in our consolidated balance sheet at December 31, 2013 as the programs were not effective until January 1, 2014.

	2014		
	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement
		(in millions)	
Premiums receivable	$ 131	$ —	$ —
Other current assets	—	586	55
Trade accounts payable and accrued expenses	(89)	—	(4)
Net current asset	$ 42	$ 586	$ 51

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2014 and 2013:

	2014	2013
	(in millions)	
Land	$ 20	$ 20
Buildings and leasehold improvements	763	693
Equipment	709	639
Computer software	1,714	1,396
	3,206	2,748
Accumulated depreciation	(1,787)	(1,530)
Property and equipment, net	$ 1,419	$ 1,218

Depreciation expense was $328 million in 2014, $309 million in 2013, and $263 million in 2012, including amortization expense for capitalized internally developed and purchased software of $191 million in 2014, $172 million in 2013, and $151 million in 2012.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2014 segment change discussed in Note 2. Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2014 and 2013 were as follows:

	Retail	Employer Group	Healthcare Services	Other Businesses	Total
			(in millions)		
Balance at December 31, 2012	$ 931	$ 363	$ 2,254	$ 92	$ 3,640
Acquisitions	76	—	40	—	116
Dispositions	—	—	(17)	—	(17)
Subsequent payments/adjustments	—	—	(6)	—	(6)
Balance at December 31, 2013	1,007	363	2,271	92	3,733
Acquisitions	—	—	19	—	19
Dispositions	—	—	(40)	—	(40)
Subsequent payments/adjustments	—	—	(1)	—	(1)
Balance at December 31, 2014	$ 1,007	$ 363	$ 2,249	$ 92	$ 3,711

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2014 and 2013:

	Weighted Average Life	2014			2013		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Customer contracts/relationships	9.8 years	$ 764	$ 368	$ 396	$ 792	$ 310	$ 482
Trade names and technology	13.2 years	198	66	132	200	40	160
Provider contracts	15.0 years	51	21	30	51	23	28
Noncompetes and other	6.5 years	51	37	14	52	29	23
Total other intangible assets	10.5 years	$ 1,064	$ 492	$ 572	$ 1,095	$ 402	$ 693

Amortization expense for other intangible assets was approximately $121 million in 2014, $117 million in 2013, and $75 million in 2012. The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,:	
2015	$ 101
2016	94
2017	85
2018	78
2019	66

10. BENEFITS PAYABLE

Activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
		(in millions)	
Balances at January 1	$ 3,893	$ 3,775	$ 3,415
Acquisitions	—	5	66
Incurred related to:			
Current year	38,641	32,711	30,198
Prior years	(518)	(474)	(257)
Total incurred	38,123	32,237	29,941
Paid related to:			
Current year	(34,357)	(29,103)	(26,738)
Prior years	(3,262)	(3,021)	(2,909)
Total paid	(37,619)	(32,124)	(29,647)
Reinsurance recoverable	78	—	—
Balances at December 31	$ 4,475	$ 3,893	$ 3,775

Amounts incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (favorable development).

Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $518 million in 2014, $474 million in 2013, and $257 million in 2012. The favorable medical claims reserve development for 2014, 2013, and 2012 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. The improvements during 2014 and 2013 resulted from increased membership and favorable medical claims reserve development due to better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

Benefits expense associated with military services and provisions associated with future policy benefits excluded from the previous table was as follows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
		(in millions)	
Military services	$ 11	$ (27)	$ 908
Future policy benefits	32	354	136
Total	$ 43	$ 327	$ 1,044

Military services benefit expense for 2014 reflects expenses associated with our contracts with the Veterans Administration. Military services benefit expense for 2013 reflects the beneficial effect of a favorable settlement of contract claims with the DoD partially offset by expenses associated with our contracts with the Veterans Administration. Due to the transition to the current TRICARE South Region contract on April 1, 2012, which is accounted for as an administrative services only contract as more fully described in Note 2 there was no military services benefits payable at December 31, 2014 or 2013. This transition is also the primary reason for the decline in military services benefits expense from 2012 to 2013.

The higher benefits expense associated with future policy benefits payable during 2013 relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG America Corporation, or KMG, acquisition more fully described in Note 18.

11. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
		(in millions)	
Current provision:			
Federal	$ 1,006	$ 595	$ 708
States and Puerto Rico	81	53	61
Total current provision	1,087	648	769
Deferred (benefit) provision	(64)	42	(80)
Provision for income taxes	$ 1,023	$ 690	$ 689

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2014, 2013 and 2012 due to the following:

	2014	2013	2012
		(in millions)	
Income tax provision at federal statutory rate	$ 759	$ 672	$ 669
States, net of federal benefit, and Puerto Rico	48	32	27
Tax exempt investment income	(27)	(26)	(26)
Health insurer fee	204	—	—
Nondeductible executive compensation	22	6	14
Other, net	17	6	5
Provision for income taxes	$ 1,023	$ 690	$ 689

The provision for income taxes for 2014, 2013, and 2012 reflects a $22 million, $6 million, and $14 million, respectively, estimated impact from limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law.

As of December 31, 2014, we do not have material uncertain tax positions reflected in our consolidated balance sheet.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled. Principal components of our net deferred tax balances at December 31, 2014 and 2013 were as follows:

	Assets (Liabilities)	
	2014	2013
	(in millions)	
Future policy benefits payable	$ 320	$ 303
Compensation and other accrued expenses	176	185
Benefits payable	138	111
Net operating loss carryforward	52	51
Deferred acquisition costs	57	46
Unearned premiums	21	10
Other	18	10
Total deferred income tax assets	782	716
Valuation allowance	(48)	(28)
Total deferred income tax assets, net of valuation allowance	734	688
Depreciable property and intangible assets	(410)	(453)
Investment securities	(168)	(78)
Prepaid expenses	(55)	(83)
Total deferred income tax liabilities	(633)	(614)
Total net deferred income tax assets (liabilities)	$ 101	$ 74
Amounts recognized in the consolidated balance sheets:		
Other current assets	$ 87	$ 60
Other long-term assets	14	14
Trade accounts payable and accrued expenses	—	—
Total net deferred income tax assets (liabilities)	$ 101	$ 74

At December 31, 2014, we had approximately $141 million of net operating losses to carry forward related to prior acquisitions and our Puerto Rico subsidiaries. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2015 through 2033. Due to limitations and uncertainty regarding our ability to use some of the carryforwards, a valuation allowance was established on $108 million of these net operating loss carryforwards and $20 million of other items related to Puerto Rico. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover all deferred tax assets.

We provide for income taxes on the undistributed earnings of our Puerto Rico operations using that jurisdiction's tax rate, which has been lower historically than the U.S. statutory tax rate. Permanent investment of these earnings has resulted in cumulative unrecognized deferred tax liabilities of approximately $31 million as of December 31, 2014.

We file income tax returns in the United States and certain foreign jurisdictions. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2012 and prior years. Our 2013 tax return is in the post-filing review period under the Compliance Assurance Process (CAP). Our 2014 tax return is under advance review by the IRS under CAP. With few exceptions, which are immaterial in the aggregate, we no longer are

subject to state, local and foreign tax examinations for years before 2011. As of December 31, 2014, we are not aware of any material adjustments that may be proposed.

12. DEBT

The carrying value of long-term debt outstanding was as follows at December 31, 2014 and 2013:

	2014	2013
	(in millions)	
Long-term debt:		
Senior notes:		
$500 million, 6.45% due June 1, 2016	$ —	$ 517
$500 million, 7.20% due June 15, 2018	504	505
$300 million, 6.30% due August 1, 2018	312	314
$400 million, 2.625% due October 1, 2019	400	—
$600 million, 3.15% due December 1, 2022	598	598
$600 million, 3.85% due October 1, 2024	599	—
$250 million, 8.15% due June 15, 2038	266	266
$400 million, 4.625% due December 1, 2042	400	400
$750 million, 4.95% due October 1, 2044	746	—
Total long-term debt	$ 3,825	$ 2,600

Senior Notes

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem the $500 million 6.45% senior unsecured notes as discussed below.

In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $560 million. We recognized a loss on extinguishment of debt, included in interest expense, of approximately $37 million for the redemption of these notes.

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes (other than the 6.30% senior notes) contain a change of control provision that may require us to purchase the notes under certain circumstances.

Prior to 2009, we were parties to interest-rate swap agreements that exchanged the fixed interest rate under our senior notes for a variable interest rate based on LIBOR. As a result, the carrying value of the senior notes was adjusted to reflect changes in value caused by an increase or decrease in interest rates. During 2008, we terminated all of our swap agreements. The cumulative adjustment to the carrying value of our senior notes was $103 million as of the termination date which is being amortized as a reduction to interest expense over the remaining term of the senior notes. In October 2014, the redemption of our 6.45% senior notes reduced the unamortized carrying value adjustment by $12 million. The unamortized carrying value adjustment was $32 million as of December 31, 2014 and $54 million as of December 31, 2013.

Credit Agreement

Our 5-year $1.0 billion unsecured revolving credit agreement expires July 2018. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110 basis points, varies depending on our credit ratings ranging from 90 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 10 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $7.8 billion at December 31, 2014 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $9.6 billion and actual leverage ratio of 1.4:1, as measured in accordance with the credit agreement as of December 31, 2014. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2014, we had no borrowings outstanding under the credit agreement. We have outstanding letters of credit of $4 million issued under the credit agreement at December 31, 2014. No amounts have been drawn on these letters of credit. Accordingly, as of December 31, 2014, we had $996 million of remaining borrowing capacity under the credit agreement, none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

In October 2014, we entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time, with the aggregate face or principal amounts outstanding under the program at any time not to exceed $1 billion. The net proceeds of issuances have been and are expected to be used for general corporate purposes, including to repurchase shares of our common stock. The maximum principal amount of commercial paper borrowings outstanding at any one time during the year ended December 31, 2014 was $175 million. There were no outstanding borrowings at December 31, 2014.

13. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $176 million in 2014, $155 million in 2013, and $138 million in 2012, all of which was funded currently to the extent it was deductible for federal income tax purposes. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $143.63 on December 31, 2014, approximately 13% of the retirement and savings plan's assets were invested in our common stock, or approximately 2.8 million shares, representing 2% of the shares outstanding as of December 31, 2014. At December 31, 2014, approximately 4.1 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock, including both restricted stock units and restricted stock awards, have been granted to executive officers, directors and key employees. The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. The stock awards of retirement-eligible participants will continue to vest upon retirement from the Company. Our equity award program includes a retirement provision that generally treats employees with a combination of age and years of services with the Company totaling 65 or greater, with a minimum required age of 55 and a minimum requirement of 5 years of service, as retirement-eligible. Upon exercise, stock-based compensation awards are settled with authorized but unissued company stock or treasury stock. The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2014, 2013, and 2012:

	2014	2013	2012
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 91	$ 84	$ 66
Stock options	7	8	16
Total stock-based compensation expense	98	92	82
Tax benefit recognized	(22)	(22)	(21)
Stock-based compensation expense, net of tax	$ 76	$ 70	$ 61

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $30 million in 2014, $20 million in 2013, and $43 million in 2012. There was no capitalized stock-based compensation expense during these years.

At December 31, 2014, there were 19.3 million shares reserved for stock award plans. These reserved shares included giving effect to, under the 2011 Plan, 10.6 million shares of common stock available for future grants assuming all stock options were granted or 4.6 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests three years from the date of grant. Certain restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $103.57 in 2014, $73.50 in 2013, and $85.29 in 2012. Activity for our restricted stock was as follows for the year ended December 31, 2014:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2013	3,642	$ 71.84
Granted	1,264	103.57
Vested	(972)	62.68
Forfeited	(299)	75.38
Nonvested restricted stock at December 31, 2014	3,635	$ 85.52

The fair value of shares vested was $99 million during 2014, $52 million during 2013, and $75 million during 2012. Total compensation expense not yet recognized related to nonvested restricted stock was $92 million at December 31, 2014. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 to 10 years after grant.

The weighted-average fair value of each option granted during 2014, 2013, and 2012 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2014	2013	2012
Weighted-average fair value at grant date	$ 22.45	$ 21.80	$ 30.15
Expected option life (years)	4.3 years	4.4 years	4.4 years
Expected volatility	27.6%	38.8%	46.3%
Risk-free interest rate at grant date	1.3%	0.8%	0.8%
Dividend yield	1.1%	1.5%	1.2%

When valuing employee stock options, we stratify the employee population into three homogenous groups that historically have exhibited similar exercise behaviors. These groups are executive officers, directors, and all other employees. We value the stock options based on the unique assumptions for each of these employee groups.

We calculate the expected term for our employee stock options based on historical employee exercise behavior and base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

The volatility used to value employee stock options is based on historical volatility. We calculate historical volatility using a simple-average calculation methodology based on daily price intervals as measured over the expected term of the option.

Activity for our option plans was as follows for the year ended December 31, 2014:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2013	1,272	$ 72.81
Granted	244	102.91
Exercised	(715)	72.27
Forfeited	(33)	82.78
Options outstanding at December 31, 2014	768	$ 82.45
Options exercisable at December 31, 2014	179	$ 67.57

As of December 31, 2014, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $49 million, and a weighted-average remaining contractual term of 4.4 years. As of December 31, 2014, exercisable stock options had an aggregate intrinsic value of $14 million, and a weighted-average remaining contractual term of 3.1 years. The total intrinsic value of stock options exercised during 2014 was $32 million, compared

with $39 million during 2013 and $45 million during 2012. Cash received from stock option exercises totaled $52 million in 2014, $67 million in 2013, and $60 million in 2012.

Total compensation expense not yet recognized related to nonvested options was $6 million at December 31, 2014. We expect to recognize this compensation expense over a weighted-average period of approximately 1.6 years.

14. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 1,147	$ 1,231	$ 1,222
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	154,187	157,503	161,484
Dilutive effect of:			
Employee stock options	230	322	576
Restricted stock	1,457	1,326	1,397
Shares used to compute diluted earnings per common share	155,874	159,151	163,457
Basic earnings per common share	$ 7.44	$ 7.81	$ 7.56
Diluted earnings per common share	$ 7.36	$ 7.73	$ 7.47
Number of antidilutive stock options and restricted stock awards excluded from computation	320	704	754

15. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2012, 2013, and 2014 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2012	$1.02	$165
2013	$1.06	$167
2014	$1.10	$170

In October 2014, the Board declared a cash dividend of $0.28 per share that was paid on January 30, 2015 to stockholders of record on December 31, 2014, for an aggregate amount of $42 million. Declaration and payment of future quarterly dividends is at the discretion of the Board and may be adjusted as business needs or market conditions change.

Stock Repurchases

In September 2014, the Board of Directors replaced a previous share repurchase authorization of up to $1 billion (of which $816 million remained unused) with the current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Under the new share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. During 2014, we repurchased 1.60 million shares in open market transactions for $195 million at an average price of $121.68 under previous share repurchase authorizations and we repurchased 4.10 million shares in open market transactions for $535 million at an average price of $130.42 under the current authorization, including $400 million of shares repurchased under an accelerated stock repurchase, or ASR, agreement described further below. During 2013, we repurchased 5.77 million shares in open market transactions for $502 million at an average price of $86.97 under previous share repurchase authorizations. During 2012, we repurchased 6.25 million shares in open market transactions for $460 million at an average price of $73.66 under previous share repurchase authorizations. As of February 18, 2015, the remaining authorized amount under the current authorization totaled $1.37 billion, which includes $100 million of stock held back as part of the accelerated share repurchase agreement as more fully described below.

On November 7, 2014, we announced that we had entered into an accelerated share repurchase agreement, or ASR Agreement, with Goldman, Sachs & Co., or Goldman Sachs, to repurchase $500 million of our common stock as part of the $2 billion share repurchase program authorized in September 2014. Under the ASR Agreement, on November 10, 2014, we made a payment of $500 million to Goldman Sachs from available cash on hand and received an initial delivery of 3.06 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $400 million increase in treasury stock, which reflects the value of the initial 3.06 million shares received upon initial settlement, and a $100 million decrease in capital in excess of par value, which reflects the value of stock held back by Goldman Sachs pending final settlement of the ASR Agreement. The final number of shares that we may receive, or be required to remit, under the ASR Agreement will be determined based on the daily volume-weighted average share price of our common stock over the term of the ASR Agreement, less a discount and subject to adjustments pursuant to the terms and conditions of the ASR Agreement. Final settlement under the ASR Agreement will occur by the end of the first quarter of 2015. The ASR agreement contains provisions customary for agreements of this type, including provisions for adjustments to the transaction terms upon certain specified events, the circumstances generally under which final settlement of the ASR Agreement may be accelerated or extended or the ASR agreement may be terminated early by Goldman Sachs or us, and various acknowledgments and representations made by the parties to each other. At final settlement, under certain circumstances, we may be entitled to receive additional shares of our

common stock from Goldman Sachs or we may be required to make a payment. If we are obligated to make a payment, we may elect to satisfy such obligation in cash or shares of our common stock. The obligations of Goldman Sachs under the ASR agreement are guaranteed by The Goldman Sachs Group, Inc.

In connection with employee stock plans, we acquired 0.4 million common shares for $42 million in 2014, 0.3 million common shares for $29 million in 2013, and 0.7 million common shares for $58 million in 2012.

Regulatory Requirements

Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurance subsidiaries had aggregate statutory capital and surplus of approximately $6.0 billion and $5.5 billion as of December 31, 2014 and 2013, respectively, which exceeded aggregate minimum regulatory requirements of $4.1 billion and $3.5 billion, respectively. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2015 is approximately $800 million in the aggregate. This compares to dividends that were paid to our parent company in 2014 of approximately $927 million.

16. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Leases

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2027. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the years ended December 31, 2014, 2013 and 2012:

	2014	2013	2012
		(in millions)	
Rent expense	$ 226	$ 227	$ 218
Sublease rental income	(14)	(11)	(11)
Net rent expense	$ 212	$ 216	$ 207

Future annual minimum payments due subsequent to December 31, 2014 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31,:			
2015	$ 232	$ (17)	$ 215
2016	198	(16)	182
2017	163	(15)	148
2018	110	(13)	97
2019	78	(9)	69
Thereafter	364	(9)	355
Total	$ 1,145	$ (79)	$ 1,066

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $94 million in 2015, $45 million in 2016, $20 million in 2017, $16 million in 2018, and none thereafter. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2014, we were not involved in any SPE transactions.

Guarantees and Indemnifications

Through indemnity agreements approved by the state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by Humana Inc., our parent company, in the event of insolvency for (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent also has guaranteed the obligations of our military services subsidiaries.

In the ordinary course of business, we enter into contractual arrangements under which we may agree to indemnify a third party to such arrangement from any losses incurred relating to the services they perform on behalf of us, or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses. Historically, payments made related to these indemnifications have been immaterial.

Government Contracts

Our Medicare products, which accounted for approximately 72% of our total premiums and services revenue for the year ended December 31, 2014, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year

in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2015, and all of our product offerings filed with CMS for 2015 have been approved.

CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity of covered members. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the Medicare FFS benchmark audit is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to the current round of RADV contract level audits being conducted on 2011 premium payments. Selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year. We have been notified that certain of our Medicare Advantage contracts have been selected for audit for contract year 2011.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For-Service business which we used to represent a proxy of the benchmark audit data in Medicare FFS which has not yet been released. We based our accrual of estimated audit settlements for contract years 2011 (the first year that application of extrapolated audit results is applicable) through 2014 on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However, as indicated, we are awaiting additional guidance from CMS regarding the benchmark audit data in Medicare FFS. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015,

appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2014, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2014, primarily consisted of the TRICARE South Region contract. The current five-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On January 27, 2015, we received notice from the Defense Health Agency, or DHA, of its intent to exercise its option to extend the TRICARE South Region contract through March 31, 2016.

The loss of any of the contracts above or significant changes in these programs as a result of legislative or regulatory action, including reductions in premium payments to us, regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

Our state-based Medicaid business accounted for approximately 2% of our total premiums and services revenue for the year ended December 31, 2014. In addition to our state-based Medicaid contracts in Florida and Kentucky, we have contracts in Illinois and Virginia for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program. We began serving members in Illinois in the first quarter of 2014 and in Virginia in the second quarter of 2014. In addition, we began serving members in Long-Term Care Support Services (LTSS) regions in Florida at various effective dates ranging from the second half of 2013 through the first quarter of 2014.

On June 26, 2013, the Puerto Rico Health Insurance Administration notified us of its election not to renew our three-year Medicaid contracts for the East, Southeast, and Southwest regions which ended June 30, 2013. Contractual transition provisions required the continuation of insurance coverage for beneficiaries through September 30, 2013 and also required an additional period of time thereafter to process residual claims.

Legal Proceedings and Certain Regulatory Matters

Florida Matters

On December 16, 2010, an individual filed a qui tam suit captioned *United States of America ex rel. Marc Osheroff v. Humana et al.* in the Southern District of Florida, against us, several of our health plan subsidiaries, and certain other companies that operate medical centers in Miami-Dade County, Florida. After the U.S. government declined to intervene, the Court ordered the complaint unsealed, and the individual plaintiff amended his complaint and served the Company on December 8, 2011. The amended complaint alleged certain civil violations by our CAC Medical Centers in Florida, including offering various amenities such as transportation and meals, to Medicare and dual eligible individuals in our community center settings. The amended complaint also alleged civil violations by our Medicare Advantage health plans in Florida, arising from the alleged activities of our CAC Medical Centers and the codefendants in the complaint. The amended complaint sought damages and penalties on behalf of the United States under the Anti-Inducement and Anti-Kickback Statutes and the False Claims Act. On September 28, 2012, the Court dismissed, with prejudice, all causes of action that were asserted in the amended complaint. On November 19, 2013, the individual plaintiff appealed the dismissal of the amended complaint. On January 16, 2015, the Court of Appeals for the Eleventh Circuit affirmed the dismissal of the amended complaint.

On January 6, 2012, the Civil Division of the United States Attorney's Office for the Southern District of Florida advised us that it is seeking documents and information from us and several of our affiliates relating to several matters including the coding of medical claims by one or more South Florida medical providers, and loans to physician practices. On May 1, 2014, the U.S. Attorney's Office filed a Notice of Non-Intervention in connection with a civil qui tam suit

related to one of these matters captioned *United States of America ex rel. Olivia Graves v. Plaza Medical Centers, et al.*, and the Court ordered the complaint unsealed. Subsequently, the individual plaintiff amended the complaint and served the Company, opting to continue to pursue the action. After the Court dismissed her complaint, the individual plaintiff filed a second amended complaint on October 23, 2014, which all defendants answered and moved to dismiss, which motions are pending with the Court. We continue to cooperate with and respond to information requests from the U.S. Attorney's office. These matters could result in additional qui tam litigation.

Recently, the Civil Division of the United States Department of Justice provided us with an information request, separate from but related to the Plaza Medical matter, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, including the providers identified in the Plaza Medical matter, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice and the U.S. Attorney's Office.

Other Lawsuits and Regulatory Matters

Our current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance, health care delivery and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For example, a number of hospitals and other providers have asserted that, under their network provider contracts, we are not entitled to reduce Medicare Advantage payments to these providers in connection with changes in Medicare payment systems and in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as "sequestration"). Those challenges have led and could lead to arbitration demands or other litigation. Also, under state guaranty assessment laws, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of non-performance of contractual obligations to providers, members, and others, including failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extracontractual damages, care delivery malpractice, and claims arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive

damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for the contingencies discussed in both sections above to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because of the inherently unpredictable nature of legal proceedings, which also may be exacerbated by various factors, including: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows, and may also affect our reputation.

17. SEGMENT INFORMATION

On January 1, 2014, we reclassified certain of our businesses from our Healthcare Services segment to our Employer Group segment to correspond with internal management reporting changes. Our reportable segments remain the same and prior period segment financial information has been recast to conform to the 2014 presentation.

We manage our business with three reportable segments: Retail, Employer Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products, marketed directly to individuals, and includes our contract with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Employer Group segment consists of Medicare and commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary benefit products, as well as administrative services only, or ASO, products and our health and wellness products primarily marketed to employer groups. The Healthcare Services segment includes services offered to our health plan members as well as to third parties including pharmacy solutions, provider services, home based services, integrated behavioral health services, and predictive modeling and informatics services. The Other Businesses category consists of our military services, primarily our TRICARE South Region contract, Puerto Rico Medicaid, and closed-block long-term care insurance policies.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of *Right*SourceRx®, our mail order pharmacy business. These revenues consist of the prescription price (ingredient cost plus dispensing fee), including the portion to be settled with the member (co-share) or with the government (subsidies), plus any associated administrative fees. Services revenues related to the distribution of prescriptions by third party retail pharmacies in our networks are recognized when the claim is processed and product revenues from dispensing prescriptions from our mail order pharmacies are recorded when the prescription or product is shipped. Our pharmacy operations, which are responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug

utilization, and processing claims, act as a principal in the arrangement on behalf of members in our other segments. As principal, our Healthcare Services segment reports revenues on a gross basis including co-share amounts from members collected by third party retail pharmacies at the point of service.

In addition, our Healthcare Services intersegment revenues include revenues earned by certain owned providers derived from risk-based managed care agreements with our health plans. Under these agreements, the provider receives a monthly capitated fee that varies depending on the demographics and health status of the member, for each member assigned to these owned providers by our health plans. The owned provider assumes the economic risk of funding the assigned members' healthcare services and related administrative costs. Accordingly, our Healthcare Services segment reports provider services related revenues on a gross basis. Capitation fee revenue is recognized in the period in which the assigned members are entitled to receive healthcare services.

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $9.7 billion in 2014, $7.3 billion in 2013, and $6.3 billion in 2012. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $116 million in 2014, $93 million in 2013, and $43 million in 2012. The increase in 2013 primarily was due to amortization expense associated with the December 21, 2012 acquisition of Metropolitan.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments consist of sales of services rendered by our Healthcare Services segment, primarily provider, pharmacy, and behavioral health services, to our Retail and Employer Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often utilize the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and included with intersegment eliminations in the tables presenting segment results below.

Our segment results were as follows for the years ended December 31, 2014, 2013, and 2012:

	Retail	Employer Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2014						
Revenues—external customers						
Premiums:						
Medicare Advantage	$ 25,941	$ 5,490	$ —	$ —	$ —	$ 31,431
Medicare stand-alone PDP	3,396	8	—	—	—	3,404
Total Medicare	29,337	5,498	—	—	—	34,835
Fully-insured	3,265	5,339	—	—	—	8,604
Specialty	256	1,098	—	—	—	1,354
Military services	—	—	—	19	—	19
Medicaid and other	1,096	—	—	51	—	1,147
Total premiums	33,954	11,935	—	70	—	45,959
Services revenue:						
Provider	—	23	1,183	—	—	1,206
ASO and other	39	339	—	481	—	859
Pharmacy	—	—	99	—	—	99
Total services revenue	39	362	1,282	481	—	2,164
Total revenues—external customers	33,993	12,297	1,282	551	—	48,123
Intersegment revenues						
Services	—	78	14,984	—	(15,062)	—
Products	—	—	3,749	—	(3,749)	—
Total intersegment revenues	—	78	18,733	—	(18,811)	—
Investment income	76	44	—	60	197	377
Total revenues	34,069	12,419	20,015	611	(18,614)	48,500
Operating expenses:						
Benefits	28,608	10,019	—	113	(574)	38,166
Operating costs	4,209	1,987	19,121	405	(18,083)	7,639
Depreciation and amortization	154	99	155	15	(90)	333
Total operating expenses	32,971	12,105	19,276	533	(18,747)	46,138
Income from operations	1,098	314	739	78	133	2,362
Interest expense	—	—	—	—	192	192
Income (loss) before income taxes	$ 1,098	$ 314	$ 739	$ 78	$ (59)	$ 2,170

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 73% for 2014, compared to 75% for 2013 and 2012.

	Retail	Employer Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2013						
Revenues—external customers						
Premiums:						
Medicare Advantage	$ 22,481	$ 4,710	$ —	$ —	$ —	$ 27,191
Medicare stand-alone PDP	3,025	8	—	—	—	3,033
Total Medicare	25,506	4,718	—	—	—	30,224
Fully-insured	1,160	5,117	—	—	—	6,277
Specialty	210	1,095	—	—	—	1,305
Military services	—	—	—	25	—	25
Medicaid and other	328	—	—	670	—	998
Total premiums	27,204	10,930	—	695	—	38,829
Services revenue:						
Provider	—	21	1,221	—	—	1,242
ASO and other	16	338	—	454	—	808
Pharmacy	—	—	59	—	—	59
Total services revenue	16	359	1,280	454	—	2,109
Total revenues—external customers	27,220	11,289	1,280	1,149	—	40,938
Intersegment revenues						
Services	—	51	11,808	—	(11,859)	—
Products	—	—	2,803	—	(2,803)	—
Total intersegment revenues	—	51	14,611	—	(14,662)	—
Investment income	74	42	—	59	200	375
Total revenues	27,294	11,382	15,891	1,208	(14,462)	41,313
Operating expenses:						
Benefits	22,914	9,124	—	935	(409)	32,564
Operating costs	2,963	1,806	15,223	446	(14,083)	6,355
Depreciation and amortization	134	102	147	20	(70)	333
Total operating expenses	26,011	11,032	15,370	1,401	(14,562)	39,252
Income (loss) from operations	1,283	350	521	(193)	100	2,061
Interest expense	—	—	—	—	140	140
Income (loss) before income taxes	$ 1,283	$ 350	$ 521	$ (193)	$ (40)	$ 1,921

Benefits expense for Other Businesses for 2013 includes $243 million for reserve strengthening associated with our closed block of long-term care insurance policies as discussed more fully in Note 18.

	Retail	Employer Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2012						
Revenues—external customers						
Premiums:						
Medicare Advantage	$ 20,788	$ 4,064	$ —	$ —	$ —	$ 24,852
Medicare stand-alone PDP	2,853	8	—	—	—	2,861
Total Medicare	23,641	4,072	—	—	—	27,713
Fully-insured	1,004	4,996	—	—	—	6,000
Specialty	171	1,070	—	—	—	1,241
Military services	—	—	—	1,017	—	1,017
Medicaid and other	185	—	—	853	—	1,038
Total premiums	25,001	10,138	—	1,870	—	37,009
Services revenue:						
Provider	—	13	1,007	—	—	1,020
ASO and other	24	358	—	308	—	690
Pharmacy	—	—	16	—	—	16
Total services revenue	24	371	1,023	308	—	1,726
Total revenues—external customers	25,025	10,509	1,023	2,178	—	38,735
Intersegment revenues						
Services	2	31	9,680	—	(9,713)	—
Products	—	—	2,342	—	(2,342)	—
Total intersegment revenues	2	31	12,022	—	(12,055)	—
Investment income	79	42	—	58	212	391
Total revenues	25,106	10,582	13,045	2,236	(11,843)	39,126
Operating expenses:						
Benefits	21,048	8,471	—	1,802	(336)	30,985
Operating costs	2,767	1,710	12,530	436	(11,613)	5,830
Depreciation and amortization	130	89	87	16	(27)	295
Total operating expenses	23,945	10,270	12,617	2,254	(11,976)	37,110
Income (loss) from operations	1,161	312	428	(18)	133	2,016
Interest expense	—	—	—	—	105	105
Income (loss) before income taxes	$ 1,161	$ 312	$ 428	$ (18)	$ 28	$ 1,911

18. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for approximately 2% of our consolidated premiums and services revenue for the year ended December 31, 2014. We use long-duration accounting for products such as long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

In addition, we establish reserves for future policy benefits in recognition of the fact that some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). As discussed in Note 2, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model because premiums received in the current year are intended to pay anticipated benefits in that year.

The table below presents deferred acquisition costs and future policy benefits payable associated with our long-duration insurance products for the years ended December 31, 2014 and 2013.

	2014		2013	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$ 167	$ —	$ 166	$ —
Trade accounts payable and accrued expenses	—	(68)	—	(67)
Long-term liabilities	—	(2,349)	—	(2,207)
Total asset (liability)	$ 167	$ (2,417)	$ 166	$ (2,274)

In addition, future policy benefits payable include amounts of $210 million at December 31, 2014 and $215 million at December 31, 2013 which are subject to 100% coinsurance agreements as more fully described in Note 19.

Benefits expense associated with future policy benefits payable was $32 million in 2014, $354 million in 2013, and $136 million in 2012. Benefits expense for 2013 included net charges of $243 million associated with our closed block of long-term care insurance policies discussed further below. Amortization of deferred acquisition costs included in operating costs was $39 million in 2014, $55 million in 2013, and $44 million in 2012.

Future policy benefits payable include $1.5 billion at December 31, 2014 and $1.4 billion at December 31, 2013 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was $123 million of additional liability at December 31, 2014 and no additional liability at December 31, 2013. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases and/or loss experience vary from our loss recognition date assumptions, future adjustments to reserves could be required.

During 2013, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2010 loss recognition date, particularly as they related to emerging experience due to an increase in life expectancies and utilization of home health care services. Based on this deterioration, and combined with lower interest rates, we determined that

our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2013 we recorded $243 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $350 million partially offset by a related reinsurance recoverable of $107 million included in other long-term assets.

During 2012, we recorded a change in estimate associated with future policy benefits payable for our closed-block of long-term care insurance policies resulting in additional benefits expense of $29 million. This change in estimate was based on current claim experience demonstrating an increase in the length of the time policyholders already in payment status remained in such status. Future policy benefits payable was increased to cover future payments to policyholders currently in payment status.

Deferred acquisition costs included $59 million and $66 million associated with our individual commercial medical policies at December 31, 2014 and December 31, 2013, respectively. Future policy benefits payable associated with our individual commercial medical policies were $297 million at December 31, 2014 and $327 million at December 31, 2013.

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, long-term care, and annuities in run-off status, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods used to determine future policy benefits payable as detailed in Note 2. Excluding reinsurance associated with the Health Care Reform Law discussed in Note 2, reinsurance recoverables, included in other current and long-term assets, were $646 million at December 31, 2014 and $578 million at December 31, 2013. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 45% at December 31, 2014 and approximately 37% at December 31, 2013. Premiums ceded were $357 million in 2014, $33 million in 2013 and $34 million in 2012. Benefits ceded were $272 million in 2014, $70 million in 2013, and $86 million in 2012. Ceded premium and benefits in 2014 reflect a July 1, 2014 amendment ceding all risk under a Medicaid contract to a third party reinsurer.

We evaluate the financial condition of these reinsurers on a regular basis. These reinsurers are well-known and well-established, as evidenced by the strong financial ratings at December 31, 2014 presented below:

Reinsurer	Total Recoverable (in millions)	A.M. Best Rating at December 31, 2014
Protective Life Insurance Company	$ 188	A+ (superior)
Munich American Reassurance Company	148	A+ (superior)
Employers Reassurance Corporation	90	A- (excellent)
General Re Life Corporation	89	A++ (superior)
All others	131	A+ to B++ (superior to good)
	$ 646	

The all other category represents 16 reinsurers with individual balances less than $80 million. Three of these reinsurers have placed an aggregate of $99 million of cash and securities in trusts and funds withheld accounts, an amount at least equal to the total recoverable from each of these reinsurers.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of Humana Inc.:

In our opinion, the consolidated balance sheets and the related consolidated statements of income, of comprehensive income, of stockholders' equity and of cash flows present fairly, in all material respects, the financial position of Humana Inc. and its subsidiaries ("Company") at December 31, 2014 and 2013, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2014 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules listed in the index appearing under Item 15(a)(2) present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on criteria established in *Internal Control – Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedules, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedules, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
Louisville, Kentucky
February 18, 2015

Humana Inc.
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31, 2014 and 2013 follows:

	2014			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 11,712	$ 12,222	$ 12,238	$ 12,328
Income before income taxes	686	646	551	287
Net income	368	344	290	145
Basic earnings per common share	$ 2.37	$ 2.22	$ 1.87	$ 0.96
Diluted earnings per common share (1)	$ 2.35	$ 2.19	$ 1.85	$ 0.94

	2013			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 10,486	$ 10,321	$ 10,319	$ 10,187
Income (loss) before income taxes	730	654	586	(49)
Net income (loss)	473	420	368	(30)
Basic earnings (loss) per common share	$ 2.97	$ 2.66	$ 2.34	$ (0.19)
Diluted earnings (loss) per common share (1)	$ 2.95	$ 2.63	$ 2.31	$ (0.19)

(1) The calculation of diluted earnings per common share is based on the weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year. In addition, for 2013, the sum of quarterly amounts does not equal full year results due to the anti-dilutive impact of a loss in the fourth quarter. The fourth quarter of 2013 includes an expense of $243 million ($154 million after tax, or $0.99 per diluted common share) for reserve strengthening associated with our closed block of long-term care insurance policies.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2014, we as the principal executive officer and the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2014. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2014, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2014 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on page 126.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2014 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Bruce D. Broussard
President and Chief Executive Officer (Principal Executive Officer)

Brian A. Kane
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

Cynthia H. Zipperle
Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

Set forth below are names and ages of all of our current executive officers as of February 1, 2015, their positions, and the date first elected an officer:

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	51	President and Chief Executive Officer, Director	12/11	(1)
James E. Murray	60	Executive Vice President and Chief Operating Officer	08/90	(2)
Roy A. Beveridge, M.D.	56	Senior Vice President and Chief Medical Officer	06/13	(3)
Jody L. Bilney	52	Senior Vice President and Chief Consumer Officer	04/13	(4)
Christopher H. Hunter	45	Senior Vice President and Chief Strategy Officer	01/14	(5)
Timothy S. Huval	47	Senior Vice President and Chief Human Resources Officer	12/12	(6)
Brian A. Kane	42	Senior Vice President and Chief Financial Officer	06/14	(7)
Christopher Kay	49	Senior Vice President and Chief Innovation Officer	03/14	(8)
Brian P. LeClaire	53	Senior Vice President and Chief Information Officer	08/11	(9)
Heidi S. Margulis	60	Senior Vice President – Corporate Affairs	12/95	(10)
Christopher M. Todoroff	51	Senior Vice President and General Counsel	08/08	(11)
Cynthia H. Zipperle	52	Vice President, Chief Accounting Officer and Controller	12/14	(12)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Mr. Murray currently serves as Executive Vice President and Chief Operating Officer, having held this position since December 2011. Mr. Murray has held the position of Chief Operating Officer since February 2006, and was the Chief Operating Officer – Market and Business Segment Operations from September 2002 to February 2006. Mr. Murray joined the Company in December 1989.

(3) Dr. Beveridge currently serves as Senior Vice President and Chief Medical Officer, having held this position since joining the Company in June 2013. Prior to joining the Company, Dr. Beveridge served as Chief Medical Officer for McKesson Specialty Health from December 2010 until June 2013. Prior to McKesson's acquisition of US Oncology, Dr. Beveridge served as the Executive Vice President and Medical Director at US Oncology from September 2009 through December 2010.

(4) Ms. Bilney currently serves as Senior Vice President and Chief Consumer Officer, having held this position since joining the Company in April 2013. Prior to joining the Company, Ms. Bilney served as Executive Vice President and Chief Brand Officer for Bloomin' Brands, Inc. from 2006 until April 2013.

(5) Mr. Hunter currently serves as Senior Vice President and Chief Strategy Officer, having held this position since joining the Company in January 2014. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(6) Mr. Huval currently serves as Senior Vice President and Chief Human Resources Officer, having been elected to this position in December 2012. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(7) Mr. Kane currently serves as Senior Vice President and Chief Financial Officer, having been elected to this position in June 2014. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(8) Mr. Kay currently serves of Senior Vice President and Chief Innovation Officer, having been elected to this position in March 2014. Prior to joining the Company, Mr. Kay was most recently Managing Director and CEO of Citi Ventures, Citigroup's global corporate venturing arm. Prior to joining Citi in 2007, Mr. Kay held several leadership positions at Target over a 12-year period.

(9) Mr. LeClaire currently serves as Senior Vice President and Chief Information Officer, having held this position since January 2014. Prior to that, he served as Senior Vice President and Chief Service and Information Officer from August 2011 to January 2014, and as Chief Technology Officer from 2002 to August 2011. Mr. LeClaire joined the Company in August 1999.

(10) Ms. Margulis currently serves as Senior Vice President – Corporate Affairs, having held this position since January 2000. Ms. Margulis joined the Company in November 1985.

(11) Mr. Todoroff currently serves as Senior Vice President and General Counsel, having held this position since August 2008. Prior to joining the Company, Mr. Todoroff served as Vice President, Senior Corporate Counsel and Corporate Secretary for Aetna Inc. from 2006 through July 2008. Mr. Todoroff joined Aetna's Legal Department in 1995 and held various positions of increasing responsibility.

(12) Mrs. Zipperle currently serves as Vice President, Chief Accounting Officer and Controller, having held this position since December 2014. Mrs. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

Section 16(a) Beneficial Ownership Reporting Compliance

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015 appearing under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of such Proxy Statement.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day. All employees and directors are required to annually affirm in writing their acceptance of the code. The Humana Inc. Ethics Every Day was adopted by our Board of Directors in June 2014, replacing a previous iteration of our Code of Ethics and Business Conduct – the Humana Inc. Principles of Business Ethics – as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Humana Inc. Ethics Every Day is available on our web site at www.humana.com. Any waiver of the application of the Humana Inc. Principles of Business Ethics to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on our Internet web site is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our by-laws and Certificate of Incorporation;
- our Majority Vote policy;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;
- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;

- stock ownership guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015 appearing under the caption "Corporate Governance – Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015 appearing under the captions "Corporate Governance – Organization & Compensation Committee – Compensation Committee Interlocks and Insider Participation," "Director Compensation," "Compensation Discussion and Analysis," "Organization & Compensation Committee Report," and "Executive Compensation" of such Proxy Statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and under which awards of restricted stock may be made to officers, directors, key employees, and consultants. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 to 10 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2014 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	767,953	$ 82.452	10,593,382	(2)(3)
Equity compensation plans not approved by security holders	—	—	—	
Total	767,953	$ 82.452	10,593,382	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 13.

(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.

(3) Of the number listed above, 4,625,931 can be issued as restricted stock at December 31, 2014 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan).

The information under the captions "Security Ownership of Certain Beneficial Owners of Company Common Stock" and "Security Ownership of Directors and Executive Officers" in our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015 appearing under the captions "Certain Transactions with Management and Others" and "Corporate Governance – Independent Directors" of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 16, 2015 appearing under the caption "Audit Committee Report" of such Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Financial Information
Schedule II	Valuation and Qualifying Accounts

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) By-Laws of Humana Inc., as amended on January 4, 2007 (incorporated herein by reference to Exhibit 3 to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2006).

4(a) Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).

(b) First Supplemental Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).

(c) Second Supplemental Indenture, dated as of May 31, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on May 31, 2006).

(d) Third Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(e) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(f) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006).

(g) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 12 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.

(h) Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(i) Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(j) Seventh Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York, Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(k) Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(l) Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

10(a)* Form of Company's Stock Option Agreement under the Amended and Restated 2003 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(f) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).

(b)* Form of Company's Stock Option Agreement under the Amended and Restated 2003 Stock Incentive Plan (Incentive Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(g) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).

(c)* Humana Inc. Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 27, 2006).

(d)* Humana Inc. Executive Management Incentive Compensation Plan, as amended and restated February 1, 2008 (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 24, 2008).

(e)* Form of Change of Control Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).

(f)* Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10 (p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999).

(g)* The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).

(h)* Severance policy as amended and restated on October 23, 2007 (incorporated herein by reference to Exhibit 10(r) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2007).

(i)* Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).

(j)* Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 17, 2011).

(k)* Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994).

(l)* Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).

(m)* Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).

(n)* ** Form of Company's Restricted Stock Unit Agreement with Time/Performance Vesting and Agreement not to Compete or Solicit, under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(t) to Humana Inc.'s Annual Report on Form 10-K/A filed on January 30, 2014).

(o)* Form of Company's Restricted Stock Agreement with Non-Solicit under the Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(u) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).

(p)* Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.

(q)* Form of Company's Restricted Stock Unit Agreement with Non-Compete/Non-Solicit under the Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(y) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(r) Five-Year Credit Agreement, dated as of July 9, 2013 (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on July 10, 2013).

(s) Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(t) Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(u) Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(v) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(w) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(x) Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(y) Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005).

(z)* Form of Company's Restricted Stock Unit Agreement with Non-Solicit under the Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).

(aa)* Form of Company's Stock Option Agreement under the Amended and Restated 2003 Stock Incentive Plan (Non-Qualified Stock Options without Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K filed on February 19, 2010).

(bb)*	Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).
(cc)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(oo) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(dd)*	Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(pp) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(ee)*	Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(rr) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(ff)*	Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).
(gg)**	Agreement between the United States Department of Defense and Humana Military Healthcare Services, Inc., a wholly owned subsidiary of Humana Inc., dated as March 3, 2011 (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).
(hh)*	Form of Amendment to Change of Control Agreement between Humana Inc. and various executive officers (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).
(ii)	Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 6, 2014).
(jj)	Master Confirmation by and between Humana Inc. and Goldman, Sachs & Co., dated November 7, 2014 (incorporated herein by reference to Humana Inc.'s current report on Form 8-K filed on November 10, 2014).
12 †	Computation of ratio of earnings to fixed charges.
14	Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).
21 †	List of subsidiaries.
23 †	Consent of PricewaterhouseCoopers LLP.
31.1 †	CEO certification pursuant to Rule 13a-14(a)/15d-14(a).
31.2 †	CFO certification pursuant to Rule 13a-14(a)/15d-14(a).
32 †	Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.
101	The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2014 and 2013; (ii) the Consolidated Statements of Income for the years ended December 31, 2014, 2013 and 2012; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2014, 2013 and 2012; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2014, 2013, and 2012; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2014, 2013 and 2012; and (vi) Notes to Consolidated Financial Statements.

*Exhibits 10(a) through and including 10(q) and 10(z) through and including 10(ff) and 10(hh) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2014	2013
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,211	$ 161
Investment securities	201	347
Receivable from operating subsidiaries	873	777
Other current assets	180	186
Total current assets	2,465	1,471
Property and equipment, net	885	709
Investments in subsidiaries	13,983	12,959
Other long-term assets	114	82
Total assets	$ 17,447	$ 15,221
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 3,130	$ 2,570
Current portion of notes payable to operating subsidiaries	28	28
Book overdraft	54	59
Other current liabilities	562	452
Total current liabilities	3,774	3,109
Long-term debt	3,825	2,600
Notes payable to operating subsidiaries	9	9
Other long-term liabilities	193	187
Total liabilities	7,801	5,905
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 197,951,551 shares issued at December 31, 2014 and 196,275,506 shares issued at December 31, 2013	33	33
Capital in excess of par value	2,330	2,267
Retained earnings	9,916	8,942
Accumulated other comprehensive income	223	158
Treasury stock, at cost, 48,347,541 shares at December 31, 2014 and 42,245,097 shares at December 31, 2013	(2,856)	(2,084)
Total stockholders' equity	9,646	9,316
Total liabilities and stockholders' equity	$ 17,447	$ 15,221

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2014	2013	2012
		(in millions)	
Revenues:			
Management fees charged to operating subsidiaries	$ 1,509	$ 1,370	$ 1,220
Investment and other income, net	4	3	5
	1,513	1,373	1,225
Expenses:			
Operating costs	1,434	1,366	1,229
Depreciation	212	193	172
Interest	192	141	106
	1,838	1,700	1,507
Loss before income taxes and equity in net earnings of subsidiaries	(325)	(327)	(282)
Benefit for income taxes	(81)	(107)	(102)
Loss before equity in net earnings of subsidiaries	(244)	(220)	(180)
Equity in net earnings of subsidiaries	1,391	1,451	1,402
Net income	$ 1,147	$ 1,231	$ 1,222

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2014	2013	2012
		(in millions)	
Net income	$ 1,147	$ 1,231	$ 1,222
Other comprehensive income (loss):			
Change in gross unrealized investment gains/losses	122	(338)	164
Effect of income taxes	(44)	124	(60)
Total change in unrealized investment gains/losses, net of tax	78	(214)	104
Reclassification adjustment for net realized gains included in investment income	(20)	(22)	(33)
Effect of income taxes	7	8	12
Total reclassification adjustment, net of tax	(13)	(14)	(21)
Other comprehensive income (loss), net of tax	65	(228)	83
Comprehensive income	$ 1,212	$ 1,003	$ 1,305

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2014	2013	2012
		(in millions)	
Net cash provided by operating activities	$ 1,499	$ 1,554	$ 1,611
Cash flows from investing activities:			
Acquisitions	—	—	(1,235)
Capital contributions to operating subsidiaries	(442)	(521)	(629)
Purchases of investment securities	(629)	(320)	(338)
Proceeds from sale of investment securities	606	35	127
Maturities of investment securities	149	104	316
Purchases of property and equipment, net	(380)	(223)	(284)
Net cash used in investing activities	(696)	(925)	(2,043)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	1,733	—	990
Repayment of long-term debt	(500)	—	—
Change in book overdraft	(5)	7	7
Common stock repurchases	(872)	(531)	(518)
Dividends paid	(172)	(168)	(165)
Tax benefit from stock-based compensation	12	8	22
Proceeds from stock option exercises and other	51	65	60
Net cash provided by (used in) financing activities	247	(619)	396
Increase (decrease) in cash and cash equivalents	1,050	10	(36)
Cash and cash equivalents at beginning of year	161	151	187
Cash and cash equivalents at end of year	$ 1,211	$ 161	$ 151

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $927 million in 2014, $967 million in 2013, and $1.2 billion in 2012.

Guarantee

Through indemnity agreements approved by state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by our parent company in the event of insolvency for; (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent has also guaranteed the obligations of our military services subsidiaries.

Notes Receivables from Operating Subsidiaries

We funded certain subsidiaries with surplus note agreements. These notes are generally non-interest bearing and may not be entered into or repaid without the prior approval of the applicable Departments of Insurance.

Notes Payable to Operating Subsidiaries

We borrowed funds from certain subsidiaries with notes generally collateralized by real estate. These notes, which have various payment and maturity terms, bear interest ranging from 0.98% to 6.65% and are payable in 2015 and 2018. We recorded interest expense of $1 million related to these notes for each of the years ended December 31, 2014, 2013 and 2012.

3. REGULATORY REQUIREMENTS

Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurance subsidiaries

had aggregate statutory capital and surplus of approximately $6.0 billion and $5.5 billion as of December 31, 2014 and 2013, respectively, which exceeded aggregate minimum regulatory requirements of $4.1 billion and $3.5 billion, respectively. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2015 is approximately $800 million in the aggregate. This compares to dividends that were paid to our parent company in 2014 of approximately $927 million.

4. ACQUISITIONS

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of acquisitions. During 2014 and 2013, we funded certain non-regulated subsidiary acquisitions, including the acquisition of American Eldercare Inc., with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 11 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 12 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 15 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2014, 2013, and 2012
(in millions)

	Balance at Beginning of Period	Acquired Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2014	$ 118	$ —	$ 32	$ 28	$ (41)	$ 137
2013	94	—	37	18	(31)	118
2012	85	—	26	8	(25)	94
Deferred tax asset valuation allowance:						
2014	(28)	—	(20)	—	—	(48)
2013	(28)	—	—	—	—	(28)
2012	(28)	—	—	—	—	(28)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE
Brian A. Kane
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

Date: February 18, 2015

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Senior Vice President and Chief Financial Officer (Principal Financial Officer)	February 18, 2015
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)	February 18, 2015
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 18, 2015
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 18, 2015
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 18, 2015
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 18, 2015
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 18, 2015
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 18, 2015
/s/ WILLIAM E. MITCHELL **William E. Mitchell**	Director	February 18, 2015
/s/ DAVID B. NASH, M.D. **David B. Nash, M.D.**	Director	February 18, 2015
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 18, 2015
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 18, 2015

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Corporate Headquarters

The Humana Building | 500 West Main Street | Louisville, KY 40202 | 502.580.1000 | Humana.com

More Information About Humana Inc.

Copies of the Company's filings with the Securities and Exchange Commission may be obtained without charge via the Investor Relations page of the Company's Internet site at Humana.com or by writing:

Regina C. Nethery
Enterprise Vice President – Investor Relations
Humana Inc.
Post Office Box 1438
Louisville, Kentucky 40201-1438

Transfer Agent and Registrar

American Stock Transfer & Trust Company, LLC
Shareholder Services - ATTN: Operations Center
6201 15th Avenue
Brooklyn, New York 11219
800.937.5449
Shareholder Services Direct Dial: 718.921.8124
www.amstock.com
Email: info@amstock.com

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2015
Annual Report

Health through partnership

Humana.com

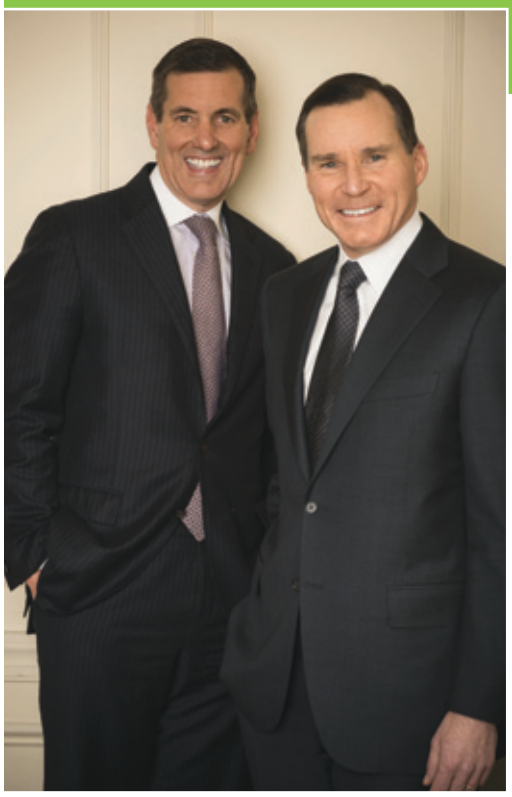
Humana®

Humana Inc. Financial Highlights

(dollars in millions, except per common share results)

	2015	2014	2013	2012	2011
Operating Results					
Revenues	$54,289	$48,500	$41,313	$39,126	$36,832
Net income	$1,276	$1,147	$1,231	$1,222	$1,419
Diluted earnings per common share	$8.44	$7.36	$7.73	$7.47	$8.46
Financial Position					
Total assets	$24,705	$23,527	$20,735	$19,979	$17,708
Total liabilities	$14,359	$13,881	$11,419	$11,132	$9,645
Total stockholders' equity	$10,346	$9,646	$9,316	$8,847	$8,063
Cash flows from operations	$868	$1,618	$1,716	$1,923	$2,079
Membership by Segment (in thousands)					
Retail Segment					
Medical membership	9,226.8	8,376.5	6,459.3	5,956.7	5,117.4
Specialty membership	1,153.1	1,165.8	1,042.5	948.7	782.5
Group Segment					
Medical membership	4,963.4	5,430.2	5,501.6	5,573.4	5,500.6
Specialty membership	6,068.7	6,502.7	6,780.8	7,136.2	6,532.6
Other Businesses					
Medical membership	32.6	35.0	23.4	558.7	566.6
Consolidated					
Medical membership	14,222.8	13,841.7	11,984.3	12,088.8	11,184.6
Specialty membership	7,221.8	7,668.5	7,823.3	8,084.9	7,315.1

Dear Fellow Stockholders,



Bruce D. Broussard, President and Chief Executive Officer, and Kurt J. Hilzinger, Chairman of the Board

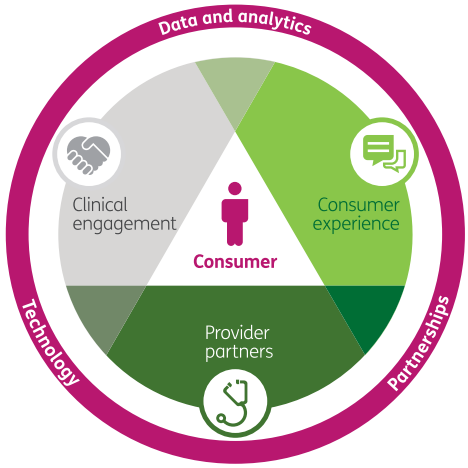
The consumer has been and continues to be at the center of Humana's integrated care delivery strategy, which is based on simplifying and personalizing the consumer experience, ultimately increasing our members' engagement in clinical and wellness programs. The other major element of our strategy is to build strong partnerships with providers to assist their transition to value-based payments by providing them with technology, expertise and resources.

Although we faced some headwinds in 2015, we believe our strategy remains sound. Our financial results did not fully reflect the strength of our integrated care model, and the progress we have made toward our vision of consumer-centric healthcare, but they did reflect the many changing variables in the industry.

As healthcare costs continue to grow and the prevalence of chronic conditions steadily increases, we must create a sustainable model that emphasizes quality of care while slowing disease progression, lowering medical costs and improving people's health. Integrated care delivery is the most effective way to accomplish these goals, by creating a personalized and integrated experience for each of our members through our growing consumer and clinical capabilities. We have enhanced these capabilities further this year, and they serve as the engine that enables us to personalize interactions and engagement with our members to provide the right care at the right time through the most effective channel.

To accelerate our health-focused efforts, last year we launched a multi-year commitment, which we call our Bold Goal: to improve the health of the communities we serve 20 percent by 2020 by making it easy for people to achieve their best health. To keep us on track, we are using the Healthy Days measurement, developed by the Centers for Disease Control and Prevention, which measures population health and health-related quality of life.

Our Integrated Care Delivery Model



We made progress

Consumer experience

2.5 million
members in Star quality plans rated 4 or above (scale of 5)

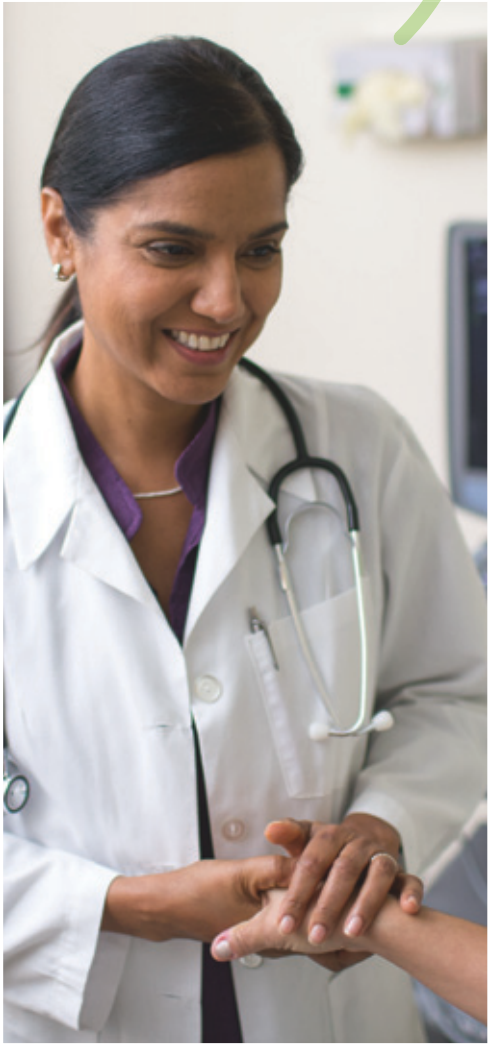
Increased transactional Net Promoter Scores (a standard measurement of the consumer experience) across our Medicare Advantage, stand-alone Prescription Drug Plans, individual and group commercial and pharmacy businesses

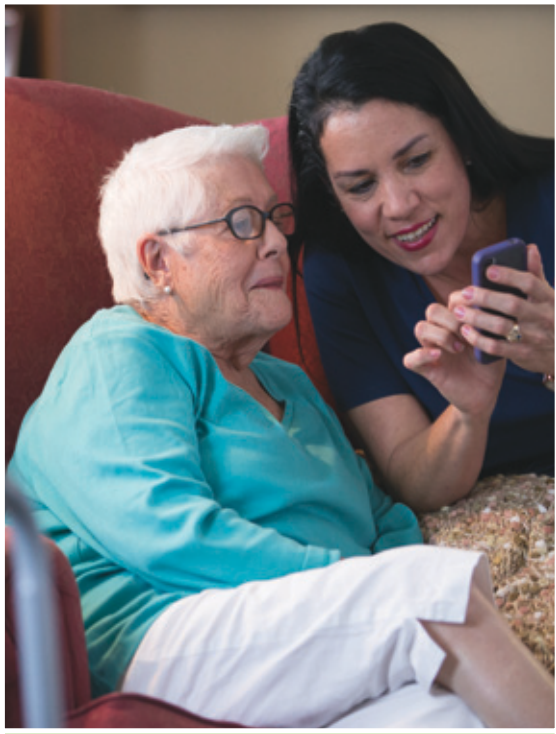
We were rated **Highest in Customer Satisfaction with Mail Order Pharmacies** in the J.D. Power 2015 U.S. Pharmacy Study

Clinical engagement

3.9 million
gaps in care closed for our members

314,000
drug safety alerts resulting in discontinued scripts





Continued success in helping people to have more days in their homes, approximately **44% fewer hospital admissions** among people living with multiple chronic conditions receiving Humana At Home care-management services

1.1 million
engaged in clinical programs identified through health risk assessments and predictive modeling capabilities

in 2015

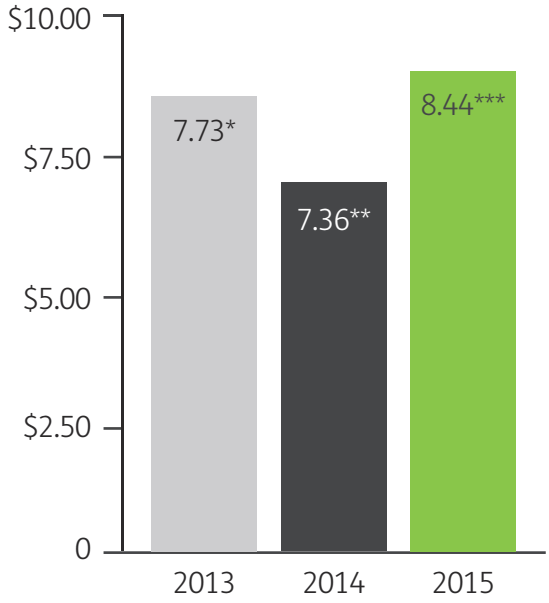
Provider partnerships

45,500
providers in value-based relationships. Providers in these types of relationships demonstrate 21 percent higher quality ratings – as measured by Healthcare Effectiveness Data and Information Set (HEDIS) scores – versus providers in standard Medicare Advantage settings

Humana Medicare Advantage members in value-based reimbursement model relationships experienced
7% fewer inpatient admissions per thousand.
In addition, screening rates for these members were 7% higher for colorectal cancer and 6 percent higher for breast cancer

Although we were pleased with the progress we made last year on the consumer front, at the same time we had to address certain challenges in our Medicare Advantage operations in 2015. Additionally, complexities associated with the healthcare exchange businesses – including unanticipated, government-mandated rule changes – are having lingering effects on pricing assumptions, including volatility in the population covered. In the second half of 2015, we took significant steps to address these issues and to provide a solid trajectory to achieve our target margins for each of our core businesses over the long term.
We also redoubled our efforts to engage our members and drive quality health outcomes for them and for our network physicians who care for them. That commitment to the consumer, combined with the operational corrections we made in 2015, provides us a solid trajectory for meaningful margin improvement as well as attractive growth in both revenues and earnings per share (EPS) in future years.

Humana believes all Americans should have access to high-quality healthcare.



Diluted Earnings per Common Share

** Includes $0.99 per share of benefits expense for our closed block long-term care insurance policies reserve strengthening.*

*** Includes $0.15 per share of expense related to early retirement of debt.*

**** Includes a gain of $1.57 per share associated with the completion of the sale of the company's wholly-owned subsidiary, Concentra Inc. on June 1, 2015, $0.14 per share of expense associated with the pending transaction with Aetna Inc., and $0.74 per share of expense related to a premium deficiency reserve (PDR) associated with certain of the company's 2016 individual commercial policies.*

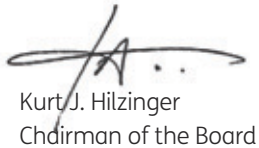
Humana believes all Americans should have access to high-quality healthcare. While we appreciate the consumer orientation of the Affordable Care Act's healthcare exchange program, it requires certain changes to make it viable in the long term. We are encouraged by CMS' recognition of the need for changes and its willingness to take steps in that direction. We will continue to partner with the government and work toward further enhancements as we evaluate our future participation in this program.

In July 2015, we signed a definitive merger agreement with Aetna Inc. We believe Aetna is the ideal business partner to accelerate our strategy and to bring the benefits of integrated care – including clinical capabilities and data analytics – to millions more Americans.

Like Humana, Aetna has a strong focus on partnering with consumers to improve their health and well-being and a distinguished history as a leading FORTUNE 100 enterprise. The transaction has already been approved by our stockholders, but it is still subject to various regulatory approvals. We continue to anticipate that the transaction will close in the latter half of 2016.

In summary, we are firmly committed to our strategy of integrated care delivery. Our value proposition is strong, and we remain dedicated to our goal of enabling better health outcomes at lower costs for our members. We would like to express our thanks to Humana's associates who, in a period of transition for our company, have continued to display resilience, compassion, skill and energy on behalf of our members, our partners and our stockholders.

Sincerely,



Kurt J. Hilzinger
Chairman of the Board

Bruce D. Broussard
President, Chief Executive Officer
and Board member

We have redoubled our efforts to engage our members and drive quality health outcomes for them and for our network physicians who care for them.

Board of Directors

Standing left to right: David A. Jones, Jr., William J. McDonald, W. Roy Dunbar, Willam E. Mitchell
Seated left to right: Bruce D. Broussard, James J. O'Brien, Frank A. D'Amelio, Kurt J. Hilzinger, David B. Nash, M.D., Marissa T. Peterson

Kurt J. Hilzinger
Chairman of the Board
Partner
Court Square Capital Partners, LP

Bruce D. Broussard
President and Chief Executive Officer
Humana Inc.

Frank A. D'Amelio
Executive Vice President,
Business Operations and
Chief Financial Officer
Pfizer, Inc.

W. Roy Dunbar
Former Chairman of the Board
NetworkSolutions

David A. Jones, Jr.
Chairman
Chrysalis Ventures, LLC

William J. McDonald
Managing Partner
Wild Irish Advisory, LLC

William E. Mitchell
Managing Partner
Sequel Venture Capital, LLC

David B. Nash, M.D.
Founding Dean
Jefferson School of Population Health
Thomas Jefferson University

James J. O'Brien
Former Chairman of the Board and
Chief Executive Officer
Ashland, Inc.

Marissa T. Peterson
President and Chief Executive Officer
Mission Peak Executive Coaching

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2015
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number 1-5975

HUMANA INC.
(Exact name of registrant as specified in its charter)

Delaware	**61-0647538**
(State of incorporation)	**(I.R.S. Employer Identification Number)**
500 West Main Street Louisville, Kentucky	**40202**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (502) 580-1000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of exchange on which registered**
Common stock, $0.16 2/3 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2015 was $28,626,230,036 calculated using the average price on June 30, 2015 of $193.67.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2016 was 148,303,389.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 21, 2016.

HUMANA INC.
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For the Year Ended December 31, 2015

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Forward-Looking Statements

Some of the statements under "Business," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere in this report may contain forward-looking statements which reflect our current views with respect to future events and financial performance. These forward-looking statements are made within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, or the Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including the information discussed under the section entitled "Risk Factors" in this report. In making these statements, we are not undertaking to address or update them in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Humana," is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. As of December 31, 2015, we had approximately 14.2 million members in our medical benefit plans, as well as approximately 7.2 million members in our specialty products. During 2015, 73% of our total premiums and services revenue were derived from contracts with the federal government, including 14% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 587,400 members as of December 31, 2015.

Humana Inc. was organized as a Delaware corporation in 1964. Our principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202, the telephone number at that address is (502) 580-1000, and our website address is www.humana.com. We have made available free of charge through the Investor Relations section of our web site our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

This Annual Report on Form 10-K, or 2015 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2015 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we will merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. Under the terms of the Merger Agreement, at the closing of the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash. The total transaction was estimated at approximately $37 billion including the assumption of Humana debt, based on the closing price of Aetna common shares on July 2, 2015. The Merger Agreement includes customary restrictions on the conduct of our business prior to the completion of the Merger,

generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna's prior written consent, including, for example, limitations on dividends (we agreed that our quarterly dividend will not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program), restrictions on our ability to enter into material contracts, and negotiated thresholds for capital expenditures, capital contributions, acquisitions and divestitures of businesses.

On October 19, 2015, our stockholders approved the adoption of the Merger Agreement at a special stockholder meeting. Also on October 19, 2015, the holders of Aetna outstanding shares approved the issuance of Aetna common stock in the Merger at a special meeting of Aetna shareholders.

The Merger is subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, (ii) the absence of legal restraints and prohibitions on the consummation of the Merger, (iii) listing of the Aetna common stock to be issued in the Merger on the New York Stock Exchange, (iv) subject to the relevant standards set forth in the Merger Agreement, the accuracy of the representations and warranties made by each party, (v) material compliance by each party with its covenants in the Merger Agreement, and (vi) no "Company Material Adverse Effect" with respect to us and no "Parent Material Adverse Effect" with respect to Aetna, in each case since the execution of and as defined in the Merger Agreement. In addition, Aetna's obligation to consummate the Merger is subject to (a) the condition that the required regulatory approvals do not impose any condition that, individually or in the aggregate, would reasonably be expected to have a "Regulatory Material Adverse Effect" (as such term is defined in the Merger Agreement), and (b) CMS has not imposed any sanctions with respect to our Medicare Advantage, or MA, business that, individually or in the aggregate, is or would reasonably be expected to be material and adverse to us and our subsidiaries, taken as a whole. The Merger is currently expected to close in the second half of 2016.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year industry wide commercial reinsurance fee. The Health Care Reform Law is discussed more fully in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Care Reform" in this 2015 Form 10-K.

Business Segments

On January 1, 2015, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes and renamed our Employer Group segment to the Group segment. Our three reportable segments remain Retail, Group, and Healthcare Services. The more significant realignments included reclassifying Medicare benefits offered to groups to the Retail segment from the Group segment, bringing all of our Medicare offerings, which are now managed collectively, together in one segment, recognizing that in some instances we market directly to individuals that are part of a group Medicare account. In addition, we realigned our military services business, primarily consisting of our TRICARE South Region contract previously included in the Other Businesses category, to our Group segment as we consider this contract with the government to be a group account. Prior period segment financial information has been recast to conform to the 2015 presentation. See Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data in this 2015 Form 10-K for segment financial information.

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, generally require a referral from the member's primary care provider before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. However PPOs generally require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, home based, and clinical programs, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2015:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 29,526	54.9%
Group Medicare Advantage	5,588	10.4%
Medicare stand-alone PDP	3,846	7.1%
Total Medicare	38,960	72.4%
Individual commercial	4,243	7.9%
State-based Medicaid	2,341	4.3%
Individual specialty	261	0.5%
Total premiums	45,805	85.1%
Services	9	—%
Total premiums and services revenue	$ 45,814	85.1%

Medicare

We have participated in the Medicare program for private health plans for over 30 years and have established a national presence, offering at least one type of Medicare plan in all 50 states. We have a geographically diverse membership base that we believe provides us with greater ability to expand our network of PPO and HMO providers. We employ strategies including health assessments and clinical guidance programs such as lifestyle and fitness programs for seniors to guide Medicare beneficiaries in making cost-effective decisions with respect to their health care. We believe these strategies result in cost savings that occur from making positive behavior changes.

Medicare is a federal program that provides persons age 65 and over and some disabled persons under the age of 65 certain hospital and medical insurance benefits. CMS, an agency of the United States Department of Health and Human Services, administers the Medicare program. Hospitalization benefits are provided under Part A, without the payment of any premium, for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Eligible beneficiaries are required to pay an annually adjusted premium to the federal government to be eligible for physician care and other services under Part B. Beneficiaries eligible for Part A and Part B coverage under traditional fee-for-service Medicare are still required to pay out-of-pocket deductibles and coinsurance. Throughout this document this program is referred to as Medicare FFS. As an alternative to Medicare FFS, in geographic areas where a managed care organization has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a Medicare Advantage organization under Medicare Part C. Pursuant to Medicare Part C, Medicare Advantage organizations contract with CMS to offer Medicare Advantage plans to provide benefits at least comparable to those offered under Medicare FFS. Our Medicare Advantage plans are discussed more fully below. Prescription drug benefits are provided under Part D.

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, and Private Fee-For-Service, or PFFS, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data analysis techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

Our Medicare HMO and PPO plans, which cover Medicare-eligible individuals residing in certain counties, may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations or as specified by the plan, most HMO plans provide no out-of-network benefits. PPO plans carry an out-of network benefit that is subject to higher member cost-sharing. In some cases, these beneficiaries are required to pay a monthly premium to the HMO or PPO plan in addition to the monthly Part B premium they are required to pay the Medicare program.

Most of our Medicare PFFS plans are network-based products with in and out of network benefits due to a requirement that Medicare Advantage organizations establish adequate provider networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. In these areas, we offer Medicare PFFS plans that have no preferred network. Individuals in these plans pay us a monthly premium to receive typical Medicare Advantage benefits along with the freedom to choose any health care provider that accepts individuals at rates equivalent to Medicare FFS payment rates.

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits and Improvement Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines.

At December 31, 2015, we provided health insurance coverage under CMS contracts to approximately 2,753,400 individual Medicare Advantage members, including approximately 587,400 members in Florida. These Florida contracts accounted for premiums revenue of approximately $7.8 billion, which represented approximately 26.3% of our individual Medicare Advantage premiums revenue, or 14.5% of our consolidated premiums and services revenue for the year ended December 31, 2015.

Our HMO, PPO, and PFFS products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2016, and all of our product offerings filed with CMS for 2016 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Medicare Part D Provisions." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2016, and all of our product offerings filed with CMS for 2016 have been approved.

We have administered CMS's Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program since 2010. This program allows individuals who receive Medicare's low-income subsidy to also receive immediate prescription drug coverage at the point of sale if they are not already enrolled in a Medicare Part D plan. CMS temporarily enrolls newly identified individuals with both Medicare and Medicaid into the LI-NET prescription drug plan program, and subsequently transitions each member into a Medicare Part D plan that may or may not be a Humana Medicare plan.

Group Medicare Advantage and Medicare stand-alone PDP

We offer products that enable employers that provide post-retirement health care benefits to replace Medicare wrap or Medicare supplement products with Medicare Advantage or stand-alone PDPs from Humana. These products offer the same types of benefits and services available to members in our individual Medicare plans discussed previously and can be tailored to closely match an employer's post-retirement benefit structure.

State-based Medicaid Contracts

Our state-based contracts allow us to serve members enrolled in state-based Medicaid programs including Temporary Assistance to Needy Families, or TANF, Long-Term Support Services, or LTSS, and dual eligible demonstration programs. TANF is a state and federally funded program that provides cash assistance and supportive services to assist families with children under age 18, helping them achieve economic self-sufficiency. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term support services for our members who receive home and community or institution-based services for long-term care. Our American Eldercare Inc., or American Eldercare, acquisition in 2013 expanded our LTSS footprint in Florida. Our contracts are generally for three to five year terms.

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. There were approximately 10.2 million dual eligible individuals in the United States in 2015, trending upward due to Medicaid eligibility expansions and individuals aging into the Medicare program. Since the enactment of the Health Care Reform Law, states are pursuing stand-alone dual eligible CMS demonstration programs in which Medicare, Medicaid, and LTSS benefits are more tightly integrated. Eligibility for participation in these stand-alone dual eligible demonstration programs may require state-based contractual relationships in existing Medicaid programs.

We have contracts to serve Medicaid eligible members in Florida under the TANF and LTSS programs. Our contracts in Virginia and Illinois serve members under each state's stand-alone dual eligible demonstration program. In addition, in Illinois we have an Integrated Care Program, or ICP, Medicaid contract. Our Kentucky Medicaid contract is subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource.

In addition to the dual eligible members we serve under the Virginia and Illinois demonstration program, we serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans. As of December 31, 2015, we served approximately 440,000 dual eligible members in our Medicare Advantage plans and approximately 1,070,000 dual eligible members in our stand-alone prescription drug plans.

Individual Commercial Coverage

Our individual health plans are marketed under the HumanaOne® brand. We offer products both on and off of the public exchange. We offer products on exchanges where we can achieve an affordable cost of care, including HMO offerings and select networks in most markets. Our off-exchange products are primarily PPO and POS offerings, including plans issued prior to 2014 that were previously underwritten. Policies issued prior to the enactment of the Health Care Reform Law on March 23, 2010 are grandfathered policies. Grandfathered policies are exempt from most of the requirements of the Health Care Reform Law, including mandated benefits. However, our grandfathered plans include provisions that guarantee renewal of coverage for as long as the plan is continued and the individual chooses to renew. Policies issued between March 23, 2010 and December 31, 2013 are required to conform to the Health Care Reform Law, including mandated benefits, upon renewal at various transition dates between 2016 and 2017 depending on the state.

Prior to 2014, our HumanaOne® plans primarily were offered as PPO plans where we could generally underwrite risk and utilize our existing networks and distribution channels.

Rewards-based wellness programs are included with many individual products. We also offer optional benefits such as dental, vision, life, and a portfolio of financial protection products.

Group Segment Products

This segment is comprised of products sold to employer groups including medical and supplemental benefit plans as well as health and wellness products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group segment by product for the year ended December 31, 2015:

	Group Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 5,493	10.2%
Group specialty	1,055	2.0%
Military services	21	—%
Total premiums	6,569	12.2%
Services	698	1.3%
Total premiums and services revenue	$ 7,267	13.5%
Intersegment services revenue:		
Wellness	$ 93	n/a
Total intersegment services revenue	$ 93	

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts. We participate in the Federal Employee Health Benefits Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government's health insurance program for Federal employees, retirees, former employees, family members, and spouses. As with our individual commercial products, the employer group offerings include HumanaVitality®, our wellness and loyalty reward program.

Our administrative services only, or ASO, products are offered to employers who self-insure their employee health plans. We receive fees to provide administrative services which generally include the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded employers. These products may include all of the same benefit and product design characteristics of our fully-insured HMO, PPO, or POS products described previously. Under ASO contracts, self-funded employers generally retain the risk of financing substantially all of the cost of health benefits. However, more than half of our ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

As with individual commercial policies, employers can customize their offerings with optional benefits such as dental, vision, life, and a portfolio of voluntary benefit products.

Military Services

Under our TRICARE South Region contract with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. On April 1, 2012, we began delivering services under our current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. Under the current contract, we provide administrative services while the federal government

retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement.

Wellness

We offer wellness solutions including our Humana Vitality® wellness and loyalty rewards program, health coaching, and clinical programs. These programs, when offered collectively to employer customers as our Total Health product, turn any standard plan of the employer's choosing into an integrated health and well-being solution that encourages participation in these programs.

Our Humana Vitality® program provides our members with access to a science-based, actuarially driven wellness and loyalty program that features a wide range of well-being tools and rewards that are customized to an individual's needs and wants. A key element of the program includes a sophisticated health-behavior-change model supported by an incentive program.

We also provide employee assistance programs and coaching services including a comprehensive turn-key coaching program, an enhancement to a medically based coaching protocol and a platform that makes coaching programs more efficient.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, home based services, clinical programs, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2015:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 20,551	n/a
Provider services	1,291	n/a
Home based services	875	n/a
Clinical programs	203	n/a
Total intersegment revenue	$ 22,920	
External services revenue:		
Provider services	$ 515	0.9%
Home based services	140	0.3%
Pharmacy solutions	30	0.1%
Total external services revenue	$ 685	1.3%

n/a – not applicable

Pharmacy solutions

Humana Pharmacy Solutions®, or HPS, manages traditional prescription drug coverage for both individuals and employer groups in addition to providing a broad array of pharmacy solutions. HPS also operates prescription mail order services for brand, generic, and specialty drugs and diabetic supplies through Humana Pharmacy, Inc., as well as research services.

Provider services

We operate full-service, multi-specialty medical centers, primarily in Florida, staffed by primary care providers and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry.

We also operate Transcend, a Medical Services Organization, or MSO, that coordinates medical care for Medicare Advantage beneficiaries primarily in Florida, Arkansas, Alabama and Kansas. Transcend provides resources in care coordination, financial risk management, clinical integration and patient engagement that help physicians improve the patient experience as well as care outcomes. Transcend collaborates with physicians, medical groups and integrated delivery systems to successfully transition to value-based care by engaging, partnering and offering practical services and solutions. Transcend represents a key component of our integrated care delivery model which we believe is scalable to new markets. In addition, we own a noncontrolling equity interest in MCCI Holdings, LLC, a privately held MSO headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida, Texas and Georgia.

Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We believe that technology represents a significant opportunity in health care that positively impacts our members. Our Transcend Insights business focuses on population health and wellness capabilities across the sector and serves health care systems, physicians and care teams by leveraging actionable data to help improve patient care. We help care teams and patients transition from a reactive approach to care to one that proactively promotes health and long-term wellness. We have enhanced our health information technology capabilities enabling us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, that delivered occupational medicine, urgent care, physical therapy, and wellness services to employees and the general public through its operation of medical centers and worksite medical facilities.

Home based services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Home based services include the operations of Humana At Home, Inc., or Humana At Home®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies, such as Florida, with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home® is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. To that end, we have accelerated our process for identifying and reaching out to members in need of clinical intervention. At December 31, 2015, we enrolled approximately 590,300 members with complex chronic conditions in the Humana Chronic Care Program, a 40.3% increase compared with approximately 420,700 members at December 31, 2014, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Clinical programs

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management, behavioral health services and wellness programs.

Our care management programs take full advantage of the population health, wellness and clinical applications offered by Transcend Insights and CareHub, our clinical management tool used by providers and care managers across the company to help our members achieve their best health, to offer various levels of support, matching the intensity of the support to the needs of members with ongoing health challenges through telephonic and onsite programs. These programs include Personal Nurse, chronic condition management, and case management as well as programs supporting maternity, cancer, neonatal intensive care unit, and transplant services.

In addition, we focus on the behavioral aspects of a members' health such as managing stress and work/life balance. Humana Behavioral Health takes a holistic, mind-and-body approach to behavioral healthcare to address the whole person, encouraging faster recovery and improving clinical outcomes while reducing costs for both the member and employer.

Other Businesses

Other Businesses primarily includes our closed block of long-term care insurance policies described below. Total premiums and services revenue for our Other Businesses was $49 million, or 0.1% of consolidated premiums and services revenue for the year ended December 31, 2015.

We have a non-strategic closed block of approximately 31,800 long-term care insurance policies associated with our acquisition of KMG America Corporation in 2007. Long-term care insurance policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block.

Membership

The following table summarizes our total medical membership at December 31, 2015, by market and product:

	Retail Segment					Group Segment					
	(in thousands)										
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Individual Commercial	State-based contracts	Fully-insured commercial Group	ASO	Military services	Other Businesses	Total	Percent of Total
Florida	587.4	19.9	320.5	288.4	351.9	168.4	33.8	—	—	1,770.3	12.5%
Texas	215.6	68.8	281.4	163.8	—	217.3	107.2	—	—	1,054.1	7.4%
Georgia	105.2	2.5	115.0	270.2	—	155.3	18.6	—	—	666.8	4.7%
Kentucky	69.9	56.1	203.8	17.6	—	109.3	195.5	—	—	652.2	4.6%
Ohio	105.8	155.6	143.5	20.8	—	46.3	70.1	—	—	542.1	3.8%
California	64.9	0.1	420.7	13.3	—	—	—	—	—	499.0	3.5%
Illinois	81.7	20.8	154.1	11.3	12.0	82.4	95.0	—	—	457.3	3.2%
Missouri/Kansas	100.6	3.4	202.0	18.7	—	52.9	9.4	—	—	387.0	2.7%
Tennessee	139.8	2.0	97.5	26.5	—	47.0	34.9	—	—	347.7	2.5%
Wisconsin	63.2	10.1	95.8	8.5	—	84.2	80.1	—	—	341.9	2.4%
Louisiana	147.2	10.9	54.4	20.6	—	67.9	31.7	—	—	332.7	2.3%
North Carolina	129.4	37.2	158.4	5.6	—	—	—	—	—	330.6	2.3%
Indiana	88.1	3.7	120.2	12.1	—	22.4	17.2	—	—	263.7	1.9%
Virginia	111.2	5.5	125.5	8.9	9.8	—	—	—	—	260.9	1.8%
Michigan	48.8	14.1	135.8	19.4	—	6.5	0.5	—	—	225.1	1.6%
Colorado	35.2	5.5	83.3	22.7	—	24.8	1.1	—	—	172.6	1.2%
Arizona	57.8	1.2	75.3	8.4	—	28.4	1.2	—	—	172.3	1.2%
Military services	—	—	—	—	—	—	—	3,074.4	—	3,074.4	21.6%
Others	601.6	66.7	1,770.7	120.9	—	65.2	14.4	—	32.6	2,672.1	18.8%
Totals	2,753.4	484.1	4,557.9	1,057.7	373.7	1,178.3	710.7	3,074.4	32.6	14,222.8	100.0%

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers whom we employ or with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care providers, specialist physicians, dentists, and providers of ancillary health care services and facilities. These ancillary services and facilities include laboratories, ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

We use a variety of techniques to provide access to effective and efficient use of health care services for our members. These techniques include the coordination of care for our members, product and benefit designs, hospital inpatient management systems, the use of sophisticated analytics, and enrolling members into various care management programs. The focal point for health care services in many of our HMO networks is the primary care provider who, under contract with us, provides services to our members, and may control utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. Some physicians may have arrangements under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met. We have available care management programs related to complex chronic conditions such as congestive heart failure and coronary artery disease. We also have programs for prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate or diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

Our contracts with physicians typically are renewed automatically each year, unless either party gives written notice, generally ranging from 90 to 120 days, to the other party of its intent to terminate the arrangement. Most of the physicians in our PPO networks and some of our physicians in our HMO networks are reimbursed based upon a fixed fee schedule, which typically provides for reimbursement based upon a percentage of the standard Medicare allowable fee schedule.

The terms of our contracts with hospitals and physicians may also vary between Medicare and commercial business. A significant portion of our Medicare network contracts, including those with both hospitals and physicians, are tied to Medicare reimbursement levels and methodologies.

Automatic reductions to the federal budget, known as sequestration, took effect on April 1, 2013, including aggregate reductions to Medicare payments to providers of up to 2% per fiscal year. Due to the uncertainty around the application of these reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs. See "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Capitation

We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. For some of our medical membership, we share risk with providers under capitation contracts where physicians and hospitals accept varying levels of financial risk for a defined set of membership, primarily HMO membership. Under the typical capitation arrangement, we prepay these providers a monthly fixed-fee per

member, known as a capitation (per capita) payment, to cover all or a defined portion of the benefits provided to the capitated member.

We believe these risk-based models represent a key element of our integrated care delivery model at the core of our strategy. Our health plan subsidiaries may enter into these risk-based contracts with third party providers or our owned provider subsidiaries.

At December 31, 2015, approximately 1,100,000 members, or 7.7% of our medical membership, were covered under risk-based contracts, including 863,000 individual Medicare Advantage members, or 31.3% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and monitor the financial performance and solvency of our capitated providers. However, we delegated claim processing functions under capitation arrangements covering approximately 196,600 HMO members, including 172,000 individual Medicare Advantage members, or 19.9% of the 863,000 individual Medicare Advantage members covered under risk-based contracts at December 31, 2015, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $768 million, or 1.7% of total benefits expense, for the year ended December 31, 2015. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Sets, or HEDIS, which is used by employers, government purchasers and the National Committee for Quality Assurance, or NCQA, to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Providers participating in our networks must satisfy specific criteria, including licensing, patient access, office standards, after-hours coverage, and other factors. Most participating hospitals also meet accreditation criteria established by CMS and/or the Joint Commission on Accreditation of Healthcare Organizations.

Recredentialing of participating providers occurs every two to three years, depending on applicable state laws. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee, composed of a peer group of providers, reviews the applications of providers being considered for credentialing and recredentialing.

We request accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care, and URAC. Accreditation or external review by an approved organization is mandatory in the states of Florida and Kansas for licensure as an HMO. Additionally, all products sold on the federal and state marketplaces are required to be accredited. Certain commercial businesses, like those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, credentialing, utilization management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in most of our commercial, Medicare and Medicaid HMO/POS markets with enough history and membership, and for many of our PPO markets.

Sales and Marketing

We use various methods to market our products, including television, radio, the Internet, telemarketing, and direct mailings.

At December 31, 2015, we employed approximately 1,600 sales representatives, as well as approximately 1,400 telemarketing representatives who assisted in the marketing of Medicare and individual commercial health insurance and specialty products in our Retail segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual commercial health insurance and specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual commercial health insurance and specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. In addition, we have begun to offer plans to employer groups through private exchanges. Employers can give their employees a set amount of money and then direct them to a private exchange. There, employees can shop for a health plan and other benefits based on what the employer has selected as options. We use licensed independent brokers, independent agents, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our individual commercial health insurance and specialty products.

Underwriting

Beginning in 2014, the Health Care Reform Law requires all individual and certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, newly issued individual and certain group health plans are not subject to underwriting in 2014 and beyond. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history.

Prior to 2014, through the use of internally developed underwriting criteria, we determined the risk we were willing to assume and the amount of premium to charge for our commercial products. In most instances, employer and other groups had to meet our underwriting standards in order to qualify to contract with us for coverage.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2015 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system.

Our management works proactively to ensure compliance with all governmental laws and regulations affecting our business. We are unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting our businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on our results of operations, financial position, or cash flows.

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2015 Form 10-K.

Certain Other Services

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers' compensation, and officer and director errors and omissions risks. Professional and general liability risks may include, for example, medical malpractice claims and disputes with members regarding benefit coverage. We retain certain of these risks through our wholly-owned, captive insurance subsidiary. We reduce exposure to these risks by insuring levels of coverage for losses in excess of our retained limits with a number of third-party insurance companies. We remain liable in the event these insurance companies are unable to pay their portion of the losses.

Centralized Management Services

We provide centralized management services to each of our health plans and to our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, billing/enrollment, and customer service. Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries.

Employees

As of December 31, 2015, we had approximately 50,100 employees and approximately 1,600 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

Risks Relating to the Merger with Aetna

The merger with Aetna is subject to various closing conditions, including governmental and regulatory approvals as well as other uncertainties and there can be no assurances as to whether and when it may be completed.

On July 2, 2015, we entered into an Agreement and Plan of Merger (which we refer to as the "Merger Agreement"), with Aetna Inc. (or "Aetna"), Echo Merger Sub, Inc. (or "Sub 1") and Echo Merger Sub, LLC (or "Sub 2"), each a wholly owned subsidiary of Aetna. Under the terms and subject to the conditions set forth in the Merger Agreement, Sub 1 will merge with and into us (the "Merger"). In the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash without interest, subject to any required withholding taxes. Immediately after the Merger, we (as the surviving corporation in the Merger) will be merged with and into Sub 2, with Sub 2 remaining as the surviving entity of that merger and as a wholly owned subsidiary of Aetna, to be renamed Humana LLC. The Merger is expected to close in the second half of 2016.

On October 19, 2015, at separate meetings, our stockholders approved the adoption of the Merger Agreement, and Aetna's shareholders approved the issuance of Aetna common stock in the Merger. Consummation of the Merger remains subject to other customary closing conditions, however, a number of which are not within our or Aetna's control, and it is possible that such conditions may prevent, delay or otherwise materially adversely affect the completion of the Merger. These conditions include, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, (ii) the absence of legal restraints and prohibitions on the consummation of the Merger, (iii) listing of the Aetna common stock to be issued in the Merger on the New York Stock Exchange, (iv) subject to the relevant standards set forth in the Merger Agreement, the accuracy of the representations and warranties made by each party, (v) material compliance by each party with its covenants in the Merger Agreement, and (vi) no "Company Material Adverse Effect" with respect to us and no "Parent Material Adverse Effect" with respect to Aetna, in each case since the execution of and as defined in the Merger Agreement. In addition, Aetna's obligation to consummate the Merger is subject to (a) the condition that the required regulatory approvals do not impose any condition that, individually or in the aggregate, would reasonably be expected to have a "Regulatory Material Adverse Effect" (as such term is defined in the Merger Agreement), and (b) CMS has not imposed any sanctions with respect to our Medicare Advantage business that, individually or in the aggregate, is or would reasonably be expected to be material and adverse to us and its subsidiaries, taken as a whole. We cannot predict with certainty whether and when any of the required closing conditions will be satisfied or if another uncertainty may arise.

If the Merger does not receive, or timely receive, the required regulatory approvals and clearances, or if any regulatory agencies impose certain conditions relating to the required regulatory approvals that would reasonably be expected to have a "Regulatory Material Adverse Effect", or if an event occurs that delays or prevents the Merger, such failure or delay to complete the Merger may cause uncertainty or other negative consequences that may materially and adversely affect our results of operations, financial position, cash flows and the price per share for our common stock.

The Merger Agreement prohibits us from pursuing alternative transactions to the Merger.

Following the receipt of approval by our stockholders and Aetna's shareholders (with respect to the Aetna stock to be issued in the transaction) on October 19, 2015, the Merger Agreement is binding on the parties, subject to customary closing conditions. The Merger Agreement prohibits us from initiating, soliciting, knowingly encouraging, knowingly facilitating or entering into discussions or negotiations with any third party regarding alternative acquisition proposals. This provision prevents us from affirmatively seeking offers from other possible acquirers that may be superior to the pending Merger. We do not have the ability to terminate the Merger Agreement in order to accept a superior proposal since our stockholders have voted to approve the adoption of the Merger Agreement.

The number of shares of Aetna common stock that our stockholders will receive in the Merger is based on a fixed exchange ratio. Because the market price of Aetna's common stock will fluctuate, our stockholders cannot be certain of the value of the portion of the merger consideration to be paid in Aetna common stock.

Upon completion of the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash without interest, subject to any required withholding taxes. The exchange ratio for determining the number of shares of Aetna common stock that our stockholders will receive in the Merger is fixed and will not be adjusted for changes in the market price of Aetna's common stock, which will likely fluctuate before and after the completion of the Merger. Fluctuations in the value of Aetna's common stock could result from changes in the business, operations or prospects of Aetna prior to or following the closing of the Merger, regulatory considerations, general market and economic conditions and other factors both within and beyond the control of us or Aetna.

While the Merger is pending, we are subject to business uncertainties and contractual restrictions that could materially adversely affect our results of operations, financial position and cash flows or result in a loss of employees, customers, members or suppliers.

The Merger Agreement includes restrictions on the conduct of our business prior to the completion or termination of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of specified limitations absent Aetna's prior written consent. We may find that these and other contractual restrictions in the Merger Agreement may delay or prevent us from responding, or limit our ability to respond, effectively to competitive pressures, industry developments and future business opportunities that may arise during such period, even if our management believes they may be advisable. The pendency of the Merger may also divert management's attention and our resources from ongoing business and operations.

Our employees, customers, members and suppliers may experience uncertainties about the effects of the Merger. In connection with the pending Merger, it is possible that some customers, members, suppliers and other parties with whom we have a business relationship may delay or defer certain business decisions or might decide to seek to terminate, change or renegotiate their relationship with us as a result of the Merger. Similarly, current and prospective employees may experience uncertainty about their future roles with us following completion of the Merger, which may materially adversely affect our ability to attract and retain key employees. If any of these effects were to occur, it could materially and adversely impact our results of operations, financial position, cash flows and the price per share for our common stock.

Failure to consummate the Merger could negatively impact our results of operations, financial position, cash flows and the price per share for our common stock.

If the Merger is not consummated, our ongoing businesses may be materially and adversely affected and, we will not have realized any of the potential benefits of having consummated the transaction, and we will be subject to a number of risks, including the following:

- matters relating to the Merger (including integration planning) may require substantial commitments of time and resources by our management, which could otherwise have been devoted to other opportunities that may have been beneficial to us;
- the Merger Agreement includes restrictions on the conduct of our business prior to the completion or termination of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of specified limitations absent Aetna's prior written consent. We may find that these and other contractual restrictions in the Merger Agreement may delay or prevent us from responding, or limit our ability to respond, effectively to competitive pressures, industry developments and future business opportunities that may arise during such period, even if our management believes they may be advisable. The pendency of the Merger may also divert management's attention and our resources from ongoing business and operations;
- we may be required to pay a termination fee to Aetna and would have incurred expenses relating to the Merger; and

- we also could be subject to litigation related to our failure to consummate the Merger or to perform our obligations under the Merger Agreement.

If the Merger is not consummated, these risks may materially and adversely affect our results of operations, financial position, cash flows and the price per share for our common stock.

Risks Relating to Our Business

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. We continually review these estimates, however these estimates involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends. Any reserve, including a premium deficiency reserve, may be insufficient.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves, including premium deficiency reserves where appropriate. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services;
- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, including new technologies;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- changes in our pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g. hurricanes and earthquakes);
- medical cost inflation; and
- government mandated benefits or other regulatory changes, including any that result from the Health Care Reform Law.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

In addition, we also estimate costs associated with long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental insurance policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these future policy benefit reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. Our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies, and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. However, to the extent premium rate increases or loss experience vary from the assumptions we have locked in, additional future adjustments to reserves could be required.

While we proactively attempt to effectively manage our operating expenses, increases or decreases in staff-related expenses, additional investment in new products (including our opportunities in the Medicare programs, state-based contracts, participation in health insurance exchanges, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well-being product offerings, acquisitions, new taxes and assessments (including the non-deductible health insurance industry fee and other assessments under the Health Care Reform Law), and implementation of regulatory requirements may increase our operating expenses.

Failure to adequately price our products or estimate sufficient benefits payable or future policy benefits payable, or effectively manage our operating expenses, may result in a material adverse effect on our results of operations, financial position, and cash flows.

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We may also face increased competition due to participation by other insurers in the health insurance exchanges implemented under the Health Care Reform Law. We believe that barriers to entry in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

The policies and decisions of the federal and state governments regarding the Medicare, military, Medicaid and health insurance exchange programs in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the premiums or other revenues to us under the programs, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, health care services, and other costs associated with these programs. Legislative or regulatory actions, such as those resulting in a reduction in premium payments to us, an increase in our cost of administrative and health care services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract.

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives, our state-based contracts strategy, and our participation in the new health insurance exchanges, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in these products.

Our future performance depends in large part upon our ability to execute our strategy, including opportunities created by the expansion of our Medicare programs, the successful implementation of our integrated care delivery model, our strategy with respect to state-based contracts, including those covering members dually eligible for the Medicare and Medicaid programs, and our participation in health insurance exchanges.

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 72% of our total premiums and services revenue for the year ended December 31, 2015 generated from our Medicare products, including 14% derived from our individual Medicare Advantage contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

The recently implemented Health Care Reform Law created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state demonstration projects to experiment with better coordination of care between Medicare and Medicaid. Depending upon the results of those demonstration projects, CMS may change the way in which dual eligibles are serviced. If we are unable to implement our strategic initiatives to address the dual eligibles opportunity, including our participation in state-based contracts, or if our initiatives are not successful at attracting or retaining dual eligible members, our business may be materially adversely affected.

Additionally, our strategy includes the growth of our commercial products, including participation in certain health insurance exchanges, introduction of new products and benefit designs, including HumanaVitality and other wellness products, growth of our specialty products such as dental, vision and other supplemental products, the adoption of new technologies, development of adjacent businesses, and the integration of acquired businesses and contracts.

There can be no assurance that we will be able to successfully implement our operational and strategic initiatives, including implementing our integrated care delivery model, that are intended to position us for future growth or that the products we design will be accepted or adopted in the time periods assumed. Failure to implement this strategy may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we fail to properly maintain the integrity of our data, to strategically implement new information systems, or to protect our proprietary rights to our systems, our business may be materially adversely affected.

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional information systems. We have reduced the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. Our information systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory or other legal problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results.

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

There can be no assurance that our information technology, or IT, process will successfully improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, defend against cybersecurity attacks, or improve service levels. In addition, there can be no assurance that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data, or to defend against cybersecurity attacks, may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we are unable to defend our information technology security systems against cybersecurity attacks or prevent other privacy or data security incidents that result in security breaches that disrupt our operations or in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could be exposed to significant regulatory fines or penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows.

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders.

The costs to eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our members' private information and result in the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

Our business may be materially adversely impacted by the adoption of a new coding set for diagnoses.

Federal regulations related to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), contain minimum standards for electronic transactions and code sets, and for the privacy and security of protected health information. On October 1, 2015, ICD-10, the current system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States, replaced the prior set of codes. For dates of service on or after October 1, 2015, health plans and providers are required to use ICD-10 codes for such diagnoses and procedures. While we prepared for the transition to ICD-10, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance, which could have a material adverse effect on our results of operations, financial position and cash flows. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, including providers in our network who are employees, we will have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in increased claim submissions or lost revenues under risk adjustment. During the transition to ICD-10, certain claims processing and payment information we have historically used to establish our reserves may not be reliable or available in a timely manner. If we do not adequately implement the new ICD-10 coding set, or if providers in our network do not adequately transition to the new ICD-10 coding set, our results of operations, financial position and cash flows may be materially adversely affected.

We are involved in various legal actions and governmental and internal investigations, any of which, if resolved unfavorably to us, could result in substantial monetary damages or changes in our business practices. Increased litigation and negative publicity could increase our cost of doing business.

We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment and employment discrimination-related suits, employee benefit claims, stockholder suits and other securities laws claims, and tort claims.

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management, and offering of products and services. These include and could include in the future:

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice;
- claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients;
- allegations of anti-competitive and unfair business activities;

- provider disputes over compensation or non-acceptance or termination of provider contracts or provider contract disputes relating to rate adjustments resulting from the Balance Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as "sequestration");
- disputes related to ASO business, including actions alleging claim administration errors;
- qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model;
- claims related to the failure to disclose some business practices;
- claims relating to customer audits and contract performance;
- claims relating to dispensing of drugs associated with our in-house mail-order pharmacy; and
- professional liability claims arising out of the delivery of healthcare and related services to the public.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act and other statutes may be sought.

While we currently have insurance coverage for some of these potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation, and governmental review of industry practices. These factors may materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, may increase the regulatory burdens under which we operate, and may require us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows.

See "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty.

As a government contractor, we are exposed to risks that may materially adversely affect our business or our willingness or ability to participate in government health care programs.

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 73% of our total premiums and services revenue for the year ended December 31, 2015. These programs involve various risks, as described further below.

- At December 31, 2015, under our contracts with CMS we provided health insurance coverage to approximately 587,400 individual Medicare Advantage members in Florida. These contracts accounted for approximately 14% of our total premiums and services revenue for the year ended December 31, 2015. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.
- At December 31, 2015, our military services business primarily consisted of the TRICARE South Region contract which covers approximately 3,074,400 beneficiaries. For the year ended December 31, 2015,

premiums and services revenue associated with the TRICARE South Region contract accounted for approximately 1% of our total premiums and services revenue. On April 1, 2012, we began delivering services under the current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On January 22, 2016, we received notice from the DHA of its intent to exercise its option to extend the TRICARE South Region contract through March 31, 2017. The loss of the TRICARE South Region contract, should it occur, may have a material adverse effect on our results of operations, financial position, and cash flows.

- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.

- CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity of covered members. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

  CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

  In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the FFS Adjuster is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits currently being conducted for contract year 2011 in which two of our Medicare Advantage plans are being audited. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year. We were notified on September 15, 2015, that five of our Medicare Advantage contracts have been selected for audit for contract year 2012.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For-Service business which we used to represent a proxy of the FFS Adjuster which has not yet been released. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However, as indicated, we are awaiting additional guidance from CMS regarding the FFS Adjuster. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

- Our CMS contracts which cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $22 million at December 31, 2015.

  Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS's portion of claims costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year.

  Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS's claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS's claim edit processes,

we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low-income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS's share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

- The Budget Control Act of 2011 increased the United States debt ceiling conditioned on deficit reductions to be achieved over the next ten years. The Budget Control Act of 2011 also established a twelve-member joint committee of Congress known as the Joint Select Committee on Deficit Reduction to propose legislation to reduce the United States federal deficit by $1.5 trillion for fiscal years 2012-2021. The failure of the Joint Select Committee on Deficit Reduction to achieve a targeted deficit reduction by December 23, 2011 triggered an automatic reduction, including aggregate reductions to Medicare payments to providers of up to 2 percent per fiscal year. These reductions took effect on April 1, 2013, and the Bipartisan Budget Act of 2013, enacted on December 26, 2013, extended the reductions for two years. We expect a corresponding substantial reduction in our obligations to providers. Due to the uncertainty around the application of any such reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs applied by the Budget Control Act of 2011.
- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations are also conducted by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 could have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with a non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. The provisions of the Health Care Reform Law include, among others, imposing a significant new non-deductible health insurance industry fee and other assessments on health insurers, limiting Medicare Advantage payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products, additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled

with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). In addition, the Health Care Reform Law has increased and will continue to increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms will come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. For additional information, please refer to the section entitled, "Health Care Reform" in "Item 7 - Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing in this annual report.

Our participation in the new federal and state health insurance exchanges, which entail uncertainties associated with mix, volume of business and the operation of premium stabilization programs, which are subject to federal administrative action, could adversely affect our results of operations, financial position, and cash flows.

The Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products. During 2015, we received our interim settlement associated with our risk corridor receivables for the 2014 coverage year. The interim settlement, representing only 12.6% of risk corridor receivables for the 2014 coverage year, was funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 risk corridor program. HHS provided guidance under the three year risk corridor program that future collections will first be applied to any shortfalls from previous coverage years before application to current year obligations. Risk corridor payables to issuers are obligations of the United States Government under the Health Care Reform law which requires the Secretary of HHS to make full payments to issuers. In the event of a shortfall at the end of the three year program, HHS has asserted it will explore other sources of funding for risk corridor payments, subject to the availability of appropriations. In addition, regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law or to enroll outside of the annual enrollment period may have an adverse effect on our pool of participants in the health insurance exchange. All of these factors may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

Our business activities are subject to substantial government regulation. New laws or regulations, or changes in existing laws or regulations or their manner of application, including reductions in Medicare Advantage payment rates, could increase our cost of doing business and may adversely affect our business, profitability, financial condition, and cash flows.

In addition to the Health Care Reform Law, the health care industry in general and health insurance are subject to substantial federal and state government regulation:

Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes

administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent.

These regulations set standards for the security of electronic health information. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. Among other requirements, the HITECH Act and HIPAA mandate individual notification in the event of a breach of unsecured, individually identifiable health information, provides enhanced penalties for HIPAA violations, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort.

American Recovery and Reinvestment Act of 2009 (ARRA)

On February 17, 2009, the American Recovery and Reinvestment Act of 2009, or ARRA, was enacted into law. In addition to including a temporary subsidy for health care continuation coverage issued pursuant to the Consolidated Omnibus Budget Reconciliation Act, or COBRA, ARRA also expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other things, ARRA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to the U.S. Department of Health and Human Services in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. ARRA also requires business associates to comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires the U.S. Department of Health and Human Services to issue regulations implementing its privacy and security enhancements.

Corporate Practice of Medicine and Other Laws

As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows.

Anti-Kickback, Physician Self-Referral, and Other Fraud and Abuse Laws

A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease, or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services to a total of 11 categories of health services. The professional groups with which we are affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

Environmental

We are subject to various federal, state, and local laws and regulations relating to the protection of human health and the environment. If an environmental regulatory agency finds any of our facilities to be in violation of environmental laws, penalties and fines may be imposed for each day of violation and the affected facility could be forced to cease operations. We could also incur other significant costs, such as cleanup costs or claims by third parties, as a result of violations of, or liabilities under, environmental laws. Although we believe that our environmental practices, including waste handling and disposal practices, are in material compliance with applicable laws, future claims or violations, or changes in environmental laws, could have a material adverse effect on our results of operations, financial position or cash flows.

State Regulation of Insurance-Related Products

Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance-related services regulate our operations including: capital adequacy and other licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re-entry into a state or market, rate increases, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance-related products we offer are sold under licenses issued by the applicable insurance regulators.

Our licensed insurance subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports.

Any failure by us to manage acquisitions, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives. The divestiture of certain businesses could result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations. There can be no assurance that we will be able to complete any such divestitures on terms favorable to us.

If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business may be adversely affected.

We employ or contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. A key component of our integrated care delivery strategy is to increase the number of providers who share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner.

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

In some situations, we have contracts with individual or groups of primary care providers for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. This type of contract

is referred to as a "capitation" contract. The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows.

Our pharmacy business is highly competitive and subjects us to regulations in addition to those we face with our core health benefits businesses.

Our pharmacy mail order business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state's board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, and the application of state laws related to the operation of internet and mail-order pharmacies. The failure to adhere to these laws and regulations may expose us to civil and criminal penalties.

Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance.

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as "AWP," average selling price, which is referred to as "ASP," and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our mail-order pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we do not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, our gross margins may decline.

We have contractual relationships with pharmaceutical manufacturers or wholesalers that provide us with purchase discounts and volume rebates on certain prescription drugs dispensed through our mail-order and specialty pharmacies. These discounts and volume rebates are generally passed on to clients in the form of steeper price discounts. Changes in existing federal or state laws or regulations or in their interpretation by courts and agencies or the adoption of new laws or regulations relating to patent term extensions, and purchase discount and volume rebate arrangements with pharmaceutical manufacturers, may reduce the discounts or volume rebates we receive and materially adversely impact our results of operations, financial position, and cash flows.

Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Dividends from our non-insurance companies such as in our Healthcare Services segment are generally not restricted by Departments of Insurance. In the event that we are unable to provide sufficient capital to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected.

Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers. In addition, our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under regulatory and public scrutiny over the ratings assigned to various fixed-income products. As a result, rating agencies may (i) become more conservative in their methodology and criteria, (ii) increase the frequency or scope of their credit reviews, (iii) request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected.

The securities and credit markets may experience volatility and disruption, which may adversely affect our business.

Volatility or disruption in the securities and credit markets could impact our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairments are considered using variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the possibility that customers or lenders could develop a negative perception of our long or short-term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2015:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	11	123	1	96	231
Texas	—	15	2	24	41
Kentucky	2	1	11	12	26
Virginia	—	8	—	8	16
California	—	2	—	13	15
Arizona	—	8	—	7	15
Louisiana	—	4	—	10	14
Ohio	—	1	—	13	14
Illinois	—	5	—	8	13
New York	—	—	—	13	13
Georgia	—	7	—	3	10
Tennessee	—	—	—	10	10
North Carolina	—	—	—	10	10
Nevada	—	5	—	5	10
South Carolina	—	—	4	6	10
Indiana	—	2	—	7	9
Puerto Rico	—	—	—	9	9
New Jersey	—	—	—	8	8
Colorado	—	3	—	4	7
Pennsylvania	—	—	—	6	6
Wisconsin	—	—	1	5	6
Others	—	3	—	47	50
Total	13	187	19	324	543

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists, urgent care facilities, and worksite medical facilities. Of the medical centers included in the table above, approximately 64 of these facilities are leased or subleased to our contracted providers to operate.

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to the headquarters in Louisville, Kentucky, we maintain other principal operating facilities used for customer service, enrollment, and/or claims processing and certain other corporate functions in Louisville, Kentucky; Green Bay, Wisconsin; Tampa, Florida; Cincinnati, Ohio; San Antonio, Texas; and San Juan, Puerto Rico.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2015 and 2014:

	High	Low
Year Ended December 31, 2015		
First quarter	$ 182.79	$ 139.09
Second quarter	$ 214.92	$ 163.07
Third quarter	$ 193.14	$ 174.16
Fourth quarter	$ 186.67	$ 164.25
Year Ended December 31, 2014		
First quarter	$ 118.78	$ 95.59
Second quarter	$ 128.95	$ 104.74
Third quarter	$ 135.51	$ 115.97
Fourth quarter	$ 149.07	$ 124.17

Holders of our Capital Stock

As of January 31, 2016, there were approximately 2,900 holders of record of our common stock and approximately 41,200 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2014 and 2015, under our Board approved quarterly cash dividend policy:

Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2014 payments			
12/31/2013	1/31/2014	$0.27	$42
3/31/2014	4/25/2014	$0.27	$42
6/30/2014	7/25/2014	$0.28	$43
9/30/2014	10/31/2014	$0.28	$43
2015 payments			
12/31/2014	1/30/2015	$0.28	$42
3/31/2015	4/24/2015	$0.28	$42
6/30/2015	7/31/2015	$0.29	$43
9/30/2105	10/30/2015	$0.29	$43

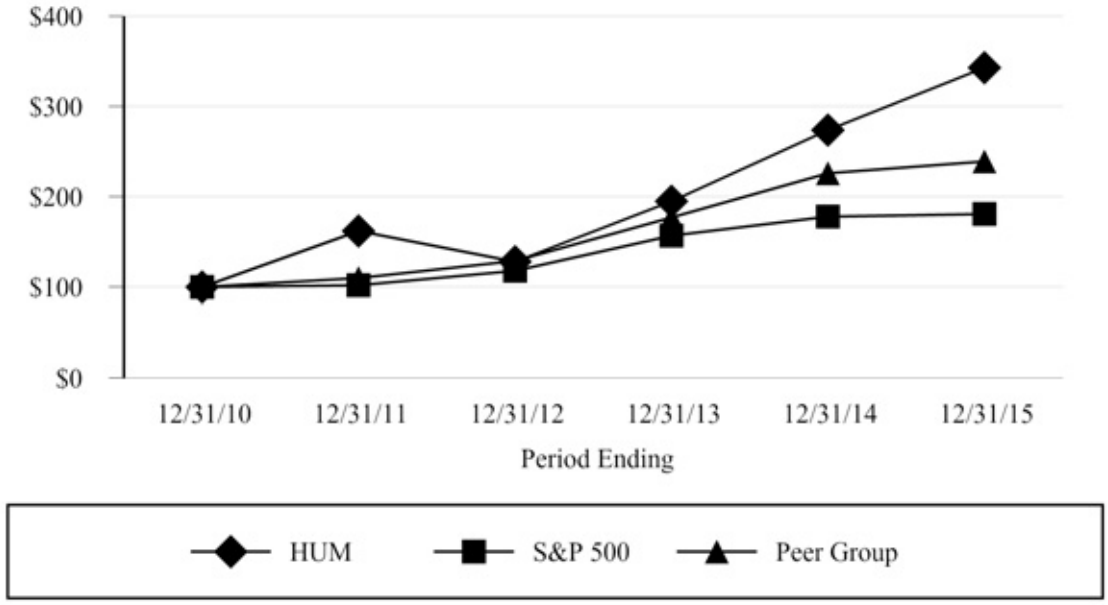
The Merger discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data does not impact our ability and intent to continue quarterly dividend payments prior to the closing of the Merger consistent with our historical dividend payments. Under the terms of the Merger Agreement, we have agreed with Aetna that our quarterly dividend will not exceed $0.29 per share prior to the closing of the Merger.

Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change. In addition, under the terms of the Merger Agreement, we have agreed with Aetna to coordinate the declaration and payment of dividends so that our stockholders do not fail to receive a quarterly dividend around the time of the closing of the Merger.

On October 29, 2015, the Board declared a cash dividend of $0.29 per share that was paid on January 29, 2016 to stockholders of record on December 30, 2015, for an aggregate amount of $43 million.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2015. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2010, and that dividends were reinvested when paid.



	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015
HUM	$ 100	$ 162	$ 128	$ 195	$ 274	$ 343
S&P 500	$ 100	$ 102	$ 118	$ 157	$ 178	$ 181
Peer Group	$ 100	$ 110	$ 129	$ 177	$ 226	$ 239

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Issuer Purchases of Equity Securities

The following table provides information about purchases by us during the three months ended December 31, 2015 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1)
October 2015	—	$ —	—	$ —
November 2015	—	—	—	—
December 2015	—	—	—	—
Total	—	$ —	—	

(1) In September 2014, the Board of Directors replaced a previous share repurchase authorization of up to $1 billion with a current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Pursuant to the Merger Agreement, after July 2, 2015, we are prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we have suspended our share repurchase program. Our remaining repurchase authorization was $1.04 billion as of July 3, 2015.

(2) Excludes 0.3 million shares repurchased in connection with employee stock plans.

The Merger Agreement includes customary restrictions on the conduct of our business prior to the completion of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna's prior written consent, including, for example, limitations on dividends (we agreed that our quarterly dividend will not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program), restrictions on our ability to enter into material contracts, and negotiated thresholds for capital expenditures, capital contributions, acquisitions and divestitures of businesses.

ITEM 6. SELECTED FINANCIAL DATA

	2015 (a)	2014 (b)	2013 (c)	2012 (d)	2011
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$ 52,409	$ 45,959	$ 38,829	$ 37,009	$ 35,106
Services	1,406	2,164	2,109	1,726	1,360
Investment income	474	377	375	391	366
Total revenues	54,289	48,500	41,313	39,126	36,832
Operating expenses:					
Benefits	44,269	38,166	32,564	30,985	28,823
Operating costs	7,318	7,639	6,355	5,830	5,395
Depreciation and amortization	355	333	333	295	270
Total operating expenses	51,942	46,138	39,252	37,110	34,488
Income from operations	2,347	2,362	2,061	2,016	2,344
Interest expense	186	192	140	105	109
Gain on sale of business	270	—	—	—	—
Income before income taxes	2,431	2,170	1,921	1,911	2,235
Provision for income taxes	1,155	1,023	690	689	816
Net income	$ 1,276	$ 1,147	$ 1,231	$ 1,222	$ 1,419
Basic earnings per common share	$ 8.54	$ 7.44	$ 7.81	$ 7.56	$ 8.58
Diluted earnings per common share	$ 8.44	$ 7.36	$ 7.73	$ 7.47	$ 8.46
Dividends declared per common share	$ 1.15	$ 1.11	$ 1.07	$ 1.03	$ 0.75
Financial Position:					
Cash and investments	$ 11,681	$ 11,482	$ 10,938	$ 11,153	$ 10,830
Total assets	24,705	23,527	20,735	19,979	17,708
Benefits payable	4,976	4,475	3,893	3,779	3,754
Debt	3,821	3,825	2,600	2,611	1,659
Stockholders' equity	10,346	9,646	9,316	8,847	8,063
Cash flows from operations	$ 868	$ 1,618	$ 1,716	$ 1,923	$ 2,079
Key Financial Indicators:					
Benefit ratio	84.5%	83.0%	83.9%	83.7%	82.1%
Operating cost ratio	13.6%	15.9%	15.5%	15.1%	14.8%
Membership by Segment:					
Retail segment:					
Medical membership	9,226,800	8,376,500	6,459,300	5,956,700	5,117,400
Specialty membership	1,153,100	1,165,800	1,042,500	948,700	782,500
Group segment:					
Medical membership	4,963,400	5,430,200	5,501,600	5,573,400	5,500,600
Specialty membership	6,068,700	6,502,700	6,780,800	7,136,200	6,532,600
Other Businesses:					
Medical membership	32,600	35,000	23,400	558,700	566,600
Consolidated:					
Total medical membership	14,222,800	13,841,700	11,984,300	12,088,800	11,184,600
Total specialty membership	7,221,800	7,668,500	7,823,300	8,084,900	7,315,100

(a) Includes a gain on the sale of Concentra Inc., net of transaction costs, of $270 million ($238 million after tax, or $1.57 per diluted common share). Also includes benefits expense of $176 million ($112 million after tax, or $0.74 per diluted common share) for a provision for probable future losses (premium deficiency) for individual commercial medical business compliant with the Health Care Reform Law for the 2016 coverage year.

(b) Includes loss on extinguishment of debt of $37 million ($23 million after tax, or $0.15 per diluted common share) for the redemption of senior notes.

(c) Includes benefits expense of $243 million ($154 million after tax, or $0.99 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies.

(d) Includes the acquired operations of Arcadian Management Services, Inc. from March 31, 2012, SeniorBridge Family Companies, Inc. from July 6, 2012, and Metropolitan Health Networks, Inc. from December 21, 2012.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Executive Overview

General

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefits expense as a percentage of premiums revenue, represents a statistic used to measure underwriting profitability. The operating cost ratio, which is computed by taking total operating costs, excluding depreciation and amortization, as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we will merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. A copy of the Merger Agreement was filed as Exhibit 2.1 to our Current Report on Form 8-K filed with the U.S. Securities and Exchange Commission on July 7, 2015. Under the terms of the Merger Agreement, at the closing of the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash. The total transaction was estimated at approximately $37 billion including the assumption of Humana debt, based on the closing price of Aetna common shares on July 2, 2015. The Merger Agreement includes customary restrictions on the conduct of our business prior to the completion of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna's prior written consent, including, for example, limitations on dividends (we agreed that our quarterly dividend will not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program), restrictions on our ability to enter into material contracts, and negotiated thresholds for capital expenditures, capital contributions, acquisitions and divestitures of businesses.

On October 19, 2015, our stockholders approved the adoption of the Merger Agreement at a special stockholder meeting. Of the 129,240,721 shares voting at the meeting, more than 99% voted in favor of the adoption of the Merger Agreement, which represented approximately 87% of our total outstanding shares of common stock as of the September 16, 2015 record date. Also on October 19, 2015, the holders of Aetna outstanding shares approved the issuance of Aetna common stock in the Merger at a special meeting of Aetna shareholders.

The Merger is subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, (ii) the absence of legal restraints and prohibitions on the consummation of the Merger, (iii) listing of the Aetna common stock to be issued in the Merger on the New York Stock Exchange, (iv) subject to the relevant standards set forth in the Merger Agreement, the accuracy of the representations and warranties made by each party, (v) material compliance by each party with its covenants in the Merger Agreement, and (vi) no "Company Material Adverse Effect" with respect to us and no "Parent Material Adverse Effect" with respect to Aetna, in each case since the execution of and as defined in the Merger Agreement. In addition, Aetna's obligation to consummate the Merger is subject to (a) the condition that the required regulatory approvals do not impose any condition that, individually or in the aggregate, would reasonably be expected to have a "Regulatory Material Adverse Effect" (as such term is defined in the Merger Agreement), and (b) CMS has not imposed any sanctions with respect

to our Medicare Advantage, or MA, business that, individually or in the aggregate, is or would reasonably be expected to be material and adverse to us and our subsidiaries, taken as a whole. The Merger is currently expected to close in the second half of 2016.

Business Segments

On January 1, 2015, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes and renamed our Employer Group segment to the Group segment. Our three reportable segments remain Retail, Group, and Healthcare Services. The more significant realignments included reclassifying Medicare benefits offered to groups to the Retail segment from the Group segment, bringing all of our Medicare offerings, which are now managed collectively, together in one segment, recognizing that in some instances we market directly to individuals that are part of a group Medicare account. In addition, we realigned our military services business, primarily consisting of our TRICARE South Region contract previously included in the Other Businesses category, to our Group segment as we consider this contract with the government to be a group account. Prior period segment financial information has been recast to conform to the 2015 presentation. This is further described in Note 2 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts, as well as individual commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products. In addition, the Retail segment also includes our contract with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Group segment consists of employer group commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary insurance benefits, as well as administrative services only, or ASO products. In addition, our Group segment includes our health and wellness products (primarily marketed to employer groups) and military services business, primarily our TRICARE South Region contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, home based services, and clinical programs, as well as services and capabilities to advance population health. We will continue to report under the category of Other Businesses those businesses which do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

The results of each segment are measured by income before income taxes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations.

Seasonality

One of the product offerings of our Retail segment is Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. Our quarterly Retail segment earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D benefit design results in coverage that varies as a member's cumulative out-of-pocket costs pass through successive stages of a member's plan period, which begins annually on January 1 for renewals. These plan designs generally result in us sharing a greater portion of the responsibility for total prescription drug costs in the early stages and less in the latter stages. As a result, the PDP benefit ratio generally decreases as the year progresses. In addition, the number of low-income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

Our Group segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Group segment's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses. Similarly, certain of our fully-insured individual commercial medical products in our Retail segment experience seasonality in the benefit ratio akin to the Group segment, including the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers. As previously underwritten members transition, it results in policy lapses and the release of reserves for future policy benefits partially offset by the recognition of previously deferred acquisition costs. These policy lapses generally occur during the first quarter of the new coverage year following the open enrollment period reducing the benefit ratio in the first quarter. The recognition of a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law in the fourth quarter of 2015, discussed in more detail in the highlights that follow, negatively impacted the benefit ratio pattern in 2015 and conversely is expected to favorably impact the benefit ratio in 2016 for this business. The quarterly benefit ratio pattern for our individual commercial medical business compliant with the Health Care Reform Law will be relatively flat throughout 2016 as opposed to the increasing benefit ratio pattern exhibited in prior years.

In addition, the Retail segment also experiences seasonality in the operating cost ratio as a result of costs incurred in the second half of the year associated with the Medicare and individual health care exchange marketing seasons.

2015 Highlights

Consolidated

- Our 2015 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2015, approximately 1,633,100 members, or 59.3%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 1,301,000 members, or 53.6%, at December 31, 2014.

- On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, to MJ Acquisition Corporation, a joint venture between Select Medical Holdings Corporation and Welsh, Carson, Anderson & Stowe XII, L.P., a private equity fund, for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $270 million, or $1.57 per diluted common share in 2015.

- During 2015, we recorded transaction costs in connection with the Merger of approximately $23.1 million, or $0.14 per diluted common share. Certain costs associated with the transaction are not deductible for tax purposes.

- Excluding the impact of the sale of Concentra and transaction costs associated with the Merger, our pretax results for 2015 as compared to 2014 reflect year-over-year improvement in the Group and Healthcare Services segment pretax results and higher investment income, partially offset by a year-over-year decline in Retail segment pretax results as discussed in the detailed segment results discussion that follows.

- Year-over-year comparisons of the operating cost ratio are impacted by an increase in 2015 of the non-deductible health insurance industry fee mandated by the Health Care Reform Law. Likewise, year-over-year comparisons of the benefit ratio reflect the increase in this fee in the pricing of our products for 2015 which reduces our benefit ratio.

- Investment income increased $97 million in 2015, primarily due to higher realized capital gains in 2015 as a result of the repositioning of our portfolio given recent market volatility and anticipated changes to interest rates.

- Year-over-year comparisons of diluted earnings per common share are favorably impacted by a lower number of shares used to compute diluted earnings per common share reflecting the impact of share repurchases.

- Operating cash flow provided by operations was $868 million for the year ended December 31, 2015 as compared to operating cash flow of $1.6 billion for the year ended December 31, 2014. The decrease in our operating cash flows primarily reflects the effect of significant growth in individual commercial medical and group Medicare Advantage membership in the prior year and changes in the timing of other working capital items related to the growth in our pharmacy business and growth in net receivables under the commercial risk adjustment, reinsurance, and risk corridor programs under the Health Care Reform Law, commonly referred to as the 3Rs. Prior year cash flows were favorably impacted from the typical pattern of claim payments that lagged premium receipts related to new membership. Individual commercial medical added 548,000 new members in 2014 compared to a decline of 90,400 members in 2015. Likewise, group Medicare Advantage added 60,600 new members in 2014 compared to a decline of 5,600 members in 2015.

- In 2015, we paid the federal government $867 million for the annual non-deductible health insurance industry fee compared to our payment of $562 million in 2014. This fee is not deductible for tax purposes, which significantly increased our effective income tax rate beginning in 2014. The health insurance industry fee is further described below under the section titled "Health Care Reform." The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. This will significantly reduce our effective tax rate in 2017.

- During 2015, we repurchased 1.85 million shares in open market transactions for $329 million and paid dividends to stockholders of $172 million. Pursuant to the Merger Agreement, after July 2, 2015, we are prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we have suspended our share repurchase program. Our remaining repurchase authorization was $1.04 billion as of July 3, 2015. The Merger does not impact our ability and intent to continue quarterly dividend payments prior to the closing of the Merger consistent with our historical dividend payments. Under the terms of the Merger Agreement, we have agreed with Aetna that our quarterly dividend will not exceed $0.29 per share prior to the closing of the Merger.

Retail Segment

- On April 6, 2015, CMS announced final 2016 Medicare benchmark payment rates and related technical factors impacting the bid benchmark premiums, which we refer to as the Final Rate Notice. We believe the Final Rate Notice, together with the impact of payment cuts associated with the Health Care Reform Law, quality bonuses,

risk coding modifications, and other funding formula changes, indicated 2016 Medicare Advantage funding increases for us of approximately 1.0% on average. Although the overall rate adjustment is positive, geographic-specific impacts may vary significantly from this average, particularly in Florida. We believe we have effectively designed Medicare Advantage products based upon the applicable level of rate changes while continuing to remain competitive compared to both the combination of original Medicare with a supplement policy and Medicare Advantage products offered by our competitors. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.

- In 2015, our Retail segment pretax income decreased by $409 million, or 30.5%, from 2014 primarily due to higher Medicare Advantage and individual commercial medical benefit ratios year-over-year, including the impact of benefits expense associated with a premium deficiency reserve for certain of our individual commercial products for the 2016 coverage year as described further below and in the results of operations discussion that follows. The higher benefit ratios were partially offset by declines in the Retail segment operating cost ratios, Medicare membership growth, and higher investment income year-over-year.

- Individual Medicare Advantage operating results for 2015 included significant membership growth but were negatively impacted by certain developments related to our product pricing assumptions for 2015. These developments primarily related to lower-than-expected 2015 financial claim recovery levels (included in medical claims reserve development) and lower-than-anticipated reductions in inpatient admissions. Claims data from the fourth quarter of 2015 and early 2016 indicate that inpatient admissions continue to develop favorably versus expectations and claim recoveries have stabilized. We are closely monitoring these favorable trends.

- Operating results for our individual commercial medical business compliant with the Health Care Reform Law have been challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. The benefit ratios associated with many of our individual commercial medical products, in particular Health Care Reform Law compliant offerings, significantly exceeded prior expectations for fiscal year 2015, driven primarily by the on-going impact of the transitional policies, special enrollment period exemptions associated with the program, and government-mandated product designs that attracted higher-utilizing members . Additionally, on June 30, 2015, CMS issued data with respect to the reinsurance and risk adjustment premium stabilization programs for the 2014 plan year which indicated a healthier risk profile comparison for our membership relative to state averages than had been previously anticipated. This resulted in adjustments to certain of the 3Rs during 2015.

  We took a number of actions in 2015 to improve the profitability of our individual commercial medical business in 2016.These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results indicating the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment of the profitability of our individual medical policies compliant with the Health Care Reform Law, in the fourth quarter of 2015, we recorded a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million, or $0.74 per diluted common share. The premium deficiency reserve includes the estimated benefit of approximately $340 million associated with risk corridor provisions expected for the 2016 coverage year.

  In light of the premium deficiency reserve recognized in the fourth quarter of 2015 for the 2016 coverage year, results for this business for 2016 are expected to primarily include results associated with the wind-down of plans that are not compliant with the Health Care Reform Law, including the related release of policy reserves, as well as indirect administrative costs associated with plans that are compliant with the Health Care Reform Law. We are continuing to evaluate our participation in the individual commercial medical line of business for 2017.

- Individual Medicare Advantage membership of 2,753,400 at December 31, 2015 increased 325,500 members, or 13.4%, from 2,427,900 at December 31, 2014 reflecting net membership additions, particularly for our Health Maintenance Organization, or HMO, offerings, for the 2015 plan year. January 2016 individual Medicare Advantage membership approximated 2,811,000, increasing approximately 57,600 members, or 2%, from December 31, 2015 reflecting net membership additions during the recently completed 2016 annual election period for Medicare beneficiaries. For full year 2016, we anticipate net membership growth in our individual Medicare Advantage offerings of 100,000 to 120,000.

- Group Medicare Advantage membership of 484,100 at December 31, 2015 decreased 5,600 members, or 1.1%, from 489,700 at December 31, 2014. For full year 2016, we expect a net membership decline in our Group Medicare Advantage offerings of 120,000 to 125,000 members primarily due to the loss of a large account that converted to a private exchange offering. Approximately 50% of members from that account selected an individual Humana offering for 2016, with the majority enrolling in a Medicare supplement plan.

- Medicare stand-alone PDP membership of 4,557,900 at December 31, 2015 increased 563,900 members, or 14.1%, from 3,994,000 at December 31, 2014 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2015 plan year. January 2016 Medicare stand-alone PDP membership (excluding transitional growth from the LI-NET prescription drug plan program) increased approximately 240,000 members, or 5%, from December 31, 2015 reflecting net membership additions, primarily for our Humana-Walmart plan offering, during the recently completed 2016 annual election period for Medicare beneficiaries. For full year 2016, we anticipate net membership growth in our Medicare stand-alone PDP offerings of 300,000 to 330,000.

- Our state-based Medicaid membership of 373,700 at December 31, 2015 increased 56,900 members, or 18.0%, from 316,800 at December 31, 2014 primarily driven by the addition of members under our Florida Medicaid contract.

- Individual commercial medical membership of 1,057,700 at December 31, 2015 decreased 90,400 members, or 7.9%, from 1,148,100 at December 31, 2014 primarily reflecting the loss of approximately 150,000 members due to termination by CMS for lack of proper eligibility documentation from the member as well as the loss of members who had subscribed to plans that were not compliant with the Health Care Reform Law. These declines were partially offset by an increase in membership in plans that are compliant with the Health Care Reform Law, primarily off-exchange. Individual commercial medical membership in plans compliant with the Health Care Reform Law experienced growth in 2015, but at a lesser rate than in 2014. At December 31, 2015, individual commercial medical membership in plans compliant with the Health Care Reform Law, both on-exchange and off-exchange, was 757,900 members, an increase of 71,600 members or 10.4% from December 31, 2014.

  We expect a net decline in individual commercial medical membership (excluding Medicare Supplement) for full year 2016 of 200,000 to 300,000, primarily reflecting increases in premiums as well as benefit redesigns that took effect on January 1, 2016. This membership expectation takes into account plans compliant with the Health Care Reform Law, both on and off exchange, and legacy plans that are not compliant with the Health Care Reform Law. Membership estimates for 2016 include the expectation of coverage termination by 50% to 60% of the approximately 100,000 members impacted by plan discontinuances.

Group Segment

- Group segment pretax income grew $107 million, or 70.9%, for the year ended December 31, 2015 primarily due to improvement in the operating cost ratio partially offset by an increase in the benefit ratio as discussed in the results of operations discussion that follows.

- Membership in HumanaVitality®, our wellness and loyalty rewards program, rose 2.0% to 3,932,300 at December 31, 2015 from 3,856,800 at December 31, 2014.

Healthcare Services Segment

- Year-over-year comparisons of results of operations are impacted by the completion of the sale of Concentra on June 1, 2015.

- As discussed in the detailed Healthcare Services segment results of operations discussion that follows, our Healthcare Services segment pretax income increased $243 million, or 32.9%, for the year ended December 31, 2015. This increase was primarily due to higher earnings from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership. High levels of Medicare membership growth as well as increased engagement of members in clinical programs have resulted in higher usage of services across this segment. In addition, improved operating efficiency in the pharmacy business primarily was driven by lower cost of goods associated with increased purchasing scale and lower cost-to-fill primarily due to improvements in technology.

- Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We have expanded our identification of and outreach to members in need of clinical intervention. At December 31, 2015, we enrolled approximately 590,300 Medicare Advantage members with complex chronic conditions in the Humana Chronic Care Program, a 40.3% increase compared with approximately 420,700 members at December 31, 2014, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year $25 billion industry wide commercial reinsurance fee. The annual health insurance industry fee levied on the insurance industry was $8 billion in 2014 and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter, and is not deductible for income tax purposes, which significantly increased our effective income tax rate. Our effective tax rate for 2015 was approximately 47.5%, including the favorable impact of the sale of Concentra on June 1, 2015. Our effective tax rate for 2016 is expected to be approximately 49% to 51%, excluding the impact of transaction costs associated with the Merger. In 2015, we paid the federal government $867 million for the annual health insurance industry fee, a 54.3% increase from $562 million in 2014, primarily reflecting an increase in the total industry fee. We expect our portion of the annual health insurance industry fee for 2016 to be higher than in 2015 given growth in our market share. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. This will significantly reduce our effective tax rate in 2017. The health insurance industry fee levied on the insurance industry was previously expected to be $14 billion in 2017.

In addition, the Health Care Reform Law expands federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms comes, in part, from material additional fees and taxes on us (as discussed above) and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described in this 2015 10-K.

As noted above, the Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk

corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products. In addition, regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law or to enroll outside of the annual enrollment period may have an adverse effect on our pool of participants in the health insurance exchange. In addition, states may impose restrictions on our ability to increase rates. All of these factors may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows and could impact our decision to participate or continue in the program in certain states.

As discussed above, it is reasonably possible that the Health Care Reform Law and related regulations, as well as future legislative changes, including legislative restrictions on our ability to manage our provider network or otherwise operate our business, or regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with the non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows (including the delayed receipt of amounts due under the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law). During 2015, we received our interim settlement associated with our risk corridor receivables for the 2014 coverage year. The interim settlement, representing only 12.6% of risk corridor receivables for the 2014 coverage year, was funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 risk corridor program. The risk corridor program is a three year program and HHS guidance provides that risk corridor collections over the life of the three year program will first be applied to any shortfalls from previous benefit years before application to current year obligations. Risk corridor payables to issuers are obligations of the United States Government under the Health Care Reform law which requires the Secretary of HHS to make full payments to issuers. In the event of a shortfall at the end of the three year program, HHS has asserted it will explore other sources of funding for risk corridor payments, subject to the availability of appropriations.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers and are described in Note 17 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2015 10-K.

Comparison of Results of Operations for 2015 and 2014

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2015 and 2014:

Consolidated

	2015	2014	Change Dollars	Change Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 45,805	$ 39,452	$ 6,353	16.1 %
Group	6,569	6,456	113	1.8 %
Other Businesses	35	51	(16)	(31.4)%
Total premiums	52,409	45,959	6,450	14.0 %
Services:				
Retail	9	39	(30)	(76.9)%
Group	698	763	(65)	(8.5)%
Healthcare Services	685	1,353	(668)	(49.4)%
Other Businesses	14	9	5	55.6 %
Total services	1,406	2,164	(758)	(35.0)%
Investment income	474	377	97	25.7 %
Total revenues	54,289	48,500	5,789	11.9 %
Operating expenses:				
Benefits	44,269	38,166	6,103	16.0 %
Operating costs	7,318	7,639	(321)	(4.2)%
Depreciation and amortization	355	333	22	6.6 %
Total operating expenses	51,942	46,138	5,804	12.6 %
Income from operations	2,347	2,362	(15)	(0.6)%
Gain on sale of business	270	—	270	100.0 %
Interest expense	186	192	(6)	(3.1)%
Income before income taxes	2,431	2,170	261	12.0 %
Provision for income taxes	1,155	1,023	132	12.9 %
Net income	$ 1,276	$ 1,147	$ 129	11.2 %
Diluted earnings per common share	$ 8.44	$ 7.36	$ 1.08	14.7 %
Benefit ratio (a)	84.5%	83.0%		1.5 %
Operating cost ratio (b)	13.6%	15.9%		(2.3)%
Effective tax rate	47.5%	47.2%		0.3 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income was $1.3 billion, or $8.44 per diluted common share, in 2015 compared to $1.1 billion, or $7.36 per diluted common share, in 2014. The completion of the sale of Concentra on June 1, 2015 resulted in an after-tax gain

of $1.57 per diluted common share in 2015. Excluding the impact of the sale of Concentra, the decrease primarily was due to a decline in Retail segment pretax results, including expense of $0.74 per diluted common share for a premium deficiency reserve for certain of our individual commercial medical products for the 2016 coverage year, and an increase in the effective tax rate as discussed below. These items were partially offset by year-over-year improvement in the Group and Healthcare Services segment pretax results and higher investment income. In addition, 2015 includes expenses of $0.14 per diluted common share for transaction costs associated with the Merger, certain of which are not deductible for tax purposes. Net income for 2014 includes expenses of $0.15 per diluted common share associated with a loss on extinguishment of debt for the redemption of certain senior notes in 2014. Year-over-year comparisons of diluted earnings per common share are also favorably impacted by a lower number of shares used to compute diluted earnings per common share in 2015 reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $6.5 billion, or 14.0%, from 2014 to $52.4 billion for 2015 primarily reflecting higher premiums in both the Retail and Group segments. These higher premiums were primarily driven by average membership growth in the Retail segment and an increase in fully-insured group commercial medical per member premiums in the Group segment. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per member premiums. Items impacting average per member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Services Revenue

Consolidated services revenue decreased $758 million, or 35.0%, from 2014 to $1.4 billion for 2015 primarily due to the completion of the sale of Concentra on June 1, 2015 as well as the loss of certain large group ASO accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.

Investment Income

Investment income totaled $474 million for 2015, an increase of $97 million, or 25.7%, from 2014, primarily due to higher realized capital gains in 2015 as a result of the repositioning of our portfolio given recent market volatility and anticipated changes to interest rates, with higher average invested balances being substantially offset by lower interest rates.

Benefits Expense

Consolidated benefits expense was $44.3 billion for 2015, an increase of $6.1 billion, or 16.0%, from 2014 primarily due to an increase in the Retail segment mainly driven by higher average Medicare Advantage membership and individual commercial medical on-exchange and off-exchange membership in plans compliant with the Health Care Reform Law. As more fully described herein under the section entitled “Benefits Expense Recognition”, actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $236 million in 2015 and $518 million in 2014. The decline in prior-period medical claims reserve development year over-year primarily was due to Medicare Advantage and individual commercial medical claims development in the Retail segment as discussed further in the segment results of operations discussion that follows.

The consolidated benefit ratio for 2015 was 84.5%, an increase of 150 basis points from 2014 primarily due to increases in the Retail segment, including the impact of a recognizing a premium deficiency reserve for certain of our individual commercial medical products for the 2016 coverage year, and Group segment ratios as discussed in the segment results of operations discussions that follows. The increase in benefits expense associated with the recognition of the premium deficiency reserve increased the consolidated benefit ratio by approximately 30 basis points in 2015. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 50 basis points in 2015 versus approximately 110 basis points in 2014.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs decreased $321 million, or 4.2%, from 2014 to $7.3 billion in 2015 primarily due to cost management initiatives across all lines of business as well as the completion of the sale of Concentra on June 1, 2015, partially offset by increases in costs mandated by the Health Care Reform Law, including the non-deductible health insurance industry fee.

The consolidated operating cost ratio for 2015 was 13.6%, decreasing 230 basis points from 2014 primarily due to decreases in the operating cost ratios in the Group and Retail segments reflecting cost management initiatives, as well as the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio.

Depreciation and Amortization

Depreciation and amortization for 2015 totaled $355 million, increasing $22 million, or 6.6% from 2014 reflecting higher depreciation expense from capital expenditures.

Interest Expense

Interest expense was $186 million for 2015 compared to $192 million for 2014, a decrease of $6 million, or 3.1%, primarily reflecting a higher average long-term debt balance due to the issuance of senior notes in September 2014, partially offset by the recognition of a loss on extinguishment of debt of approximately $37 million in October 2014 for the redemption of our $500 million 6.45% senior unsecured notes due June 1, 2016.

Income Taxes

Our effective tax rate during 2015 was 47.5% compared to the effective tax rate of 47.2% in 2014. The increase in the effective tax rate primarily was due to an increase in the non-deductible health insurance industry fee from 2014, substantially offset by the favorable tax effect of the gain on the sale of Concentra. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate. Our effective tax rate for 2016 is expected to be approximately 49% to 51%, excluding the impact of any non-deductible transaction costs associated with the Merger.

Retail Segment

	2015	2014	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,753,400	2,427,900	325,500	13.4 %
Group Medicare Advantage	484,100	489,700	(5,600)	(1.1)%
Medicare stand-alone PDP	4,557,900	3,994,000	563,900	14.1 %
Total Retail Medicare	7,795,400	6,911,600	883,800	12.8 %
Individual commercial (a)	1,057,700	1,148,100	(90,400)	(7.9)%
State-based Medicaid	373,700	316,800	56,900	18.0 %
Total Retail medical members	9,226,800	8,376,500	850,300	10.2 %
Individual specialty membership (b)	1,153,100	1,165,800	(12,700)	(1.1)%

(a) Individual commercial medical membership includes Medicare Supplement members.

(b) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2015	2014	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 29,526	$ 25,782	$ 3,744	14.5 %
Group Medicare Advantage	5,588	5,490	98	1.8 %
Medicare stand-alone PDP	3,846	3,404	442	13.0 %
Total Retail Medicare	38,960	34,676	4,284	12.4 %
Individual commercial	4,243	3,265	978	30.0 %
State-based Medicaid	2,341	1,255	1,086	86.5 %
Individual specialty	261	256	5	2.0 %
Total premiums	45,805	39,452	6,353	16.1 %
Services	9	39	(30)	(76.9)%
Total premiums and services revenue	$ 45,814	$ 39,491	$ 6,323	16.0 %
Income before income taxes	$ 930	$ 1,339	$ (409)	(30.5)%
Benefit ratio	86.7%	84.9%		1.8 %
Operating cost ratio	11.2%	11.6%		(0.4)%

Pretax Results

- Retail segment pretax income was $930 million in 2015, a decrease of $409 million, or 30.5%, compared to 2014 primarily driven by an increase in the benefit ratio for 2015, including the impact of recognizing a premium deficiency reserve of approximately $176 million for certain of our individual commercial medical products for the 2016 coverage year, partially offset by a decline in the operating cost ratio, Medicare Advantage membership growth, and higher investment income year-over-year.

Enrollment

- Individual Medicare Advantage membership increased 325,500 members, or 13.4%, from December 31, 2014 to December 31, 2015 reflecting net membership additions, particularly for our HMO offerings, for the 2015 plan year.

- Group Medicare Advantage membership decreased 5,600 members, or 1.1%, from December 31, 2014 to December 31, 2015.

- Medicare stand-alone PDP membership increased 563,900 members, or 14.1%, from December 31, 2014 to December 31, 2015 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2015 plan year.

- Individual commercial medical membership decreased 90,400 members, or 7.9%, from December 31, 2014 to December 31, 2015 primarily reflecting the loss of approximately 150,000 members due to termination by CMS for lack of proper eligibility documentation from the member as well as the loss of members who had subscribed to plans that were not compliant with the Health Care Reform Law. These declines were partially offset by an increase in membership in plans that are compliant with the Health Care Reform Law, primarily off-exchange.

- State-based Medicaid membership increased 56,900 members, or 18.0%, from December 31, 2014 to December 31, 2015 primarily driven by the addition of members under our Florida Medicaid contract.

- Individual specialty membership decreased 12,700 members, or 1.1%, from December 31, 2014 to December 31, 2015 primarily driven by a membership decline in supplemental health and financial protection product and vision offerings.

Premiums revenue

- Retail segment premiums increased $6.4 billion, or 16.1%, from 2014 to 2015 primarily due to membership growth across our Medicare Advantage, state-based Medicaid, and Medicare stand-alone PDP lines of business, as well as a heavier percentage of individual commercial medical business in higher premium plans compliant with the Health Care Reform Law. Average Medicare Advantage membership increased 11.8% in 2015.

Benefits expense

- The Retail segment benefit ratio of 86.7% for 2015 increased 180 basis points from 2014 primarily due to higher than expected medical costs as compared to the assumptions used in our pricing, the recognition of a premium deficiency reserve in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year, and unfavorable year-over-year comparisons of prior-period medical claims reserve development as discussed below. In addition, the increase reflects higher benefit ratios associated with a greater number of members from state-based contracts and the impact of the change in estimate for the 2014 net 3Rs receivables in 2015. These items were partially offset by the impact of the increase in the health insurance industry fee included in the pricing of our products. In addition, the 2015 period was favorably impacted by the release of reserves for future policy benefits as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

  We experienced higher than expected medical costs as compared to the assumptions used in our pricing for 2015 primarily due to lower-than-expected 2015 Medicare Advantage financial claim recovery levels and lower-than-anticipated reductions in inpatient admissions. In addition, medical claims associated with certain individual commercial medical products, in particular products compliant with the Health Care Reform Law, exceeded the assumptions used when we set pricing for 2015. We took a number of actions in 2015 to improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and

administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results indicating the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment of the profitability of our individual medical policies compliant with the Health Care Reform Law, in the fourth quarter of 2015, we recorded a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million. The increase in benefits expense associated with the recognition of the premium deficiency reserve increased the Retail segment benefit ratio by approximately 40 basis points in 2015.

- The Retail segment's benefits expense for 2015 included the beneficial effect of $228 million in favorable prior-year medical claims reserve development versus $488 million in 2014. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 50 basis points in 2015 versus approximately 120 basis points in 2014. The year-over-year decline in prior-period medical claims reserve development primarily was due to the impact of lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products.

Operating costs

- The Retail segment operating cost ratio of 11.2% for 2015 decreased 40 basis points from 2014 primarily reflecting administrative cost efficiencies associated with medical membership growth in the segment and other discretionary cost reductions, partially offset by the increase in the non-deductible health insurance industry fee. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2015 as compared to 120 basis points in 2014.

Group Segment

			Change	
	2015	2014	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,178,300	1,235,500	(57,200)	(4.6)%
ASO	710,700	1,104,300	(393,600)	(35.6)%
Military services	3,074,400	3,090,400	(16,000)	(0.5)%
Total group medical members	4,963,400	5,430,200	(466,800)	(8.6)%
Group specialty membership (a)	6,068,700	6,502,700	(434,000)	(6.7)%

(a) Specialty products include dental, vision, and other voluntary benefit products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2015	2014	Change	
			Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,493	$ 5,339	$ 154	2.9 %
Group specialty	1,055	1,098	(43)	(3.9)%
Military services	21	19	2	10.5 %
Total premiums	6,569	6,456	113	1.8 %
Services	698	763	(65)	(8.5)%
Total premiums and services revenue	$ 7,267	$ 7,219	$ 48	0.7 %
Income before income taxes	$ 258	$ 151	$ 107	70.9 %
Benefit ratio	80.2%	79.5%		0.7 %
Operating cost ratio	24.0%	26.5%		(2.5)%

Pretax Results

- Group segment pretax income increased $107 million, or 70.9%, to $258 million in 2015 primarily reflecting improvement in the operating cost ratio partially offset by an increase in the benefit ratio as discussed below.

Enrollment

- Fully-insured commercial group medical membership decreased 57,200 members, or 4.6% from December 31, 2014 reflecting lower membership in both large and small group accounts.

- Group ASO commercial medical membership decreased 393,600 members, or 35.6%, from December 31, 2014 to December 31, 2015 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.

- Group specialty membership decreased 434,000 members, or 6.7%, from December 31, 2014 to December 31, 2015 primarily due to the loss of certain fully-insured group medical accounts that also had specialty coverage.

Premiums revenue

- Group segment premiums increased $113 million, or 1.8%, from 2014 to 2015 primarily due to an increase in fully-insured commercial medical per member premiums partially offset by a net decline in fully-insured commercial medical membership.

Services revenue

- Group segment services revenue decreased $65 million, or 8.5%, from 2014 to 2015 primarily due to a decline in group ASO commercial medical membership.

Benefits expense

- The Group segment benefit ratio increased 70 basis points from 79.5% in 2014 to 80.2% in 2015 primarily reflecting the impact of higher specialty drug costs, net of rebates, as well as higher outpatient costs and lower prior-period medical claims reserve development, partially offset by an increase in the non-deductible health insurance industry fee included in the pricing of our products.

- The Group segment's benefits expense included the beneficial effect of $7 million in favorable prior-year medical claims reserve development versus $29 million in 2014. This favorable prior-year medical claims reserve development decreased the Group segment benefit ratio by approximately 10 basis points in 2015 versus approximately 40 basis points in 2014. The year-over-year decline in favorable prior-period medical

claims reserve development primarily was due to a relatively small number of higher severity claims in the 2015 period associated with prior periods.

Operating costs

- The Group segment operating cost ratio of 24.0% for 2015 decreased 250 basis points from 26.5% for 2014, reflecting a decline in our group ASO commercial medical membership which carries a higher operating cost ratio than our fully-insured commercial medical membership, as well as operating cost efficiencies associated with our fully-insured business. Operating cost efficiencies were the result of both sustainable cost reduction initiatives and discretionary reductions. These declines were partially offset by the impact of an increase in the non-deductible health insurance industry fee. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 140 basis points in 2015 as compared to 100 basis points in 2014.

Healthcare Services Segment

			Change	
	2015	2014	Dollars	Percentage
		(in millions)		
Revenues:				
Services:				
Provider services	$ 515	$ 1,147	$ (632)	(55.1)%
Home based services	140	107	33	30.8 %
Pharmacy solutions	30	99	(69)	(69.7)%
Total services revenues	685	1,353	(668)	(49.4)%
Intersegment revenues:				
Pharmacy solutions	20,551	16,905	3,646	21.6 %
Provider services	1,291	1,149	142	12.4 %
Home based services	875	585	290	49.6 %
Clinical programs	203	208	(5)	(2.4)%
Total intersegment revenues	22,920	18,847	4,073	21.6 %
Total services and intersegment revenues	$ 23,605	$ 20,200	$ 3,405	16.9 %
Income before income taxes	$ 981	$ 738	$ 243	32.9 %
Operating cost ratio	95.2%	95.6%		(0.4)%

Pretax results

- Healthcare Services segment pretax income of $981 million for 2015 increased $243 million, or 32.9%, from 2014 primarily due to higher earnings from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group segment membership increased to approximately 398 million in 2015, up 21% versus scripts of approximately 329 million in 2014. The increase primarily reflects growth associated with higher average medical membership for 2015 than in 2014.

Services revenue

- Services revenue decreased $668 million, or 49.4%, from 2014 to $685 million for 2015 primarily due to the completion of the sale of Concentra on June 1, 2015.

Intersegment revenues

- Intersegment revenues increased $4.1 billion, or 21.6%, from 2014 to $22.9 billion for 2015 primarily due to growth in our Medicare membership which resulted in higher utilization of our Healthcare Services segment businesses.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.2% for 2015 decreased 40 basis points from 95.6% for 2014 primarily due to lower operating costs in our pharmacy business together with discretionary cost reductions across the segment, partially offset by the increasing percentage of pharmacy business associated with lower margin specialty drugs. Improving operating efficiency in the pharmacy business was primarily driven by lower cost of goods associated with increased purchasing scale and lower cost-to-fill primarily due to improvements in technology.

Comparison of Results of Operations for 2014 and 2013

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2014 and 2013:

Consolidated

	2014	2013	Change Dollars	Change Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 39,452	$ 31,922	$ 7,530	23.6 %
Group	6,456	6,237	219	3.5 %
Other Businesses	51	670	(619)	(92.4)%
Total premiums	45,959	38,829	7,130	18.4 %
Services:				
Retail	39	18	21	116.7 %
Group	763	735	28	3.8 %
Healthcare Services	1,353	1,350	3	0.2 %
Other Businesses	9	6	3	50.0 %
Total services	2,164	2,109	55	2.6 %
Investment income	377	375	2	0.5 %
Total revenues	48,500	41,313	7,187	17.4 %
Operating expenses:				
Benefits	38,166	32,564	5,602	17.2 %
Operating costs	7,639	6,355	1,284	20.2 %
Depreciation and amortization	333	333	—	— %
Total operating expenses	46,138	39,252	6,886	17.5 %
Income from operations	2,362	2,061	301	14.6 %
Interest expense	192	140	52	37.1 %
Income before income taxes	2,170	1,921	249	13.0 %
Provision for income taxes	1,023	690	333	48.3 %
Net income	$ 1,147	$ 1,231	$ (84)	(6.8)%
Diluted earnings per common share	$ 7.36	$ 7.73	$ (0.37)	(4.8)%
Benefit ratio (a)	83.0%	83.9%		(0.9)%
Operating cost ratio (b)	15.9%	15.5%		0.4 %
Effective tax rate	47.2%	35.9%		11.3 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income was $1.1 billion, or $7.36 per diluted common share, in 2014 compared to $1.2 billion, or $7.73 per diluted common share, in 2013. Net income for 2014 includes expenses of $0.15 per diluted common share associated with a loss on extinguishment of debt for the redemption of certain senior notes in 2014 and net income for 2013 includes benefits expense of $0.99 per diluted common share for reserve strengthening associated with our closed-

block of long-term care insurance policies included with Other Businesses as discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data as well as the benefit of a reduction in benefits expense in 2013 related to a favorable settlement of contract claims with the DoD. Excluding these items, the increase in net income primarily resulted from higher pretax income in our Healthcare Services segment substantially offset by lower pretax income in our Retail and Group segments. In addition, 2014 was favorably impacted by a lower number of shares used to compute diluted earnings per common share reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $7.1 billion, or 18.4%, from 2013 to $46.0 billion for 2014 primarily due to increases in both Retail and Group segment premiums mainly driven by higher average individual and group Medicare Advantage membership as well as higher individual commercial medical membership. In addition, year-over-year comparisons to 2013 were negatively impacted by sequestration which became effective April 1, 2013. Premiums revenue for our Other Businesses declined primarily due to the loss of our Puerto Rico Medicaid contracts effective September 30, 2013.

Services Revenue

Consolidated services revenue increased $55 million, or 2.6%, from 2013 to $2.2 billion for 2014 primarily due to an increase in services revenue in our Retail segment due to the acquisition of American Eldercare in September 2013.

Investment Income

Investment income totaled $377 million for 2014, an increase of $2 million from 2013, as higher average invested balances were partially offset by lower interest rates.

Benefits Expense

Consolidated benefits expense was $38.2 billion for 2014, an increase of $5.6 billion, or 17.2%, from 2013 primarily due to increases in both the Retail and Group segments mainly driven by higher average individual and group Medicare Advantage membership as well as higher individual commercial medical membership. We experienced favorable medical claims reserve development related to prior fiscal years of $518 million in 2014 and $474 million in 2013. These increases in favorable medical claims reserve development primarily resulted from increased membership and better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

The consolidated benefit ratio for 2014 was 83.0%, a decrease of 90 basis points from 2013 primarily due to reserve strengthening in 2013 associated with our closed-block of long-term care insurance policies included with Other Businesses as discussed above, as well as the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013 which more than offset higher ratios year-over-year in the Retail and Group segments.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs increased $1,284 million, or 20.2%, in 2014 compared to 2013 primarily due to costs mandated by the Health Care Reform Law, including the non-deductible health insurance industry fee, and investments in health care exchanges and state-based contracts, partially offset by operating cost efficiencies.

The consolidated operating cost ratio for 2014 was 15.9%, increasing 40 basis points from 2013 primarily due to increases in the operating cost ratios in our Retail and Group segments due to the same factors impacting consolidated operating costs as described above.

Depreciation and Amortization

Depreciation and amortization for 2014 totaled $333 million, unchanged from 2013.

Interest Expense

Interest expense was $192 million for 2014 compared to $140 million for 2013, an increase of $52 million, or 37.1%. In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, We recognized a loss on extinguishment of debt of approximately $37 million in October 2014 for the redemption of these notes.

Income Taxes

Our effective tax rate during 2014 was 47.2% compared to the effective tax rate of 35.9% in 2013. The non-deductible nature of the health insurance industry fee levied on the insurance industry beginning in 2014 as mandated by the Health Care Reform Law increased our effective tax rate by approximately 9.4 percentage points for 2014.

Retail Segment

			Change	
	2014	2013	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,427,900	2,068,700	359,200	17.4%
Group Medicare Advantage	489,700	429,100	60,600	14.1%
Medicare stand-alone PDP	3,994,000	3,275,900	718,100	21.9%
Total Retail Medicare	6,911,600	5,773,700	1,137,900	19.7%
Individual commercial (a)	1,148,100	600,100	548,000	91.3%
State-based Medicaid	316,800	85,500	231,300	270.5%
Total Retail medical members	8,376,500	6,459,300	1,917,200	29.7%
Individual specialty membership (b)	1,165,800	1,042,500	123,300	11.8%

(a) Individual commercial medical membership includes Medicare Supplement members.

(b) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2014	2013	Change	
			Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 25,782	$ 22,481	$ 3,301	14.7 %
Group Medicare Advantage	5,490	4,710	780	16.6 %
Medicare stand-alone PDP	3,404	3,033	371	12.2 %
Total Retail Medicare	34,676	30,224	4,452	14.7 %
Individual commercial	3,265	1,160	2,105	181.5 %
State-based Medicaid	1,255	328	927	282.6 %
Individual specialty	256	210	46	21.9 %
Total premiums	39,452	31,922	7,530	23.6 %
Services	39	18	21	116.7 %
Total premiums and services revenue	$ 39,491	$ 31,940	$ 7,551	23.6 %
Income before income taxes	$ 1,339	$ 1,490	$ (151)	(10.1)%
Benefit ratio	84.9%	85.1%		(0.2)%
Operating cost ratio	11.6%	10.1%		1.5 %

Pretax Results

- Retail segment pretax income was $1.3 billion in 2014, a decrease of $151 million, or 10.1%, compared to 2013 primarily driven by investment spending for health care exchanges and state-based contracts and higher specialty prescription drug costs associated with a new treatment for Hepatitis C, partially offset by Medicare Advantage and individual commercial medical membership growth as well as increased membership in our clinical programs.

Enrollment

- Individual Medicare Advantage membership increased 359,200 members, or 17.4%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, particularly for our HMO offerings, for the 2014 plan year.
- Fully-insured group Medicare Advantage membership increased 60,600 members, or 14.1%, from December 31, 2013 to December 31, 2014 primarily due to the addition of a new large group account.
- Medicare stand-alone PDP membership increased 718,100 members, or 21.9%, from December 31, 2013 to December 31, 2014 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2014 plan year.
- Individual commercial medical membership increased 548,000 members, or 91.3%, from December 31, 2013 to December 31, 2014 primarily reflecting new sales, both on-exchange and off-exchange, of plans compliant with the Health Care Reform Law.
- State-based Medicaid membership increased 231,300 members, or 270.5%, from December 31, 2013 to December 31, 2014 primarily driven by the addition of members under our Florida Medicaid and Florida Long-Term Support Services contracts as well as 18,300 dual eligible members from state-based contracts in Virginia and Illinois.
- Individual specialty membership increased 123,300 members, or 11.8%, from December 31, 2013 to December 31, 2014 primarily driven by increased membership in dental and vision offerings.

Premiums revenue

- Retail segment premiums increased $7.5 billion, or 23.6%, from 2013 to 2014 primarily due to membership growth across all lines of business, particularly for our Medicare Advantage, individual commercial medical, primarily on the health care exchanges, and state-based Medicaid businesses. Individual Medicare Advantage average membership increased 16.6% in 2014. Individual Medicare Advantage per member premiums decreased approximately 1.7% in 2014 compared to 2013, primarily due to Medicare rate reductions and the impact of sequestration which became effective on April 1, 2013.

Benefits expense

- The Retail segment benefit ratio of 84.9% for 2014 decreased 20 basis points from 2013 primarily due to increased membership in our clinical programs and the inclusion of the health insurance industry fee in the pricing of our products, partially offset by higher specialty prescription drug costs associated with a new treatment for Hepatitis C, higher planned clinical investment spending, and higher benefit ratios associated with members from state-based contracts.

- The Retail segment's benefits expense for 2014 included the beneficial effect of $488 million in favorable prior-year medical claims reserve development versus $428 million in 2013. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 120 basis points in 2014 versus approximately 130 basis points in 2013.

Operating costs

- The Retail segment operating cost ratio of 11.6% for 2014 increased 150 basis points from 2013 primarily due to the non-deductible health insurance industry fee mandated by the Health Care Reform Law and investment spending for health care exchanges and state-based contracts, partially offset by scale efficiencies from Medicare and individual commercial medical membership growth.

Group Segment

			Change	
	2014	2013	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,235,500	1,237,000	(1,500)	(0.1)%
ASO	1,104,300	1,162,800	(58,500)	(5.0)%
Military services	3,090,400	3,101,800	(11,400)	(0.4)%
Total group medical members	5,430,200	5,501,600	(71,400)	(1.3)%
Group specialty membership (a)	6,502,700	6,780,800	(278,100)	(4.1)%

(a) Specialty products include dental, vision, and voluntary benefit products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2014	2013	Change	
			Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,339	$ 5,117	$ 222	4.3 %
Group specialty	1,098	1,095	3	0.3 %
Military services	19	25	(6)	(24.0)%
Total premiums	6,456	6,237	219	3.5 %
Services	763	735	28	3.8 %
Total premiums and services revenue	$ 7,219	$ 6,972	$ 247	3.5 %
Income before income taxes	$ 151	$ 240	$ (89)	(37.1)%
Benefit ratio	79.5%	77.7%		1.8 %
Operating cost ratio	26.5%	26.5%		— %

Pretax Results

- Group segment pretax income decreased $89 million, or 37.1%, to $151 million in 2014 primarily reflecting higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes which allowed individuals to remain in plans not compliant with the Health Care Reform Law.

Enrollment

- Fully-insured commercial group medical membership decreased 1,500 members, or 0.1% from December 31, 2013 as an increase in small group business membership was generally offset by lower membership in large group accounts. Approximately 65% of our fully-insured commercial group medical membership was in small group accounts at December 31, 2014 compared to 61% at December 31, 2013.

- Group ASO commercial medical membership decreased 58,500 members, or 5.0%, from December 31, 2013 to December 31, 2014 primarily due to continued pricing discipline in a highly competitive environment for self-funded accounts.

- Group specialty membership decreased 278,100 members, or 4.1%, from December 31, 2013 to December 31, 2014 primarily due to declines in dental and vision membership related to our planned discontinuance of certain unprofitable product distribution partnerships.

Premiums revenue

- Group segment premiums increased $219.0 million, or 3.5%, from 2013 to 2014 primarily due to higher fully-insured commercial group medical premiums per member that more than offset a slight decline in total membership for this segment.

Benefits expense

- The Group segment benefit ratio increased 180 basis points from 77.7% in 2013 to 79.5% in 2014 primarily due to higher utilization, mainly due to higher specialty prescription drug costs associated with a new treatment for Hepatitis C, as well as the continuing impact of transitional policy changes, partially offset by the inclusion of the health insurance industry fee and other fees mandated by the Health Care Reform Law in our pricing.

- The Group segment's benefits expense included the beneficial effect of $29 million in favorable prior-year medical claims reserve development versus $42 million in 2013. This favorable prior-year medical claims reserve development decreased the Group segment benefit ratio by approximately 40 basis points in 2014 versus approximately 70 basis points in 2013.

Operating costs

- The Group segment operating cost ratio of 26.5% was unchanged from 2013, reflecting the impact of the non-deductible health insurance industry fee and other fees mandated by the Health Care Reform Law as well as a higher percentage of small group commercial business which carries a higher operating cost ratio than large group business, offset by operating cost efficiencies.

Healthcare Services Segment

	2014	2013	Change	
			Dollars	Percentage
		(in millions)		
Revenues:				
Services:				
Provider services	$ 1,147	$ 1,195	$ (48)	(4.0)%
Home based services	107	94	13	13.8 %
Pharmacy solutions	99	59	40	67.8 %
Clinical programs	—	2	(2)	(100.0)%
Total services revenues	1,353	1,350	3	0.2 %
Intersegment revenues:				
Pharmacy solutions	16,905	13,079	3,826	29.3 %
Provider services	1,149	1,102	47	4.3 %
Home based services	585	326	259	79.4 %
Clinical programs	208	186	22	11.8 %
Total intersegment revenues	18,847	14,693	4,154	28.3 %
Total services and intersegment revenues	$ 20,200	$ 16,043	$ 4,157	25.9 %
Income before income taxes	$ 738	$ 520	$ 218	41.9 %
Operating cost ratio	95.6%	95.8%		(0.2)%

Pretax results

- Healthcare Services segment pretax income of $738 million for 2014 increased $218 million from 2013. The increase is primarily due to a decline in the operating cost ratio in 2014 on a revenue base that reflects growth from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group segment membership increased to approximately 329 million in 2014, up 20% versus scripts of approximately 274 million in 2013. The increase primarily reflects growth associated with higher average medical membership for 2014 than in 2013.

Services revenue

- Services revenue for 2014 were relatively unchanged from 2013, increasing $3 million, or 0.2%, to $1.4 billion for 2014.

Intersegment revenues

- Intersegment revenues increased $4.2 billion, or 28.3%, from 2013 to $18.8 billion for 2014 primarily due to growth in our Medicare membership which resulted in higher utilization of our pharmacy solutions and home based services businesses.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.6% for 2014 decreased 20 basis points from 95.8% for 2013 primarily due to an improvement in the ratio for our pharmacy solutions business partially offset by our investment in home based services and other businesses across the segment.

Other Businesses

Our Other Businesses pretax income of $1 million for 2014 compared to a pretax loss of $289 million for 2013. The pretax loss in 2013 included net expense of $243 million for reserve strengthening for our closed-block of long-term care insurance policies further discussed in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. Year-over-year comparisons also reflect the loss of our Medicaid contracts in Puerto Rico effective September 30, 2013.

Liquidity

The Merger Agreement includes customary restrictions on the conduct of our business prior to the completion of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of specified limitations absent Aetna's prior written consent. Historically, our primary sources of cash have included receipts of premiums, services revenue, and investment and other income, as well as proceeds from the sale or maturity of our investment securities, borrowings, and proceeds from sales of businesses. Our primary uses of cash historically have included disbursements for claims payments, operating costs, interest on borrowings, taxes, purchases of investment securities, acquisitions, capital expenditures, repayments on borrowings, dividends, and share repurchases. Because premiums generally are collected in advance of claim payments by a period of up to several months, our business normally should produce positive cash flows during periods of increasing premiums and enrollment. Conversely, cash flows would be negatively impacted during periods of decreasing premiums and enrollment. From period to period, our cash flows may also be affected by the timing of working capital items including premiums receivable, benefits payable, and other receivables and payables. Our cash flows are impacted by the timing of payments to and receipts from CMS associated with Medicare Part D subsidies for which we do not assume risk. The use of operating cash flows may be limited by regulatory requirements of state departments of insurance (or comparable state regulators) which require, among other items, that our regulated subsidiaries maintain minimum levels of capital and seek approval before paying dividends from the subsidiaries to the parent. Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

The effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law impact the timing of our operating cash flows, as we build receivables for each coverage year that are expected to be collected in subsequent coverage years. On June 30, 2015 we received notification from CMS of risk adjustment and reinsurance settlement amounts for 2014. During 2015, we collected $392 million net for risk adjustment and reinsurance recoverable settlements associated with the 2014 coverage year. In addition, during 2015, we received our interim settlement associated with our risk corridor receivables for the 2014 coverage year. The interim settlement, representing only 12.6% of risk corridor receivables for the 2014 coverage year, was funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 risk corridor program. We collected $25 million net of payments for risk corridor associated with the 2014 coverage year during 2015. HHS provided guidance under the three year risk corridor program that future collections will first be applied to any shortfalls from previous coverage years before application to current year obligations. Risk corridor payables to issuers are obligations of the United States Government under the Health Care Reform law which requires the Secretary of HHS to make full payments to issuers. In the event of a shortfall at the end of the three year program, HHS has asserted it will explore other sources of funding for risk corridor payments, subject to the availability of appropriations. The

remaining net receivable balance associated with the 3Rs was approximately $982 million at December 31, 2015, including $219 million related to the 2014 coverage year, and $679 million at December 31, 2014. Any amounts receivable or payable associated with these risk limiting programs may have an impact on subsidiary liquidity, with any temporary shortfalls funded by the parent company.

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2015 Form 10-K.

Cash and cash equivalents increased to $2.6 billion at December 31, 2015 from $1.9 billion at December 31, 2014. The change in cash and cash equivalents for the years ended December 31, 2015, 2014 and 2013 is summarized as follows:

	2015	2014	2013
		(in millions)	
Net cash provided by operating activities	$ 868	$ 1,618	$ 1,716
Net cash provided by (used in) investing activities	320	(63)	(1,182)
Net cash used in financing activities	(552)	(758)	(702)
Increase (decrease) in cash and cash equivalents	$ 636	$ 797	$ (168)

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in earnings, enrollment activity, and the timing of working capital items as discussed below. The lower operating cash flows in 2015 primarily reflect the effect of significant growth in individual commercial medical and group Medicare Advantage membership in 2014 and changes in the timing of working capital items related to the growth in our pharmacy business. Operating cash flows for 2014 were favorably impacted and conversely operating cash flows for 2015 were negatively impacted from the typical pattern of claim payments that lagged premium receipts related to new membership in 2014. Individual commercial medical added 548,000 new members in 2014 compared to a decline of 90,400 members in 2015. Likewise, group Medicare Advantage added 60,600 new members in 2014 compared to a decline of 5,600 members in 2015. In addition, 2015 and 2014 operating cash flows were impacted by increased receivables associated with the 3Rs.

The most significant drivers of changes in our working capital are typically the timing of payments of benefits expense and receipts for premiums. We illustrate these changes with the following summaries of benefits payable and receivables.

The detail of benefits payable was as follows at December 31, 2015, 2014 and 2013:

	2015	2014	2013	Change 2015	Change 2014	Change 2013
			(in millions)			
IBNR (1)	$ 3,730	$ 3,254	$ 2,586	$ 476	$ 668	$ 34
Reported claims in process (2)	600	475	381	125	94	66
Premium deficiency reserve (3)	176	—	—	176	—	—
Other benefits payable (4)	470	746	926	(276)	(180)	14
Total benefits payable	$ 4,976	$ 4,475	$ 3,893	501	582	114
Payables from acquisition				—	—	(5)
Change in benefits payable per cash flow statement resulting in cash from operations				$ 501	$ 582	$ 109

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date and includes unprocessed claim inventories. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).

(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling, as well as amounts owed to our pharmacy benefit administrator which fluctuate due to bi-weekly payments and the month-end cutoff.

(3) Premium deficiency reserve recognized in 2015 for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year.

(4) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The increases in benefits payable in 2015 and 2014 largely were due to an increase in IBNR. IBNR increased during 2015 primarily as a result of individual Medicare Advantage membership growth while during 2014 IBNR also increased as a result of individual Medicare Advantage membership growth as well as significant growth in individual commercial medical and group Medicare Advantage membership. As discussed previously, our cash flows are impacted by changes in enrollment. In 2014 (the first year plans compliant with the Health Care Reform Law were effective), membership in new fully-insured individual commercial medical plans compliant with the Health Care Reform Law grew as compared with a decline in membership in these plans in 2015. Similarly, growth in group Medicare Advantage membership in 2014 favorably impacted the 2014 cash flows while a decline in group Medicare Advantage membership in 2015 negatively impacted the 2015 cash flows.

In addition, the increase in benefits payable in 2015 reflects the recognition of a premium deficiency reserve associated with our individual commercial medical products compliant with the Health Care Reform Law for the 2016 coverage year. An increase in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuates due to month-end cutoff, also contributed to the benefits payable increase in each of 2015 and 2014. These items were partially offset by a decrease in amounts owed to providers under capitated and risk sharing arrangements in both 2015 and 2014, including the disbursement of a portion of our Medicare risk adjustment collections under our contractual obligations associated with our risk sharing arrangements. The increase in benefits payable in 2013 primarily was due to an increase in the amount of processed but unpaid claims due to our pharmacy benefit administrator and an increase in IBNR, primarily as a result of Medicare Advantage membership growth.

The detail of total net receivables was as follows at December 31, 2015, 2014 and 2013:

	2015	2014	2013	Change 2015	Change 2014	Change 2013
			(in millions)			
Medicare	$ 765	$ 664	$ 576	$ 101	$ 88	$ 154
Commercial and other	420	381	219	39	162	59
Military services	77	106	87	(29)	19	28
Allowance for doubtful accounts	(101)	(98)	(71)	(3)	(27)	(24)
Total net receivables	$ 1,161	$ 1,053	$ 811	108	242	217
Reconciliation to cash flow statement:						
Provision for doubtful accounts				61	32	37
Change in receivables acquired, held-for-sale, or disposed from sale of business				11	(10)	(3)
Change in receivables per cash flow statement resulting in cash from operations				$ 180	$ 264	$ 251

As disclosed previously, on June 1, 2015, we completed the sale of our wholly owned subsidiary Concentra. Net receivables associated with Concentra were classified as held-for-sale at December 31, 2014 and December 31, 2013 and excluded from the table above for comparative purposes.

Medicare receivables are impacted by revenue growth associated with growth in individual and group Medicare membership and the timing of accruals and related collections associated with the CMS risk-adjustment model.

The increases in commercial and other receivables in each of 2015, 2014, and 2013 primarily are due to growth in the business. Excluding the effect of classifying Concentra receivables as held-for-sale at December 31, 2014, the increase in commercial and other receivables from 2013 to 2014 is primarily due to the commercial risk adjustment provision of the Health Care Reform Law which became effective in 2014.

Military services receivables at December 31, 2015, 2014, and 2013 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our current TRICARE South Region contract.

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. As discussed previously, the timing of payments and receipts associated with these provisions impact our operating cash flows as we build receivables for each coverage year that are expected to be collected in subsequent coverage years. The net receivable balance associated with the 3Rs was approximately $982 million at December 31, 2015 and $679 million at December 31, 2014, including certain amounts recorded in receivables as noted above. In 2015, we paid the federal government $867 million for the annual health insurance industry fee compared to our payment of $562 million in 2014.

In addition to the timing of payments of benefits expense, receipts for premiums and services revenues, and amounts due under the risk limiting and health insurance industry fee provisions of the Health Care Reform Law, other items impacting operating cash flows primarily resulted from the timing of working capital related to the growth in our pharmacy and payments for the Medicare Part D risk corridor provisions of our contracts with CMS.

Cash Flow from Investing Activities

On June 1, 2015, we completed the sale of Concentra for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs.

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $523 million in 2015, $528 million in 2014, and $441 million in 2013.

In 2015, we purchased a $284 million note receivable directly from a third-party bank syndicate related to the financing of MCCI Holdings, LLC's business as described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The purchase of this note is included with purchases of investment securities in our consolidated statement of cash flows.

Proceeds from sales and maturities of investment securities exceeded purchases by $103 million in 2015 and $411 million in 2014. These net proceeds were used to fund normal working capital needs due to an increase in receivables associated with the 3Rs in addition to the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies, as discussed below. We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $592 million in 2013.

Cash consideration paid for acquisitions, net of cash acquired, was $38 million in 2015, $18 million in 2014, and $187 million in 2013. Acquisitions in 2015 and 2014 included health and wellness related acquisitions. Cash paid for acquisitions in 2013 primarily related to the American Eldercare and other health and wellness related acquisitions.

Cash Flow from Financing Activities

Claims payments were $361 million higher than receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk during 2015, $945 million higher during 2014, and $155 million higher during 2013. Our 2014 financing cash flows were negatively impacted by the timing of payments to and receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. We experienced higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which resulted in higher subsidy receivable balances in 2014 that were settled in 2015 under the terms of our contracts with CMS. Our net receivable for CMS subsidies and brand name prescription drug discounts was $2.0 billion at December 31, 2015 compared to $1.7 billion at December 31, 2014. Refer to Note 6 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Under our administrative services only TRICARE South Region contract, health care cost payments for which we do not assume risk exceeded reimbursements from the federal government by $4 million in 2015 and were less than reimbursements from the federal government by $5 million in 2013. Reimbursements from the federal government equaled health care cost payments for which we do not assume risk in 2014. Receipts from HHS associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were higher than claims payments by $69 million in 2015 and $26 million in 2014. See Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for further description.

We repurchased 1.9 million shares for $329 million in 2015, 5.7 million shares for $730 million in 2014 (excludes another $100 million held back pending final settlement of an accelerated stock repurchase plan in March 2015), and 5.8 million shares for $502 million in 2013 under share repurchase plans authorized by the Board of Directors. We also acquired common shares in connection with employee stock plans for an aggregate cost of $56 million in 2015, $42 million in 2014, and $29 million in 2013.

As discussed further below, we paid dividends to stockholders of $172 million in each of 2015 and 2014 and $168 million in 2013.

We entered into a commercial paper program in October 2014. Net proceeds from the issuance of commercial paper were $298 million 2015 and the maximum principal amount outstanding at any one time during 2015 was $414 million. There were no net proceeds from the issuance of commercial paper in 2014 and the maximum principal amount outstanding at any one time during 2014 was $175 million.

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem our $500 million 6.45% senior unsecured notes.

The remainder of the cash used in or provided by financing activities in 2015, 2014, and 2013 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2013, 2014, and 2015 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2013	$1.06	$ 167
2014	$1.10	$ 170
2015	$1.14	$ 170

The Merger discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data does not impact our ability and intent to continue quarterly dividend payments prior to the closing of the Merger consistent with our historical dividend payments. Under the terms of the Merger Agreement, we have agreed with Aetna that our quarterly dividend will not exceed $0.29 per share prior to the closing of the Merger. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change. In addition, under the terms of the Merger Agreement, we have agreed with Aetna to coordinate the declaration and payment of dividends so that our stockholders do not fail to receive a quarterly dividend around the time of the closing of the Merger.

On October 29, 2015, the Board declared a cash dividend of $0.29 per share that was paid on January 29, 2016 to stockholders of record on December 30, 2015, for an aggregate amount of $43 million.

Stock Repurchases

In September 2014, our Board of Directors replaced a previous share repurchase authorization of up to $1 billion (of which $816 million remained unused) with a new current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Under the share repurchase authorization, shares may be purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. Pursuant to the Merger Agreement, after July 2, 2015, we are prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we have suspended our share repurchase program. Our remaining repurchase authorization was $1.04 billion as of July 3, 2015.

Senior Notes

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem the 6.45% senior unsecured notes as discussed below. We previously issued $500 million of 6.45% senior notes due June 1, 2016 that were redeemed in October 2014, $500 million of 7.20% senior notes due June 15, 2018, $300 million of 6.30% senior notes due August 1, 2018, $600 million of 3.15% senior notes due December 1, 2022, $250 million of 8.15% senior notes due June 15, 2038, and $400 million of 4.625% senior notes due December 1, 2042.

In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $560 million. We recognized a loss on extinguishment of debt of approximately $37 million in October 2014 in connection with the redemption of these notes.

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, each series of our senior notes (other than the 6.30% senior notes) contain a change of control provision that may require us to purchase the notes under certain circumstances. On July 2, 2015 we entered into a Merger Agreement with Aetna that, when closed, may require redemption of the notes if the notes are downgraded below investment grade by both Standard & Poor's Rating Services, or S&P and Moody's Investors Services, Inc., or Moody's.

Credit Agreement

Our 5-year $1.0 billion unsecured revolving credit agreement expires July 2018. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110 basis points, varies depending on our credit ratings ranging from 90 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 10 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $8.5 billion at December 31, 2015 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $10.3 billion and an actual leverage ratio of 1.3:1, as measured in accordance with the credit agreement as of December 31, 2015. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2015, we had no borrowings outstanding under the credit agreement and we had outstanding letters of credit of $1 million secured under the credit agreement. No amounts have been drawn on these letters of credit. Accordingly, as of December 31, 2015, we had $999 million of remaining borrowing capacity under the credit agreement, none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

In October 2014, we entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time, with the aggregate face or principal amount outstanding under the program at any time not to exceed $1 billion. The net proceeds of issuances have been and are

expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2015 was $414 million. There was $299 million outstanding at December 31, 2015.

Liquidity Requirements

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement and our commercial paper program or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares.

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2015 was BBB+ according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $750 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $2 million, up to a maximum 100 basis points, or annual interest expense by $8 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company increased to $1.6 billion at December 31, 2015 from $1.4 billion at December 31, 2014. This increase primarily reflects proceeds from the sale of Concentra on June 1, 2015, proceeds from issuance of commercial paper and subsidiary dividends to the parent company, partially offset by funding of subsidiary working capital requirements, common stock repurchases, capital expenditures, and payment of stockholder dividends. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance. Our regulated subsidiaries paid dividends to the parent of $493 million in 2015, $927 million in 2014, and $967 million in 2013. Subsidiary dividends in 2015 reflect the impact of losses for our individual commercial medical business compliant with the Health Care Reform Law and the November 5, 2015 revised statutory accounting guidance requiring the exclusion of risk corridor receivables from related statutory surplus described below. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2016 is approximately $900 million, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

On November 5, 2015, the National Association of Insurance Commissioners, or NAIC, issued statutory accounting guidance for receivables associated with the risk corridor provisions under the Health Care Reform Law, which requires the receivables to be excluded from subsidiary surplus. This accounting guidance required additional capital contributions into certain subsidiaries during 2015. This statutory accounting guidance does not affect our financial statements prepared in accordance with generally accepted accounting principles, under which we have recorded a receivable for risk corridor amounts due to us as an obligation of the United States Government under the Health Care Reform Law. At December 31, 2015, our gross risk corridor receivable for the 2014 and 2015 coverage years in the aggregate was $459 million. We expect to record a risk corridor receivable of approximately $340 million in 2016 for the 2016 coverage year.

Certain regulated subsidiaries recognized premium deficiency reserves for our individual commercial medical policies compliant with the Health Care Reform Law for the 2016 coverage year in the fourth quarter of 2015. Further, the statutory-based premium deficiency excludes the estimated benefit associated with the risk corridor provisions as a reduction in subsidiary surplus in accordance with the previously discussed November 5, 2015 statutory accounting guidance requiring the exclusion of risk corridor amounts from subsidiary surplus. As a result of the statutory-based premium deficiency, we will fund capital contributions into certain regulated subsidiaries of $450 million during the first quarter of 2016.

In 2015, we paid the federal government $867 million for the annual health insurance industry fee and expect to pay a higher amount in 2016 given an increase in market share. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to the parent, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2015 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
			(in millions)		
Debt	$ 4,099	$ 299	$ 800	$ 400	$ 2,600
Interest (1)	2,539	188	342	244	1,765
Operating leases (2)	697	173	286	148	90
Purchase obligations (3)	150	74	74	2	—
Future policy benefits payable and other long-term liabilities (4)	2,578	79	462	204	1,833
Total	$ 10,063	$ 813	$ 1,964	$ 998	$ 6,288

(1) Interest includes the estimated contractual interest payments under our debt agreements.

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2026. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. An operating lease is a type of off-balance sheet arrangement. Assuming we acquired the asset, rather than leased such asset, we would have recognized a liability for the financing of these assets. See also Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(3) Purchase obligations include agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty.

(4) Includes future policy benefits payable ceded to third parties through 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We expect the assuming reinsurance carriers to fund these obligations and reflected these amounts as reinsurance recoverables included in other long-term assets on our consolidated balance sheet. Amounts payable in less than one year are included in trade accounts payable and accrued expenses in the consolidated balance sheet.

Off-Balance Sheet Arrangements

As of December 31, 2015, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion off-balance sheet arrangements, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion our guarantees and indemnifications, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Critical Accounting Policies and Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements and accompanying notes, which have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements and accompanying notes requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We continuously evaluate our estimates and those critical accounting policies primarily related to benefits expense and revenue recognition as well as accounting for impairments related to our investment securities, goodwill, and long-lived assets. These estimates are based on knowledge of current events and anticipated future events and, accordingly, actual results ultimately may differ from those estimates. We believe the following critical accounting policies involve the most significant judgments and estimates used in the preparation of our consolidated financial statements.

Benefits Expense Recognition

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. IBNR represents a substantial portion of our benefits payable as follows:

	December 31, 2015	Percentage of Total	December 31, 2014	Percentage of Total
	(dollars in millions)			
IBNR	$ 3,730	75.0%	$ 3,254	72.7%
Reported claims in process	600	12.1%	475	10.6%
Premium deficiency reserve	176	3.5%	—	—%
Other benefits payable	470	9.4%	746	16.7%
Total benefits payable	$ 4,976	100.0%	$ 4,475	100.0%

Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent two months, the key assumption used in estimating our IBNR is that the completion factor pattern remains consistent over a rolling 12-month period after adjusting for known changes in claim inventory levels and known changes in claim payment processes. Completion factors result from the calculation of the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. For the most recent two months, the incurred claims are estimated primarily from a trend analysis

based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and weekday seasonality.

The completion factor method is used for the months of incurred claims prior to the most recent two months because the historical percentage of claims processed for those months is at a level sufficient to produce a consistently reliable result. Conversely, for the most recent two months of incurred claims, the volume of claims processed historically is not at a level sufficient to produce a reliable result, which therefore requires us to examine historical trend patterns as the primary method of evaluation. Changes in claim processes, including recoveries of overpayments, receipt cycle times, claim inventory levels, outsourcing, system conversions, and processing disruptions due to weather or other events affect views regarding the reasonable choice of completion factors. Claim payments to providers for services rendered are often net of overpayment recoveries for claims paid previously, as contractually allowed. Claim overpayment recoveries can result from many different factors, including retroactive enrollment activity, audits of provider billings, and/or payment errors. Changes in patterns of claim overpayment recoveries can be unpredictable and result in completion factor volatility, as they often impact older dates of service. The receipt cycle time measures the average length of time between when a medical claim was initially incurred and when the claim form was received. Increases in electronic claim submissions from providers decrease the receipt cycle time. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claim may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required.

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, and epidemics also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent two months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent two months. Each of these factors requires significant judgment by management.

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderate adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2015 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
0.60%	$(181)	(2.75)%	$(298)
0.50%	$(151)	(2.50)%	$(271)
0.40%	$(120)	(2.25)%	$(244)
0.30%	$(90)	(2.00)%	$(217)
0.20%	$(60)	(1.75)%	$(190)
0.10%	$(30)	(1.50)%	$(162)
—%	$—	(1.25)%	$(135)

(a) Reflects estimated potential changes in benefits payable at December 31, 2015 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2015 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

(c) The factor change indicated represents the percentage point change.

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals.

	2015	2014	2013
		(in millions)	
Balances at January 1	$ 4,475	$ 3,893	$ 3,775
Less: Reinsurance recoverables	(78)	—	—
Balances at January 1, net	4,397	3,893	3,775
Acquisitions	—	—	5
Incurred related to:			
Current year	44,397	38,641	32,711
Prior years	(236)	(518)	(474)
Total incurred	44,161	38,123	32,237
Paid related to:			
Current year	(39,802)	(34,357)	(29,103)
Prior years	(4,041)	(3,262)	(3,021)
Total paid	(43,843)	(37,619)	(32,124)
Premium deficiency reserve	176	—	—
Reinsurance recoverable	85	78	—
Balances at December 31	$ 4,976	$ 4,475	$ 3,893

The following table summarizes the changes in estimate for incurred claims related to prior years attributable to our key assumptions. As previously described, our key assumptions consist of trend and completion factors estimated using an assumption of moderately adverse conditions. The amounts below represent the difference between our original estimates and the actual benefits expense ultimately incurred as determined from subsequent claim payments.

	Favorable Development by Changes in Key Assumptions					
	2015		2014		2013	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
	(dollars in millions)					
Trend factors	$ (145)	(1.5)%	$ (266)	(3.7)%	$ (233)	(3.4)%
Completion factors	(91)	0.4 %	(252)	1.2 %	(241)	1.2 %
Total	$ (236)		$ (518)		$ (474)	

(a) The factor change indicated represents the percentage point change.

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $236 million in 2015, $518 million in 2014, and $474 million in 2013. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2015, 2014, and 2013.

	Favorable Medical Claims Reserve Development			Change	
	2015	2014	2013	2015	2014
	(in millions)				
Retail Segment	$ (228)	$ (488)	$ (428)	$ 260	$ (60)
Group Segment	(7)	(29)	(42)	22	13
Other Businesses	(1)	(1)	(4)	—	3
Total	$ (236)	$ (518)	$ (474)	$ 282	$ (44)

The favorable medical claims reserve development for 2015, 2014, and 2013 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. The decline in favorable prior period development in 2015 primarily was due to the impact of lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products. The higher favorable prior period development during 2014 and 2013 resulted from increased membership, better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2015 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
		(in millions)	
Premium deficiency reserve for short-duration policies	$ 176	$ —	$ —
Military services	12	11	(27)
Future policy benefits	(80)	32	354
Total	$ 108	$ 43	$ 327

In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Military services benefits expense for 2015 and 2014 reflect expenses associated with our contracts with the Veterans Administration. Military services benefits expense for 2013 reflects the beneficial effect of a favorable settlement of contract claims with the DoD partially offset by expenses associated with our contracts with the Veterans Administration.

Certain health policies sold to individuals prior to 2014 (the first year plans compliant with the Health Care Reform Law were effective) are accounted for as long-duration as more fully described below. The reduction in future policy benefits in 2015 reflects the release of reserves as individual commercial medical members transition to plans compliant with the Health Care Reform Law.

Future policy benefits payable of $2.2 billion and $2.3 billion at December 31, 2015 and 2014, respectively, represent liabilities for long-duration insurance policies including long-term care insurance, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs.

Future policy benefits payable include $1.5 billion at December 31, 2015 and 2014 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Approximately 31,800 policies remain in force as of December 31, 2015. No new policies have been written since 2005 under this closed block. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was no additional liability at December 31, 2015 and $123 million of additional liability at December 31, 2014. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. A prolonged period during which interest rates remain at levels lower than those anticipated in our reserving would result in shortfalls in investment income on assets supporting our obligation under long term care policies because the long duration of the policy obligations exceeds the duration of the supporting investment assets. Further, we monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience vary from our loss recognition date assumptions, future material adjustments to reserves could be required.

During 2013, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2010 loss recognition date, particularly as they related to emerging experience due to an increase in life expectancies and utilization of home health care services. Based on this deterioration, and combined with lower interest rates, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2013 we recorded $243 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $350 million partially offset by a related reinsurance recoverable of $107 million included in other long-term assets.

For our closed block of long-term care policies, actuarial assumptions used to estimate reserves are inherently uncertain due to the potential changes in trends in mortality, morbidity, persistency and interest rates as well as premium rate increases. As a result, our long term care reserves may be subject to material increases if these trends develop adversely to our expectations. The estimated increase in reserves and additional benefit expense from hypothetically modeling adverse variations in our actuarial assumptions, in the aggregate, could be up to $400 million, net of reinsurance. Although such hypothetical revisions are not currently appropriate, we believe they could occur based on past variances in experience and our expectation of the ranges of future experience that could reasonably occur, and any such revision could be material. Generally accepted accounting principles do not allow us to unlock our assumptions for favorable items.

In addition, future policy benefits payable includes amounts of $205 million at December 31, 2015, $210 million at December 31, 2014, and $215 million at December 31, 2013 which are subject to 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, and as such are offset by a related reinsurance recoverable included in other long-term assets.

Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Our commercial contracts establish rates on a per employee basis for each month of coverage based on the type of coverage purchased (single to family coverage options). Our Medicare and Medicaid contracts also establish monthly rates per member. However, our Medicare contracts also have additional provisions as outlined in the following separate section.

Premiums revenue and administrative services only, or ASO, fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. In addition, we adjust revenues for estimated changes in an employer's enrollment and individuals that ultimately may fail to pay, and for estimated rebates under the minimum benefit ratios required under the Health Care Reform Law. Enrollment changes not yet processed or not yet reported by an employer group or the government, also known as retroactive membership adjustments, are estimated based on

available data and historical trends. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in the current period's revenue.

We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from for our Medicare and individual commercial medical products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are recognized when the amounts become determinable and the collectibility is reasonably assured.

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage plans according to health severity. The risk-adjustment model pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all Medicare Advantage plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to Medicare Advantage plans. Rates paid to Medicare Advantage plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model is more fully described in Item 1. – Business under the section titled "Individual Medicare."

Investment Securities

Investment securities totaled $9.1 billion, or 37% of total assets at December 31, 2015, and $9.5 billion, or 41% of total assets at December 31, 2014. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2015 and 2014. The fair value of debt securities were as follows at December 31, 2015 and 2014:

	December 31, 2015	Percentage of Total	December 31, 2014	Percentage of Total
	(dollars in millions)			
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 332	3.6%	$ 374	3.9%
Mortgage-backed securities	1,891	20.8%	1,498	15.7%
Tax-exempt municipal securities	2,668	29.3%	3,068	32.1%
Mortgage-backed securities:				
Residential	13	0.1%	17	0.2%
Commercial	985	10.8%	843	8.8%
Asset-backed securities	263	2.9%	29	0.3%
Corporate debt securities	2,958	32.5%	3,718	39.0%
Total debt securities	$ 9,110	100.0%	$ 9,547	100.0%

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2015. Most of the debt securities that were below investment-grade were rated BB, the

higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $178 million at December 31, 2015 and $199 million at December 31, 2014. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.0 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for $1.4 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 11%. In addition, certain monoline insurers guarantee the timely repayment of bond principal and interest when a bond issuer defaults and generally provide credit enhancement for bond issues related to our tax-exempt municipal securities. We have no direct exposure to these monoline insurers. We owned $173 million and $484 million at December 31, 2015 and 2014, respectively, of tax-exempt securities guaranteed by monoline insurers. The equivalent weighted average S&P credit rating of these tax-exempt securities without the guarantee from the monoline insurer was AA.

Our direct exposure to subprime mortgage lending is limited to investment in residential mortgage-backed securities and asset-backed securities backed by home equity loans. The fair value of securities backed by Alt-A and subprime loans was $1 million at December 31, 2015 and 2014. There are no collateralized debt obligations or structured investment vehicles in our investment portfolio. The percentage of corporate securities associated with the financial services industry was 25% at December 31, 2015 and 21% at December 31, 2014.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2015:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2015						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 195	$ (1)	$ 14	$ —	$ 209	$ (1)
Mortgage-backed securities	1,484	(20)	86	(3)	1,570	(23)
Tax-exempt municipal securities	843	(3)	52	(1)	895	(4)
Mortgage-backed securities:						
Residential	2	—	4	—	6	—
Commercial	626	(13)	265	(28)	891	(41)
Asset-backed securities	258	(2)	—	—	258	(2)
Corporate debt securities	918	(45)	63	(10)	981	(55)
Total debt securities	$ 4,326	$ (84)	$ 484	$ (42)	$ 4,810	$ (126)

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows

to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an investment is other than temporary requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2015 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2015.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2015 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2015, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2015. There were no material other-than-temporary impairments in 2015, 2014, or 2013.

Goodwill and Long-lived Assets

At December 31, 2015, goodwill and other long-lived assets represented 20% of total assets and 48% of total stockholders' equity, compared to 24% and 59%, respectively, at December 31, 2014.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition. The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2015 segment change discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our provider services reporting unit in our Healthcare Services segment. The provider services reporting unit would decline to approximately 10% margin after factoring in a 100 basis point increase in the discount rate.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk, including those resulting from changes in interest rates.

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. Prior to 2009, under interest rate swap agreements, we exchanged the fixed interest rate under all of our senior notes for a variable interest rate based on LIBOR using interest rate swap agreements. We terminated all of our interest rate swap agreements in 2008. We may re-enter into interest rate swap agreements in the future depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $1.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2015 or December 31, 2014.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA at December 31, 2015. Our net unrealized position decreased $383 million from a net unrealized gain position of $475 million at December 31, 2014 to a net unrealized gain position of $92 million at December 31, 2015. At December 31, 2015, we had gross unrealized losses of $126 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. There were no material other-than-temporary impairments during 2015. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the

sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 4.1 years as of December 31, 2015 and 4.1 years as of December 31, 2014. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $459 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2015 and 2014. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have exceeded 300 basis points once, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points two times, and have changed by less than 100 basis points seven times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2015						
Investment income (a)	$ (33)	$ (27)	$ (21)	$ 41	$ 82	$ 124
Interest expense (b)	3	3	3	(3)	(6)	(9)
Pretax	$ (30)	$ (24)	$ (18)	$ 38	$ 76	$ 115
As of December 31, 2014						
Investment income (a)	$ (20)	$ (15)	$ (9)	$ 42	$ 85	$ 128
Interest expense (b)	—	—	—	—	—	—
Pretax	$ (20)	$ (15)	$ (9)	$ 42	$ 85	$ 128

(a) As of December 31, 2015 and 2014, some of our investments had interest rates below 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2015 or December 31, 2014. There was $299 million outstanding under our commercial paper program at December 31, 2015. As of December 31, 2015, our interest rate under our commercial paper program was less than 1% so the assumed hypothetical change in pretax earnings does not reflect the full 1% point reduction. There were no borrowings outstanding under our commercial paper program at December 31, 2014.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2015	2014
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,571	$ 1,935
Investment securities	7,267	7,598
Receivables, less allowance for doubtful accounts of $101 in 2015 and $98 in 2014	1,161	1,053
Other current assets	4,712	4,007
Assets held-for-sale	—	943
Total current assets	15,711	15,536
Property and equipment, net	1,384	1,228
Long-term investment securities	1,843	1,949
Goodwill	3,265	3,231
Other long-term assets	2,502	1,583
Total assets	$ 24,705	$ 23,527
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 4,976	$ 4,475
Trade accounts payable and accrued expenses	2,212	2,095
Book overdraft	301	334
Unearned revenues	364	361
Short-term borrowings	299	—
Liabilities held-for-sale	—	206
Total current liabilities	8,152	7,471
Long-term debt	3,821	3,825
Future policy benefits payable	2,151	2,349
Other long-term liabilities	235	236
Total liabilities	14,359	13,881
Commitments and contingencies (Note 16)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,372,059 shares issued at December 31, 2015 and 197,951,551 shares issued at December 31, 2014	33	33
Capital in excess of par value	2,530	2,330
Retained earnings	11,017	9,916
Accumulated other comprehensive income	58	223
Treasury stock, at cost, 50,084,043 shares at December 31, 2015 and 48,347,541 shares at December 31, 2014	(3,292)	(2,856)
Total stockholders' equity	10,346	9,646
Total liabilities and stockholders' equity	$ 24,705	$ 23,527

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2015	2014	2013
	(in millions, except per share results)		
Revenues:			
Premiums	$ 52,409	$ 45,959	$ 38,829
Services	1,406	2,164	2,109
Investment income	474	377	375
Total revenues	54,289	48,500	41,313
Operating expenses:			
Benefits	44,269	38,166	32,564
Operating costs	7,318	7,639	6,355
Depreciation and amortization	355	333	333
Total operating expenses	51,942	46,138	39,252
Income from operations	2,347	2,362	2,061
Gain on sale of business	270	—	—
Interest expense	186	192	140
Income before income taxes	2,431	2,170	1,921
Provision for income taxes	1,155	1,023	690
Net income	$ 1,276	$ 1,147	$ 1,231
Basic earnings per common share	$ 8.54	$ 7.44	$ 7.81
Diluted earnings per common share	$ 8.44	$ 7.36	$ 7.73
Dividends declared per common share	$ 1.15	$ 1.11	$ 1.07

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2015	2014	2013
	(in millions)		
Net income	$ 1,276	$ 1,147	$ 1,231
Other comprehensive (loss) income:			
Change in gross unrealized investment gains/losses	(114)	122	(338)
Effect of income taxes	42	(44)	124
Total change in unrealized investment gains/losses, net of tax	(72)	78	(214)
Reclassification adjustment for net realized gains included in investment income	(146)	(20)	(22)
Effect of income taxes	53	7	8
Total reclassification adjustment, net of tax	(93)	(13)	(14)
Other comprehensive (loss) income, net of tax	(165)	65	(228)
Comprehensive income	$ 1,111	$ 1,212	$ 1,003

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2013	194,471	$ 32	$ 2,101	$ 7,881	$ 386	$ (1,553)	$ 8,847
Net income				1,231			1,231
Other comprehensive income					(228)		(228)
Common stock repurchases						(531)	(531)
Dividends and dividend equivalents			—	(170)			(170)
Stock-based compensation			92				92
Restricted stock unit vesting	563	—					—
Stock option exercises	1,242	1	66				67
Stock option and restricted stock tax benefit			8				8
Balances, December 31, 2013	196,276	33	2,267	8,942	158	(2,084)	9,316
Net income				1,147			1,147
Other comprehensive loss					65		65
Common stock repurchases			(100)			(772)	(872)
Dividends and dividend equivalents			—	(173)			(173)
Stock-based compensation			98				98
Restricted stock unit vesting	966	—					—
Stock option exercises	710	—	52				52
Stock option and restricted stock tax benefit			13				13
Balances, December 31, 2014	197,952	33	2,330	9,916	223	(2,856)	9,646
Net income				1,276			1,276
Other comprehensive income					(165)		(165)
Common stock repurchases			100			(485)	(385)
Dividends and dividend equivalents			—	(175)			(175)
Stock-based compensation			109				109
Restricted stock unit vesting	159	—	(49)			49	—
Stock option exercises	261	—	23				23
Stock option and restricted stock tax benefit			17				17
Balances, December 31, 2015	198,372	$ 33	$ 2,530	$ 11,017	$ 58	$ (3,292)	$ 10,346

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2015	2014	2013
		(in millions)	
Cash flows from operating activities			
Net income	$ 1,276	$ 1,147	$ 1,231
Adjustments to reconcile net income to net cash provided by operating activities:			
Gain on sale of business	(270)	—	—
Depreciation	354	328	309
Amortization	93	121	117
Stock-based compensation	109	98	92
Net realized capital gains	(146)	(20)	(22)
(Benefit) provision for deferred income taxes	(2)	(64)	42
Provision for doubtful accounts	61	32	37
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(180)	(264)	(251)
Other assets	(872)	(952)	(330)
Benefits payable	501	582	109
Other liabilities	(129)	413	313
Unearned revenues	3	155	(24)
Other	70	42	93
Net cash provided by operating activities	868	1,618	1,716
Cash flows from investing activities			
Acquisitions, net of cash acquired	(38)	(18)	(187)
Proceeds from sale of business	1,061	72	34
Purchases of property and equipment	(523)	(528)	(441)
Proceeds from sales of property and equipment	1	—	4
Purchases of investment securities	(6,739)	(2,883)	(3,261)
Maturities of investment securities	1,065	885	1,077
Proceeds from sales of investment securities	5,493	2,409	1,592
Net cash provided by (used in) investing activities	320	(63)	(1,182)
Cash flows from financing activities			
Receipts (withdrawals) from contract deposits, net	(296)	(919)	(150)
Proceeds from issuance of senior notes, net	—	1,733	—
Proceeds from issuance of commercial paper, net	298	—	—
Repayment of long-term debt	—	(500)	—
Common stock repurchases	(385)	(872)	(531)
Dividends paid	(172)	(172)	(168)
Excess tax benefit from stock-based compensation	15	12	8
Change in book overdraft	(33)	(69)	79
Proceeds from stock option exercises and other, net	21	29	60
Net cash used in financing activities	(552)	(758)	(702)
Increase (decrease) in cash and cash equivalents	636	797	(168)
Cash and cash equivalents at beginning of year	1,935	1,138	1,306
Cash and cash equivalents at end of year	$ 2,571	$ 1,935	$ 1,138
Supplemental cash flow disclosures:			
Interest payments	$ 187	$ 143	$ 146
Income tax payments, net	$ 1,179	$ 1,030	$ 734
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 38	$ 18	$ 196
Less: Fair value of liabilities assumed	—	—	(9)
Cash paid for acquired businesses, net of cash acquired	$ 38	$ 18	$ 187

The accompanying notes are an integral part of the consolidated financial statements.

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 73% of our total premiums and services revenue from contracts with the federal government in 2015, including 14% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

Our financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America. Our consolidated financial statements include the accounts of Humana Inc. and subsidiaries that the Company controls, including variable interest entities associated with medical practices for which we are the primary beneficiary. We do not own many of our medical practices but instead enter into exclusive management agreements with the affiliated Professional Associations, or P.A.s, that operate these medical practices. Based upon the provisions of these agreements, these affiliated P.A.s are variable interest entities and we are the primary beneficiary, and accordingly we consolidated the affiliated P.A.s. All significant intercompany balances and transactions have been eliminated.

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, future policy benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

Certain amounts have been reclassified to conform to the current year presentation, including business segment reclassifications discussed below and the reclassification of Concentra Inc. assets and liabilities as held-for-sale in our December 31, 2014 balance sheet for comparative purposes. Refer to Note 3 for a discussion of the sale of Concentra in June 2015.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we will merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger. Under the terms of the Merger Agreement, at the closing of the Merger, each outstanding share of our common stock will be converted into the right to receive (i) 0.8375 of a share of Aetna common stock and (ii) $125 in cash. The total transaction was estimated at approximately $37 billion including the assumption of Humana debt, based on the closing price of Aetna common shares on July 2, 2015. The Merger Agreement includes customary restrictions on the conduct of our business prior to the completion of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna's prior written consent, including, for example, limitations on dividends (we agreed that our

quarterly dividend will not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program), restrictions on our ability to enter into material contracts, and negotiated thresholds for capital expenditures, capital contributions, acquisitions and divestitures of businesses.

On October 19, 2015, our stockholders approved the adoption of the Merger Agreement at a special stockholder meeting. Also on October 19, 2015, the holders of Aetna outstanding shares approved the issuance of Aetna common stock in the Merger at a special meeting of Aetna shareholders.

The Merger is subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, (ii) the absence of legal restraints and prohibitions on the consummation of the Merger, (iii) listing of the Aetna common stock to be issued in the Merger on the New York Stock Exchange, (iv) subject to the relevant standards set forth in the Merger Agreement, the accuracy of the representations and warranties made by each party, (v) material compliance by each party with its covenants in the Merger Agreement, and (vi) no "Company Material Adverse Effect" with respect to us and no "Parent Material Adverse Effect" with respect to Aetna, in each case since the execution of and as defined in the Merger Agreement. In addition, Aetna's obligation to consummate the Merger is subject to (a) the condition that the required regulatory approvals do not impose any condition that, individually or in the aggregate, would reasonably be expected to have a "Regulatory Material Adverse Effect" (as such term is defined in the Merger Agreement), and (b) CMS has not imposed any sanctions with respect to our Medicare Advantage, or MA, business that, individually or in the aggregate, is or would reasonably be expected to be material and adverse to us and our subsidiaries, taken as a whole. The Merger is currently expected to close in the second half of 2016.

Business Segment Reclassifications

On January 1, 2015, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes and renamed our Employer Group segment to the Group segment. Our three reportable segments remain Retail, Group, and Healthcare Services. The more significant realignments included reclassifying Medicare benefits offered to groups to the Retail segment from the Group segment, bringing all of our Medicare offerings, which are now managed collectively, together in one segment, recognizing that in some instances we market directly to individuals that are part of a group Medicare account. In addition, we realigned our military services business, primarily consisting of our TRICARE South Region contract previously included in the Other Businesses category, to our Group segment as we consider this contract with the government to be a group account. Prior period segment financial information has been recast to conform to the 2015 presentation. See Note 17 for segment financial information and Note 9 for goodwill information by segment.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges coupled with three premium stabilization programs, as described more fully below.

The Health Care Reform Law imposes an annual premium-based fee on health insurers for each calendar year beginning on or after January 1, 2014 which is not deductible for tax purposes. We are required to estimate a liability for the health insurer fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurer fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurer fee in September of each year. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. See Note 7 for detail regarding amounts paid for the annual health insurer fee.

The Health Care Reform Law also establishes risk spreading premium stabilization programs effective January 1, 2014. The risk spreading programs are applicable to certain of our commercial medical insurance products. In the aggregate, our commercial medical insurance products represented approximately 18% of our total premiums and services revenue for the year ended December 31, 2015, a subset of which is subject to these programs. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs are for years 2014 through 2016, with potential for additional reinsurance recoveries through 2018 to the extent funds are available. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the Health Care Reform Law to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the Health Care Reform Law.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans (except certain exempt and grandfathered plans as discussed above) operating both inside and outside of the health insurance exchanges established under the Health Care Reform Law. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state. Each health insurance issuer's average risk score is compared to the state's average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. We generally rely on providers, including certain network providers who are our employees, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for our risk scores under the program. Our estimate of amounts receivable and/or payable under the risk adjustment program is based on our estimate of both our own and the state average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including our historical experience in markets we have participated in over a long period of time, member demographics (including age and gender for our members and other health insurance issuers), our pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the Health Care Reform Law. We refine our estimates as new information becomes available, including additional data released by the Department of Health and Human Services, or HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there will be no payments associated with these audits for 2015, the pilot year for the audits.

The temporary risk corridor program applies to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including our small group health plans, were not subject to the risk corridor program in 2014 or 2015. The risk corridor provisions limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to us or require us to refund HHS a portion of the premiums we received.

We estimate and recognize adjustments to premiums revenue for the risk adjustment and risk corridor provisions by projecting our ultimate premium for the calendar year separately for individual and group plans by state and legal entity. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. We record receivables or payables at the individual or group level within each state and legal entity and classify the amounts as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

The transitional reinsurance program requires us to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the Health Care Reform Law in the individual commercial market will be eligible for recoveries if individual claims exceed a specified threshold. Accordingly, we account for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in our consolidated statements of income. We account for contributions made by individual commercial plans compliant with the Health Care Reform Law, which are subject to recoveries, as ceded premiums (a reduction of premiums) and similarly we account for any recoveries as ceded benefits (a reduction of benefits expense) in our consolidated statements of income.

We are required to remit payment for our per member reinsurance contribution, exclusive of the portion payable to the U.S. Treasury, by January 15 of the year following the coverage year, or January 15, 2016 for the 2015 coverage year. The portion of the reinsurance contribution due to the U.S. Treasury must be paid by November 15 of the year following the coverage year, or November 15, 2016 for the 2015 coverage year. Risk adjustment calculations will be completed and HHS will notify us of recoveries due or payments owed to/from us under the risk adjustment and reinsurance programs by June 30 of the year following the coverage year. Following this notification, risk corridor calculations are then due by July 31 of the year following the coverage year. Payments due to HHS under the risk adjustment and risk corridor programs must be remitted within 30 days of notification for each program and will be collected prior to the distribution of recoveries by HHS under each program. Payment and recovery amounts associated with reinsurance and risk adjustment will generally be settled with HHS annually in the year following the coverage year. Accordingly, for the 2015 coverage year, we expect to receive recoveries and/or pay amounts due under these programs in 2016. The risk corridor program is a three year program. We are required to pay gross risk corridor payables in the second half of the year following the coverage year. Interim settlements of risk corridor receivables in the year following the coverage year are limited to risk corridor amounts collected by HHS and available for distribution in the year following the coverage year. HHS guidance provides that risk corridor collections over the life of the three year program will first be applied to any shortfalls from previous coverage years before application to current year obligations. Risk corridor payables to issuers are obligations of the United States Government under the Health Care Reform law which requires the Secretary of HHS to make full payments to issuers. In the event of a shortfall at the end of the three year program, HHS has asserted it will explore other sources of funding for risk corridor payments, subject to the availability of appropriations.

See Note 7 for detail regarding amounts recorded to the consolidated balance sheets related to the 3Rs.

In addition to the provisions discussed above, beginning in 2014, HHS pays us a portion of the health care costs for low-income individual members for which we assume no risk in accordance with the Health Care Reform Law. We account for these subsidies as a deposit in our consolidated balance sheets and as a financing activity in our consolidated statements of cash flows. We do not recognize premiums revenue or benefits expense for these subsidies. Receipt and payment activity is accumulated at the state and legal entity level and recorded in our consolidated balance sheet in other current assets or trade accounts payable and accrued expenses depending on the state and legal entity balance at the end of the reporting period. We will be notified of final settlement amounts by June 30 of the year following the coverage year. Receipts from HHS associated with cost sharing subsidies for which we do not assume risk were approximately $478 million, exceeding payments of $409 million by $69 million for the year ended December 31, 2015. For the year ended December 31, 2014, receipts from HHS associated with cost sharing subsidies for which we do not assume risk were approximately $281 million, exceeding payments of $255 million by $26 million. The program began in 2014, and as such, there were no receipts or payments from HHS for cost sharing subsidies in 2013.

Cash and Cash Equivalents

Cash and cash equivalents include cash, time deposits, money market funds, commercial paper, other money market instruments, and certain U.S. Government securities with an original maturity of three months or less. Carrying value approximates fair value due to the short-term maturity of the investments.

Investment Securities

Investment securities, which consist entirely of debt securities, have been categorized as available for sale and, as a result, are stated at fair value. Investment securities available for current operations are classified as current assets. Investment securities available for our long-term insurance products and professional liability funding requirements, as well as restricted statutory deposits, are classified as long-term assets. For the purpose of determining gross realized gains and losses, which are included as a component of investment income in the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or other-than-temporary impairment.

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase.

Receivables and Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions. Individual polices are subject to the requirements of the Health Care Reform Law as discussed previously.

Premiums Revenue

We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues for our Medicare and individual commercial medical products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership and changes in risk corridor estimates are recognized when the amounts become determinable and the collectibility is reasonably assured.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the individual, small group, and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Beginning

in 2014, Medicare Advantage products were also subject to minimum benefit ratio requirements under the Health Care Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

We cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments we receive monthly from CMS and members, which are determined from our annual bid, represent amounts for providing prescription drug insurance coverage. We recognize premiums revenue for providing this insurance coverage ratably over the term of our annual contract. Our CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which we are not at risk.

The risk corridor provisions compare costs targeted in our bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. As risk corridor provisions are considered in our overall annual bid process, we estimate and recognize an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2015, subsidy and discount payments of $8.9 billion exceeded reimbursements of $8.6 billion by $361 million. For 2014, subsidy and discount payments of $6.7 billion exceeded reimbursements of $5.8 billion by $945 million. For 2013, subsidy and discount payments of $4.8 billion exceeded reimbursements of $4.6 billion by $154 million. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 6 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS.

Services Revenue

Patient services revenue

Patient services include injury and illness care and related services as well as other healthcare services related to employer needs or as required by law. Patient services revenues are recognized in the period services are provided to the customer when the sales price is fixed or determinable, and are net of contractual allowances.

Administrative services fees

Administrative services fees cover the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded groups. Revenues from providing administration services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs. Accordingly, we have recorded premiums revenue and benefits expense related to these stop loss insurance contracts. We routinely monitor the collectibility of specific accounts, the aging of receivables, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. ASO fees received prior to the service period are recorded as unearned revenues.

Under our current TRICARE South Region contract with the Department of Defense, we provide administrative services, including offering access to our provider networks and clinical programs, claim processing, customer service, enrollment, and other services, while the federal government retains all of the risk of the cost of health benefits. We account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. The current contract includes fixed administrative services fees and incentive fees and penalties. Administrative services fees are recognized as services are performed.

Our TRICARE members are served by both in-network and out-of-network providers in accordance with the current contract. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2015, health care cost reimbursements and payments were each approximately $3.3 billion, with payments exceeding reimbursements by $4 million for the year. For 2014, health care cost reimbursements and payments were each $3.2 billion. For 2013, health care cost reimbursements and payments were each approximately $3.2 billion, with reimbursements exceeding payments by $5 million for the year.

Receivables

Receivables, including premium receivables, patient services revenue receivables, and ASO fee receivables, are shown net of allowances for estimated uncollectible accounts, retroactive membership adjustments, and contractual allowances.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be cancelled upon 30 days notice by the employer group.

Life insurance, annuities, and certain health and other supplemental policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As

a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 18.

Beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model and accordingly policy acquisition costs are expensed as incurred because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the recognition of previously deferred acquisition costs.

Long-Lived Assets

Property and equipment is recorded at cost. Gains and losses on sales or disposals of property and equipment are included in operating costs. Certain costs related to the development or purchase of internal-use software are capitalized. Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years for equipment, 3 to 7 years for computer software, and 20 to 40 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

We periodically review long-lived assets, including property and equipment and other intangible assets, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in our operations when the undiscounted future cash flows expected to result from the use of the asset are less than its carrying value. We recognize an impairment loss based on the excess of the carrying value over the fair value of the asset. A long-lived asset held for sale is reported at the lower of the carrying amount or fair value less costs to sell. Depreciation expense is not recognized on assets held for sale. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Goodwill and Other Intangible Assets

Goodwill represents the unamortized excess of cost over the fair value of the net tangible and other intangible assets acquired. We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. Impairment tests completed for 2015, 2014, and 2013 did not result in an impairment loss.

Other intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Other intangible assets are amortized over the useful life, based upon the pattern of future cash flows attributable to the asset. This sometimes results in an accelerated method of amortization for customer contracts because the asset tends to dissipate at a more rapid rate in earlier periods. Other than customer contracts, other intangible assets generally are amortized using the straight-line method. We review other finite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on

or prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in other current assets in our consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health and financial protection products.

We estimate the costs of our benefits expense payments using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors, and record benefit reserves for future payments. We continually review estimates of future payments relating to claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise. In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7.

We believe our benefits payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs. We adjust future policy benefits payable for the additional liability that would have been recorded if investment securities backing the liability had been sold at their stated aggregate fair value and the proceeds reinvested at current yields. We include the impact of this adjustment, if any, net of applicable deferred taxes, with the change in unrealized investment gain (loss) in accumulated other comprehensive income in stockholders' equity. As discussed previously, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model under which policy reserves are not established because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the release of reserves for future policy benefits.

Book Overdraft

Under our cash management system, checks issued but not yet presented to banks that would result in negative bank balances when presented are classified as a current liability in the consolidated balance sheets. Changes in book overdrafts from period to period are reported in the consolidated statement of cash flows as a financing activity.

Income Taxes

We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets or liabilities and their reported amounts in the consolidated financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. We also recognize the future tax benefits such as net operating and capital loss carryforwards as deferred tax assets. A valuation allowance is provided against these deferred tax assets if it is more likely than not that some portion or all of the deferred tax assets will not be realized. Future years' tax expense may be increased or decreased by adjustments to the valuation allowance or to the estimated accrual for income taxes.

We record tax benefits when it is more likely than not that the tax return position taken with respect to a particular transaction will be sustained. A liability, if recorded, is not considered resolved until the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired, or the tax position is ultimately settled through examination, negotiation, or litigation. We classify interest and penalties associated with uncertain tax positions in our provision for income taxes.

Derivative Financial Instruments

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, a privately held Medical Services Organization, or MSO, headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida, Texas and Georgia. Our agreement with MCCI includes a put option that would allow the controlling interest holder to put their interest to us beginning in 2018 as well as a call option that would allow us to purchase the controlling interest beginning in 2021. Accordingly, we recorded, at fair value, a liability and an asset associated with the put and call, respectively. Changes in the fair value of the liability and asset during the years ended December 31, 2015, 2014, and 2013 were not material to our results of operations, financial condition, or cash flows.

At times, we may use interest-rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as adjustments to interest expense in the consolidated statements of income. We were not party to any interest-rate swap agreements in 2015, 2014, or 2013.

Related Party

As noted above, MCCI is a related party to Humana. In December 2015, we purchased a note receivable directly from a third-party bank syndicate related to the financing of MCCI's business and extended the exercise date of the put option to 2018 and the call option to 2021 as previously discussed. The $284 million note receivable bears interest at 10% annually, payable in quarterly installments, and matures in December 2020. We have also entered into a revolving note agreement providing a line of credit up to $55 million under which no amounts have been drawn. The note receivable is included with other long-term assets in our consolidated balance sheet and with purchases of investment securities in our consolidated statement of cash flows. The related interest income is included in investment income in our consolidated statement of income. MCCI provides services to Humana Medicare Advantage members under capitation contracts with our health plans. Under these capitation agreements with Humana, MCCI assumes the financial risk associated with these Medicare Advantage members. We also advanced MCCI $9 million, with repayment terms tied to the performance under the capitation agreements. We recognized benefits expense of approximately $1.0 billion in 2015, $962 million in 2014 and $873 million in 2013 under these capitation agreements with MCCI.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. However, prior to July 2, 2015, for awards granted to retirement eligible employees, compensation expense is recognized on a straight-line basis over the shorter of the requisite service period or the period from the date

of grant to an employee's eligible retirement date. For awards granted on or after July 2, 2015 to retirement eligible employees, we recognize expense on a straight-line basis over the service period (the vesting period). We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate the grant-date fair value of stock options using the Black-Scholes option-pricing model. In addition, we report certain tax effects of stock-based compensation as a financing activity rather than an operating activity in the consolidated statement of cash flows. Additional detail regarding our stock-based compensation plans is included in Note 13.

Earnings Per Common Share

We compute basic earnings per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted earnings per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding employee stock options and restricted shares, or units, using the treasury stock method.

Fair Value

Assets and liabilities measured at fair value are categorized into a fair value hierarchy based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from independent sources, while unobservable inputs reflect our own assumptions about the assumptions market participants would use. The fair value hierarchy includes three levels of inputs that may be used to measure fair value as described below.

Level 1 – Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt securities that are traded in an active exchange market.

Level 2 – Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting our own assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. We obtain at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates, and prepayment speeds. We are responsible for the determination of fair value and as such we perform analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by our third party investment advisor. In addition, on a quarterly basis we examine the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations.

Fair value of privately held debt securities, as well as auction rate securities, are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not

exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows. Auction rate securities are debt instruments with interest rates that reset through periodic short-term auctions. From time to time, liquidity issues in the credit markets have led to failed auctions. Given the liquidity issues, fair value could not be estimated based on observable market prices, and as such, unobservable inputs were used. For auction rate securities, valuation methodologies include consideration of the quality of the sector and issuer, underlying collateral, underlying final maturity dates, and liquidity.

Recently Issued Accounting Pronouncements

In January 2016, the Financial Accounting Standards Board, or FASB, issued new guidance related to classification and measurement of financial instruments which requires equity securities that are not accounted for using the equity method or that do not result in consolidation, to be accounted for at fair value with changes in fair value recognized through net income. The new guidance is effective for us beginning with annual and interim periods in 2018 with early adoption permitted under certain circumstances. We are currently evaluating the impact, if any, on our results of operations, financial position, and cash flows.

In November 2015, the FASB issued new guidance related to accounting for income taxes which changes the balance sheet classification of deferred taxes, requiring deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. The new guidance is effective for us beginning with annual and interim periods in 2017, with early adoption permitted. We elected to early adopt the guidance and have classified all deferred tax liabilities and assets as noncurrent in our consolidated balance sheet at December 31, 2015 to simplify their presentation. Prior periods were not retrospectively adjusted. The adoption of the new guidance did not have any impact on our results of operations or cash flows.

In May 2015, the FASB issued new guidance requiring insurance entities to provide additional disclosures about claim liabilities including paid claims development information by accident year and claim frequency data and related methodologies. The guidance is effective for us beginning with the 2016 annual reporting period and interim periods beginning in 2017. We are currently evaluating the impact the new guidance will have on our disclosures.

In April 2015, the FASB issued new guidance to help entities determine whether a cloud computing arrangement contains a software license that should be accounted for as internal-use software or as a service contract. The guidance is effective for us beginning with interim and annual reporting periods in 2016, with early adoption permitted. Upon adoption, an entity has the option to apply the provisions either prospectively to all arrangements entered into or materially modified, or retrospectively. We are currently evaluating the impact, if any, on our results of operations, financial position, and cash flows.

In March 2015, the FASB issued new guidance which changes the presentation of debt issuance costs from an asset to a direct reduction of the related debt liability. The new guidance is effective for us beginning with annual and interim periods in 2016 with early adoption permitted. The adoption of the new guidance will not have a material impact on our results of operations, financial condition, or cash flows.

In February 2015, the FASB issued an amendment to current consolidation guidance that modifies the evaluation of whether limited partnerships and similar legal entities are variable interest entities or voting interest entities, eliminating the presumption that a general partner should consolidate a limited partnership, and affects the consolidation analysis of reporting entities that are involved with variable interest entities. The new guidance is effective for us beginning with interim and annual reporting periods in 2016, with early adoption permitted. All legal entities are subject to reevaluation under the revised consolidation model. We are currently evaluating the impact, if any, on our results of operations, financial position, and cash flows.

In May 2014, the FASB issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not included in the scope of this new guidance. In July 2015, the FASB decided to defer the effective date provided in the new revenue guidance by

one year. Giving effect to this deferral, the new guidance is effective for us beginning with annual and interim periods in 2018. We are currently evaluating the impact on our results of operations, financial condition, and cash flows.

There are no other recently issued accounting standards that apply to us or that are expected to have a material impact on our results of operations, financial condition, or cash flows.

3. ACQUISITIONS AND DIVESTITURES

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, to MJ Acquisition Corporation, a joint venture between Select Medical Holdings Corporation and Welsh, Carson, Anderson & Stowe XII, L.P., a private equity fund, for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $270 million which is reported as gain on sale of business in the accompanying condensed consolidated statements of income for the year ended December 31, 2015.

In March 2015, we classified Concentra as held-for-sale and aggregated Concentra's assets and liabilities separately on the balance sheet, including a reclassification of the December 31, 2014 balance sheet for comparative purposes. The assets and liabilities of Concentra that were disposed of on June 1, 2015 and classified as held-for-sale as of December 31, 2014 were as follows:

	June 1, 2015	December 31, 2014
Assets	(in millions)	
Receivables, net	$ 130	$ 115
Property and equipment, net	197	191
Goodwill	480	480
Other intangible assets, net	124	132
Other assets	27	25
Total assets disposed/held-for-sale	$ 958	$ 943
Liabilities		
Trade accounts payable and accrued expenses	81	90
Other liabilities	114	116
Total liabilities disposed/held-for-sale	$ 195	$ 206
Net assets disposed	$ 763	$ 737

For the year ended December 31, 2015, the accompanying condensed consolidated statements of income include revenues related to Concentra of $411 million in 2015, $998 million in 2014, and $981 million in 2013.

On September 6, 2013, we acquired American Eldercare Inc., or American Eldercare, the largest provider of nursing home diversion services in the state of Florida, serving frail and elderly individuals in home and community-based settings. American Eldercare complements our core capabilities and strength in serving seniors and disabled individuals with a unique focus on individualized and integrated care, and has contracts to provide Medicaid long-term support services across the entire state of Florida. The enrollment effective dates for the various regions ranged from August 2013 to March 2014. The allocation of the purchase price resulted in goodwill of $76 million and other intangible assets of $75 million. The goodwill was assigned to the Retail segment. The other intangible assets, which primarily consist of customer contracts and technology, have a weighted average useful life of 9.3 years. Goodwill and other intangible assets are amortizable as deductible expenses for tax purposes.

The results of operations and financial condition of American Eldercare has been included in our consolidated statements of income and consolidated balance sheets from the acquisition date. In addition, during 2015, 2014 and

2013, we acquired other health and wellness and technology related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our condensed consolidated statements of income and condensed consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2015, 2014, and 2013 were not material to our results of operations. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

4. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2015 and 2014, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2015				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 331	$ 2	$ (1)	$ 332
Mortgage-backed securities	1,902	12	(23)	1,891
Tax-exempt municipal securities	2,611	61	(4)	2,668
Mortgage-backed securities:				
Residential	13	—	—	13
Commercial	1,024	2	(41)	985
Asset-backed securities	264	1	(2)	263
Corporate debt securities	2,873	140	(55)	2,958
Total debt securities	$ 9,018	$ 218	$ (126)	$ 9,110
December 31, 2014				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 365	$ 10	$ (1)	$ 374
Mortgage-backed securities	1,453	50	(5)	1,498
Tax-exempt municipal securities	2,931	140	(3)	3,068
Mortgage-backed securities:				
Residential	17	—	—	17
Commercial	846	16	(19)	843
Asset-backed securities	28	1	—	29
Corporate debt securities	3,432	299	(13)	3,718
Total debt securities	$ 9,072	$ 516	$ (41)	$ 9,547

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2015 and 2014, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2015						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 195	$ (1)	$ 14	$ —	$ 209	$ (1)
Mortgage-backed securities	1,484	(20)	86	(3)	1,570	(23)
Tax-exempt municipal securities	843	(3)	52	(1)	895	(4)
Mortgage-backed securities:						
Residential	2	—	4	—	6	—
Commercial	626	(13)	265	(28)	891	(41)
Asset-backed securities	258	(2)	—	—	258	(2)
Corporate debt securities	918	(45)	63	(10)	981	(55)
Total debt securities	$ 4,326	$ (84)	$ 484	$ (42)	$ 4,810	$ (126)
December 31, 2014						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 79	$ —	$ 80	$ (1)	$ 159	$ (1)
Mortgage-backed securities	22	—	320	(5)	342	(5)
Tax-exempt municipal securities	131	(1)	118	(2)	249	(3)
Mortgage-backed securities:						
Residential	1	—	4	—	5	—
Commercial	31	(1)	267	(18)	298	(19)
Asset-backed securities	13	—	—	—	13	—
Corporate debt securities	219	(6)	128	(7)	347	(13)
Total debt securities	$ 496	$ (8)	$ 917	$ (33)	$ 1,413	$ (41)

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2015. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. At December 31, 2015, 7% of our tax-exempt municipal securities were pre-refunded, generally with U.S. government and agency securities. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for 42% of the tax-exempt municipals that were not pre-refunded in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for the remaining 58% of these municipals. Our general obligation bonds are diversified across the United States with no individual state exceeding 11%. In addition, 6% of our tax-exempt securities were insured by bond insurers and had an equivalent weighted average S&P credit rating of AA exclusive of the bond insurers' guarantee. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Residential mortgage back securities comprised approximately 98% of our agency mortgage-backed securities at December 31, 2015 and 99% at December 31, 2014.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2015 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2015.

The percentage of corporate securities associated with the financial services industry was 25% at December 31, 2015 and 21% at December 31, 2014.

Our unrealized loss from all securities was generated from approximately 690 positions out of a total of approximately 2,000 positions at December 31, 2015. All issuers of securities we own that were trading at an unrealized loss at December 31, 2015 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2015, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2015.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2015, 2014, and 2013:

	2015	2014	2013
		(in millions)	
Gross realized gains	$ 179	$ 29	$ 33
Gross realized losses	(33)	(9)	(11)
Net realized capital gains	$ 146	$ 20	$ 22

There were no material other-than-temporary impairments in 2015, 2014, or 2013.

The contractual maturities of debt securities available for sale at December 31, 2015, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 438	$ 439
Due after one year through five years	1,829	1,871
Due after five years through ten years	1,244	1,264
Due after ten years	2,304	2,384
Mortgage and asset-backed securities	3,203	3,152
Total debt securities	$ 9,018	$ 9,110

5. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2015 and 2014, respectively, for financial assets measured at fair value on a recurring basis:

		Fair Value Measurements Using		
	Fair Value	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2015				
Cash equivalents	$ 2,229	$ 2,229	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	332	—	332	—
Mortgage-backed securities	1,891	—	1,891	—
Tax-exempt municipal securities	2,668	—	2,663	5
Mortgage-backed securities:				
Residential	13	—	13	—
Commercial	985	—	985	—
Asset-backed securities	263	—	263	—
Corporate debt securities	2,958	—	2,952	6
Total debt securities	9,110	—	9,099	11
Total invested assets	$ 11,339	$ 2,229	$ 9,099	$ 11
December 31, 2014				
Cash equivalents	$ 1,712	$ 1,712	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	374	—	374	—
Mortgage-backed securities	1,498	—	1,498	—
Tax-exempt municipal securities	3,068	—	3,060	8
Mortgage-backed securities:				
Residential	17	—	17	—
Commercial	843	—	843	—
Asset-backed securities	29	—	28	1
Corporate debt securities	3,718	—	3,695	23
Total debt securities	9,547	—	9,515	32
Total invested assets	$ 11,259	$ 1,712	$ 9,515	$ 32

There were no material transfers between Level 1 and Level 2 during 2015 or 2014.

Our Level 3 assets had a fair value of $11 million at December 31, 2015, or 0.1% of our total invested assets. During the years ended December 31, 2015, 2014, and 2013, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the years ended December 31,								
	2015			2014			2013		
	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total
	(in millions)								
Beginning balance at January 1	$ 24	$ 8	$ 32	$ 24	$ 13	$ 37	$ 25	$ 13	$ 38
Total gains or losses:									
Realized in earnings	(1)	—	(1)	—	—	—	—	—	—
Unrealized in other comprehensive income	—	—	—	—	—	—	—	—	—
Purchases	—	—	—	—	—	—	—	—	—
Sales	(17)	(3)	(20)	—	(5)	(5)	—	—	—
Settlements	—	—	—	—	—	—	(1)	—	(1)
Balance at December 31	$ 6	$ 5	$ 11	$ 24	$ 8	$ 32	$ 24	$ 13	$ 37

Financial Liabilities

Our long-term debt, recorded at carrying value in our consolidated balance sheets, was $3,821 million at December 31, 2015 and $3,825 million at December 31, 2014. The fair value of our long-term debt was $3,986 million at December 31, 2015 and $4,102 million at December 31, 2014. The fair value of our long-term debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Due to the short-term nature, carrying value approximates fair value for our commercial paper borrowings.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we completed our acquisition of American Eldercare and other companies during 2015, 2014, and 2013. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the related tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected cash flows and discount rates in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2015, 2014, or 2013.

6. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2015 and 2014. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2015		2014	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 25	$ 2,082	$ 105	$ 1,690
Trade accounts payable and accrued expenses	(47)	(63)	(36)	(32)
Net current (liability) asset	$ (22)	$ 2,019	$ 69	$ 1,658

7. HEALTH CARE REFORM

Operating results for our individual commercial medical business compliant with the Health Care Reform Law have been challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. We took a number of actions in 2015 to improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results indicating the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment of the profitability of our individual medical policies compliant with the Health Care Reform Law, in the fourth quarter of 2015, we recorded a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million in benefits payable in our consolidated balance sheet with a corresponding increase in benefits expense in our consolidated statement of income. The premium deficiency reserve includes the estimated benefit of approximately $340 million associated with risk corridor provisions expected for the 2016 coverage year.

On June 30, 2015 we received notification from CMS of risk adjustment and reinsurance settlement amounts for 2014. We revised our 2014 coverage year estimates to reflect actual amounts and also made a corresponding adjustment to our risk corridor estimate based on these results. The change in estimate for risk adjustment was substantially offset by the corresponding change in estimate for risk corridor, both of which are reflected as changes in premiums revenue in our consolidated statements of income. The change in estimate related to the 3Rs for the 2014 coverage year was a decline in the estimated net receivable of approximately $43 million for the year ended December 31, 2015. In addition, we revised our 3Rs estimates for the 2015 coverage year based on the data from CMS for 2014.

During the year ended December 31, 2015, we paid $186 million in risk adjustment charges and $1 million in risk corridor charges associated with the 2014 coverage year. We received payments of $521 million for reinsurance recoverables, $57 million for risk adjustment settlements, and $26 million for risk corridor settlements associated with the 2014 coverage year during the year ended December 31, 2015. We expect to collect the remaining risk adjustment receivable for the 2014 coverage year of approximately $4 million in 2016.

During 2015, we received our interim settlement associated with our risk corridor receivables for the 2014 coverage year. The interim settlement, representing only 12.6% of risk corridor receivables for the 2014 coverage year, was funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 risk corridor program. As discussed in Note 2, HHS provided guidance under the three year risk corridor program that future collections will first be applied to any shortfalls from previous coverage years before application

to current year obligations. Risk corridor payables to issuers are obligations of the United States Government under the Health Care Reform law which requires the Secretary of HHS to make full payments to issuers. In the event of a shortfall at the end of the three year program, HHS has asserted it will explore other sources of funding for risk corridor payments, subject to the availability of appropriations. Based on the notice from CMS and collections in the fourth quarter of 2015, we classified our remaining gross risk corridor receivables for both the 2014 and 2015 coverage years as long-term because settlement is expected to exceed 12 months at December 31, 2015.

The accompanying consolidated balance sheets include the following amounts associated with the 3Rs at December 31, 2015 and December 31, 2014. Amounts classified as long-term represent settlements that we expect to exceed 12 months at December 31, 2015.

	2015			2014		
	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement
	(in millions)					
2014 Coverage Year						
Premiums receivable	$ 4	$ —	$ —	$ 131	$ —	$ —
Other current assets	—	—	—	—	586	55
Trade accounts payable and accrued expenses	—	—	—	(89)	—	(4)
Net current asset	4	—	—	42	586	51
Other long-term assets	—	—	215	—	—	—
Other long-term liabilities	—	—	—	—	—	—
Net long-term asset	—	—	215	—	—	—
Total 2014 coverage year net asset	4	—	215	42	586	51
2015 Coverage Year						
Premiums receivable	122	—	—	—	—	—
Other current assets	—	610	—	—	—	—
Trade accounts payable and accrued expenses	(223)	—	—	—	—	—
Net current (liability) asset	(101)	610	—	—	—	—
Other long-term assets	10	—	244	—	—	—
Other long-term liabilities	—	—	—	—	—	—
Net long-term asset	10	—	244	—	—	—
Total 2015 coverage year net (liability) asset	(91)	610	244	—	—	—
Total net (liability) asset	$ (87)	$ 610	$ 459	$ 42	$ 586	$ 51

In 2015, we paid the federal government $867 million for the annual health insurance industry fee attributed to calendar year 2015, in accordance with the Health Care Reform Law. In 2014, we paid the federal government $562 million for the annual health insurance industry fee attributed to calendar year 2014. This fee is not deductible for tax purposes.

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2015 and 2014, excluding Concentra amounts classified as held-for-sale at December 31, 2014 for comparative purposes. Net property and equipment associated with Concentra and classified as held-for sale at December 31, 2014 was $191 million.

	2015	2014
	(in millions)	
Land	$ 20	$ 18
Buildings and leasehold improvements	633	602
Equipment	645	631
Computer software	1,424	1,656
	2,722	2,907
Accumulated depreciation	(1,338)	(1,679)
Property and equipment, net	$ 1,384	$ 1,228

Depreciation expense was $354 million in 2015, $328 million in 2014, and $309 million in 2013, including amortization expense for capitalized internally developed and purchased software of $220 million in 2015, $191 million in 2014, and $172 million in 2013.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

The carrying amounts of goodwill for our reportable segments have been retrospectively adjusted as of January 1, 2014 to conform to the 2015 segment change discussed in Note 2. Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2015 and 2014 were as follows:

	Retail	Group	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2014	$ 1,069	$ 385	$ 1,799	$ 3,253
Acquisitions	—	—	19	19
Dispositions	—	—	(40)	(40)
Subsequent payments/adjustments	—	—	(1)	(1)
Balance at December 31, 2014	1,069	385	1,777	3,231
Acquisitions	—	—	35	35
Dispositions	—	—	(1)	(1)
Balance at December 31, 2015	$ 1,069	$ 385	$ 1,811	$ 3,265

Healthcare Services segment goodwill of $480 million associated with the sale of Concentra was reclassified to assets held-for-sale as of January 1, 2014 for comparative purposes and excluded from the table above. This $480 million of goodwill was disposed of on June 1, 2015 with the completion of the sale of Concentra.

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2015 and 2014 and excludes Concentra amounts classified as held-for-sale as of December 31, 2014 for comparative purposes. Net other intangible assets associated with Concentra and classified as held-for-sale at December 31, 2014 were $132 million.

	Weighted Average Life	2015			2014		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Customer contracts/relationships	9.8 years	$ 566	$ 292	$ 274	$ 657	$ 326	$ 331
Trade names and technology	8.3 years	104	54	50	115	50	65
Provider contracts	14.6 years	51	24	27	52	21	31
Noncompetes and other	8.2 years	32	26	6	41	28	13
Total other intangible assets	9.8 years	$ 753	$ 396	$ 357	$ 865	$ 425	$ 440

Amortization expense for other intangible assets was approximately $93 million in 2015, $121 million in 2014, and $117 million in 2013. The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,:	
2016	$ 78
2017	71
2018	62
2019	51
2020	47

10. BENEFITS PAYABLE

Activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
		(in millions)	
Balances at January 1	$ 4,475	$ 3,893	$ 3,775
Less: Reinsurance recoverables	(78)	—	—
Balances at January 1, net	4,397	3,893	3,775
Acquisitions	—	—	5
Incurred related to:			
Current year	44,397	38,641	32,711
Prior years	(236)	(518)	(474)
Total incurred	44,161	38,123	32,237
Paid related to:			
Current year	(39,802)	(34,357)	(29,103)
Prior years	(4,041)	(3,262)	(3,021)
Total paid	(43,843)	(37,619)	(32,124)
Premium deficiency reserve	176	—	—
Reinsurance recoverable	85	78	—
Balances at December 31	$ 4,976	$ 4,475	$ 3,893

Amounts incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (favorable development).

Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $236 million in 2015, $518 million in 2014, and $474 million in 2013. The favorable medical claims reserve development for 2015, 2014, and 2013 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. The decline in favorable prior period development in 2015 primarily was due to the impact of lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products. The higher favorable prior period development during 2014 and 2013 resulted from increased membership, better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
		(in millions)	
Premium deficiency reserve for short-duration policies	$ 176	$ —	$ —
Military services	12	11	(27)
Future policy benefits	(80)	32	354
Total	$ 108	$ 43	$ 327

In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7.

Military services benefits expense for 2015 and 2014 reflect expenses associated with our contracts with the Veterans Administration. Military services benefits expense for 2013 reflects the beneficial effect of a favorable settlement of contract claims with the DoD partially offset by expenses associated with our contracts with the Veterans Administration.

The decrease in benefits expense associated with future policy benefits payable in 2015 primarily reflects the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law. The higher benefits expense associated with future policy benefits payable during 2013 relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG America Corporation, or KMG, acquisition more fully described in Note 18.

11. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
		(in millions)	
Current provision:			
Federal	$ 1,067	$ 1,006	$ 595
States and Puerto Rico	90	81	53
Total current provision	1,157	1,087	648
Deferred (benefit) provision	(2)	(64)	42
Provision for income taxes	$ 1,155	$ 1,023	$ 690

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2015, 2014 and 2013 due to the following:

	2015	2014	2013
		(in millions)	
Income tax provision at federal statutory rate	$ 851	$ 759	$ 672
States, net of federal benefit, and Puerto Rico	44	48	32
Tax exempt investment income	(24)	(27)	(26)
Health insurer fee	314	204	—
Nondeductible executive compensation	18	22	6
Concentra sale	(67)	—	—
Other, net	19	17	6
Provision for income taxes	$ 1,155	$ 1,023	$ 690

The provision for income taxes for 2015, 2014, and 2013 reflects an $18 million, $22 million, and $6 million, respectively, estimated impact from limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. As of December 31, 2015, we do not have material uncertain tax positions reflected in our consolidated balance sheet.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled. Principal components of our net deferred tax balances at December 31, 2015 and 2014 were as follows, excluding Concentra amounts classified as held-for-sale at December 31, 2014 for comparative purposes. The net deferred tax liability associated with Concentra and classified as held-for sale at December 31, 2014 was $55 million.

	Assets (Liabilities)	
	2015	2014
	(in millions)	
Future policy benefits payable	$ 200	$ 320
Compensation and other accrued expenses	130	168
Benefits payable	267	138
Net operating loss carryforward	47	52
Deferred acquisition costs	64	57
Unearned revenues	22	21
Other	13	17
Total deferred income tax assets	743	773
Valuation allowance	(42)	(48)
Total deferred income tax assets, net of valuation allowance	701	725
Depreciable property and intangible assets	(363)	(346)
Investment securities	(37)	(168)
Prepaid expenses	(45)	(55)
Total deferred income tax liabilities	(445)	(569)
Total net deferred income tax assets	$ 256	$ 156
Amounts recognized in the consolidated balance sheets:		
Other current assets	$ —	$ 79
Other long-term assets	256	77
Total net deferred income tax assets	$ 256	$ 156

In November 2015, the FASB issued new guidance related to accounting for income taxes which changes the balance sheet classification of deferred taxes, requiring deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. We elected to early adopt the guidance and have classified all deferred tax liabilities and assets as noncurrent in our consolidated balance sheet at December 31, 2015 to simplify their presentation. Prior periods were not retrospectively adjusted. If we had retrospectively adjusted our consolidated balance sheet, our other current assets would have declined by $79 million and, similarly, our other long-term assets would have increased by $79 million at December 31, 2014.

At December 31, 2015, we had approximately $126 million of net operating losses to carry forward related to prior acquisitions and our Puerto Rico subsidiaries. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2016 through 2033. Due to limitations and uncertainty regarding our ability to use some of the carryforwards, a valuation allowance was established on $105 million of these net operating loss carryforwards and $7 million of other items related to Puerto Rico. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover all deferred tax assets.

We provide for income taxes on the undistributed earnings of our Puerto Rico operations using that jurisdiction's tax rate, which has been lower historically than the U.S. statutory tax rate. Permanent investment of these earnings has resulted in cumulative unrecognized deferred tax liabilities of approximately $30 million as of December 31, 2015.

We file income tax returns in the United States and certain foreign jurisdictions. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2013 and prior years. Our 2014 tax return is in the post-filing review period under the Compliance Assurance Process (CAP). Our 2015 tax return is under advance review by the IRS under CAP. With few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2012. As of December 31, 2015, we are not aware of any material adjustments that may be proposed.

12. DEBT

The carrying value of long-term debt outstanding was as follows at December 31, 2015 and 2014:

	2015	2014
	(in millions)	
Long-term debt:		
Senior notes:		
$500 million, 7.20% due June 15, 2018	$ 503	$ 504
$300 million, 6.30% due August 1, 2018	309	312
$400 million, 2.625% due October 1, 2019	400	400
$600 million, 3.15% due December 1, 2022	598	598
$600 million, 3.85% due October 1, 2024	599	599
$250 million, 8.15% due June 15, 2038	266	266
$400 million, 4.625% due December 1, 2042	400	400
$750 million, 4.95% due October 1, 2044	746	746
Total long-term debt	$ 3,821	$ 3,825

Senior Notes

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem the $500 million 6.45% senior unsecured notes as discussed below.

In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $560 million. We recognized a loss on extinguishment of debt of approximately $37 million in October 2014 for the redemption of these notes.

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes (other than the 6.30% senior notes) contain a change of control provision that may require us to purchase the notes under certain circumstances. On July 2, 2015 we entered into a Merger Agreement with Aetna that, when closed, may require redemption of the notes if the notes are downgraded below investment grade by both Standard & Poor's Rating Services, or S&P and Moody's Investors Services, Inc., or Moody's.

Prior to 2009, we were parties to interest-rate swap agreements that exchanged the fixed interest rate under our senior notes for a variable interest rate based on LIBOR. As a result, the carrying value of the senior notes was adjusted to reflect changes in value caused by an increase or decrease in interest rates. During 2008, we terminated all of our swap agreements. The cumulative adjustment to the carrying value of our senior notes was $103 million as of the termination date which is being amortized as a reduction to interest expense over the remaining term of the senior notes. In October 2014, the redemption of our 6.45% senior notes reduced the unamortized carrying value adjustment by $12 million. The unamortized carrying value adjustment was $28 million as of December 31, 2015 and $32 million as of December 31, 2014.

Credit Agreement

Our 5-year $1.0 billion unsecured revolving credit agreement expires July 2018. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 110 basis points, varies depending on our credit ratings ranging from 90 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 15 basis points, may fluctuate between 10 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $8.5 billion at December 31, 2015 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $10.3 billion and an actual leverage ratio of 1.3:1, as measured in accordance with the credit agreement as of December 31, 2015. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2015, we had no borrowings outstanding under the credit agreement and we had outstanding letters of credit of $1 million secured under the credit agreement. No amounts have been drawn on these letters of credit. Accordingly, as of December 31, 2015, we had $999 million of remaining borrowing capacity under the credit agreement, none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

In October 2014, we entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time, with the aggregate face or principal amount outstanding under the program at any time not to exceed $1 billion. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during

the year ended December 31, 2015 was $414 million, with $299 million outstanding at December 31, 2015. There were no outstanding borrowings at December 31, 2014.

13. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $188 million in 2015, $176 million in 2014, and $155 million in 2013. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $178.51 on December 31, 2015, approximately 13% of the retirement and savings plan's assets were invested in our common stock, or approximately 2.5 million shares, representing 2% of the shares outstanding as of December 31, 2015. At December 31, 2015, approximately 3.4 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. For awards granted prior to July 2, 2015, our equity award agreements generally contain provisions whereby the awards automatically accelerate and vest upon change in control, including those granted to retirement-eligible participants described below. The Merger discussed in Note 2 qualifies as a change in control event under our equity award agreements. Awards granted on or after July 2, 2015 would generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. We have also granted awards to certain employees that vest upon a combination of time and performance-based conditions. The stock awards of retirement-eligible participants granted prior to July 2, 2015 generally will continue to fully vest on the originally scheduled vest date upon retirement from the Company. For stock awards of retirement-eligible employees granted on or after July 2, 2015, awards are generally earned ratably over the service period for each tranche. Accordingly, upon retirement the earned portion of the current tranche will continue to vest on the originally scheduled vest date and any remaining unearned portion of the award will be forfeited. Our equity award program includes a retirement provision that generally treats employees with a combination of age and years of services with the Company totaling 65 or greater, with a minimum required age of 55 and a minimum requirement of 5 years of service, as retirement-eligible. Upon exercise, stock-based compensation awards are settled with authorized but unissued company stock or treasury stock.

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2015, 2014, and 2013:

	2015	2014	2013
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 99	$ 91	$ 84
Stock options	10	7	8
Total stock-based compensation expense	109	98	92
Tax benefit recognized	(26)	(22)	(22)
Stock-based compensation expense, net of tax	$ 83	$ 76	$ 70

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based

on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $34 million in 2015, $30 million in 2014, and $20 million in 2013. There was no capitalized stock-based compensation expense during these years.

At December 31, 2015, there were 18.1 million shares reserved for stock award plans. These reserved shares included giving effect to, under the 2011 Plan, 8.7 million shares of common stock available for future grants assuming all stock options were granted or 3.8 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests three years from the date of grant. Restricted stock granted on or after July 2, 2015, generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock units also include performance-based conditions generally associated with strategic membership growth and return on invested capital. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $165.26 in 2015, $103.57 in 2014, and $73.50 in 2013. Activity for our restricted stock was as follows for the year ended December 31, 2015:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2014	3,635	$ 85.52
Granted	837	165.26
Vested	(919)	84.95
Forfeited	(188)	98.92
Nonvested restricted stock at December 31, 2015	3,365	$ 104.58

Approximately 30% of the nonvested restricted stock at December 31, 2015 included performance-based conditions.

The fair value of shares vested was $153 million during 2015, $99 million during 2014, and $52 million during 2013. Total compensation expense not yet recognized related to nonvested restricted stock was $88 million at December 31, 2015. We expect to recognize this compensation expense over a weighted-average period of approximately 1.4 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 years after grant.

The weighted-average fair value of each option granted during 2015, 2014, and 2013 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2015	2014	2013
Weighted-average fair value at grant date	$ 36.91	$ 22.45	$ 21.80
Expected option life (years)	4.2 years	4.3 years	4.4 years
Expected volatility	27.4%	27.6%	38.8%
Risk-free interest rate at grant date	1.4%	1.3%	0.8%
Dividend yield	0.7%	1.1%	1.5%

When valuing employee stock options, we stratify the employee population into three homogenous groups that historically have exhibited similar exercise behaviors. These groups are executive officers, directors, and all other employees. We value the stock options based on the unique assumptions for each of these employee groups.

We calculate the expected term for our employee stock options based on historical employee exercise behavior and base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

The volatility used to value employee stock options is based on historical volatility. We calculate historical volatility using a simple-average calculation methodology based on daily price intervals as measured over the expected term of the option.

Activity for our option plans was as follows for the year ended December 31, 2015:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2014	768	$ 82.45
Granted	377	164.80
Exercised	(304)	76.25
Forfeited	(6)	83.58
Options outstanding at December 31, 2015	835	$ 121.89
Options exercisable at December 31, 2015	203	$ 78.30

As of December 31, 2015, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $48 million, and a weighted-average remaining contractual term of 5.0 years. As of December 31, 2015, exercisable stock options had an aggregate intrinsic value of $20 million, and a weighted-average remaining contractual term of 3.5 years. The total intrinsic value of stock options exercised during 2015 was $28 million, compared with $32 million during 2014 and $39 million during 2013. Cash received from stock option exercises totaled $23 million in 2015, $52 million in 2014, and $67 million in 2013.

Total compensation expense not yet recognized related to nonvested options was $10 million at December 31, 2015. We expect to recognize this compensation expense over a weighted-average period of approximately 1.9 years.

14. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 1,276	$ 1,147	$ 1,231
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	149,455	154,187	157,503
Dilutive effect of:			
Employee stock options	192	230	322
Restricted stock	1,495	1,457	1,326
Shares used to compute diluted earnings per common share	151,142	155,874	159,151
Basic earnings per common share	$ 8.54	$ 7.44	$ 7.81
Diluted earnings per common share	$ 8.44	$ 7.36	$ 7.73
Number of antidilutive stock options and restricted stock awards excluded from computation	415	320	704

15. STOCKHOLDERS' EQUITY

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2013, 2014, and 2015 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2013	$1.06	$167
2014	$1.10	$170
2015	$1.14	$170

The Merger Agreement discussed in Note 2 does not impact our ability and intent to continue quarterly dividend payments prior to the closing of the Merger consistent with our historical dividend payments. Under the terms of the Merger Agreement, we have agreed with Aetna that our quarterly dividend will not exceed $0.29 per share prior to the closing of the Merger. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change. In addition, under the terms of the Merger Agreement, we have agreed with Aetna to coordinate the declaration and payment of dividends so that our stockholders do not fail to receive a quarterly dividend around the time of the closing of the Merger.

On October 29, 2015, the Board declared a cash dividend of $0.29 per share that was paid on January 29, 2016 to stockholders of record on December 30, 2015, for an aggregate amount of $43 million.

Stock Repurchases

In September 2014, our Board of Directors replaced a previous share repurchase authorization of up to $1 billion (of which $816 million remained unused) with a new current authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2016. Under the share repurchase authorization, shares may be purchased from time to time at prevailing prices in the

open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. Pursuant to the Merger Agreement, after July 2, 2015, we are prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we have suspended our share repurchase program. Our remaining repurchase authorization was $1.04 billion as of July 3, 2015.

Excluding shares acquired in connection with employee stock plans as well as 0.36 million shares received in March 2015 upon final settlement of our accelerated share repurchase agreement, or ASR Agreement, described below for which no cash was paid during the period, share repurchases were as follows during the years ended December 31, 2015, 2014 and 2013:

		Year Ended December 31,					
		2015		2014		2013	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost	Shares	Cost
		(in millions)					
September 2014	$ 2,000	1.85	$ 329	4.10	$ 635 (a)	—	$ —
April 2014	1,000	—	—	1.50	184	—	—
April 2013	1,000	—	—	0.10	11	4.55	420
April 2012	1,000	—	—	—	—	1.22	82
Total repurchases		1.85	$ 329	5.70	$ 830	5.77	$ 502

(a) Includes $100 million held back by Goldman Sachs pending final settlement of the ASR Agreement in March 2015 at which time we received an additional 0.36 million shares which are excluded from the table above.

On November 7, 2014, we announced that we had entered into an accelerated share repurchase agreement, or ASR Agreement, with Goldman, Sachs & Co., or Goldman Sachs, to repurchase $500 million of our common stock as part of the $2 billion share repurchase program authorized in September 2014. Under the ASR Agreement, on November 10, 2014, we made a payment of $500 million to Goldman Sachs from available cash on hand and received an initial delivery of 3.06 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $400 million increase in treasury stock, which reflected the value of the initial 3.06 million shares received upon initial settlement, and a $100 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the ASR Agreement. Upon settlement of the ASR on March 13, 2015, we received an additional 0.36 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the ASR Agreement of $146.21, bringing the total shares received under this program to 3.42 million. In addition, upon settlement we reclassified the $100 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock.

In connection with employee stock plans, we acquired 0.3 million common shares for $56 million in 2015, 0.4 million common shares for $42 million in 2014, and 0.3 million common shares for $29 million in 2013.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $6.6 billion and $6.0 billion as of December 31, 2015 and 2014, respectively, which exceeded aggregate minimum regulatory requirements of $4.6 billion and $4.1 billion, respectively. Subsidiary dividends are subject to state regulatory approval, the amount and timing of which could be reduced or delayed. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2016 is approximately $900 million in the aggregate. This compares to dividends that were paid to our parent company in 2015 of approximately $493 million. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

16. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Leases

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2026. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the years ended December 31, 2015, 2014 and 2013:

	2015	2014	2013
		(in millions)	
Rent expense	$ 201	$ 226	$ 227
Sublease rental income	(25)	(14)	(11)
Net rent expense	$ 176	$ 212	$ 216

Future annual minimum payments due subsequent to December 31, 2015 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31,:			
2016	$ 173	$ (16)	$ 157
2017	159	(16)	143
2018	127	(14)	113
2019	94	(11)	83
2020	54	(7)	47
Thereafter	90	(45)	45
Total	$ 697	$ (109)	$ 588

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $74 million in 2016, $44 million in 2017, $30 million in 2018, $1 million in 2019, and $1 million thereafter. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2015, we were not involved in any SPE transactions.

Guarantees and Indemnifications

Through indemnity agreements approved by the state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by Humana Inc., our parent company, in the event of insolvency for (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent also has guaranteed the obligations of our military services subsidiaries.

In the ordinary course of business, we enter into contractual arrangements under which we may agree to indemnify a third party to such arrangement from any losses incurred relating to the services they perform on behalf of us, or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses. Historically, payments made related to these indemnifications have been immaterial.

Government Contracts

Our Medicare products, which accounted for approximately 72% of our total premiums and services revenue for the year ended December 31, 2015, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2016, and all of our product offerings filed with CMS for 2016 have been approved.

CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity of covered members. The risk-adjustment model pays more for enrollees with predictably higher costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data

and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the FFS Adjuster is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits currently being conducted for contract year 2011 in which two of our Medicare Advantage plans are being audited. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year. We were notified on September 15, 2015, that five of our Medicare Advantage contracts have been selected for audit for contract year 2012.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For-Service business which we used to represent a proxy of the FFS Adjuster which has not yet been released. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However, as indicated, we are awaiting additional guidance from CMS regarding the FFS Adjuster. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2015, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2015, primarily consisted of the TRICARE South Region contract. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On January 22, 2016, we received notice from the Defense Health Agency, or DHA, of its intent to exercise its option to extend the TRICARE South Region contract through March 31, 2017. On April 24, 2015, a request for proposal was issued for the next generation of TRICARE contracts for the period beginning April 1, 2017. The request for proposal provides for the consolidation of three regions into two - East and West. The current North Region and South Region are to be combined to form the East Region. We responded to the request for proposal on July 22, 2015. On January 15, 2016, we received a request for Final Proposal Revisions that we responded to on February 16, 2016.

Our state-based Medicaid business accounted for approximately 4% of our total premiums and services revenue for the year ended December 31, 2015. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Illinois and Virginia for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program as well as an Integrated Care Program, or ICP, Medicaid contract in Illinois. We began serving members in Illinois in the first quarter of 2014 and in Virginia in the second quarter of 2014. In addition, we began serving members in Long-Term Support Services (LTSS) regions in Florida at various effective dates ranging from the second half of 2013 through the first quarter of 2014.

The loss of any of the contracts above or significant changes in these programs as a result of legislative or regulatory action, including reductions in premium payments to us, regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

Legal Proceedings and Certain Regulatory Matters

Florida Matters

On January 6, 2012, the Civil Division of the United States Attorney's Office for the Southern District of Florida advised us that it is seeking documents and information from us and several of our affiliates relating to several matters including the coding of medical claims by one or more South Florida medical providers, and loans to physician practices. On May 1, 2014, the U.S. Attorney's Office filed a Notice of Non-Intervention in connection with a civil qui tam suit related to one of these matters captioned *United States of America ex rel. Olivia Graves v. Plaza Medical Centers, et al.*, and the Court ordered the complaint unsealed. Subsequently, the individual plaintiff amended the complaint and served the Company, opting to continue to pursue the action. The individual plaintiff has filed a third amended complaint which we answered on October 16, 2015. The Court has ordered trial to commence on October 3, 2016 if the matter is not resolved prior to trial. We continue to cooperate with and respond to information requests from the U.S. Attorney's office. These matters could result in additional qui tam litigation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided us with an information request, separate from but related to the Plaza Medical matter, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, including the providers identified in the Plaza Medical matter, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice and the U.S. Attorney's Office. These matters are expected to result in additional qui tam litigation.

On June 16, 2015, the U.S. Attorney's Office filed a Declination Notice, indicating its intent not to intervene, in connection with a civil qui tam suit captioned *U.S. ex rel. Ramsey-Ledesma v. Censeo, et al.*, and the Court ordered the complaint unsealed. Subsequently, the individual plaintiff filed a second amended complaint and served the Company, opting to continue to pursue the action. The plaintiff's second amended complaint names several other defendants, including CenseoHealth. On January 8, 2016, we and the other defendants each filed a motion to dismiss the second amended complaint.

Litigation Related to the Merger

In connection with the Merger, three putative class action complaints were filed by purported Humana stockholders challenging the Merger, two in the Circuit Court of Jefferson County, Kentucky and one in the Court of Chancery of the State of Delaware. The complaints are captioned Solak v. Broussard et al., Civ. Act. No. 15CI03374 (Kentucky

state court), Litwin v. Broussard et al., Civ. Act. No. 15CI04054 (Kentucky state court) and Scott v. Humana Inc. et al., C.A. No. 11323-VCL (Delaware state court). The complaints name as defendants each member of Humana's board of directors, Aetna, and, in the case of the Delaware complaint, Humana. The complaints generally allege, among other things, that the individual members of our board of directors breached their fiduciary duties owed to our stockholders by entering into the Merger Agreement, approving the mergers as contemplated by the Merger Agreement, and failing to take steps to maximize the value of Humana to our stockholders, and that Aetna, and, in the case of the Delaware complaint, Humana aided and abetted such breaches of fiduciary duties. In addition, the complaints allege that the merger undervalues Humana, that the process leading up to the execution of the Merger Agreement was flawed, that the members of our board of directors improperly placed their own financial interests ahead of those of our stockholders, and that certain provisions of the Merger Agreement improperly favor Aetna and impede a potential alternative transaction. Among other remedies, the complaints seek equitable relief rescinding the Merger Agreement and enjoining the defendants from completing the mergers as well as costs and attorneys' fees. We refer to all these cases collectively in this report as the Merger Litigation. On August 20, 2015, the parties in the Kentucky state cases filed a stipulation and proposed order with the court to consolidate these cases into a single action captioned In re Humana Inc. Shareholder Litigation, Civ. Act. No. 15CI03374.

On October 9, 2015, solely to avoid the costs, risks, and uncertainties inherent in litigation, and without admitting any liability or wrongdoing, we and the other named defendants in the Merger Litigation signed a memorandum of understanding, which we refer to as the MOU, to settle the Merger Litigation. Subject to court approval and further definitive documentation in a stipulation of settlement that will be subject to customary conditions, the MOU resolved the claims brought in the Merger Litigation and provided that we would make certain additional disclosures related to the proposed mergers. The MOU further provided for, among other things, dismissal of the Merger Litigation with prejudice and a release and settlement by the purported class of our stockholders of all claims against the defendants and their affiliates and agents in connection with the Merger Agreement and transactions and disclosures related to the Merger Agreement. The asserted claims will not be released until such stipulation of settlement receives court approval. The foregoing terms and conditions will be defined by the stipulation of settlement, and class members will receive a separate notice describing the settlement terms and their rights in connection with the approval of the settlement. In connection with the settlement, the parties contemplate that plaintiffs' counsel will file a petition for an award of attorneys' fees and expenses. We will pay or cause to be paid any court awarded attorneys' fees and expenses. There can be no assurance that the parties will ultimately enter into a stipulation of settlement or that a court will approve such settlement even if the parties were to enter into such stipulation. In such event, the proposed settlement as contemplated by the MOU may be terminated. Because the MOU contemplates that the Kentucky court will be asked to approve the settlement, the plaintiffs have already withdrawn the Delaware case.

Other Lawsuits and Regulatory Matters

Our current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance, health care delivery and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, statutory capital requirements, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For example, a number of hospitals and other providers have asserted that, under their network provider contracts, we are not entitled to reduce Medicare Advantage payments to these providers in connection with changes in Medicare payment systems and in accordance with the Balanced Budget and Emergency Deficit Control

Act of 1985, as amended (commonly referred to as "sequestration"). Those challenges have led and could lead to arbitration demands or other litigation. Also, under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of non-performance of contractual obligations to providers, members, and others, including failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extracontractual damages, care delivery malpractice, and claims arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for the contingencies discussed in the sections above to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because of the inherently unpredictable nature of legal proceedings, which also may be exacerbated by various factors, including: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows, and may also affect our reputation.

17. SEGMENT INFORMATION

On January 1, 2015, we realigned certain of our businesses among our reportable segments to correspond with internal management reporting changes and renamed our Employer Group segment to the Group segment. Our three reportable segments remain Retail, Group, and Healthcare Services. The more significant realignments included reclassifying Medicare benefits offered to groups to the Retail segment from the Group segment, bringing all of our Medicare offerings, which are now managed collectively, together in one segment, recognizing that in some instances we market directly to individuals that are part of a group Medicare account. In addition, we realigned our military services business, primarily consisting of our TRICARE South Region contract previously included in the Other Businesses category, to our Group segment as we consider this contract with the government to be a group account. Prior period segment financial information has been recast to conform to the 2015 presentation.

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts, as well as individual commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products. In addition, the Retail segment also includes our contract with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Group segment consists of employer group commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary insurance benefits, as well as administrative services only, or ASO products. In addition, our Group segment includes our health and wellness products (primarily marketed to employer groups) and military services business, primarily our TRICARE South Region contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, home based services, and clinical programs, as well as services and capabilities to advance population health. We will continue to report under the category of Other Businesses those businesses which do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of Humana Pharmacy, Inc., our mail order pharmacy business. These revenues consist of the prescription price (ingredient cost plus dispensing fee), including the portion to be settled with the member (co-share) or with the government (subsidies), plus any associated administrative fees. Services revenues related to the distribution of prescriptions by third party retail pharmacies in our networks are recognized when the claim is processed and product revenues from dispensing prescriptions from our mail order pharmacies are recorded when the prescription or product is shipped. Our pharmacy operations, which are responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims, act as a principal in the arrangement on behalf of members in our other segments. As principal, our Healthcare Services segment reports revenues on a gross basis including co-share amounts from members collected by third party retail pharmacies at the point of service.

In addition, our Healthcare Services intersegment revenues include revenues earned by certain owned providers derived from risk-based and non risk-based managed care agreements with our health plans. Under risk based agreements, the provider receives a monthly capitated fee that varies depending on the demographics and health status of the member, for each member assigned to these owned providers by our health plans. The owned provider assumes the economic risk of funding the assigned members' healthcare services. Under non risk-based agreements, our health plans retain the economic risk of funding the assigned members' healthcare services. Our Healthcare Services segment reports provider services revenues associated with risk-based agreements on a gross basis, whereby capitation fee

revenue is recognized in the period in which the assigned members are entitled to receive healthcare services. Provider services revenues associated with non risk-based agreements are presented net of associated healthcare costs.

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $12.3 billion in 2015, $9.7 billion in 2014, and $7.3 billion in 2013. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $92 million in 2015, $116 million in 2014, and $93 million in 2013.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations in the tables presenting segment results below.

Our segment results were as follows for the years ended December 31, 2015, 2014, and 2013:

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2015						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 29,526	$ —	$ —	$ —	$ —	$ 29,526
Group Medicare Advantage	5,588	—	—	—	—	5,588
Medicare stand-alone PDP	3,846	—	—	—	—	3,846
Total Medicare	38,960	—	—	—	—	38,960
Fully-insured	4,243	5,493	—	—	—	9,736
Specialty	261	1,055	—	—	—	1,316
Medicaid and other	2,341	21	—	35	—	2,397
Total premiums	45,805	6,569	—	35	—	52,409
Services revenue:						
Provider	—	40	655	—	—	695
ASO and other	9	658	—	14	—	681
Pharmacy	—	—	30	—	—	30
Total services revenue	9	698	685	14	—	1,406
Total revenues—external customers	45,814	7,267	685	49	—	53,815
Intersegment revenues						
Services	—	93	17,997	—	(18,090)	—
Products	—	—	4,923	—	(4,923)	—
Total intersegment revenues	—	93	22,920	—	(23,013)	—
Investment income	134	26	—	76	238	474
Total revenues	45,948	7,386	23,605	125	(22,775)	54,289
Operating expenses:						
Benefits	39,708	5,266	—	87	(792)	44,269
Operating costs	5,118	1,769	22,481	14	(22,064)	7,318
Depreciation and amortization	192	93	143	—	(73)	355
Total operating expenses	45,018	7,128	22,624	101	(22,929)	51,942
Income from operations	930	258	981	24	154	2,347
Gain on sale of business	—	—	—	—	270	270
Interest expense	—	—	—	—	186	186
Income before income taxes	$ 930	$ 258	$ 981	$ 24	$ 238	$ 2,431

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 73% for 2015, compared to 73% for 2014, and 75% for 2013.

Benefits expense for the Retail segment for 2015 includes $176 million for a provision for probable future losses (premium deficiency) for individual commercial medical business compliant with the Health Care Reform Law for the 2016 coverage year as discussed more fully in Note 7.

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2014						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 25,782	$ —	$ —	$ —	$ —	$ 25,782
Group Medicare Advantage	5,490	—	—	—	—	5,490
Medicare stand-alone PDP	3,404	—	—	—	—	3,404
Total Medicare	34,676	—	—	—	—	34,676
Fully-insured	3,265	5,339	—	—	—	8,604
Specialty	256	1,098	—	—	—	1,354
Medicaid and other	1,255	19	—	51	—	1,325
Total premiums	39,452	6,456	—	51	—	45,959
Services revenue:						
Provider	—	23	1,254	—	—	1,277
ASO and other	39	740	—	9	—	788
Pharmacy	—	—	99	—	—	99
Total services revenue	39	763	1,353	9	—	2,164
Total revenues—external customers	39,491	7,219	1,353	60	—	48,123
Intersegment revenues						
Services	—	78	15,098	—	(15,176)	—
Products	—	—	3,749	—	(3,749)	—
Total intersegment revenues	—	78	18,847	—	(18,925)	—
Investment income	97	23	—	60	197	377
Total revenues	39,588	7,320	20,200	120	(18,728)	48,500
Operating expenses:						
Benefits	33,508	5,130	—	102	(574)	38,166
Operating costs	4,576	1,936	19,307	17	(18,197)	7,639
Depreciation and amortization	165	103	155	—	(90)	333
Total operating expenses	38,249	7,169	19,462	119	(18,861)	46,138
Income from operations	1,339	151	738	1	133	2,362
Interest expense	—	—	—	—	192	192
Income (loss) before income taxes	$ 1,339	$ 151	$ 738	$ 1	$ (59)	$ 2,170

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2013						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 22,481	$ —	$ —	$ —	$ —	$ 22,481
Group Medicare Advantage	4,710	—	—	—	—	4,710
Medicare stand-alone PDP	3,033	—	—	—	—	3,033
Total Medicare	30,224	—	—	—	—	30,224
Fully-insured	1,160	5,117	—	—	—	6,277
Specialty	210	1,095	—	—	—	1,305
Medicaid and other	328	25	—	670	—	1,023
Total premiums	31,922	6,237	—	670	—	38,829
Services revenue:						
Provider	—	21	1,291	—	—	1,312
ASO and other	18	714	—	6	—	738
Pharmacy	—	—	59	—	—	59
Total services revenue	18	735	1,350	6	—	2,109
Total revenues—external customers	31,940	6,972	1,350	676	—	40,938
Intersegment revenues						
Services	—	51	11,890	—	(11,941)	—
Products	—	—	2,803	—	(2,803)	—
Total intersegment revenues	—	51	14,693	—	(14,744)	—
Investment income	92	24	—	59	200	375
Total revenues	32,032	7,047	16,043	735	(14,544)	41,313
Operating expenses:						
Benefits	27,164	4,847	—	962	(409)	32,564
Operating costs	3,232	1,860	15,372	56	(14,165)	6,355
Depreciation and amortization	146	100	151	6	(70)	333
Total operating expenses	30,542	6,807	15,523	1,024	(14,644)	39,252
Income (loss) from operations	1,490	240	520	(289)	100	2,061
Interest expense	—	—	—	—	140	140
Income (loss) before income taxes	$ 1,490	$ 240	$ 520	$ (289)	$ (40)	$ 1,921

Benefits expense for Other Businesses for 2013 includes $243 million for reserve strengthening associated with our closed block of long-term care insurance policies as discussed more fully in Note 18.

18. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for approximately 1% of our consolidated premiums and services revenue for the year ended December 31, 2015. We use long-duration accounting for products such as long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

In addition, we establish reserves for future policy benefits in recognition of the fact that some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). As discussed in Note 2, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model because premiums received in the current year are intended to pay anticipated benefits in that year.

The table below presents deferred acquisition costs and future policy benefits payable associated with our long-duration insurance products for the years ended December 31, 2015 and 2014.

	2015		2014	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$ 135	$ —	$ 167	$ —
Trade accounts payable and accrued expenses	—	(64)	—	(68)
Long-term liabilities	—	(2,151)	—	(2,349)
Total asset (liability)	$ 135	$ (2,215)	$ 167	$ (2,417)

In addition, future policy benefits payable include amounts of $205 million at December 31, 2015 and $210 million at December 31, 2014 which are subject to 100% coinsurance agreements as more fully described in Note 19.

In 2015, we recorded a net reduction in benefits expense of $80 million associated with future policy benefits primarily due to the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law. Benefits expense associated with future policy benefits payable was $32 million in 2014 and $354 million in 2013. Benefits expense for 2013 included net charges of $243 million associated with our closed block of long-term care insurance policies discussed further below. Amortization of deferred acquisition costs included in operating costs was $63 million in 2015, $39 million in 2014, and $55 million in 2013. The increase in amortization in 2015 primarily reflects the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers.

Future policy benefits payable include $1.5 billion at December 31, 2015 and 2014 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was no additional liability at December 31, 2015 and $123 million of additional liability at December 31, 2014. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual premium rate increase, interest, morbidity, mortality, persistency, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience vary from our loss recognition date assumptions, material future adjustments to reserves could be required.

During 2013, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2010 loss recognition date, particularly as they related to emerging experience due to an increase in life expectancies and utilization of home health care services. Based on this deterioration, and combined with lower interest rates, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2013 we recorded $243 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $350 million partially offset by a related reinsurance recoverable of $107 million included in other long-term assets.

Deferred acquisition costs included $26 million and $59 million associated with our individual commercial medical policies at December 31, 2015 and December 31, 2014, respectively. Future policy benefits payable associated with our individual commercial medical policies were $180 million at December 31, 2015 and $297 million at December 31, 2014. The decline in deferred acquisition costs and future policy benefits payable primarily reflects the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers.

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, long-term care, and annuities in run-off status, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods used to determine future policy benefits payable as detailed in Note 2. Excluding reinsurance associated with the Health Care Reform Law discussed in Note 2, reinsurance recoverables, included in other current and long-term assets, were $668 million at December 31, 2015 and $646 million at December 31, 2014. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 43% at December 31, 2015 and approximately 45% at December 31, 2014. Premiums ceded were $821 million in 2015, $357 million in 2014 and $33 million in 2013. Benefits ceded were $666 million in 2015, $272 million in 2014, and $70 million in 2013. Ceded premium and benefits reflect a July 1, 2014 amendment ceding all risk under a Medicaid contract to a third party reinsurer.

We evaluate the financial condition of these reinsurers on a regular basis. These reinsurers are well-known and well-established, as evidenced by the strong financial ratings at December 31, 2015 presented below:

Reinsurer	Total Recoverable	A.M. Best Rating at December 31, 2015
	(in millions)	
Protective Life Insurance Company	$ 184	A+ (superior)
Munich American Reassurance Company	155	A+ (superior
Employers Reassurance Corporation	91	A- (excellent)
General Re Life Corporation	90	A++ (superior)
All others	148	A+ to B++ (superior to good)
	$ 668	

The all other category represents 18 reinsurers with individual balances less than $85 million. Three of these reinsurers with recoverables of $104 million are subject to trust or funds withheld accounts, requiring amounts at least equal to the total recoverable from each of these reinsurers.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.:

In our opinion, the consolidated balance sheets and the related consolidated statements of income, of comprehensive income, of stockholders' equity and of cash flows present fairly, in all material respects, the financial position of Humana Inc. and its subsidiaries at December 31, 2015 and 2014, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2015 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules listed in the index appearing under Item 15(a)(2) present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedules, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedules, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky
February 18, 2016

Humana Inc.
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31, 2015 and 2014 follows:

	2015			
	First	Second	Third	Fourth (2)
	(in millions, except per share results)			
Total revenues	$ 13,833	$ 13,732	$ 13,363	$ 13,361
Income before income taxes	744	793	648	246
Net income	430	431	314	101
Basic earnings per common share	$ 2.86	$ 2.88	$ 2.11	$ 0.68
Diluted earnings per common share (1)	$ 2.82	$ 2.85	$ 2.09	$ 0.67

	2014			
	First	Second	Third	Fourth
	(in millions, except per share results)			
Total revenues	$ 11,712	$ 12,222	$ 12,238	$ 12,328
Income before income taxes	686	646	551	287
Net income	368	344	290	145
Basic earnings per common share	$ 2.37	$ 2.22	$ 1.87	$ 0.96
Diluted earnings per common share (1)	$ 2.35	$ 2.19	$ 1.85	$ 0.94

(1) The calculation of diluted earnings per common share is based on the weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

(2) The fourth quarter of 2015 includes an expense of $176 million ($112 million after tax, or $0.74 per diluted common share) for a premium deficiency reserve associated with our individual commercial medical policies compliant with the Health Care Reform Law associated with the 2016 coverage year.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2015, we as the principal executive officer and the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2015. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2015, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2015 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on page 136.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2015 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Bruce D. Broussard
President and Chief Executive Officer (Principal Executive Officer)

Brian A. Kane
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

Cynthia H. Zipperle
Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

Set forth below are names and ages of all of our current executive officers as of February 1, 2016, their positions, and the date first elected an officer:

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	53	President and Chief Executive Officer, Director	12/11	(1)
James E. Murray	62	Executive Vice President and Chief Operating Officer	08/90	(2)
Roy A. Beveridge, M.D.	58	Senior Vice President and Chief Medical Officer	06/13	(3)
Jody L. Bilney	54	Senior Vice President and Chief Consumer Officer	04/13	(4)
Christopher H. Hunter	47	Senior Vice President and Chief Strategy Officer	01/14	(5)
Timothy S. Huval	49	Senior Vice President and Chief Human Resources Officer	12/12	(6)
Brian A. Kane	43	Senior Vice President and Chief Financial Officer	06/14	(7)
Christopher Kay	50	Senior Vice President and Chief Innovation Officer	03/14	(8)
Brian P. LeClaire	55	Senior Vice President and Chief Information Officer	08/11	(9)
Heidi S. Margulis	62	Senior Vice President – Corporate Affairs	12/95	(10)
Christopher M. Todoroff	53	Senior Vice President and General Counsel	08/08	(11)
Cynthia H. Zipperle	53	Vice President, Chief Accounting Officer and Controller	12/14	(12)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Mr. Murray currently serves as Executive Vice President and Chief Operating Officer, having held this position since December 2011. Mr. Murray has held the position of Chief Operating Officer since February 2006, and was the Chief Operating Officer – Market and Business Segment Operations from September 2002 to February 2006. Mr. Murray joined the Company in December 1989.

(3) Dr. Beveridge currently serves as Senior Vice President and Chief Medical Officer, having held this position since joining the Company in June 2013. Prior to joining the Company, Dr. Beveridge served as Chief Medical Officer for McKesson Specialty Health from December 2010 until June 2013. Prior to McKesson's acquisition

of US Oncology, Dr. Beveridge served as the Executive Vice President and Medical Director at US Oncology from September 2009 through December 2010.

(4) Ms. Bilney currently serves as Senior Vice President and Chief Consumer Officer, having held this position since joining the Company in April 2013. Prior to joining the Company, Ms. Bilney served as Executive Vice President and Chief Brand Officer for Bloomin' Brands, Inc. from 2006 until April 2013.

(5) Mr. Hunter currently serves as Senior Vice President and Chief Strategy Officer, having held this position since joining the Company in January 2014. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(6) Mr. Huval currently serves as Senior Vice President and Chief Human Resources Officer, having been elected to this position in December 2012. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(7) Mr. Kane currently serves as Senior Vice President and Chief Financial Officer, having been elected to this position in June 2014. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(8) Mr. Kay currently serves of Senior Vice President and Chief Innovation Officer, having been elected to this position in March 2014. Prior to joining the Company, Mr. Kay was most recently Managing Director and CEO of Citi Ventures, Citigroup's global corporate venturing arm. Prior to joining Citi in 2007, Mr. Kay held several leadership positions at Target over a 12-year period.

(9) Mr. LeClaire currently serves as Senior Vice President and Chief Information Officer, having held this position since January 2014. Prior to that, he served as Senior Vice President and Chief Service and Information Officer from August 2011 to January 2014, and as Chief Technology Officer from 2002 to August 2011. Mr. LeClaire joined the Company in August 1999.

(10) Ms. Margulis currently serves as Senior Vice President – Corporate Affairs, having held this position since January 2000. Ms. Margulis joined the Company in November 1985.

(11) Mr. Todoroff currently serves as Senior Vice President and General Counsel, having held this position since August 2008. Prior to joining the Company, Mr. Todoroff served as Vice President, Senior Corporate Counsel and Corporate Secretary for Aetna Inc. from 2006 through July 2008. Mr. Todoroff joined Aetna's Legal Department in 1995 and held various positions of increasing responsibility.

(12) Mrs. Zipperle currently serves as Vice President, Chief Accounting Officer and Controller, having held this position since December 2014. Mrs. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

Section 16(a) Beneficial Ownership Reporting Compliance

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016 appearing under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of such Proxy Statement.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day. All employees and directors are required to annually affirm in writing their acceptance of the code. The Humana Inc. Ethics Every Day was adopted by our Board of Directors in June 2014, replacing a previous iteration of our Code of Ethics and Business Conduct – the Humana Inc. Principles of Business Ethics – as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Humana Inc. Ethics Every Day is available on our web site at www.humana.com. Any waiver of the application of the Humana Inc. Principles of Business Ethics to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on our Internet web site is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our by-laws and Certificate of Incorporation;
- our Majority Vote policy;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;
- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016 appearing under the caption "Corporate Governance – Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016 appearing under the captions "Corporate Governance – Organization & Compensation Committee – Compensation Committee Interlocks and Insider Participation," "Director Compensation," "Compensation Discussion and Analysis," "Organization & Compensation Committee Report," and "Executive Compensation" of such Proxy Statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, key employees, and consultants. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2015 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	835,123	$ 121.889	8,734,399	(2)(3)
Equity compensation plans not approved by security holders	—	—	—	
Total	835,123	$ 121.889	8,734,399	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 13.

(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.

(3) Of the number listed above, 3,814,148 can be issued as restricted stock at December 31, 2015 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan).

The information under the captions "Security Ownership of Certain Beneficial Owners of Company Common Stock" and "Security Ownership of Directors and Executive Officers" in our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016 appearing under the captions "Certain Transactions with Management and Others" and "Corporate Governance – Independent Directors" of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 21, 2016 appearing under the caption "Audit Committee Report" of such Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Financial Information
Schedule II	Valuation and Qualifying Accounts

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

2.1 Agreement and Plan of Merger, dated as of July 2, 2015 among Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc. (incorporated herein by reference to Exhibit 2.1 to Humana Inc.'s Current Report on Form 8-K filed on July 7, 2015).

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) By-Laws of Humana Inc., as amended on January 4, 2007 (incorporated herein by reference to Exhibit 3 to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2006).

4(a) Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).

(b) First Supplemental Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).

(c) Second Supplemental Indenture, dated as of May 31, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on May 31, 2006).

(d) Third Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(e) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(f) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006).

(g) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 12 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.

(h) Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(i) Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(j) Seventh Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York, Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(k) Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(l) Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

10(a)*† Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions)

(b)*† Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions).

(c)* Humana Inc. Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 27, 2006).

(d)* Humana Inc. Executive Management Incentive Compensation Plan, as amended and restated February 1, 2008 (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 24, 2008).

(e)* Form of Change of Control Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).

(f)* Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999).

(g)* The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).

(h)* Severance policy as amended and restated on October 23, 2007 (incorporated herein by reference to Exhibit 10(r) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2007).

(i)* Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).

(j)* Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 17, 2011).

(k)* Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994).

(l)* Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).

(m)* Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).

(n)* ** Form of Company's Restricted Stock Unit Agreement with Time/Performance Vesting and Agreement not to Compete or Solicit, under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10 (t) to Humana Inc.'s Annual Report on Form 10-K/A filed on January 30, 2014).

(o)*† Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (with retirement provisions).

(p)* Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.

(q)*† Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (without retirement provisions).

(r) Five-Year Credit Agreement, dated as of July 9, 2013 (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on July 10, 2013).

(s) Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(t) Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(u) Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(v) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(w) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(x) Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(y) Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005).

(z)* Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).

(aa)* Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(oo) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(bb)* Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(pp) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(cc)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(rr) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(dd)* Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).

(ee)* Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).

(ff)** Agreement between the United States Department of Defense and Humana Military Healthcare Services, Inc., a wholly owned subsidiary of Humana Inc., dated as March 3, 2011 (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(gg)* Form of Amendment to Change of Control Agreement between Humana Inc. and various executive officers (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).

(hh) Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 6, 2014).

(ii) Master Confirmation by and between Humana Inc. and Goldman, Sachs & Co., dated November 7, 2014 (incorporated herein by reference to Humana Inc.'s current report on Form 8-K filed on November 10, 2014).

(jj)*† Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options).

(kk)*† Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit).

12 † Computation of ratio of earnings to fixed charges.

14 Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).

21 † List of subsidiaries.

23 † Consent of PricewaterhouseCoopers LLP.

31.1 † CEO certification pursuant to Rule 13a-14(a)/15d-14(a).

31.2 † CFO certification pursuant to Rule 13a-14(a)/15d-14(a).

32 † Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.

101 The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2015 and 2014; (ii) the Consolidated Statements of Income for the years ended December 31, 2015, 2014 and 2013; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2015, 2014 and 2013; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2015, 2014, and 2013; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2015, 2014 and 2013; and (vi) Notes to Consolidated Financial Statements.

*Exhibits 10(a) through and including 10(q) and 10(z) through and including 10(ee),10(gg),10(jj) and 10(ii) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2015	2014
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,389	$ 1,211
Investment securities	256	201
Receivable from operating subsidiaries	1,124	873
Other current assets	224	180
Total current assets	2,993	2,465
Property and equipment, net	1,011	885
Investments in subsidiaries	14,276	13,983
Other long-term assets	437	114
Total assets	$ 18,717	$ 17,447
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 3,322	$ 3,130
Current portion of notes payable to operating subsidiaries	28	28
Book overdraft	38	54
Short-term borrowings	299	—
Other current liabilities	572	562
Total current liabilities	4,259	3,774
Long-term debt	3,821	3,825
Notes payable to operating subsidiaries	9	9
Other long-term liabilities	282	193
Total liabilities	8,371	7,801
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,372,059 shares issued at December 31, 2015 and 197,951,551 shares issued at December 31, 2014	33	33
Capital in excess of par value	2,530	2,330
Retained earnings	11,017	9,916
Accumulated other comprehensive income	58	223
Treasury stock, at cost, 50,084,043 shares at December 31, 2015 and 48,347,541 shares at December 31, 2014	(3,292)	(2,856)
Total stockholders' equity	10,346	9,646
Total liabilities and stockholders' equity	$ 18,717	$ 17,447

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2015	2014	2013
		(in millions)	
Revenues:			
Management fees charged to operating subsidiaries	$ 1,469	$ 1,509	$ 1,370
Investment and other income, net	5	4	3
	1,474	1,513	1,373
Expenses:			
Operating costs	1,370	1,434	1,366
Depreciation	252	212	193
Interest	186	192	141
	1,808	1,838	1,700
Loss before gain on sale of business, income taxes and equity in net earnings of subsidiaries	(334)	(325)	(327)
Gain on sale of business	270	—	—
Loss before income taxes and equity in net earnings of subsidiaries	(64)	(325)	(327)
Benefit for income taxes	(70)	(81)	(107)
Income (loss) before equity in net earnings of subsidiaries	6	(244)	(220)
Equity in net earnings of subsidiaries	1,270	1,391	1,451
Net income	$ 1,276	$ 1,147	$ 1,231

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2015	2014	2013
	(in millions)		
Net income	$ 1,276	$ 1,147	$ 1,231
Other comprehensive (loss) income:			
Change in gross unrealized investment gains/losses	(114)	122	(338)
Effect of income taxes	42	(44)	124
Total change in unrealized investment gains/losses, net of tax	(72)	78	(214)
Reclassification adjustment for net realized gains included in investment income	(146)	(20)	(22)
Effect of income taxes	53	7	8
Total reclassification adjustment, net of tax	(93)	(13)	(14)
Other comprehensive (loss) income, net of tax	(165)	65	(228)
Comprehensive income	$ 1,111	$ 1,212	$ 1,003

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2015	2014	2013
		(in millions)	
Net cash provided by operating activities	$ 953	$ 1,499	$ 1,554
Cash flows from investing activities:			
Proceeds from sale of business	1,055	—	—
Acquisitions	—	—	—
Capital contributions to operating subsidiaries	(833)	(442)	(521)
Purchases of investment securities	(507)	(629)	(320)
Proceeds from sale of investment securities	18	606	35
Maturities of investment securities	108	149	104
Purchases of property and equipment, net	(378)	(380)	(223)
Net cash used in investing activities	(537)	(696)	(925)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	—	1,733	—
Proceeds from issuance of commercial paper, net	298	—	—
Repayment of long-term debt	—	(500)	—
Change in book overdraft	(16)	(5)	7
Common stock repurchases	(385)	(872)	(531)
Dividends paid	(172)	(172)	(168)
Tax benefit from stock-based compensation	15	12	8
Proceeds from stock option exercises and other	22	51	65
Net cash (used in) provided by financing activities	(238)	247	(619)
Increase in cash and cash equivalents	178	1,050	10
Cash and cash equivalents at beginning of year	1,211	161	151
Cash and cash equivalents at end of year	$ 1,389	$ 1,211	$ 161

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

Related Party

Refer to Note 2 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of our related party transactions. A related party note receivable in the amount of $284 million is included with other long-term assets in our condensed balance sheet at December 31, 2015 and with purchases of investment securities in our condensed statement of cash flows. The related interest income is included in investment income in our consolidated statement of income.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $493 million in 2015, $927 million in 2014, and $967 million in 2013. Subsidiary dividends in 2015 reflect the impact of losses for our individual commercial medical business compliant with the Health Care Reform Law and the November 5, 2015 revised statutory accounting guidance requiring the exclusion of risk corridor receivables from related statutory surplus discussed in Note 3 below.

Guarantee

Through indemnity agreements approved by state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by our parent company in the event of insolvency for: (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent has also guaranteed the obligations of our military services subsidiaries.

Notes Receivables from Operating Subsidiaries

We funded certain subsidiaries with surplus note agreements. These notes are generally non-interest bearing and may not be entered into or repaid without the prior approval of the applicable Departments of Insurance or other state regulatory authorities.

Notes Payable to Operating Subsidiaries

We borrowed funds from certain subsidiaries with notes generally collateralized by real estate. These notes, which have various payment and maturity terms, bear interest ranging from 1.51% to 6.65% and are payable in 2016 and 2019. We recorded interest expense of $1 million related to these notes for each of the years ended December 31, 2015, 2014 and 2013.

3. REGULATORY REQUIREMENTS

Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $6.6 billion and $6.0 billion as of December 31, 2015 and 2014, respectively, which exceeded aggregate minimum regulatory requirements of $4.6 billion and $4.1 billion, respectively. Subsidiary dividends are subject to state regulatory approval, the amount and timing of which could be reduced or delayed. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2016 is approximately $900 million in the aggregate. This compares to dividends that were paid to our parent company in 2015 of approximately $493 million. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

On November 5, 2015, the National Association of Insurance Commissioners, or NAIC, issued statutory accounting guidance for receivables associated with the risk corridor provisions under the Health Care Reform Law, which requires the receivables to be excluded from subsidiary surplus. This accounting guidance required additional capital contributions into certain subsidiaries during 2015.

Certain regulated subsidiaries recognized premium deficiency reserves for our individual commercial medical policies compliant with the Health Care Reform Law for the 2016 coverage year in the fourth quarter of 2015. Further, the statutory-based premium deficiency excludes the estimated benefit associated with the risk corridor provisions as a reduction in subsidiary surplus in accordance with the previously discussed November 5, 2015 statutory accounting guidance requiring the exclusion of risk corridor amounts from subsidiary surplus. As a result of the statutory-based premium deficiency, we will fund capital contributions into certain regulated subsidiaries of $450 million during the first quarter of 2016.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc. During 2015, 2014 and 2013, we funded certain non-regulated subsidiary acquisitions, including the acquisition of American Eldercare Inc., with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 11 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 15 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2015, 2014, and 2013
(in millions)

	Balance at Beginning of Period	Acquired/ (Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2015	$ 137	$ (39)	$ 61	$ (7)	$ (51)	$ 101
2014	118	—	32	28	(41)	137
2013	94	—	37	18	(31)	118
Deferred tax asset valuation allowance:						
2015	(48)	—	6	—	—	(42)
2014	(28)	—	(20)	—	—	(48)
2013	(28)	—	—	—	—	(28)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE
Brian A. Kane
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

Date: February 18, 2016

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Senior Vice President and Chief Financial Officer (Principal Financial Officer)	February 18, 2016
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)	February 18, 2016
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 18, 2016
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 18, 2016
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 18, 2016
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 18, 2016
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 18, 2016
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 18, 2016
/s/ WILLIAM E. MITCHELL **William E. Mitchell**	Director	February 18, 2016
/s/ DAVID B. NASH, M.D. **David B. Nash, M.D.**	Director	February 18, 2016
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 18, 2016
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 18, 2016

Corporate Headquarters

The Humana Building | 500 West Main Street | Louisville, KY 40202 | 502.580.1000 | Humana.com

More Information About Humana Inc.

Copies of the Company's filings with the Securities and Exchange Commission may be obtained without charge via the Investor Relations page of the Company's Internet site at Humana.com or by writing:

Regina C. Nethery
Enterprise Vice President – Investor Relations Humana Inc.
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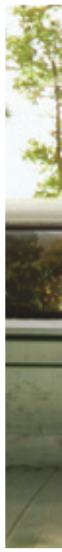

Humana®

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2016 ANNUAL REPORT

Humana®

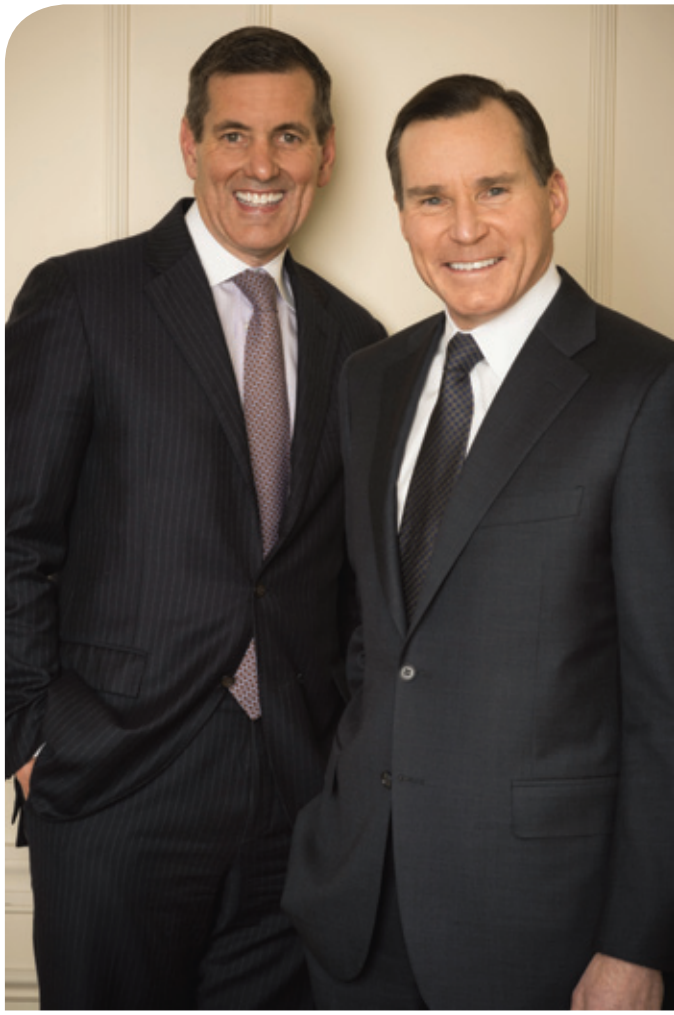
HUMANA INC. FINANCIAL HIGHLIGHTS (dollars in millions, except per common share results)

	2016	2015	2014	2013	2012
OPERATING RESULTS					
Revenues	$54,379	$54,289	$48,500	$41,313	$39,126
Net income	$614	$1,276	$1,147	$1,231	$1,222
Diluted earnings per common share	$4.07	$8.44	$7.36	$7.73	$7.47
FINANCIAL POSITION					
Total assets	$25,396	$24,678	$23,497	$20,719	$19,962
Total liabilities	$14,711	$14,332	$13,851	$11,403	$11,115
Total shareholder equity	$10,685	$10,346	$9,646	$9,316	$8,847
Cash Flows from Operations	$1,936	$868	$1,618	$1,716	$1,923
MEMBERSHIP BY SEGMENT (IN THOUSANDS)					
Retail					
Medical membership	9,406.1	9,226.8	8,376.5	6,459.3	5,956.7
Specialty membership	1,088.1	1,153.1	1,165.8	1,042.5	948.7
Group					
Medical membership	4,793.3	4,963.4	5,430.2	5,501.6	5,573.4
Specialty membership	5,873.1	6,068.7	6,502.7	6,780.8	7,136.2
Other businesses					
Medical membership	30.8	32.6	35.0	23.4	558.7
Consolidated					
Medical membership	14,230.2	14,222.8	13,841.7	11,984.3	12,088.8
Specialty membership	6,961.2	7,221.8	7,668.5	7,823.3	8,084.9

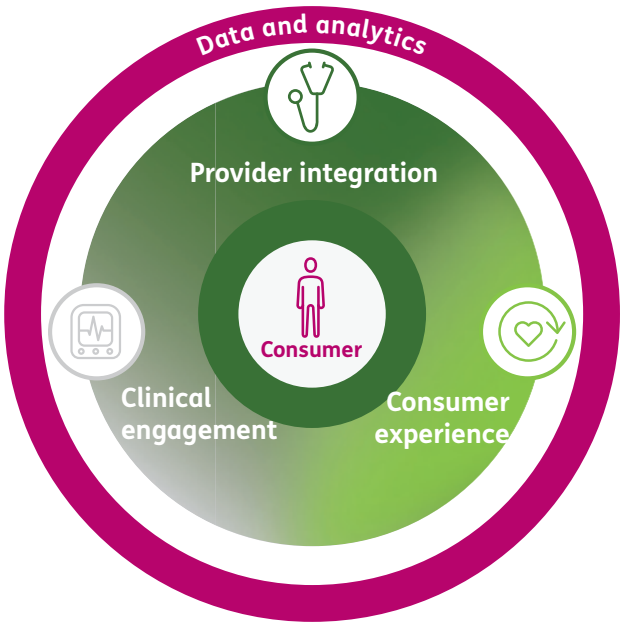
DEAR FELLOW STOCKHOLDERS,

Healthcare is in a dynamic state, and the public is looking to companies like Humana to make health benefits more affordable while improving the overall cost of care and consumer experience. To that end, Humana's innovative strategy continues to capitalize on industry changes to progress toward these goals through our ***integrated care delivery model.***

We understand that healthcare is complicated, and dealing with multiple physicians and other healthcare professionals can be a confusing and daunting task. That is one of the principal reasons why Humana will enhance its integrated care delivery strategy in key areas to enable a better and more seamless locally delivered health care experience for our members.



Bruce Broussard, President and Chief Executive Officer, and Kurt Hilzinger, Chairman of the Board



Our integrated care delivery model

As we have entered 2017, WE ARE PROUD OF OUR ACCOMPLISHMENTS during 2016. Some of our more notable achievements included:

18% GROWTH RATE

in our Adjusted earnings per share, accompanied by cash flows from operations that more than doubled.

Strong growth in our stand-alone PDP membership with the beneficial impact of this **HIGHER GROWTH** realized across the enterprise.

Distinct progress in our trend-bender activities **REDUCING THE COST OF CARE** without sacrificing quality. Metrics of note included:

11% INCREASE

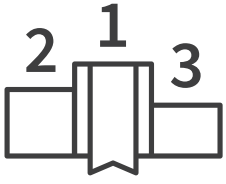
in the number of physicians in value-based arrangements.

7% INCREASE

in the number of high-risk discharges enrolled in the Humana Transitions program.

250 BASIS POINT INCREASE

in Humana Pharmacy Solutions' mail-order penetration.

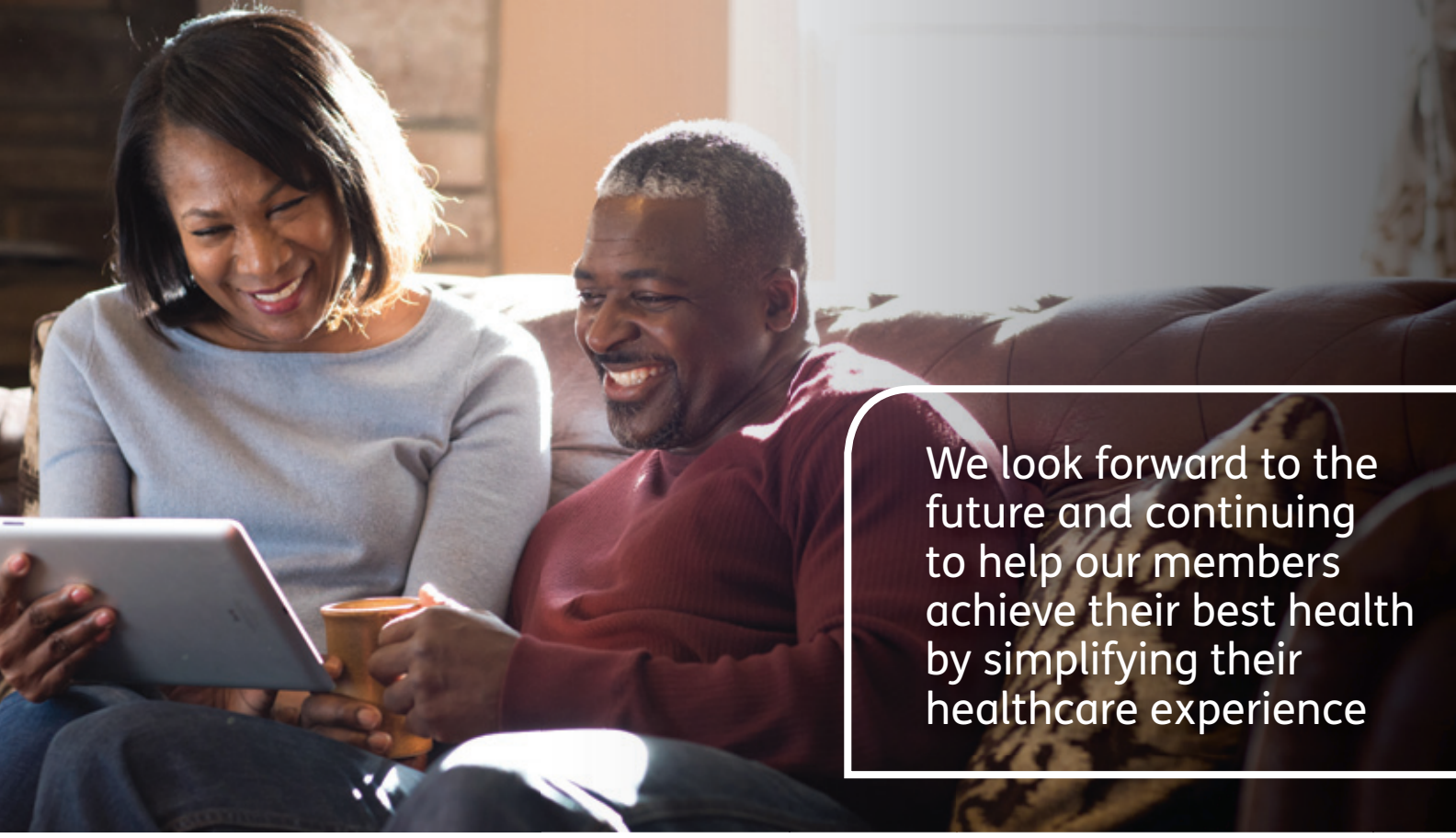


WINNING THE TRICARE East Region contract, a testament to our dedication to serving those in the military and their dependents.

Achieving associate engagement scores in the

90th PERCENTILE

a rarity in the circumstances we have navigated over the past year.

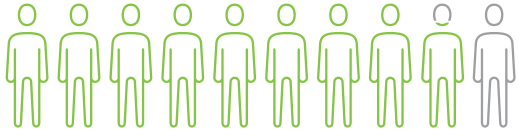


We look forward to the future and continuing to help our members achieve their best health by simplifying their healthcare experience

Our 2016 operating results are strong, particularly given the complex operating environment during the extended transaction process that was terminated by mutual agreement on February 14, 2017.

As we **renew and enhance** as an independent company, we are continuing to build on our integrated care delivery strategy by intensifying our focus on the cohort of people living with chronic conditions—particularly those who are aging into or are already in Medicare Advantage plans. This population is fast-growing, with more than 85 percent of seniors having at least one chronic condition and 65 percent having multiple chronic conditions.[A]

MORE THAN 85 PERCENT
of seniors have at least one chronic condition



65 PERCENT
have multiple chronic conditions

[A]Chronic condition charts 2014, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts.html

Humana is enhancing its integrated care delivery strategy in several key areas to further enable a rich, LOCALLY DELIVERED HEALTHCARE experience for all our members, by doing the following:

Increasing risk-based arrangements through expanding partnerships with physicians, offering sophisticated population health technology and services, and expanding primary care clinics.

Expanding complementary clinical capabilities that assist members outside of doctors' offices and institutions, with a focus on home health services, local pharmacy access and behavioral health.

Integrating technology among healthcare professionals, members and Humana together with advanced analytics to simplify the experience, eliminate "friction points," increase transparency and make access to care more convenient.

We believe by extending and expanding the local capabilities of our Healthcare Services businesses and supporting doctors and other healthcare professionals with unsurpassed population-health tools, we can remove barriers for our members. This will better help them achieve their best health by enabling both members and healthcare professionals easier engagement in more holistic health—engagement that brings together the lifestyle and clinical factors so critical to improving lifelong health and well-being. We expect this will, in turn, continue to drive growth across the enterprise as growth in our health plans furthers growth in our Healthcare Services businesses. We believe this will, in turn, lead to favorable returns for our stockholders.

We will continue our practice of evaluating our portfolio of businesses to ensure focus on those lines of business where our integrated care delivery strategy can add value for health plan members, healthcare professionals and our government program and employer group customers.

Over the past few years, we also have attempted to bring accessible, quality healthcare to individuals in a number of state markets across the U.S. through our Affordable Care Act healthcare exchange offerings and have worked diligently to maintain the viability of the product and continued availability across most parts of the country.

However, due to a persistently unbalanced risk pool in this market driven by programmatic factors, we will not continue to offer this coverage for 2018.

Turning to other elements of our strategy for 2017 and beyond, we have established a thoughtful capital deployment plan to raise our cash dividend and to implement a strategic share repurchase program. These efforts should jump start activities such as these that were frozen while the proposed merger was pending. Additionally, we will focus our mergers and acquisitions efforts on capabilities that enhance the clinical and consumer experience for our members. We believe our strategic, operating and capital deployment plans not only improve the value Humana brings to members and healthcare providers, they also enhance the growth platform for both our health plans and our Healthcare Services businesses, positioning us well for long-term, sustainable growth.

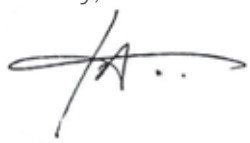
036
119
097

We look forward to the future with confidence, while gratefully acknowledging the enormous contributions to our success over the past quarter-century of Jim Murray, our retiring Executive Vice President and Chief Operating Officer. Jim's exceptional mentoring for many of our leaders, particularly those in segment president roles, has positioned us well for the future as our segment presidents are ready for broader responsibilities within the organization.

Throughout its history, **Humana has been dedicated to improving people's health**, from our start as a nursing home company more than 50 years ago through our transition to a hospital company and today as a health and wellness enterprise.

We look forward to continuing to help our members achieve their best health by simplifying their healthcare experience—one that combines their unique needs with the clinical aspects critical to improving their lifelong health and well-being.

Sincerely,



Kurt J. Hilzinger
Chairman of the Board
Humana Inc.

Bruce D. Broussard
President, Chief Executive Officer and Board member
Humana Inc.

DILUTED EARNINGS PER COMMON SHARE	2016[B]	2015[C]
Generally Accepted Accounting Principles (GAAP)	$4.07	$8.44
Transaction and integration costs associated with then-pending transaction	0.64	0.14
Amortization associated with identifiable intangibles	0.32	0.39
Write-off of risk corridor receivables	2.43	–
Reserve strengthening for the company's non-strategic closed block of long-term care insurance business	2.11	–
Premium deficiency reserve for certain 2016 individual commercial medical policies	–	0.74
Gain related to sale of Concentra Inc.	–	(1.57)
Adjusted (non-GAAP)	$9.57	$8.14

The company has included financial measures herein that are not in accordance with GAAP. Management believes that these measures, when presented in conjunction with the comparable GAAP measures, are useful to both management and its investors in analyzing the company's ongoing business and operating performance. Consequently, management uses these non-GAAP financial measures as indicators of the company's business performance, as well as for operational planning and decision making purposes. Non-GAAP financial measures should be considered in addition to, but not as a substitute for, or superior to, financial measures prepared in accordance with GAAP. All financial measures herein are in accordance with GAAP unless otherwise indicated.

[B] 2016 Adjusted results exclude the following:

- *Pretax transaction and integration costs of $104 million, or $0.64 per diluted common share, associated with the then-pending transaction.*
- *Pretax amortization expense associated with identifiable intangibles of $77 million, or $0.32 per diluted common share.*
- *The pretax write-off of approximately $583 million, or $2.43 per diluted common share, in receivables associated with the risk corridor premium stabilization program for the Affordable Care Act (ACA) healthcare exchanges.*
- *Pretax expenses of $505 million, or $2.11 per diluted common share, of reserve strengthening related to the company's non-strategic closed block of long-term care insurance business.*

[C] 2015 Adjusted results exclude the following:

- *Pretax transaction and integration costs of $23 million, or $0.14 per diluted common share, associated with the then-pending transaction.*
- *Pretax amortization expense associated with identifiable intangibles of $93 million, or $0.39 per diluted common share.*
- *A premium deficiency reserve of $176 million, or $0.74 per diluted common share, related to the company's 2016 ACA-compliant individual commercial medical offerings.*
- *A pretax gain of $270 million, or approximately $1.57 per diluted common share, associated with the completion of the company's sale of its wholly-owned subsidiary, Concentra Inc. on June 1, 2015.*

BOARD OF DIRECTORS

Kurt J. Hilzinger
Chairman of the Board
Humana Inc.
Partner
Court Square Capital Partners, LP

Bruce D. Broussard
President and Chief Executive Officer
Humana Inc.

Frank A. D'Amelio
Executive Vice President,
Business Operations and
Chief Financial Officer
Pfizer, Inc.

W. Roy Dunbar
Former Chairman of the Board
NetworkSolutions

David A. Jones, Jr.
Chairman and Managing Partner
Chrysalis Ventures, LLC

William J. McDonald
Managing Partner
Wild Irishman Advisory, LLC

William E. Mitchell
Managing Partner
Sequel Capital Management, LLC

David B. Nash, M.D.
Founding Dean
Jefferson College of Population Health
Thomas Jefferson University

James J. O'Brien
Former Chairman of the Board and
Chief Executive Officer
Ashland, Inc.

Marissa T. Peterson
President and Chief Executive Officer
Mission Peak Executive Consulting

Standing left to right: David A. Jones, Jr., William J. McDonald, W. Roy Dunbar, William E. Mitchell
Seated left to right: Bruce D. Broussard, James J. O'Brien, Frank A. D'Amelio, Kurt J. Hilzinger, David B. Nash, M.D., Marissa T. Peterson

Humana®

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

☑ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2016
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15 (d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to
Commission file number 1-5975

HUMANA INC.
(Exact name of registrant as specified in its charter)

Delaware	**61-0647538**
(State of incorporation)	**(I.R.S. Employer Identification Number)**
500 West Main Street Louisville, Kentucky	**40202**
(Address of principal executive offices)	**(Zip Code)**

Registrant's telephone number, including area code: (502) 580-1000
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of exchange on which registered**
Common stock, $0.16 2/3 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☑

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☑ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☑

Indicate by checkmark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☑

The aggregate market value of voting stock held by non-affiliates of the Registrant as of June 30, 2016 was $26,887,040,202 calculated using the average price on June 30, 2016 of $180.70.

The number of shares outstanding of the Registrant's Common Stock as of January 31, 2017 was 149,324,101.

DOCUMENTS INCORPORATED BY REFERENCE

Parts II and III incorporate herein by reference portions of the Registrant's Proxy Statement to be filed pursuant to Regulation 14A with respect to the Annual Meeting of Stockholders scheduled to be held on April 20, 2017.

HUMANA INC.
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For the Year Ended December 31, 2016

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Forward-Looking Statements

Some of the statements under "Business," "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere in this report may contain forward-looking statements which reflect our current views with respect to future events and financial performance. These forward-looking statements are made within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, or the Exchange Act. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe harbor provisions. We have based these forward-looking statements on our current expectations and projections about future events, trends and uncertainties. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions, including the information discussed under the section entitled "Risk Factors" in this report. In making these statements, we are not undertaking to address or update them in future filings or communications regarding our business or results. Our business is highly complicated, regulated and competitive with many different factors affecting results.

PART I

ITEM 1. BUSINESS

General

Headquartered in Louisville, Kentucky, Humana Inc. and its subsidiaries, referred to throughout this document as "we," "us," "our," the "Company" or "Humana," is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. As of December 31, 2016, we had approximately 14.2 million members in our medical benefit plans, as well as approximately 7.0 million members in our specialty products. During 2016, 75% of our total premiums and services revenue were derived from contracts with the federal government, including 14% derived from our individual Medicare Advantage contracts in Florida with the Centers for Medicare and Medicaid Services, or CMS, under which we provide health insurance coverage to approximately 598,100 members as of December 31, 2016.

Humana Inc. was organized as a Delaware corporation in 1964. Our principal executive offices are located at 500 West Main Street, Louisville, Kentucky 40202, the telephone number at that address is (502) 580-1000, and our website address is www.humana.com. We have made available free of charge through the Investor Relations section of our web site our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the Securities and Exchange Commission.

This Annual Report on Form 10-K, or 2016 Form 10-K, contains both historical and forward-looking information. See Item 1A. – Risk Factors in this 2016 Form 10-K for a description of a number of factors that may adversely affect our results or business.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger.

The Merger was subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, and (ii) the absence of legal restraints and prohibitions on the consummation of the Merger.

On December 22, 2016, in order to extend the "End Date" (as defined in the Merger Agreement), Aetna and Humana each agreed to waive until 11:59 p.m. (Eastern time) on February 15, 2017 its right to terminate the Merger Agreement due to a failure of the Mergers to have been completed on or before December 31, 2016.

On July 21, 2016, the U.S. Department of Justice and the attorneys general of certain U.S. jurisdictions filed a civil antitrust complaint in the U.S. District Court for the District of Columbia against us and Aetna, alleging that the Merger would violate Section 7 of the Clayton Antitrust Act and seeking a permanent injunction to prevent the Merger from being completed. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders.Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year industry wide commercial reinsurance fee. The Health Care Reform Law is discussed more fully in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Health Care Reform" in this 2016 Form 10-K.

If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

Business Segments

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

Our Products

Our medical and specialty insurance products allow members to access health care services primarily through our networks of health care providers with whom we have contracted. These products may vary in the degree to which members have coverage. Health maintenance organizations, or HMOs, generally require a referral from the member's primary care provider before seeing certain specialty physicians. Preferred provider organizations, or PPOs, provide members the freedom to choose a health care provider without requiring a referral. However PPOs generally require the member to pay a greater portion of the provider's fee in the event the member chooses not to use a provider participating in the PPO's network. Point of Service, or POS, plans combine the advantages of HMO plans with the

flexibility of PPO plans. In general, POS plans allow members to choose, at the time medical services are needed, to seek care from a provider within the plan's network or outside the network. In addition, we offer services to our health plan members as well as to third parties that promote health and wellness, including pharmacy solutions, provider, home based, and clinical programs, as well as services and capabilities to advance population health. At the core of our strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Three core elements of the model are to improve the consumer experience by simplifying the interaction with us, engaging members in clinical programs, and offering assistance to providers in transitioning from a fee-for-service to a value-based arrangement. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. The discussion that follows describes the products offered by each of our segments.

Our Retail Segment Products

This segment is comprised of products sold on a retail basis to individuals including medical and supplemental benefit plans described in the discussion that follows. The following table presents our premiums and services revenue for the Retail segment by product for the year ended December 31, 2016:

	Retail Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Premiums:		
Individual Medicare Advantage	$ 31,863	59.0%
Group Medicare Advantage	4,283	8.0%
Medicare stand-alone PDP	4,009	7.4%
Total Medicare	40,155	74.4%
Individual commercial	3,492	6.4%
State-based Medicaid	2,640	4.9%
Individual specialty	259	0.5%
Total premiums	46,546	86.2%
Services	8	—%
Total premiums and services revenue	$ 46,554	86.2%

Medicare

We have participated in the Medicare program for private health plans for over 30 years and have established a national presence, offering at least one type of Medicare plan in all 50 states. We have a geographically diverse membership base that we believe provides us with greater ability to expand our network of PPO and HMO providers. We employ strategies including health assessments and clinical guidance programs such as lifestyle and fitness programs for seniors to guide Medicare beneficiaries in making cost-effective decisions with respect to their health care. We believe these strategies result in cost savings that occur from making positive behavior changes.

Medicare is a federal program that provides persons age 65 and over and some disabled persons under the age of 65 certain hospital and medical insurance benefits. CMS, an agency of the United States Department of Health and Human Services, administers the Medicare program. Hospitalization benefits are provided under Part A, without the payment of any premium, for up to 90 days per incident of illness plus a lifetime reserve aggregating 60 days. Eligible beneficiaries are required to pay an annually adjusted premium to the federal government to be eligible for physician care and other services under Part B. Beneficiaries eligible for Part A and Part B coverage under traditional fee-for-service Medicare are still required to pay out-of-pocket deductibles and coinsurance. Throughout this document this program is referred to as Medicare FFS. As an alternative to Medicare FFS, in geographic areas where a managed care organization has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a Medicare Advantage organization under Medicare Part C. Pursuant to Medicare Part

C, Medicare Advantage organizations contract with CMS to offer Medicare Advantage plans to provide benefits at least comparable to those offered under Medicare FFS. Our Medicare Advantage, or MA, plans are discussed more fully below. Prescription drug benefits are provided under Part D.

Individual Medicare Advantage Products

We contract with CMS under the Medicare Advantage program to provide a comprehensive array of health insurance benefits, including wellness programs, chronic care management, and care coordination, to Medicare eligible persons under HMO, PPO, and Private Fee-For-Service, or PFFS, plans in exchange for contractual payments received from CMS, usually a fixed payment per member per month. With each of these products, the beneficiary receives benefits in excess of Medicare FFS, typically including reduced cost sharing, enhanced prescription drug benefits, care coordination, data analysis techniques to help identify member needs, complex case management, tools to guide members in their health care decisions, care management programs, wellness and prevention programs and, in some instances, a reduced monthly Part B premium. Most Medicare Advantage plans offer the prescription drug benefit under Part D as part of the basic plan, subject to cost sharing and other limitations. Accordingly, all of the provisions of the Medicare Part D program described in connection with our stand-alone prescription drug plans in the following section also are applicable to most of our Medicare Advantage plans. Medicare Advantage plans may charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1.

Our Medicare HMO and PPO plans, which cover Medicare-eligible individuals residing in certain counties, may eliminate or reduce coinsurance or the level of deductibles on many other medical services while seeking care from participating in-network providers or in emergency situations. Except in emergency situations or as specified by the plan, most HMO plans provide no out-of-network benefits. PPO plans carry an out-of network benefit that is subject to higher member cost-sharing. In some cases, these beneficiaries are required to pay a monthly premium to the HMO or PPO plan in addition to the monthly Part B premium they are required to pay the Medicare program.

Most of our Medicare PFFS plans are network-based products with in and out of network benefits due to a requirement that Medicare Advantage organizations establish adequate provider networks, except in geographic areas that CMS determines have fewer than two network-based Medicare Advantage plans. In these areas, we offer Medicare PFFS plans that have no preferred network. Individuals in these plans pay us a monthly premium to receive typical Medicare Advantage benefits along with the freedom to choose any health care provider that accepts individuals at rates equivalent to Medicare FFS payment rates.

CMS uses monthly rates per person for each county to determine the fixed monthly payments per member to pay to health benefit plans. These rates are adjusted under CMS's risk-adjustment model which uses health status indicators, or risk scores, to improve the accuracy of payment. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997 (BBA) and the Benefits and Improvement Protection Act of 2000 (BIPA), generally pays more for members with predictably higher costs and uses principal hospital inpatient diagnoses as well as diagnosis data from ambulatory treatment settings (hospital outpatient department and physician visits) to establish the risk-adjustment payments. Under the risk-adjustment methodology, all health benefit organizations must collect from providers and submit the necessary diagnosis code information to CMS within prescribed deadlines. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnosis data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit those claims that pass the filtering logic. For submissions through EDS, CMS requires MA plans to submit all the claims data and CMS will apply the risk adjustment filtering logic to determine the risk adjustment data used to calculate risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017.

At December 31, 2016, we provided health insurance coverage under CMS contracts to approximately 2,837,600 individual Medicare Advantage members, including approximately 598,100 members in Florida. These Florida contracts accounted for premiums revenue of approximately $7.7 billion, which represented approximately 24.2% of our individual Medicare Advantage premiums revenue, or 14.0% of our consolidated premiums and services revenue for the year ended December 31, 2016.

Our HMO, PPO, and PFFS products covered under Medicare Advantage contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare Advantage products have been renewed for 2017, and all of our product offerings filed with CMS for 2017 have been approved.

Individual Medicare Stand-Alone Prescription Drug Products

We offer stand-alone prescription drug plans, or PDPs, under Medicare Part D, including a PDP offering co-branded with Wal-Mart Stores, Inc., or the Humana-Walmart plan. Generally, Medicare-eligible individuals enroll in one of our plan choices between October 15 and December 7 for coverage that begins on the following January 1. Our stand-alone PDP offerings consist of plans offering basic coverage with benefits mandated by Congress, as well as plans providing enhanced coverage with varying degrees of out-of-pocket costs for premiums, deductibles, and co-insurance. Our revenues from CMS and the beneficiary are determined from our PDP bids submitted annually to CMS. These revenues also reflect the health status of the beneficiary and risk sharing provisions as more fully described in Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations under the section titled "Medicare Part D Provisions." Our stand-alone PDP contracts with CMS are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare stand-alone PDP products have been renewed for 2017, and all of our product offerings filed with CMS for 2017 have been approved.

We have administered CMS's Limited Income Newly Eligible Transition, or LI-NET, prescription drug plan program since 2010. This program allows individuals who receive Medicare's low-income subsidy to also receive immediate prescription drug coverage at the point of sale if they are not already enrolled in a Medicare Part D plan. CMS temporarily enrolls newly identified individuals with both Medicare and Medicaid into the LI-NET prescription drug plan program, and subsequently transitions each member into a Medicare Part D plan that may or may not be a Humana Medicare plan.

Group Medicare Advantage and Medicare stand-alone PDP

We offer products that enable employers that provide post-retirement health care benefits to replace Medicare wrap or Medicare supplement products with Medicare Advantage or stand-alone PDPs from Humana. These products offer the same types of benefits and services available to members in our individual Medicare plans discussed previously and can be tailored to closely match an employer's post-retirement benefit structure.

State-based Medicaid Contracts

Our state-based contracts allow us to serve members enrolled in state-based Medicaid programs including Temporary Assistance to Needy Families, or TANF, Long-Term Support Services, or LTSS, and dual eligible demonstration programs. TANF is a state and federally funded program that provides cash assistance and supportive services to assist families with children under age 18, helping them achieve economic self-sufficiency. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term support services for our members who receive home and community or institution-based services for long-term care. Our contracts are generally for three to five year terms.

Medicare beneficiaries who also qualify for Medicaid due to low income or special needs are known as dual eligible beneficiaries, or dual eligibles. The dual eligible population represents a disproportionate share of Medicaid and Medicare costs. There were approximately 10.4 million dual eligible individuals in the United States in 2016, trending upward due to Medicaid eligibility expansions and individuals aging into the Medicare program. Since the enactment of the Health Care Reform Law, states are pursuing stand-alone dual eligible CMS demonstration programs in which Medicare, Medicaid, and LTSS benefits are more tightly integrated. Eligibility for participation in these stand-alone dual eligible demonstration programs may require state-based contractual relationships in existing Medicaid programs.

We have contracts to serve Medicaid eligible members in Florida under the TANF and LTSS programs. Our contracts in Virginia and Illinois serve members under each state's stand-alone dual eligible demonstration program. In addition, in Illinois we have an Integrated Care Program, or ICP, Medicaid contract. Our Kentucky Medicaid contract is subject to a 100% coinsurance contract with CareSource Management Group Company, ceding all the risk to CareSource.

In addition to the dual eligible members we serve under the Virginia and Illinois demonstration program, we serve other dual eligible members enrolled in our Medicare Advantage and stand-alone prescription drug plans. As of December 31, 2016, we served approximately 486,000 dual eligible members in our Medicare Advantage plans and approximately 1,179,000 dual eligible members in our stand-alone prescription drug plans.

Individual Commercial Coverage

Our individual health plans are marketed under the HumanaOne brand. We offer products both on and off of the public exchange. We offer products on exchanges where we can achieve an affordable cost of care, including HMO offerings and select networks in most markets. Our off-exchange products are primarily PPO and POS offerings, including plans issued prior to 2014 that were previously underwritten. For 2017, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017. Policies issued prior to the enactment of the Health Care Reform Law on March 23, 2010 are grandfathered policies. Grandfathered policies are exempt from most of the requirements of the Health Care Reform Law, including mandated benefits. However, our grandfathered plans include provisions that guarantee renewal of coverage for as long as the plan is continued and the individual chooses to renew. Policies issued between March 23, 2010 and December 31, 2013 are required to conform to the Health Care Reform Law, including mandated benefits, upon renewal at various transition dates between 2016 and 2017 depending on the state.

On February 14, 2017, we announced we are exiting our individual commercial medical businesses January 1, 2018 as more fully described in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Rewards-based wellness programs are included with many individual products. We also offer optional benefits such as dental, vision, life, and a portfolio of financial protection products.

Group Segment Products

This segment is comprised of products sold to employer groups including medical and supplemental benefit plans as well as health and wellness products as described in the discussion that follows. The following table presents our premiums and services revenue for the Group segment by product for the year ended December 31, 2016:

	Group Segment Premiums and Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
External Revenue:		
Premiums:		
Fully-insured commercial group	$ 5,405	10.0%
Group specialty	1,020	1.9%
Military services	12	—%
Total premiums	6,437	11.9%
Services	694	1.3%
Total premiums and services revenue	$ 7,131	13.2%
Intersegment services revenue:		
Wellness	$ 99	n/a
Total intersegment services revenue	$ 99	

n/a – not applicable

Group Commercial Coverage

Our commercial products sold to employer groups include a broad spectrum of major medical benefits with multiple in-network coinsurance levels and annual deductible choices that employers of all sizes can offer to their employees on either a fully-insured, through HMO, PPO, or POS plans, or self-funded basis. Our plans integrate clinical programs, plan designs, communication tools, and spending accounts. We participate in the Federal Employee Health Benefits Program, or FEHBP, primarily with our HMO offering in certain markets. FEHBP is the government's health insurance program for Federal employees, retirees, former employees, family members, and spouses. As with our individual commercial products, the employer group offerings include Go365™, our wellness and loyalty reward program.

Our administrative services only, or ASO, products are offered to employers who self-insure their employee health plans. We receive fees to provide administrative services which generally include the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded employers. These products may include all of the same benefit and product design characteristics of our fully-insured HMO, PPO, or POS products described previously. Under ASO contracts, self-funded employers generally retain the risk of financing substantially all of the cost of health benefits. However, more than half of our ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs.

As with individual commercial policies, employers can customize their offerings with optional benefits such as dental, vision, life, and a portfolio of voluntary benefit products.

Military Services

Under our TRICARE South Region contract with the United States Department of Defense, or DoD, we provide administrative services to arrange health care services for the dependents of active duty military personnel and for retired military personnel and their dependents. We have participated in the TRICARE program since 1996 under contracts with the DoD. On April 1, 2012, we began delivering services under our current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. Under the current contract, we provide administrative services while the federal government

retains all of the risk of the cost of health benefits. Accordingly, we account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement.

Wellness

We offer wellness solutions including our Go365 wellness and loyalty rewards program, health coaching, employee assistance program, and clinical programs. These programs, when offered collectively to employer customers as our Total Health product, turn any standard plan of the employer's choosing into an integrated health and well-being solution that encourages participation in these programs.

Our Go365 program provides our members with access to a science-based, actuarially driven wellness and loyalty program that features a wide range of well-being tools and rewards that are customized to an individual's needs and wants. A key element of the program includes a sophisticated health-behavior-change model supported by an incentive program.

We also provide employee assistance programs and coaching services including a comprehensive turn-key coaching program, an enhancement to a medically based coaching protocol and a platform that makes coaching programs more efficient.

Our Healthcare Services Segment Products

The products offered by our Healthcare Services segment are key to our integrated care delivery model. This segment is comprised of stand-alone businesses that offer services including pharmacy solutions, provider services, home based services, clinical programs, and predictive modeling and informatics services to other Humana businesses, as well as external health plan members, external health plans, and other employers or individuals and are described in the discussion that follows. Our intersegment revenue is described in Note 17 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The following table presents our services revenue for the Healthcare Services segment by line of business for the year ended December 31, 2016:

	Healthcare Services Segment Services Revenue	Percent of Consolidated Premiums and Services Revenue
	(dollars in millions)	
Intersegment revenue:		
Pharmacy solutions	$ 21,952	n/a
Provider services	1,677	n/a
Home based services	1,026	n/a
Clinical programs	180	n/a
Total intersegment revenue	$ 24,835	
External services revenue:		
Pharmacy solutions	$ 31	0.1%
Provider services	78	0.1%
Home based services	148	0.3%
Total external services revenue	$ 257	0.5%

n/a – not applicable

Pharmacy solutions

Humana Pharmacy Solutions®, or HPS, manages traditional prescription drug coverage for both individuals and employer groups in addition to providing a broad array of pharmacy solutions. HPS also operates prescription mail order services for brand, generic, and specialty drugs and diabetic supplies through Humana Pharmacy, Inc., as well as research services.

Provider services

We operate full-service, multi-specialty medical centers, primarily in Florida, staffed by primary care providers and medical specialists practicing cardiology, endocrinology, geriatric medicine, internal medicine, ophthalmology, neurology, and podiatry.

We also operate Transcend, a Medical Services Organization, or MSO, that coordinates medical care for Medicare Advantage beneficiaries primarily in four states. Transcend provides resources in care coordination, financial risk management, clinical integration and patient engagement that help physicians improve the patient experience as well as care outcomes. Transcend collaborates with physicians, medical groups and integrated delivery systems to successfully transition to value-based care by engaging, partnering and offering practical services and solutions. Transcend represents a key component of our integrated care delivery model which we believe is scalable to new markets. In addition, we own a noncontrolling equity interest in MCCI Holdings, LLC, a privately held MSO headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida, Texas and Georgia.

Programs to enhance the quality of care for members are key elements of our integrated care delivery model. We believe that technology represents a significant opportunity in health care that positively impacts our members. Our Transcend Insights business focuses on population health and wellness capabilities across the sector and serves health care systems, physicians and care teams by leveraging actionable data to help improve patient care. We help care teams and patients transition from a reactive approach to care to one that proactively promotes health and long-term wellness. We have enhanced our health information technology capabilities enabling us to create a more complete view of an individual's health, designed to connect, coordinate and simplify health care while reducing costs. These capabilities include our health care analytics engine, which reviews billions of clinical data points on millions of patients each day to provide members, providers, and payers real-time clinical insights to identify evidence-based gaps-in-care, drug safety alerts and other critical health concerns to improve outcomes. Additionally, our technology connects Humana and disparate electronic health record systems to enable the exchange of essential health information in real-time to provide physicians and care teams with a single, comprehensive patient view.

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, that delivered occupational medicine, urgent care, physical therapy, and wellness services to employees and the general public through its operation of medical centers and worksite medical facilities. See Note 3 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data.

Home based services

Via in-home care, telephonic health counseling/coaching, and remote monitoring, we are actively involved in the care management of our customers with the greatest needs. Home based services include the operations of Humana At Home, Inc., or Humana At Home®. As a chronic-care provider of in-home care for seniors, we provide innovative and holistic care coordination services for individuals living with multiple chronic conditions, individuals with disabilities, fragile and aging-in-place members and their care givers. We focus our deployment of these services in geographies, such as Florida, with a high concentration of members living with multiple chronic conditions. The clinical support and care provided by Humana At Home is designed to improve health outcomes and result in a higher number of days members can spend at their homes instead of in an acute care facility. To that end, we have accelerated our process for identifying and reaching out to members in need of clinical intervention. At December 31, 2016, we enrolled approximately 622,300 members with complex chronic conditions in the Humana Chronic Care Program, a 5.4% increase compared with approximately 590,300 members at December 31, 2015, reflecting enhanced predictive modeling capabilities and focus on proactive clinical outreach and member engagement, particularly for our Medicare Advantage membership. We believe these initiatives lead to better health outcomes for our members and lower health care costs.

Clinical programs

We are committed to the integrated physical and mental health of our members. Accordingly, we take a holistic approach to healthcare, offering care management, behavioral health services and wellness programs.

Our care management programs take full advantage of the population health, wellness and clinical applications offered by Transcend Insights and CareHub, our clinical management tool used by providers and care managers across the company to help our members achieve their best health, to offer various levels of support, matching the intensity of the support to the needs of members with ongoing health challenges through telephonic and onsite programs. These programs include Personal Nurse, chronic condition management, and case management as well as programs supporting maternity, cancer, neonatal intensive care unit, and transplant services.

In addition, we focus on the behavioral aspects of a members' health such as managing stress and work/life balance. Humana Behavioral Health takes a holistic, mind-and-body approach to behavioral healthcare to address the whole person, encouraging faster recovery and improving clinical outcomes while reducing costs for both the member and employer.

Other Businesses

Other Businesses primarily includes our closed block of long-term care insurance policies described below. Total premiums and services revenue for our Other Businesses was $48 million, or 0.1% of consolidated premiums and services revenue for the year ended December 31, 2016.

We have a non-strategic closed block of approximately 30,800 long-term care insurance policies associated with our acquisition of KMG America Corporation in 2007. Long-term care insurance policies are intended to protect the insured from the cost of long-term care services including those provided by nursing homes, assisted living facilities, and adult day care as well as home health care services. No new policies have been written since 2005 under this closed block.

Membership

The following table summarizes our total medical membership at December 31, 2016, by market and product:

	Retail Segment						Group Segment					
	(in thousands)											
	Individual Medicare Advantage	Group Medicare Advantage	Medicare stand-alone PDP	Individual Commercial	Medicare Supplement	State-based contracts	Fully-insured commercial Group	ASO	Military services	Other Businesses	Total	Percent of Total
Florida	598.1	16.0	345.0	194.4	6.7	365.9	140.2	50.7	—	—	1,717.0	12.1%
Texas	222.5	69.9	309.7	101.4	7.5	—	203.1	24.6	—	—	938.7	6.6%
Kentucky	76.3	58.2	206.5	10.1	5.4	—	107.7	170.1	—	—	634.3	4.5%
Georgia	115.8	2.5	130.2	163.7	9.9	—	158.1	20.8	—	—	601.0	4.2%
California	70.0	0.1	444.3	—	15.7	—	—	—	—	—	530.1	3.7%
Ohio	118.2	16.3	181.8	5.8	48.5	—	51.0	69.1	—	—	490.7	3.4%
Illinois	87.8	21.3	174.7	5.4	4.4	11.5	72.8	89.9	—	—	467.8	3.3%
Missouri/Kansas	90.7	4.3	213.2	16.4	8.1	—	54.9	10.8	—	—	398.4	2.8%
North Carolina	146.4	39.5	178.3	2.6	4.7	—	—	—	—	—	371.5	2.6%
Tennessee	144.9	3.7	108.6	27.9	4.0	—	46.7	29.4	—	—	365.2	2.6%
Louisiana	155.9	11.5	58.2	29.2	1.6	—	68.6	32.9	—	—	357.9	2.5%
Wisconsin	63.2	10.6	113.0	5.9	5.0	—	89.0	37.2	—	—	323.9	2.3%
Virginia	112.3	6.1	140.3	1.4	7.9	10.7	—	—	—	—	278.7	2.0%
Indiana	93.1	3.7	133.3	2.1	7.5	—	22.8	14.2	—	—	276.7	1.9%
Michigan	47.4	14.0	147.6	27.2	2.9	—	5.3	0.5	—	—	244.9	1.7%
Pennsylvania	40.3	0.9	157.4	—	4.6	—	—	—	—	—	203.2	1.4%
South Carolina	95.0	0.8	86.0	0.2	4.7	—	—	—	—	—	186.7	1.3%
Military services	—	—	—	—	—	—	—	—	3,084.1	—	3,084.1	21.7%
Others	559.7	76.0	1,823.3	61.1	69.7	—	115.8	23.0	—	30.8	2,759.4	19.4%
Totals	2,837.6	355.4	4,951.4	654.8	218.8	388.1	1,136.0	573.2	3,084.1	30.8	14,230.2	100.0%

Provider Arrangements

We provide our members with access to health care services through our networks of health care providers whom we employ or with whom we have contracted, including hospitals and other independent facilities such as outpatient surgery centers, primary care providers, specialist physicians, dentists, and providers of ancillary health care services and facilities. These ancillary services and facilities include laboratories, ambulance services, medical equipment services, home health agencies, mental health providers, rehabilitation facilities, nursing homes, optical services, and pharmacies. Our membership base and the ability to influence where our members seek care generally enable us to obtain contractual discounts with providers.

We use a variety of techniques to provide access to effective and efficient use of health care services for our members. These techniques include the coordination of care for our members, product and benefit designs, hospital inpatient management systems, the use of sophisticated analytics, and enrolling members into various care management programs. The focal point for health care services in many of our HMO networks is the primary care provider who, under contract with us, provides services to our members, and may control utilization of appropriate services by directing or approving hospitalization and referrals to specialists and other providers. Some physicians may have arrangements under which they can earn bonuses when certain target goals relating to the provision of quality patient care are met. We have available care management programs related to complex chronic conditions such as congestive heart failure and coronary artery disease. We also have programs for prenatal and premature infant care, asthma related illness, end stage renal disease, diabetes, cancer, and certain other conditions.

We typically contract with hospitals on either (1) a per diem rate, which is an all-inclusive rate per day, (2) a case rate or diagnosis-related groups (DRG), which is an all-inclusive rate per admission, or (3) a discounted charge for inpatient hospital services. Outpatient hospital services generally are contracted at a flat rate by type of service, ambulatory payment classifications, or APCs, or at a discounted charge. APCs are similar to flat rates except multiple services and procedures may be aggregated into one fixed payment. These contracts are often multi-year agreements, with rates that are adjusted for inflation annually based on the consumer price index, other nationally recognized inflation indexes, or specific negotiations with the provider. Outpatient surgery centers and other ancillary providers typically are contracted at flat rates per service provided or are reimbursed based upon a nationally recognized fee schedule such as the Medicare allowable fee schedule.

Our contracts with physicians typically are renewed automatically each year, unless either party gives written notice, generally ranging from 90 to 120 days, to the other party of its intent to terminate the arrangement. Most of the physicians in our PPO networks and some of our physicians in our HMO networks are reimbursed based upon a fixed fee schedule, which typically provides for reimbursement based upon a percentage of the standard Medicare allowable fee schedule.

The terms of our contracts with hospitals and physicians may also vary between Medicare and commercial business. A significant portion of our Medicare network contracts, including those with both hospitals and physicians, are tied to Medicare reimbursement levels and methodologies.

Automatic reductions to the federal budget, known as sequestration, took effect on April 1, 2013, including aggregate reductions to Medicare payments to providers of up to 2% per fiscal year. Due to the uncertainty around the application of these reductions, there can be no assurances that we can completely offset any reductions to the Medicare healthcare programs.

Capitation

We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. For some of our medical membership, we share risk with providers under capitation contracts where physicians and hospitals accept varying levels of financial risk for a defined set of membership, primarily HMO membership. Under the typical capitation arrangement, we prepay these providers a monthly fixed-fee per member, known as a capitation (per capita) payment, to cover all or a defined portion of the benefits provided to the capitated member.

We believe these risk-based models represent a key element of our integrated care delivery model at the core of our strategy. Our health plan subsidiaries may enter into these risk-based contracts with third party providers or our owned provider subsidiaries.

At December 31, 2016, approximately 1,193,400 members, or 8.4% of our medical membership, were covered under risk-based contracts, including 921,000 individual Medicare Advantage members, or 32.5% of our total individual Medicare Advantage membership.

Physicians under capitation arrangements typically have stop loss coverage so that a physician's financial risk for any single member is limited to a maximum amount on an annual basis. We typically process all claims and monitor the financial performance and solvency of our capitated providers. However, we delegated claim processing functions under capitation arrangements covering approximately 191,300 HMO members, including 170,500 individual Medicare Advantage members, or 18.5% of the 921,000 individual Medicare Advantage members covered under risk-based contracts at December 31, 2016, with the provider assuming substantially all the risk of coordinating the members' health care benefits. Capitation expense under delegated arrangements for which we have a limited view of the underlying claims experience was approximately $1.3 billion, or 2.9% of total benefits expense, for the year ended December 31, 2016. We remain financially responsible for health care services to our members in the event our providers fail to provide such services.

Accreditation Assessment

Our accreditation assessment program consists of several internal programs, including those that credential providers and those designed to meet the audit standards of federal and state agencies as well as external accreditation standards. We also offer quality and outcome measurement and improvement programs such as the Health Care Effectiveness Data and Information Sets, or HEDIS, which is used by employers, government purchasers and the National Committee for Quality Assurance, or NCQA, to evaluate health plans based on various criteria, including effectiveness of care and member satisfaction.

Providers participating in our networks must satisfy specific criteria, including licensing, patient access, office standards, after-hours coverage, and other factors. Most participating hospitals also meet accreditation criteria established by CMS and/or the Joint Commission on Accreditation of Healthcare Organizations.

Recredentialing of participating providers occurs every two to three years, depending on applicable state laws. Recredentialing of participating providers includes verification of their medical licenses, review of their malpractice liability claims histories, review of their board certifications, if applicable, and review of applicable quality information. A committee, composed of a peer group of providers, reviews the applications of providers being considered for credentialing and recredentialing.

We request accreditation for certain of our health plans and/or departments from NCQA, the Accreditation Association for Ambulatory Health Care, and URAC. Accreditation or external review by an approved organization is mandatory in the states of Florida and Kansas for licensure as an HMO. Additionally, all products sold on the federal and state marketplaces are required to be accredited. Certain commercial businesses, like those impacted by a third-party labor agreement or those where a request is made by the employer, may require or prefer accredited health plans.

NCQA reviews our compliance based on standards for quality improvement, credentialing, utilization management, member connections, and member rights and responsibilities. We have achieved and maintained NCQA accreditation in most of our commercial, Medicare and Medicaid HMO/POS markets with enough history and membership, and for many of our PPO markets.

Sales and Marketing

We use various methods to market our products, including television, radio, the Internet, telemarketing, and direct mailings.

At December 31, 2016, we employed approximately 1,500 sales representatives, as well as approximately 1,300 telemarketing representatives who assisted in the marketing of Medicare and individual commercial health insurance

and specialty products in our Retail segment, including making appointments for sales representatives with prospective members. We have a marketing arrangement with Wal-Mart Stores, Inc., or Wal-Mart, for our individual Medicare stand-alone PDP offering. We also sell group Medicare Advantage products through large employers. In addition, we market our Medicare and individual commercial health insurance and specialty products through licensed independent brokers and agents. For our Medicare products, commissions paid to employed sales representatives and independent brokers and agents are based on a per unit commission structure, regulated in structure and amount by CMS. For our individual commercial health insurance and specialty products, we generally pay brokers a commission based on premiums, with commissions varying by market and premium volume. In addition to a commission based directly on premium volume for sales to particular customers, we also have programs that pay brokers and agents based on other metrics. These include commission bonuses based on sales that attain certain levels or involve particular products. We also pay additional commissions based on aggregate volumes of sales involving multiple customers.

In our Group segment, individuals may become members of our commercial HMOs and PPOs through their employers or other groups, which typically offer employees or members a selection of health insurance products, pay for all or part of the premiums, and make payroll deductions for any premiums payable by the employees. We attempt to become an employer's or group's exclusive source of health insurance benefits by offering a variety of HMO, PPO, and specialty products that provide cost-effective quality health care coverage consistent with the needs and expectations of their employees or members. In addition, we have begun to offer plans to employer groups through private exchanges. Employers can give their employees a set amount of money and then direct them to a private exchange where employees can shop for a health plan and other benefits based on what the employer has selected as options. We use licensed independent brokers, independent agents, and employees to sell our group products. Many of our larger employer group customers are represented by insurance brokers and consultants who assist these groups in the design and purchase of health care products. We pay brokers and agents using the same commission structure described above for our individual commercial health insurance and specialty products.

Underwriting

Since 2014, the Health Care Reform Law requires all individual and certain group health plans to guarantee issuance and renew coverage without pre-existing condition exclusions or health-status rating adjustments. Accordingly, newly issued individual and certain group health plans are not subject to underwriting. Further, underwriting techniques are not employed in connection with our Medicare, military services, or Medicaid products because government regulations require us to accept all eligible applicants regardless of their health or prior medical history.

Competition

The health benefits industry is highly competitive. Our competitors vary by local market and include other managed care companies, national insurance companies, and other HMOs and PPOs. Many of our competitors have a larger membership base and/or greater financial resources than our health plans in the markets in which we compete. Our ability to sell our products and to retain customers may be influenced by such factors as those described in Item 1A. – Risk Factors in this 2016 Form 10-K.

Government Regulation

Diverse legislative and regulatory initiatives at both the federal and state levels continue to affect aspects of the nation's health care system.

Our management works proactively to ensure compliance with all governmental laws and regulations affecting our business. We are unable to predict how existing federal or state laws and regulations may be changed or interpreted, what additional laws or regulations affecting our businesses may be enacted or proposed, when and which of the proposed laws will be adopted or what effect any such new laws and regulations will have on our results of operations, financial position, or cash flows.

For a description of certain material current activities in the federal and state legislative areas, see Item 1A. – Risk Factors in this 2016 Form 10-K.

Certain Other Services

Captive Insurance Company

We bear general business risks associated with operating our Company such as professional and general liability, employee workers' compensation, and officer and director errors and omissions risks. Professional and general liability risks may include, for example, medical malpractice claims and disputes with members regarding benefit coverage. We retain certain of these risks through our wholly-owned, captive insurance subsidiary. We reduce exposure to these risks by insuring levels of coverage for losses in excess of our retained limits with a number of third-party insurance companies. We remain liable in the event these insurance companies are unable to pay their portion of the losses.

Centralized Management Services

We provide centralized management services to each of our health plans and to our business segments from our headquarters and service centers. These services include management information systems, product development and administration, finance, human resources, accounting, law, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, billing/enrollment, and customer service. Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries.

Employees

As of December 31, 2016, we had approximately 51,600 employees and approximately 2,600 additional medical professionals working under management agreements primarily between us and affiliated physician-owned associations. We believe we have good relations with our employees and have not experienced any work stoppages.

ITEM 1A. RISK FACTORS

Risks Relating to the Terminated Merger with Aetna

Our proposed merger with Aetna has affected and may in the future, materially and adversely affect our results of operations and stock price.

On February 14, 2017, we and Aetna agreed to mutually terminate our Merger Agreement, as our Board determined that an appeal of the Court's ruling enjoining the transaction would not be in the best interest of our stockholders. Although difficult to quantify, we believe that the proposed merger with Aetna, and subsequent termination of the Merger Agreement, has affected and may, in the future, materially and adversely affect our results of operations, due to the following:

- continued liability for certain transaction costs, including legal, accounting, financial advisory and other costs relating to the transaction;
- diverted management attention to the transaction and integration planning efforts;
- disruption of our business due to member uncertainty over when or if the acquisition will be completed or members' perception of us as a standalone company, our perception among and activities by external brokers, as well as our ability to negotiate and maintain relationships with certain providers in our network;
- certain restrictions in the Merger Agreement on the conduct of our business prior to its termination; and
- other uncertainties that have impaired our ability to retain, recruit and motivate key personnel.

The occurrence, continuation or exacerbation of any of these events individually or in combination could materially and adversely affect our results of operations.

Risks Relating to Our Business

If we do not design and price our products properly and competitively, if the premiums we charge are insufficient to cover the cost of health care services delivered to our members, if we are unable to implement clinical initiatives to provide a better health care experience for our members, lower costs and appropriately document the risk profile of our members, or if our estimates of benefits expense are inadequate, our profitability may be materially adversely affected. We estimate the costs of our benefits expense payments, and design and price our products accordingly, using actuarial methods and assumptions based upon, among other relevant factors, claim payment patterns, medical cost inflation, and historical developments such as claim inventory levels and claim receipt patterns. We continually review these estimates, however these estimates involve extensive judgment, and have considerable inherent variability because they are extremely sensitive to changes in claim payment patterns and medical cost trends. Any reserve, including a premium deficiency reserve, may be insufficient.

We use a substantial portion of our revenues to pay the costs of health care services delivered to our members. These costs include claims payments, capitation payments to providers (predetermined amounts paid to cover services), and various other costs incurred to provide health insurance coverage to our members. These costs also include estimates of future payments to hospitals and others for medical care provided to our members. Generally, premiums in the health care business are fixed for one-year periods. Accordingly, costs we incur in excess of our benefit cost projections generally are not recovered in the contract year through higher premiums. We estimate the costs of our future benefit claims and other expenses using actuarial methods and assumptions based upon claim payment patterns, medical inflation, historical developments, including claim inventory levels and claim receipt patterns, and other relevant factors. We also record benefits payable for future payments. We continually review estimates of future payments relating to benefit claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves, including premium deficiency reserves where appropriate. However, these estimates involve extensive judgment, and have considerable inherent variability that is sensitive to claim payment patterns and medical cost trends. Many factors may and often do cause actual health care costs to exceed what was estimated and used to set our premiums. These factors may include:

- increased use of medical facilities and services;

- increased cost of such services;
- increased use or cost of prescription drugs, including specialty prescription drugs;
- the introduction of new or costly treatments, including new technologies;
- our membership mix;
- variances in actual versus estimated levels of cost associated with new products, benefits or lines of business, product changes or benefit level changes;
- changes in the demographic characteristics of an account or market;
- changes or reductions of our utilization management functions such as preauthorization of services, concurrent review or requirements for physician referrals;
- changes in our pharmacy volume rebates received from drug manufacturers;
- catastrophes, including acts of terrorism, public health epidemics, or severe weather (e.g. hurricanes and earthquakes);
- medical cost inflation; and
- government mandated benefits or other regulatory changes, including any that result from the Health Care Reform Law.

Key to our operational strategy is the implementation of clinical initiatives that we believe provide a better health care experience for our members, lower the cost of healthcare services delivered to our members, and appropriately document the risk profile of our members. Our profitability and competitiveness depend in large part on our ability to appropriately manage health care costs through, among other things, the application of medical management programs such as our chronic care management program.

In addition, we also estimate costs associated with long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental insurance policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these future policy benefit reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. Our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies, and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. However, to the extent premium rate increases or loss experience vary from the assumptions we have locked in, additional future adjustments to reserves could be required.

While we proactively attempt to effectively manage our operating expenses, increases or decreases in staff-related expenses, any costs associated with exiting products, additional investment in new products (including our opportunities in the Medicare programs, state-based contracts, participation in health insurance exchanges, and expansion of clinical capabilities as part of our integrated care delivery model), investments in health and well-being product offerings, acquisitions, new taxes and assessments (including the non-deductible health insurance industry fee and other assessments under the Health Care Reform Law), and implementation of regulatory requirements may increase our operating expenses.

Failure to adequately price our products or estimate sufficient benefits payable or future policy benefits payable, or effectively manage our operating expenses, may result in a material adverse effect on our results of operations, financial position, and cash flows.

We are in a highly competitive industry. Some of our competitors are more established in the health care industry in terms of a larger market share and have greater financial resources than we do in some markets. In addition, other companies may enter our markets in the future, including emerging competitors in the Medicare program or competitors in the delivery of health care services. We may also face increased competition due to participation by other insurers in the health insurance exchanges implemented under the Health Care Reform Law. We believe that barriers to entry

in our markets are not substantial, so the addition of new competitors can occur relatively easily, and customers enjoy significant flexibility in moving between competitors. Contracts for the sale of commercial products are generally bid upon or renewed annually. While health plans compete on the basis of many factors, including service and the quality and depth of provider networks, we expect that price will continue to be a significant basis of competition. In addition to the challenge of controlling health care costs, we face intense competitive pressure to contain premium prices. Factors such as business consolidations, strategic alliances, legislative reform, and marketing practices create pressure to contain premium price increases, despite being faced with increasing medical costs.

The policies and decisions of the federal and state governments regarding the Medicare, military, Medicaid and health insurance exchange programs in which we participate have a substantial impact on our profitability. These governmental policies and decisions, which we cannot predict with certainty, directly shape the premiums or other revenues to us under the programs, the eligibility and enrollment of our members, the services we provide to our members, and our administrative, health care services, and other costs associated with these programs. Legislative or regulatory actions, such as those resulting in a reduction in premium payments to us, an increase in our cost of administrative and health care services, or additional fees, taxes or assessments, may have a material adverse effect on our results of operations, financial position, and cash flows.

Premium increases, introduction of new product designs, and our relationships with our providers in various markets, among other issues, could also affect our membership levels. Other actions that could affect membership levels include our possible exit from or entrance into Medicare or commercial markets, or the termination of a large contract.

If we do not compete effectively in our markets, if we set rates too high or too low in highly competitive markets to keep or increase our market share, if membership does not increase as we expect, if membership declines, or if we lose membership with favorable medical cost experience while retaining or increasing membership with unfavorable medical cost experience, our results of operations, financial position, and cash flows may be materially adversely affected.

If we fail to effectively implement our operational and strategic initiatives, including our Medicare initiatives, our state-based contracts strategy, and our participation in the new health insurance exchanges, our business may be materially adversely affected, which is of particular importance given the concentration of our revenues in these products.

Our future performance depends in large part upon our ability to execute our strategy, including opportunities created by the expansion of our Medicare programs, the successful implementation of our integrated care delivery model, our strategy with respect to state-based contracts, including those covering members dually eligible for the Medicare and Medicaid programs, and our participation in health insurance exchanges.

We have made substantial investments in the Medicare program to enhance our ability to participate in these programs. We have increased the size of our Medicare geographic reach through expanded Medicare product offerings. We offer both stand-alone Medicare prescription drug coverage and Medicare Advantage health plans with prescription drug coverage in addition to our other product offerings. We offer a Medicare prescription drug plan in 50 states as well as Puerto Rico and the District of Columbia. The growth of our Medicare products is an important part of our business strategy. Any failure to achieve this growth may have a material adverse effect on our results of operations, financial position, or cash flows. In addition, the expansion of our Medicare products in relation to our other businesses may intensify the risks to us inherent in Medicare products. There is significant concentration of our revenues in Medicare products, with approximately 74% of our total premiums and services revenue for the year ended December 31, 2016 generated from our Medicare products, including 14% derived from our individual Medicare Advantage contracts with CMS in Florida. These expansion efforts may result in less diversification of our revenue stream and increased risks associated with operating in a highly regulated industry, as discussed further below.

The Health Care Reform Law created a federal Medicare-Medicaid Coordination Office to serve dual eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state demonstration projects to experiment with better coordination of care between Medicare and Medicaid. Depending upon the results of those demonstration projects, CMS may change the way in which dual eligibles are serviced. If we are unable to implement our strategic initiatives

to address the dual eligibles opportunity, including our participation in state-based contracts, or if our initiatives are not successful at attracting or retaining dual eligible members, our business may be materially adversely affected.

Additionally, our strategy includes the growth of our commercial products, including participation in certain health insurance exchanges, introduction of new products and benefit designs, including Go365 and other wellness products, growth of our specialty products such as dental, vision and other supplemental products, the adoption of new technologies, development of adjacent businesses, and the integration of acquired businesses and contracts.

There can be no assurance that we will be able to successfully implement our operational and strategic initiatives, including implementing our integrated care delivery model, that are intended to position us for future growth or that the products we design will be accepted or adopted in the time periods assumed. Failure to implement this strategy may result in a material adverse effect on our results of operations, financial position, and cash flows.

There can be no assurances that we will be successful in maintaining or improving our Star ratings in future years. In addition, there can be no guarantees that the reconsideration that we filed with respect to certain of our Star rating measures for the 2018 bonus year will be successful, that operational measures we may take will successfully mitigate any negative effects of Star quality ratings for the 2018 bonus year or future years, or that we will not experience a decline in membership growth for 2018 as a result of our 2018 bonus year Star ratings.

The achievement of Star ratings of 4-Star or higher qualifies Medicare Advantage plans for premium bonuses. Our Medicare Advantage plans' operating results may be significantly affected by their star ratings. Despite our operational efforts to improve our star ratings, there can be no assurances that we will be successful in maintaining or improving our star ratings in future years. In addition, audits of our performance for past or future periods may result in downgrades to our Star ratings. Accordingly, our plans may not be eligible for full level quality bonuses, which could adversely affect the benefits such plans can offer, reduce membership and/or reduce profit margins.

On October 12, 2016, CMS published updated Star quality ratings for the 2018 bonus year, which showed that the percentage of our July 31, 2016 Medicare Advantage membership in 4-Star plans or higher had declined to approximately 37 percent from approximately 78 percent of our July 31, 2015 Medicare Advantage membership. This decline in membership in 4-Star rated plans does not take into account certain operational actions we intend to take over the coming quarters to mitigate any potential negative impact of these published ratings on Star bonus revenues for 2018. Moreover, we expect the impact of CMS' comprehensive program audit on our Star ratings to be limited to the 2018 bonus year, and Star results for the 2018 bonus year are not expected to materially impact our Medicare revenue for 2017.

We believe that our Star ratings for the 2018 bonus year do not accurately reflect our actual performance under the applicable Star measures. Consequently, we have filed for reconsideration of certain of those ratings by CMS under the appropriate administrative process.

There can be no guarantees, however, that the request for reconsideration that we filed with CMS will be successful, that any operational measures we may take will successfully mitigate all negative effects of our Star quality ratings for the 2018 bonus year, which could be material, or that we will not experience a decline in membership growth for 2018 as a result of our 2018 bonus year Star ratings.

If we fail to properly maintain the integrity of our data, to strategically implement new information systems, or to protect our proprietary rights to our systems, our business may be materially adversely affected.

Our business depends significantly on effective information systems and the integrity and timeliness of the data we use to run our business. Our business strategy involves providing members and providers with easy to use products that leverage our information to meet their needs. Our ability to adequately price our products and services, provide effective and efficient service to our customers, and to timely and accurately report our financial results depends significantly on the integrity of the data in our information systems. As a result of our past and on-going acquisition activities, we have acquired additional information systems. We have reduced the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating existing business to fewer systems. Our information systems require an ongoing commitment of significant resources to maintain, protect, and

enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, and changing customer preferences. If the information we rely upon to run our businesses was found to be inaccurate or unreliable or if we fail to maintain effectively our information systems and data integrity, we could have operational disruptions, have problems in determining medical cost estimates and establishing appropriate pricing, have customer and physician and other health care provider disputes, have regulatory or other legal problems, have increases in operating expenses, lose existing customers, have difficulty in attracting new customers, or suffer other adverse consequences.

We depend on independent third parties for significant portions of our systems-related support, equipment, facilities, and certain data, including data center operations, data network, voice communication services and pharmacy data processing. This dependence makes our operations vulnerable to such third parties' failure to perform adequately under the contract, due to internal or external factors. A change in service providers could result in a decline in service quality and effectiveness or less favorable contract terms which may adversely affect our operating results.

We rely on our agreements with customers, confidentiality agreements with employees, and our trade secrets and copyrights to protect our proprietary rights. These legal protections and precautions may not prevent misappropriation of our proprietary information. In addition, substantial litigation regarding intellectual property rights exists in the software industry, including litigation involving end users of software products. We expect software products to be increasingly subject to third-party infringement claims as the number of products and competitors in this area grows.

There can be no assurance that our information technology, or IT, process will successfully improve existing systems, develop new systems to support our expanding operations, integrate new systems, protect our proprietary information, defend against cybersecurity attacks, or improve service levels. In addition, there can be no assurance that additional systems issues will not arise in the future. Failure to adequately protect and maintain the integrity of our information systems and data, or to defend against cybersecurity attacks, may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we are unable to defend our information technology security systems against cybersecurity attacks or prevent other privacy or data security incidents that result in security breaches that disrupt our operations or in the unintended dissemination of sensitive personal information or proprietary or confidential information, we could be exposed to significant regulatory fines or penalties, liability or reputational damage, or experience a material adverse effect on our results of operations, financial position, and cash flows.

In the ordinary course of our business, we process, store and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or a third-party. A cybersecurity attack may penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information or that of third-parties, create system disruptions, cause shutdowns, or deploy viruses, worms, and other malicious software programs that attack our systems. A cybersecurity attack that bypasses our IT security systems successfully could materially affect us due to the theft, destruction, loss, misappropriation or release of confidential data or intellectual property, operational or business delays resulting from the disruption of our IT systems, or negative publicity resulting in reputation or brand damage with our members, customers, providers, and other stakeholders.

The costs to eliminate or address cybersecurity threats and vulnerabilities before or after an incident could be substantial. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of existing or potential members. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary or confidential information about us or our members or other third-parties, could expose our members' private information and result in the risk of financial or medical identity theft, or expose us or other third-parties to a risk of loss or misuse of this information, result in significant regulatory fines or penalties, litigation and potential liability for us, damage our brand and reputation, or otherwise harm our business.

We are involved in various legal actions and governmental and internal investigations, any of which, if resolved unfavorably to us, could result in substantial monetary damages or changes in our business practices. Increased litigation and negative publicity could increase our cost of doing business.

We are or may become a party to a variety of legal actions that affect our business, including breach of contract actions, employment and employment discrimination-related suits, employee benefit claims, stockholder suits and other securities laws claims, and tort claims.

In addition, because of the nature of the health care business, we are subject to a variety of legal actions relating to our business operations, including the design, management, and offering of products and services. These include and could include in the future:

- claims relating to the methodologies for calculating premiums;
- claims relating to the denial of health care benefit payments;
- claims relating to the denial or rescission of insurance coverage;
- challenges to the use of some software products used in administering claims;
- claims relating to our administration of our Medicare Part D offerings;
- medical malpractice actions based on our medical necessity decisions or brought against us on the theory that we are liable for providers' alleged malpractice;
- claims arising from any adverse medical consequences resulting from our recommendations about the appropriateness of providers' proposed medical treatment plans for patients;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation or non-acceptance or termination of provider contracts or provider contract disputes relating to rate adjustments resulting from the Balance Budget and Emergency Deficit Control Act of 1985, as amended (commonly referred to as "sequestration");
- disputes related to ASO business, including actions alleging claim administration errors;
- qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that we, as a government contractor, submitted false claims to the government including, among other allegations, resulting from coding and review practices under the Medicare risk-adjustment model;
- claims related to the failure to disclose some business practices;
- claims relating to customer audits and contract performance;
- claims relating to dispensing of drugs associated with our in-house mail-order pharmacy; and
- professional liability claims arising out of the delivery of healthcare and related services to the public.

In some cases, substantial non-economic or punitive damages as well as treble damages under the federal False Claims Act, Racketeer Influenced and Corrupt Organizations Act and other statutes may be sought.

While we currently have insurance coverage for some of these potential liabilities, other potential liabilities may not be covered by insurance, insurers may dispute coverage, or the amount of our insurance may not be enough to cover the damages awarded. In addition, some types of damages, like punitive damages, may not be covered by insurance. In some jurisdictions, coverage of punitive damages is prohibited. Insurance coverage for all or some forms of liability may become unavailable or prohibitively expensive in the future.

The health benefits industry continues to receive significant negative publicity reflecting the public perception of the industry. This publicity and perception have been accompanied by increased litigation, including some large jury awards, legislative activity, regulation, and governmental review of industry practices. These factors may materially adversely affect our ability to market our products or services, may require us to change our products or services or otherwise change our business practices, may increase the regulatory burdens under which we operate, and may require

us to pay large judgments or fines. Any combination of these factors could further increase our cost of doing business and adversely affect our results of operations, financial position, and cash flows.

See "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. - Financial Statements and Supplementary Data. We cannot predict the outcome of these matters with certainty.

As a government contractor, we are exposed to risks that may materially adversely affect our business or our willingness or ability to participate in government health care programs.

A significant portion of our revenues relates to federal and state government health care coverage programs, including the Medicare, military, and Medicaid programs. These programs accounted for approximately 75% of our total premiums and services revenue for the year ended December 31, 2016. These programs involve various risks, as described further below.

- At December 31, 2016, under our contracts with CMS we provided health insurance coverage to approximately 598,100 individual Medicare Advantage members in Florida. These contracts accounted for approximately 14% of our total premiums and services revenue for the year ended December 31, 2016. The loss of these and other CMS contracts or significant changes in the Medicare program as a result of legislative or regulatory action, including reductions in premium payments to us or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.
- At December 31, 2016, our military services business primarily consisted of the TRICARE South Region contract which covers approximately 3,084,100 beneficiaries. For the year ended December 31, 2016, premiums and services revenue associated with the TRICARE South Region contract accounted for approximately 1% of our total premiums and services revenue. On April 1, 2012, we began delivering services under the current TRICARE South Region contract that the Defense Health Agency, or DHA (formerly known as the TRICARE Management Activity), awarded to us on February 25, 2011. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On March 30, 2016, we received notice that the DHA exercised its option to extend the TRICARE South Region contract through March 31, 2017. On July 21, 2016, we were notified by the DHA that we were awarded the contract for the new TRICARE East Region, which is a consolidation of the former North and South Regions, with delivery of health care services expected to commence on October 1, 2017. The next generation East Region and West Region contract awards are currently subject to protests by unsuccessful bidders in the U.S. Court of Federal Claims and before the DHA. The loss of the TRICARE South Region contract or an overturn of the award of the East Region contract to us, should either occur, may have a material adverse effect on our results of operations, financial position, and cash flows.
- There is a possibility of temporary or permanent suspension from participating in government health care programs, including Medicare and Medicaid, if we are convicted of fraud or other criminal conduct in the performance of a health care program or if there is an adverse decision against us under the federal False Claims Act. As a government contractor, we may be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government. Litigation of this nature is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own.
- CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical

diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnosis data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit those claims that pass the filtering logic. For submissions through EDS, CMS requires MA plans to submit all the claims data and CMS will apply the risk adjustment filtering logic to determine the risk adjustment data used to calculate risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the FFS Adjuster is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for contract years 2011, 2012, and 2013, in which two, five, and five of our Medicare Advantage plans are being audited, respectively. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For-Service business which we used to represent a proxy of the FFS Adjuster which has not yet been released. We based our accrual of estimated audit settlements for each contract year on the results of

these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However, as indicated, we are awaiting additional guidance from CMS regarding the FFS Adjuster. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

- Our CMS contracts which cover members' prescription drugs under Medicare Part D contain provisions for risk sharing and certain payments for prescription drug costs for which we are not at risk. These provisions, certain of which are described below, affect our ultimate payments from CMS.

  The premiums from CMS are subject to risk corridor provisions which compare costs targeted in our annual bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received (known as a "risk corridor"). We estimate and recognize an adjustment to premiums revenue related to the risk corridor payment settlement based upon pharmacy claims experience. The estimate of the settlement associated with these risk corridor provisions requires us to consider factors that may not be certain, including member eligibility differences with CMS. Our estimate of the settlement associated with the Medicare Part D risk corridor provisions was a net payable of $150 million at December 31, 2016.

  Reinsurance and low-income cost subsidies represent payments from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent payments for CMS's portion of claims costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent payments from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the applicable year.

  Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. This reconciliation process requires us to submit claims data necessary for CMS to administer the program. Our claims data may not pass CMS's claims edit processes due to various reasons, including discrepancies in eligibility or classification of low-income members. To the extent our data does not pass CMS's claim edit processes, we may bear the risk for all or a portion of the claim which otherwise may have been subject to the risk corridor provision or payment which we would have otherwise received as a low-income subsidy or reinsurance claim. In addition, in the event the settlement represents an amount CMS owes us, there is a negative impact on our cash flows and financial condition as a result of financing CMS's share of the risk. The opposite is true in the event the settlement represents an amount we owe CMS.

- We are also subject to various other governmental audits and investigations. Under state laws, our HMOs and health insurance companies are audited by state departments of insurance for financial and contractual compliance. Our HMOs are audited for compliance with health services by state departments of health. Audits and investigations are also conducted by state attorneys general, CMS, the Office of the Inspector General of Health and Human Services, the Office of Personnel Management, the Department of Justice, the Department of Labor, and the Defense Contract Audit Agency. All of these activities could result in the loss of licensure or the right to participate in various programs, including a limitation on our ability to market

or sell products, the imposition of fines, penalties and other civil and criminal sanctions, or changes in our business practices. The outcome of any current or future governmental or internal investigations cannot be accurately predicted, nor can we predict any resulting penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities. Nevertheless, it is reasonably possible that any such outcome of litigation, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows. Certain of these matters could also affect our reputation. In addition, disclosure of any adverse investigation or audit results or sanctions could negatively affect our industry or our reputation in various markets and make it more difficult for us to sell our products and services.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 could have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs by, among other things, requiring a minimum benefit ratio on insured products, lowering our Medicare payment rates and increasing our expenses associated with a non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows.

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. The provisions of the Health Care Reform Law include, among others, imposing a significant new non-deductible health insurance industry fee and other assessments on health insurers, limiting Medicare Advantage payment rates, stipulating a prescribed minimum ratio for the amount of premiums revenue to be expended on medical costs for insured products, additional mandated benefits and guarantee issuance associated with commercial medical insurance, requirements that limit the ability of health plans to vary premiums based on assessments of underlying risk, and heightened scrutiny by state and federal regulators of our business practices, including our Medicare bid and pricing practices. The Health Care Reform Law also specifies benefit design guidelines, limits rating and pricing practices, encourages additional competition (including potential incentives for new market entrants), establishes federally-facilitated or state-based exchanges for individuals and small employers (with up to 100 employees) coupled with programs designed to spread risk among insurers (subject to federal administrative action), and expands eligibility for Medicaid programs (subject to state-by-state implementation of this expansion). In addition, the Health Care Reform Law has increased and will continue to increase federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms will come, in part, from material additional fees and taxes on us and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

For additional information, please refer to the section entitled, "Health Care Reform" in "Item 7 - Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing in this annual report.

Our continued participation in the federal and state health insurance exchanges, which entail uncertainties associated with mix, volume of business and the operation of premium stabilization programs, which are subject to federal administrative action, could adversely affect our results of operations, financial position, and cash flows.

The Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products. The risk corridor program is a three-

year program, and the Department of Health and Human Services (HHS) guidance provides that risk corridor collections over the life of the three year program will first be applied to any shortfalls from previous benefit years before application to current year obligations. On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off our risk corridor receivables. In addition, other regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law or to enroll outside of the annual enrollment period may have an adverse effect on our pool of participants in the health insurance exchange.

For 2017, we are offering on-exchange individual commercial medical plans in 11 states, a reduction from the 15 states in which we offered on-exchange coverage in 2016. In addition, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans in 2017. Despite this reduction in our individual commercial membership plans, the above factors, in addition to competitor actions to withdraw from exchanges and/or alter their product offerings, may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. In addition, audits of our submissions under the risk adjustment program may result in repayment of amounts distributed under the program. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows, and we may be unable to adjust our product offerings, geographic footprint, or pricing during any given year in sufficient time to mitigate any such effects.

Our business activities are subject to substantial government regulation. New laws or regulations, or changes in existing laws or regulations or their manner of application, including reductions in Medicare Advantage payment rates, could increase our cost of doing business and may adversely affect our business, profitability, financial condition, and cash flows.

In addition to the Health Care Reform Law, the health care industry in general and health insurance are subject to substantial federal and state government regulation:

Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The use of individually identifiable health data by our business is regulated at federal and state levels. These laws and rules are changed frequently by legislation or administrative interpretation. Various state laws address the use and maintenance of individually identifiable health data. Most are derived from the privacy provisions in the federal Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA includes administrative provisions directed at simplifying electronic data interchange through standardizing transactions, establishing uniform health care provider, payer, and employer identifiers, and seeking protections for confidentiality and security of patient data. The rules do not provide for complete federal preemption of state laws, but rather preempt all inconsistent state laws unless the state law is more stringent.

These regulations set standards for the security of electronic health information. Violations of these rules could subject us to significant criminal and civil penalties, including significant monetary penalties. Compliance with HIPAA regulations requires significant systems enhancements, training and administrative effort. HIPAA can also expose us to additional liability for violations by our business associates (e.g., entities that provide services to health plans and providers).

The HITECH Act, one part of the American Recovery and Reinvestment Act of 2009, significantly broadened the scope of the privacy and security regulations of HIPAA. Among other requirements, the HITECH Act and HIPAA mandate individual notification in the event of a breach of unsecured, individually identifiable health information,

provides enhanced penalties for HIPAA violations, requires business associates to comply with certain provisions of the HIPAA privacy and security rule, and grants enforcement authority to state attorneys general in addition to the HHS Office of Civil Rights.

In addition, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state and could impose additional penalties. Violations of HIPAA or applicable federal or state laws or regulations could subject us to significant criminal or civil penalties, including significant monetary penalties. Compliance with HIPAA and other privacy regulations requires significant systems enhancements, training and administrative effort.

American Recovery and Reinvestment Act of 2009 (ARRA)

On February 17, 2009, the American Recovery and Reinvestment Act of 2009, or ARRA, was enacted into law. In addition to including a temporary subsidy for health care continuation coverage issued pursuant to the Consolidated Omnibus Budget Reconciliation Act, or COBRA, ARRA also expands and strengthens the privacy and security provisions of HIPAA and imposes additional limits on the use and disclosure of protected health information, or PHI. Among other things, ARRA requires us and other covered entities to report any unauthorized release or use of or access to PHI to any impacted individuals and to HHS in those instances where the unauthorized activity poses a significant risk of financial, reputational or other harm to the individuals, and to notify the media in any states where 500 or more people are impacted by any unauthorized release or use of or access to PHI. ARRA also requires business associates to comply with certain HIPAA provisions. ARRA also establishes higher civil and criminal penalties for covered entities and business associates who fail to comply with HIPAA's provisions and requires HHS to issue regulations implementing its privacy and security enhancements.

Corporate Practice of Medicine and Other Laws

As a corporate entity, Humana Inc. is not licensed to practice medicine. Many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary widely from state to state. Under management agreements between certain of our subsidiaries and affiliated physician-owned professional groups, these groups retain sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed healthcare providers, developing operating policies and procedures, implementing professional standards and controls, and maintaining malpractice insurance. We believe that our health services operations comply with applicable state statutes regarding corporate practice of medicine, fee-splitting, and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these statutes, which could subject us to penalties or restructuring or reorganization of our business, may result in a material adverse effect on our results of operations, financial position, or cash flows.

Anti-Kickback, Physician Self-Referral, and Other Fraud and Abuse Laws

A federal law commonly referred to as the "Anti-Kickback Statute" prohibits the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of Medicare or other governmental health program patients or patient care opportunities, or in return for the purchase, lease, or order of items or services that are covered by Medicare or other federal governmental health programs. Because the prohibitions contained in the Anti-Kickback Statute apply to the furnishing of items or services for which payment is made in "whole or in part," the Anti-Kickback Statute could be implicated if any portion of an item or service we provide is covered by any of the state or federal health benefit programs described above. Violation of these provisions constitutes a felony criminal offense and applicable sanctions could include exclusion from the Medicare and Medicaid programs.

Section 1877 of the Social Security Act, commonly known as the "Stark Law," prohibits physicians, subject to certain exceptions described below, from referring Medicare or Medicaid patients to an entity providing "designated health services" in which the physician, or an immediate family member, has an ownership or investment interest or with which the physician, or an immediate family member, has entered into a compensation arrangement. These prohibitions, contained in the Omnibus Budget Reconciliation Act of 1993, commonly known as "Stark II," amended

prior federal physician self-referral legislation known as "Stark I" by expanding the list of designated health services to a total of 11 categories of health services. The professional groups with which we are affiliated provide one or more of these designated health services. Persons or entities found to be in violation of the Stark Law are subject to denial of payment for services furnished pursuant to an improper referral, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

Many states also have enacted laws similar in scope and purpose to the Anti-Kickback Statute and, in more limited instances, the Stark Law, that are not limited to services for which Medicare or Medicaid payment is made. In addition, most states have statutes, regulations, or professional codes that restrict a physician from accepting various kinds of remuneration in exchange for making referrals. These laws vary from state to state and have seldom been interpreted by the courts or regulatory agencies. In states that have enacted these statutes, we believe that regulatory authorities and state courts interpreting these statutes may regard federal law under the Anti-Kickback Statute and the Stark Law as persuasive.

We believe that our operations comply with the Anti-Kickback Statute, the Stark Law, and similar federal or state laws addressing fraud and abuse. These laws are subject to modification and changes in interpretation, and are enforced by authorities vested with broad discretion. We continually monitor developments in this area. If these laws are interpreted in a manner contrary to our interpretation or are reinterpreted or amended, or if new legislation is enacted with respect to healthcare fraud and abuse, illegal remuneration, or similar issues, we may be required to restructure our affected operations to maintain compliance with applicable law. There can be no assurances that any such restructuring will be possible or, if possible, would not have a material adverse effect on our results of operations, financial position, or cash flows.

Environmental

We are subject to various federal, state, and local laws and regulations relating to the protection of human health and the environment. If an environmental regulatory agency finds any of our facilities to be in violation of environmental laws, penalties and fines may be imposed for each day of violation and the affected facility could be forced to cease operations. We could also incur other significant costs, such as cleanup costs or claims by third parties, as a result of violations of, or liabilities under, environmental laws. Although we believe that our environmental practices, including waste handling and disposal practices, are in material compliance with applicable laws, future claims or violations, or changes in environmental laws, could have a material adverse effect on our results of operations, financial position or cash flows.

State Regulation of Insurance-Related Products

Laws in each of the states (and Puerto Rico) in which we operate our HMOs, PPOs and other health insurance-related services regulate our operations including: capital adequacy and other licensing requirements, policy language describing benefits, mandated benefits and processes, entry, withdrawal or re-entry into a state or market, rate increases, delivery systems, utilization review procedures, quality assurance, complaint systems, enrollment requirements, claim payments, marketing, and advertising. The HMO, PPO, and other health insurance-related products we offer are sold under licenses issued by the applicable insurance regulators.

Our licensed insurance subsidiaries are also subject to regulation under state insurance holding company and Puerto Rico regulations. These regulations generally require, among other things, prior approval and/or notice of new products, rates, benefit changes, and certain material transactions, including dividend payments, purchases or sales of assets, intercompany agreements, and the filing of various financial and operational reports.

Any failure by us to manage acquisitions, divestitures and other significant transactions successfully may have a material adverse effect on our results of operations, financial position, and cash flows.

As part of our business strategy, we frequently engage in discussions with third parties regarding possible investments, acquisitions, divestitures, strategic alliances, joint ventures, and outsourcing transactions and often enter into agreements relating to such transactions in order to further our business objectives. In order to pursue our acquisition strategy successfully, we must identify suitable candidates for and successfully complete transactions, some of which

may be large and complex, and manage post-closing issues such as the integration of acquired companies or employees. Integration and other risks can be more pronounced for larger and more complicated transactions, transactions outside of our core business space, or if multiple transactions are pursued simultaneously. The failure to successfully integrate acquired entities and businesses or failure to produce results consistent with the financial model used in the analysis of our acquisitions may have a material adverse effect on our results of operations, financial position, and cash flows. If we fail to identify and complete successfully transactions that further our strategic objectives, we may be required to expend resources to develop products and technology internally. In addition, from time to time, we evaluate alternatives for our businesses that do not meet our strategic, growth or profitability objectives. The divestiture of certain businesses could result, individually or in the aggregate, in the recognition of material losses and a material adverse effect on our results of operations. There can be no assurance that we will be able to complete any such divestitures on terms favorable to us.

If we fail to develop and maintain satisfactory relationships with the providers of care to our members, our business may be adversely affected.

We employ or contract with physicians, hospitals and other providers to deliver health care to our members. Our products encourage or require our customers to use these contracted providers. A key component of our integrated care delivery strategy is to increase the number of providers who share medical cost risk with us or have financial incentives to deliver quality medical services in a cost-effective manner.

In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions that could result in higher health care costs for us, less desirable products for customers and members or difficulty meeting regulatory or accreditation requirements. In some markets, some providers, particularly hospitals, physician specialty groups, physician/hospital organizations, or multi-specialty physician groups, may have significant market positions and negotiating power. In addition, physician or practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, may compete directly with us. If these providers refuse to contract with us, use their market position to negotiate unfavorable contracts with us or place us at a competitive disadvantage, or do not enter into contracts with us that encourage the delivery of quality medical services in a cost-effective manner, our ability to market products or to be profitable in those areas may be adversely affected.

In some situations, we have contracts with individual or groups of primary care providers for an actuarially determined, fixed fee per month to provide a basket of required medical services to our members. This type of contract is referred to as a "capitation" contract. The inability of providers to properly manage costs under these capitation arrangements can result in the financial instability of these providers and the termination of their relationship with us. In addition, payment or other disputes between a primary care provider and specialists with whom the primary care provider contracts can result in a disruption in the provision of services to our members or a reduction in the services available to our members. The financial instability or failure of a primary care provider to pay other providers for services rendered could lead those other providers to demand payment from us even though we have made our regular fixed payments to the primary provider. There can be no assurance that providers with whom we contract will properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events may have a material adverse effect on the provision of services to our members and our results of operations, financial position, and cash flows.

Our pharmacy business is highly competitive and subjects us to regulations in addition to those we face with our core health benefits businesses.

Our pharmacy mail order business competes with locally owned drugstores, retail drugstore chains, supermarkets, discount retailers, membership clubs, internet companies and other mail-order and long-term care pharmacies. Our pharmacy business also subjects us to extensive federal, state, and local regulation. The practice of pharmacy is generally regulated at the state level by state boards of pharmacy. Many of the states where we deliver pharmaceuticals, including controlled substances, have laws and regulations that require out-of-state mail-order pharmacies to register with that state's board of pharmacy. Federal agencies further regulate our pharmacy operations, requiring registration with the U.S. Drug Enforcement Administration and individual state controlled substance authorities in order to dispense controlled substances. In addition, the FDA inspects facilities in connection with procedures to effect recalls of

prescription drugs. The Federal Trade Commission also has requirements for mail-order sellers of goods. The U.S. Postal Service, or USPS, has statutory authority to restrict the transmission of drugs and medicines through the mail to a degree that may have an adverse effect on our mail-order operations. The USPS historically has exercised this statutory authority only with respect to controlled substances. If the USPS restricts our ability to deliver drugs through the mail, alternative means of delivery are available to us. However, alternative means of delivery could be significantly more expensive. The U.S. Department of Transportation has regulatory authority to impose restrictions on drugs inserted in the stream of commerce. These regulations generally do not apply to the USPS and its operations. In addition, we are subject to CMS rules regarding the administration of our PDP plans and intercompany pricing between our PDP plans and our pharmacy business.

We are also subject to risks inherent in the packaging and distribution of pharmaceuticals and other health care products, and the application of state laws related to the operation of internet and mail-order pharmacies. The failure to adhere to these laws and regulations may expose us to civil and criminal penalties.

Changes in the prescription drug industry pricing benchmarks may adversely affect our financial performance.

Contracts in the prescription drug industry generally use certain published benchmarks to establish pricing for prescription drugs. These benchmarks include average wholesale price, which is referred to as "AWP," average selling price, which is referred to as "ASP," and wholesale acquisition cost. It is uncertain whether payors, pharmacy providers, pharmacy benefit managers, or PBMs, and others in the prescription drug industry will continue to utilize AWP as it has previously been calculated, or whether other pricing benchmarks will be adopted for establishing prices within the industry. Legislation may lead to changes in the pricing for Medicare and Medicaid programs. Regulators have conducted investigations into the use of AWP for federal program payment, and whether the use of AWP has inflated drug expenditures by the Medicare and Medicaid programs. Federal and state proposals have sought to change the basis for calculating payment of certain drugs by the Medicare and Medicaid programs. Adoption of ASP in lieu of AWP as the measure for determining payment by Medicare or Medicaid programs for the drugs sold in our mail-order pharmacy business may reduce the revenues and gross margins of this business which may result in a material adverse effect on our results of operations, financial position, and cash flows.

If we do not continue to earn and retain purchase discounts and volume rebates from pharmaceutical manufacturers at current levels, our gross margins may decline.

We have contractual relationships with pharmaceutical manufacturers or wholesalers that provide us with purchase discounts and volume rebates on certain prescription drugs dispensed through our mail-order and specialty pharmacies. These discounts and volume rebates are generally passed on to clients in the form of steeper price discounts. Changes in existing federal or state laws or regulations or in their interpretation by courts and agencies or the adoption of new laws or regulations relating to patent term extensions, and purchase discount and volume rebate arrangements with pharmaceutical manufacturers, may reduce the discounts or volume rebates we receive and materially adversely impact our results of operations, financial position, and cash flows.

Our ability to obtain funds from certain of our licensed subsidiaries is restricted by state insurance regulations.

Because we operate as a holding company, we are dependent upon dividends and administrative expense reimbursements from our subsidiaries to fund the obligations of Humana Inc., our parent company. Certain of our insurance subsidiaries operate in states that regulate the payment of dividends, loans, administrative expense reimbursements or other cash transfers to Humana Inc., and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these insurance subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix. Dividends from our non-insurance companies such as in our Healthcare Services segment are generally not restricted by Departments of Insurance. In the event that we are unable to provide sufficient capital to fund the obligations of Humana Inc., our results of operations, financial position, and cash flows may be materially adversely affected.

Downgrades in our debt ratings, should they occur, may adversely affect our business, results of operations, and financial condition.

Claims paying ability, financial strength, and debt ratings by recognized rating organizations are an increasingly important factor in establishing the competitive position of insurance companies. Ratings information is broadly disseminated and generally used throughout the industry. We believe our claims paying ability and financial strength ratings are an important factor in marketing our products to certain of our customers. In addition, our debt ratings impact both the cost and availability of future borrowings. Each of the rating agencies reviews its ratings periodically and there can be no assurance that current ratings will be maintained in the future. Our ratings reflect each rating agency's opinion of our financial strength, operating performance, and ability to meet our debt obligations or obligations to policyholders, but are not evaluations directed toward the protection of investors in our common stock and should not be relied upon as such.

Historically, rating agencies take action to lower ratings due to, among other things, perceived concerns about liquidity or solvency, the competitive environment in the insurance industry, the inherent uncertainty in determining reserves for future claims, the outcome of pending litigation and regulatory investigations, and possible changes in the methodology or criteria applied by the rating agencies. In addition, rating agencies have come under regulatory and public scrutiny over the ratings assigned to various fixed-income products. As a result, rating agencies may (i) become more conservative in their methodology and criteria, (ii) increase the frequency or scope of their credit reviews, (iii) request additional information from the companies that they rate, or (iv) adjust upward the capital and other requirements employed in the rating agency models for maintenance of certain ratings levels.

We believe that some of our customers place importance on our credit ratings, and we may lose customers and compete less successfully if our ratings were to be downgraded. In addition, our credit ratings affect our ability to obtain investment capital on favorable terms. If our credit ratings were to be lowered, our cost of borrowing likely would increase, our sales and earnings could decrease, and our results of operations, financial position, and cash flows may be materially adversely affected.

The securities and credit markets may experience volatility and disruption, which may adversely affect our business.

Volatility or disruption in the securities and credit markets could impact our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities sold is based upon specific identification. For debt securities held, we recognize an impairment loss in income when the fair value of the debt security is less than the carrying value and we have the intent to sell the debt security or it is more likely than not that we will be required to sell the debt security before recovery of our amortized cost basis, or if a credit loss has occurred. When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairments are considered using variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. We continuously review our investment portfolios and there is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares. However, continuing adverse securities and credit market conditions may significantly affect the availability of credit. While there is no assurance in the current economic environment, we have no reason to believe the lenders participating in our credit agreement will not be willing and able to provide financing in accordance with the terms of the agreement.

Our access to additional credit will depend on a variety of factors such as market conditions, the general availability of credit, both to the overall market and our industry, our credit ratings and debt capacity, as well as the possibility that customers or lenders could develop a negative perception of our long or short-term financial prospects. Similarly, our access to funds could be limited if regulatory authorities or rating agencies were to take negative actions against us. If a combination of these factors were to occur, we may not be able to successfully obtain additional financing on favorable terms or at all.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table lists, by state, the number of medical centers and administrative offices we owned or leased at December 31, 2016:

	Medical Centers		Administrative Offices		
	Owned	Leased	Owned	Leased	Total
Florida	11	129	—	87	227
Texas	—	16	2	17	35
Kentucky	2	1	11	12	26
Arizona	—	10	—	6	16
Virginia	—	8	—	8	16
California	—	2	—	13	15
South Carolina	—	6	4	5	15
Illinois	—	5	—	9	14
Louisiana	—	4	—	10	14
New York	—	—	—	13	13
Ohio	—	1	—	11	12
Indiana	—	4	—	7	11
Nevada	—	6	—	5	11
Tennessee	—	—	—	11	11
Colorado	—	5	—	4	9
Georgia	—	5	—	3	8
New Jersey	—	—	—	8	8
Washington	—	4	—	4	8
Puerto Rico	—	—	—	7	7
Michigan	—	2	—	4	6
North Carolina	—	—	—	6	6
Others	—	—	1	46	47
Total	13	208	18	296	535

The medical centers we operate are primarily located in Florida and Texas, including full-service, multi-specialty medical centers staffed by primary care providers and medical specialists. Of the medical centers included in the table above, approximately 67 of these facilities are leased or subleased to our contracted providers to operate.

Our principal executive office is located in the Humana Building, 500 West Main Street, Louisville, Kentucky 40202. In addition to the headquarters in Louisville, Kentucky, we maintain other principal operating facilities used

for customer service, enrollment, and/or claims processing and certain other corporate functions in Louisville, Kentucky; Green Bay, Wisconsin; Tampa, Florida; Cincinnati, Ohio; San Antonio, Texas; and San Juan, Puerto Rico.

ITEM 3. LEGAL PROCEEDINGS

We are party to a variety of legal actions in the ordinary course of business, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For a discussion of our material legal actions, including those not in the ordinary course of business, see "Legal Proceedings and Certain Regulatory Matters" in Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We cannot predict the outcome of these suits with certainty.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR THE REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information

Our common stock trades on the New York Stock Exchange under the symbol HUM. The following table shows the range of high and low closing sales prices as reported on the New York Stock Exchange Composite Price for each quarter in the years ended December 31, 2016 and 2015:

	High	Low
Year Ended December 31, 2016		
First quarter	$ 186.91	$ 156.96
Second quarter	$ 190.07	$ 165.23
Third quarter	$ 180.86	$ 153.38
Fourth quarter	$ 216.76	$ 165.31
Year Ended December 31, 2015		
First quarter	$ 182.79	$ 139.09
Second quarter	$ 214.92	$ 163.07
Third quarter	$ 193.14	$ 174.16
Fourth quarter	$ 186.67	$ 164.25

Holders of our Capital Stock

As of January 31, 2017, there were approximately 2,700 holders of record of our common stock and approximately 92,300 beneficial holders of our common stock.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2015 and 2016, under our Board approved quarterly cash dividend policy:

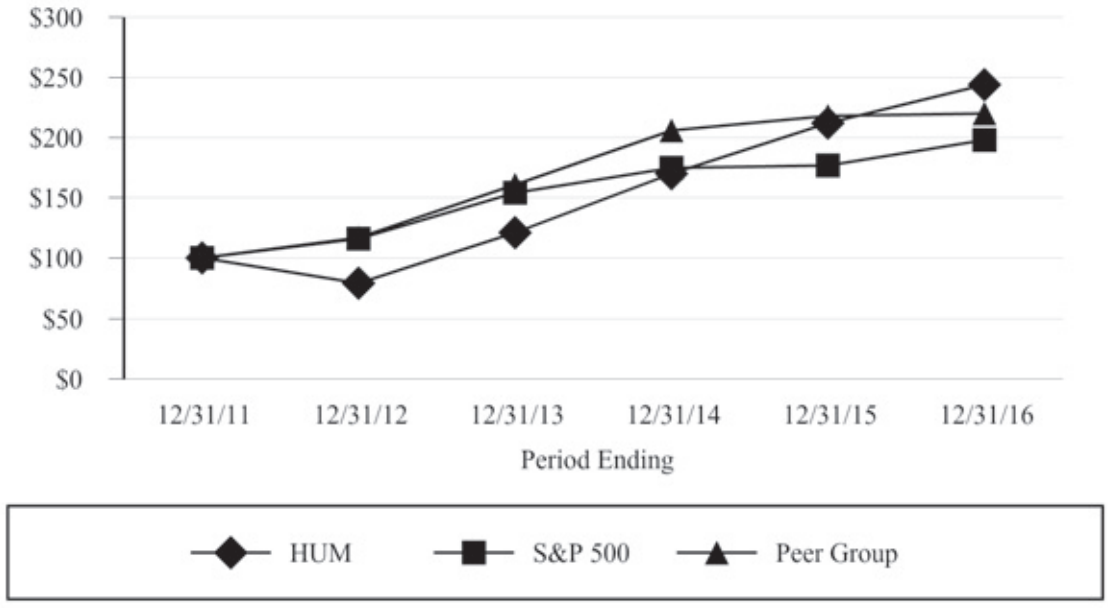
Record Date	Payment Date	Amount per Share	Total Amount
			(in millions)
2015 payments			
12/31/2014	1/30/2015	$0.28	$42
3/31/2015	4/24/2015	$0.28	$42
6/30/2015	7/31/2015	$0.29	$43
9/30/2015	10/30/2015	$0.29	$43
2016 payments			
12/30/2015	1/29/2016	$0.29	$43
3/31/2016	4/29/2016	$0.29	$43
6/30/2016	7/29/2016	$0.29	$43
10/13/2016	10/28/2016	$0.29	$43

Under the terms of the Merger Agreement, we agreed with Aetna that our quarterly dividend would not exceed $0.29 per share prior to the closing or termination of the Merger. On October 26, 2016, the Board declared a cash dividend of $0.29 per share that was paid on January 27, 2017 to stockholders of record on January 12, 2017, for an aggregate amount of $43 million.

On February 14, 2017, following the termination of the Merger Agreement, the Board declared a cash dividend of $0.40 per share, to be paid on April 28, 2017, to the stockholders of record on March 31, 2017. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

Stock Total Return Performance

The following graph compares our total return to stockholders with the returns of the Standard & Poor's Composite 500 Index ("S&P 500") and the Dow Jones US Select Health Care Providers Index ("Peer Group") for the five years ended December 31, 2016. The graph assumes an investment of $100 in each of our common stock, the S&P 500, and the Peer Group on December 31, 2011, and that dividends were reinvested when paid.



	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016
HUM	$ 100	$ 79	$ 121	$ 170	$ 212	$ 244
S&P 500	$ 100	$ 116	$ 154	$ 175	$ 177	$ 198
Peer Group	$ 100	$ 117	$ 161	$ 206	$ 218	$ 220

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

Issuer Purchases of Equity Securities

The following table indicates that we made no purchases during the three months ended December 31, 2016 of equity securities that are registered by us pursuant to Section 12 of the Exchange Act:

Period	Total Number of Shares Purchased (1)(2)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (1)(2)	Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1)
October 2016	—	$ —	—	$ —
November 2016	—	—	—	—
December 2016	—	—	—	—
Total	—	$ —	—	

(1) In September 2014, the Board of Directors replaced a previous share repurchase authorization of up to $1 billion with an authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, which expired on December 31, 2016. Pursuant to the Merger Agreement, after July 2, 2015, we were prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we suspended our share repurchase program.

(2) Excludes 0.6 million shares repurchased in connection with employee stock plans.

The Merger Agreement included customary restrictions on the conduct of our business prior to the completion of the Merger, generally requiring us to conduct our business in the ordinary course and subjecting us to a variety of customary specified limitations absent Aetna's prior written consent, including, for example, limitations on dividends (we agreed that our quarterly dividend would not exceed $0.29 per share) and repurchases of our securities (we agreed to suspend our share repurchase program). On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017. Under this new authorization, we expect to complete a $1.5 billion accelerated share repurchase program in the first quarter of 2017.

ITEM 6. SELECTED FINANCIAL DATA

	2016 (a)	2015 (b)(c)	2014 (b)(d)	2013 (b)(e)	2012 (b)(f)
	(dollars in millions, except per common share results)				
Summary of Operating Results:					
Revenues:					
Premiums	$ 53,021	$ 52,409	$ 45,959	$ 38,829	$ 37,009
Services	969	1,406	2,164	2,109	1,726
Investment income	389	474	377	375	391
Total revenues	54,379	54,289	48,500	41,313	39,126
Operating expenses:					
Benefits	45,007	44,269	38,166	32,564	30,985
Operating costs	7,277	7,318	7,639	6,355	5,830
Depreciation and amortization	354	355	333	333	295
Total operating expenses	52,638	51,942	46,138	39,252	37,110
Income from operations	1,741	2,347	2,362	2,061	2,016
Gain on sale of business	—	270	—	—	—
Interest expense	189	186	192	140	105
Income before income taxes	1,552	2,431	2,170	1,921	1,911
Provision for income taxes	938	1,155	1,023	690	689
Net income	$ 614	$ 1,276	$ 1,147	$ 1,231	$ 1,222
Basic earnings per common share	$ 4.11	$ 8.54	$ 7.44	$ 7.81	$ 7.56
Diluted earnings per common share	$ 4.07	$ 8.44	$ 7.36	$ 7.73	$ 7.47
Dividends declared per common share	$ 1.16	$ 1.15	$ 1.11	$ 1.07	$ 1.03
Financial Position:					
Cash and investments	$ 13,675	$ 11,681	$ 11,482	$ 10,938	$ 11,153
Total assets	25,396	24,678	23,497	20,719	19,962
Benefits payable	4,563	4,976	4,475	3,893	3,779
Debt	4,092	4,093	3,795	2,584	2,594
Stockholders' equity	10,685	10,346	9,646	9,316	8,847
Cash flows from operations	$ 1,936	$ 868	$ 1,618	$ 1,716	$ 1,923
Key Financial Indicators:					
Benefit ratio	84.9%	84.5%	83.0%	83.9%	83.7%
Operating cost ratio	13.5%	13.6%	15.9%	15.5%	15.1%
Membership by Segment:					
Retail segment:					
Medical membership	9,406,100	9,226,800	8,376,500	6,459,300	5,956,700
Specialty membership	1,088,100	1,153,100	1,165,800	1,042,500	948,700
Group segment:					
Medical membership	4,793,300	4,963,400	5,430,200	5,501,600	5,573,400
Specialty membership	5,873,100	6,068,700	6,502,700	6,780,800	7,136,200
Other Businesses:					
Medical membership	30,800	32,600	35,000	23,400	558,700
Consolidated:					
Total medical membership	14,230,200	14,222,800	13,841,700	11,984,300	12,088,800
Total specialty membership	6,961,200	7,221,800	7,668,500	7,823,300	8,084,900

(a) Includes a reduction in premiums revenue of $583 million ($367 million after tax, or $2.43 per diluted common share) associated with the write-off of commercial risk corridor receivables. Also includes benefits expense of $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies. In addition, we recorded transaction and integration planning costs in connection with the Merger of approximately $104 million, or $0.64 per diluted common share.

(b) Debt for prior periods has been recast to conform to the 2016 presentation which presents debt issuance cost as a direct reduction of the related liability instead of an asset.

(c) Includes a gain on the sale of Concentra Inc., net of transaction costs, of $270 million ($238 million after tax, or $1.57 per diluted common share). Also includes benefits expense of $176 million ($112 million after tax, or $0.74 per diluted common share) for a provision for probable

future losses (premium deficiency) for individual commercial medical business compliant with the Health Care Reform Law for the 2016 coverage year.

(d) Includes loss on extinguishment of debt of $37 million ($23 million after tax, or $0.15 per diluted common share) for the redemption of senior notes.

(e) Includes benefits expense of $243 million ($154 million after tax, or $0.99 per diluted common share) for reserve strengthening associated with our non-strategic closed block of long-term care insurance policies.

(f) Includes the acquired operations of Arcadian Management Services, Inc. from March 31, 2012, SeniorBridge Family Companies, Inc. from July 6, 2012, and Metropolitan Health Networks, Inc. from December 21, 2012.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Executive Overview

General

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country.

Our industry relies on two key statistics to measure performance. The benefit ratio, which is computed by taking total benefits expense as a percentage of premiums revenue, represents a statistic used to measure underwriting profitability. The operating cost ratio, which is computed by taking total operating costs, excluding depreciation and amortization, as a percentage of total revenue less investment income, represents a statistic used to measure administrative spending efficiency.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger.

The Merger was subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, and (ii) the absence of legal restraints and prohibitions on the consummation of the Merger.

On December 22, 2016, in order to extend the "End Date" (as defined in the Merger Agreement), Aetna and Humana each agreed to waive until 11:59 p.m. (Eastern time) on February 15, 2017 its right to terminate the Merger Agreement due to a failure of the Mergers to have been completed on or before December 31, 2016.

On July 21, 2016, the U.S. Department of Justice and the attorneys general of certain U.S. jurisdictions filed a civil antitrust complaint in the U.S. District Court for the District of Columbia against us and Aetna, alleging that the Merger would violate Section 7 of the Clayton Antitrust Act and seeking a permanent injunction to prevent the Merger from being completed. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

Business Segments

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts, as well as individual commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products. In addition, the Retail segment also includes our contract

with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Group segment consists of employer group commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary insurance benefits, as well as administrative services only, or ASO products. In addition, our Group segment includes our health and wellness products (primarily marketed to employer groups) and military services business, primarily our TRICARE South Region contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, home based services, and clinical programs, as well as services and capabilities to advance population health. We will continue to report under the category of Other Businesses those businesses which do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

The results of each segment are measured by income before income taxes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations.

Seasonality

One of the product offerings of our Retail segment is Medicare stand-alone prescription drug plans, or PDPs, under the Medicare Part D program. Our quarterly Retail segment earnings and operating cash flows are impacted by the Medicare Part D benefit design and changes in the composition of our membership. The Medicare Part D benefit design results in coverage that varies as a member's cumulative out-of-pocket costs pass through successive stages of a member's plan period, which begins annually on January 1 for renewals. These plan designs generally result in us sharing a greater portion of the responsibility for total prescription drug costs in the early stages and less in the latter stages. As a result, the PDP benefit ratio generally decreases as the year progresses. In addition, the number of low-income senior members as well as year-over-year changes in the mix of membership in our stand-alone PDP products affects the quarterly benefit ratio pattern.

Our Group segment also experiences seasonality in the benefit ratio pattern. However, the effect is opposite of Medicare stand-alone PDP in the Retail segment, with the Group segment's benefit ratio increasing as fully-insured members progress through their annual deductible and maximum out-of-pocket expenses. Similarly, certain of our fully-insured individual commercial medical products in our Retail segment experience seasonality in the benefit ratio akin to the Group segment, including the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers. As previously underwritten members transition, it results in policy lapses and the release of reserves for future policy benefits partially offset by the recognition of previously deferred acquisition costs. These policy lapses generally occur during the first quarter of the new coverage year following the open enrollment period reducing the benefit ratio in the first quarter. The recognition of a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law in the fourth quarter of 2015, and subsequent changes in estimates, also impact the quarterly benefit ratio pattern for this business in 2016 and 2015.

In addition, the Retail segment also experiences seasonality in the operating cost ratio as a result of costs incurred in the second half of the year associated with the Medicare and individual health care exchange marketing seasons.

Highlights

Consolidated

- On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017. Under this new authorization, we expect to complete a $1.5 billion accelerated share repurchase program in the first quarter of 2017. Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

- Our 2016 results reflect the continued implementation of our strategy to offer our members affordable health care combined with a positive consumer experience in growing markets. At the core of this strategy is our integrated care delivery model, which unites quality care, high member engagement, and sophisticated data analytics. Our approach to primary, physician-directed care for our members aims to provide quality care that is consistent, integrated, cost-effective, and member-focused, provided by both employed physicians and physicians with network contract arrangements. The model is designed to improve health outcomes and affordability for individuals and for the health system as a whole, while offering our members a simple, seamless healthcare experience. We believe this strategy is positioning us for long-term growth in both membership and earnings. We offer providers a continuum of opportunities to increase the integration of care and offer assistance to providers in transitioning from a fee-for-service to a value-based arrangement. These include performance bonuses, shared savings and shared risk relationships. At December 31, 2016, approximately 1,816,300 members, or 64.0%, of our individual Medicare Advantage members were in value-based relationships under our integrated care delivery model, as compared to 1,633,100 members, or 59.3%, at December 31, 2015.

- On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million ($367 million after-tax, or $2.43 per diluted common share) in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. At December 31, 2016, we estimate that we are entitled to collect a total of $619 million from HHS under the commercial risk corridor program for the 2014 through 2016 program years.

- In the fourth quarter of 2016, we increased the future policy benefits expense by approximately $505 million ($318 million after tax, or $2.11 per diluted common share) for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies.

- As discussed in the Retail segment highlights that follow, during 2015, we recognized a premium deficiency reserve of approximately $176 million for certain of our individual commercial medical products for the 2016 coverage year. During 2016, we increased this premium deficiency reserve associated with the 2016 coverage year by $208 million, or $0.87 per diluted common share.

- During 2016, we recorded transaction and integration planning costs in connection with the Merger of approximately $104 million, or $0.64 per diluted common share. During 2015, we recorded transaction costs in connection with the Merger of approximately $23 million, or $0.14 per diluted common share. Certain costs associated with the transaction were not deductible for tax purposes.

- On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, to MJ Acquisition Corporation, a joint venture between Select Medical Holdings Corporation and Welsh, Carson, Anderson & Stowe XII, L.P., a private equity fund, for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $270 million, or $1.57 per diluted common share in 2015.

- Excluding the impact of the risk corridor receivables write-off, the long-term care reserve strengthening, the premium deficiency reserve recorded for the 2016 coverage year, and the sale of Concentra in 2015, the increase in pretax income primarily was due to year-over-year improvements in results for our individual Medicare Advantage business and Healthcare Services segment as well as increased profitability in our state-based contracts business.

- Year-over-year comparisons of the operating cost ratio are impacted by the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio than our Group and Retail segments. This was partially offset by the risk corridor receivables write-off.

- Investment income decreased $85 million in 2016, primarily due to lower realized capital gains in 2016 and lower interest rates partially offset by a higher average invested balance.

- As disclosed in Note 2 to the consolidated financial statements included in this report, we elected to early adopt new accounting guidance related to accounting for employee share-based payments, which changes how income tax effects of employee share-based payments are recorded. We adopted this guidance prospectively effective January 1, 2016. The adoption of this new guidance resulted in the recognition of approximately $20 million of tax benefits in net income, or $0.12 per diluted common share, in the first quarter of 2016.

- Operating cash flow provided by operations was $1.9 billion for the year ended December 31, 2016 as compared to operating cash flow provided by operations of $868 million for the year ended December 31, 2015. The increase in operating cash flow primarily was due to significantly favorable working capital items and higher earnings exclusive of the commercial risk corridor receivables write-off and the long-term care reserve strengthening in 2016, as well as the gain on sale of Concentra and the recognition of the premium deficiency reserve in 2015 discussed previously. The working capital changes year-over-year primarily reflect lower income tax payments, changes in the net receivable balance associated with the premium stabilization programs established under health care reform, or the 3R's, and the timing of payroll cycles resulting in one less payroll cycle in 2016, partially offset by the timing of payments for benefits expense.

- In 2016, we paid the federal government $916 million for the annual non-deductible health insurance industry fee compared to our payment of $867 million in 2015. This fee is not deductible for tax purposes, which significantly increased our effective income tax rate beginning in 2014. The health insurance industry fee is further described below under the section titled "Health Care Reform." The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. This suspension will significantly reduce our operating costs and effective tax rate in 2017. Our effective tax rate for 2017 is expected to be approximately 36% to 37%. The decline in the effective tax rate primarily is due to the suspension of the annual health insurance industry fee in 2017.

- We paid dividends to stockholders of $177 million in 2016 as compared to $172 million in 2015.

Retail Segment

- On February 1, 2017, CMS issued its preliminary 2018 Medicare Advantage and Part D payment rates and proposed policy changes, which we refer to collectively as the Advance Notice. CMS has invited public comment on the Advance Notice before publishing final rates on April 3, 2017 (the Final Notice). In the Advance Notice, CMS estimates Medicare Advantage plans across the sector will, on average, experience a 0.25 percent increase in benchmark funding based on proposals included therein. As indicated by CMS, its estimate excludes the impact of fee-for-service county rebasing/re-pricing since the related impact is dependent upon finalization of certain data, which will be available with the publication of the Final Notice. CMS' estimate

includes 40 basis points of negative impact associated with Star quality bonuses sector-wide. Excluding that item, CMS' estimate would be a 0.65 percent increase. Based on our preliminary analysis using the same factors CMS included in its estimate, the components of which are detailed on CMS' website, we anticipate the proposals in the Advance Notice would result in a change to our benchmark funding relatively in line with CMS' estimate, excluding the impact attributable to Star quality bonuses. We believe we can design our 2018 Medicare Advantage plan filings, including the applicable level of rate changes, to remain competitive compared to both the combination of original Medicare with a supplement policy and Medicare Advantage products offered by our competitors. Failure to execute these strategies may result in a material adverse effect on our results of operations, financial position, and cash flows.

- The achievement of Star Ratings of four or higher qualifies Medicare Advantage plans for premium bonuses. Star Ratings for the 2018 bonus year issued by CMS in October 2016 indicated that the percentage of our July 31, 2016 Medicare Advantage membership in 4-Star plans or higher declined to approximately 37% from approximately 78% of our July 31, 2015 Medicare Advantage membership. The decline in membership in 4-Star rated plans does not take into account certain operational actions discussed below that we have taken and intend to take over the coming months to mitigate any potential negative impact of these published ratings on Star bonus revenues for 2018.

  We believe that the decline is primarily attributable to the impact of lower scores for certain Stars measures as a result of our 2015 comprehensive program audit by CMS. The Civil Monetary Penalty imposed by CMS following the audit resulted in a significant reduction to the Beneficiary Access and Plan Performance, or BAPP, measure. Additionally, an issue with the timeliness of appeal decisions noted in the audit resulted in automatic downgrades to two additional Star measures. Moreover, higher threshold levels for certain individual Star measures as compared to the previous year reduced our ratings on these measures. Thresholds for Star measures are calculated across the sector, without regard to weighted average membership of each plan. Together, these factors more than offset our improved Star rating performance in certain quality measures such as Healthcare Effectiveness Data and Information, or HEDIS.

  Our Healthcare Effectiveness Data and Information Set, or HEDIS, measures, demonstrating the achievement of clinical outcomes, are at record-high results for the company. Accordingly, we believe that our Star ratings for the 2018 bonus year do not accurately reflect our actual performance under certain Star measures. Consequently, we filed for reconsideration of certain of those ratings under the appropriate administrative process. We are also evaluating our contract structures for rationalization to mitigate the negative impact on Star bonus revenues for 2018.

  The ultimate financial impact to us related to 2018 Star bonus revenues is dependent upon multiple variables including, but not limited to, the number of Medicare Advantage members in 4-Star or higher rated plans and the geographic distribution of those members as well as a number of operational initiatives which would serve to mitigate the negative impact of our Star performance. Star results for the 2018 bonus year are not expected to materially impact our Medicare revenue for 2017 but could be material to 2018 Medicare revenues.

- In 2016, our Retail segment pretax income increased by $7 million, or 0.8%, from 2015 primarily driven by the year-over-year improvement in our individual Medicare Advantage and state-based Medicaid businesses along with the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 associated with certain individual commercial medical policies for the 2016 coverage year. These items were substantially offset by the write-off of commercial risk corridor receivables as described further below and in the results of operations discussion that follows.

- Our Medicare Advantage results improved year-over-year primarily due to lower utilization and favorable year-over-year comparisons of prior-period medical claims reserve development. Operational initiatives are centered around optimizing the performance of our clinical programs to reduce medical cost trend. In addition our Medicare Advantage membership increased year-over-year as discussed below.

- Operating results for our individual commercial medical business compliant with the Health Care Reform Law have been challenged primarily due to unanticipated modifications in the program subsequent to the

passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. We took a number of actions in 2015 that we believed would improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results that included the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment in the fourth quarter of 2015 of the profitability of our individual commercial medical policies compliant with the Health Care Reform Law, we recorded in that quarter a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million, or $0.74 per diluted common share. In 2016, we increased the premium deficiency reserve for the 2016 coverage year by $208 million, primarily as a result of unfavorable current and projected claims experience at that time. As of December 31, 2016, we had no remaining premium deficiency reserve.

For 2017, we are offering on-exchange individual commercial medical plans in 11 states, a reduction from the 15 states in which we offered on-exchange coverage in 2016. In addition, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017. Our 2017 geographic presence for our individual commercial medical offerings covers 156 counties, down from our 2016 presence in 1,351 counties (covering both on-exchange and off-exchange offerings). Given recent competitor actions, including market exits resulting in the automatic assignment of members to our plans, as well as sales and renewal results from the open enrollment process, we now expect 2017 premiums associated with Health Care Reform Law compliant offerings to be in the range of $850 million to $900 million. By comparison, our full year 2016 premiums associated with Health Care Reform Law compliant offerings were $3.3 billion. The decrease from 2016 results reflects the adjustment to our geographic presence and product discontinuances, erosion of competitive position, partially offset by premium increases as well as the projected impact of certain competitor actions.

On February 14, 2017, we announced we are exiting our individual commercial medical businesses January 1, 2018. As discussed previously, we have worked over the past several years to address market and programmatic challenges in order to keep coverage options available wherever we could offer a viable product. This has included pursuing business changes, such as modifying networks, restructuring product offerings, reducing the company's geographic footprint and increasing premiums. All of these actions were taken with the expectation that our individual commercial medical business would stabilize to the point where we could continue to participate in the program. However, based on our initial analysis of data associated with our healthcare exchange membership following the 2017 open enrollment period, we are seeing further signs of an unbalanced risk pool. Therefore, we have decided that we cannot continue to offer this coverage for 2018.

- Individual Medicare Advantage membership of 2,837,600 at December 31, 2016 increased 84,200 members, or 3.1%, from 2,753,400 at December 31, 2015 reflecting net membership additions, particularly for our Medicare Advantage Health Maintenance Organization, or HMO, offerings. January 2017 individual Medicare Advantage membership approximated 2,848,000, increasing approximately 10,400 members from December 31, 2016 reflecting net membership additions during the recently completed Annual Election Period for Medicare beneficiaries, including the loss of approximately 50,000 members in plans no longer offered for 2017. For full year 2017, we anticipate net membership growth in our individual Medicare Advantage offerings of 30,000 to 40,000.
- Group Medicare Advantage membership of 355,400 at December 31, 2016 decreased 128,700 members, or 26.6%, from 484,100 at December 31, 2015 primarily reflecting the loss of a large account that moved to a private exchange offering on January 1, 2016. January 2017 group Medicare Advantage membership approximated 431,000, increasing approximately 75,600 members, or 21%, from December 31, 2016 reflecting net membership additions during the recently completed Annual Election Period for Medicare beneficiaries.

For full year 2017, we expect net membership growth in our Group Medicare Advantage offerings of 70,000 to 80,000.

- Medicare stand-alone PDP membership of 4,951,400 at December 31, 2016 increased 393,500 members, or 8.6%, from 4,557,900 at December 31, 2015 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2016 plan year. January 2017 Medicare stand-alone PDP membership (excluding transitional growth from the LI-NET prescription drug plan program) increased approximately 222,600 members, or 4%, from December 31, 2016 to 5,174,000 members reflecting net membership additions during the recently completed Annual Election Period for Medicare beneficiaries. For full year 2017, we anticipate net membership growth in our Medicare stand-alone PDP offerings of 320,000 to 340,000.
- Our state-based Medicaid membership of 388,100 at December 31, 2016 increased 14,400 members, or 3.9%, from 373,700 at December 31, 2015 primarily driven by the addition of members under our Florida Medicaid contract.
- Individual commercial medical membership of 654,800 at December 31, 2016 decreased 244,300 members, or 27.2%, from 899,100 at December 31, 2015 primarily reflecting the loss of on-exchange members due to product competitiveness, the loss of membership associated with the discontinuance of certain Health Care Reform Law compliant plans in 2016, the loss of membership associated with non-payment of premiums or termination by CMS due to lack of eligibility documentation, and the loss of members subscribing to plans that are not compliant with the Health Care Reform Law. At December 31, 2016, individual commercial medical membership in plans compliant with the Health Care Reform Law, both on-exchange and off-exchange, was 580,100 members, a decrease of 177,800 members or 23.5% from December 31, 2015.

  January 2017 individual commercial medical membership approximated 204,000, including 152,000 enrolled in plans compliant with the Health Care Reform Law. The decline of approximately 450,800 members, or 69%, from December 31, 2016 reflects net membership declines during the on-going open enrollment period for healthcare exchanges and the impact of product and service area reductions.

Group Segment

- Group segment pretax income for the year ended December 31, 2016 was essentially unchanged from the year ended December 31, 2015 as discussed in the results of operations discussion that follows.
- On July 21, 2016, we were notified by the Defense Health Agency, or DHA, that we were awarded the TRICARE East Region contract, with delivery of health care services expected to commence on October 1, 2017. The new East Region is a combination of the current North Region and South Region. The next generation East Region and West Region contract awards are currently subject to protests by unsuccessful bidders in the U.S. Court of Federal Claims and before the DHA. Our current TRICARE South Region contract expires March 31, 2017.
- Membership in Go365™ (known as HumanaVitality® prior to January 2017), our wellness and loyalty rewards program, declined 7.2% to 3,649,100 at December 31, 2016 from 3,932,300 at December 31, 2015 reflecting a decline in group Medicare Advantage membership from the loss of the large account on January 1, 2016 and a decline in individual commercial medical membership.

Healthcare Services Segment

- Year-over-year comparisons of results of operations are impacted by the completion of the sale of Concentra on June 1, 2015.

- As discussed in the detailed Healthcare Services segment results of operations discussion that follows, our Healthcare Services segment pretax income increased $86 million, or 8.8%, for the year ended December 31, 2016. This increase was primarily due to incremental earnings associated with revenue growth from our pharmacy solutions business as it increased mail-order penetration and served our growing individual Medicare membership, partially offset by ongoing pressures in our provider services business reflecting significantly lower Medicare rates year-over-year associated with CMS' risk coding recalibration for 2016 in geographies where our provider assets are primarily located.
- Programs to enhance the quality of care for members are key elements of our integrated care delivery model. At December 31, 2016, we enrolled approximately 622,300 Medicare Advantage members with complex chronic conditions in the Humana Chronic Care Program, a 5.4% increase compared with approximately 590,300 members at December 31, 2015, reflecting a greater focus on members living with the most chronic conditions. Enhanced predictive modeling capabilities and proactive clinical outreach and engagement of those members helped drive increased clinical program participation, offset by the loss of engaged members associated with the group Medicare Advantage account that termed on January 1, 2016 as discussed previously. We continue to refine our clinical management programs to help optimize the quality of healthcare for our members and ensure appropriate returns on our investments.

Other Businesses

- As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2016 Form 10-K.

Health Care Reform

The Health Care Reform Law enacted significant reforms to various aspects of the U.S. health insurance industry. Certain significant provisions of the Health Care Reform Law include, among others, mandated coverage requirements, mandated benefits and guarantee issuance associated with commercial medical insurance, rebates to policyholders based on minimum benefit ratios, adjustments to Medicare Advantage premiums, the establishment of federally-facilitated or state-based exchanges coupled with programs designed to spread risk among insurers, and the introduction of plan designs based on set actuarial values. In addition, the Health Care Reform Law established insurance industry assessments, including an annual health insurance industry fee and a three-year $25 billion industry wide commercial reinsurance fee. The annual health insurance industry fee levied on the insurance industry was $8 billion in 2014 and $11.3 billion in each of 2015 and 2016, with increasing annual amounts starting in 2018, and is not deductible for income tax purposes, which significantly increased our effective income tax rate. Our effective tax rate for 2016 was approximately 60.5%. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. This suspension will significantly reduce our operating costs and effective tax rate in 2017. Our effective tax rate for 2017 is expected to be approximately 36% to 37%. The decline in the effective tax rate primarily is due to the suspension of the annual health insurance industry fee in 2017. The health insurance industry fee levied on the insurance industry was previously expected to be $14 billion in 2017. In 2016, we paid the federal government $916 million for the annual health insurance industry fee, a 5.7% increase from $867 million in 2015, primarily reflecting growth in our market share.

In addition, the Health Care Reform Law expands federal oversight of health plan premium rates and could adversely affect our ability to appropriately adjust health plan premiums on a timely basis. Financing for these reforms comes, in part, from material additional fees and taxes on us (as discussed above) and other health plans and individuals which began in 2014, as well as reductions in certain levels of payments to us and other health plans under Medicare as described in this 2016 Form 10-K.

As noted above, the Health Care Reform Law required the establishment of health insurance exchanges for individuals and small employers to purchase health insurance that became effective January 1, 2014, with an annual open enrollment period. Insurers participating on the health insurance exchanges must offer a minimum level of benefits

and are subject to guidelines on setting premium rates and coverage limitations. We may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants in this market. In addition, the risk corridor, reinsurance, and risk adjustment provisions of the Health Care Reform Law, established to apportion risk for insurers, may not be effective in appropriately mitigating the financial risks related to our products, and audits of our submissions under these programs may result in returns of funds distributed. In addition, regulatory changes to the implementation of the Health Care Reform Law that allowed individuals to remain in plans that are not compliant with the Health Care Reform Law or to enroll outside of the annual enrollment period may have an adverse effect on our pool of participants in the health insurance exchange. In addition, states may impose restrictions on our ability to increase rates. All of these factors may have a material adverse effect on our results of operations, financial position, or cash flows if our premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions used in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows and could impact our decision to participate or continue in the program in certain states. For 2017, we are offering on-exchange individual commercial medical plans in 11 states, a reduction from the 15 states in which we offered on-exchange coverage in 2016. In addition, we discontinued substantially all Health Care Reform Law compliant off-exchange individual commercial medical plans effective January 1, 2017.

If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur. We may be unable to adjust our product offerings, geographic footprint, or pricing during any given year such legislative changes occur in sufficient time to mitigate any adverse effects.

As discussed above, it is reasonably possible that the Health Care Reform Law and related regulations, as well as future legislative changes, including legislative restrictions on our ability to manage our provider network or otherwise operate our business, or regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, in the aggregate may have a material adverse effect on our results of operations (including restricting revenue, enrollment and premium growth in certain products and market segments, restricting our ability to expand into new markets, increasing our medical and operating costs, further lowering our Medicare payment rates and increasing our expenses associated with the non-deductible health insurance industry fee and other assessments); our financial position (including our ability to maintain the value of our goodwill); and our cash flows (including the delayed receipt of amounts due under the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law).

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2016, we collected approximately $36 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program.

We intend for the discussion of our financial condition and results of operations that follows to assist in the understanding of our financial statements and related changes in certain key items in those financial statements from year to year, including the primary factors that accounted for those changes. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers and are described in Note 17 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2016 Form 10-K.

Comparison of Results of Operations for 2016 and 2015

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2016 and 2015:

Consolidated

	2016	2015	Change	
			Dollars	Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 46,546	$ 45,805	$ 741	1.6 %
Group	6,437	6,569	(132)	(2.0)%
Other Businesses	38	35	3	8.6 %
Total premiums	53,021	52,409	612	1.2 %
Services:				
Retail	8	9	(1)	(11.1)%
Group	694	698	(4)	(0.6)%
Healthcare Services	257	685	(428)	(62.5)%
Other Businesses	10	14	(4)	(28.6)%
Total services	969	1,406	(437)	(31.1)%
Investment income	389	474	(85)	(17.9)%
Total revenues	54,379	54,289	90	0.2 %
Operating expenses:				
Benefits	45,007	44,269	738	1.7 %
Operating costs	7,277	7,318	(41)	(0.6)%
Depreciation and amortization	354	355	(1)	(0.3)%
Total operating expenses	52,638	51,942	696	1.3 %
Income from operations	1,741	2,347	(606)	(25.8)%
Gain on sale of business	—	270	(270)	100.0 %
Interest expense	189	186	3	1.6 %
Income before income taxes	1,552	2,431	(879)	(36.2)%
Provision for income taxes	938	1,155	(217)	(18.8)%
Net income	$ 614	$ 1,276	$ (662)	(51.9)%
Diluted earnings per common share	$ 4.07	$ 8.44	$ (4.37)	(51.8)%
Benefit ratio (a)	84.9%	84.5%		0.4 %
Operating cost ratio (b)	13.5%	13.6%		(0.1)%
Effective tax rate	60.5%	47.5%		13.0 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income for 2016 was $614 million, or $4.07 per diluted common share, in 2016 compared to $1.3 billion, or $8.44 per diluted common share, in 2015. Net income includes a write-off of $2.43 per diluted common share in

receivables associated with the commercial risk corridor premium stabilization program and reserve strengthening for our non-strategic closed block of long-term care insurance business of $2.11 per diluted common share, as discussed below. These items were partially offset by the impact of the premium deficiency reserve of $0.74 per diluted common share recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. In addition, the completion of the sale of Concentra on June 1, 2015 resulted in an after-tax gain of $1.57 per diluted common share in 2015. Excluding these items, the increase primarily was due to year-over-year improvement in results for our individual Medicare Advantage business and our Healthcare Services segment as well as increased profitability in our state-based Medicaid business, partially offset by an increase in the effective tax rate as discussed below. In addition, 2016 includes expenses of $0.64 per diluted common share and 2015 includes expenses of $0.14 per diluted common share for transaction and integration planning costs associated with the Merger, certain of which were not deductible for tax purposes.

Premiums Revenue

Consolidated premiums increased $612 million, or 1.2%, from 2015 to $53.0 billion for 2016 primarily reflecting higher premiums in the Retail segment mainly driven by average membership growth and per member premium increases for certain of our lines of business. These increases were partially offset by the write-off of $583 million of receivables associated with the commercial risk corridor premium stabilization program, the loss of premiums associated with a large group Medicare account that moved to a private exchange on January 1, 2016, and a decline in premiums revenue associated with fewer individual commercial medical members as discussed in our segment results of operations discussion that follows. Average membership is calculated by summing the ending membership for each month in a period and dividing the result by the number of months in a period. Premiums revenue reflects changes in membership and average per member premiums. Items impacting average per member premiums include changes in premium rates as well as changes in the geographic mix of membership, the mix of product offerings, and the mix of benefit plans selected by our membership.

Services Revenue

Consolidated services revenue decreased $437 million, or 31.1%, from 2015 to $1.0 billion for 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

Investment Income

Investment income totaled $389 million for 2016, a decrease of $85 million, or 17.9%, from 2015, primarily due to lower realized capital gains in 2016 and lower interest rates partially offset by a higher average invested balance.

Benefits Expense

Consolidated benefits expense was $45.0 billion for 2016, an increase of $738 million, or 1.7%, from 2015 primarily due to $505 million in incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies partially offset by the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. Excluding the long-term care reserve strengthening and impact of the premium deficiency reserve, the increase is primarily due to an increase in the Retail segment mainly driven by higher average individual Medicare Advantage membership. As more fully described herein under the section entitled “Benefits Expense Recognition”, actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $582 million in 2016 and $236 million in 2015. The increase in prior-period medical claims reserve development year over-year primarily was due to favorable year-over-year comparisons for our Medicare Advantage and individual commercial medical businesses.

The consolidated benefit ratio for 2016 was 84.9%, an increase of 40 basis points from 2015 primarily due to the incremental benefits expense for the reserve strengthening in our non-strategic closed block of long-term care insurance policies, the impact on the benefit ratio of lower consolidated premiums associated with the write-off of receivables for the commercial risk corridor premium stabilization program, and the impact of the premium deficiency reserve

recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. Excluding the impact of the write-off of the commercial risk corridor receivables and the premium deficiency reserve, these items were partially offset by year-over-year improvement in both the Retail and Group segment benefit ratios as discussed in the segment results of operations discussion that follows. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 110 basis points in 2016 versus approximately 50 basis points in 2015.

Operating Costs

Our segments incur both direct and shared indirect operating costs. We allocate the indirect costs shared by the segments primarily as a function of revenues. As a result, the profitability of each segment is interdependent.

Consolidated operating costs decreased $41 million, or 0.6%, from 2015 to $7.3 billion in 2016 primarily due to the completion of the sale of Concentra on June 1, 2015

The consolidated operating cost ratio for 2016 was 13.5%, decreasing 10 basis points from 2015 primarily due to the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio than our Group and Retail segments. This was partially offset by the unfavorable year-over-year comparison associated with the temporary suspension of certain discretionary administrative costs in the latter half of 2015, along with the impact of the commercial risk corridor receivables write-off in the fourth quarter of 2016. In addition, transaction and integration planning costs associated with the Merger increased the operating cost ratio by 20 basis points in 2016. There was minimal impact for transaction costs to the operating cost ratio in 2015.

Depreciation and Amortization

Depreciation and amortization for 2016 of $354 million was relatively unchanged from 2015.

Interest Expense

Interest expense was $189 million for 2016 compared to $186 million for 2015, an increase of $3 million, or 1.6%.

Income Taxes

Our effective tax rate during 2016 was 60.5% compared to the effective tax rate of 47.5% in 2015 primarily reflecting lower pretax income year-over-year, the beneficial effect of the sale of Concentra on June 1, 2015 and the impact of non-deductible transaction costs associated with the Merger. Non-deductible transaction and integration planning costs associated with the Merger increased our effective tax rate by approximately 3.4 percentage points in 2016 versus approximately 0.4 percentage points in 2015. Conversely, the tax effect of the sale of Concentra reduced our effective tax rate by approximately 4.5 percentage points in 2015. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate. Our effective tax rate for 2017 is expected to be approximately 36% to 37%. The decline in the effective tax rate primarily is due to the suspension of the annual health insurance industry fee in 2017.

The effective tax rate for 2016 also reflects tax benefits associated with adopting new guidance related to the accounting for employee share-based payments effective January 1, 2016 as described in Note 2 to the condensed consolidated financial statements included in this report, which decreased our effective tax rate by approximately 1.2 percentage points in 2016.

Retail Segment

	2016	2015	Change Members	Change Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,837,600	2,753,400	84,200	3.1 %
Group Medicare Advantage	355,400	484,100	(128,700)	(26.6)%
Medicare stand-alone PDP	4,951,400	4,557,900	393,500	8.6 %
Total Retail Medicare	8,144,400	7,795,400	349,000	4.5 %
Individual commercial	654,800	899,100	(244,300)	(27.2)%
State-based Medicaid	388,100	373,700	14,400	3.9 %
Medicare Supplement	218,800	158,600	60,200	38.0 %
Total Retail medical members	9,406,100	9,226,800	179,300	1.9 %
Individual specialty membership (a)	1,088,100	1,153,100	(65,000)	(5.6)%

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2016	2015	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 31,863	$ 29,526	$ 2,337	7.9 %
Group Medicare Advantage	4,283	5,588	(1,305)	(23.4)%
Medicare stand-alone PDP	4,009	3,846	163	4.2 %
Total Retail Medicare	40,155	38,960	1,195	3.1 %
Individual commercial	3,064	3,939	(875)	(22.2)%
State-based Medicaid	2,640	2,341	299	12.8 %
Medicare Supplement	428	304	124	40.8 %
Individual specialty	259	261	(2)	(0.8)%
Total premiums	46,546	45,805	741	1.6 %
Services	8	9	(1)	(11.1)%
Total premiums and services revenue	$ 46,554	$ 45,814	$ 740	1.6 %
Income before income taxes	$ 937	$ 930	$ 7	0.8 %
Benefit ratio	86.2%	86.7%		(0.5)%
Operating cost ratio	11.5%	11.2%		0.3 %

Pretax Results

- Retail segment pretax income was $937 million in 2016, an increase of $7 million, or 0.8%, compared to 2015 primarily driven by the year-over-year improvement in our individual Medicare Advantage and state-based Medicaid businesses along with the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 associated with certain individual commercial medical policies for the 2016 coverage year. These items were substantially offset by the write-off of commercial risk corridor receivables as discussed below.

Enrollment

- Individual Medicare Advantage membership increased 84,200 members, or 3.1%, from December 31, 2015 to December 31, 2016 reflecting net membership additions, particularly for our HMO offerings, for the 2016 plan year.

- Group Medicare Advantage membership decreased 128,700 members, or 26.6%, from December 31, 2015 to December 31, 2016 reflecting the loss of a large account that moved to a private exchange offering on January 1, 2016.

- Medicare stand-alone PDP membership increased 393,500 members, or 8.6%, from December 31, 2015 to December 31, 2016 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2016 plan year.

- Individual commercial medical membership decreased 244,300 members, or 27.2%, from December 31, 2015 to December 31, 2016 primarily reflecting the loss of on-exchange members due to product competitiveness, the loss of membership associated with the discontinuance of certain Health Care Reform Law compliant plans in 2016, the loss of membership associated with non-payment of premiums or termination by CMS due to lack of eligibility documentation, and the loss of members subscribing to plans that are not compliant with the Health Care Reform Law.

- State-based Medicaid membership increased 14,400 members, or 3.9%, from December 31, 2015 to December 31, 2016 primarily driven by the addition of members under our Florida Medicaid contract.

- Individual specialty membership decreased 65,000 members, or 5.6%, from December 31, 2015 to December 31, 2016 primarily due to the loss of individual commercial medical members that also had specialty coverage.

Premiums revenue

- Retail segment premiums increased $741 million, or 1.6%, from 2015 to 2016 primarily due to higher average membership for our individual Medicare Advantage and state-based Medicaid businesses and per member premium increases for certain lines of business. Average individual Medicare Advantage membership increased 3.9% in 2016. These items were partially offset by the write-off of approximately $583 million of receivables associated with the commercial risk corridor premium stabilization program, and declines in group Medicare Advantage (including the loss of a large group Medicare Advantage account) and individual commercial medical membership.

Benefits expense

- The Retail segment benefit ratio of 86.2% for 2016 decreased 50 basis points from 2015 primarily due to lower year-over-year Medicare Advantage utilization, favorable comparisons of prior-year medical claims reserve development, and the impact of the premium deficiency reserve recorded in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year. These items were partially offset by the reduction of premiums related to the write-off of receivables associated with the commercial risk corridor premium stabilization program which increased the Retail segment benefit ratio by approximately 100 basis points in 2016. As previously disclosed, in the fourth quarter of 2015 we recorded a premium deficiency reserve associated with our 2016 individual commercial offerings compliant with the Health Care Reform Law, increasing our 2015 benefit ratio by 40 basis points. During 2016, we increased the premium deficiency reserve for the 2016 coverage year and recorded a change in estimate of $208 million with a corresponding increase in benefits expense primarily as a result of unfavorable current and projected claims experience.

- The Retail segment's benefits expense for 2016 included the beneficial effect of $535 million in favorable prior-year medical claims reserve development versus $228 million in 2015. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 110 basis points in

2016 versus approximately 50 basis points in 2015. The year-over-year increase in prior-period medical claims reserve development primarily was due to favorable year-over-year comparisons for our Medicare Advantage and individual commercial medical business.

Operating costs

- The Retail segment operating cost ratio of 11.5% for 2016 increased 30 basis points from 2015 primarily due to the impact on premiums of the write-off of receivables associated with the commercial risk corridor premium stabilization program, the unfavorable comparison to unusually low operating expenses in 2015 resulting from the temporary suspension of certain discretionary administrative costs, and the loss of a large group Medicare Advantage account which carried a lower operating cost ratio than that for our individual Medicare Advantage business. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 170 basis points in 2016 as compared to 160 basis points in 2015.

Group Segment

			Change	
	2016	2015	Members	Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,136,000	1,178,300	(42,300)	(3.6)%
ASO	573,200	710,700	(137,500)	(19.3)%
Military services	3,084,100	3,074,400	9,700	0.3 %
Total group medical members	4,793,300	4,963,400	(170,100)	(3.4)%
Group specialty membership (a)	5,873,100	6,068,700	(195,600)	(3.2)%

(a) Specialty products include dental, vision, and other voluntary benefit products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

			Change	
	2016	2015	Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,405	$ 5,493	$ (88)	(1.6)%
Group specialty	1,020	1,055	(35)	(3.3)%
Military services	12	21	(9)	(42.9)%
Total premiums	6,437	6,569	(132)	(2.0)%
Services	694	698	(4)	(0.6)%
Total premiums and services revenue	$ 7,131	$ 7,267	$ (136)	(1.9)%
Income before income taxes	$ 257	$ 258	$ (1)	(0.4)%
Benefit ratio	79.6%	80.2%		(0.6)%
Operating cost ratio	24.6%	24.0%		0.6 %

Pretax Results

- Group segment pretax income was relatively unchanged, decreasing $1 million, or 0.4%, to $257 million in 2016 as an increase in the operating cost ratio was substantially offset by improvement in the benefit ratio as discussed below.

Enrollment

- Fully-insured commercial group medical membership decreased 42,300 members, or 3.6% from December 31, 2015 reflecting lower membership in both large and small group accounts.

- Group ASO commercial medical membership decreased 137,500 members, or 19.3%, from December 31, 2015 to December 31, 2016 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.

- Group specialty membership decreased 195,600 members, or 3.2%, from December 31, 2015 to December 31, 2016 primarily due to the loss of several large stand-alone dental and vision accounts as well as the loss of certain fully-insured group medical accounts that also had specialty coverage.

Premiums revenue

- Group segment premiums decreased $132 million, or 2.0%, from 2015 to 2016 primarily due to a decline in fully-insured commercial medical membership as described above, partially offset by an increase in fully-insured commercial medical per member premiums.

Services revenue

- Group segment services revenue decreased $4 million, or 0.6%, from 2015 to 2016 primarily due to a decline in group ASO commercial medical membership.

Benefits expense

- The Group segment benefit ratio decreased 60 basis points from 80.2% in 2015 to 79.6% in 2016 primarily reflecting the beneficial effect of higher prior-year medical claims reserve development in 2016 and lower utilization.

- The Group segment's benefits expense included the beneficial effect of $46 million in favorable prior-year medical claims reserve development in 2016 versus $7 million in 2015. This favorable prior-year medical claims reserve development decreased the Group segment benefit ratio by approximately 70 basis points in 2016 versus approximately 10 basis points in 2015.

Operating costs

- The Group segment operating cost ratio of 24.6% for 2016 increased 60 basis points from 24.0% for 2015 primarily due to the unfavorable comparison to unusually low operating expenses in 2015 resulting from the temporary suspension of certain discretionary administrative costs. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 150 basis points in 2016 as compared to 140 basis points in 2015.

Healthcare Services Segment

	2016	2015	Change	
			Dollars	Percentage
		(in millions)		
Revenues:				
Services:				
Provider services	$ 78	$ 515	$ (437)	(84.9)%
Home based services	148	140	8	5.7 %
Pharmacy solutions	31	30	1	3.3 %
Total services revenues	257	685	(428)	(62.5)%
Intersegment revenues:				
Pharmacy solutions	21,952	20,551	1,401	6.8 %
Provider services	1,677	1,291	386	29.9 %
Home based services	1,026	875	151	17.3 %
Clinical programs	180	203	(23)	(11.3)%
Total intersegment revenues	24,835	22,920	1,915	8.4 %
Total services and intersegment revenues	$ 25,092	$ 23,605	$ 1,487	6.3 %
Income before income taxes	$ 1,067	$ 981	$ 86	8.8 %
Operating cost ratio	95.4%	95.2%		0.2 %

Pretax results

- Healthcare Services segment pretax income of $1,067 million for 2016 increased $86 million, or 8.8%, from 2015 primarily due to incremental earnings associated with revenue growth from our pharmacy solutions business as it increased mail-order penetration and served our growing individual Medicare membership. The increase was partially offset by ongoing pressures in our provider services business reflecting significantly lower Medicare rates year-over-year associated with CMS' risk coding recalibration for 2016 in geographies where our provider assets are primarily located.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group segment membership increased to approximately 426 million in 2016, up 7% versus scripts of approximately 398 million in 2015. The increase primarily reflects growth associated with higher average medical membership for 2016 than in 2015.

Services revenue

- Services revenue decreased $428 million, or 62.5%, from 2015 to $257 million for 2016 primarily due to the completion of the sale of Concentra on June 1, 2015.

Intersegment revenues

- Intersegment revenues increased $1.9 billion, or 8.4%, from 2015 to $24.8 billion for 2016 primarily due to increased mail order penetration and growth in our individual Medicare Advantage and Medicare stand-alone PDP membership which resulted in increased engagement of members in clinical programs and higher utilization of services across the segment.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.4% for 2016 increased slightly from 2015 primarily due to a higher operating cost ratio for our provider services business reflecting significantly lower Medicare rates year-over-year as discussed above, partially offset by operating cost efficiencies associated with our pharmacy operations.

Other Businesses

As previously disclosed, in the fourth quarter of 2016, we increased future policy benefits expense by approximately $505 million for reserve strengthening associated with our closed block of long-term care insurance policies. This increase primarily was driven by emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies as discussed further in Note 18 to the consolidated financial statements included in Item 8. Financial Statements and Supplementary Data in this 2016 Form 10-K.

Comparison of Results of Operations for 2015 and 2014

Certain financial data on a consolidated basis and for our segments was as follows for the years ended December 31, 2015 and 2014:

Consolidated

	2015	2014	Change Dollars	Change Percentage
	(dollars in millions, except per common share results)			
Revenues:				
Premiums:				
Retail	$ 45,805	$ 39,452	$ 6,353	16.1 %
Group	6,569	6,456	113	1.8 %
Other Businesses	35	51	(16)	(31.4)%
Total premiums	52,409	45,959	6,450	14.0 %
Services:				
Retail	9	39	(30)	(76.9)%
Group	698	763	(65)	(8.5)%
Healthcare Services	685	1,353	(668)	(49.4)%
Other Businesses	14	9	5	55.6 %
Total services	1,406	2,164	(758)	(35.0)%
Investment income	474	377	97	25.7 %
Total revenues	54,289	48,500	5,789	11.9 %
Operating expenses:				
Benefits	44,269	38,166	6,103	16.0 %
Operating costs	7,318	7,639	(321)	(4.2)%
Depreciation and amortization	355	333	22	6.6 %
Total operating expenses	51,942	46,138	5,804	12.6 %
Income from operations	2,347	2,362	(15)	(0.6)%
Gain on sale of business	270	—	270	100.0 %
Interest expense	186	192	(6)	(3.1)%
Income before income taxes	2,431	2,170	261	12.0 %
Provision for income taxes	1,155	1,023	132	12.9 %
Net income	$ 1,276	$ 1,147	$ 129	11.2 %
Diluted earnings per common share	$ 8.44	$ 7.36	$ 1.08	14.7 %
Benefit ratio (a)	84.5%	83.0%		1.5 %
Operating cost ratio (b)	13.6%	15.9%		(2.3)%
Effective tax rate	47.5%	47.2%		0.3 %

(a) Represents total benefits expense as a percentage of premiums revenue.

(b) Represents total operating costs, excluding depreciation and amortization, as a percentage of total revenues less investment income.

Summary

Net income was $1.3 billion, or $8.44 per diluted common share, in 2015 compared to $1.1 billion, or $7.36 per diluted common share, in 2014. The completion of the sale of Concentra on June 1, 2015 resulted in an after-tax gain of $1.57 per diluted common share in 2015. Excluding the impact of the sale of Concentra, the decrease primarily was

due to a decline in Retail segment pretax results, including expense of $0.74 per diluted common share for a premium deficiency reserve for certain of our individual commercial medical products for the 2016 coverage year, and an increase in the effective tax rate as discussed below. These items were partially offset by year-over-year improvement in the Group and Healthcare Services segment pretax results and higher investment income. In addition, 2015 includes expenses of $0.14 per diluted common share for transaction costs associated with the Merger, certain of which were not deductible for tax purposes. Net income for 2014 includes expenses of $0.15 per diluted common share associated with a loss on extinguishment of debt for the redemption of certain senior notes in 2014. Year-over-year comparisons of diluted earnings per common share are also favorably impacted by a lower number of shares used to compute diluted earnings per common share in 2015 reflecting the impact of share repurchases.

Premiums Revenue

Consolidated premiums increased $6.5 billion, or 14.0%, from 2014 to $52.4 billion for 2015 primarily reflecting higher premiums in both the Retail and Group segments. These higher premiums were primarily driven by average membership growth in the Retail segment and an increase in fully-insured group commercial medical per member premiums in the Group segment.

Services Revenue

Consolidated services revenue decreased $758 million, or 35.0%, from 2014 to $1.4 billion for 2015 primarily due to the completion of the sale of Concentra on June 1, 2015 as well as the loss of certain large group ASO accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.

Investment Income

Investment income totaled $474 million for 2015, an increase of $97 million from 2014, primarily due to higher realized capital gains in 2015 as a result of the repositioning of our portfolio given recent market volatility and anticipated changes to interest rates, with higher average invested balances being substantially offset by lower interest rates.

Benefits Expense

Consolidated benefits expense was $44.3 billion for 2015, an increase of $6.1 billion, or 16.0%, from 2014 primarily due to an increase in the Retail segment mainly driven by higher average Medicare Advantage membership and individual commercial medical on-exchange and off-exchange membership in plans compliant with the Health Care Reform Law. As more fully described herein under the section entitled “Benefits Expense Recognition”, actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $236 million in 2015 and $518 million in 2014. The decline in prior-period medical claims reserve development year over-year primarily was due to Medicare Advantage and individual commercial medical claims development in the Retail segment as discussed further in the segment results of operations discussion that follows.

The consolidated benefit ratio for 2015 was 84.5%, an increase of 150 basis points from 2014 primarily due to increases in the Retail segment, including the impact of recognizing a premium deficiency reserve for certain of our individual commercial medical products for the 2016 coverage year, and Group segment ratios as discussed in the segment results of operations discussion that follows. The increase in benefits expense associated with the recognition of the premium deficiency reserve increased the consolidated benefit ratio by approximately 30 basis points in 2015. Favorable prior-period medical claims reserve development decreased the consolidated benefit ratio by approximately 50 basis points in 2015 versus approximately 110 basis points in 2014.

Operating Costs

Consolidated operating costs decreased $321 million, or 4.2%, in 2015 compared to 2014 primarily due to cost management initiatives across all lines of business as well as the completion of the sale of Concentra on June 1, 2015, partially offset by increases in costs mandated by the Health Care Reform Law, including the non-deductible health insurance industry fee.

The consolidated operating cost ratio for 2015 was 13.6%, decreasing 230 basis points from 2014 primarily due to decreases in the operating cost ratios in the Group and Retail segments reflecting cost management initiatives, as well as the completion of the sale of Concentra on June 1, 2015. Concentra carried a higher operating cost ratio.

Depreciation and Amortization

Depreciation and amortization for 2015 totaled $355 million, increasing $22 million, or 6.6% from 2014, reflecting higher depreciation expense from capital expenditures.

Interest Expense

Interest expense was $186 million for 2015 compared to $192 million for 2014, a decrease of $6 million, or 3.1%, primarily reflecting a higher average long-term debt balance due to the issuance of senior notes in September 2014, partially offset by the recognition of a loss on extinguishment of debt of approximately $37 million in October 2014 for the redemption of our $500 million 6.45% senior unsecured notes due June 1, 2016.

Income Taxes

Our effective tax rate during 2015 was 47.5% compared to the effective tax rate of 47.2% in 2014. The increase in the effective tax rate primarily was due to an increase in the non-deductible health insurance industry fee from 2014, substantially offset by the favorable tax effect of the gain on the sale of Concentra. See Note 11 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for a complete reconciliation of the federal statutory rate to the effective tax rate.

Retail Segment

			Change	
	2015	2014	Members	Percentage
Membership:				
Medical membership:				
Individual Medicare Advantage	2,753,400	2,427,900	325,500	13.4 %
Group Medicare Advantage	484,100	489,700	(5,600)	(1.1)%
Medicare stand-alone PDP	4,557,900	3,994,000	563,900	14.1 %
Total Retail Medicare	7,795,400	6,911,600	883,800	12.8 %
Individual commercial	899,100	1,016,200	(117,100)	(11.5)%
State-based Medicaid	373,700	316,800	56,900	18.0 %
Medicare Supplement	158,600	131,900	26,700	20.2 %
Total Retail medical members	9,226,800	8,376,500	850,300	10.2 %
Individual specialty membership (a)	1,153,100	1,165,800	(12,700)	(1.1)%

(a) Specialty products include dental, vision, and other supplemental health and financial protection products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2015	2014	Change	
			Dollars	Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Individual Medicare Advantage	$ 29,526	$ 25,782	$ 3,744	14.5 %
Group Medicare Advantage	5,588	5,490	98	1.8 %
Medicare stand-alone PDP	3,846	3,404	442	13.0 %
Total Retail Medicare	38,960	34,676	4,284	12.4 %
Individual commercial	3,939	3,020	919	30.4 %
State-based Medicaid	2,341	1,255	1,086	86.5 %
Medicare Supplement	304	245	59	24.1 %
Individual specialty	261	256	5	2.0 %
Total premiums	45,805	39,452	6,353	16.1 %
Services	9	39	(30)	(76.9)%
Total premiums and services revenue	$ 45,814	$ 39,491	$ 6,323	16.0 %
Income before income taxes	$ 930	$ 1,339	$ (409)	(30.5)%
Benefit ratio	86.7%	84.9%		1.8 %
Operating cost ratio	11.2%	11.6%		(0.4)%

Pretax Results

- Retail segment pretax income was $930 million in 2015, a decrease of $409 million, or 30.5%, compared to 2014 primarily driven by an increase in the benefit ratio for 2015, including the impact of recognizing a premium deficiency reserve of approximately $176 million for certain of our individual commercial medical products for the 2016 coverage year, partially offset by a decline in the operating cost ratio, Medicare Advantage membership growth, and higher investment income year-over-year.

Enrollment

- Individual Medicare Advantage membership increased 325,500 members, or 13.4%, from December 31, 2014 to December 31, 2015 reflecting net membership additions, particularly for our HMO offerings, for the 2015 plan year.
- Group Medicare Advantage membership decreased 5,600 members, or 1.1%, from December 31, 2014 to December 31, 2015.
- Medicare stand-alone PDP membership increased 563,900 members, or 14.1%, from December 31, 2014 to December 31, 2015 reflecting net membership additions, primarily for our Humana-Walmart plan offering, for the 2015 plan year.
- Individual commercial medical membership decreased 117,100 members, or 11.5%, from December 31, 2014 to December 31, 2015 primarily reflecting the loss of approximately 150,000 members due to termination by CMS for lack of proper eligibility documentation from the member as well as the loss of members who had subscribed to plans that were not compliant with the Health Care Reform Law. These declines were partially offset by an increase in membership in plans that are compliant with the Health Care Reform Law, primarily off-exchange
- State-based Medicaid membership increased 56,900 members, or 18.0%, from December 31, 2014 to December 31, 2015 primarily driven by the addition of members under our Florida Medicaid contract.

- Individual specialty membership decreased 12,700 members, or 1.1%, from December 31, 2014 to December 31, 2015 primarily driven by a membership decline in supplemental health and financial protection product and vision offerings.

Premiums revenue

- Retail segment premiums increased $6.4 billion, or 16.1%, from 2014 to 2015 primarily due to membership growth across our Medicare Advantage, state-based Medicaid, and Medicare stand-alone PDP lines of business, as well as a heavier percentage of individual commercial medical business in higher premium plans compliant with the Health Care Reform Law. Average Medicare Advantage membership increased 11.8% in 2015.

Benefits expense

- The Retail segment benefit ratio of 86.7% for 2015 increased 180 basis points from 2014 primarily due to higher than expected medical costs as compared to the assumptions used in our pricing, the recognition of a premium deficiency reserve in the fourth quarter of 2015 for certain of our individual commercial medical products for the 2016 coverage year, and unfavorable year-over-year comparisons of prior-period medical claims reserve development as discussed below. In addition, the increase reflects higher benefit ratios associated with a greater number of members from state-based contracts and the impact of the change in estimate for the 2014 net 3Rs receivables in 2015. These items were partially offset by the impact of the increase in the health insurance industry fee included in the pricing of our products. In addition, the 2015 period was favorably impacted by the release of reserves for future policy benefits as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

- We experienced higher than expected medical costs as compared to the assumptions used in our pricing for 2015 primarily due to lower-than-expected 2015 Medicare Advantage financial claim recovery levels and lower-than-anticipated reductions in inpatient admissions. In addition, medical claims associated with certain individual commercial medical products, in particular products compliant with the Health Care Reform Law, exceeded the assumptions used when we set pricing for 2015. We took a number of actions in 2015 to improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results indicating the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment of the profitability of our individual medical policies compliant with the Health Care Reform Law, in the fourth quarter of 2015, we recorded a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million. The increase in benefits expense associated with the recognition of the premium deficiency reserve increased the Retail segment benefit ratio by approximately 40 basis points in 2015.

- The Retail segment's benefits expense for 2015 included the beneficial effect of $228 million in favorable prior-year medical claims reserve development versus $488 million in 2014. This favorable prior-year medical claims reserve development decreased the Retail segment benefit ratio by approximately 50 basis points in 2015 versus approximately 120 basis points in 2014. The year-over-year decline in prior-period medical claims reserve development primarily was due to the impact of lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products.

Operating costs

- The Retail segment operating cost ratio of 11.2% for 2015 decreased 40 basis points from 2014 primarily reflecting administrative cost efficiencies associated with medical membership growth in the segment and other discretionary cost reductions, partially offset by the increase in the non-deductible health insurance

industry fee. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 160 basis points in 2015 as compared to 120 basis points in 2014.

Group Segment

	2015	2014	Change Members	Change Percentage
Membership:				
Medical membership:				
Fully-insured commercial group	1,178,300	1,235,500	(57,200)	(4.6)%
ASO	710,700	1,104,300	(393,600)	(35.6)%
Military services	3,074,400	3,090,400	(16,000)	(0.5)%
Total group medical members	4,963,400	5,430,200	(466,800)	(8.6)%
Group specialty membership (a)	6,068,700	6,502,700	(434,000)	(6.7)%

(a) Specialty products include dental, vision, and voluntary benefit products. Members included in these products may not be unique to each product since members have the ability to enroll in multiple products.

	2015	2014	Change Dollars	Change Percentage
		(in millions)		
Premiums and Services Revenue:				
Premiums:				
Fully-insured commercial group	$ 5,493	$ 5,339	$ 154	2.9 %
Group specialty	1,055	1,098	(43)	(3.9)%
Military services	21	19	2	10.5 %
Total premiums	6,569	6,456	113	1.8 %
Services	698	763	(65)	(8.5)%
Total premiums and services revenue	$ 7,267	$ 7,219	$ 48	0.7 %
Income before income taxes	$ 258	$ 151	$ 107	70.9 %
Benefit ratio	80.2%	79.5%		0.7 %
Operating cost ratio	24.0%	26.5%		(2.5)%

Pretax Results

- Group segment pretax income increased $107 million, or 70.9%, to $258 million in 2015 primarily reflecting improvement in the operating cost ratio partially offset by an increase in the benefit ratio as discussed below.

Enrollment

- Fully-insured commercial group medical membership decreased 57,200 members, or 4.6% from December 31, 2014 reflecting lower membership in both large and small group accounts.

- Group ASO commercial medical membership decreased 393,600 members, or 35.6%, from December 31, 2014 to December 31, 2015 primarily due to the loss of certain large group accounts as a result of continued discipline in pricing of services for self-funded accounts amid a highly competitive environment.

- Group specialty membership decreased 434,000 members, or 6.7%, from December 31, 2014 to December 31, 2015 primarily due to the loss of certain fully-insured group medical accounts that also had specialty coverage.

Premiums revenue

- Group segment premiums increased $113.0 million, or 1.8%, from 2014 to 2015 primarily due to an increase in fully-insured commercial medical per member premiums partially offset by a net decline in fully-insured commercial medical membership.

Benefits expense

- The Group segment benefit ratio increased 70 basis points from 79.5% in 2014 to 80.2% in 2015 primarily reflecting the impact of higher specialty drug costs, net of rebates, as well as higher outpatient costs and lower prior-period medical claims reserve development, partially offset by an increase in the non-deductible health insurance industry fee included in the pricing of our products.

- The Group segment's benefits expense included the beneficial effect of $7 million in favorable prior-year medical claims reserve development versus $29 million in 2014. This favorable prior-year medical claims reserve development decreased the Group segment benefit ratio by approximately 10 basis points in 2015 versus approximately 40 basis points in 2014. The year-over-year decline in favorable prior-period medical claims reserve development primarily was due to a relatively small number of higher severity claims in the 2015 period associated with prior periods.

Operating costs

- The Group segment operating cost ratio of 24.0% for 2015 decreased 250 basis points from 26.5% for 2014, reflecting a decline in our group ASO commercial medical membership which carries a higher operating cost ratio than our fully-insured commercial medical membership, as well as operating cost efficiencies associated with our fully-insured business. Operating cost efficiencies were the result of both sustainable cost reduction initiatives and discretionary reductions. These declines were partially offset by the impact of an increase in the non-deductible health insurance industry fee. The non-deductible health insurance industry fee increased the operating cost ratio by approximately 140 basis points in 2015 as compared to 100 basis points in 2014.

Healthcare Services Segment

			Change	
	2015	2014	Dollars	Percentage
		(in millions)		
Revenues:				
Services:				
Provider services	$ 515	$ 1,147	$ (632)	(55.1)%
Home based services	140	107	33	30.8 %
Pharmacy solutions	30	99	(69)	(69.7)%
Total services revenues	685	1,353	(668)	(49.4)%
Intersegment revenues:				
Pharmacy solutions	20,551	16,905	3,646	21.6 %
Provider services	1,291	1,149	142	12.4 %
Home based services	875	585	290	49.6 %
Clinical programs	203	208	(5)	(2.4)%
Total intersegment revenues	22,920	18,847	4,073	21.6 %
Total services and intersegment revenues	$ 23,605	$ 20,200	$ 3,405	16.9 %
Income before income taxes	$ 981	$ 738	$ 243	32.9 %
Operating cost ratio	95.2%	95.6%		(0.4)%

Pretax results

- Healthcare Services segment pretax income of $981 million for 2015 increased $243 million, or 32.9%, from 2014 primarily due to higher earnings from our pharmacy solutions and home based services businesses as they serve our growing Medicare membership.

Script Volume

- Humana Pharmacy Solutions® script volumes for the Retail and Group segment membership increased to approximately 398 million in 2015, up 21% versus scripts of approximately 329 million in 2014. The increase primarily reflects growth associated with higher average medical membership for 2015 than in 2014.

Services revenue

- Services revenue for 2015 decreased $668 million, or 49.4% from 2014, to $685 million for 2015, primarily due to the completion of the sale of Concentra on June 1, 2015.

Intersegment revenues

- Intersegment revenues increased $4.1 billion, or 21.6%, from 2014 to $22.9 billion for 2015 primarily due to growth in our Medicare membership which resulted in higher utilization of our Healthcare Services segment businesses.

Operating costs

- The Healthcare Services segment operating cost ratio of 95.2% for 2015 decreased 40 basis points from 95.6% for 2014 primarily due to lower operating costs in our pharmacy business together with discretionary cost reductions across the segment, partially offset by the increasing percentage of pharmacy business associated with lower margin specialty drugs. Improving operating efficiency in the pharmacy business was primarily driven by lower cost of goods associated with increased purchasing scale and lower cost-to-fill primarily due to improvements in technology.

Liquidity

Historically, our primary sources of cash have included receipts of premiums, services revenue, and investment and other income, as well as proceeds from the sale or maturity of our investment securities, borrowings, and proceeds from sales of businesses. Our primary uses of cash historically have included disbursements for claims payments, operating costs, interest on borrowings, taxes, purchases of investment securities, acquisitions, capital expenditures, repayments on borrowings, dividends, and share repurchases. Because premiums generally are collected in advance of claim payments by a period of up to several months, our business normally should produce positive cash flows during periods of increasing premiums and enrollment. Conversely, cash flows would be negatively impacted during periods of decreasing premiums and enrollment. From period to period, our cash flows may also be affected by the timing of working capital items including premiums receivable, benefits payable, and other receivables and payables. Our cash flows are impacted by the timing of payments to and receipts from CMS associated with Medicare Part D subsidies for which we do not assume risk. The use of operating cash flows may be limited by regulatory requirements of state departments of insurance (or comparable state regulators) which require, among other items, that our regulated subsidiaries maintain minimum levels of capital and seek approval before paying dividends from the subsidiaries to the parent. Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

The effect of the commercial risk adjustment, risk corridor, and reinsurance provisions of the Health Care Reform Law impact the timing of our operating cash flows, as we build receivables for each coverage year that are expected to be collected in subsequent coverage years. During 2016, net collections under the 3Rs associated with prior coverage years were $383 million. We expect to collect the remaining $54 million of reinsurance recoverables related to prior coverage years in 2017. On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all

of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2016, we collected approximately $36 million from CMS for risk corridor receivables associated with the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program. The remaining net receivable balance associated with the 3Rs was approximately $456 million at December 31, 2016, including the $54 million related to the 2015 coverage year, as compared to $982 million at December 31, 2015. Any amounts receivable or payable associated with these risk limiting programs may have an impact on subsidiary liquidity, with any temporary shortfalls funded by the parent company.

For additional information on our liquidity risk, please refer to Item 1A. – Risk Factors in this 2016 Form 10-K.

Cash and cash equivalents increased to $3.9 billion at December 31, 2016 from $2.6 billion at December 31, 2015. The change in cash and cash equivalents for the years ended December 31, 2016, 2015 and 2014 is summarized as follows:

	2016	2015	2014
		(in millions)	
Net cash provided by operating activities	$ 1,936	$ 868	$ 1,618
Net cash (used in) provided by investing activities	(1,362)	320	(63)
Net cash provided by (used in) financing activities	732	(552)	(758)
Increase in cash and cash equivalents	$ 1,306	$ 636	$ 797

Cash Flow from Operating Activities

The change in operating cash flows over the three year period primarily results from the corresponding change in the timing of working capital items, earnings, and enrollment activity as discussed below. The increase in operating cash flows in 2016 primarily was due to significantly favorable working capital items and higher earnings exclusive of the commercial risk corridor receivables write-off and the long-term care reserve strengthening in 2016, as well as the gain on sale of Concentra and the recognition of the premium deficiency reserve in 2015 discussed previously. The working capital changes year-over-year primarily reflect lower income tax payments, changes in the net receivable balance associated with the premium stabilization programs established under health care reform, or the 3R's, and the timing of payroll cycles resulting in one less payroll cycle in 2016, partially offset by the timing of payments for benefits expense. The lower operating cash flows in 2015 primarily reflect the effect of significant growth in individual commercial medical and group Medicare Advantage membership in 2014 and changes in the timing of working capital items related to the growth in our pharmacy business.

The most significant drivers of changes in our working capital are typically the timing of payments of benefits expense and receipts for premiums. We illustrate these changes with the following summaries of benefits payable and receivables.

The detail of benefits payable was as follows at December 31, 2016, 2015 and 2014:

	2016	2015	2014	Change 2016	Change 2015	Change 2014
			(in millions)			
IBNR (1)	$ 3,422	$ 3,730	$ 3,254	$ (308)	$ 476	$ 668
Reported claims in process (2)	654	600	475	54	125	94
Premium deficiency reserve (3)	—	176	—	(176)	176	—
Other benefits payable (4)	487	470	746	17	(276)	(180)
Total benefits payable	$ 4,563	$ 4,976	$ 4,475	$ (413)	$ 501	$ 582

(1) IBNR represents an estimate of benefits payable for claims incurred but not reported (IBNR) at the balance sheet date and includes unprocessed claim inventories. The level of IBNR is primarily impacted by membership levels, medical claim trends and the receipt cycle time, which represents the length of time between when a claim is initially incurred and when the claim form is received (i.e. a shorter time span results in a lower IBNR).

(2) Reported claims in process represents the estimated valuation of processed claims that are in the post claim adjudication process, which consists of administrative functions such as audit and check batching and handling, as well as amounts owed to our pharmacy benefit administrator which fluctuate due to bi-weekly payments and the month-end cutoff.

(3) Premium deficiency reserve recognized for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year.

(4) Other benefits payable include amounts owed to providers under capitated and risk sharing arrangements.

The decrease in benefits payable in 2016 largely was due to a decrease in IBNR, discussed further below, as well as the application of 2016 results to the premium deficiency reserve liability recognized in 2015 associated with our individual commercial medical products compliant with the Health Care Reform Law for the 2016 coverage year. There was no premium deficiency reserve liability at December 31, 2016. The increases in benefits payable in 2015 and 2014 largely were due to increases in IBNR as well as an increase in the amount of processed but unpaid claims due to our pharmacy benefit administrator, which fluctuates due to month-end cutoff. These items were partially offset by a decrease in amounts owed to providers under capitated and risk sharing arrangements in both 2015 and 2014, including the disbursement of a portion of our Medicare risk adjustment collections under our contractual obligations associated with our risk sharing arrangements. In addition, benefits payable in 2015 reflects the recognition of the premium deficiency reserve discussed previously.

IBNR decreased during 2016 primarily due to declines in group Medicare Advantage, individual commercial medical, and fully-insured commercial group medical membership in 2016. IBNR increased during 2015 primarily as a result of individual Medicare Advantage membership growth while during 2014 IBNR also increased as a result of individual Medicare Advantage membership growth as well as significant growth in individual commercial medical and group Medicare Advantage membership. As discussed previously, our cash flows are impacted by changes in enrollment. In 2014 (the first year plans compliant with the Health Care Reform Law were effective), membership in new fully-insured individual commercial medical plans compliant with the Health Care Reform Law grew as compared with much lower growth in membership in these plans in 2015 and a decline in membership in these plans in 2016. Similarly, growth in group Medicare Advantage membership in 2014 favorably impacted the 2014 cash flows while a decline in group Medicare Advantage membership in 2015 and more significantly in 2016, negatively impacted the 2015 and 2016 cash flows.

The detail of total net receivables was as follows at December 31, 2016, 2015 and 2014:

	2016	2015	2014	Change 2016	Change 2015	Change 2014
			(in millions)			
Medicare	$ 787	$ 765	$ 664	$ 22	$ 101	$ 88
Commercial and other	579	420	381	159	39	162
Military services	32	77	106	(45)	(29)	19
Allowance for doubtful accounts	(118)	(101)	(98)	(17)	(3)	(27)
Total net receivables	$ 1,280	$ 1,161	$ 1,053	119	108	242
Reconciliation to cash flow statement:						
Provision for doubtful accounts				39	61	32
Change in receivables acquired, held-for-sale, or disposed from sale of business				—	11	(10)
Change in receivables per cash flow statement resulting in cash from operations				$ 158	$ 180	$ 264

As disclosed previously, on June 1, 2015, we completed the sale of our wholly owned subsidiary Concentra. Net receivables associated with Concentra were classified as held-for-sale at December 31, 2014 excluded from the table above for comparative purposes.

Medicare receivables are impacted by changes in revenue associated with individual and group Medicare membership changes as well as the timing of accruals and related collections associated with the CMS risk-adjustment model.

The increases in commercial and other receivables in 2016 as compared to 2015 primarily reflects an increase in our receivable associated with the commercial risk adjustment provision of the Health Care Reform Law. Similarly, excluding the effect of classifying Concentra receivables as held-for-sale at December 31, 2014, the increase in commercial and other receivables in 2014 primarily was due to the commercial risk adjustment provisions of the Health Care Reform Law which became effective in 2014.

Military services receivables at December 31, 2016, 2015, and 2014 primarily consist of administrative services only fees owed from the federal government for administrative services provided under our current TRICARE South Region contract.

Many provisions of the Health Care Reform Law became effective in 2014, including the commercial risk adjustment, risk corridor, and reinsurance provisions as well as the non-deductible health insurance industry fee. As discussed previously, the timing of payments and receipts associated with these provisions impact our operating cash flows as we build receivables for each coverage year that are expected to be collected in subsequent coverage years. During 2016, net collections under the 3Rs associated with prior coverage years were $383 million as compared to net collections of $417 million in 2015. There were no amounts collected in 2014, the first year of the programs. The net receivable balance associated with the 3Rs was approximately $456 million at December 31, 2016, including certain amounts recorded in receivables as noted above. In 2016, we paid the federal government $916 million for the annual health insurance industry fee compared to our payments of $867 million in 2015 and $562 million in 2014.

In addition to the timing of payments of benefits expense, receipts for premiums and services revenues, and amounts due under the risk limiting and health insurance industry fee provisions of the Health Care Reform Law, other items impacting operating cash flows include income tax payments and the timing of payroll cycles resulting in one less payroll cycle in 2016 than in 2015.

Cash Flow from Investing Activities

Our ongoing capital expenditures primarily relate to our information technology initiatives, support of services in our provider services operations including medical and administrative facility improvements necessary for activities such as the provision of care to members, claims processing, billing and collections, wellness solutions, care coordination, regulatory compliance and customer service. Total capital expenditures, excluding acquisitions, were $527 million in 2016, $523 million in 2015, and $528 million in 2014.

We reinvested a portion of our operating cash flows in investment securities, primarily investment-grade fixed income securities, totaling $828 million in 2016. Proceeds from sales and maturities of investment securities exceeded purchases by $103 million in 2015 and $411 million in 2014. These net proceeds were used to fund normal working capital needs due to an increase in receivables associated with the 3Rs in addition to the timing of payments to and receipts from CMS associated with Medicare Part D reinsurance subsidies, as discussed below.

In 2015, we purchased a $284 million note receivable directly from a third-party bank syndicate related to the financing of MCCI Holdings, LLC's business as described in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. The purchase of this note is included with purchases of investment securities in our consolidated statement of cash flows.

On June 1, 2015, we completed the sale of Concentra for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs.

Cash consideration paid for acquisitions, net of cash acquired, was $7 million in 2016, $38 million in 2015, and $18 million in 2014. Acquisitions in each year included health and wellness related acquisitions.

Cash Flow from Financing Activities

Our financing cash flows are significantly impacted by the timing of claims payments and the related receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. Settlement of the reinsurance and low-income cost subsidies is based on a reconciliation made approximately 9 months after the close of each calendar year. Receipts from CMS associated with Medicare Part D claim subsidies for which we do not assume risk were $1.1 billion higher than claims payments during 2016. Conversely, claims payments were $361 million higher than receipts from CMS associated with Medicare Part D claims subsidies for which we do not assume risk during 2015 and $945 million higher during 2014. In 2014 and 2015, we experienced higher specialty prescription drug costs associated with a new treatment for Hepatitis C than were contemplated in our bids which resulted in higher subsidy receivable balances in those years that were settled in 2015 and 2016, respectively, under the terms of our contracts with CMS. Our net receivable for CMS subsidies and brand name prescription drug discounts was $0.9 billion at December 31, 2016 compared to $2.0 billion at December 31, 2015. Refer to Note 6 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Under our administrative services only TRICARE South Region contract, health care cost payments for which we do not assume risk exceeded reimbursements from the federal government by $25 million in 2016 and by $4 million in 2015. Reimbursements from the federal government equaled health care cost payments for which we do not assume risk in 2014.

Claims payments associated with cost sharing provisions of the Health Care Reform Law for which we do not assume risk were higher than reimbursements from HHS by $28 million in 2016 and less than reimbursements by $69 million in 2015 and by $26 million in 2014. See Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for further description.

We repurchased 1.85 million shares for $329 million in 2015 and 5.7 million shares for $730 million in 2014 (excludes another $100 million held back pending final settlement of an accelerated stock repurchase plan in March 2015) under share repurchase plans authorized by the Board of Directors. We did not repurchase shares in 2016 due to restrictions under the Merger Agreement. We also acquired common shares in connection with employee stock plans for an aggregate cost of $104 million in 2016, $56 million in 2015, and $42 million in 2014.

As discussed further below, we paid dividends to stockholders of $177 million in 2016 and $172 million in each of 2015 and 2014.

We entered into a commercial paper program in October 2014. Net repayments of commercial paper were $2 million in 2016 and the maximum principal amount outstanding at any one time during 2016 was $475 million. Net proceeds from the issuance of commercial paper were $298 million in 2015 and the maximum principal amount outstanding at any one time during 2015 was $414 million. There were no net proceeds from the issuance of commercial paper in 2014 and the maximum principal amount outstanding at any one time during 2014 was $175 million.

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem our $500 million 6.45% senior unsecured notes.

The remainder of the cash used in or provided by financing activities in 2016, 2015, and 2014 primarily resulted from proceeds from stock option exercises and the change in book overdraft.

Future Sources and Uses of Liquidity

Dividends

For a detailed discussion of dividends to stockholders, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Stock Repurchases

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, and also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017. Under this new authorization, we expect to complete a $1.5 billion accelerated share repurchase program in the first quarter of 2017. For a detailed discussion of stock repurchases, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Debt

For a detailed discussion of our debt, including our senior notes, credit agreement and commercial paper program, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Liquidity Requirements

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement and our commercial paper program or from other public or private financing sources, taken together, provide adequate resources to fund ongoing operating and regulatory requirements, acquisitions, future expansion opportunities, and capital expenditures for at least the next twelve months, as well as to refinance or repay debt, and repurchase shares.

Adverse changes in our credit rating may increase the rate of interest we pay and may impact the amount of credit available to us in the future. Our investment-grade credit rating at December 31, 2016 was A- according to Standard & Poor's Rating Services, or S&P, and Baa3 according to Moody's Investors Services, Inc., or Moody's. A downgrade by S&P to BB+ or by Moody's to Ba1 triggers an interest rate increase of 25 basis points with respect to $750 million of our senior notes. Successive one notch downgrades increase the interest rate an additional 25 basis points, or annual interest expense by $2 million, up to a maximum 100 basis points, or annual interest expense by $8 million.

In addition, we operate as a holding company in a highly regulated industry. Humana Inc., our parent company, is dependent upon dividends and administrative expense reimbursements from our subsidiaries, most of which are subject to regulatory restrictions. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our state-regulated operating subsidiaries. Cash, cash equivalents, and short-term investments at the parent company

increased to $2.0 billion at December 31, 2016 from $1.6 billion at December 31, 2015. This increase primarily reflects operating cash derived from our non-insurance subsidiaries' profits partially offset by capital expenditures, payment of stockholder dividends, and common stock repurchases. Our use of operating cash derived from our non-insurance subsidiaries, such as our Healthcare Services segment, is generally not restricted by Departments of Insurance (or comparable state regulatory agencies). Our regulated subsidiaries paid dividends to the parent of $763 million in 2016, $493 million in 2015, and $927 million in 2014. Subsidiary dividends in 2015 reflect the impact of losses for our individual commercial medical business compliant with the Health Care Reform Law and the November 5, 2015 revised statutory accounting guidance requiring the exclusion of risk corridor receivables from related statutory surplus. Refer to our parent company financial statements and accompanying notes in Schedule I - Parent Company Financial Information. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2017 is approximately $850 million, in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Our parent company funded a subsidiary capital contribution of approximately $535 million in the first quarter of 2017 for reserve strengthening associated with our closed block of long-term care insurance policies discussed further in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

In 2016, we paid the federal government $916 million for the annual health insurance industry fee. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee.

Regulatory Requirements

For a detailed discussion of our regulatory requirements, including aggregate statutory capital and surplus as well as dividends paid from the subsidiaries to the parent, please refer to Note 15 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Contractual Obligations

We are contractually obligated to make payments for years subsequent to December 31, 2016 as follows:

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
			(in millions)		
Debt	$ 4,100	$ 300	$ 1,200	$ —	$ 2,600
Interest (1)	2,354	188	283	236	1,647
Operating leases (2)	697	185	283	134	95
Purchase obligations (3)	348	184	156	7	1
Future policy benefits payable and other long-term liabilities (4)	3,279	93	453	215	2,518
Total	$ 10,778	$ 950	$ 2,375	$ 592	$ 6,861

(1) Interest includes the estimated contractual interest payments under our debt agreements.

(2) We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2037. We sublease facilities or partial facilities to third party tenants for space not used in our operations which partially mitigates our operating lease commitments. An operating lease is a type of off-balance sheet arrangement. Assuming we acquired the asset, rather than leased such asset, we would have recognized a liability for the financing of these assets. See also Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

(3) Purchase obligations include agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. Purchase obligations exclude agreements that are cancelable without penalty.

(4) Includes future policy benefits payable ceded to third parties through 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. We expect the assuming reinsurance carriers to fund these obligations and reflected these amounts as reinsurance recoverables included in other long-term assets on our consolidated balance sheet. Amounts payable in less than one year are included in trade accounts payable and accrued expenses in the consolidated balance sheet.

Off-Balance Sheet Arrangements

As of December 31, 2016, we were not involved in any special purpose entity, or SPE, transactions. For a detailed discussion of off-balance sheet arrangements, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Guarantees and Indemnifications

For a detailed discussion of our guarantees and indemnifications, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Government Contracts

For a detailed discussion of our government contracts, including our Medicare, Military, and Medicaid contracts, please refer to Note 16 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Other

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

Under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do. Penn Treaty is a financially distressed unaffiliated long-term care insurance company. A final court ruling on Penn Treaty's insolvency would trigger a guarantee fund assessment that would result in expense for us, based on current information, estimated at approximately $30 million.

Critical Accounting Policies and Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements and accompanying notes, which have been prepared in accordance with accounting principles generally accepted in the United States of America. The preparation of these financial statements and accompanying notes requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We continuously evaluate our estimates and those critical accounting policies primarily related to benefits expense and revenue recognition as well as accounting for impairments related to our investment securities, goodwill, and long-lived assets. These estimates are based on knowledge of current events and anticipated future events and, accordingly, actual results ultimately may differ from those estimates. We believe the following critical accounting policies involve the most significant judgments and estimates used in the preparation of our consolidated financial statements.

Benefits Expense Recognition

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. IBNR represents a substantial portion of our benefits payable as follows:

	December 31, 2016	Percentage of Total	December 31, 2015	Percentage of Total
	(dollars in millions)			
IBNR	$ 3,422	75.0%	$ 3,730	75.0%
Reported claims in process	654	14.3%	600	12.1%
Premium deficiency reserve	—	—%	176	3.5%
Other benefits payable	487	10.7%	470	9.4%
Total benefits payable	$ 4,563	100.0%	$ 4,976	100.0%

Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. For further discussion of our reserving methodology, including our use of completion and claims per member per month trend factors to estimate IBNR, refer to Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

The completion and claims per member per month trend factors are the most significant factors impacting the IBNR estimate. The portion of IBNR estimated using completion factors for claims incurred prior to the most recent two months is generally less variable than the portion of IBNR estimated using trend factors. The following table illustrates the sensitivity of these factors assuming moderate adverse experience and the estimated potential impact on our operating results caused by reasonably likely changes in these factors based on December 31, 2016 data:

Completion Factor (a):		Claims Trend Factor (b):	
Factor Change (c)	Decrease in Benefits Payable	Factor Change (c)	Decrease in Benefits Payable
	(dollars in millions)		
0.60%	$(186)	(2.75)%	$(296)
0.50%	$(155)	(2.50)%	$(269)
0.40%	$(124)	(2.25)%	$(242)
0.30%	$(93)	(2.00)%	$(215)
0.20%	$(62)	(1.75)%	$(188)
0.10%	$(31)	(1.50)%	$(162)
—%	$—	(1.25)%	$(135)

(a) Reflects estimated potential changes in benefits payable at December 31, 2016 caused by changes in completion factors for incurred months prior to the most recent two months.

(b) Reflects estimated potential changes in benefits payable at December 31, 2016 caused by changes in annualized claims trend used for the estimation of per member per month incurred claims for the most recent two months.

(c) The factor change indicated represents the percentage point change.

The following table provides a historical perspective regarding the accrual and payment of our benefits payable, excluding military services. Components of the total incurred claims for each year include amounts accrued for current year estimated benefits expense as well as adjustments to prior year estimated accruals. Refer to Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data for Retail and Group segment tables including information about incurred and paid claims development as of December 31, 2016, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts.

	2016	2015	2014
		(in millions)	
Balances at January 1	$ 4,976	$ 4,475	$ 3,893
Less: Premium deficiency reserve	(176)	—	—
Less: Reinsurance recoverables	(85)	(78)	—
Balances at January 1, net	4,715	4,397	3,893
Incurred related to:			
Current year	45,318	44,397	38,641
Prior years	(582)	(236)	(518)
Total incurred	44,736	44,161	38,123
Paid related to:			
Current year	(40,852)	(39,802)	(34,357)
Prior years	(4,112)	(4,041)	(3,262)
Total paid	(44,964)	(43,843)	(37,619)
Premium deficiency reserve	—	176	—
Reinsurance recoverable	76	85	78
Balances at December 31	$ 4,563	$ 4,976	$ 4,475

The following table summarizes the changes in estimate for incurred claims related to prior years attributable to our key assumptions. As previously described, our key assumptions consist of trend and completion factors estimated using an assumption of moderately adverse conditions. The amounts below represent the difference between our original estimates and the actual benefits expense ultimately incurred as determined from subsequent claim payments.

	Favorable Development by Changes in Key Assumptions					
	2016		2015		2014	
	Amount	Factor Change (a)	Amount	Factor Change (a)	Amount	Factor Change (a)
			(dollars in millions)			
Trend factors	$ (316)	(2.9)%	$ (145)	(1.5)%	$ (266)	(3.7)%
Completion factors	(266)	0.9 %	(91)	0.4 %	(252)	1.2 %
Total	$ (582)		$ (236)		$ (518)	

(a) The factor change indicated represents the percentage point change.

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $582 million in 2016, $236 million in 2015, and $518 million in 2014. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2016, 2015, and 2014.

	Favorable Medical Claims Reserve Development			Change	
	2016	2015	2014	2016	2015
			(in millions)		
Retail Segment	$ (535)	$ (228)	$ (488)	$ (307)	$ 260
Group Segment	(46)	(7)	(29)	(39)	22
Other Businesses	(1)	(1)	(1)	—	—
Total	$ (582)	$ (236)	$ (518)	$ (346)	$ 282

The favorable medical claims reserve development for 2016, 2015, and 2014 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Our favorable development for each of the years presented above is discussed further in Note 10 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We continually adjust our historical trend and completion factor experience with our knowledge of recent events that may impact current trends and completion factors when establishing our reserves. Because our reserving practice is to consistently recognize the actuarial best point estimate using an assumption of moderately adverse conditions as required by actuarial standards, there is a reasonable possibility that variances between actual trend and completion factors and those assumed in our December 31, 2016 estimates would fall towards the middle of the ranges previously presented in our sensitivity table.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Premium deficiency reserve for short-duration policies	$ (176)	$ 176	$ —
Military services	8	12	11
Future policy benefits	439	(80)	32
Total	$ 271	$ 108	$ 43

In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

Military services benefits expense for each year in the table above reflect expenses associated with our contracts with the Veterans Administration.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG America Corporation, or KMG, acquisition more fully described below and in Note 18 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data. Certain health policies sold to individuals prior to 2014 (the first year plans compliant with the Health Care Reform Law were effective) are accounted for as long-duration as more fully described below. The decrease in benefits expense associated with future policy benefits payable in 2015 primarily reflects the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

Future policy benefits payable of $2.8 billion and $2.2 billion at December 31, 2016 and 2015, respectively, represent liabilities for long-duration insurance policies including long-term care insurance, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). Because these policies have long-term claim payout periods, there is a greater risk of significant variability in claims costs, either positive or negative. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present

value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs.

Future policy benefits payable include $2.2 billion at December 31, 2016 and $1.5 billion at December 31, 2015 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Approximately 30,800 policies remain in force as of December 31, 2016. No new policies have been written since 2005 under this closed block. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current yields. There was a $77 million additional liability at December 31, 2016 and no additional liability at December 31, 2015. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual interest, morbidity, mortality, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. A prolonged period during which interest rates remain at levels lower than those anticipated in our reserving would result in shortfalls in investment income on assets supporting our obligation under long term care policies because the long duration of the policy obligations exceeds the duration of the supporting investment assets. Further, we monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience vary from our loss recognition date assumptions, future material adjustments to reserves could be required.

During 2016, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2013 loss recognition date, particularly as they related to emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies. Based on this deterioration, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2016 we recorded $505 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $659 million partially offset by a related reinsurance recoverable of $154 million included in other long-term assets.

For our closed block of long-term care policies, actuarial assumptions used to estimate reserves are inherently uncertain due to the potential changes in trends in mortality, morbidity, persistency and interest rates as well as premium rate increases. As a result, our long term care reserves may be subject to material increases if these trends develop adversely to our expectations. The estimated increase in reserves and additional benefit expense from hypothetically modeling adverse variations in our actuarial assumptions, in the aggregate, could be up to $250 million, net of reinsurance. Although such hypothetical revisions are not currently appropriate, we believe they could occur based on past variances in experience and our expectation of the ranges of future experience that could reasonably occur, and any such revision could be material. Generally accepted accounting principles do not allow us to unlock our assumptions for favorable items.

In addition, future policy benefits payable includes amounts of $201 million at December 31, 2016, $205 million at December 31, 2015, and $210 million at December 31, 2014 which are subject to 100% coinsurance agreements as more fully described in Note 19 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data, and as such are offset by a related reinsurance recoverable included in other long-term assets.

Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions.

Our commercial contracts establish rates on a per employee basis for each month of coverage based on the type of coverage purchased (single to family coverage options). Our Medicare and Medicaid contracts also establish monthly rates per member. However, our Medicare contracts also have additional provisions as outlined in the following separate section.

Premiums revenue and administrative services only, or ASO, fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. In addition, we adjust revenues for estimated changes in an employer's enrollment and individuals that ultimately may fail to pay, and for estimated rebates under the minimum benefit ratios required under the Health Care Reform Law. Enrollment changes not yet processed or not yet reported by an employer group or the government, also known as retroactive membership adjustments, are estimated based on available data and historical trends. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in the current period's revenue.

We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues from for our Medicare and individual commercial medical products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership are recognized when the amounts become determinable and the collectibility is reasonably assured.

Medicare Risk-Adjustment Provisions

CMS utilizes a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits and Improvement Protection Act of 2000 (BIPA), generally pays more for enrollees with predictably higher costs. Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses this diagnosis data to calculate the risk-adjusted premium payment to MA plans. Rates paid to MA plans are established under an actuarial bid model, including a process that bases our payments on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's Medicare FFS program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on providers to appropriately document all medical data, including the diagnosis data submitted with claims. CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnosis data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit those claims that pass the filtering logic. For submissions through EDS, CMS requires MA plans to submit all the claims data and CMS will apply the risk adjustment filtering logic to determine the risk adjustment data used to calculate risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows. We estimate risk-adjustment revenues based on medical diagnoses for our membership. The risk-adjustment model, including CMS changes to the submission process, is more fully described in Item 1. – Business under the section titled "Individual Medicare."

Investment Securities

Investment securities totaled $9.8 billion, or 39% of total assets at December 31, 2016, and $9.1 billion, or 37% of total assets at December 31, 2015. Debt securities, detailed below, comprised this entire investment portfolio at December 31, 2016 and 2015. The fair value of debt securities were as follows at December 31, 2016 and 2015:

	December 31, 2016	Percentage of Total	December 31, 2015	Percentage of Total
	(dollars in millions)			
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 786	8.0%	$ 332	3.6%
Mortgage-backed securities	1,637	16.7%	1,891	20.8%
Tax-exempt municipal securities	3,305	33.7%	2,668	29.3%
Mortgage-backed securities:				
Residential	9	0.1%	13	0.1%
Commercial	304	3.1%	985	10.8%
Asset-backed securities	160	1.7%	263	2.9%
Corporate debt securities	3,597	36.7%	2,958	32.5%
Total debt securities	$ 9,798	100.0%	$ 9,110	100.0%

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2016. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Tax-exempt municipal securities included pre-refunded bonds of $276 million at December 31, 2016 and $178 million at December 31, 2015. These pre-refunded bonds were secured by an escrow fund consisting of U.S. government obligations sufficient to pay off all amounts outstanding at maturity. The ratings of these pre-refunded bonds generally assume the rating of the government obligations at the time the fund is established. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for $1.4 billion of these municipals in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for $1.6 billion of these municipals. Our general obligation bonds are diversified across the U.S. with no individual state exceeding 11%. In addition, certain monoline insurers guarantee the timely repayment of bond principal and interest when a bond issuer defaults and generally provide credit enhancement for bond issues related to our tax-exempt municipal securities. We have no direct exposure to these monoline insurers. We owned $132 million and $173 million at December 31, 2016 and 2015, respectively, of tax-exempt securities guaranteed by monoline insurers. The equivalent weighted average S&P credit rating of these tax-exempt securities without the guarantee from the monoline insurer was AA.

Our direct exposure to subprime mortgage lending is limited to investment in residential mortgage-backed securities and asset-backed securities backed by home equity loans. The fair value of securities backed by Alt-A and subprime loans was less than $1 million at December 31, 2016 and $1 million at December 31, 2015. There are no collateralized debt obligations or structured investment vehicles in our investment portfolio. The percentage of corporate securities associated with the financial services industry was 23% at December 31, 2016 and 25% at December 31, 2015.

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2016:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2016						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 697	$ (15)	$ 3	$ —	$ 700	$ (15)
Mortgage-backed securities	1,528	(31)	3	—	1,531	(31)
Tax-exempt municipal securities	2,756	(67)	43	(1)	2,799	(68)
Mortgage-backed securities:						
Residential	—	—	4	—	4	—
Commercial	182	(3)	24	(1)	206	(4)
Asset-backed securities	51	—	63	—	114	—
Corporate debt securities	1,544	(71)	69	(7)	1,613	(78)
Total debt securities	$ 6,758	$ (187)	$ 209	$ (9)	$ 6,967	$ (196)

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase. The risks inherent in assessing the impairment of an investment include the risk that market factors may differ from our expectations, facts and circumstances factored into our assessment may change with the passage of time, or we may decide to subsequently sell the investment. The determination of whether a decline in the value of an investment is other than temporary requires us to exercise significant diligence and judgment. The discovery of new information and the passage of time can significantly change these judgments. The status of the general economic environment and significant changes in the national securities markets influence the determination of fair value and the assessment of investment impairment. There is a continuing risk that declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2016 primarily were composed of senior tranches having high

credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2016.

All issuers of securities we own that were trading at an unrealized loss at December 31, 2016 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2016, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2016. There were no material other-than-temporary impairments in 2016, 2015, or 2014.

Goodwill and Long-lived Assets

At December 31, 2016, goodwill and other long-lived assets represented 20% of total assets and 47% of total stockholders' equity, compared to 20% and 48%, respectively, at December 31, 2015.

We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We are required to aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition. The carrying amount of goodwill for our reportable segments has been retrospectively adjusted to conform to the 2015 segment change discussed in Note 2 to the consolidated financial statements included in Item 8. – Financial Statements and Supplementary Data.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Our strategy, long-range business plan, and annual planning process support our goodwill impairment tests. These tests are performed, at a minimum, annually in the fourth quarter, and are based on an evaluation of future discounted cash flows. We rely on this discounted cash flow analysis to determine fair value. However outcomes from the discounted cash flow analysis are compared to other market approach valuation methodologies for reasonableness. We use discount rates that correspond to a market-based weighted-average cost of capital and terminal growth rates that correspond to long-term growth prospects, consistent with the long-term inflation rate. Key assumptions in our cash flow projections, including changes in membership, premium yields, medical and operating cost trends, and certain government contract extensions, are consistent with those utilized in our long-range business plan and annual planning process. If these assumptions differ from actual, including the impact of the Health Care Reform Law or changes in Government rates, the estimates underlying our goodwill impairment tests could be adversely affected. Goodwill impairment tests completed in each of the last three years did not result in an impairment loss. The fair value of our reporting units with significant goodwill exceeded carrying amounts by a substantial margin. A 100 basis point increase in the discount rate would not have a significant impact on the amount of margin for any of our reporting units with significant goodwill, with the exception of our provider services reporting unit in our Healthcare Services segment. The provider services reporting unit would decline to less than 10% margin after factoring in a 100 basis point increase in the discount rate.

Long-lived assets consist of property and equipment and other finite-lived intangible assets. These assets are depreciated or amortized over their estimated useful life, and are subject to impairment reviews. We periodically review long-lived assets whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. In assessing recoverability, we must make assumptions regarding estimated future cash flows and other factors to determine if an impairment loss may exist, and, if so, estimate fair value. We also must estimate and make assumptions regarding the useful life we assign to our long-lived assets. If these estimates or their related assumptions change in the future, we may be required to record impairment losses or change the useful life, including accelerating depreciation or amortization for these assets. There were no material impairment losses in the last three years.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our earnings and financial position are exposed to financial market risk, including those resulting from changes in interest rates.

The level of our pretax earnings is subject to market risk due to changes in interest rates and the resulting impact on investment income and interest expense. Prior to 2009, under interest rate swap agreements, we exchanged the fixed interest rate under all of our senior notes for a variable interest rate based on LIBOR using interest rate swap agreements. We terminated all of our interest rate swap agreements in 2008. We may re-enter into interest rate swap agreements in the future depending on market conditions and other factors. Amounts borrowed under the revolving credit portion of our $1.0 billion unsecured revolving credit agreement bear interest at either LIBOR plus a spread or the base rate plus a spread. There were no borrowings outstanding under our credit agreement at December 31, 2016 or December 31, 2015.

Interest rate risk also represents a market risk factor affecting our consolidated financial position due to our significant investment portfolio, consisting primarily of fixed maturity securities of investment-grade quality with a weighted average S&P credit rating of AA at December 31, 2016. Our net unrealized position decreased $120 million from a net unrealized gain position of $92 million at December 31, 2015 to a net unrealized loss position of $28 million at December 31, 2016. At December 31, 2016, we had gross unrealized losses of $196 million on our investment portfolio primarily due to an increase in market interest rates since the time the securities were purchased. There were no material other-than-temporary impairments during 2016. While we believe that these impairments are temporary and we currently do not have the intent to sell such securities, given the current market conditions and the significant judgments involved, there is a continuing risk that future declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

Duration is the time-weighted average of the present value of the bond portfolio's cash flow. Duration is indicative of the relationship between changes in fair value and changes in interest rates, providing a general indication of the sensitivity of the fair values of our fixed maturity securities to changes in interest rates. However, actual fair values may differ significantly from estimates based on duration. The average duration of our investment portfolio, including cash and cash equivalents, was approximately 4.4 years as of December 31, 2016 and 4.1 years as of December 31, 2015. Based on the duration including cash equivalents, a 1% increase in interest rates would generally decrease the fair value of our securities by approximately $590 million.

We have also evaluated the impact on our investment income and interest expense resulting from a hypothetical change in interest rates of 100, 200, and 300 basis points over the next twelve-month period, as reflected in the following table. The evaluation was based on our investment portfolio and our outstanding indebtedness at December 31, 2016 and 2015. Our investment portfolio consists of cash, cash equivalents, and investment securities. The modeling technique used to calculate the pro forma net change in pretax earnings considered the cash flows related to fixed income investments and debt, which are subject to interest rate changes during a prospective twelve-month period. This evaluation measures parallel shifts in interest rates and may not account for certain unpredictable events that may affect interest income, including unexpected changes of cash flows into and out of the portfolio, changes in the asset allocation, including shifts between taxable and tax-exempt securities, and spread changes specific to various investment categories. In the past ten years, changes in 3 month LIBOR rates during the year have exceeded 300 basis points once, have not changed between 200 and 300 basis points, have changed between 100 and 200 basis points two times, and have changed by less than 100 basis points seven times.

	Increase (decrease) in pretax earnings given an interest rate decrease of X basis points			Increase (decrease) in pretax earnings given an interest rate increase of X basis points		
	(300)	(200)	(100)	100	200	300
	(in millions)					
As of December 31, 2016						
Investment income (a)	$ (49)	$ (44)	$ (36)	$ 53	$ 107	$ 162
Interest expense (b)	3	3	3	(2)	(5)	(9)
Pretax	$ (46)	$ (41)	$ (33)	$ 51	$ 102	$ 153
As of December 31, 2015						
Investment income (a)	$ (33)	$ (27)	$ (21)	$ 41	$ 82	$ 124
Interest expense (b)	3	3	3	(3)	(6)	(9)
Pretax	$ (30)	$ (24)	$ (18)	$ 38	$ 76	$ 115

(a) As of December 31, 2016 and 2015, some of our investments had interest rates below 3% so the assumed hypothetical change in pretax earnings does not reflect the full 3% point reduction.

(b) The interest rate under our senior notes is fixed. There were no borrowings outstanding under the credit agreement at December 31, 2016 or December 31, 2015. There was $300 million outstanding under our commercial paper program at December 31, 2016. As of December 31, 2016, our interest rate under our commercial paper program was less than 2% so the assumed hypothetical change in pretax earnings does not reflect the full 2% point reduction.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Humana Inc.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2016	2015
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 3,877	$ 2,571
Investment securities	7,595	7,267
Receivables, less allowance for doubtful accounts of $118 in 2016 and $101 in 2015	1,280	1,161
Other current assets	3,438	4,712
Total current assets	16,190	15,711
Property and equipment, net	1,505	1,384
Long-term investment securities	2,203	1,843
Goodwill	3,272	3,265
Other long-term assets	2,226	2,475
Total assets	$ 25,396	$ 24,678
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Benefits payable	$ 4,563	$ 4,976
Trade accounts payable and accrued expenses	2,467	2,212
Book overdraft	212	301
Unearned revenues	280	364
Short-term borrowings	300	299
Total current liabilities	7,822	8,152
Long-term debt	3,792	3,794
Future policy benefits payable	2,834	2,151
Other long-term liabilities	263	235
Total liabilities	14,711	14,332
Commitments and contingencies (Note 16)		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,495,007 shares issued at December 31, 2016 and 198,372,059 shares issued at December 31, 2015	33	33
Capital in excess of par value	2,562	2,530
Retained earnings	11,454	11,017
Accumulated other comprehensive (loss) income	(66)	58
Treasury stock, at cost, 49,189,811 shares at December 31, 2016 and 50,084,043 shares at December 31, 2015	(3,298)	(3,292)
Total stockholders' equity	10,685	10,346
Total liabilities and stockholders' equity	$ 25,396	$ 24,678

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF INCOME

	For the year ended December 31,		
	2016	2015	2014
	(in millions, except per share results)		
Revenues:			
Premiums	$ 53,021	$ 52,409	$ 45,959
Services	969	1,406	2,164
Investment income	389	474	377
Total revenues	54,379	54,289	48,500
Operating expenses:			
Benefits	45,007	44,269	38,166
Operating costs	7,277	7,318	7,639
Depreciation and amortization	354	355	333
Total operating expenses	52,638	51,942	46,138
Income from operations	1,741	2,347	2,362
Gain on sale of business	—	270	—
Interest expense	189	186	192
Income before income taxes	1,552	2,431	2,170
Provision for income taxes	938	1,155	1,023
Net income	$ 614	$ 1,276	$ 1,147
Basic earnings per common share	$ 4.11	$ 8.54	$ 7.44
Diluted earnings per common share	$ 4.07	$ 8.44	$ 7.36
Dividends declared per common share	$ 1.16	$ 1.15	$ 1.11

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2016	2015	2014
	(in millions)		
Net income	$ 614	$ 1,276	$ 1,147
Other comprehensive (loss) income:			
Change in gross unrealized investment gains/losses	(101)	(114)	122
Effect of income taxes	38	42	(44)
Total change in unrealized investment gains/losses, net of tax	(63)	(72)	78
Reclassification adjustment for net realized gains included in investment income	(96)	(146)	(20)
Effect of income taxes	35	53	7
Total reclassification adjustment, net of tax	(61)	(93)	(13)
Other comprehensive (loss) income, net of tax	(124)	(165)	65
Comprehensive income	$ 490	$ 1,111	$ 1,212

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Capital In Excess of Par Value	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Treasury Stock	Total Stockholders' Equity
	Issued Shares	Amount					
	(dollars in millions, share amounts in thousands)						
Balances, January 1, 2014	196,276	$ 33	$ 2,267	$ 8,942	$ 158	$ (2,084)	$ 9,316
Net income				1,147			1,147
Other comprehensive income					65		65
Common stock repurchases			(100)			(772)	(872)
Dividends and dividend equivalents			—	(173)			(173)
Stock-based compensation			98				98
Restricted stock unit vesting	966	—	—			—	—
Stock option exercises	710	—	52				52
Stock option and restricted stock tax benefit			13				13
Balances, December 31, 2014	197,952	33	2,330	9,916	223	(2,856)	9,646
Net income				1,276			1,276
Other comprehensive loss					(165)		(165)
Common stock repurchases			100			(485)	(385)
Dividends and dividend equivalents			—	(175)			(175)
Stock-based compensation			109				109
Restricted stock unit vesting	159	—	(49)			49	—
Stock option exercises	261	—	23				23
Stock option and restricted stock tax benefit			17				17
Balances, December 31, 2015	198,372	33	2,530	11,017	58	(3,292)	10,346
Net income				614			614
Other comprehensive loss					(124)		(124)
Common stock repurchases			—			(104)	(104)
Dividends and dividend equivalents			—	(177)			(177)
Stock-based compensation			115				115
Restricted stock unit vesting	13	—	(98)			98	—
Stock option exercises	110	—	13				13
Stock option and restricted stock tax benefit			2				2
Balances, December 31, 2016	198,495	$ 33	$ 2,562	$ 11,454	$ (66)	$ (3,298)	$ 10,685

The accompanying notes are an integral part of the consolidated financial statements.

Humana Inc.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2016	2015	2014
		(in millions)	
Cash flows from operating activities			
Net income	$ 614	$ 1,276	$ 1,147
Adjustments to reconcile net income to net cash provided by operating activities:			
Gain on sale of business	—	(270)	—
Depreciation	388	354	328
Amortization	77	93	121
Stock-based compensation	115	109	98
Net realized capital gains	(96)	(146)	(20)
Benefit for deferred income taxes	(71)	(2)	(64)
Provision for doubtful accounts	39	61	32
Changes in operating assets and liabilities, net of effect of businesses acquired and dispositions:			
Receivables	(158)	(180)	(264)
Other assets	426	(872)	(952)
Benefits payable	(413)	501	582
Other liabilities	937	(129)	413
Unearned revenues	(84)	3	155
Other	162	70	42
Net cash provided by operating activities	1,936	868	1,618
Cash flows from investing activities			
Acquisitions, net of cash acquired	(7)	(38)	(18)
Proceeds from sale of business	—	1,061	72
Purchases of property and equipment	(527)	(523)	(528)
Proceeds from sales of property and equipment	—	1	—
Purchases of investment securities	(6,566)	(6,739)	(2,883)
Maturities of investment securities	1,426	1,065	885
Proceeds from sales of investment securities	4,312	5,493	2,409
Net cash (used in) provided by investing activities	(1,362)	320	(63)
Cash flows from financing activities			
Receipts (withdrawals) from contract deposits, net	1,093	(296)	(919)
Proceeds from issuance of senior notes, net	—	—	1,733
(Repayments) proceeds from issuance of commercial paper, net	(2)	298	—
Repayment of long-term debt	—	—	(500)
Common stock repurchases	(104)	(385)	(872)
Dividends paid	(177)	(172)	(172)
Excess tax benefit from stock-based compensation	—	15	12
Change in book overdraft	(89)	(33)	(69)
Proceeds from stock option exercises and other, net	11	21	29
Net cash provided by (used in) financing activities	732	(552)	(758)
Increase in cash and cash equivalents	1,306	636	797
Cash and cash equivalents at beginning of year	2,571	1,935	1,138
Cash and cash equivalents at end of year	$ 3,877	$ 2,571	$ 1,935
Supplemental cash flow disclosures:			
Interest payments	$ 185	$ 187	$ 143
Income tax payments, net	$ 916	$ 1,179	$ 1,030
Details of businesses acquired in purchase transactions:			
Fair value of assets acquired, net of cash acquired	$ 7	$ 38	$ 18
Less: Fair value of liabilities assumed	—	—	—
Cash paid for acquired businesses, net of cash acquired	$ 7	$ 38	$ 18

The accompanying notes are an integral part of the consolidated financial statements.

1. REPORTING ENTITY

Nature of Operations

Humana Inc., headquartered in Louisville, Kentucky, is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. Our strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country. References throughout these notes to consolidated financial statements to "we," "us," "our," "Company," and "Humana," mean Humana Inc. and its subsidiaries. We derived approximately 75% of our total premiums and services revenue from contracts with the federal government in 2016, including 14% related to our federal government contracts with the Centers for Medicare and Medicaid Services, or CMS, to provide health insurance coverage for individual Medicare Advantage members in Florida. CMS is the federal government's agency responsible for administering the Medicare program.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

Our financial statements and accompanying notes are prepared in accordance with accounting principles generally accepted in the United States of America. Our consolidated financial statements include the accounts of Humana Inc. and subsidiaries that the Company controls, including variable interest entities associated with medical practices for which we are the primary beneficiary. We do not own many of our medical practices but instead enter into exclusive management agreements with the affiliated Professional Associations, or P.A.s, that operate these medical practices. Based upon the provisions of these agreements, these affiliated P.A.s are variable interest entities and we are the primary beneficiary, and accordingly we consolidated the affiliated P.A.s. All significant intercompany balances and transactions have been eliminated.

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. The areas involving the most significant use of estimates are the estimation of benefits payable, future policy benefits payable, the impact of risk adjustment provisions related to our Medicare contracts, the valuation and related impairment recognition of investment securities, and the valuation and related impairment recognition of long-lived assets, including goodwill. These estimates are based on knowledge of current events and anticipated future events, and accordingly, actual results may ultimately differ materially from those estimates.

Certain amounts have been reclassified to conform to the current year presentation.

Aetna Merger

On July 2, 2015, we entered into an Agreement and Plan of Merger, which we refer to in this report as the Merger Agreement, with Aetna Inc. and certain wholly owned subsidiaries of Aetna Inc., which we refer to collectively as Aetna, which sets forth the terms and conditions under which we agreed to merge with, and become a wholly owned subsidiary of Aetna, a transaction we refer to in this report as the Merger.

The Merger was subject to customary closing conditions, including, among other things, (i) the expiration or termination of the applicable waiting period under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and the receipt of necessary approvals under state insurance and healthcare laws and regulations and pursuant to certain licenses of certain of Humana's subsidiaries, and (ii) the absence of legal restraints and prohibitions on the consummation of the Merger.

On December 22, 2016, in order to extend the "End Date" (as defined in the Merger Agreement), Aetna and Humana each agreed to waive until 11:59 p.m. (Eastern time) on February 15, 2017 its right to terminate the Merger Agreement due to a failure of the Mergers to have been completed on or before December 31, 2016.

On July 21, 2016, the U.S. Department of Justice and the attorneys general of certain U.S. jurisdictions filed a civil antitrust complaint in the U.S. District Court for the District of Columbia against us and Aetna, alleging that the Merger would violate Section 7 of the Clayton Antitrust Act and seeking a permanent injunction to prevent the Merger from being completed. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement, as our Board determined that an appeal of the Court's ruling would not be in the best interest of our stockholders. Under terms of the Merger Agreement, we are entitled to a breakup fee of $1 billion.

Health Care Reform

The Patient Protection and Affordable Care Act and The Health Care and Education Reconciliation Act of 2010 (which we collectively refer to as the Health Care Reform Law) enacted significant reforms to various aspects of the U.S. health insurance industry. Certain of these reforms became effective January 1, 2014, including an annual insurance industry premium-based fee and the establishment of federally-facilitated or state-based exchanges coupled with three premium stabilization programs, as described more fully below.

The Health Care Reform Law imposes an annual premium-based fee on health insurers for each calendar year beginning on or after January 1, 2014 which is not deductible for tax purposes. We are required to estimate a liability for the health insurer fee and record it in full once qualifying insurance coverage is provided in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized ratably to expense over the same calendar year. We record the liability for the health insurer fee in trade accounts payable and accrued expenses and record the deferred cost in other current assets in our consolidated financial statements. We pay the health insurer fee in September of each year. The Consolidated Appropriations Act, 2016, enacted on December 18, 2015, included a one-time one year suspension in 2017 of the health insurer fee. See Note 7 for detail regarding amounts paid for the annual health insurer fee.

The Health Care Reform Law also establishes risk spreading premium stabilization programs effective January 1, 2014. The risk spreading programs are applicable to certain of our commercial medical insurance products. In the aggregate, our commercial medical insurance products represented approximately 16% of our total premiums and services revenue for the year ended December 31, 2016, a subset of which is subject to these programs. These programs, commonly referred to as the 3Rs, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridors program designed to more evenly spread the financial risk borne by issuers and to mitigate the risk that issuers would have mispriced products. The transitional reinsurance and temporary risk corridors programs were for years 2014 through 2016. Policies issued prior to March 23, 2010 are considered grandfathered policies and are exempt from the 3Rs. Certain states have allowed non-grandfathered policies issued prior to January 1, 2014 to extend the date of required transition to policies compliant with the Health Care Reform Law to as late as 2017. Accordingly, such policies are exempt from the 3Rs until they transition to policies compliant with the Health Care Reform Law.

The permanent risk adjustment program adjusts the premiums that commercial individual and small group health insurance issuers receive based on the demographic factors and health status of each member as derived from current year medical diagnosis as reported throughout the year. This program transfers funds from lower risk plans to higher risk plans within similar plans in the same state. The risk adjustment program is applicable to commercial individual and small group health plans (except certain exempt and grandfathered plans as discussed above) operating both inside and outside of the health insurance exchanges established under the Health Care Reform Law. Under the risk adjustment program, a risk score is assigned to each covered member to determine an average risk score at the individual and small group level by legal entity in a particular market in a state. Additionally, an average risk score is determined for the entire subject population for each market in each state. Settlements are determined on a net basis by legal entity and state. Each health insurance issuer’s average risk score is compared to the state’s average risk score. Plans with an average risk score below the state average will pay into a pool and health insurance issuers with an average risk score that is greater than the state average risk score will receive money from that pool. We generally rely on providers, including certain network providers who are our employees, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for our risk scores under the program. Our estimate of amounts receivable and/or payable under the risk adjustment program is based on our estimate of both our own and the state

average risk scores. Assumptions used in these estimates include but are not limited to published third party studies and other publicly available data including regulatory plan filings, geographic considerations including our historical experience in markets we have participated in over a long period of time, member demographics (including age and gender for our members and other health insurance issuers), our pricing model, sales data for each metal tier (different metal tiers yield different risk scores), and the mix of previously underwritten membership as compared to new members in plans compliant with the Health Care Reform Law. We refine our estimates as new information becomes available, including additional data released by the Department of Health and Human Services, or HHS, regarding estimates of state average risk scores. Risk adjustment is subject to audit by HHS beginning with the 2015 coverage year, however, there will be no payments associated with these audits for 2015, the pilot year for the audits.

The temporary risk corridor program applies to individual and small group Qualified Health Plans (or substantially equivalent plans), or QHPs, as defined by HHS, operating both inside and outside of the exchanges. Accordingly, plans subject to risk adjustment that are not QHPs, including our small group health plans, were not subject to the risk corridor program. The risk corridor provisions limit issuer gains and losses by comparing allowable medical costs to a target amount, each defined/prescribed by HHS, and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from HHS. Variances from the target exceeding certain thresholds may result in HHS making additional payments to us or require us to refund HHS a portion of the premiums we received.

We estimate and recognize adjustments to premiums revenue for the risk adjustment and risk corridor provisions by projecting our ultimate premium for the calendar year separately for individual and group plans by state and legal entity. Estimated calendar year settlement amounts are recognized ratably during the year and are revised each period to reflect current experience, including changes in risk scores derived from medical diagnoses submitted by providers. We record receivables or payables at the individual or group level within each state and legal entity and classify the amounts as current or long-term in our consolidated balance sheets based on the timing of expected settlement. On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, and ceased recognizing revenues under the risk corridor program as discussed further in Note 7.

The transitional reinsurance program required us to make reinsurance contributions for calendar years 2014 through 2016 to a state or HHS established reinsurance entity based on a national contribution rate per covered member as determined by HHS. While all commercial medical plans, including self-funded plans, are required to fund the reinsurance entity, only fully-insured non-grandfathered plans compliant with the Health Care Reform Law in the individual commercial market will be eligible for recoveries if individual claims exceed a specified threshold. Accordingly, we account for transitional reinsurance contributions associated with all commercial medical health plans other than these non-grandfathered individual plans as an assessment in operating costs in our consolidated statements of income. We account for contributions made by individual commercial plans compliant with the Health Care Reform Law, which are subject to recoveries, as ceded premiums (a reduction of premiums) and similarly we account for any recoveries as ceded benefits (a reduction of benefits expense) in our consolidated statements of income.

We were required to remit payment for our per member reinsurance contribution, exclusive of the portion payable to the U.S. Treasury, by January 15 of the year following the coverage year, or January 15, 2017 for the 2016 coverage year. The portion of the reinsurance contribution due to the U.S. Treasury must be paid by November 15 of the year following the coverage year, or November 15, 2017 for the 2016 coverage year. Risk adjustment calculations will be completed and HHS will notify us of recoveries due or payments owed to/from us under the risk adjustment and reinsurance programs by June 30 of the year following the coverage year. Following this notification, risk corridor calculations are then due by July 31 of the year following the coverage year. Payments due to HHS under the risk adjustment and risk corridor programs must be remitted within 30 days of notification for each program and will be collected prior to the distribution of recoveries by HHS under each program. Payment and recovery amounts associated

with reinsurance and risk adjustment will generally be settled with HHS annually in the year following the coverage year. Accordingly, for the 2016 coverage year, we expect to receive recoveries and/or pay amounts due under these programs in 2017.

See Note 7 for detail regarding amounts recorded to the consolidated balance sheets related to the 3Rs.

In addition to the provisions discussed above, beginning in 2014, HHS pays us a portion of the health care costs for low-income individual members for which we assume no risk in accordance with the Health Care Reform Law. We account for these subsidies as a deposit in our consolidated balance sheets and as a financing activity in our consolidated statements of cash flows. We do not recognize premiums revenue or benefits expense for these subsidies. Receipt and payment activity is accumulated at the state and legal entity level and recorded in our consolidated balance sheet in other current assets or trade accounts payable and accrued expenses depending on the state and legal entity balance at the end of the reporting period. We will be notified of final settlement amounts by June 30 of the year following the coverage year. For 2016, payments to HHS associated with cost sharing subsidies for which we do not assume risk were approximately $373 million, exceeding receipts of $345 million by $28 million. For 2015, receipts from HHS associated with cost sharing subsidies for which we do not assume risk were approximately $478 million, exceeding payments of $409 million by $69 million. For 2014, receipts from HHS associated with cost sharing subsidies for which we do not assume risk were approximately $281 million, exceeding payments of $255 million by $26 million.

If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

Cash and Cash Equivalents

Cash and cash equivalents include cash, time deposits, money market funds, commercial paper, other money market instruments, and certain U.S. Government securities with an original maturity of three months or less. Carrying value approximates fair value due to the short-term maturity of the investments.

Investment Securities

Investment securities, which consist entirely of debt securities, have been categorized as available for sale and, as a result, are stated at fair value. Investment securities available for current operations are classified as current assets. Investment securities available for our long-term insurance products and professional liability funding requirements, as well as restricted statutory deposits, are classified as long-term assets. For the purpose of determining gross realized gains and losses, which are included as a component of investment income in the consolidated statements of income, the cost of investment securities sold is based upon specific identification. Unrealized holding gains and losses, net of applicable deferred taxes, are included as a component of stockholders' equity and comprehensive income until realized from a sale or other-than-temporary impairment.

Under the other-than-temporary impairment model for debt securities held, we recognize an impairment loss in income in an amount equal to the full difference between the amortized cost basis and the fair value when we have the intent to sell the debt security or it is more likely than not we will be required to sell the debt security before recovery of our amortized cost basis. However, if we do not intend to sell the debt security, we evaluate the expected cash flows to be received as compared to amortized cost and determine if a credit loss has occurred. In the event of a credit loss, only the amount of the impairment associated with the credit loss is recognized currently in income with the remainder of the loss recognized in other comprehensive income.

When we do not intend to sell a security in an unrealized loss position, potential other-than-temporary impairment is considered using a variety of factors, including the length of time and extent to which the fair value has been less than cost; adverse conditions specifically related to the industry, geographic area or financial condition of the issuer or underlying collateral of a security; payment structure of the security; changes in credit rating of the security by the rating agencies; the volatility of the fair value changes; and changes in fair value of the security after the balance sheet date. For debt securities, we take into account expectations of relevant market and economic data. For example, with

respect to mortgage and asset-backed securities, such data includes underlying loan level data and structural features such as seniority and other forms of credit enhancements. A decline in fair value is considered other-than-temporary when we do not expect to recover the entire amortized cost basis of the security. We estimate the amount of the credit loss component of a debt security as the difference between the amortized cost and the present value of the expected cash flows of the security. The present value is determined using the best estimate of future cash flows discounted at the implicit interest rate at the date of purchase.

Receivables and Revenue Recognition

We generally establish one-year commercial membership contracts with employer groups, subject to cancellation by the employer group on 30-day written notice. Our Medicare contracts with CMS renew annually. Our military services contracts with the federal government and our contracts with various state Medicaid programs generally are multi-year contracts subject to annual renewal provisions. Individual polices are subject to the requirements of the Health Care Reform Law as discussed previously.

Premiums Revenue

We bill and collect premium from employer groups and members in our Medicare and other individual products monthly. We receive monthly premiums from the federal government and various states according to government specified payment rates and various contractual terms. Changes in revenues for our Medicare and individual commercial medical products resulting from the periodic changes in risk-adjustment scores derived from medical diagnoses for our membership and changes in risk corridor estimates are recognized when the amounts become determinable and the collectibility is reasonably assured.

Premiums revenue is estimated by multiplying the membership covered under the various contracts by the contractual rates. Premiums revenue is recognized as income in the period members are entitled to receive services, and is net of estimated uncollectible amounts, retroactive membership adjustments, and adjustments to recognize rebates under the minimum benefit ratios required under the Health Care Reform Law. We estimate policyholder rebates by projecting calendar year minimum benefit ratios for the individual, small group, and large group markets, as defined by the Health Care Reform Law using a methodology prescribed by HHS, separately by state and legal entity. Medicare Advantage products are also subject to minimum benefit ratio requirements under the Health Care Reform Law. Estimated calendar year rebates recognized ratably during the year are revised each period to reflect current experience. Retroactive membership adjustments result from enrollment changes not yet processed, or not yet reported by an employer group or the government. We routinely monitor the collectibility of specific accounts, the aging of receivables, historical retroactivity trends, estimated rebates, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. Premiums received prior to the service period are recorded as unearned revenues.

Medicare Part D

We cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments we receive monthly from CMS and members, which are determined from our annual bid, represent amounts for providing prescription drug insurance coverage. We recognize premiums revenue for providing this insurance coverage ratably over the term of our annual contract. Our CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which we are not at risk.

The risk corridor provisions compare costs targeted in our bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to us or require us to refund to CMS a portion of the premiums we received. As risk corridor provisions are considered in our overall annual bid process, we estimate and recognize an adjustment to premiums revenue related to these provisions based upon pharmacy claims experience. We record a receivable or payable at the contract level and classify the amount as current or long-term in our consolidated balance sheets based on the timing of expected settlement.

Reinsurance and low-income cost subsidies represent funding from CMS in connection with the Medicare Part D program for which we assume no risk. Reinsurance subsidies represent funding from CMS for its portion of prescription drug costs which exceed the member's out-of-pocket threshold, or the catastrophic coverage level. Low-income cost subsidies represent funding from CMS for all or a portion of the deductible, the coinsurance and co-payment amounts above the out-of-pocket threshold for low-income beneficiaries. Monthly prospective payments from CMS for reinsurance and low-income cost subsidies are based on assumptions submitted with our annual bid. A reconciliation and related settlement of CMS's prospective subsidies against actual prescription drug costs we paid is made after the end of the year. The Health Care Reform Law mandates consumer discounts of 50% on brand name prescription drugs for Part D plan participants in the coverage gap. These discounts are funded by CMS and pharmaceutical manufacturers while we administer the application of these funds. We account for these subsidies and discounts as a deposit in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2016, subsidy and discount reimbursements of $11.1 billion exceeded payments of $10.0 billion by $1.1 billion. For 2015, subsidy and discount payments of $8.9 billion exceeded reimbursements of $8.6 billion by $361 million. For 2014, subsidy and discount payments of $6.7 billion exceeded reimbursements of $5.8 billion by $945 million. We do not recognize premiums revenue or benefit expenses for these subsidies or discounts. Receipt and payment activity is accumulated at the contract level and recorded in our consolidated balance sheets in other current assets or trade accounts payable and accrued expenses depending on the contract balance at the end of the reporting period.

Settlement of the reinsurance and low-income cost subsidies as well as the risk corridor payment is based on a reconciliation made approximately 9 months after the close of each calendar year. Settlement with CMS for brand name prescription drug discounts is based on a reconciliation made approximately 14 to 18 months after the close of each calendar year. We continue to revise our estimates with respect to the risk corridor provisions based on subsequent period pharmacy claims data. See Note 6 for detail regarding amounts recorded to our consolidated balance sheets related to the risk corridor settlement and subsidies from CMS with respect to the Medicare Part D program.

Services Revenue

Patient services revenue

Patient services include injury and illness care and related services as well as other healthcare services related to employer needs or as required by law. Patient services revenues are recognized in the period services are provided to the customer when the sales price is fixed or determinable, and are net of contractual allowances.

Administrative services fees

Administrative services fees cover the processing of claims, offering access to our provider networks and clinical programs, and responding to customer service inquiries from members of self-funded groups. Revenues from providing administration services, also known as administrative services only, or ASO, are recognized in the period services are performed and are net of estimated uncollectible amounts. ASO fees are estimated by multiplying the membership covered under the various contracts by the contractual rates. Under ASO contracts, self-funded employers retain the risk of financing substantially all of the cost of health benefits. However, many ASO customers purchase stop loss insurance coverage from us to cover catastrophic claims or to limit aggregate annual costs. Accordingly, we have recorded premiums revenue and benefits expense related to these stop loss insurance contracts. We routinely monitor the collectibility of specific accounts, the aging of receivables, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. ASO fees received prior to the service period are recorded as unearned revenues.

Under our current TRICARE South Region contract with the Department of Defense, we provide administrative services, including offering access to our provider networks and clinical programs, claim processing, customer service, enrollment, and other services, while the federal government retains all of the risk of the cost of health benefits. We account for revenues under the current contract net of estimated health care costs similar to an administrative services fee only agreement. The current contract includes fixed administrative services fees and incentive fees and penalties. Administrative services fees are recognized as services are performed.

Our TRICARE members are served by both in-network and out-of-network providers in accordance with the current contract. We pay health care costs related to these services to the providers and are subsequently reimbursed by the DoD for such payments. We account for the payments of the federal government's claims and the related reimbursements under deposit accounting in our consolidated balance sheets and as a financing activity under receipts (withdrawals) from contract deposits in our consolidated statements of cash flows. For 2016, health care cost reimbursements and payments were each approximately $3.3 billion, with payments exceeding reimbursements by $25 million for the year. For 2015, health care cost reimbursements and payments were each approximately $3.3 billion, with payments exceeding reimbursements by $4 million for the year. For 2014, health care cost reimbursements and payments were each $3.2 billion.

Receivables

Receivables, including premium receivables, patient services revenue receivables, and ASO fee receivables, are shown net of allowances for estimated uncollectible accounts, retroactive membership adjustments, and contractual allowances.

Other Current Assets

Other current assets includes amounts associated with Medicare Part D as discussed above and in Note 6, rebates due from pharmaceutical manufacturers and other amounts due within one year. We accrue pharmaceutical rebates as they are earned based on contractual terms and usage of the product. The balance of pharmaceutical rebates was $889 million at December 31, 2016 and $723 million at December 31, 2015.

Policy Acquisition Costs

Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include commissions, costs of policy issuance and underwriting, and other costs we incur to acquire new business or renew existing business. We expense policy acquisition costs related to our employer-group prepaid health services policies as incurred. These short-duration employer-group prepaid health services policies typically have a 1-year term and may be canceled upon 30 days notice by the employer group.

Life insurance, annuities, and certain health and other supplemental policies sold to individuals are accounted for as long-duration insurance products because they are expected to remain in force for an extended period beyond one year and premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned. Deferred acquisition costs are reviewed to determine if they are recoverable from future income. See Note 18.

Beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model and accordingly policy acquisition costs are expensed as incurred because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the recognition of previously deferred acquisition costs.

Long-Lived Assets

Property and equipment is recorded at cost. Gains and losses on sales or disposals of property and equipment are included in operating costs. Certain costs related to the development or purchase of internal-use software are capitalized. Depreciation is computed using the straight-line method over estimated useful lives ranging from 3 to 10 years for equipment, 3 to 5 years for computer software, and 10 to 20 years for buildings. Improvements to leased facilities are depreciated over the shorter of the remaining lease term or the anticipated life of the improvement.

We periodically review long-lived assets, including property and equipment and other intangible assets, for impairment whenever adverse events or changes in circumstances indicate the carrying value of the asset may not be recoverable. Losses are recognized for a long-lived asset to be held and used in our operations when the undiscounted

future cash flows expected to result from the use of the asset are less than its carrying value. We recognize an impairment loss based on the excess of the carrying value over the fair value of the asset. A long-lived asset held for sale is reported at the lower of the carrying amount or fair value less costs to sell. Depreciation expense is not recognized on assets held for sale. Losses are recognized for a long-lived asset to be abandoned when the asset ceases to be used. In addition, we periodically review the estimated lives of all long-lived assets for reasonableness.

Goodwill and Other Intangible Assets

Goodwill represents the unamortized excess of cost over the fair value of the net tangible and other intangible assets acquired. We are required to test at least annually for impairment at a level of reporting referred to as the reporting unit, and more frequently if adverse events or changes in circumstances indicate that the asset may be impaired. A reporting unit either is our operating segments or one level below the operating segments, referred to as a component, which comprise our reportable segments. A component is considered a reporting unit if the component constitutes a business for which discrete financial information is available that is regularly reviewed by management. We aggregate the components of an operating segment into one reporting unit if they have similar economic characteristics. Goodwill is assigned to the reporting unit that is expected to benefit from a specific acquisition.

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. Impairment tests are performed, at a minimum, in the fourth quarter of each year supported by our long-range business plan and annual planning process. We rely on an evaluation of future discounted cash flows to determine fair value of our reporting units. Impairment tests completed for 2016, 2015, and 2014 did not result in an impairment loss.

Other intangible assets primarily relate to acquired customer contracts/relationships and are included with other long-term assets in the consolidated balance sheets. Other intangible assets are amortized over the useful life, based upon the pattern of future cash flows attributable to the asset. This sometimes results in an accelerated method of amortization for customer contracts because the asset tends to dissipate at a more rapid rate in earlier periods. Other than customer contracts, other intangible assets generally are amortized using the straight-line method. We review other finite-lived intangible assets for impairment under our long-lived asset policy.

Benefits Payable and Benefits Expense Recognition

Benefits expense includes claim payments, capitation payments, pharmacy costs net of rebates, allocations of certain centralized expenses and various other costs incurred to provide health insurance coverage to members, as well as estimates of future payments to hospitals and others for medical care and other supplemental benefits provided on or prior to the balance sheet date. Capitation payments represent monthly contractual fees disbursed to primary care and other providers who are responsible for providing medical care to members. Pharmacy costs represent payments for members' prescription drug benefits, net of rebates from drug manufacturers. Receivables for such pharmacy rebates are included in other current assets in our consolidated balance sheets. Other supplemental benefits include dental, vision, and other supplemental health and financial protection products.

We estimate the costs of our benefits expense payments using actuarial methods and assumptions based upon claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors, and record benefit reserves for future payments. We continually review estimates of future payments relating to claims costs for services incurred in the current and prior periods and make necessary adjustments to our reserves.

Benefits expense is recognized in the period in which services are provided and includes an estimate of the cost of services which have been incurred but not yet reported, or IBNR. Our reserving practice is to consistently recognize the actuarial best point estimate within a level of confidence required by actuarial standards. Actuarial standards of practice generally require a level of confidence such that the liabilities established for IBNR have a greater probability of being adequate versus being insufficient, or such that the liabilities established for IBNR are sufficient to cover obligations under an assumption of moderately adverse conditions. Adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of the estimate. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice.

We develop our estimate for IBNR using actuarial methodologies and assumptions, primarily based upon historical claim experience. Depending on the period for which incurred claims are estimated, we apply a different method in determining our estimate. For periods prior to the most recent two months, the key assumption used in estimating our IBNR is that the completion factor pattern remains consistent over a rolling 12-month period after adjusting for known changes in claim inventory levels and known changes in claim payment processes. Completion factors result from the calculation of the percentage of claims incurred during a given period that have historically been adjudicated as of the reporting period. For the most recent two months, the incurred claims are estimated primarily from a trend analysis based upon per member per month claims trends developed from our historical experience in the preceding months, adjusted for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and weekday seasonality.

The completion factor method is used for the months of incurred claims prior to the most recent two months because the historical percentage of claims processed for those months is at a level sufficient to produce a consistently reliable result. Conversely, for the most recent two months of incurred claims, the volume of claims processed historically is not at a level sufficient to produce a reliable result, which therefore requires us to examine historical trend patterns as the primary method of evaluation. Changes in claim processes, including recoveries of overpayments, receipt cycle times, claim inventory levels, outsourcing, system conversions, and processing disruptions due to weather or other events affect views regarding the reasonable choice of completion factors. Claim payments to providers for services rendered are often net of overpayment recoveries for claims paid previously, as contractually allowed. Claim overpayment recoveries can result from many different factors, including retroactive enrollment activity, audits of provider billings, and/or payment errors. Changes in patterns of claim overpayment recoveries can be unpredictable and result in completion factor volatility, as they often impact older dates of service. The receipt cycle time measures the average length of time between when a medical claim was initially incurred and when the claim form was received. Increases in electronic claim submissions from providers decrease the receipt cycle time. If claims are submitted or processed on a faster (slower) pace than prior periods, the actual claim may be more (less) complete than originally estimated using our completion factors, which may result in reserves that are higher (lower) than required.

Medical cost trends potentially are more volatile than other segments of the economy. The drivers of medical cost trends include increases in the utilization of hospital facilities, physician services, new higher priced technologies and medical procedures, and new prescription drugs and therapies, as well as the inflationary effect on the cost per unit of each of these expense components. Other external factors such as government-mandated benefits or other regulatory changes, the tort liability system, increases in medical services capacity, direct to consumer advertising for prescription drugs and medical services, an aging population, lifestyle changes including diet and smoking, catastrophes, and epidemics also may impact medical cost trends. Internal factors such as system conversions, claims processing cycle times, changes in medical management practices and changes in provider contracts also may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. All of these factors are considered in estimating IBNR and in estimating the per member per month claims trend for purposes of determining the reserve for the most recent two months. Additionally, we continually prepare and review follow-up studies to assess the reasonableness of the estimates generated by our process and methods over time. The results of these studies are also considered in determining the reserve for the most recent two months. Each of these factors requires significant judgment by management.

We reassess the profitability of our contracts for providing insurance coverage to our members when current operating results or forecasts indicate probable future losses. We establish a premium deficiency reserve in current operations to the extent that the sum of expected future costs, claim adjustment expenses, and maintenance costs exceeds related future premiums under contracts without consideration of investment income. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with our method of acquiring, servicing, and measuring the profitability of such contracts. Losses recognized as a premium deficiency result in a beneficial effect in subsequent periods as operating losses under these contracts are charged to the liability previously established. Because the majority of our member contracts renew annually, we would not record a material premium deficiency reserve, except when unanticipated adverse events or changes in circumstances indicate otherwise. In the fourth quarter of 2015, we recognized a premium deficiency reserve of $176 million for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year and recorded a change in estimate of $208 million in the second quarter of 2016 associated with the 2016 coverage year as discussed in more detail in Note 7. As of December 31, 2016, we had no remaining premium deficiency reserve.

We believe our benefits payable are adequate to cover future claims payments required. However, such estimates are based on knowledge of current events and anticipated future events. Therefore, the actual liability could differ materially from the amounts provided.

Future policy benefits payable

Future policy benefits payable include liabilities for long-duration insurance policies including long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals for which some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on interest rates, mortality, morbidity, and maintenance expense assumptions. Interest rates are based on our expected net investment returns on the investment portfolio supporting the reserves for these blocks of business. Mortality, a measure of expected death, and morbidity, a measure of health status, assumptions are based on published actuarial tables, modified based upon actual experience. Changes in estimates of these reserves are recognized as an adjustment to benefits expense in the period the changes occur. We perform loss recognition tests at least annually in the fourth quarter, and more frequently if adverse events or changes in circumstances indicate that the level of the liability, together with the present value of future gross premiums, may not be adequate to provide for future expected policy benefits and maintenance costs. During 2016, we recorded a loss for a premium deficiency as discussed further in Note 18.

We adjust future policy benefits payable for the additional liability that would have been recorded if investment securities backing the liability had been sold at their stated aggregate fair value and the proceeds reinvested at current yields. We include the impact of this adjustment, if any, net of applicable deferred taxes, with the change in unrealized investment gain (loss) in accumulated other comprehensive income in stockholders' equity. As discussed previously, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model under which policy reserves are not established because premiums received in the current year are intended to pay anticipated benefits in that year. In addition, as previously underwritten members transition to plans compliant with the Health Care Reform Law, it results in policy lapses and the release of reserves for future policy benefits.

Book Overdraft

Under our cash management system, checks issued but not yet presented to banks that would result in negative bank balances when presented are classified as a current liability in the consolidated balance sheets. Changes in book overdrafts from period to period are reported in the consolidated statement of cash flows as a financing activity.

Income Taxes

We recognize an asset or liability for the deferred tax consequences of temporary differences between the tax bases of assets or liabilities and their reported amounts in the consolidated financial statements. These temporary differences will result in taxable or deductible amounts in future years when the reported amounts of the assets or liabilities are recovered or settled. We also recognize the future tax benefits such as net operating and capital loss carryforwards as

deferred tax assets. A valuation allowance is provided against these deferred tax assets if it is more likely than not that some portion or all of the deferred tax assets will not be realized. Future years' tax expense may be increased or decreased by adjustments to the valuation allowance or to the estimated accrual for income taxes.

We record tax benefits when it is more likely than not that the tax return position taken with respect to a particular transaction will be sustained. A liability, if recorded, is not considered resolved until the statute of limitations for the relevant taxing authority to examine and challenge the tax position has expired, or the tax position is ultimately settled through examination, negotiation, or litigation. We classify interest and penalties associated with uncertain tax positions in our provision for income taxes.

Derivative Financial Instruments

On October 29, 2012, we acquired a noncontrolling equity interest in MCCI Holdings, LLC, or MCCI, a privately held Medical Services Organization, or MSO, headquartered in Miami, Florida, that primarily coordinates medical care for Medicare Advantage beneficiaries in Florida, Texas and Georgia. Our agreement with MCCI includes a put option that would allow the controlling interest holder to put their interest to us beginning in 2018 as well as a call option that would allow us to purchase the controlling interest beginning in 2021. Accordingly, we recorded, at fair value, a liability and an asset associated with the put and call, respectively. Changes in the fair value of the liability and asset during the years ended December 31, 2016, 2015, and 2014 were not material to our results of operations, financial condition, or cash flows.

At times, we may use interest-rate swap agreements to manage our exposure to interest rate risk. The differential between fixed and variable rates to be paid or received is accrued and recognized over the life of the agreements as adjustments to interest expense in the consolidated statements of income. We were not party to any interest-rate swap agreements in 2016, 2015, or 2014.

Related Party

As noted above, MCCI is a related party to Humana. In December 2015, we purchased a note receivable directly from a third-party bank syndicate related to the financing of MCCI's business and extended the exercise date of the put option to 2018 and the call option to 2021. The note balance was $314 million at December 31, 2016 and $284 million at December 31, 2015. The note receivable bears interest at 10% annually, payable in quarterly installments, and matures in December 2020. We have also entered into a revolving note agreement providing a line of credit up to $55 million under which no balance is outstanding at December 31, 2016. The note receivable is included with other long-term assets in our consolidated balance sheet and with purchases of investment securities in our consolidated statement of cash flows. The related interest income of $30 million for 2016 is included in investment income in our consolidated statement of income. The interest was accrued to the loan balance during 2016 pursuant to the terms of the note. MCCI provides services to Humana Medicare Advantage members under capitation contracts with our health plans. Under these capitation agreements with Humana, MCCI assumes the financial risk associated with these Medicare Advantage members. We also have an outstanding advance to MCCI of approximately $6 million at December 31, 2016, with repayment terms tied to the performance under the capitation agreements. We recognized benefits expense of approximately $1.1 billion in 2016, $1.0 billion in 2015 and $962 million in 2014 under these capitation agreements with MCCI.

Stock-Based Compensation

We generally recognize stock-based compensation expense, as determined on the date of grant at fair value, on a straight-line basis over the period during which an employee is required to provide service in exchange for the award (the vesting period). In addition, for awards with both time and performance-based conditions, we generally recognize compensation expense on a straight line basis over the vesting period when it is probable that the performance condition will be achieved. However, prior to July 2, 2015, for awards granted to retirement eligible employees, compensation expense is recognized on a straight-line basis over the shorter of the requisite service period or the period from the date of grant to an employee's eligible retirement date. For awards granted on or after July 2, 2015 to retirement eligible employees, we recognize expense on a straight-line basis over the service period (the vesting period). We estimate expected forfeitures and recognize compensation expense only for those awards which are expected to vest. We estimate

the grant-date fair value of stock options using the Black-Scholes option-pricing model. Prior to 2016 we reported certain tax effects of stock-based compensation as a financing activity rather than an operating activity in the consolidated statement of cash flows. In 2016, we prospectively applied the provisions of new guidance issued by the Financial Accounting Standards Board, or FASB, related to the presentation of windfall tax benefits as cash flows from operating activities which resulted in reclassifying $20 million of cash flows from financing activities to operating activities for the three months ended March 31, 2016. We elected to continue to estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period.

Additional detail regarding our stock-based compensation plans is included in Note 13.

Earnings Per Common Share

We compute basic earnings per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted earnings per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding employee stock options and restricted shares, or units, using the treasury stock method.

Fair Value

Assets and liabilities measured at fair value are categorized into a fair value hierarchy based on whether the inputs to valuation techniques are observable or unobservable. Observable inputs reflect market data obtained from independent sources, while unobservable inputs reflect our own assumptions about the assumptions market participants would use. The fair value hierarchy includes three levels of inputs that may be used to measure fair value as described below.

Level 1 – Quoted prices in active markets for identical assets or liabilities. Level 1 assets and liabilities include debt securities that are traded in an active exchange market.

Level 2 – Observable inputs other than Level 1 prices such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities. Level 2 assets and liabilities include debt securities with quoted prices that are traded less frequently than exchange-traded instruments as well as debt securities whose value is determined using a pricing model with inputs that are observable in the market or can be derived principally from or corroborated by observable market data.

Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes assets and liabilities whose value is determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting our own assumptions about the assumptions market participants would use as well as those requiring significant management judgment.

Fair value of actively traded debt securities are based on quoted market prices. Fair value of other debt securities are based on quoted market prices of identical or similar securities or based on observable inputs like interest rates generally using a market valuation approach, or, less frequently, an income valuation approach and are generally classified as Level 2. We obtain at least one price for each security from a third party pricing service. These prices are generally derived from recently reported trades for identical or similar securities, including adjustments through the reporting date based upon observable market information. When quoted prices are not available, the third party pricing service may use quoted market prices of comparable securities or discounted cash flow analysis, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include benchmark yields, reported trades, credit spreads, broker quotes, default rates, and prepayment speeds. We are responsible for the determination of fair value and as such we perform analysis on the prices received from the third party pricing service to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of monthly price fluctuations as well as a quarterly comparison of the prices received from the pricing service to prices reported by our third party investment advisor. In addition, on a quarterly basis we examine the underlying inputs and assumptions for a sample of individual securities across asset classes, credit rating levels, and various durations.

Fair value of privately held debt securities, as well as auction rate securities, are estimated using a variety of valuation methodologies, including both market and income approaches, where an observable quoted market does not exist and are generally classified as Level 3. For privately-held debt securities, such methodologies include reviewing the value ascribed to the most recent financing, comparing the security with securities of publicly-traded companies in similar lines of business, and reviewing the underlying financial performance including estimating discounted cash flows. Auction rate securities are debt instruments with interest rates that reset through periodic short-term auctions. From time to time, liquidity issues in the credit markets have led to failed auctions. Given the liquidity issues, fair value could not be estimated based on observable market prices, and as such, unobservable inputs were used. For auction rate securities, valuation methodologies include consideration of the quality of the sector and issuer, underlying collateral, underlying final maturity dates, and liquidity.

Recently Issued Accounting Pronouncements

Recently Adopted Accounting Pronouncements

In March 2016, the FASB issued new guidance related to accounting for employee share-based payments, which changes how income tax effects of share-based payments are recorded as well as the minimum statutory tax withholding requirements and allows an accounting policy election to recognize forfeitures when they occur. As permitted, we elected to early adopt this new guidance during the second quarter of 2016 prospectively effective January 1, 2016. The adoption of this new guidance resulted in the recognition of approximately $20 million, or $0.12 per diluted common share, of tax benefits in net income in our consolidated statement of income for the three months ended March 31, 2016 that had previously been recorded as additional paid-in capital in our condensed consolidated balance sheet. We also prospectively applied the provisions of the new guidance related to the presentation of windfall tax benefits as cash flows from operating activities which resulted in reclassifying $20 million of cash flows from financing activities to operating activities for the three months ended March 31, 2016. We elected to continue to estimate forfeitures expected to occur to determine the amount of compensation cost to be recognized in each period.

In November 2015, the FASB issued new guidance related to accounting for income taxes which changes the balance sheet classification of deferred taxes, requiring deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. The new guidance is effective for us beginning with annual and interim periods in 2017, with early adoption permitted. We elected to early adopt the guidance and have classified all deferred tax liabilities and assets as noncurrent in our consolidated balance sheet at December 31, 2015 to simplify their presentation. The adoption of the new guidance did not have any impact on our results of operations or cash flows.

In May 2015, the FASB issued new guidance requiring insurance entities to provide additional disclosures about claim liabilities including paid claims development information by accident year and claim frequency data and related methodologies. We adopted this new guidance in this 2016 Form 10-K. The applicable disclosures are included in this Note 2 and Note 10.

In March 2015, the FASB issued new guidance which changes the presentation of debt issuance costs from an asset to a direct reduction of the related debt liability. We adopted this new guidance on January 1, 2016 on a retrospective basis by directly deducting unamortized debt issuance costs from long-term debt on our balance sheet for all periods presented. Debt issuance costs had previously been classified in our balance sheet as other long-term assets.

Accounting Pronouncements Effective in Future Periods

In June 2016, the FASB issued guidance introducing a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The guidance is effective for us beginning January 1, 2019. The new current expected credit losses (CECL) model generally calls for the immediate recognition of all expected credit losses and applies to loans, accounts and trade receivables as well as other financial assets measured at amortized cost, loan commitments and off-balance sheet credit exposures, debt securities and other financial assets measured at fair value through other comprehensive income, and beneficial interests in securitized financial assets. The new guidance replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available-for-sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities, and provides for additional disclosure requirements. Our investment portfolio

consists of available for sale debt securities. We are currently evaluating the impact on our results of operations, financial condition, or cash flows.

In February 2016, the FASB issued new guidance related to accounting for leases which requires lessees to record assets and liabilities reflecting the leased assets and lease obligations, respectively, while following the dual model for recognition in statements of income requiring leases to be classified as either operating or finance. Operating leases will result in straight-line expense (similar to current operating leases) while finance leases will result in a front-loaded expense pattern (similar to current capital leases). The new guidance is effective for us beginning with annual and interim periods in 2019, with earlier adoption permitted, and requires retrospective application to previously issued annual and interim financial statements. We have begun the process of identifying the population of lease agreements and other arrangements that may contain embedded leases for purposes of adopting the new standard. While we expect to record significant leased assets and corresponding lease obligations based on our existing population of individual leases, we continue to evaluate the impact on our results of operations, financial position and cash flows.

In May 2014, the FASB issued new guidance that amends the accounting for revenue recognition. The amendments are intended to provide a more robust framework for addressing revenue issues, improve comparability of revenue recognition practices, and improve disclosure requirements. Insurance contracts are not included in the scope of this new guidance. Accordingly, our premiums revenue and investment income, collectively representing approximately 98% of our consolidated external revenues for 2016, are not included in the scope of the new guidance. We are analyzing how we may recognize revenue under the new guidance by reviewing selected sample contracts presently in place. The new guidance is effective for us beginning with annual and interim periods in 2018. While we expect revenue related to our Pharmacy, Provider Services, ASO and other services businesses to remain primarily unchanged, we are still evaluating the impact of the new guidance on the customer arrangements for these businesses. Accordingly, we continue to evaluate the impact of the new standard on our results of operations, financial condition and cash flows.

There are no other recently issued accounting standards that apply to us or that are expected to have a material impact on our results of operations, financial condition, or cash flows.

3. ACQUISITIONS AND DIVESTITURES

On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc., or Concentra, to MJ Acquisition Corporation, a joint venture between Select Medical Holdings Corporation and Welsh, Carson, Anderson & Stowe XII, L.P., a private equity fund, for approximately $1,055 million in cash, excluding approximately $22 million of transaction costs. In connection with the sale, we recognized a pre-tax gain, net of transaction costs, of $270 million which is reported as gain on sale of business in the accompanying consolidated statements of income for the year ended December 31, 2015. The accompanying consolidated statements of income include revenues related to Concentra of $411 million in 2015 and $998 million in 2014.

During 2016, 2015 and 2014, we acquired health and wellness related businesses which, individually or in the aggregate, have not had a material impact on our results of operations, financial condition, or cash flows. The results of operations and financial condition of these businesses have been included in our condensed consolidated statements of income and condensed consolidated balance sheets from the respective acquisition dates. Acquisition-related costs recognized in each of 2016, 2015, and 2014 were not material to our results of operations. The pro forma financial information assuming the acquisitions had occurred as of the beginning of the calendar year prior to the year of acquisition, as well as the revenues and earnings generated during the year of acquisition, were not material for disclosure purposes.

4. INVESTMENT SECURITIES

Investment securities classified as current and long-term were as follows at December 31, 2016 and 2015, respectively:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
		(in millions)		
December 31, 2016				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 800	$ 1	$ (15)	$ 786
Mortgage-backed securities	1,662	6	(31)	1,637
Tax-exempt municipal securities	3,358	15	(68)	3,305
Mortgage-backed securities:				
Residential	9	—	—	9
Commercial	307	1	(4)	304
Asset-backed securities	160	—	—	160
Corporate debt securities	3,530	145	(78)	3,597
Total debt securities	$ 9,826	$ 168	$ (196)	$ 9,798
December 31, 2015				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	$ 331	$ 2	$ (1)	$ 332
Mortgage-backed securities	1,902	12	(23)	1,891
Tax-exempt municipal securities	2,611	61	(4)	2,668
Mortgage-backed securities:				
Residential	13	—	—	13
Commercial	1,024	2	(41)	985
Asset-backed securities	264	1	(2)	263
Corporate debt securities	2,873	140	(55)	2,958
Total debt securities	$ 9,018	$ 218	$ (126)	$ 9,110

Gross unrealized losses and fair values aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position were as follows at December 31, 2016 and 2015, respectively:

	Less than 12 months		12 months or more		Total	
	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses	Fair Value	Gross Unrealized Losses
	(in millions)					
December 31, 2016						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 697	$ (15)	$ 3	$ —	$ 700	$ (15)
Mortgage-backed securities	1,528	(31)	3	—	1,531	(31)
Tax-exempt municipal securities	2,756	(67)	43	(1)	2,799	(68)
Mortgage-backed securities:						
Residential	—	—	4	—	4	—
Commercial	182	(3)	24	(1)	206	(4)
Asset-backed securities	51	—	63	—	114	—
Corporate debt securities	1,544	(71)	69	(7)	1,613	(78)
Total debt securities	$ 6,758	$ (187)	$ 209	$ (9)	$ 6,967	$ (196)
December 31, 2015						
U.S. Treasury and other U.S. government corporations and agencies:						
U.S. Treasury and agency obligations	$ 195	$ (1)	$ 14	$ —	$ 209	$ (1)
Mortgage-backed securities	1,484	(20)	86	(3)	1,570	(23)
Tax-exempt municipal securities	843	(3)	52	(1)	895	(4)
Mortgage-backed securities:						
Residential	2	—	4	—	6	—
Commercial	626	(13)	265	(28)	891	(41)
Asset-backed securities	258	(2)	—	—	258	(2)
Corporate debt securities	918	(45)	63	(10)	981	(55)
Total debt securities	$ 4,326	$ (84)	$ 484	$ (42)	$ 4,810	$ (126)

Approximately 98% of our debt securities were investment-grade quality, with a weighted average credit rating of AA by S&P at December 31, 2016. Most of the debt securities that were below investment-grade were rated BB, the higher end of the below investment-grade rating scale. At December 31, 2016, 8% of our tax-exempt municipal securities were pre-refunded, generally with U.S. government and agency securities. Tax-exempt municipal securities that were not pre-refunded were diversified among general obligation bonds of U.S. states and local municipalities as well as special revenue bonds. General obligation bonds, which are backed by the taxing power and full faith of the issuer, accounted for 46% of the tax-exempt municipals that were not pre-refunded in the portfolio. Special revenue bonds, issued by a municipality to finance a specific public works project such as utilities, water and sewer, transportation, or education, and supported by the revenues of that project, accounted for the remaining 54% of these municipals. Our general obligation bonds are diversified across the United States with no individual state exceeding 11%. In addition, 4% of our tax-exempt securities were insured by bond insurers and had an equivalent weighted average S&P credit rating of AA exclusive of the bond insurers' guarantee. Our investment policy limits investments in a single issuer and requires diversification among various asset types.

Residential mortgage back securities comprised approximately 99% of our agency mortgage-backed securities at December 31, 2016 and 98% at December 31, 2015.

The recoverability of our non-agency residential and commercial mortgage-backed securities is supported by factors such as seniority, underlying collateral characteristics and credit enhancements. These residential and commercial mortgage-backed securities at December 31, 2016 primarily were composed of senior tranches having high credit support, with over 99% of the collateral consisting of prime loans. The weighted average credit rating of all commercial mortgage-backed securities was AA+ at December 31, 2016.

The percentage of corporate securities associated with the financial services industry was 23% at December 31, 2016 and 25% at December 31, 2015.

Our unrealized loss from all securities was generated from approximately 990 positions out of a total of approximately 2,140 positions at December 31, 2016. All issuers of securities we own that were trading at an unrealized loss at December 31, 2016 remain current on all contractual payments. After taking into account these and other factors previously described, we believe these unrealized losses primarily were caused by an increase in market interest rates in the current markets than when the securities were purchased. At December 31, 2016, we did not intend to sell the securities with an unrealized loss position in accumulated other comprehensive income, and it is not likely that we will be required to sell these securities before recovery of their amortized cost basis. As a result, we believe that the securities with an unrealized loss were not other-than-temporarily impaired at December 31, 2016.

The detail of realized gains (losses) related to investment securities and included within investment income was as follows for the years ended December 31, 2016, 2015, and 2014:

	2016	2015	2014
		(in millions)	
Gross realized gains	$ 120	$ 179	$ 29
Gross realized losses	(24)	(33)	(9)
Net realized capital gains	$ 96	$ 146	$ 20

There were no material other-than-temporary impairments in 2016, 2015, or 2014.

The contractual maturities of debt securities available for sale at December 31, 2016, regardless of their balance sheet classification, are shown below. Expected maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Amortized Cost	Fair Value
	(in millions)	
Due within one year	$ 635	$ 635
Due after one year through five years	2,424	2,426
Due after five years through ten years	1,938	1,893
Due after ten years	2,691	2,734
Mortgage and asset-backed securities	2,138	2,110
Total debt securities	$ 9,826	$ 9,798

5. FAIR VALUE

Financial Assets

The following table summarizes our fair value measurements at December 31, 2016 and 2015, respectively, for financial assets measured at fair value on a recurring basis:

	Fair Value	Fair Value Measurements Using		
		Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
		(in millions)		
December 31, 2016				
Cash equivalents	$ 3,654	$ 3,654	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	786	—	786	—
Mortgage-backed securities	1,637	—	1,637	—
Tax-exempt municipal securities	3,305	—	3,302	3
Mortgage-backed securities:				
Residential	9	—	9	—
Commercial	304	—	304	—
Asset-backed securities	160	—	160	—
Corporate debt securities	3,597	—	3,593	4
Total debt securities	9,798	—	9,791	7
Total invested assets	$ 13,452	$ 3,654	$ 9,791	$ 7
December 31, 2015				
Cash equivalents	$ 2,229	$ 2,229	$ —	$ —
Debt securities:				
U.S. Treasury and other U.S. government corporations and agencies:				
U.S. Treasury and agency obligations	332	—	332	—
Mortgage-backed securities	1,891	—	1,891	—
Tax-exempt municipal securities	2,668	—	2,663	5
Mortgage-backed securities:				
Residential	13	—	13	—
Commercial	985	—	985	—
Asset-backed securities	263	—	263	—
Corporate debt securities	2,958	—	2,952	6
Total debt securities	9,110	—	9,099	11
Total invested assets	$ 11,339	$ 2,229	$ 9,099	$ 11

There were no material transfers between Level 1 and Level 2 during 2016 or 2015.

Our Level 3 assets had a fair value of $7 million at December 31, 2016, or 0.1% of our total invested assets. During the years ended December 31, 2016, 2015, and 2014, the changes in the fair value of the assets measured using significant unobservable inputs (Level 3) were comprised of the following:

	For the years ended December 31,								
	2016			2015			2014		
	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total	Private Placements	Auction Rate Securities	Total
	(in millions)								
Beginning balance at January 1	$ 6	$ 5	$ 11	$ 24	$ 8	$ 32	$ 24	$ 13	$ 37
Total gains or losses:									
Realized in earnings	—	—	—	(1)	—	(1)	—	—	—
Unrealized in other comprehensive income	—	—	—	—	—	—	—	—	—
Purchases	—	—	—	—	—	—	—	—	—
Sales	—	—	—	(17)	(3)	(20)	—	(5)	(5)
Settlements	(2)	(2)	(4)	—	—	—	—	—	—
Balance at December 31	$ 4	$ 3	$ 7	$ 6	$ 5	$ 11	$ 24	$ 8	$ 32

Financial Liabilities

Our long-term debt, recorded at carrying value in our consolidated balance sheets, was $3,792 million at December 31, 2016 and $3,794 million at December 31, 2015. The fair value of our long-term debt was $4,004 million at December 31, 2016 and $3,986 million at December 31, 2015. The fair value of our long-term debt is determined based on Level 2 inputs, including quoted market prices for the same or similar debt, or if no quoted market prices are available, on the current prices estimated to be available to us for debt with similar terms and remaining maturities.

Due to the short-term nature, carrying value approximates fair value for our commercial paper borrowings.

Assets and Liabilities Measured at Fair Value on a Nonrecurring Basis

As disclosed in Note 3, we completed our acquisition of certain health and wellness related businesses during 2016, 2015, and 2014. The values of net tangible assets acquired and the resulting goodwill and other intangible assets were recorded at fair value using Level 3 inputs. The majority of the related tangible assets acquired and liabilities assumed were recorded at their carrying values as of the respective dates of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in these acquisitions were internally estimated primarily based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets are expected to generate in the future. We developed internal estimates for the expected cash flows and discount rates in the present value calculations. Other than assets acquired and liabilities assumed in these acquisitions, there were no material assets or liabilities measured at fair value on a nonrecurring basis during 2016, 2015, or 2014.

6. MEDICARE PART D

As discussed in Note 2, we cover prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The accompanying consolidated balance sheets include the following amounts associated with Medicare Part D as of December 31, 2016 and 2015. CMS subsidies/discounts in the table below include the reinsurance and low-income cost subsidies funded by CMS for which we assume no risk as well as brand name prescription drug discounts for Part D plan participants in the coverage gap funded by CMS and pharmaceutical manufacturers.

	2016		2015	
	Risk Corridor Settlement	CMS Subsidies/ Discounts	Risk Corridor Settlement	CMS Subsidies/ Discounts
	(in millions)			
Other current assets	$ 8	$ 1,001	$ 25	$ 2,082
Trade accounts payable and accrued expenses	(158)	(128)	(47)	(63)
Net current (liability) asset	$ (150)	$ 873	$ (22)	$ 2,019

7. HEALTH CARE REFORM

Operating results for our individual commercial medical business compliant with the Health Care Reform Law have been challenged primarily due to unanticipated modifications in the program subsequent to the passing of the Health Care Reform Law, resulting in higher covered population morbidity and the ensuing enrollment and claims issues causing volatility in claims experience. We took a number of actions in 2015 that we believed would improve the profitability of our individual commercial medical business in 2016. These actions were subject to regulatory restrictions in certain geographies and included premium increases for the 2016 coverage year related generally to the first half of 2015 claims experience, the discontinuation of certain products as well as exit of certain markets for 2016, network improvements, enhancements to claims and clinical processes and administrative cost control. Despite these actions, the deterioration in the second half of 2015 claims experience together with 2016 open enrollment results that included the retention of many high-utilizing members for 2016 resulted in a probable future loss. As a result of our assessment in the fourth quarter of 2015 of the profitability of our individual commercial medical policies compliant with the Health Care Reform Law, we recorded in that quarter a provision for probable future losses (premium deficiency reserve) for the 2016 coverage year of $176 million in benefits payable in our consolidated balance sheet with a corresponding increase in benefits expense in our consolidated statement of income. As noted in the table below, in the second quarter of 2016, we increased the premium deficiency reserve for the 2016 coverage year and recorded a change in estimate of $208 million with a corresponding increase in benefits expense in our condensed consolidated statement of income primarily as a result of currently and projected unfavorable claims experience.

Changes in the premium deficiency reserve for the 2016 coverage year for the years ended December 31, 2016 and 2015 were as follows. There was no premium deficiency reserve in 2014.

	Premium Deficiency Reserve For the years ended December 31,	
	2016	2015
	(in millions)	
Balance at January 1	176	$ —
Current period results applied to the PDR liability for the 2016 coverage year	(384)	—
Change in full year estimate recorded in benefits expense	208	176
Balance at December 31	$ —	$ 176

On November 10, 2016, the U.S. Court of Federal Claims ruled in favor of the government in one of a series of cases filed by insurers, unrelated to us, against HHS to collect risk corridor payments, rejecting all of the insurer's statutory, contract and Constitutional claims for payment. On November 18, 2016, HHS issued a memorandum indicating a significant funding shortfall for the 2015 coverage year, the second consecutive year of significant shortfalls. Given the successful challenge of the risk corridor provisions in court, Congressional inquiries into the funding of the risk corridor program, and significant funding shortfalls under the first two years of the program, during the fourth quarter of 2016 we wrote-off $583 million in risk corridor receivables outstanding as of September 30, 2016, including $415 million associated with the 2014 and 2015 coverage years. From inception of the risk corridor program through December 31, 2016, we collected approximately $36 million from CMS for risk corridor receivables associated with

the 2014 coverage year funded by HHS in accordance with previous guidance, utilizing funds HHS collected from us and other carriers under the 2014 and 2015 risk corridor program.

On February 14, 2017, we announced we are exiting our individual commercial medical businesses January 1, 2018. As discussed previously, we have worked over the past several years to address market and programmatic challenges in order to keep coverage options available wherever we could offer a viable product. This has included pursuing business changes, such as modifying networks, restructuring product offerings, reducing the company's geographic footprint and increasing premiums. All of these actions were taken with the expectation that our individual commercial medical business would stabilize to the point where we could continue to participate in the program. However, based on our initial analysis of data associated with our healthcare exchange membership following the 2017 open enrollment period, we are seeing further signs of an unbalanced risk pool. Therefore, we have decided that we cannot continue to offer this coverage for 2018.

The accompanying consolidated balance sheets include the following amounts associated with the 3Rs at December 31, 2016 and December 31, 2015. Amounts classified as long-term represent settlements that we expect to exceed 12 months at December 31, 2016.

	2016			2015		
	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement	Risk Adjustment Settlement	Reinsurance Recoverables	Risk Corridor Settlement
	(in millions)					
Prior Coverage Years						
Premiums receivable	$ —	$ —	$ —	$ 126	$ —	$ —
Other current assets	—	54	—	—	610	—
Trade accounts payable and accrued expenses	—	—	—	(223)	—	—
Net current asset (liability)	—	54	—	(97)	610	—
Other long-term assets	—	—	—	10	—	459
Total prior coverage years' net asset (liability)	—	54	—	(87)	610	459
Current Coverage Year						
Premiums receivable	307	—	—	—	—	—
Other current assets	—	206	—	—	—	—
Trade accounts payable and accrued expenses	(117)	—	—	—	—	—
Net current asset	190	206	—	—	—	—
Other long-term assets	6	—	—	—	—	—
Total current coverage year net asset	196	206	—	—	—	—
Total net asset (liability)	$ 196	$ 260	$ —	$ (87)	$ 610	$ 459

Changes in estimate of the risk adjustment and reinsurance receivables and payables for prior coverage years primarily result from the annual June 30 notification from CMS of risk adjustment and reinsurance settlement amounts. These changes in estimate were substantially offset by changes in estimate of risk corridor receivables that were subsequently written off in the fourth quarter of 2016 as discussed above. During 2016, net collections under the 3Rs associated with prior coverage years were $383 million. We expect to collect the remaining $54 million of reinsurance recoverables related to prior coverage years in 2017.

To the extent certain provisions of the Health Care Reform Law are successfully challenged in court or there are changes in legislation or the application of legislation, there can be no guarantee that receivables established under the reinsurance or risk adjustment provisions of the Health Care Reform Law will ultimately be collected. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of the Health Care Reform Law, our business may be materially adversely affected. Additionally, potential legislative changes, including activities to repeal or replace the Health Care Reform Law, creates uncertainty for our business, and we cannot predict when, or in what form, such legislative changes may occur.

In 2016, we paid the federal government $916 million for the annual health insurance industry fee attributed to calendar year 2016, compared to $867 million in 2015 and $562 million in 2014, in accordance with the Health Care Reform Law. This fee is not deductible for tax purposes. The annual health insurance industry fee has been suspended for calendar year 2017 but is scheduled to resume in calendar year 2018.

8. PROPERTY AND EQUIPMENT, NET

Property and equipment was comprised of the following at December 31, 2016 and 2015.

	2016	2015
	(in millions)	
Land	$ 20	$ 20
Buildings and leasehold improvements	681	633
Equipment	750	645
Computer software	1,744	1,424
	3,195	2,722
Accumulated depreciation	(1,690)	(1,338)
Property and equipment, net	$ 1,505	$ 1,384

Depreciation expense was $388 million in 2016, $354 million in 2015, and $328 million in 2014, including amortization expense for capitalized internally developed and purchased software of $255 million in 2016, $220 million in 2015, and $191 million in 2014.

9. GOODWILL AND OTHER INTANGIBLE ASSETS

Changes in the carrying amount of goodwill for our reportable segments for the years ended December 31, 2016 and 2015 were as follows:

	Retail	Group	Healthcare Services	Total
		(in millions)		
Balance at January 1, 2015	$ 1,069	$ 385	$ 1,777	$ 3,231
Acquisitions	—	—	35	35
Dispositions	—	—	(1)	(1)
Balance at December 31, 2015	1,069	385	1,811	3,265
Acquisitions	—	—	7	7
Balance at December 31, 2016	$ 1,069	$ 385	$ 1,818	$ 3,272

Healthcare Services segment goodwill of $480 million associated with the sale of Concentra was included with assets-held-for sale as of January 1, 2015 and is excluded from the table above. This $480 million of goodwill was disposed of on June 1, 2015 with the completion of the sale of Concentra.

The following table presents details of our other intangible assets included in other long-term assets in the accompanying consolidated balance sheets at December 31, 2016 and 2015.

	Weighted Average Life	2016			2015		
		Cost	Accumulated Amortization	Net	Cost	Accumulated Amortization	Net
				(in millions)			
Other intangible assets:							
Customer contracts/relationships	9.8 years	$ 566	$ 347	$ 219	$ 566	$ 292	$ 274
Trade names and technology	8.3 years	104	69	35	104	54	50
Provider contracts	14.7 years	51	29	22	51	24	27
Noncompetes and other	8.2 years	32	28	4	32	26	6
Total other intangible assets	9.9 years	$ 753	$ 473	$ 280	$ 753	$ 396	$ 357

Amortization expense for other intangible assets was approximately $77 million in 2016, $93 million in 2015, and $121 million in 2014. The following table presents our estimate of amortization expense for each of the five next succeeding fiscal years:

	(in millions)
For the years ending December 31,	
2017	$ 71
2018	63
2019	52
2020	48
2021	14

10. BENEFITS PAYABLE

On a consolidated basis, activity in benefits payable, excluding military services, was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Balances at January 1	$ 4,976	$ 4,475	$ 3,893
Less: Premium deficiency reserve	(176)	—	—
Less: Reinsurance recoverables	(85)	(78)	—
Balances at January 1, net	4,715	4,397	3,893
Incurred related to:			
Current year	45,318	44,397	38,641
Prior years	(582)	(236)	(518)
Total incurred	44,736	44,161	38,123
Paid related to:			
Current year	(40,852)	(39,802)	(34,357)
Prior years	(4,112)	(4,041)	(3,262)
Total paid	(44,964)	(43,843)	(37,619)
Premium deficiency reserve	—	176	—
Reinsurance recoverable	76	85	78
Balances at December 31	$ 4,563	$ 4,976	$ 4,475

Amounts incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled. Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (favorable development).

As previously discussed, our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for claims. Actuarial standards require the use of assumptions based on moderately adverse experience, which generally results in favorable reserve development, or reserves that are considered redundant. We experienced favorable medical claims reserve development related to prior fiscal years of $582 million in 2016, $236 million in 2015, and $518 million in 2014. The table below details our favorable medical claims reserve development related to prior fiscal years by segment for 2016, 2015, and 2014.

	Favorable Medical Claims Reserve Development		
	2016	2015	2014
Retail Segment	$ (535)	$ (228)	$ (488)
Group Segment	(46)	(7)	(29)
Other Businesses	(1)	(1)	(1)
Total	$ (582)	$ (236)	$ (518)

The favorable medical claims reserve development for 2016, 2015, and 2014 primarily reflects the consistent application of trend and completion factors estimated using an assumption of moderately adverse conditions. Favorable prior period development in 2016 primarily resulted from our Medicare Advantage and individual commercial medical businesses. The decline in favorable prior period development in 2015 primarily was due to the impact of lower financial claim recoveries due in part to our gradual implementation during 2014 of inpatient authorization review prior to admission as opposed to post adjudication, as well as higher than expected flu associated claims from the fourth quarter of 2014 and continued volatility in claims associated with individual commercial medical products. The favorable prior

period development during 2014 resulted from increased membership, better than originally expected utilization across most of our major business lines and increased financial recoveries. The increase in financial recoveries primarily resulted from claim audit process enhancements as well as increased volume of claim audits and expanded audit scope. All lines of business benefited from these improvements.

Benefits expense excluded from the previous table was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Premium deficiency reserve for short-duration policies	$ (176)	$ 176	$ —
Military services	8	12	11
Future policy benefits	439	(80)	32
Total	$ 271	$ 108	$ 43

In the fourth quarter of 2015, we recognized a premium deficiency reserve for our individual commercial medical business compliant with the Health Care Reform Law associated with the 2016 coverage year as discussed in more detail in Note 7.

Military services benefits expense for each year in the table above reflect expenses associated with our contracts with the Veterans Administration.

The higher benefits expense associated with future policy benefits payable during 2016 primarily relates to reserve strengthening for our closed block of long-term care insurance policies acquired in connection with the 2007 KMG America Corporation, or KMG, acquisition more fully described in Note 18. The decrease in benefits expense associated with future policy benefits payable in 2015 primarily reflects the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law.

Incurred and Paid Claims Development

The following discussion provides information about incurred and paid claims development for our Retail and Group segments as of December 31, 2016, net of reinsurance, as well as cumulative claim frequency and the total of IBNR included within the net incurred claims amounts. The information about incurred and paid claims development for the years ended December 31, 2014 and 2015 is presented as supplementary information.

For both our Retail and Group segments, claims frequency is measured as medical fee-for-service claims for each service encounter with a unique provider identification number. Our claims frequency measure includes claims covered by deductibles as well as claims under capitated arrangements. Claim counts may vary based on product mix and the percentage of delegated capitation arrangements.

Retail Segment

Activity in benefits payable for our Retail segment was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Balances at January 1	$ 4,296	$ 3,879	$ 3,268
Less: Premium deficiency reserve	(176)	—	—
Less: Reinsurance recoverables	(85)	(78)	—
Balances at January 1, net	4,035	3,801	3,268
Incurred related to:			
Current year	40,854	39,760	33,996
Prior years	(535)	(228)	(488)
Total incurred	40,319	39,532	33,508
Paid related to:			
Current year	(36,967)	(35,835)	(30,305)
Prior years	(3,487)	(3,463)	(2,670)
Total paid	(40,454)	(39,298)	(32,975)
Premium deficiency reserve	—	176	—
Reinsurance recoverable	76	85	78
Balances at December 31	$ 3,976	$ 4,296	$ 3,879

At December 31, 2016, benefits payable for our Retail segment included IBNR of approximately $2.9 billion, primarily associated with claims incurred in 2016. The cumulative number of reported claims as of December 31, 2016 was approximately 87.7 million for claims incurred in 2016, 88.8 million for claims incurred in 2015, and 74.3 million for claims incurred in 2014.

The following tables provide information about incurred and paid claims development for the Retail segment as of December 31, 2016, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2014 Unaudited	2015 Unaudited	2016
		(in millions)	
2014	$ 33,996	$ 33,800	$ 33,749
2015	—	39,760	39,289
2016	—	—	40,854
Total			$ 113,892

Claims Incurred Year	Cumulative Paid Claims, Net of Reinsurance For the Years Ended December 31, 2014 Unaudited	2015 Unaudited	2016
		(in millions)	
2014	$ 30,305	$ 33,704	$ 33,740
2015		35,835	39,285
2016			36,967
Total			$ 109,992
All outstanding benefit liabilities before 2014, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 3,900

Group Segment

Activity in benefits payable for our Group segment, excluding military services, was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Balances at January 1	$ 600	$ 578	$ 577
Less: Reinsurance recoverables	—	—	—
Balances at January 1, net	600	578	577
Incurred related to:			
Current year	5,160	5,261	5,148
Prior years	(46)	(7)	(29)
Total incurred	5,114	5,254	5,119
Paid related to:			
Current year	(4,605)	(4,671)	(4,574)
Prior years	(546)	(561)	(544)
Total paid	(5,151)	(5,232)	(5,118)
Balances at December 31	$ 563	$ 600	$ 578

At December 31, 2016, benefits payable for our Group segment included IBNR of approximately $468 million, primarily associated with claims incurred in 2016. The cumulative number of reported claims as of December 31, 2016 was approximately 23.3 million for claims incurred in 2016, 29.1 million for claims incurred in 2015, and 27.3 million for claims incurred in 2014.

The following tables provide information about incurred and paid claims development for the Group segment as of December 31, 2016, net of reinsurance.

	Incurred Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2014 Unaudited	2015 Unaudited	2016
		(in millions)	
2014	$ 5,148	$ 5,135	$ 5,135
2015	—	5,261	5,217
2016	—	—	5,160
Total			$ 15,512

	Cumulative Paid Claims, Net of Reinsurance		
	For the Years Ended December 31,		
Claims Incurred Year	2014 Unaudited	2015 Unaudited	2016
		(in millions)	
2014	$ 4,574	$ 5,126	$ 5,134
2015		4,671	5,210
2016			4,605
Total			$ 14,949
All outstanding benefit liabilities before 2014, net of reinsurance			N/A
Benefits payable, net of reinsurance			$ 563

Reconciliation to Consolidated

The reconciliation of the net incurred and paid claims development tables to benefits payable in the consolidated statement of financial position is as follows:

	December 31, 2016
Net outstanding liabilities	
Retail	$ 3,900
Group	563
Other insurance lines	24
Benefits payable, net of reinsurance	4,487
Reinsurance recoverable on unpaid claims	
Retail	76
Group	—
Other insurance lines	—
Total reinsurance recoverable on unpaid claims	76
Total benefits payable, gross	$ 4,563

11. INCOME TAXES

The provision for income taxes consisted of the following for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Current provision:			
Federal	$ 921	$ 1,067	$ 1,006
States and Puerto Rico	88	90	81
Total current provision	1,009	1,157	1,087
Deferred benefit	(71)	(2)	(64)
Provision for income taxes	$ 938	$ 1,155	$ 1,023

The provision for income taxes was different from the amount computed using the federal statutory rate for the years ended December 31, 2016, 2015 and 2014 due to the following:

	2016	2015	2014
		(in millions)	
Income tax provision at federal statutory rate	$ 543	$ 851	$ 759
States, net of federal benefit, and Puerto Rico	41	44	48
Tax exempt investment income	(20)	(24)	(27)
Health insurer fee	336	314	204
Nondeductible executive compensation	30	18	22
Concentra sale	—	(67)	—
Other, net	8	19	17
Provision for income taxes	$ 938	$ 1,155	$ 1,023

The provision for income taxes for 2016, 2015, and 2014 reflects a $30 million, $18 million, and $22 million, respectively, estimated impact from limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. We do not have material uncertain tax positions reflected in our consolidated balance sheets.

Deferred income tax balances reflect the impact of temporary differences between the tax bases of assets or liabilities and their reported amounts in our consolidated financial statements, and are stated at enacted tax rates expected to be in effect when the reported amounts are actually recovered or settled. Principal components of our net deferred tax balances at December 31, 2016 and 2015 were as follows.

	Assets (Liabilities)	
	2016	2015
	(in millions)	
Future policy benefits payable	$ 355	$ 200
Benefits payable	196	267
Compensation and other accrued expenses	153	130
Net operating loss carryforward	52	47
Deferred acquisition costs	72	64
Unearned revenues	18	22
Investment securities	12	—
Other	6	13
Total deferred income tax assets	864	743
Valuation allowance	(49)	(42)
Total deferred income tax assets, net of valuation allowance	815	701
Depreciable property and intangible assets	(363)	(363)
Prepaid expenses	(53)	(45)
Investment securities	—	(37)
Total deferred income tax liabilities	(416)	(445)
Total net deferred income tax assets	$ 399	$ 256
Amounts recognized in the consolidated balance sheets:		
Other long-term assets	$ 399	$ 256

In November 2015, the FASB issued new guidance related to accounting for income taxes which changes the balance sheet classification of deferred taxes, requiring deferred tax liabilities and assets be classified as noncurrent in a classified statement of financial position. We elected to early adopt the guidance and have classified all deferred tax liabilities and assets as noncurrent in our consolidated balance sheets at December 31, 2016 and 2015 to simplify their presentation.

At December 31, 2016, we had approximately $138 million of net operating losses to carry forward related to prior acquisitions and our Puerto Rico subsidiaries. These net operating loss carryforwards, if not used to offset future taxable income, will expire from 2017 through 2033. Due to limitations and uncertainty regarding our ability to use some of the carryforwards, a valuation allowance was established on $126 million of these net operating loss carryforwards and $4 million of other items related to Puerto Rico. For the remainder of the net operating loss carryforwards and other cumulative temporary differences, based on our historical record of producing taxable income and profitability, we have concluded that future operating income will be sufficient to give rise to tax expense to recover all deferred tax assets.

We provide for income taxes on the undistributed earnings of our Puerto Rico operations using that jurisdiction's tax rate, which has been lower historically than the U.S. statutory tax rate. Permanent investment of these earnings has resulted in cumulative unrecognized deferred tax liabilities of approximately $30 million as of December 31, 2016.

We file income tax returns in the United States and certain foreign jurisdictions. The U.S. Internal Revenue Service, or IRS, has completed its examinations of our consolidated income tax returns for 2014 and prior years. Our 2015 tax return is in the post-filing review period under the Compliance Assurance Process (CAP). Our 2016 tax return is under advance review by the IRS under CAP. With few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local and foreign tax examinations for years before 2013. We are not aware of any material adjustments that may be proposed.

12. DEBT

The carrying value of long-term debt outstanding was as follows at December 31, 2016 and 2015:

	2016	2015
	(in millions)	
Long-term debt:		
Senior notes:		
$500 million, 7.20% due June 15, 2018	$ 501	$ 502
$300 million, 6.30% due August 1, 2018	304	307
$400 million, 2.625% due October 1, 2019	398	398
$600 million, 3.15% due December 1, 2022	595	595
$600 million, 3.85% due October 1, 2024	595	595
$250 million, 8.15% due June 15, 2038	264	263
$400 million, 4.625% due December 1, 2042	396	396
$750 million, 4.95% due October 1, 2044	739	738
Total long-term debt	$ 3,792	$ 3,794

Senior Notes

In September 2014, we issued $400 million of 2.625% senior notes due October 1, 2019, $600 million of 3.85% senior notes due October 1, 2024 and $750 million of 4.95% senior notes due October 1, 2044. Our net proceeds, reduced for the underwriters' discount and commission and offering expenses, were $1.73 billion. We used a portion of the net proceeds to redeem the $500 million 6.45% senior unsecured notes as discussed below.

In October 2014, we redeemed the $500 million 6.45% senior unsecured notes due June 1, 2016, at 100% of the principal amount plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling approximately $560 million. We recognized a loss on extinguishment of debt of approximately $37 million in October 2014 for the redemption of these notes which is included in interest expense in the consolidated statement of income.

Our senior notes, which are unsecured, may be redeemed at our option at any time at 100% of the principal amount plus accrued interest and a specified make-whole amount. The 7.20% and 8.15% senior notes are subject to an interest rate adjustment if the debt ratings assigned to the notes are downgraded (or subsequently upgraded). In addition, our senior notes (other than the 6.30% senior notes) contain a change of control provision that may require us to purchase the notes under certain circumstances.

Prior to 2009, we were parties to interest-rate swap agreements that exchanged the fixed interest rate under our senior notes for a variable interest rate based on LIBOR. As a result, the carrying value of the senior notes was adjusted to reflect changes in value caused by an increase or decrease in interest rates. During 2008, we terminated all of our swap agreements. The cumulative adjustment to the carrying value of our senior notes was $103 million as of the termination date which is being amortized as a reduction to interest expense over the remaining term of the senior notes. In October 2014, the redemption of our 6.45% senior notes reduced the unamortized carrying value adjustment by $12 million. The unamortized carrying value adjustment was $23 million as of December 31, 2016 and $28 million as of December 31, 2015.

Credit Agreement

Our 5-year $1.0 billion unsecured revolving credit agreement expires July 2018. Under the credit agreement, at our option, we can borrow on either a competitive advance basis or a revolving credit basis. The revolving credit portion bears interest at either LIBOR plus a spread or the base rate plus a spread. The LIBOR spread, currently 100 basis points, varies depending on our credit ratings ranging from 90 to 150 basis points. We also pay an annual facility fee regardless of utilization. This facility fee, currently 12.5 basis points, may fluctuate between 10 and 25 basis points, depending upon our credit ratings. The competitive advance portion of any borrowings will bear interest at market rates prevailing at the time of borrowing on either a fixed rate or a floating rate based on LIBOR, at our option.

The terms of the credit agreement include standard provisions related to conditions of borrowing, including a customary material adverse effect clause which could limit our ability to borrow additional funds. In addition, the credit agreement contains customary restrictive and financial covenants as well as customary events of default, including financial covenants regarding the maintenance of a minimum level of net worth of $9.0 billion at December 31, 2016 and a maximum leverage ratio of 3.0:1. We are in compliance with the financial covenants, with actual net worth of $10.7 billion and an actual leverage ratio of 1.4:1, as measured in accordance with the credit agreement as of December 31, 2016. In addition, the credit agreement includes an uncommitted $250 million incremental loan facility.

At December 31, 2016, we had no borrowings outstanding under the credit agreement and no letters of credit outstanding under the credit agreement. Accordingly, as of December 31, 2016, we had $1 billion of remaining borrowing capacity under the credit agreement, none of which would be restricted by our financial covenant compliance requirement. We have other customary, arms-length relationships, including financial advisory and banking, with some parties to the credit agreement.

Commercial Paper

In October 2014, we entered into a commercial paper program pursuant to which we may issue short-term, unsecured commercial paper notes privately placed on a discount basis through certain broker dealers. Amounts available under the program may be borrowed, repaid and re-borrowed from time to time, with the aggregate face or principal amount outstanding under the program at any time not to exceed $1 billion. The net proceeds of issuances have been and are expected to be used for general corporate purposes. The maximum principal amount outstanding at any one time during the year ended December 31, 2016 was $475 million, with $300 million outstanding at December 31, 2016, compared to $299 million outstanding at December 31, 2015.

13. EMPLOYEE BENEFIT PLANS

Employee Savings Plan

We have defined contribution retirement savings plans covering eligible employees which include matching contributions based on the amount of our employees' contributions to the plans. The cost of these plans amounted to approximately $196 million in 2016, $188 million in 2015, and $176 million in 2014. The Company's cash match is invested pursuant to the participant's contribution direction. Based on the closing price of our common stock of $204.03 on December 31, 2016, approximately 13% of the retirement and savings plan's assets were invested in our common stock, or approximately 2.5 million shares, representing 2% of the shares outstanding as of December 31, 2016. At December 31, 2016, approximately 2.8 million shares of our common stock were reserved for issuance under our defined contribution retirement savings plans.

Stock-Based Compensation

We have plans under which options to purchase our common stock and restricted stock units have been granted to executive officers, directors and key employees. For awards granted prior to July 2, 2015, our equity award agreements generally contain provisions whereby the awards automatically accelerate and vest upon change in control, including those granted to retirement-eligible participants described below. Awards granted on or after July 2, 2015 would generally require both a change in control and termination of employment within 2 years of the date of the change in control to accelerate the vesting, including those granted to retirement-eligible participants.

The terms and vesting schedules for stock-based awards vary by type of grant. Generally, the awards vest upon time-based conditions. We have also granted awards to certain employees that vest upon a combination of time and performance-based conditions. The stock awards of retirement-eligible participants granted prior to July 2, 2015 generally will continue to fully vest on the originally scheduled vest date upon retirement from the Company. For stock awards of retirement-eligible employees granted on or after July 2, 2015, awards are generally earned ratably over the service period for each tranche. Accordingly, upon retirement the earned portion of the current tranche will continue to vest on the originally scheduled vest date and any remaining unearned portion of the award will be forfeited. Our equity award program includes a retirement provision that generally treats employees with a combination of age and years of services with the Company totaling 65 or greater, with a minimum required age of 55 and a minimum requirement of 5 years of service, as retirement-eligible. Upon exercise, stock-based compensation awards are settled with authorized but unissued company stock or treasury stock.

The compensation expense that has been charged against income for these plans was as follows for the years ended December 31, 2016, 2015, and 2014:

	2016	2015	2014
		(in millions)	
Stock-based compensation expense by type:			
Restricted stock	$ 106	$ 99	$ 91
Stock options	9	10	7
Total stock-based compensation expense	115	109	98
Tax benefit recognized	(20)	(26)	(22)
Stock-based compensation expense, net of tax	$ 95	$ 83	$ 76

The tax benefit recognized in our consolidated financial statements is based on the amount of compensation expense recorded for book purposes, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized in our tax return is based on the intrinsic value, or the excess of the market value over the exercise or purchase price, of stock options exercised and restricted stock vested during the period, subject to limitations on the deductibility of annual compensation in excess of $500,000 per employee as mandated by the Health Care Reform Law. The actual tax benefit realized for the deductions taken on our tax returns from option exercises and restricted stock vesting totaled $53 million in 2016, $34 million in 2015, and $30 million in 2014. There was no capitalized stock-based compensation expense during these years.

At December 31, 2016, there were 16.4 million shares reserved for stock award plans. These reserved shares included giving effect to, under the 2011 Plan, 7.1 million shares of common stock available for future grants assuming all stock options were granted or 3.1 million shares available for future grants assuming all restricted stock were granted. Shares may be issued from authorized but unissued company stock or treasury stock.

Restricted Stock

Restricted stock is granted with a fair value equal to the market price of our common stock on the date of grant and generally vests three years from the date of grant. Restricted stock granted on or after July 2, 2015, generally vests in equal annual tranches over a three year period from the date of grant. Certain of our restricted stock units also include performance-based conditions generally associated with strategic membership growth and return on invested capital. Restricted stock units have forfeitable dividend equivalent rights equal to the dividend paid on common stock. The weighted-average grant date fair value of our restricted stock was $168.12 in 2016, $165.26 in 2015, and $103.57 in 2014. Activity for our restricted stock was as follows for the year ended December 31, 2016:

	Shares	Weighted-Average Grant-Date Fair Value
	(shares in thousands)	
Nonvested restricted stock at December 31, 2015	3,365	$ 104.58
Granted	656	168.12
Vested	(1,455)	87.77
Forfeited	(74)	135.32
Nonvested restricted stock at December 31, 2016	2,492	$ 121.94

Approximately 27% of the nonvested restricted stock at December 31, 2016 included performance-based conditions.

The fair value of shares vested was $253 million during 2016, $153 million during 2015, and $99 million during 2014. Total compensation expense not yet recognized related to nonvested restricted stock was $97 million at December 31, 2016. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years. There are no other contractual terms covering restricted stock once vested.

Stock Options

Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire 7 years after grant.

The weighted-average fair value of each option granted during 2016, 2015, and 2014 is provided below. The fair value was estimated on the date of grant using the Black-Scholes pricing model with the weighted-average assumptions indicated below:

	2016	2015	2014
Weighted-average fair value at grant date	$ 37.12	$ 36.91	$ 22.45
Expected option life (years)	4.2 years	4.2 years	4.3 years
Expected volatility	27.6%	27.4%	27.6%
Risk-free interest rate at grant date	1.1%	1.4%	1.3%
Dividend yield	0.7%	0.7%	1.1%

When valuing employee stock options, we stratify the employee population into three homogeneous groups that historically have exhibited similar exercise behaviors. These groups are executive officers, directors, and all other employees. We value the stock options based on the unique assumptions for each of these employee groups.

We calculate the expected term for our employee stock options based on historical employee exercise behavior and base the risk-free interest rate on a traded zero-coupon U.S. Treasury bond with a term substantially equal to the option's expected term.

The volatility used to value employee stock options is based on historical volatility. We calculate historical volatility using a simple-average calculation methodology based on daily price intervals as measured over the expected term of the option.

Activity for our option plans was as follows for the year ended December 31, 2016:

	Shares Under Option	Weighted-Average Exercise Price
	(shares in thousands)	
Options outstanding at December 31, 2015	835	$ 121.89
Granted	362	167.81
Exercised	(161)	86.86
Forfeited	(14)	163.94
Options outstanding at December 31, 2016	1,022	$ 143.04
Options exercisable at December 31, 2016	342	$ 111.28

As of December 31, 2016, outstanding stock options, substantially all of which are expected to vest, had an aggregate intrinsic value of $62 million, and a weighted-average remaining contractual term of 4.9 years. As of December 31, 2016, exercisable stock options had an aggregate intrinsic value of $32 million, and a weighted-average remaining contractual term of 3.8 years. The total intrinsic value of stock options exercised during 2016 was $18 million, compared with $28 million during 2015 and $32 million during 2014. Cash received from stock option exercises totaled $14 million in 2016, $23 million in 2015, and $52 million in 2014.

Total compensation expense not yet recognized related to nonvested options was $14 million at December 31, 2016. We expect to recognize this compensation expense over a weighted-average period of approximately 1.7 years.

14. EARNINGS PER COMMON SHARE COMPUTATION

Detail supporting the computation of basic and diluted earnings per common share was as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
	(dollars in millions, except per common share results, number of shares/options in thousands)		
Net income available for common stockholders	$ 614	$ 1,276	$ 1,147
Weighted-average outstanding shares of common stock used to compute basic earnings per common share	149,375	149,455	154,187
Dilutive effect of:			
Employee stock options	219	192	230
Restricted stock	1,323	1,495	1,457
Shares used to compute diluted earnings per common share	150,917	151,142	155,874
Basic earnings per common share	$ 4.11	$ 8.54	$ 7.44
Diluted earnings per common share	$ 4.07	$ 8.44	$ 7.36
Number of antidilutive stock options and restricted stock awards excluded from computation	748	415	320

15. STOCKHOLDERS' EQUITY

As discussed in Note 2, we elected to early adopt new guidance related to accounting for employee share-based payments prospectively effective January 1, 2016. The adoption of this new guidance resulted in the recognition of approximately $20 million of tax benefits in net income in our consolidated statement of income for the three months ended March 31, 2016 that had previously been recorded as additional paid-in capital in our consolidated balance sheet.

Dividends

The following table provides details of dividend payments, excluding dividend equivalent rights, in 2014, 2015, and 2016 under our Board approved quarterly cash dividend policy:

Payment Date	Amount per Share	Total Amount
		(in millions)
2014	$1.10	$170
2015	$1.14	$170
2016	$1.16	$172

Under the terms of the Merger Agreement, we agreed with Aetna that our quarterly dividend would not exceed $0.29 per share prior to the closing or termination of the Merger. On October 26, 2016, the Board declared a cash dividend of $0.29 per share that was paid on January 27, 2017 to stockholders of record on January 12, 2017, for an aggregate amount of $43 million.

On February 14, 2017, following the termination of the Merger Agreement, the Board declared a cash dividend of $0.40 per share, to be paid on April 28, 2017, to the stockholders of record on March 31, 2017. Declaration and payment of future quarterly dividends is at the discretion of our Board and may be adjusted as business needs or market conditions change.

Stock Repurchases

In September 2014, our Board of Directors replaced a previous share repurchase authorization of up to $1 billion (of which $816 million remained unused) with an authorization for repurchases of up to $2 billion of our common shares exclusive of shares repurchased in connection with employee stock plans, which expired on December 31, 2016. Under the share repurchase authorization, shares may have been purchased from time to time at prevailing prices in the open market, by block purchases, through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended, or in privately-negotiated transactions (including pursuant to accelerated share repurchase agreements with investment banks), subject to certain regulatory restrictions on volume, pricing, and timing. Pursuant to the Merger Agreement, after July 2, 2015, we were prohibited from repurchasing any of our outstanding securities without the prior written consent of Aetna, other than repurchases of shares of our common stock in connection with the exercise of outstanding stock options or the vesting or settlement of outstanding restricted stock awards. Accordingly, as announced on July 3, 2015, we suspended our share repurchase program.

On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement. We also announced that the Board had approved a new authorization for share repurchases of up to $2.25 billion of our common stock exclusive of shares repurchased in connection with employee stock plans, expiring on December 31, 2017.

Excluding shares acquired in connection with employee stock plans as well as 0.36 million shares received in March 2015 upon final settlement of our accelerated share repurchase agreement, or ASR Agreement, described below, for which no cash was paid during the period, share repurchases were as follows during the years ended December 31, 2015 and 2014. Excluding shares acquired in connection with employee stock plans, there were no share repurchases in 2016.

		Year Ended December 31,			
		2015		2014	
Authorization Date	Purchase Not to Exceed	Shares	Cost	Shares	Cost
		(in millions)			
September 2014	$ 2,000	1.85	$ 329	4.10	$ 635 (a)
April 2014	1,000	—	—	1.50	184
April 2013	1,000	—	—	0.10	11
Total repurchases		1.85	$ 329	5.70	$ 830

(a) Includes $100 million held back by Goldman Sachs pending final settlement of the ASR Agreement in March 2015 at which time we received an additional 0.36 million shares which are excluded from the table above.

On November 7, 2014, we announced that we had entered into an accelerated share repurchase agreement, or ASR Agreement, with Goldman, Sachs & Co., or Goldman Sachs, to repurchase $500 million of our common stock as part of the $2 billion share repurchase program authorized in September 2014. Under the ASR Agreement, on November 10, 2014, we made a payment of $500 million to Goldman Sachs from available cash on hand and received an initial delivery of 3.06 million shares of our common stock from Goldman Sachs based on the then current market price of Humana common stock. The payment to Goldman Sachs was recorded as a reduction to stockholders' equity, consisting of a $400 million increase in treasury stock, which reflected the value of the initial 3.06 million shares received upon initial settlement, and a $100 million decrease in capital in excess of par value, which reflected the value of stock held back by Goldman Sachs pending final settlement of the ASR Agreement. Upon settlement of the ASR on March 13, 2015, we received an additional 0.36 million shares as determined by the average daily volume weighted-average share price of our common stock during the term of the ASR Agreement of $146.21, bringing the total shares received under this program to 3.42 million. In addition, upon settlement we reclassified the $100 million value of stock initially held back by Goldman Sachs from capital in excess of par value to treasury stock.

In connection with employee stock plans, we acquired 0.6 million common shares for $104 million in 2016, 0.3 million common shares for $56 million in 2015, and 0.4 million common shares for $42 million in 2014.

Regulatory Requirements

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $7.7 billion and $6.6 billion as of December 31, 2016 and 2015, respectively, which exceeded aggregate minimum regulatory requirements of $4.8 billion and $4.6 billion, respectively. Subsidiary dividends are subject to state regulatory approval, the amount and timing of which could be

reduced or delayed. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2017 is approximately $850 million in the aggregate. This compares to dividends that were paid to our parent company in 2016 of approximately $763 million. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

16. COMMITMENTS, GUARANTEES AND CONTINGENCIES

Leases

We lease facilities, computer hardware, and other furniture and equipment under long-term operating leases that are noncancelable and expire on various dates through 2037. We sublease facilities or partial facilities to third party tenants for space not used in our operations. Rent with scheduled escalation terms are accounted for on a straight-line basis over the lease term. Rent expense and sublease rental income, which are recorded net as an operating cost, for all operating leases were as follows for the years ended December 31, 2016, 2015 and 2014:

	2016	2015	2014
		(in millions)	
Rent expense	$ 179	$ 201	$ 226
Sublease rental income	(26)	(25)	(14)
Net rent expense	$ 153	$ 176	$ 212

Future annual minimum payments due subsequent to December 31, 2016 under all of our noncancelable operating leases with initial terms in excess of one year are as follows:

	Minimum Lease Payments	Sublease Rental Receipts	Net Lease Commitments
		(in millions)	
For the years ending December 31,:			
2017	$ 185	$ (19)	$ 166
2018	157	(18)	139
2019	126	(14)	112
2020	81	(11)	70
2021	53	(8)	45
Thereafter	95	(17)	78
Total	$ 697	$ (87)	$ 610

Purchase Obligations

We have agreements to purchase services, primarily information technology related services, or to make improvements to real estate, in each case that are enforceable and legally binding on us and that specify all significant terms, including: fixed or minimum levels of service to be purchased; fixed, minimum or variable price provisions; and the appropriate timing of the transaction. We have purchase obligation commitments of $184 million in 2017, $108 million in 2018, $48 million in 2019, $5 million in 2020, and $3 million thereafter. Purchase obligations exclude agreements that are cancelable without penalty.

Off-Balance Sheet Arrangements

As part of our ongoing business, we do not participate or knowingly seek to participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet

arrangements or other contractually narrow or limited purposes. As of December 31, 2016, we were not involved in any SPE transactions.

Guarantees and Indemnifications

Through indemnity agreements approved by the state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by Humana Inc., our parent company, in the event of insolvency for (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent also has guaranteed the obligations of our military services subsidiaries.

In the ordinary course of business, we enter into contractual arrangements under which we may agree to indemnify a third party to such arrangement from any losses incurred relating to the services they perform on behalf of us, or for losses arising from certain events as defined within the particular contract, which may include, for example, litigation or claims relating to past performance. Such indemnification obligations may not be subject to maximum loss clauses. Historically, payments made related to these indemnifications have been immaterial.

Government Contracts

Our Medicare products, which accounted for approximately 74% of our total premiums and services revenue for the year ended December 31, 2016, primarily consisted of products covered under the Medicare Advantage and Medicare Part D Prescription Drug Plan contracts with the federal government. These contracts are renewed generally for a calendar year term unless CMS notifies us of its decision not to renew by May 1 of the calendar year in which the contract would end, or we notify CMS of our decision not to renew by the first Monday in June of the calendar year in which the contract would end. All material contracts between Humana and CMS relating to our Medicare products have been renewed for 2017, and all of our product offerings filed with CMS for 2017 have been approved.

CMS uses a risk-adjustment model which apportions premiums paid to Medicare Advantage, or MA, plans according to health severity of covered members. The risk-adjustment model, which CMS implemented pursuant to the Balanced Budget Act of 1997(BBA) and the Benefits Improvement and Protection Act of 2000 (BIPA), generally pays more where a plan's membership has higher expected costs. Under this model, rates paid to MA plans are based on actuarially determined bids, which include a process whereby our prospective payments are based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's traditional fee-for-service Medicare program (referred to as "Medicare FFS"). Under the risk-adjustment methodology, all MA plans must collect and submit the necessary diagnosis code information from hospital inpatient, hospital outpatient, and physician providers to CMS within prescribed deadlines. The CMS risk-adjustment model uses the diagnosis data to calculate the risk-adjusted premium payment to MA plans, which CMS adjusts for coding pattern differences between the health plans and the government fee-for-service program. We generally rely on providers, including certain providers in our network who are our employees, to code their claim submissions with appropriate diagnoses, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. We also rely on these providers to document appropriately all medical data, including the diagnosis data submitted with claims. In addition, we conduct medical record reviews as part of our data and payment accuracy compliance efforts, to more accurately reflect diagnosis conditions under the risk adjustment model. These compliance efforts include the internal contract level audits described in more detail below.

CMS is phasing-in the process of calculating risk scores using diagnoses data from the Risk Adjustment Processing System, or RAPS, to diagnosis data from the Encounter Data System, or EDS. The RAPS process requires MA plans to apply a filter logic based on CMS guidelines and only submit those claims that pass the filtering logic. For submissions through EDS, CMS requires MA plans to submit all the claims data and CMS will apply the risk adjustment filtering logic to determine the risk adjustment data used to calculate risk scores. For 2016, 10% of the risk score was calculated from claims data submitted through EDS, increasing to 25% of the risk score calculated from claims data through EDS for 2017. The phase-in from RAPS to EDS could result in different risk scores from each dataset as a result of plan processing issues, CMS processing issues, or filtering logic differences between RAPS and EDS, and could have a material adverse effect on our results of operations, financial position, or cash flows.

CMS is continuing to perform audits of various companies' selected MA contracts related to this risk adjustment diagnosis data. We refer to these audits as Risk-Adjustment Data Validation Audits, or RADV audits. RADV audits review medical records in an attempt to validate provider medical record documentation and coding practices which influence the calculation of premium payments to MA plans.

In 2012, CMS released a "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation (RADV) Contract-Level Audits." The payment error calculation methodology provides that, in calculating the economic impact of audit results for an MA contract, if any, the results of the audit sample will be extrapolated to the entire MA contract based upon a comparison to "benchmark" audit data in Medicare FFS (which we refer to as the "FFS Adjuster"). This comparison to the FFS Adjuster is necessary to determine the economic impact, if any, of audit results because the government program data set, including any attendant errors that are present in that data set, provides the basis for MA plans' risk adjustment to payment rates. CMS already makes other adjustments to payment rates based on a comparison of coding pattern differences between MA plans and Medicare FFS data (such as for frequency of coding for certain diagnoses in MA plan data versus the government program data set).

The final methodology, including the first application of extrapolated audit results to determine audit settlements, is expected to be applied to RADV contract level audits conducted for contract year 2011 and subsequent years. CMS is currently conducting RADV contract level audits for contract years 2011, 2012, and 2013, in which two, five, and five of our Medicare Advantage plans are being audited, respectively. Per CMS guidance, selected MA contracts will be notified of an audit at some point after the close of the final reconciliation for the payment year being audited. The final reconciliation occurs in August of the calendar year following the payment year.

Estimated audit settlements are recorded as a reduction of premiums revenue in our consolidated statements of income, based upon available information. We perform internal contract level audits based on the RADV audit methodology prescribed by CMS. Included in these internal contract level audits is an audit of our Private Fee-For-Service business which we used to represent a proxy of the FFS Adjuster which has not yet been released. We based our accrual of estimated audit settlements for each contract year on the results of these internal contract level audits and update our estimates as each audit is completed. Estimates derived from these results were not material to our results of operations, financial position, or cash flows. However, as indicated, we are awaiting additional guidance from CMS regarding the FFS Adjuster. Accordingly, we cannot determine whether such RADV audits will have a material adverse effect on our results of operations, financial position, or cash flows.

In addition, CMS' comments in formalized guidance regarding "overpayments" to MA plans appear to be inconsistent with CMS' prior RADV audit guidance. These statements, contained in the preamble to CMS' final rule release regarding Medicare Advantage and Part D prescription drug benefit program regulations for Contract Year 2015, appear to equate each Medicare Advantage risk adjustment data error with an "overpayment" without reconciliation to the principles underlying the FFS Adjuster referenced above. We will continue to work with CMS to ensure that MA plans are paid accurately and that payment model principles are in accordance with the requirements of the Social Security Act, which, if not implemented correctly could have a material adverse effect on our results of operations, financial position, or cash flows.

At December 31, 2016, our military services business, which accounted for approximately 1% of our total premiums and services revenue for the year ended December 31, 2016, primarily consisted of the TRICARE South Region contract. The current 5-year South Region contract, which expires March 31, 2017, is subject to annual renewals on April 1 of each year during its term at the government's option. On March 30, 2016, we received notice the Defense Health Agency, or DHA, exercised its option to extend the TRICARE South Region contract through March 31, 2017. On July 21, 2016, we were notified by the DHA that we were awarded the contract for the new TRICARE East Region, which is a consolidation of the former North and South Regions, with delivery of health care services expected to commence on October 1, 2017. The next generation East Region and West Region contract awards are currently subject to protests by unsuccessful bidders in the U.S. Court of Federal Claims and before the DHA.

Our state-based Medicaid business accounted for approximately 5% of our total premiums and services revenue for the year ended December 31, 2016. In addition to our state-based Temporary Assistance for Needy Families, or TANF, Medicaid contracts in Florida and Kentucky, we have contracts in Florida for Long Term Support Services

(LTSS), in Illinois and Virginia for stand-alone dual eligible demonstration programs serving individuals dually eligible for both the federal Medicare program and the applicable state-based Medicaid program as well as an Integrated Care Program, or ICP, Medicaid contract in Illinois.

The loss of any of the contracts above or significant changes in these programs as a result of legislative or regulatory action, including reductions in premium payments to us, regulatory restrictions on profitability, including by comparison of our Medicare Advantage profitability to our non-Medicare Advantage business profitability and a requirement that they remain within certain ranges of each other, or increases in member benefits without corresponding increases in premium payments to us, may have a material adverse effect on our results of operations, financial position, and cash flows.

Legal Proceedings and Certain Regulatory Matters

Florida Matters

On January 6, 2012, the Civil Division of the United States Attorney's Office for the Southern District of Florida advised us that it is seeking documents and information from us and several of our affiliates relating to several matters including the coding of medical claims by one or more South Florida medical providers, and loans to physician practices. On May 1, 2014, the U.S. Attorney's Office filed a Notice of Non-Intervention in connection with a civil qui tam suit related to one of these matters captioned *United States of America ex rel. Olivia Graves v. Plaza Medical Centers, et al.*, and the Court ordered the complaint unsealed. Subsequently, the individual plaintiff amended the complaint and served the Company, opting to continue to pursue the action. The individual plaintiff has filed a fourth amended complaint which we answered on February 19, 2016. The Court has ordered trial to commence on March 6, 2017 if the matter is not resolved prior to trial. We continue to cooperate with and respond to information requests from the U.S. Attorney's office. These matters could result in additional qui tam litigation.

As previously disclosed, the Civil Division of the United States Department of Justice had provided us with an information request, separate from but related to the Plaza Medical matter, concerning our Medicare Part C risk adjustment practices. The request relates to our oversight and submission of risk adjustment data generated by providers in our Medicare Advantage network, including the providers identified in the Plaza Medical matter, as well as to our business and compliance practices related to risk adjustment data generated by our providers and by us, including medical record reviews conducted as part of our data and payment accuracy compliance efforts, the use of health and well-being assessments, and our fraud detection efforts. We believe that this request for information is in connection with a wider review of Medicare Risk Adjustment generally that includes a number of Medicare Advantage plans, providers and vendors. We continue to cooperate with and voluntarily respond to the information requests from the Department of Justice and the U.S. Attorney's Office. These matters are expected to result in additional qui tam litigation.

Litigation Related to the Merger

DOJ Action

On July 21, 2016, the United States government (acting under the U.S. Attorney General), along with the states of Delaware, Florida, Georgia, Illinois, Iowa and Ohio, the commonwealths of Pennsylvania and Virginia, and the District of Columbia, acting by and through their respective attorneys general, filed a civil complaint against us and Aetna in the U.S. District Court for the District of Columbia (we refer to this as the DOJ Action). The complaint alleges, among other things, that the proposed Merger would violate Section 7 of the Clayton Antitrust Act and seeks a permanent injunction to prevent the Merger. The trial commenced on December 5, 2016 and concluded on December 30, 2016. On January 23, 2017, the Court ruled in favor of the DOJ and granted a permanent injunction of the proposed transaction. On February 14, 2017, we and Aetna agreed to mutually terminate the Merger Agreement.

Shareholder Action

In connection with the Merger, three putative class action complaints were filed by purported Humana stockholders challenging the Merger, two in the Circuit Court of Jefferson County, Kentucky and one in the Court of Chancery of the State of Delaware. The complaints are captioned Solak v. Broussard et al., Civ. Act. No. 15CI03374 (Kentucky

state court), Litwin v. Broussard et al., Civ. Act. No. 15CI04054 (Kentucky state court) and Scott v. Humana Inc. et al., C.A. No. 11323-VCL (Delaware state court). The complaints named as defendants each member of Humana's board of directors, Aetna, and, in the case of the Delaware complaint, Humana. The complaints generally alleged, among other things, that the individual members of our board of directors breached their fiduciary duties owed to our stockholders by entering into the Merger Agreement, approving the mergers as contemplated by the Merger Agreement, and failing to take steps to maximize the value of Humana to our stockholders, and that Aetna, and, in the case of the Delaware complaint, Humana aided and abetted such breaches of fiduciary duties. In addition, the complaints alleged that the merger undervalues Humana, that the process leading up to the execution of the Merger Agreement was flawed, that the members of our board of directors improperly placed their own financial interests ahead of those of our stockholders, and that certain provisions of the Merger Agreement improperly favor Aetna and impede a potential alternative transaction. Among other remedies, the complaints sought equitable relief rescinding the Merger Agreement and enjoining the defendants from completing the mergers as well as costs and attorneys' fees. We refer to all these cases collectively in this report as the Merger Litigation. On August 20, 2015, the parties in the Kentucky state cases filed a stipulation and proposed order with the court to consolidate these cases into a single action captioned In re Humana Inc. Shareholder Litigation, Civ. Act. No. 15CI03374.

On October 9, 2015, solely to avoid the costs, risks, and uncertainties inherent in litigation, and without admitting any liability or wrongdoing, we and the other named defendants in the Merger Litigation signed a memorandum of understanding, which we refer to as the MOU, to settle the Merger Litigation. Subject to court approval and further definitive documentation in a stipulation of settlement that will be subject to customary conditions, the MOU resolved the claims brought in the Merger Litigation and provided that we would make certain additional disclosures related to the proposed mergers. The MOU further provided for, among other things, dismissal of the Merger Litigation with prejudice and a release and settlement by the purported class of our stockholders of all claims against the defendants and their affiliates and agents in connection with the Merger Agreement and transactions and disclosures related to the Merger Agreement. The asserted claims will not be released until such stipulation of settlement receives court approval. The foregoing terms and conditions will be defined by the stipulation of settlement, and class members will receive a separate notice describing the settlement terms and their rights in connection with the approval of the settlement. In connection with the settlement, the parties contemplate that plaintiffs' counsel will file a petition for an award of attorneys' fees and expenses. We will pay or cause to be paid any court awarded attorneys' fees and expenses. There can be no assurance that the parties will ultimately enter into a stipulation of settlement or that a court will approve such settlement even if the parties were to enter into such stipulation. In such event, the proposed settlement as contemplated by the MOU may be terminated. Because the MOU contemplates that the Kentucky court will be asked to approve the settlement, the plaintiffs have already withdrawn the Delaware case.

Other Lawsuits and Regulatory Matters

Our current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance, health care delivery and benefits companies. These reviews focus on numerous facets of our business, including claims payment practices, statutory capital requirements, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to some of our practices. We continue to be subject to these reviews, which could result in additional fines or other sanctions being imposed on us or additional changes in some of our practices.

We also are involved in various other lawsuits that arise, for the most part, in the ordinary course of our business operations, certain of which may be styled as class-action lawsuits. Among other matters, this litigation may include employment matters, claims of medical malpractice, bad faith, nonacceptance or termination of providers, anticompetitive practices, improper rate setting, provider contract rate disputes, failure to disclose network discounts and various other provider arrangements, general contractual matters, intellectual property matters, and challenges to subrogation practices. For example, a number of hospitals and other providers have asserted that, under their network provider contracts, we are not entitled to reduce Medicare Advantage payments to these providers in connection with changes in Medicare payment systems and in accordance with the Balanced Budget and Emergency Deficit Control

Act of 1985, as amended (commonly referred to as "sequestration"). Those challenges have led and could lead to arbitration demands or other litigation. Also, under state guaranty assessment laws, including those related to state cooperative failures in the industry, we may be assessed (up to prescribed limits) for certain obligations to the policyholders and claimants of insolvent insurance companies that write the same line or lines of business as we do. Penn Treaty is a financially distressed unaffiliated long-term care insurance company. A final court ruling on Penn Treaty's insolvency would trigger a guarantee fund assessment that would result in expense for us, based on current information, estimated at approximately $30 million.

As a government contractor, we may also be subject to qui tam litigation brought by individuals who seek to sue on behalf of the government, alleging that the government contractor submitted false claims to the government including, among other allegations, those resulting from coding and review practices under the Medicare risk adjustment model. Qui tam litigation is filed under seal to allow the government an opportunity to investigate and to decide if it wishes to intervene and assume control of the litigation. If the government does not intervene, the lawsuit is unsealed, and the individual may continue to prosecute the action on his or her own, on behalf of the government. We also are subject to other allegations of non-performance of contractual obligations to providers, members, and others, including failure to properly pay claims, improper policy terminations, challenges to our implementation of the Medicare Part D prescription drug program and other litigation.

A limited number of the claims asserted against us are subject to insurance coverage. Personal injury claims, claims for extracontractual damages, care delivery malpractice, and claims arising from medical benefit denials are covered by insurance from our wholly owned captive insurance subsidiary and excess carriers, except to the extent that claimants seek punitive damages, which may not be covered by insurance in certain states in which insurance coverage for punitive damages is not permitted. In addition, insurance coverage for all or certain forms of liability has become increasingly costly and may become unavailable or prohibitively expensive in the future.

We record accruals for the contingencies discussed in the sections above to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. No estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made at this time regarding the matters specifically described above because of the inherently unpredictable nature of legal proceedings, which also may be exacerbated by various factors, including: (i) the damages sought in the proceedings are unsubstantiated or indeterminate; (ii) discovery is not complete; (iii) the proceeding is in its early stages; (iv) the matters present legal uncertainties; (v) there are significant facts in dispute; (vi) there are a large number of parties (including where it is uncertain how liability, if any, will be shared among multiple defendants); or (vii) there is a wide range of potential outcomes.

The outcome of any current or future litigation or governmental or internal investigations, including the matters described above, cannot be accurately predicted, nor can we predict any resulting judgments, penalties, fines or other sanctions that may be imposed at the discretion of federal or state regulatory authorities or as a result of actions by third parties. Nevertheless, it is reasonably possible that any such outcome of litigation, judgments, penalties, fines or other sanctions could be substantial, and the outcome of these matters may have a material adverse effect on our results of operations, financial position, and cash flows, and may also affect our reputation.

17. SEGMENT INFORMATION

We manage our business with three reportable segments: Retail, Group, and Healthcare Services. In addition, the Other Businesses category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles. These segments are based on a combination of the type of health plan customer and adjacent businesses centered on well-being solutions for our health plans and other customers, as described below. These segment groupings are consistent with information used by our Chief Executive Officer to assess performance and allocate resources.

The Retail segment consists of Medicare benefits, marketed to individuals or directly via group accounts, as well as individual commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and financial protection products. In addition, the Retail segment also includes our contract with CMS to administer the LI-NET prescription drug plan program and contracts with various states to provide Medicaid, dual eligible, and Long-Term Support Services benefits, collectively our state-based contracts. The Group

segment consists of employer group commercial fully-insured medical and specialty health insurance benefits, including dental, vision, and other supplemental health and voluntary insurance benefits, as well as administrative services only, or ASO products. In addition, our Group segment includes our health and wellness products (primarily marketed to employer groups) and military services business, primarily our TRICARE South Region contract. The Healthcare Services segment includes services offered to our health plan members as well as to third parties, including pharmacy solutions, provider services, home based services, and clinical programs, as well as services and capabilities to advance population health. We will continue to report under the category of Other Businesses those businesses which do not align with the reportable segments described above, primarily our closed-block long-term care insurance policies.

Our Healthcare Services intersegment revenues primarily relate to managing prescription drug coverage for members of our other segments through Humana Pharmacy Solutions®, or HPS, and includes the operations of Humana Pharmacy, Inc., our mail order pharmacy business. These revenues consist of the prescription price (ingredient cost plus dispensing fee), including the portion to be settled with the member (co-share) or with the government (subsidies), plus any associated administrative fees. Services revenues related to the distribution of prescriptions by third party retail pharmacies in our networks are recognized when the claim is processed and product revenues from dispensing prescriptions from our mail order pharmacies are recorded when the prescription or product is shipped. Our pharmacy operations, which are responsible for designing pharmacy benefits, including defining member co-share responsibilities, determining formulary listings, contracting with retail pharmacies, confirming member eligibility, reviewing drug utilization, and processing claims, act as a principal in the arrangement on behalf of members in our other segments. As principal, our Healthcare Services segment reports revenues on a gross basis including co-share amounts from members collected by third party retail pharmacies at the point of service.

In addition, our Healthcare Services intersegment revenues include revenues earned by certain owned providers derived from risk-based and non risk-based managed care agreements with our health plans. Under risk based agreements, the provider receives a monthly capitated fee that varies depending on the demographics and health status of the member, for each member assigned to these owned providers by our health plans. The owned provider assumes the economic risk of funding the assigned members' healthcare services. Under non risk-based agreements, our health plans retain the economic risk of funding the assigned members' healthcare services. Our Healthcare Services segment reports provider services revenues associated with risk-based agreements on a gross basis, whereby capitation fee revenue is recognized in the period in which the assigned members are entitled to receive healthcare services. Provider services revenues associated with non risk-based agreements are presented net of associated healthcare costs.

We present our consolidated results of operations from the perspective of the health plans. As a result, the cost of providing benefits to our members, whether provided via a third party provider or internally through a stand-alone subsidiary, is classified as benefits expense and excludes the portion of the cost for which the health plans do not bear responsibility, including member co-share amounts and government subsidies of $13.4 billion in 2016, $12.3 billion in 2015, and $9.7 billion in 2014. In addition, depreciation and amortization expense associated with certain businesses in our Healthcare Services segment delivering benefits to our members, primarily associated with our provider services and pharmacy operations, are included with benefits expense. The amount of this expense was $111 million in 2016, $92 million in 2015, and $116 million in 2014.

Other than those described previously, the accounting policies of each segment are the same and are described in Note 2. Transactions between reportable segments primarily consist of sales of services rendered by our Healthcare Services segment, primarily pharmacy, provider, and home based services as well as clinical programs, to our Retail and Group customers. Intersegment sales and expenses are recorded at fair value and eliminated in consolidation. Members served by our segments often use the same provider networks, enabling us in some instances to obtain more favorable contract terms with providers. Our segments also share indirect costs and assets. As a result, the profitability of each segment is interdependent. We allocate most operating expenses to our segments. Assets and certain corporate income and expenses are not allocated to the segments, including the portion of investment income not supporting segment operations, interest expense on corporate debt, and certain other corporate expenses. These items are managed at a corporate level. These corporate amounts are reported separately from our reportable segments and are included with intersegment eliminations in the tables presenting segment results below.

Our segment results were as follows for the years ended December 31, 2016, 2015, and 2014:

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2016						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 31,863	$ —	$ —	$ —	$ —	$ 31,863
Group Medicare Advantage	4,283	—	—	—	—	4,283
Medicare stand-alone PDP	4,009	—	—	—	—	4,009
Total Medicare	40,155	—	—	—	—	40,155
Fully-insured	3,492	5,405	—	—	—	8,897
Specialty	259	1,020	—	—	—	1,279
Medicaid and other	2,640	12	—	38	—	2,690
Total premiums	46,546	6,437	—	38	—	53,021
Services revenue:						
Provider	—	52	226	—	—	278
ASO and other	8	642	—	10	—	660
Pharmacy	—	—	31	—	—	31
Total services revenue	8	694	257	10	—	969
Total revenues—external customers	46,554	7,131	257	48	—	53,990
Intersegment revenues						
Services	—	99	18,842	—	(18,941)	—
Products	—	—	5,993	—	(5,993)	—
Total intersegment revenues	—	99	24,835	—	(24,934)	—
Investment income	101	19	30	66	173	389
Total revenues	46,655	7,249	25,122	114	(24,761)	54,379
Operating expenses:						
Benefits	40,143	5,122	—	617	(875)	45,007
Operating costs	5,339	1,778	23,926	16	(23,782)	7,277
Depreciation and amortization	236	92	129	1	(104)	354
Total operating expenses	45,718	6,992	24,055	634	(24,761)	52,638
Income (loss) from operations	937	257	1,067	(520)	—	1,741
Interest expense	—	—	—	—	189	189
Income (loss) before income taxes	$ 937	$ 257	$ 1,067	$ (520)	$ (189)	$ 1,552

Premium and services revenues derived from our contracts with the federal government, as a percentage of our total premium and services revenues, was approximately 75% for 2016, compared to 73% for 2015, and 73% for 2014.

Premiums revenue for our Retail segment for 2016 includes a reduction of $583 million associated with the write-off of commercial risk corridor receivables as discussed more fully in Note 7.

Benefits expense for Other Businesses for 2016 includes $505 million for reserve strengthening associated with our closed block of long-term care insurance policies as discussed more fully in Note 18.

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2015						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 29,526	$ —	$ —	$ —	$ —	$ 29,526
Group Medicare Advantage	5,588	—	—	—	—	5,588
Medicare stand-alone PDP	3,846	—	—	—	—	3,846
Total Medicare	38,960	—	—	—	—	38,960
Fully-insured	4,243	5,493	—	—	—	9,736
Specialty	261	1,055	—	—	—	1,316
Medicaid and other	2,341	21	—	35	—	2,397
Total premiums	45,805	6,569	—	35	—	52,409
Services revenue:						
Provider	—	40	655	—	—	695
ASO and other	9	658	—	14	—	681
Pharmacy	—	—	30	—	—	30
Total services revenue	9	698	685	14	—	1,406
Total revenues—external customers	45,814	7,267	685	49	—	53,815
Intersegment revenues						
Services	—	93	17,997	—	(18,090)	—
Products	—	—	4,923	—	(4,923)	—
Total intersegment revenues	—	93	22,920	—	(23,013)	—
Investment income	134	26	—	76	238	474
Total revenues	45,948	7,386	23,605	125	(22,775)	54,289
Operating expenses:						
Benefits	39,708	5,266	—	87	(792)	44,269
Operating costs	5,118	1,769	22,481	14	(22,064)	7,318
Depreciation and amortization	192	93	143	—	(73)	355
Total operating expenses	45,018	7,128	22,624	101	(22,929)	51,942
Income from operations	930	258	981	24	154	2,347
Gain on sale of business	—	—	—	—	270	270
Interest expense	—	—	—	—	186	186
Income before income taxes	$ 930	$ 258	$ 981	$ 24	$ 238	$ 2,431

Benefits expense for the Retail segment for 2015 includes $176 million for a provision for probable future losses (premium deficiency) for individual commercial medical business compliant with the Health Care Reform Law for the 2016 coverage year as discussed more fully in Note 7.

	Retail	Group	Healthcare Services	Other Businesses	Eliminations/ Corporate	Consolidated
			(in millions)			
2014						
Revenues—external customers						
Premiums:						
Individual Medicare Advantage	$ 25,782	$ —	$ —	$ —	$ —	$ 25,782
Group Medicare Advantage	5,490	—	—	—	—	5,490
Medicare stand-alone PDP	3,404	—	—	—	—	3,404
Total Medicare	34,676	—	—	—	—	34,676
Fully-insured	3,265	5,339	—	—	—	8,604
Specialty	256	1,098	—	—	—	1,354
Medicaid and other	1,255	19	—	51	—	1,325
Total premiums	39,452	6,456	—	51	—	45,959
Services revenue:						
Provider	—	23	1,254	—	—	1,277
ASO and other	39	740	—	9	—	788
Pharmacy	—	—	99	—	—	99
Total services revenue	39	763	1,353	9	—	2,164
Total revenues—external customers	39,491	7,219	1,353	60	—	48,123
Intersegment revenues						
Services	—	78	15,098	—	(15,176)	—
Products	—	—	3,749	—	(3,749)	—
Total intersegment revenues	—	78	18,847	—	(18,925)	—
Investment income	97	23	—	60	197	377
Total revenues	39,588	7,320	20,200	120	(18,728)	48,500
Operating expenses:						
Benefits	33,508	5,130	—	102	(574)	38,166
Operating costs	4,576	1,936	19,307	17	(18,197)	7,639
Depreciation and amortization	165	103	155	—	(90)	333
Total operating expenses	38,249	7,169	19,462	119	(18,861)	46,138
Income from operations	1,339	151	738	1	133	2,362
Interest expense	—	—	—	—	192	192
Income (loss) before income taxes	$ 1,339	$ 151	$ 738	$ 1	$ (59)	$ 2,170

18. EXPENSES ASSOCIATED WITH LONG-DURATION INSURANCE PRODUCTS

Premiums associated with our long-duration insurance products accounted for approximately 1% of our consolidated premiums and services revenue for the year ended December 31, 2016. We use long-duration accounting for products such as long-term care, life insurance, annuities, and certain health and other supplemental policies sold to individuals because they are expected to remain in force for an extended period beyond one year and because premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. As a result, we defer policy acquisition costs, primarily consisting of commissions, and amortize them over the estimated life of the policies in proportion to premiums earned.

In addition, we establish reserves for future policy benefits in recognition of the fact that some of the premium received in the earlier years is intended to pay anticipated benefits to be incurred in future years. At policy issuance, these reserves are recognized on a net level premium method based on premium rate increase, interest rate, mortality, morbidity, persistency (the percentage of policies remaining in-force), and maintenance expense assumptions. The assumptions used to determine the liability for future policy benefits are established and locked in at the time each contract is issued and only change if our expected future experience deteriorates to the point that the level of the liability, together with the present value of future gross premiums, are not adequate to provide for future expected policy benefits and maintenance costs (i.e. the loss recognition date). As discussed in Note 2, beginning in 2014, health policies sold to individuals that conform to the Health Care Reform Law are accounted for under a short-duration model because premiums received in the current year are intended to pay anticipated benefits in that year.

The table below presents deferred acquisition costs and future policy benefits payable associated with our long-duration insurance products for the years ended December 31, 2016 and 2015.

	2016		2015	
	Deferred acquisition costs	Future policy benefits payable	Deferred acquisition costs	Future policy benefits payable
	(in millions)			
Other long-term assets	$ 119	$ —	$ 135	$ —
Trade accounts payable and accrued expenses	—	(62)	—	(64)
Long-term liabilities	—	(2,834)	—	(2,151)
Total asset (liability)	$ 119	$ (2,896)	$ 135	$ (2,215)

In addition, future policy benefits payable include amounts of $201 million at December 31, 2016 and $205 million at December 31, 2015 which are subject to 100% coinsurance agreements as more fully described in Note 19.

In 2016, we recorded a net increase in benefits expense of $439 million, including a net charge of $505 million associated with our closed block of long-term care insurance policies discussed further below, partially offset by the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law. In 2015, we recorded a net reduction in benefits expense of $80 million associated with future policy benefits primarily due to the release of reserves as individual commercial medical members transitioned to plans compliant with the Health Care Reform Law. Benefits expense associated with future policy benefits payable was $32 million in 2014. Amortization of deferred acquisition costs included in operating costs was $67 million in 2016, $63 million in 2015, and $39 million in 2014. The higher amortization in 2015 and 2016 primarily reflects the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers.

Future policy benefits payable include $2.2 billion at December 31, 2016 and $1.5 billion at December 31, 2015 associated with a non-strategic closed block of long-term care insurance policies acquired in connection with the 2007 acquisition of KMG. Future policy benefits payable includes amounts charged to accumulated other comprehensive income for an additional liability that would exist on our closed-block of long-term care insurance policies if unrealized gains on the sale of the investments backing such products had been realized and the proceeds reinvested at then current

yields. There was a $77 million additional liability at December 31, 2016 and no additional liability at December 31, 2015. Amounts charged to accumulated other comprehensive income are net of applicable deferred taxes.

Long-term care insurance policies provide nursing home and home health coverage for which premiums are collected many years in advance of benefits paid, if any. Therefore, our actual claims experience will emerge many years after assumptions have been established. The risk of a deviation of the actual premium rate increase, interest, morbidity, mortality, persistency, and maintenance expense assumptions from those assumed in our reserves are particularly significant to our closed block of long-term care insurance policies. We monitor the loss experience of these long-term care insurance policies and, when necessary, apply for premium rate increases through a regulatory filing and approval process in the jurisdictions in which such products were sold. To the extent premium rate increases, interest rates, and/or loss experience vary from our loss recognition date assumptions, material future adjustments to reserves could be required.

During 2016, we recorded a loss for a premium deficiency. The premium deficiency was based on current and anticipated experience that had deteriorated from our locked-in assumptions from the previous December 31, 2013 loss recognition date, particularly as they related to emerging experience indicating longer claims duration, a prolonged lower interest rate environment, and an increase in policyholder life expectancies. Based on this deterioration, we determined that our existing future policy benefits payable, together with the present value of future gross premiums, associated with our closed block of long-term care insurance policies were not adequate to provide for future policy benefits and maintenance costs under these policies; therefore we unlocked and modified our assumptions based on current expectations. Accordingly, during 2016 we recorded $505 million of additional benefits expense, with a corresponding increase in future policy benefits payable of $659 million partially offset by a related reinsurance recoverable of $154 million included in other long-term assets.

Deferred acquisition costs included $16 million and $26 million associated with our individual commercial medical policies at December 31, 2016 and December 31, 2015, respectively. Future policy benefits payable associated with our individual commercial medical policies were $86 million at December 31, 2016 and $180 million at December 31, 2015. The decline in deferred acquisition costs and future policy benefits payable primarily reflects the effect of existing previously underwritten members transitioning to policies compliant with the Health Care Reform Law with us and other carriers.

19. REINSURANCE

Certain blocks of insurance assumed in acquisitions, primarily life, long-term care, and annuities in run-off status, are subject to reinsurance where some or all of the underwriting risk related to these policies has been ceded to a third party. In addition, a large portion of our reinsurance takes the form of 100% coinsurance agreements where, in addition to all of the underwriting risk, all administrative responsibilities, including premium collections and claim payment, have also been ceded to a third party. We acquired these policies and related reinsurance agreements with the purchase of stock of companies in which the policies were originally written. We acquired these companies for business reasons unrelated to these particular policies, including the companies' other products and licenses necessary to fulfill strategic plans.

A reinsurance agreement between two entities transfers the underwriting risk of policyholder liabilities to a reinsurer while the primary insurer retains the contractual relationship with the ultimate insured. As such, these reinsurance agreements do not completely relieve us of our potential liability to the ultimate insured. However, given the transfer of underwriting risk, our potential liability is limited to the credit exposure which exists should the reinsurer be unable to meet its obligations assumed under these reinsurance agreements.

Reinsurance recoverables represent the portion of future policy benefits payable and benefits payable that are covered by reinsurance. Amounts recoverable from reinsurers are estimated in a manner consistent with the methods used to determine future policy benefits payable as detailed in Note 2. Excluding reinsurance associated with the Health Care Reform Law discussed in Note 2, reinsurance recoverables, included in other current and long-term assets, were $822 million at December 31, 2016 and $668 million at December 31, 2015. The percentage of these reinsurance recoverables resulting from 100% coinsurance agreements was approximately 34% at December 31, 2016 and approximately 43% at December 31, 2015. Premiums ceded were $842 million in 2016, $821 million in 2015 and $357

million in 2014. Benefits ceded were $767 million in 2016, $666 million in 2015, and $272 million in 2014. Ceded premium and benefits reflect a July 1, 2014 amendment ceding all risk under a Medicaid contract to a third party reinsurer.

We evaluate the financial condition of these reinsurers on a regular basis. These reinsurers are well-known and well-established, as evidenced by the strong financial ratings at December 31, 2016 presented below:

Reinsurer	Total Recoverable	A.M. Best Rating at December 31, 2016
	(in millions)	
Munich American Reassurance Company	$ 248	A+ (superior)
Protective Life Insurance Company	182	A+ (superior)
Employers Reassurance Corporation	130	A- (excellent)
General Re Life Corporation	129	A++ (superior)
All others	133	A+ to A- (superior to excellent)
	$ 822	

The all other category represents 18 reinsurers with individual balances less than $76 million. Three of these reinsurers with recoverables of $93 million are subject to trust or funds withheld accounts, requiring amounts at least equal to the total recoverable from each of these reinsurers.

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Humana Inc.:

In our opinion, the consolidated balance sheets and the related consolidated statements of income, of comprehensive income, of stockholders' equity and of cash flows present fairly, in all material respects, the financial position of Humana Inc. and its subsidiaries at December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2016 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules listed in the index appearing under Item 15(a)(2) present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedules, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedules, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP

Louisville, Kentucky
February 17, 2017

Humana Inc.
QUARTERLY FINANCIAL INFORMATION
(Unaudited)

A summary of our quarterly unaudited results of operations for the years ended December 31, 2016 and 2015 follows:

	2016			
	First	Second	Third	Fourth (2)(3)
	(in millions, except per share results)			
Total revenues	$ 13,800	$ 14,007	$ 13,694	$ 12,878
Income (loss) before income taxes	500	636	902	(486)
Net income (loss)	254	311	450	(401)
Basic earnings (loss) per common share	$ 1.70	$ 2.08	$ 3.01	$ (2.68)
Diluted earnings (loss) per common share (1)	$ 1.68	$ 2.06	$ 2.98	$ (2.68)

	2015			
	First	Second	Third	Fourth (4)
	(in millions, except per share results)			
Total revenues	$ 13,833	$ 13,732	$ 13,363	$ 13,361
Income before income taxes	744	793	648	246
Net income	430	431	314	101
Basic earnings per common share	$ 2.86	$ 2.88	$ 2.11	$ 0.68
Diluted earnings per common share (1)	$ 2.82	$ 2.85	$ 2.09	$ 0.67

(1) The calculation of diluted earnings per common share is based on the weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year. In addition, for 2016, the sum of quarterly amounts does not equal full year results due to the anti-dilutive impact of a loss in the fourth quarter. The loss position in the fourth quarter required the use of basic weighted-average common shares outstanding in the calculation of diluted loss per share.

(2) The fourth quarter of 2016 includes an expense of $505 million ($318 million after tax, or 2.11 per diluted common share) for reserve strengthening associated with our closed block of long-term care insurance policies.

(3) Total revenue for 2016 includes a reduction of $583 million ($367 million after-tax, or $2.43 per diluted common share) in premiums associated with the write-off of risk corridor receivables.

(4) The fourth quarter of 2015 includes an expense of $176 million ($112 million after tax, or $0.74 per diluted common share) for a premium deficiency reserve associated with our individual commercial medical policies compliant with the Health Care Reform Law associated with the 2016 coverage year.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

Not applicable.

ITEM 9A. CONTROLS AND PROCEDURES

Management's Responsibility for Financial Statements and Other Information

We are responsible for the preparation and integrity of the consolidated financial statements appearing in our Annual Report. The consolidated financial statements were prepared in conformity with accounting principles generally accepted in the United States and include amounts based on our estimates and judgments. All other financial information in this report has been presented on a basis consistent with the information included in the financial statements.

Our control environment is the foundation for our system of internal control over financial reporting and is embodied in our Code of Ethics and Business Conduct, which we currently refer to as the Humana Inc. Ethics Every Day. It sets the tone of our organization and includes factors such as integrity and ethical values. Our internal control over financial reporting is supported by formal policies and procedures which are reviewed, modified and improved as changes occur in business conditions and operations.

The Audit Committee of the Board of Directors, which is composed solely of independent outside directors, meets periodically with members of management, the internal auditors and our independent registered public accounting firm to review and discuss internal controls over financial reporting and accounting and financial reporting matters. Our independent registered public accounting firm and internal auditors report to the Audit Committee and accordingly have full and free access to the Audit Committee at any time.

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures to ensure that material information relating to the Company, including its consolidated subsidiaries, is made known to members of senior management and the Board of Directors.

Based on our evaluation as of December 31, 2016, we as the principal executive officer and the principal financial officer and the principal accounting officer of the Company have concluded that the Company's disclosure controls and procedures (as defined in the Securities Exchange Act of 1934) are effective to ensure that the information required to be disclosed by the Company in the reports that it files or submits under the Securities Exchange Act of 1934 is recorded, processed, summarized and reported as specified in Securities and Exchange Commission rules and forms.

Management's Report on Internal Control Over Financial Reporting

We are responsible for establishing and maintaining effective internal control over financial reporting as defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate or that the degree of compliance with the policies or procedures may deteriorate.

We assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2016. In making this assessment, we used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (COSO) in *Internal Control – Integrated Framework* (2013). Based on our assessment, we determined that, as of December 31, 2016, the Company's internal control over financial reporting was effective based on those criteria.

The effectiveness of our internal control over financial reporting as of December 31, 2016 has been audited by PricewaterhouseCoopers LLP, our independent registered public accounting firm, who also audited the Company's consolidated financial statements included in our Annual Report on Form 10-K, as stated in their report which appears on page 138.

Changes in Internal Control over Financial Reporting

There have been no changes in the Company's internal control over financial reporting during the quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Bruce D. Broussard
President and Chief Executive Officer (Principal Executive Officer)

Brian A. Kane
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

Cynthia H. Zipperle
Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Directors

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Proposal One: Election of Directors" in such Proxy Statement.

Executive Officers of the Registrant

Set forth below are names and ages of all of our current executive officers as of February 1, 2017, their positions, and the date first elected an officer:

Name	Age	Position	First Elected Officer	
Bruce D. Broussard	54	President and Chief Executive Officer, Director	12/11	(1)
James E. Murray	63	Executive Vice President and Chief Operating Officer	08/90	(2)
Roy A. Beveridge, M.D.	59	Senior Vice President and Chief Medical Officer	06/13	(3)
Jody L. Bilney	55	Senior Vice President and Chief Consumer Officer	04/13	(4)
Christopher H. Hunter	48	Senior Vice President and Chief Strategy Officer	01/14	(5)
Timothy S. Huval	50	Senior Vice President and Chief Human Resources Officer	12/12	(6)
Brian A. Kane	44	Senior Vice President and Chief Financial Officer	06/14	(7)
Christopher Kay	51	Senior Vice President and Chief Innovation Officer	03/14	(8)
Brian P. LeClaire	56	Senior Vice President and Chief Information Officer	08/11	(9)
Heidi S. Margulis	63	Senior Vice President – Corporate Affairs	12/95	(10)
Christopher M. Todoroff	54	Senior Vice President and General Counsel	08/08	(11)
Cynthia H. Zipperle	54	Vice President, Chief Accounting Officer and Controller	12/14	(12)

(1) Mr. Broussard currently serves as Director, President and Chief Executive Officer (Principal Executive Officer), having held these positions since January 1, 2013. Mr. Broussard was elected President upon joining the Company in December 2011 and served in that capacity through December 2012. Prior to joining the Company, Mr. Broussard was Chief Executive Officer of McKesson Specialty/US Oncology, Inc. US Oncology was purchased by McKesson in December 2010. At US Oncology, Mr. Broussard served in a number of senior executive roles, including Chief Financial Officer, Chief Executive Officer, and Chairman of the Board.

(2) Mr. Murray currently serves as Executive Vice President and Chief Operating Officer, having held this position since December 2011. Mr. Murray has held the position of Chief Operating Officer since February 2006, and was the Chief Operating Officer – Market and Business Segment Operations from September 2002 to February 2006. Mr. Murray joined the Company in December 1989. On February 8, 2017, the Company announced that Mr. Murray intends to retire from the position of Executive Vice President and Chief Operating Office effective March 31, 2017.

(3) Dr. Beveridge currently serves as Senior Vice President and Chief Medical Officer, having held this position since joining the Company in June 2013. Prior to joining the Company, Dr. Beveridge served as Chief Medical Officer for McKesson Specialty Health from December 2010 until June 2013. Prior to McKesson's acquisition of US Oncology, Dr. Beveridge served as the Executive Vice President and Medical Director at US Oncology from September 2009 through December 2010.

(4) Ms. Bilney currently serves as Senior Vice President and Chief Consumer Officer, having held this position since joining the Company in April 2013. Prior to joining the Company, Ms. Bilney served as Executive Vice President and Chief Brand Officer for Bloomin' Brands, Inc. from 2006 until April 2013.

(5) Mr. Hunter currently serves as Senior Vice President and Chief Strategy Officer, having held this position since joining the Company in January 2014. Prior to joining the Company, Mr. Hunter served as President of Provider Markets at The TriZetto Group, Inc. from July 2012 until December 2013, and as Senior Vice President, Emerging Markets at BlueCross BlueShield of Tennessee from 2009 through July 2012. While at BlueCross BlueShield of Tennessee, Mr. Hunter was simultaneously President and Chief Executive Officer of Onlife Health, a national health and wellness subsidiary of BlueCross BlueShield of Tennessee.

(6) Mr. Huval currently serves as Senior Vice President and Chief Human Resources Officer, having been elected to this position in December 2012. Prior to joining the Company, Mr. Huval spent 10 years at Bank of America in multiple senior-level roles, including Human Resources executive and Chief Information Officer for Global Wealth & Investment Management, as well as Human Resources executive for both Global Treasury Services and Technology & Global Operations.

(7) Mr. Kane currently serves as Senior Vice President and Chief Financial Officer, having been elected to this position in June 2014. Prior to joining the Company, Mr. Kane spent nearly 17 years at Goldman, Sachs & Co. As a managing director, he was responsible for client relationships as well as for leading strategic and financing transactions for a number of companies in multiple industries.

(8) Mr. Kay currently serves of Senior Vice President and Chief Innovation Officer, having been elected to this position in March 2014. Prior to joining the Company, Mr. Kay was most recently Managing Director and CEO of Citi Ventures, Citigroup's global corporate venturing arm. Prior to joining Citi in 2007, Mr. Kay held several leadership positions at Target over a 12-year period.

(9) Mr. LeClaire currently serves as Senior Vice President and Chief Information Officer, having held this position since January 2014. Prior to that, he served as Senior Vice President and Chief Service and Information Officer from August 2011 to January 2014, and as Chief Technology Officer from 2002 to August 2011. Mr. LeClaire joined the Company in August 1999.

(10) Ms. Margulis currently serves as Senior Vice President – Corporate Affairs, having held this position since January 2000. Ms. Margulis joined the Company in November 1985.

(11) Mr. Todoroff currently serves as Senior Vice President and General Counsel, having held this position since August 2008. Prior to joining the Company, Mr. Todoroff served as Vice President, Senior Corporate Counsel and Corporate Secretary for Aetna Inc. from 2006 through July 2008. Mr. Todoroff joined Aetna's Legal Department in 1995 and held various positions of increasing responsibility.

(12) Mrs. Zipperle currently serves as Vice President, Chief Accounting Officer and Controller, having held this position since December 2014. Mrs. Zipperle previously served as the Vice President - Finance from January 2013 until her election to her current role, and as the Assistant Controller from January 1998 until January 2013.

Executive officers are elected annually by our Board of Directors and serve until their successors are elected or until resignation or removal. There are no family relationships among any of our executive officers.

Section 16(a) Beneficial Ownership Reporting Compliance

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of such Proxy Statement.

Code of Conduct for Chief Executive Officer and Senior Financial Officers

We have adopted a Code of Conduct for the Chief Executive Officer and Senior Financial Officers, violations of which should be reported to the Audit Committee. The code may be viewed through the Investor Relations section of our web site at www.humana.com. Any amendment to or waiver of the application of the Code of Conduct for the Chief Executive Officer and Senior Financial Officers will be promptly disclosed through the Investor Relations section of our web site at www.humana.com.

Code of Business Conduct and Ethics

Since 1995, we have operated under an omnibus Code of Ethics and Business Conduct, currently known as the Humana Inc. Ethics Every Day. All employees and directors are required to annually affirm in writing their acceptance of the code. The Humana Inc. Ethics Every Day was adopted by our Board of Directors in June 2014, replacing a previous iteration of our Code of Ethics and Business Conduct – the Humana Inc. Principles of Business Ethics – as the document to comply with the New York Stock Exchange Corporate Governance Standard 303A.10. The Humana Inc. Ethics Every Day is available on our web site at www.humana.com. Any waiver of the application of the Humana Inc. Principles of Business Ethics to directors or executive officers must be made by the Board of Directors and will be promptly disclosed on our web site at www.humana.com.

Corporate Governance Items

We have made available free of charge on or through the Investor Relations section of our web site at www.humana.com our annual reports on Form 10-K, quarterly reports on Form 10-Q, proxy statements, and all of our other reports, and, if applicable, amendments to those reports filed or furnished pursuant to Section 13(a) of the Exchange Act, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Also available on our Internet web site is information about our corporate governance, including:

- a determination of independence for each member of our Board of Directors;
- the name, membership, role, and charter of each of the various committees of our Board of Directors;
- the name(s) of the directors designated as a financial expert under rules and regulations promulgated by the SEC;
- the responsibility of the Company's Lead Independent Director, if applicable, to convene, set the agenda for, and lead executive sessions of the non-management directors;
- the pre-approval process of non-audit services provided by our independent accountants;
- our by-laws and Certificate of Incorporation;
- our Majority Vote policy;
- our Related Persons Transaction Policy;
- the process by which interested parties can communicate with directors;
- the process by which stockholders can make director nominations (pursuant to our By-laws);
- our Corporate Governance Guidelines;
- our Policy Regarding Transactions in Company Securities, Inside Information and Confidentiality;
- Stock Ownership Guidelines for directors and for executive officers;
- the Humana Inc. Ethics Every Day and any waivers thereto; and
- the Code of Conduct for the Chief Executive Officer and Senior Financial Officers and any waivers thereto.

Additional information about these items can be found in, and is incorporated by reference to, our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017.

Material Changes to the Procedures by which Security Holders May Recommend Nominees to the Registrant's Board of Directors

None.

Audit Committee Financial Expert

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Corporate Governance – Audit Committee" of such Proxy Statement.

Audit Committee Composition and Independence

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Corporate Governance – Committee Membership and Attendance" of such Proxy Statement.

ITEM 11. EXECUTIVE COMPENSATION

Additional information required by this Item is incorporated herein by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the captions "Corporate Governance – Organization & Compensation Committee – Compensation Committee Interlocks and Insider Participation," "Director Compensation," "Compensation Discussion and Analysis," "Organization & Compensation Committee Report," and "Executive Compensation" of such Proxy Statement.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

Equity compensation plan information

We maintain plans under which options to purchase our common stock and awards of restricted stock may be made to officers, directors, key employees, and consultants. Stock options are granted with an exercise price equal to the fair market value of the underlying common stock on the date of grant. Our stock plans, as approved by the Board of Directors and stockholders, define fair market value as the average of the highest and lowest stock prices reported on the composite tape by the New York Stock Exchange on a given date. Exercise provisions vary, but most options vest in whole or in part 1 to 3 years after grant and expire up to 7 years after grant.

Information concerning stock option awards and the number of securities remaining available for future issuance under our equity compensation plans in effect as of December 31, 2016 follows:

Plan category	(a) Number of securities to be issued upon exercise of outstanding options, warrants and rights	(b) Weighted-average exercise price of outstanding options, warrants and rights	(c) Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column(a))	
Equity compensation plans approved by security holders (1)	1,021,590	$ 143.043	7,052,923	(2)(3)
Equity compensation plans not approved by security holders	—	—	—	
Total	1,021,590	$ 143.043	7,052,923	

(1) The above table does not include awards of shares of restricted stock or restricted stock units. For information concerning these awards, see Note 13.

(2) The Humana Inc. 2011 Stock Incentive Plan was approved by stockholders at the Annual Meeting held on April 21, 2011. On July 5, 2011, 18.5 million shares were registered with the Securities and Exchange Commission on Form S-8.
(3) Of the number listed above, 3,079,879 can be issued as restricted stock at December 31, 2016 (giving effect to the provision that one restricted share is equivalent to 2.29 stock options in the 2011 Plan).

The information under the captions "Security Ownership of Certain Beneficial Owners of Company Common Stock" and "Security Ownership of Directors and Executive Officers" in our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017, is herein incorporated by reference.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the captions "Certain Transactions with Management and Others" and "Corporate Governance – Independent Directors" of such Proxy Statement.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this Item is herein incorporated by reference from our Proxy Statement for the Annual Meeting of Stockholders scheduled to be held on April 20, 2017 appearing under the caption "Audit Committee Report" of such Proxy Statement.

PART IV

ITEM 15. EXHIBITS, FINANCIAL STATEMENT SCHEDULES

(a) The financial statements, financial statement schedules and exhibits set forth below are filed as part of this report.

(1) Financial Statements – The response to this portion of Item 15 is submitted as Item 8 of Part II of this report.

(2) The following Consolidated Financial Statement Schedules are included herein:

Schedule I	Parent Company Financial Information
Schedule II	Valuation and Qualifying Accounts

All other schedules have been omitted because they are not applicable.

(3) Exhibits:

2.1 Agreement and Plan of Merger, dated as of July 2, 2015 among Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc. (incorporated herein by reference to Exhibit 2.1 to Humana Inc.'s Current Report on Form 8-K filed on July 7, 2015).

2.2 Letter Agreement, dated as of December 21, 2016, between Aetna Inc., Echo Merger Sub, Inc., Echo Merger Sub, LLC and Humana Inc. (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Current Report on Form 8-K filed on December 22, 2016).

2.3 Termination letter dated as of February 14, 2017, by and among Humana Inc., Aetna Inc., Echo Merger Sub, Inc. and Echo Merger Sub LLC (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Current Report on Form 8-K filed on February 14, 2017).

3(a) Restated Certificate of Incorporation of Humana Inc. filed with the Secretary of State of Delaware on November 9, 1989, as restated to incorporate the amendment of January 9, 1992, and the correction of March 23, 1992 (incorporated herein by reference to Exhibit 4(i) to Humana Inc.'s Post-Effective Amendment No.1 to the Registration Statement on Form S-8 (Reg. No. 33-49305) filed February 2, 1994).

(b) By-Laws of Humana Inc., as amended on January 4, 2007 (incorporated herein by reference to Exhibit 3 to Humana Inc.'s Annual Report on Form 10-K for the year ended December 31, 2006).

4(a) Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).

(b) First Supplemental Indenture, dated as of August 5, 2003, by and between Humana Inc. and The Bank of New York, as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2003).

(c) Second Supplemental Indenture, dated as of May 31, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on May 31, 2006).

(d) Third Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(e) Fourth Supplemental Indenture, dated as of June 5, 2008, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on June 5, 2008).

(f) Indenture, dated as of March 30, 2006, by and between Humana Inc. and The Bank of New York Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Registration Statement on Form S-3 filed on March 31, 2006).

(g) There are no instruments defining the rights of holders with respect to long-term debt in excess of 10 percent of the total assets of Humana Inc. on a consolidated basis. Other long-term indebtedness of Humana Inc. is described herein in Note 12 to Consolidated Financial Statements. Humana Inc. agrees to furnish copies of all such instruments defining the rights of the holders of such indebtedness not otherwise filed as an Exhibit to this Annual Report on Form 10-K to the Commission upon request.

(h) Fifth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.1 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(i) Sixth Supplemental Indenture, dated as of December 10, 2012, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.3 to Humana Inc.'s Current Report on Form 8-K filed on December 10, 2012).

(j) Seventh Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York, Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.2 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(k) Eighth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.4 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

(l) Ninth Supplemental Indenture, dated as of September 19, 2014, by and between Humana Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (incorporated herein by reference to Exhibit 4.6 to Humana Inc.'s Current Report on Form 8-K filed on September 19, 2014).

10(a)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(b)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10 (b) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(c)* Humana Inc. Amended and Restated 2003 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 27, 2006).

(d)* Humana Inc. Executive Management Incentive Compensation Plan, as amended and restated February 1, 2008 (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 24, 2008).

(e)* Form of Change of Control Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).

(f)* Trust under Humana Inc. Deferred Compensation Plans (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1999).

(g)* The Humana Inc. Deferred Compensation Plan for Non-Employee Directors (as amended on October 18, 2012) (incorporated herein by reference to Exhibit 10(m) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2012).

(h)* Severance policy as amended and restated on October 23, 2007 (incorporated herein by reference to Exhibit 10(r) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2007).

(i)* Humana Inc. Deferred Compensation Plan (incorporated herein by reference to Exhibit 4.1 to the Company's Registration Statement on Form S-8 (Reg. No. 333-171616), filed on January 7, 2011).

(j)* Humana Retirement Equalization Plan, as amended and restated as of January 1, 2011 (incorporated herein by reference to Exhibit 10(p) to Humana Inc.'s Annual Report on Form 10-K filed on February 17, 2011).

(k)* Letter agreement with Humana Inc. officers concerning health insurance availability (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 1994).

(l)* Executive Long-Term Disability Program (incorporated herein by reference to Exhibit 10(a) to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2004).

(m)* Indemnity Agreement (incorporated herein by reference to Appendix B to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on January 8, 1987).

(n)* ** Form of Company's Restricted Stock Unit Agreement with Time/Performance Vesting and Agreement not to Compete or Solicit, under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10 (t) to Humana Inc.'s Annual Report on Form 10-K/A filed on January 30, 2014).

(o)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (with retirement provisions) (incorporated herein by reference to Exhibit 10(o) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(p)* Summary of the Company's Financial Planning Program for our executive officers (incorporated herein by reference to Exhibit 10(v) to Humana's Inc.'s Annual Report on Form 10-K filed on February 22, 2013.

(q)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Solicit under the 2011 Stock Incentive Plan (without retirement provisions) (incorporated herein by reference to Exhibit 10(q) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(r) Five-Year Credit Agreement, dated as of July 9, 2013 (incorporated herein by reference to Exhibit 10 to Humana Inc.'s Current Report on Form 8-K filed on July 10, 2013).

(s) Form of CMS Coordinated Care Plan Agreement (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(t) Form of CMS Private Fee for Service Agreement (incorporated herein by reference to Exhibit 10.2 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(u) Addendum to Agreement Providing for the Operation of a Medicare Voluntary Prescription Drug Plan (incorporated herein by reference to Exhibit 10.3 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(v) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage Prescription Drug Plan (incorporated herein by reference to Exhibit 10.4 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(w) Addendum to Agreement Providing for the Operation of an Employer/Union-only Group Medicare Advantage-Only Plan (incorporated herein by reference to Exhibit 10.5 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(x) Addendum to Agreement Providing for the Operation of a Medicare Advantage Regional Coordinated Care Plan (incorporated herein by reference to Exhibit 10.6 to Humana Inc.'s Quarterly Report on Form 10-Q for the quarter ended September 30, 2005).

(y) Explanatory Note regarding Medicare Prescription Drug Plan Contracts between Humana and CMS (incorporated herein by reference to Exhibit 10(nn) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2005).

(z)* Humana Inc. 2011 Stock Incentive Plan (incorporated herein by reference to Appendix A to Humana Inc.'s Proxy Statement with respect to the Annual Meeting of Stockholders held on April 21, 2011).

(aa)* Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(oo) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(bb)* Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(pp) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(cc)* Form of Company's Restricted Stock Unit Agreement and Agreement not to Compete or Solicit under the 2011 Stock Incentive Plan (incorporated herein by reference to Exhibit 10(rr) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(dd)* Amended and Restated Employment Agreement, dated as of February 27, 2014, by and between Humana Inc. and Bruce D. Broussard (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 28, 2014).

(ee)* Amendment to the Amended and Restated Employment Agreement between Humana Inc. and Bruce D. Broussard, dated July 2, 2015 (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on July 9, 2015).

(ff)** Agreement between the United States Department of Defense and Humana Military Healthcare Services, Inc., a wholly owned subsidiary of Humana Inc., dated as March 3, 2011 (incorporated herein by reference to Exhibit 10(mm) to Humana Inc.'s Annual Report on Form 10-K filed on February 24, 2012).

(gg)* Form of Amendment to Change of Control Agreement between Humana Inc. and various executive officers (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on February 24, 2014).

(hh) Form of Commercial Paper Dealer Agreement between Humana Inc., as Issuer, and the Dealer party thereto (incorporated herein by reference to Exhibit 10.1 to Humana Inc.'s current report on Form 8-K filed on October 6, 2014).

(ii) Master Confirmation by and between Humana Inc. and Goldman, Sachs & Co., dated November 7, 2014 (incorporated herein by reference to Humana Inc.'s current report on Form 8-K filed on November 10, 2014).

(jj)* Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Incentive Stock Options) (incorporated herein by reference to Exhibit 10(jj) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

(kk)* Form of Company's Stock Option Agreement under the 2011 Stock Incentive Plan (Non-Qualified Stock Options with Non-Compete/Non-Solicit) (incorporated herein by reference to Exhibit 10(kk) to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2015).

12 † Computation of ratio of earnings to fixed charges.

14 Code of Conduct for Chief Executive Officer & Senior Financial Officers (incorporated herein by reference to Exhibit 14 to Humana Inc.'s Annual Report on Form 10-K for the fiscal year ended December 31, 2003).

21 † List of subsidiaries.

23 † Consent of PricewaterhouseCoopers LLP.

31.1 † CEO certification pursuant to Rule 13a-14(a)/15d-14(a).

31.2 † CFO certification pursuant to Rule 13a-14(a)/15d-14(a).

32 † Certification pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes – Oxley Act of 2002.

101 The following materials from Humana Inc.'s Annual Report on Form 10-K formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets at December 31, 2016 and 2015; (ii) the

Consolidated Statements of Income for the years ended December 31, 2016, 2015 and 2014; (iii) the Consolidated Statements of Comprehensive Income for the years ended December 31, 2016, 2015 and 2014; (iv) the Consolidated Statements of Stockholders' Equity as of December 31, 2016, 2015, and 2014; (v) the Consolidated Statements of Cash Flows for the years ended December 31, 2016, 2015 and 2014; and (vi) Notes to Consolidated Financial Statements.

*Exhibits 10(a) through and including 10(q) and 10(z) through and including 10(ee),10(gg),10(jj) and 10(ii) are compensatory plans or management contracts.

**Pursuant to Rule 24b-2 of the Securities Exchange Act of 1934, as amended, confidential portions of this exhibit have been omitted and filed separately with the Securities and Exchange Commission pursuant to a request for confidential treatment.

†Submitted electronically with this report.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED BALANCE SHEETS

	December 31,	
	2016	2015
	(in millions, except share amounts)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,710	$ 1,389
Investment securities	300	256
Receivable from operating subsidiaries	1,136	1,124
Other current assets	122	224
Total current assets	3,268	2,993
Property and equipment, net	1,086	1,011
Investments in subsidiaries	15,276	14,276
Other long-term assets	374	410
Total assets	$ 20,004	$ 18,690
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Payable to operating subsidiaries	$ 4,107	$ 3,322
Current portion of notes payable to operating subsidiaries	28	28
Book overdraft	38	38
Short-term borrowings	300	299
Other current liabilities	708	572
Total current liabilities	5,181	4,259
Long-term debt	3,792	3,794
Notes payable to operating subsidiaries	9	9
Other long-term liabilities	337	282
Total liabilities	9,319	8,344
Commitments and contingencies		
Stockholders' equity:		
Preferred stock, $1 par; 10,000,000 shares authorized; none issued	—	—
Common stock, $0.16 2/3 par; 300,000,000 shares authorized; 198,495,007 shares issued at December 31, 2016 and 198,372,059 shares issued at December 31, 2015	33	33
Capital in excess of par value	2,562	2,530
Retained earnings	11,454	11,017
Accumulated other comprehensive income	(66)	58
Treasury stock, at cost, 49,189,811 shares at December 31, 2016 and 50,084,043 shares at December 31, 2015	(3,298)	(3,292)
Total stockholders' equity	10,685	10,346
Total liabilities and stockholders' equity	$ 20,004	$ 18,690

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF INCOME

	For the year ended December 31,		
	2016	2015	2014
		(in millions)	
Revenues:			
Management fees charged to operating subsidiaries	$ 1,683	$ 1,469	$ 1,509
Investment and other income, net	42	5	4
	1,725	1,474	1,513
Expenses:			
Operating costs	1,623	1,370	1,434
Depreciation	302	252	212
Interest	189	186	192
	2,114	1,808	1,838
Loss before gain on sale of business, income taxes and equity in net earnings of subsidiaries	(389)	(334)	(325)
Gain on sale of business	—	270	—
Loss before income taxes and equity in net earnings of subsidiaries	(389)	(64)	(325)
Benefit for income taxes	(107)	(70)	(81)
Income (loss) before equity in net earnings of subsidiaries	(282)	6	(244)
Equity in net earnings of subsidiaries	896	1,270	1,391
Net income	$ 614	$ 1,276	$ 1,147

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF COMPREHENSIVE INCOME

	For the year ended December 31,		
	2016	2015	2014
	(in millions)		
Net income	$ 614	$ 1,276	$ 1,147
Other comprehensive (loss) income:			
Change in gross unrealized investment gains/losses	(101)	(114)	122
Effect of income taxes	38	42	(44)
Total change in unrealized investment gains/losses, net of tax	(63)	(72)	78
Reclassification adjustment for net realized gains included in investment income	(96)	(146)	(20)
Effect of income taxes	35	53	7
Total reclassification adjustment, net of tax	(61)	(93)	(13)
Other comprehensive (loss) income, net of tax	(124)	(165)	65
Comprehensive income	$ 490	$ 1,111	$ 1,212

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
CONDENSED STATEMENTS OF CASH FLOWS

	For the year ended December 31,		
	2016	2015	2014
		(in millions)	
Net cash provided by operating activities	$ 1,848	$ 953	$ 1,499
Cash flows from investing activities:			
Proceeds from sale of business	—	1,055	—
Capital contributions to operating subsidiaries	(895)	(833)	(442)
Purchases of investment securities	(151)	(507)	(629)
Proceeds from sale of investment securities	25	18	606
Maturities of investment securities	143	108	149
Purchases of property and equipment, net	(382)	(378)	(380)
Net cash used in investing activities	(1,260)	(537)	(696)
Cash flows from financing activities:			
Proceeds from issuance of senior notes, net	—	—	1,733
Proceeds from issuance of commercial paper, net	(2)	298	—
Repayment of long-term debt	—	—	(500)
Change in book overdraft	5	(16)	(5)
Common stock repurchases	(104)	(385)	(872)
Dividends paid	(177)	(172)	(172)
Tax benefit from stock-based compensation	—	15	12
Proceeds from stock option exercises and other	11	22	51
Net cash (used in) provided by financing activities	(267)	(238)	247
Increase in cash and cash equivalents	321	178	1,050
Cash and cash equivalents at beginning of year	1,389	1,211	161
Cash and cash equivalents at end of year	$ 1,710	$ 1,389	$ 1,211

See accompanying notes to the parent company financial statements.

Humana Inc.

SCHEDULE I—PARENT COMPANY FINANCIAL INFORMATION
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

Parent company financial information has been derived from our consolidated financial statements and excludes the accounts of all operating subsidiaries. This information should be read in conjunction with our consolidated financial statements.

Related Party

Refer to Note 2 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of our related party transactions. A related party note receivable is included with other long-term assets in our condensed balance sheet at December 31, 2016 and December 31, 2015 in the amount of $314 million and $284 million, respectively. The related interest income of $30 million for 2016 is included in investment and other income in our condensed statement of income.

2. TRANSACTIONS WITH SUBSIDIARIES

Management Fee

Through intercompany service agreements approved, if required, by state regulatory authorities, Humana Inc., our parent company, charges a management fee for reimbursement of certain centralized services provided to its subsidiaries including information systems, disbursement, investment and cash administration, marketing, legal, finance, and medical and executive management oversight.

Dividends

Cash dividends received from subsidiaries and included as a component of net cash provided by operating activities were $763 million in 2016, $493 million in 2015, and $927 million in 2014.

Guarantee

Through indemnity agreements approved by state regulatory authorities, certain of our regulated subsidiaries generally are guaranteed by our parent company in the event of insolvency for: (1) member coverage for which premium payment has been made prior to insolvency; (2) benefits for members then hospitalized until discharged; and (3) payment to providers for services rendered prior to insolvency. Our parent has also guaranteed the obligations of our military services subsidiaries.

Notes Receivables from Operating Subsidiaries

We funded certain subsidiaries with surplus note agreements. These notes are generally non-interest bearing and may not be entered into or repaid without the prior approval of the applicable Departments of Insurance or other state regulatory authorities.

Notes Payable to Operating Subsidiaries

We borrowed funds from certain subsidiaries with notes generally collateralized by real estate. These notes, which have various payment and maturity terms, bear interest ranging from 1.93% to 6.65% and are payable in 2017 and 2019. We recorded interest expense of $1 million related to these notes for each of the years ended December 31, 2016, 2015 and 2014.

3. REGULATORY REQUIREMENTS

Certain of our subsidiaries operate in states that regulate the payment of dividends, loans, or other cash transfers to Humana Inc., our parent company, and require minimum levels of equity as well as limit investments to approved securities. The amount of dividends that may be paid to Humana Inc. by these subsidiaries, without prior approval by state regulatory authorities, or ordinary dividends, is limited based on the entity's level of statutory income and statutory capital and surplus. In most states, prior notification is provided before paying a dividend even if approval is not required.

Although minimum required levels of equity are largely based on premium volume, product mix, and the quality of assets held, minimum requirements vary significantly at the state level. Our state regulated insurances subsidiaries had aggregate statutory capital and surplus of approximately $7.7 billion and $6.6 billion as of December 31, 2016 and 2015, respectively, which exceeded aggregate minimum regulatory requirements of $4.8 billion and $4.6 billion, respectively. Subsidiary dividends are subject to state regulatory approval, the amount and timing of which could be reduced or delayed. Excluding Puerto Rico subsidiaries, the amount of ordinary dividends that may be paid to our parent company in 2017 is approximately $850 million in the aggregate. This compares to dividends that were paid to our parent company in 2016 of approximately $763 million. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

Our parent company funded a subsidiary capital contribution of approximately $535 million in the first quarter of 2017 for reserve strengthening associated with our closed block of long-term care insurance policies discussed further in Note 18 of the notes to consolidated financial statements in this Annual Report on Form 10-K.

Our use of operating cash flows derived from our non-insurance subsidiaries, such as in our Healthcare Services segment, is generally not restricted by state departments of insurance (or comparable state regulators).

4. ACQUISITIONS AND DIVESTITURES

Refer to Note 3 of the notes to consolidated financial statements in this Annual Report on Form 10-K for a description of certain acquisitions and divestitures. On June 1, 2015, we completed the sale of our wholly owned subsidiary, Concentra Inc. During 2016, 2015 and 2014, we funded certain non-regulated subsidiary acquisitions with contributions from Humana Inc., our parent company, included in capital contributions in the condensed statement of cash flows.

5. INCOME TAXES

Refer to Note 11 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of income taxes.

6. DEBT

Refer to Note 12 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of debt.

7. STOCKHOLDER'S EQUITY

Refer to Note 15 of the notes to consolidated financial statements included in this Annual Report on Form 10-K for a description of stockholders' equity, including stock repurchases and stockholder dividends.

Humana Inc.
SCHEDULE II—VALUATION AND QUALIFYING ACCOUNTS
For the Years Ended December 31, 2016, 2015, and 2014
(in millions)

	Balance at Beginning of Period	Acquired/ (Disposed) Balances	Additions: Charged (Credited) to Costs and Expenses	Additions: Charged to Other Accounts (1)	Deductions or Write-offs	Balance at End of Period
Allowance for loss on receivables:						
2016	$ 101	$ —	$ 39	$ 19	$ (41)	$ 118
2015	137	(39)	61	(7)	(51)	101
2014	118	—	32	28	(41)	137
Deferred tax asset valuation allowance:						
2016	(42)	—	(7)	—	—	(49)
2015	(48)	—	6	—	—	(42)
2014	(28)	—	(20)	—	—	(48)

(1) Represents changes in retroactive membership adjustments to premiums revenue and contractual allowances adjustments to services revenue as more fully described in Note 2 to the consolidated financial statements included in this annual report on Form 10-K.

SIGNATURES

Pursuant to the requirements of Sections 13 or 15(d) of the Securities Exchange Act of 1934, the Company has duly caused this report to be signed on its behalf by the undersigned, thereto duly authorized.

HUMANA INC.

By: /s/ BRIAN A. KANE
Brian A. Kane
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

Date: February 17, 2017

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the Company and in the capacities and on the date indicated.

Signature	Title	Date
/s/ BRIAN A. KANE **Brian A. Kane**	Senior Vice President and Chief Financial Officer (Principal Financial Officer)	February 17, 2017
/s/ CYNTHIA H. ZIPPERLE **Cynthia H. Zipperle**	Vice President, Chief Accounting Officer and Controller (Principal Accounting Officer)	February 17, 2017
/s/ BRUCE D. BROUSSARD **Bruce D. Broussard**	President and Chief Executive Officer, Director (Principal Executive Officer)	February 17, 2017
/s/ KURT J. HILZINGER **Kurt J. Hilzinger**	Chairman of the Board	February 17, 2017
/s/ FRANK A. D'AMELIO **Frank A. D'Amelio**	Director	February 17, 2017
/s/ W. ROY DUNBAR **W. Roy Dunbar**	Director	February 17, 2017
/s/ DAVID A. JONES, JR. **David A. Jones, Jr.**	Director	February 17, 2017
/s/ WILLIAM J. MCDONALD **William J. McDonald**	Director	February 17, 2017
/s/ WILLIAM E. MITCHELL **William E. Mitchell**	Director	February 17, 2017
/s/ DAVID B. NASH, M.D. **David B. Nash, M.D.**	Director	February 17, 2017
/s/ JAMES J. O'BRIEN **James J. O'Brien**	Director	February 17, 2017
/s/ MARISSA T. PETERSON **Marissa T. Peterson**	Director	February 17, 2017

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Corporate Headquarters

The Humana Building | 500 West Main Street | Louisville, KY 40202 | 502.580.1000 | Humana.com

More Information About Humana Inc.

Copies of the Company's filings with the Securities and Exchange Commission may be obtained without charge via the Investor Relations page of the Company's Internet site at Humana.com or by writing:

Regina C. Nethery
Enterprise Vice President – Investor Relations
Humana Inc.
Post Office Box 1438
Louisville, Kentucky 40201-1438

Transfer Agent and Registrar

American Stock Transfer & Trust Company, LLC
Shareholder Services – ATTN: Operations Center
6201 15th Avenue
Brooklyn, New York 11219
800.937.5449
Shareholder Services Direct Dial: 718.921.8124
www.amstock.com
Email: info@amstock.com

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Introduction to Pro Forma Financial Statements

Introduction to Pro Forma Financial Statements

As requested in Section e., Financial Information, item 2., Pro Forma Financial Statements, Humana has included pro forma financial statements for Humana Medical Plan, Inc.'s Florida operation, broken down by line of business beginning with 10/31/2018. We have also provided supplemental data for 2016 and 2017 for additional context. The pro forma financial statements are prepared on an accrual basis by month for the first three (3) years.

The pro forma financial statements, which immediately follow, are tabbed separately as shown below:

		Page Numbers
1.	Assets	1-7
2.	Liabilities, Surplus and Capital	8-14
3.	Summary of Operations – Total	15-20
4.	Cash Flows	21-27
5.	Summary of Operations	28-46
6.	Assumptions	47

Humana Medical Plan, Inc.
ASSETS

	12/31/2016	12/31/2017	10/31/2018	11/30/2018	12/31/2018	1/31/2019
	Assets Actual	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection
1. Bonds						
2. Stocks:						
2.1 Preferred stocks						
2.2 Common stocks						
3. Mortgage loans on real estate						
3.1 First liens						
3.2 Other than first liens						
4. Real estate:						
4.1 Properties occupied by the company (less $0 encumbrances)						
4.2 Properties held for the production of income (less $0 encumbrances)						
4.3 Properties held for sale (less $0 encumbrances)						
5. Cash, cash equivalents and short-term investments						
6. Contract loans						
7. Derivatives						
8. Other invested assets						
9. Receivable from securities						
10. Securities lending reinvested collateral assets						
11. Aggregate write-ins for invested assets						
12. Subtotals, cash and invested assets (Lines 1 to 11)						
13. Title plants						
14. Investment income due and accrued						
15. Premiums and considerations						
15.1 Uncollected premiums and agents balances in course of collection						
15.2 Deferred premiums, agents' balances and installments booked but deferred						
15.3 Accrued retrospective premiums						
16. Reinsurance						
16.1 Amounts recoverable from reinsurers						
16.2 Funds held by or deposited with reinsured companies						
16.3 Other amounts receivable under reinsurance contracts						
17. Amounts receivable relating to uninsured plans						
18.1 Current federal and foreign income tax recoverable and interest thereon						
18.2 Net deferred tax asset						
19. Guaranty funds receivable or on deposit						
20. Electronic data processing equipment and software						
21. Furniture and equipment, including healthcare delivery assets						
22. Net adjustment in assets and liabilities due to foreign exchange rates						
23. Receivable from parent, subsidiaries and affiliates						
24. Health care and other amounts receivable						
25. Aggregate write-ins for other than invested assets						
26. Total assets excluding Separate Accounts business (Lines 12 to 25)						
27. From Separate Accounts Statement						
28. Total (Lines 26 and 27)						

Trade secret as defined in Section 812.081, Florida Statutes

Humana Medical Plan, Inc.
ASSETS

	2/28/2019	3/31/2019	4/30/2019	5/31/2019	6/30/2019	7/31/2019
	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection
1. Bonds	Trade secret as defined in Section 812.081, Florida Statutes					
2. Stocks:						
2.1 Preferred stocks						
2.2 Common stocks						
3. Mortgage loans on real estate						
3.1 First liens						
3.2 Other than first liens						
4. Real estate:						
4.1 Properties occupied by the company (less $0 encumbrances)						
4.2 Properties held for the production of income (less $0 encumbrances)						
4.3 Properties held for sale (less $0 encumbrances)						
5. Cash, cash equivalents and short-term investments						
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26. Total assets excluding Separate Accounts business (Lines 12 to 25)						
27. From Separate Accounts Statement						
28. Total (Lines 26 and 27)						

Humana Medical Plan, Inc.
ASSETS

	8/31/2019	9/30/2019	10/31/2019	11/30/2019	12/31/2019	1/31/2020
	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection
1. Bonds	Trade secret as defined in Section 812.081, Florida Statutes					
2. Stocks:						
2.1 Preferred stocks						
2.2 Common stocks						
3. Mortgage loans on real estate						
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4. Real estate:						
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28. Total (Lines 26 and 27)						

Humana Medical Plan, Inc.
ASSETS

	2/29/2020	3/31/2020	4/30/2020	5/31/2020	6/30/2020	7/31/2020
	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection
1. Bonds	Trade secret as defined in Section 812.081, Florida Statutes					
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26. Total assets excluding Separate Accounts business (Lines 12 to 25)						
27. From Separate Accounts Statement						
28. Total (Lines 26 and 27)						

Humana Medical Plan, Inc.
ASSETS

	8/31/2020	9/30/2020	10/31/2020	11/30/2020	12/31/2020	1/31/2021
	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection
1. Bonds	Trade secret as defined in Section 812.081, Florida Statutes					
2. Stocks:						
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26. Total assets excluding Separate Accounts business (Lines 12 to 25)						
27. From Separate Accounts Statement						
28. Total (Lines 26 and 27)						

Humana Medical Plan, Inc.
ASSETS

	2/28/2021	3/31/2021	4/30/2021	5/31/2021	6/30/2021	7/31/2021
	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection
1. Bonds	Trade secret as defined in Section 812.081, Florida Statutes					
2. Stocks:						
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26. Total assets excluding Separate Accounts business (Lines 12 to 25)						
27. From Separate Accounts Statement						
28. Total (Lines 26 and 27)						

Humana Medical Plan, Inc.
ASSETS

	8/31/2021	9/30/2021	10/31/2021	11/30/2021	12/31/2021
	Assets Projection	Assets Projection	Assets Projection	Assets Projection	Assets Projection
1. Bonds	Trade secret as defined in Section 812.081, Florida Statutes				
2. Stocks:					
2.1 Preferred stocks					
2.2 Common stocks					
3. Mortgage loans on real estate					
3.1 First liens					
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4.3 Properties held for sale (less $0 encumbrances)					
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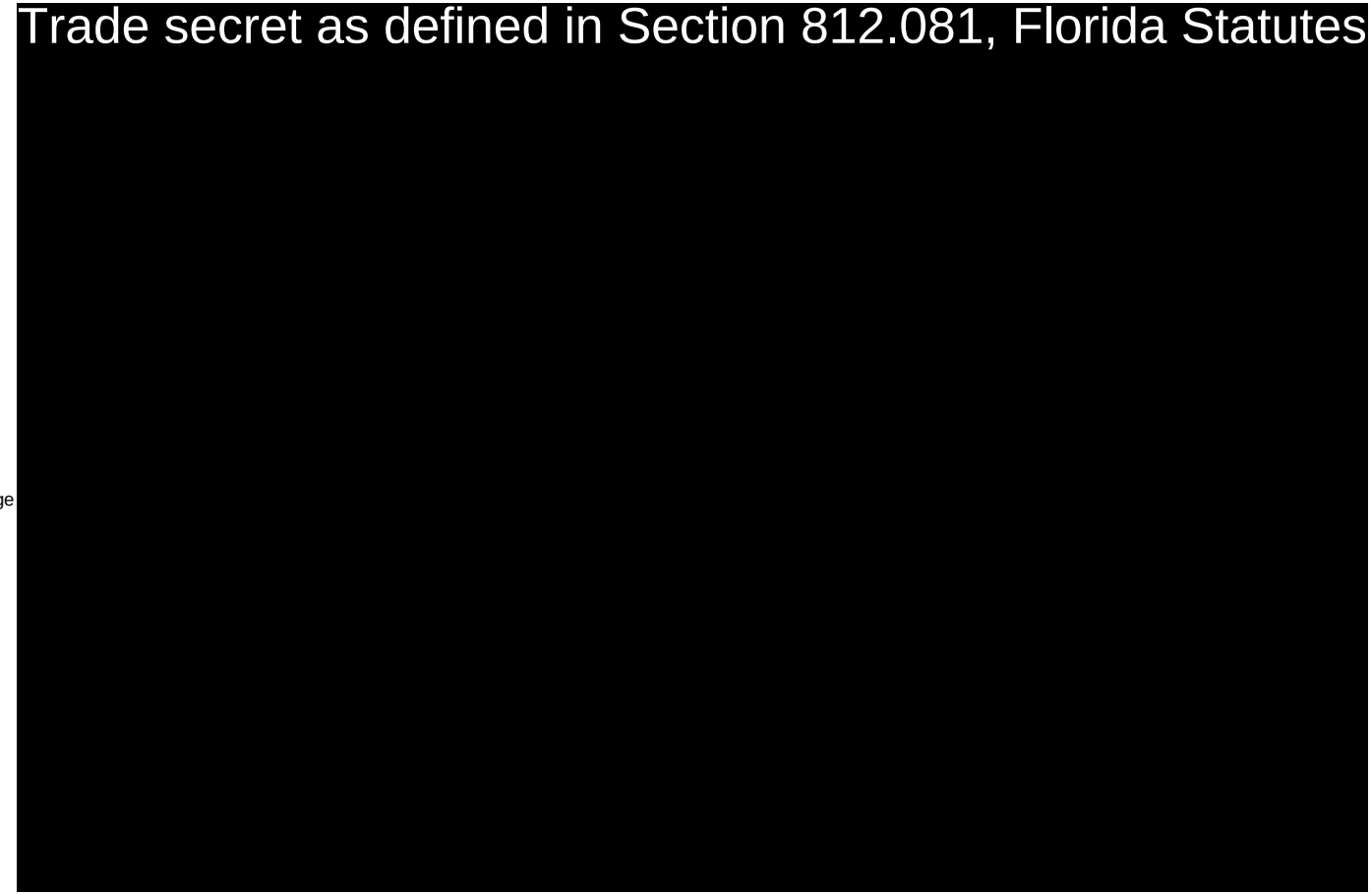
22. Net adjustment in assets and liabilities due to foreign exchange rates					
23. Receivable from parent, subsidiaries and affiliates					
24. Health care and other amounts receivable					
25. Aggregate write-ins for other than invested assets					
26. Total assets excluding Separate Accounts business (Lines 12 to 25)					
27. From Separate Accounts Statement					
28. Total (Lines 26 and 27)					

Humana Medical Plan, Inc.
LIABILITIES, CAPITAL AND SURPLUS

12/31/2016	12/31/2017	10/31/2018	11/30/2018	12/31/2018	1/31/2019
Liabilities & Surplus Actual	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection
1. Claims unpaid					
2. Accrued medical incentive pool and bonus amounts					
3. Unpaid claims adjustment expenses					
4. Aggregate health policy reserves					
5. Aggregate life policy reserves					
6. Property/casualty unearned premium reserves					
7. Aggregate health claim reserves					
8. Premiums received in advance					
9. General expenses due or accrued					
10.1 Current federal and foreign income tax payable					
10.2 Net deferred tax liability					
11. Ceded reinsurance premiums payable					
12. Amounts withheld or retained for the account of others					
13. Remittances and items not allocated					
14. Borrowed money					
15. Amounts due to parent, subsidiaries and affiliates					
16. Derivatives					
17. Payable for securities					
18. Payable for securities lending					
19. Funds held under reinsurance treaties					
20. Reinsurance in unauthorized and certified companies					
21. Net adjustments in assets and liabilities due to foreign exchange					
22. Liability for amounts held under uninsured plans					
23. Aggregate write-ins for other liabilities					
24. Total liabilities (Lines 1 to 23)					
25. Aggregate write-ins for special surplus funds					
26. Common capital stock					
27. Preferred capital stock					
28. Gross paid in and contributed surplus					
29. Surplus notes					
30. Aggregate write-ins for other than special surplus funds					
31. Unassigned funds (surplus)					
32. Less treasury stock, at cost:					
(1) 0 shares common (value included in Line 26 $0)					
(2) 0 shares preferred (value included in Line 27 $0)					
33. Total capital and surplus (Lines 25 to 31 minus Line 32)					
34. Total liabilities, capital and surplus (Lines 24 and 33)					



Humana Medical Plan, Inc.
LIABILITIES, CAPITAL AND SURPLUS

2/28/2019	3/31/2019	4/30/2019	5/31/2019	6/30/2019	7/31/2019
Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection

1. Claims unpaid
2. Accrued medical incentive pool and bonus amounts
3. Unpaid claims adjustment expenses
4. Aggregate health policy reserves
5. Aggregate life policy reserves
6. Property/casualty unearned premium reserves
7. Aggregate health claim reserves
8. Premiums received in advance
9. General expenses due or accrued
10.1 Current federal and foreign income tax payable
10.2 Net deferred tax liability
11. Ceded reinsurance premiums payable
12. Amounts withheld or retained for the account of others
13. Remittances and items not allocated
14. Borrowed money
15. Amounts due to parent, subsidiaries and affiliates
16. Derivatives
17. Payable for securities
18. Payable for securities lending
19. Funds held under reinsurance treaties
20. Reinsurance in unauthorized and certified companies
21. Net adjustments in assets and liabilities due to foreign exchange rat
22. Liability for amounts held under uninsured plans
23. Aggregate write-ins for other liabilities
24. Total liabilities (Lines 1 to 23)
25. Aggregate write-ins for special surplus funds
26. Common capital stock
27. Preferred capital stock
28. Gross paid in and contributed surplus
29. Surplus notes
30. Aggregate write-ins for other than special surplus funds
31. Unassigned funds (surplus)
32. Less treasury stock, at cost:
    (1) 0 shares common (value included in Line 26 $0)
    (2) 0 shares preferred (value included in Line 27 $0)
33. Total capital and surplus (Lines 25 to 31 minus Line 32)
34. Total liabilities, capital and surplus (Lines 24 and 33)

Trade secret as defined in Section 812.081, Florida Statutes

Humana Medical Plan, Inc.
LIABILITIES, CAPITAL AND SURPLUS

8/31/2019	9/30/2019	10/31/2019	11/30/2019	12/31/2019	1/31/2020
Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection

1. Claims unpaid
2. Accrued medical incentive pool and bonus amounts
3. Unpaid claims adjustment expenses
4. Aggregate health policy reserves
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Trade secret as defined in Section 812.081, Florida Statutes

Humana Medical Plan, Inc.
LIABILITIES, CAPITAL AND SURPLUS

2/29/2020	3/31/2020	4/30/2020	5/31/2020	6/30/2020	7/31/2020
Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection

1. Claims unpaid
2. Accrued medical incentive pool and bonus amounts
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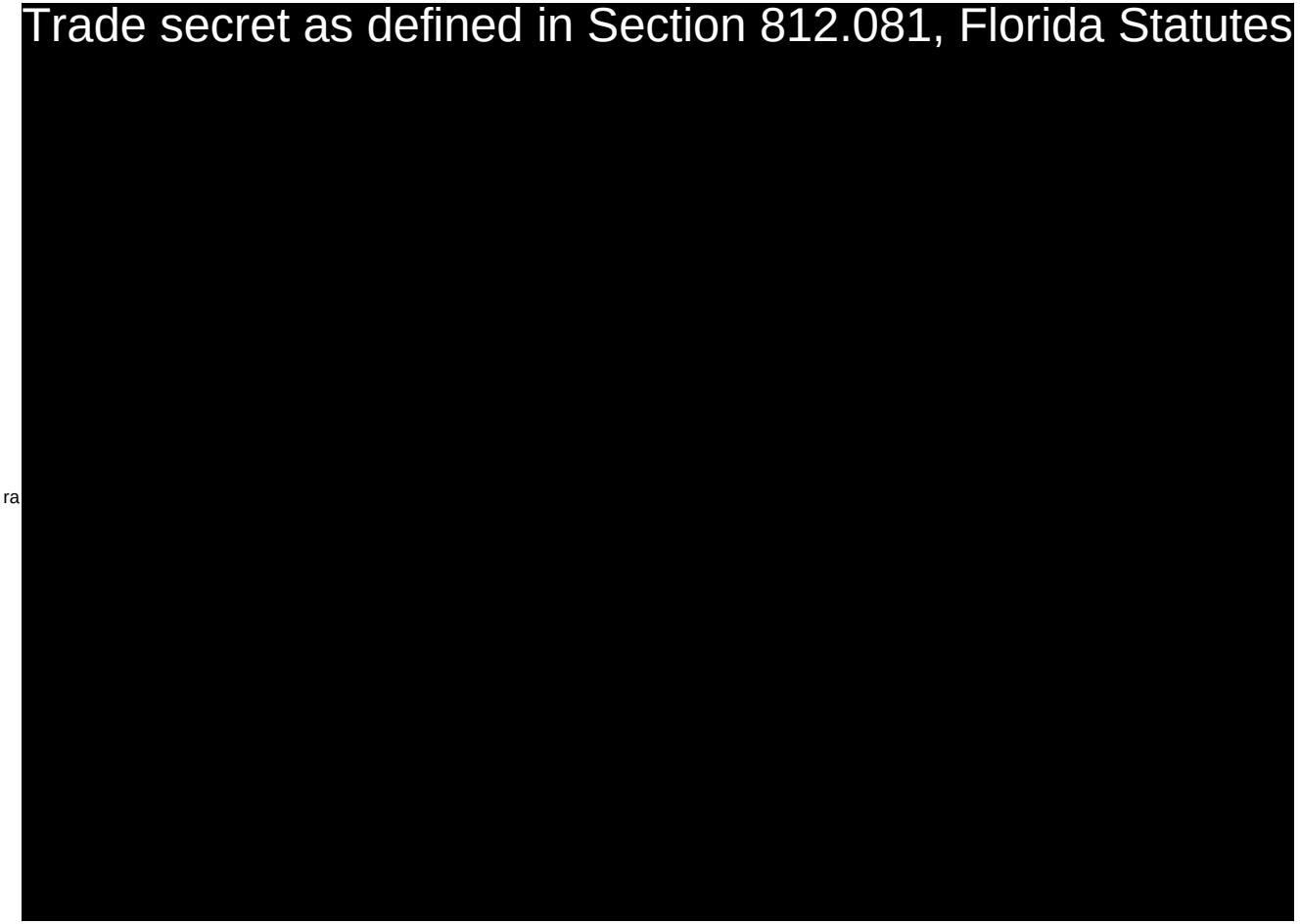

Humana Medical Plan, Inc.
LIABILITIES, CAPITAL AND SURPLUS

8/31/2020	9/30/2020	10/31/2020	11/30/2020	12/31/2020	1/31/2021
Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection

1. Claims unpaid
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10.1 Current federal and foreign income tax payable
10.2 Net deferred tax liability
11. Ceded reinsurance premiums payable
12. Amounts withheld or retained for the account of others
13. Remittances and items not allocated
14. Borrowed money
15. Amounts due to parent, subsidiaries and affiliates
16. Derivatives
17. Payable for securities
18. Payable for securities lending
19. Funds held under reinsurance treaties
20. Reinsurance in unauthorized and certified companies
21. Net adjustments in assets and liabilities due to foreign exchange r
22. Liability for amounts held under uninsured plans
23. Aggregate write-ins for other liabilities
24. Total liabilities (Lines 1 to 23)
25. Aggregate write-ins for special surplus funds
26. Common capital stock
27. Preferred capital stock
28. Gross paid in and contributed surplus
29. Surplus notes
30. Aggregate write-ins for other than special surplus funds
31. Unassigned funds (surplus)
32. Less treasury stock, at cost:
    (1) 0 shares common (value included in Line 26 $0)
    (2) 0 shares preferred (value included in Line 27 $0)
33. Total capital and surplus (Lines 25 to 31 minus Line 32)
34. Total liabilities, capital and surplus (Lines 24 and 33)

Trade secret as defined in Section 812.081, Florida Statutes

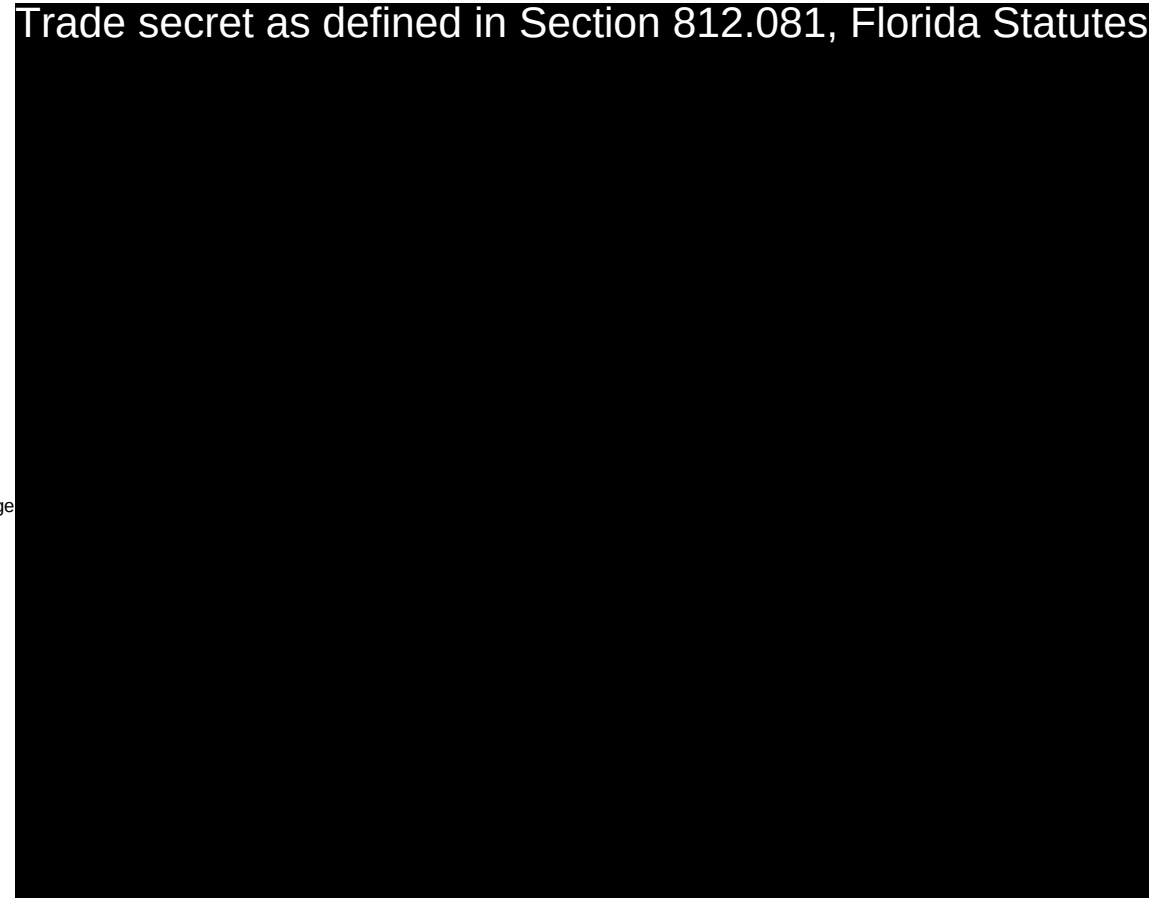
Humana Medical Plan, Inc.
LIABILITIES, CAPITAL AND SURPLUS

	2/28/2021	3/31/2021	4/30/2021	5/31/2021	6/30/2021	7/31/2021
	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection
1. Claims unpaid	Trade secret as defined in Section 812.081, Florida Statutes					
2. Accrued medical incentive pool and bonus amounts						
3. Unpaid claims adjustment expenses						
4. Aggregate health policy reserves						
5. Aggregate life policy reserves						
6. Property/casualty unearned premium reserves						
7. Aggregate health claim reserves						
8. Premiums received in advance						
9. General expenses due or accrued						
10.1 Current federal and foreign income tax payable						
10.2 Net deferred tax liability						
11. Ceded reinsurance premiums payable						
12. Amounts withheld or retained for the account of others						
13. Remittances and items not allocated						
14. Borrowed money						
15. Amounts due to parent, subsidiaries and affiliates						
16. Derivatives						
17. Payable for securities						
18. Payable for securities lending						
19. Funds held under reinsurance treaties						
20. Reinsurance in unauthorized and certified companies						
21. Net adjustments in assets and liabilities due to foreign exchange rat						
22. Liability for amounts held under uninsured plans						
23. Aggregate write-ins for other liabilities						
24. Total liabilities (Lines 1 to 23)						
25. Aggregate write-ins for special surplus funds						
26. Common capital stock						
27. Preferred capital stock						
28. Gross paid in and contributed surplus						
29. Surplus notes						
30. Aggregate write-ins for other than special surplus funds						
31. Unassigned funds (surplus)						
32. Less treasury stock, at cost:						
(1) 0 shares common (value included in Line 26 $0)						
(2) 0 shares preferred (value included in Line 27 $0)						
33. Total capital and surplus (Lines 25 to 31 minus Line 32)						
34. Total liabilities, capital and surplus (Lines 24 and 33)						

Humana Medical Plan, Inc.
LIABILITIES, CAPITAL AND SURPLUS

8/31/2021	9/30/2021	10/31/2021	11/30/2021	12/31/2021
Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection	Liabilities & Surplus Projection

1. Claims unpaid
2. Accrued medical incentive pool and bonus amounts
3. Unpaid claims adjustment expenses
4. Aggregate health policy reserves
5. Aggregate life policy reserves
6. Property/casualty unearned premium reserves
7. Aggregate health claim reserves
8. Premiums received in advance
9. General expenses due or accrued
10.1 Current federal and foreign income tax payable
10.2 Net deferred tax liability
11. Ceded reinsurance premiums payable
12. Amounts withheld or retained for the account of others
13. Remittances and items not allocated
14. Borrowed money
15. Amounts due to parent, subsidiaries and affiliates
16. Derivatives
17. Payable for securities
18. Payable for securities lending
19. Funds held under reinsurance treaties
20. Reinsurance in unauthorized and certified companies
21. Net adjustments in assets and liabilities due to foreign exchange
22. Liability for amounts held under uninsured plans
23. Aggregate write-ins for other liabilities
24. Total liabilities (Lines 1 to 23)
25. Aggregate write-ins for special surplus funds
26. Common capital stock
27. Preferred capital stock
28. Gross paid in and contributed surplus
29. Surplus notes
30. Aggregate write-ins for other than special surplus funds
31. Unassigned funds (surplus)
32. Less treasury stock, at cost:
    (1) 0 shares common (value included in Line 26 $0)
    (2) 0 shares preferred (value included in Line 27 $0)
33. Total capital and surplus (Lines 25 to 31 minus Line 32)
34. Total liabilities, capital and surplus (Lines 24 and 33)



Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS-TOTAL

Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date
12/31/2016	12/31/2017	10/31/2018	11/30/2018	12/31/2018	1/31/2019
Actual	Projection	Projection	Projection	Projection	Projection

Trade secret as defined in Section 812.081, Florida Statutes

2. Net premium income
3. Change in unearned premium reserves and reserve for rate credits
4. Fee-for-service
5. Risk revenue
6. Aggregate write-ins for other health care related revenues
7. Aggregate write-ins for other non-health revenues
8. Total revenues (Lines 2 to 7)
9. Hospital/medical benefits
10. Other professional services
11. Outside referrals
12. Emergency room and out-of-area
13. Prescription drugs
14. Aggregate write-ins for other hospital and medical
15. Incentive pool, withhold adjustments and bonus amounts
16. Subtotal (Lines 9 to 15)
17. Net reinsurance recoveries
18. Total hospital and medical (Lines 16 minus 17)
19. Non-health claims
20. Claims adjustment expenses
21. General administrative expenses
22. Increase in reserves for life and accident and health contracts
23. Total underwriting deductions (Lines 18 through 22)
24. Net underwriting gain or (loss) (Lines 8 minus 23)
25. Net investment income earned
26. Net realized capital gains or (losses)
27. Net investment gains or (losses) (Lines 25 plus 26)
28. Net gain or (loss) from agents' or premium balances charged off
29. Aggregate write-ins for other income or expenses
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24+27+28+29)
31. Federal and foreign income taxes incurred
32. Net income (loss) (Line 30 minus Line 31)

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Membershi
Member Month
PMPM (Premiums
PMPM (Medical Cost
PMPM (Admin Cost

CAPITAL AND SURPLUS ACCOUNT

33. Capital and surplus, December 31, prior year
34. Net income (Line 32)
35. Change in valuation basis of aggregate policy and claim reserves
36. Change in net unrealized capital gains or (losses)
37. Change in net unrealized foreign exchange capital gain (loss)
38. Change in net deferred income tax
39. Change in nonadmitted assets
46. Dividends to stockholders
47. Aggregate write-ins for gains and (losses) in surplus
48. Net change in capital and surplus for the year (Lines 34 through 47)
49. Capital and surplus, as of statement date (lines 33 + 48)

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS-TOTAL

	Year-to-Date 2/28/2019 Projection	Year-to-Date 3/31/2019 Projection	Year-to-Date 4/30/2019 Projection	Year-to-Date 5/31/2019 Projection	Year-to-Date 6/30/2019 Projection	Year-to-Date 7/31/2019 Projection	Year-to-Date 8/31/2019 Projection
2. Net premium income	Trade secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate cre							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
18. Total hospital and medical (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for life and accident and health contracts							
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
25. Net investment income earned							
26. Net realized capital gains or (losses)							
27. Net investment gains or (losses) (Lines 25 plus 26)							
28. Net gain or (loss) from agents' or premium balances charged of							
29. Aggregate write-ins for other income or expenses							
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24+27+28+29)							
31. Federal and foreign income taxes incurred							
32. Net income (loss) (Line 30 minus Line 31)							
Admin							
Member							
Member Mo							
PMPM (Premi							
PMPM (Medical							
PMPM (Admin							
CAPITAL AND SURPLUS ACCOUNT							
33. Capital and surplus, December 31, prior year							
34. Net income (Line 32)							
35. Change in valuation basis of aggregate policy and claim reserve							
36. Change in net unrealized capital gains or (losses)							
37. Change in net unrealized foreign exchange capital gain (loss)							
38. Change in net deferred income tax							
39. Change in nonadmitted assets							
46. Dividends to stockholders							
47. Aggregate write-ins for gains and (losses) in surplus							
48. Net change in capital and surplus for the year (Lines 34 through							
49. Capital and surplus, as of statement date (lines 33 + 48)							

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS-TOTAL

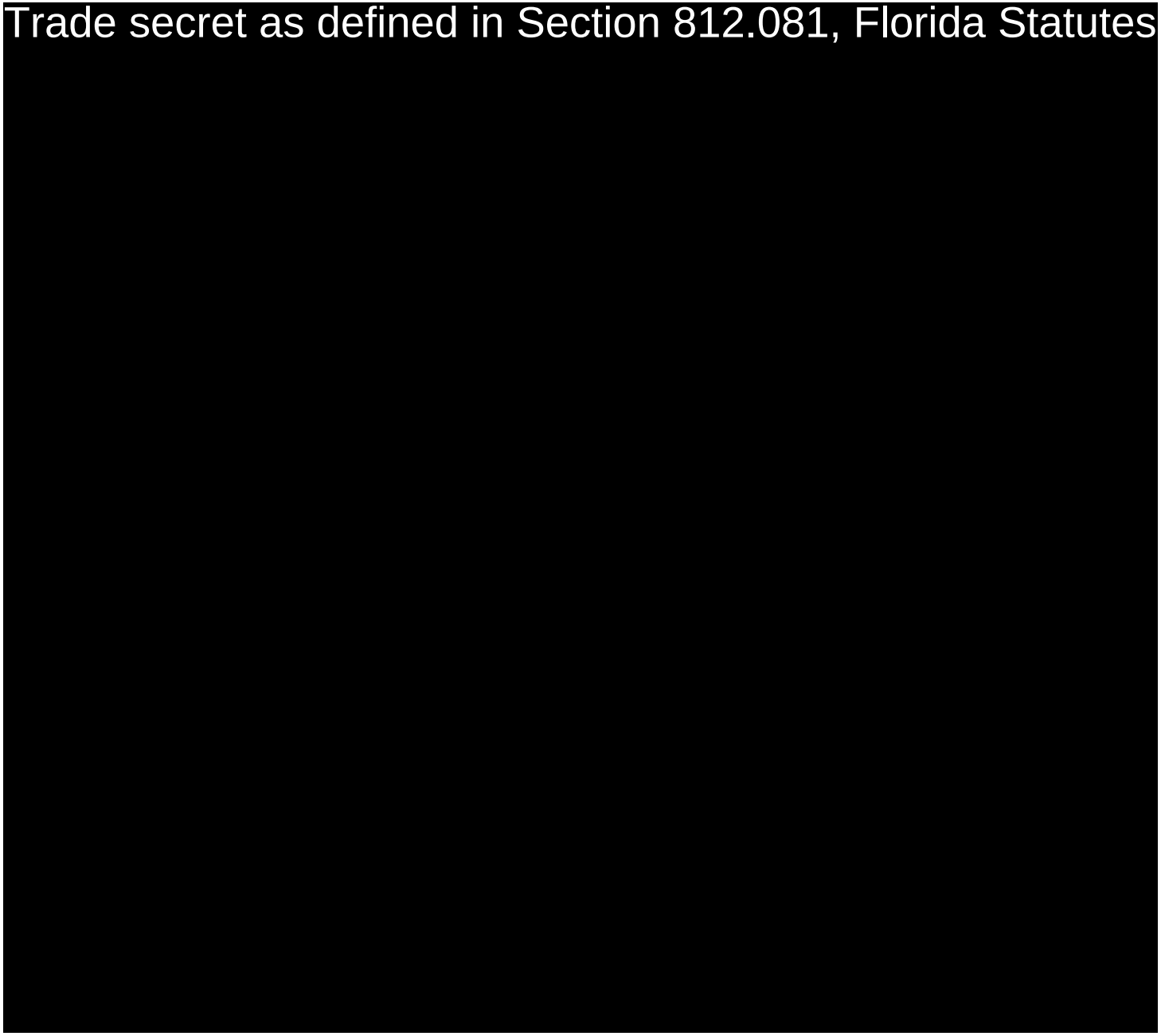
	Year-to-Date 9/30/2019 Projection	Year-to-Date 10/31/2019 Projection	Year-to-Date 11/30/2019 Projection	Year-to-Date 12/31/2019 Projection	Year-to-Date 1/31/2020 Projection	Year-to-Date 2/29/2020 Projection	Year-to-Date 3/31/2020 Projection
2. Net premium income	Trade secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate credi							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
18. Total hospital and medical (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for life and accident and health contracts							
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
25. Net investment income earned							
26. Net realized capital gains or (losses)							
27. Net investment gains or (losses) (Lines 25 plus 26)							
28. Net gain or (loss) from agents' or premium balances charged off							
29. Aggregate write-ins for other income or expenses							
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24+27+28+29)							
31. Federal and foreign income taxes incurred							
32. Net income (loss) (Line 30 minus Line 31)							
Admin R							
Members							
Member Mon							
PMPM (Premiu							
PMPM (Medical C							
PMPM (Admin C							
CAPITAL AND SURPLUS ACCOUNT							
33. Capital and surplus, December 31, prior year							
34. Net income (Line 32)							
35. Change in valuation basis of aggregate policy and claim reserves							
36. Change in net unrealized capital gains or (losses)							
37. Change in net unrealized foreign exchange capital gain (loss)							
38. Change in net deferred income tax							
39. Change in nonadmitted assets							
46. Dividends to stockholders							
47. Aggregate write-ins for gains and (losses) in surplus							
48. Net change in capital and surplus for the year (Lines 34 through							
49. Capital and surplus, as of statement date (lines 33 + 48)							

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS-TOTAL

	Year-to-Date 4/30/2020 Projection	Year-to-Date 5/31/2020 Projection	Year-to-Date 6/30/2020 Projection	Year-to-Date 7/31/2020 Projection	Year-to-Date 8/31/2020 Projection	Year-to-Date 9/30/2020 Projection	Year-to-Date 10/31/2020 Projection
2. Net premium income	Trade secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate c							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
18. Total hospital and medical (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for life and accident and health contract							
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
25. Net investment income earned							
26. Net realized capital gains or (losses)							
27. Net investment gains or (losses) (Lines 25 plus 26)							
28. Net gain or (loss) from agents' or premium balances charged							
29. Aggregate write-ins for other income or expenses							
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24+27+28+29)							
31. Federal and foreign income taxes incurred							
32. Net income (loss) (Line 30 minus Line 31)							
Adm							
Mem							
Member							
PMPM (Pre							
PMPM (Medic							
PMPM (Admi							
CAPITAL AND SURPLUS ACCOUNT							
33. Capital and surplus, December 31, prior year							
34. Net income (Line 32)							
35. Change in valuation basis of aggregate policy and claim rese							
36. Change in net unrealized capital gains or (losses)							
37. Change in net unrealized foreign exchange capital gain (loss)							
38. Change in net deferred income tax							
39. Change in nonadmitted assets							
46. Dividends to stockholders							
47. Aggregate write-ins for gains and (losses) in surplus							
48. Net change in capital and surplus for the year (Lines 34 throu							
49. Capital and surplus, as of statement date (lines 33 + 48)							

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS-TOTAL

Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date
11/30/2020	12/31/2020	1/31/2021	2/28/2021	3/31/2021	4/30/2021	5/31/2021
Projection	Projection	Projection	Projection	Projection	Projection	Projection



2. Net premium income
3. Change in unearned premium reserves and reserve for rate cr
4. Fee-for-service
5. Risk revenue
6. Aggregate write-ins for other health care related revenues
7. Aggregate write-ins for other non-health revenues
8. Total revenues (Lines 2 to 7)
9. Hospital/medical benefits
10. Other professional services
11. Outside referrals
12. Emergency room and out-of-area
13. Prescription drugs
14. Aggregate write-ins for other hospital and medical
15. Incentive pool, withhold adjustments and bonus amounts
16. Subtotal (Lines 9 to 15)
17. Net reinsurance recoveries
18. Total hospital and medical (Lines 16 minus 17)
19. Non-health claims
20. Claims adjustment expenses
21. General administrative expenses
22. Increase in reserves for life and accident and health contracts
23. Total underwriting deductions (Lines 18 through 22)
24. Net underwriting gain or (loss) (Lines 8 minus 23)
25. Net investment income earned
26. Net realized capital gains or (losses)
27. Net investment gains or (losses) (Lines 25 plus 26)
28. Net gain or (loss) from agents' or premium balances charged
29. Aggregate write-ins for other income or expenses
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24+27+28+29)
31. Federal and foreign income taxes incurred
32. Net income (loss) (Line 30 minus Line 31)

Admin
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Member M
PMPM (Prem
PMPM (Medical
PMPM (Admin

CAPITAL AND SURPLUS ACCOUNT

33. Capital and surplus, December 31, prior year
34. Net income (Line 32)
35. Change in valuation basis of aggregate policy and claim reserv
36. Change in net unrealized capital gains or (losses)
37. Change in net unrealized foreign exchange capital gain (loss)
38. Change in net deferred income tax
39. Change in nonadmitted assets
46. Dividends to stockholders
47. Aggregate write-ins for gains and (losses) in surplus
48. Net change in capital and surplus for the year (Lines 34 throug
49. Capital and surplus, as of statement date (lines 33 + 48)

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS-TOTAL

	Year-to-Date 6/30/2021	Year-to-Date 7/31/2021	Year-to-Date 8/31/2021	Year-to-Date 9/30/2021	Year-to-Date 10/31/2021	Year-to-Date 11/30/2021	Year-to-Date 12/31/2021
2. Net premium income	Trade secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate cr							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
18. Total hospital and medical (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for life and accident and health contracts							
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
25. Net investment income earned							
26. Net realized capital gains or (losses)							
27. Net investment gains or (losses) (Lines 25 plus 26)							
28. Net gain or (loss) from agents' or premium balances charged							
29. Aggregate write-ins for other income or expenses							
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24+27+28+29)							
31. Federal and foreign income taxes incurred							
32. Net income (loss) (Line 30 minus Line 31)							
Admin							
Memb							
Member M							
PMPM (Prem							
PMPM (Medical							
PMPM (Admin							
CAPITAL AND SURPLUS ACCOUNT							
33. Capital and surplus, December 31, prior year							
34. Net income (Line 32)							
35. Change in valuation basis of aggregate policy and claim reserv							
36. Change in net unrealized capital gains or (losses)							
37. Change in net unrealized foreign exchange capital gain (loss)							
38. Change in net deferred income tax							
39. Change in nonadmitted assets							
46. Dividends to stockholders							
47. Aggregate write-ins for gains and (losses) in surplus							
48. Net change in capital and surplus for the year (Lines 34 throug							
49. Capital and surplus, as of statement date (lines 33 + 48)							

Humana Medical Plan, Inc.
CASH FLOWS

12/31/2016	12/31/2017	10/31/2018	11/30/2018	12/31/2018	1/31/2019
Cash Flow Actual	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection

Trade Secret as defined in Section 812.081, Florida Statutes

CASH FROM OPERATIONS

LINE 1 - Premiums collected net of reinsurance
LINE 2 - Net investment income
LINE 3 - Miscellaneous income
TOTAL (Lines 1 through 3)

LINE 5 - Benefits and loss related payments
LINE 6 - Net transfers to or (from) Separate Account
LINE 7 - Commissions, expenses paid and aggregate write-ins for deductions
LINE 8 - Dividends paid to policyholders
LINE 9 - Federal and foreign income taxes paid
TOTAL (Lines 5 through 9)

Net cash from operations (Line 4 minus Line 10)

CASH FROM INVESTMENTS

LINE 12 - Proceeds from investments sold, matured or repaid
LINE 12.1 - Bonds
LINE 12.2 - Stocks
LINE 12.3 - Mortgage loans
LINE 12.4 - Real estate
LINE 12.5 - Other invested assets
LINE 12.6 - Net gains or (losses) on cash, cash equivalents and short-term investments
LINE 12.7 - Miscellaneous proceeds

LINE 12.8 - Total investment proceeds (Lines 12.1 to 12.7)

LINE 13 - Cost of investments acquired (long-term only)
LINE 13.1 - Bonds
LINE 13.2 - Stocks
LINE 13.3 - Mortgage loans
LINE 13.4 - Real estate
LINE 13.5 - Other invested assets
LINE 13.6 - Miscellaneous applications

LINE 13.7 - Total investments acquired (lines 13.1 to 13.6)

Net increase (decrease) in contract loans and premium notes

Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)

CASH FROM FINANCING & MISCELLANEOUS SOURCES

LINE 16 - Cash provided (applied)
LINE 16.1 - Surplus notes, capital notes
LINE 16.2 - Capital and paid in surplus, less treasury stock
LINE 16.3 - Borrowed funds
LINE 16.4 - Net deposits on deposit-type contracts and other insurance liabilities
LINE 16.5 - Dividends to stockholders
LINE 16.6 - Other cash provided (applied)

Net cash from financing and miscellaneous sources
(Line 16.1 through Line 16.4 minus Line 16.5)

RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENT

LINE 18 - Net change in cash, cash equivalents and short-term investments
LINE 19 - Cash, cash equivalents and short-term investments
LINE 19.1 - Beginning of period

LINE 19.2 - End of period (Line 18 plus Line 19.1)

Humana Medical Plan, Inc.
CASH FLOWS

2/28/2019	3/31/2019	4/30/2019	5/31/2019	6/30/2019	7/31/2019
Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection

CASH FROM OPERATIONS

LINE 1 - Premiums collected net of reinsurance
LINE 2 - Net investment income
LINE 3 - Miscellaneous income
TOTAL (Lines 1 through 3)

LINE 5 - Benefits and loss related payments
LINE 6 - Net transfers to or (from) Separate Account
LINE 7 - Commissions, expenses paid and aggregate write-ins for deductions
LINE 8 - Dividends paid to policyholders
LINE 9 - Federal and foreign income taxes paid
TOTAL (Lines 5 through 9)

Net cash from operations (Line 4 minus Line 10)

CASH FROM INVESTMENTS

LINE 12 - Proceeds from investments sold, matured or repaid
LINE 12.1 - Bonds
LINE 12.2 - Stocks
LINE 12.3 - Mortgage loans
LINE 12.4 - Real estate
LINE 12.5 - Other invested assets
LINE 12.6 - Net gains or (losses) on cash, cash equivalents and short-term investments
LINE 12.7 - Miscellaneous proceeds

LINE 12.8 - Total investment proceeds (Lines 12.1 to 12.7)

LINE 13 - Cost of investments acquired (long-term only)
LINE 13.1 - Bonds
LINE 13.2 - Stocks
LINE 13.3 - Mortgage loans
LINE 13.4 - Real estate
LINE 13.5 - Other invested assets
LINE 13.6 - Miscellaneous applications

LINE 13.7 - Total investments acquired (lines 13.1 to 13.6)

Net increase (decrease) in contract loans and premium notes

Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)

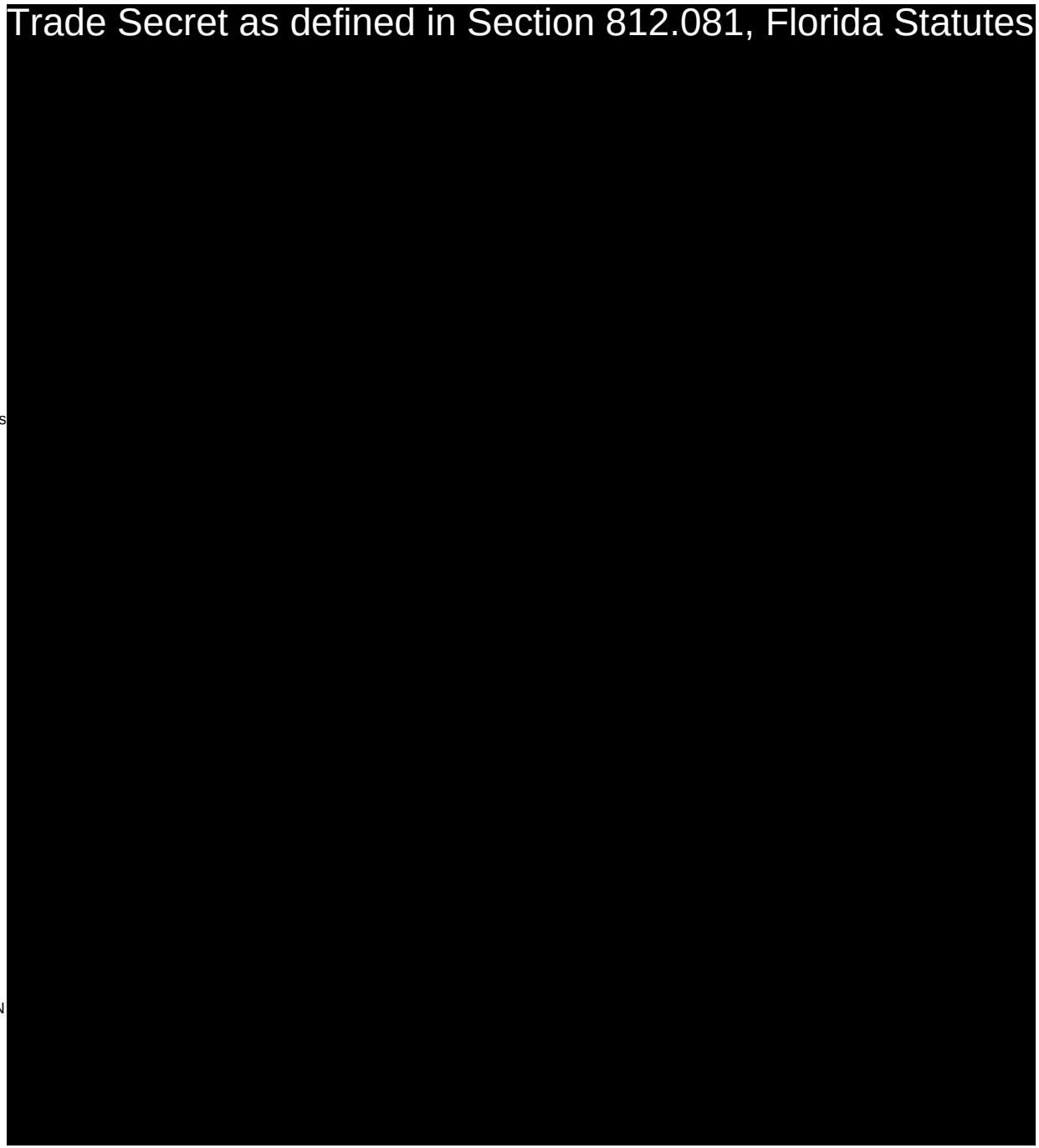
CASH FROM FINANCING & MISCELLANEOUS SOURCES

LINE 16 - Cash provided (applied)
LINE 16.1 - Surplus notes, capital notes
LINE 16.2 - Capital and paid in surplus, less treasury stock
LINE 16.3 - Borrowed funds
LINE 16.4 - Net deposits on deposit-type contracts and other insurance liabilities
LINE 16.5 - Dividends to stockholders
LINE 16.6 - Other cash provided (applied)

Net cash from financing and miscellaneous sources
(Line 16.1 through Line 16.4 minus Line 16.5)

RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMEN
LINE 18 - Net change in cash, cash equivalents and short-term investments
LINE 19 - Cash, cash equivalents and short-term investments
LINE 19.1 - Beginning of period

LINE 19.2 - End of period (Line 18 plus Line 19.1)



Humana Medical Plan, Inc.
CASH FLOWS

8/31/2019	9/30/2019	10/31/2019	11/30/2019	12/31/2019	1/31/2020
Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection

CASH FROM OPERATIONS

LINE 1 - Premiums collected net of reinsurance
LINE 2 - Net investment income
LINE 3 - Miscellaneous income
TOTAL (Lines 1 through 3)

LINE 5 - Benefits and loss related payments
LINE 6 - Net transfers to or (from) Separate Account
LINE 7 - Commissions, expenses paid and aggregate write-ins for deductions
LINE 8 - Dividends paid to policyholders
LINE 9 - Federal and foreign income taxes paid
TOTAL (Lines 5 through 9)

Net cash from operations (Line 4 minus Line 10)

CASH FROM INVESTMENTS

LINE 12 - Proceeds from investments sold, matured or repaid
LINE 12.1 - Bonds
LINE 12.2 - Stocks
LINE 12.3 - Mortgage loans
LINE 12.4 - Real estate
LINE 12.5 - Other invested assets
LINE 12.6 - Net gains or (losses) on cash, cash equivalents and short-term investments
LINE 12.7 - Miscellaneous proceeds

LINE 12.8 - Total investment proceeds (Lines 12.1 to 12.7)

LINE 13 - Cost of investments acquired (long-term only)
LINE 13.1 - Bonds
LINE 13.2 - Stocks
LINE 13.3 - Mortgage loans
LINE 13.4 - Real estate
LINE 13.5 - Other invested assets
LINE 13.6 - Miscellaneous applications

LINE 13.7 - Total investments acquired (lines 13.1 to 13.6)

Net increase (decrease) in contract loans and premium notes

Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)

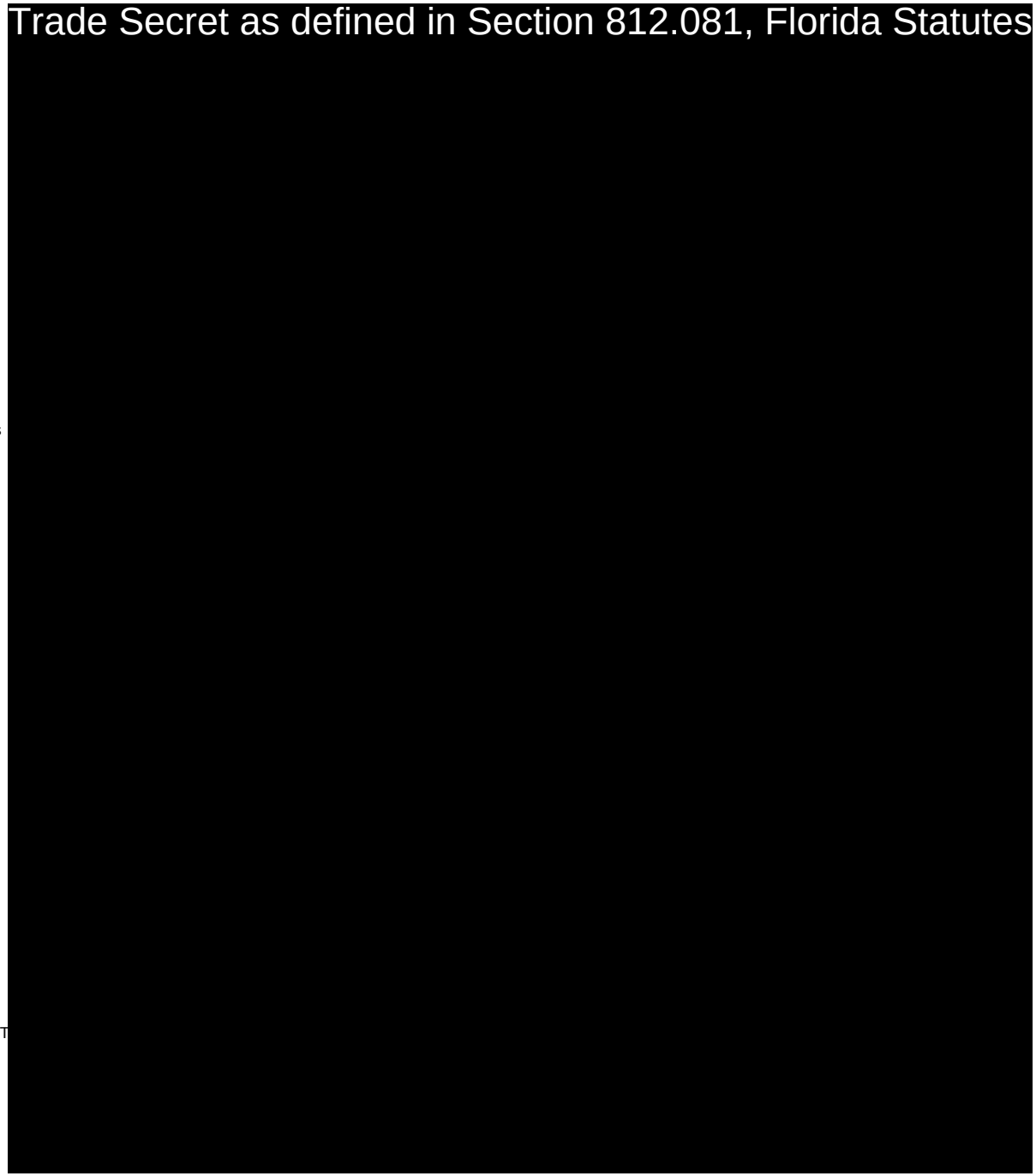
CASH FROM FINANCING & MISCELLANEOUS SOURCES

LINE 16 - Cash provided (applied)
LINE 16.1 - Surplus notes, capital notes
LINE 16.2 - Capital and paid in surplus, less treasury stock
LINE 16.3 - Borrowed funds
LINE 16.4 - Net deposits on deposit-type contracts and other insurance liabilities
LINE 16.5 - Dividends to stockholders
LINE 16.6 - Other cash provided (applied)

Net cash from financing and miscellaneous sources
(Line 16.1 through Line 16.4 minus Line 16.5)

RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENT
LINE 18 - Net change in cash, cash equivalents and short-term investments
LINE 19 - Cash, cash equivalents and short-term investments
LINE 19.1 - Beginning of period

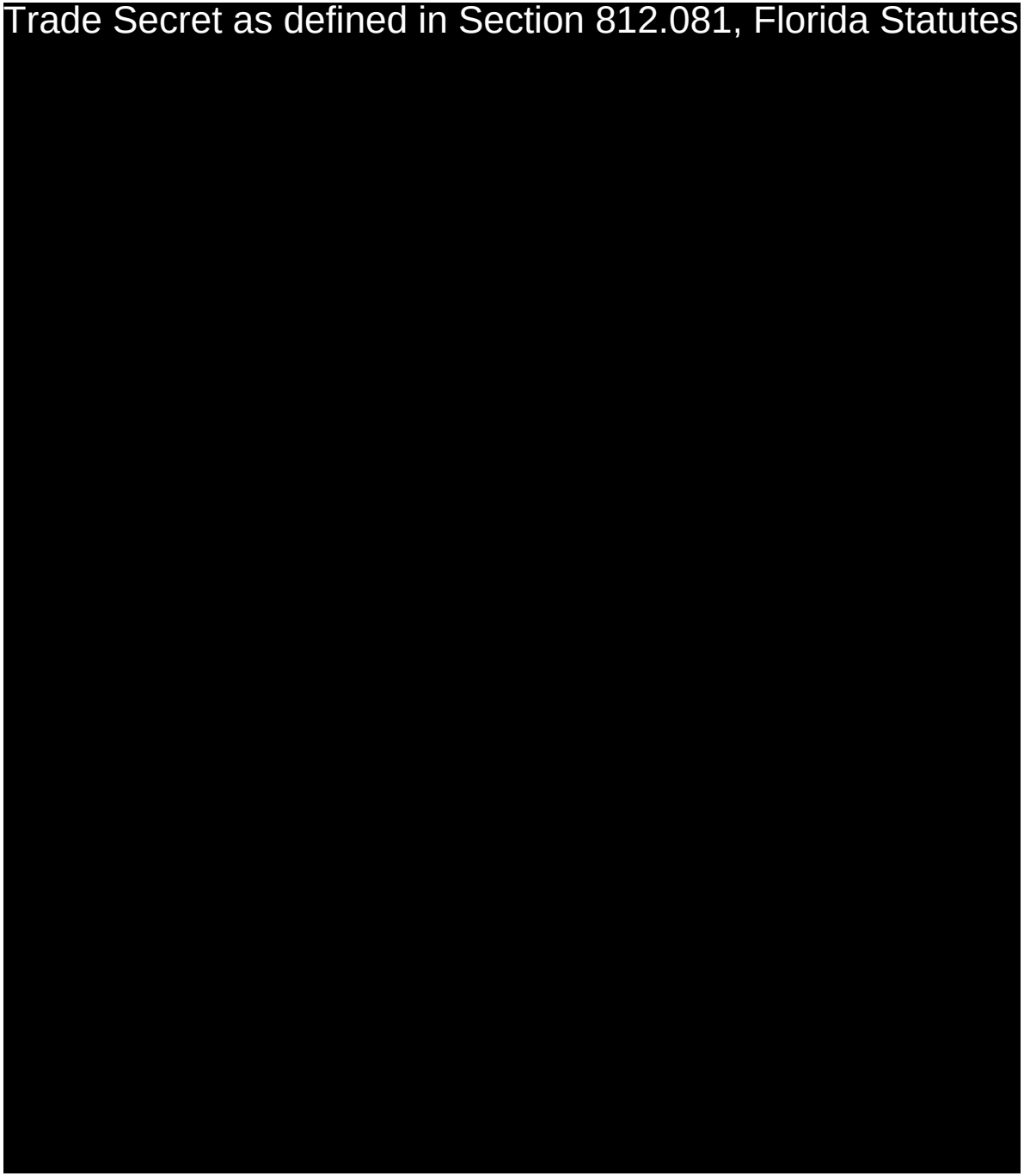
LINE 19.2 - End of period (Line 18 plus Line 19.1)



Humana Medical Plan, Inc.
CASH FLOWS

2/29/2020	3/31/2020	4/30/2020	5/31/2020	6/30/2020	7/31/2020
Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection

Trade Secret as defined in Section 812.081, Florida Statutes



CASH FROM OPERATIONS

LINE 1 - Premiums collected net of reinsurance
LINE 2 - Net investment income
LINE 3 - Miscellaneous income
TOTAL (Lines 1 through 3)

LINE 5 - Benefits and loss related payments
LINE 6 - Net transfers to or (from) Separate Account
LINE 7 - Commissions, expenses paid and aggregate write-ins for deductions
LINE 8 - Dividends paid to policyholders
LINE 9 - Federal and foreign income taxes paid
TOTAL (Lines 5 through 9)

Net cash from operations (Line 4 minus Line 10)

CASH FROM INVESTMENTS

LINE 12 - Proceeds from investments sold, matured or repaid
LINE 12.1 - Bonds
LINE 12.2 - Stocks
LINE 12.3 - Mortgage loans
LINE 12.4 - Real estate
LINE 12.5 - Other invested assets
LINE 12.6 - Net gains or (losses) on cash, cash equivalents and short-term investments
LINE 12.7 - Miscellaneous proceeds

LINE 12.8 - Total investment proceeds (Lines 12.1 to 12.7)

LINE 13 - Cost of investments acquired (long-term only)
LINE 13.1 - Bonds
LINE 13.2 - Stocks
LINE 13.3 - Mortgage loans
LINE 13.4 - Real estate
LINE 13.5 - Other invested assets
LINE 13.6 - Miscellaneous applications

LINE 13.7 - Total investments acquired (lines 13.1 to 13.6)

Net increase (decrease) in contract loans and premium notes

Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)

CASH FROM FINANCING & MISCELLANEOUS SOURCES

LINE 16 - Cash provided (applied)
LINE 16.1 - Surplus notes, capital notes
LINE 16.2 - Capital and paid in surplus, less treasury stock
LINE 16.3 - Borrowed funds
LINE 16.4 - Net deposits on deposit-type contracts and other insurance liabilities
LINE 16.5 - Dividends to stockholders
LINE 16.6 - Other cash provided (applied)

Net cash from financing and miscellaneous sources
(Line 16.1 through Line 16.4 minus Line 16.5)

RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENT

LINE 18 - Net change in cash, cash equivalents and short-term investments
LINE 19 - Cash, cash equivalents and short-term investments
LINE 19.1 - Beginning of period

LINE 19.2 - End of period (Line 18 plus Line 19.1)

Humana Medical Plan, Inc.
CASH FLOWS

8/31/2020	9/30/2020	10/31/2020	11/30/2020	12/31/2020	1/31/2021
Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection

CASH FROM OPERATIONS

LINE 1 - Premiums collected net of reinsurance
LINE 2 - Net investment income
LINE 3 - Miscellaneous income
TOTAL (Lines 1 through 3)

LINE 5 - Benefits and loss related payments
LINE 6 - Net transfers to or (from) Separate Account
LINE 7 - Commissions, expenses paid and aggregate write-ins for deductions
LINE 8 - Dividends paid to policyholders
LINE 9 - Federal and foreign income taxes paid
TOTAL (Lines 5 through 9)

Net cash from operations (Line 4 minus Line 10)

CASH FROM INVESTMENTS

LINE 12 - Proceeds from investments sold, matured or repaid
LINE 12.1 - Bonds
LINE 12.2 - Stocks
LINE 12.3 - Mortgage loans
LINE 12.4 - Real estate
LINE 12.5 - Other invested assets
LINE 12.6 - Net gains or (losses) on cash, cash equivalents and short-term investments
LINE 12.7 - Miscellaneous proceeds

LINE 12.8 - Total investment proceeds (Lines 12.1 to 12.7)

LINE 13 - Cost of investments acquired (long-term only)
LINE 13.1 - Bonds
LINE 13.2 - Stocks
LINE 13.3 - Mortgage loans
LINE 13.4 - Real estate
LINE 13.5 - Other invested assets
LINE 13.6 - Miscellaneous applications

LINE 13.7 - Total investments acquired (lines 13.1 to 13.6)

Net increase (decrease) in contract loans and premium notes

Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)

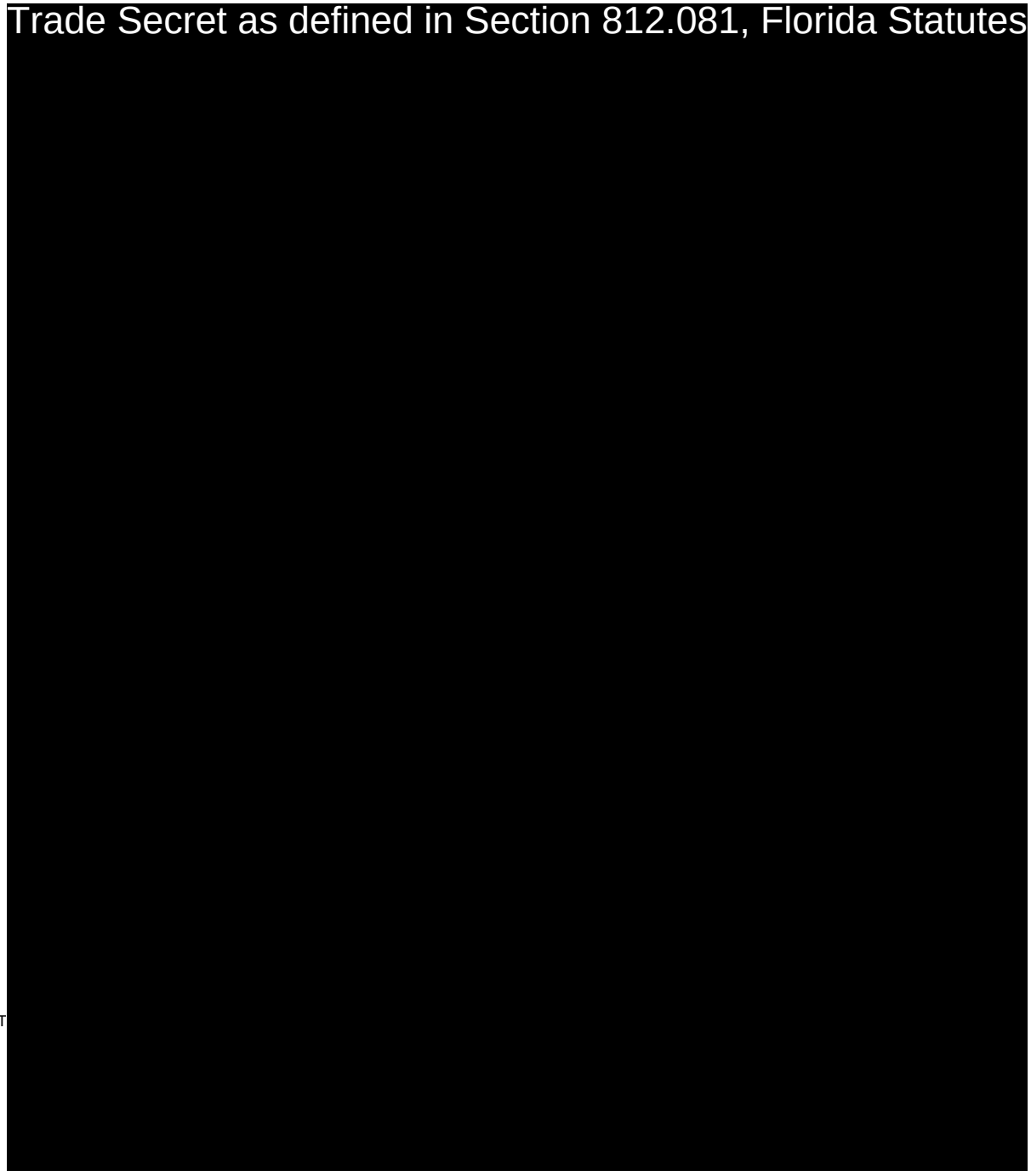
CASH FROM FINANCING & MISCELLANEOUS SOURCES

LINE 16 - Cash provided (applied)
LINE 16.1 - Surplus notes, capital notes
LINE 16.2 - Capital and paid in surplus, less treasury stock
LINE 16.3 - Borrowed funds
LINE 16.4 - Net deposits on deposit-type contracts and other insurance liabilities
LINE 16.5 - Dividends to stockholders
LINE 16.6 - Other cash provided (applied)

Net cash from financing and miscellaneous sources
(Line 16.1 through Line 16.4 minus Line 16.5)

RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENT
LINE 18 - Net change in cash, cash equivalents and short-term investments
LINE 19 - Cash, cash equivalents and short-term investments
LINE 19.1 - Beginning of period

LINE 19.2 - End of period (Line 18 plus Line 19.1)



Humana Medical Plan, Inc.
CASH FLOWS

2/28/2021	3/31/2021	4/30/2021	5/31/2021	6/30/2021	7/31/2021
Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection

Trade Secret as defined in Section 812.081, Florida Statutes

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CASH FROM OPERATIONS

LINE 1 - Premiums collected net of reinsurance
LINE 2 - Net investment income
LINE 3 - Miscellaneous income
TOTAL (Lines 1 through 3)

LINE 5 - Benefits and loss related payments
LINE 6 - Net transfers to or (from) Separate Account
LINE 7 - Commissions, expenses paid and aggregate write-ins for deductions
LINE 8 - Dividends paid to policyholders
LINE 9 - Federal and foreign income taxes paid
TOTAL (Lines 5 through 9)

Net cash from operations (Line 4 minus Line 10)

CASH FROM INVESTMENTS

LINE 12 - Proceeds from investments sold, matured or repaid
LINE 12.1 - Bonds
LINE 12.2 - Stocks
LINE 12.3 - Mortgage loans
LINE 12.4 - Real estate
LINE 12.5 - Other invested assets
LINE 12.6 - Net gains or (losses) on cash, cash equivalents and short-term investments
LINE 12.7 - Miscellaneous proceeds

LINE 12.8 - Total investment proceeds (Lines 12.1 to 12.7)

LINE 13 - Cost of investments acquired (long-term only)
LINE 13.1 - Bonds
LINE 13.2 - Stocks
LINE 13.3 - Mortgage loans
LINE 13.4 - Real estate
LINE 13.5 - Other invested assets
LINE 13.6 - Miscellaneous applications

LINE 13.7 - Total investments acquired (lines 13.1 to 13.6)

Net increase (decrease) in contract loans and premium notes

Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)

CASH FROM FINANCING & MISCELLANEOUS SOURCES

LINE 16 - Cash provided (applied)
LINE 16.1 - Surplus notes, capital notes
LINE 16.2 - Capital and paid in surplus, less treasury stock
LINE 16.3 - Borrowed funds
LINE 16.4 - Net deposits on deposit-type contracts and other insurance liabilities
LINE 16.5 - Dividends to stockholders
LINE 16.6 - Other cash provided (applied)

Net cash from financing and miscellaneous sources
(Line 16.1 through Line 16.4 minus Line 16.5)

RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENT

LINE 18 - Net change in cash, cash equivalents and short-term investments
LINE 19 - Cash, cash equivalents and short-term investments
LINE 19.1 - Beginning of period

LINE 19.2 - End of period (Line 18 plus Line 19.1)

Humana Medical Plan, Inc.
CASH FLOWS

	8/31/2021	9/30/2021	10/31/2021	11/30/2021	12/31/2021
	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection	Cash Flow Projection
CASH FROM OPERATIONS					
LINE 1 - Premiums collected net of reinsurance					
LINE 2 - Net investment income					
LINE 3 - Miscellaneous income					
TOTAL (Lines 1 through 3)					
LINE 5 - Benefits and loss related payments					
LINE 6 - Net transfers to or (from) Separate Account					
LINE 7 - Commissions, expenses paid and aggregate write-ins for deductions					
LINE 8 - Dividends paid to policyholders					
LINE 9 - Federal and foreign income taxes paid					
TOTAL (Lines 5 through 9)					
Net cash from operations (Line 4 minus Line 10)					
CASH FROM INVESTMENTS					
LINE 12 - Proceeds from investments sold, matured or repaid					
LINE 12.1 - Bonds					
LINE 12.2 - Stocks					
LINE 12.3 - Mortgage loans					
LINE 12.4 - Real estate					
LINE 12.5 - Other invested assets					
LINE 12.6 - Net gains or (losses) on cash, cash equivalents and short-term investments					
LINE 12.7 - Miscellaneous proceeds					
LINE 12.8 - Total investment proceeds (Lines 12.1 to 12.7)					
LINE 13 - Cost of investments acquired (long-term only)					
LINE 13.1 - Bonds					
LINE 13.2 - Stocks					
LINE 13.3 - Mortgage loans					
LINE 13.4 - Real estate					
LINE 13.5 - Other invested assets					
LINE 13.6 - Miscellaneous applications					
LINE 13.7 - Total investments acquired (lines 13.1 to 13.6)					
Net increase (decrease) in contract loans and premium notes					
Net cash from investments (Line 12.8 minus Line 13.7 and Line 14)					
CASH FROM FINANCING & MISCELLANEOUS SOURCES					
LINE 16 - Cash provided (applied)					
LINE 16.1 - Surplus notes, capital notes					
LINE 16.2 - Capital and paid in surplus, less treasury stock					
LINE 16.3 - Borrowed funds					
LINE 16.4 - Net deposits on deposit-type contracts and other insurance liabilities					
LINE 16.5 - Dividends to stockholders					
LINE 16.6 - Other cash provided (applied)					
Net cash from financing and miscellaneous sources (Line 16.1 through Line 16.4 minus Line 16.5)					
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENT					
LINE 18 - Net change in cash, cash equivalents and short-term investments					
LINE 19 - Cash, cash equivalents and short-term investments					
LINE 19.1 - Beginning of period					
LINE 19.2 - End of period (Line 18 plus Line 19.1)					

Trade Secret as defined in Section 812.081, Florida Statutes

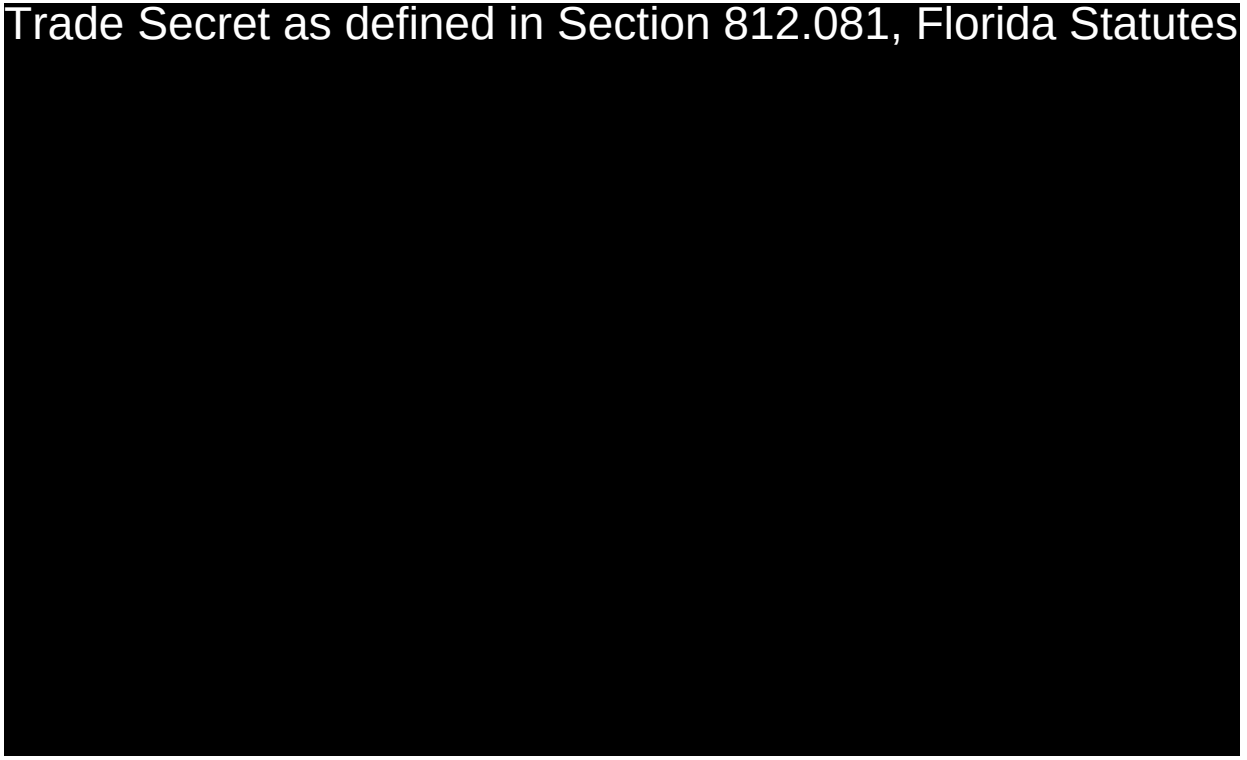
Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

SPECIALTY
Existing Business including Medicare & Commercial Group

Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date
12/31/2016	12/31/2017	10/31/2018	11/30/2018	12/31/2018	1/31/2019
Actual	Projection	Projection	Projection	Projection	Projection

2. Net premium income
3. Change in unearned premium reserves and reserve for rate credits
4. Fee-for-service
5. Risk revenue
6. Aggregate write-ins for other health care related revenues
7. Aggregate write-ins for other non-health revenues
8. Total revenues (Lines 2 to 7)
9. Hospital/medical benefits
10. Other professional services
11. Outside referrals
12. Emergency room and out-of-area
13. Prescription drugs
14. Aggregate write-ins for other hospital and medical
15. Incentive pool, withhold adjustments and bonus amounts
16. Subtotal (Lines 9 to 15)
17. Net reinsurance recoveries
18. Total hospital and medical (Lines 16 minus 17)
19. Non-health claims
20. Claims adjustment expenses
21. General administrative expenses
22. Increase in reserves for life and accident and health contracts
23. Total underwriting deductions (Lines 18 through 22)
24. Net underwriting gain or (loss) (Lines 8 minus 23)

MLR
Admin Rate
Membership
Member Months
PMPM (Premiums)
PMPM (Medical Cost)
PMPM (Admin Cost, exc. CAE)
PMPM (CAE)



Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

SPECIALTY
Existing Business including Medicare & Commercial Group

	Year-to-Date 2/28/2019 Projection	Year-to-Date 3/31/2019 Projection	Year-to-Date 4/30/2019 Projection	Year-to-Date 5/31/2019 Projection	Year-to-Date 6/30/2019 Projection	Year-to-Date 7/31/2019 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes					
3. Change in unearned premium reserves and reserve for rate credits						
4. Fee-for-service						
5. Risk revenue						
6. Aggregate write-ins for other health care related revenues						
7. Aggregate write-ins for other non-health revenues						
8. Total revenues (Lines 2 to 7)						
9. Hospital/medical benefits						
10. Other professional services						
11. Outside referrals						
12. Emergency room and out-of-area						
13. Prescription drugs						
14. Aggregate write-ins for other hospital and medical						
15. Incentive pool, withhold adjustments and bonus amounts						
16. Subtotal (Lines 9 to 15)						
17. Net reinsurance recoveries						
18. Total hospital and medical (Lines 16 minus 17)						
19. Non-health claims						
20. Claims adjustment expenses						
21. General administrative expenses						
22. Increase in reserves for life and accident and health contracts						
23. Total underwriting deductions (Lines 18 through 22)						
24. Net underwriting gain or (loss) (Lines 8 minus 23)						
MLR						
Admin Rate						
Membership						
Member Months						
PMPM (Premiums)						
PMPM (Medical Cost)						
PMPM (Admin Cost, exc. CAE)						
PMPM (CAE)						

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

SPECIALTY
Existing Business including Medicare & Commercial Group

	Year-to-Date 8/31/2019 Projection	Year-to-Date 9/30/2019 Projection	Year-to-Date 10/31/2019 Projection	Year-to-Date 11/30/2019 Projection	Year-to-Date 12/31/2019 Projection	Year-to-Date 1/31/2020 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes					
3. Change in unearned premium reserves and reserve for rate credits						
4. Fee-for-service						
5. Risk revenue						
6. Aggregate write-ins for other health care related revenues						
7. Aggregate write-ins for other non-health revenues						
8. Total revenues (Lines 2 to 7)						
9. Hospital/medical benefits						
10. Other professional services						
11. Outside referrals						
12. Emergency room and out-of-area						
13. Prescription drugs						
14. Aggregate write-ins for other hospital and medical						
15. Incentive pool, withhold adjustments and bonus amounts						
16. Subtotal (Lines 9 to 15)						
17. Net reinsurance recoveries						
18. Total hospital and medical (Lines 16 minus 17)						
19. Non-health claims						
20. Claims adjustment expenses						
21. General administrative expenses						
22. Increase in reserves for life and accident and health contracts						
23. Total underwriting deductions (Lines 18 through 22)						
24. Net underwriting gain or (loss) (Lines 8 minus 23)						
MLR						
Admin Rate						
Membership						
Member Months						
PMPM (Premiums)						
PMPM (Medical Cost)						
PMPM (Admin Cost, exc. CAE)						
PMPM (CAE)						

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

SPECIALTY
Existing Business including Medicare & Commercial Group

	Year-to-Date 2/29/2020 Projection	Year-to-Date 3/31/2020 Projection	Year-to-Date 4/30/2020 Projection	Year-to-Date 5/31/2020 Projection	Year-to-Date 6/30/2020 Projection	Year-to-Date 7/31/2020 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes					
3. Change in unearned premium reserves and reserve for rate credits						
4. Fee-for-service						
5. Risk revenue						
6. Aggregate write-ins for other health care related revenues						
7. Aggregate write-ins for other non-health revenues						
8. Total revenues (Lines 2 to 7)						
9. Hospital/medical benefits						
10. Other professional services						
11. Outside referrals						
12. Emergency room and out-of-area						
13. Prescription drugs						
14. Aggregate write-ins for other hospital and medical						
15. Incentive pool, withhold adjustments and bonus amounts						
16. Subtotal (Lines 9 to 15)						
17. Net reinsurance recoveries						
18. Total hospital and medical (Lines 16 minus 17)						
19. Non-health claims						
20. Claims adjustment expenses						
21. General administrative expenses						
22. Increase in reserves for life and accident and health contracts						
23. Total underwriting deductions (Lines 18 through 22)						
24. Net underwriting gain or (loss) (Lines 8 minus 23)						
MLR						
Admin Rate						
Membership						
Member Months						
PMPM (Premiums)						
PMPM (Medical Cost)						
PMPM (Admin Cost, exc. CAE)						
PMPM (CAE)						

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

SPECIALTY
Existing Business including Medicare & Commercial Group

	Year-to-Date 8/31/2020 Projection	Year-to-Date 9/30/2020 Projection	Year-to-Date 10/31/2020 Projection	Year-to-Date 11/30/2020 Projection	Year-to-Date 12/31/2020 Projection	Year-to-Date 1/31/2021 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes					
3. Change in unearned premium reserves and reserve for rate credits						
4. Fee-for-service						
5. Risk revenue						
6. Aggregate write-ins for other health care related revenues						
7. Aggregate write-ins for other non-health revenues						
8. Total revenues (Lines 2 to 7)						
9. Hospital/medical benefits						
10. Other professional services						
11. Outside referrals						
12. Emergency room and out-of-area						
13. Prescription drugs						
14. Aggregate write-ins for other hospital and medical						
15. Incentive pool, withhold adjustments and bonus amounts						
16. Subtotal (Lines 9 to 15)						
17. Net reinsurance recoveries						
18. Total hospital and medical (Lines 16 minus 17)						
19. Non-health claims						
20. Claims adjustment expenses						
21. General administrative expenses						
22. Increase in reserves for life and accident and health contracts						
23. Total underwriting deductions (Lines 18 through 22)						
24. Net underwriting gain or (loss) (Lines 8 minus 23)						
MLR						
Admin Rate						
Membership						
Member Months						
PMPM (Premiums)						
PMPM (Medical Cost)						
PMPM (Admin Cost, exc. CAE)						
PMPM (CAE)						

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

SPECIALTY
Existing Business including Medicare & Commercial Group

	Year-to-Date 2/28/2021 Projection	Year-to-Date 3/31/2021 Projection	Year-to-Date 4/30/2021 Projection	Year-to-Date 5/31/2021 Projection	Year-to-Date 6/30/2021 Projection	Year-to-Date 7/31/2021 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes					
3. Change in unearned premium reserves and reserve for rate credits						
4. Fee-for-service						
5. Risk revenue						
6. Aggregate write-ins for other health care related revenues						
7. Aggregate write-ins for other non-health revenues						
8. Total revenues (Lines 2 to 7)						
9. Hospital/medical benefits						
10. Other professional services						
11. Outside referrals						
12. Emergency room and out-of-area						
13. Prescription drugs						
14. Aggregate write-ins for other hospital and medical						
15. Incentive pool, withhold adjustments and bonus amounts						
16. Subtotal (Lines 9 to 15)						
17. Net reinsurance recoveries						
18. Total hospital and medical (Lines 16 minus 17)						
19. Non-health claims						
20. Claims adjustment expenses						
21. General administrative expenses						
22. Increase in reserves for life and accident and health contracts						
23. Total underwriting deductions (Lines 18 through 22)						
24. Net underwriting gain or (loss) (Lines 8 minus 23)						
MLR						
Admin Rate						
Membership						
Member Months						
PMPM (Premiums)						
PMPM (Medical Cost)						
PMPM (Admin Cost, exc. CAE)						
PMPM (CAE)						

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

SPECIALTY
Existing Business including Medicare & Commercial Group

	Year-to-Date 8/31/2021 Projection	Year-to-Date 9/30/2021 Projection	Year-to-Date 10/31/2021 Projection	Year-to-Date 11/30/2021 Projection	Year-to-Date 12/31/2021 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes				
3. Change in unearned premium reserves and reserve for rate credits					
4. Fee-for-service					
5. Risk revenue					
6. Aggregate write-ins for other health care related revenues					
7. Aggregate write-ins for other non-health revenues					
8. Total revenues (Lines 2 to 7)					
9. Hospital/medical benefits					
10. Other professional services					
11. Outside referrals					
12. Emergency room and out-of-area					
13. Prescription drugs					
14. Aggregate write-ins for other hospital and medical					
15. Incentive pool, withhold adjustments and bonus amounts					
16. Subtotal (Lines 9 to 15)					
17. Net reinsurance recoveries					
18. Total hospital and medical (Lines 16 minus 17)					
19. Non-health claims					
20. Claims adjustment expenses					
21. General administrative expenses					
22. Increase in reserves for life and accident and health contracts					
23. Total underwriting deductions (Lines 18 through 22)					
24. Net underwriting gain or (loss) (Lines 8 minus 23)					
MLR					
Admin Rate					
Membership					
Member Months					
PMPM (Premiums)					
PMPM (Medical Cost)					
PMPM (Admin Cost, exc. CAE)					
PMPM (CAE)					

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

LTSS - Region 1

	Year-to-Date 10/31/2018 Projection	Year-to-Date 11/30/2018 Projection	Year-to-Date 12/31/2018 Projection	Year-to-Date 1/31/2019 Projection	Year-to-Date 2/28/2019 Projection	Year-to-Date 3/31/2019 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes					
3. Change in unearned premium reserves and reserve for rate credits						
4. Fee-for-service						
5. Risk revenue						
6. Aggregate write-ins for other health care related revenues						
7. Aggregate write-ins for other non-health revenues						
8. Total revenues (Lines 2 to 7)						
9. Hospital/medical benefits						
10. Other professional services						
11. Outside referrals						
12. Emergency room and out-of-area						
13. Prescription drugs						
14. Aggregate write-ins for other hospital and medical						
15. Incentive pool, withhold adjustments and bonus amounts						
16. Subtotal (Lines 9 to 15)						
17. Net reinsurance recoveries						
18. Total hospital and medical (Lines 16 minus 17)						
19. Non-health claims						
20. Claims adjustment expenses						
21. General administrative expenses						
22. Increase in reserves for life and accident and health contracts						
23. Total underwriting deductions (Lines 18 through 22)						
24. Net underwriting gain or (loss) (Lines 8 minus 23)						
MLR						
Admin Rate						
Membership						
Member Months						
PMPM (Premiums)						
PMPM (Medical Cost)						
PMPM (Admin Cost)						

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

LTSS - Region 1

	Year-to-Date 4/30/2019 Projection	Year-to-Date 5/31/2019 Projection	Year-to-Date 6/30/2019 Projection	Year-to-Date 7/31/2019 Projection	Year-to-Date 8/31/2019 Projection	Year-to-Date 9/30/2019 Projection	Year-to-Date 10/31/2019 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate credits							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
18. Total hospital and medical (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for life and accident and health contracts							
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
MLR							
Admin Rate							
Membership							
Member Months							
PMPM (Premiums)							
PMPM (Medical Cost)							
PMPM (Admin Cost)							

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

LTSS - Region 1

Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date	Year-to-Date
11/30/2019	12/31/2019	1/31/2020	2/29/2020	3/31/2020	4/30/2020
Projection	Projection	Projection	Projection	Projection	Projection

Trade Secret as defined in Section 812.081, Florida Statutes

2. Net premium income
3. Change in unearned premium reserves and reserve for rate credits
4. Fee-for-service
5. Risk revenue
6. Aggregate write-ins for other health care related revenues
7. Aggregate write-ins for other non-health revenues
8. Total revenues (Lines 2 to 7)
9. Hospital/medical benefits
10. Other professional services
11. Outside referrals
12. Emergency room and out-of-area
13. Prescription drugs
14. Aggregate write-ins for other hospital and medical
15. Incentive pool, withhold adjustments and bonus amounts
16. Subtotal (Lines 9 to 15)
17. Net reinsurance recoveries
18. Total hospital and medical (Lines 16 minus 17)
19. Non-health claims
20. Claims adjustment expenses
21. General administrative expenses
22. Increase in reserves for life and accident and health contracts
23. Total underwriting deductions (Lines 18 through 22)
24. Net underwriting gain or (loss) (Lines 8 minus 23)

MLR
Admin Rate
Membership
Member Months
PMPM (Premiums)
PMPM (Medical Cost)
PMPM (Admin Cost)

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

LTSS - Region 1

	Year-to-Date 5/31/2020 Projection	Year-to-Date 6/30/2020 Projection	Year-to-Date 7/31/2020 Projection	Year-to-Date 8/31/2020 Projection	Year-to-Date 9/30/2020 Projection	Year-to-Date 10/31/2020 Projection	Year-to-Date 11/30/2020 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate credits							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
18. Total hospital and medical (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for life and accident and health contracts							
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
MLR							
Admin Rate							
Membership							
Member Months							
PMPM (Premiums)							
PMPM (Medical Cost)							
PMPM (Admin Cost)							

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

LTSS - Region 1

	Year-to-Date 12/31/2020 Projection	Year-to-Date 1/31/2021 Projection	Year-to-Date 2/28/2021 Projection	Year-to-Date 3/31/2021 Projection	Year-to-Date 4/30/2021 Projection	Year-to-Date 5/31/2021 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes					
3. Change in unearned premium reserves and reserve for rate credits						
4. Fee-for-service						
5. Risk revenue						
6. Aggregate write-ins for other health care related revenues						
7. Aggregate write-ins for other non-health revenues						
8. Total revenues (Lines 2 to 7)						
9. Hospital/medical benefits						
10. Other professional services						
11. Outside referrals						
12. Emergency room and out-of-area						
13. Prescription drugs						
14. Aggregate write-ins for other hospital and medical						
15. Incentive pool, withhold adjustments and bonus amounts						
16. Subtotal (Lines 9 to 15)						
17. Net reinsurance recoveries						
18. Total hospital and medical (Lines 16 minus 17)						
19. Non-health claims						
20. Claims adjustment expenses						
21. General administrative expenses						
22. Increase in reserves for life and accident and health contracts						
23. Total underwriting deductions (Lines 18 through 22)						
24. Net underwriting gain or (loss) (Lines 8 minus 23)						
MLR						
Admin Rate						
Membership						
Member Months						
PMPM (Premiums)						
PMPM (Medical Cost)						
PMPM (Admin Cost)						

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

LTSS - Region 1

	Year-to-Date 6/30/2021 Projection	Year-to-Date 7/31/2021 Projection	Year-to-Date 8/31/2021 Projection	Year-to-Date 9/30/2021 Projection	Year-to-Date 10/31/2021 Projection	Year-to-Date 11/30/2021 Projection	Year-to-Date 12/31/2021 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate credits							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
18. Total hospital and medical (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for life and accident and health contracts							
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
MLR							
Admin Rate							
Membership							
Member Months							
PMPM (Premiums)							
PMPM (Medical Cost)							
PMPM (Admin Cost)							

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

MMA - Region 1

Year-to-Date 10/31/2018 Projection	Year-to-Date 11/30/2018 Projection	Year-to-Date 12/31/2018 Projection	Year-to-Date 1/31/2019 Projection	Year-to-Date 2/28/2019 Projection	Year-to-Date 3/31/2019 Projection
Trade Secret as defined in Section 812.081, Florida Statutes					

2. Net premium income
3. Change in unearned premium reserves and reserve for rate credits
4. Fee-for-service
5. Risk revenue
6. Aggregate write-ins for other health care related revenues
7. Aggregate write-ins for other non-health revenues
8. Total revenues (Lines 2 to 7)
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10. Other professional services
11. Outside referrals
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19. Non-health claims
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21. General administrative expenses
22. Increase in reserves for life and accident and health contracts
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MLR
Admin Rate
Membership
Member Months
PMPM (Premiums)
PMPM (Medical Cost)
PMPM (Admin Cost)

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

MMA - Region 1

	Year-to-Date 4/30/2019 Projection	Year-to-Date 5/31/2019 Projection	Year-to-Date 6/30/2019 Projection	Year-to-Date 7/31/2019 Projection	Year-to-Date 8/31/2019 Projection	Year-to-Date 9/30/2019 Projection	Year-to-Date 10/31/2019 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate credits							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
10. Other professional services							
11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
18. Total hospital and medical (Lines 16 minus 17)							
19. Non-health claims							
20. Claims adjustment expenses							
21. General administrative expenses							
22. Increase in reserves for life and accident and health contracts							
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
MLR							
Admin Rate							
Membership							
Member Months							
PMPM (Premiums)							
PMPM (Medical Cost)							
PMPM (Admin Cost)							

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

MMA - Region 1

Year-to-Date 11/30/2019 Projection	Year-to-Date 12/31/2019 Projection	Year-to-Date 1/31/2020 Projection	Year-to-Date 2/29/2020 Projection	Year-to-Date 3/31/2020 Projection	Year-to-Date 4/30/2020 Projection
Trade Secret as defined in Section 812.081, Florida Statutes					

2. Net premium income
3. Change in unearned premium reserves and reserve for rate credits
4. Fee-for-service
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Admin Rate
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Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

MMA - Region 1

	Year-to-Date 5/31/2020 Projection	Year-to-Date 6/30/2020 Projection	Year-to-Date 7/31/2020 Projection	Year-to-Date 8/31/2020 Projection	Year-to-Date 9/30/2020 Projection	Year-to-Date 10/31/2020 Projection	Year-to-Date 11/30/2020 Projection
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Admin Rate							
Membership							
Member Months							
PMPM (Premiums)							
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Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

MMA - Region 1

Year-to-Date 12/31/2020 Projection	Year-to-Date 1/31/2021 Projection	Year-to-Date 2/28/2021 Projection	Year-to-Date 3/31/2021 Projection	Year-to-Date 4/30/2021 Projection	Year-to-Date 5/31/2021 Projection
Trade Secret as defined in Section 812.081, Florida Statutes					

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MLR
Admin Rate
Membership
Member Months
PMPM (Premiums)
PMPM (Medical Cost)
PMPM (Admin Cost)

Humana Medical Plan, Inc.
SUMMARY OF OPERATIONS

MMA - Region 1

	Year-to-Date 6/30/2021 Projection	Year-to-Date 7/31/2021 Projection	Year-to-Date 8/31/2021 Projection	Year-to-Date 9/30/2021 Projection	Year-to-Date 10/31/2021 Projection	Year-to-Date 11/30/2021 Projection	Year-to-Date 12/31/2021 Projection
2. Net premium income	Trade Secret as defined in Section 812.081, Florida Statutes						
3. Change in unearned premium reserves and reserve for rate credits							
4. Fee-for-service							
5. Risk revenue							
6. Aggregate write-ins for other health care related revenues							
7. Aggregate write-ins for other non-health revenues							
8. Total revenues (Lines 2 to 7)							
9. Hospital/medical benefits							
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11. Outside referrals							
12. Emergency room and out-of-area							
13. Prescription drugs							
14. Aggregate write-ins for other hospital and medical							
15. Incentive pool, withhold adjustments and bonus amounts							
16. Subtotal (Lines 9 to 15)							
17. Net reinsurance recoveries							
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20. Claims adjustment expenses							
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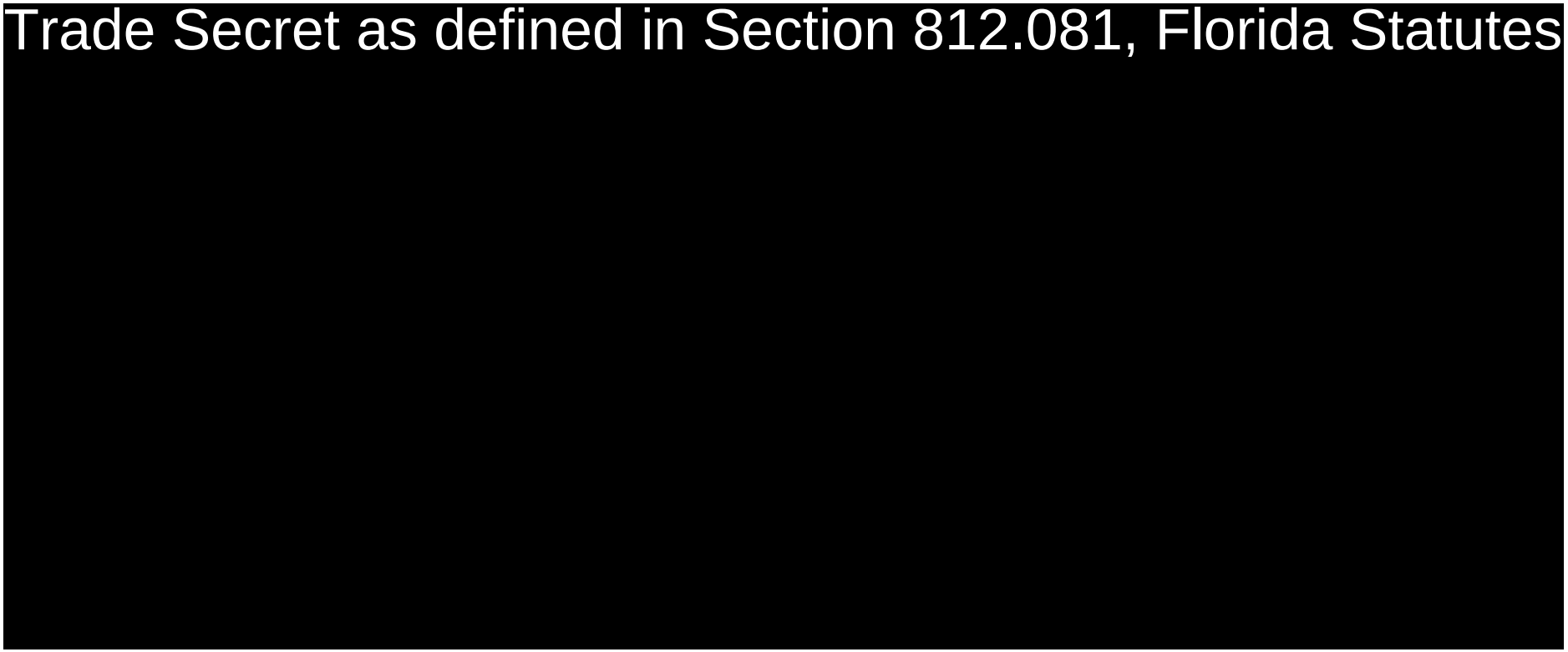
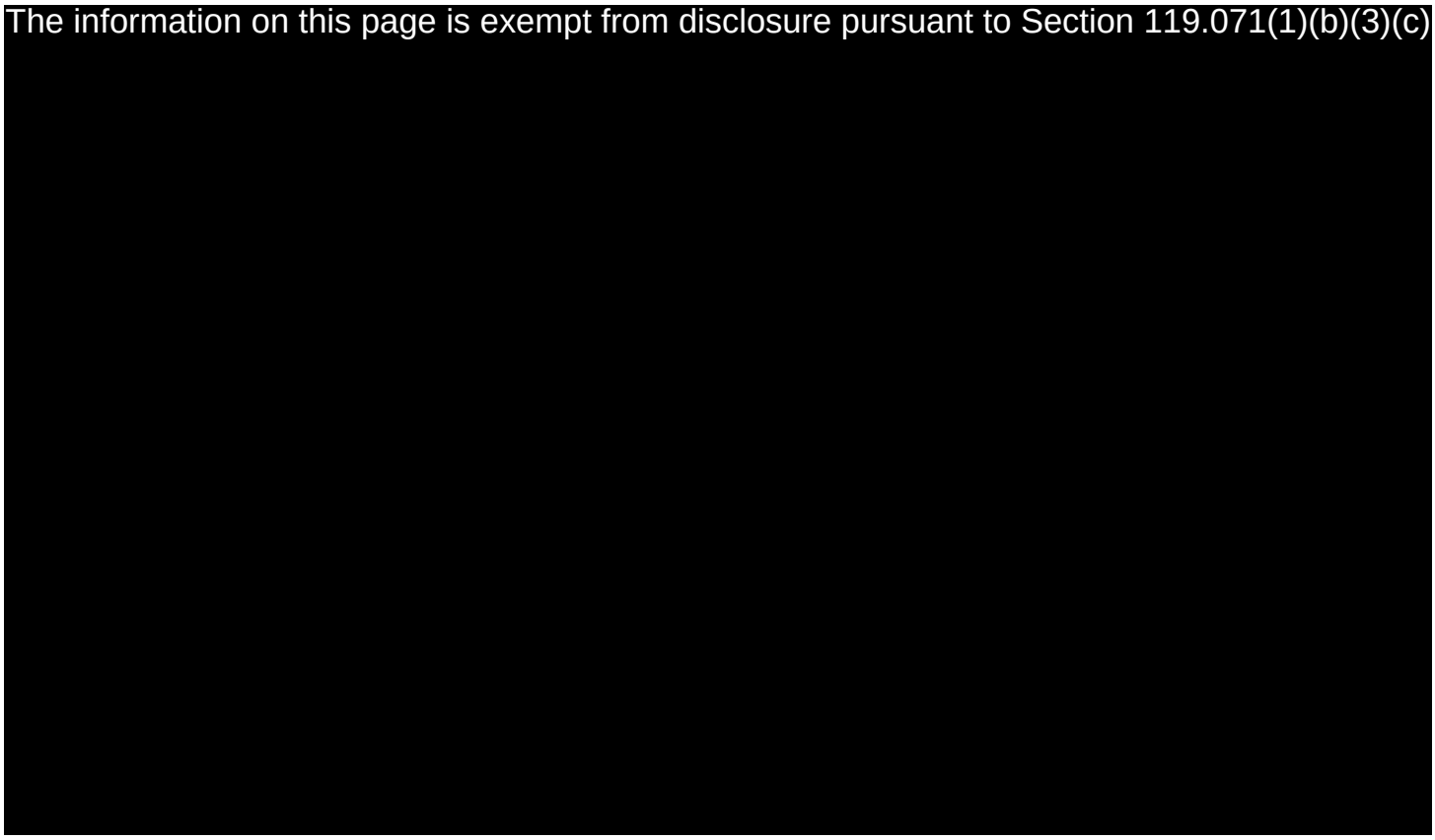
23. Total underwriting deductions (Lines 18 through 22)							
24. Net underwriting gain or (loss) (Lines 8 minus 23)							
MLR							
Admin Rate							
Membership							
Member Months							
PMPM (Premiums)							
PMPM (Medical Cost)							
PMPM (Admin Cost)							

Assumptions



Financial Information - Surplus

The information on this page is exempt from disclosure pursuant to Section 119.071(1)(b)(3)(c)



Financial Information – Insolvency Protection Account

4. Insolvency Protection Account

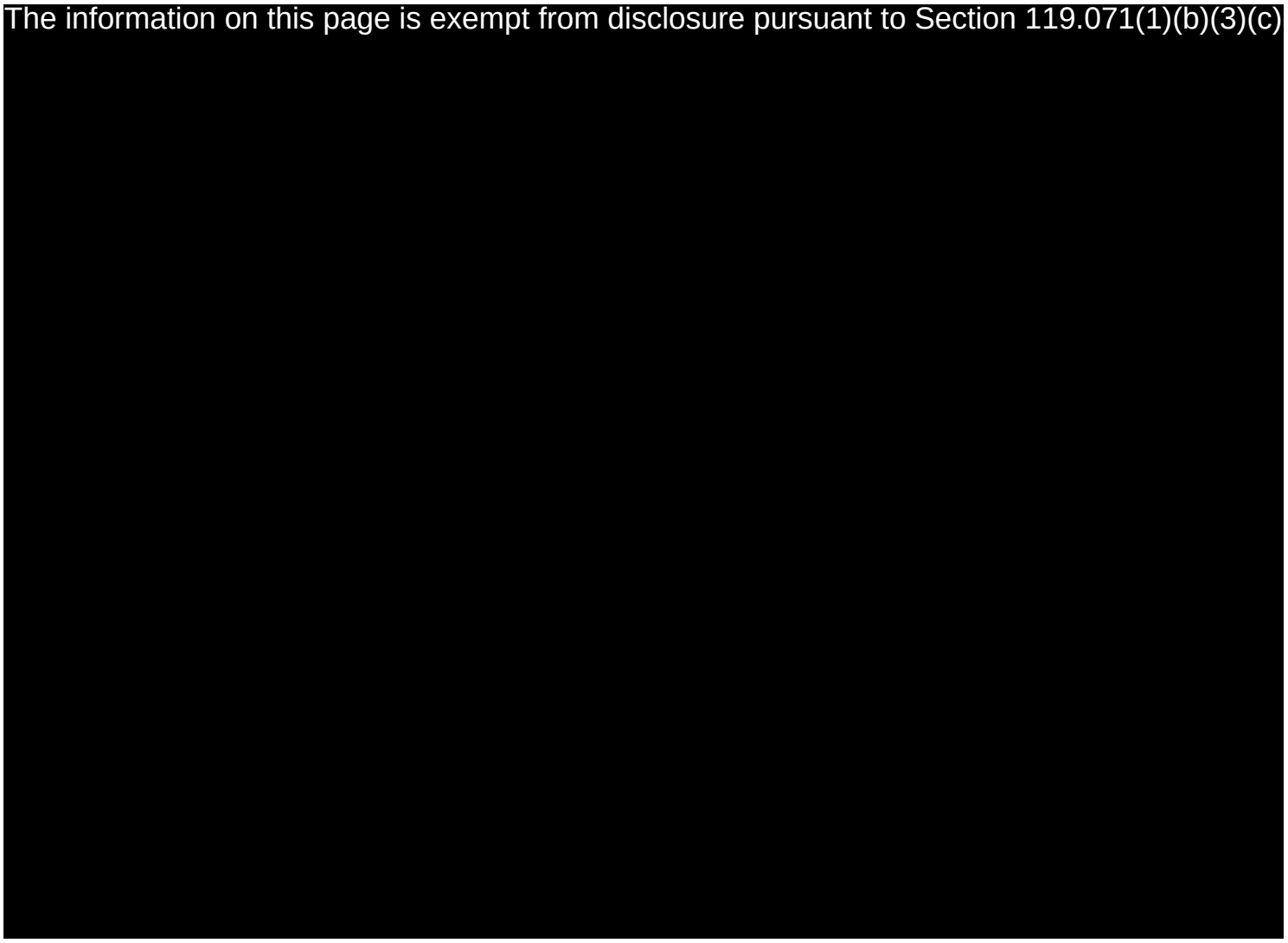


EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

RESPONDENT NAME: Humana Medical Plan, Inc.

A. RESPONDENT BACKGROUND / EXPERIENCE

SRC# 1 – Managed Care Experience (Statewide):

The respondent, including respondent's parent, affiliate(s) and subsidiary(ies), shall provide a list of all current and/or recent (within five (5) years of the issue date of this solicitation (since July 14, 2012) contracts for managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support).

The respondent shall provide the following information for each identified contract:

a. The Medicaid population served (such as TANF, ABD, dual eligible);
b. The name and address of the client;
c. The name of the contract;
d. The specific start and end dates of the contract;
e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
f. The use of administrative and/or delegated subcontractor(s) and their scope of work;
g. The annual contract amount (payment to the respondent) and annual claims payment amount;
h. The scheduled and actual completion dates for contract implementation;
i. The barriers encountered that hindered implementation (if applicable) and the resolutions;
j. Accomplishments and achievements;
k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
l. Whether the contract was capitated, FFS or other payment method.

In addition, the respondent shall describe its experience in delivering managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support), to Medicaid populations similar to the target population (such as TANF, ABD, dual eligible) identified in this solicitation.

For this SRC, the respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program.

Response:

Humana Medical Plan, Inc., along with its parent company Humana, Inc. (Humana), is pleased to submit our proposal for the Florida Agency for Health Care Administration's (AHCA) Statewide Medicaid Managed Care (SMMC) Program. For this ITN, Humana is bidding as a Comprehensive Long-Term Care Plan (Comprehensive Plan) across all eleven (11) SMMC regions statewide.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We have served Florida's Medicaid populations since 1997. As a Comprehensive Plan in Florida Medicaid today, Humana serves enrollees across both the Managed Medical Assistance (MMA) and Long-term Care (LTC) programs. We are also Florida's largest health plan for both Medicare Advantage (MA) and Dual-Eligible Special Needs Plans (D-SNP). Our unique set of program experience, population expertise, and provider and community relationships both nationally and in Florida positions us ideally to help the State meet its goals for the SMMC Program.

Nationally, Humana manages the care of fourteen million (14,000,000) medical benefit enrollees and six point nine million (6.9M) specialty benefit enrollees with an approach built around the understanding that health encompasses much more than just medical care; that is, health is comprised of an individual's physical, mental, and social well-being. While many services may be delivered in clinical or institutional settings, it is in the many communities across Florida and the nation where individuals' and families' health and well-being are truly impacted and influenced. Those communities are, therefore, the focus of our model. We recognize that it is imperative to understand and impact the social and environmental dynamics individuals and families face in their homes and communities. To that end, Humana established an enterprise-wide initiative, our "Bold Goal": to improve the health of the communities we serve by twenty (20) percent by 2020. We are working to accomplish this goal through partnerships with local non-profit organizations, businesses, government agencies, and providers. In Florida specifically, we have piloted these efforts and initiatives in three communities: Broward County, Tampa, and Jacksonville. Due to the success of these pilots in Florida and similar pilots in several other communities around the nation, in the coming years, we intend to expand the initiative to many more communities throughout the state and across the country.

In this section, we will discuss Humana's experience and presence in Florida, our national managed care experience, and the key elements of our approach to the SMMC program. We will then address requirements (a) through (l) for our managed care experience with Temporary Assistance for Needy Families (TANF), Aged, Blind, and Disabled (ABD), and Dual Eligible populations.

HUMANA IN FLORIDA

In Florida today, Humana serves Medicaid-eligible enrollees through our Comprehensive Medicaid contract, which covers MMA and LTC benefits, MA, Prescription Drug Plans (PDP), D-SNPs, and Tricare. Through decades of experience, Humana has cultivated strong relationships and an intimate knowledge of the health, social, and community care and support needs of Florida's vulnerable populations at both the statewide and local levels. Our Florida operations are deeply embedded into communities across the state, with more than ten thousand (10,000) associates based in Florida. Humana currently has Florida Medicaid plans in all eleven (11) SMMC Regions, offering MMA and LTC coverage through an integrated Comprehensive Plan in five regions and LTC coverage across all eleven (11) regions.

Prior to the MMA program, Humana started coordinating care for Florida Medicaid enrollees in 1997 through a Medicaid HMO plan. We served over fifty thousand (50,000) enrollees in Broward, Dade, Hillsborough, Pinellas, and Pasco Counties until the inception of the MMA program. In 2013, Humana was selected to serve as a managed care organization (MCO) for the MMA program. We currently serve over three hundred twenty-five thousand (325,000) MMA

enrollees, including TANF, ABD, and dual eligible populations. Through the MMA program, Humana covers and integrates services including medical, behavioral health, pharmacy, and transportation. According to the National Committee on Quality Assurance (NCQA), from 2011 to 2015 Humana had the highest rated plan in Florida Medicaid, amongst a group that includes many national and local MCOs.

Through a partnership with the Florida Department of Elder Affairs, Humana participated in the Nursing Home Diversion (NHD) program for Florida's frail and elderly population from 2007 to 2013. The coordination of LTC services in the NHD program enabled enrollees to maintain their lives in the community and prevent unnecessary transitions into nursing facilities. The state transitioned the NHD program in 2013 to the Long-term Care program. Today, Humana provides managed LTC services to approximately twenty-one thousand (21,000) enrollees across all eleven 11 regions, serving as the only statewide LTC health plan. We cover LTC for ABD and dual eligible enrollees in the LTC program.

Effective coordination across Medicaid and Medicare improves health outcomes and enrollee experience for the highly vulnerable dual eligible populations (duals). As the largest Medicare Advantage plan in the state, with over six hundred nineteen thousand (619,000) enrollees across all eleven (11) SMMC regions, Humana is uniquely positioned to support AHCA's short and long-term duals integration goals. Our MA D-SNPs, which includes Medicaid benefits, integrate services for more than one hundred five thousand (105,000) duals in Florida, more than any other D-SNP plan in the state. Additionally, our experience serving our nearly three hundred ninety thousand (390,000) MA Prescription Drug Plan (PDP) enrollees has afforded us with valuable experiential insights into this critically impactful component of care and supports integration for duals. Moreover, given Humana's statewide MA and D-SNP presence, we can maintain continuity of care for SMMC enrollees' medical and social needs as their health status changes or as they age into Medicare.

Humana is also proud to be the long-time contractor for the U.S. Department of Defense (DOD) Tricare South Region, which includes more than seven hundred thousand (700,000) Florida residents, to provide benefits for active duty and retired military and their families. Given the prevalence of behavioral health and severe or persistent mental illness (SPMI) within the Tricare population, we have developed significant local experience addressing these conditions from both a medical and social perspective. This unique experience has provided us with insights and perspectives that translate directly into serving the Medicaid population given the overlap of demographics across Tricare and Medicaid enrollees as well as the common community and social complexities they face.

Alongside the enrollees Humana serves through the SMMC program, Medicare plans, and Tricare, we also offer coverage through individual commercial plans (on and off-exchange), commercial employer group plans, and managed dental and vision plans. In total, Humana serves more than two (2) million medical enrollees in medical plans across the state of Florida. Humana offers Florida a unique combination of deep local experience and expertise paired with the capabilities, best practices, scale, innovation, and stability of a national health and well-being company.

HUMANA NATIONALLY

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana's fifty-six (56) years as a health services organization has afforded us broad experience serving vulnerable populations through a variety of different models. David Jones and Wendell Cherry founded Humana in 1961 as a nursing home company and long-term care provider on the belief that they could impact many of the problems associated with the care delivery models of the day. Since then, our company has evolved and grown tremendously, adapting with the needs of the day and the enrollees we serve, but we remain dedicated to improving enrollees' health and well-being.

In addition to our Florida programs, our national experience includes working with Medicaid beneficiaries through Medicaid managed care (MMC) and managed long-term care (MLTC) programs, CMS Dual Eligible Financial Alignment Demonstrations (Duals Demos), and MA D-SNPs. Humana has served Medicaid populations continuously for more than two decades, and currently manages traditional Medicaid benefits for more than five hundred twelve thousand (512,000) enrollees. Through these years of experience, we have developed significant expertise in integrating medical and behavioral health services to positively impact health outcomes.

In January 2013, Humana began serving Kentucky Medicaid-eligible beneficiaries in the Louisville metropolitan area. We subsequently expanded coverage statewide and began to serve the ACA Expansion population. This contract now serves the TANF, ABD, dual eligible, and ACA Expansion populations statewide for more than one hundred forty-five thousand (145,000) enrollees. Humana provides integrated medical and behavioral health services for enrollees in this program.

Since 2014, Humana has provided managed Medicaid coverage under Illinois' Integrated Care Program (ICP) for more than five thousand, six hundred (5,600) ABD enrollees. In this program we cover integrated medical and behavioral health services, long-term services and support (LTSS), and transportation services.

In Illinois, we also contract with the Department of Healthcare and Family Services (HFS) and CMS to participate in the Greater Chicago Region for the Medicare-Medicaid Alignment Initiative (Duals Demonstration). We currently have serve more than six thousand, three hundred (6,300) dual eligible enrollees enrolled, for whom we provide integrated medical and behavioral health services, LTSS, and transportation services. By serving both programs, we are able to ensure that we can continue providing LTSS to our enrollees as their Medicare eligibility status changes.

In Virginia, we contract with the Department of Medical Assistance (DMAS) and CMS for the Commonwealth Coordinated Care program (Duals Demonstration) to operate in all regions, serving over eight thousand, six hundred (8,600) dual eligible enrollees. Humana covers integrated medical and behavioral health services, LTSS, and transportation services through the CCC program.

Over the past thirty (30) years, Humana has become an industry leader in Medicare Advantage (MA) and Medicare Part D Prescription Drug Plans (PDPs), both in terms of enrollment and quality. Nationally, Humana administers and manages the Medicare benefits for more than three million two hundred (3,200,000) beneficiaries through our MA plans, as well as more than five million (5,000,000) through our stand-alone PDP plans. More than four hundred seventy-six thousand (476,000) of our MA enrollees are also eligible for Medicaid. Given our extensive

experience with this population, we understand these individuals, their needs, and how to best serve them to achieve health and social outcomes as well as their personal definitions of well-being.

Humana also has broad experience with care coordination for the dual-eligible population nationally and in Florida through our D-SNPs, which we have been operating since 2006. Today, we are a national leader in D-SNPs, with more than one hundred ninety thousand (190,000) enrollees across twenty-two (22) states and Puerto Rico.

Humana also provided traditional Medicaid benefits to more than five hundred thousand (500,000) TANF, ABD, and dual eligible enrollees in Puerto Rico from 1995 until 2013. Through this program we covered medical and transportation services for our enrollees.

In addition to our Medicaid and Medicare experience, Humana offers individual commercial coverage (on and off-exchange), commercial employer group coverage, managed dental and managed vision, Tricare Military, and Go365, Humana's wellness incentive program. Nationwide, Humana provides medical benefits for fourteen million (14,000,000) enrollees and employs fifty-one thousand six hundred (51,600) associates.

KEY ELEMENTS OF HUMANA'S SMMC APPROACH

Humana's person-centered approach to improving Florida SMMC enrollees' health and well-being is built on a strong foundation of experience with similar populations. Through our Comprehensive Plan offering, Humana will support AHCA in achieving its goals for the SMMC program through our clinical care model, integrated technology platforms, quality-oriented service delivery, provider engagement models, and community development programs.

CLINICAL CARE MODEL

An effective approach to identifying, assessing and implementing interventions for high-risk enrollees must be multi-faceted, enrollee-driven, and encompass all levels of care. Humana has decades of experience providing case management and care coordination for Medicaid populations and vulnerable subpopulations. Our comprehensive case management program is dedicated to identifying, engaging, and managing our enrollees who require care coordination and case management services, and tailoring those services to the specific needs of the enrollee. Humana's process for identifying and monitoring the highest need and highest risk enrollees integrates robust data analytics with specialized care coordination strategies. This approach allows us to proactively identify high-risk enrollees and proactively address emerging health issues. Humana's case management program includes a Multi-Disciplinary Team (MDT) model. The MDT promotes holistic, integrated care by inviting key stakeholders to participate in care planning, including the enrollee and their representatives, case managers, PCPs, and behavioral health providers.

SYSTEMS INTEGRATION

Through ongoing clinical monitoring of claims, pharmacy utilization, and diagnoses, we identify and refer enrollees into case management and disease management programs. All of our various sources of identification and referral – from predictive modeling to claims data and lab results – are integrated into our powerful CareHub platform, Humana's innovative enterprise solution for complete program integration for Humana's provider community and enrollees. The

CareHub Clinical Guidance eXchange (CGX) clinical workflow system supports an integrated approach to care coordination. As a fully integrated approach, this enterprise solution provides enhanced capabilities to identify enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention. Through CGX, case managers can also monitor care across enrollees' varied coverage, including MMA, LTC, MA, PDP, and D-SNPs. Integrated systems like these are particularly important for coordinating care across MMA and LTC for Humana's Comprehensive Medicaid enrollees.

QUALITY-ORIENTED SERVICE DELIVERY

We prioritize quality initiatives that ensure we are effectively supporting enrollees and providers and driving continuous improvement. Humana's Quality Improvement (QI) program helps us monitor, evaluate, and facilitate improvement in the quality of healthcare services we provide. Humana's current SMMC program coordinates quality initiatives across both corporate and local market support. Corporate support helps provide direction, oversight, and guidance when needed, while the local market leadership leads quality initiatives in Florida. Our QI program aligns with The National Quality Strategy, which the Agency for Healthcare Research and Quality leads on behalf of the U.S. Department of Health and Human Services. Further, we have designed this program to comply with contractual, governmental, accreditation, and organizational requirements and guidelines, including the National Committee for Quality Assurance (NCQA). In the Florida Medicaid HMO program, Humana was Florida's top NCQA quality-rated Medicaid health plan from 2011 to 2015. In MA, we are an industry-leader in quality. Humana Medical Plan's Florida MA and D-SNP plans each have a CMS Star Rating of four point five (4.5) (out of five (5)). These quality ratings are the result of our commitment to continuous quality improvement and our strongly engaged provider relationships.

PROVIDER ENGAGEMENT MODELS

Humana is deeply committed to improving outcomes and impacting unnecessary costs through provider engagement and Value-Based Purchasing (VBP) arrangements. We now have more than eight hundred thousand (800,000) Florida Medicaid and Medicare enrollees attributed to local PCPs engaged in VBP arrangements throughout the state. These providers deliver better performance when offered thoughtful incentives, consultative provider guidance, and care gap alerts that are integrated with comparative metrics and benchmarks. Humana offers a continuum of VBP arrangements that incentivize providers to undertake initiatives to reduce preventable events, improve chronic condition care delivery, reduce medical costs, and improve enrollee satisfaction. We meet providers at their respective levels of readiness for VBP and help them to move along this continuum of programs using data analytics and in-person support.

COMMUNITY DEVELOPMENT PROGRAM

While access to high quality health care is a top priority, we understand that social, environmental, and economic factors can have an even greater impact on health and well-being. Our determination to address these issues is captured in Humana's Bold Goal to make the communities we serve twenty (20) percent healthier by 2020. Achieving this goal is only possible through strong relationships with local organizations that help enrollees adopt healthy behaviors and address the many social determinants of health and wellness. In 2015, Humana launched Bold Goal markets in Florida, including Broward County, Tampa, and Jacksonville. In each of these regions, Humana established a local Bold Goal Health Advisory Board, which brings dozens of local stakeholders together to collaborate and find solutions to improve the local systems of care. The Humana Foundation, a 501(c)(3) entity with a governing and grant-

making body separate from Humana Inc. market leadership, has also contributed more than four million one hundred thousand dollars ($4,100,000) to local Florida non-profits since 2012, demonstrating dedication to community organizations and the individuals they work to serve. Most recently, in the immediate aftermath of Hurricane Irma, the Humana Foundation donated one million dollars ($1,000,000) to the American Red Cross and one hundred thousand dollars ($100,000) to Feeding America affiliates in Florida. Finally, Humana's Florida associates are highly-engaged in their communities, with more than thirty-three thousand six hundred (33,600) volunteerism hours logged in 2016.

APPROACH: IN SUMMATION

Through our diverse managed care experience, we have developed expertise providing service coordination, care planning, and specialized clinical management for the complex needs of TANF, ABD, and dual eligible populations within a social supports-based framework. This experience will help us effectively deliver an enhanced coordination and social support model in Florida's MMA and LTC programs. Humana's national and Florida-based experience demonstrates a strong ability to manage complex populations in large numbers and at industry-leading levels of quality while continually improving health and well-being outcomes for enrollees.

APPLICABLE TANF, ABD, AND DUAL ELIGIBLE EXPERIENCE

FLORIDA MANAGED MEDICAL ASSISTANCE

a. The Medicaid population served (such as TANF, ABD, dual eligible):
TANF, ABD, dual eligible

b. The name and address of the client:
Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308

c. The name of the contract:
Florida Managed Medical Assistance

d. The specific start and end dates of the contract:
January 2014 – September 2018

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

Humana covers medical, behavioral, pharmacy, dental, and transportation services for Medicaid populations including TANF, ABD, and dual eligible individuals in five (5) of eleven (11) regions. To help our enrollees manage conditions and receive appropriate care, we offer care coordination, disease management programs, utilization management, network management, and enrollee and provider call centers.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For the Florida MMA program, Humana uses select delegated subcontractors to cover behavioral health services and management, dental services, vision services, hearing services, non-emergency medical transportation services, 24/7 nurse advice line services, and translation services. For select services, we use administrative subcontractors for utilization management, claims processing, credentialing services, and network management.

We select subcontractors with strong performance metrics and positive reputations. When possible, we seek to establish long-standing relationships with strategic partners across our managed care programs nationwide. For instance, Humana is proud of its relationship with Beacon Health Options. Beacon's extensive behavioral health experience includes participating in twenty-six (26) states for Medicaid and six (6) states for dual-eligibles. Beacon also received or achieved accreditation by both URAC and NCQA. They are a trusted partner we use across all of our managed care programs covering behavioral health. Moreover, Humana ensures our subcontractors meet quality standards through continuous evaluation and oversight.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
2016 revenue: $1,317,449,049
2016 claims expense: $1,158,520,115

h. The scheduled and actual completion dates for contract implementation:
Scheduled: June to August 2014
Actual: June to August 2014

For the Florida MMA program, Humana successfully met all scheduled implementation deadlines.

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:
Barrier: During MMA program implementation, Humana's Florida Medicaid enrollment quickly grew from fifty thousand (50,000) to more than two hundred thousand (200,000) enrollees. This large influx of new enrollees created challenges to rapidly scale operations and meet enrollment requirements.

Resolution: To accommodate this high level of new enrollment, we brought in expert managers and representatives from our Care Centers to handle calls through implementation, and backfilled their previous roles in long-running centers with new associates. Moreover, given the scale of Humana's enrollment across all lines of business, we were capable of leveraging vast company-wide resources to ensure enrollee satisfaction didn't suffer.

Barrier: Another issue related to the large increase of enrollment was the ability to conduct all welcome calls within the required sixty (60)-day timeframe.

Resolution: To meet this requirement, Humana utilized both temporary and permanent staffing. We also created a sophisticated autodialing service to effectively serve our enrollment volume. Moreover, we reached out to enrollees six (6) times as compared to the required three (3) times. Ultimately, Humana was able to conduct all welcome calls within the required timeframe.

j. Accomplishments and achievements:

Humana has attained some notable quality achievements in the MMA program. In 2016, we performed above the statewide average on the following HEDIS areas of care:
- pregnancy-related care
- keeping kids healthy
- keeping adults healthy
- living with illness

For the AHCA MMA Health Plan Report Card, these quality scores resulted in ratings of three 4-star ratings and one five (5)-star rating in each area of care. Only one other standard MMA plan received more four (4) and five (5) star ratings on the MMA Health Plan Report Card. Further, Humana's enrollee satisfaction with help received from customer service was rated higher than all other standard MMA plans for adult enrollees.

Another area of achievement is our success limiting preventable hospital readmissions. In 2016, we reached a sixteen percent (16%) readmission rate, a seven-percent improvement over the previous year. As one example of an initiative to reduce readmissions, for our most complex enrollees, we operate our Frequently Admitted Member (FAM) program. In FAM, our clinical teams use real-time data and analytics to identify enrollees with the most acute facility inpatient admissions during the most recent 3-month period. As a result, we have achieved a fifty percent (50%) reduction in readmission rates for enrollees targeted by this program in a twelve (12)-month period.

We are also particularly proud of our accomplishments in our Bold Goal community development programs. In Broward County, Tampa, and Jacksonville, Humana has implemented its Bold Goal program, in which we have launched Health Advisory Boards that bring dozens of local stakeholders together to improve the communities' nutrition, access to care, and health education. The Humana Foundation, a 501(c)(3) entity with a governing and grant-making body separate from Humana Inc. market leadership, has also contributed more than four million one hundred thousand dollars ($4,100,000) to Florida non-profit organizations since 2012.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
325,909 Medicaid enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

FLORIDA LONG-TERM CARE

a. The Medicaid population served (such as TANF, ABD, dual eligible):
ABD, dual eligible

b. The name and address of the client:
Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308

c. The name of the contract:
Florida Long-term Care

d. The specific start and end dates of the contract:
January 2014 – September 2018

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

For the Florida Long-term Care program, Humana covers institutional and community-based long-term services and supports and transportation services for the ABD and dual eligible populations in all eleven (11) regions. Further, we provide care coordination, utilization management, network management, and enrollee and provider call centers to ensure enrollees receive the most appropriate services.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For the Florida LTC program, Humana uses various delegated subcontractors to cover non-emergency medical transportation. For expanded benefits, Humana uses subcontractors for non-medical transportation, vision services, and hearing services. For select services, Humana uses administrative subcontractors for claims processing, credentialing services, and network management. We select subcontractors with long-standing and significant experience in their fields. For instance, our vision services partner, iCare Health Solutions, has over three million enrollees in its networks. Humana ensures our subcontractors meet quality standards through continuous evaluation and oversight.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
2016 revenue: $757,356,420
2016 claims expense: $707,311,910

h. The scheduled and actual completion dates for contract implementation:
Scheduled: August 2013 to December 2013
Actual: August 2013 to March 2014

For the Florida LTC program, Humana successfully met all scheduled implementation deadlines.

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: To meet the needs of a relatively larger enrollment as compared to the NHD program, Humana needed to appropriately staff its care management operations.

Resolution: Humana developed a rapid hiring and training process to ensure we could effectively meet all of our enrollees' needs upon go-live. To do so, we developed an intensive six- (6) week training course for new care managers to guarantee they were capable of meeting all contract requirements and serving enrollees.

Barrier: Similarly, another barrier faced in implementing the Florida LTC program was the availability of qualified care management associates to meet contractual care coordinator eligibility requirements. Facing a large influx of new enrollees, there was a significant need for

Humana to hire additional care coordinators to provide ongoing care management services for enrollees.

Resolution: To alleviate this issue, Humana partnered with local area agencies on aging (AAA) for many care management functions. The AAAs were especially critical in providing continuity of care to waiver enrollees. In addition to alleviating a workforce shortage, the AAAs also provided historical expertise on the population, which further aided in better serving our membership. This partnership also allowed us to maintain and further develop existing enrollee relationships. Moreover, this approach allowed us to enhance, rather than supplant, local health care resources.

Barrier: For Comprehensive enrollees enrolled across both LTC and MMA, benefit integration between the two programs presented another implementation barrier. To provide holistic care across all benefits, Humana needed to develop systems that integrate information from both programs for care coordinators.

Resolution: Humana's current Comprehensive Plan has served as the catalyst for Humana to make significant investments in our integrated care delivery platform, CGX, which promotes enhanced care coordination for LTC eligible enrollees. CGX is a proprietary system that provides real-time coordination capabilities between primary and acute care, LTC, behavioral health, and a wide range of additional benefits and social supports categories. CGX gives clinical associates a 360-degree view of enrollees' clinical and social needs as well as the care being provided by MMA, LTC, and even the Medicare Advantage program for Duals enrolled across Humana's Medicaid and Medicare plans (including D-SNPs). This enhanced care coordination enables Humana to provide the most person-centered and individualized care plans possible. In our experience, effective clinical interventions are one of the keys to providing better health to enrollees and CGX has enabled our care management team to deliver essential integrated care. Humana supports integrated models because holding a single entity – as compared to multiple entities or bifurcating services across multiple programs – responsible for coordinating care can more likely improve health outcomes and enrollee experience while reducing avoidable costs. For these reasons, Humana is bidding as a Comprehensive Plan in all regions.

j. Accomplishments and achievements:

Humana is committed to helping LTC enrollees live in their setting of choice. For many enrollees, that means aging at home, rather than in an institution. Through extensive experience managing LTC services, we have developed evidence-based programs and processes to support enrollees with the services needed to stay in their homes and communities. For enrollees that are living in institutions with an interest and appropriate health status to move back to a community setting, we are proud of our accomplishments in coordinating their successful transitions. Most notably, Humana has helped more than one thousand seven hundred (1,700) Florida LTC enrollees transition from institutions to community settings since 2014.

We have also achieved notable success with our LTC performance measures. For the percentage of LTC plan enrollees who have documentation of a comprehensive health assessment within the appropriate time frame in 2016, Humana surpassed the benchmark of ninety (90) percent. Additionally, for the percentage of LTC plan enrollees who have

documentation of a comprehensive LTC care plan within the appropriate timeframe in 2016, Humana surpassed the benchmark of ninety percent (90%) with a score of ninety-five percent (95%).

Additionally, Humana performed above the AHCA's target benchmark rates for the following LTC quality measures in 2016:
- Advanced Care Planning - Total: 69.52% (AHCA target rate: 31.6%)
- Medication Review - Total: 98.84% (AHCA target rate: 80.9%)
- Functional Status Assessment - Total: 93.89% (AHCA target rate: 61.8%)
- Call Answer Timeliness: 97.75% (AHCA target rate: 81.50%)
- Required Record Documentation - Freedom of Choice Form: 90.71% (AHCA target rate: 90.0%)
- Face-to-Face Encounters (F2F) = 93.95% (AHCA target rate: 90.0%)
- Timeliness of Service (TOS) = 93.27% (AHCA target rate: 90.0%)

Our Florida SMMC program executive management team has extensive knowledge and experience both in health care generally and specifically in Florida Medicaid. Combined, our Florida leadership has one hundred thirty-three (133) years of experience serving LTC-eligible elderly and disabled populations. This experience is critical to managing health plans and improving the health outcomes of our enrollees.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
21,239 Medicaid enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

KENTUCKY MEDICAID MANAGED CARE

a. The Medicaid population served (such as TANF, ABD, dual eligible):
TANF, ABD, dual eligible

b. The name and address of the client:
Kentucky Department for Medicaid Services, 275 East Main Street, Frankfort, KY 40621

c. The name of the contract:
Kentucky Medicaid Managed Care

d. The specific start and end dates of the contract:
Origination: January 2013
Current contract period: July 2017 – December 2017, with optional contract renewals through 2020

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

For the Kentucky Medicaid Managed Care program, Humana covers medical, behavioral, pharmacy, and dental services for the TANF, ABD, and dual eligible Medicaid populations on a statewide basis. We also offer care coordination, disease management programs, and utilization

management to help our enrollees manage conditions and receive appropriate care. Humana also manages the provider network for this program.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For the Kentucky Medicaid Managed Care program, Humana delegates behavioral services and management, dental services, vision services, medical management, case management, utilization management, claims processing, and enrollee and provider call centers.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
Fiscal Year 2016 revenue: $795,085,463
Fiscal Year 2016 claims expense: $674,825,083

h. The scheduled and actual completion dates for contract implementation:
Scheduled: June 2012 to January 2013
Actual: June 2012 to January 2013

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:
Barrier: Upon receiving the contract initial award, Humana had a timeframe of only six (6) months to implement all contract requirements before enrollment began. Moreover, as Humana expanded its contract from the Louisville metropolitan region to the entire state, we experienced a more than one hundred percent (100%) enrollment increase.

Resolution: To ensure all contract requirements were met effectively and comprehensively, Humana developed an implementation command center. We focused resources to guarantee all issues were rapidly resolved. Humana developed an internal information sharing repository to house all communication surrounding contract implementation activities. Ahead of enrollment, Humana conducted numerous cross-functional tests to limit any problems thereafter. Further, to handle the large increase in enrollment, Humana took the lessons of its original, rapid contract implementation to establish a long-term, methodical process.

Barrier: With the implementation of the new managed care program, Humana identified enrollee engagement and education regarding the benefits of their new plan as an important barrier to address.

Resolution: To ensure all enrollees received effective program education, Humana took a multi-pronged approach. In addition to traditional welcome calls and welcome kits, we understood one of the most effective ways to reach enrollees was in their communities. Humana participated in copious community events, such as fairs and festivals, to reach our enrollees close to their homes. In August 2016 alone, Humana participated in over four hundred 400 public events.

j. Accomplishments and achievements:

Non-emergent use of the emergency room is a notable problem in the Kentucky Medicaid managed care program. As a result, Humana has increased its focus on addressing this matter. From 2014 to 2016, Humana’s quality initiatives on this issue led to a nearly fifteen (15) percent decrease in non-emergency use of the emergency. Moreover, Humana plans to launch a pilot focused on communication with the homeless of how to most appropriately access care.

Humana and Beacon Health Options played a major role in the rollout of a substance se Medicaid service continuum across the state by partnering with several new substance use provider types. Humana was one of the first health plans to successfully contract the bulk of Suboxone providers in Kentucky, and continues to assist providers with innovative treatment programing, such as the use of partial hospital and intensive outpatient programs in conjunction with inpatient residential services.

NCQA completed the annual review of HEDIS® data for 2017 as outlined in the 2017 Standards and Guidelines for the Accreditation of Health Plans. Based on our HEDIS 2017 results, the accreditation status for Humana Health Plan, Inc. (Kentucky)'s Medicaid HMO increased to Commendable.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
145,088 Medicaid enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

VIRGINIA COMMONWEALTH COORDINATED CARE

a. The Medicaid population served (such as TANF, ABD, dual eligible):
ABD, dual eligible

b. The name and address of the client:
Virginia Department of Medical Assistance Services (DMAS), 600 East Broad Street, Richmond, VA 23219

Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244

c. The name of the contract:
Virginia Commonwealth Coordinated Care

d. The specific start and end dates of the contract:
April 2014 – December 2017

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

For the Virginia Commonwealth Coordinated Care program (CCC), Humana covers medical, behavioral, pharmacy, LTSS, and transportation services across Medicare and Medicaid for the ABD and dual eligible populations in all regions. To help our enrollees manage conditions and receive appropriate care, we offer care coordination, utilization management, disease management programs, network management, and enrollee and provider call centers.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For the Virginia CCC program, Humana partners with delegated subcontractors for behavioral health services and management, vision services, non-emergency medical transportation, and LTSS transition services and care management.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
2016 revenue: $97,712,326
2016 claims expense: $87,428,433

h. The scheduled and actual completion dates for contract implementation:
Scheduled: March to November 2014
Actual: March to November 2014

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: One of the primary issues with a new managed care program is lack of enrollee and provider education. This is particularly true for demonstration programs such as this. As a result, the Virginia CCC program initially experienced high opt-out rates.

Resolution: To address this issue with providers, we conducted ongoing educational meetings to understand the benefits of the program and how to handle administrative changes (e.g., billing). We also learned that conducting educational meetings early and often with community-based organizations prior to program implementation was necessary. Prior to the CCC program, many organizations still operated on a fee-for-service (FFS) basis, had limited exposure to managed care programs, or were unaware of the dynamics of managed care. During program implementation, we helped educate these groups on the benefits of the program, how they could best support the program goals, and their reporting needs. We made it clear how highly we value their continued relationships with enrollees. Many were concerned the CCC program and the advent of the care coordination role would replace the need for their role. To alleviate these concerns, we met with them personally to propose how we planned to collaborate, gain their feedback, and include them in the model of care (MOC). Additionally, given the unique education needs of the program, we also provided education on more tangible items, such as coordination of benefits and enrollee identification cards.

Our existing processes help us consistently review implementation progress and adapt early to any identified needs and any gaps. Through our experience, we have finely tuned many areas of our implementation plan, such as:
- Program management structure organized across functional areas
- A structured playbook that outlines our implementation process, deliverables, roles and responsibilities
- Command Center structure for go-live to quickly react to production issues
- Continued commitment to remain aligned with the Department of Medical Assistance Services to best meet their objectives through our existing relationship
- To further streamline and simplify the LTSS implementation process, Humana recently invested more than $9,000,000 in a new LTSS integrated care management platform

Barrier: Access to health care and social support services varies across Virginia's regions. For example, the Southwest Region in the Appalachian Mountains is less populated and particularly

underserved. Ensuring access to care in regions like these was an important implementation barrier to address for the Virginia CCC program.

Resolution: To overcome these barriers, we used mobile health clinics and telehealth capabilities to try to reach enrollees in geographies with limited access to care, and worked to leverage our community relationships across the state to refer to community-based social supports that play a role in preventing the need for utilization of some of these services.

Barrier: Some nursing facility enrollees were previously receiving services from unaffiliated providers without Medicaid credentials. Upon implementation of the CCC program, these enrollees had difficulty receiving care within the facility.

Resolution: To overcome this misalignment, Humana worked to ensure the unaffiliated providers became credentialed for facilities in which they had patients. Humana worked closely with these facilities and providers to resolve any administrative burdens preventing alignment. This process guaranteed enrollees could retain their providers and receive care within their facility.

j. Accomplishments and achievements:

Humana has achieved some notable quality results in the CCC program. In an evaluation of Humana's first year performance, we had an overall score of 90.28%. Specifically, we scored over 90% in 9 of the 14 standards. In 2015, enrollees of Humana's CCC program provided strong, positive reactions to their care coordinator (CC) relationships:
- 90% responded "the CC understands what is important to me"
- 97% responded they received satisfaction with support and help from the CC
- 97% responded the CC helped them learn to better care for themselves
- 93% responded the CC helped form a plan and followed up
- 83% responded they would likely recommend care management services

89.4% of enrollees rated the help received from the CC was excellent, very good, or good; further, more than eighty percent (80%) indicated they have better control of their health since working with their CC.

Humana has achieved a strong adoption of value-based payment models among primary and acute providers. With focused investment in provider development to build infrastructure and capabilities that support these engagements, Humana now has more than 1,500 Virginia providers under VBP arrangements and approximately 80% of our CCC primary and acute care payments going to these providers.

As the CCC program rolled out, we noticed there were issues with process for transferring enrollees from one MCO to another. Specifically, the authorization transfer process lacked critical information elements to smoothly conduct this process. Humana noted these information gaps and submitted a revised form to DMAS to use for this process. Ultimately, DMAS selected Humana's revised form as the new template for the authorization transfer process.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
8,621 Medicaid-Medicare enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

ILLINOIS MEDICARE-MEDICAID ALIGNMENT INITIATIVE

a. The Medicaid population served (such as TANF, ABD, dual eligible):
ABD, dual eligible

b. The name and address of the client:
Illinois Department of Healthcare and Family Services (DHFS), 201 South Grand Avenue E, Springfield, IL 62704

Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244

c. The name of the contract:
Illinois Medicare-Medicaid Alignment Initiative

d. The specific start and end dates of the contract:
March 2014 – December 2017 (renewals through December 2019)

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

For the Illinois Medicare-Medicaid Alignment Initiative (MMAI), Humana covers medical, behavioral, pharmacy, LTSS, and transportation services across Medicare and Medicaid for the ABD and dual eligible populations in the Greater Chicago area. To help enrollees manage conditions and receive the most appropriate care, we offer care coordination, disease management programs, utilization management, network management, and enrollee and provider call centers.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For the Illinois MMAI program, Humana uses delegated subcontractors for behavioral health services and management, dental services, vision services, non-emergency medical transportation services, and LTSS care coordination and claims processing.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
2016 revenue: $161,877,647
2016 claims expense: $140,921,786

h. The scheduled and actual completion dates for contract implementation:
Scheduled: December 2013 to June 2014
Actual: December 2013 to June 2014

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: Through the MMAI program, we noticed there was a strong need to conduct provider engagement and education early and often in new managed care programs.

Resolution: We connected with providers before MMAI was implemented to educate on what it is, how it works, the benefits of participating, and how it positively impacts the health of those they serve. Humana gave providers opportunities to ask questions and voice their concerns, and we were responsive to their needs. Forums were also available to community-based organizations to ensure all parties effectively engage in and support the program's enrollees. Additionally, Humana conducted face-to-face sessions with providers who needed further assistance. A specific example was our successful partnership with the AIDS Foundation of Illinois. Through this unique partnership we developed a 'Medicaid Managed Care Training Program' focused on educating case managers who work directly with enrollees in their homes or in the field. These training sessions bridged gaps in communication, increased the understanding of the managed care program, and increased access to care for the hard-to-reach population. Participants were supplied with a 'Medicaid Guide' brochure and a Resource Guide which contained valuable forms and information for all participating health plans.

Barrier: Another barrier Humana experienced in the Illinois MMAI program was unable-to-contact (UTC) enrollees.

Resolution: In the dual eligible population, the UTC problem is particularly problematic as these enrollees often have a higher risk acuity. To help alleviate this issue, we worked closely with DHFS, community organizations, and our care model partners to ensure we received all available contact information on enrollees. Our call center also alerted care managers when a UTC enrollee called. Humana employed a feet-on-the-street approach to more actively find enrollees. For instance, we visited community-based partners, such as homeless shelters, in an attempt to find enrollees in locations where they might be.

j. Accomplishments and achievements:

For the Illinois MMAI program, Humana's 2017 HEDIS scores are in the top fifth (5th) percentile relative to national benchmarks for all measures. For example, below are select screening rates for our MMAI enrollees:
- Diabetes A1c testing: 87%
- Diabetes Nephrology testing: 91%
- Adult BMI assessment: 92%

Humana partnered with Thresholds, a community mental health center provider in Cook and Kankakee counties in Illinois, to provide wraparound services to enrollees identified as having a severe mental health diagnosis and who have also been identified as being high utilizers of inpatient services to manage their healthcare. The goal of the program is to connect these vulnerable enrollees to resources within their community. These resources include emergency housing, food pantries, counseling services, psychiatric services, substance abuse programs, vocational rehabilitation programs, long-term housing, primary care services, safe housing for victims of domestic violence, and medication management. Enrollees who have been involved for six (6) months have seen a sixty-four percent (64%) decrease in inpatient utilization.

Humana also noticed issues related to language translation services with this program's population. Specifically, our care coordinators realized telephonic translation services weren't

always an effective means of communication, especially as it related to overcoming cultural barriers. As a result, we identified and contracted with a local and certified community agency that provides culturally appropriate in-home translation services between the enrollees, Humana care coordinators, and case managers. This helped to build trust between enrollees and case managers and increase the success rate of care assessments and screenings.

We have also sought to improve problems related to food deserts and food insecurity in our service areas through a health and nutrition program. Specifically, Humana identifies communities with a high concentration of individuals experiencing food disparities. We provide education on the functionality of various grains, produce, meat, and dairy products and nutrition label interpretation. Additionally, our program demonstrates the cooking of various food products. Finally, our associates help enrollees through a "grocery store shopping challenge" (meal planning for under ten dollars ($10.00)) by showing how to find ingredients to cook the most nutritional meals on a small budget.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
6,355 Medicaid-Medicare enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

ILLINOIS INTEGRATED CARE PROGRAM

a. The Medicaid population served (such as TANF, ABD, dual eligible):
ABD

b. The name and address of the client:

Illinois Department of Healthcare and Family Services (DHFS), 201 South Grand Avenue E, Springfield, IL 62704

c. The name of the contract:
Illinois Integrated Care Program

d. The specific start and end dates of the contract:
February 2014 – January 2018

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

For the Illinois Integrated Care Program (ICP), Humana covers medical, behavioral, pharmacy, dental, LTSS, and transportation services for the TANF, ABD, and dual eligible populations in the Greater Chicago area. To help our enrollees manage conditions and receive appropriate care, we offer care coordination, disease management programs, utilization management, network management, and enrollee and provider call centers.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For Illinois ICP, Humana uses delegated subcontractors for behavioral health services and management, dental services, vision services, non-emergency medical transportation services, and LTSS care coordination and claims processing.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
2016 revenue: $97,712,326
2016 claims expense: $87,428,433

h. The scheduled and actual completion dates for contract implementation:
Scheduled: February to May 2014
Actual: February to May 2014

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: During implementation of Illinois ICP, health plans were not receiving proper documentation of new enrollees' transition from existing care plans. As a result, authorization for services could not be provided until after an initial visit with the enrollee, which could be up to 90 days from the enrollee's effective date.

Resolution: To overcome this barrier, Humana obtained access to the Department on Aging and Department of Rehabilitation Services Systems to proactively verify enrollees' care plans. Providers were encouraged to request authorization at the time the enrollee became effective with the new health plan. When an authorization was requested, Humana could now verify services through the State and create shell service plans with provider authorizations pending the initial enrollee assessment. This process significantly reduced denied claims, complaints from providers, and the need to reprocess claims once the initial assessment was completed.

Barrier: Similarly, Humana experienced issues educating enrollees about the new program.

Resolution: In addition to providing enrollees with a welcome kit and handbook, we also conducted program education seminars in the community. For instance, we held these sessions at local community and faith centers. These events were aimed at gathering enrollees within their neighborhoods and communities to better educate them on how the program works and its benefits.

j. Accomplishments and achievements:

Throughout this program, Humana made significant strides in improving encounter data reporting. Specifically, we formed a specialized Encounter Submission Team that collaborated with the Department of Healthcare and Family Services and other ICP MCOs to find innovative solutions to this issue. As a result, Humana increased its encounter acceptance rate from 43.5% in Q3 2014 to 90.8% in Q2 2016.

To more proactively address complications related to homelessness, Humana worked to increase communication between shelters, health care facilities, and health plans about how to place homeless enrollees within shelters. Additionally, Humana is working with local housing agencies in an attempt to increase the availability of affordable housing.

To further address issues associated with homelessness in our service area, Humana had its associates volunteer to fill one thousand (1,000) lunch bags and also distributed snack packs to local community agency partners. For our volunteerism, Humana received the 2016 CASA Central Community Builder Award, which is presented to a company who has distinguished themselves as a close partner who has consistently engaged in volunteer efforts, special events, educational programs, and in-kind donations.

For the Illinois ICP, Humana's HEDIS scores are in the top fifth (5th) percentile compared to national benchmarks in all measures. For instance, below are select screening rates our ICP enrollees:
- Diabetes A1c testing: 85%
- Diabetes Nephrology testing: 93%
- Adult BMI assessment: 88%

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
5,626 Medicaid enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

MEDICARE ADVANTAGE

a. The Medicaid population served (such as TANF, ABD, dual eligible):
ABD, dual eligible

b. The name and address of the client:
Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244

c. The name of the contract:
Medicare Advantage

d. The specific start and end dates of the contract:

February 1986 – present. Humana's first MA contract began in February 1986. Since then, we have obtained and operated numerous MA contracts with varying durations and renewal periods on a continual basis.

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

In Humana's Medicare Advantage plans, we cover medical, behavioral, pharmacy, and transportation services for the ABD and dual eligible populations on a nationwide basis. To help our enrollees manage conditions and receive appropriate care, we offer care coordination, disease management programs, utilization management, network management, and enrollee and provider call centers.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For its MA plans, Humana uses delegated subcontractors for telemedicine services, 24/7 nurse advice line services, claims processing, and credentialing services.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
2016 revenue: $35,247,406,498
2016 claims expense: $28,146,219,949

h. The scheduled and actual completion dates for contract implementation:
Scheduled: February 1986
Actual: February 1986

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: When Humana associates interacted with our enrollees through experiences such as an in-home visits or phone calls, they weren't able to see important enrollee milestones and key interactions that have occurred or will occur with other departments across the Humana organization. This limited view hampered their ability to provide complete, personalized, and connected support. It also limited their ability to go above and beyond to help the enrollee with potential best next decision.

Resolution: To resolve this issue, Humana launched its Customer Relationship Management (CRM) Service to associates across the organization. This service provides a single, consistent view of our enrollees and their interactions with Humana in order to deliver a more informed and valuable experience. Our associates are now better enabled to help enrollees get the specific care and support they need through a consistent experience across their health journey. CRM and its parallel platforms, Consumer360 and CRM Marketing, can help deliver targeted and personalized messaging based on enrollee preferences, health needs, and recent life events.

Barrier: A general challenge frequently faced with MA plans is coordinating with other types of insurance, specifically Medicaid. For instance, there is a need for comprehensive, integrated data spanning enrollees' Medicare and Medicaid benefits and services.

Resolution: To resolve this matter, Humana has invested significant time and resources toward building a fully integrated, all-internal care management IT platform – Clinical Guidance eXchange (CGX) – that provides a 360-degree view across an enrollee's full spectrum of care, including medical, behavioral health, LTSS, and social services. Another issue MA plans can face in coordinating with Medicaid is identifying enrollees' primary care provider (PCP) of record when the PCP is not in a Humana program (enrollee is in an unaligned plan or FFS Medicare). Humana care coordinators work diligently with enrollees and their points of care to identify the appropriate PCP and incentivize the PCP to join the enrollee's care team and Humana's provider network. Additionally, ensuring appropriate provider payment can present a challenge in coordinating across MA and Medicaid. Humana establishes detailed, effective coordination of benefits policies and procedures to ensure providers are paid properly and timely.

j. Accomplishments and achievements:

Humana's leadership in quality improvement is evident in many associated accomplishments and achievements for our MA plans. For example, we were the first publicly-traded health plan

to achieve a full 5-Star rating from CMS. In the recently-published 2018 ratings, all Humana MA HMO membership in Florida received a 4.5-star rating. Other notable accomplishments from the most recent ratings include:
- 2,400,000 Humana MA enrollees are in contracts with ratings for 4 stars or greater
- Humana received a 4.5-star rating for five Medicare Advantage contracts offered in 8 states
- For Humana Medical Plan, Inc.'s Florida MA contract (CMS number H1036), we have achieved a CMS Rating of 4.5. Further, this plan has an NCQA status of Commendable.

Overall, this contract has more than 456,000 enrollees; in Florida specifically, this contract has nearly 365,000 enrollees.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
3,263,400 Medicare enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

DUAL ELIGIBLE SPECIAL NEEDS PLAN

a. The Medicaid population served (such as TANF, ABD, dual eligible):
Dual eligible

b. The name and address of the client:
Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244

c. The name of the contract:
Dual Eligible Special Needs Plans

d. The specific start and end dates of the contract:

January 2006 – present. Humana's first D-SNP contract began in January 2006. Since then, we have obtained and operated numerous MA contracts with varying durations and renewal periods on a continual basis.

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

In Humana's Dual Eligible Special Needs Plans, we cover medical, behavioral, pharmacy, and transportation services across Medicare and Medicaid for the dual eligible population in 22 states and Puerto Rico. To help our enrollees manage conditions and receive appropriate care, we offer care coordination, disease management programs, utilization management, network management, and enrollee and provider call centers.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For its D-SNP programs, Humana uses delegated subcontractors for telemedicine services, 24/7 nurse advice line services, claims processing, and credentialing services.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
2016 revenue: $2,762,606,316
2016 claims expense: $2,152,521,416

h. The scheduled and actual completion dates for contract implementation:
Scheduled: January 2006
Actual: January 2006

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: Upon implementation of the D-SNP program, customer service representatives and providers were unfamiliar with cost sharing and benefits. Customer Service at times misquoted the enrollee responsibility for medical cost-sharing for D-SNPs and providers were erroneously billing D-SNP enrollees for cost shares for medical services.

Resolution: To address the matter, Humana took the following approaches:

- Overhauled training and source documentation for Customer Service

- Added alerts that display to a customer service representatives when they take a call for a D-SNP enrollee that reminds them of a D-SNP enrollee's protection from cost-sharing for medical services

- Added more specific information to the provider training on cost share protection

- Added information to the enrollee materials (Evidence of Coverage, Acknowledgement of Enrollment Letter, Welcome Packet) that asks the enrollee to display their Medicaid ID card along with their Humana D-SNP ID Card to ensure the provider and their front office associates know they are serving a cost-share protected enrollee

Barrier: Humana had a state-specific automated crossover claims process whereby the provider was taken out of the middle of having to bill two entities – Humana and the state – for a single service rendered. Initially, we experienced challenges with national provider identifier (NPI) data matching between Humana systems and the state database. This NPI "mismatch" created a backlog of pended/incorrect/unidentifiable claims for our state partner and created provider complaints, as some weren't receiving their "secondary" payment.

Resolution: Humana implemented a new process to eliminate the NPI "mismatch" proactively by utilizing a provider data report the state published monthly and by developing a program using comparison logic to identify and eliminate the mismatch. This remediation effort included a provider outreach campaign to help educate providers of the importance of keeping their state and Humana registration information up-to-date.

Barrier: Additionally, D-SNP enrollees were losing and gaining eligibility frequently, causing enrollees to be dis-enrolled frequently and then be re-enrolled in the plan when they regained eligibility soon thereafter. Continual changes in eligibility presented negative impacts on continuity of care.

Resolution: To resolve the issue, Humana changed its policy to move from the minimum deeming period allotment of one (1) month to the maximum CMS allowed grace period of six (6) months. This allows those enrollees that are frequently losing and then regaining their qualifying level of Medicaid status, to remain on the plan and receive consistent care management.

j. Accomplishments and achievements:

For Humana's Florida D-SNP contract (H1036), we have achieved a Medicare Stars Rating of 4.5. Additionally, this plan's NCQA status is Commendable.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
190,992 Medicare (dual-eligible) enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

FLORIDA MEDICAID HMO

a. The Medicaid population served (such as TANF, ABD, dual eligible):
TANF, ABD, dual eligible

b. The name and address of the client:
Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, Florida 32308

c. The name of the contract:
Florida Medicaid HMO

d. The specific start and end dates of the contract:
Origination: 1997
Last Contract Period: September 2012 – December 2013

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

For the Florida Medicaid HMO program, Humana covered medical, behavioral, pharmacy, and dental services for the TANF, ABD, and dual eligible populations in Broward, Dade, Hillsborough, Pinellas, and Pasco Counties. To help our enrollees manage conditions and receive appropriate care, we offered care coordination, disease management programs, utilization management, network management, and enrollee and provider call centers.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For the Florida Medicaid HMO program, Humana used delegated subcontractors for utilization management, behavioral health services and management, dental services, non-emergency medical transportation, and vision services. We selected subcontractors with strong performance metrics and positive reputations. Humana ensured our subcontractors met quality standards through continuous evaluation and oversight.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
Contract revenue: approximately $161,000,000
Contract claims expense: approximately $143,000,000

h. The scheduled and actual completion dates for contract implementation:

Scheduled:
- Origination: 1997
- Last Contract Period: September 2012

Actual:
- Origination: 1997
- Last Contract Period: September 2012

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: Prior to the introduction of managed care in the state of Florida, the majority of enrollees had never been in a managed care program and were thus unaccustomed to these changes.

Resolution: As a result, some enrollees experienced confusion surrounding benefit changes and their relationship with Humana. To address these matters, Humana worked closely with enrollees ensure they received comprehensive information about their plan benefits and how to access care.

Barrier: Similarly, many providers were unaccustomed to managed care. Some providers seemed frustrated with programmatic changes and had difficulty adjusting to the new program.

Resolution: To resolve these issues, Humana ensured providers received education – both remotely and in-person – on items such as prior authorization and claims submission and on the broader goals and potential of managed care.

j. Accomplishments and achievements:

In the Florida Medicaid HMO program, Humana was Florida's top NCQA quality-rated Medicaid health plan from 2011 to 2013. Specifically, Humana achieved an NCQA accreditation status of Commendable and was rated the number one Medicaid plan in Florida by NCQA and number 50 in the nation based on HEDIS, CAHPS, and accreditation scores. Additionally, Humana scored 95.8 percent on the 2012 ACHA On-Site Survey and Comprehensive Desk Review Complied, with 100% of ACHA contract deliverables.

To further drive quality performance in the Florida Medicaid HMO program, Humana created an Advisory Panel and ER Overutilization Task Force to identify best practices including: real-time data sharing with hospitals allowing early enrollee intervention; improve communication; targeting PCP practices with high ER utilization and encouraging them to extend office hours, improve enrollee accessibility, and engage around best practices.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
50,438 Medicaid enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

FLORIDA NURSING HOME DIVERSION

a. The Medicaid population served (such as TANF, ABD, dual eligible):
ABD, dual eligible

b. The name and address of the client:
Florida Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399

c. The name of the contract:
Florida Nursing Home Diversion

d. The specific start and end dates of the contract:
March 2007 – February 2014

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

For the Florida Nursing Home Diversion program, Humana covered long-term services and supports for the ABD and dual eligible populations on a statewide basis. To ensure enrollees received the most appropriate services, we offered care coordination, utilization management, network management, and enrollee and provider call centers.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For the Florida NHD program, Humana delegated subcontractors for non-emergency medical transportation. We selected subcontractors with strong performance metrics and positive reputations. Humana ensured our subcontractors met quality standards through continuous evaluation and oversight.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
Contract revenue: $23,342,071
Contract claims expense: $17,662,742

h. The scheduled and actual completion dates for contract implementation:
Scheduled: March 2007
Actual: March 2007

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: Prior to the introduction of managed care in the state of Florida, the majority of enrollees had never been in a coordinated care program. Because were unaccustomed to managed care plans, they needed education to understand their benefits, the clinical programs available, and more.

Resolution: As a result, some enrollees experienced confusion surrounding benefit changes and their relationship with Humana. To address these matters, Humana worked closely with enrollees ensure they received comprehensive information about their plan benefits and how to access care.

Barrier: Similarly, many providers were unaccustomed to managed care. Some providers seemed frustrated with programmatic changes and had difficulty adjusting to the new program.

Resolution: To resolve these issues, Humana ensured providers received education – both remotely and in-person – on items such as prior authorization and claims submission and on the broader goals and potential of managed care.

j. Accomplishments and achievements:

As an NHD plan, Humana developed six (6) years of experience in Florida helping the frail dual eligible population remain in the community and stay out of nursing facilities. By providing our enrollees with home and community-based services (HCBS), including intensive case management, we have been able to reduce their Medicare costs. Humana's NHD plan consistently received high satisfaction evaluations from enrollees. For four (4) consecutive annual enrollee satisfaction surveys, more than 86% of our enrollees ranked the plan 8 through 10 on a scale of 1 through 10 with 10 being the highest ranking

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
1,669 Medicaid enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

PUERTO RICO MI SALUD

a. The Medicaid population served (such as TANF, ABD, dual eligible):
TANF, ABD, dual eligible

b. The name and address of the client:
Departamento de Salud, Centro Médico Norte Calle Periferial Interior, Bo. Monacillos Rio Piedras, San Juan, Puerto Rico

c. The name of the contract:
Puerto Rico Mi Salud

d. The specific start and end dates of the contract:
December 1995 – June 2014

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

For the Puerto Rico Mi Salud program, Humana covered medical, pharmacy, dental, and transportation services for the TANF, ABD, and dual eligible populations in the state on a

territory-wide basis. To help our enrollees manage conditions and receive appropriate care, we offer care coordination, disease management programs, and utilization management.

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

For the Puerto Rico Mi Salud program, Humana used a delegated subcontractor for dental services.

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
2012 revenue $812,286,892
2012 claims expense: $775,052,363

h. The scheduled and actual completion dates for contract implementation:
Scheduled: December 1995
Actual: December 1995

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Barrier: In 2010, Humana expanded into Puerto Rico's Southwest region, the transition of care information for new enrollees we received from other MCOs was often incomplete, making it difficult to effectively meet continuity of care requirements.

Resolution: In order to ensure access and continuity of care for the new enrollees, Humana established partnerships with all PCPs, independent provider associations, and the territorial government to collaborate in the exchange of enrollee information. Humana built databases and diagnoses registries based on information provided by each individual PCP. Such partnerships helped us in establishing a starting point to make sure all enrollees had access to the benefits they required in a seamless transition upon their enrollment with Humana.

j. Accomplishments and achievements:

Since 1999, Humana was in full compliance with NCQA Certified external audit requirements. Auditors are in charge of performing a full NCQA/HEDIS Compliance Audit of the HEDIS reporting measures. Every audit report has confirmed that Humana Performance Reports have been prepared according to the corresponding HEDIS Specifications and standard procedures. The aforementioned audit reports indicated that improvements have been observed in many types of care: i.e., prevention, acute care and treatment of chronic illness.

Humana launched the PulmonesSanos program in 2007, targeting beneficiaries with severe stratification in respiratory health. The program integrated a comprehensive clinical evaluation, self-assessments utilizing the evidenced based Asthma Control Test (ACT), medication optimization, as well as continued telephonic follow-up based on risk. This model differs from the traditional disease management model since Humana had the pulmonologist directly assessing health risks and respiratory health of participating beneficiaries and Humana assuming the financial risk for these specialists as well as for the prescriptions they prescribe for participants. The program resulted in a reduction in ER visits and admissions and improved ACT scores.

k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid):
532,588 Medicaid enrollees

l. Whether the contract was capitated, FFS or other payment method:
Capitated

Evaluation Criteria:

1. The extent of the respondent's experience with providing integrated medical and behavioral health services.

2. The extent of the respondent's subcontractors' experience in coordinating or providing services to Medicaid recipients.

3. The extent to which the barriers to implementation experienced by the respondent have clear resolutions outlined.

4. The extent to which the respondent has listed accomplishments and achievements that are relevant to this solicitation.

5. The extent to which the respondent's Medicaid populations served are similar to the populations served by the SMMC program.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 2 – Florida Experience (Regional):

The respondent shall provide documentation of the extent to which it has experience operating as a Florida Medicaid health plan in the region in which it plans to provide services or in any other region in the State of Florida. If applicable, the respondent shall provide the Agency Contract number and the regions of operation to show it has experience providing managed care services and/or LTC services in Florida. The respondent shall provide documentation of any Medicare Advantage Plan contracts for counties in the State of Florida.

Response:

FLORIDA REGION 1 PRESENCE

In Region 1 of Florida's Statewide Medicaid Managed Care (SMMC) program, Humana has a:
- Comprehensive SMMC contract (FP023), and
- Medicare Advantage (MA) contract (Centers for Medicare and Medicaid Services (CMS) contract number H1036).

Attachment 2-1, the CMS 2017 Contract Management Report, provides documentation for Humana's MA contract number H1036 in Region 1.

FLORIDA STATEWIDE PRESENCE

Humana's SMMC contract includes all eleven (11) regions. We have a Comprehensive Long-Term Care (LTC) plan in Regions 1, 6, 9, 10, and 11. Similarly, we have an LTC plan in Regions 2, 3, 4, 5, 7, and 8.

Humana's MA contract (H1036) covers counties in all eleven (11) SMMC Regions. Additionally, Humana operates an MA Dual-Eligible Special Needs Plan (D-SNP) contract (H1036) in Region 1 and every other SMMC region.

Evaluation Criteria:

For the Managed Care Plan that is proposing to provide services under this solicitation, whether the respondent has:

- An existing SMMC Contract in that region;
- An existing SMMC Contract in another region in the State of Florida; or
- A Medicare Advantage Plan contract in that region.

Score: This section is worth a maximum of 30 raw points as outlined below.

1. 20 points if the respondent already has an SMMC Contract in the region that it plans to provide services (MMA, LTC and/or Specialty).

2. 10 points if the respondent has an SMMC Contract in other regions in the State.

3. 5 additional points will be awarded if the respondent has a comprehensive (MMA & LTC) SMMC Contract in the region that it plans to provide Medicaid services.

4. 5 additional points will be awarded if the plan has a Medicare Advantage Plan in the region that it plans to provide services.

5. 0 points will be awarded if the plan does not have an SMMC Contract in Florida or a Medicare Advantage Plan contract in the region.

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Contract Service Area Report

Region: Kansas City

Contract Number: H1036
Organization Name: HUMANA MEDICAL PLAN, INC.
Organization Type: Local CCP
Plan Type: HMO/HMOPOS

State	County	County Code	Employer-Only County?	Pending County?	Partial County?
Florida	Alachua	10000	No	No	No
	Baker	10010	No	No	No
	Bay	10020	No	No	No
	Broward	10050	No	No	No
	Charlotte	10070	No	No	No
	Citrus	10080	No	No	No
	Clay	10090	No	No	No
	Collier	10100	No	No	No
	Columbia	10110	No	No	No
	Duval	10150	No	No	No
	Escambia	10160	No	No	No
	Flagler	10170	No	No	No
	Glades	10210	No	No	No
	Hardee	10240	No	No	No
	Hernando	10260	No	No	No
	Highlands	10270	No	No	No
	Hillsborough	10280	No	No	No
	Lee	10350	No	No	No
	Manatee	10400	No	No	No

	Martin	10420	No	No	No
	Miami-Dade	10120	No	No	No
	Nassau	10440	No	No	No
	Okeechobee	10460	No	No	No
	Orange	10470	No	No	No
	Osceola	10480	No	No	No
	Palm Beach	10490	No	No	No
	Pasco	10500	No	No	No
	Pinellas	10510	No	No	No
	Polk	10520	No	No	No
	Putnam	10530	No	No	No
	Santa Rosa	10560	No	No	No
	Sarasota	10570	No	No	No
	Seminole	10580	No	No	No
	St. Johns	10540	No	No	No
	St. Lucie	10550	No	No	No
	Volusia	10630	No	No	No
	Walton	10650	No	No	No
Kentucky	Jefferson	18550	No	No	No
Mississippi	Attala	25030	No	No	No
	Copiah	25140	No	No	No
	DeSoto	25160	No	No	No
	Hancock	25220	No	No	No
	Harrison	25230	No	No	No
	Hinds	25240	No	No	No
	Jackson	25290	No	No	No
	Madison	25440	No	No	No
	Pearl River	25540	No	No	No
	Rankin	25600	No	No	No

North Carolina	Alamance	34000	No	No	No
	Anson	34030	No	No	No
	Burke	34110	No	No	No
	Cabarrus	34120	No	No	No
	Caldwell	34130	No	No	No
	Caswell	34160	No	No	No
	Catawba	34170	No	No	No
	Davidson	34280	No	No	No
	Davie	34290	No	No	No
	Forsyth	34330	No	No	No
	Gaston	34350	No	No	No
	Guilford	34400	No	No	No
	Iredell	34480	No	No	No
	Mecklenburg	34590	No	No	No
	Person	34720	No	No	No
	Randolph	34750	No	No	No
	Rockingham	34780	No	No	No
	Rowan	34790	No	No	No
	Stanly	34830	No	No	No
	Stokes	34840	No	No	No
	Wake	34910	No	No	No
	Yadkin	34980	No	No	No
Oregon	Clackamas	38020	No	No	No
	Deschutes	38080	No	No	No
	Jefferson	38150	No	No	No
	Multnomah	38250	No	No	No
	Washington	38330	No	No	No

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 3 – Statutorily Required Florida Presence (Statewide):

The respondent shall provide information regarding whether each operational function, as defined in Section 409.966(3)(c)3, Florida Statutes, will be based in the State of Florida, and the extent to which operational functions will be conducted by staff in-house or through contracted arrangements, located in the State of Florida. This includes:

a. Specifying the location of where the respondent's corporate headquarters will be located (as defined by Section 409.966(3)(c)3, Florida Statutes);

b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and

c. Identifying the number of full-time staff, by operational function (as defined in Section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Humana's Florida operations are deeply embedded into communities across the State, employing more than ten thousand (10,000) associates throughout our Florida offices. Our current participation in the Florida Medicaid Managed Medical Assistance (MMA) and Long-term Care (LTC) programs has led to a strong foundation of existing operational infrastructure. Since 1997, Humana has provided exceptional care and support to our Florida Medicaid enrollees. Our operational functions align with our staffing plan to ensure all services meet or exceed the Agency's and enrollees' expectations. Humana's Florida-based leadership and associates have built a strong relationship with the Agency and we will continue to work together to carry out our shared mission of improving the health and well-being of Florida Medicaid recipients.

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a. Specifying the location of where the respondent's corporate headquarters will be located (as defined by Section 409.966(3)(c)3, Florida Statutes);
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Incorporated in Florida in 1986, Humana Medical Plan, Inc. (HMP) headquarters is located at 3501 SW 160th Avenue, Miramar, Florida, 33027. HMP continues to operate as a licensed Health Maintenance Organization (HMO) in the State of Florida today.

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b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the state of Florida
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As a legal entity established more than thirty (30) years ago, Humana Medical Plan, Inc. (HMP) has drawn upon the experience and resources of its parent company, Humana Inc., and

affiliates to support its delivery of accessible and timely care to enrollees. Humana's integrated organizational model allows for our principal corporate office to be located outside Florida while still allowing us to deliver highly localized care and support in Florida. Our principal corporate office is located at 500 West Main Street, Louisville, Kentucky, 40202.

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c. Identifying the number of full-time staff, by operational function (as defined in Section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

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Humana's operational functions staffing plan was built recognizing the value of having in-state personnel supplemented by an infrastructure of shared services support. In-state associates primarily address the most critical elements of care and support delivery. For example, four hundred and ninety-nine (499) out of five hundred and one (501) case managers reside in Florida, a ninety-nine (99) percent in-state ratio. Out-of-state shared services associates enables Humana to handle peak volumes or seasonal variances without interruption to in-state services, agencies, or enrollees. In addition, out-of-state shared services associates provide necessary back-up in the event of a natural disaster or other outage with in-state functional operations. For instance, Humana can quickly shift Customer Care operational functions to a backup site. By shifting certain operational functions out-of-state during a disaster, Humana ensures business continuity and support for our plan enrollees, as well as Humana personnel. For example, during Hurricane Irma, we shifted our inbound Customer Care functions away from our Florida associates to unaffected locations until normal business service could be resumed. This ensured our enrollees could personally connect with us for current plan information and any related concerns regarding disaster relief.

Humana employs nine hundred and fifty-nine (959) full-time, Florida-based associates to perform our Medicaid operational functions as defined in Section 409.966(3)(c)3, Florida Statutes. Our full-time, Florida-based associates account for seventy-five percent (75%) of the total workforce attributed to the Medicaid operational functions outlined. The remaining twenty-five (25) percent are Humana associates located outside the State of Florida. All operational functions provided outside of Florida are accountable to Florida leadership, governance, and executive management escalation processes.

Humana performs the vast majority of our operational functions in-house, while delegating a small portion to specific subcontractors, primarily behavioral health and transportation, to perform relevant functions (e.g. claims processing). Oversight and monitoring procedures are conducted by Humana associates located in and outside the State of Florida to effectively manage the subcontractors performing these operational functions.

FULL-TIME ASSOCIATES BY OPERATIONAL FUNCTION

The operational functions (as defined in Section 409.966(3)(c)3) performed by existing full-time, Florida-based associates and existing, full-time associates outside of Florida is provided below and in Attachment 3-1.

Claims Processing:

- Forty-four (44) full-time Humana associates located in the State of Florida (twenty-seven percent (27%) of the total Humana associates performing Florida Medicaid Claims Processing)
- One hundred eighteen (118) full-time Humana associates located outside the State of Florida (seventy-three percent (73%) peXrcent of the total Humana associates performing Florida Medicaid Claims Processing)

Enrollee/Member Services:
- One hundred eighty-one (181) full-time Humana associates in Florida (sixty-nine percent (69%) of the total Humana associates performing Florida Medicaid Enrollee/Member Services)
- Eighty-three (83) full-time Humana associates located outside the State of Florida (thirty-one percent (31%) of the total Humana associates performing Florida Medicaid Enrollee/Member Services)

Provider Relations:
- Sixty-five (65) full-time Humana associates located in Florida (One hundred (100) percent of the total Humana associates performing Florida Medicaid Provider Relations)
- Zero (0) out-of-state Humana associates (zero percent (0%) of the total Humana associates performing Florida Medicaid Provider Relations)

Utilization and Prior Authorization:
- Forty-eight (48) full-time Humana associates in Florida (Sixty-one percent (61%) of the total Humana associates performing Florida Medicaid of Utilization and Prior Authorization)
- Thirty-one (31) full-time Humana associates located outside the State of Florida (thirty-nine percent (39%) of the total Humana associates performing Florida Medicaid Utilization and Prior Authorization)

Case Management:
- Four-hundred fifty-nine (459) full-time Humana associates in Florida (ninety-nine percent (99%) of the total Humana associates performing Florida Medicaid Case Management)
- Two (2) full-time Humana associates located outside the State of Florida (one percent (1%) of the total Humana associates performing Florida Medicaid Case Management)

Disease Management and Quality Functions:
- Seventy-four (74) full-time Humana associates in Florida (Eighty-one percent (81%) of the total Humana associates performing Florida Medicaid Disease and Quality Functions)
- Seventeen (17) full-time Humana associates located outside the State of Florida (Nineteen percent (19%) of the total Humana associates performing Florida Medicaid Disease and Quality Functions)

Finance and Administration:
- Eighty-eight (88) full-time Humana associates in Florida (fifty-eight percent (58%) of the total Humana associates performing Florida Medicaid Finance and Administration)
- Sixty-four (64) full-time Humana associates located outside the State of Florida (forty-two percent (42%) of the total Humana associates performing Florida Medicaid Finance and Administration)

Beyond the operational functions described above, our Florida-based teams are also comprised of a number of specialized employees who ensure the delivery of integrated, person-centered, comprehensive care to our SMMC enrollees. In alignment with the SMMC contract, our current

Humana Florida Medicaid Contract Manager, Humana Florida Medical Director, Humana Florida Medicaid President, and Humana Florida Medicaid Compliance Officer dedicate one hundred percent (100%) of their time to this contract and are located and operate within the State of Florida. Additionally, we meet or exceed all contractual staffing requirements, including the following areas: Medicaid Quality, Medicaid Recipient/Provider Assistance, Medicaid Policy, Medicaid Data Analytics, Medicaid Finance, Claims and Encounter Data, Program Integrity, and Subcontractor Oversight.

Not only does the State of Florida house a majority of our Humana Florida Medicaid leadership, our presence also provides an extensive opportunity for enrollees to seek guidance in-person about their benefits, as they are able to do so at any of our office locations in Florida. As an extension of the in-person enrollee services provided, we also have an Inbound Enrollee Customer Care Center located in Tampa and an Outbound Enrollee Customer Care Center located in Miramar. Furthermore, case managers and their teams live in the Florida regions they serve. Our office locations, Customer Care teams, and case managers enable enrollees to discuss their current health plan benefits and services with local associates.

In addition to Humana office locations, we have neighborhood Humana locations across Florida. These neighborhood locations are open to the public and are an integral part of our Bold Goal initiative—making every community we serve twenty percent (20%) healthier by 2020. Our neighborhood locations provide health and wellness education, healthy cooking classes, computer and technology classes to help visitors better manage their health, community experts who come to share their knowledge, walking clubs, and social events. Individuals can also speak with a Humana Care Specialist to address questions about their current health plan benefits and services and get help navigating their health care choices. Humana enrollees can also access additional programs, such as exercise classes, to encourage physical fitness and social interaction. Our neighborhood locations are listed below.

- Bradenton location: Bayshore Gardens, 6036 14th Street West, Bradenton, FL 34207

- Clearwater location: Bayside Bridge Plaza, 1530 N. McMullen Booth Road, Suite D2, Clearwater, FL 33759

- Kissimmee location: 3189 W. Vine Street, Kissimmee, FL 34741

- Port Richey location: Embassy Crossing, 9550 US Highway 19, Suite D-4, Port Richey, FL 34668

- Spring Hill location: 4314 Commercial Way, Spring Hill, FL 34606

- Tamarac location: Kings Point Shopping Center, 7666 Nob Hill Road, Tamarac, FL 33321

- Tampa location: Carollwood Center, 10037 North Dale Mabry Highway, Tampa, FL 33618

- Zephyrhills location: Zephyr Commons, 7920 Gall Boulevard, Zephyrhills, FL 33541

Humana has managed the care of Floridians for decades, from clinics to pharmacies to enrollee education to outreach, we have built a robust and experienced team within the State. As a nationwide health and wellness company, we have resources available on-demand to ensure

our enrollees receive the care they need when they need it. Humana offers the State of Florida the background, experience, and financial strength of a company with a strong national presence and local Florida associates who deliver hands-on care and support.

Evaluation Criteria:

1. Whether the respondent's corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).

2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida.

Score: This section is worth a maximum of 15 raw points. Each of the above components is worth a maximum of 5 points each as described below. 5 additional points will be awarded if respondent meets Items 1(a) and 2(a) below.

For Item 1:

(a) 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
(b) 0 points if no relevant corporate headquarters in Florida.

For Item 2:

(a) 5 points if all functions will be performed in Florida;
(b) 4 points for 6-7 functions to be performed in Florida;
(c) 3 points for 4-5 functions to be performed in Florida;
(d) 2 points for 2-3 functions to be performed in Florida;
(e) 1 point for 1 function to be performed in Florida;
(f) 0 points for no functions to be performed in Florida;
(g) 0 points if only community outreach, medical director and State administrative functions will be performed in Florida.

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Attachment 3-1: Statutorily Required Florida Presence

Full-Time Associates by Operational Function

Humana employs 959 full-time, Florida-based associates, who perform 75 percent of Medicaid operational functions as defined in Section 409.966(3)(C)3, Florida Statutes.

	Claims Processing	Enrollee / Member Services	Provider Relations	Utilization and Prior Authorization	Case Management	Disease Management and Quality Functions	Finance and Administration	Total
In Florida	44	181	65	48	459	74	88	959
Out of Florida	118	83	0	31	2	17	64	315
Total	162	264	65	79	461	91	152	1,274

% of FTEs located in Florida	27%	69%	100%	61%	99%	81%	58%	75%

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 4 – Contract Performance (Statewide):

The respondent shall state whether, in the past five (5) years (since July 14, 2012), it has voluntarily terminated all or part of a managed care contract under which it provided health care services as the insurer; has had such a contract partially or fully terminated before the contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address and telephone number of the client/other party. If the Contract was terminated based on the respondent's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries.

Response:

The respondent, Humana Medical Plan, Inc., its affiliates, subsidiaries, and parent company Humana Inc. and its subsidiaries and affiliates, are hereinafter collectively referred to as "Humana".

In the past five (5) years, Humana has not voluntarily terminated all or part of a managed care contract under which it provided health care services as the insurer, has not had such a contract partially or fully terminated before the contract end date (with or without cause), has not withdrawn from a contracted service area, and has not requested a reduction of enrollment levels.

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1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.
==========

Humana has not requested enrollment level reductions or voluntarily terminated all or part of a contract.

==========
2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.
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Humana has not had any contracts terminated due to performance.

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3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).
==========

Humana has not had terminations for either performance issues related to patient care or administrative concerns (e.g., reporting timeliness).

==========
4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.
==========

Humana has not had terminations for performance issues related to provider network management, claims processing, or solvency concerns.

Evaluation Criteria:

1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.

2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.

3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).

4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each as described below.

For Item 1:

(a) 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction and no service area withdrawals;
(b) 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

For Item 2:

(a) 5 points for no involuntary terminations;
(b) 0 points for any involuntary termination based on performance.

For Item 3:

(a) 5 points for no contract terminations related to patient care;
(b) 0 points if termination related to patient care.

For Item 4:

(a) 5 points for no contract terminations related to provider network management, claims processing or solvency concerns;

(b) 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.

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B. Agency Goals

SRC# 5 – Disease Management (DM) Program (Statewide):

The respondent shall describe its proposed approach to implementation of specific disease management programs and how they will be used to advance the Agency's goals as stated in **Attachment A**, Instructions and Special Conditions, **Section A.,** Overview, **Sub-Section 15.**, Program Objectives and Goals, of this solicitation. The respondent's description shall include:

a. A description of each proposed disease management program;

b. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;

c. A description of the evidence-based guidelines utilized in the approach;

d. A description of how disease management programs are integrated with case management/care coordination programs; and

e. A description of performance metrics used to evaluate the efficacy of the disease management program, including cost-savings, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics.

Response:

Empowering enrollees with chronic diseases to care for themselves on a daily basis is critical to minimizing the impacts of these illnesses. Routine and consistent self-care, monitoring change in condition, and enrollee-initiated rapid response when an impending exacerbation is detected will help control the condition, avert medical emergencies, and forestall disease progression. Thus, enrollee self-management in collaboration with the disease management (DM) and healthcare team ultimately reduces or prevents the need for unnecessary acute interventions and hospitalizations. Humana's approach to disease management is to deliver a system of coordinated healthcare interventions for populations with conditions in which patient self-care efforts can have a significant impact on the condition. Our multi-faceted approach is designed to achieve the best possible outcomes based on access to care, assessment of enrollee needs, ongoing care monitoring and evaluation, and tailored enrollee and provider interventions, including wellness and prevention.

Central to Humana's approach is that our disease management programs are much more than population health strategies; they are, at their core, disease-focused case management programs. Humana recognizes that the management of chronic conditions involves more than addressing the disease process. Living with and managing diseases is challenging; therefore, Humana's DM programs provide support and guidance so the enrollee does not have to manage their condition alone. We deliver a holistic, interdisciplinary structure designed to take into account the individual's physical, behavioral, and social conditions along with comorbid diagnoses. The intent of this approach is to assist enrollees and their caregivers in meeting their personally-identified health improvement goals. In addition to addressing and increasing an

enrollee's knowledge of their disease process and treatment plan, each disease management program aims to assist them in the development of improved health-related behaviors and coping skills, while providing them with needed support and resources. The program uses a versatile approach to achieve the best possible therapeutic outcomes based on assessment of enrollee needs, ongoing care monitoring, evaluation, and tailored enrollee and practitioner interventions.

Humana has a long history of offering a comprehensive portfolio of educational programs and health support services that complement physicians' care and promote enrollee self-management. Among these offerings are a wide array of disease management programs that reinforce the importance of adhering to physician instructions and plan of care, such as, education on chronic diseases, and promoting healthy living. Our DM programs focus on specific diseases that are of particular concern to the populations we serve and are tailored to the needs of those populations.

OVERVIEW OF PROGRAM OFFERINGS

The disease management programs that will be available to all enrollees in our Comprehensive Plan living in the community include those that are currently available in our Managed Medical Assistance (MMA) program and those available in our Long-term Care (LTC) program. Our disease management programs cover a range of chronic diseases, with a focus on those conditions that are of particular concern to our enrollee population.

Our DM programs for Congestive Heart Failure, Diabetes, Hypertension, Asthma, and HIV/AIDS have been offered to our MMA-only enrollees for years. In 2014, we added a Cancer DM program to our MMA offerings.

SPOTLIGHT ON INNOVATION: In June 2017 we added Sickle Cell Disease. The impetus for this addition was our concern that the high ER utilization and high overall costs we were experiencing for enrollees with this condition suggested that care for this condition was not being managed efficiently. We designed this DM program to help our enrollees benefit from self-management techniques that can have a positive impact.

Also available to our Medicaid enrollees is our End-Stage Renal Disease (ESRD) DM program offered through our contract with Village Health, the country's largest renal disease management organization and the first to achieve National Committee on Quality Assurance (NCQA) DM accreditation.

Our Diabetes and Cancer DM programs have also been available to our LTC enrollees. In addition, we offer DM programs in Chronic Obstructive Pulmonary Disease (COPD), Dementia and Alzheimer's Issues, and End of Life Issues to our LTC enrollees.

As noted above, all of our current programs will be offered to all of our enrollees living in the community under the new contract, whether they are MMA only or receive comprehensive MMA and LTC benefits through our plan. All of our DM programs are managed internally, with the exception of our Mental Health and Substance Abuse programs, which are currently provided by our behavioral health partners, and ESRD, which Village Health manages.

We have developed a policy to deliver a consistent referral of enrollees to appropriate programs whereby enrollees with more than one of these conditions are referred to the DM program that addresses their primary need. That program is supplemented by selected efforts aimed at any co-morbidities noted to deliver a holistic approach to the enrollee's care.

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1. The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (a) Cancer, (b) Diabetes, (c) Asthma, (d) Hypertension.

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In addition to the six (6) DM programs mentioned in this ITN (i.e., Cancer, Diabetes, Asthma, Hypertension, Mental Health, and Substance Abuse) Humana also offers another seven (7) programs to our Comprehensive enrollees.

CANCER

Each enrollee of our Cancer DM program is assigned a Registered Nurse (RN) DM case manager. Our qualified case manager educates enrollees to better understand the diagnosis, proper nutrition, and disease process. The case managers stress the importance of following the treatment plan and pain control regimen.

The Cancer DM Program is measured by the following outcomes:

- Decreased inpatient utilization
- Decreased emergency department utilization for a primary diagnosis of cancer.
- Improved pain control
- Reduced BMI
- Increased medication adherence

DIABETES

Eligible enrollees who choose to participate in Humana's Diabetes DM program are assigned a DM case manager who supports them through preventative and ongoing care. The DM case manager provides the enrollee with a working blood glucose meter and contact number for additional supplies and ensures the enrollee is compliant with testing and examinations recommended by their PCP or specialist. This program educates our enrollees on the disease process, potential end organ damage, and diet and food choices.

The Diabetes Disease Management Program is measured by improvement in the following HEDIS rates for comprehensive diabetic care outcomes:

- HbA1c testing
- HbA1c poor control
- HbA1c good control
- Eye examination
- LDL cholesterol screening

- LDL cholesterol level <100mg/dL
- Nephropathy screening
- Blood pressure control
- Medication adherence

ASTHMA

Through our Asthma DM program enrollees are assigned a RN DM case manager. The DM case manager helps the enrollee gain an understanding of asthma triggers, how to minimize the triggers, the disease process, and the complications associated with not following a provider issued treatment plan. With the DM case manager's help, they work with their PCP to develop and adhere to an Asthma Action Plan and set goals around appropriate lifestyle changes. The DM case manager also educates the enrollee on Asthma mitigation strategies and community resources.

The Asthma Disease Management Program is measured by the following outcomes:

- Decreased inpatient utilization
- Decreased average length of stay for inpatient services
- Decreased emergency department utilization for a primary diagnosis of asthma
- Decreased Per Member Per Month (PMPM) costs
- Improved Healthcare Effectiveness Data and Information Set (HEDIS) rate for use of appropriate medications for enrollees with asthma

HYPERTENSION (HTN)

The goal of Humana's HTN DM program for eligible enrollees is to lower high blood pressure and protect important organs from damage. DM case managers guide enrollees in this program to more positive results stemming from daily blood pressure readings, lab work monitoring, adherence to appropriate nutritional and exercise regimens, treatment compliance, and regular communication with doctors and/or specialists.

The HTN Disease Management Program is measured by the following outcomes:

- Decreased inpatient utilization
- Decreased average length of stay for inpatient services
- Decreased emergency department utilization for a primary diagnosis of Hypertension
- Decreased PMPM costs
- Adequate control of blood pressure
- Medication adherence

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Through our COPD DM program, RN DM case managers help enrollees gain an understanding of the early warning signs of COPD exacerbation and the importance of following their medication regimen, routine blood work, proper diet, PCP follow-up, and influenza and

pneumonia vaccines. Enrollees participate in goal setting around appropriate lifestyle modifications, often related to exercise and smoking cessation.

The COPD DM Program is measured by the following outcomes:

- Decreased inpatient utilization
- Decreased average length of stay for inpatient services
- Decreased emergency department utilization for a primary diagnosis of COPD
- Enrollment into a smoking cessation program
- Enrollee is under the care of a pulmonologist
- Medication adherence

CONGESTIVE HEART FAILURE (CHF)

DM Case Managers help enrollees in our CHF program adhere to disease-specific, individualized treatment plans and medication regimens. The CHF DM program encourages enrollees to have active communication with doctors and specialists (e.g., cardiologist, pulmonologist) and are given ongoing education with helpful tips to manage their condition. Key components also include following appropriate nutritional and exercise plans and participating in a smoking cessation program.

The CHF Disease Management Program is measured by the following outcomes:

- Decreased inpatient utilization
- Decreased average length of stay for inpatient services
- Decreased emergency department utilization for a primary diagnosis of congestive heart failure
- Decreased PMPM costs
- Medication adherence

ALZHEIMER'S/DEMENTIA

Humana's Alzheimer's/Dementia DM program explores options to increase support for caregivers of enrollees with these diseases. Caregivers learn about the disease progression, building strong partnerships with the health community, the financial and legal impacts of the disease, and the importance a safe, secure, and familiar home environment for the enrollee from DM case managers specializing in dementia care.

The Alzheimer's/Dementia DM Program is measured by the following outcomes:

- Impact ADL decline
- Use of PERS
- Use of Pill Organizer
- Measure BMI
- Medication adherence

END OF LIFE ISSUES

Humana's End of Life Issues DM program attends to not just the physical, but the psychosocial and spiritual needs of the enrollee and their family. By proactively addressing care needs and concerns, as well as barriers to care, this program offers goal oriented quality of life directives, religious support, and financial affairs preparation, among others.

The End of Life DM Program is measured by the following outcomes:

- Enrollee is participating in a palliative/ hospice program
- PCP accessibility and medical support.
- Enrollee has pain control
- 5 Wishes given to enrollee

HIV/AIDS

Our HIV/AIDS DM program provides enrollees with an individualized plan of care (POC), optimizing management of the disease process and minimizing the risk of related complications. Humana's DM case managers help enrollees to remain compliant with active treatment and medications, monitor lab work, and assist with ongoing communication with doctors and specialists to have a better understanding of the progression of this illness and opportunistic infections that may arise.

The HIV/AIDS Disease Management Program is measured by the following outcomes:

- Decreased inpatient utilization
- Decreased average length of stay for inpatient services
- Decreased emergency department utilization for a primary diagnosis of HIV/AIDS
- Decreased PMPM costs
- Medication adherence
- HIV lab results (Viral Load, T-cell counts)

SICKLE CELL DISEASE

The Sickle Cell DM program at Humana is offered to eligible enrollees to effectively promote preventative treatment, understand the importance of regular PCP health checkups and healthy habits. Specialized DM case managers also assist enrollees in accessing support groups and community organizations.

The Sickle Cell DM Program is measured by the following outcomes:
- Decreased inpatient utilization
- Decreased average length of stay for inpatient services
- Decreased emergency department utilization for a primary diagnosis of Sickle Cell Disease
- Decreased PMPM costs
- Medication adherence
- Improvement in acute pain

END-STAGE RENAL DISEASE (ESRD)

Through an agreement with VillageHealth® Disease Management, Humana offers a renal disease management program designed to provide individual care guidance, patient education, and coordination of care for enrollees with ESRD. Each identified member is assigned a RN DM case manager with extensive experience in renal disease. The DM case manager monitors the member's health status, facilitates compliance with physician-directed goals, communicates with the member's physicians and serves as a liaison and advocate for the member and his or her family.

Details on our DM program approach are provided in the remainder of this response to SRC# 5. Throughout our response, we address the components of our DM programs that are common across all of the programs (e.g., algorithm for identification and stratification, and key program capabilities such as symptom management and medication support) and those components that vary by program, including disease-specific goals and disease-specific evidence-based guidelines.

All of our disease management programs operate under the aegis of approved and proven clinical practice guidelines, such as those specified by the American Heart Association (AHA), American Diabetes Association (ADA), and Centers for Disease Control (CDC), and are compliant with federal, state, and National Committee for Quality Assurance (NCQA) guidelines. At a broad level, Humana's DM programs incorporate the NCQA guidelines for accredited disease management programs in each of the following areas addressed by NCQA:

- Element A: Program Content
- Element B: Identifying Members for DM Programs
- Element C: Frequency of Member Identification
- Element D: Providing Members with Information
- Element E: Interventions Based on Assessment
- Element F: Eligible Member Active Participation
- Element G: Informing and Educating Practitioners
- Element H: Integrating Member Information
- Element I: Experience with Disease Management
- Element J: Measuring Effectiveness

Nationally-recognized care guidelines from MCG (formerly Milliman Care Guidelines) and specific disease clinical-based guidelines (e.g., American Heart Association, American Diabetes Association) are accessible through the disease management documentation database as on-line resources for best practices in the industry. These guidelines provide DM with an evidence-based clinical approach to teaching that integrates pathophysiological rationale, caregiver experience, and patient preferences with valid and current clinical research evidence. Please see Attachment 5-1 for the disease-specific evidence-based guidelines used as resources in supporting and educating enrollees in our in-house DM programs and in creating the plan of care.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Below are high-level summaries of our Mental Health and Substance Abuse DM programs, which are administered by our Behavioral Health partners. Again, these programs incorporate the key program components and capabilities described in the remainder of our response.

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The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions: (e) mental health and (f) substance abuse.
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A unique and distinct feature of Humana's Behavioral Health disease management program is our partnership with two behavioral health vendors. We have partnered with Access Behavioral Health (ABH) to serve our enrollees in regions 1 and 2, and Beacon Health Options (Beacon) to serve our enrollees in all other regions, based on these vendors' unique capacities, networks, and strengths in their respective regions, as well as on our enrollees' established provider relationships. This attention to the regional needs of our enrollees helps us to deliver behavioral health management in the most flexible, adaptive, and effective manner possible.

Through Beacon and ABH, we deliver enhanced disease management and case management programs for enrollees who are identified with high risk behavioral conditions. Eligibility criteria for the program include rapid readmission (within 60 days); frequent emergency department visits; recent suicide attempt; and co-morbid medical condition with mental health and/or substance abuse disorder that could result in exacerbation of the enrollee's fragile medical status. Enrollees are identified through various means, including but not limited to the following:

- Utilization data

- Clinical triage and assessment – completed by Humana, Humana's behavioral health partner, or Primary Care Provider (PCP)

- Enrollee outreach to Humana for assistance

- Pharmacy data – certain medications and frequency can also trigger case reviews for possible referral

The program incorporates both short- and long-term goals specifically tailored toward the management of condition-specific symptomology through education, community connection, increasing functional ability in areas such as self-care, work and school, family, interpersonal relations to reduce barriers to treatment, and long-term health management. Behavioral Health DM interventions are generally telephonic though may also include face-to-face field-based interventions. Field-based case managers work directly with enrollees in their community at facilities or, in some instances, in practitioner offices to review medical and treatment records, develop care plans and to better engage enrollees in their care. Self-management plans are a subset of the larger care plan. They contain activities undertaken by enrollees, and when appropriate, their treating providers, to help them manage their condition, and include instructions or materials. The DM Case Manager provides the enrollee with health information and education to increase disease or condition knowledge that supports adherence and self-management, as well as condition-specific self-management tools and assistance in developing self-management strategies. Enrollees are also given instructions for accessing self-management and self-assessment tools online. The Behavioral Health DM Case Managers

work closely with community resources, patient advocates, community mental health centers (CMHCs), providers, and others to provide the enrollee with the tools they need to live healthy, successful, and productive lives.

Behavioral Health DM Case Managers are licensed behavioral health professionals who are trained to effectively address the full range of behavioral health conditions utilizing condition-specific assessment tools and treatment guidelines. The following tools are used to monitor enrollee condition-specific acuity and DM effectiveness:

- PH Q-2 and PH Q-9 (depression screening)

- PH-Q A-A (depression screening for adolescents)

- Modified Mini Screening Tool (assesses 3 major areas of mental illness – mood disorders, anxiety, and psychotic disorders)

-The Mood Disorder Questionnaire (MDQ) is also used to assess the needs for enrollees with conditions such as bipolar disorder

- Generalized Anxiety Disorder (GAD) Screening – assesses the severity of anxiety

- CAGE-ID (drug and alcohol assessment that is used to assess the existence of substance use, severity, and clinically appropriate next steps)

Assessment tools and guidance used for program delivery and ongoing case management are based upon clinical best practices tools and guidelines as well as evidence-based practices identified by organizations such as Substance Abuse Mental Health Services Administration (SAMHSA), World Health Organization (WHO), National Institute on Drug Abuse (NIDA), and the National Institutes of Health (NIH). Programs and tools are evaluated annually to ensure that the most current research on clinical best practices and condition-specific assessment and management are incorporated and being applied.

The evaluation of our Behavioral Health DM programs focuses on outcomes that include, but are not limited to, the following:

- Program activity
- Clinical and functional outcomes
- Individual goal attainment and participant satisfaction
- Length of stay in the facility
- Ambulatory follow-up post discharge
- Length of time in the community following discharge (without a relapse)
- Re-admission rates
- Enrollee satisfaction

In addition to our mental health and substance abuse DM programs described above, Humana also offers an Agency for Health Care Administration (AHCA) approved “Healthy Behaviors” Substance Abuse Program, administered by Beacon throughout the state. The program offers enrollees eighteen (18) years of age or older an incentive to attain and maintain a drug-free and alcohol-free lifestyle. Enrollees in the six-month program are engaged in treatment with

community practitioners and providers; Alcoholics Anonymous and Narcotics Anonymous; on-line and face-to-face support groups; and other resources to assist the enrollee in attaining sobriety and working through their recovery. Beacon's Case Management department has a Healthy Behaviors track within the Encompass Program and utilizes a process to facilitate referrals from the plan, primary care providers, and other providers. The program has multiple elements to address the needs of the enrollees, from the identification of an existing substance abuse clinical issue or diagnosis, through the treatment phase of the interventions, and to the abstinence and recovery period. Program components including case management, active participation in community support groups, and access and engagement in appropriate treatment have all been shown effective in facilitating recovery. Beacon uses an interdisciplinary approach to address substance abuse issues. With oversight by Beacon's Medical Director, a board-certified psychiatrist and certified physician in addiction medicine, all treatment interventions and coordination efforts promote a path from addiction to recovery that is readily accessible to all individuals.

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2. The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals.

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The goals of all of our disease management programs include the following:

- To encourage enrollees in the self-management of their illness through education;

- To encourage a collaborative effort with their medical and behavioral health provider or specialist;

- To assist the enrollee in attaining and or maintaining optimal disease-specific management, including any potential comorbidities; and

- To assess enrollee needs and facilitate increased enrollee compliance and disease specific knowledge with a plan of care, timely medical and psychological visits, and appropriate access to, and utilization of, care to include use of home healthcare services with appropriate referral to community resources.

These goals align well with the Agency's stated goals, particularly its goals to: (a) reduce potentially preventable inpatient and outpatient hospital events and unnecessary ancillary services, and (b) rebalance long-term services and supports systems by increasing the percentage of enrollees receiving services in the community instead of an institution. Our DM programs utilize innovative, evidence-based approaches to achieve these goals and enhance the enrollee and provider experience. Moreover, they have resulted in high rates of enrollee satisfaction.

We continually explore DM additions and innovations that will help achieve Humana's and AHCA's mutual goals. For example, AHCA's Spring 2017 Quarterly Statewide Medicaid Managed Care Report, Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees, indicates that in Regions 9, 10, and 11, sickle cell anemia is a primary cause of potentially preventable hospital admissions and potentially preventable hospital readmissions. Our recent introduction (in June 2017) of our new Sickle Cell DM program is indicative of our

commitment to partner with AHCA to improve outcomes for enrollees struggling with sickle cell anemia and achieve reduction in potentially preventable events.

*SPOTLIGHT ON INNOVATION: Separate from but related to our DM programs, Humana's Bold Goal initiative is focused on making the communities we serve twenty percent (20%) healthier by 2020. Broward County is one of Humana's Bold Goal Florida communities. The current campaign we are conducting through our Broward Bold Goal Health Advisory Board is a "Know Your Numbers/Did You Know" campaign that includes a series of flyers that provide medical information and link the audience to free services in the community. We have started with Hypertension and Diabetes and will be adding others in the future. Please see Attachment 5-2 for examples of this initiative's flyers.

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3. The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized.

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IDENTIFICATION AND ENGAGEMENT OF ELIGIBLE ENROLLEES

Medicaid enrollees are identified by their unique group identifier. Through queried claims data that is inclusive of medical and pharmacy codes related to any of the specified conditions, a report known as the "Potentials Report" is generated and pulled by the disease management unit on a monthly basis. Additional potential identifiers for DM inclusion are as follows:

- Data collected through Utilization Management or Case Management processes
- Hospital admission and discharge data including Readmission Reports
- Claims and encounter data
- Health Risk Assessment
- High Utilizer Report
- New enrollee welcome calls
- Electronic medical record access
- Outlier Report
- Pharmacy data
- Electronic and automated reports
- 24/7 nurse call line
- Enrollee referrals
- Referrals from caregivers, providers, and community agencies
- Laboratory reports
- Health management and wellness and health coaching programs

Humana includes a description of disease management program opportunities for self-referral in the enrollee handbook and through our quarterly enrollee newsletter. To further disseminate information about these programs, we include descriptions in our Provider Manuals that are given to all physicians and are available online.

All enrollees with a confirmed diagnosis are eligible for the DM program. If a behavioral health diagnosis is confirmed during the completion of the Behavioral Health survey within the Humana General Survey, the enrollee is referred to Humana's behavioral health partner in their region for

initial outreach and further assessment and stratification. If no physical health needs are identified, the DM Case Manager (DM CM) will close the medical case and our behavioral health partner will manage the enrollee's behavioral health issues. If the enrollee has both behavioral health and physical health needs, we will co-manage with our Behavioral Health partner.

Enrollees identified for our DM programs through these various sources are contacted by telephone within seven (7) to ten (10) days of identification and given the choice of participating in the DM program. If the DM CM is unable to contact an enrollee in two (2) attempts, he or she refers the case to an Unable to Contact (UTC) Customer Care Specialist within Humana's Medicaid Administration Education and Satisfaction Unit (ESU), who will begin the process of locating the enrollee in the most effective and timely manner possible. Additionally, the DM CM will enter a notation in the file of an unreachable enrollee so that if the enrollee later calls Customer Care, the specialist can "warm transfer" the enrollee to the DM CM. Once the enrollee is located, the DM CM is notified and we update our clinical information system to include best time to call, alternative numbers, and other pertinent information.

Upon reaching the enrollee, the primary diagnosis and co-morbidities are confirmed with the enrollee (and subsequently with the enrollee's PCP). The enrollee is given the choice of accepting participation in the DM program and informed that he or she may end participation voluntarily at any time.

Our DM CMs are selected based on qualifications of nursing license (or behavioral health license for our Behavioral Health DM programs) and who have the skills to triage, assess, monitor, evaluate, instruct, intervene, and document goals and outcomes of enrollees with the specific condition they are hired to manage. Pediatric enrollees who are identified are managed by a DM CM who specializes in pediatric care. Humana's Clinical Learning and Development (CLD) team delivers a two (2) week orientation that includes training on Medicaid, Humana's systems, ethics, cultural competency, motivational interviewing, and other computer-based training. After initial orientation, DM CMs are mentored by senior case managers for eight (8) weeks through onsite-office, field based, and WebEx training. This training equips DM CMs to find and locate appropriate community resources and help resolve enrollee issues in a timely manner. They learn strategies to identify barriers to access to care, prioritize immediate needs, identify enrollee health literacy, and display empathy and emotional support. Humana delivers a half-day monthly meeting of continuous education and training, in addition to oversight, ensuring DM CMs have the most up-to-date information.

ASSESSMENT, STRATIFICATION, AND MANAGEMENT

An initial acuity level is assigned prior to the enrollee's consent of participation (i.e., as enrollees are identified for potential disease management) based on data available in our Clinical Guidance eXchange (CGX) system. CGX supports an integrated, comprehensive approach to medical, behavioral health, pharmacy, utilization, and care management. Full system integration allows our care team the capability to identify potential enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify opportunities for intervention. We use proprietary predictive modeling tools to identify enrollees who would benefit from our various clinical programs and to provide an initial stratification. This risk stratification does not determine the level of case management or disease management

needed, but instead stratifies enrollees by severity score for prioritization of outreach. Our predictive modeling capabilities, which have led the industry for years and continue to innovate, include the following:

- Humana's Medicaid Severity Score Predictive Model is the primary predictive model used across the entire Medicaid population (i.e., not just on those who are hospitalized as with the Readmission Predictive Model described below). Using this proprietary model, a severity score generated from medical, behavioral health, and pharmacy claims is incorporated into monthly reports identifying enrollees with high costs and clinically complex health conditions over a rolling twelve (12) month period. The severity score is a predictor of future medical and pharmacy costs over the next twelve (12) months. Use of this data allows Humana to identify enrollees with changing care needs, enrolling them in case management, moving them between acuity levels, or altering their level of case management intervention, all the while gauging the stage of readiness of the enrollee to accept disease management support.

SPOTLIGHT ON INNOVATION: This innovative model addresses the challenges of modeling for a diverse group such as that represented by Humana's Medicaid population. For such diverse populations, the large array of characteristics makes it difficult to score the enrollees under the same circumstances. Humana's model groups the individuals together based on certain characteristics and builds individual models for each group. This two-stage meta modeling is reliable and efficient with greater accuracy.

The severity scores are stratified into complex, high, moderate, and low categories allowing our case management team to identify the enrollees at greatest risk for a clinical event that could be devastating to the enrollee and their family. Disease management processes are prioritized to ensure that enrollees identified as complex or high risk receive intervention first, so potential crises or transition situations are mitigated to the extent possible.

- Humana also calculates the Readmission Predictive Model (RPM) to assess the probability of an enrollee being readmitted into a facility within thirty (30) days. The RPM is a true predictive modeling process with inputs from over fifty (50) variables including demographics, such as the enrollee's age and gender, previous medical and pharmacy claims including physician visits, admissions, days since last admission, Charlson Comorbidity Index (validated instrument regarding co-morbidities), and number of medications, as well as information regarding their current admission (procedure, diagnosis, bed type, length of stay, and discharge disposition). The process generates a numerical RPM score, which allows stratification and prioritization based on the risk of all-cause readmission within thirty (30) days.

- Humana uses Emergency Department (ED) Predictive Models that prospectively identify enrollees likely to use EDs, likely to become high ED utilizers, and likely to use EDs for non-emergent reasons, creating 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, which also helps create a stronger patient-physician care partnership.

On acceptance to the DM program by the enrollee, the DM CM:

- Completes a Consent and Disclosure Form attesting that the enrollee has consented to participation;

- Sends the enrollee an introductory letter with the DM Case Manager's name and contact information, as well as an easy-to-read one-page tool that includes tips on self-management of the relevant disease; and

- Completes a telephonic assessment (for enrollees in the HIV-AIDS DM program in Broward and Dade Counties, the assessment is administered by an HIV-AIDS dedicated field case manager).

The disease-specific assessment includes, but is not limited to:

- Gathering a health history;

- Completing a multi-system assessment that includes cognitive, psychological, or depression screenings and psychological growth and development assessment; determining whether a current treatment plan is in place with a physician or medical specialist;

- Assessing emotional issues of the caregiver; reviewing current medication regimen identifying compliance, adverse reactions, or contraindications; and identifying any transportation obstacles.

The additional information gathered through the assessment enables the DM CM to make a final determination on acuity. With all factors in mind, including predictive model scores and information gathered during the comprehensive assessment, the DM CM makes a final determination on acuity based on clinical judgment. Within each level, there are specific sets of enrollee and provider initiatives and interventions. Attachment 5-3 presents the acuity levels and related contact frequencies used in our DM programs administered in-house. Our Mental Health, Substance Abuse, and ESRD programs utilize similar risk categories.

At all acuity levels, Humana's provider interventions include disease-specific information on the provider website and in provider newsletters, introductory letters, sharing of clinical guidelines, the provider manual, enrollee summary, and monthly care gap reports.

The assessment also gives the DM CM the ability to formulate a plan of care that is tailored to the individual's needs. The plan of care assists in monitoring the enrollee's ongoing medical conditions, ensuring the enrollee is receiving necessary routine medical care and has adequate support at home, addressing any safety concerns that are identified, and assisting the enrollees who are unable to access necessary care due to their medical or emotional conditions. As necessary, the DM CM will refer the enrollee who also has behavioral health needs to our behavioral health partner in the region.

Care is directed as clinically indicated by DM guidelines through enrollee assessment and determination of acuity. The disease management activities are documented using assessments, case notes, care plans, and referrals to internal and external resources contained within the Humana clinical system, CGX. The CGX workflow system supports an integrated approach to utilization and case management. It documents both medical and LTC information, allowing us a full view of our comprehensive enrollees. We currently are building additional integrated capabilities within CGX so that not only is it a 360° view for all Humana associates, but also for our Behavioral Health DM Case Managers.

Education is based on the enrollee assessment of health risks and the enrollee's specific chronic condition and co-morbidities. Follow-up communication with the enrollee or enrollee's designee (if applicable) is scheduled as the enrollee's condition warrants, but at least per acuity assessment levels outlined above. Ongoing disease management focuses on previous contact with a collaborative update and prioritized interventions and goals contained within the care plan. Any new areas identified are addressed, documented, and updated in the care plan accordingly. Previous documentation is easily accessible in the documentation system, allowing for review of new or previous issues and actions. Compliance with the plan of care, including physician visits, therapy sessions, diet, and medication are discussed to identify and successfully address barriers. Enrollees are continually educated on medicinal contraindications and adverse effects and interactions.

SPOTLIGHT ON INNOVATION: We have developed a Disease Management Resource Guide for case and disease managers and the enrollees they serve. Its purpose is to supply tools to aid the development of self-management skills. The Resource Guide contains evidence-based guidelines and treatment goals, disease basics, websites, print materials, educational programs, videos, phone applications, support groups, and games. Instructions are given so that assistance can be given to help enrollees find each tool. An excerpt from the DM Resource Guide is included in Attachment 5-4.

SPOTLIGHT ON INNOVATION: In June of 2016, we implemented field case management for enrollees participating in our HIV/AIDS DM program and residing in Dade and Broward counties. Humana has one dedicated HIV/AIDS DM case manager in Broward and one in Dade who meet with their assigned enrollees wherever is best for the enrollee – in the home, PCP office, hospital, or other location. We initiated this program to enhance our disease management services for this population, as we found that many enrollees with HIV/AIDS felt uncomfortable engaging over the phone. We selected these counties because they are home to a large number of new infections. Through the successful engagement of these enrollees, guiding them to the appropriate care setting and enrolling them in DM, Humana was able to reduce our average per enrollee per month cost by forty-eight percent (48%). Lower PMPM costs indicate better overall management of these enrollees, thereby improving overall outcomes.

In addition to our HIV/AIDS Field Case Management, we have recently instituted a field visit component for all of our telephonic DM CMs in our MMA program. While the majority of enrollee contacts continue to be telephonic, each DM CM conducts at least one (1) field visit per month at the hospital or PCP office to engage enrollees identified for disease management whom they have been unable to contact. For instance, if a high utilizer with asthma whom we have been unable to reach and engage in disease management is hospitalized, there will be an alert in the system so that the asthma DM CM may visit the enrollee in the hospital and try to engage them. Similarly, if a complex-acuity enrollee is already engaged, but would benefit from direct contact

between the DM CM and the PCP, the DM CM can meet with the enrollee and the PCP at an office visit.

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4. The adequacy of the respondent's description of how its disease management programs will be integrated into case management/care coordination programs.

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The integration of Humana's DM programs with our case management and care coordination programs differs by eligibility group as a result of their differing needs and characteristics.

For our MMA-only population, enrollees with the disease processes that are addressed by our DM programs are assigned to a DM Nurse who becomes their primary Case Manager. That is, the DM programs are fully formulated disease-specific case management programs that manage and coordinate care for enrollees with one or more of the conditions addressed by our DM programs who agree to participate. For enrollees in one of these DM programs, the DM CM is the Case Manager. (For MMA-only enrollees who are eligible for and participate in the Village Health ESRD program, they retain their market-based Humana Case Manager, and disease management services are provided by Village Health programs as a supplement.)

For our LTC enrollees living in the community, their disease management needs often are additional to their broader long-term services and supports needs. For this reason, they retain their primary LTC Case Manager as their overall care coordinator, and the DM CM supplements the role of the LTC Case Manager with disease-specific expertise. We should note a significant number of our LTC enrollees are dual eligibles and enrolled in Medicare fee-for-service or a Medicare health plan that is primary for acute care. Many of our dual eligible enrollees participate in a Humana Medicare plan, which offers DM programs in CHF, Coronary Artery Disease, COPD, and Diabetes. Regardless of whether the LTC dual eligible enrollee is in a Humana Medicare plan or another Medicare plan, the enrollee's LTC Case Manager coordinates with the Medicare plan's DM and other clinical programs to ensure seamless, comprehensive care for the enrollee.

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5. The extent to which the respondent's disease management programs include the following components: Symptom management; Medication support; Emotional support; Behavior change; and Communication with providers, including the PCP/specialists.

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The education and support our DM programs provide address a number of areas to assist the enrollee and caregiver in managing chronic diseases, including symptom management, medication support, emotional support, behavior change, and communication with providers. Our program capability in each of these areas is summarized below.

SYMPTOM MANAGEMENT

DM CMs deliver information on symptom management to enrollees and caregivers of enrollees identified with a chronic disease. In addition, Humana provides information and educational materials and programs to assist the enrollee and caregiver in self-management of symptoms.

Finally, enrollees and caregivers are encouraged to be active participants in development and monitoring of the enrollee's plan of care, where symptom management issues and recommendations will be discussed.

Example: For enrollees participating in our CHF DM program, the DM CM nurses will provide information about daily weight monitoring and keeping daily logs of such weights; fluid intake and signs/symptoms of fluid retention, which may lead to edema and shortness of breath with or without exertion; and sodium intake. The DM CM will stress the importance of reading nutrition labels and will encourage enrollees to contact their PCP immediately if they have a weight gain or begin experiencing shortness of breath.

MEDICATION SUPPORT

DM CMs review each enrollee's medication regimen with him or her and his or her caregiver (if applicable so that the caregiver can help monitor medication use) during each contact. The focus of the review is to ensure the enrollee understands the reason for taking the medication(s), the proper route, side effects, adverse reactions, and contraindications, and when to seek medical attention from the prescribing physician. DM CMs are also trained to identify signs of medication non-adherence through methods such as reviewing refill history, and will work with the enrollee and caregivers to ensure they understand the importance of each medication. They also help enrollees obtain devices that promote adherence, such as pill boxes and pill cutters. In addition, pharmacists provide medication consultation and reviews to enrollees and caregivers as necessary. Finally, the Pharmacy Management program offers comprehensive oversight and management by working with all providers along the care continuum to ensure management and oversight of pharmacy services.

Example: The HIV/AIDS FCMs have the ability to visit enrollees in their homes to, among other things, review the enrollee's medications. The FCMs collaborate with a pharmacist in real time, with the enrollee present, to conduct an in-depth review of the medications to ensure the enrollee understands the medications and to reinforce compliance with the medication regimen. The HIV/AIDS nurses also review medication adherence reports that indicate which enrollees are not compliant and will intervene with those enrollees as needed to reinforce the education provided and encourage compliance.

EMOTIONAL SUPPORT

DM CMs are trained to conduct phone consultations, during which he or she assesses the enrollee and caregiver's emotional needs and gives support as necessary. The enrollee's psychosocial situation is assessed for emotional support systems, not only from the parent or legal guardian or significant other, but also to extended family, friends, neighbors, community groups, and faith-based organizations. The DM CM also provides information on community resources, including emotional support groups. In addition, social workers are available to assist with connecting enrollees to community resources.

Example: Our enhanced care coordination nurses provide additional support for parents in need of respite services as well as support groups for parents who have children with special and complex needs. They also work closely with both Humana social workers and social workers in

Skilled Nursing Facilities (SNF) to help guide parents to resources provided within the community to obtain services that may not be covered by the plan such as home modifications or Prescribed Pediatric Extended Care (PPEC) services.

BEHAVIOR CHANGE

The focus of self-supported care is shifting from simply providing knowledge of condition-specific care to developing strategies to effect behavior change. The combination of knowledge, disease skill abilities, level of interest, and motivation of the enrollee impacts his or her choices and desirable behavior in self-supported care. DM CMs work with each enrollee and his or her caregiver(s) to identify and address barriers to compliance with the plan of care, such as poor understanding of the treatment regimen and difficulty remembering to take medications. DM CMs also utilize techniques such as motivational interviewing to engage the enrollee in self-management of his or her condition. The sensitivity and cultural competency training our DM CMs receive fosters their ability to motivate behavior change. Finally, identified behavioral changes result in the convening of the multidisciplinary care team, during which such changes can be addressed by all persons involved in the enrollee's care.

Example: For our Sickle Cell enrollees, the DM CM nurse works with the enrollee to identify key behaviors that contribute to exacerbation of the disease process or result in higher utilization of resources such as the emergency department or hospital. By identifying these behaviors, the DM CM nurse is able to suggest alternate behaviors that may result in reduced exacerbations and/or utilization. The DM CM educates the enrollee about the signs and symptoms of a sickle cell crisis and works with the enrollee to gain an increased awareness of behaviors that could produce positive or negative outcomes.

COMMUNICATION WITH PROVIDERS

Giving providers the tools and knowledge necessary to encourage self-management of chronic disease is another crucial aspect of our Disease Management programs. We inform providers of services offered to enrollees who have the conditions addressed by our DM programs, including:

- Provider manual
- Provider newsletters
- Provider meetings and presentations

We also send an introductory letter to enrollees' PCPs informing them when one of their patients has been offered participation in the DM program, whether the enrollee accepted or declined enrollment, and providing information on accessing clinical guidelines on our website. In addition, we offer innovative tools and programs to our providers to assist in management of enrollees with chronic conditions, including the following:

- Enrollee Summary: The Humana Enrollee Summary is a physician tool that gives a high-level overview of a patient's key quality-related metrics and medically relevant information in a consolidated format for use by a provider as a quick reference when care is delivered. Providers will have access to print or print to file a summary of enrollee-specific information (e.g., Enrollee

Demographics, Healthcare Effectiveness Data and Information Set (HEDIS) Stars, Care Alerts, Lab History, Prescription History, and Patient Admissions/Readmissions History). The purpose of the Enrollee Summary is to assist providers in identifying additional actionable opportunities for improving clinical outcomes when care is delivered.

- Provider Action Lists and Care Gap Reports: Currently, provider action lists are created for various HEDIS measures, including the following that are pertinent to our enrollees in Disease Management:
-- CCS: Cervical Cancer Screening
-- CDC – eye: Comprehensive Diabetes Care, eye exam performed
-- CDC – A1c: Comprehensive Diabetes Care, hemoglobin A1c testing
-- CDC – LDL: Comprehensive Diabetes Care, LDL-C screening
-- ASM: Use of Appropriate Medications for People with Asthma

Action lists identify enrollees who appear non-compliant with measures based on claims and encounter data. Depending on the specific measure, the action list may include information alerting the provider to a certain condition or diagnosis. The action lists include a call to action for the specific measures and, depending on the measure, are produced on a monthly cycle. These are delivered to providers on a monthly basis. Humana has placed Quality Improvement Nurses (QINs) throughout the state of Florida who visit provider offices to discuss and support accurate and complete medical record documentation, close gaps in care, and promote referrals into our clinical programs. Discussion of the action lists by the QINs includes an overview of measures identified in the action list and additional HEDIS measures applicable to the Medicaid population. Available provider education and reference documents are also discussed and shared by the QINs. Additionally, our Medical Director for Physician Education and Compliance visits targeted offices in conjunction with the QINs.

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6. The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

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DM PROGRAM EVALUATION METHODOLOGY

A key component of our DM program is evaluation. The primary goals for self-management education vary by disease, as do the outcomes we measure to assess the effectiveness of the program (for an example, please see Attachment 5-5). We continuously evaluate operational, humanistic, clinical, and economic outcomes to improve overall enrollee health and well-being. Below we summarize examples of metrics used for each of these categories of evaluation, and follow with a brief discussion of each.

OPERATIONAL OUTCOMES EVALUATION
- Definition: Efficient operations, high participation rate, effective outreach
- Sample Metrics: Program participation, outreach frequency

The potential DM enrollment is compared to the actual DM enrollment as a core quality indicator of enrollee engagement, and trends are tracked over time. As an example, the following presents recent Diabetes DM participation results.

MEASUREMENT PERIOD AND PROCESS
The total measurement period is from October 2015 through September 2016. Potential enrollees were identified monthly and contact attempts were made by a non-clinical Specialist and/or a DM CM to encourage enrollees to participate in the Disease Management Program.

PARTICIPATION RATE FOR DM PROGRAM:

MEDICAID
Diabetes 2015
- Potential Enrollees: 3,101
- Enrolled in DM: 514
- Percent Enrolled: 17%
- Goal: 20%

Diabetes 2016
- Potential Enrollees: 1,219
- Enrolled in DM: 733
- Percent Enrolled: 60%
- Goal: 20%

ANALYSIS:
- Potential enrollees decreased from 2015 to 2016 by 61%

- Participation Rate (Enrollment) of potential enrollees in the Diabetes DM Program for 2016 was 60%, exceeding the goal of 20%. These enrollees sign consent and disclosure, receive an assessment and participate in creating a care plan

- Enrollees in the Diabetes DM Program increased by 43% from 2015 to 2016

HUMANISTIC OUTCOMES EVALUATION
- Definition: Positive trends in patient-reported indicators (subjective measures).
- Sample Metrics: Participation satisfaction, improved quality of life, readiness to change.

Humana conducts enrollee surveys to assess satisfaction among enrollees who participate in our DM programs. In August and September 2016, Humana conducted a survey to assess satisfaction among enrollees who participated in the Humana Medicaid Disease Management Program. Evaluated measures included program's impact on enrollees' likelihood to make changes in their health and enrollees' preparedness to manage their health, as well as overall case manager ratings. As with previous DM Enrollee Satisfaction Surveys, our most recent results are very positive. The percentages below reflect percent of enrollees who gave ratings of four or five (4 or 5) (the top two ratings) on a scale of one to five (1 to 5):

- DM Case Manager Rating – Overall: 94%
- DM Case Manager Rating – Knowledgeable: 90%

- Likely to make change in how you take care of your health: 78%
- Whether you feel more prepared to manage your own health: 87%

SPOTLIGHT ON INNOVATION: In an effort to track enrollee satisfaction with our DM programs throughout the year, and not just rely on the annual survey, we recently developed and obtained approval from AHCA to implement a mini-satisfaction survey to enrollees seven to thirty (7 to 30) days following closure of a DM case (i.e., enrollee has met their goals and case is closed). The mini-survey is essentially a shortened version of the annual survey, but it provides more timely information on what is happening throughout the year and allows us to make ongoing improvements as needed. Since we just started administering the mini-survey in the past several weeks, we only have five (5) completed surveys thus far. However, we are pleased to report that all five (5) enrollees who completed the survey gave the highest possible rating on each of the survey questions.

CLINICAL OUTCOMES EVALUATION
- Definition: Achievement of clinical standards of care (objective measures)
- Sample Metrics: Increased medication compliance, reduction in adverse events (e.g., ED visits, hospital stays)

Healthcare status of disease management program participants is evaluated through case notes, care plans, hospitalizations, and length of active enrollment in the program as an appraisal of the program's effectiveness. Individual case audits are performed no less than quarterly to identify, correct, or improve quality of care in the program.

Humana also selects measures or processes that have significant and demonstrable bearing on a defined portion or subset of the disease management population or processes so that appropriate interventions will result in significant improvement for the population. Analysis of findings includes comparison of results against the goal and the cause of any deficiencies. Outcomes are reviewed by the Corporate Quality Improvement Committee. Healthcare Effectiveness Data and Information Set (HEDIS) is the most widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

For adult and pediatric enrollees participating in our MMA disease management programs between January 1, 2016 and June 30, 2017, we looked at annualized admissions per thousand (APT) and emergency room visits per thousand (EPT), as well as per member per month (PMPM) costs, in the six (6) months prior to their enrollment in DM and in the twelve (12) months following their enrollment in DM. Results by program are as follows (please see Attachment 5-6 for additional detail):

Asthma DM
- For adult Asthma DM enrollees, APT decreased 66%, EPT decreased 36%, and PMPM costs decreased 58% from the pre-DM enrollment period to the post-DM enrollment period.

- For pediatric Asthma DCM enrollees, APT decreased 84%, EPT decreased 54%, and PMPM costs decreased 47% from the pre-DM enrollment period to the post-DM enrollment period.

Diabetes DM

- For adult Diabetes DM enrollees, APT decreased 45%, EPT decreased 34%, and PMPM costs decreased 10% from the pre-DM enrollment period to the post-DM enrollment period.

- For pediatric Diabetes DM enrollees, APT decreased 67%, EPT decreased 59%, and PMPM costs decreased 31% from the pre-DM enrollment period to the post-DM enrollment period.

CHF DM
- For adult CHF DM enrollees, APT decreased 50%, EPT decreased 17%, and PMPM costs decreased 39% from the pre-DM enrollment period to the post-DM enrollment period.

HIV DM
- For adult HIV DM enrollees, APT decreased 54%, EPT decreased 52%, and PMPM costs decreased 35% from the pre-DM enrollment period to the post-DM enrollment period.

Hypertension DM
- For adult Hypertension DM enrollees, APT decreased 70%, EPT decreased 53%, and PMPM costs decreased 51% from the pre-DM enrollment period to the post-DM enrollment period.

EXAMPLES OF BEHAVIORAL HEALTH DM PROGRAM RESULTS

- The impact of ABH special programs serving high risk enrollees in Region 1 include:

-- Reduction in 1-day Behavioral Health-related Hospital Stays for Humana enrollees (Adults). There has been a reduction in 1-day hospital stays (from a high of almost 20%) in July 2015 to a low of 7% in May 2017), indicating inappropriate admissions have been reduced due to the interventions of the special programs.

-- Reduction in 1-day Behavioral Health-related Hospital Stays for Humana enrollees (Children and Adolescents). There has been a reduction in one-day hospital stays (from 32% in December 2015 to 20% in May 2017), indicating inappropriate admissions have been reduced due to the interventions of the special programs.

-The 30-day readmission rate for our enrollees with primary behavioral health diagnoses is below goal (below 22%) and has been trending favorably throughout the State. In Region 1, the rate has decreased from 18% in 2015 to 16% year to date in 2017. In all other regions, the rate – which had been consistently above 22% in late 2016 – is now consistently under 22% and is approaching 20%.

We intend to leverage our Florida analytics team to track, trend, and report on disease-specific clinical outcomes measures, such as HbA1C control and LDL cholesterol level for enrollees in Diabetes DM, HIV lab results for enrollees in HIV/AIDS DM, etc. This will supplement the granular clinical outcomes evaluation conducted through case notes with a more aggregate assessment of clinical impact.

ECONOMIC OUTCOMES EVALUATION

- Definition: Healthcare cost savings
- Sample Metrics: Reduction in overall costs per member per month, by condition

For adult and pediatric enrollees participating in our MMA disease management programs, we have provided under Clinical Outcomes Evaluation, above, the per member per month (PMPM) costs in the six (6) months prior to their enrollment in DM and in the twelve (12) months following their enrollment in DM. Please see Attachment 5-6 for additional detail.

We recently conducted an analysis of our LTC DM programs, where we looked at per member per month (PMPM) claims cost for our comprehensive enrollees in our DM programs (i.e., those enrollees in both our LTC plan and our MMA plan). For an appropriate sample size the analysis grouped all of our DM enrollees in each DM program together. The analysis looked at both LTC PMPM costs and MMA PMPM costs both during the period prior to the enrollee's participation in the DM program and during the period after their enrollment in the DM program. Results were as follows:

- Average MMA PMPM costs decreased by more than fifty percent (50%) between the pre enrollment period to the post enrollment period ($582 in pre vs. $246 in post). MMA costs PMPM decreased after enrollment in DM for sixty-six percent (66%) of participating enrollees. Findings strongly point to the effectiveness of the DM programs.

- Average LTC PMPM costs were relatively unchanged from the pre-enrollment to the post enrollment period ($1,039 vs. $1,059). This result was not surprising, since LTC costs are generally less related to disease state than are medical costs.

SUMMARY

The ultimate goal of Humana's DM program is to improve enrollee quality of life, reduce healthcare costs by preventing unnecessary utilization, and proactively address chronic issues. To accomplish this, our program is built upon an enrollee-centered model with support from knowledgeable DM Case Managers who work with other Care Management team members to address complex enrollee needs and strive for seamless continuity of care. This includes an emphasis on delivering the right care at the right time, improving access to care across providers and community resources, and enabling enrollees to take control of their own care. Humana is committed to continually identifying, incorporating, and evaluating program innovations to enhance the effectiveness of our DM programs.

Evaluation Criteria:

1. The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions:

(a) Cancer (Section 409.966, Florida Statutes);
(b) Diabetes (Section 409.966, Florida Statutes);
(c) Asthma;
(d) Hypertension;
(e) Mental health; and
(f) Substance abuse.

2. The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals.

3. The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized.

4. The adequacy of the respondent's description of how its disease management programs will be integrated into case management/care coordination programs.

5. The extent to which the respondent's disease management programs include the following components:

(a) Symptom management;
(b) Medication support;
(c) Emotional support;
(d) Behavior change; and
(e) Communication with providers, including the PCP/specialists.

6. The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

Score: This section is worth a maximum of 75 raw points with each component being worth a maximum of 5 points each.

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Attachment 5-1: Disease Management Program Resources

The table below shows disease-specific evidence-based guidelines used as resources in supporting and educating enrollees in our in-house DM programs and in creating the plan of care.

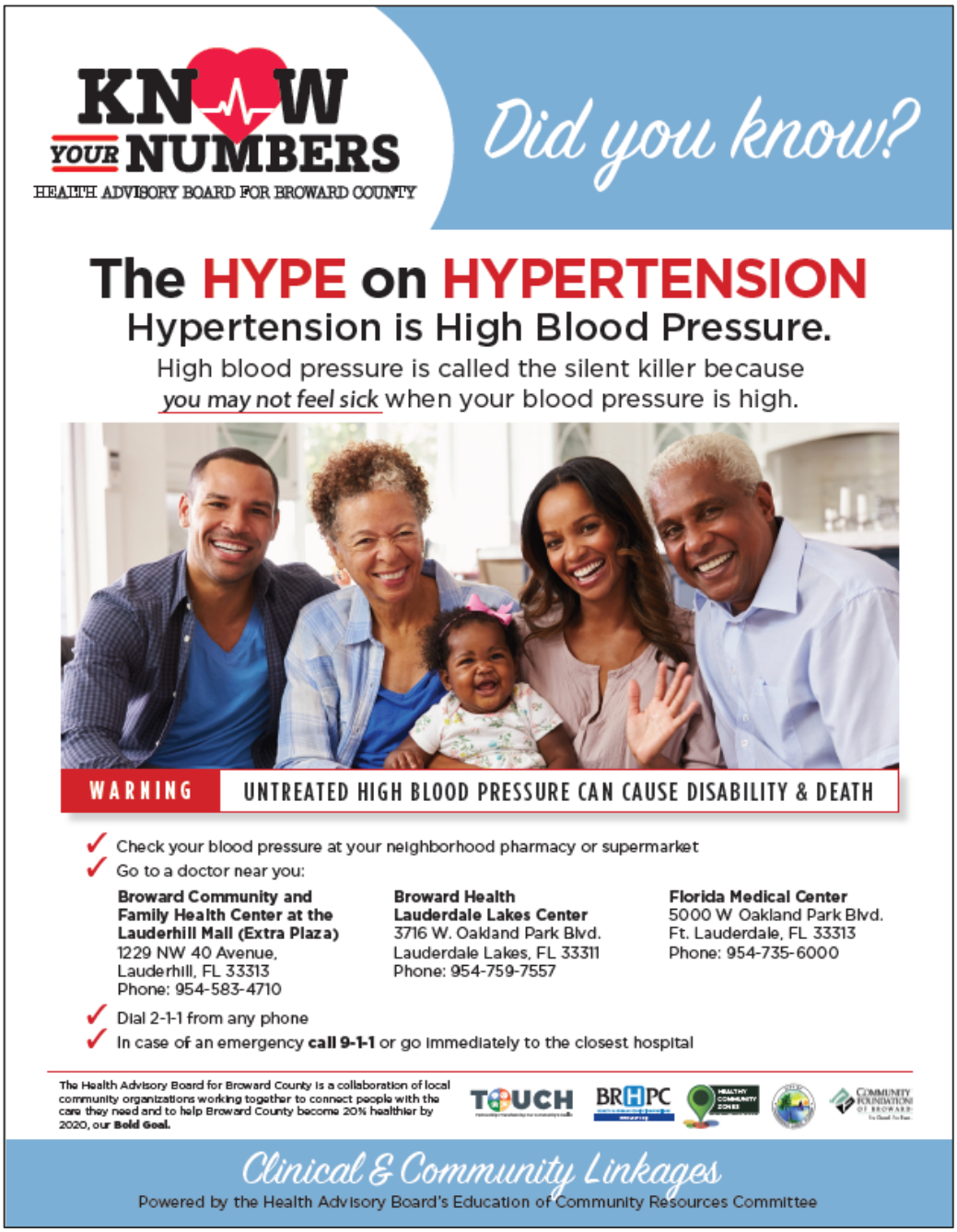
	Program	Sources
Asthma	• Global Initiative for Asthma (ginasthma.org) • NIH National Heart, Lung and Blood Institute: Expert Panel Report 3(EPR3) Guide for the Diagnosis and Management of Asthma	➢ https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines ➢ http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.pdf ➢ http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf ➢ http://www.nhlbi.nih.gov/health/public/lung/index.htm#asthma
Diabetes	• American Diabetes Association Clinical Practice Guidelines	➢ http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160 ➢ https://www.cdc.gov/diabetes/managing/index.html
Congestive Heart Failure	• CHF Practice Guidelines for Providers 2010, Heart Failure Society of America • Guidelines for Diagnosis and Management of Heart Failure in Adults, 2009, American College of Cardiology Foundation)/American Heart Association	➢ http://www.hfsa.org/hf_guidelines.asp ➢ http://content.onlinejacc.org/article.aspx?articleid=1139600 ➢ http://www.hfsa.org/patient/patient-tools/educational-modules/ ➢ http://www.heart.org/HEARTORG/Conditions/HeartFailure/Heart-Failure_UCM_002019_SubHomePage.jsp
Hyper-tension	• NIH National Heart, Lung and Blood Institute High Blood Pressure Guidelines (JNC 7), 2003 • NIH National Heart, Lung and Blood Institute: High Blood Pressure in Children and Adolescents	➢ http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm ➢ https://www.nhlbi.nih.gov/health/health-topics/topics/hbp ➢ http://www.nhlbi.nih.gov/health/public/heart/index.htm#hbp ➢ http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure_UCM_002020_SubHomePage.jsp ➢ http://millionhearts.hhs.gov/index.html
HIV / AIDS	• HIV/AIDS Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents – A Working Group of the Office of AIDS Research Advisory Council, 3/27/2012	➢ http://aidsinfo.nih.gov/guidelines/ ➢ https://www.cdc.gov/hiv/library/index.html
Sickle Cell Disease	• NIH National Heart, Lung and Blood Institute: Evidence-Based Management of Sickle Cell Disease: Expert Panel Report, 2014	➢ http://www.nhlbi.nih.gov/health-pro/guidelines/sickle-cell-disease-guidelines ➢ https://www.cdc.gov/ncbddd/sicklecell/recommendations.html

Attachment 5-1: Disease Management Program Resources

	• Centers for Disease Control (CDC)	
Cancer	• American Cancer Society	➢ http://www.cancer.org
Alzheimer's / Dementia	• Recommendations from the National Institute on Aging-Alzheimer's. 2012	➢ http://www.alz.org ➢ http://www.communityresoursefinding.org
COPD	• National Heart Lung Association • Global Initiative for Chronic Obstructive Lung Disease (goldcopd.org) • NIH National Heart, Lung and Blood Institute: High Blood Pressure in Children and Adolescents	➢ http://www.nhlbi.nih.gov/copd/guidelines/index.htm ➢ http://www.nhlbi.nih.gov/copd/index.html ➢ http://www.healthline.com/health/copd/index.html
End Of Life		➢ http://vitas.com ➢ http://www.nhpco.org

Attachment 5-2: Bold Goal Initiative Flyers

Humana's Bold Goal initiative is focused on making the communities we serve 20 percent healthier by 2020. Broward County is one of Humana's Bold Goal communities. The current campaign we are conducting through our Broward Bold Goal Health Advisory Board is a "Know Your Numbers/Did You Know" campaign that includes a series of flyers that provide medical information and link the audience to free services in the community. Below are some examples.



DIABETES
Did you know?
HIGH BLOOD SUGARS from DIABETES can cause stroke, blindness, or even loss of limbs.
RISK FACTORS
for diabetes are lack of activity/exercise, being overweight, or if your parents or siblings have diabetes.
SYMPTOMS
may be blurred vision, tingling of toes or fingers, and sores that take long to heal.
Have your BLOOD SUGAR checked at:
BROWARD COMMUNITY AND FAMILY HEALTH CENTER AT THE LAUDERHILL MALL (Extra Plaza), 1229 NW 40 Avenue, Lauderhill, FL 33313 or contact them at 954-583-4710
BROWARD HEALTH LAUDERDALE LAKES CENTER at 3716 Oakland Park Blvd., Lauderdale Lakes, FL 33311 or contact them at 954-759-7557
FLORIDA MEDICAL CENTER at 5000 W Oakland Park Blvd., Ft. Lauderdale, FL 33313 or contact them at 954-735-6000
Broward's Bold Goal is a collaboration of local community organizations working together to connect people with the care they need and help Broward County become 20 percent healthier by 2020?
BRHPC
TOUCH
HEALTHY COMMUNITY ZONES
KNOW YOUR NUMBERS
Clinical & Community Linkages
Powered by the Health Advisory Board's Education & Community Resources Committee

You're Invited!

Join us on Saturday, August 12th at Vincent Torres Park

Learn your Numbers!

HEALTHY COMMUNITY ZONES

About the Healthy Community Zone:

The Healthy Community Zone is a collaborative effort championed by BRHPC's Partnerships Transforming Our Community's Health (TOUCH), the Community Foundation of Broward, and Broward's **"Bold Goal"** partnerships of community organizations working together to connect people with the care they need to help Broward County become 20 percent healthier by 2020.

KNOW YOUR NUMBERS
BROWARD COUNTY HEALTH ADVISORY BOARD

WEIGHT:

HEIGHT:

BLOOD PRESSURE:

RISK FACTORS THAT CAN BE MANAGED

You can control or treat these risk factors with lifestyle changes and your healthcare provider's help:

- ✓ High blood pressure
- ✓ High blood cholesterol
- ✓ Obesity or overweight
- ✓ Smoking
- ✓ Lack of regular activity
- ✓ Diabetes

AMERICAN HEART ASSOCIATION
RECOMMENDATION FOR HEALTHY BLOOD PRESSURE

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Normal	less than 120	and	less than 80
Prehypertension	120 – 139	or	80 – 89
High Blood Pressure (Hypertension) Stage 1	140 – 159	or	90 – 99
High Blood Pressure (Hypertension) Stage 2	160 or higher	or	100 or higher
Hypertensive Crisis (Emergency care needed)	Higher than 180	or	Higher than 110

SAVE THE DATE!
AUGUST 12

We want to see you at

LAUDERDALE LAKES

COMMUNITY EVENT

Vincent Torres Park
4331 NW 36th Street,
Lauderdale Lakes, FL 33319

Here's a doctor near you.

BROWARD COMMUNITY AND FAMILY HEALTH CENTER
Lauderhill Mall
(Extra Plaza)
1229 NW 40 Avenue
Lauderhill, FL 33313
or contact them at
954-583-4710

BROWARD HEALTH LAUDERDALE LAKES CENTER
3716 Oakland Park Blvd.
Lauderdale Lakes, FL
33311
or contact them at
954-759-7557

FLORIDA MEDICAL CENTER
5000 W Oakland Park Blvd.,
Ft. Lauderdale, FL 33313
or contact them at
954-735-6000

Made possible by the following Healthy Eating Active Living partners:

BRHPC HEALTH & HUMAN SERVICE INNOVATIONS www.BRHPC.org
TOUCH Partnerships Transforming Our Community's Health
CITY OF LAUDERDALE LAKES
COMMUNITY FOUNDATION OF BROWARD For Good. For Ever.
KNOW YOUR NUMBERS BROWARD COUNTY HEALTH ADVISORY BOARD
HEALTHY COMMUNITY ZONES

Attachment 5-3: Humana Disease Management Protocols based on Acuity Level

With all factors in mind, including predictive model scores and information gathered during a comprehensive assessment, a case manager makes a final determination on acuity of an enrollee based on clinical judgment. Within each level, there are specific sets of enrollee and provider initiatives and interventions. Below is a chart of the acuity levels and related contact frequencies used in our DM programs administered in-hous

Risk Level	Definition	Outreach Frequency
Complex	• At least 2 hospitalizations w/in 30 days • Medical, educational and psychosocial barriers that lead to emergency department/readmissions • Collaboration w/multidisciplinary teams and Associate Medical Directors • Present during monthly MDT call • Complex needs for care coordination	Weekly
High	• At least 2 hospitalizations within the last 3 months • Medical, educational and psychosocial barriers that lead to ED/Readmissions • Ongoing needs for care coordination	Monthly
Medium	• At least 2 previous hospitalizations within the last 6 months • Provide reinforcement about plan of care • Barriers to educational and self-healthcare management	Every other month
Low (short-term, episodic clinical management, and participation)	• No hospital admissions, but has emergency department utilization greater than 2 per 30 days • Knowledge deficit of the use of emergency department vs. urgent care and PCP visits for follow up care and sick visits	Every three months
Low (nonclinical monitored and pending High Utilizer Report monitoring status) Case Management Assistant	• No hospital admission within last 6 months • Stable with mild or no symptoms • Understands their disease and plan of follow up. Follow up every 6 months • Compliant with their plan of care and/or do not require assistance with care coordination	Six months following enrollment into DM, then annually

Disease Management Resource Guide

An Introduction

This Disease Management Resource Guide is for case/disease managers and the members they serve. Its purpose is to supply tools to aid the development of self-management skills. Inside you will find **evidence based guidelines** and **treatment goals**, **disease basics**, **websites**, **print materials**, **educational programs**, **videos**, **phone apps**, **support groups** and **games**. Almost everything listed is free. Instructions are provided so that assistance can be given to help members find each tool.

The contents are not designed to replace the need for case management or PCP visits. The tools are to enhance self-management skills. Everyone learns differently. For this reason, a variety of educational tools are provided. Most print materials meet the plain language (PCP) requirement for health literacy.

Attachment 5-5: Disease-Specific Program Goals and Outcomes Measured

A key component of our DM program is evaluation. The primary goals for self-management education vary by disease, as do the outcomes we measure to assess the effectiveness of the program. We continuously evaluate operational, humanistic, clinical, and economic outcomes to improve overall enrollee health and well-being.

Disease	Program Goals *Ensure Each Enrollee:*	Outcomes Measured
Asthma	• Has an understanding of asthma triggers and how to minimize such triggers • Is encouraged to work with his/her Primary Care Physician (PCP) to develop and adhere to an Asthma Action Plan • Participates in goal setting and appropriate lifestyle modification around exercise and smoking • Understands his/her medication regimen, including the use of rescue controller and beta agonist • Verbalizes an understanding of disease process and the complications associated with non-compliance of a provider issues treatment plan	The Asthma Disease Management Program is measured by the following outcomes: • Decreased inpatient utilization • Decreased average length of stay for inpatient services • Decreased ER utilization for a primary diagnosis of asthma • Decreased Per Member Per Month (PMPM) costs • Improved Healthcare Effectiveness Data and Information Set (HEDIS) rate for use of appropriate medications for enrollees with asthma
Diabetes	• Has a working blood glucose meter and contact number for additional supplies • Is testing his/her blood sugar as recommended by their PCP or specialist • Has Hemoglobin A1C (HbA1c) testing done yearly or more often for enrollees whose therapy has changed or who are not meeting their individualized glycemic goals, in accordance with current ADA guidelines • Has a dilated eye examination at least yearly if indicated • Has a foot examination performed by the PCP/specialist at each visit as indicated • Receives education on the disease process and potential end organ damage • Can verbalized signs & symptoms of hyper/hypoglycemia and actions to take for each • Has received education related to diet and food choices and can verbalize a diabetic compliant diet • Has microalbumin and Low-density Lipoprotein (LDL) levels tested at least yearly	The Diabetes Disease Management Program is measured by the following HEDIS rates for comprehensive diabetic care outcomes: • HbA1c testing • HbA1c poor control • HbA1c good control • Eye examination • LDL cholesterol screening • LDL cholesterol level <100mg/dL • Nephropathy screening • Blood pressure control • Medication adherence

Attachment 5-5: Disease-Specific Program Goals and Outcomes Measured

Hypertension	• Is obtaining blood pressure readings daily or as recommended by the PCP and/or specialist • Is monitoring lab work regularly (lipid profile) • Is following the appropriate nutritional and exercise regimens • Understands and is compliant with treatment plan and medication regimen • Is having active treatment and communication with doctors and/or specialists (cardiologist and/or nephrologist)	The Hypertension Disease Management Program is measured by the following outcomes: • Decreased inpatient utilization • Decreased average length of stay for inpatient services • Decreased ER utilization for a primary diagnosis of Hypertension • Decreased PMPM costs • Adequate control of blood pressure • Medication adherence
CHF	• Is obtaining blood pressure reading daily or as recommended by PCP and/or specialist • Is monitoring lab work regularly • Is weighing himself/herself daily • Is following appropriate nutritional and exercise regimens • Understands and is compliant with treatment plan and medication regimen • Is having active treatment and communication with doctors and/or specialists (cardiologist and/or pulmonologist • Does not smoke or participates in a smoking cessation program	The CHF Disease Management Program is measured by the following outcomes: • Decreased inpatient utilization • Decreased average length of stay for inpatient services • Decreased ER utilization for a primary diagnosis of congestive heart failure • Decreased PMPM costs • Medication adherence
HIV/AIDS	• Has an understanding of progression of illness and opportunistic infections • Is monitoring HIV lab work regularly • Is compliant with treatment plan, inclusive of medication regimen (HAART) • Is having active treatment and communication with doctors and/or specialists (PCP and/or infectious disease) • Verbalizes understanding of transmission prevention • Does not smoke or participates in a smoking cessation program	The HIV/AIDS Disease Management Program is measured by the following outcomes: • Decreased inpatient utilization • Decreased average length of stay for inpatient services • Decreased ER utilization for a primary diagnosis of HIV/AIDS • Decreased PMPM costs • Medication adherence • HIV lab results (Viral Load, T-cell counts)

Attachment 5-5: Disease-Specific Program Goals and Outcomes Measured

Sickle Cell Disease	• Understands the importance of regular health checkups with PCP • Takes appropriate steps to prevent infections (e.g., hand-washing, food safety, vaccines) • Verbalizes understanding of healthy habits that will help them stay as healthy as possible (e.g., maintaining hydration, proper nutrition, and balanced body temperature, participating in but not overdoing physical activity) • Is aware of patient support groups and community organizations that can provide information, assistance and support	The Sickle Cell DM Program is measured by the following outcomes: • Decreased inpatient utilization • Decreased average length of stay for inpatient services • Decreased ED utilization for a primary diagnosis of Sickle Cell Disease • Decreased PMPM costs • Medication adherence • Improvement in acute pain
Cancer	• Has an understanding of the diagnosis and recommendations of specialist with symptom triggers and how to manage pain • Understands pain regiment. • Understands the importance of nutrition. • Participates in goal setting and appropriate lifestyle modification around exercise and smoking • Verbalizes an understanding of disease process and the complications associated with non-compliance of a provider issued treatment plan. • Encouraged to work with their PCP	The Cancer DM Program is measured by the following outcomes: • Decreased inpatient utilization • Decreased ED utilization for a primary diagnosis of cancer. • Control of Pain • Measure of BMI • Medication adherence
Alzheimer/Dementia	• Explores options to increase support for caregivers • Builds strong partnership with the health community • Caregivers to learn and has an understanding about financial and legal impacts • Maintain maximum ADL's • Home environment reflects safe/secure/ familiarity. • Enrollee/Caregiver has an understanding of disease progression • Is following the appropriate nutritional and exercise regimens • Understands and is compliant with treatment plan and medication regimen	The Alzheimer DM Program is measured by the following outcomes: • Impact ADL decline • Use of PERS • Use of Pill Organizer • Measure BMI Medication adherence

Attachment 5-5: Disease-Specific Program Goals and Outcomes Measured

COPD	• Has understanding of early warning signs of COPD exacerbation; sputum amount, thickness, color, or presence of blood. Increased shortness of breath during ADL's and at rest • Has understanding of medication, routine blood work, compliance of diet, PCP follow-up, Flu and pneumonia vaccine • Participates in goal setting and appropriate lifestyle modification around exercising and smoking. Understands medication regime, including the use of bronchodilators and systemic or inhaled corticosteroids	The COPD DM Program is measured by the following outcomes: • Decreased inpatient utilization • Decreased average length of stay for inpatient services • Decreased ED utilization for a primary diagnosis of COPD • Enrollment into a smoking cessation program. • Enrollee is under the care of a pulmonologist. • Medication adherence
End of Life	• Has understanding of advanced directives • Has understanding of disease entity • Has family support • Has goal oriented quality of life directives • Religious support available • Enrollee reports pain control. • Have financial affairs in order • Barriers to care addressed	The End of Life DM Program is measured by the following outcomes: • Enrollee is participating palliative/ hospice program • PCP accessibility and medical support. • Has pain control. • 5 Wishes given to enrollee

Humana.

Attachment 5-6: MMA Disease Management Program Outcomes

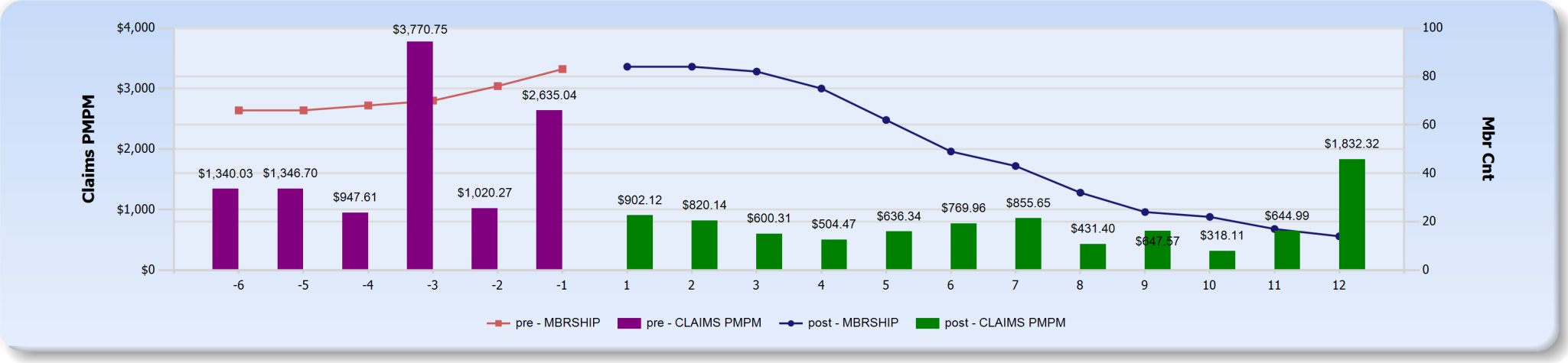
As at : 8/18/2017

Program Name : ASTHMA

LOB : MEDICAID

Patient Type : ADULT

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	**PRE PMPM**	**POST PMPM- 12 Months Post**
-57.98%	$1,869.38	$785.55

APT Trend			
Trend		**6-Month Pre**	**12 - Month Post**
-66.33%		1,846	622

EPT Trend			
Trend		**6-Month Pre**	**12 - Month Post**
-35.90%		2,322	1,488

Humana.

Attachment 5-6: MMA Disease Management Program Outcomes

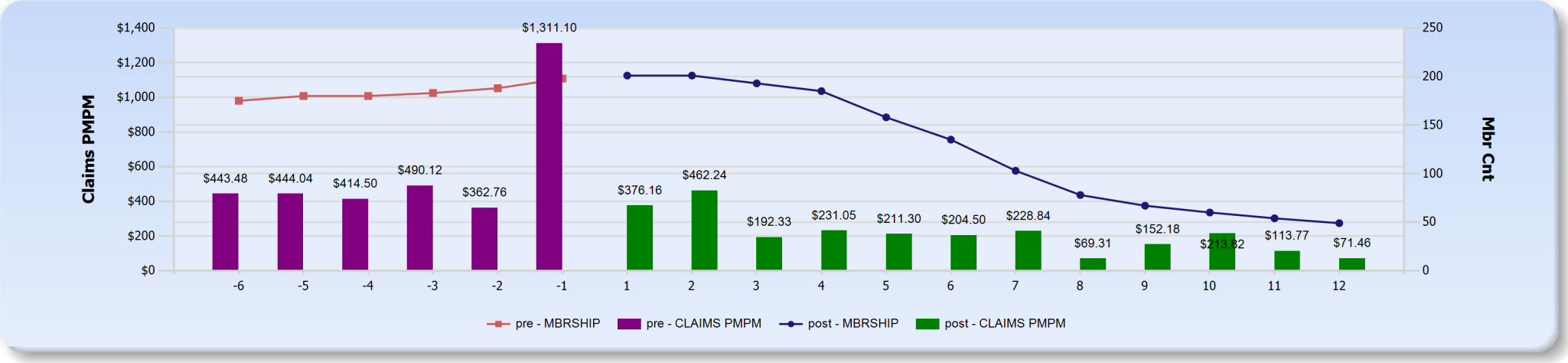
As at : 8/18/2017

Program Name : ASTHMA

LOB : MEDICAID

Patient Type : PEDIATRICS

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	PRE PMPM	POST PMPM- 12 Months Post
-47.27%	$588.44	$310.26

APT Trend		
Trend	6-Month Pre	12 - Month Post
-84.19%	750	119

EPT Trend		
Trend	6-Month Pre	12 - Month Post
-54.26%	2,609	1,193

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Attachment 5-6: MMA Disease Management Program Outcomes

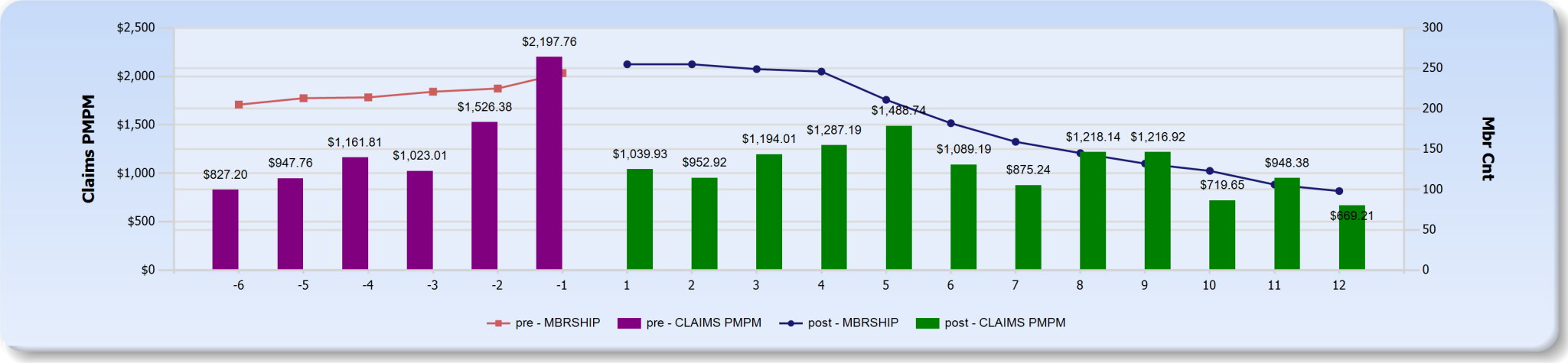
As at : 8/18/2017

Program Name : DIABETES

LOB : MEDICAID

Patient Type : ADULT

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	**PRE PMPM**	**POST PMPM- 12 Months Post**
-9.86%	$1,305.48	$1,176.75

APT Trend			
Trend		**6-Month Pre**	**12 - Month Post**
-45.22%		1,244	681

EPT Trend			
Trend		**6-Month Pre**	**12 - Month Post**
-34.35%		1,888	1,239

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Attachment 5-6: MMA Disease Management Program Outcomes

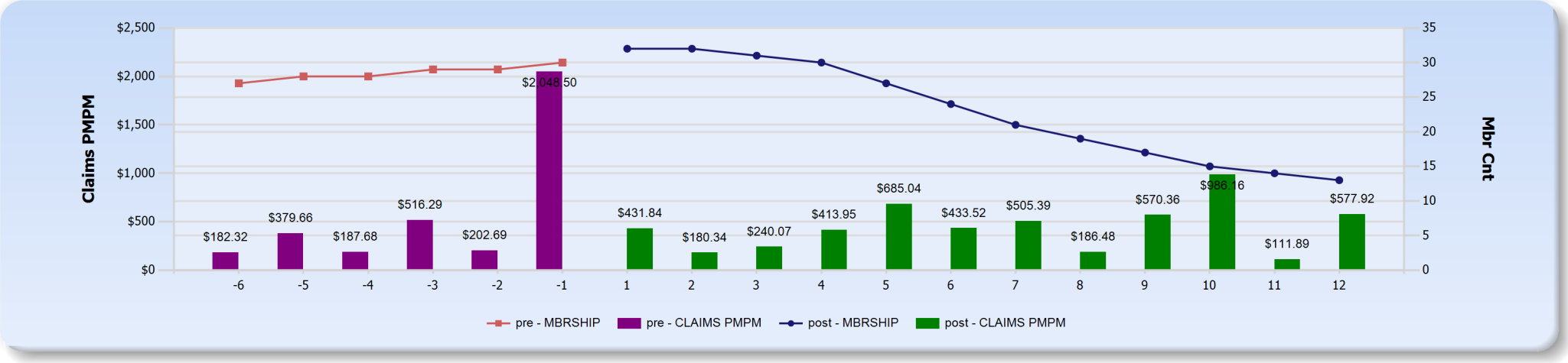
As at : 8/18/2017

Program Name : DIABETES

LOB : MEDICAID

Patient Type : PEDIATRICS

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	**PRE PMPM**	**POST PMPM- 12 Months Post**
-31.05%	$603.00	$415.76

APT Trend		
Trend	**6-Month Pre**	**12 - Month Post**
-66.64%	842	281

EPT Trend		
Trend	**6-Month Pre**	**12 - Month Post**
-59.15%	1,474	602

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Attachment 5-6: MMA Disease Management Program Outcomes

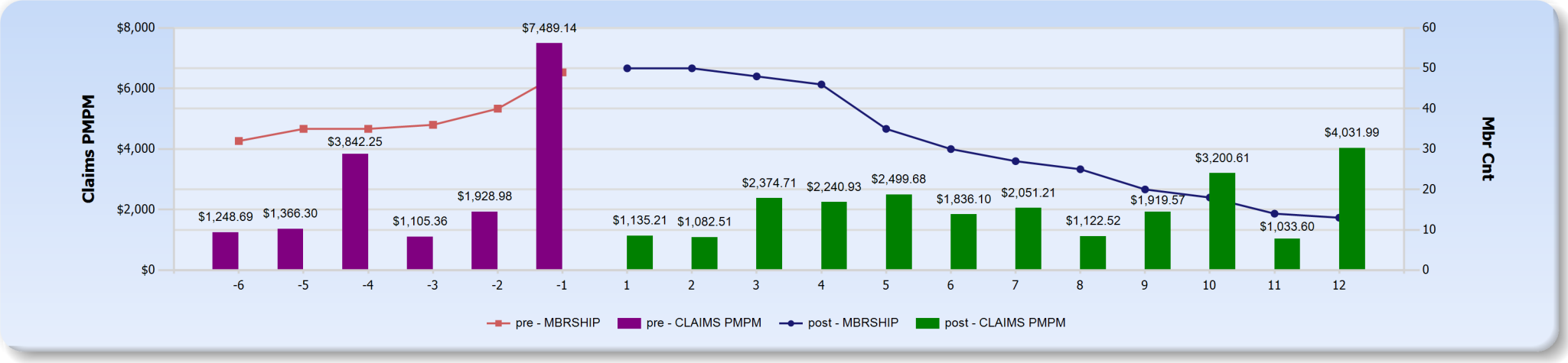
As at : 8/18/2017

Program Name : CONGESTED HEART FAILURE

LOB : MEDICAID

Patient Type : ADULT

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	PRE PMPM	POST PMPM- 12 Months Post
-38.57%	$3,110.91	$1,911.09

APT Trend			
Trend		6-Month Pre	12 - Month Post
-50.30%		2,855	1,419

EPT Trend			
Trend		6-Month Pre	12 - Month Post
-17.03%		1,639	1,360

Humana.

Attachment 5-6: MMA Disease Management Program Outcomes

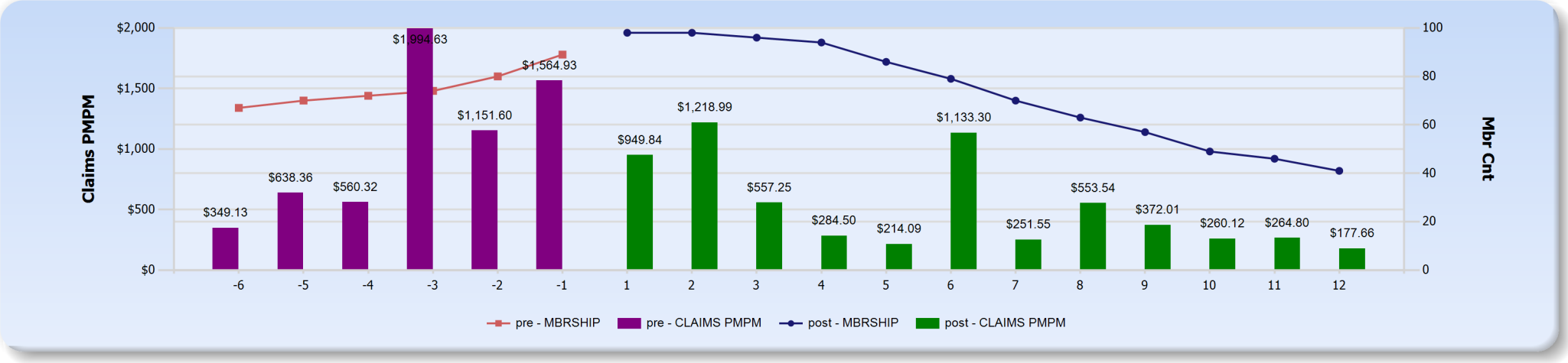
As at : 8/18/2017

Program Name : HIV/AIDS

LOB : MEDICAID

Patient Type : ADULT

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	PRE PMPM	POST PMPM- 12 Months Post
-34.57%	$1,078.38	$705.59

APT Trend		
Trend	6-Month Pre	12 - Month Post
-54.35%	770	351

EPT Trend		
Trend	6-Month Pre	12 - Month Post
-52.10%	2,018	967

Humana.

Attachment 5-6: MMA Disease Management Program Outcomes

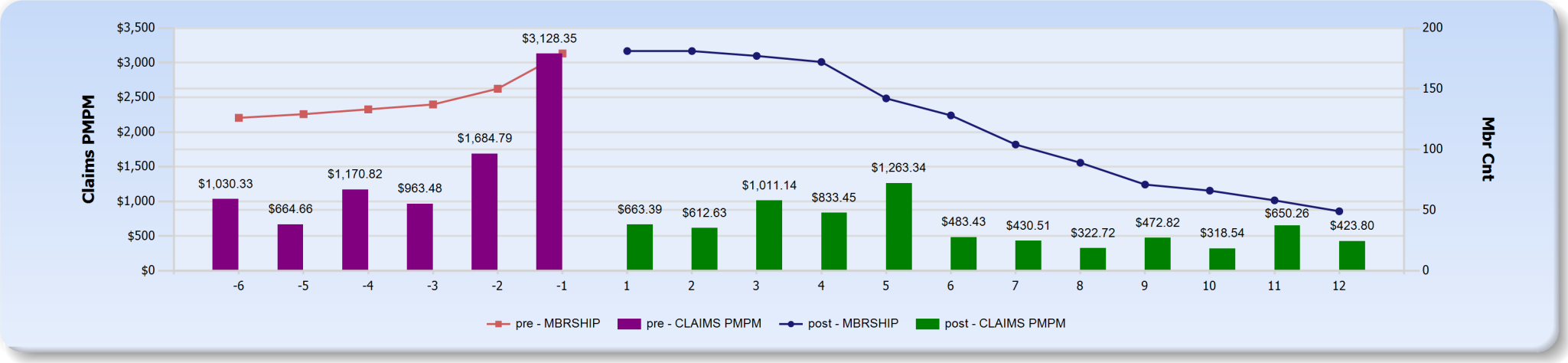
As at : 8/18/2017

Program Name : HYPERTENSION

LOB : MEDICAID

Patient Type : ADULT

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	PRE PMPM	POST PMPM- 12 Months Post
-50.97%	$1,540.95	$755.46

APT Trend		
Trend	6-Month Pre	12 - Month Post
-70.13%	1,377	411

EPT Trend		
Trend	6-Month Pre	12 - Month Post
-53.20%	2,206	1,032

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 6 – HEDIS Measures (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include, in table format, the target population (TANF, ABD, dual eligible), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-a-1**, General Performance Measurement Tool to provide results for the following HEDIS measures:

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Response:

Humana is committed to providing high quality care for our enrollees. Our performance and experience meeting quality standards in Florida, and nationally, demonstrate our commitment to quality:

- Humana is ranked 2nd in quality among Florida's Medicaid plans according to the National Committee for Quality Assurance (NCQA)[1], serving approximately 325,000 enrollees in Florida

- Humana's Florida Medicaid plan has been NCQA accredited since 1997. We are in the process of seeking an additional NCQA certification for Long-term Care Case Management.

- We are one of the top quality Medicare Advantage plans in the State of Florida, according to the Centers for Medicare and Medicaid Services' (CMS) Star rating, having achieved 4.5 (of five 5.0) Stars. On our respondent plan, Humana Medical Plan, Inc., we serve more than 365,000 Medicare beneficiaries across the state. Across all of our plans in the State of Florida, we serve more than 620,000 Medicare beneficiaries, including more than 105,000 who are eligible for both Medicare and Medicaid.

- Nationally, two point four (2.4) million, or approximately seventy-four (74) percent, of Humana Medicare Advantage members are in 4-plus Stars contracts. Humana has received a four point five (4.5) -star rating for five (5) of our Medicare Advantage contracts offered in eight (8) states.

HEDIS data plays a major role in how we measure, monitor, and improve the quality of care being provided to enrollees. Humana's robust quality improvement program promotes quality of care and patient outcomes performance for all of our Medicaid membership. We regularly measure, monitor, and evaluate our performance against AHCA and NCQA benchmarks in order to conduct oversight and improvement of medical and behavioral health care and support services.

==========
The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.
==========

Humana has extensive experience achieving quality standards with similar target populations for HEDIS measures listed in this SRC. We have monitored and tracked HEDIS measures in our Florida SMMC plan for more than twenty (20) years, in our Florida Group Commercial plan for more than twenty (20) years, and in our Florida Commonwealth Marketplace (Exchange) plan since it went live in 2014. Below we have included a brief overview of the top three (3) largest Medicaid and Commercial contracts for our respondent plan in Florida, Humana Medical Plan, Inc. These correlate to the three (3) contracts shown in attached Exhibit A-4-a-1.

- Florida Medicaid Managed Care
-- Approximately 325,000 enrollees
-- Program Summary and Populations Served: Medicaid, Temporary Assistance for Needy Families (TANF) and Aged, Blind, and Disabled (ABD)

- Florida Group Commercial
-- 167,336 enrollees
-- Program Summary and Populations Served: Commercial group benefits for ages 0 to 64

- Florida Marketplace (Exchange)
-- 19,998 enrollees
-- Program Summary and Populations Served: Exchange benefits for commercial ages 0 to 64

DETAILED DESCRIPTION OF PERFORMANCE MEASURE EXPERIENCE
FLORIDA STATEWIDE MEDICAID MANAGED CARE (SMMC)

Humana currently operates as a Managed Medical Assistance (MMA) plan across five (5) regions, serving approximately three hundred thirty thousand (330,000) Florida enrollees. We provide the full range of Medicaid preventive services for Medicaid TANF-eligible individuals, as well as those who are ABD. We have operated as a Medicaid plan in Florida since 1997. We currently monitor the following forty-two (42) measures in our Florida SMMC operations, including those measures listed in this SRC:

- Adolescent Well Care Visits – (AWC)
- Adults' Access to Preventive/Ambulatory Health Service – (AAP)
- Annual Dental Visits (ADV)
- Antidepressant Medication Management - (AMM)
- Adult BMI Assessment – (ABA)
- Breast Cancer Screening – (BCS)
- Cervical Cancer Screening - (CCS)
- Childhood Immunization Status – (CIS) – Combo 2 and 3
- Comprehensive Diabetes Care – (CDC)
-- Hemoglobin A1c (HbA1c) testing
-- HbA1c poor control
-- HbA1c control (<8%)
-- Eye exam (retinal) performed
-- Medical attention for nephropathy
- Controlling High Blood Pressure – (CBP)
- Follow-up Care for Children Prescribed ADHD Medication – (ADD)
- Immunization for Adolescents – (IMA)
- Chlamydia Screening in Women – (CHL)
- Prenatal and Postpartum Care – (PPC)
- Medication Management for People with Asthma – (MMA)
- Well-Child Visits in the First 15 Mos. of Life – (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34)
- Children and Adolescents' Access to Primary Care Practitioners – (CAP)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – (IET)
- Ambulatory Care – (AMB)
- Lead Screening in Children – (LSC)
- Annual Monitoring for Patients on Persistent Medications – (MPM)
- Frequency of Ongoing Prenatal Care – (FPC)
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia – (SAA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics – (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents – (APC)
- Follow-Up After Emergency Department Visit for Mental Illness – (FUM)
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence Treatment – (FUA)
- Diabetes Screening for People Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications – (SSD)

HEDIS & AHCA-Defined
- Follow-Up after Hospitalization for Mental Illness – (FHM)

AHCA-Defined
- Mental Health Readmission Rate – (RER)
- Transportation Timeliness – (TRT)
- Transportation Availability – (TRA)
- Highly Active Anti-Retroviral Treatment – (HAART)
- HIV-Related Outpatient Medical Visits – (HIVV)

Child Health Check Up Report (CMS-416)
- Dental Treatment Services – (TDENT)

- Sealants – (SEA)
- Preventive Dental Services – (PDENT)

Child Core Set
- Dental Sealants for 6-9 yr. old children at Elevated Carries Risk – (SEAL)
-Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents – (WCC)

Adult Core Set
- Plan All-Cause Readmissions – (PCR)
- HIV Viral Load Suppression – (VLS)
- Medical Assistance with Smoking and Tobacco Use Cessation – (MSC)

FLORIDA GROUP COMMERCIAL

Humana currently operates as a Group Commercial plan statewide in Florida, serving more than one hundred sixty-seven thousand (167,000) Florida enrollees. We provide the full range of commercial benefits for enrollees aged zero (0) to sixty-four (64). We currently monitor the following measures in our Florida Group Commercial operations:

- Adult BMI Assessment
- Child and Adolescent BMI, Nutrition, Physical Activity
-- BMI Percentile Total
-- Nutrition Counseling Total
-- Physical Activity Counseling Total
- Childhood Immunization
-- DTaP
-- IPV
-- MMR
-- HIB
-- Hepatitis B
-- Varicella
-- Pneumococcal Conjugate
-- Combination 2
-- Combination 3
- Adolescent Immunization
-- Combo 1
-- Meningococcal
-- Tdap/Td
- Human Papillomavirus Vaccine (HPV) for Female Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Chlamydia Screening in Women: Ages 16-20 yrs., 21-24 yrs., and total
- Appropriate Testing for Pharyngitis
- URI Treatment
- Acute Bronchitis Treatment
- Spirometry Testing

- Pharmacotherapy for COPD
-- Bronchodilator
-- Corticosteroid
- Appropriate Medication for Asthma: Ages 5-11 yrs., 12-18 yrs., 19-50 yrs., 51-64 yrs., and total
- Medication Management for People With Asthma
-- Medication Compliance 75%
- Controlling High Blood Pressure
- Persistence Beta-Blocker Treatment
- Comprehensive Diabetes Care
-- Blood Pressure Control < 140/90
-- Eye Exam
-- Good HbA1C Control < 8.0
-- HbA1c <7.0% Special Population
-- HbA1c Testing
-- Monitoring Diabetic Nephropathy
-- Poor HbA1c Control
- Imaging Studies for Low Back Pain
- Antidepressant Treatment
-- Acute Phase Treatment
-- Continuation Phase Treatment
- Follow-up Care for ADHD Medication
-- C&M
-- Initiation
- Follow-up Mental Illness Discharges
-- 7 Days
-- 30 Days
- Monitoring for Long Term Med ACE or ARBs
-- Digoxin
-- Diuretics
-- Total
- Adult Access to Preventive Care: Ages 20-44 yrs., 45-64 yrs., 65 yrs. and older, and total
- Children's Access to Primary Care: Ages 12-24 mos., 25 mos.-6 yrs., 7-11 yrs., 12-19 yrs.
- AOD Treatment
-- Initiation
-- Engagement
- Prenatal and Postpartum Care
-- Postpartum Care
-- Prenatal Care
- Well-Child Visit in first 15 mos. of life
-- Six or More Visits
- Well-Child Visit, 3-6 yrs.
- Well-Care Visit, Adolescent
- Plan All-Cause Readmissions
-- Total (Obs-to-Expct Ratio)

FLORIDA COMMERCIAL MARKETPLACE (EXCHANGE)

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana currently operates as a Florida Commercial Marketplace plan statewide, serving more than one hundred ninety thousand (190,000) Florida enrollees. We provide the full range of commercial benefits for enrollees aged zero (0) to sixty-four (64). We currently monitor the following measures in our Florida Commercial Marketplace operations:

- Child and Adolescent BMI, Nutrition, Physical Activity
-- BMI Percentile Total
-- Nutrition Counseling Total
-- Physical Activity Counseling Total
- Cervical Cancer Screening
- Chlamydia Screening in Women: Ages 16-20 yrs., 21-24 yrs., and total
- Appropriate Testing for Pharyngitis
- URI Treatment
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
-- Eye Exam
-- Good HbA1C Control < 8.0
-- HbA1c Testing
-- Monitoring Diabetic Nephropathy
- Imaging Studies for Low Back Pain
-- Total
- Follow-up Mental Illness Discharges
-- 7 days
- Monitoring for Long Term Med
-- ACE or ARBs
-- Digoxin
-- Diuretics
-- Total
- AOD Treatment
-- Initiation
-- Engagement
- Prenatal and Postpartum Care
-- Postpartum Care
-- Prenatal Care
- Well-Child Visit, 3-6 yrs.
-- 6 or More Visits

EXPERIENCE MEASURING HEDIS IN OTHER MEDICAID PLANS

In addition to our experience as Humana Medical Plan, Inc. in Florida, Humana has broad experience measuring HEDIS performance in our Medicaid plans in other states. We describe our experience in Kentucky and Illinois below.

KENTUCKY MEDICAID

Humana has served as a Medicaid health plan in Kentucky since 2013, and currently covers the physical and behavioral health services for more than one hundred forty thousand (140,000) enrollees statewide. We currently monitor the follow measures in our Kentucky program:

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

HEDIS measures
- Well-Child Visits in the 1st 15 mos. of life
- Well-Child Visits, 3-6 yrs. old
- Well-Child Visits, 12-21 yrs. old
- Lead Screening in Children
- Annual Dental Visit, 2-21 yrs. old
- Ht. and Wt. Measurement, 3-17 yrs. old
- BMI Measurement, 3-17 yrs. old
- Counseling for Nutrition, 3-17 yrs. old
- Counseling for Physical Activity, 3- 7 yrs. old
- Timeliness of Prenatal Care
- Frequency of Prenatal Care Visits, >=81%
- Timeliness of Postpartum Care
- Screening for Tobacco Use
- Counseling/Education for Tobacco Use
- Antidepressant Medication Management, Acute and Continuation Phase
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Diabetes Monitoring for People with Diabetes and Schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotics
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Follow-Up Care for Children Prescribed ADHD Medication, Initiation and Continuation Phase
- Follow-Up After Hospitalization for Mental Illness within 7 days and within 30 days of Discharge
- Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment
- Use of Appropriate Meds for People with Asthma, Total
- Med Management for People with Asthma, Compliance 75%
- Asthma Medication Ratio, Total
- Hemoglobin A1c (HbA1c) Testing
- HbA1c Poor Control (>9.0%)
- Eye Exam (Retinal) Performed
- Medical Attention for Nephropathy
- Blood Pressure Control (<140/90 mm Hg)
- Adult BMI Assessment
- Breast Cancer Screening
- Cervical Cancer Screening
- Persistence of Beta-Blocker Tx After a Heart Attack
- Cholesterol Management for Patients With Cardiovascular Conditions
- Controlling High Blood Pressure Appropriate Testing for children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infections (URI)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
-- Systemic Corticosteroid
-- Bronchodilator
- Adult Access to Preventive/Ambulatory Health Services: Ages 20-44 yrs., 45-64 yrs., 65+ yrs.
- Children and Adolescent Access to PCP: Ages 12-24 mos., 25 mos.-6 yrs., 7-11 yrs., 12-19 yrs.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

KY HEALTH OUTCOME PERFORMANCE MEASURES
- Screening and/or Counseling for Tobacco
- Screening and/or Counseling for Alcohol/Substance Use
- Screening and/or Counseling for Sexual Activity
- Screening for Depression
- Annual Dental Visit in CSHCN, 2-21 yrs.
- Well-Child Visits in CSHCN, in the 1st 15 mos., 3-6 yrs., 12-21 yrs.
- Access to PCP in CSHCN: Ages 12-24 mos., 25 mos.-6 yrs., 7-11 yrs., 12-19 yrs.
- Screening for Tobacco Use
- Positive Screening for Tobacco Use
- Received Intervention for Tobacco Use
- Screening for Alcohol Use
- Positive Screening for Alcohol Use
- Received Intervention for Alcohol Use
- Screening for Substance/Drug Use
- Positive Screening for Substance/Drug Use
- Received Intervention for Substance/Drug Use
- Assessment/Education/Counselling for Nutrition
- Assessment/Education/Counselling for OTC/Prescription Med
- Screening for Domestic Violence
- Postpartum Depression
- Healthy Weight for Height
- Counselling for Nutrition
- Counselling for Physical Activity
- LDL-C/Cholesterol Screening

ILLINOIS INTEGRATED CARE PROGRAM (ICP)
Humana has served as a Medicaid health plan in the Illinois Integrated Care Program (ICP), and currently covers the medical and LTC services for more than five thousand six hundred (5,600) enrollees in the state. We currently monitor the following measures in our ICP program:

- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Adult BMI Assessment
- Annual Dental Visit
- Antidepressant Medication Management
-- Acute
-- Continuation
- Asthma Medication Ratio
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Adolescent Well-Care Visits
- Breast Cancer Screening
- Controlling Blood Pressure
- Cervical Cancer Screening
- Comprehensive Diabetes Care
-- CDC-<100LDL-C
-- CDC-BP<140/80
-- CDC-BP<140/90
-- CDC-CDC HBA <8
-- CDC-CDC Neph

-- CDC-CDC-HbA1c
-- CDC-Eye Exams
-- CDC-HbA1c<7
-- CDC-HbA1c>9
-- CDC-LDL-C
- Chlamydia Screening in Women
- Frequency of Prenatal Care
-- FPC-21-40%
-- FPC-41-60%
-- FPC-61-80%
-- FPC-< 21%
-- FPC->= 81%
- Follow up after Hospitalization
-- FUH-30-Day
-- FUH-7-Day
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
-- Engagement
-- Initiation
- Use of Imaging Studies for Low Back Pain
- Medication Management for People With Asthma
-- 50%COMPLI
-- 75%COMPLI
- Annual Monitoring for Patients on Persistent Medications
-- ARBs
-- Digoxin
-- Diuretics
- Non-Recommended Cervical Cancer Screening in Adolescent Females
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation
-- Bronchodil
-- SCsteroid
-- Prenatal and Postpartum Care
-- Postpartum
-- Prenatal
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Statin Use in Patients with Cardiovascular Disease
- Statin therapy for patients with diabetes
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

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The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Exhibit A-4-a-1 contains our HEDIS 2016 and HEDIS 2017 performance for the measures listed in this SRC.

Footnotes

[1] http://healthinsuranceratings.ncqa.org/2017/search/Medicaid/FL

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.

2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 160 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 150 points as described below:

Exhibit A-4-a-1, General Performance Measurement Tool, provides for seventy-two (72) opportunities for a respondent to report prior experience in meeting quality standards (twelve (12) measure rates, three (3) states each, two (2) years each).

For each of the measure rates, a total of 10 points is available per state reported (for a total of 360 points available). The respondent will be awarded 2 points if their reported plan rate exceeded the national Medicaid mean and 2 points if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 2 points for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 150 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 360 points, the final score will be 150 points (100%). If a respondent receives 324 (90%) of the available 360 points, the final score will be 135 points (90%). If a respondent receives 36 (10%) of the available 360 points, the final score will be 15 points (10%).

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EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL (10-2-2017)

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/HEDIS 2017 performance measure data for the selected HEDIS measures for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

If the respondent does not have HEDIS results for at least (3) three Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The performance measures that respondents are required to report on can be found on the Performance Measure Group A tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year.

EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL (10-2-2017)

RESPONDENT NAME:	Humana Medical Plan					
Group A						
	State #1:	Florida	State #2:	Florida	State #3:	Florida
HEDIS Performance Measure	**CY 2015 Rate**	**CY 2016 Rate**	**CY 2015 Rate**	**CY 2016 Rate**	**CY 2015 Rate**	**CY 2016 Rate**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	**61.85**	**64.77**				
Antidepressant Medication Management - Acute Phase	**54.34**	**55.12**	**62.20**	**63.53**	**61.36**	**63.69**
Comprehensive Diabetes Care - HbA1c Control (<8%)	**49.88**	**47.45**	**63.26**	**59.61**	**56.20**	**63.02**
Controlling High Blood Pressure	**60.38**	**63.26**	**47.07**	**63.50**	**57.55**	**56.82**
Follow-Up After Hospitalization for Mental Illness - 7 day	**36.67**	**27.06**	**35.71**	**32.35**	**25.76**	**32.78**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation - Total	**33.29**	**32.71**	**32.41**	**30.69**	**33.14**	**31.63**
Medication Management for People with Asthma - 75% Compliance - Total	**22.49**	**27.23**	**45.54**	**45.41**	**41.07**	**42.35**
Children and Adolescents' Access to Primary Care Practitioners - 12-24 months	**93.89**	**93.67**	**98.86**	**98.62**		
Children and Adolescents' Access to Primary Care Practitioners - 25 months - 6 years	**88.34**	**87.14**	**95.26**	**95.08**		
Children and Adolescents' Access to Primary Care Practitioners - 7-11 years	**91.60**	**87.59**	**93.92**	**94.16**		
Children and Adolescents' Access to Primary Care Practitioners - 12-19 years	**87.99**	**84.69**	**87.68**	**89.00**		
Adults' Access to Preventive/Ambulatory Health Services - Total	**81.67**	**79.29**	**94.92**	**94.67**		

Total Points	**164**

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 7 – HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

Response:

Humana employs continuous quality improvement (CQI) strategies to ensure we are constantly improving the care and outcomes for our enrollees. Through our CQI approach, we execute a planned sequence of systematic and documented activities aimed at both resolving identified variances and improving processes. To address areas where we have performed below the state or national target, we employthe following high-level processes to address those issues:

- Analysis of plan demographics, including clinical, geographical, and cultural, to identify high-risk populations, areas of network need, enrollee education opportunities, and performance improvement opportunities

- Analysis of access and availability issues including after-hours availability of Primary Care Physicians

- Analysis of continuity and coordination of care

- Review of other non-clinical areas of performance, such as Customer Care call statistics and other enrollee services functions, marketing and outreach, claims processing timeliness and accuracy, and provider satisfaction

FLORIDA SMMC

Per the SMMC Contract, plans are required to meet the National Committee for Quality Assurance (NCQA) 50th percentile in order to be in compliance with contract quality standards. In calendar year (CY) 2015, Humana performed below Healthcare Effectiveness Data and Information Set (HEDIS) or Contract-required quality standards for the following measures listed in this SRC in our Florida SMMC program:
- Adults' Access to Preventive and Ambulatory Health Services (Total)

- Children and Adolescents' Access To Primary Care Physician (PCP) 12-19 yrs.
- Children and Adolescents' Access To PCP 12-24 mos.
- Follow Up After Hospitalization For Mental Illness – 7 days
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation Total
- Medication Management for People With Asthma: Medication Compliance 75% Total

In CY2016, Humana performed below HEDIS and/or contract required quality standards for the following measures listed in this SRC in our FL SMMC program:
- Adults' Access to Preventive/Ambulatory Health Services (Total)
- Children and Adolescents' Access To PCP 12-19 yrs.
- Children and Adolescents' Access To PCP 12-24 mos.
- Children and Adolescents' Access To PCP 25 mos. - 6 yrs.
- Children and Adolescents' Access To PCP 7-11 yrs.
- Comprehensive Diabetes Care - HbA1c Control < 8%
- Follow Up After Hospitalization For Mental Illness – 7 days
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation Total
- Medication Management for People With Asthma: Medication Compliance 75% Total

COMPARISON TO FLORIDA ALL-PLAN AVERAGE
Each year, AHCA releases the SMMC HEDIS all-plan averages, providing the average for all SMMC plans in the state, by measure. In 2015, we performed at or above the all-plan average for the following measures listed in this SRC:

- Adults' Access to Preventive/Ambulatory Health Services (Total) – Performed above all-plan average
- Children and Adolescents' Access To PCP (7-11 yrs.) – Performed above all-plan average
- Children and Adolescents' Access To PCP (12-19 yrs.) – Performed above all-plan average
- Comprehensive Diabetes Care - HbA1c Control (<8%) – Performed above all-plan average
- Controlling High Blood Pressure – Performed above all-plan average
- Antidepressant Medication Management – Acute Phase – Performed above all-plan average
- Follow Up After Hospitalization For Mental Illness – 7 days – Performed above all-plan average

In 2016, we performed at or above the all plan average for the following measures listed in this SRC:
- Adults' Access to Preventive/Ambulatory Health Services (Total) – Performed above all-plan average
- Children and Adolescents' Access To PCP (12-24 Months) – Performed at all-plan average
- Children and Adolescents' Access To PCP (12-19 Yrs) – Performed at all-plan average
- Comprehensive Diabetes Care - HbA1c Control (<8%) – Performed above all-plan average
- Follow Up After Hospitalization For Mental Illness – 7 days – Performed above all-plan average
- Controlling High Blood Pressure – Performed above all-plan average
- Antidepressant Medication Management – Acute Phase – Performed above all-plan average

STRATEGIC ACTIONS TAKEN TO IMPROVE PERFORMANCE MEASURES
Humana actively monitors and takes action to improve performance measures. We hold a monthly Medicaid Strategy meeting, which includes the Medicaid Medical Director, to review HEDIS measures and discuss successes and areas for improvement. Our Florida HEDIS team

holds monthly meetings on specific HEDIS measures to drill down on root causes of any performance issues. We continuously monitor performance through HEDIS dashboards, showing real time performance on measures and our compliance with NCQA and AHCA standards. Finally, HEDIS performance is a discussion topic at the quarterly comprehensive Quality Improvement Committee (QIC) meetings. We discuss how improvements on the medical and Long-term Care (LTC) components of care can improve outcomes for both populations.

SPECIFIC ACTIONS TAKEN IN FL SMMC PROGRAM TO IMPROVE HEDIS PERFORMANCE
Following our analysis of where we performed below targets, we identified opportunities for improvement and barriers that may be impeding improvement. We conducted quarterly Florida QIC meetings to initiate and evaluate various action plans specific to various performance metrics and quality benchmarks.

We identified the following opportunities and barriers between CY 2015 and CY 2016.

ENROLLEE-BASED OPPORTUNITIES
- Failure to schedule or keep appointments for chronic conditions or preventive care.

- Failure to establish initial appointment; enrollee has no established relationship with a primary care physician (PCP)

- Lack of health education regarding the importance of preventive screenings, immunizations, or warning signs for chronic conditions.

- Lack of transportation, which varies, but some examples include the enrollee being allowed only one escort or enrollee and children may have different provider and health plan, making it difficult to coordinate transportation in this situation.

- Denial of chronic conditions and ignoring health issues.

PROVIDER-BASED OPPORTUNITIES
- No available office staff to contact enrollees for preventive screenings, immunizations, or follow up on chronic conditions.

- Incorrect demographic data received from the plan or state and unable to locate enrollee.

- Lack of knowledge of the enrollee incentives offered by plan.

IMPROVEMENTS, INTERVENTIONS, ACTIONS:
We have developed a HEDIS improvement roadmap, Years 2015 through 2017, included in Attachment 7-1, to outline initiatives for all HEDIS measures where we identified areas for improvement. We have included only the measures included in this SRC in Attachment 7-1, but Humana's HEDIS roadmap includes all measures for the Florida SMMC program. We have also included three (3) years of roadmaps to illustrate Humana's ongoing commitment to continuously improve quality for our enrollees. The measures in which we performed below targets were predominantly focused on getting enrollees preventive care and treatment and ensuring access to such care. Accordingly, we focused our interventions on those that encourage and incentivize enrollees to seek preventive services. Below, we discuss the

initiatives undertaken between Calendar Year 2015 and 2016 for the measures where we performed below Contract-required standards.

ENROLLEE BASED INITIATIVES

- Conducted welcome calls in 2016 to new Medicaid enrollees and caregivers to encourage them to schedule their recommended routine and disease specific screenings and immunizations. The enrollee and caregiver are also offered assistance with scheduling the visits and transportation (This initiative was started in 2015.)

- Conducted Birthday Wellness and Postpartum calls –automated calls specific to enrollee having a birthday or having given birth that month – to remind enrollees to make an appointment for their checkup and screenings.

- Continued distribution of Wellness wallet and immunization cards for convenient enrollee access to health information in 2016.

- Childhood Check-up Call Campaign for education and appointment initiatives was on-going throughout 2016.

- Continued the Targeted Women and Children Outreach Campaign in 2016 in order to reach the non-compliant woman of child-bearing age with and without children in order for them to receive cervical cancer screening, breast cancer screening, and chlamydia screening.

- Revised the Healthy Behavior Programs, provider-based programs that were revised as of February 1, 2016. These programs include: Baby Well Visits Program, Pediatric Well Visit Program, MomsFirst Prenatal and Post-Partum Program, Smoking Cessation Program, Substance Abuse Program, and the Humana Family Fit Program. These programs are aimed at improving our healthy enrollee behaviors. Once the enrollee meets the requirements of the program, they receive a gift card.

- Identified enrollees who have asthma through claims and outreach by our disease management team to encourage enrollees to enroll into the disease management program. The program will stratify the enrollee in accordance with the level of severity and manage the enrollees who opt-in to the program telephonically. The frequency of the outbound call will depend on the level of severity. The program will educate enrollees on disease process, self-management, and medication management and adherence.

- Letters and flyers are sent to enrollees identified to the denominator of the HEDIS Measure – Medication Management for People with Asthma (MMA). The goal is to educate enrollees on asthma management.

- Asthma: Targeted Voice Activated Technology (VAT) call conducted by a vendor to adult enrollees with asthma medication. The goal is to improve medication adherence, remind enrollees to refill medication, and address barriers if they are adhering to their medication regimen.

- Clinical Alert (enrollees): The clinical alert is a reminder banner with different message each month. The banner is placed on the enrollee portal. (Attachment 7-2)

PROVIDER-BASED INITIATIVES
- Throughout 2016, action lists in the form of Tool Kits and gap reports were distributed and discussed with Medicaid providers to include performance measures that are required by the Agency for Health Care Administration. Providers are encouraged to fax in documents and lab results as supplemental data to close the gaps.

- PCP quality bonus encouraging providers to meet quality standards.

- Continued to distribute Provider Education for Asthma Management Communication to the providers during 2016.

- Continued use of Enhanced Medicaid specific performance report card to show the provider how they compare to peers.

- Continued distribution of a childhood checkup up provider tool.

- Distribution of Provider Medicaid HEDIS checklist, a one-page document that allows providers to keep track of what services has been completed. (Attachment 7-3)

- Clinical Alert (Providers): The clinical alert is a reminder banner with different well-being message each month. The banner is placed on the provider portal. (Attachment 7-4)

CONCLUSIONS AND RECOMMENDATIONS:
- Continue the Welcome, Birthday, and Postpartum Calls.

- Maintain the PCP bonus to engage Medicaid provider offices to submit medical records to close enrollee gaps.

- Continue Provider Rewards – The programs will be continued and we will look at increasing rewards.

- Continue with the quarterly Medicaid Quality Improvement Committee to target measures related to performance and quality metrics and sanctions or liquidated damages.

- Maintain Provider Organized Delivery System (PODS) and have representatives continue to complete provider visits and distribute educational materials related to improving patient experience and provide guidance through data, tools, and resources. Extend the program to reach providers through virtual visits by PODS representatives.

- Continue to evaluate and enhance enrollee and provider-specific programs in order to optimize results.

- Communicate with providers – Continue to monitor all proposed provider communication and engagement activities to promote the best provider experience.

ONGOING IMPROVEMENT INITIATIVES FOR MEASURES THAT MET BENCHMARKS
Humana continuously strives to improve quality outcomes, including areas where we have met contract-required benchmarks but improvement is still desirable. We can always improve the quality of care provided to our enrollees. Each year, we develop our HEDIS roadmap,

containing strategies and initiatives to improve all of our HEDIS measures. Our roadmaps include ongoing improvement initiatives for those measures where we have fallen below contract standards, as well as those where we have met contract standards, but we are seeking to improve. Below, we include an example of initiatives from our 2018 roadmap, based on HEDIS 2017 results, where we met the benchmark for the measure, illustrating how we are constantly working to improve quality outcomes.

Antidepressant Medication Management - Effective Acute Phase Treatment
HEDIS 2016
- Humana: 54.34
- NCQA 50th Percentile: 53.38

HEDIS 2017
-Humana: 55.12
-NCQA 50th Percentile: 51.89

For this measure, we met the benchmark for HEDIS 2016 and HEDIS 2017 and even improved from one year to the next. Despite the successful results we felt we could improve even further. Going into HEDIS 2018 reporting year, we identified the following initiatives to increase our performance on this measure and fully expect marked improvement:

- Monthly Action List delivered to Behavioral Health Subcontractors
- 2017 Medicaid HEDIS/CAHPS Guide & Checklist delivered to Providers
- VAT call to remind enrollee to refill medication

FLORIDA GROUP COMMERCIAL

While there are no contractually required benchmarks for our Florida Group Commercial plan, we monitor our performance against the NCQA Health Maintenance Organization/Point of Service Option (HMO/POS) fiftieth (50th) percentile to identify areas for improvement. In CY2015 and CY2016 we monitored and measured all HEDIS measures listed in this SRC, except Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

In CY2015 (HEDIS 2016), Humana performed below the NCQA Fiftieth (50th) percentile standard for the following measures listed in this SRC in our Florida Group Commercial program:

- Antidepressant Medication Management - Acute Phase Treatment
- Children and Adolescents' Access To PCP (Twelve (12) – Nineteen (19) Years)
- Controlling High Blood Pressure – Total
- Follow Up After Hospitalization For Mental Illness – Seven (7) days
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation Total
- Medication Management for People With Asthma: Medication Compliance seventy-five (75) percent (Total)

In CY2016 (HEDIS 2017), Humana performed below the NCQA fiftieth (50th) percentile standard for the following measures listed in this SRC in our Florida Group Commercial program:

- Antidepressant Medication Management - Acute Phase Treatment
- Children and Adolescents' Access To PCP (Twelve (12) – Twenty-four (24) Months)
- Children and Adolescents' Access To PCP (Twelve (12) – Nineteen (19) Years)
- Follow Up After Hospitalization For Mental Illness – Seven (7) days
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation Total
- Medication Management for People With Asthma: Medication Compliance seventy-five (75) percent (Total)

SPECIFIC ACTIONS TAKEN IN FLORIDA GROUP COMMERCIAL PROGRAM TO IMPROVE HEDIS PERFORMANCE
We conducted an analysis of our performance, and identified the following opportunities and barriers, improvements and changes, and conclusions and recommendations:

Opportunities and Barriers:
- Lack of knowledge of plan coverage, particularly for preventive services.
- Limited scope and effectiveness of provider-directed initiatives.
- Early stages of provider reward program building awareness to engage providers in quality improvement.

Improvements and Changes:
- Dedicated chart chase team resulted in closure of nearly four thousand four hundred (4,400) open gaps.

- Continue connections with other areas, such as ProActive and Marketing, to multi-message enrollees on topics of importance, such as plan coverage and preventive services.

- Increase provider relationships by engaging with existing PODS groups or Virtual PODS; partner with Provider Development Center of Excellence to expand rewards coverage.

- Leverage website for wellness related educational opportunities (e.g., Humana Beginnings, Smoking Cessation, and Personal Nurse).

- Expand blood pressure and maternity care email campaigns.

CONCLUSIONS AND RECOMMENDATIONS:
- Focus on expansion of successful pilots throughout remainder of the year with specific emphasis on highest Federal Employees Health Benefits prioritized markets and measures. For priority measures, move towards a proactive approach that limits future penalties and corrective action plans.

- Focus on enrollee awareness of preventive services, maternity, and diabetes related initiatives.

- Leverage PODS model and other market resources to engage in communication and relationship-building with Commercial providers to broaden range of message.

While there are no contractually required benchmarks for our Florida Commercial Marketplace plan, we monitor our performance against the NCQA HMO/POS fiftieth (50th) percentile to identify areas for improvement. In CY2015 and CY2016 we monitored and measured all HEDIS measures listed in this SRC, except for the following:
- Adults' Access to Preventive/Ambulatory Health Services (Total)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Children and Adolescents' Access To PCP 12-24 mos.
- Children and Adolescents' Access To PCP 25 mos. - 6 yrs.
- Children and Adolescents' Access To PCP 7-11 yrs.
- Children and Adolescents' Access To PCP 12-19 yrs.

In 2015 (HEDIS 2016), Humana performed below the NCQA fiftieth (50th) percentile standard for the following measures listed in this SRC in our Florida Commercial Marketplace Plan:
- Antidepressant Medication Management - Acute Phase Treatment
- Comprehensive Diabetes Care - HbA1c Control (<8%)
- Controlling High Blood Pressure - Total
- Follow Up After Hospitalization For Mental Illness – 7 days
- Medication Management for People With Asthma: Medication Compliance 75% Total

In 2016 (HEDIS 2017), Humana performed below the NCQA fiftieth (50th) percentile standard for the following measures listed in this SRC in our Florida Commercial Marketplace Plan:
- Antidepressant Medication Management - Acute Phase Treatment
- Comprehensive Diabetes Care - HbA1c Control < 8%
- Controlling High Blood Pressure - Total
- Follow Up After Hospitalization For Mental Illness – 7 days
- Medication Management for People With Asthma: Medication Compliance 75% Total

SPECIFIC ACTIONS TAKEN IN FLORIDA COMMERCIAL MARKETPLACE PROGRAM TO IMPROVE HEDIS PERFORMANCE
We conducted an analysis of our performance, and identified the following opportunities and barriers, improvements and changes, and conclusions and recommendations:

Opportunities and Barriers:
- High turnover rate among Marketplace membership decreases effectiveness of quality initiatives, especially enrollee experience focused initiatives

- Data indicates high out-of-network utilization, emergent care services, and a low number of PCP visits

- Out-of-network emergent access to care leads to a higher financial burden for enrollees and does not link to positive changes in health outcomes

- Lack of education on how and where to utilize health insurance. Coverage levels and clarity on out of pocket costs as it relates specifically to preventive screenings

- Provider attribution issues, specifically auto-assignment to a PCP when an enrollee is unfamiliar with their assigned physician, or physician hours, costs, and geography are primary driving factors. Strong PCP relationships are critical to gap closure

- Providers are unfamiliar with QRS measure specifications

Improvements and Changes:
- Quality Improvement Strategy (QIS) focused on enrollee-PCP engagement has been submitted to CMS. Enrollee-PCP relationships are key to enrollee retention and gap closure

- Preliminary data indicates increased enrollee experience scores versus 2014 beta test results. Increased focus on enrollee perception related initiatives throughout the year played a contributing factor

- Increased scope of Provider outreach initiatives aimed at improving HEDIS scores

- Commercial team dedicated to chart chase activity resulted in increased gap closure for reporting year 2015 versus reporting year 2014

Conclusions and Recommendations:
- Continued focus on improving enrollee experience scores related to Enrollee Survey, which is heavily weighted in the calculation in overall quality star scores.

- QIS Strategy to enhance enrollee-PCP engagement remains a priority and improves the opportunity to coordinate care.

- Continued focus on tactics to drive up results in specific HEDIS preventive areas and Qualified Health Plan (QHP) Enrollee Scores.

- Better understand emergency department utilization to effectively encourage enrollees to engage in PCP relationships.

- Continued maturity of Commercial rewards program.

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.

2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

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Attachment 7-1: Improvement Ratings

HEDIS Measure	2015 Initiatives	Start Date	End Date
Adults' Access to Preventative / Ambulatory Health Services	2015 Medicaid PCP Bonus	1/1/2015	12/31/2015
	Monthly Action List	1/1/2015	12/31/2015
	Monthly Welcome Call to New Enrollee	1/1/2015	12/31/2015
	Monthly QIN Educational Visits	1/1/2015	12/31/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	Children/Adolescent Wellness Wallet Card	6/1/2015	12/31/2015
	One-time Targeted Women and Children Outreach Campaign (Include Health Choice)	7/28/2015	9/30/2015
	One-time Letter Drop Campaign (non-compliant male only)	9/11/2015	9/30/2015
Children and Adolescents' Access to PCP (4 Submeasures)	Healthy Behavior Reward Program: Adolescent Well Child Visit, Children's Nutrition	1/1/2015	12/31/2015
	2015 Medicaid PCP Bonus	1/1/2015	12/31/2015
	Monthly CHCUP Call Campaign	1/1/2015	12/31/2015
	Monthly Action List	1/1/2015	12/31/2015
	Monthly Welcome Call to New Enrollee	1/1/2015	12/31/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	QIN Educational Visits to Pediatrician Offices	4/1/2015	6/30/2015
	Provider Educational Pamphlet: FL Medicaid Child Check-Up Information	4/1/2015	12/31/2015
	Children/Adolescent Wellness Wallet Card	6/1/2015	12/31/2015
	One-time Targeted Women and Children Outreach Campaign (Include Health Choice)	7/22/2015	9/30/2015

Attachment 7-1: Improvement Ratings

HEDIS Measure	2015 Initiatives	Start Date	End Date
Comprehensive Diabetes Care – HbA1c Testing & Control	Monthly Action List	1/1/2015	12/31/2015
	2015 Medicaid PCP Bonus	1/1/2015	12/31/2015
	Monthly QIN Educational Visits	1/1/2015	12/31/2015
	Disease Management	1/1/2015	12/31/2015
	2015 Hypertensive and Diabetic Member Watch List	3/1/2015	4/30/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	"My Health Manager" booklet enrollees in DM and CM	5/1/2015	12/31/2015
	Novo Nordisk Initiative	9/1/2015	12/31/2015
	Diabetes VAT Call (Include Health Choice)	9/1/2015	12/31/2015
Controlling High Blood Pressure – Total	Monthly QIN Educational Visits	1/1/2015	12/31/2015
	Disease Management	1/1/2015	12/31/2015
	2015 Hypertensive and Diabetic Member Watch List	3/1/2015	4/30/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	"My Health Manager" booklet enrollees in DM and CM	5/1/2015	12/31/2015
Use of Appropriate Medications for People with Asthma - Total	Monthly Action List	1/1/2015	12/31/2015
	Monthly QIN Educational Visits	1/1/2015	12/31/2015
	2015 Medicaid PCP Bonus	1/1/2015	12/31/2015
	Disease Management	1/1/2015	12/31/2015
	Pharmacist Outreach	1/1/2015	12/31/2015
	2015 Asthma Member Watch List	3/1/2015	4/30/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	Provider Educational Pamphlet: Asthma HEDIS Measure Overview	3/1/2015	12/31/2015
	Targeted Asthma Gap Closure Outreach (Member/Providers)	10/12/2015	12/31/2015
	Asthma Letter Campaign	11/1/2015	12/31/2015

Attachment 7-1: Improvement Ratings

HEDIS Measure	2015 Initiatives	Start Date	End Date
Antidepressant Medication Management	Monthly Action List Behavioral Vendors	1/1/2015	12/31/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	AMM Fact Sheet	10/15/2015	12/31/2015
Follow Up After Hospitalization for Mental Illness (*Agency Defined)*	Monthly Action List Behavioral Vendors	1/1/2015	12/31/2015
	Bridge Visit	1/1/2015	12/31/2015
	Home Visit for those members discharge from facilities with no bridge service	1/1/2015	12/31/2015
	Case Management Follow Up Call	1/1/2015	12/31/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	Enhancement Request to Include "Event Date" and "Facility Name" *(June report that released in August includes both enhancements)*	4/1/2015	12/31/2015
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment - Total	Monthly Action List Behavioral Vendors	1/1/2015	12/31/2015
	Monthly QIN Educational Visits	1/1/2015	12/31/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	Provider Educational Pamphlet: IET – Psychcare Encompass Program	5/1/2015	12/31/2015
	Enhancement Request to Include "Rendering Provider Name" *(QSI is still working on the enhancement request)*	4/1/2015	12/31/2015

Attachment 7-1: Improvement Ratings

HEDIS Measure	2016 Initiatives	Start Date	End Date
Adults' Access to Preventative / Ambulatory Health Services	2016 Medicaid PCP Bonus	1/1/2016	12/31/2016
	Monthly Action List	4/1/2016	12/31/2016
	Monthly Welcome Call to New Enrollee	1/1/2016	12/31/2016
	Monthly QIN Educational Visits	1/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/25/2016	12/31/2016
	Children/Adolescent Wellness Wallet Card	1/1/2016	12/31/2016
	Clinical Alert *(Members and Providers)* ***New****	1/1/2016	12/31/2016
	Health Fair Events host at PCP Centers - Continucare	4/1/2016	4/30/2016
	Health Fair Events host at PCP Centers – MSO Health	6/1/2016	6/30/2016
	Targeted Women and Children Outreach Campaign	9/15/2016	10/31/2016
	Adult Wellness Campaign	8/1/2016	12/31/2016
Children and Adolescents' Access to PCP (4 Submeasures)	Healthy Behavior Reward Program: Baby Well Visit and Pediatric Well Visit Programs	2/1/2016	12/31/2016
	2016 Medicaid PCP Bonus	1/1/2016	12/31/2016
	Monthly CHCUP and Dental Reminder Call Campaign	1/1/2016	12/31/2016
	Monthly Action List	1/1/2016	12/31/2016
	Monthly Welcome Call to New Enrollee	1/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/1/2016	12/31/2016
	QIN Educational Visits to Pediatrician Offices	1/1/2016	12/31/2016
	Provider Educational Pamphlet: FL Medicaid Child Check-Up Information	1/1/2016	1/31/2016
	Children/Adolescent Wellness Wallet Card	1/1/2016	1/31/2016
	Clinical Alert *(Members and Providers)* ***New****	1/1/2016	12/31/2016
	Health Fair Events host at PCP Centers - Continucare	4/1/2016	4/30/2016
	Health Fair Events host at PCP Centers – MSO Health	6/1/2016	6/30/2016
	Targeted Women and Children Outreach Campaign	9/15/2016	10/31/2016

Attachment 7-1: Improvement Ratings

HEDIS Measure	2016 Initiatives	Start Date	End Date
Comprehensive Diabetes Care – HbA1c Testing & Control	Monthly Action List	4/1/2016	12/31/2016
	2016 Medicaid PCP Bonus – HbA1c Control	1/1/2016	12/31/2016
	Monthly QIN Educational Visits	1/1/2016	12/31/2016
	Disease Management	1/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/1/2016	12/31/2016
	"My Health Manager" booklet enrollees in DM and CM	1/1/2016	12/31/2016
	Novo Nordisk Initiative	2/1/2016	12/31/2016
	2016 Diabetic Member Watch List	3/1/2016	12/31/2016
	Clinical Alert *(Members and Providers)* ***New***	11/1/2016	11/30/2016
	Diabetes VAT Call (Include Health Choice)	8/1/2016	9/30/2016
Controlling High Blood Pressure – Total	2016 Hypertensive Member Watch List	4/1/2016	4/30/2016
	Monthly QIN Educational Visits	1/1/2016	12/31/2016
	Disease Management	1/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/25/2016	12/31/2016
	"My Health Manager" booklet enrollees in DM and CM	1/1/2016	12/31/2016
	Clinical Alert *(Members and Providers)* ***New***	5/1/2016	5/31/2016
Medication for People with Asthma - Total	Monthly Action List	4/1/2016	12/31/2016
	Monthly QIN Educational Visits	1/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/25/2016	12/31/2016
	Disease Management	1/1/2016	12/31/2016
	Provider Education Letter	4/1/2016	4/30/2016
	Pharmacist Outreach	4/1/2016	12/31/2016
	Asthma Medication Adherence – Impactable Report	9/1/2016	12/31/2016
	VAT call to remind member to refill medication	8/8/2016	12/31/2016

Attachment 7-1: Improvement Ratings

HEDIS Measure	2016 Initiatives	Start Date	End Date
Antidepressant Medication Management	Monthly Action List Behavioral Vendors	3/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/25/2016	12/31/2016
	AMM Fact Sheet	1/1/2016	12/31/2016
	AMM Medication Adherence – Impactable Report	5/1/2016	12/31/2016
	VAT call to remind member to refill medication	8/8/2016	12/31/2016
Follow Up After Hospitalization for Mental Illness (*Agency Defined)*	Monthly Action List Behavioral Vendors	1/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/25/2016	12/31/2016
	Bridge Visit	1/1/2016	12/31/2016
	Home Visit for those members discharge from facilities with no bridge service	1/1/2016	12/31/2016
	Case Management Follow Up Call	1/1/2016	12/31/2016
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment - Total	Monthly Action List Behavioral Vendors	7/1/2016	12/31/2016
	Monthly QIN Educational Visits	1/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/25/2016	12/31/2016
	Clinical Alert *(Members and Providers)* ***New***	4/1/2016	4/30/2016
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Monthly Action List Behavioral Vendors	3/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/25/2016	12/31/2016
	Adherence Letters send to Members and Prescribers through Beacon's PDIP program with fill lag > 10 days	1/1/2016	12/31/2016
	Antipsychotic Medication Adherence – Impactable Report – *Still pending report*	TBD	TBD

Attachment 7-1: Improvement Ratings

HEDIS Measure	2017 Initiatives	Start Date	End Date
Adults' Access to Preventative / Ambulatory Health Services	2017 Medicaid PCP Bonus	1/1/2017	12/31/2017
	Monthly Action List (PCPs)	3/1/2017	12/31/2017
	Monthly Welcome Call to New Enrollee	1/1/2017	12/31/2017
	Monthly QIN Educational Visits	1/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	Children/Adolescent Wellness Wallet Card	1/1/2017	12/31/2017
	Clinical Alert *(Members and Providers)*	1/1/2017	12/31/2017
	VAT call targeted to member non-compliant for a well-care visit, CCS, BMI and CHL	1/1/2017	12/31/2017
	Targeted Adult & Child Wellness Letter Campaign	1/1/2017	12/31/2017
Children and Adolescents' Access to PCP (4 Submeasures)	Healthy Behavior Reward Program: Baby Well Visit and Pediatric Well Visit Programs	1/1/2017	12/31/2017
	2017 Medicaid PCP Bonus	1/1/2017	12/31/2017
	Monthly CHCUP and Dental Reminder Call Campaign	1/1/2017	12/31/2017
	Monthly Action List (PCPs)	3/1/2017	12/31/2017
	Monthly Welcome Call to New Enrollee	1/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	QIN Educational Visits to Pediatrician Offices	1/1/2017	12/31/2017
	Provider Educational Pamphlet: FL Medicaid Child Check-Up Information	1/1/2017	12/31/2017
	Children/Adolescent Wellness Wallet Card	1/1/2017	12/31/2017
	Clinical Alert *(Members and Providers)*	1/1/2017	12/31/2017
	VAT call targeted to member non-compliant for a well-care visit, CCS, BMI and CHL	1/1/2017	12/31/2017
	Targeted Adult & Child Wellness Letter Campaign	1/17/2017	12/31/2017

Attachment 7-1: Improvement Ratings

HEDIS Measure	2017 Initiatives	Start Date	End Date
Comprehensive Diabetes Care – HbA1c Testing & Control	Monthly Action List (PCPs)	3/1/2017	12/31/2017
	2017 Medicaid PCP Bonus – HbA1c Testing and Control	1/1/2017	12/31/2017
	Monthly QIN Educational Visits	1/1/2017	12/31/2017
	Disease Management	1/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	2017 Diabetic Member Watch List	3/1/2017	3/31/2017
	Clinical Alert *(Members and Providers)*	11/1/2017	11/30/2017
	Diabetes Letter Campaign: Encourage diabetes screenings and control	1/1/2017	12/31/2017
Controlling High Blood Pressure – Total	2017 Hypertensive Member Watch List	3/1/2017	3/31/2017
	Monthly QIN Educational Visits	1/1/2017	12/31/2017
	Disease Management	1/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	2017Hypertensive Member Watch List	3/1/2017	3/31/2017
	Clinical Alert *(Members and Providers)*	5/1/2017	5/31/2017
	Provider Education Pamphlet: HEDIS Education on Controlling Blood Pressure	5/1/2017	5/31/2017
Medication for People with Asthma - Total	Monthly Action List (PCPs)	3/1/2017	12/31/2017
	Monthly QIN Educational Visits	1/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	Disease Management	1/1/2017	12/31/2017
	Letter Campaign: Encourage members to manage asthma medications appropriately	1/1/2017	12/31/2017
	Asthma Medication Adherence – Impactable Report	1/1/2017	12/31/2017
	VAT call to remind member to refill medication	1/1/2017	12/31/2017

Attachment 7-1: Improvement Ratings

HEDIS Measure	2017 Initiatives	Start Date	End Date
Antidepressant Medication Management	Monthly Action List Behavioral Vendors	3/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	AMM Medication Adherence – Impactable Report	1/1/2017	12/31/2017
	VAT call to remind member to refill medication	1/1/2017	12/31/2017
Follow Up After Hospitalization for Mental Illness (*Agency Defined)*	Monthly Action List Behavioral Vendors	3/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	Bridge Visit	1/1/2017	12/31/2017
Initiation and Engagement of Alcohol & Other Drug Dependence Treatment - Total	Monthly Action List Behavioral Vendors	3/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	Clinical Alert *(Members and Providers)*	4/1/2017	4/30/2017
	Provider Educational Pamphlet: IET	4/1/2017	12/31/2017
	ER Notification Initiatives	6/1/2017	12/31/2017
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Monthly Action List Behavioral Vendors	3/1/2017	12/31/2017
	2017 Medicaid HEDIS CAHPS Guide & Checklist	1/30/2017	12/31/2017
	Adherence Letters send to Members and Prescribers through Beacon's PDIP program with fill lag > 10 days	1/1/2017	12/31/2017
	Antipsychotic Medication Adherence – Impactable Report	3/1/2017	12/31/2017

Attachment 7-2: Member Portal Clinical Alerts

The clinical alert is a reminder banner with a different message each month. The banner is placed on the member portal.

Clinical Timeline 2016 – Clinical Alerts Member Portal

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Cervical Health Awareness	Healthy Heart Month	Colorectal Cancer Awareness	Alcohol Awareness Month	High Blood Pressure Education	Mid-Year Wellness Reminder	Promote Eye Exam	Immunization Awareness Month	Healthy Eating & Lifestyle	Breast Cancer Awareness	Diabetes Awareness Month	National Influenza Vaccination

All Year Round (Except June): *Don't forget to schedule yours and/or your child's free yearly well-visit and dental checkup. Call your doctors or call Customer Service at 1-800-477-6931 (TYY: 711) to schedule appointments today, and remember these visits are at no cost to you!*
Jan: If you are a female, consult your doctor or an OB/GYN for an annual Pap smear testing
Feb: This is Healthy Heart Month. Time to think about eating healthy and exercising to keep your heart strong. Consult your doctor on lifestyle changes.
Mar: If you are age 50 and older, it is important to talk to your doctor about a colon screening.
Apr: If you or someone you love struggles with drugs and/or alcohol, speak with your physician. You may also call our Customer Services at 1-800-477-6931 and ask about the Healthy Behavior Reward Program.
May: Is your blood pressure below 120/80? If not or you are not sure, consult your doctor to discuss treatment options.
Jun: We are half way through the year. Have you schedule yours and/or your child's free yearly well0visit and dental check-up. *Call your doctors or call Customer Service at 1-800-477-6931 (TYY: 711) to schedule appointments today, and remember these visits are at no cost to you!*
Jul: Have you or your child had an eye exam this year? If not, we encourage you to schedule with an in-network eye doctor. Yearly eye exam is important to maintain good vision.
Aug: Are you or your child up to date on all immunization? Consult your doctor about the importance of getting immunized.
Sept: It is important to maintain a healthy diet and weight. Humana offers nutritional counseling for free. Call Customer Services at 1-800-477-6931 and ask about the benefit.
Oct: Are you a female age 50-74? Have you had a mammogram done this year or last year? If not, consult your doctor about a mammogram.
Nov: If you or someone you love are living with diabetes, education and support are important to help you stay in control and healthy. Humana offers a Diabetes Disease Management Program for free. To learn more about our program, call at 1-800-322-2758
Dec: It's not too late! A yearly flu vaccine is recommended for everyone 6 months and older. Consult your doctor and get your flu vaccine today.

1.0.9.5 12/2015 Katie Wetherington – SMCC Contract Manager

2017 ADULT MEDICAID SCREENINGS, SERVICES AND EDUCATION CHECKLIST

MEMBER NAME: _____ DOB: _____ HUMANA ID:_____

PREVENTION AND SCREENINGS	DESCRIPTION OF REQUIREMENT	DATE COMPLETED
❑ Adult body mass index (BMI)	BMI assessment for adults ages 18 to 74 between Jan. 1, 2016, and Dec. 31, 2017	___/___/___ **Result:**
❑ Breast cancer screening	Mammography for women ages 50 to 74 between Oct. 1, 2015, and Dec. 31, 2017, or exclusion due to bilateral mastectomy	___/___/___
❑ Cervical cancer screening	Pap smear evident for women ages 21 to 64 between Jan. 1, 2015, and Dec. 31, 2017, or pap/human papillomavirus co-testing for women ages 30 to 64 between Jan. 1, 2013, and Dec. 31, 2017, or exclusion due to complete/total/radical hysterectomy	___/___/___
❑ Chlamydia screening	At least one test for chlamydia in women ages 16 to 24, who are sexually active, before Dec. 31, 2017	___/___/___
❑ Ambulatory or preventive care visit	An ambulatory or preventive care visit as defined for adults ages 20 and older before Dec. 31, 2017	___/___/___
RESPIRATORY CONDITIONS	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Medication management for people with asthma	Monitor adherence to asthma controller medication regimen for members ages 5 to 64 diagnosed with persistent asthma **Asthma controller medications:** **Antibody inhibitor:** omalizumab; **Inhaled steroid combinations:** Symbicort®, Advair®, Dulera®; **Inhaled corticosteroid:** beclomethasone, Pulmicort®, fluticasone CFC-free, mometasone; **Leukotriene modifiers:** montelukast, zafirlukast; **Mast cell stabilizers:** cromolyn; **Methylxanthines:** theophylline	___/___/___ **Rx:**
CARDIOVASCULAR CONDITIONS	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Controlling high blood pressure	Blood pressure controlled in adults ages 18 to 85 (target depends on age and diabetes diagnosis) prior to Dec. 31, 2017, with a diagnosis of hypertension prior to June 30, 2017	___/___/___ **Result:**
DIABETES CARE (ADULTS 18 AND OLDER)	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Annual diabetic retinal eye exam	Diabetic retinal eye exam before Dec. 31, 2017	__/__/__ **Result:**
❑ Annual HbA1c testing	Testing and control of HbA1c lower than 8 percent before Dec. 31, 2017	__/__/__ **Result:**
❑ Medical attention for nephropathy	Nephropathy screening test or evidence of nephropathy as per claim/ encounter, nephrologist visit, urine protein test or ACE inhibitor/ARB therapy before Dec. 31, 2017	__/__/__ **Result:**
BEHAVIORAL HEALTH MANAGEMENT	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Antidepressant medication management	Encourage and monitor compliance with antidepressant medications for members ages 18 and older, newly diagnosed with major depression	__/__/__
❑ Initiation and engagement of alcohol and drug dependence treatment	Initiate treatment through an inpatient alcohol or other drug dependence (AOD) admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis and have two or more additional services with a diagnosis of AOD within 30 days of the initial visit	Initial: __/__/__ Follow-ups: __/__/__ __/__/__
❑ Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	One blood glucose or HbA1c test for members ages 18 to 64 years old with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication before Dec. 31, 2017	Glucose/HbA1c: __/__/__

Please note: This is for office use only and should not be submitted to Humana to close Healthcare Effectiveness Data and Information Set (HEDIS®) gaps in care for your patients.

2017 MEDICAID PEDIATRIC SCREENINGS, SERVICES AND EDUCATION CHECKLIST

MEMBER NAME: _____ DOB:_____ HUMANA ID: _____

PREVENTION AND SCREENINGS	DESCRIPTION OF REQUIREMENT	DATE COMPLETED
❑ Chlamydia screening	At least one test for chlamydia in women ages 16 to 24, who are sexually active, before Dec. 31, 2017	____/____/____
❑ Immunizations (childhood and adolescent)	• Childhood immunizations are up to date by the child's second birthday • Adolescent immunizations are up to date by the child's 13th birthday	____/____/____
❑ Lead screening	At least one blood lead screening before the child's second birthday	____/____/____ **Result:**
❑ Well-care visit (childhood and adolescent)	• At least six well-child visits prior to **15 months** of age • At least one well-child visit for children/adolescents 1 to 21 years of age before Dec. 31, 2017 *(Note: Documentation should include complete history, including physical and mental health, physical exam, BMI/BMI percentile, nutrition counseling and anticipatory guidance.)*	____/____/____
❑ Annual dental visit	An annual dental visit with a dental practitioner for all members ages 2 to 20 before Dec. 31, 2017	____/____/____
RESPIRATORY CONDITIONS	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Medication management for people with asthma	Monitor adherence with asthma controller medication regimen for members ages 5 to 64 diagnosed with persistent asthma **Asthma controller medications:** **Antibody inhibitor:** omalizumab **Inhaled steroid combinations:** Symbicort®, Advair®, Dulera® **Inhaled corticosteroid:** beclomethasone, Pulmicort®, fluticasone CFC-free, mometasone **Leukotriene modifiers:** montelukast, zafirlukast **Mast cell stabilizers:** cromolyn **Methylxanthines:** theophylline	____/____/____ **Rx:**
BEHAVIORAL HEALTH MANAGEMENT	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Follow-up management for children with newly prescribed attention deficit disorder/ attention deficit hyperactivity disorder (ADD/ADHD)	• An in-person outpatient visit within 30 days of prescription fill • Two additional in-person outpatient follow-up visits between days 31 and 300 of prescription fill	____/____/____ ____/____/____ ____/____/____
❑ Initiation and engagement of alcohol and drug dependence treatment	• Initiate treatment through an inpatient alcohol or other drug dependence (AOD) admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis and • Have two or more additional services with a diagnosis of AOD within 30 days of the initial visit	Initial: ___ /____ / ____ Follow-ups: ___ /____ /____ ___ /____ /____
❑ Metabolic monitoring for children and adolescents on antipsychotics	One blood glucose or HbA1c test and one LDL-C or cholesterol test for children/adolescents 1 to 17 years old who had two or more antipsychotic prescriptions before Dec. 31, 2017	Glucose/HbA1c: ___/___/___ LDL-C/cholesterol: ___/___/___

Please note: This document is for office use only and should not be submitted to Humana to close Healthcare Effectiveness Data and Information Set (HEDIS®) gaps in care for your patients.

Attachment 7-4: Provider Portal Clinical Alerts

2017 Florida Medicaid Provider Web Banners

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Cervical Health Awareness	Healthy Heart Month	Colorectal Cancer Awareness	Alcohol Awareness Month	High Blood Pressure Education	Mid-Year Wellness Reminder	Promote Eye Exam	Immunization Awareness Month	Healthy Eating & Lifestyle	Breast Cancer Awareness	Diabetes Awareness Month	National Influenza Vaccination

Jan: Jan is Cervical Health Awareness Month. Please help us raise awareness on the importance of getting an annual well-woman check.
Feb: February is Healthy Heart Month. Please educate your patients to make heart-healthy choices to prevent the nation's leading killers.
Mar: March is Colorectal Cancer Awareness Month. Please help us raise awareness on the importance of getting colorectal cancer screening regularly.
Apr: April is Alcohol Awareness Month. Humana offers a Healthy Behavior Substance Abuse Program. To refer a member, please call 1-800-221-5487.
May: May is High Blood Pressure Education Month. Please educate your patients about contributing lifestyle factors and healthy choices.
Jun: We are halfway through the year. Please be sure to reach out to those patients who have not had a yearly check-up.
Jul: Encourage your patients to schedule an annual eye exam with an in-network optometrist or ophthalmologist to maintain good vision.
Aug: August is Immunization Awareness Month. Please educate patients and caregivers about the value of immunization throughout their lifespans to prevent dangerous and deadly diseases.
Sept: It is important to maintain a healthy diet and weight. Patients can learn more about Humana's free nutritional counseling by calling Customer Service at 1-800-477-6931.
Oct: October is Breast Cancer Awareness Month. Please help us raise awareness on the importance of getting a mammogram.
Nov: November is Diabetes Awareness Month. Refer patients to our free Diabetes Disease Management Program by calling 1-800-322-2758.
Dec: It's not too late! A yearly flu vaccine is recommended for everyone 6 months old and older. Please encourage your patients to get vaccinated today.

SRC# 8 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Robert, a 50-year-old man, was diagnosed with chronic obstructive pulmonary disease (COPD) five (5) years ago. His symptoms have been worsening recently, and he has presented at the emergency department three (3) times during the past thirty (30) days. Robert previously smoked twenty-five (25) cigarettes per day for thirty (30) years, but cut down to ten (10) cigarettes per day after his first COPD exacerbation two (2) years ago. He has attempted to quit smoking on several occasions without any success. Robert is prescribed several regular medications for his COPD, as well as for hypertension and hypercholesterolemia. He is pre-diabetic and obese with a BMI of 35. His last appointment with his specialist was ten (10) months ago. Robert has difficulty taking his medications regularly, as he is sometimes unable to get his prescriptions in his rural community and he lacks transportation. After his last visit to the emergency department, Robert was prescribed oxygen treatments and a new medication; however, he has not filled these orders. Robert lives with his 15-year old son and is a single parent. Robert and his son have been on Medicaid for the last four (4) years since he lost his job. Robert has been a member of the plan since December 2016.*

The respondent shall describe its approach to coordinating care for an enrollee with Robert's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

LOOKING BACK: HUMANA'S INTRODUCTION TO ROBERT

Robert's eligibility, effective December 1, 2016, comes to Humana via the 834 enrollment file sent by the Florida Agency for Health Care Administration (AHCA) and is an automated electronic transmission into our Customer Interface (CI) enrollment system. Robert's eligibility information loads into the CI system within twenty-four (24) hours of receipt of his enrollment.
Our processes ensure Robert's information is accessible in real-time and that the information flows downstream into our CareHub Clinical Guidance Exchange (CGX) [1] and Client

Relationship Management (CRM) [2] systems, advising our Humana clinical and customer care teams that Robert is a newly eligible, non-LTSS, MMA Medicaid enrollee.

LOOKING BACK: WELCOME CALL OUTREACH TO ROBERT

Robert's phone number was automatically loaded into Humana's auto dialer software upon enrollment. Anna, a Customer Care Specialist (CCS) in our Florida-based Humana Medicaid Administration Education and Satisfaction Unit (ESU), calls Robert to welcome him to Humana. After securing Robert's permission to continue the call, Anna completes a Health Risk Assessment (HRA) to quickly identify his needs and confirms his current providers, noting that an appointment is scheduled with his Primary Care Provider (PCP). Anna also reviews Robert's available benefits, confirms he has received his enrollee ID cards, and welcome materials, and updates his demographic information. After Anna informs Robert of his eligibility to participate in Humana's Disease Management (DM) program, Robert agrees to speak with a DM Registered Nurse (RN). Anna informs him that he will receive a call from a DM RN within seven to ten days, as well as a letter in the mail.

LOOKING BACK: STRATIFYING ROBERT'S NEEDS FOR APPROPRIATE CARE

In addition to Anna's Welcome call, Robert's new enrollee information (such as claims, pharmacy, demographic, diagnosis) is run within the first thirty (30) days of enrollment and monthly thereafter, through our proprietary Medicaid Severity Score algorithm. The resulting score provides insight to identify Medicaid enrollees with higher complexity (projected higher utilization and cost in the upcoming year) triggering them for case management outreach and participation efforts. Additionally, his information from claims diagnosis and current pharmacy National Drug Codes (NDC) is captured in a monthly "Potentials Report" that identifies disease management candidates for outreach to discuss program benefits and enrollment. We stratify Robert's information to pro-actively apply case and disease management resources to his specific needs and he is identified as being a candidate for the COPD disease management program. Robert's clinical information identifying him for case or disease management can come from other sources including: Utilization Management data, Health Risk Assessment completion, 24/7 Nurse line referral, pharmacy data, self-referral, and provider referral.

LOOKING BACK: ROBERT JOINS THE DISEASE MANAGEMENT PROGRAM

The next week, Robert receives a call from his assigned disease management case manager, David, a Humana-employed nurse who has extensive training and expertise working with enrollees with chronic conditions such as Robert's. Robert is one of fifteen complex patients David supports. In addition to his experience, David has completed the Humana Clinical Learning and Development (CLD) team's two-week orientation. This orientation includes training on Medicaid, Humana's systems, ethics, cultural competency, motivational interviewing, and other computer based training. He then was mentored by senior case managers through onsite-office, field-based, and online training. This training equips David to find and locate appropriate community resources and help resolve Robert's issues. Through half-day monthly meetings of continuous education and training, he also learns strategies to identify access-to-care barriers, prioritize immediate needs, identify enrollee health literacy, and display empathy and emotional support.

After David confirms Robert's consent for participation in the program, they complete a comprehensive assessment which addresses multiple body systems, including the pulmonary system, and they discuss Robert's hypertension and hypercholesterolemia. David also provides condition-specific education and reviews supports available to help Robert manage his care.

Together, they develop a plan of care (POC). David sends an introductory letter to Robert's PCP letting him know that Robert is participating in the program and providing information on accessing related clinical guidelines on the Humana website.

LOOKING BACK: ROBERT'S PROGRAM ENGAGEMENT

Robert's initial reaction to the call was positive and as they conversed, Robert voiced no concern about his overall health. However, as time passed David had a hard time contacting Robert, who was reluctant to acknowledge the severity of his diagnosis and risks. Robert eventually stopped responding to contact attempts altogether. Due to Robert's reluctance to engage in the program, David places his case in monitoring status, ensuring he would continue to receive notifications of a change in Robert's clinical status such as emergency department visits. David enters a note in the file saying that Robert was unreachable, so that if he later calls Customer Care, then the specialist will be able to connect him with David via a conference call.

DAYS 1 – 30: ROBERT'S VISITS TO THE EMERGENCY DEPARTMENT

In January of 2019, Robert's condition suddenly begins to worsen, resulting in three trips to the emergency department within thirty (30) days. David, Robert's DM RN Case Manager, receives notification of each emergency department visit via a daily report called the Florida Health Information Exchange-Event Notification Service (HIE-ENS). David makes outreach attempts as soon as he receives notification of the first emergency visit, but is unsuccessful at reaching Robert. These contact attempts continue with the second ER notification.

DAY 31 – 32: DAVID SUCCESSFULLY ENGAGES ROBERT

After the third emergency visit, David is successful at reaching and engaging Robert in a discussion about his current health. David gleans that Robert is worried about his serious condition and is now ready to discuss and learn about it and his broader health and well-being. Robert reveals that the past thirty (30) days have been very frightening for him, and he tells David he wants to be there for his fifteen (15) year old son, who he is raising on his own. Knowing this is a crucial time of engagement, David leverages his training and experience along with the skills and techniques of motivational interviewing to take a holistic approach to his conversation with Robert. David focuses on understanding Robert's health issues, identifying his key social determinants, assessing his situation for urgent behavioral health needs requiring referral, and determining his overall challenges and barriers to meeting his goals. David assesses that Robert requires more frequent outreach and that it is appropriate to classify him at a complex acuity level in the disease management program, due to his COPD exacerbation, emergency room utilization, and lack of knowledge about condition management.

David updates the comprehensive assessment and additional disease-specific assessments applicable for COPD and hypertension within CGX. David employs his training to address critical components of care first. He starts with assessing Robert's understanding and knowledge of his current status and overall health. He also understands that Robert has several new medications to fill and that he has been told he must use oxygen for treatments, but has not yet obtained an oxygen source. This information is also captured in Robert's assessments and POC in CGX. Robert is making some progress on his own by decreasing his smoking to 10 cigarettes per day, but continues to struggle to keep up with other important health maintenance

activities, such as attending appointments with his pulmonologist. During this conversation, Robert shares the difficulty he's experienced getting transportation to his appointments. David reminds Robert he has a non-emergent medical transportation benefit available to him, as well as the option for prescription delivery.

Together, David and Robert:

- Update Robert's PCP information

- Schedule a ride for Robert to pick up his medications at the earliest available time

- Confirm Robert's appointments with his Primary Care Provider (PCP) and pulmonologist

- Schedule transportation to Robert's follow up appointments

- Walk through the process of downloading a transportation scheduling app to Robert's smart phone

- Facilitate the processing of the oxygen orders through Humana's Clinical Intake Team, who set up the provider and delivery

- Review risks of smoking while using oxygen and cover safety protocols to prevent injury

- Determine key members of the Multidisciplinary Team (MDT): Robert, David, PCP, and pulmonologist

David's actions help Robert to better understand ways to navigate these components of the complex health care delivery system.

The day after David and Robert's discussion, David reviews the approved DME authorizations for oxygen concentrators in CGX. He looks for a home unit, as well as a portable unit he can carry on his hip. David understands the importance of oxygen therapy, as well as the importance of getting it delivered and in place quickly to stabilize Robert's condition. David requests an expedited authorization for the portable unit as it will allow Robert to begin using the oxygen but remain mobile. David recognizes that without the delivery, Robert could experience an adverse event such as another emergency room visit or even admission to the hospital, which would limit his ability to care for his son. For this reason, David calls Robert on the scheduled delivery date to confirm the delivery of the portable unit, as well as the nasal cannulas and necessary supportive supplies.

DAY 33 – 150: DAVID'S ONGOING CONTACT WITH ROBERT

David continues to work closely and frequently with Robert and ensures all the identified components of Robert's care are quickly addressed and Robert's plan of care is fully implemented. Robert's appointments are kept with both his PCP and his pulmonologist, the medications are obtained, the home oxygen concentrator was also delivered the next week, and he has begun taking the medications and using the oxygen routinely.

DAY 151: ENGAGING ROBERT'S SON

Robert had shared his primary personal goal of being healthy enough to be there for his son and makes clear that he does not want to burden his son. David understands that Robert's fifteen (15) year-old son is not an appropriate caregiver, however, the family unit should be educated on critical components of Robert's POC for added safety and in case of an urgent or emergent need. David works with Robert to identify the critical components of his POC and helps Robert plan for a discussion about them with his son once he returns home from school. Throughout the conversation, David also explains how each of the actions derived from his POC will help Robert in achieving his goal of being healthy enough to be available and supportive to his son.

At this time David, also completes a medication reconciliation to identify any concerns and important components to educate Robert about his conditions, medications, and oxygen. As Robert was started on a metered-dose inhaler, which can be difficult to use, David educates him on a helpful spacer device that will make it easier for Robert to breathe in the correct dose. David also educates Robert on mail order pharmacy and the benefit of obtaining a one hundred (100) day supply of medications, which will decrease the need to go to the pharmacy. Robert also downloads the Humana RX Mentor pharmacy application for his smart phone, granting him easy access to his full medication list if he is in the doctor office or out in the community.

DAY 160: ESTABLISHING AND MAINTAINING AN EFFECTIVE SELF-MANAGEMENT PLAN FOR ROBERT

As part of his plan of care, David helps develop a self-management plan so Robert can identify early indicators, triggers to avoid, symptoms of worsening breathing status and exacerbation of his COPD, ways to monitor and potentially improve his blood pressure, and an action plan for times when his COPD deteriorates despite self-intervention. The discussions include environmental triggers such as how Robert heats his home (for example, a wood stove is not advisable), whether he has any allergies, how Robert handles cutting the grass, or if he lives in a wooded area where flora might lead to an allergic reaction. Robert reports he is still smoking ten (10) cigarettes per day but has not increased his smoking. David confirms cigarettes are Robert's only type of tobacco use and that Robert drinks alcohol moderately. To determine pulmonary status, David discusses Robert's ability to sleep through the night and asks if he sleeps in an upright or a sitting position, or if he is able to tolerate lying down for sleep. David asks Robert to notify him of any change in his sleeping or symptom status at any point during his engagement so he can cpmtact Robert's PCP and pulmonologist as needed to facilitate scheduling appointments and corresponding transportation.

Access-to-care is a critical part of Robert's overall plan of care, so David and Robert also discuss some options for him to receive very timely care, even in his home, in the event that his health deteriorates. Since Robert's PCP is engaged in a value-based relationship with Humana, she will have aligned incentives to ensure Robert has the right care, at the right place and in the right time and sends a nurse practitioner directly to his home for assessment. Additionally, Robert could take advantage of Humana's new partnership with Doctor on Demand, which allows him to talk with a physician from the comfort of his home, via live video feed, within five

minutes of his request. This telemedicine option provides Robert with an effective alternative to seeking urgent care or an emergency department.

As part of his crisis plan, Robert is also able to identify a neighbor with a generator in case of loss of power and knows to call 9-1-1 for emergency services if he becomes acutely short of breath. In Robert's area, another in-home option is for Robert to sign up for the Transitional Health Solutions Program. This is a program that allows Robert to call a nurse practitioner who can be to his home within thirty (30) minutes, to enable Robert to avoid making an urgent care or emergency department visit. If the nurse practitioner's visit determines Robert should go to a hospital, he may have the option of going to his pulmonologist's preferred hospital, rather than the closest hospital where the emergency response team would take him.

At the end of each call, David and Robert schedule their next contact and David creates a self-task within CGX as a reminder to contact Robert and to follow up on the agreed upon action items. Because of the discussions with David in his critical first week of engagement, Robert begins to understand how his medications work together when taken consistently. David coaches Robert on ways to pair scheduled medications and supplemental oxygen with daily activities like brushing his teeth, drinking his mid-morning coffee, and watching the evening news. He also advises Robert on other mechanisms to remind himself, such as cell phone alarms and a pill box. With Robert's new understanding of his treatment plan, he begins to follow a personalized reminder system and now remembers to take his medications and treatments very close to the schedule.

Throughout the process, and as part of his overall approach to disease management, David ensures that Robert's PCP stays informed of David's actions and Robert's progress. He also ensures that the PCP remains engaged in the care planning process so that they can work together effectively to coordinate his care. David also schedules regular MDT meetings to ensure he will have support in the discussion of the complexities of Robert's case, the interventions to date, Robert's progress towards goals, and determinations of potential additional resources to be offered.

DAY 161 – 179: ROBERT'S PROGRESS

Robert starts making significant progress toward managing his symptoms and reports he is beginning to breathe with less effort and is feeling a little better overall. He is prepared with several options to receive urgent care conveniently if needed. His pulmonologist orders a pulmonary rehabilitation and Robert uses his new smart phone app to arrange his own transportation. David compliments Robert on his impressive progress. Robert shares that he was able to have a conversation with his son about his condition, including his needs to avoid environmental triggers, his crisis plan, proper use of his rescue medications, and the proper times his son should call 9-1-1 if Robert needs emergency assistance. His son also created a list of medications with times due and instructions for how to take the medications or treatment. He places one on the refrigerator and one in the garage above Robert's workbench.

David introduces Robert to the Disease Management (DM) Program Resource Guide. This guide contains evidence-based guidelines and treatment goals, and other helpful resources Robert can view from his phone. Robert is able to easily find information on local support groups and the benefits of having access to a behavioral health counselor. Robert is not interested in a

counselor now, but verbalizes that he may consider attending a support group. David also provides Robert with several sets of pertinent, internationally-recognized educational materials written by the American College of Chest Physicians (ACCP).

David and Robert leverage their MDT meetings as an additional source of support. The MDT reviews Robert's history, conditions, risks, barriers, resolved issues, and current status. They also discuss financial and community resources available to Robert to help alleviate some of the stress Robert has been experiencing. David shares his concern about Robert's underlying anxiety and depression. The MDT discusses methods of motivating Robert to become more accepting of additional interventions such as involvement in support groups or therapy. The team concurs that the best approach is to tie Robert's needs back to his motivation to ultimately be healthier and to be there for his son.

DAY 180 – 360: ROBERT'S ONGOING DISEASE MANAGEMENT AND NEW GOAL

Over the next six months, and leading up to the next MDT meeting, David maintains contact according to Robert's schedule, reviews his progress, and updates the plan of care and personal goals within CGX. David continues educating Robert on his benefits, such as the benefit of twenty-five dollars per month toward over-the-counter (OTC) medication including items for cough, cold, allergy, aches, and pain relief. David watches for any changes to Robert's condition, while monitoring CGX for any potential flags or alerts such as missed medication refills. Through their discussions, David educates Robert on diabetes and risk factors which place him at risk for developing diabetes. On one call, Robert voices that he is ready to take the next steps toward quitting smoking. David offers a referral to the Healthy Behaviors smoking cessation program, which is a six-month program with tiered incentives for participation and milestone achievements, as he feels these incentives may bolster Robert's efforts to quit smoking. Although Robert would also benefit from the Humana Family Fit weight loss program, David recognizes that to be the most successful, Robert should tackle one lifestyle change at a time. David holds off referring Robert, but notes that once he completes the smoking cessation program, he will introduce him to the Humana Family Fit program and eventually encourage him to enroll, as David recognizes weight loss and improved nutrition may prevent Robert from developing diabetes.

Robert is actively working through the smoking cessation program and has been able to schedule and keep his follow-up appointments with doctors. Robert tells David that he feels like he might be able to regain control over his COPD and continue to improve his health. Robert has not visited the emergency department in the last nine months.

Robert communicates to David that he has a new personal goal, which is to get a part-time job. David provides community resources available, such as vocational rehabilitations and local organizations for job skills training and employment assistance, as well as transportation provided for those activities. David also encourages Robert, as he knows that taking on a part-time job will help to re-engage Robert in his community, may boost his confidence, and may improve his overall well-being as part of a comprehensive approach to work towards a healthier lifestyle.

Additionally, because Humana's approach is to work with both the individual enrollee and the family unit, David recognizes that Robert's son qualifies for Early and Periodic Screening

Diagnosis and Treatment. David makes Robert aware of this and gives him information and helpful guidance on accessing this care and what benefits his son may be eligible for through his son's plan.

DAY 361 AND BEYOND: ROBERT'S IMPROVED OUTLOOK

Robert's improving health status has resulted in a lowered acuity level. This is reflected in CGX as Robert moving from "complex" to "moderate", and he has a large variety of resources available. Robert's story exemplifies our approach to care management, which engages enrollees in lifelong self-management and is timely, personalized, and flexible to suit changing circumstances. The ultimate goal for Robert is self-management and supporting his son. He has demonstrated his ability to achieve it. Robert will remain in case management for periodic outreach and reassessments to identify any new issues and to continue to help Robert improve his overall health and well-being.

Footnotes

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[1] CareHub is Humana's enterprise solution for complete program integration for our provider community and enrollees. CGX supports an integrated, comprehensive approach to medical, behavioral health, pharmacy, utilization, and care management. Full system integration allows our care team the capability to identify potential enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify opportunities for intervention.

[2] CRM is Humana's documentation system for enrollee support activities, providing message optimization, enrollee-centric prioritization, data mining and reporting, and enhanced processes for quality management to streamline the flow of data to other internal systems.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

- **a.** Identification processes for enrollees with complex health conditions or who are in need of care coordination;
- **b.** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **c.** Application of the respondent's case management risk stratification protocol;
- **d.** Identification of service needs (covered and non-covered) and a description for service referral processes;
- **e.** Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
- **f.** Application of discharge and aftercare planning protocols that facilitate a successful transition;
- **g.** Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and

community partners particularly when referrals are needed for non-covered services;

h. Description of the assessment of provider capacity to meet the specific needs of enrollees;

i. Identification of strategies that promote enrollee self-management and treatment adherence;

j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and

k. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provides evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

Attachment SRC 08-1: Robert's Visual Story Guide

We have provided this document as a visual guide to our response. The key timelines from our core response are duplicated here in a format intended to supplement and enable a comprehensive review of Humana's approach to Robert.

About Robert:

Robert is a fifty (50)-year-old, MMA Medicaid enrollee and has been with Humana's plan since December 2016. He was diagnosed with COPD five (5) years ago, a smoker for the past thirty (30) years, is pre-diabetic and obese, with hypertension and hypercholesterolemia, and is non-compliant with his treatment plan and medications. He has presented at the emergency department three (3) times during the past thirty (30) days, was prescribed Oxygen treatments and new medications, but hasn't filled these orders. He is a single parent to his son. Both live in a rural community, and have both been on Medicaid the last four (4) years since Robert lost his job.

Key Components of Care

- Humana's **proprietary Medicaid Severity Score** quickly stratifies him for disease management, triggering proactive case management and participation efforts
- **Welcome call HRA rapidly identifies needs** and confirms Robert's DM participation
- **DM-specific case management and monitoring** keep outreach open even during low engagement and especially when his conditions worsen
- **Holistic plan of care (POC)** helps identify all health issues, social determinants, and behavioral health needs, and tie in Robert's goals to get healthier and un-burden son
- **Multidisciplinary team (MDT)** includes DM CM, PCP, pulmonologist, and Robert in supporting Robert's improving health and stated objectives, including lifelong self-management

Robert's Support System

Anna
Education and Satisfaction Unit (ESU) Customer Care Specialist (CCS)

David
Disease Management Case Manager

Robert's MDT including PCP, pulmonologist, David, Anna, & Robert

Robert's Son

Robert's Timeline:

1 — Looking Back: Welcome Call Outreach
ESU CCS Anna calls Robert to welcome him; completes Health Risk Assessment (HRA); gets him to agree to DM

2 — Looking Back: Robert Joins DM program
DM CM David calls Robert; confirms participation; completes comprehensive assessment; develops POC

3 — Looking Back: Reluctant to Engage
Robert becomes hard to contact and reluctant to engage; David places his case in monitoring status

4 — Day 1-30: Robert Visits Emergency Department Three Times
Robert makes 3 trips to the emergency department, recorded in HIE-ENS; David attempts outreach

5 — Days 31-32: Successfully Engages
David reaches a concerned Robert; takes holistic approach to understanding health issues, social determinants, BH needs; places him at complex acuity level and updates the comprehensive, DM-specific POC

6 — Day 32: Educates on Benefits
David shares non-emergent medical transportation benefit and prescription delivery benefits; reviews and approves DME; identifies and involves MDT; confirms DME delivery & appointments

7 — Days 33-150: Ongoing Contact
David ensures all components of Robert's care are addressed and implemented

8 — Day 151: Engaging Robert's Son
David educates on care components; completes medication reconciliation and equipment education

9 — Day 160: Self-Management Plan
David & Robert co-develop plan to self-manage, including crisis plan, neighbor supports, and access to care options

10 — Days 180-360: Ongoing Disease Management
David maintains monthly contact, refers to smoking cessation program. Robert's successful management helps lower his acuity level to moderate

C. RECIPIENT EXPERIENCE

SRC# 9 – Expanded Benefits (Regional):

Based upon the expanded benefits listed in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent shall identify the benefits it proposes to offer its enrollees for all eligible populations (TANF, ABD, dual eligible, and LTC populations). **Exhibit A-4-a-2**, Expanded Benefits Tool outlines specific expanded benefits, including category, procedure code descriptions and procedure codes. When electing to offer expanded benefits included in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in **Exhibit A-4-a-2**.

Response: The respondent shall select the following expanded benefits it will offer, as listed in **Exhibit A-4-a-2**, Expanded Benefits Tool (Respondent shall check all that apply):

☒ Dental benefits for adults
☒ Over-the-counter benefits
☒ Occupational Therapy benefits for adults
☒ Physical Therapy benefits for adults
☒ Hearing benefit for adults
☒ Vision benefit for adults
☒ Prenatal benefit
☒ Respiratory Therapy benefit for adults
☒ Speech Therapy benefit for adults
☒ Additional Primary Care services benefit
☒ Newborn Circumcision benefit

Evaluation Criteria:

Score: This section is worth a maximum of 190 raw points as outlined below.

(a)	Election of the Dental benefit for adults:	50 pts
(b)	Election of the Over-the-counter benefit:	25 pts
(c)	Election of the Occupational Therapy benefits for adults:	20 pts
(d)	Election of the Physical Therapy benefit for adults:	20 pts
(e)	Election of the Prenatal benefit:	20 pts
(f)	Election of the Hearing benefit for adults:	10 pts
(g)	Election of the Vision benefit for adults:	10 pts
(h)	Election of the Respiratory Therapy benefit for adults:	10 pts
(i)	Election of the Speech Therapy benefit for adults:	10 pts
(j)	Election of the Additional Primary Care services benefit:	10 pts
(k)	Election of the Newborn Circumcision benefit:	5 pts

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 10 – Additional Expanded Benefits (Regional)

The respondent shall identify each additional expanded benefit that it proposes to offer its enrollees by eligible population (TANF, ABD, dual eligible, and LTC populations). For the purposes of this SRC, the respondent must not select expanded benefits that are included in **Exhibit A-4-a-2,** Expanded Benefits Tool described in SRC# 9. The respondent shall include the name of the benefit, procedure code descriptions, procedure codes and any limitations (frequency/duration, etc.).

The respondent shall submit documentation that includes the calculations used to determine the per-member-per-month (PMPM) cost and the data source used for the calculations (e.g. previous SMMC experience, commercial experience). The submitted PMPM cost must be developed on a "total member" basis, rather than a "per user" or "per benefit eligible" basis (e.g., if the benefit is for adults only, do not submit the expected monthly cost per adult but rather the expected cost per member; or, if the benefit is for the household, its expected monthly cost must be converted to the expected cost per member) and should exclude administrative costs. The respondent shall submit **Exhibit A-4-a-3**, Additional Expanded Benefits Template (Regional).

Response:

Through two (2) decades serving Florida Medicaid populations, Humana identified and continuously refined our understanding of expanded benefits that improve enrollee health outcomes and overall well-being. In addition to our commitment to offer all of the Expanded Benefits in SRC #9, we will offer sixteen (16) Additional Expanded Benefits, as detailed in Exhibit A-4-a-3. These benefits align with Humana's and AHCA's goals to promote preventive care, reduce preventable emergency department visits and hospitalizations, and improve enrollee experience.

Humana's Additional Expanded Benefits are also designed to improve social determinants of health, particularly for enrollees eligible for Long-Term Care (LTC) services. For example, most LTC enrollees prefer to age in their homes, rather than a nursing facility, so Humana offers a Nursing Facility Transition benefit that helps enrollees overcome the financial barriers to moving back into a community setting. For enrollees receiving home and community-based services, Humana offers a non-medical transportation benefit to visit friends, family, faith-based organizations, or community events. These benefits reduce social isolation, a particularly important determinant of health for disabled populations.

Calculations used to determine the per-enrollee-per-month costs for these Additional Expanded Benefits, along with data sources used for the calculations, can be found in Attachment 10-1.

Evaluation Criteria:

a. The extent to which the respondent identifies the expanded benefits it will provide and the information included in **Exhibit A-4-a-3**, Additional Expanded Benefits Template (Regional).

Score: This section is worth a maximum of 5 raw points with the above component being worth a maximum of 5 points.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

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Exhibit A-4-a-3
SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit
Home health Care (non Pregnant adult)	Home Health Procedures and Services, not otherwise specified (NOS), in member's home or residence	99503- 99507, 99509-99512, 99600-99602, G0151-G0162, G0164, G0471, Q5001, Q5002, Q5009, S0274, S5497, S5498, S5501, S5502, S5517, S5518, S5520-S5523, S9061, S9097, S9098, S9122-S9129, S9131, S9325-S9331, S9335, S9336, S9338-S9343, S9345-S9349, S9351, S9353, S9355, S9357, S9359, S9361, S9363-S9368, S9370, S9372-S9377, S9379, S9490, S9494, S9497, S9500-S9504, S9529, S9537, S9538, S9542, S9558-S9560, S9562, S9590, S9810, T1019, T1020, T1021, T1028, T1030, T1031, T2042, T2043	21	999	Age 21 and older: Licensed nurse and home health aide visits Limited durable medical equipment and supplies Limited therapy evaluations 3 home health visits	Unlimited home health visits; subject to medical necessity and prior authorization	None	Trade Secret as defined	ll members 1 and over	Keep members healthy and avoid more costly care and readmissions by providing integrated health care delivery and services in the patient's residence or home.
Physician home visit	Physician visit at member's home	S0273, H1004, G0161, G0160, G0159, G0153, G0152, G0151, 99350, 99349, 99348, 99347, 99345, 99344, 99343, 99342, 99341, 99340, 99339, 99337, 99336, 99335, 99334, 99328, 99327, 99326, 99325, 99324, 90966, 90965, 90964, 90963	0	999	Subject to Medical Necessity	1 visit per month limited to homebound enrollees or those who are non-compliant per their PCP; subject to prior authorization.	None		ll members	Keep members healthy and avoid more costly care by providing integrated health care delivery and services in the patient's residence or home.
Outpatient Services	N/A	N/A	21	999	Members 21 and older: Limited to $1,500 outpatient cap Members under 21: No limit on outpatient services but services must be medically necessary as determined by a physician.	$1,500 limit on outpatient services subject to medical necessity; may require prior authorization	None		ll members 1 and over	Enhance access to care for all members by providing medically necessary services in the most appropriate setting

Waived Copayments	N/A	N/A	21	999	None	Enrollees shall not be subject to co-payment charges.	None	Trade Secret as define	ll 21 and over embers who re not regnant, eceiving ervices in an npatient ospital etting or long-erm care acility, or ndividuals ho require mergency ervices	Enhance member experience by offering cost-savings directly to the member with no copays
Adult Vaccine (Pneumonia , Influenza, Shingles)	Vaccines, toxoids Influenza Virus vaccine Pneumococcal vaccine/administration	90630, 90653-90658, 90660-90662, 90664, 90666-90670, 90672, 90673, 90685-90688, 90732, 90736, G0008, G0009, Q2034-Q2039, S0195	21	999	None	Ages 21 & Over: Administered as medically advised.	None		ll members 1 and over	Help people stay healthy by offering medically appropriate vaccines to all our members
Post Discharge Meals	N/A	N/A	0	999	None	Ten home delivered meals, limit one set of deliveries per year subject to prior authorization	None		ll members	Ensure a positive member experience by offering benefits that help people stay healthy and readmissions
Medically Related Lodging and food	Lodging, per diem Meals, per diem	S9976, S9977	0	999	None	Limited to enrollee and 1 traveling partner; maximum benefit of $150 per day; maximum 5 days per year; benefit only available if enrollee is required to travel more than 200 miles from home for medically necessary treatment; subject to prior authorization	None		ll members	Ensure a positive member experience by offering services that support access to care for necessary medical treatment

Assisted Living Facility/Adult Family Care Home (ALF/AFCH) Bed Hold	T2033 = Residential care, not otherwise specified (NOS)	T2033	0	999	None	21 days bed hold for Assisted Living Facility (ALF) and Assisted Family Care Home (AFCH) Limitations: Enrollee must intend to return to the ALF/AFCH Enrollee must maintain room and board and share of cost payments while away Enrollee must live in the ALF/AFCH for at least 30 days between each episode ALF/AFCH must inform the plan within 24 hours of the enrollee leaving in order to be eligible for this benefit.	None	[redacted]	C Eligibles	Ensure a positive member experience by offering services that support access to care for necessary medical treatment
Cellular Phone Service	N/A	N/A	0	999	None	1 cell phone per enrollee household, to include 1 charger, set of instructions and enrollee/caregiver training at the initial case manager orientation visit; 350 minutes of air time per month; free unlimited text messages; free calls to Humana Customer Care team; 1 GB free data every month; 1 replacement phone every 2 years; unlimited prepaid and pre-programmed air time for access to the enrollee's case manager and critical health care providers.	None		ll Members	Ensure a positive member experience by offering technology tools and services actively engage people stay healthy

Trade Secret as defined in

Non- Medical Transportation	N/A	N/A	0	999	None	1 round-trip service per month; enrollee must reside in a home and community-based setting; limited to trips within the enrollee's home county/local area; subject to prior authorization	None		TC Eligibles	Ensure positive member experience by offering access to community events and other social/emotional supports
Nursing Facility Transition	N/A	N/A	0	999	None	Up to $2500 per lifetime to help an enrollee move out of a nursing facility. This benefit is to help pay for things like security and utility deposits, household furnishings/supplies and moving expenses. Plan approval needed. Enrollee must be moving out of a nursing facility into their own home where they are responsible for their own living expenses.	None		TC Eligibles	Rebalance long-term services and supports systems by helping members transition from settings to live in the community
Emergency Meal Supply	N/A	N/A	0	999	None	10 shelf-stable meals prior to a hurricane or other disaster for enrollees at significant nutritional risk; benefit applies in lieu of home delivered meals covered by the managed care plan; subject to medical necessity.	None		TC Eligibles	Ensure a positive member experience by offering benefits that help people stay healthy
Pill Organizer	N/A	N/A	0	999	None	1 seven-day pill organizer at initial enrollment for each community-based enrollee taking more than 5 medications	None		TC Eligibles	Ensure a positive member experience by offering tools that help people stay healthy
Caregiver Information/Support	N/A	N/A	0	999	None	1 caregiver toolkit to all home and community-based enrollees with a caregiver actively involved in their care.	None		TC Eligibles	Ensure a positive member experience by offering tools that help people stay healthy

Exhibit A-4-a-3
SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)

Trade Secret as define

Document Keeper	N/A	N/A	0	999	NONE	1 document keeper per lifetime for enrollees residing in their own home, Assisted Family Care Home (ACFH) or family home to hold important health plan papers.	None	TC Eligibles	Ensure a positive member experience by offering tools that help people stay healthy
Virtual Urgent Care	N/A	N/A	0	999	None	Limit 4 visits per member per year	None	ll members	Increase access to care by offering on-demand services and technology that avoids more costly care

Attachment 10-1: Supporting Documentation

SRC 10 Benefit Category	Cost per Unit	Utilization per 1000 Members per Year	PMPM	Procedure Code	Eligible Populations	Data Source
Home health Care (non Pregnant adult) (1)	Trade Secret as defined in Section 812.081, Florida Statutes					
Physician home visit (2)						
Outpatient Services						
Waived Copayments						
Adult Vaccine (Pneumonia Influenza, Shingles)						
Post Discharge Meals						
Medically Related Lodging and food						
Assisted Living Facility/Adu Family Care Home (ALF/AFCH) Bed Hold						
Cellular Phone Service						
Non- Medical Transportatio (3)						
Nursing Facility Transition (						
Emergency Meal Supply						

Attachment 10-1: Supporting Documentation

SRC 10 Benefit Category	Cost per Unit	Utilization per 1000	PMPM	Procedure Code	Eligible Populations	Data Source
Pill Organizer	[redacted]					
Caregiver Information/Support						
Document Keeper						
Virtual Urgent Care (Doc on Demand)						

[redacted]

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 11 – Online Provider Directory (Statewide):

The respondent shall describe the provider search function for the online provider directory, including submission of:

a. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether or not the online provider directory is mobile friendly.

b. Screen shots for each mouse click required from the start of the respondent's home page to actual search results for a provider, using durable medical equipment providers and zip code as the search elements.

c. A list of performance indicators the respondent will include for each provider type listed in its provider directory.

d. A description of the respondent's process for verification of provider information in the online provider directory, including delegated subcontractor provider information, and the method(s) the respondent uses to ensure the weekly network file submission to the Agency is accurate.

Response:

Humana's network of high quality providers is one of our greatest strengths. For decades, Humana has measured and identified the strongest providers and facilities to serve our enrollees. As the single most popular resource for use by Humana enrollees, our online provider directory, Physician Finder Plus (PFP), serves as the gateway to identify and locate these providers. Humana's PFP supported nearly twenty-five million (25M) visitor interactions in 2016, with 2017 data to-date showing enrollee utilization well in excess of those levels.

Maintaining an accurate directory saves enrollees, providers, and Humana time and energy, helping enrollees connect to in-network providers quickly and easily. This is why Humana invests significant resources in our online provider directory and the proprietary systems that support it. Our robust search capability gives enrollees the parameters they need to quickly find the providers they are looking for, with added tools to help them more easily access those providers and the care they need and want. Sophisticated tools and systems support providers and Humana in keeping provider data as up-to-date as possible.

Finally, knowing how providers perform across standard quality performance metrics and having access to enrollee feedback on these providers helps enrollees make informed decisions about which providers to use. Humana's online provider directory (including enhancements underway) is designed to meet or exceed all Agency for Health Care Administration (AHCA) requirements and demonstrate Humana's commitment to ongoing improvements to best serve enrollees.

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1. The extent of the respondent's search functions for the respondent's online directory and ease of access for enrollees' navigation of the online provider directory, including whether or not the online directory is mobile friendly.

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Humana makes it easy for enrollees to navigate our online provider directory and find in-network providers quickly and easily. Equally essential is making the provider directory accessible via mobile technology.

SEARCH FUNCTIONS AND NAVIGATION

Ensuring enrollees can easily find a provider through relevant, useful, and accessible search functions is an essential element to a strong online directory. As an example, Attachment 11-1 demonstrates how an enrollee can find durable medical equipment providers by zip code. From the Humana Florida Medicaid home page, an enrollee clicks on the quick link, “Find a Provider,” and is taken directly to Physician Finder Plus (PFP). The directory asks for a zip code, the type of health insurance program, and type of network they are looking for. If the enrollee is logged in to Humana’s secure portal, their home zip code, insurance program, and network are automatically populated for them. "Mouseovers", or hover boxes, exist to support enrollees if any of the search parameters are unclear or confusing. There is also a Portable Document Format (PDF) document on the PFP search page that provides additional enrollee support for using the tool.

Next, enrollees are given several options from which to begin their search: provider name, specialty, and condition. If an enrollee searches by specialty, Humana’s database intuitively draws from related specialties. For example, if an enrollee searches for “Primary Care,” Humana’s system will display all primary care specialities, including “Internal Medicine.”

Once an initial list of results is generated, an enrollee has numerous ways to filter those search results. Specifically, a provider’s location can be refined in increments between three (3) and one hundred (100) miles of a zip code or a specific address. Enrollees can further narrow results by the following parameters:
- Provider last name
- Gender
- Whether the provider is accepting new patients
- Languages spoken
- Specialty
- Medical group affiliations
- Hospital affiliations
- Board certification
- City and state
- Accessibility

Of the above search parameters, several categories are especially important to Florida Medicaid’s diverse enrollee population. Within Florida, many residents speak languages other than English and may, for example, prefer a provider who is fluent in Spanish or Creole. Humana’s PFP allows for that level of selection.

Humana’s PFP also works with accessibility tools and screen readers to ensure that disabled enrollees are not limited in their access to the tool. Of particular relevance to Medicaid enrollees is not simply how far a provider may be from an address, but how truly accessible those

providers are. For this reason, Humana enables enrollees to further filter their provider search results by whether the provider:
- Is close to any form of public transportation
- Is handicap-accessible
- Offers mental or physical impairment services
- Serves the hearing impaired

When an enrollee selects a provider from the search results, additional relevant information can be viewed about that provider, including: full contact information, office hours, all locations where the provider works, specialties, education, certifications and certifying body, langauge spoken within their office, and whether the provider has completed Humana's cultural competency training. To help easily access these providers, "Get Directions" provides door-to-door directions to the enrollee.

To aid enrollees on deciding on a provider, Humana's PFP allows enrollees to compare up to three (3) providers across all of these attributes.

MYHUMANA© MOBILE APPLICATION

In 2018, to support the smart phone technology-using Medicaid population in Florida, Humana will expand its MyHumana© mobile application to our Medicaid plans. Available for iOS and Android, the MyHumana application gives enrollees easy and intuitive ways to understand their coverage, check the status of their claims, view identification (ID) cards, research drug pricing, and find in-network providers. The provider search tool within the MyHumana application includes the same search functions and filters that are currently available online through Humana's PFP, putting access to in-network providers and care at our enrollees' fingertips. Humana leverages lessons learned on our mobile technology through various lines of business to benefit all enrollees and to realize economies of scale when improvements are implemented. Furthermore, as Humana implements improvements to search functionality and expands information within the PFP, similar improvements will follow within the MyHumana application.

ENHANCING THE ENROLLEE EXPERIENCE

Humana's Provider Center of Excellence performs a comprehensive evaluation of our web-based directories for clarity and usefulness to enrollees and prospective enrollees at least every three (3) years – or more often in response to changes in requirements, complaints, and quality initiatives, or to reflect advances in technology. This comprehensive evaluation considers reading level, intuitive content organization, ease of navigation, and font size. Our most recent comprehensive update took place in 2016. After monitoring enrollee usage of the PFP tool, Humana identified opportunities to further enhance the enrollee experience. The highest priority improvements were identified by speaking with enrollees and cross referencing their feedback with data analysis of the user experience.

In response, Humana immediately simplified the log-in process to automatically populate an enrollee's plan into the pre-search fields if an enrollee identification (ID) number was used to initiate the search. This decreased the time it took for enrollees to reach a list of relevant providers to choose from.

Other opportunities to improve the PFP were addressed with the start of a comprehensive update in 2017. Humana invested in critical infrastructure improvements to the provider data architecture (the back-end of PFP) to improve the user interface and customer experience within the PFP search and display functions. These near-term investments are intended to continuously improve how Humana systems display information in a manner that is organized and easy to understand based on how an enrollee searches for providers, minimize information gaps between back-end systems, and strengthen Humana querying systems for accurate and timely provider display.

In parallel, Humana will continue to conduct focus groups and usability testing to design the future search experiences our customers desire. The ultimate goal of these investments is to ensure that enrollees can more easily and intuitively find the providers they are looking for, decreasing delays in getting the care they need.

Humana has initiated several additional steps to improve access to and usability of the online provider directory. First, Humana has implemented an improved design of the Humana Florida Medicaid home page, eliminating extraneous text and focusing the enrollee on what they access most via quick links at the top of the page. These include the provider directory, the enrollee handbook, and additional support from Humana associates. By streamlining the home page, enrollees can more easily and intuitively find and use key resources, thereby reducing the time and effort required to access the care and information they need. Additional improvements to the Humana Florida Medicaid website will be prioritized for implementation by October 1, 2018, adding new functions and features based on feedback from enrollees and Humana associates serving those enrollees in Florida.

Second, to systematically improve enrollee experience, Humana has initiated its "Member 360" Committee for Florida Medicaid plans. Comprised of Florida market leadership and Humana corporate functional partners, the committee meets monthly to review all metrics applicable to enrollees (such as grievance and appeals data, Customer Care call trends, Care Coordination reports, and web and mobile application usage reports), conduct root cause analysis, and identify process improvement opportunities. In concert with the "Member 360" Committee, Humana also initiated the Provider 360 Committee for Florida. This committee reviews provider-related data and metrics to evaluate opportunities to improve the provider experience and strengthen our provider network. Leadership within Humana's corporate divisions may also present matters to this committee that are relevant to specific providers within Florida or that may have a particular impact on them. For example, if the Provider Network Operations team, who oversees the PFP, notices trends of enrollee disatifaction about providers within Florida, it will work with the Florida market's "Member 360" and Provider 360 Committees to discuss probable causes and next steps to mitigate issues.

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2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5).

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Attachment 11-1 demonstrates an enrollee's navigation through Humana's online provider directory, Physician Finder Plus, to find in-network durable medical equipment providers by zip code. Using Humana's search options and within three (3) clicks, an enrollee can access a list

of providers within these specific parameters, and then: refine search results further, compare providers, and access detailed information about each provider to assist that enrollee in finding providers who speak a specific language or whose office locations offer public transportation options.

Starting Point: Humana Florida Medicaid Home Page
- (https://www.humana.com/medicaid/florida/mma)

CLICK #1:
- From the Quick Links at top of page, Enrollee *clicks* on “Find a Provider”

CLICK #2:
- Enrollee selects Coverage Type as “Medicaid”
- Enrollee enters zip code
- Enrollee selects Network as “Florida Humana Medical Plan”
- Enrollee selects Specialty and types in “Durable Medical Equipment”
- Enrollee *clicks* “Search”

CLICK #3:
- System displays results for Durable Medical Equipment within a 15-mile radius (default distance)
- Enrollee can refine search by numerous criteria, and compare up to three (3) providers
- Enrollee can view detailed provider information by clicking on provider name
- Enrollee *clicks* “South Beach Orthodics Prosthetics”

Enrollees can view full contact and related information about providers, including: public transportation options, office locations and contact information, languages spoken, whether the provider is accepting new patients, and other enrollees’ feedback. If logged into their Humana account, the enrollee can provide feedback on providers. Additionally, the secured login enables Humana to prepopulate the Coverage Type, enrollee’s home Zip Code, and Network, enabling enrollees to more easily search for and find in-network providers.

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3. The extent and relevance of the performance indicators available in the respondent’s provider directory for each provider type listed.
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For nearly thirty (30) years, Humana has been actively measuring our network providers and facilities, paying careful attention to their effectiveness and efficiency. Within the PFP, enrollees can view provider credentials such as education and board certification, as well as the certifying body. During Humana’s current contract with Florida to serve the Medicaid population, Humana partnered with vitals.com to give enrollees access to provider performance data. This data is available via a link to vitals.com from the provider’s information within Humana’s PFP.

To bring provider performance data to our enrollees, in Spring of 2017, Humana launched the Physician Performance Measurement initiative, developed in consultation with current Humana providers. The initiative intends to evaluate providers on evidence-based clinical measures developed by credible organizations such as National Committee for Quality Assurance (NCQA) and the AQA Alliance (formerly known as the Ambulatory Care Quality Alliance), and endorsed

by the National Quality Forum (NQF). To support this initiative, Humana has invested in Optum Symmetry EBM Connect software and embarked on an 18-month project to secure NCQA certification for our physician measurement program to assure the quality of provider performance data.

Providers will be evaluated by effectiveness measures specific to their specialty and compared to peers within similar geographic locations. Providers will be placed into four (4) performance tiers based on Humana's effectiveness performance index, calculated by dividing the actual compliance rate by the expected compliance rate. The expected compliance rate is a composite value derived by multiplying the peer's compliance rate by the provider's prevalence rate for each given measure. Physicians with an effectiveness index significantly below their peer average are referred to Humana's Quality department for physician outreach geared toward performance improvement. In addition, these physicians may not be eligible for participation in Humana's Medicaid network.

When displayed within the PFP, these performance tiers will be color-coded and will form the foundation for how Humana translates complex and complicated provider performance data into useful and understandable formats for enrollees. Humana intends to solicit input from network providers and AHCA as it works through this important initiative prior to our planned implementation in the first quarter of 2019. Attachment 11-2 includes the preliminary list of performance measures by specialty that may be translated for display within the PFP. As Humana moves forward with this initiative, launches it, and learns how best to communicate provider performance to enrollees, it is expected that the effectiveness measurements will evolve over time.

ENROLLEE FEEDBACK

Humana has built a feedback mechanism whereby any logged-in enrollee can submit feedback on a provider. Two data elements are collected, each on five (5)-point scales, with five (5) being the highest possible score for each. These elements are: 1) enrollee's experience and 2) enrollee's likelihood to recommend that provider to others. A logged-in enrollee may only submit one rating per individual provider, but they can update the rating over time. While the ability to provide feedback is only available via the secure portal to ensure only enrollees are submitting feedback, submitted feedback can be viewed by anyone, whether logged in or not. Humana also reviews this information to help identify poor performing providers. Within a twelve (12)-month period, providers receiving a rating of two (2) or below for five (5) consecutive instances are referred to the Provider Relations team, which has accountability for oversight of the Humana Florida Medical Plan network and responsibility for taking appropriate action.

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4. The extent of the respondent's efforts to ensure information in the respondent's online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.

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Humana is committed to meeting all contractual obligations related to our provider directory, including working in partnership with AHCA to ensure accuracy of the provider data within the

directory. In 2016, AHCA conducted an audit of Humana's MMA and LTC online searchable directories with respect to accessibility and completeness and layout. Humana worked immediately to address open gaps and continues to improve our provider data accuracy process. Those processes are described further below, and include ongoing monitoring and outreach to ensure the PFP is always up-to-date.

ENSURING ACCURACY: LOADING AND AUDITING PROVIDER DATA

An accurate provider directory relies on maintenance of up-to-date provider data as well as robust systems and processes that support timely updates. When a provider first contracts with Humana, provider contract and demographic information is loaded into Humana's data system. Provider Information Management System (PIMS) is the primary database used to store provider information and houses the source data for the PFP. Specific logic is used to generate the most accurate list of current providers: the system first looks for an active Medicaid contract and then verifies active credentialing status for the provider. It then ensures a valid service location within the designated county (or counties), a valid phone number, and specific display filters applied to reflect the information within the PFP.

TOOLS FOR MONITORING AND UPDATING PROVIDER DATA

Humana uses multiple resources to monitor changes to provider data, including Humana associates, Humana data systems and algorithms, providers, and enrollees. Providers and subcontractors alike are obligated to inform Humana of any changes in demographic information and accepting new patient status per their contracts with Humana. To make the updating process as easy as possible, in January 2017, Humana released Availity Provider Data Management to all of our providers. Availity enables providers to update, validate, and attest to their provider demographics. The information is then validated through Humana's Data Collection and Verification (DCAV) process, described further below.

Humana has recently initiated a Directory Data Cleansing project, aimed at piloting a combination of in-house and vendor solutions that enable Humana to partner in the development and implementation of effective data cleansing strategies. Humana's efforts in this pilot include the use of an advanced analytics algorithm to identify potential provider data errors and even recommend corrections automatically. The algorithm uses data sources like web searches (e.g., Google) and the Drug Enforcement Agency (DEA) with our own claims and call data to find these errors. We are currently automating the process of producing a list of providers with potential data errors every month. In the next phase, we plan to recommend the change that needs to be made when an error is detected using internal and open source data.

The scope of this pilot with vendors includes a multi-phased approach where the vendor will utilize their data cleansing analytical model to provide Humana with accurate provider data. Phase One of the project encompasses the exchange of data and the performance of vendor's analytical data model on base data sets, in addition to source data from vendor. Phase Two incorporates lessons learned regarding Phase One results, determination of additional source data (e.g., Claims, Referral), and an updated data sampling for repeat of Phase One steps to be performed. This multi-phased initiative will continue until Humana and vendor are satisfied with the results of the program or end of 2018, whichever comes first.

Humana associates who visit every network primary care physician (PCP) and large group practices on a monthly basis gather necessary provider information updates at each visit and feed those updates to the data load team. This creates another avenue for providers to easily ensure the accuracy of their data within Humana's systems and PFP.

Humana may also receive updates about a provider's information directly from an enrollee. Information from enrollees about potential errors or inaccuracies triggers Humana to make necessary corrections to provider data within our system. Enrollee reports of provider information errors are given directly to Humana associates within that provider's region. As soon as information is validated or corrected, it is communicated to the data load team and included within Humana's nightly update process.

MANAGING DELEGATED SUBCONTRACTOR DATA

Humana's Delegated Vendor Oversight Committee (DVOC) plays a key role in managing subcontractor activities by oversight of delegated vendor activities relating to utilization management, credentialing, customer services (enrollee and provider), contractual compliance, and claims processing and payment. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring (oversight program). Opportunities for vendor performance improvement and enhancement are identified and resolved during Joint Operational Committee meetings with vendors. It is through this oversight that Humana ensures that subcontractors meet contractual obligations to communicate their provider network files to Humana in a timely fashion. Subcontractors either submit a verified provider file within Humana's required Provider Network Verification (PNV) layout or submit a weekly network report of their own that is then integrated into Humana's provider directory. If the former, Humana compares the subcontractor's file to the Florida Medicaid directory file to ensure the provided Medicaid identification (ID) numbers are in the directory. This example applies to behavioral health providers that are integrated into Humana's PFP. The latter approach is taken when subcontracted providers, such as pharmacies and dentists, are listed outside of Humana's PFP. Examples of how two of Humana's dental and behavioral health providers communicate and ensure provider data accuracy are offered below.

SUBCONTRACTOR EXAMPLE 1: DENTAQUEST
DentaQuest serves as Humana's dental care provider. It maintains an active provider listing that details provider and practice specialties, licensing and credentialing statistics, language capacities, as well as the office's ability to serve enrollees with special needs. This listing is updated constantly using data gathered through the service accessibility survey, direct provider request, Provider Engagement Representatives, provider termination reports, and other data sources.

DentaQuest monitors network adequacy every month using several data sources including, but not limited to:
- Geo maps: These maps provide a detailed overview of the provider network, including the number of enrollees who have access to care in the required distance criteria and average distances to the three closest provider options.

- Monthly/Quarterly provider listing: This report provides a snapshot of the current network, showing the number of providers accepting new patients (number with open panels) and the number of providers accepting existing patients only (number with restricted panels, existing patients only). Additionally, DentaQuest has a dedicated resource based in Florida who audits the Florida database of providers on an ongoing basis, checking for office hours, open and closed status, and also any other updates applicable or education required.

- Monthly provider encounter submissions: This report provides a snapshot of the current encounter errors, if any. Provider Engagement and Client Data Management work together to identify the root causes of those errors. If it is related to provider data, Provider Engagement takes responsibility to correct the provider data in the DQ system. Furthermore, DentaQuest loads all 277/999 files to scrub the systems to meet the ninety-eight (98) percent to one hundred (100) percent acceptance rates requirements.

- Provider communication and office visits: DentaQuest's Provider Engagement staff are continually in touch with network providers and their staff to ensure that they have the knowledge and tools to provide high quality care.

To ensure accurate data, DentaQuest conducts quarterly and annual surveys of all providers to verify their participation in the network. DentaQuest's Provider Engagement Representatives also conduct outreach to all offices that have not returned their verification of information document. Information is updated via DentaQuest's system during this annual campaign, when changes are discovered during the re-credentialing process, and at any time a provider makes us aware of a change. When this information is updated in DentaQuest's Windward system, it simultaneously updates the information in real time available through DentaQuest's online Find-A-Dentist tool in addition to provider extracts submitted to Humana.

SUBCONTRACTOR EXAMPLE 2: BEACON HEALTH OPTIONS
Beacon Health Options (Beacon) serves as one of Humana's primary behavioral healthcare providers covering ten (10) out of twelve (12) SMMC regions. Beacon uses quarterly canvassing of prescribers and demographic attestations to ensure accuracy of provider network data.

Beacon has initiated a plan to ensure that Medicaid enrollees have timely access to providers. Beacon Provider Relations staff contact all network providers each quarter and ask questions to determine the provider's ability to accommodate a Beacon Medicaid enrollee. If a provider is unable to accommodate an enrollee according to Medicaid access standards, Beacon ensures that the provider has an alternate plan in place to help enrollees access care during urgent, emergent, and routine situations. Once the calls have been made to the prescribers, any changes that need to be made in the system are documented via Beacon's management information system. If additional documentation is needed, Beacon's Provider Relations staff follows up to obtain it from the provider. The script includes the following questions:

- Can you accommodate a Beacon Medicaid enrollee who has an emergency twenty-four (24) hours a day, seven (7) days a week?

- Can you accommodate a Beacon Medicaid enrollee in need of an urgent care within one (1) day of the request?

- Can you accommodate a Florida Medicaid enrollee in need of a routine initial evaluation within one (1) week of the request?

- Can you accommodate a Florida Medicaid enrollee in need of a routine follow up appointment within one (1) month of the routine initial evaluation request?

Beacon also requires providers to update and maintain demographic attestations to ensure Beacon's network directory of providers is accurate and meets Humana and AHCA's standards. Each quarter, every clinician is sent a demographic attestation that lists the provider's demographic information, all assigned provider identification numbers, and the health plans and lines of business that the provider is contracted with Beacon to serve. The providers are asked to attest to the information and return it to Beacon's Provider Relations team, whether changes are indicated or not. Once the attestations have been received, any changes that need to be made in the system are documented in Beacon's management information system. If additional documentation is needed prior to creating these events, the Provider Relations team follows up to obtain them from the provider.

OUTREACH EFFORTS

On a quarterly basis, Humana's Data Collection and Verification (DCAV) department performs outreach communication to all participating professional offices in Humana's networks, including Florida Medicaid. The outreach is a request for provider offices to review the information Humana has on file and posted within its provider directory, and for the provider's office and practitioners to identify errors, make corrections, and provide updates. Providers respond to these requests at their discretion. The focus of the quarterly review is to ensure accuracy of directory demographics like address and appointment phone number, as well as verify the practitioners that work in that office.

Humana recently secured BetterDoctor to support these outreach efforts and ensure provider data accuracy. BetterDoctor's purpose is to reduce the administrative burden of maintaining provider data for both Humana and our providers. To do this, it conducts quarterly outreach to all providers, and uses validation tools to make the updating and validation process as easy as possible for providers. This data is shared with Humana and integrated into PIMS for rapid verification and uploading into the PFP.

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5. The extent to which the respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency's Information.

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As Humana's PFP is the top accessed tool for enrollees, Humana works on a daily basis to ensure information in the provider online directory is accurate. This includes daily processing of updates Humana receives from providers (including demographic information and accepting new patient status) and nightly refreshes of the data within PFP. This daily exercise minimizes delays for enrollees to access the most up-to-date information on providers.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana's PFP includes the following provider information, any and all of which can be updated through Humana's nightly PFP refreshes:
1. Name
2. Gender
3. Accepting new patients status
4. Languages spoken by the physician or clinical staff
5. Specialty
6. Medical group affiliations (if applicable)
7. Hospital affiliations
8. Board certifications
9. Office locations and contact information
10. Cultural competency training
11. Feedback from each provider's patients

Humana continually works to ensure that provider and subcontractor provider information is the same between the PNV file Humana submits to AHCA on a weekly basis and Humana's PFP. For example: previously, Humana staff in both Florida and at the corporate level would share responsibility for reconciling provider information often through separate processes and across more than one database, and the weekly Florida Medicaid PNV file submission to AHCA would be generated from Florida's MMA and LTC databases rather than Humana's corporate PIMS system. This approach necessitated several workarounds and could cause delays in provider updates being reflected within the online provider directory. In response, Humana initiated a process whereby provider data is automatically extracted from our centralized database to produce the weekly PNV file for reconciliation with AHCA's information. As Humana implements this new and improved process and validates this transition to be sound, Florida's MMA and LTC databases will be sunset. This new process will extend to subcontractors.

The PNV file generation process is conducted in phases and in partnership with AHCA to ensure the utmost data integrity and accuracy. Every Tuesday, the PNV file is generated and submitted to AHCA as a test file. A response file is sent from AHCA on Wednesday morning. If there are errors, the records are fixed and the corrected file is regenerated on the same day. Any discrepant providers are removed from the PFP or the PNV file to ensure that these data sets are a perfect match. The final and accurate PNV file is submitted to AHCA every Thursday, with supporting attestations by Florida Market leadership as to the file's accuracy.

Evaluation Criteria:

1. The extent of the respondent's search functions for the respondent's online directory and ease of access for enrollees' navigation of the online provider directory, including whether or not the online directory is mobile friendly.

2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5).

3. The extent and relevance of the performance indicators available in the respondent's provider directory for each provider type listed.

4. The extent of the respondent's efforts to ensure information in the respondent's online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.

5. The extent to which the respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency's information.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment 11-1: Statewide Online Provider Directory Screenshots

Attachment 11-1: How an enrollee finds durable medical equipment providers by ZIP code using Humana's Online Provider Directory, and features of the MyHumana Mobile Application

Using Humana's Online Provider Directory – Physician Finder Plus:

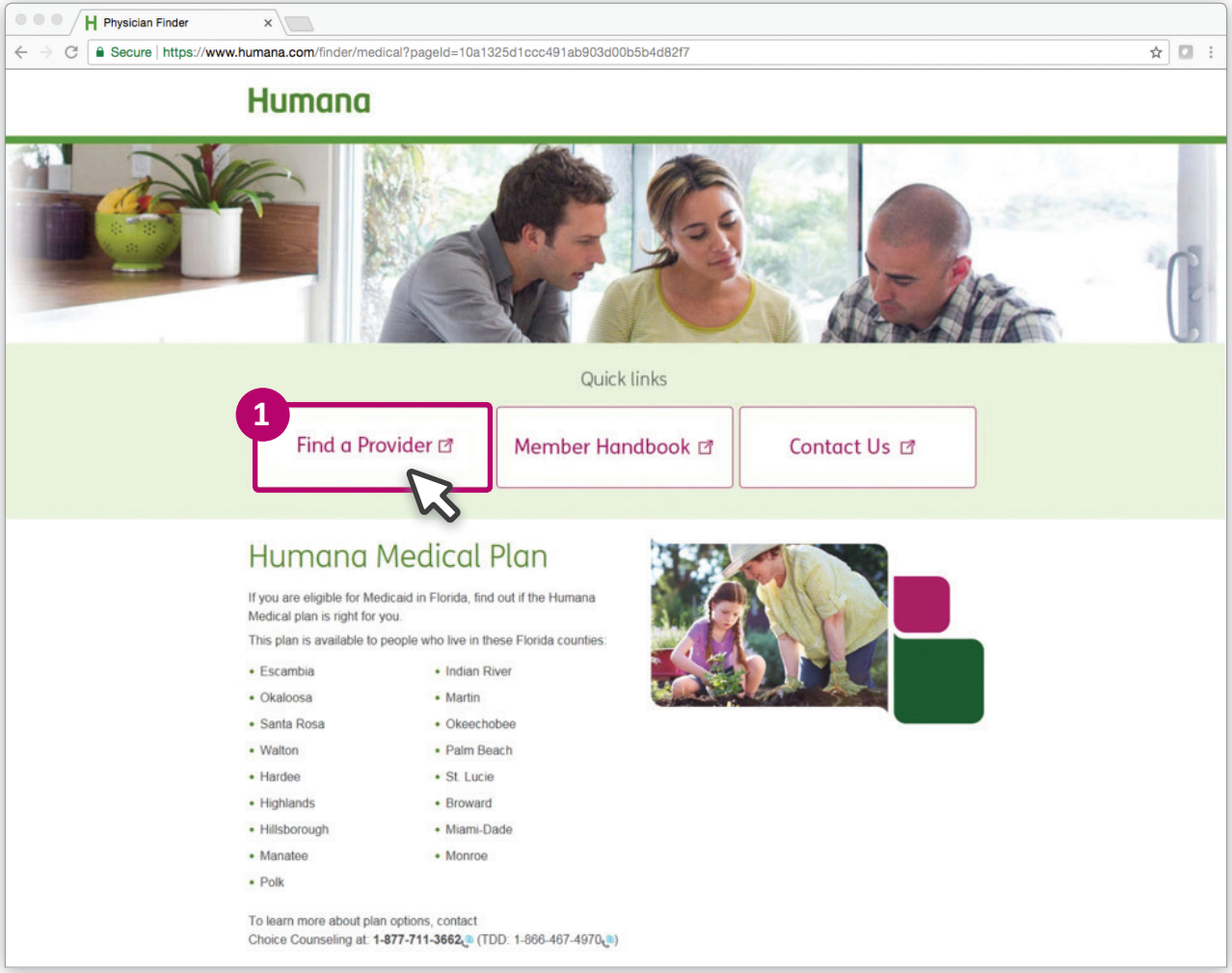
Starting Point:

Humana Florida Medicaid Home Page:
https://www.humana.com/medicaid/florida/mma

1st CLICK

From the Quick links at top of page,

Enrollee clicks on **Find a Provider**



Attachment 11-1: Statewide Online Provider Directory Screenshots

2nd CLICK

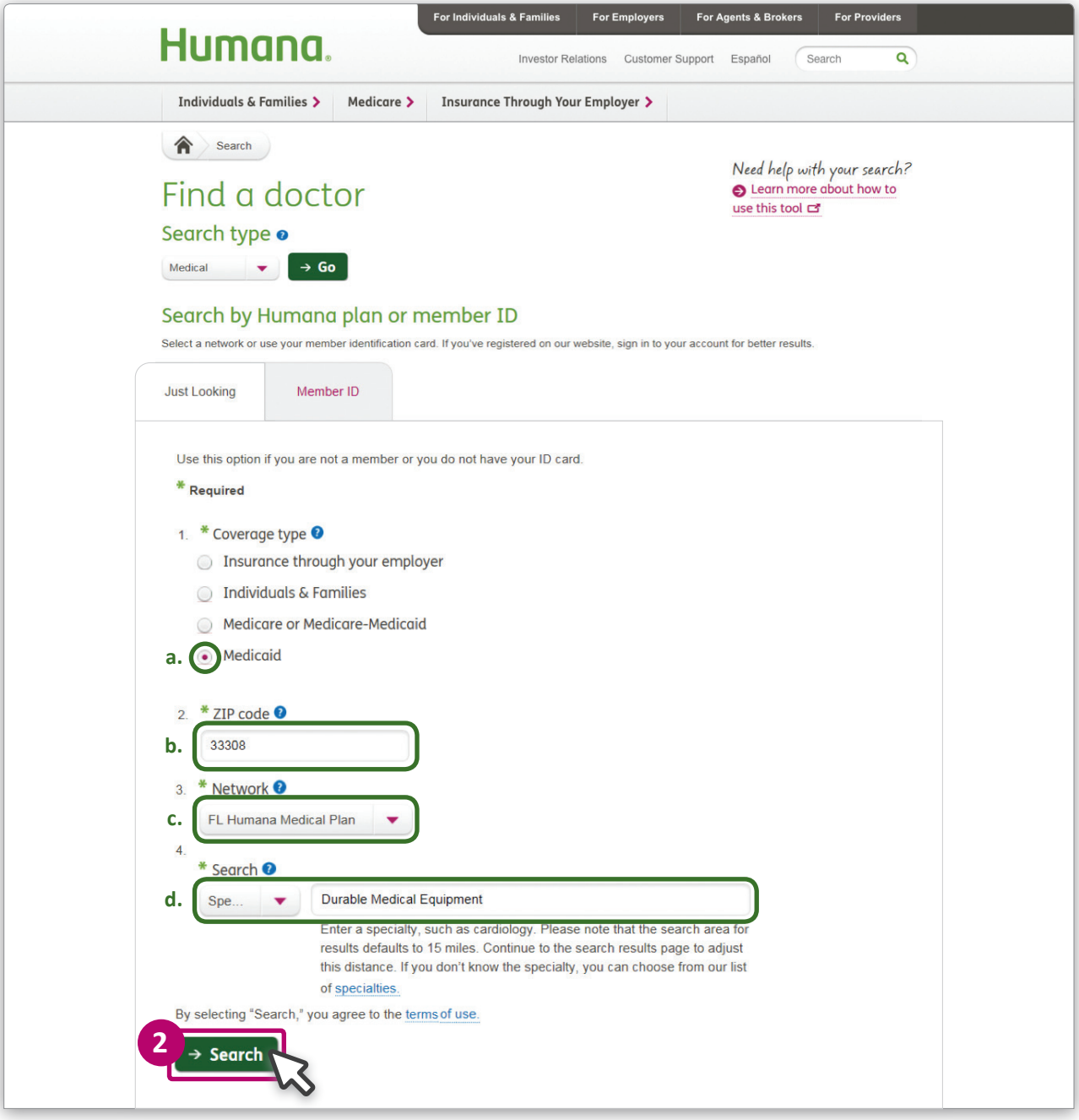
a. Enrollee selects Coverage Type as “Medicaid”

b. Enrollee enters ZIP code

c. From Network drop-down menu, enrollee selects “FL Humana Medical Plan”

d. Enrollee selects Specialty from drop-down menu and types in “Durable Medical Equipment”

Enrollee clicks → Search



Attachment 11-1: Statewide Online Provider Directory Screenshots

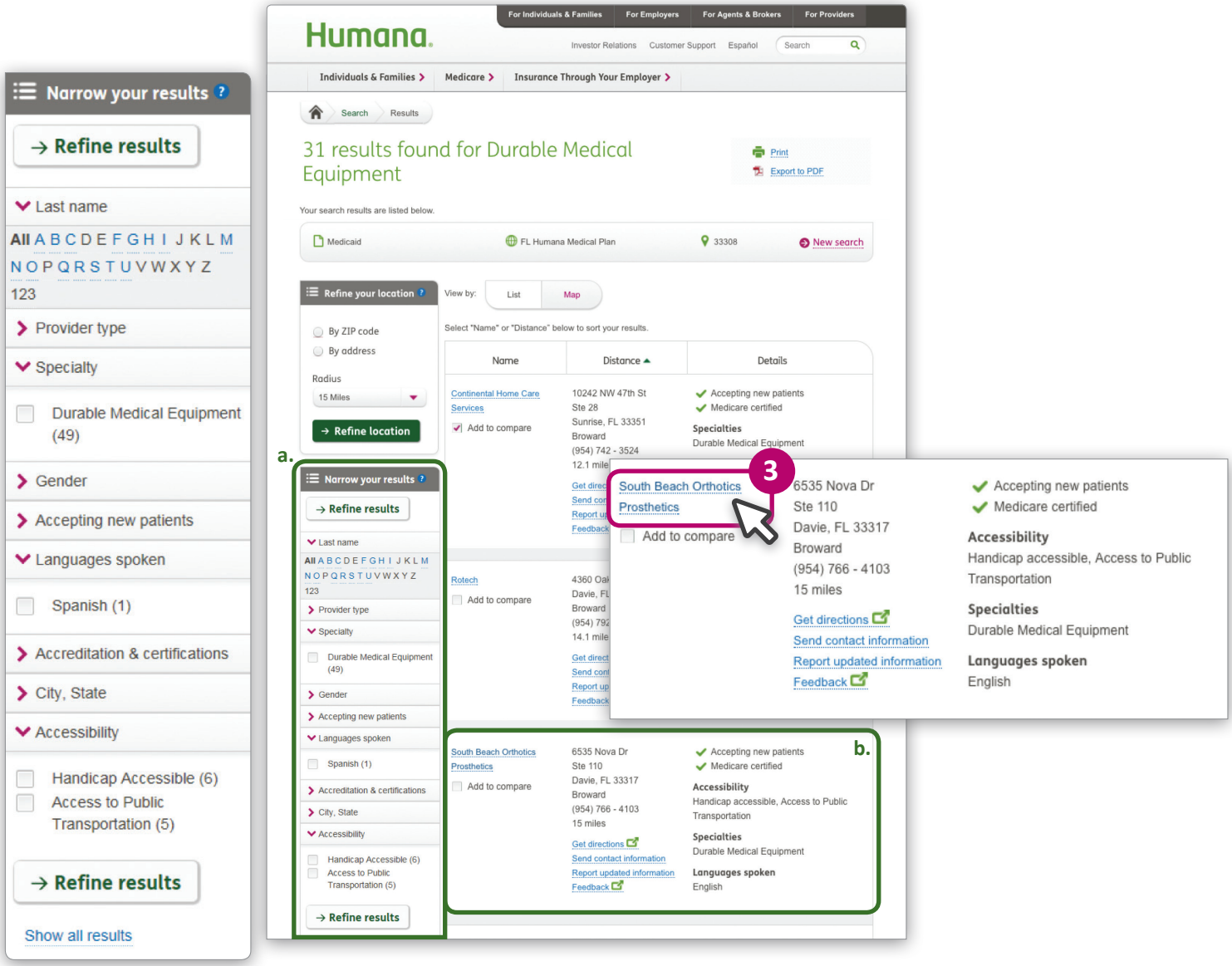
3rd CLICK

System provides results for Durable Medical Equipment within a 15-mile radius (default mileage).

a. Enrollee can refine search with numerous criteria

b. Enrollee can view detailed provider information by clicking on provider name

Enrollee clicks South Beach Orthotics Prosthetics



Attachment 11-1: Statewide Online Provider Directory Screenshots

After clicking the provider name, enrollees can view full contact and related information about providers, including:

a. Whether the provider is accepting new patients

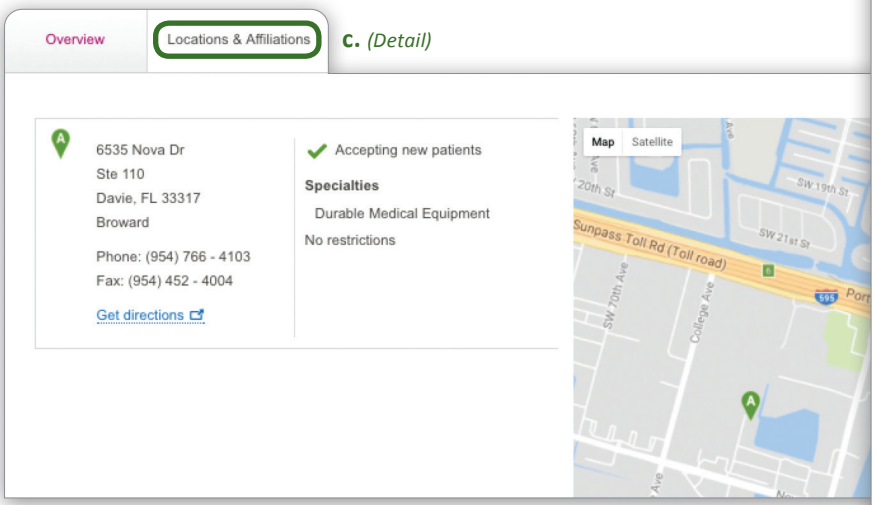
b. Other enrollees' feedback

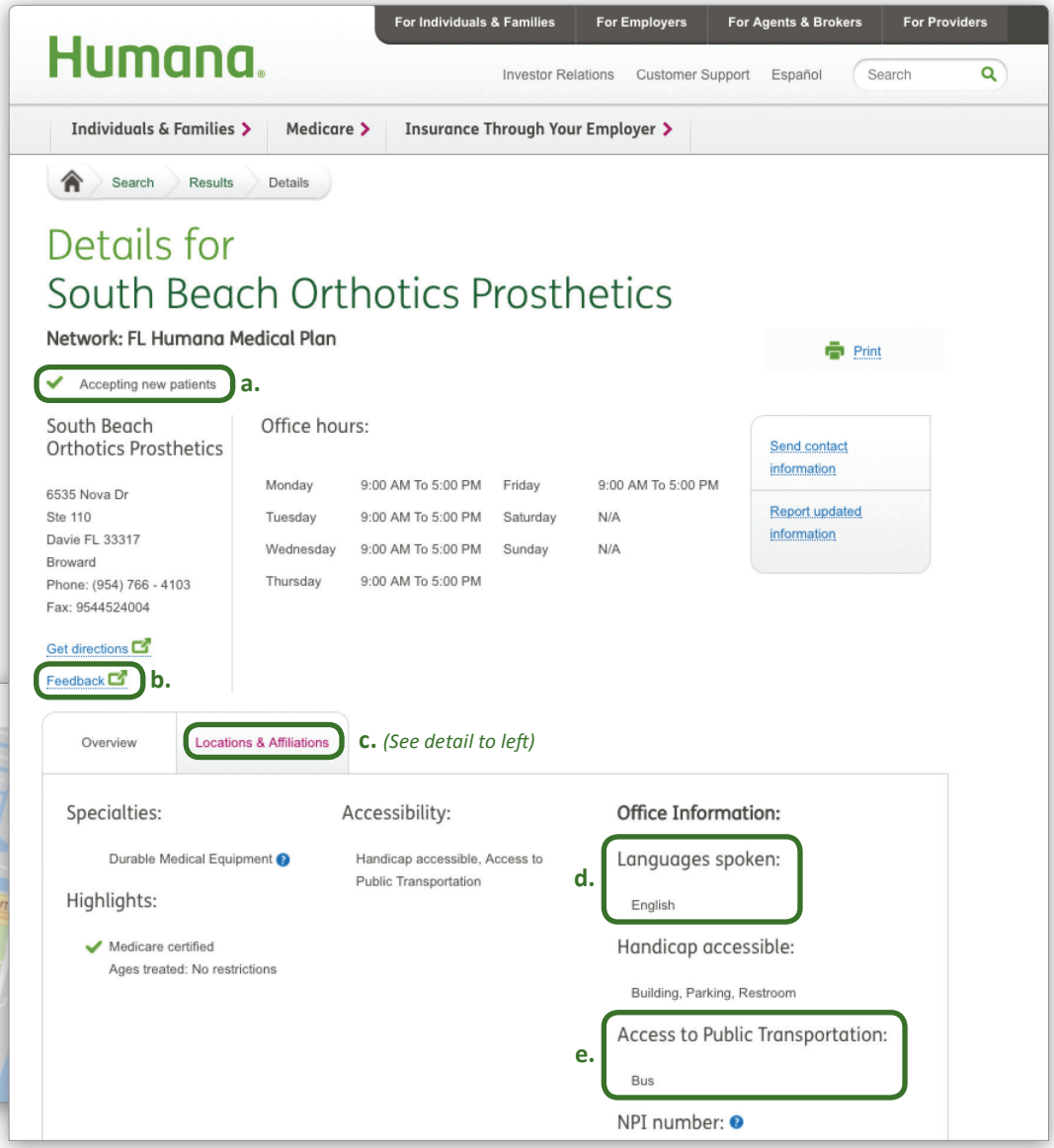
c. Office locations and contact information

d. Languages spoken

e. Public transportation options

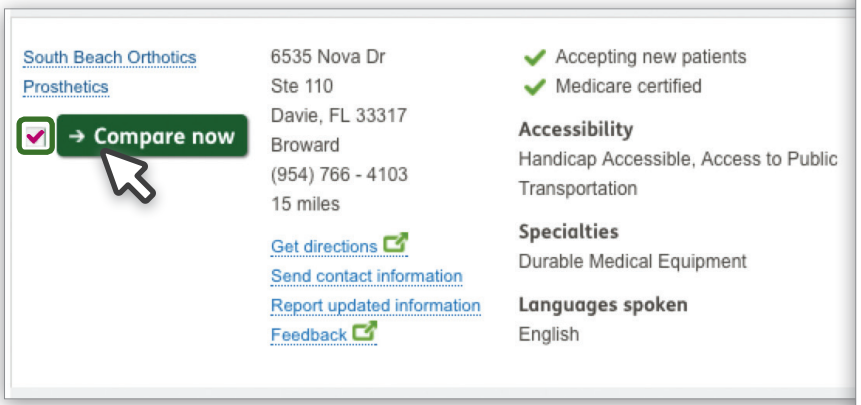
If logged into their Humana account, the enrollee can provide feedback on providers. Additionally, the secured login enables Humana to prepopulate the Coverage Type, ZIP Code, and Network, allowing the enrollee to more easily search for and find in-network providers.

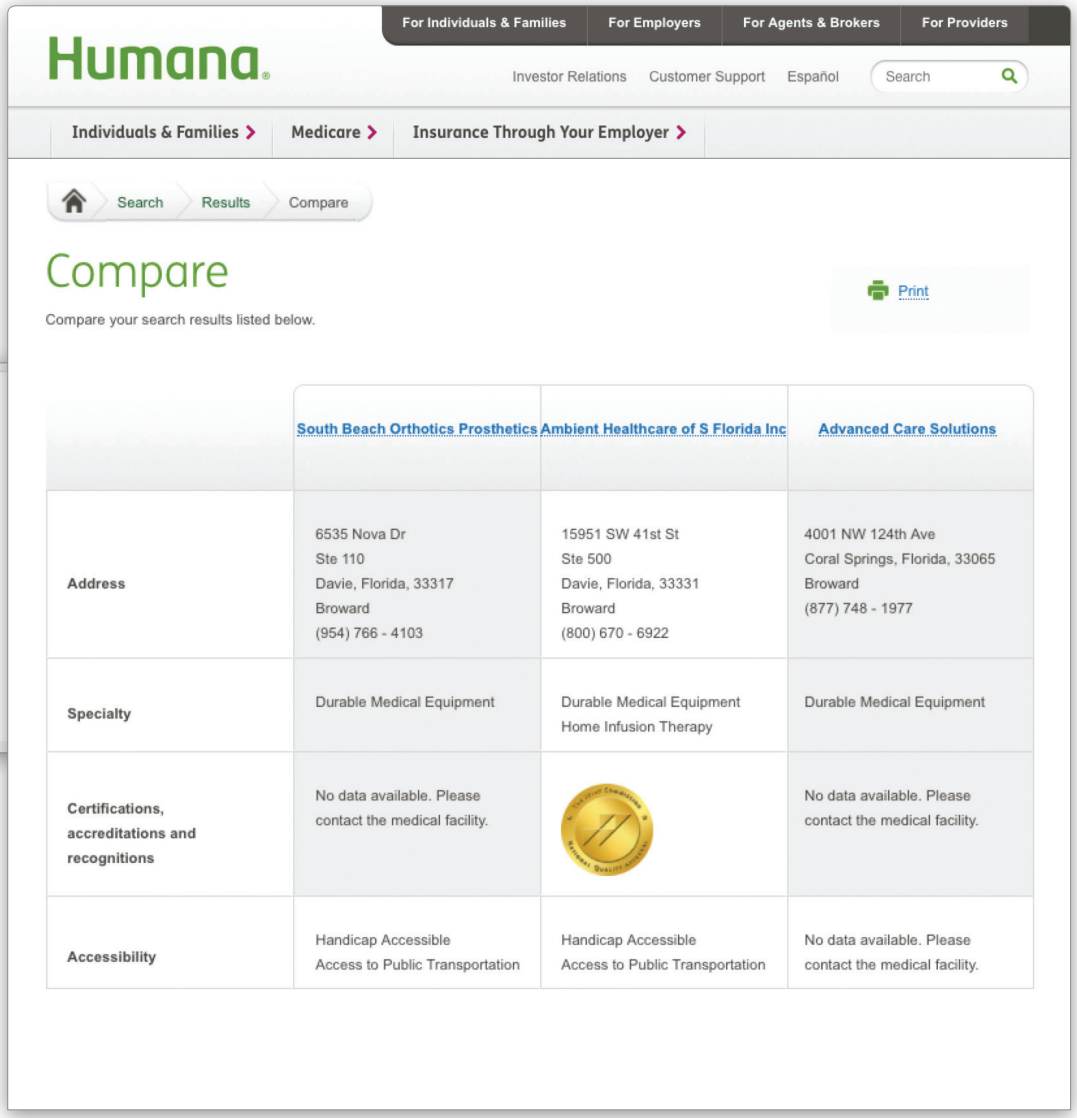




Attachment 11-1: Statewide Online Provider Directory Screenshots

Enrollees can compare up to three (3) providers at a time





	South Beach Orthotics Prosthetics	Ambient Healthcare of S Florida Inc	Advanced Care Solutions
Address	6535 Nova Dr Ste 110 Davie, Florida, 33317 Broward (954) 766 - 4103	15951 SW 41st St Ste 500 Davie, Florida, 33331 Broward (800) 670 - 6922	4001 NW 124th Ave Coral Springs, Florida, 33065 Broward (877) 748 - 1977
Specialty	Durable Medical Equipment	Durable Medical Equipment Home Infusion Therapy	Durable Medical Equipment
Certifications, accreditations and recognitions	No data available. Please contact the medical facility.		No data available. Please contact the medical facility.
Accessibility	Handicap Accessible Access to Public Transportation	Handicap Accessible Access to Public Transportation	No data available. Please contact the medical facility.

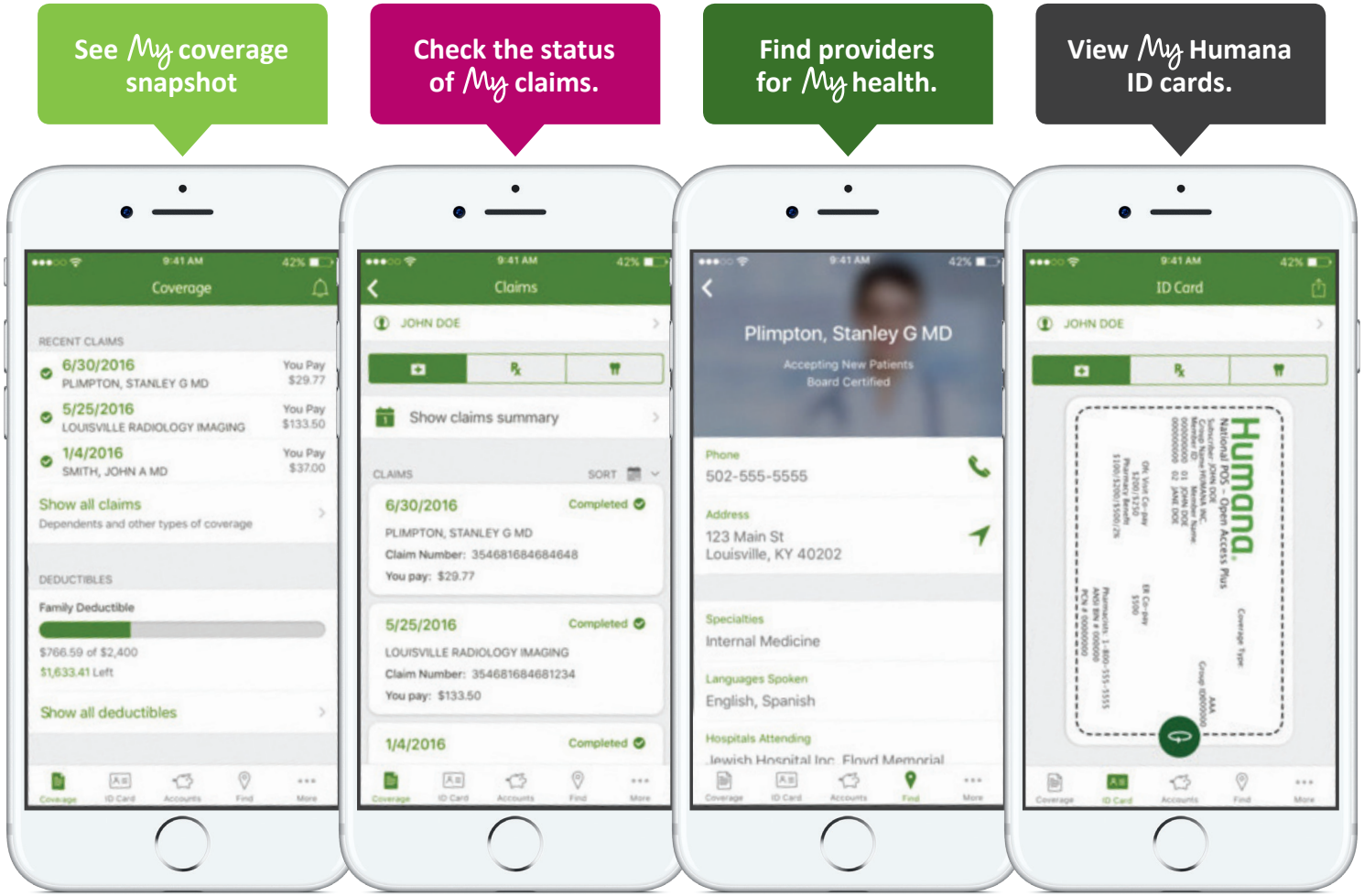
MyHumana

Mobile Application (iOS and Android)

The MyHumana Mobile Application puts access to care at enrollees' fingertips. They can search for providers just as they do via the Humana Online Provider Directory, view their coverage, see the status of claims, research drug pricing, and access their ID cards on the go.

Easy access to:

- claims
- drug pricing
- ID cards
- in-network providers
- and more



Attachment 11-2: Preliminary List of Performance Measures by Specialty

Humana Physician Performance Measurement Effectiveness Measures (obtained from the EBM Connect program)

Author and Rule Release Date

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Allergy & Immunology	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	COPD, Use of Spirometry Testing in Assessment and Diagnosis (National Standard)	Patient(s) that had appropriate spirometry testing to confirm COPD diagnosis.	National Standard		
	Pharyngitis, Appropriate Testing for Children (National Standard)	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	National Standard		
	Upper Respiratory Infection (URI), Appropriate Treatment for Children (National Standard)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
Cardiology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Persistence of Beta-Blocker Treatment after a Heart Attack (National Standard)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge.	National Standard		
	Statin Therapy for Patients with Cardiovascular Disease (National Standard)	Patient(s) with cardiovascular disease that received a high or moderate-intensity statin medication.	National Standard		
Chiropractic	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
Endocrinology/ Diabetes & Metabolism	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Diabetes Care (National Standard)	Patient(s) 18 - 64 years of age with evidence of good diabetic control, defined as the most recent HbA1c result value less than 7.0% in selected populations.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had a HbA1c test in last 12 reported months.	National Standard	HEDIS 2016	

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Endocrinology/ Diabetes & Metabolism	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age with evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%.	National Standard	HEDIS 2016	
	Diabetes: Appropriate Treatment of Hypertension-Part D (National Standard)	Patient(s) with diabetes and HTN who had a Renin Angiotensin System (RAS) Antagonist dispensed during the report period.	National Standard		2015
	Osteoporosis Management in Women Who Had a Fracture (National Standard)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	National Standard		
	Renin Angiotensin System (RAS) Antagonists-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed RAS antagonist medication (minimum compliance 80% or higher).	National Standard		2014
	Statin Therapy for Patients with Cardiovascular Disease (National Standard)	Patient(s) with cardiovascular disease that received a high or moderate-intensity statin medication.	National Standard		
	Statins-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed statin medication (minimum compliance 80% or higher).	National Standard		2014
Family/General Practice	ADHD, Follow-Up Care for Children Prescribed ADHD Medication (National Standard)	Patient(s) with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a prescribing provider during the 30 days after the initial ADHD prescription.	National Standard		
	Annual Monitoring for Patients on Persistent Medications (National Standard)	Adult patient(s) persistently taking angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) who received a serum potassium AND serum creatinine within the last 12 reported months.	National Standard		
	Annual Monitoring for Patients on Persistent Medications (National Standard)	Adult patient(s) persistently taking diuretics who received a serum potassium AND serum creatinine within the last 12 reported months.	National Standard		
	Antidepressant Medication Management (National Standard)	Patient(s) with a major depression who start an antidepressant medication that remained on treatment for at least 6 months (continuation phase treatment).	National Standard		
	Antidepressant Medication Management (National Standard)	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 week (acute phase treatment).	National Standard		
	Breast Cancer Screening (National Standard)	Patient(s) 52 - 74 years of age that had a screening mammogram in last 27 reported months.	National Standard		
	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Cervical Cancer Screening (National Standard)	Women that had appropriate screening for cervical cancer (Commercial enrollment).	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Colorectal Cancer Screening (National Standard)	Patient(s) 50 - 75 years of age that had appropriate screening for colorectal cancer.	National Standard		

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Family/General Practice	COPD, Use of Spirometry Testing in Assessment and Diagnosis (National Standard)	Patient(s) that had appropriate spirometry testing to confirm COPD diagnosis.	National Standard		
	Diabetes Care (National Standard)	Patient(s) 18 - 64 years of age with evidence of good diabetic control, defined as the most recent HbA1c result value less than 7.0% in selected populations.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had a HbA1c test in last 12 reported months.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age with evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%.	National Standard	HEDIS 2016	
	Diabetes: Appropriate Treatment of Hypertension-Part D (National Standard)	Patient(s) with diabetes and HTN who had a Renin Angiotensin System (RAS) Antagonist dispensed during the report period.	National Standard		2015
	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
	Osteoporosis Management in Women Who Had a Fracture (National Standard)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	National Standard		
	Persistence of Beta-Blocker Treatment after a Heart Attack (National Standard)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge.	National Standard		
	Pharyngitis, Appropriate Testing for Children (National Standard)	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	National Standard		
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients who had an accidental fall or hip fracture who took an anticonvulsant, nonbenzodiazepine hypnotic, SSRI, antiemetic, antipsychotic, benzodiazepine, or tricyclic antidepressant after the incident.	National Standard	HEDIS 2016	
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with chronic kidney disease who took a Cox-2 selective or nonaspirin NSAID after the earliest record of chronic kidney disease.	National Standard	HEDIS 2016	
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with dementia who took an antiemetic, antipsychotic, benzodiazepine, tricyclic antidepressant, H2 receptor antagonist, nonbenzodiazepine hypnotic or anticholinergic agent after the earliest record of dementia.	National Standard	HEDIS 2016	
	Renin Angiotensin System (RAS) Antagonists-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed RAS antagonist medication (minimum compliance 80% or higher).	National Standard		2014
	Statin Therapy for Patients with Cardiovascular Disease (National Standard)	Patient(s) with cardiovascular disease that received a high or moderate-intensity statin medication.	National Standard		
	Statins-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed statin medication (minimum compliance 80% or higher).	National Standard		2014
	Upper Respiratory Infection (URI), Appropriate Treatment for Children (National Standard)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Use of High-Risk Medications in the Elderly (National Standard)	Patients 66 years of age and older that received one or more high-risk medications in the elderly in the last 12 reported months (HEDIS criteria).	National Standard		
Gastroenterology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Gastroenterology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
Hematology/ Oncology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
Infectious Disease	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Pharyngitis, Appropriate Testing for Children (National Standard)	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	National Standard		
	Upper Respiratory Infection (URI), Appropriate Treatment for Children (National Standard)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
Internal Medicine	Annual Monitoring for Patients on Persistent Medications (National Standard)	Adult patient(s) persistently taking angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) who received a serum potassium AND serum creatinine within the last 12 reported months.	National Standard		
	Annual Monitoring for Patients on Persistent Medications (National Standard)	Adult patient(s) persistently taking diuretics who received a serum potassium AND serum creatinine within the last 12 reported months.	National Standard		
	Antidepressant Medication Management (National Standard)	Patient(s) with a major depression who start an antidepressant medication that remained on treatment for at least 6 months (continuation phase treatment).	National Standard		
	Antidepressant Medication Management (National Standard)	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 week (acute phase treatment).	National Standard		
	Breast Cancer Screening (National Standard)	Patient(s) 52 - 74 years of age that had a screening mammogram in last 27 reported months.	National Standard		
	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Internal Medicine	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Colorectal Cancer Screening (National Standard)	Patient(s) 50 - 75 years of age that had appropriate screening for colorectal cancer.	National Standard		
	COPD, Use of Spirometry Testing in Assessment and Diagnosis (National Standard)	Patient(s) that had appropriate spirometry testing to confirm COPD diagnosis.	National Standard		
	Diabetes Care (National Standard)	Patient(s) 18 - 64 years of age with evidence of good diabetic control, defined as the most recent HbA1c result value less than 7.0% in selected populations.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had a HbA1c test in last 12 reported months.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age with evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%.	National Standard	HEDIS 2016	
	Diabetes: Appropriate Treatment of Hypertension-Part D (National Standard)	Patient(s) with diabetes and HTN who had a Renin Angiotensin System (RAS) Antagonist dispensed during the report period.	National Standard		2015
	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
	Osteoporosis Management in Women Who Had a Fracture (National Standard)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	National Standard		
	Persistence of Beta-Blocker Treatment after a Heart Attack (National Standard)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge.	National Standard		
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients who had an accidental fall or hip fracture who took an anticonvulsant, nonbenzodiazepine hypnotic, SSRI, antiemetic, antipsychotic, benzodiazepine, or tricyclic antidepressant after the incident.	National Standard	HEDIS 2016	
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with chronic kidney disease who took a Cox-2 selective or nonaspirin NSAID after the earliest record of chronic kidney disease.	National Standard	HEDIS 2016	
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with dementia who took an antiemetic, antipsychotic, benzodiazepine, tricyclic antidepressant, H2 receptor antagonist, nonbenzodiazepine hypnotic or anticholinergic agent after the earliest record of dementia.	National Standard	HEDIS 2016	
	Renin Angiotensin System (RAS) Antagonists-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed RAS antagonist medication (minimum compliance 80% or higher).	National Standard		2014
	Statin Therapy for Patients with Cardiovascular Disease (National Standard)	Patient(s) with cardiovascular disease that received a high or moderate-intensity statin medication.	National Standard		
	Statins-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed statin medication (minimum compliance 80% or higher).	National Standard		2014
	Use of High-Risk Medications in the Elderly (National Standard)	Patients 66 years of age and older that received one or more high-risk medications in the elderly in the last 12 reported months (HEDIS criteria).	National Standard		
Neurology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Neurology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients who had an accidental fall or hip fracture who took an anticonvulsant, nonbenzodiazepine hypnotic, SSRI, antiemetic, antipsychotic, benzodiazepine, or tricyclic antidepressant after the incident.	National Standard	HEDIS 2016	
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with dementia who took an antiemetic, antipsychotic, benzodiazepine, tricyclic antidepressant, H2 receptor antagonist, nonbenzodiazepine hypnotic or anticholinergic agent after the earliest record of dementia.	National Standard	HEDIS 2016	
Neurosurgery	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients who had an accidental fall or hip fracture who took an anticonvulsant, nonbenzodiazepine hypnotic, SSRI, antiemetic, antipsychotic, benzodiazepine, or tricyclic antidepressant after the incident.	National Standard	HEDIS 2016	
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with dementia who took an antiemetic, antipsychotic, benzodiazepine, tricyclic antidepressant, H2 receptor antagonist, nonbenzodiazepine hypnotic or anticholinergic agent after the earliest record of dementia.	National Standard	HEDIS 2016	
Obstetrics & Gynecology	Antidepressant Medication Management (National Standard)	Patient(s) with a major depression who start an antidepressant medication that remained on treatment for at least 6 months (continuation phase treatment).	National Standard		
	Antidepressant Medication Management (National Standard)	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 week (acute phase treatment).	National Standard		
	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Diabetes Care (National Standard)	Patient(s) 18 - 64 years of age with evidence of good diabetic control, defined as the most recent HbA1c result value less than 7.0% in selected populations.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had a HbA1c test in last 12 reported months.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age with evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%.	National Standard	HEDIS 2016	

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Obstetrics & Gynecology	Diabetes: Appropriate Treatment of Hypertension-Part D (National Standard)	Patient(s) with diabetes and HTN who had a Renin Angiotensin System (RAS) Antagonist dispensed during the report period.	National Standard		2015
	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
	Osteoporosis Management in Women Who Had a Fracture (National Standard)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	National Standard		
	Pharyngitis, Appropriate Testing for Children (National Standard)	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	National Standard		
	Renin Angiotensin System (RAS) Antagonists-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed RAS antagonist medication (minimum compliance 80% or higher).	National Standard		2014
	Statin Therapy for Patients with Cardiovascular Disease (National Standard)	Patient(s) with cardiovascular disease that received a high or moderate-intensity statin medication.	National Standard		
	Statins-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed statin medication (minimum compliance 80% or higher).	National Standard		2014
	Upper Respiratory Infection (URI), Appropriate Treatment for Children (National Standard)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
Ophthalmology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
Orthopedic Surgery	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (National Standard)	Patient(s) who had a prescription dispensed for a disease modifying anti-rheumatic drug (DMARD) during the report period.	National Standard	HEDIS 2016	
	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
	Osteoporosis Management in Women Who Had a Fracture (National Standard)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	National Standard		
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with chronic kidney disease who took a Cox-2 selective or nonaspirin NSAID after the earliest record of chronic kidney disease.	National Standard	HEDIS 2016	
Otolaryngology	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Otolaryngology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	COPD, Use of Spirometry Testing in Assessment and Diagnosis (National Standard)	Patient(s) that had appropriate spirometry testing to confirm COPD diagnosis.	National Standard		
	Pharyngitis, Appropriate Testing for Children (National Standard)	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	National Standard		
	Upper Respiratory Infection (URI), Appropriate Treatment for Children (National Standard)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
Pediatrics	ADHD, Follow-Up Care for Children Prescribed ADHD Medication (National Standard)	Patient(s) with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a prescribing provider during the 30 days after the initial ADHD prescription.	National Standard		
	Annual Monitoring for Patients on Persistent Medications (National Standard)	Adult patient(s) persistently taking angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) who received a serum potassium AND serum creatinine within the last 12 reported months.	National Standard		
	Annual Monitoring for Patients on Persistent Medications (National Standard)	Adult patient(s) persistently taking diuretics who received a serum potassium AND serum creatinine within the last 12 reported months.	National Standard		
	Antidepressant Medication Management (National Standard)	Patient(s) with a major depression who start an antidepressant medication that remained on treatment for at least 6 months (continuation phase treatment).	National Standard		
	Antidepressant Medication Management (National Standard)	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 12 week (acute phase treatment).	National Standard		
	Breast Cancer Screening (National Standard)	Patient(s) 52 - 74 years of age that had a screening mammogram in last 27 reported months.	National Standard		
	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Colorectal Cancer Screening (National Standard)	Patient(s) 50 - 75 years of age that had appropriate screening for colorectal cancer.	National Standard		
	Diabetes Care (National Standard)	Patient(s) 18 - 64 years of age with evidence of good diabetic control, defined as the most recent HbA1c result value less than 7.0% in selected populations.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had a HbA1c test in last 12 reported months.	National Standard	HEDIS 2016	

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Pediatrics	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	National Standard	HEDIS 2016	
	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age with evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%.	National Standard	HEDIS 2016	
	Diabetes: Appropriate Treatment of Hypertension-Part D (National Standard)	Patient(s) with diabetes and HTN who had a Renin Angiotensin System (RAS) Antagonist dispensed during the report period.	National Standard		2015
	Pharyngitis, Appropriate Testing for Children (National Standard)	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	National Standard		
	Renin Angiotensin System (RAS) Antagonists-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed RAS antagonist medication (minimum compliance 80% or higher).	National Standard		2014
	Statin Therapy for Patients with Cardiovascular Disease (National Standard)	Patient(s) with cardiovascular disease that received a high or moderate-intensity statin medication.	National Standard		
	Statins-Part D Medication Adherence (National Standard)	Patient(s) compliant with prescribed statin medication (minimum compliance 80% or higher).	National Standard		2014
	Upper Respiratory Infection (URI), Appropriate Treatment for Children (National Standard)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
Physical Medicine/Rehabilitation	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
	Osteoporosis Management in Women Who Had a Fracture (National Standard)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	National Standard		
Podiatry	Diabetes Care (National Standard)	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	National Standard	HEDIS 2016	
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with chronic kidney disease who took a Cox-2 selective or nonaspirin NSAID after the earliest record of chronic kidney disease.	National Standard	HEDIS 2016	
Pulmonary Medicine	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Pulmonary Medicine	COPD, Use of Spirometry Testing in Assessment and Diagnosis (National Standard)	Patient(s) that had appropriate spirometry testing to confirm COPD diagnosis.	National Standard		
	Pharyngitis, Appropriate Testing for Children (National Standard)	Patient(s) treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	National Standard		
	Upper Respiratory Infection (URI), Appropriate Treatment for Children (National Standard)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
Rheumatology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (National Standard)	Patient(s) who had a prescription dispensed for a disease modifying anti-rheumatic drug (DMARD) during the report period.	National Standard	HEDIS 2016	
	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
	Osteoporosis Management in Women Who Had a Fracture (National Standard)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	National Standard		
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with chronic kidney disease who took a Cox-2 selective or nonaspirin NSAID after the earliest record of chronic kidney disease.	National Standard	HEDIS 2016	
Sports Medicine	Bronchitis, Acute, Avoidance of Antibiotic Treatment in Adults (National Standard)	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
	COPD, Use of Spirometry Testing in Assessment and Diagnosis (National Standard)	Patient(s) that had appropriate spirometry testing to confirm COPD diagnosis.	National Standard		
	Low Back Pain, Use of Imaging Studies (National Standard)	Patient(s) with uncomplicated low back pain that did not have imaging studies.	National Standard		
	Osteoporosis Management in Women Who Had a Fracture (National Standard)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	National Standard		
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with chronic kidney disease who took a Cox-2 selective or nonaspirin NSAID after the earliest record of chronic kidney disease.	National Standard	HEDIS 2016	
	Upper Respiratory Infection (URI), Appropriate Treatment for Children (National Standard)	Patient(s) with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	National Standard		

Attachment 11-2: Preliminary List of Performance Measures by Specialty

Specialty	Condition Description	Measure Description	Category	NCQA/HEDIS	PQA
Thoracic Surgery	Persistence of Beta-Blocker Treatment after a Heart Attack (National Standard)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge.	National Standard		
	Statin Therapy for Patients with Cardiovascular Disease (National Standard)	Patient(s) with cardiovascular disease that received a high or moderate-intensity statin medication.	National Standard		
Urology	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12 - 24 months of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 12-19 years of age that had a PCP visit during the 24 month report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period.	National Standard		
	Children and Adolescents' Access to Primary Care Practitioners (National Standard)	Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period.	National Standard		
Vascular Surgery	Persistence of Beta-Blocker Treatment after a Heart Attack (National Standard)	Patient(s) hospitalized with an acute myocardial infarction (AMI) persistently taking a beta-blocker for six months after discharge.	National Standard		
	Potentially Harmful Drug-Disease Interactions in the Elderly (National Standard)	Elderly patients with chronic kidney disease who took a Cox-2 selective or nonaspirin NSAID after the earliest record of chronic kidney disease.	National Standard	HEDIS 2016	
	Statin Therapy for Patients with Cardiovascular Disease (National Standard)	Patient(s) with cardiovascular disease that received a high or moderate-intensity statin medication.	National Standard		

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 12 – Enrollee Grievance and Appeal System (Statewide):

The respondent shall provide a flowchart and written description of how the respondent will execute its enrollee grievance and appeal system, including identifying, tracking and analysis of enrollee complaints, grievances, appeals and Medicaid fair hearing data. The respondent shall include in the description detail regarding how data resulting from the grievance and appeal system are used to improve the operational performance of the respondent.

Response:

Humana strives to process and resolve complaints, grievances, and appeals within timeframes that are less than those specified in federal and State requirements. We have designed our Grievance and Appeal System to ensure we treat enrollees fairly and with respect, and that we communicate regularly with them throughout the process. It is essential for all parties involved in the delivery of care – providers, enrollees, and Humana associates – to understand enrollees' rights and the steps to initiate a complaint, grievance, or appeal. This system is the voice of the enrollee, and one of the most important aspects of delivering Humana's vision of the Perfect Experience. Caring for enrollees and their health is at the heart of Humana's goal to create the Perfect Experience. Humana's collective commitment is to help people achieve their best health and lifelong well-being.

It is Humana's policy to maintain complaint, grievance, appeal, and Medicaid Fair Hearing standards in compliance with the rules and regulations set forth by the Contract, Federal, and State statutes and accreditation bodies. We have designed Humana's Grievance and Appeal System in accordance with State and Federal requirements: s.641.511, F.S., 42 CFR Part 431, Subpart E (Fair Hearings for Applicants and Beneficiaries) and 42 CFR 438, Subpart F (Grievance System), and Rule 59G-1.100, F.A.C. The goal is to provide enrollees with a process to address areas of dissatisfaction with Humana, a provider, or subcontractor. Neither enrollees nor their authorized representatives are subject to punitive or retaliatory actions as the result of exercising their grievance and appeals rights.

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1. The extent to which the respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities of who speak other languages.

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EASE OF ACCESS

There are multiple ways an enrollee or the enrollee's authorized representative can submit a complaint, grievance, or an appeal. Humana has implemented processes to ensure that no matter how the enrollee submits, whether in person, by phone, in writing by the enrollee or the enrollee's authorized representative, through the Agency for Health Care Administration (AHCA), or through a subcontractor, that we adequately and efficiently address every complaint, grievance, and appeal. We also ensure that we communicate steps and decisions to enrollees.
Humana assists enrollees submitting a complaint, grievance, or appeal. For the hearing impaired, we provide a teletype (TTY) line to ensure smooth communication between the enrollee and the Humana associate. Humana provides a Spanish-speaking associate to any

caller requesting one at the start of the call, and will connect an enrollee to oral interpretation services in two hundred (200) languages, video interpretation in twenty-four (24) languages including American Sign Language (ASL), and translated written materials of vital documents based on threshold languages and auxiliary aids that disabled enrollees require. Humana also provides additional accommodations for any enrollee with special needs who is unable to follow the standard process. For example, should enrollees have difficulty writing because of physical impairment, literacy, or language barriers, Humana associates at local Humana offices and Case Managers (CMs) assist in writing and filing the formal grievance. The flowcharts in Attachment 12-1 demonstrates ease of access for enrollees and their authorized representatives, offering several avenues through which they may file a complaint, grievance, or appeal.

Humana seeks to develop associates' abilities to meet the cultural and linguistic needs of enrollees, and has undertaken quality improvement efforts to enhance workforce sensitivity to diversity, disparities, and the need to provide appropriate and effective services. Humana recognizes that associate training is a key component in providing culturally competent care. We require all associates to take Humana's Cultural Competency training upon hiring and annually thereafter in concert with Ethics re-training. We also administer additional and specialized training to specific areas, including the Grievance and Appeal department, to associates who have direct contact or interaction with enrollees. In addition to proactive training initiatives, Humana's Quality committee reviews documentation and data we receive from complaints, grievances, and appeals to determine and ensure continued ease of access.

Cultural, linguistic, and disability customer care training helps ensure that we deliver covered services in a culturally competent manner to the target population. This is especially important for enrollee-facing associates with regular contact with disabled and non-English speaking enrollees. Examples of training include:

- Policies and procedures for accessing language assistance and working effectively with Limited English Proficiency (LEP) enrollees;

- Training on how to work effectively with in-person and telephonic interpreters, and information on cultural differences and diversity within our enrollee population;

- How to access TTY, video relay services, and remote interpreting services;

- How to access oral interpretation services and written materials in prevalent languages; and

- How to access materials for blind, limited sight, and deaf enrollees.

Humana also recognizes that enrollees interact with many of our subcontractors' associates. For this reason, all subcontractors also receive training on Cultural Competency and Ethics as well as the enrollee complaint, grievance, and appeal process. This occurs upon contracting, whenever there are revisions to the process, and annually thereafter. Periodic trainings ensure subcontractors understand the timeframes, manner, and method that enrollees may file complaints, grievances and appeals and how to assist with the intake.
Humana plans to conduct a Structured Submissions pilot to assist with ease of access. An online intake form hosted on Humana.com will guide enrollees through the submission process and enable them to track the status of their complaint, grievance, or appeal. This ensures that

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana receives all the correct information when the enrollee first files and reduces the need to have to ask for additional information. When the enrollee completes this form or files it through the website, the enrollee can track the status of their case from when we receive it, assign it to a representative, review it and make a decision. Attachment 12-2 displays the proposed intake form and status tracker.

GRIEVANCE AND APPEALS SYSTEM PROCESS

Humana informs enrollees of their right to file a complaint, grievance, or appeal and specific instructions for how to do so in all enrollee communications. Approved by AHCA, these communications include the Enrollee Handbook, enrollee website, and all communications related to a filed grievance or appeal. In addition, CMs explain to enrollees the right to file a complaint, grievance, or appeal. Attachment 12-1 depicts Humana's complaint, grievance, and appeal submission and resolution system. Enrollees and their authorized representatives may file a complaint, grievance, or appeal by calling Customer Care, mailing the request to Humana, visiting a local Humana office, asking their provider to submit on their behalf, speaking with their CM, or filing with AHCA so the matter can communicate directly to Humana. We discuss the process for complaints from AHCA in further detail under Evaluation Criteria 5. We strive to ensure that we track and resolve all complaints, including those submitted to Humana by AHCA or Humana's subcontractors, as part of Humana's established complaint, grievance, and appeal process.

All complaints, grievances, and appeals are stamped with the date we receive and enter them into our Customer Relationship Management tool (CRM) along with the enrollee’s name, Medicaid identification (ID) number, type of complaint, grievance or appeal, and expedited status. If we do not resolve a complaint by the end of the business day we receive it, we re-categorize the complaint and transition it to the grievance process.

Humana’s Grievance and Appeals team, which includes the Medicaid Fair Hearing specialists, relies on twenty-two (22) trained and highly experienced Grievance and Appeals full-time associates to effectively track and resolve all complaints, grievances, and appeals from enrollees or their authorized representatives, whether they are submitted directly to Humana or to our subcontractors. Our Grievance and Appeals team represents a combined one hundred fifteen (115) years of experience and an average tenure of nearly twelve (12) years with Humana. They work closely with Humana CMs who may support enrollees voicing issues. Our Critical Inquiry (CI) team, which works complaints and grievances filed directly with AHCA, consists of eleven (11) full-time associates with a combined ninety-five (95) total years of experience, and an average of more than eight (8) years with Humana.

GRIEVANCE PROCESSING

We have established the grievance process to address and resolve all enrollee concerns in a thorough and timely manner. The process meets all requirements set forth by the State of Florida and covers an enrollee’s expression of dissatisfaction about:

- Availability, quality of care, delivery or quality of healthcare services, including a written complaint regarding an adverse determination made by Humana pursuant to utilization review;

- Any matter other than an adverse benefit determination;

- Aspects of interpersonal relationships such as provider or Humana associate rudeness;

- Failure to respect the enrollee's rights;

- Dispute of an extension of time to make an authorization decision; or

- Claims payment, handling, or reimbursement for healthcare services.

All enrollee-facing areas throughout Humana can receive grievances, which we route to our centralized Grievance and Appeals department. When the enrollee submits a grievance, we send an acknowledgement letter confirming receipt of the grievance, written in the enrollee's preferred language, to the enrollee within five (5) business days of receipt. When someone other than the enrollee submits a grievance, our Grievance and Appeals department obtains an Appointment of Representative (AOR) form or other legal document to validate the authorized representative's authority to act on behalf of the enrollee before sending an acknowledgement letter to the enrollee, if it is not already on file.

When Humana receives a grievance, a Grievance and Appeals specialist researches authorization, claims, and enrollment systems, as well as enrollee certificate and provider contract information. The team then contacts the appropriate department(s) or subcontractor to gather additional information to resolve the enrollee's grievance.

The Grievance and Appeals associate ensures enrollees and their authorized representatives:

- Have a reasonable opportunity to present evidence and allegations of fact or law in person, as well as in writing;

- Understand any time limits that may apply; and

- Can examine the case file, including medical and case records, and any other material to consider during the process.

Receipt date of a written grievance is the date that Humana, any of its subcontractors, or its designee receives a grievance or upon receipt of the AOR form. Upon receipt, the receiving department date stamps, scans or attaches all written grievances; we note oral grievances as the date and time we received the enrollee's call. We use the date and time of receipt to calculate the resolution due date and timely filing requirements.

GRIEVANCE RESOLUTION

Upon resolution of the grievance, a Grievance and Appeal associate communicates a written resolution to the enrollee. We send notices to the enrollee as expeditiously as possible considering the enrollee's health condition while adhering to the required timeframes:

- We resolve the grievance and notify the enrollee within ninety (90) calendar days.

- We may extend the grievance up to fourteen (14) calendar days at the enrollee's request or if we determine and document that the extension is in the best interest of the enrollee.

- If the timeframe extends other than at the enrollee's request, Humana provides oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay to the enrollee within two (2) calendar days of the determination.

- Humana completes the grievance process in time to permit the enrollee's disenrollment to be effective in accordance with the timeframes specified in 42 CFR 438.56(e)(1).

APPEAL RESOLUTION

Once Humana's Grievance and Appeal associates receive and research an appeal, they may determine that the appeal falls under one of the following scenarios, which we handle according to the guidelines described below:

- The requested services for a pre-service appeal request have been rendered; therefore, we will handle the case according to the appropriate process.

- An appeal has been previously submitted and the appeal process has been exhausted. We will conduct an internal courtesy review if we receive additional information.

- An expedited appeal was previously submitted and the decision was upheld. The resolution letter gives the next level of appeal rights. If the enrollee later submits a post-service appeal, we process the appeal as a first-level post-service appeal.

- The request includes new or additional information such as medical records, and is submitted after a decision has been rendered. The case will be subject to a courtesy review by a qualified reviewer.

- The appeal has already been resolved by another area prior to receipt by the Grievance and Appeals department, or was resolved after receipt by the Grievance and Appeals department but prior to issuing a determination letter. We will not code these cases as a complaint or correspondence, but instead as an appeal resolved as an overturn, using the letter appropriate to the previously resolved issue.

Humana ensures that we resolve appeals by healthcare professionals with relevant clinical expertise. We also ensure that we did not involve decision-makers on grievances and appeals in previous levels of review or decision. Communication protocol for appeals matches those of grievances, as described above.

EXPEDITED APPEALS

If the appeal meets the expedited criteria, the Grievance and Appeals associate conducts further research to understand the initial decision. Humana then implements an expedited

review process for that appeal. This process takes place when Humana determines or the provider indicates that following the standard resolution timeframe could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. If Humana is unable to obtain a supporting statement from the provider, then a Grievance and Appeals associate sends an expedited appeal request to our Medical Director for review, ensuring that clinical expertise informs the decision.
Enrollees may file expedited appeals either orally or in writing with no additional follow up required. Humana will:

- Inform the enrollee of the limited time available to present evidence and allegations of fact or law, in person, and in writing;

- Resolve each expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, not to exceed seventy-two (72) hours;

- Provide written notice of disposition; and

- Make reasonable efforts to also provide oral notice of disposition immediately after the decision.

If the services have already been rendered or if the case does not meet expedited criteria, we handle the case as a standard appeal. For written requests or oral requests allowed by Florida regulations, reclassifying the expedited appeal to the standard appeal process does not change the received date. We verbally notify the enrollee immediately and provide written notice, which includes an explanation that we will automatically transfer and process the request under the standard appeal time frame, and that the enrollee may file an expedited grievance if they disagree with the decision to not handle the case as such. Humana will also inform the enrollee of the right to resubmit the request with support from the treating provider and explain that if the provider indicates that applying the standard review process could seriously jeopardize the enrollee's life or health, we will automatically expedite the request if the service has not been rendered.

NOTIFICATION OF RESOLUTION

The enrollee or the enrollee's authorized representative may request a copy of the complete file containing documents, records, and any clinical guidelines we use in the case decision. The enrollee or authorized representative can review and examine the information before and during the appeal process. Humana will provide the records free of charge, within seven (7) calendar days of receiving the request.

Following resolution of the issue, the Grievance and Appeals associate issues a written response. Humana issues all resolution letters according to the type of case and specific timeframes for resolution. The letter gives a brief overview of the issue and any actions taken that we can disclose, as well as any supporting documentation. Humana maintains records of all complaints, grievances, and appeals, including resolutions for at least ten (10) years as required by Federal and state requirements. Humana will make all records available to AHCA and CMS upon request.

MEDICAID FAIR HEARING

An enrollee or their authorized representative has the right to request a Medicaid Fair Hearing after completing the appeal process.

Our Grievance and Appeals department and Medical Director are responsible for preparing an appeal summary for Medicaid Fair Hearings. The appeal summary includes all facts and documents relevant to the issues and all documentation to support our decision. Our Grievance and Appeals department and Medical Director will participate in the Medicaid Fair Hearing in person or by telephone and complete the required forms and documentation. In 2016 Humana participated in a total of thirty-nine (39) Florida Medicaid Fair Hearings, thirty-six (36) of which were upheld. Thus far in 2017, there have been a total of ten (10) Florida Medicaid Fair Hearings, eight (8) of which have been upheld.

If Humana determines, or if we receive notification from a Florida Fair Hearing Board, that the criteria for a continuation of benefits has been met, the Grievance and Appeals associate updates Humana systems to recognize that the enrollee's benefits should continue until receiving the outcome of the hearing. For appeals decided in favor of the enrollee, Humana will authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires if the services were not furnished while the appeal was pending. Humana will also pay for the disputed services if the enrollee received the services while the appeal was pending.

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2. The extent to which the respondent's timelines for acknowledging and responding to complaints, grievances and appears are less than those specified in federal and State requirements.

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Humana complies with all Federal and State requirements for acknowledging and responding to complaints, grievances, and appeals, and does so in less than the timeframes specified in Federal and State requirements.

For January through August of 2017, we resolved forty-four percent (44%) of the complaints received before the end of the next business day following receipt of the complaint, and classified the remaining fifty-six percent (56%) as grievances.

Per Contract requirements, Humana acknowledges standard enrollee appeals within five (5) business days and expedited appeals within twenty-four (24) hours. We provide oral notification to the enrollee within seventy-two (72) hours or less. To support enrollees during this process, Humana will allow coverage for any denied medication during the review process. We provide the resolution letter, written in the enrollee's primary language, within two (2) calendar days of the oral notification. Appeal determinations are rendered as expeditiously as the enrollee's health condition requires, but no later than thirty (30) calendar days from receipt, whether we receive them orally or in writing.

Humana's average acknowledgement times over the past ninety (90) days compared to required timeframes are:

- Grievances – Requirement: within 5 business days; Humana's average: 4 business days

- Standard Appeals – Requirement: within 5 business days; Humana's average: 4 business days

- Expedited Appeals – Requirement: within 24 hours; Humana's average: 8 hours

Humana's average written resolution times over the past 90 days compared to required timeframes are:

- Grievances – Requirement: no later than 90 calendar days; Humana's average: 26 calendar days.

- Standard Appeals – Requirement: within 30 calendar days; Humana's average: 21 calendar days.

- Expedited Appeals – Requirement: within 72 hours; Humana's average: 35 hours.

We program AHCA's required timeframes for resolution of verbal and written enrollee complaints, grievances, and appeals in CRM, creating alerts and reminders so that we review and resolve matters as expeditiously as the enrollee's health conditions require. Attachment 12-3, visuals 1a and 1b show examples of Humana's Medicaid Dashboard, which offers a point-in-time snapshot of the status of all of Humana's active grievances, including response times.

Compliance ratings for both of our Florida Managed Medical Assistance (MMA) and Long-term Care (LTC) membership display a positive trend and attest to the impact of process improvements we have made during the current contract administration. August 2017 compliance ratings highlighted below capture our best performance to date:

- Grievance acknowledgment letter sent within 5 business days: over 98%
- Grievance resolution letter sent within 90 calendar days: 100%
- Appeal acknowledgment letter sent within 5 business days: over 97%
- Appeal resolution letter sent within 30 calendar days: 100%
- Expedited Appeal verbal acknowledgement within 24 hours: 100%
- Expedited Appeal resolution (verbal and written acknowledgment) within 72 hours: 100%
- All complaints received from AHCA were responded to on time: 100%

To ensure the Grievance and Appeals and the CI teams are aware of and compliant with any relevant regulatory changes that impact any part of the processes or systems, Humana dedicates many resources to monitoring regulatory changes and implementing any necessary changes. Some examples of these resources include: the Florida Market team, the Contract Management Unit (CMU), a Compliance department, Quality Operations, and Accreditation.

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3. The extent to which the respondent's complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate associates or committee for analysis and prioritization of correction action and/or improvement initiatives.

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Humana aggregates all complaint, grievance, and appeal and Medicaid Fair Hearing data so we can swiftly resolve issues while simultaneously protecting enrollee privacy. Market- and corporate-level committees regularly review data to ensure quality of service and prioritized improvements.

CREATING ACTIONABLE DATA

Humana's Grievance and Appeal System generates daily, quarterly, and annual reports, which our Customer Care, Grievance and Appeal, and CI teams continuously review to ensure timely and appropriate resolution, and to identify emerging or recurring trends that warrant root cause analysis. The reports include open inventory arranged by nature of case, due date, enrollee's name, Medicaid ID number, case type, and expedited status. We also log disposition type and the disposition date. Attachment 12-3, visual 2 is a point in time view of the daily report.

The Grievance and Appeals department conducts monthly and quarterly root cause analysis, which escalates to market- and corporate-level quality committees. Attachment 12-3, Visual 3 includes aggregate data of the top five (5) grievances and top five (5) appeals submitted to Humana in 2017.

In addition, Humana uses Grievance and Appeal System reports to monitor quality of care issues, access to care, improper billing, and oversight of subcontractors. Humana has processes in place for ongoing monitoring and detection of risk to inform the Grievance and Appeals System. Potential risks that may impact enrollees may include claims issues related to providers and subcontractors and internal system errors. While Humana proactively informs enrollees of major issues that may impact their claims or services, ensuring Customer Care Specialists (CCS), CI, and Grievance and Appeal associates are aware of all current issues will allow them to quickly and easily resolve related enrollee complaints, grievances, and appeals.

Our Grievance and Appeals System considers the perspectives of both the market and corporate levels, further ensuring all teams involved have thoroughly researched the issues and provide input regarding how Humana can best serve enrollees. Because the market team represents where the enrollees live and work, the partnership between market and corporate Medicaid leadership provides the necessary context to best understand and most effectively resolve enrollees' issues.

PROTECTING ENROLLEE PRIVACY

Humana protects all enrollee information. As a first step, Humana's Privacy Policy incorporates all Federal and State regulations.

Humana's Privacy Policy details, among other items: the authentication process required for enrollee and authorized representative communication; consent requirements for the release of protected health information (PHI); de-identification of enrollee information for the sake of data aggregation and analysis; specifications of Humana associate roles and permissions related to enrollee PHI; and subcontractor requirements for abiding by Humana policies.

We restrict access to PHI, granting access to associates based on the minimum necessary to perform their assigned responsibilities. All Humana associates undergo ethics training to ensure they understand and comply with all laws that protect enrollee privacy and PHI. From the start of the grievance and appeals process, Humana associates authenticate the enrollee's identity and ensure that for any complaint, grievance, or appeal submitted on behalf of the enrollee, that proper legal documentation is on hand, including an AOR form or Power of Attorney (POA) form. The only exception is for expedited appeals that the enrollee's provider submits. Associates also ensure that we communicate any information regarding resolution of complaints, grievances, or appeals through a secure process solely to the enrollee and the authorized representative.

We transmit all internal e-mail communication related to a complaint, grievance, or appeal via a secure email server. Additional safeguards are in place for Medicaid Fair Hearing submissions, using AHCA's secure database to upload relevant enrollee information. We limit access to this database to the Grievance and Appeals Medicaid Fair Hearing specialist, the team Frontline Leader, and the team Production Lead.

We de-identify aggregated data for regular reporting and analysis to protect enrollee privacy. To identify and mitigate any threats to the security of enrollee information or Humana's information systems, Humana's Enterprise Information Protection (EIP) team continually monitors subscription-based threat feeds, subcontractor-provided security websites, and mailing lists. EIP reviews these threats and searches asset inventories to determine whether the threat is applicable to Humana. EIP tracks remediation progress by reviewing reports the Information Technology (IT) team provides as well as through subject matter experts, and validates remediation through vulnerability scanning tools.

USING DATA TO SUPPORT IMPROVEMENTS

Numerous cross-departmental forums, including the Process Council, discuss aggregated data for prioritization and implementation. As the governing body for Humana's Resolution team, the Process Council connects the overall goals and strategies of Humana's lines of business with performance of the individual business processes. The Process Council also provides a mechanism for allocation of scarce resources, prioritization, implementation strategy approval, oversight of post-implementation process change performance, and change control management.

Another forum for cross-departmental collaboration on potential improvements is the 811 Committee, which meets on a weekly basis. The purpose of 811 Committee meetings are to provide preemptive risk mitigation. Committee members assess the impact of proposed process changes prior to their implementation. Delegates from relevant business areas within the Resolution team participate to review system and downstream impacts.

Both the Process Council and the 811 Committee offer opportunities for Medicaid Grievance and Appeals and CI leadership to discuss compliance and reporting risks associated with implementation of improvements. This allows Humana to leverage capabilities based on efforts relevant to other plans and business processes. These forums allow for the Resolution teams to discuss compliance and reporting risk associated with any changes.

Humana has created the new Florida Medicaid Member 360 Committee to systematically improve the enrollee experience. The Committee meets monthly to review all metrics applicable to enrollees, including grievance and appeals data, and provides a forum for review of enrollee-related metrics, root cause analysis, process improvement opportunities, and escalation of enrollee concerns.

Additionally, we cover issues we need to address with subcontractors via Joint Operations Committee (JOC) meetings. These meetings provide an opportunity to address subcontractor needs, such as additional training, that Humana can provide to mitigate future issues.

Quarterly, our Grievance and Appeals department provides reports and recommendations to our corporate Quality Improvement Committee (QIC) for review. The QIC then either approves the recommendations or suggests alternative action. Our Decision Support and Informatics department provides aggregated reporting to the appropriate committees to ensure enrollee privacy. The appropriate committees use the aggregated reporting to initiate process improvements.

Additional options for improvements include Quality Improvement (QI) Plans and process improvement initiatives. Approved by and reported to the QIC, QI Plans are initiated for key process improvements. The Business Owner of the QI Plan is responsible for ensuring actions established in the QI Plan take place within the timeframes established and that we report results accordingly. We initiate process improvement initiatives for smaller improvements that a workgroup can perform.

Finally, for quality improvement efforts specific to Florida, the Florida Medicaid QIC provides operational oversight for the Quality Improvement program activities and recommends policy decisions. The Committee oversees the Florida-market Quality Improvement program and measurement of quality activities on a regular basis. Specifically, the Florida QIC will review data to determine trends and follow up with relevant departments to identify areas for improvement and develop initiatives.

From an enterprise perspective, Humana prioritizes and executes process improvements at various levels following specific business policies. We initiate and require an “issue or opportunity” (IOP) when Humana is noncompliant on a regulatory issue; for all internal Corrective Action Plans (CAPs); for all self-reported issues; and for all external notices, external CAPs, and fines or penalties. Improvement Action Plans (IAPs) document how Humana will remediate an IOP, governed by a specific workflow. Humana logs and monitors IOPs and IAPs via Enterprise Solution Point (ESP), an internal platform used to assist in tracking such efforts.

Florida Medicaid Compliance associates oversee the remediation of open issues or opportunities. Business owners provide anticipated remediation dates as well as status updates, and report the status of issues or opportunities regularly to senior leadership. If

appropriate, we escalate IOPs to the Medicaid Compliance Committee, which we discuss in further detail in Evaluation Criteria 4 below.

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4. The extent to which the respondent's complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.

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As discussed above, Humana uses actionable data to identify compliance gaps in internal processes. Such situations typically result in the implementation of a CAP.

Humana places CAPs into two (2) categories: 1) CAPs put in place at AHCA's request to remedy contractual non-compliance; and 2) CAPs that Humana puts in place internally to resolve problems or remedy a deficiency in the performance of one of our internal business units or subcontractors.

Humana works cooperatively with AHCA to remediate identified issues subject to a CAP put in place at AHCA's request. We require responsible business owners to promptly conduct root cause analyses and develop detailed action plans for remediation. Compliance associates monitor all CAPs received from AHCA to ensure the CAP remains on track for timely remediation.

CAPs developed internally are the result of data and input from multiple levels within the organization. We aggregate and report out data to numerous committees such as the market-level and corporate-level QICs. Our Florida QIC and corporate Grievance and Appeals department report to the corporate QIC on a quarterly basis. By reporting quarterly, Humana can quickly identify trends and make changes where necessary using CAPs or smaller improvement efforts as described above. Once issued, the impacted business area responds rapidly by setting an appropriate deadline and developing a work plan for the issued CAP.

The scope of a CAP can include any service provided to enrollees; can relate to one (1) or more treatment, process, or outcome; and include an awareness of factors that impact healthcare utilization and wellness for diverse populations related to ethnic, racial, and socioeconomic influences. We include all populations in the scope and content of the plan, and analyze demographic data to address any specific needs related to cultural, racial, or ethnic differences. Performance monitoring is the key to measuring the effectiveness of any improvement effort. We monitor CAPs regularly to track progress against set goals throughout the implementation of the work plan, and even after closing the CAP to ensure the solutions have appropriately addressed the issue. This monitoring includes input from all departments involved in enrollee care and services, relying on interdisciplinary Quality Improvement teams, both market- and corporate-based, to produce the best outcomes. As a result of this performance monitoring, AHCA has not requested that Humana submit any external CAPs for complaints, grievances, or appeals.

Humana's Medicaid Compliance Steering Committee meets each month, coordinated by the Operational Risk Management (ORM) team. Meeting invitees include but are not limited to leaders that are critical to the escalation process: Medicaid Operational Leadership; Florida Medicaid Vice President; Medicaid Segment Vice President; Compliance associates; and

Operational Risk Management Vice President. We invite all applicable business owners for each team that handle complaints, grievances, and appeals to this meeting monthly. Its purpose is to provide a forum to present, review, analyze, and make recommendations on issues pertaining to Humana Medicaid programs. The agenda includes discussion of pressing compliance issues in each Medicaid program, including Florida Medicaid. The vehicle used to drive discussion by the Medicaid Compliance Committee enrollees is the Medicaid Integrated Compliance Scorecard. Part of ORM, the Metrics team compiles the Scorecard monthly which includes a point-in-time assessment of compliance for each contract and performance on compliance metrics including current compliance measurements for the reporting month. Florida Medicaid Compliance associates can issue internal CAPs to compel a business owner to create a plan that identifies root cause deficiencies for non-compliance on a specific metric, and the corresponding action plan to bring Humana to a compliant state.

The Scorecard facilitates the success of external and internal CAPs and other notifications of non-compliance. We share Scorecards, Dashboards, and the results of the Medicaid Compliance Committee discussion with senior leaders across Humana, including our Chief Compliance Officer, Chief Operating Officer, President of Medicare and Medicaid Operations, and the Vice President of Medicaid. Attachment 12-3, visual 1a and 1b, provide the Grievance and Appeals summary extracted from the Florida Medicaid Compliance Dashboard.

Given the importance of resolutions for complaints, grievances, and appeals as well as CI processes within our Medicaid program, Humana's Compliance team organizes a monthly Medicaid Grievance and Appeals Compliance Subcommittee to ensure ongoing communication about Grievance and Appeal System-related issues across business units. Some of the topics the subcommittee cover include issue status, upcoming or recently implemented process changes, and recent internal and external audit results.

We address CAPs that are consistently in a non-compliant status as separate agenda items to give in-depth attention to the issues and assist in remediation. The subcommittee includes representation from all areas, so productive discussion helps drive the escalation, accountability, and resource allocation to move the issue along to successful completion.

Finally, as described above, Humana also uses IOPs, IAPs, QI Plans, and process improvement initiatives to tackle issues that do not require a CAP, and tracks their progress using similar and appropriate goals and deadlines. For example, if we identify an overarching departmental issue through a complaint, grievance, or appeal, Compliance associates handle it through their team IOP process.

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5. The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent's established complaint, grievance and appeal process.

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Enrollees have numerous ways of submitting complaints. No matter how Humana receives complaints (in person, by phone, in writing by the enrollee or the enrollee's authorized representative or through AHCA or a subcontractor) we ensure that we adequately and efficiently address every complaint, grievance, and appeal, and communicate related steps and

decisions to enrollees. Humana addresses, logs, tracks, and trends all complaints, regardless of the nature of the complaint or whether the enrollee expressly requests filing one.

For MMA enrollees, when we receive an oral complaint through Customer Care, we send it to the Oral Grievance Oversight (OGO) team, which assists Customer Care in maintaining its compliance with Federal and State regulations and guidelines for appropriately resolving enrollee oral complaints. The OGO team reviews all oral complaints either resolved during the call or still pending. The team also confirms that we addressed all issues if the CCS marked it as "complete," and works toward resolution of pending complaints if the CCS could not resolve the issue during the call. If we do not resolve the issue by the end of the next business day, the OGO team ensures that we recategorize the complaint as a grievance and transfer it to the Grievance and Appeals team for resolution.

When an LTC enrollee files an oral complaint through Customer Care, we send it to the Case Manager (CM). If the complaint happens to be about the enrollee's CM, we route it to the CM's Supervisor. If the Care Management team does not resolve the complaint by the close of business the next business day, they route the complaint to the Grievance and Appeals team for reclassification and resolution as a grievance.

Humana CCSs have access to Grievance and Appeal cases and resolution letters to efficiently support enrollees with questions or update requests. Subcontractors can also help enrollees initiate complaints, but only Humana handles research and resolution of grievance and appeal requests. This includes complaints reported to subcontractors that cannot be resolved by the end of the following business day of receipt of the complaint. Because Humana is responsible for all research and resolution, it is imperative that subcontractors report complaints and grievances in a timely manner. Subcontractors use a fax process to send complaints and grievances to Humana. Additionally, subcontractors submit expedited grievances via email to Humana. Humana partners with the subcontractor when we need more information to drive resolution. To ensure compliance, Humana has a monthly operational call with each subcontractor to discuss numerous topics, including the Grievances and Appeals System. If we identify and attribute a trend to the subcontractor, we convene an ad-hoc meeting to discuss and resolve the issues. Subcontractors train annually on Humana's submission process and on an ad-hoc basis to support subcontractors' new hires and Contract amendments.

We resolve complaints by the end of the following business day of receipt of the complaint, and date stamp and manually enter all requests received for complaints, grievances or appeals with the date received as well as the enrollee's name, Medicaid ID number, type of complaint, grievance or appeal, expedited status, disposition type, and the disposition date. We recategorize complaints that are not resolved by the end of following business day as grievances. The Grievance and Appeals Reporting team generates reports and forwards them to the Medicaid Compliance Reporting team, which submits the reports to AHCA as contractually required.

ENROLLEE COMPLAINTS RECEIVED FROM AHCA

Enrollees can submit complaints directly to AHCA, which AHCA then routes to the CI team. Humana ensures a timely response by using a separate fast-track process for AHCA requests. We log all AHCA inquiries in the same system used by the Grievance and Appeals department.

For reporting purposes, we integrate enrollee complaints and grievances from AHCA with other enrollee complaints and grievances, and include them in monthly and annual reports.

Led by the department manager, Humana's CI team consists of two (2) coordinators, five (5) analysts, a lead analyst, a consultant, and the Frontline Leader. We train the full team on AHCA's contractual requirements. Associates receive retraining when there are changes to processes and procedures or as needed based on audit results and Contract amendments.

The CI team follows the same contractual and best-known methods that the Grievance and Appeals department uses. CI works closely with AHCA as we address the complaint. We assign all complaints immediately to analysts on the team. In addition, CI personally guides each inquiry to resolution. For every AHCA inquiry, the CI analyst places a courtesy acknowledgment call to the enrollee. These calls assure enrollees that we are handling their inquiry and allows them to ask questions and provide any additional information. We give the CI analyst's direct phone number to the enrollee for any questions or concerns during the review process.

Upon receipt of the complaint, the CI analyst sends an acknowledgment to AHCA. The analyst, who can provide status updates to AHCA during the review process, researches the issue, engages the enrollee for additional information, determines the resolution, and oversees the implementation of the resolution, including claim adjudication, if applicable. The CI team ensures a timely response to AHCA through daily monitoring of the status of research and resolution, working with other subject matter experts across Humana to address and resolve issues. The analyst notifies both AHCA and the enrollee of the resolution. In addition to required written resolution letters, we also place a courtesy resolution call to the enrollee. This is an opportunity to ensure satisfaction and answer any enrollee questions.

AHCA assigns a severity level to each complaint. The CI analyst provides an update status to AHCA based on severity level due dates of "High" (close of the next business day), "Medium" (close of the third business day), and "Low" (close of the fifth business day). For the month of August 2017, the CI team had a total of seventy-eight (78) complaints. Of those, eleven (11) were "High" severity, seven (7) were "Medium" severity, and sixty (60) were "Low" severity. We completed one hundred percent (100%) of these complaints in a timely manner. If we do not resolve a complaint by the end of the business day after receipt, then we transition the complaint to the grievance process, and send a grievance acknowledgment letter by the fifth business day after receipt. Since these grievances are worked within AHCA severity level due dates, we complete all of them within the ninety (90) days allowed for grievances.

Tracked in CRM, the Manager, Frontline Leader and Production Lead of each team can access and pull reports of inquiries at any time of their inventory. These reports can include specific elements such as open inventory arranged by nature of case, due date, enrollee's name, Medicaid ID number, case type, and expedited status. In addition to the reports, the Grievance and Appeal and CI leadership also uses SPLUNK Inventory Manager, which is a real-time inventory management tool. This tool allows leadership to pull real-time data, which can include the number of cases that are pending with the Letter Review team, have an acknowledgement due, have a status due, or are pending for a resolution. Attachment 12-3, visuals 4a, 4b, and 4c are a point-in-time view sample of the information that SPLUNK displays for leadership.

Metrics are tracked through ESP on a monthly basis. Once the metrics are entered by the individual business owners, the Medicaid Compliance Reporting (MCR) team combines the data into appropriate AHCA report template and submits to the state.

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6. The extent to which the respondent's grievance and appeal system data resulted in operational improvements of the respondent.

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Humana's ongoing analysis of the Grievance and Appeals System data helps identify both market-specific and corporate-level operational improvements, detailing which points of service to enhance to improve the enrollee experience.

In the last year, Humana has identified and implemented several operational improvements in response to Grievances and Appeals data trends that helped to expose processes requiring adjustments. One of those improvements was via collaboration between Customer Care and the OGO team to significantly enhance the system and process for routing verbal complaints and grievances to the Grievance and Appeals team for our MMA enrollees. Previously, the routing process was manual and time-consuming, leading to potential delays in complaint resolution.

We implemented specific improvements in stages beginning in November 2016. One (1) month later, the OGO developed reporting mechanisms to capture data on all grievances regardless of the method through which we first collected the grievance. After some time using these improvements, Humana realized that we could do even more to improve call routing. In April 2017 we implemented automated mechanisms to correctly route and queue Florida Medicaid complaints directly to the OGO. Shortly thereafter, Humana committed resources to review routing of Florida Medicaid verbal complaints, resulting in higher complaint resolution, reducing the number of grievances for our MMA enrollees, and reducing the timeframe for resolution of the enrollee's issue(s). Pending improvements for verbal complaints will support improved documentation and resolution. Thanks to these targeted improvements, the current process is more efficient, helps Humana comply with acknowledgement timeframes, increases complaint resolution, and has significantly less room for error. Since complaint resolution increased, the number of complaints reclassified as grievances decreased, and enrollees received their resolution in a more timely manner.

We made additional improvements in 2016 and 2017 to ensure we properly manage grievances and appeals:

- Previously, we routed Medicaid inquiries to a joint team that had Medicare and Medicaid inventory. In 2016, we implemented a system enhancement to route all Medicaid grievance and appeal mail directly to the Medicaid Grievance and Appeals team, eliminating potential delays in handling of case upon receipt.

- In 2016 the Grievance and Appeals team developed a process to communicate to the enrollee's assigned Case Manager (CM) when we receive a complaint, grievance, or appeal that would impact the enrollee's access to care or where they need service arrangement, closing potential communication gaps between associates. If the enrollee does not have an assigned CM but needs assistance, the CM team reaches out to the enrollee and assigns a CM to assist.

- Similarly, we developed a new process for CMs to assign grievances or appeals to the Grievance and Appeals team directly via Clinical Guidance eXchange (CGX), Humana's system that houses enrollee medical pre-authorization data. This enables the CM to better assist the enrollee in filing a grievance or appeal during outreach.

- The Medicaid Grievance and Appeals team currently uses a Letter Review team to ensure accuracy prior to mailing the resolution letter. In addition to the second layer of review, this process allows Humana to track resolution letters we send to the enrollee or authorized representative. The Letter Review team supports all of Humana's work and is one of many processes that demonstrate the capacity and best practices that Humana leverages for Medicaid.

- In the last year, we have used grievance and appeal data to create a better experience for both MMA and LTC enrollees. For MMA enrollees, in the third quarter of 2016, the Grievance and Appeals department reported an increase in pharmacy appeals because of not meeting formulary exceptions and clinical criteria. An internal audit with our Pharmacy department revealed opportunities for improved alignment on medication reviews. As a result of this analysis, the overturn percentage of appeals is currently twenty-three percent (23%) lower than in August 2016, which reduces enrollee appeal resolution turnaround time. To support ongoing alignment and mitigate future issues, the Grievance and Appeals department continues to work with the Pharmacy department, reviewing prescription orders as soon as they are submitted.

- In working with our transportation subcontractor for our LTC enrollees, we identified a need for additional drivers to fulfill the trip requests submitted. The shortage of drivers resulted in missed and late pick-ups, which in turn led to an increase in complaints and grievances. The subcontractor increased its associates to meet this need, and related complaints and grievances decreased.

Humana takes all our Medicaid Fair Hearings very seriously. Since 2015 Grievance and Appeals added an additional step in the Medicaid Fair Hearing procedure, where a Medical Director performs a courtesy review of all Medicaid Fair Hearings. The additional step in the process ensures the initial decision provided by the Grievance and Appeals department was accurate and verifies that any additional information provided for the hearing does not change the outcome of the case

In September 2016, the Grievance and Appeal team identified an opportunity to add additional quality oversight of our Medicaid Fair Hearings by implementing an internal auditing process, which audits one hundred percent (100%) of the cases. The National Quality Auditors (NQA) perform these audits on all Medicaid Fair Hearing cases to verify we process each case according to the policies and procedures put in place to ensure contractual compliance. We provide results of the audits to the Frontline Leader and the Medicaid Fair Hearing associate weekly. In addition to this quality control, Humana also added additional internal compliance metrics to monitor adherence to the Contract requirements, including changes that may occur through a Contract Amendment. SPLUNK monitors the compliance of Medicaid Fair Hearing cases in real-time. We also capture and monitor them daily in a dashboard.

In August 2017, Humana initiated its Member 360 Committee to systematically improve the enrollee experience including the complaint, grievance, and appeal process. This Committee

provides a forum for review of enrollee-related metrics, root cause analysis, process improvement opportunities and escalation of enrollee concerns. Composed of Florida market leadership and Humana functional areas, the Committee meets monthly to review all metrics applicable to enrollees, such as grievance and appeals data, Customer Care call trends, Care Coordination reports, and web and mobile application usage reports, to conduct root cause analysis and identify process improvement opportunities. Monthly metrics and root cause analysis of what drives enrollees to file a complaint, grievance, or appeal will be critical to measure success. The sole objective of the Committee is for Humana to better understand concerns from enrollees and look for opportunities to improve their experience.

These examples demonstrate how internal and external collaboration allows Humana to ensure a positive enrollee experience. By using data to inform improvements, we can more easily identify barriers. Understanding the structure of internal areas also helps create efficiencies within our processes to further reduce resolution times. These improvements make Humana's Grievance and Appeals System stronger and consistently compliant with both AHCA's requirements and with the high expectations of Humana's enrollee-centered approach.

Evaluation Criteria:

1. The extent to which the respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages.

2. The extent to which the respondent's timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements.

3. The extent to which the respondent's complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.

4. The extent to which the respondent's complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.

5. The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent's established complaint, grievance and appeal process.

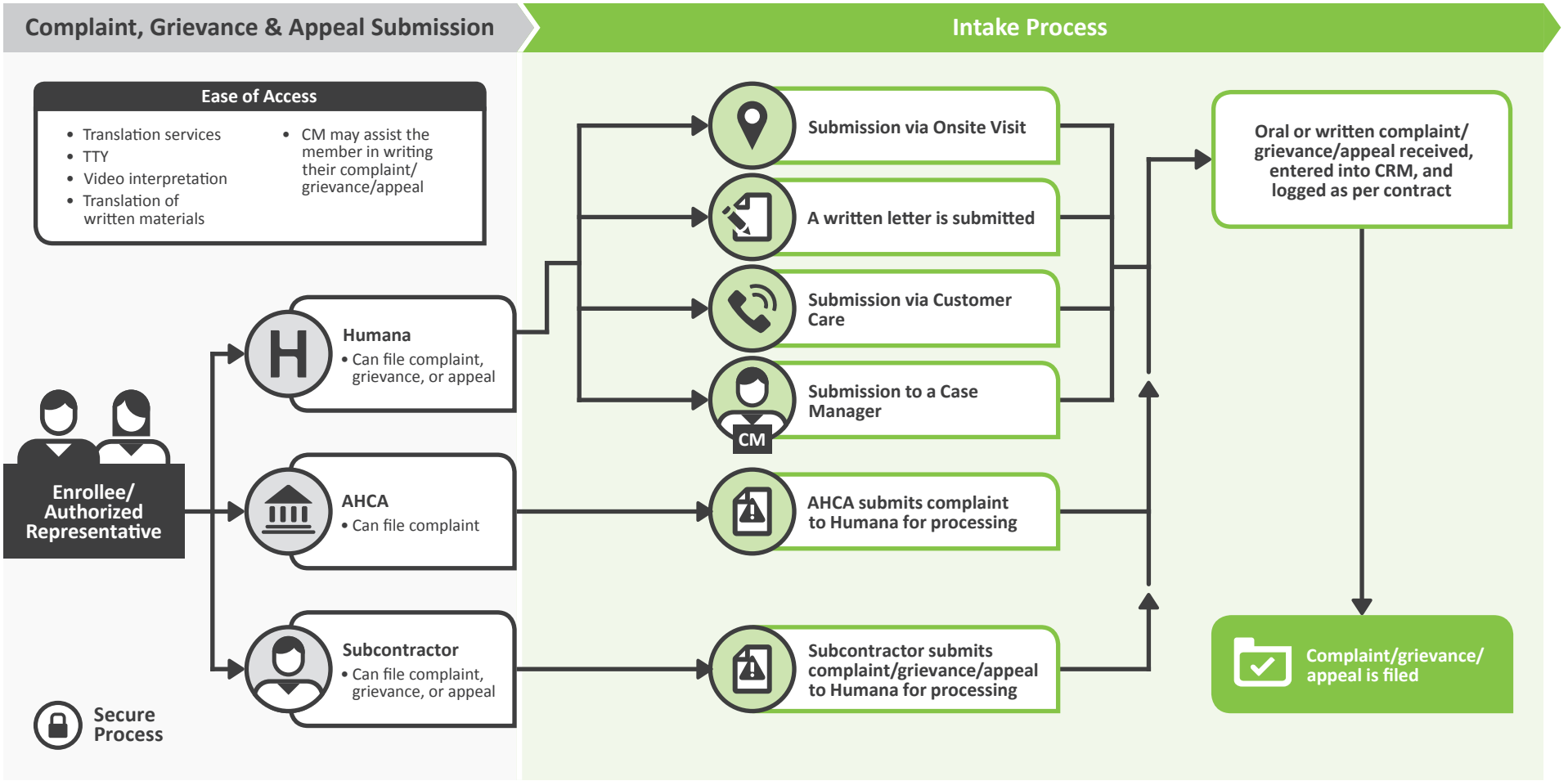
6. The extent to which the respondent's grievance and appeal system data resulted in operational improvements of the respondent.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Attachment 12-1: Enrollee Grievance & Appeal System

Enrollee Complaint, Grievance & Appeals Submission Process

CM = Case Manager
AOR = Appointment of Representative
G&A = Grievance and Appeal
TTY = Teletype
CI = Critical Inquiry
CRM = Customer Relationship Management



Attachment 12-1: Enrollee Grievance & Appeal System

Enrollee Complaint & Grievance Process

CM = Case Manager
AOR = Appointment of Representative
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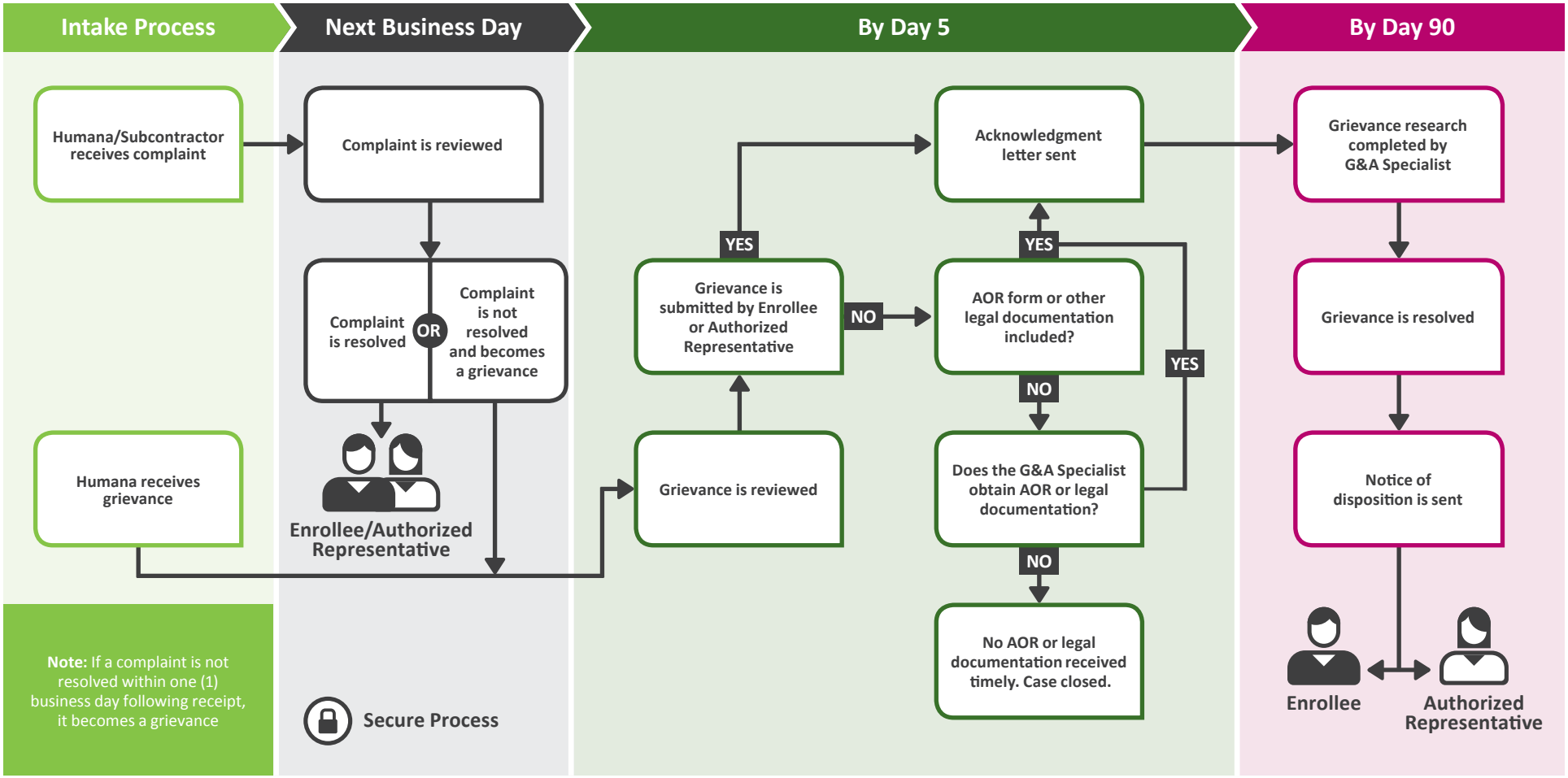
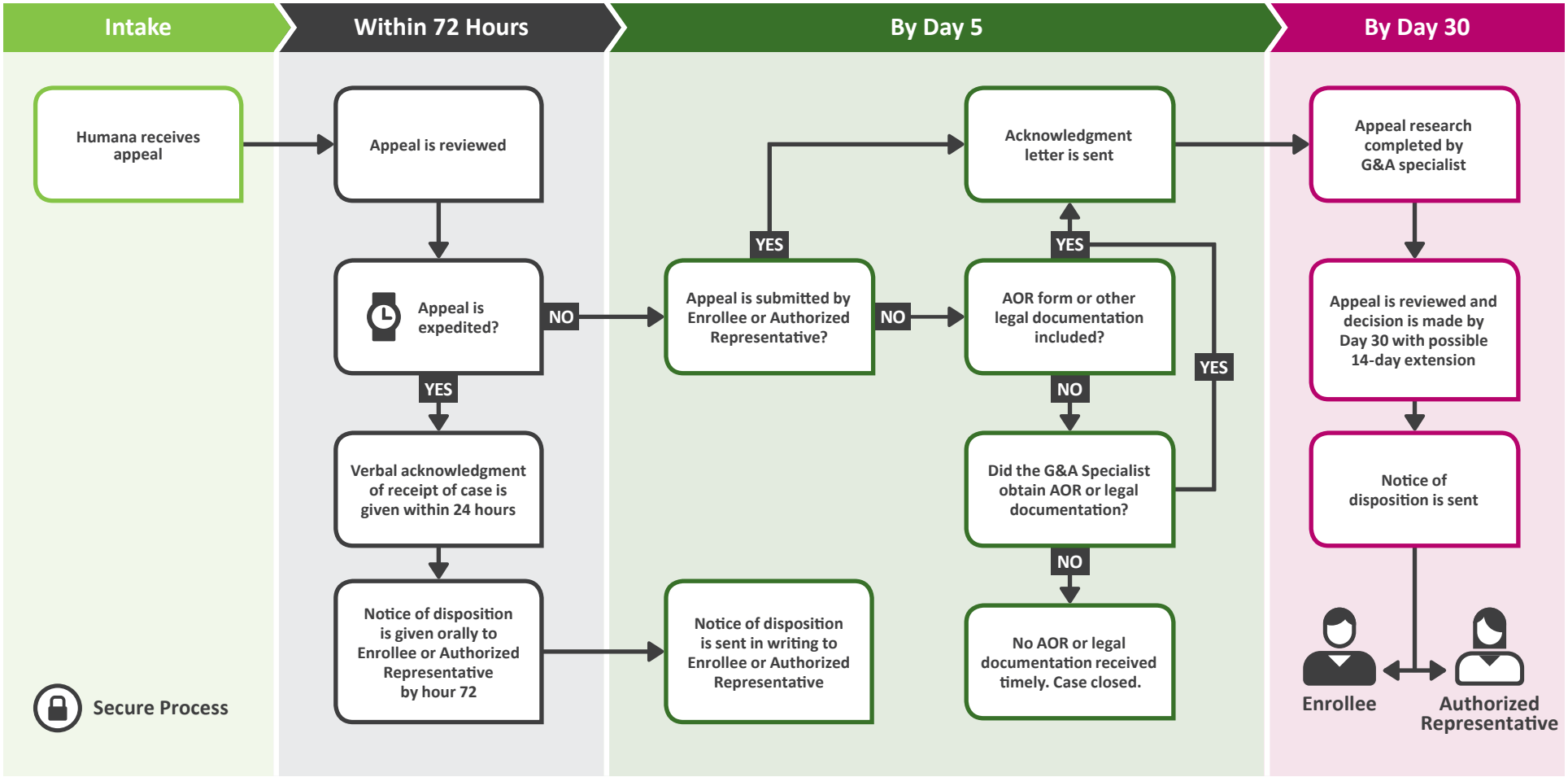


Attachment 12-1: Enrollee Grievance & Appeal System

Enrollee Appeals Process

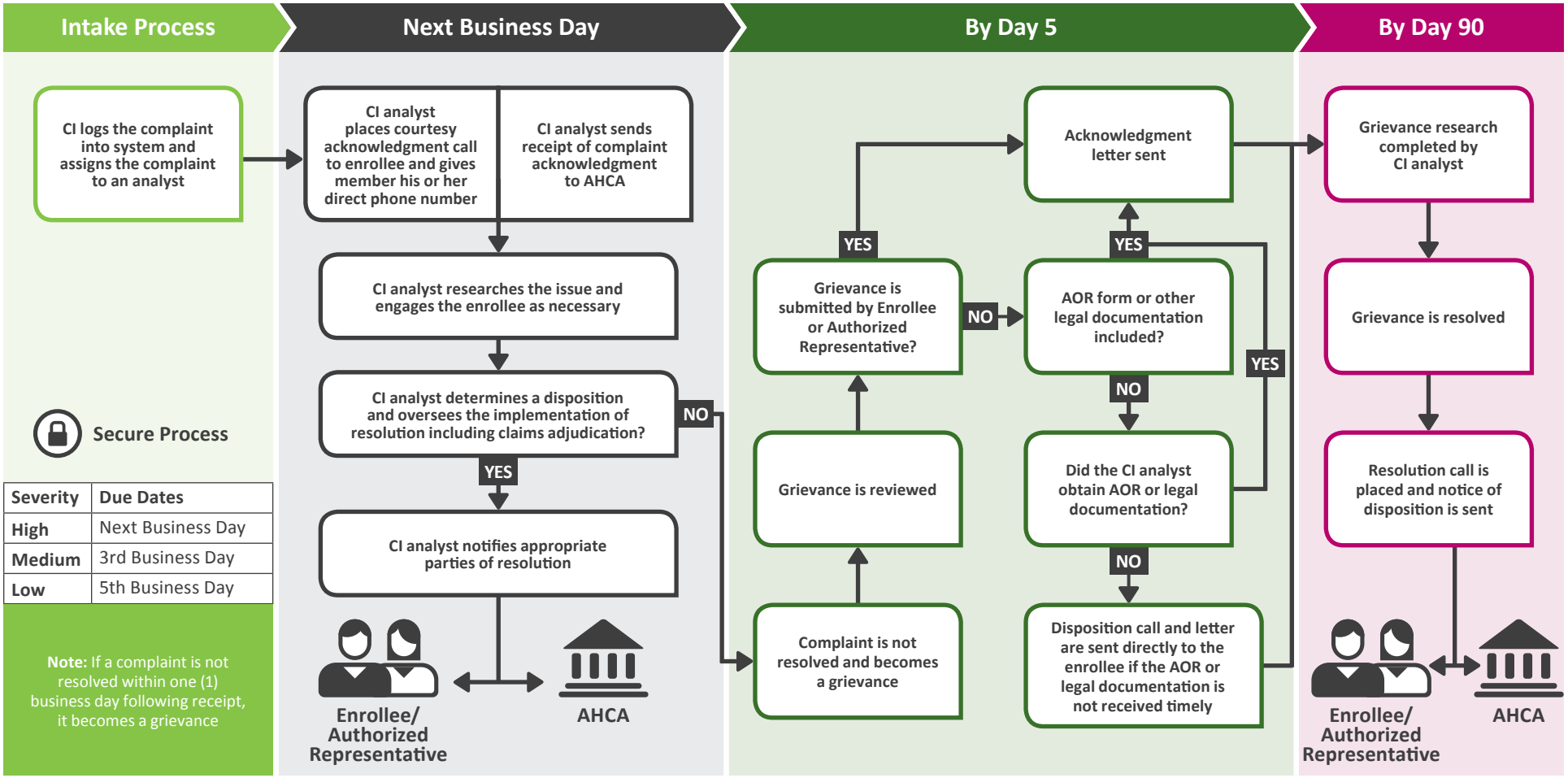
CM = Case Manager
AOR = Appointment of Representative
G&A = Grievance and Appeal
TTY = Teletype
CI = Critical Inquiry
CRM = Customer Relationship Management



Attachment 12-1: Enrollee Grievance & Appeal System

AHCA Enrollee Complaint Process

CM = Case Manager
AOR = Appointment of Representative
G&A = Grievance and Appeal
TTY = Teletype
CI = Critical Inquiry
CRM = Customer Relationship Management

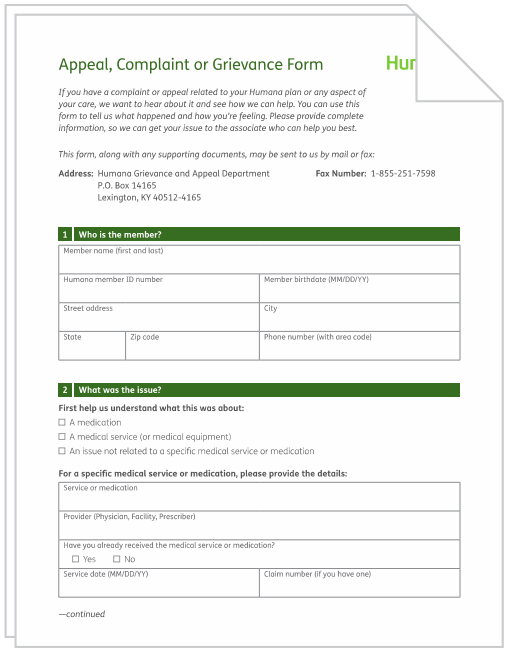


Attachment 12-2: Structured Submission and Status Tracker

For intake, we are enabling Structured Submissions for enrollees across all channels and giving visibility through a status tracker

STRUCTURED SUBMISSIONS

PRINT



Appeal, Complaint or Grievance Form

Hur

If you have a complaint or appeal related to your Humana plan or any aspect of your care, we want to hear about it and see how we can help. You can use this form to tell us what happened and how you're feeling. Please provide complete information, so we can get your issue to the associate who can help you best.

This form, along with any supporting documents, may be sent to us by mail or fax:

Address: Humana Grievance and Appeal Department
P.O. Box 14165
Lexington, KY 40512-4165

Fax Number: 1-855-251-7598

1 Who is the member?

Member name (first and last)

Humana member ID number | Member birthdate (MM/DD/YY)

Street address | City

State | Zip code | Phone number (with area code)

2 What was the issue?

First help us understand what this was about:

☐ A medication
☐ A medical service (or medical equipment)
☐ An issue not related to a specific medical service or medication

For a specific medical service or medication, please provide the details:

Service or medication

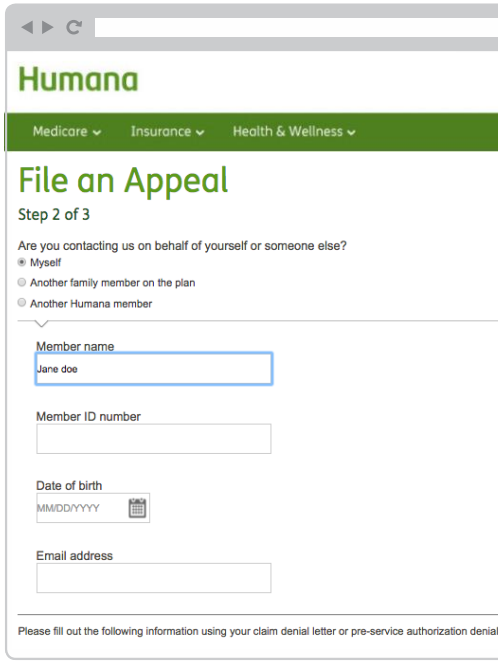
Provider (Physician, Facility, Prescriber)

Have you already received the medical service or medication?
☐ Yes ☐ No

Service date (MM/DD/YY) | Claim number (if you have one)

—continued

DIGITAL



Humana

Medicare ⌄ Insurance ⌄ Health & Wellness ⌄

File an Appeal

Step 2 of 3

Are you contacting us on behalf of yourself or someone else?

- Myself
- Another family member on the plan
- Another Humana member

Member name

Jane doe

Member ID number

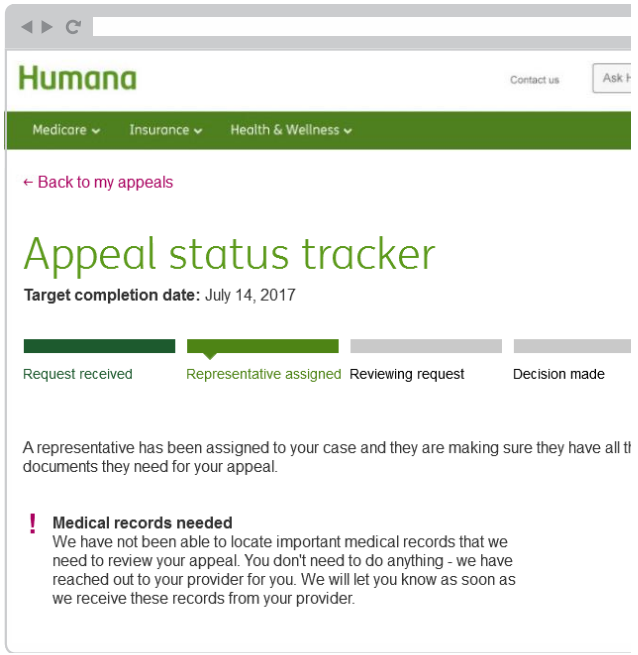
Date of birth

MM/DD/YYYY

Email address

Please fill out the following information using your claim denial letter or pre-service authorization denial

STATUS TRACKER



Humana

Contact us

Medicare ⌄ Insurance ⌄ Health & Wellness ⌄

← Back to my appeals

Appeal status tracker

Target completion date: July 14, 2017

Request received | Representative assigned | Reviewing request | Decision made

A representative has been assigned to your case and they are making sure they have all th documents they need for your appeal.

! **Medical records needed**
We have not been able to locate important medical records that we need to review your appeal. You don't need to do anything - we have reached out to your provider for you. We will let you know as soon as we receive these records from your provider.

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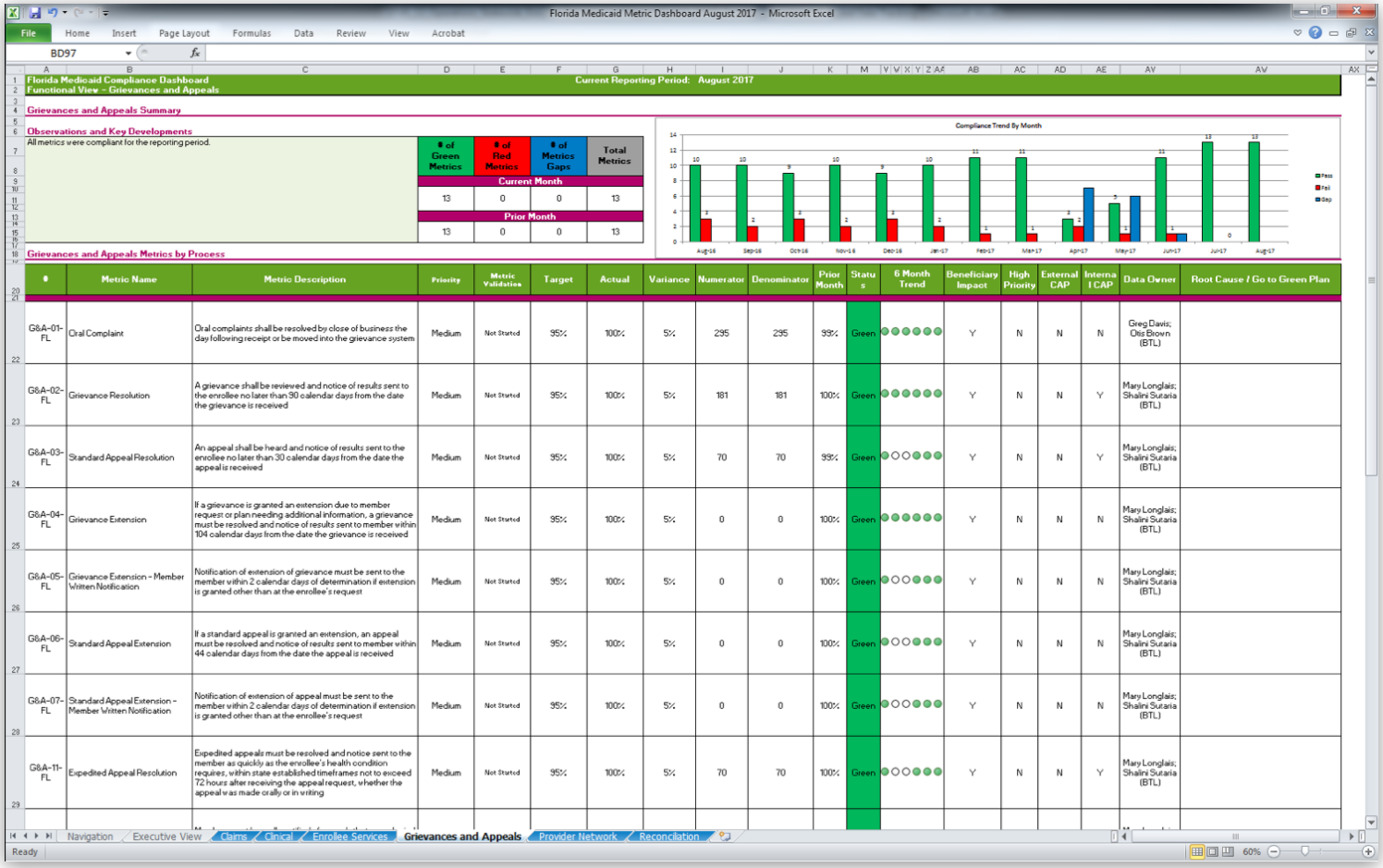
Attachment 12-3: Enrollee Grievance and Appeals Data Tracking

Visual 1a:

Humana Florida Managed Medical Assistance (MMA) Compliance Dashboard (monthly): Excerpt of August 2017 Grievances and Appeals Summary



Florida Medicaid Metric Dashboard August 2017 - Microsoft Excel

Florida Medicaid Compliance Dashboard
Functional View – Grievances and Appeals

Current Reporting Period: August 2017

Grievances and Appeals Summary

Observations and Key Developments

All metrics were compliant for the reporting period.

	# of Green Metrics	# of Red Metrics	# of Metrics Gaps	Total Metrics
Current Month	13	0	0	13
Prior Month	13	0	0	13

Compliance Trend By Month

Grievances and Appeals Metrics by Process

#	Metric Name	Metric Description	Priority	Metric Validation	Target	Actual	Variance	Numerator	Denominator	Prior Month	Status	6 Month Trend	Beneficiary Impact	High Priority	External CAP	Internal CAP	Data Owner	Root Cause / Go to Green Plan
G&A-01-FL	Oral Complaint	Oral complaints shall be resolved by close of business the day following receipt or be moved into the grievance system	Medium	Not Started	95%	100%	5%	295	295	99%	Green		Y	N	N	N	Greg Davis; Otis Brown (BTL)	
G&A-02-FL	Grievance Resolution	A grievance shall be reviewed and notice of results sent to the enrollee no later than 30 calendar days from the date the grievance is received	Medium	Not Started	95%	100%	5%	181	181	100%	Green		Y	N	N	Y	Mary Longlais; Shalini Sutaria (BTL)	
G&A-03-FL	Standard Appeal Resolution	An appeal shall be heard and notice of results sent to the enrollee no later than 30 calendar days from the date the appeal is received	Medium	Not Started	95%	100%	5%	70	70	99%	Green		Y	N	N	Y	Mary Longlais; Shalini Sutaria (BTL)	
G&A-04-FL	Grievance Extension	If a grievance is granted an extension due to member request or plan needing additional information, a grievance must be resolved and notice of results sent to member within 104 calendar days from the date the grievance is received	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	N	Mary Longlais; Shalini Sutaria (BTL)	
G&A-05-FL	Grievance Extension – Member Written Notification	Notification of extension of grievance must be sent to the member within 2 calendar days of determination if extension is granted other than at the enrollee's request	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	N	Mary Longlais; Shalini Sutaria (BTL)	
G&A-06-FL	Standard Appeal Extension	If a standard appeal is granted an extension, an appeal must be resolved and notice of results sent to member within 44 calendar days from the date the appeal is received	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	N	Mary Longlais; Shalini Sutaria (BTL)	
G&A-07-FL	Standard Appeal Extension – Member Written Notification	Notification of extension of appeal must be sent to the member within 2 calendar days of determination if extension is granted other than at the enrollee's request	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	N	Mary Longlais; Shalini Sutaria (BTL)	
G&A-11-FL	Expedited Appeal Resolution	Expedited appeals must be resolved and notice sent to the member as quickly as the enrollee's health condition requires, within state established timeframes not to exceed 72 hours after receiving the appeal request, whether the appeal was made orally or in writing	Medium	Not Started	95%	100%	5%	70	70	100%	Green		Y	N	N	Y	Mary Longlais; Shalini Sutaria (BTL)	

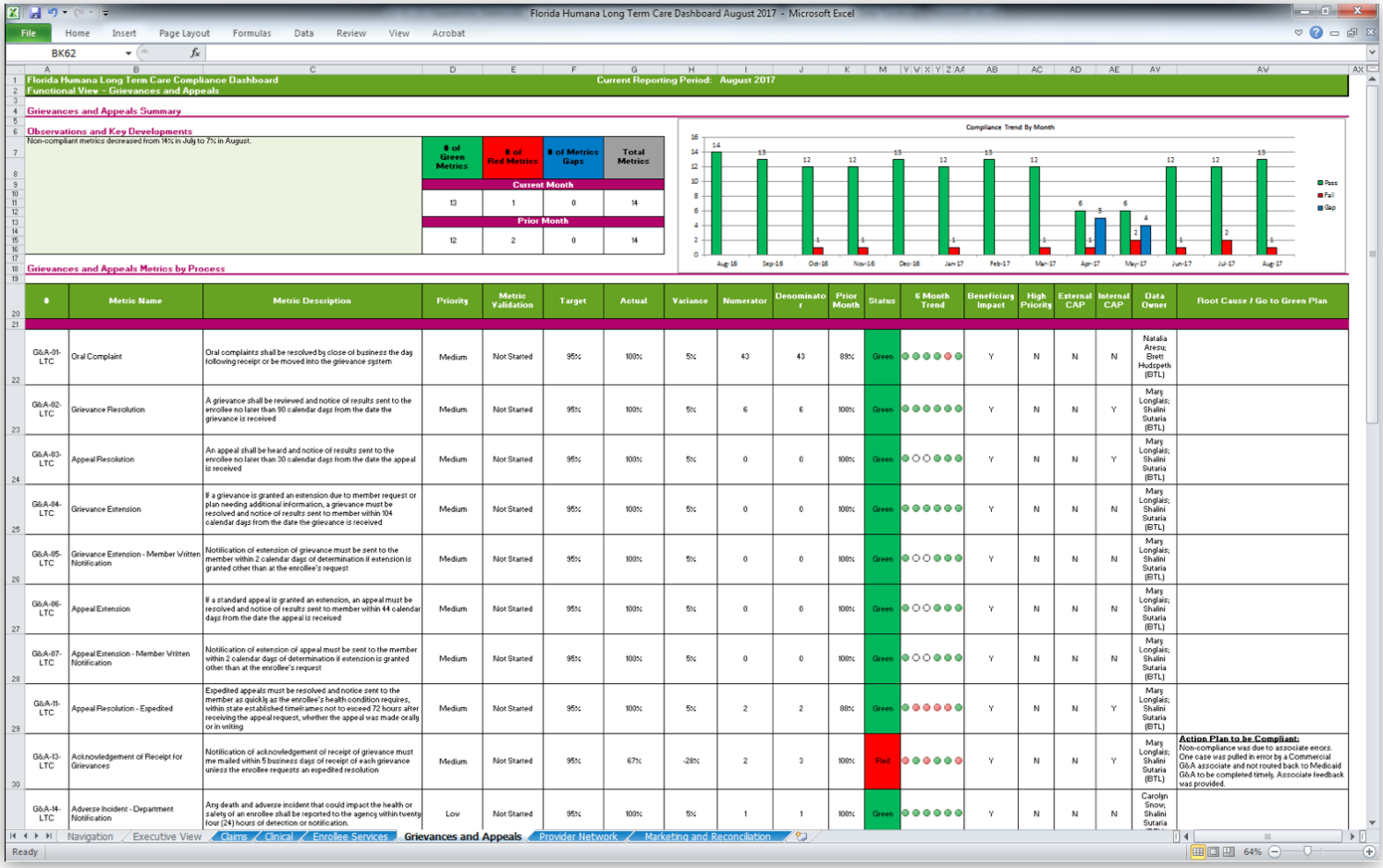
Navigation | Executive View | Claims | Clinical | Enrollee Services | Grievances and Appeals | Provider Network | Reconciliation

Ready

Attachment 12-3: Enrollee Grievance and Appeals Data Tracking

Visual 1b:

Humana Florida Long-term Care Compliance Dashboard (monthly): Excerpt of August 2017 Grievances and Appeals Summary



Florida Humana Long Term Care Dashboard August 2017 - Microsoft Excel

Florida Humana Long Term Care Compliance Dashboard
Functional View – Grievances and Appeals
Current Reporting Period: August 2017

Grievances and Appeals Summary

Observations and Key Developments

Non-compliant metrics decreased from 14% in July to 7% in August.

	# of Green Metrics	# of Red Metrics	# of Metrics Gaps	Total Metrics
Current Month	13	1	0	14
Prior Month	12	2	0	14

Compliance Trend By Month

Grievances and Appeals Metrics by Process

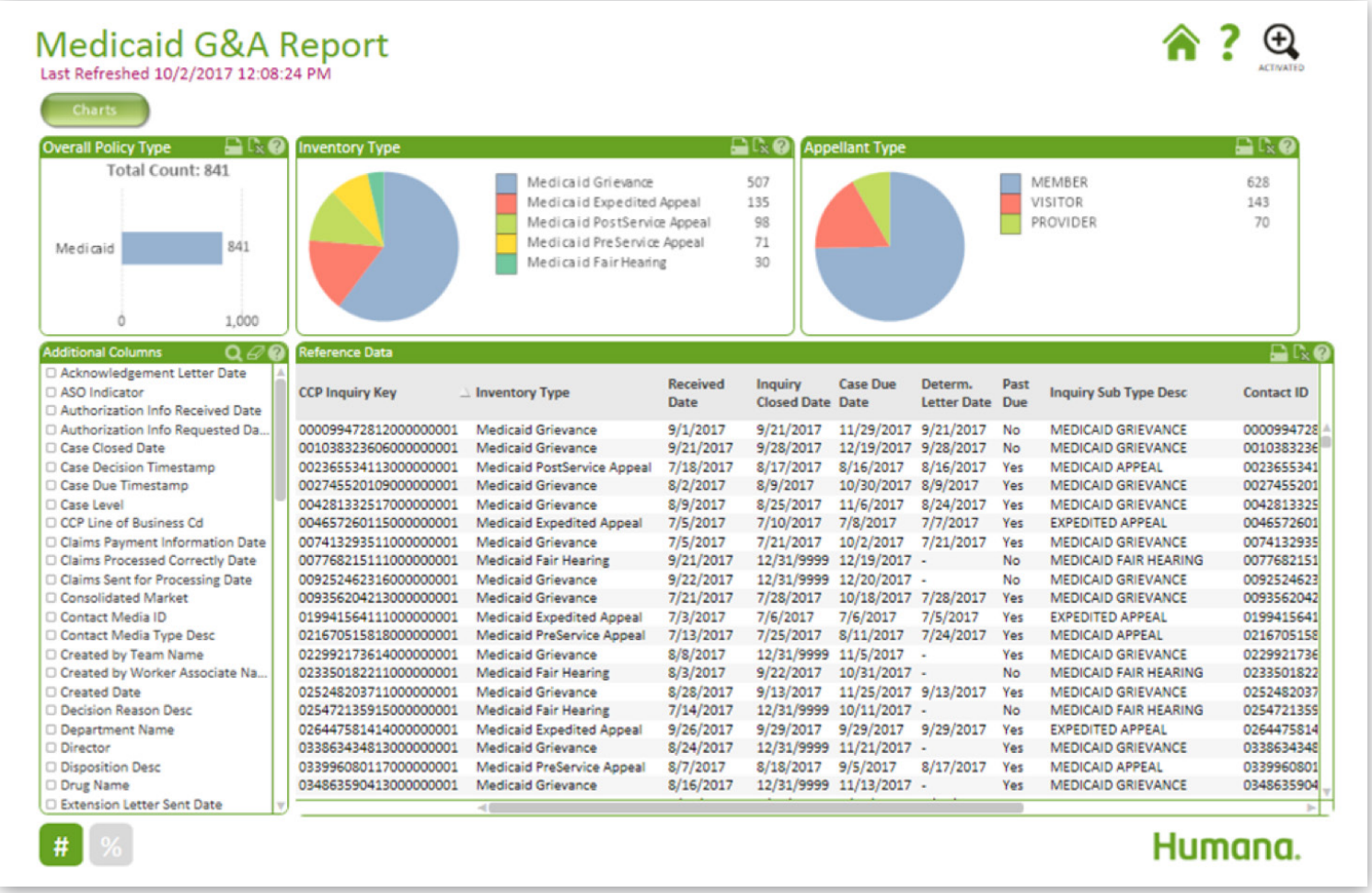
#	Metric Name	Metric Description	Priority	Metric Validation	Target	Actual	Variance	Numerator	Denominator	Prior Month	Status	6 Month Trend	Beneficiary Impact	High Priority	External CAP	Internal CAP	Data Owner	Root Cause / Go to Green Plan
G&A-01-LTC	Oral Complaint	Oral complaints shall be resolved by close of business the day following receipt or be moved into the grievance system	Medium	Not Started	95%	100%	5%	43	43	88%	Green		Y	N	N	N	Natalia Aresu; Brett Hudspeth (BTL)	
G&A-02-LTC	Grievance Resolution	A grievance shall be reviewed and notice of results sent to the enrollee no later than 90 calendar days from the date the grievance is received	Medium	Not Started	95%	100%	5%	6	6	100%	Green		Y	N	N	Y	Mary Longlais; Shalini Sutaria (BTL)	
G&A-03-LTC	Appeal Resolution	An appeal shall be heard and notice of results sent to the enrollee no later than 30 calendar days from the date the appeal is received	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	Y	Mary Longlais; Shalini Sutaria (BTL)	
G&A-04-LTC	Grievance Extension	If a grievance is granted an extension due to member request or plan needing additional information, a grievance must be resolved and notice of results sent to member within 104 calendar days from the date the grievance is received	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	N	Mary Longlais; Shalini Sutaria (BTL)	
G&A-05-LTC	Grievance Extension - Member Written Notification	Notification of extension of grievance must be sent to the member within 2 calendar days of determination if extension is granted other than at the enrollee's request	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	N	Mary Longlais; Shalini Sutaria (BTL)	
G&A-06-LTC	Appeal Extension	If a standard appeal is granted an extension, an appeal must be resolved and notice of results sent to member within 44 calendar days from the date the appeal is received	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	N	Mary Longlais; Shalini Sutaria (BTL)	
G&A-07-LTC	Appeal Extension - Member Written Notification	Notification of extension of appeal must be sent to the member within 2 calendar days of determination if extension is granted other than at the enrollee's request	Medium	Not Started	95%	100%	5%	0	0	100%	Green		Y	N	N	N	Mary Longlais; Shalini Sutaria (BTL)	
G&A-11-LTC	Appeal Resolution - Expedited	Expedited appeals must be resolved and notice sent to the member as quickly as the enrollee's health condition requires, within state established timeframes not to exceed 72 hours after receiving the appeal request, whether the appeal was made orally or in writing	Medium	Not Started	95%	100%	5%	2	2	80%	Green		Y	N	N	Y	Mary Longlais; Shalini Sutaria (BTL)	
G&A-13-LTC	Acknowledgement of Receipt for Grievances	Notification of acknowledgement of receipt of grievance must me mailed within 5 business days of receipt of each grievance unless the enrollee requests an expedited resolution	Medium	Not Started	95%	67%	-28%	2	3	100%	Red		Y	N	N	Y	Mary Longlais; Shalini Sutaria (BTL)	**Action Plan to be Compliant:** Non-compliance was due to associate errors. One case was pulled in error by a Commercial G&A associate and not routed back to Medicaid G&A to be completed timely. Associate feedback was provided.
G&A-14-LTC	Adverse Incident - Department Notification	Any death and adverse incident that could impact the health or safety of an enrollee shall be reported to the agency within twenty four (24) hours of detection or notification.	Low	Not Started	95%	100%	5%	1	1	100%	Green		Y	N	N	N	Carolyn Snow; Shalini Sutaria	

Navigation | Executive View | Claims | Clinical | Enrollee Services | Grievances and Appeals | Provider Network | Marketing and Reconciliation

Ready

Visual 2:

Humana Medicaid Grievance and Appeals Report (point-in-time view)

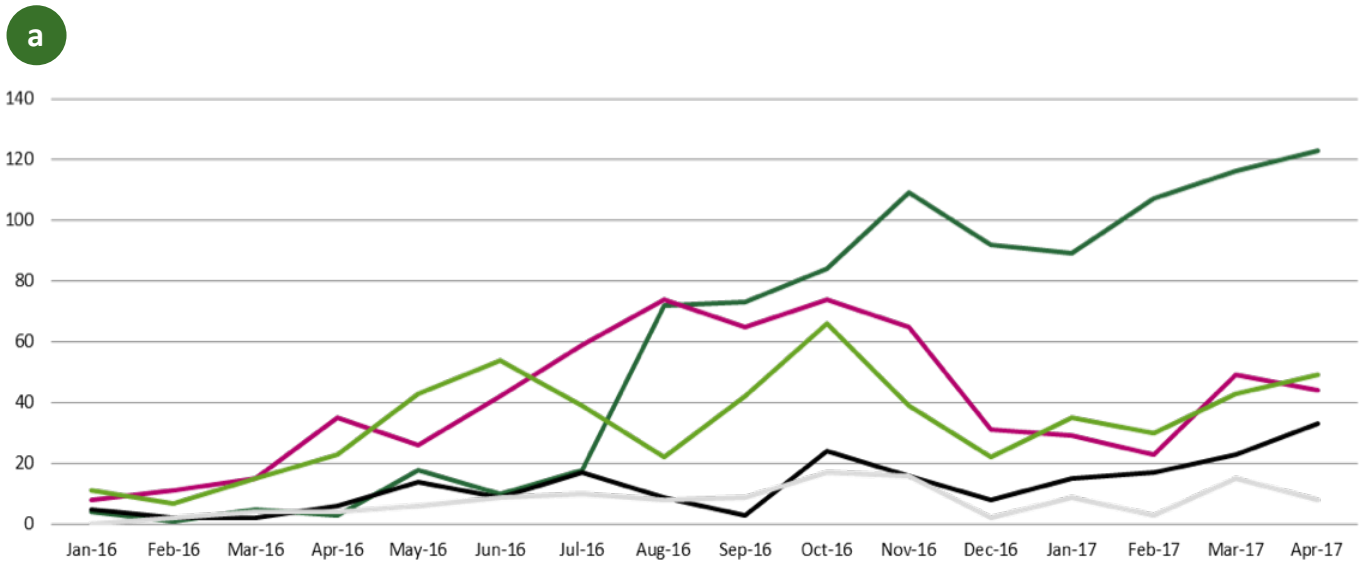


Attachment 12-3: Enrollee Grievance and Appeals Data Tracking

Visual 3:

Top 5 (5) Medicaid Grievances
and Top 5 Medicaid Appeals

a. Top Five (5) Medicaid Grievance Reasons (January 2016 – April 2017)



b. Top Five (5) Florida Medicaid Appeals (January 2016 – April 2017)

b

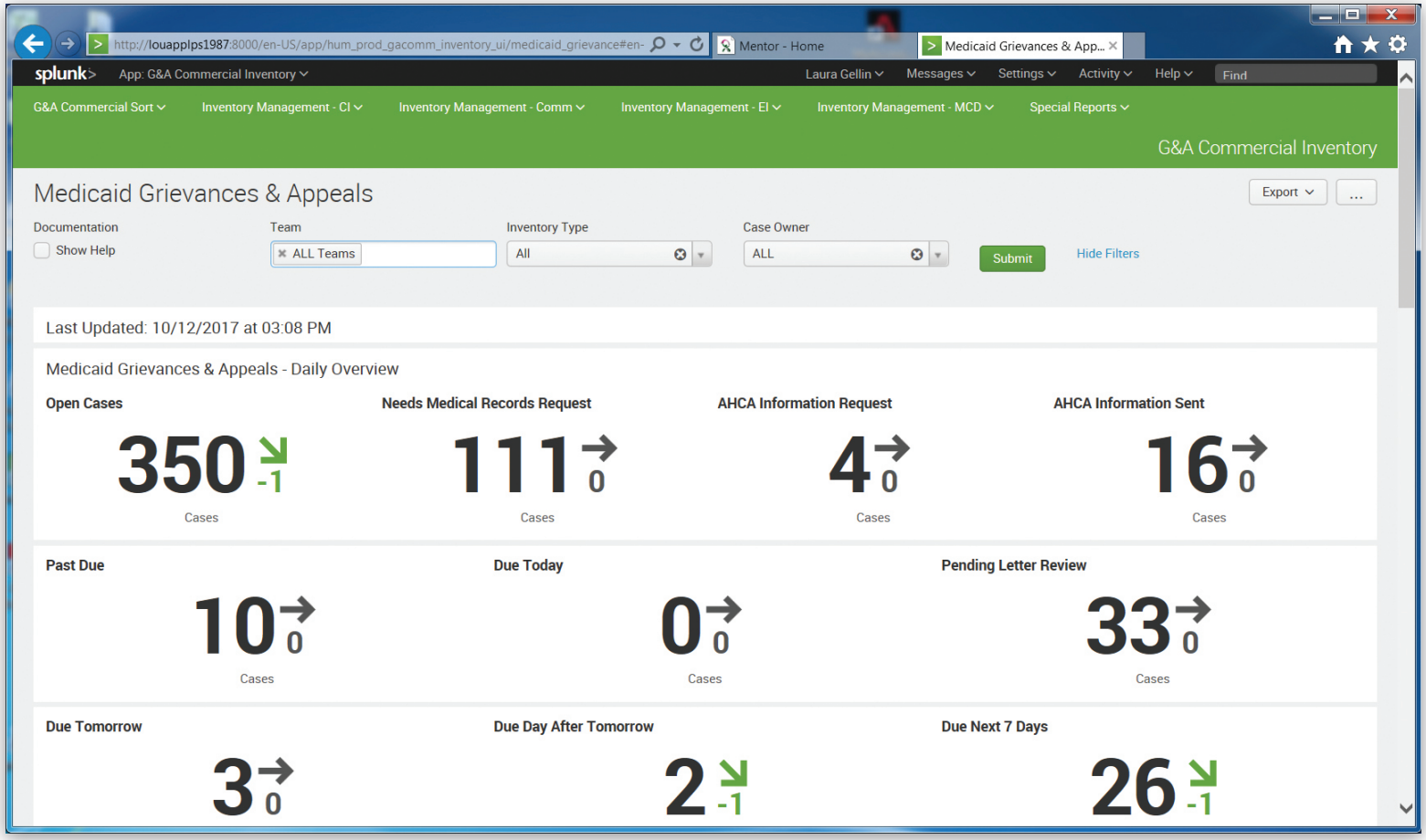
	Reason Code	Volume	Inventory Percentage
1	Medical Necessity - RX	589	30.81%
2	Medical Necessity - Medical	363	18.99%
3	Limitations and Exclusion	213	11.14%
4	Non-formulary dispute/exception	208	10.88%
5	Services are not payable without Referral	110	5.75%

Humana.

Attachment 12-3: Enrollee Grievance and Appeals Data Tracking

Visual 4a:

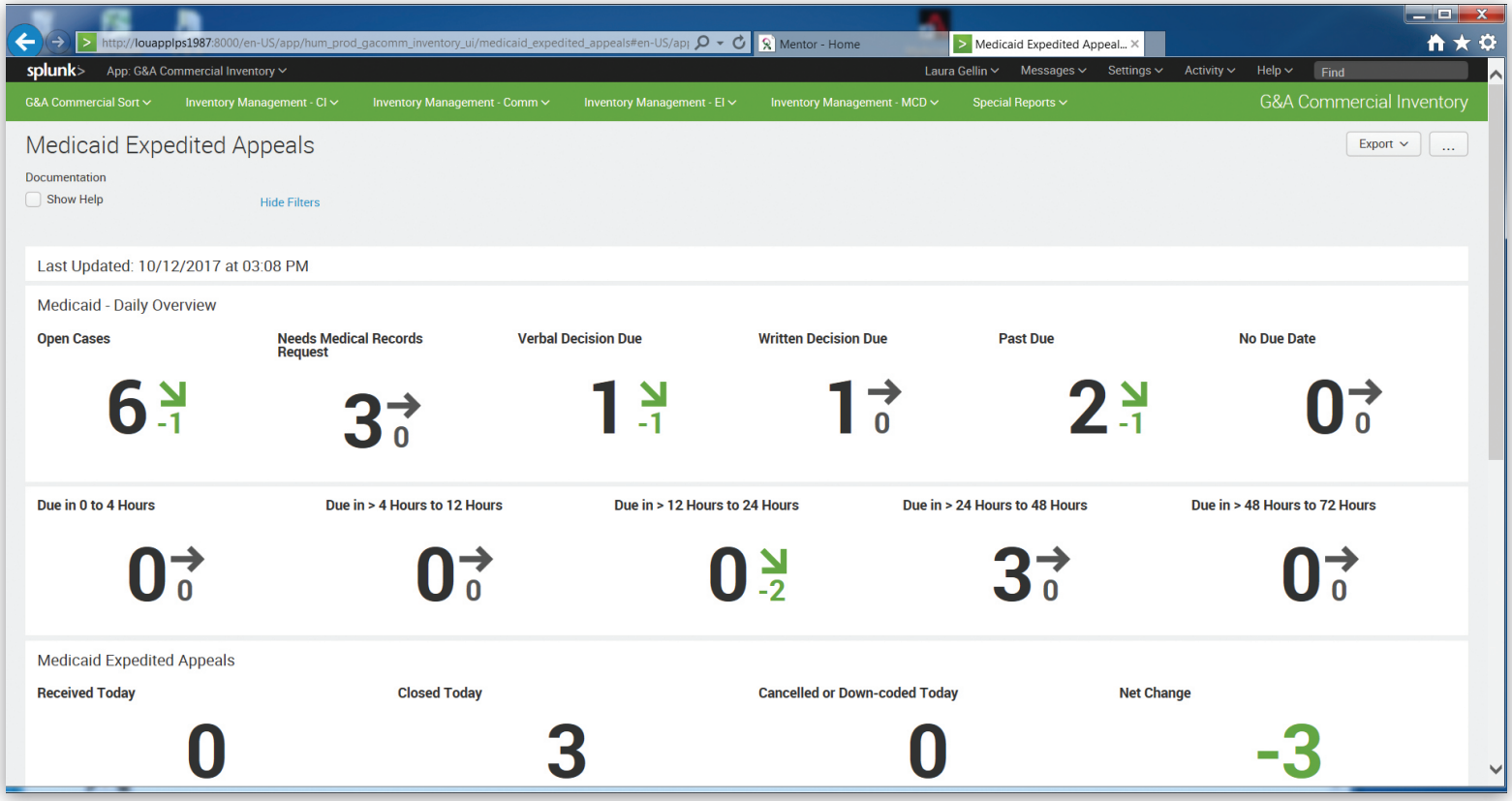
SPLUNK, Inventory Manager, a real time inventory management tool



Attachment 12-3: Enrollee Grievance and Appeals Data Tracking

Visual 4b:

SPLUNK, Inventory Manager, a real time inventory management tool



Attachment 12-3: Enrollee Grievance and Appeals Data Tracking

Visual 4c:

SPLUNK, Inventory Manager, a real time inventory management tool

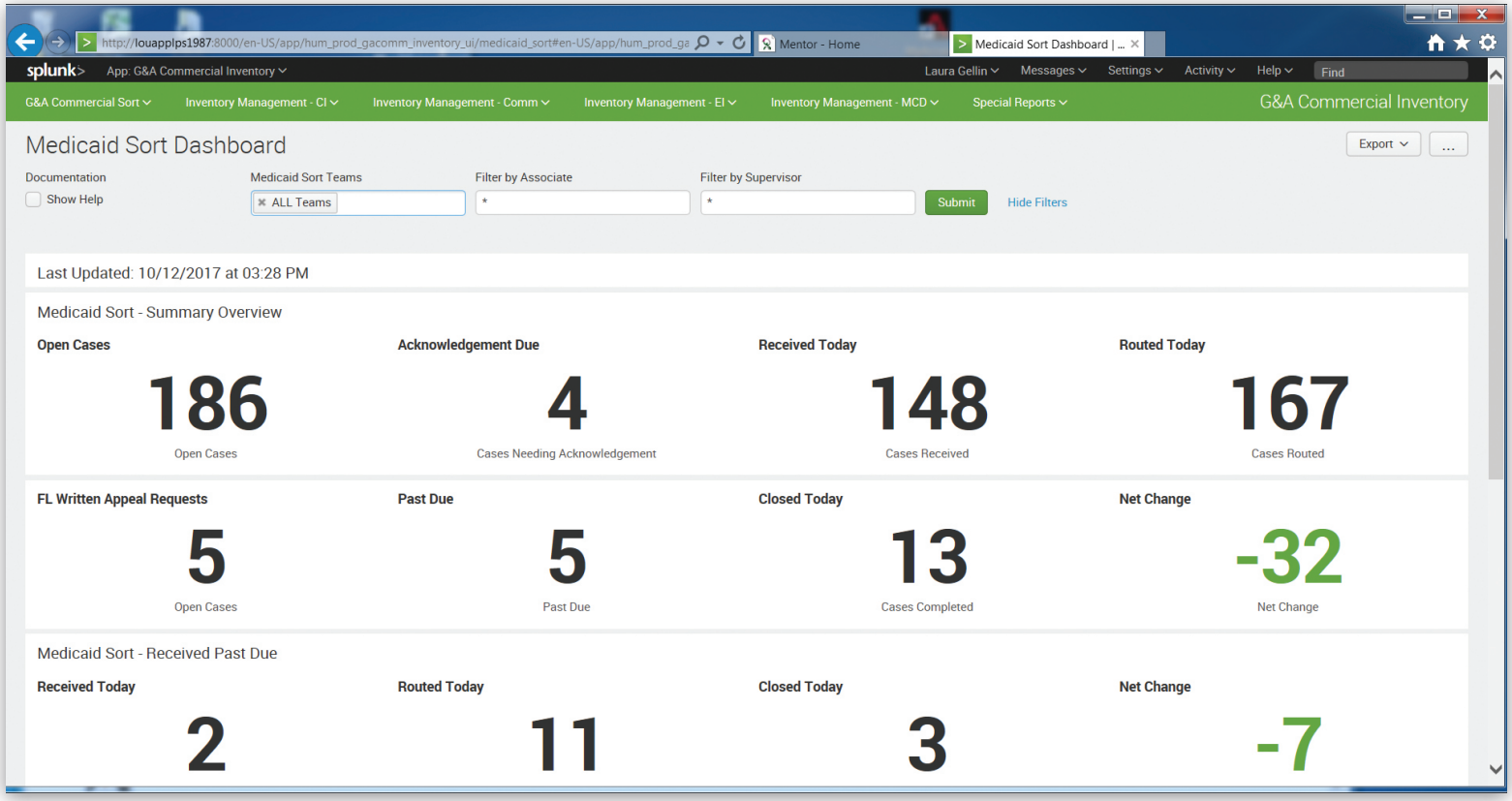


EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 13 – Social Media (Statewide):

The respondent shall describe its approach for engaging enrollees by using innovative communication methods and technologically advanced resources, including, but not limited to the use of social media, texting and smartphone application platforms.

Response:

Humana has built meaningful relationships with Medicaid enrollees across Florida thorugh face-to-face interactions, phone calls, and other traditional communication. To enhance this approach, we have progressively rolled-out our digital strategy to supplement these connections. For the upcoming contract, we have designed a Florida Medicaid-specific digital engagement and social media strategy to enhance our current methods. Across our enterprise, Humana has experience offering a range of innovative technologies including a social media presence, text messaging platform, and mobile applications. We have leveraged the insights gained throughout the current contract, our enterprise-wide efforts, and feedback from enrollees to design this strategy. The strategy is focused on improving access to care, enhancing health literacy and education, improving engagement in care, and enhancing quality of care, all while protecting enrollee privacy and protected health information (PHI) and respecting enrollee communication preferences.

Our digital strategy includes: use of our Customer Relationship Management (CRM) tool health literacy training for employees, regular audits and enrollee feedback surveys to ensure we exceed standards, a redesigned health and well-being website, social media platforms for enrollee education and engagement, and mobile-friendly access to Humana resources.

Humana's award-winning digital team – the Digital Center of Excellence (DCoE) – will manage these efforts. The team comprises individuals from areas across our organization, such as digital outreach, messaging, and Information Technology. This team also includes a predictive analytics team which leverages enrollee data.

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1. The extent to which the respondent described how these technology investments will be used to improve health literacy and promote improved health outcomes.
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Our digital engagement strategy is designed to engage all enrollees, with special attention directed at hard-to-reach enrollees. We use technology to inform enrollees on the importance of timely and regular care and how to access it. Our innovative engagement techniques build on our prior experience using both automated and live agent calls to notify enrollees of needed care and the avenues they have available when a barrier to care is determined.

Humana is investing the following to enhance our engagements: a Medicaid health and well-being website, Medicaid focused social media platforms, improved digital communication platforms, and digital campaigns designed specifically to improve both health literacy and health outcomes.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

HUMANA'S INTEGRATED HEALTH AND WELL-BEING WEBSITE

Humana is developing a fully redesigned, integrated health and well-being website that will offer information and improved functionality for Florida Medicaid Enrollees. This integrated site will be created using the latest standards to ensure an engaging experience and allow all enrollees, including those with low health literacy, to navigate the pages and find the information that they need.

Our redesigned website will be available by October 1, 2018, ahead of the new contract start date. Changes include adding "Quick Links" at the top of every page that navigate to the most used features: Find a Provider, Enrollee Handbook, and Contact Us. We will continue to offer a translation function so that the website will be available in both English and Spanish. Enrollees can also call our Customer Care Center, which will connect them to oral interpretation services in two hundred (200) languages, video interpretation in twenty-four (24) languages (including American Sign Language), and translated written materials of vital documents based on threshold languages and auxiliary aids required by disabled enrollees. Since language is not the only barrier to access, website users may also adapt font sizes for easier viewing.

Our new website will utilize our proprietary search engine, "AskHumana," which actively engages with enrollees based on past search behavior. AskHumana uses intelligent algorithms to include results that are related to the enrollee's search topics, in hopes of guiding the enrollee to the information they need rather than only what they typed. This best in class feature is especially important for enrollees with lower literacy levels and those with less experience searching online. Our goal is to further adapt AskHumana to include enrollee-specific information, such as the enrollee's specific primary care provider's (PCP) name and the PCP's phone number in response to a search for "PCP."

SOCIAL MEDIA PLATFORMS

Humana has a company-wide presence on social media platforms including Facebook, YouTube, Twitter, Instagram, and LinkedIn. Social media is a primary information and communication vehicle for many generations, and it serves an especially critical and connective purpose for the younger generation of enrollees. With more than two hundred twenty-one thousand (221,000) Florida Medicaid enrollees under the age of twenty-one (21), Humana continues to innovate in its approaches to engaging this young age group and their caregivers.

We deliver tailored messaging to followers who opt-in to our feeds based on their interest in Humana and their desire to receive information and content from us, ensuring compliance with Medicaid and Agency for Health Care Administration (AHCA) standards. The following section details our plans for social media and other innovative engagement techniques.

FACEBOOK

On October 1, 2018, our new Florida Medicaid Facebook page will go live. This page will include information that is focused on topics specific to Medicaid enrollees. We will leverage organic content in addition to content based on location, interests, behaviors, and demographics. Our Facebook page will be curated by our award-winning DCoE, which leverages its extensive expertise in this area.

We will tailor social media messages and campaigns to address key health topics that are relevant to Florida enrollees. Some examples include:

- Flu Shot Campaign: Our goal is to educate enrollees about the importance of getting a flu shot, especially in warm weather markets, and to drive traffic to the Humana.com/flu website. In 2016, we ran a Facebook paid advertising campaign for flu shot awareness. From October through December, we spent approximately thirty-five thousand dollars ($35,000) to reach an audience throughout the U.S. and delivered messages encouraging individuals to get their flu shot to protect themselves and their loved ones. Through this campaign, we earned more than three (3) million impressions and nearly thirteen thousand (13,000) clicks to the Humana flu website with more information on the benefits of flu shots. We are currently running a similar campaign for the 2017 through 2018 flu season.

- More Healthy Days Campaign: We are implementing a data-driven social media campaign to drive Center for Disease Control (CDC) Healthy Days by empowering enrollees to take control of their own health and self-assess what having more Healthy Days means to them. This campaign was designed in response to enrollee reports of poor health status. As data points, we will use six (6) Facebook posts, including one (1) pre-campaign Healthy Days Facebook Live poll, four (4) interactive video posts that offer an opportunity to assess an aspect of the user's health (vision, balance, hearing, and stress), and one (1) post-campaign Healthy Days Facebook Live poll. Through the pre- and post-campaign polls, we will be able to measure the impact of our campaign on our target audience. That is, if the messages resonated with them and if they chose to engage in their health using a Facebook ad.

YOUTUBE
To share detailed video content to Medicaid-eligible individuals through YouTube, we plan to create a Medicaid-specific playlist within our corporate YouTube channel. This playlist will allow us to post and share health literacy videos providing education and information about key topics such as navigating the healthcare system, questions to ask during a routine visit, and recommended screenings. We can increase the visibility of this content by creating shortened versions of the same content to share on Facebook. Humana's YouTube channel currently has approximately two hundred (200) videos and nearly one point five (1.5) million views. These videos address the importance of Healthy Days, how to access care, demonstrations of the MyHumana mobile application, and more.

CUSTOMER RELATIONSHIP MANAGEMENT

CUSTOMER CARE
Humana has invested heavily in a state-of-the-art, award winning Customer Relationship Managerment (CRM) system in order to provide Customer Care representatives with a 360-degree view of the consumer that can be leveraged to better serve our enrollees and deliver a personalized care experience. Our CRM is integrated with more than ninety (90) data sources and, through a combination of automation and advanced analytics, delivers a comprehensive record of each enrollee to our representatives. CRM enables connected, meaningful interactions so we can help enrollees, particularly those with healthcare needs, to get the care and support they need, engage in appropriate health and clinical programs, and receive a consistent, positive experience throughout their health journey.

MEMBER OUTREACH

CRM will serve as the central point for a consistent, enterprise-wide approach for the planning, implementation, fulfillment, and tracking of communication across all of our channels. CRM will allow Humana to compliantly deliver targeted and personalized messaging based on member preferences and needs. CRM leverages a real-time member view that ensures we are messaging to the most accurate phone numbers, email addresses, and physical addresses. CRM also connects to a preference management system to utilize appropriate preferences and opt-ins as part of the fulfillment process. CRM will then coordinate the fulfillment of the communication to the member in their desired format (whether that is through automated calls, emails, mobile push notifications, texts, or by mail), and track that the communication occurred. All of the communications fulfilled via CRM are stored in a central repository that allows associates to see the communications that a member has received.

To inform effective member outreach incorporated within CRM platform is IBM's Watson Campaign Automation system that includes:

- A centralized management and workflow tool to track campaigns from intake through reporting activities, regardless of the team completing the activity

- A campaign eligibility tool to select and target the appropriate population for personalized messaging

CELL PHONE PROGRAMS

TEXT MESSAGING

To support our digital outreach strategy for the new contract, we will continue our partnership with Safelink Wireless to offer a free smartphone and cell phone service to all enrollees. We will also use text messaging to engage enrollees in obtaining their prescriptions, setting up appointments, reminding enrollees of appointments, and providing directions to appointments. All messages offer enrollees instructions on how to opt-out.

Upon approval by AHCA in 2018, we will launch a pilot program to solidify our approach to text messaging Medicaid enrollees. We will send text messages to engage a subset of Florida Medicaid enrollees who are due or overdue for their annual wellness visit. We will monitor the pilot’s ability to engage our enrollees via text message to both schedule and attend their yearly wellness visit compared to a control group of enrollees who are not participating in the pilot program and have only received a reminder via our Medicaid wellness letter. The goal of this data collection is to refine and enhance our systems to better assist our enrollees’ in attaining their health goals.

MOBILE APPLICATIONS

MYHUMANA© MOBILE APPLICATION AND MYHUMANA PORTAL

The MyHumana portal allows the enrollee to: access health information to improve health education and literacy; increase engagement and self-service in care; view benefit information; access enrollee identification (ID) cards; find a provider; view clinical alerts and plans of care;

and send secure messages to a team of Humana associates. Humana enrollees can access the portal through the website, a mobile device, or within the MyHumana mobile application. In the first half of 2017, enrollees actively using the MyHumana app nearly tripled to one hundred forty thousand (140,000) from fifty-six thousand (56,000) in 2016. Humana will extend the use of mobile apps to all Medicaid enrollees by October 1, 2018.

The MyHumana portal has a built-in algorithm to remind enrollees of critical health-related activities such as screenings, exams, and medication reminders. Enrollee data is compiled from care plans and claims. We then run this data through our algorithms to determine what care the enrollees should be receiving. Each time the enrollee logs on to MyHumana, he or she will see a gap-in-care alert if he or she has at least one gap.

RXMENTOR
RxMentor, a new application which will be available to our Florida Medicaid enrollees in 2018, allows enrollees to add to their prescription medication list, vitamins or supplements list, and over-the-counter medication list. RxMentor includes details about medications (strength, dosage, allergic reactions), images of the pills to make them easier to distinguish, and options to discussion medications with a pharmacist. Between April 2017 (the time the program launched) and August 2017, over eighty thousand (80,000) verified medication lists were added to the database.

EFFORTS TO INCREASE HEALTH LITERACY AND PROMOTE HEALTH OUTCOMES

Humana is developing the following multi-channel, enrollee-centric engagement efforts for Florida Medicaid by utilizing digital channels and customized messaging to impact health literacy and health outcomes. We will use the results of these efforts to drive future engagement efforts.

- Digital Tool Promotion: In recognition of how our enrollees function in today's digital world, our goal is to engage enrollees and drive awareness of our numerous electronic health tools and resources (MyHumana portal, MyHumana app, RxMentor). We will include reminders about our various resources on each of our current platforms to drive enrollees to the tools. We also plan to train and engage all areas of our organization, such as Customer Care, the Education and Satisfaction Unit (ESU), and Care Managers, to be ambassadors in encouraging, training, and assisting our enrollees with the use of our redesigned website and digital health tools.

- MyHumana Gap-in-Care Alerts: These alerts promote awareness of preventive screenings, their importance to enrollee health, and guidance for how to complete needed screenings. When enrollees log in to their MyHumana account, they will receive customized alerts based on their health profile.

- Women's Health Campaign: To decrease barriers to accessing care, we have an extensive women's wellness education program that includes information on coverage so that our female enrollees can make informed decisions for themselves and their families. We are focusing on women who are actively engaged in care by contacting them with texts and emails to drive them to the Humana website for information about specific conditions relevant to their health.

- Maternity Program Collaboration: Early pregnancy is the ideal time to contact women and engage them in care that is essential to both the baby and developing fetus. Expanding our existing maternity program, our goal is to conduct outreach to pregnant women to provide them with information and education on what to expect during their pregnancy, the risks in pregnancy, and conditions and changes to look for to have a successful, healthy birth.

- Child Wellness Campaign: With the goal of providing education on child wellness and benefit coverage, this campaign will send texts and emails to parents and caregivers that have customized reminders based on the child's milestones (birthday, age group, back to school, or season).

- Doctor on Demand: This telemedicine enhanced benefit gives enrollees with twenty-four (24) hours a day, seven (7) days a week access to physicians from their phone or computer. This will help prevent enrollees from making unnecessary trips to the Emergency Department by offering appointments with PCPs, internists, Emergency Medicine physicians, Allergy and Immunology physicians, and preventive health clinicians. Providers are board-certified in Florida.

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2. The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population.

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DIGITAL CENTER OF EXCELLENCE AND INNOVATION TEAMS

The foundation of our online and other electronic platforms is our dedicated DCoE comprising teams of experts in their disciplines who work across Humana to provide a well-informed, integrated approach to technology that aligns with Humana's and AHCA's goals and continuously reviews the efficacy of our efforts. The DCoE vets and reviews all innovative enhancements to our technology landscape including social media pages, texting campaigns, and other new technologies. Importantly, each of our local markets, including our Florida Market, has extensive input in the strategy of the DCoE and retains leadership about Florida-specific needs. In 2016, as a testament to our team's successes and capabilities, our DCoE earned accolades from:

- PR Daily (Best Multi-Media Campaign, Best Use of Digital and Social Media for Healthcare, Best Use of Digital and Social Media for Internal Communications)

- Ex Award (Best Use of Digital and Social Media)

- Halo (Best Video Award)

- SABRE (Best Sponsorships Campaign)

Our Proactive Care Strategies team designs digital outreach campaigns based on proprietary predictive algorithms. We use the following data points to craft our algorithms: claims, outreach efforts, clinical outcomes, historical compliance in care routines, and medication adherence. From the data, we create outreach efforts that are individually crafted to ensure we have the

greatest impact on the enrollee, and we utilize their desired communication pathway from the information we have stored in our CRM platform. An example of one of these models is our Predictive Emergency Department Use Model. This allows us to predict the likelihood of an enrollee utilizing the Emergency Department when another form of care, such as urgent care or an office visit would be more appropriate. We reach out to enrollees identified as being likely to use the Emergency Department for a non-emergent reason to educate on the proper uses of the Emergency Department and the other avenues to care that are available.

Humana has a specific approach to design, test, implement, and continuously monitor our digital engagement. Our proactive strategy includes the following steps to support clinical and quality initiatives:

- Intake: Each week, we review requests for new engagements to support clinical and quality initiatives that are informed by the DCoE and Clinical Analytics team

- Strategy: Our strategy is guided by data points from multiple sources, including predictive models that look at enrollee behavior and use trends

- Content and Campaign Build: We use our dedicated teams to develop content and implement campaigns or enhancements

- Launch: We implement our engagement and begin outreaching to enrollees

- Monitoring: We review reach, response, email open, click, intent to schedule, and appointment schedule rates to determine the effectiveness of our campaign. We adjust our approach based on these rates, if needed

- Outcomes: We monitor clinical outcomes six (6) months and onward after the campaign ends to determine overall the effectiveness of our campaign on enrollee actions

Our strategies in action: Since we recognized that smartphones are an integral part of today's society and often a preferred outlet to electronic resources, we created the MyHumana application. This involved determining how to best display the MyHumana portal in a mobile friendly way. We piloted use of the application with our Medicare population and we've achieved great results—with over one hundred forty thousand (140,000) active users as of August 2017, compared to just fifty-six thousand (56,000) in all of 2016.

EFFICACY OF OUR APPROACH

We measure the impact of our new technologies on enrollee health. We do this by reviewing whether our various platforms are effective in reaching our enrollees and providing them with the tools they need and want to determine future innovations.

PRIOR EXPERIENCE

We have seen success with the efforts mentioned above in increasing health literacy and promoting health outcomes:

- Flu shot campaign: reached sixty-five percent (65%) of enrollees and made over three (3) million impressions

- Florida Medicaid Well-care visit campaign: seventy percent (70%) gap closure rate

- Non-Digital Women's Health Campaign: seventy-five percent (75%) of our Florida enrollees who were messaged closed their gap in care

- Women and Child Campaign: seventy-nine percent (79%) appointment schedule rate among those reached

To align these prior campaigns with our updated digital outreach strategy, we now use multi-channel campaigns across our lines of business. Specifically, we have found that our emails have a thirty-three percent (33%) open rate, substantially higher than the health industry's overall email open rate of just twenty-two percent (22%) [1]. However, we seek to continually improve upon our successes. We've found that when we pair emails, or other engagements, with phone calls, we have a significantly higher gap closure rate. Examples of emails include informing the enrollee that they've missed a needed appointment and that there are screening kits available. We are piloting adding links to schedule appointments and order kits to determine if these are effective in engaging enrollees in care.

WEBSITE
In addition to our insights into engaging enrollees through phone calls and emails, we have successfully implemented new website strategies that engage enrollees. We increased our year-over-year conversion rate by twenty-one percent (21%), meaning that visitors to our website are reaching desired information goals, engaging them in their own health journey—whether that is through taking a survey, logging-in to the MyHumana portal, or accessing health education information.

CUSTOMER CARE CENTER
We support our Customer Care Representatives (CCRs), who receive thirteen (13) weeks of intensive training, with an Artificial Intelligence (AI) assistant designed by Mattersight. This AI assistant improved the rate at which enrollees were helped the first time by eight percent (8%). Now, over ninety percent (90%) of enrollees report that the Customer Care Center usually or always solved their questions.

The assistant identifies an individual caller's personality type based on collected behavioral data. It then instantly routes that call to the available agent who is best able to successfully communicate with that personality type, based on past performance data. This personality-based approach pairs callers and agents who are most likely to have natural, effortless chemistry. This allows calls to be succinct, yet impactful.

Our new AI assistant guides CCRs and gauges the receptivity of the conversation and our enrollee's emotions. During the call, the AI signals CCRs in real-time about the experience the enrollee is having during the interaction. The AI assistant helps CCRs identify enrollees who may have low literacy, low health literacy, or who are not following along in the conversation. CCRs are alerted to slow the pace of the conversation and ask if the enrollee comprehends the conversation.

The AI technology does not replace how we monitor the performance of our Customer Care Center associates. Rather, it supports them with real-time feedback and avoids enrollee dissatisfaction with the call experience. The Customer Care Center uses data to assess Individual CCR performance on a weekly basis. Led by the Front-Line Leader and Production Lead, we evaluate CCRs by listening into live phone calls, monitoring that systems are used correctly, ensuring processes are followed based on call need, and verifying appropriate documentation of the inquiry.

MOBILE ENGAGEMENT

According to The Kaiser Family Foundation, seventy-eight percent (78%) of cell phone users earning an annual income of less than thirty thousand dollars ($30,000) send and receive text messages and forty-eight percent (48%) use internet or email mostly on their cell phones [3]. We understand the importance of an engaged population and have confirmed that most of our enrollees have access to smart phones. Humana currently offers SafeLink Wireless internet-enabled smart phones to each of our LTC enrollees at no cost. Of those who have requested and received information on the cellphone program, thirteen percent (13%) have completed the process of obtaining a phone—above the ten percent (10%) typical utilization rate. Our enrollees currently registered in this program averaged nearly twenty (20) minutes of calls to Customer Care, one hundred seventy-one (171) minutes per month of regular calls, sixty (60) texts, and twenty-one (21) MB of data use per month. Enrollees have called us to praise the SafeLink phones, their ability to connect in rural areas, and the number of minutes provided. One of our LTC enrollees shared, “I receive enough minutes to last through the month and the phone doesn’t have any connection issues even though I live in a rural area.”

With the recent addition of cell phone numbers into enrollment files, we have built modules within Clinical Guidance eXchange (CGX), our proprietary clinical software system, to add this data to our files for access by care managers. We’ve also added fields for email addresses, should the enrollee provide one. This increased information from the enrollment files has prompted Humana to increase efforts to engage enrollees via mobile platforms.

TEXT MESSAGING

Our research has demonstrated that text messaging is thirty (30) times more effective than voice calls and ninety-five percent (95%) of text messages are read within three (3) minutes of receipt. This makes text messaging the superior mode of communication for many of our enrollees. Therefore, we plan to implement a text messaging platform after AHCA approves vendors for this engagement pathway.

MOBILE APPLICATIONS

We launched the MyHumana application in 2016 for a pilot audience. We enrolled fifty-six thousand (56,000) users in 2016, and expanded to over one hundred forty thousand (140,000) in 2017. We also launched RxMentor in early 2017. By the summer, we had over eighty thousand (80,000) medication lists stored within the application. Because of these successes, we are expanding these services to our Florida Medicaid enrollees.

TELEHEALTH PLATFORM

We partner with Doctor on Demand to offer access to providers using telemedicine technology. In studying a population similar to our Florida Medicaid enrollees, we found that: five percent (5%) of enrollees would have gone to the emergency department forty-one percent (41%) to urgent care, thirty-six percent (36%) to a PCP, twelve percent (12%) not gone anywhere, and

six percent (6%) to another location had they not used the platform. Thanks to this partnership, enrollees were able to get the care and direction they needed without having to physically travel to a physician office.

TRAINING ASSOCIATES ON HEALTH LITERACY
Our Florida-based Customer Care Center and clinical care managers have completed the health literacy training course. Our Customer Care Center associates are equipped with technologies that alert them of key warning signs of low health literacy, including but not limited to: frequently missed appointments incomplete registration forms noncompliance with medication and lack of follow-through on tests or referrals. Customer Care Center Associate orientation includes New Enrollee Communication training and Clinical Health Literacy Training. Further, associates who engage with enrollees in-person are asked to consider issues with health literacy based on whether the enrollee is hesitant to ask questions or is unable to provide coherent, as well as their sequential clinical hostory and whether the enrollee identifies pills by looking at them rather than reading the label; or if the enrollee brings bags of medicines that contain duplicates.

Associates are also trained to focus enrollee engagement on what the enrollee needs to know and needs to do, ensuring they have concrete next steps. To address overall literacy levels, our teams are equipped with pictures and equipment to demonstrate what is being asked of the enrollee. Associates provide enrollees with educational materials that they can understand based on how they prefer to learn information and based on language preferences. Enrollee preferences will soon be entered into our CRM to ensure we always communicate with enrollees via their desired pathway. This allows us to effectively communicate with our enrollees regardless of their literacy skills and improve our communication with our enrollees overall.

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3. The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline).

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Humana's website, mobile applications, and portals have been thoughtfully designed to ensure that they work regardless of the user's operating system. We recognize that our enrollees may be using multiple types of devices and computers, including public computers in schools and libraries, or mobile devices to access our systems. We perform testing on externally-facing platforms through Internet Explorer, Google Chrome, and iOS and Android operating systems prior to launching any initiative or tool to ensure our enrollees will have access on as many of their devices as possible. Our adaptive website is viewable on any device with an internet connection, automatically adjusting font size, placement, and page width based on screen size and user settings. Humana is certified in HITRUST CSF v7, which is more comprehensive than HIPAA standards and demonstrates our commitment to protecting enrollee data.

MOBILE-FRIENDLY
Humana's website is designed to ensure our enrollees have access to key pieces of information without navigating through several pages. The website responds to the type of device the enrollee is using—whether that is a smartphone, tablet, or computer. This ensures that all content available on our desktop site is viewable through adapted versions. Through the mobile-

friendly MyHumana secured portal page, enrollees can access their enrollee ID card, be reminded who their PCP is, view prescription drugs, and set communication preferences.

MOBILE APPLICATIONS
Humana's mobile applications, MyHumana and RxMentor, are designed to work on both iOS and Android. We have thoroughly tested them to ensure they are interoperable with our current systems. This allows them to pull enrollee-specific data, such as their PCP's name and phone number. Our applications offer the same resources as our online versions, but in a mobile friendly manner. These applications work on the free SafeLink phone, which ensures all enrollees have access to them.

DOCTOR ON DEMAND
Humana is launching a telemedicine partnership with Doctor on Demand, to encourage telemedicine as a means ability to limit out-of-network utilization and enhance non-emergency ED diversion. Doctor on Demand is a platform that provides enrollees with access to physicians twenty-four (24) hours per day, seven (7) days a week from the enrollee's phone or computer. The platform allows enrollees to see or speak with a physician immediately using video or phone services or to make an appointment for a later time. Additionally, the platform allows an enrollee to upload medical history, send images if necessary, and obtain a prescription. Enrollees may access Doctor on Demand via a mobile application that is compatible with both iOS and Android operating systems.

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4. The extent to which the respondent is able to provide routine performance data to support member usage trends.
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The DCoE is the home of our digital technologies performance data monitoring. The DCoE works with our Predictive Analytics team to determine the optimal courses of action to take for our enrollee engagement strategies. During engagement efforts, the Predictive Analytics team uses our predictive algorithms to form our approach to enrollee outreach. We perform pre-, mid-, and post-engagement surveys and regularly monitor operational performance dashboards to determine how effective our campaigns are. If we are not satisfied with the progress we are making based on the results of our mid-engagement survey, we adjust our approach.

The DCoE also uses performance data to enhance future technological innovation strategies. This has led to our texting pilot, which is our proactive response to the fact that texting is thirty (30) times more effective than voice calls. However, when our enrollees feel that they would benefit from a phone call, our CCRs are able to help as efficiently and correctly as possible the first call. With the help of our AI assistant, Mattersight, we have reduced the occurrence of required call backs after the first call by eight percent (8%). In the coming months, we will be able to measure just how impactful these two (2) programs have been for our enrollees. We will utilize the knowledge gained by the DCoE through their own research and through the active engagement of the Florida Market team to drive additional partnerships and pilots.

We regularly monitor and evaluate the efficacy of our website and social media pages to measure engagement through traffic, engagement and response rate, retention time, number of clicks, and features used. We create future campaigns based on current issues, enrollee needs, and projected future health trends. We utilize pre- and post-initiative polls for certain campaigns

to measure their success and to guide future campaigns based on the lessons learned from previous ones. On a yearly basis, we compare our website statistics, such as number of visits and conversion rate, to our previous year metrics. We then compare these results to what we expected based on the innovations we implemented to help shape future changes. We have had great success in our strategies as evidenced by our twenty-one percent (21%) increase in our conversion rate.

Finally, enrollees can directly rate the variety of applications we make available to them—the MyHumana App, Doctor on Demand, and RxMentor. We always consider the feedback on these platforms for future iterations of them.

Footnotes

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[1] www.mailchimp.com/resources/research/email-marketing-benchmarks/

[2] Stewart DW, Adams CE, Cano MA, et al. Associations Between Health Literacy and Established Predictors of Smoking Cessation. American Journal of Public Health. 2013;103 (7):e43-e49. doi:10.2105/AJPH.2012.301062.

[3]http://www.kff.org/medicaid/issue-brief/profiles-of-medicaid-outreach-and-enrollment-strategies-using-text-messaging-to-reach-and-enroll-uninsured-individuals-into-medicaid-and-chip/

Evaluation Criteria:

1. The extent to which the respondent described how these technology investments will be used to improve health literacy and promote improved health outcomes.

2. The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population.

3. The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline).

4. The extent to which the respondent is able to provide routine performance data to support enrollee usage trends.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 14 – CAHPS Results (Statewide):

The Respondent (including respondents' parent, affiliate(s), or subsidiary(ies)) shall include in table format, the target population (TANF, ABD, dual eligible) and the respondent's results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid Contracts (as measured by number of enrollees). If the Respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent's largest Contracts. If the Respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported. Respondents shall provide the data requested in **Exhibit A-4-a-4**, Standard CAHPS Measurement Tool, to provide results for the following CAHPS items/composites:

a. Health Plan Rating;
b. Health Care Rating;
c. Getting Needed Care (composite);
d. Getting Care Quickly (composite); and
e. Getting Help for Customer Service (composite).

Response:

Humana is committed to continuously improving the quality of care, supports, and outcomes for our Florida Medicaid enrollees. One of the best ways to determine our level of success at achieving this goal is to ask the enrollees themselves. Through our Consumer Agreement of Healthcare Providers and Systems (CAHPS) survey processes, we understand how we are best serving our enrollees and identify areas where we can improve enrollee experience.

In 2016, Humana contracted with Decision Support System (DSS) Research, the National Committee for Quality Assurance (NCQA) certified vendor that conducted the CAHPS survey for the Florida Medicaid Adult and Child markets. DSS has thirty-five (35) years' experience successfully developing and administering research surveys for the healthcare industry. DSS is certified and approved for administration of MEdicaid CAHPS.

Enrollees were most recently surveyed between February and May of 2017, using a combined mail and telephonic methodology.

CAHPS RESULTS

Our three (3) largest Medicaid contracts, including our respondent, Humana Medical Plan, Inc., its affiliates, subsidiaries, and parent company, Humana Inc., and its subsidiaries and affiliates, include those listed here. These correlate to the three (3) contracts shown in attached Exhibit A-4-a-4.

1. Florida Medicaid Managed Care
 - Three hundred twenty-five thousand nine hundred and nine (325,909) enrollees
 - Populations served - Medicaid TANF, ABD, Dual Eligible

2. Kentucky Medicaid Managed Care
- One hundred forty-five thousand eighty-eight (145,088) enrollees
- Populations served - Medicaid TANF, ABD, Expansion, Dual Eligible

3. Virginia Commonwealth Coordinated Care
- Eight thousand six hundred twenty-one (8,621) enrollees
- Populations served - Dual eligibles (CMS Financial Alignment Demo), ABD

Our Florida Medicaid Managed Care contract illustrates our experience serving the exact population included in this ITN. The additional two (2) contracts – Kentucky Medicaid Managed Care and Virginia Commonwealth Coordinated Care - closely resemble the populations included in this ITN and in our current Florida SMMC Comprehensive program. In our Kentucky Medicaid program, we serve the same TANF population, consisting of pregnant women and children under the age of twenty-one (21), as well as those enrollees who are aged, blind or disabled. In our Virginia Commonwealth Coordinated Care, we cover a population very similar to our current Florida Comprehensive enrollees receiving long-term care (LTC) services; however, it should be noted that the Virginia Commonwealth Coordinated Care does not include certain populations included in the SMMC program, such as children under the age of twenty-one (21). We do not perform a child CAHPS survey in that program, and as such, we do not have child CAHPS scores for our third Medicaid contract.

Humana's Adult and Child CAHPS results can be found in Exhibit A-4-a-4.

Evaluation Criteria:

1. The extent to which the respondent exceeded the national Medicaid mean for each CAHPS survey item/component reported.

Score: This section is worth a maximum of 20 raw points as described below.

Exhibit A-4-a-4, Standard CAHPS Measurement Tool, provides for thirty (30) opportunities for a respondent to report prior experience in providing desirable experiences with health care (five (5) measures, three (3) states each, adult population for each, and child population for each). For each of the five (5) measures, a total of six (6) points are available.

The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean, for each available state, for adults and for children, respectively. An aggregate score will be calculated and respondents will receive a final score of 0 through 20 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 30 points, the final score will be 20 points (100%). If a respondent receives 27 (90%) of the available 30 points, the final score will be 18 points (90%). If a respondent receives 3 (10%) of the available 30 points, the final score will be 2 points (10%).

EXHIBIT A-4-a-4
SRC#14 - STANDARD CAHPS MEASUREMENT TOOL

INSTRUCTIONS:

Respondents should provide results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid contracts (as measured by number of enrollees).

If the respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent’s largest Contracts. If the respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported.

The CAHPS items/composites that the respondent is required to report on are located in the CAHPS Results tab.

Use the drop-down box to select the state for which you are reporting and enter the CAHPS results (to the hundredths place, or XX.XX) for that state's Medicaid population for the 2017 survey.

EXHIBIT A-4-a-4
SRC#14 - STANDARD CAHPS MEASUREMENT TOOL

RESPONDENT NAME: Humana Medical Plan, Inc.

	State #1:	Florida	State #2:	Kentucky	State #3:	Virginia
CAHPS Item/Composite	**2017 Adult**	**2017 Child**	**2017 Adult**	**2017 Child**	**2017 Adult**	**2017 Child**
Rating of Health Plan (the percentage of respondents rating their plan an 8, 9, or 10 out of 10)	**68.93**	**86.05**	**80.67**	**83.80**	**81.97**	
Rating of Health Care (the percentage of respondents rating their health care an 8, 9, or 10 out of 10)	**70.19**	**86.45**	**78.81**	**86.22**	**78.81**	
Getting Needed Care Composite (the percentage of respondents reporting it is usually or always easy to get needed care)	**79.49**	**75.87**	**86.36**	**88.81**	**80.02**	
Getting Care Quickly Composite (the percentage of respondents reporting it is usually or always easy to get care quickly)	**78.62**	**86.94**	**85.57**	**92.59**	**74.75**	
Getting Help from Customer Service Composite (the percentage of respondents reporting it is usually or always easy to get help needed from customer service)	**90.63**	**91.09**	**92.02**	**94.82**	**89.92**	

Total Points	**16**

D. PROVIDER EXPERIENCE

SRC# 15 – Provider Engagement Model (Statewide):

The respondent shall describe in detail its provider engagement model. The respondent shall include the following elements in its description, at a minimum:

a. The respondent's staff that play a role in provider engagement;
b. The presence of local provider field representatives and their role;
c. The mechanism to track interactions with providers (electronic, physical and telephonic);
d. How the respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;
e. The metrics used to measure the overall satisfaction of network providers with the respondent; and
f. The approach and frequency of provider training on respondent and Agency requirements.

Response:

Humana's team recognizes the importance of a strong Provider Engagement model. Our partnership empowers providers to deliver a high quality, clinically integrated healthcare model while helping us achieve our common goal to provide quality care to enrollees. To support this goal, we focus on administrative simplicity, financial partnership, and strong provider satisfaction. Humana has a proven record of quality initiatives and successful enrollee outcomes while serving Florida's Medicaid population over the past twenty (20) years. We currently rank second in NCQA quality rankings among MMA Medicaid plans in Florida.

Humana dedicates more than one thousand (1,000) full-time employees nationwide to provider network management, recruitment, operations, education, and value-based contracting. Our Medicaid Provider Relations teams in Florida have significant experience. Our current team has an average of over eight (8) years of provider relations experience in the state of Florida and an average of over seventeen (17) years of experience in the healthcare industry. Humana's Florida-based Provider Relations teams include approximately seventy (70) full-time employees. Humana reviews our staffing model on an ongoing basis to ensure we have adequate resources to meet the needs of our providers.

Our investments in associates and information system technologies enable us to offer efficient and cost-effective support to our providers across our spectrum of products in Florida, including Medicaid, Medicare, and Commercial plans, while enhancing our connection to the provider community. When we recruit providers for our Medicaid network, they often have had exposure to Humana through other lines of business. The scope of Humana's Florida Operations gives us a larger volume of relationships with providers, enables more frequent interactions between our associates and provider associates, and fosters more sophisticated, aligned, performance-based financial arrangements aimed at improving quality outcomes while containing cost.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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1. The extent to which plan leadership are involved in provider engagement.

2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.

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Our successful Provider Engagement model focuses on establishing and maintaining a one-on-one relationship between each provider and our local Provider Relations representative. Provider Relations representatives are assigned geographically at a ratio of one (1) representative per fifty-seven (57) providers which represents monthly visits to high touch providers such as primary care, personal care, assisted living facilities, and skilled nursing facilities. For high volume specialists visited quarterly, including OB/GYNs, cardiology, orthopedic, urology, adult day care, and respite care, the ratio is one (1) representative per eighty-nine (89) providers. Our partnership works toward a common goal: delivering quality care to enrollees. Humana's comprehensive Provider Engagement model includes our leadership team's direct and frequent interaction with providers and participation on our internal Provider 360 Committee. In addition to our leadership, Humana's Florida-based Provider Relations team currently consists of approximately seventy (70) experienced and talented full-time associates. Our local Provider Relations Representative has the one-on-one relationship with the provider and is assisted by both local and corporate support teams. Humana dedicates more than one thousand (1,000) full-time associates nationwide to support teams including provider network operations, finance, provider development, value-based contracting, and claims resolution.

Attachment 15-1 shows Florida Provider Relations representatives' footprint across the state. Attachment 15-2 illustrates our provider support system which includes local and corporate support.

LEADERSHIP COMMITMENT

Humana has a long-standing presence in Florida serving Medicaid, Medicare, and Commercial populations. We have served enrollees through our Medicaid plan for twenty (20) years and offered Medicare plans for thirty (30) years in Florida. Provider satisfaction and engagement are critical to our success serving enrollees. Humana's local leadership team is committed to provider engagement and has established strong relationships with our providers in Florida through extensive interactions. Humana leadership regularly attends Joint Operating Committee (JOC) meetings, provider association meetings, and individualized strategy meetings with providers to discuss new initiatives and opportunities to achieve our common goals.

JOINT OPERATING COMMITTEE (JOC) MEETINGS: Humana holds JOC meetings with our value-based, high volume, delegated, and subcontractor provider partners to review their financial, quality, and service level agreement performance. During these JOC meetings, we discuss topics including, but not limited to, health services, quality, Healthcare Effectiveness Data and Information Set (HEDIS), Medical Risk Adjustment (MRA), pharmacy, provider network, finance, and emerging industry trends. Our JOC meetings are an opportunity to develop and enhance our collaborative partnerships. These meetings offer insight, enabling us to evaluate opportunities to improve our provider experience and address specific provider needs. For instance, if Humana's Finance team recognizes that a provider has specific reporting

needs, we will discuss tailoring the report to meet the provider's need as a JOC action item. Another JOC meeting action item example is to discuss ad hoc reporting by our pharmacy team to assist providers experiencing a spike in prescription drug or prior authorization requests. JOC meetings may be scheduled monthly, every other month, or quarterly depending on the needs of the provider network or Humana. Our Provider Relations Director and the representative responsible for the provider partnership attend all JOCs in person. Our Regional Vice Presidents, Market Presidents, and Humana's Medicaid Segment President also frequently attend JOCs with our providers.

STRATEGY MEETINGS: Humana's senior leadership team initiates meetings with provider groups to discuss specific quality improvement, administrative simplicity, and financial initiatives in support of our common goals. Examples of these strategy meetings and their outcomes are described below.

- Humana leadership worked directly with our contracted providers to support improved birth outcomes. Since 2016, Humana's Chief Medical Officer and Market Vice President, along with our Provider Relations directors, have conducted a series of strategy meetings with targeted OB/GYN providers, to partner on Humana's quality and HEDIS initiatives, including our goal of lowering our overall medically unnecessary C-section rate. This collaboration has resulted in a decrease in our C-section rate from forty percent (40%) in 2015 to thirty-seven percent (37%) in May 2017. We have also experienced an improvement in our HEDIS prenatal and postpartum care rates. In 2015, Humana's Frequency of Ongoing Prenatal Care score was sixty-nine percent (69%), and in 2016, this score increased to seventy-one percent (71%). In 2015, Humana's Postpartum Care score was sixty-seven percent (67%), and in 2016, this score increased to seventy percent (70%).

- Following MMA implementation in Region 1, we received feedback during our provider education town halls that there were administrative challenges with the pre-authorization process. In response, our leadership conducted strategy meetings with providers throughout the region to further understand the challenges and develop a tailored solution. As a result, a customized pre-process was created for Region 1, including significant cross-functional involvement and IT infrastructure enhancements.

- Humana leadership met with Pediatric Associates, a large, statewide pediatric group serving over fifty-six thousand (56,000) Humana Medicaid enrollees, to discuss their new telemedicine program which was launched in July 2017. They partnered with American Well, a telehealth company, to develop their system and use a mobile application called Kids Now for their patients to schedule a telemedicine appointment. The application is connected to their EMR and appointment scheduling system. They have four (4) dedicated full-time physicians who provide telemedicine services via video conferencing for their patients across the state. In our strategy meeting, Humana and Pediatric Associates agreed to partner together to expand their program for all Humana pediatric and adult enrollees statewide. Follow-up meetings have been scheduled to further develop the strategy for a possible 2018 implementation.

ASSOCIATION MEETINGS: Humana's long-standing relationships with provider associations contribute to our ability to maintain provider engagement. Our partnerships with physician, hospital, long-term care, and ancillary provider associations enable open and ongoing communications. Humana engages with provider associations through regularly scheduled conference calls and meetings, frequently attended by Humana's senior leadership team.

Association meetings are a particularly effective way to work with medical and long-term care providers on issues unique to these providers, such as Medicare crossover claim processes. Below are a few examples of our outcomes working with provider associations:

- A Humana leader was recently elected to the Florida Assisted Living Association (FALA) advisory board, as well as the advisory board to the Florida Area Agencies on Aging. This relationship has enabled Humana to play an instrumental role in improving coordination between various Councils on Aging.

- Humana's Market Director and National Medicaid Director also meet monthly with Leading Age and Florida Association of Homes for the Aging to work through open items, such as provider concerns, possible innovations to payment arrangements, and stay updated with the Nursing Facility and Assisted Living Community.

- Humana leaders attend the annual Florida Hospice and Palliative Care Association (FHPCA) meeting, where we have developed an improved understanding of and relationship with hospice providers. During the most recent FHPCA meeting, we received positive feedback on our claims and referral processes. As a result of this meeting, we also recognized hospice providers' need to better understand the coordination between medical and long-term care as it relates to claims, authorizations, and enrollee responsibility. We are developing a quick reference guide for these providers to assist in clarifying the process.

INTERNAL ENGAGEMENT SUPPORT MODEL

Our Provider Relations associates meet biweekly to discuss trends, initiatives, and opportunities to train and educate frontline Provider Relations representatives. Educational opportunities include Medicaid related topics such as AHCA alerts, fee schedule changes and monthly AHCA agenda topics. This meeting serves as a forum to discuss best practices and provider specific challenges like those we have experienced with specialty providers. These meetings enable Humana Provider Relations leaders to obtain frontline information to inform the development of new educational materials or the presentation of an issue or concern to the Provider 360 Committee for consideration.

- For example, in March 2017, our long-term care providers were receiving authorization faxes multiple times due to the conversion from the American ElderCare (AEC) system to the Clinical Guidance eXchange (CGX) system. Provider Relations representatives escalated the concerns to a cross-functional Command Center team and several of our representatives visited providers' offices to resolve their issues.

Beyond established relationships with our providers, Humana is continually advancing our internal infrastructure to support provider engagement and satisfaction. We have established the Provider 360 Committee, a multifunctional team representing provider support areas, which is chaired by our Medicaid Market Vice President. The committee's objective is to review all functional areas to improve provider experience through review of provider metrics, identification of process improvement opportunities, and development of provider education initiatives and materials. The committee includes representation from Market Executive Leadership, Regulatory Compliance, Market Provider Relations and Contracting, Market Hospital Contracting, Market Service Alignment managers, Provider Customer Care, Provider Directory,

Claims Processing, Availity Liaison team, eHUB team, Physician Performance Management, Market Quality Operations, Market Clinical leaders, Corporate Medicaid Implementation, Critical Inquiry team, Provider Communications, and the Quality Improvement Committee (QIC).

ASSOCIATES WHO PLAY A ROLE IN HUMANA'S PROVIDER ENGAGEMENT MODEL

Recognizing the challenges and barriers our providers face, our Provider Relations associates deliver cross-functional support to ensure we are aligned with our providers in achieving our mutual goal of improved quality outcomes for our enrollees. Following is a description of the roles of our team members who interface with providers, serving as the face of our Provider Engagement model, including the Humana leadership team.

REGIONAL VICE PRESIDENT OF NETWORK OPERATIONS AND PROVIDER EXPERIENCE – Regional Vice President of Network Operations and Provider Experience oversees Provider Relations functions and associates.

PROVIDER RELATIONS DIRECTORS – Provider Relations directors oversee contracting and provider education strategies, develop goals for the department, assist in developing relationships with our providers and are responsible for translating national initiatives to our local market. Our current six (6) Provider Relations directors have been in this role for an average of ten (10) years and have established relationships with providers throughout Florida.

PROVIDER RELATIONS MANAGERS – Provider Relations managers are responsible for driving our provider goals, directives, and strategies. They are also available for coaching providers to help resolve the escalation of any provider issues. We currently have nine (9) Provider Relations managers, who have served in this role for an average of over ten (10) years.

PROVIDER RELATIONS REPRESENTATIVES – Provider Relations representatives are the direct liaisons and field representatives responsible for meeting with designated providers monthly. In this frontline position, they are also responsible for educating our providers, clarifying provider inquiries, and relaying provider concerns to the broader Provider Relations team. We currently have more than fifty (50) Provider Relations representatives who have established strong relationships with providers throughout the State.

PROVIDER RELATIONS CONSULTANTS – Consultants lead provider-focused operations and processes in support of a broad, quality provider network. Our Consultants manage projects and drive successful outcomes. They spearhead various projects, including but not limited to, development and revision of departmental policies and procedures, provider education materials, provider communications, internal associate Medicaid training and updates, surveys and tracking and trending of service level agreements. They also focus on departmental data analytics, including data reconciliation of the Provider Network Verification (PNV) file and identification of potential network gaps.

QUALITY IMPROVEMENT NURSES (QINS) AND CARE COACHES – Humana QINs effectively develop, enhance, and maintain our provider clinical relationships. QINs work collaboratively with provider groups to guide, recommend, and develop practice-specific strategies to improve all aspects of quality. They meet with our PCPs and high-volume

specialists monthly to deliver provider and enrollee-specific metrics, such as care gaps and HEDIS measures. QINs also work with provider practices to identify specific practice needs and supports, then communicate these needs to Humana internal associates. Humana currently has eighteen (18) QINs in Florida. We have three hundred thirty-one (331) Humana Care coaches who interact with providers and enhance our Long-Term Care (LTC) provider relationships. They meet with our LTC providers on a routine basis and support providers in delivering enrollee care.

COMMUNITY OUTREACH REPRESENTATIVES – Community Outreach representatives are responsible for organizing provider-based events encouraging and targeting enrollee wellness. This is accomplished through events such as health fairs, which target HEDIS measures and back to school campaigns to encourage vaccinations. One of our newer initiatives currently piloting is Humana Storks program which targets enrollees who have just given birth by educating the new mother on how to access health services that will help ensure the best health outcomes for her and her baby.

ENTERPRISE AND FLORIDA-BASED PROVIDER SUPPORT – Humana's Provider Engagement model includes local Provider Relations representatives, as well as additional local and corporate support. This cross-functional support model includes representatives from Clinical, Pharmacy, and Finance services. Health Services Case Managers also play a role in connecting our providers to our enrollees. Our centralized provider services include our provider Customer Care. Our provider Customer Care associates are trained to assist providers with questions, as well as directing them to appropriate resources as needed.

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c. The mechanism to track interactions with providers (electronic, physical, and telephonic);

d. How the respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;

3. The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas.

4. The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs.
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We monitor and review provider interactions to gauge the effectiveness of our provider support processes. We use these reviews to identify external and internal opportunities to address clinical and administrative issues. To support our Provider Engagement model, we track provider interactions through a number of avenues, as described below.

PROVIDER DISPUTE RESOLUTIONS – Provider complaints and disputes, which are received telephonically, electronically, and physically (through mail or Provider Relations representatives) are tracked through our Customer Relationship Management (CRM) system by Provider Relations or Customer Service. CRM enables concerns, which may involve issues relating to procedures, claims, or specific issues related to a given enrollee's situation, to be routed to the appropriate area for resolution. We identify, track, and trend for root cause analysis to resolve

concerns. We record the full interaction in our CRM for reporting purposes, including response resolution time, which is reported to AHCA.

CLAIMS – We capture and track claims interactions, whether paper or electronic, from receipt of a claim to payment and delivery of remittance advice. The processing of provider claims transactions is tracked through the Availity portal, e-Hub, and Claims Administrative System (Humana's claims adjudication platform). Our claims data and analytics system enables Humana to track claims-related performance measures such as timeliness of claims submission, percentage of clean claims, and percentage of denied claims for each individual provider. In 2016, nearly ninety-nine (99) percent of our electronic clean claims were paid within ten (10) days.

Our Service Alignment Manager (SAM) addresses service and operational issues. The SAM's role is to work across enterprise support services and market representatives to drive resolution across processes and technology while identifying opportunities for improvement. Support services areas include, but are not limited to, Provider Relations, Claims, Financial Recovery, Clinical, and Customer Service. The SAM analyzes various provider interactions and touch points across these matrixed teams to resolve immediate, identified issues and to proactively identify trends and opportunities for process improvement with the ultimate goal of enhancing the provider service experience by reducing escalations of issues.

SERVICE FUND DATA ANALYTICS – Humana developed a proprietary Service Fund risk sharing management application for providers engaged in a risk or capitated arrangement. We use this innovative tool to calculate reimbursements to providers in these arrangements by tracking and aggregating information on capitation payments, claims expensing, claims payment, reconciliation, and settlement for all PCP contracts.

Service Fund makes monthly data files available containing information regarding provider membership, funding, claims activity, progress toward value-based payments, and capitation payments at both individual provider and group levels. Humana tailors the reports to providers in risk or value-based arrangements. Providers can access these reports through an online portal, as well as through our Provider Relations representatives. Humana also educates providers using Service Fund by walking through standard reports during initial training to show providers the data they can access and how to use it to help manage their financials. Our Provider Relations representatives meet monthly with PCPs to review Service Fund reports and to discuss any concerns or barriers they may be facing.

CUSTOMER CARE – Customer Care provider and enrollee calls are tracked by our Customer Service representatives in CRM. The Customer Service representative logs the call topic and outcomes of the call, routing the call, if needed, through CRM to the appropriate associate for resolution. We log, monitor, and trend the entire interaction for analysis and review.

PROVIDER RELATIONS REPRESENTATIVE VISITS – Provider Relations representative visits are recorded in a database, which includes the topic of the provider conversations and identified future education needs. Our Provider Relations leadership monitors this database weekly to ensure that Provider Relations representatives are completing visits, identifying training needs, and tracking visit subject matter.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

CREDENTIALING, RECREDENTIALING, AND APPLICATION LOADING – Our proprietary workflow management tool, APEX, tracks provider credentialing and application information. This tool initiates communication with providers when credentialing or recredentialing information is needed, and offers Humana associates insight into a provider's credentialing status. Once the credentialing or recredentialing application is complete, it is input into our APEX workflow. Our Provider Relations and our Customer Service associates use APEX as a resource when an inquiry is received from a provider regarding credentialing/recredentialing and participation status. We reduced the average credential and load time to thirty-two (32) days following recent implementation of system efficiencies.

We recently implemented a Provider Data management feature on our Availity web portal. In this workflow, the provider can update their demographic information including service locations, any new providers joining the organization, contact information, and panel status. Once the provider attests to the information, Humana will have access to the updated information through APEX.

CLINICAL DATA ANALYTICS – Providers can request authorizations telephonically or electronically. Our Clinical Intelligence Analytics team uses a combination of authorization and claim data to capture utilization trends and generate reports on short hospital stays. Our Hospital Opportunity Tool reviews readmission rates, re-hospitalization rates, emergency department rates, and daily inpatient census. We use the collected data to develop clinical initiatives, implement trend benders, and enhance case and disease management programs. We share this data which is stored and tracked in CGX and CareHub, with our provider partners during JOC meetings.

QUALITY IMPROVEMENT NURSES – Our QINs are assigned to providers based on geography and meet with providers at least quarterly. During these meetings, QINs discuss quality measures and performance gaps in care reporting. They also discuss provider performance reports, which are generated by our HEDIS reporting process. We use these reports to identify provider training and education needs (example provided in Attachment 15-3). We record QIN visits in a database which contains the provider group name, date of visit, detail of visit, and follow-up details.

Humana business leaders review reports summarizing interactions with providers on an ongoing basis. Each interaction with a provider, whether administrative or clinical, drives future interactions. If we see negative trends in any of our reports from a provider or if we receive negative feedback, we arrange for a more in-depth training session with Provider Relations representatives. For example, if a provider is below the county average on HEDIS scores, we engage our QINs and Provider Relations representatives to provide detailed training on HEDIS measures. If we see that a provider is prescribing drugs outside of the formulary or is outside of the county average in generic prescriptions, our Pharmacy associates contact the provider and review drug alternatives for enrollees. Once an issue is identified, we proactively reach out to the provider for resolution.

Humana maintains multiple forums to review data regarding the provider experience and gain insights from trended data points including provider portal usage, claims, complaints from providers, provider call center metrics, provider quality measures, and contract load metrics. Our Provider 360 Committee is one of these forums, which uses data and representatives from all provider areas in the company to survey the provider experience and proactively improve it.

This committee's sole objective is to improve the provider's experience with Humana. Other forums addressing provider issues include the Local Operating Committee, Quality Improvement Committee, Command Center and local Provider Relations associate meetings.

PROVIDER TRAINING AND PROVIDER RELATIONS TRAINING

Humana's robust associate recruitment and training program supports our Provider Engagement model. We recruit Provider Relations representatives with extensive network experience to ensure our associates can fully support providers. Provider Relations associates are required to complete our Provider Contracting University to understand Humana's processes and model for interacting with providers. During this process, our Provider Relations representatives participate in virtual and in-person training. Further, our representatives are required to complete the same annual compliance training modules our network providers complete.

As we track and trend provider interactions with Humana to improve our processes and provider experience, we also use this data to develop training for Provider Relations associates. On a monthly or more frequent basis, our Provider Relations associates meet internally, and we educate our representatives on contract changes, programmatic changes, and educational needs.

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e. The metrics used to measure the overall satisfaction of network providers with the respondent; and

5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.

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Our support and engagement model enables our providers to accomplish our mutual goal of improving quality outcomes for enrollees and containing costs. Our model is built around attaining improved quality outcomes by aligning on the common tenets of this goal, including financial incentives, provider partnership, administrative simplicity, and provider satisfaction. Our model is designed to ensure providers are satisfied with our level of support and attentiveness offered through our responsive and comprehensive Provider Engagement model. We continually measure provider satisfaction to identify opportunities for improvement in how we interact with and support our providers. A key measure of provider satisfaction is our provider termination rate. For example, since SMMC inception, month-to-month provider termination rates are less than one (1) percent. Additionally, our hospital network has remained stable since the implementation of the MMA program.

PROVIDER ENGAGEMENT IN OUR VALUE-BASED PURCHASING (VBP) MODEL

An effective provider engagement strategy enables the formation of true partnerships and optimizes the payer-provider relationship. Humana has extensive experience in creating value-based, engaged provider partnerships that involve substantial financial risk/reward sharing and

performance-based incentives for providers, which support our provider retention goals. Our program is designed to support the needs of providers, working constructively with providers regardless of their organizational size or level of technological sophistication. Humana provides a step-by-step opportunity to earn financial rewards for achieving certain clinical measures of success. As providers mature in their ability to achieve basic milestones, additional measures are added or increased outcome performance targets are established which enable providers to earn even greater rewards.

Humana's sophisticated value-based models in Florida establish financial and quality aligned incentive contracts with our providers. The number of Florida providers in Humana's VBP arrangements has increased dramatically over the past decade. Today, Humana has more than eight hundred thousand 800,000 Florida Medicaid and Medicare enrollees attributed to PCPs engaged in VBP arrangements. We anticipate that our volume of VBP contracts will continue to grow.

These agreements include full risk (global) capitation, shared savings models, a quality-cap bonus program, and MMA Physician Incentive Program payments to reward our providers for providing high quality care. Humana's model is designed to drive greater provider engagement and improve clinical outcomes based on the concept that reward incentives, packaged with consultative provider guidance and care gap alerts, helps providers raise the quality bar. We support providers in these models using various resources including in-person assistance and data analytics. Our Provider Engagement program enables Humana to truly partner with our network partners and optimize the payer-provider relationship, which keeps providers satisfied with their financial incentives and the care they are delivering.

PROVIDER SATISFACTION SURVEY

The Provider Relations team conducts an annual provider satisfaction survey in all our contracted regions in accordance with contractual obligations and state approved sample methodology and metrics. The survey enables Humana to evaluate and measure satisfaction across the following service metric areas: provider relations and communication, clinical management processes, authorization processes including denials and appeals, timeliness of claims payment and assistance with claims processing, complaint resolution process, and care coordination/case management support. In 2017, the response rate increased to thirty percent (30%) from seventeen percent (17%) the year prior.

Humana has received positive feedback in our provider satisfaction survey regarding our Provider Engagement model. For example, in 2017, ninety-nine percent (99%) of MMA respondents said their Provider Relations representative was able to answer all their questions and was professional and courteous. Additionally, ninety-eight percent (98%) of respondents said the educational and training materials are easy to understand. For LTC respondents, eighty-six percent (86%) were satisfied with Humana's service. Eighty-three percent (83%) responded that the Provider Relations representative was knowledgeable and able to answer their questions and eighty-one percent (81%) felt that their needs and concerns were addressed.

Attachment 15-4 offers a snapshot of results of Humana's 2017 provider satisfaction survey. Also see Attachment 15-5 for letters of support from Florida Medicaid providers.

IDENTIFICATION OF PROVIDER ENGAGEMENT AND PROVIDER COMMUNICATION IMPROVEMENT OPPORTUNITIES

Humana uses multiple provider input sources to improve our provider engagement and communication. These sources inform how we interact, train, and communicate with our providers to ensure we fully support them and keep them satisfied as they deliver care to our enrollees.

PROVIDER SATISFACTION SURVEY – Our provider survey results help identify potential areas of opportunity for Humana. We share results of the survey across all the service teams for development of an action and improvement plan, which we then send to AHCA. Based on the 2017 MMA results, for example, one (1) of the areas identified as an opportunity of improvement in the Provider Relations and Communication category was where forty-two percent (42%) of the providers surveyed responded negatively to the question "In the last twelve months I received or viewed the Humana Medicaid newsletter." To improve penetration of this important communication tool, Humana has started collecting current email addresses and fax numbers for our PCPs, obstetric and gynecologists, and our high-volume specialist providers so that we can send these newsletters, as well as other important updates like AHCA alerts, fee schedule changes, and policy changes to them through this additional communication avenue instead of relying on regular mail.

JOC, STRATEGY, AND ASSOCIATION MEETINGS – Humana uses our meetings with providers to identify opportunities to improve provider satisfaction, training and communication.

PROVIDER 360 COMMITTEE – Our monthly Provider 360 Committee meetings seek to advance our provider support to improve provider engagement and satisfaction. During these meetings, committee members review administrative improvement opportunities and functional areas to improve provider experience through review of provider metrics, identification of process improvement and provider performance opportunities, and development of provider education initiatives and materials.

PROVIDER RELATIONS REPRESENTATIVES AND LEADERS – Through our frequent provider interactions, our Provider Relations representatives and leaders provide insightful opportunities for us to adjust our Provider Engagement model and provider communication to meet the needs of our providers.

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6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

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Humana's comprehensive provider training program helps us achieve more sophisticated, integrated, and engaged partnerships. Humana offers a variety of training formats to ensure that information is accessible and convenient. We have structured training programs to support providers' varying knowledge bases, needs, and learning styles. Our trainings are flexible and

scalable. We provide web-based trainings for busy providers, conference-style trainings, and one-on-one trainings. The training formats used include face-to-face orientation and monthly meetings, Humana's Provider Handbook, materials available on our website and our Availity portal, quarterly provider newsletters, and ongoing support available from our Provider Relations representatives.

INITIAL PROVIDER TRAINING PROGRAM

Our strong relationships with providers strengthen the SMMC program by enhancing access and improving quality outcomes for our enrollees. We use a cross-functional, integrated, and "high-touch" approach to support and train our providers. This approach begins once a provider is credentialed and contracted. Within thirty (30) days of their contract effective date, all providers new to Humana's network receive orientation training from their assigned Provider Relations representative, who will also serve as their point of contact for all future trainings. This training is an opportunity for providers to understand Humana operations and processes, provider roles and responsibilities, and the vast resources available to them. We conduct the initial orientation in the provider's office, which includes information on all necessary topics to help guarantee a mutually successful partnership. Below is a comprehensive list of all the topics covered during the orientation training:

- Introduction to the Florida SMMC program
- Contracting and credentialing
- Access to care requirements
- Web resources
- Preauthorization and notification process
- Claims processing and claims resolution process
- Continuity of care
- Enrollee special needs consideration
- Enrollee screening for alcohol and substance abuse
- Clinical management programs
- Patient-centered medical home
- Medicaid risk adjustment
- Medicaid Advisory Panel
- Service level agreements
- Agency for Health Care Administration (AHCA) provider based guidelines
- Annual compliance trainings
- Cultural Competency
- Health, Safety, and Welfare (HSW)
- Fraud, Waste, and Abuse (FWA) and Business Ethics
- OB/GYN training (for OB/GYNs only)
- Critical incident reporting
- Disenrollment or transfer of member
- Helpful numbers and regionally specific Quick Reference Guides
- Florida Medicaid Provider Handbook
- Behavioral health tool kit for Primary Care Providers (for PCPs only)
- MMA physician incentive program (MPIP)
- Electronic Health Records (EHR) and Health Information Exchange (HIE)

Since 2013, we have conducted provider orientation training for more than four thousand (4,000) providers in Florida. We use provider feedback to continually modify and improve our provider training content, materials, and delivery sources. We have attached copies of our MMA provider orientation training modules and new provider orientation checklist in Attachment 15-6.

ONGOING PROVIDER TRAINING PROGRAM

Humana's provider training program is ongoing and we are continuously adding new providers to our network. Providers also often experience associate turnover or growth, which may result in a need for additional training activities. We have many avenues for providers and their associates to receive training or supplemental training. Humana's Provider Relations representatives develop an open dialogue that allows us to meet each of a provider's ongoing and specific training needs.

We recognize that provider education is not a static process and we have to reach providers in different ways, at different times, and through different delivery methods. We use four simultaneous avenues of training to ensure we support our providers in delivering the best care to our enrollees, which include:

1. Face-to-face training
2. Web-based individual training
3. Webinars
4. Available resources and "on-demand" training

FACE-TO-FACE TRAINING

Providers are assigned a Provider Relations representative who is their point of contact for all training. In addition to the initial orientation training, we routinely review internal policy changes and those of governing agencies to ensure that our trainings are capturing up-to-date and relevant information. We seek to schedule these training sessions at the provider's convenience, at a time when there is minimal patient care activity and where as many provider associates as possible can attend. We may conduct one-on-one trainings in the provider's offices or at a Humana location. Conference-style, region-based trainings are held in a centrally located location (e.g. hotel conference room or Chamber of Commerce facility). We welcome and encourage AHCA representatives to attend any education seminars we conduct.

Additionally, Humana's Provider Relations representatives visit our providers regularly. During these visits, we deliver information to help the provider understand their overall performance metrics and ascertain whether their associates have any questions or training needs. During visits that follow a recent training session, we ask whether there are any issues related to the prior training that they would like more information about, or refresher information. We also use these visits as a mechanism to hand deliver important communications and publications that may previously have been mailed or posted to our provider website.

Recognizing that PCPs serve as a medical home, our Provider Relations representatives visit PCPs monthly. Below is a list of reports and data they share with PCP offices monthly:

- Performance profile and report card – snapshot used to review encounter rates, admits and days per thousand, average length of stay, ER visits per thousand, and pharmacy opportunities

- New enrollment and disenrollment reports – reports listing all new and disenrolled enrollees from the PCP's panel

- Top 40 enrollees – report identifying the top 40 enrollees with highest incurred cost

- Top 40 drugs – report identifying the top 40 drugs prescribed and evaluation of any opportunities for generic equivalencies

- HEDIS reports including identification of gaps

- Encounter data – provides a 12-month trend and benchmark analysis for PCP encounters and fee for service claims by incurred and processed dates

- ER trends – report identifying enrollees who have had repetitive and excessive ER visits during a specific period

- Delivery system reports – provides a list of highly utilized, efficient specialists, and mandatory networks available for enrollees

- Network changes – report that outlines changes to the network that may impact the PCP and enrollees

- Newsletters – quarterly publications that summarize topics vital to provider practices

- Mailings – various imperative communications that we may have mailed to their office and reinforce during visits

WEB-BASED INDIVIDUAL TRAINING

Humana provides web-based training through the Availity portal, which is our health information network that optimizes information exchange between multiple healthcare stakeholders through a single, secure network. The Availity portal encompasses business and clinical services, and supports nationwide real-time and batch electronic data interchange via the web and through business-to-business integration. Recorded web-based trainings may be taken anywhere and are available twenty-four (24) hours a day/seven (7) days a week. In addition, instructor-led training is available at least one (1) day per week. Through Availity, providers and their associates may access training related to:

- Claims management
- Authorizations management
- ERA and EFT management
- Clinical Solutions
- Electronic Data Interchange (EDI)
- Eligibility and Benefits Inquiry
- Patient Responsibility Estimator Tools

- Payment Collection and Processing
- 5010 Overview
- Annual Compliance training
- Humana Orientation
- Cultural Competency
- Health, Safety, and Welfare
- Fraud, Waste and Abuse and Business Ethics

During orientations we train providers on compliance concepts and materials that they are also required to complete on an annual basis. Humana sends multiple reminders to providers through email, fax blast, and phone calls throughout the year using multiple communication mechanisms to ensure these important compliance topics are met.

WEBINARS

Humana continuously offers interactive webinars throughout the year. The subject matter of these webinars is determined by requests from providers, trends observed by our Provider Relations department, and system or programmatic changes. For example, we offer Availity claims webinars twice a week for our LTC providers.

AVAILABLE RESOURCES AND ON-DEMAND TRAINING

In addition to face-to-face training, webinars, and web-based training, Humana offers resources and on-demand training through our provider handbook, provider website, quick reference guides, service fund trainings, and self-guided modules.

EDUCATIONAL PROVIDER MATERIALS

Humana distributes a provider handbook to all our providers, which includes a comprehensive review of educational topics, quick reference guides regarding prior authorizations, and enrollee covered services materials. After a provider executes an agreement with us and during their orientation training, we review the handbook contents as well as any other information related to our health plan. Our handbook contains comprehensive information about a variety of topics and is a contractual extension to their provider agreement. Below is an overview of the topics covered in the handbook:

- MMA Program Description
- Covered Services
- Emergency Service Responsibility
- Child Health Checkup
- Provider Complaints
- Grievance System
- Chronic and Complex Conditions
- PCP and Other Provider and Subcontractor Responsibilities
- Telemedicine Protocols and Requirements
- Delegation or Subcontract Function
- Florida Health Information Exchange (HIE)
- Preauthorization and Referral Procedures

- Medical Records Requirement
- Claims and Encounter Submission Protocols and Standards
- Cultural Competency Plan
- Member Rights and Responsibilities
- Fraud and Abuse Policy
- Health, Safety, and Welfare
- Patient-Centered Medical Home (PCMH)
- Medicaid Advisory Panel
- Provider Rewards and Incentives
- Provider Resource Website
- Provider Training
- Availity
- Helpful Numbers

Humana sends out quarterly provider newsletters as well as email blasts containing important information on policy changes, quality, industry changes, and medical protocols. Examples of recent newsletters are included in Attachment 15-7.

PROVIDER WEBSITE MATERIALS
Humana has a dedicated webpage where providers can easily access Medicaid provider materials. We also prominently display urgent updates and specific quality initiatives for our providers, such as annual checkups or breast cancer screenings, see Attachment 15-8.

Humana measures and tracks how often the website is accessed to understand whether this delivery method is a valuable avenue for our providers. Between Jan. 1, 2015, and June 30, 2017, Humana's provider website had one hundred ninety-five thousand, five hundred ninety (195,590) views. The following is a list of some of the information available on our provider website:

- Provider Handbook
- Region-Specific Quick Reference Guides
- Assistive Care Quick Reference Guides
- Medicaid preauthorization and notification list
- Enrollee Handbook
- Cultural Competency Plan
- Provider tools to address gaps in care
- Prescription Drug Guide
- Florida Medicaid Preferred Drug List
- Behavioral Health Tool Kit
- Home Health visit information
- Referral to Medicaid Case Management Form
- Urgent Updates
- Breast Pump Coverage
- Minority recruitment and retention information
- Provider nomination form
- Florida Medicaid Vaccines for Children (VFC) Program and child blood lead screening
- Crossover claims
- Child health checkup
- Medicaid eligibility for newborn babies

- Healthy Behavior Programs
- Quality Resources
- Program information
- Provider Directory
- Helpful Numbers
- Provider Training Calendar
- Electronic Billing
- Provider ebilling Companion Guide

Evaluation Criteria:

1. The extent to which plan leadership are involved in provider engagement.

2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.

3. The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas.

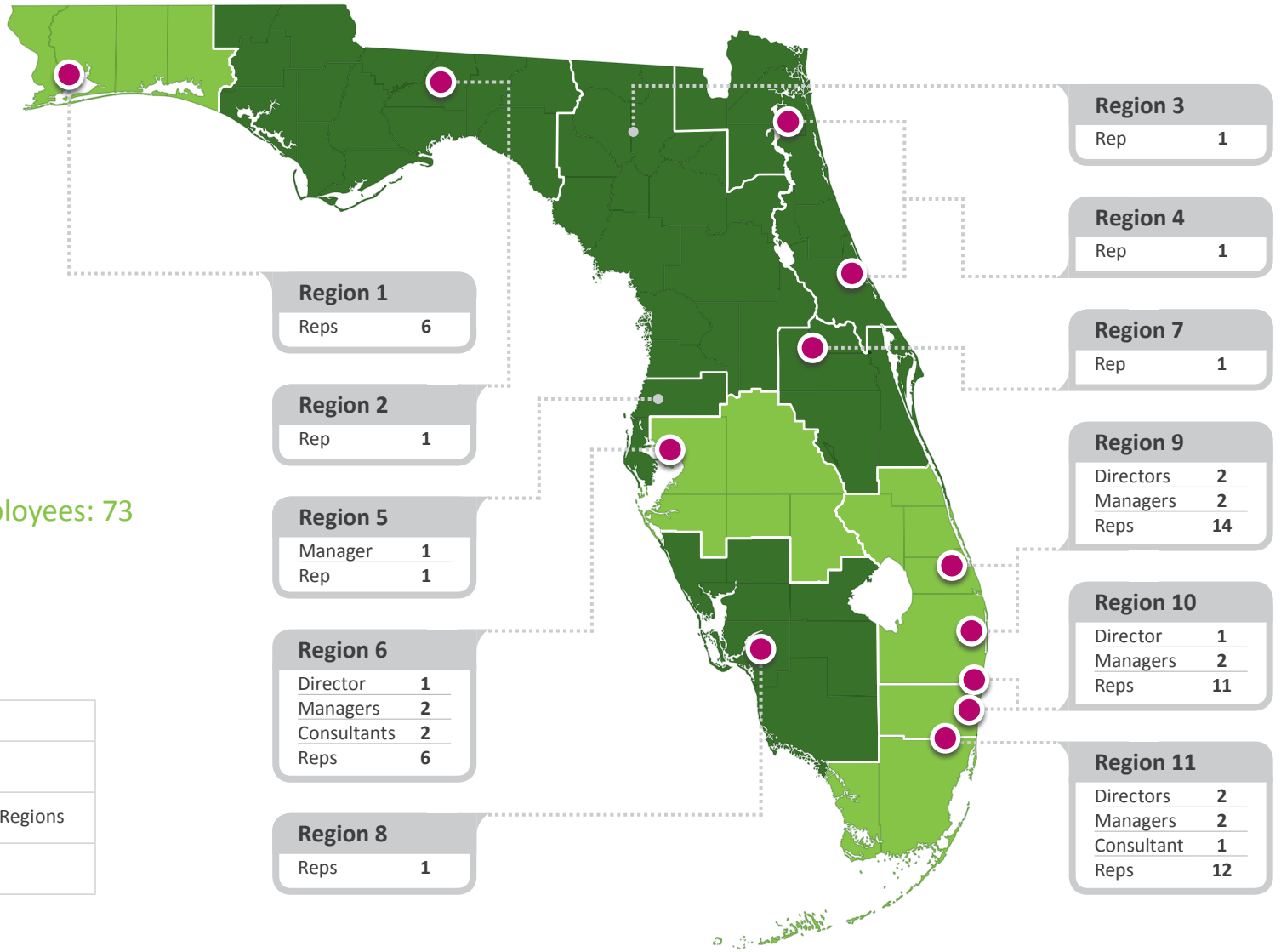
4. The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs.

5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.

6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Attachment 15-1: Florida Humana Office Locations



Region 1
Reps 6

Region 2
Rep 1

Region 3
Rep 1

Region 4
Rep 1

Region 5
Manager 1
Rep 1

Region 6
Director 1
Managers 2
Consultants 2
Reps 6

Region 7
Rep 1

Region 8
Reps 1

Region 9
Directors 2
Managers 2
Reps 14

Region 10
Director 1
Managers 2
Reps 11

Region 11
Directors 2
Managers 2
Consultant 1
Reps 12

Total FL Humana Employees: 73

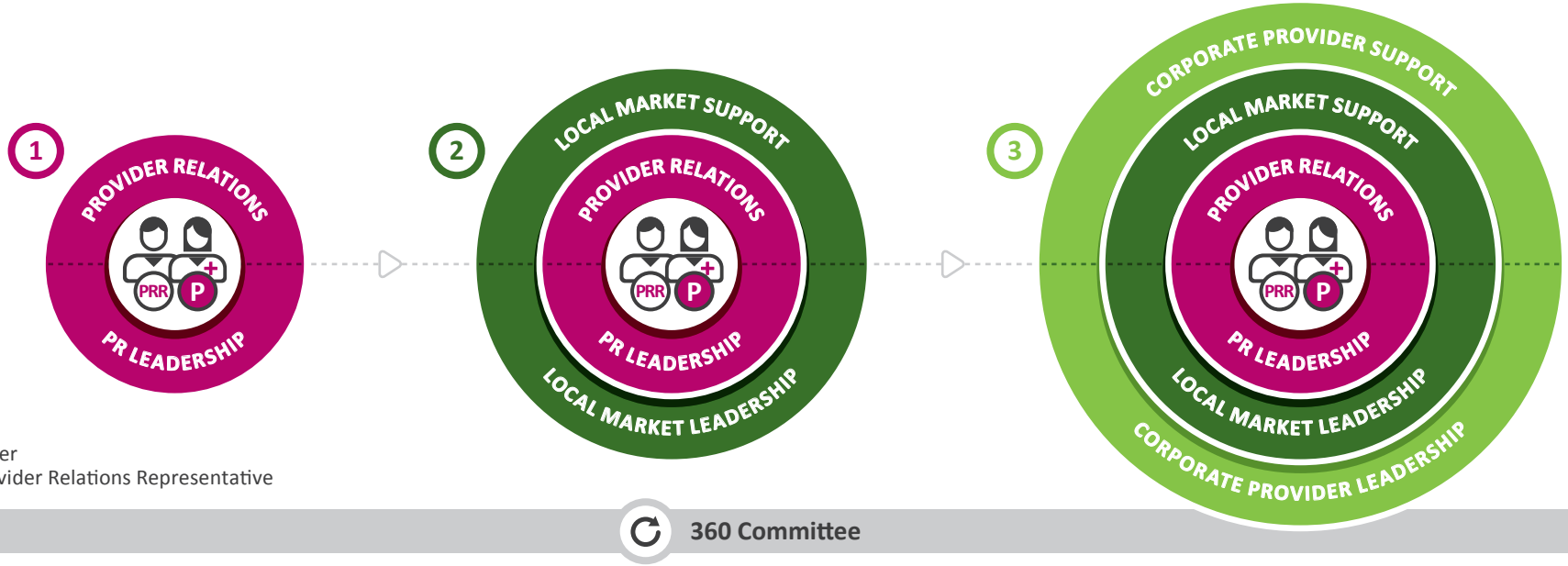
Directors: 6
Managers: 9
Consultants: 3
Representatives: 55

Map Key	
	Existing Humana Office
	Humana Comprehensive Regions
	Humana LTC Regions

Humana.

Attachment 15-2: Provider Support System

The diagram below conveys Humana's provider engagement model. Our model delivers cross-functional support to our providers to ensure we are aligned in achieving our mutual goal of improved quality outcomes for our enrollees through administrative simplicity, financial partnership, and provider satisfaction.



P = Provider
PRR = Provider Relations Representative

360 Committee

Provider Relations & Leadership

- **Provider Relations Representative (PRR)**
  - Face-to-face relationship with Provider
- Provider Relations Manager
- Provider Relations Director
- Regional VP Network Operations & Provider Experience

Local Market Support & Leadership

- Case Management
- Claims Resolution Team
- Compliance
- Disease Management
- Finance
- Legal
- Medicaid Operations
- Pharmacy
- Quality Nurses
- Service Alignment Manager
- Value-Based Payment

Corporate Provider Support & Leadership

- Claims Resolution Unit/Provider Claims Unit
- Corporate Finance
- Enterprise Medicaid Operations
- Enterprise Provider Support
- Provider Development
- Provider Network Operations
  - Contract Load Team
  - Credentialing
  - Directory
  - Fee Schedule Management
- Provider Payment Integrity
- Value-Based Payment

Humana.

Attachment 15-3: InfoMarket Claims Reporting

MCD_Ranking_Adult_SFL_May_2017_Posted_7.27.17

Market	South FL	**Average POINT Score:**	1.94
Grouper Name:	AMERICAN CARE OF SO FLA INC	**Average Percent:**	49.28%
Membership:	1528	**Percentile Among Similar Groups:**	62
Size:	LARGE	**Period:**	2nd Qtr 2017

Weighted Average

Prev.Mth.	Curr. Mth.	Status
1.63	1.94	↑

* Data as of 5/31/2017 for claims with dates of service 01/01/2017 - 5/31/2017 & last attributed PCP.

POINT Measure	# GAPS	Passes	RATE	# Elig	POINTS	NCQA Gaps to 5	*AVG %	NCQA/HUM Benchmarks 4 POINT	NCQA/HUM Benchmarks 5 POINT	Gaps to BONUS 75th	HUMANA SFL BONUS 50th	HUMANA SFL BONUS 75th
Adolescent Well Care	92	18	16.36%	110	1	46	14.63%	52.11%	57.66%	0	n/a	n/a
Adult Access to Primary Care (Total)	643	633	49.61%	1276	1	459	58.68%	83.51%	85.54%	503	86.00%	89.00%
Adult BMI Assessment	90	431	82.73%	521	2	35	76.86%	86.40%	89.35%	0	n/a	n/a
Annual Dental Visit	92	20	17.86%	112	1	48	23.46%	55.02%	60.01%	0	n/a	n/a
Annual Monitoring on Persistent Meds (Total)	8	82	91.11%	90	5	0	79.28%	88.16%	89.56%	0	n/a	n/a
Antidepressant Medication Management (Acute)	23	12	34.29%	35	1	9	48.13%	55.89%	59.56%	0	n/a	n/a
Antidepressant Medication Management (Contin)	30	5	14.29%	35	1	11	25.70%	40.23%	43.45%	0	n/a	n/a
Breast Cancer Screening	43	46	51.69%	89	1	12	57.57%	60.91%	65.06%	15	60.00%	68.00%
Cervical Cancer Screening	366	372	50.41%	738	2	97	50.43%	58.95%	63.52%	123	60.00%	67.00%
Children & Adolescent Access to Primary Care d (12 - 19 Yrs)	22	32	59.26%	54	1	19	60.26%	90.69%	92.67%	19	91.00%	93.00%
Chlamydia Screening (Total)	23	38	62.30%	61	5	0	54.47%	57.77%	61.69%	0	n/a	n/a
Diabetes Care - HbA1c <8%	70	58	45.31%	128	2	10	36.67%	48.99%	52.51%	14	50.00%	56.00%
Diabetes Care - HbA1c Testing	27	101	78.91%	128	1	14	70.76%	87.34%	89.43%	16	87.00%	91.00%
Diabetes Care - Monitoring Diabetic Nephropathy	8	120	93.75%	128	5	0	85.88%	91.09%	91.97%	0	n/a	n/a
Diabetes Care - Eye Exam	76	52	40.63%	128	1	27	37.97%	56.82%	61.50%	0	n/a	n/a
Medication Management for People with Asthma	2	0	0.00%	2	1	1	0.07%	33.90%	37.63%	0	n/a	n/a

AMERICAN CARE OF SO FLA INC Is Ranked 8 **Out Of** 21 Groups w/ Similar Humana MCD Adult mbrs in **South FL**

AMERICAN CARE OF SO FLA INC Is Ranked 8 **Out Of** 23 Groups w/ Similar Humana MCD Adult mbrs in **Florida**

* The Average Percent is based upon Groupers with Comparable Humana Medicaid Adult membership in the overall Florida MCD market. (Small = 0-99 Members, Medium = 100-999 Members, Large = 1000+ Members)

Attachment 15-3: InfoMarket Claims Reporting

MCD_Ranking_Ped_SFL_May_2017_Posted_7.27.17

Market	South FL
Grouper Name:	PEDIATRIC ASSOCIATES PA
Membership:	55689
Size:	LARGE

Average POINT Score:	2.06
Average Percent:	61.27%
Percentile Among Similar Groups:	94
Period:	2nd Qtr 2017

Weighted Average

Prev.Mth.	Curr. Mth.	Status
1.94	2.06	↑

* Data as of 5/31/2017 for claims with dates of service 01/01/2017 - 5/31/2017 & last attributed PCP.

POINT Measure	# GAPS	Passes	RATE	# Elig	POINTS	NCQA Gaps to 5	*AVG %	NCQA/HUM Benchmarks 4 POINT	NCQA/HUM Benchmarks 5 POINT	Gaps to BONUS 75th	HUMANA SFL BONUS 50th	HUMANA SFL BONUS 75th
Adolescent Well Care	11697	4356	27.14%	16053	1	4901	18.90%	52.11%	57.66%	0	n/a	n/a
Annual Dental Visit	31354	17188	35.41%	48542	1	11943	29.27%	55.02%	60.01%	0	n/a	n/a
Childhood Immunization Combo 3	2270	2282	50.13%	4552	1	1160	33.43%	72.88%	75.60%	1315	74.00%	79.00%
Children & Adolescent Access to Primary Care a (12-24 mos)	224	4580	95.34%	4804	2	94	87.19%	96.36%	97.28%	176	98.00%	99.00%
Children & Adolescent Access to Primary Care b (25 mos- 6 yrs)	4538	14377	76.01%	18915	1	2832	64.31%	89.01%	90.98%	3214	90.00%	93.00%
Children & Adolescent Access to Primary Care c (7 - 11 Yrs)	940	10139	91.52%	11079	3	193	82.32%	91.90%	93.25%	387	92.00%	95.00%
Children & Adolescent Access to Primary Care d (12 - 19 Yrs)	1610	11460	87.68%	13070	2	652	76.76%	90.69%	92.67%	696	91.00%	93.00%
Chlamydia Screening (Total)	463	416	47.33%	879	1	127	51.20%	57.77%	61.69%	0	n/a	n/a
Follow Up Care ADHD Medication (Initiation)	305	151	33.11%	456	1	75	24.41%	45.13%	49.55%	0	n/a	n/a
Immunizations for Adolescents Combo1	564	1524	72.99%	2088	2	191	51.81%	77.55%	82.09%	251	78.00%	85.00%
Immunizations for Adolescents Combo2	1801	287	13.75%	2088	0	0	12.80%	0.00%	0.00%	0	n/a	n/a
Lead Screening in Children	378	4183	91.71%	4561	5	0	59.98%	74.43%	79.50%	0	n/a	n/a
Medication Management for People With Asthma	404	0	0.00%	404	1	153	0.17%	33.90%	37.63%	0	n/a	n/a
WCC - BMI Percentile	5285	19216	78.43%	24501	5	0	48.88%	71.64%	77.78%	0	n/a	n/a
WCC - Counseling for Nutrition	12313	12188	49.74%	24501	1	5179	38.04%	65.94%	70.88%	0	n/a	n/a
WCC - Counseling for Physical Activity	24439	62	0.25%	24501	0	0	19.00%	58.62%	63.47%	0	n/a	n/a
Well Child Visits First 15 Months (0 Visits)*Lower is Better*	40	3956	1.00%	3996	4	2	95.25%	1.40%	0.93%	0	n/a	n/a
Well Child Visits First 15 Months (6 Visits or More)	1601	2395	59.93%	3996	3	313	37.87%	62.85%	67.76%	403	63.00%	70.00%
Well-Child Visit Ages 3-6	7758	6663	46.20%	14421	1	4524	31.24%	73.88%	77.57%	0	n/a	n/a

PEDIATRIC ASSOCIATES PA Is Ranked 1 **Out Of** 16 Groups w/ Similar Humana MCD Peds mbrs in **South FL**

PEDIATRIC ASSOCIATES PA Is Ranked 1 **Out Of** 19 Groups w/ Similar Humana MCD Peds mbrs in **Florida**

* The Average Percent is based upon Groupers with Comparable Humana Medicaid Pediatric membership in the overall Florida MCD market. (Small = 0-99 Members, Medium = 100-999 Members, Large = 1000+ Members)

Humana

Attachment 15-4: 2017 MMA Provider Satisfaction Survey for Regions 1, 6, 9, 10 and 11

Survey Details (all regions)

	Total Sample Size	Total Surveys Completed
Primary Care Provider Locations	77	19
Specialist Provider Locations	147	49
Total	224	68

Top 5 Highest Overall Agree / Strongly Agree Responses – Areas of Strength

Section	Question	%
Provider Relations and Communications	1b. My provider relations representative is: Able to answer my questions.	99%
	1d. My provider relations representative is: Professional and courteous.	99%
	3. Educational and training materials are easy to understand.	98%
	4. My provider relations specialist: Responds to my needs or concerns in a timely manner.	81%
Care Coordination and Authorizations	10. Denial notifications, including the denial reason(s), are provided in a timely manner.	100%
Clinical Management	20. Case Managers are knowledgeable, professional land courteous.	100%
Authorization Process	10. Does the authorization clearly define what services are provided.	88%
Customer Service Department	19. When contacting Customer Service Department: Staff allows enough time to respond to my inquiries.	83%
Overall	2. I am satisfied with Humana Long-Term Care's service.	86%

Quotes from Letters of Support:

"We have had excellent customer service when dealing with our Humana Medicaid area representatives….We have also had excellent customer service with the Prior Authorization team. Due to our EHR we are unable to upload supporting medical documents to the Humana website. When a PA pends, we receive a call and we have a decision within a few hours of us faxing in the supporting documentation."

Christina Averhart, LPN, CLC
Clinical Team Lead
Fort Walton Beach Pediatrics, Sacred Heart Medical Group, Region 1 Walton County

"The provider website, especially the authorization submission portion, is very straight forward and easy to use. Our provider rep Jerred visits the office regularly to notify us of any recent changes to policy as well as make sure there is nothing that we need."

Amber Singh
Patient Accounts Genesis OB/GYN, Region 6 Hillsborough County

"The patients that we see here with Humana are genuinely happy with the options of the healthcare management Humana provides them… I would also like to add that the face to face contact that I have had with John Paul and Justin have been helpful, insightful and informative. Lastly Tori Woods, is always a joy to have here for our patients' education of Humana and Humana Plans."

Jennifer Johnson
Cantonment Medical Clinic, Site Coordinator, Region 1 Escambia County

"The Humana Medicaid program team has been responsive, professional and willing to work collaboratively to ensure that operational processes are timely for our patients. Humana demonstrates a real commitment to quality of care for their members. Humana has done an outstanding job delivering a MMA education program for our staff and physicians, and they have continued to our support our sites with ongoing programs."

Evan C. Jones

Executive Vice President/CFO, Region 6 Polk County

Humana continues to partner with our organization and provide ongoing education, support, and guidance. Our organizations regularly collaborate on many initiatives which benefit Pediatric Medicaid recipients in the communities we serve.

Scott Farr, COO and Peter Shulman, CEO

Pediatric Associates, Regions 4, 6,9,10, and 11

"We have the pleasure of working hand and hand with our provider relations representative Marianne Hall. The provider relations representative has always gone out of her way to assist us with provider related issues such as but not limited to Claim issues, Authorization issues, and she also makes personal visits throughout the year to ensure we maintain an open relationship with American Eldercare of Humana and keep the lines of communication open."

Jessenia Velez

CEO Quality Family Care, Region 9 Palm Beach County

"Humana's quality of services is outstanding, providing our elderly population and their members with superior quality of care. I say without a doubt that Humana is one of the finest organization, and there group of staff are people of very good moral character. Humana Health Plan operates with integrity, dignity and respect."

Wilma Rivera

Assistant Administrator, Suky Health Care Services, Inc., Region 11 Miami-Dade County

Good Afternoon Justin,

I would like to say that the experience that I have had with Humana in the past couple of years has been a pleasant one. The pt.'s that we see here with Humana are genuinely happy with the options of the healthcare management Humana provides them. I have always experienced the best quality of customer service when I have had to call any of the help desks to better help our pt.'s here. I would also like to add that the face to face contact that I have had with John Paul and Justin have been helpful, insightful and informative. Lastly Tori Woods, is always a joy to have here for our pt.'s education of Humana and Humana Plans.

Thank you and have a Great Day.

Jennifer Johnson
CMC Site Coordinator
748 N. Hwy. 29
Cantonment, Florida 32533

The information on this page is exempt from disclosure pursuant to Section 119.071(5)

We have had excellent customer service when dealing with our Humana Medicaid area representatives. They are always able to answer questions, provide written information, and chase up issues that have previously been reported. It is wonderful that they round on a monthly basis, this gives us the chance to ask questions.
We have also had excellent customer service with the Prior Authorization team. Due to our EHR we are unable to upload supporting medical documents to the Humana website. When a PA pends, we receive a call and we have a decision within a few hours of us faxing in the supporting documentation.

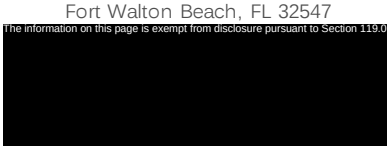
Christina Averhart, LPN, CLC

Clinical Team Lead

Fort Walton Beach Pediatrics

1025 Beal Pkwy, NW, Ste D

Fort Walton Beach, FL 32547



I just wanted to take the time to say that I really appreciate Humana's customer service. Any time that I need to call them, they are always extremely helpful and courteous. The provider website, especially the authorization submission portion, is very straight forward and easy to use. Our provider rep Jerred visits the office regularly to notify us of any recent changes to policy as well as make sure there is nothing that we need.

Thank you,
Amber Singh
Patient Accounts Genesis OB/GYN

Justin,

Our initial going live with Humana was not without a few glitches, these issues were addressed to our Provider Relations Specialist and was corrected immediately, which was additional training from Humana side.

We have been very satisfied with the Provider Specialist John-Paul Shaddock and his replacement Justin Donato.

Our claims are being paid in a very timely manner. access to the website is available to all of my employees to search for eligibility before the patient visit.

My over all assessment of Humana is a positive one. I will say the key to the success between our practice and Humana is the ease in which we can communicate with all department and not feel frustrated.

We are happy to be a provider of Humana Health Care.

Sincerely,

Jeanette Mobley
Office Manager for
Heba El Goweni, M.D., F.A.A.P.
Omaima Mousa, M.D., F.A.A.P.
Navarre Pediatrics, P.L.
8880 Navarre Pkwy Suite 102
Navarre, FL 32566

The information on this page is exempt from disclosure pursuant to Section 119.071(5)

May 8, 2017

To Whom It May Concern,

Over the past few years dealing with Humana Medicaid my experience has been overall very well. When I need guidance or assistance with something, whether it is for a prior authorizations or getting a patient assigned to us through provider/customer services, it has was handled promptly and efficiently. Justin Donato is always there to assist my office in any way, shape, or form. When I need help locating a specialist in our area, or if I just need him to look at a claim for me, he is always so helpful and assertive. Since this managed care plan has been in effect, I have had no problems with the service that was provided to me. The level of service that Justin extends to your company is far beyond my expectations. I am so impressed by customer service provided throughout the last year. It appears that it was simply Justin's extraordinary commitment to excellence in customer service and support that motivates him. Should you have any comments, questions, or concerns feel free to reach me at the office a The information

The information

Sincerely,

Morgan Brooks,CPC-A.

Medical Office Secretary
SHMG Pediatrics at Pace
5565 Woodbine Road
Pace, Florida 32533

Lakeland Regional Health®

1324 LAKELAND HILLS BLVD
LAKELAND, FL 33805

PO BOX 95448
LAKELAND, FL 33804-5448

The information on this page is nyLRH.org

May 10, 2017

To whom it may concern:

Lakeland Regional Health's Medical Center and Physician group has been contracted with Humana's Managed Medicaid Assistance (MMA) program since 2012 and 2013 respectively. The Humana Medicaid program team has been responsive, professional and willing to work collaboratively to ensure that operational processes are timely for our patients. Humana demonstrates a real commitment to quality of care for their members. Humana has done an outstanding job delivering a MMA education program for our staff and physicians, and they have continued to our support our sites with ongoing programs. LRH supports Humana's bid for continued participation in the Florida MMA program.

Sincerely,

Evan C. Jones
Executive Vice President/CFO

PEDIATRIC ASSOCIATES

To Whom It May Concern,

On behalf of Pediatric Associates, we are providing this letter in support of Humana's bid to provide services to children covered by the Florida Managed Medical Assistance program. Pediatric Associates has been working with Humana for many years to coordinate care for children in the Florida market.

Humana continues to partner with our organization and provide ongoing education, support, and guidance. Our organizations regularly collaborate on many initiatives which benefit Pediatric Medicaid recipients in the communities we serve.

Pediatric Associates supports Humana in the bid process for Medicaid Managed Care throughout the state of Florida.

Sincerely,

Scott Farr, MBA, MHA, CMPE
Chief Operating Officer

Peter J. Shulman, MD, MBA
Chief Executive Officer

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WATERS PEDIATRIC CENTER

7730 W WATERS AVE.
TAMPA FL 33615

The information on this page is exempt from disclosure pursuant to Section

May 11, 2017

To whom it may concern:

By this means I wish to express our experience as a Provider of Humana. We are really satisfied with the service that Humana Insurance Company giving to the patients and to our office.

The Company and the employee are really efficient and we are very happy to have business with that Insurance.

If you have questions, call us at The information on this page is exempt from disclosure pursuant to

Sincerely,

Dr. Sita Duggirala
Pediatrician

DOCTORS HEALTH GROUP
of South Florida

May 17, 2017

RE: Support for Humana Health Plans ITN

On behalf of Doctors Health Group of South Florida, I am pleased to submit a letter of support for Humana Health Plans' submission of the Florida Agency for Health Care Administration Medicaid ITN. We are proud of our almost five year Medicaid partnership with Humana for Regions ten and eleven. In that time, we have seen Humana's provider relations department works tirelessly to achieve a Medicaid delivery model that aligns with the needs of providers and patients.

Humana has created a delivery model that drives innovation and favorable outcomes while improving care and reducing costs by developing improved processes. Case management, chronic disease management, patient education and health improvement initiatives are just some of the overall services that as a provider we are leveraging to meet our objective to deliver the very best possible care.

Notably, Humana's support services help our organization achieve mutual objectives. We are aligned on quality of care and services to our Medicaid patients. Our organizations stand committed to continuing our work on behalf of Medicaid recipients to deliver the highest quality healthcare possible.

We appreciate your consideration of Humana's Medicaid ITN and are pleased to add our name in support of this award.

Sincerely,

Jorge L. Basto

201 N.W. 70 Avenue, Suite D. Plantation, FL 33317 • Phone:

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Health Practice Management, LLC
14750 N.W. 77th Court Suite 303
Miami Lakes, Florida 33016
(305) 777-3515

June 22, 2017

To Whom It May Concern:

I am pleased to have the opportunity to attest to my relationship and experiences with Humana. I have been contracted with Humana since the company expanded to Florida in the late 1980's. I have watched it grow and change to meet the needs of the community and the State of Florida as the demands and expectations have changed.

The one constant has been the quality of their Provider Relations Department, which prepares all new providers for the delivery of quality care to their members, by giving them the tools with which to meet the established standards. They, continually, update the new and seasoned providers by providing on-going support, by keeping Centers up to date and informed of new criteria, guidelines and services available that impact our Patients, their members, your Medicaid recipients.

They visit our Centers on a monthly basis and alert us, as the MSO, along with those with whom we are contracted, of all changes and new strategies that need to be implemented. They provide monthly data to every Center regarding their status and goals met. They are supportive of our needs and make every effort to resolve our concerns. We are better providers of care because of their determination to make us the best. Our being the best ensures that every Medicaid member receives quality care and services in every area.

Our goal is the same. We are their vehicle to the provision of care and they are our support while delivering it. Humana encourages Centers to become certified as PCMH. Many of our Centers are now certified, or are becoming certified, due to their support and that of the special people with whom our Centers work to attain this goal.

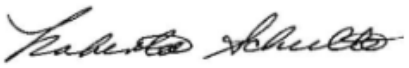
We know the importance of doing the best we can to keep our Patients healthy. Humana's special departments help us to do so by supporting the members and providers of care by identifying those in need of additional support and care. We, with their support, have been able to change lives by removing barriers for those that are viewed as "non-compliant" and/or "needy". When barriers are identified we, together, try to remove those barriers and find ways to change their path. We know that we will not always be successful due to circumstances, medical or social, that we, Humana and the Patient cannot control. When facing situations we, alone, cannot impact, we look to the special

teams to help us find the best way to help the members through these times, even if it is to help them accept what cannot be changed. We cannot touch all of those in need, although we try, but do not stop in our attempts to locate and serve.

We are grateful for being among those providers chosen to deal with the unique needs of the Medicaid recipients in the State of Florida and value those at Humana that support us and our efforts to meet the needs of those Medicaid lives entrusted to us and Humana.

I, again, thank you for the opportunity to express to you the role Humana plays in making us able to better serve Medicaid recipients and to help improve the delivery of care to this deserving population. They are our partners in meeting challenges and celebrating successes.

Sincerely,



Roberta Schulte
Chief Operating Officer
Health Practice Management, LLC

mso+Health Systems
A Division of Independent Living Systems

July 6, 2017

Re: HUMANA

To whom it may concern,

Independent Living Systems ("ILS") would like to express our support for HUMANA in their bid for the Medicaid ITN in Florida. ILS and HUMANA have worked for over 16 years in Florida and nationally to provide quality and compassionate care to its members.

ILS enjoys open lines of communication with HUMANA. HUMANA is committed to maintaining these lines open with monthly meetings, education and guidance. We have worked jointly on various collaborations and initiatives for their members. Through their many years of service, HUMANA has been an excellent partner in the care of the Medicaid population.

If you have any questions or require further information, please do not hesitate to contact me directly at

The information on this page is exempt from

Sincerely,

Nestor J. Plana
CEO & Chairman of the Board

NJP/cmg

5200 Blue Lagoon Drive • Suite 500 • Miami, Florida 33126 •
www.ilshealth.com

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Fatima Home Care, Inc.

August 24, 2017

To Whom It May Concern:

It is with great pleasure and sincerity that we recommend Humana Health Plan to be selected as a provider for the SMMC and MMA Program. We have worked with this health plan for over 10 years. Humana Health Plan can continue to be an excellent asset to States Medicaid Program.

Humana Health Plan has excelled in meeting beneficiaries needs in a manner that has been cost effective to the State. In a time where healthcare cost is out of control they have been a very good at controlling cost. We at Fatima Home Care, Inc give our wholehearted endorsement to Humana Health Plans and their affiliates.

If you should have any further questions please feel free to reach us at The information on this page is exempt from disclosure pursuant to The information on this page is exempt from disclosure pursuant

Sincerely,

Javier C. Moreno, LPN, MBA
Director of Operations

JCM/cm

SUKY HEALTH CARE SERVICES, INC.
2350 SW 8 STREET, SUITE #202, MIAMI, FLORIDA 33135
The information on this page is exempt from disclosure pursuant to Section 119.071(5)

August 23, 2017

To Whom It May Concern:

I am writing to tell you of the many fine qualities of Humana Health Plan. Humana Health Plan has worked with Suky Health Care Services, Inc. for quite some time now, it has been a great pleasure working with Humana as a provider and wish to continue working with you in the near future. Humana's quality of services is outstanding, providing our elderly population and their members with superior quality of care.

I say without a doubt that Humana is one of the finest organization, and there group of staff are people of very good moral character. Humana Health Plan operates with integrity, dignity and respect.

We hope that Humana Health Plan gets awarded the contract you seek with the State of Florida. If you have any further questions, please do not hesitate to contact me at The

Respectfully,

WILMA RIVERA

Wilma Rivera,
Assistant Administrator

Quality Family Care

Home Health Care Referral Agency

August 31, 2017

Re: Letter of Recommendation for American Eldercare

To whom it may concern:

We are delighted to write this letter of recommendation for American Eldercare of Humana for their bidding process. Quality Family Care has been working with American Eldercare since 2013. We have the pleasure of working hand and hand with our provider relations representative Marianne Hall. The provider relations representative has always gone out of her way to assist us with provider related issues such as but not limited to Claim Issues, Authorization Issues, and she also makes personal visits throughout the year to ensure we maintain an open relationship with American Eldercare of Humana and keep the lines of communication open. Customer service and claims department are always helpful and efficient when resolving claim issues and errors. They are easy to reach and eager to assist us with denial errors.

Sincerely,

Jessenia Velez

Jessenia Velez
CEO

7500 S DIXIE HWY WEST PALM BACH, FLORIDA 33405

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FAHA Health and Services

A subsidiary of LeadingAge Florida

October 6, 2017

Mark Henry, Director
Network Development, LTSS
Humana Long Term Care
777 Yamato Road, Ste. 510
Boca Raton, FL 33431

Dear Mark,

This letter is written in support of Humana for the Statewide Medicaid Managed Care Long Term Care program bid. Florida Association of Homes for the Aging Health and Services Corporation (FAHA Health & Services) is a network of nursing homes consisting of approximately 2,900 beds. FAHA Health & Services has been in network with Humana serving the long term care residents since September 2013.

Our experience working with the Humana provider relations team, specifically Mark Henry and Ed Miller, has been consistently professional and positive. The FAHA H&S providers greatly appreciate Humana's common sense provider and member centric approach. We look forward to continuing to work with the Humana Long Term Care team after the new SMMC contract renewal.

Please feel free to share this letter in support of Humana's continued participation in the SMMC LTC program.

Sincerely,

Dana McHugh
Executive Director

Brian Robare, *Board Chair*
Dana McHugh, *Executive Director*

The information on this page is exempt from disclosure

gins Road, *Tallahassee, Florida 32308*
www.leadingageflorida.org/?FAHAhs

Humana Medicaid Provider Orientation Training

Information for Medicaid health care providers and administrators

Effective January 2018

Florida

Humana.

442MUL0817-C FLHK2X5EN

Notable changes

This overview has been provided to list the key points of notable changes and the sections in which they are detailed.

Section	Page	Summary of change
Notable changes	2	Added to provide additional guidance for contracted health care providers and business partners who may have taken this training in 2017.
Contracting process – required information	15	Defined Medicaid provider number.
CAQH ProView streamlines credentialing process	17	Exchanged on process and advantages of CAQH.
Crossover claims	41	Added disclaimer that Medicare crossover claims for dual eligibles no longer need to be directly sent to Humana.
Patient-centered medical home	61	Provided more comprehensive description.
Electronic Health Record (EHR)	74 – 75	Expanded to include description of advantages of EHR and how to obtain assistance.
Managed Medical Assistance Program	99 – 101	Added section regarding incentive program for physicians that demonstrate high quality.
Medicaid Enrollment for Claims Payment	102 – 103	Added section regarding the requirement to have a valid Medicaid enrollment to receive claims payment.

Humana

Training topics

	Topic	General guidance	Page
1.	**About Humana**	• Types of offerings • Company size, revenue and membership	7
2.	**Statewide Medical Managed Care Program**	• The purpose, eligibility and components of the program	8 – 9
3.	**Florida's Managed Medical Assistance Program**	• Design • Objectives	10
4.	**Humana's foundation for Florida Medicaid**	• Engagement strategy • Support infrastructure	11 – 12
5.	**Contracting and credentialing**	• Requirements • Contact information for them	13 – 20
6.	**Access to care requirements**	• Pertains to what providers must assure for members	21
7.	**Web resources**	• Humana-specific and related web pages • Contact information for access assistance to the secured pages	22 – 25
8.	**Preauthorization and notification**	• Purpose • Humana-specific web pages with more information • Contact information for these processes	26 – 30

Training topics are based on the following:

- Humana's contract with the Florida Agency for Health Care Administration (AHCA)
- Humana's policies and procedures

Humana

Training topics (continued)

	Topic	General guidance	Page
9.	**Claims processing**	• Electronic and paper claim submissions • Encounter submissions • Avoiding submission errors • Timeliness requirements • Online resource for claim status and edit questions • Claim escalation or dispute process and contacts • Electronic claims payment option • Balance billing • Crossover claims	31 – 43
10.	**Continuity of care**	• Process overview	44 – 45
11.	**Member special needs consideration**	• Expectations of providers regarding special needs • Multidisciplinary team approach to determine a member's care plan and care coordination	46 – 48
12.	**Member screening for alcohol and substance abuse**	• Related requirements for primary care providers	49
13.	**Clinical management programs**	• Their purpose • Humana-specific web pages with more information • Programs offered	50 – 61
14.	**Patient-centered medical home**	• Definition of and requirements for this model of care	62 – 65
15.	**Medicaid Risk Adjustment**	• Reimbursement calculation method and example • Documentation guidelines	66 – 70

Humana

Training topics (continued)

	Topic	General guidance	Page
16.	**Medicaid Advisory Panel**	• How Humana assesses needs of members are being addressed and opportunities for improvement are being identified • Composition and objectives of the panels	71 – 73
17.	**Service level agreements**	• Timelines and percentage requirements by core service • Electronic health records (EHRs)	74 – 80
18.	**Agency for Health Care Administration (AHCA) provider-based marketing guidelines**	• What providers may and may not market	81 – 87
19.	**Additional training**	• List of other trainings, where to find them and how to assure completion is documented	88 – 89
20.	**Fraud, waste and abuse**	• Requirement to report, reporting options and protections related to reports of suspected false claims	90 – 93
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Humana

Training topics (continued)

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	Appendix – Region-specific information	• Rewards and incentives • Additional clinical management program (ER) for region 11	114 – 122

Humana

1. About Humana

- Insurance products
- Health and wellness services
- $39 billion in annual revenues
- 50,000 employees
- Plans for employer groups, individuals and government agencies
- Commercial, Medicare and Medicaid (in select markets)
- Plans include health, dental, vision and behavioral health
- 14.3 million medical members
- 7 million specialty members

Humana

2. Statewide Medical Managed Care Program (SMMC) – Purpose and Eligibility

SMMC is designed to care for all eligible individuals by providing access to:

Long-Term Care

- Care in a nursing home or a less-restrictive environment in the community.

Eligibility requirements:

- 21 years of age or older
- Reside in Florida
- Meet physical and financial requirements as determined by the state

Humana
Long-Term Care

MMA

- Comprehensive Medicaid services

Eligibility requirements:

- Beneficiaries ages birth to 21 and 21 and over
- Reside in Florida
- Meet the eligibility requirements as established by the Agency for Health Care Administration (AHCA)

Humana

Humana

2. SMMC Program – Overview

The SMMC Program has two components:

- **Long-Term Care (LTC)**
  Medicaid recipients who qualify and become enrolled in the Florida Long-Term Care Managed Care (LTCMC) program will receive LTC services through an LTC managed care plan.
- **Managed Medical Assistance (MMA)**
  Medicaid recipients who qualify and become enrolled in the Florida MMA program will receive all health care services other than long-term care though a managed care plan.

Humana

3. Florida's Managed Medical Assistance Program

- Florida's MMA program is designed to provide a statewide managed care delivery system that will improve outcomes, improve consumer satisfaction and reduce and control costs.
- The Florida MMA program focuses on four key objectives in order to support successful implementation:
  1. Preserving continuity of care.
  2. Requiring sufficient and accurate networks under contract and taking patients, allowing for an informed choice of plans for recipients and the ability to make appointments.
  3. Paying providers fully and promptly to preclude provider cash flow or payroll issues and giving providers ample opportunity to learn and understand the plan's prior authorization procedures.
  4. Coordinating with the Choice Counseling Call Center and website operated by the Agency's contracted enrollment broker.

Humana

4. Humana's foundation for Florida Medicaid

- Our focus on member well-being through a coordinated care and engagement strategy and strong support infrastructure simultaneously benefits each of our members on his or her journey to better health.

MEMBER ENGAGEMENT
- Continuity of care
- Member outreach
- Healthy behavior incentives
- Case management
- Disease management
- Care coordination (LTC)
- Interdisciplinary care team (LTC)

PROVIDER ENGAGEMENT
- Initial and ongoing training
- Town halls for each region
- Monthly primary care provider (PCP) staff visits
- Quality bonuses
- Preferred PCP network

COMMUNITY ENGAGEMENT
- Advisory panels
- Healthy Start collaboration
- Community outreach

SUPPORT INFRASTRUCTURE
- Member and provider services
- Quality management and improvement
- Compliance
- Administrative services
- Collaboration and alignment with AHCA

STRATEGY & IMPLEMENTATION APPROACH

How Humana will provide a seamless transition and continuity of care for Florida members:
- Organizational structure
- Clinical staffing support
- Florida training program
- Transition/continuity of care
- Leveraging behavioral health expertise

Humana

Keys to success

- Humana has the proven track record to provide high-quality care to Florida members.
  - Florida-based market support team
  - Experience with Florida and its unique populations
  - Seamless and scalable network
  - Community integration and outreach
  - Dedication to lifelong well-being
  - Focus on measureable outcomes

Humana

5. Contracting and credentialing

Humana.

Contracting process

Humana MMA

Visit:

www.humana.com/provider/medical-providers/network/learn-more/

- Click on "Complete our online form"
- Complete the form

Humana LTC

Call:

- Customer Service at 1-888-998-7735
- Provider Relations at 1-561-860-8660 to connect with a provider service representative

After receipt and review of the submitted form, a provider contracting specialist will contact you.

Humana

Contracting process – required information

- Physician/practice/facility name
- Service address with phone, fax and email information (for LTC – provide counties served)
- Mailing address, if different than service address
- Taxpayer identification number (TIN)
- Specialty
- Medicaid provider number (enrolled or limited with correct specialty and type)
- National Provider Identifier (NPI)
- CAQH number
- For LTC: Florida state license and proof of insurance
- Lines of business (e.g., Medicaid, Medicare, etc.) of interest
- Type of contract (e.g., individual, group, facility)

Humana

Credentialing

- Health care providers must be credentialed prior to network participation in order to treat Humana members.
- Provider office site evaluations must be completed for all PCP and OB-GYN provider locations prior to participation with Humana and during recredentialing.
- Recredentialing occurs at least every three years.
- Some circumstances require shorter recredentialing cycles.
- Humana participates with CAQH® (Council for Affordable Quality Healthcare) for applicable provider types.

✓ Further details regarding Humana's credentialing/recredentialing requirements can be found in Humana's Provider Manual at https://www.humana.com/provider/support/publications

Humana

CAQH ProView®

- Physicians and health care professionals need to use the Council for Affordable Quality Healthcare (CAQH) ProView tool to provide credentialing information to Humana. Note: This excludes facilities.
- CAQH ProView is the trusted source and industry standard for self-reported provider data and eliminates redundant applications, including state applications, required by a health care professional's contracted health plans, including Humana. Using CAQH reduces the amount of time health care professionals spend on credentialing and recredentialing by allowing them to submit information to the tool once and then update it via the attestation process.

Humana

CAQH ProView (cont'd)

- How this affects health care professionals:
  - **Initial applicants** must use CAQH for requests submitted **Jan, 1, 2017, and after.**
  - Health care professionals due for **recredentialing Sept. 1, 2017, and after** will need to submit their information through CAQH.
  - The use of **CAQH will reduce the amount of time involved with credentialing and recredentialing, as well as costs.**
  - Network health care professionals who have not used CAQH or who have outdated information have been notified via fax to their credentialing point of contact.

Humana

CAQH ProView (cont'd)

- How this affects health care professionals:
  - If you are **already registered** with CAQH, then please ensure your information is current and complete and that you have granted Humana authorization to review/receive the credentialing information.
  - If you **are not registered** with CAQH, then please complete a registration form via https://proview.caqh.org/PR/Registration. Once the registration is submitted, you will receive an email from CAQH with a CAQH Provider ID. You will then need to complete the online CAQH application and grant Humana authorization to review/receive your information.
  - Questions may be emailed to CredentialingInquiries@humana.com.

Humana

Contacts for contracting/credentialing

- **For Humana MMA**: To check the status of your credentialing or contract, please call Humana Provider Relations at 1-800-626-2741 (Monday through Friday, 9 a.m. to 6 p.m. Eastern time) or contact your local contracting representative.
- **For Humana LTC**: To check the status of your credentialing or contract, please contact your local contracting representative or call Humana Provider Relations at 1-561-860-8660 (Monday through Friday, 8 a.m. to 5 p.m. Eastern time).

Humana

6. Access to care requirements

- Participating primary care physicians (PCP) and specialists are required to ensure adequate accessibility for health care 24 hours per day, seven days per week and shall not discriminate against members. An after-hours telephone number must be available to members (voice mail is not permitted). Members should be triaged and provided appointments for care within the following time frames:
  - **Urgent care** – member must be provided an appointment within 24 hours.
  - **Routine sick member care** – member must be provided an appointment within seven calendar days of making a request.
  - **Well-care and routine visits** – member must be provided an appointment within 30 calendar days of making a request.

Humana

7. Web resources

Humana.

Provider website – public

Humana MMA

Humana.com/providers and Humana.com/floridamedicaid

- Health and wellness programs
- Clinical practice guidelines
- Provider publications (*including Provider Manual – Florida Appendix*)
- Pharmacy services
- Claim resources
- Quality resources
- What's new

Humana LTC

- **Humana.com/humanalongtermcare**
  - Provider handbook
  - Provider directory
  - Provider education
  - Provider e-billing
  - Updates

Humana

Provider self-service help

For help or more information regarding web-based tools

Humana MMA

- Visit **eBusiness@humana.com**

Humana LTC

- Call 1- 561-860-8660

For training

Humana MMA

- Visit **www.humana.com/providerwebinars**

Humana LTC

- Visit **www.humana.com/humanalongtermcare**

Humana

Working with Humana online? Use the multipayer Availity Web Portal

The Availity Web Portal is Humana's preferred method for online transactions.

- ✓ Use one consistent site to work with Humana and other payers
- ✓ Check eligibility and benefits
- ✓ Submit referrals and authorizations (MMA)
- ✓ Manage claim status
- ✓ Use Humana-specific tools

About Availity

- Cofounded by Humana
- Humana's clearinghouse for electronic transactions (EDI) with providers

How to register

- Go to **www.Availity.com**.

Join us for a training session

- Visit **www.Availity.com/Humana** to learn about training opportunities and reserve your space.

Questions?

- Availity help with registration and tools: Call 1-800-AVAILITY (1-800-282-4548).
- Questions for Humana: Email eBusiness@Humana.com.

Humana

8. Preauthorization and notification

Humana.

Preauthorization and notification

- Allows Humana to provide members' benefit information. (For LTC, contact provider relations at 1-561-860-8660.)
- Required for many services and medications.
- Access lists at **Humana.com/PAL**
  - Select the current "Medicaid Preauthorization and Notification List."

Humana

Preauthorization for medical procedures

Humana MMA

- Call 1-800-523-0023 (available 24 hours a day) for automated requests
- Representatives available 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding major holidays)
- Press "0" or say "representative" for live help
- Have tax ID number available

Humana LTC

- Authorizations are requested through the provider or the member's care manager
- Provider receives a faxed copy of the authorization

Humana

Drug prior authorization and notification

- Get forms at **www.humana.com/pa** or call 1-800-555-2546 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)
- For drugs delivered/administered in physician's office, clinic, outpatient or home setting (fee-for-service providers only):
  - **www.humana.com/medpa**
  - 1-866-461-7273 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)

Humana

Online authorizations for MMA

- **Online submission**
  - Fast and easy entry of authorizations
  - Express entry feature
  - Real-time responses
  - Ability to add attachments
  - Quick print feature

Sign into Humana's secure provider portal at:
Availity.com

Email questions to:
eBusiness@humana.com

- **Online management**
  - Access to last 18 months of authorization history
  - Ability to update authorizations
  - Status updates on submitted authorizations

This process does not apply to Humana LTC providers.

Humana

9. Claims processing

Humana.

Electronic claim submission

- Claims clearinghouses:*
  - Availity www.availity.com 1-800-282-4548
  - Change Healthcare (formerly Emdeon) www.changehealthcare.com 1-888-363-3361
  - ZirMed www.zirmed.com 1-877-494-7633
  - TriZetto www.trizettoprovider.com 1-800-969-3666
  - RelayHealth www.relayhealth.com 1-800-388-2316
  - SSI Group www.thessigroup.com 1-800-881-2739

*Some clearinghouses and vendors charge a service fee. Contact the clearinghouse for more information.

Humana MMA providers

- Go to: Humana.com/claimresources
- Choose "Claims and encounter submission"

Humana LTC providers

- Go to: www.availity.com

Humana

Payer IDs

- When filing an electronic claim, you will need to utilize one of the following payer IDs:

Humana MMA

- **61101** for fee-for-service claims
- **61102** for encounter claims

Questions

eBusiness@humana.com

Humana LTC

- **61115** for all claims

Questions

LTCProviderrelations@humana.com

Humana

Paper claims submission

- Paper claims should be submitted to the address listed on the back of the member's ID card or to the appropriate address listed below:

Medical claims
Humana Claims Office
P.O. Box 14601
Lexington, KY 40512-4601

Encounters
Humana Claims Office
P.O. Box 14605
Lexington, KY 40512-4605

Behavorial health claims
Region 1 only
Access Behavioral Health
1221 W. Lakeview Ave.
Pensacola, FL 32501

Behavorial health claims
Regions 6, 9, 10 and 11
Beacon Health Options
Attn: Claims Dept.
10200 Sunset Drive
Miami, FL 33173-3033

Humana LTC claims
Humana Long-Term Care Plan
P.O. Box 14732
Lexington, KY 40512-4732

Humana

Importance of encounter submissions in Medicaid

- AHCA requires 100 percent encounter submissions.
  - 95 percent must pass through state system.
    - Necessitates proper AHCA registration and billing.
      - Accurate NPI, taxonomy and ZIP code (including the last four digits of ZIP code) must be submitted on all transactions.
  - Fee-for-service and capitated providers included.
- Encounters and claims identify members who received services.
  - Decreases the need for medical record review during Healthcare Effectiveness Data and Information Set (HEDIS).
  - Will be critical for future world of Medicaid Risk Adjustment.
  - Helps identify members receiving preventive screenings – decreases members listed in GAP reports.
- Providers may receive sanctions for noncompliance.
  - Can include liquidated damages and even enrollment freezes.

Humana

Claims submission errors and how to avoid them

- Common rejection or denial reasons:
  - Patient not found.
  - Insured subscriber not found.
  - Patient birthdate is incorrect.
  - Invalid Healthcare Common Procedure Coding System (HCPCS) code submitted.
  - No authorization or referral found.
  - Billed amount missing.
- How to avoid these errors:
  - Confirm that patient information received and submitted is accurate and correct.
  - Ensure that all required claim form fields are complete and accurate.
  - Obtain proper authorizations and/or referrals for services rendered.
  - Ensure billed amounts are not zero dollar.

Humana

Timely filing

- **MMA**: Fee-for-service claims should be filed as soon as possible, but no later than **six** months, per state guidelines.
- **LTC**: Claims should be filed as soon as possible, but no later than **six** months after the date of service, per state guidelines.
- **Encounter** claims should be filed within **30** days of the date of service.
- Claims timely filing and HEDIS:
  - Providers are required to timely file their claims/encounters for all services rendered to members. Timely filing is an essential component reflected in Humana's HEDIS reporting and can ultimately affect how a plan and its providers are measured in member preventive care and screening compliance.

Humana

Claim status and edit questions

- Sign into Humana's secure provider portal at **availity.com** (registration required) to take advantage of the following self-service tools:
  - View claims status
  - Submit claims
  - View and download remittance advices
- For more information on claims processing edits and how to submit questions regarding them, visit:
  - **Humana.com/edits**

Humana

Claim escalation

- Step 1: Call the number on the back of the member's ID card.
  - Have reference number handy.
  - Ask for front-line leader.
- Step 2: Submit claim dispute to the following address:
  - **MMA**: Humana Provider Correspondence, P.O. Box 14601, Lexington, KY 40512-4601
  - **LTC**: Humana LTC, Attention Grievance and Appeals Dept., P.O. Box 14546, Lexington, KY 40512-4546
- Step 3: If there is a factual disagreement with the response, send an email with the reference number to humanaproviderservices@humana.com.

Humana

Claims payment: Electronic funds transfer (EFT) and electronic remittance advice (ERA)

Receive Humana payments via direct deposit into the bank account of your choice.

Receive HIPAA-compliant ERA transactions.

Get paid up to seven days faster than via mail.

Have remittances sent to your clearinghouse, or view them online.

Reduce the risk of lost or stolen checks.

Reduce paper mail and time spent on manual processes.

Humana

Ebusiness resources

Contact us if your organization needs:

Payments deposited in **more than one bank account.**

Separate remittance information for different providers or facilities.

ERA/EFT setup for **multiple provider groups, facilities and/or individuals.**

An eBusiness consultant can help set up ERA and EFT quickly and accurately.

Send an email to **eBusiness@Humana.com** for assistance.

Humana

Balance billing

- Per Humana's Provider Manual:
  - **Services that are not medically necessary:** The provider agrees that in the event of a denial of payment for services rendered to members determined not to be medically necessary by Humana, that the provider shall not bill, charge, seek payment or have any recourse against the member for such services.

Humana

Crossover claims

- Effective Oct. 1, 2016, providers no longer need to send Medicare crossover claims for dually eligible recipients directly to Humana. Under this initiative, providers only need to submit their claims once to the Centers for Medicare & Medicaid Services (CMS) for processing and are no longer required to submit secondary claims to Humana. This means CMS will automatically forward claims for members who are dually eligible for both Medicare and Medicaid coverage.
  - **Please note:** If a provider submits a claim for a dually eligible member that CMS has already forwarded to Humana, Humana will deny the provider-submitted claim as a duplicate claim.

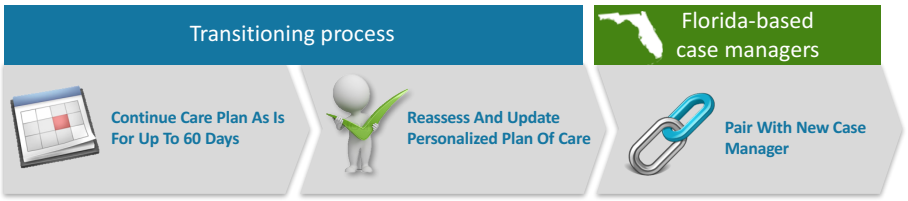
Humana

10. Continuity of care

Humana.

Transition/continuity of care: Enrollee services/care coordination/utilization management

- Through the following process, we will **ensure that transitioning members will still receive care** even if Humana does not have a contract with their current provider:



- Ensure no care disruptions
- Emphasize maintaining member's well-being and safety while addressing unmet needs
- Contract with nonparticipating providers

- Identify members to transition
- Determine unmet needs and put necessary services in place
- Coordinate and build relationships with providers

- Based on location to ensure familiarity with local resources
- Assign PCP Center to facilitate coordinated care with PCP
- Consider cultural and language needs

Humana

11. Member special needs consideration

- Providers must make efforts to understand the special needs required by members. The member may have challenges that include physical compromises as well as cognitive, behavioral, social and financial issues. Multiple comorbidities, complex conditions, frailty, disability, end-of-life issues, end-stage renal disease (ESRD), isolation, depression and polypharmacy are some of the challenges facing these members each day.
- Recognizing the significant needs of members, Humana incorporates person-centered care planning, coordination and treatment in our care coordination program.

Humana

Member special needs consideration (cont'd)

- Care management is delivered within a multidisciplinary team (MDT) structure and holistically addresses the needs of each member.
- The member and/or his/her authorized caregiver are maintained at the core of the model of care, ensuring person-centered care and supported self-care.
- The Humana case manager leads the member's MDT and links closely to the member's PCP to support him/her in ensuring the member gets the care needed across the full spectrum of medical, behavioral health and other services. PCP participation in the MDT is a critical component in the success of the member's care.

Humana

Member special needs consideration (cont'd)

- Humana's predictive model, based on claims history and analytics, is used to determine each member's risk level and level of intervention required in order to channel the member to the required level of coordination.
- A comprehensive assessment is completed for each member to evaluate his or her medical, behavioral and psychosocial status to determine the plan of care.

Humana

12. Screening for alcohol or substance abuse

- Participating PCPs must screen members for signs of alcohol or substance abuse as part of prevention evaluations during the following times:
  - Initial contact with a new enrollee
  - Routine physical examinations
  - Initial prenatal contact
  - When the enrollee shows evidence of serious overutilization of medical, surgical, trauma or emergency services
  - When documentation of emergency room visits suggests the need
- Members who are determined to have met one of the above indicators may be referred to an appropriate participating behavioral health provider.

Humana

13. Clinical management programs

Humana.

Clinical management programs

- Clinical management programs are designed to:
  - Reinforce medical provider's instructions.
  - Promote healthy living.
  - Provide guidance to members with complex conditions.
- To learn more, visit **Humana.com/healthwellness**

Humana

Health services and utilization management

Utilization management

- Provide on-site and telephonic concurrent review and discharge planning.
- Promote effective level of care based on member's individual needs.
- Provide disease-specific education.
- Refer to appropriate Humana programs.

Humana

On-site/telephonic review

- On-site and telephonic nurse reviewers' responsibilities:
  - Reconcile census and updating existing cases as needed.
  - Review clinical information on all new admissions.
  - Perform concurrent review and update UM cases as needed.
  - Facilitate transition to alternate level of care.
- Per-diem and DRG-contracted hospitals' responsibilities:
  - Review clinical information for appropriateness of level of care.
  - Communicate case status to the facility as needed.

Humana

On-site/telephonic review (cont'd)

- Discharge planning associates' responsibilities:
  - Interact with member and member's family at bedside.
  - Collaborate with member's health care team to maximize member's benefits and resources, including referrals to case management and contracting providers.
  - Facilitate referrals to various Humana programs.
  - Provide disease management education and tools for members with diabetes, ESRD, chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF).

Humana

Health services and case management

Case management:

There is collaboration on cases where there are discharge needs identified when an MMA, LTC or MMA/LTC member is an inpatient.

When the member has both MMA and LTC benefits, LTC case management is primary.

- Receives referrals from on-site/telephonic UM nurses following discharge, PCPs, self-referral, internal/external programs, community partners, etc.
- Bases assignment on PCP/center.
- Completes post-discharge telephonic outreach within three days of discharge (when applicable).
- Identifies gaps in care, addresses post-discharge needs and assists in making follow-up appointment with PCP.
- Stratifies members into various acuities utilizing some of the following criteria:
  - Readmission Predictive Model Score
  - Admission history
  - Metric reports (e.g., high-cost members, etc.)

Humana

Complex case management

- Complex case management responsibilities:
  - Manages and coordinates care for members requiring ongoing case management based on assigned acuity (with varying contact expectations and required time in program for each).
  - Identifies triggers for ER visit/admission.
  - Completes a comprehensive assessment of the member's current health status.
  - Creates an individualized care plan with the member and works toward identified goals.
  - Addresses HEDIS measures for members' gap reports or alerts on file.
  - Refers to internal and external programs and community resources as needed (e.g., Village Health, RxMentor, Beacon Health Options, Access Behavioral Health, bariatric, transplant, etc.).
  - Participates in interdisciplinary case conferences for complex members to identify the best course of action for improved outcomes.

Humana

Complex case management (cont'd)

- Complex case management does not replace or interfere with the care members receive from their physicians.
- Complex case management liaisons will reinforce the physician's plan of care and facilitate the utilization of services that promote wellness and prevent unnecessary hospital admissions.

Humana

Health services and disease management

Disease management

MMA Programs

- Diabetes
- Asthma
- CHF
- Hypertension
- HIV/AIDS
- Cancer

LTC Programs

- Dementia and Alzheimer's issues
- Cancer
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- End-of-life issues/advanced directives

Goal

- Help our members and family members become empowered through education and the development of self-management skills that foster treatment plan compliance and better health outcomes.

Overview

- Participation is voluntary.
- Referrals received from claims data, on-site/telephonic nurses after discharge, PCPs, self-referral, internal/ external programs, community partners, etc.
- Telephonic outreach.
- Assessment includes health history, cognitive/psychological/ depression screening, medication review, diet compliance.
- Collaborative team approach.
- Members stratified into various acuities utilizing some of the following criteria:
  - Admission history
  - Stability of symptoms
  - Understanding/compliance of disease/plan of care

Humana

Disease management

Disease management programs' responsibilities:

- Completes a comprehensive assessment of the member's current health status.
- Creates an individualized care plan with the member and works toward identified goals.
- Addresses HEDIS measures for members on gap reports or with alerts on file.
- Refers to internal and external programs and community resources as needed (e.g., Village Health, RxMentor, Beacon Health Options, etc.).

Note:

- Disease management does not replace or interfere with care that members receive from their physicians.
- Disease management nurses will reinforce the physician's plan of care and facilitate utilization of services that promote wellness and prevent unnecessary hospital admissions.

Humana

Disease management (cont'd)

Additional features for LTC members in a disease management program:

- Education based on the enrollee assessment of health risks and chronic conditions
- Symptom management, including addressing needs such as working with the enrollee on health goals
- Emotional issues of the caregiver
- Behavioral management issues of the enrollee
- Communicating effectively with providers
- Medication management, including the review of medications that an enrollee is currently taking to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications.

Humana

Health services and other programs for MMA members

Other health services programs

- **MomsFirst**
  - Manages prenatal and postpartum members from onset of pregnancy through the 42nd post-partum day.
  - Facilitates care coordination with WIC, Healthy Start and other internal/external programs.
  - Ensures provision of Healthy Behavior Reward for program participation and visit compliance.
- **Social worker**
  - Assists members with social needs including transportation and community resources.
  - Receives referrals from CM, DM and on-site NL.
- **Pediatric case management and pediatric utilization management**
  - Provides telephonic case and disease management for pediatric members.
  - Manages all pediatric inpatient utilization.

Humana

14. Patient-centered medical home

Humana.

Patient-centered medical home

- A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.
- Humana implemented a new patient-centered medical home (PCMH) program to empower patients as they interact with their primary care physicians (PCPs) and health care delivery teams (e.g., family, therapist, specialist, diagnostic center, hospital and laboratory). The PCMH program focuses on a team-based approach to health care delivery. Open communications between the health care team and patient allow for the patient to be more actively involved in health care decisions with a potential for better health outcomes and cost-effective treatment of ongoing health conditions.

Humana

Patient-centered medical home (cont'd)

- According to the Agency for Healthcare Research and Quality, a PCMH program includes the following functions that transform traditional primary care into advanced primary care:
  - **Comprehensive care:** A team that includes physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators and care coordinators, guides patients through the health care delivery system.
  - **Patient-centered care:** The patient is primary in the relationship and drives decisions that influence his or her health. Physicians provide education and establish a plan of care.
  - **Coordinated care:** The PCP communicates with the health care delivery team and manages coordination of care.

Humana

Patient-centered medical home (cont'd)

- **Accessible services:** The patient's access-to-care preferences are important. Shorter wait times, urgent needs, after-hours and around-the-clock access, as well as openness to different types of communication besides the telephone, are taken into consideration by the physician.
- **Quality and safety:** The PCP uses evidence-based medicine and clinical decision-support tools to guide the patient and health care delivery.
- PCPs who are interested in the PCMH program, certification requirements and the benefits may contact:

Latoya Powell, PCMH CCE

Phone: 1-305-626-5746

Email: pcmh@humana.com

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15. Medicaid Risk Adjustment

Humana.

Medicaid Risk Adjustment risk model selection: Chronic Illness Disability Payment System (CDPS) + RX

- Medicaid has changed the way it calculates reimbursement.
- The diagnosis code (ICD-10-CM) is now the most critical piece of information on a claim or encounter.
- The MMA program uses CDPS + Rx version 5.4.
  - Diagnostic- and pharmacy-based risk adjustment model.
  - Specifically developed for Medicaid populations.
  - Demographic component based on age and gender.
  - Utilizes 67 CDPS medical condition categories, plus 15 Medicaid Rx categories.
    - Includes Rx categories that improved the predictive power of the diagnostic model.
    - Excludes Rx categories that are relatively more susceptible to variations in practice patterns.

Humana

Include comorbidities

- Medicaid allows up to 12 diagnosis codes on electronic claims.
  - First, code the acute condition(s).
  - Next, add chronic conditions also addressed in the same visit.
  - Finally, include conditions affecting patient management.

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Clinical example

- Example:
  - S- "16 y/o asthmatic male with a sore throat and runny nose." No recent asthma exacerbations. No cough or wheeze or shortness of breath.
  - O-Alert NAD, (-) neck stiffness (-) conjunctival erythema (-) excessive lacrimation, EOMI, (+) red reflex, BIL TM pink with light reflex, BIL pink patent nares (+) clear discharge, (-) pharyngeal erythema uvula midline.
  - A=Allergic Rhinitis
    - Asthma

CODED AS….

Incomplete Coding

- 477.9 Allergic Rhinitis

Complete Coding

- J45.9Ø9 Unspecified asthma, uncomplicated

Humana

Documentation guidelines

- "One of the largest problems following the implementation date for ICD-10 will be documentation insufficient to support the specificity required for the new ICD-10 code sets. We believe a behavioral change in documentation habits for most providers will be necessary – and now is the time to start preparing."
  - **CLEAR:** Communicate to all readers the documenter's intent.
  - **CONCISE:** Use key coding terms, and avoid use of uncommon abbreviations or truncated words.
  - **CONSISTENT:** Record the same diagnoses and other medical information on all documents.
  - **COMPLETE:** Record full information promptly on all appropriate documents.
  - **LEGIBLE:** Use handwriting that can be read and interpreted accurately by others.

Source: "Will your documentation be ready for ICD-10?", *AAPC Coding Edge*, October 2011, Page 17

Humana

16. Medicaid Advisory Panel

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About our Medicaid Advisory Panel

- Humana recognizes that our Medicaid plan is but one spoke in a wheel of health care providers, community organizations, health plans and other programs that provide essential services, programs and resources to enable Medicaid-qualified members to maintain quality of life and optimal well-being.
- To ensure that the needs of members are being addressed and opportunities for improvement are being identified, Humana has developed a Medicaid Advisory Panel.
- The panel includes community providers, such as medical service organizations and hospital corporations, nonprofit organizations, community agencies that serve the Medicaid population, a member advocate and Humana leaders.

Humana

Medicaid Advisory Panel goals and objectives

- Obtain input from subject matter experts on initiatives and methods that can be used to better serve enrollees.
- Create new ways to approach universal challenges, with the objective of developing pilot projects the committee can track.
- Recommend improvements for health plan processes.
- Discuss topics, such as adolescent engagement, ER overutilization, pregnant women and their access to care, as well as social deterrents.
- Represent local communities by having a panel cover each region.
- Share best practices between regional panels.

Humana

17. Service level agreements

Humana.

Service level agreements

Claims and provider payment

- Electronic clean claims paid/contested within 15 calendar days.
- Nonelectronic clean claims paid/contested within 20 calendar days.
- 50 percent of all clean claims submitted paid in seven calendar days.
- 70 percent of all clean claims submitted paid in 10 calendar days.
- 90 percent of all clean claims submitted paid in 20 calendar days.

Network adequacy

- 90/85 percent of required PCPs by region accepting new members.
- 90 percent of required specialists by region accepting new members.
- 30/35/40 percent of PCPs by region offer afterhours appointments.
- No more than 5/10/8 percent of hospital admissions occur in nonparticipating facilities (excludes continuity of care and ER).
- No more than 8/10 percent of specialty care by region shall occur with nonparticipating specialists.

Note: There is a filling limit of six months for clean claims (electronic and paper)

Humana

Service level agreements (cont'd)

Utilization management

- Standard authorization decisions made within seven days of request.
- Authorization decisions can be extended seven days if the need is justified.
- Expedited decisions processed within 48 hours after receipt of request.
- Expedited decisions can be extended up to two days if the need is justified.
- 95 percent of standard authorizations processed in 14 calendar days with an average turnaround of seven days.

Enrollee/Provider helpline

- Average answer speed not to exceed 30 seconds.
- Wait time for calls placed in system queue not to exceed 60 seconds.
- Average call block rate for direct calls not to exceed .5 percent.
- Average call abandonment rate for direct calls not to exceed 3 percent.

Humana

Electronic health records (EHRs)

- Florida Medicaid-eligible hospitals and professionals as defined by the Health Information Technology for Economic and Clinical Health (HITECH) Act are required to use certified Electronic Health Records in a meaningful manner.
- An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care.

Humana

Electronic health records (cont'd)

- Advantages of EHRs:
  - EHRs and the ability to exchange health information electronically can help you provide higher quality and safer care for patients while creating tangible enhancements for your organization. EHRs help providers better manage care for patients and provide better health care by:
  - Providing **accurate, up-to-date and complete information about patients** at the point of care
  - Enabling quick access to patient records for more **coordinated, efficient care**
  - Securely **sharing electronic information** with patients and other clinicians
  - Helping providers more effectively **diagnose patients, reduce medical errors, and provide safer care**

Humana

Electronic health records (cont'd)

- Advantages of EHRs:
  - Improving patient and provider interaction and communication, as well as **health care convenience**
  - Enabling safer, **more reliable prescribing**
  - Helping promote **legible, complete documentation** and accurate, streamlined coding and billing
  - Enhancing privacy and security of patient data
  - Helping providers **improve productivity** and **work-life balance**

Humana

Electronic health records (cont'd)

For assistance:

- Regional extension centers
  - If providers need assistance with selecting an EHR system, they can reach out to their local regional extension center (REC). RECs offer unbiased EHR implementation support throughout the implementation process, from start to finish. These organizations, funded by the Office of the National Coordinator for Health Information Technology (ONC), can also serve as a two-way pipeline to local and federal resources.
  - RECs can help with EHR implementation and project management, vendor selection, workflow redesign, privacy and security, training, ongoing technical assistance and more. Visit https://www.healthit.gov/providers-professionals/get-ehr-implementation-support for more information.
- Florida Health Information Exchange (Florida HIE)
  - If providers need assistance in technically connecting to other providers, they can reach out to the Florida HIE or visit https://www.florida-hie.net. The Florida HIE enables the secure exchange of health information between health care providers.

Humana

18. AHCA provider-based marketing guidelines

Humana.

AHCA provider-based marketing guidelines

- Providers are permitted to make available and/or distribute managed care plan marketing materials as long as the provider and/or the facility distributes or makes available marketing materials for all managed care plans with which the provider participates.
- Providers may engage in discussions with recipients should a recipient seek advice. However, providers must remain neutral when assisting with enrollment decisions.
- Materials that indicate the provider has an affiliation with certain managed care plans and that only list managed care plan names and/or contact information do not require agency approval.

✓ The above information was extracted directly from AHCA contractual requirements.

Humana

AHCA provider-based marketing guidelines (cont'd)

- Providers may distribute printed information provided by the managed care plan to their patients comparing the benefits of all of the different managed care plans with which the providers contract. The managed care plan shall ensure that:
  - Materials do not "rank order" or highlight specific managed care plans and include only objective information.
  - Such materials have the concurrence of all managed care plans involved in the comparison and are approved by the agency prior to distribution.
  - The managed care plans identify a lead managed care plan to coordinate submission of the materials.

✓ The above information was extracted directly from AHCA contractual requirements.

Humana

AHCA provider-based marketing guidelines (cont'd)

- **Providers may:**
  - Provide the names of the managed care plans with which they participate.
  - Make available and/or distribute managed care plan marketing materials.*
  - Refer their patients to other sources of information, such as the managed care plan, the enrollment broker or the local Medicaid Area Office.
  - Share information with patients from the agency's website or CMS' website.

✓ The above information was extracted directly from AHCA contractual requirements.

* Materials must be reviewed/approved by the plan and submitted to AHCA for approval, as necessary, before distributing.

Humana

AHCA provider-based marketing guidelines (cont'd)

- **Providers may not:**
  - Offer marketing/appointment forms.
  - Make phone calls or direct, urge or attempt to persuade recipients to enroll in the managed care plan based on financial or any other interests of the provider.
  - Mail marketing materials on behalf of the managed care plan.
  - Offer anything of value to induce recipients/enrollees to select them as their provider.
  - Offer inducements to persuade recipients to enroll in the managed care plan.
  - Conduct health screenings as a marketing activity.
  - Accept compensation directly or indirectly from the managed care plan for marketing activities.
  - Distribute marketing materials within an exam room setting.
  - Furnish to the managed care plan lists of their Medicaid patients or the membership of any managed care plan.

✓ The above information was extracted directly from AHCA contractual requirements.

Humana

AHCA provider-based marketing guidelines (cont'd)

- Providers may announce new or continuing affiliations with the managed care plan through general advertising (e.g., radio, television, websites).
- Providers may make new affiliation announcements within the first 30 days of the new provider contract.
- Providers may make one announcement to patients of a new affiliation that names only the managed care plan when such announcement is conveyed through direct mail, email or phone.

✓ The above information was extracted directly from AHCA contractual requirements

Humana

AHCA provider-based marketing guidelines (cont'd)

- Additional direct mail and/or email communications from providers to their patients regarding affiliations must include a list of all managed care plans with which the provider contracts.
- Any affiliation communication material that includes managed-care-plan-specific information (e.g., benefits, formularies) must be prior approved by the agency.

✓ The above information was extracted directly from AHCA contractual requirements.

Humana

19. Additional training requirements

Humana.

Additional training requirements

- Providers must complete additional annual required compliance training on the following topics:
  - General Compliance and Fraud, Waste and Abuse
  - Cultural Competency
  - Health, Safety and Welfare (Abuse, Neglect and Exploitation)
  - Others as required
- These trainings can be located on the following secure provider websites: **Humana.com/providers** and **www.availity.com**.
- Be sure to complete the "Medicaid Partner Training Attestation" form to ensure completion is documented.

Humana

20. Fraud, waste and abuse

Humana.

Fraud, waste and abuse reporting requirement and reporting options

- Anyone who suspects or detects an FWA violation is required to report it either to Humana or within his/her respective organization, which then must report it to Humana:
  - **Telephone:**
    - Special Investigations Unit (SIU) Direct Line: 1-800-558-4444 (Monday through Friday, 8 a.m. to 4 p.m. Eastern time)
    - Special Investigations Unit Hotline: 1-800-614-4126 (24/7 access)
    - Ethics Help Line: 1-877-5-THE-KEY (1-877-584-3539)
  - **Email:** siureferrals@humana.com or ethics@humana.com
  - **Web:** www.ethicshelpline.com
  - **Fax:** 1-920-339-3613

All information will be kept confidential.

Entities are protected from retaliation under 31 U.S.C. 3730 (h) for False Claims Act complaints. Also, Humana has a zero tolerance policy for retaliation or retribution against any person who reports suspected misconduct.

Humana

FWA reporting information (cont'd)

Suspected fraud, waste and abuse pertaining to Florida MMA/LTC must be reported to:

- Medicaid Program Integrity (MPI) Administrator by calling 1-850-412-4600
- Florida Agency Consumer Complaint Hotline by calling 1-888-419-3456
- Florida Attorney General by calling 1-866-966-7226
- AHCA FWA Complaint Form through the following website:
  - https://apps.ahca.myflorida.com/inspectorgeneral/fraud_complaintform.aspx. If the suspected fraud appears to be substantial, along with reporting as indicated above, a phone call will be made directly to AHCA immediately.
  - All final resolutions of a case will include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter.

Humana

False Claims Act

- The False Claims Act also permits a person with knowledge of fraud against the U.S. government to file a lawsuit (plaintiff) on behalf of the government against the person or business that committed the fraud (defendant). The state of Florida has a statute matching the Federal False Claims Act that allows for the recovery of Medicaid funds by the state of Florida.
- Individuals who file such suits are known as "**whistleblowers**."
  - If the action is successful, the plaintiff is rewarded with a percentage of the recovery. Retaliation against individuals for investigating, filing or participating in a whistleblower action is prohibited.

Disallowed Actions (31 U.S.C. §§ 3729-3733)
Links to the above provisions of this act are listed within Humana's Compliance Policy for Contracted Health Care Providers and Business Partners, which is available on Humana.com/fraud

Liability (31 U.S.C. 3729(a)(1) and (a)(3)): Liability for the foregoing acts includes:

- A civil penalty of $5,000-$10,000; and
- Three times the amount of damages which the Government sustains because of that act.
- A person or company who violates the False Claims Act is also liable to the government

Humana

21. Critical incident reporting

Humana.

Critical incident reporting

- Humana's Risk Management Program includes a critical and adverse incident reporting and management system for critical events that negatively impact the health, safety or welfare of members.
- Participating providers should:
  - Identify a critical and/or adverse incident:
    - **Examples include** major medication errors; death, major illness or injury; wrong surgical procedure, wrong site or wrong patient; surgical procedure to remove foreign objects remaining from a surgical procedure; involvement with law enforcement; altercations requiring surgical intervention and/or elopement/ missing patient.

Humana

Critical incident reporting (cont'd)

  - Report the critical and/or adverse incident to the appropriate entity (e.g., police, adult protective services).
  - Call 911 if the member is in immediate danger.
  - Report the critical and/or adverse incident to the Agency and Humana's health plan risk management department at 1-855-281-6067 and/or via email to riskmanagementadministration@humana.com within 24 hours of identifying the incident.
  - Report suspected abuse, neglect and exploitation of a member immediately in accordance with s.39-201 and Chapter 415, F.S.
- Humana has the right to take corrective action as needed to ensure its staff, participating providers and direct service providers comply with the critical incident reporting requirements.

Humana

22. Disenrollment/transfer of members

Humana.

Disenrollment for cause of member

- If a PCP or group is requesting the disenrollment of a Florida Medicaid member, the request must be handled in accordance with rules established by the Florida Agency for Health Care Administration (AHCA). The PCP must complete an AHCA "Request for Involuntary Disenrollment" and submit it and all required supporting documentation to Humana's Medicaid Administration office, via his or her provider representative, where it will be reviewed and processed in accordance with AHCA requirements.
  - Humana's disenrollment for cause process must be followed.
  - Provider cannot dismiss member until approved.

Humana

Disenrollment for cause of member (cont'd)

- Humana will work with AHCA to approve all requests.
- Provider must provide detailed documentation of rationale and office attempts to assist member.
- AHCA Involuntary Disenrollment form must be completed.
- Financial or mental-health-related reasons are not acceptable to AHCA.
- Only AHCA-approved letters may be used to communicate with member.

  This means AHCA must approve each individual, member-specific letter prior to the plan sending it to the member.
- PCP office is responsible for all member costs until disenrollment is approved.

Health care providers are not to directly request disenrollment with AHCA, or obtain AHCA-approved disenrollment letters; these matters are handled by Humana.

Humana

Transfer of member

- A member's PCP, a physician group or independent practice association (IPA) acting on behalf of the PCP may initiate a request to Humana to transfer a member to another PCP. In some situations, if the PCP is with an IPA or physician group, the request can be to transfer the member to an entirely different IPA or physician group.
- Generally, the request would be appropriate for situations in which the member and/or power of attorney (POA) or legal guardian have engaged in behavior that is disruptive, unruly, abusive or uncooperative to the extent that it seriously impairs the PCP's ability to furnish services to either the member in question or other members.

Humana

Transfer of member (cont'd)

- Humana's PCP request-to-transfer process must be followed.
- Provider cannot dismiss members without approval.
- Members can be transferred only if they agree or as a result of the grievance process.
- Detailed documentation of rationale and office attempts to assist member must be provided.
- Only AHCA-approved letters may be used to communicate with member.
- PCP office is responsible for all member costs until issue is resolved.

Letters to use for member transfers are obtained and delivered by Humana, not the health care provider.

Humana

23. Managed Medical Assistance Physician Incentive Program

Humana.

Managed Medical Assistance Physician Incentive Program (MPIP)

The MMA Physician Incentive Program's aim is to promote quality of care for our Medicaid members and recognize those physicians who demonstrate high levels of performance for selected criteria.

The MPIP provides the opportunity for designated physician types to earn enhanced payments equivalent to the appropriate Medicare Fee-for-Service Rate, as established by the Agency for Health Care Administration (Agency) based on the achievement of key access and quality measures.

To be eligible for the program:

Pediatricians, family practice providers and general practice providers need to be practicing as a primary care physician with a pediatric panel size of 200 members or greater.

OB/GYNs and pediatric specialists will need to be board-certified by the respective boards as listed below.

Specialty	Certifying Board
OB/GYNs	American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology
Pediatric Cardiology	American Board of Pediatrics
Pediatric Endocrinology	American Board of Pediatrics or the American Osteopathic Board of Pediatrics
Pediatric Nephrology	American Board of Pediatrics
Pediatric Neurology	American Board of Pediatrics and American Board of Psychiatry and Neurology
Pediatric Psychology	American Board of Psychiatry and Neurology

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Managed Medical Assistance Physician Incentive Program (MPIP) Cont.

- The incentive program will not be extended to any of the following:

1. Physicians not participating in Humana's Medicaid network
2. OBGYNs with less than 10 deliveries for the measurement period
3. Primary care physicians with a pediatric panel size less than 200 Medicaid members during the measurement period
4. Federally Qualified Health Centers (FQHCs)*
5. Rural Health Clinics (RHCs)*
6. County Health Departments (CHDs)*
7. Medical School Faculty Plans*

**Services provided in any of these facilities or faculty plan may not be included in the MPIP, regardless of whether or not the service is billed by the facility or faculty plan as a facility or plan service or by the rendering provider using the provider's own Medicaid ID.*

Once providers meet the selected Medical and Quality criteria, will be in effect for one year from October 1, 2017, through September 30, 2018. Every six months, Humana will reassess all eligible providers to determine if any additional providers qualify for the Incentive Program.

Additional information regarding the incentive program can be found on the Agency for Healthcare Administration (AHCA) website:
http://ahca.myflorida.com/medicaid/statewide_mc/mma_physician_incentive.shtml

Humana

24.
Medicaid enrollment for claims payment

Humana.

Medicaid enrollment for claims payment

- Effective April 10, 2017, claims will be denied for physicians and health care professionals with invalid Medicaid enrollment. To receive Medicaid reimbursement, a physician or health care professional must be fully enrolled in Medicaid or have “limited enrollment status,” as well as meet all provider requirements at the time the service is rendered. Any entity that bills Humana for Medicaid-compensable services provided to Medicaid recipients or that provides billing services of any kind to Medicaid providers must enroll as a Medicaid provider.

Medicaid enrollment for claims payment

- **Proper Medicaid enrollment is critical for claims payment. All physicians and health care professionals need to confirm their Medicaid enrollment with AHCA.**
- Physicians and other health care professionals can verify their enrollment via the AHCA website: http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml

Humana

Medicaid enrollment for claims payment (cont'd)

- Please note the following details regarding the listing:
  - Current listing of Medicaid numbers for all providers confirmed active on the AHCA Portal Provider Master List (PML).
  - Provider must be listed as "ENROLLMENT" or "Limited Enrollment" in Enrollment Type column L and as "ACTIVE (A)" in Current Medicaid Enrollment Status column V.
  - Provider's billing NPI and/or rendering NPI must be accurate and affiliated with the provider's Medicaid ID.

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Medicaid enrollment for claims payment (cont'd)

- Incorrect enrollment can affect the way a physician, health care professional or provider group is identified by AHCA and its Choice Counselors, as well as how a physician, health care professional or provider group is listed in Physician Finder, Humana's online provider directory.
- AHCA's Provider Enrollment area is available to assist with enrollment issues, such as change of address, change of ownership and re-enrollment issues via the AHCA website: http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/tabId/42/Default.aspx

Humana

Medicaid enrollment for claims payment (cont'd)

- Guidelines about how physicians and other health care professionals should enroll with Medicaid can be found in the Provider General Handbook's Reference Chapter 2: https://www.flrules.org/Gateway/reference.asp?No=Ref-02671

Humana

25. Helpful numbers

Humana.

Helpful numbers

- **Medicaid customer service:**
  - Please call the number on the back of the member's ID card for the most efficient call routing.
- **Prior authorization (PA) assistance for medical procedures:** 1-800-523-0023 (Monday through Friday, 8 a.m. to 8 p.m. Eastern time)
- **PA for medication billed as medical claim:** 1-866-461-7273 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)
- **PA for pharmacy drugs:** 1-800-555-2546 (Monday through Friday, 8 a.m. to 6 p.m. local time)
- **Provider relations:**
  - **MMA:** 1-800-626-2741 (Monday through Friday, 8 a.m. to 5 p.m. Central time) for fee schedule requests, demographic changes, credentialing status.
  - **LTC:** Customer Service 1-888-998-7735, Provider Relations 1-561-860-8660

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Helpful numbers (cont'd)

- **Commercial case management:** 1-800-327-9496
- **Medicare/Medicaid case management:** 1-800-322-2758
- **Commercial concurrent review:** 1-800-545-6775
- **Medicare/Medicaid concurrent review:** 1-800-322-2758
- **Clinical management program information:** 1-800-491-4164
- **PrescribeIT:** 1-800-526-1490
- **Availity customer service/tech support:** 1-800-282-4548
- **Ethics and compliance concerns:** 1-877-5 THE KEY (1-877-584-3539)
- **Fraud, waste and abuse reporting:** 1-800-614-4126

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Appendix

Region-specific information

Humana.

Provider rewards

(Regions 9, 10 and 11 –
Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach and St. Lucie counties)

Humana.

Provider rewards and incentives – Regions 9, 10 and 11 only

- **Provider quality bonus** – Program aims to promote improvement and quality by providing additional financial compensation to PCP centers that demonstrate high levels of performance for select quality factors
  - Eligibility:
    - PCP must have an open panel for Medicaid line of business.
    - PCP serves more than 49 Medicaid enrollees.
  - Implementation:
    - No later than third quarter 2014
    - Letters outlining criteria released April/May 2014
    - Quarterly incentives

Humana

Provider rewards and incentives – Regions 9, 10 and 11 only (cont'd)

- **Platinum provider program** – Annual award and recognition program for PCPs who achieve high levels of performance.
  - Criteria:
    - EHR usage, HEDIS scores, encounter submissions, appointment accessibility, financial performance, etc.
- Criteria and eligibility for all rewards and incentives programs are subject to change at Humana's discretion.

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Patient-centered medical home incentive – Regions 9, 10 and 11 only

- Definition: A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.
  - Humana offers financial incentives to providers to promote National Committee for Quality Assurance (NCQA) certification, dependent on the size of the practice.
  - Practices achieving Level 2 or 3 NCQA PCMH certification will be considered a preferred provider for mandatory assignments.
  - Practices with Level 2 or 3 NCQA PCMH certification will be designated as PCMH-certified in Humana's online provider directory.

Humana

Additional clinical management program
(Region 11 – Miami-Dade County)

Humana.

Real-time ER initiative – Region 11 only

Real-time ER initiative

(currently in Region 11 only)

- Receives referrals while member is in the ER or within 24 hours.
- Includes three participating providers (Baptist Urgent Care Centers, North Shore and Palmetto General Hospital).
- Completes post-ER telephonic outreach within 24 to 48 hours or less of ER visit.
- Identifies reason for ER visit, assesses gaps in care, addresses needs and assists in making follow-up appointments with PCP.
- Educates members on disease process, proper utilization of ER and Humana's 24-hour nurse phone line.
- Refers to other clinical programs when applicable.

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Real-time ER initiative – Region 11 only

- ER nurses – For all participating facilities (North Shore, Baptist and Palmetto)
  - Identifies triggers for ER visit
  - Completes an ER assessment of member's current health status
  - Provides members with the following:
    - Education related to alternatives to ER and importance of maintaining physician/patient relationships
    - Help with setting up appointments
    - Assistance with medication issues
  - Refers to internal and external programs and community resources as needed (e.g., SCM, DM, Village Health, Beacon Health Options, etc.)

Humana

Real-time ER initiative – Region 11 only

- ER nurses will reinforce the need to utilize physicians' offices for continuum of care for nonemergent needs.
- ER nurses will contact the PCP to notify of a member's visit to the ER and provide a discharge summary.

Humana

Humana Medicaid

First Quarter 2017

Updates for Physicians and Health Care Providers

In this issue

- Complete 2017 compliance training requirements
- CAQH ProView® makes credentialing simpler
- Medicaid orientation training for OB/GYNs
- Patients share tips for improvement in annual surveys
- Help keep your directory information current
- Humana welcomes provider nominations
- Changes announced for physician extender reimbursement
- Member transfer provider training available online
- Humana posts new Florida Medicaid Provider Handbook

Confirm your Medicaid ID for claim payments

Beginning April 10, claims will be denied for physicians and health care professionals with invalid Medicaid enrollment. To receive Medicaid reimbursement, a physician or health care professional must be fully enrolled in Medicaid or have "limited enrollment status," as well as meet all provider requirements at the time the service is rendered. Any entity that bills Humana for Medicaid-compensable services provided to Medicaid recipients or that provides billing services of any kind to Medicaid providers must enroll as a Medicaid provider.

PROPER MEDICAID ENROLLMENT IS CRITICAL FOR CLAIMS PAYMENT. ALL PHYSICIANS AND HEALTH CARE PROFESSIONALS NEED TO CONFIRM THEIR MEDICAID ENROLLMENT WITH THE AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA).

Physicians and other health care professionals can verify their enrollment via the AHCA website:
http://portal.flmmis.com/FLPublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabId/77/Default.aspx?linkid=pml

Please note the following details regarding the listing:

- Current listing of Medicaid numbers for ALL providers CONFIRMED ACTIVE ON AHCA PORTAL Provider Master List (PML).
- Provider must be listed as "ENROLLMENT" or "Limited Enrollment" in Enrollment Type column L and as ACTIVE (A) in Current Medicaid Enrollment Status column V.
- Provider's billing NPI and/or rendering NPI must be accurate and affiliated with the provider's Medicaid ID.

Incorrect enrollment can affect the way a physician, health care professional or provider group is identified by AHCA and its Choice Counselors, as well as how a physician, health care professional or provider group is listed in Physician Finder, Humana's online provider directory.

AHCA's Provider Enrollment area is available to assist with enrollment issues, such as change of address, change of ownership and re-enrollment issues via the AHCA website:
http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_Enrollment/tabId/42/Default.aspx

Guidelines about how physicians and other health care professionals should enroll with Medicaid can be found in the Provider General Handbook's Reference Chapter 2:

https://www.flrules.org/Gateway/reference.asp?No=Ref-02671

Humana®

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CAQH ProView® streamlines credentialing process

Physicians and health care professionals need to use the Council for Affordable Quality Healthcare (CAQH) ProView tool to provide credentialing information to Humana. Note: This excludes facilities.

CAQH ProView is the trusted source and industry standard for self-reported provider data and eliminates redundant applications, including state applications, required by a health care professional's contracted health plans, including Humana. Using CAQH reduces the amount of time health care professionals spend on credentialing and recredentialing by allowing them to submit information to the tool once and then update it via the attestation process.

How this affects you:

- **Initial applicants** must use CAQH for requests submitted **Jan, 1, 2017, and after.**
- Health care professionals due for **recredentialing Sept. 1, 2017, and after** will need to submit their information through CAQH.
- The use of **CAQH will reduce the amount of time involved with credentialing and recredentialing, as well as costs.**
- Network health care professionals who have not used CAQH or who have outdated information have been notified via fax to their credentialing point of contact.
    - If you are **already registered** with CAQH, then please ensure your information is current and complete and that you have granted Humana authorization to review/receive the credentialing information.
    - If you **are not registered** with CAQH, then please complete a registration form via https://proview.caqh.org/PR/Registration. Once the registration is submitted, you will receive an email from CAQH with a CAQH Provider ID. You will then need to complete the online CAQH application and grant Humana authorization to review/receive your information.

Questions may be emailed to CredentialingInquiries@humana.com

Medicaid orientation training for obstetricians and gynecologists available online

Find training specifically for OB/GYNs on Humana's provider website, including information on the following topics:

- Authorization process
- Billing for GYN, OB and high-risk deliveries
- Postpartum visits
- Family planning
- Mom's First program
- HEDIS® measures

Complete 2017 compliance training requirements

Participating physicians and health care professionals are required to complete and attest to understanding and adhering to compliance program requirements available online.

Highlights include:

- **Humana Medicaid provider orientation** details how to do business with Humana and covers subjects such as contracting, credentialing, access to care, clinical programs, web resources, authorizations and claims processing.
- **Health, safety and welfare training** provides definitions of abuse, neglect and exploitation, steps for prevention and instructions for reporting suspected cases of abuse, neglect or exploitation.
- **Cultural competency** information discusses what the terms "culture" and "cultural competence" mean, the benefits of clear communication, strategies for working with seniors and individuals with disabilities and interpretive services.
- **Compliance and FWA training** defines fraud, waste and abuse, outlines steps for prevention and reporting of suspected cases of fraud, waste and abuse and provides information on the Whistleblower Act.

Find the training modules by logging in at **Humana.com/providers** (registration required) or www.availity.com (registration required). More information is available on Humana's website at https://www.humana.com/provider/support/clinical/medicaid-materials/florida by choosing the "Health Care Provider Training Materials" tab.

Patients share tips for improvement in annual surveys

Annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) member surveys run each February through June. Last year's surveys showed the following areas with the most room for improvement:

- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate

Patients shared the following suggestions for improvement:

Getting Care Quickly

Suggested Improvements/Actions: Minimize wait times, communicate the reason for delays and apologize, provide updates on remaining wait times, show respect for the patient's time, offer to reschedule appointments, avoid overscheduling or double-booking, be on time and spend enough time with the patient.

Getting Needed Care

Suggested Improvements/Actions: Provide prompt and efficient care and follow up including referring to other health care professionals, ensure the patient is treated with courtesy and respect, schedule follow-up appointments quickly, follow through on recommendations and requests, schedule appointments with sufficient time to allow question/answer and explanation or review of test results.

How Well Doctors Communicate

Suggested Improvements/Actions: Emphasize good communication skills, make eye contact, use appropriate body language, confirm that the patient understands the topic on which you are trying to educate him/her, write down instructions, use simple language, communicate directly with the patient, provide visit notes, listen actively and respond to the patient's questions/concerns and repeat back what the patient said, explain concepts in layman's terms, address language barriers, educate patients and help them stay informed, avoid interrupting patients and/or multitasking, respect the patient's opinion and values.

To learn more about CAHPS data, visit https://cahpsdatabase.ahrq.gov/.

Humana®

Humana.com

Help keep your directory information current

To maintain accurate participating provider directories and reimbursement information, physicians and other health care professionals need to report all changes of address or other practice information (see table below for other examples) at least 30 days prior to the effective date of the change.

Examples of information changes that need to be reported:

Provider information	Adding a provider (i.e., physician or health care professional joining the practice/group)
Tax identification number	Provider deletions (i.e., physician or health care professional no longer participating with the practice/group)
National Provider Identifier (NPI)	Medicare/Medicaid numbers
Address	Office hours/after hours
Phone number	Languages spoken
Practice name	*Please note some of these changes may require a new amendment or agreement depending on the reason for the change.*

There are multiple ways to report changes to Humana:

- If you usually send this type of information to a local market representative or other Humana Provider Relations staff, please continue to do so.
- If your practice is managed by an independent practice association (IPA), management services organization (MSO), physician organization (PO) or physician hospital organization (PHO), please report demographic changes to the administrative office of that organization, which will then update your information with Humana.
- **Additional options:**
  - Submit changes electronically on Humana.com (registration required) using the Manage My Demographics tool under the "Resources" tab.
  - Contact Humana provider relations at 1-800-626-2741, Monday through Friday, 8 a.m. to 5 p.m. Central time.
  - Fax changes to Humana provider relations at 1-800-626-1686.
  - Contact your local Humana provider contracting representative.

For more information, please refer to the Humana provider manual.

If you have questions, please contact Humana provider relations at 1-800-626-2741.

Humana posts new Florida Medicaid Provider Handbook

HEALTH CARE PROVIDERS CAN FIND THE NEW FLORIDA MEDICAID PROVIDER HANDBOOK, ALONG WITH OTHER HELPFUL MATERIALS, ON THE HUMANA FLORIDA MEDICAID PROVIDER WEBSITE AT HTTPS://WWW.HUMANA.COM/PROVIDER/SUPPORT/CLINICAL/MEDICAID-MATERIALS/FLORIDA.

Provider nominations welcome

Humana makes every effort to recruit and retain physicians and health care professionals of all ethnicities to support the cultural preferences of our members. Currently, Humana's Medicaid provider networks are open to new physicians and health care professionals who agree to Humana's contractual requirements and rates, as well as satisfy all credentialing and regulatory requirements.

We review and accommodate all provider nomination requests, when appropriate, from members and others to facilitate equal representation in our provider network. Questions about Humana's recruitment and retention of minority physicians and health care providers may be directed to your provider relations representative.

The status of Humana's networks is subject to change based on continual assessment of our provider network requirements. Therefore, there may be closed panels for select specialties in specific geographic areas.

Member transfer provider training available online

Find training on Humana's member-transfer policy and procedure online, which covers the following topics:

- Appropriate reasons for potential transfers
- Situations for which transfers are not permitted
- How to submit member-transfer requests to Humana
- Documentation required to support a potential transfer
- Sample patient communications

Changes announced for physician extender reimbursement

As you know, Humana follows state-specific regulations regarding fee schedule management and payments to health care providers, and therefore, Humana Medical Plan's fee schedules mirror the Agency for Health Care Administration's (AHCA) provider fee schedules. Consistent with that approach, effective as of March 1, 2017, Humana Medical Plan will reimburse physician extenders in accordance with the current published AHCA fee schedules. Under these AHCA fee schedules, services provided by physician extenders are paid at a different rate under Medicaid than other types of health care providers.

Physician extenders include, but are not limited to, the following:

- Licensed midwives
- Certified nurse midwives
- Advanced registered nurse practitioners
- Registered nurse first assistants
- Physician assistants
- Certified registered nurse anesthetists
- Anesthesiologist assistants

If you have questions about the Humana Medical Plan fee schedule, please contact your provider relations representative or visit the Florida Medicaid Web portal's provider fee schedules page: http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml.

For more information, refer to the list below for your region's contact information:

- Region 1 (Walton and Okaloosa counties), call Jerred Carter at 1-813-294-5886 or email Jerred_Carter@iasishealthcare.com.
- Region 1 (Escambia and Santa Rosa counties), call John Paul Shaddock at 1-813-541-7034 or email JShaddock@iasishealthcare.com
- Region 6 (South Hillsborough, Hardee, Highlands and Manatee counties), call Ramon Paulino at 1-813-309-3581 or email RPaulino@iasishealthcare.com.
- Region 6 (North Hillsborough and Polk counties), call Robert Castillo at 1-813-309-7045 or email RCastillo@iasishealthcare.com.
- Regions 9, 10, 11, contact Katrina Knight-Vera at 1-305-626-5006.

Attachment 15-8: Provider Website Health Banner Example

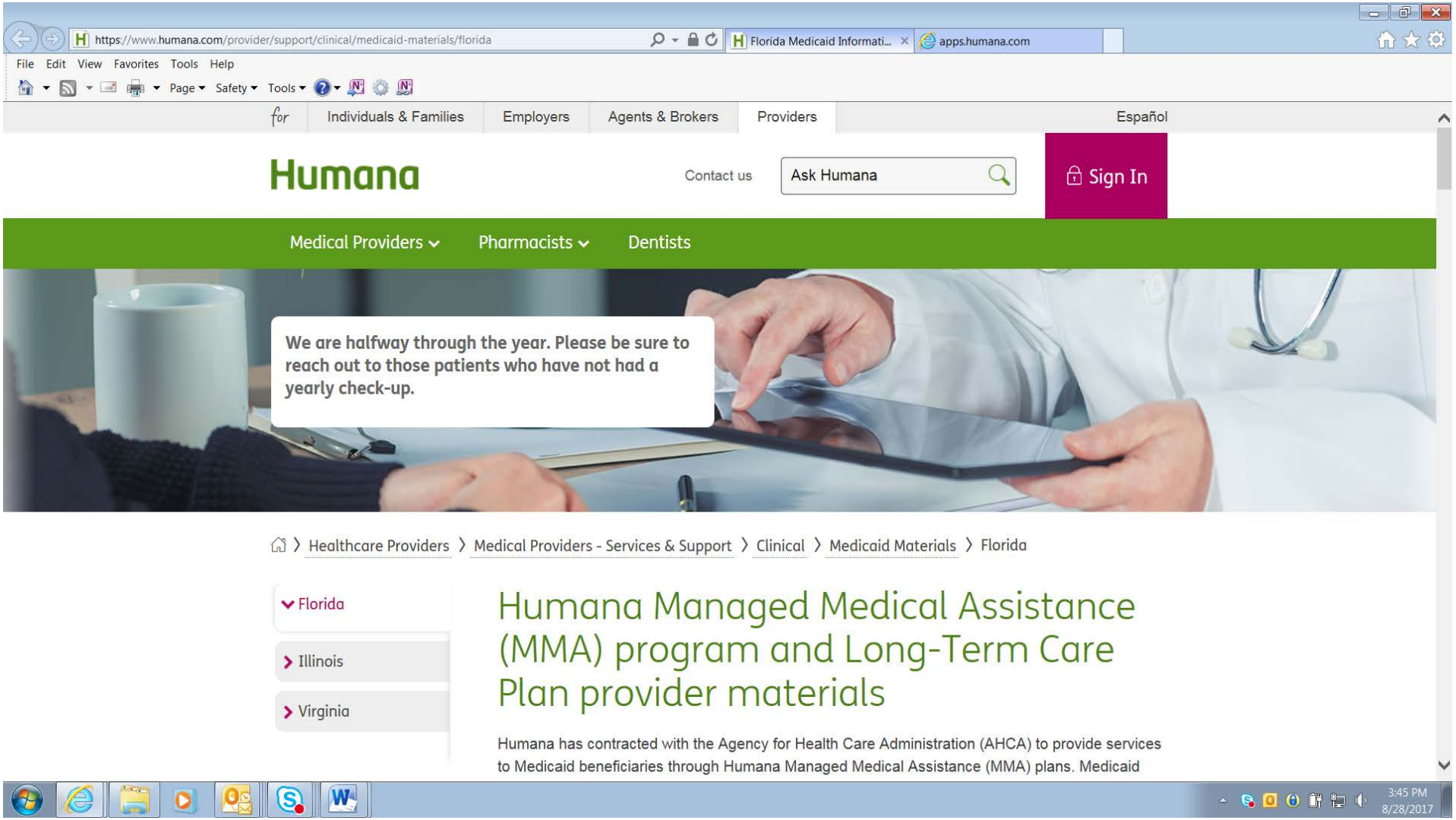

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 16 – Dispute Resolution (Statewide):

The respondent shall describe in detail its provider dispute resolution process.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Humana has a proven process for resolving provider complaints and disputes, hereafter referred to as provider complaints to be consistent with Agency for Health Care Administration (AHCA) terminology. We base our approach to provider complaints on a "no wrong door" policy that ensures that we track and address all provider complaints and that we comply with all contractual and regulatory requirements concerning complaint resolution. We understand that provider complaints are a critical source of information about the quality of our operations and provider satisfaction. Because provider complaints are a window into accurate and timely payment of claims, prior authorization practices, and provider education and training, we review them with the most critical eye on our internal processes to identify what would have prevented this complaint. We have designed our provider-centric approach and strategy to proactively prevent provider complaints, thereby mitigating unnecessary provider complaints.

Humana's provider network delivers high-quality services to our enrollees and provides the foundation for our overall success. It is critical to have a collaborative partnership with our providers and active monitoring and expeditious resolution of all issues that arise. Our regular continuous improvement activities, led by our Florida market team, have identified provider complaints as an opportunity for improvement within Humana. To improve the way we support our providers, we have undertaken a process reengineering effort. The goal is to focus on examining all aspects of our provider relationships including resolution of provider complaints.

To date, our process improvements have resulted in a more effective procedure for resolving provider complaints, from receipt via multiple channels to our tracking systems to our follow-up procedures. Our follow-up procedures include ensuring we make payments and determining if there are additional opportunities for improvement. We handle our provider complaint process separately from our grievance and appeals process so that we ensure we pay attention to our providers by our specially trained Provider Complaint Resolution teams, including the Critical Inquiry (CI) team.

Another outcome has been the establishment of our Florida-hosted forum, the Provider 360 Committee, a cross-functional committee whose primary objective is to improve the interaction between Humana and our providers. The Provider 360 Committee offers an excellent opportunity to improve providers' experience with Humana while delivering executive-level oversight of our provider complaint resolution process for our Florida Medicaid providers. The Provider 360 Committee meets monthly to:

- Discuss and analyze the trend data in our information management and reporting system, Customer Relationship Management (CRM)

- Hear directly from Humana operations associates involved in provider complaint research and resolution

- Receive comments from providers

- Request root cause analysis research

- Identify potential process improvements and system enhancements

The Provider 360 Committee identifies and escalates opportunities to the Medicaid Governance Triage and specific project teams, comprising both market and corporate associates. Chaired by our new Provider Services leader, the committee includes market leadership and a mix of market and corporate support areas, including Florida's Compliance Officer and Compliance associates, Provider Relations, Claims Performance Management, Integrated Provider Solutions, Provider Escalation representatives, which we call Service Alignment Managers (SAMs), and Provider Communications.

- Our Provider Services leader oversees all provider dispute resolution teams to ensure compliance with AHCA requirements as well as implementation of best practices across our provider organization

- Our Florida Compliance Officer and additional Compliance associates monitor our contractual requirements

- The Provider Relations team offers a provider perspective to complaints and identifies complaints that need further provider education on our policies

- Our Claims Performance Management team identifies areas where we can improve our claims processing needs and when there are opportunities for additional provider education on claims submission

- Integrated Provider Solutions (IPS) supports Availity, our secured provider portal, which allows claims to be submitted and status provided via standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions

- SAMs connect the dots between various provider-facing teams and provide support for process improvement

- Provider Communications is the central team that reviews and manages all provider communications through various outlets

Other key components of our strategy to address provider complaints include:

- Thorough training of our associates, including Customer Care and Care Management associates to equip them with the knowledge and resources to address complaints on the spot if possible

- A streamlined system to record and monitor all provider complaints, both claims- and non-claims-related)

- Real-time analytics, including trended data, that alert Humana to issues within our claims processing and payment system

- Leadership recognition and ownership of our Provider 360 Committee that meets monthly to discuss opportunities to improve the provider experience

DESCRIPTION OF HUMANA'S PROVIDER COMPLAINT RESOLUTION PROCESS

Humana's Provider Complaint Resolution process includes an end-to-end tracking system in which we process all provider complaints consistently and within State-mandated timeframes. This is true of both claims- and non-claims-related complaints, regardless of who submits the complaint, the provider, a third party, AHCA, and whether the complaint is a result of the AHCA Claim Dispute Resolution process. On Humana's end, it is irrelevant who receives the provider complaint or the method through which it is received (e.g., telephone, electronic mail, regular mail, or in person) because we process all complaints consistently and within the State's timelines. In our Provider Manual, we suggest to providers that they submit complaints to our Provider Customer Care unit or their Provider Relations representative. However, we have designed our process to ensure that we accept and process complaints regardless of the door through which it enters our organization.

Upon receipt of a complaint, we require our associates to enter it electronically into our CRM system, which will route the complaint via an automated workflow to the Provider Complaint Resolution team within Humana that has the appropriate expertise to resolve the complaint. This ensures that we direct provider complaints to the team with the most appropriate expertise to respond as quickly as possible.

PROVIDER COMPLAINTS RESEARCH AND RESOLUTION BY RESOLUTION TEAMS

Our Provider Complaint Resolution teams are composed of associates with specific knowledge and expertise about each topic for which they are responsible: claims review and payment, clinical authorizations, Managed Medical Assistance (MMA) provider issues, Long-term Care (LTC) provider issues, AHCA contract requirements, and financial recovery. Within three (3) business days of receipt of the provider complaint, the team assigned the provider complaint notifies the provider either orally or in writing, depending upon how we received it, that we have received the complaint and its expected date of disposition.

The Provider Complaint Resolution team thoroughly researches the provider's complaint, reaching out to the provider as necessary to obtain additional information and determining how to resolve the complaint in accordance with applicable statutory, regulatory, contractual, and provider agreement provisions. The Provider Complaint Resolution team, which logs its work in CRM for tracking purposes, has the authority to make resolution decisions, including re-adjudicating claims. The Provider Complaint Resolution team has responsibility for providing all required written notices to the provider and meeting the contract deadlines for complaint resolution. As part of our Provider Dispute Process Improvement, our executive leadership on the Provider 360 Committee reviews summaries from the Provider Complaint Resolution teams to understand the complaint issues and identify process improvements that could improve the provider experience.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

CUSTOMER CARE SYSTEM FOR COMPLAINT INTEGRATION, TRACKING, AND REPORTING

As the repository we use to record, track, and report all provider complaints and disputes, we have designed our CRM to support our provider complaints process. The Complaint Resolution teams use CRM to track receipt of claims-related provider complaints and ensure that we:

- Acknowledge provider complaints within three (3) business days

- Give written notice of the status of the provider complaint to the provider within fifteen (15) days of receipt and every fifteen (15) days thereafter

- Resolve provider complaints within sixty (60) days (claims-related) or ninety (90) days (non-claims related)

- Send written notice of the disposition and basis for resolution to the provider within three (3) business days of resolution

To ensure compliance with timeliness requirements, the daily reports from CRM offer a summary and detailed review of all claims-related provider complaints, including the number of days remaining to complete the next action in the complaint resolution process.

We code non-claims-related provider complaints in CRM to ensure not only that we meet the contractual timeframes for acknowledgement, but to also route the provider complaint to the correct team for resolution. If we have not resolved a provider complaint within the first fifteen (15) days, we document the reason why in a written notice, with written notification to the provider of the status every fifteen (15) days thereafter until we resolve it. We resolve all non-claims-related provider complaints within ninety (90) days and send notice of the disposition and basis for resolution to the provider within three (3) business days of resolution. Humana's ninety (90) day provider complaint timely resolution rate is approximately one-hundred percent (100%) over the last year.

Humana enters all information and documentation concerning provider complaints, from the receipt of the complaint to resolution, including through AHCA’s dispute resolution process, in CRM, where it is stored for reporting, trending analysis, querying, and retrieval by Humana associates.

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1. The extent to which the respondent’s process identifies claims related dispute trends and initiatives process improvement activities/system enhancements.

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Our provider complaints and disputes monitoring process includes comprehensive, real-time feedback to upstream processes when appropriate and root cause analysis for issues that span multiple providers. CRM reporting will allow us to examine the data for trends and to identify the process improvements necessary to avoid similar complaints going forward.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana's CRM captures and stores all data related to provider complaints, and has the capability to produce summary and drill-down reports based on that data to allow for in-depth analysis. We are still implementing certain elements of functionality within CRM and when fully operational it will provide detailed reports including:

- On a daily basis, CRM will be capable of generating a Daily Provider Complaints Dashboard to identify the status of provider complaints against the contractual processing requirements, regardless of whether the provider's complaint is claims- or non-claims-related.

- On a weekly basis, CRM will generate a Weekly Provider Complaints Dashboard that lists the number of provider complaints not resolved during the previous month, categorized by week for the previous four (4) weeks and by the length of time the case has been open to ensure we address all claims in a timely manner and prior to any required timeframes.

- On a monthly basis, CRM will generate a report concerning claims-related provider complaints submitted by providers to the AHCA Provider Complaint Resolution program. This report will track the date the provider submitted the complaint to AHCA, the date Humana received the provider complaint, and the date we responded to AHCA and the provider.

- CRM will also generate a monthly report detailing the date of requests for information from AHCA's contracted dispute resolution vendor, currently Maximus, the date we responded to such requests, the date of the AHCA order, and the content of the order. This report will also track the timeliness of our payment of AHCA orders in favor of providers to ensure we monitor this payment and identify any trends in these types of orders so that we can address the cause of these trends.

- A Monthly Provider Complaint Dashboard that rolls up data from other reports and displays provider complaint data over each of the prior twelve (12) months, showing trends in provider complaints. The Provider 360 Committee reviews and analyzes this report for trends to be improved on to better the provider experience.

- A Quarterly Provider Complaints Dashboard for review by Humana's Quality Improvement Committee (QIC).

- CRM allows for additional ad hoc drill-down reporting to review all provider complaints over an unlimited period of time, by provider, by provider type, by type of complaint, and other groupings.

The monthly trended data includes Humana's performance on timeliness metrics and the number and percent of provider complaints in each of the following categories:
- Type of provider complaint (claims-related, non-claims-related)
- Reason for the provider complaint
- Type of provider (e.g., hospital, personal care provider)
- Location of provider (region within the state)
- Timeliness metrics and benchmarks for provider complaint acknowledgements
- Status updates to the provider
- Extension requests if applicable
- Provider complaint resolution
- Payment of claims following a complaint resolution

- Disposition

These reports both ensure compliance and initiate our process improvement activities. The following review these daily reports:
- Production Leads of each Provider Complaints Resolution team included in the report
- Frontline Leaders
- Managers of the Provider Complaints Resolution teams included in the report

Humana's lines of accountability are clear. Our Production Leads are responsible for escalating provider complaints that require additional attention. Our Frontline Leaders are responsible for addressing barriers to resolving provider complaints. Business unit managers are responsible for compliance to the Contract requirements. Humana's new Provider Services Leader is responsible for connecting with the Provider Complaints Resolution teams to ensure we adequately address all provider complaints, meet compliance, and initiate process improvements, where needed.

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2. The extent to which the respondent's process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes resolved within required timeframes.
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Humana understands the importance of closely monitoring that our provider complaint dispositions and resolutions are appropriate and made on a timely basis, and that we pay providers promptly following a claims-related complaint resolution in their favor.

The Provider Complaint Resolution teams provide daily oversight of provider complaints, including claims disputes, timely payments, and resolution within the required timeframes, which begins with review of the Daily Provider Complaints Dashboard. We train these teams on applicable requirements in the Contract, statutes and regulations, and our provider agreements. It is each team's responsibility to ensure that we meet these requirements during the complaint resolution process.

To ensure accountability, Humana has put in place several monitoring and oversight redundancies. First, the Provider Complaint Resolution team leaders are accountable to our new Provider Services Leader for the compliance of complaint resolution, including the timeliness of payment determinations when the complaint is claims-related. This allows for a single point of contact for AHCA and executive leadership as needed.

Second, several internal committees with various levels of expertise review our provider complaint performance metrics. For example, the Medicaid Compliance Committee reviews metrics related to provider complaints. Our committees have several options for implementing process improvements, which we prioritize and execute at all levels and ensure they follow a clearly delineated process. We require the issuance of an "issue or opportunity" (IOP) in response to the following:

- We identify an area of regulatory noncompliance

- For all Corrective Action Plans (CAPs)

- For all self-reported issues

- For all external notices

- For all CAPs required by an outside organization such as AHCA or the Centers for Medicare and Medicaid Services (CMS)

- In instances of fines or penalties

Any provider complaint or provider complaint trend that falls into one of the above categories would be subject to this process. We also use Improvement Action Plans (IAPs) to document how Humana will remediate an IOP. We log and monitor all our IOPs and IAPs through Enterprise Solution Point (ESP), an internal tracking platform.

Finally, the Provider 360 Committee reviews the monthly Provider Complaint Dashboard generated by CRM that we describe above. Accompanying the Dashboard are drill-down reports that track compliance with AHCA's and Humana's timeliness metrics and benchmarks for provider complaint acknowledgements, extension requests, status updates, provider complaint resolution, and payment of claims following complaint resolution, both by Humana and AHCA's Complaint Resolution process. The Committee is responsible for making recommendations to the QIC, the Local Market Operating Committee, and the Medicaid Operations Steering Committee for process improvements and system enhancements.

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3. The extent to which the respondent's process incorporates timely response to Agency requests related to the complaint resolution in accordance with the scope of services.

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Humana prioritizes and works diligently to ensure timely responses to provider complaints received from AHCA. The CI team and specifically, the CI team manager, is the single point of contact for provider complaints we receive via AHCA. The CI team uses a distinct and integrated fast-track process for AHCA requests. Our CI team is uniquely qualified to play this role as we draw CI analysts from internal associates with experience in Humana's operations.

We also ensure these associates have strong investigative and writing skills. We give all new CI analysts specialized training regarding the lines of business relevant to their substantive responsibilities as well as the provider complaint process so they are familiar with every potential avenue of complaint. Finally, we train CI analysts on the contractual requirements for our enrollees and their benefits. CI analysts also receive retraining when there are changes to processes and procedures when contract amendments are added or as needed based on internal audit results or performance analysis.

We mark all AHCA inquiries in CRM as such so the CI team can directly address them. The CI team loads all inquiry documents into CRM so we can integrate them with other provider complaints, include them in reports, and track them by oversight functions, such as the Provider 360 Committee, to identify ongoing process improvements.

Committed to ensuring a true partnership with AHCA, the CI team ensures that associates are available and accessible to AHCA, to providers, and to enrollees. It works in a collaborative manner and strives to exceed performance expectations to address concerns effectively and in a timely manner from the perspective of our provider or enrollee's need. Upon receipt from AHCA, we assign all provider complaints to a CI analyst. Once they receive a provider complaint, the CI analyst researches the issue and reaches out to the provider within three (3) days to acknowledge the complaint and to request any additional information needed to resolve the complaint. The CI analyst also works with other subject matter experts across Humana to address and resolve issues fully and in a timely manner. After researching the issue, the CI analyst drafts a disposition and oversees the implementation of the resolution, including claim adjudication, if applicable. We send a resolution letter to the provider within three (3) days of disposition.

CI leadership ensures a timely response to AHCA requests by daily monitoring of the status of research and resolution. The team notifies both AHCA and the provider of the resolution and ensures that the Provider 360 Committee and other internal committees receive a summary of the issue(s) and resolution for analytical and oversight purposes.

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4. The extent to which the respondent integrates all complaints, regardless of the complaint referral source (e.g., Agency, third party).

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We process all provider complaints consistently and through the same system, whether the complaint comes to Humana from the provider, AHCA, or a third party, and regardless of the door through which we receive the provider complaint. The integration point for all provider complaints is our CRM, which captures and stores all provider complaint information and routes all complaints directly to the appropriate team. CRM captures the provider complaint referral source and intake team to identify the provider complaint source and to support prioritization and timely resolution. Attached is a flow chart depicting how we handle provider complaints once received to communicating the resolution to the provider or AHCA (Attachment 16-01).

Since Humana offers providers a "no wrong door" entry into the provider complaint process, we train all associates who may receive a provider complaint to enter all the information they receive about a provider complaint directly into CRM in a uniform format. Thus, the information captured about each provider complaint is consistent across all complaints. In addition, we require associates to upload data about the status of the provider complaint to CRM as it is processed. This includes documentation relating to the provider's complaint such as copies of correspondence with providers and AHCA. CRM stores it and makes it available for retrieval. By requiring that we track all provider complaints, regardless of referral sources, through CRM, we ensure that our provider complaint reports capture all complaint data, the data accurately reflects trends in complaints, and that we can identify trends across providers and provider types.

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5. The extent to which the respondent's resolution process includes the respondent's participation in the Agency's claims dispute resolution program authorized in Section 408.7057, Florida Statues, as well as includes the following:

a) Responding to requests for information from the State contracted independent dispute resolution organization;

b) A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and

c) Prompt payment of final orders issued by the Agency related to claims arbitration case determinations.

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Humana has a successful track record in addressing all claims disputes directed by the State of Florida for our commercial line of business. Further, no claims disputes have routed to AHCA's claims dispute resolution vendor, currently Maximus, which speaks to the success of our process in communicating the reason for any denied claims and our resolution process. Humana will continue to participate in AHCA's Dispute Resolution program, established under Florida Statute (F.S.) §408.7057, and will work closely with AHCA and AHCA's claims dispute resolution vendor to ensure that we respond promptly to requests for information and promptly pay AHCA final orders. We will analyze those orders to identify possible process improvements and system enhancements. Further, as mentioned earlier, Humana's CI team will work to ensure continuous open communications. We will also ensure that we route any provider that goes directly to AHCA, and that has not filed a complaint with Humana, through our internal tracking procedures to support resolution and identification of any process improvements.

One of the results of our Provider Dispute Process Improvement was the identification of a new report that identifies and tracks all claim disputes submitted by providers to the AHCA Claim Dispute Resolution program. As stated earlier, CRM will generate a monthly report that identifies and tracks all claims disputes submitted by providers to the AHCA dispute resolution program, the date the dispute was submitted to AHCA's vendor, the date of requests for information from the vendor, the date we responded to such requests, the date of the AHCA order, the content of the order, and the timeliness of our payment of AHCA orders in favor of providers. This report, along with the Contract, will provide the information needed to comply with the requirements of the statute establishing the AHCA Claims Dispute Resolution program (§408.7057) and the AHCA regulations implementing that statute (F.A.C. §59A-12.030). Our Provider 360 Committee will use this report to identify process changes and will send it to our Florida Compliance associates to support ongoing monitoring.

RESPONDING TO REQUESTS FOR INFORMATION FROM THE STATE CONTRACTED INDEPENDENT DISPUTE RESOLUTION ORGANIZATION

Humana has established a process under which all requests for supporting documentation from AHCA's Claims Dispute Resolution vendor go to the CI team. Notably, to date, we have not yet had a dispute arise under this process. Upon receipt, the CI analyst will acknowledge receipt of the dispute to ACHA's independent dispute resolution vendor, via phone, letter, or email, by the end of the next business day of receipt.

The CI analyst will review the request and work with the appropriate subject matter experts to respond to the information request. Once the CI analyst has received all the requested information, he or she will forward this supporting information to AHCA's independent dispute

resolution vendor by the requested due date or within fifteen (15) days of receipt of the request, whichever is earlier. If the CI Team and Claims team find it will take longer than fifteen (15) days to prepare a response, then the CI Team will submit a request for an extension to the resolution organization vendor.

GLOBAL PROCESS FOR ANALYSIS OF ARBITRATED CASES FOR IDENTIFICATION OF POSSIBLE PROCESS IMPROVEMENTS AND SYSTEM ENHANCEMENTS

The CI team's expertise is particularly important when it comes to analyzing arbitrated cases for process improvements and system enhancements. Arbitrated cases typically involve disputed issues of importance to both parties and are not amenable to resolution without a neutral arbitrator. Consequently, the CI team gives these cases heightened attention. When the CI team receives an order from AHCA at the conclusion of a dispute resolution case, it enters a copy of the order into CRM along with the date of the order to ensure tracking in compliance with our procedures.

The CI analyst will ensure that we overturn and pay the claim within thirty (30) days of the notice from AHCA to pay or adjust. The CI analyst will contact AHCA with resolution on or before the due date to notify them that we have paid the claim. We will forward the requested information to the resolution vendor, including the claim settlement and payment details. If the request or final order indicates that Humana is to notify the provider of the resolution, the CI analyst will contact the provider to notify them of the payment on the claim.

The CI team is responsible for analyzing the order and summarizing its contents in a report that it presents to the Provider 360 Committee, as discussed above. The Provider 360 Committee reviews and discusses these reports at its monthly meetings. If the Provider 360 Committee identifies any issues that indicate we might need a process improvement or system enhancement, it refers the issue to the Medicaid Governance Triage meeting for assignment to a project team. The project team researches the question and reports back to the Provider 360 Committee with research findings and recommendations. The Provider 360 Committee then decides whether to make a recommendation for a process improvement or system enhancement to the Medicaid Operations Committee. If the CI team identifies an issue of critical importance, it will notify Humana's President of Florida Medicaid Operations, who will escalate the issue to national leadership if necessary.

PROMPT PAYMENT OF FINAL AHCA ORDERS

Humana recognizes that when AHCA issues a final order, it is essential to pay these orders promptly in compliance with §408.7057. Upon receipt, Humana will pay an order issued by AHCA in compliance with the order and within thirty (30) days of receiving the notice from AHCA. The CI analyst completes this process and tracks all final orders to ensure payment. Humana's Provider Services Leader is responsible for overseeing this process in conjunction with the CI team to ensure overall accountability for this function.

Evaluation Criteria:

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent's process identifies claims related dispute trends and initiates process improvement activities/system enhancements.

2. The extent to which the respondent's process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes resolved within required timeframes.

3. The extent to which the respondent's process incorporates timely response to Agency requests related to complaint resolution in accordance with the scope of services.

4. The extent to which the respondent integrates all complaints, regardless of the complaint referral source (e.g., Agency, third party).

5. The extent to which the respondent's resolution process includes the respondent's participation in the Agency's claims dispute resolution program authorized in Section 408.7057, Florida Statues, as well as includes the following:

(a) Responding to requests for information from the State contracted independent dispute resolution organization;

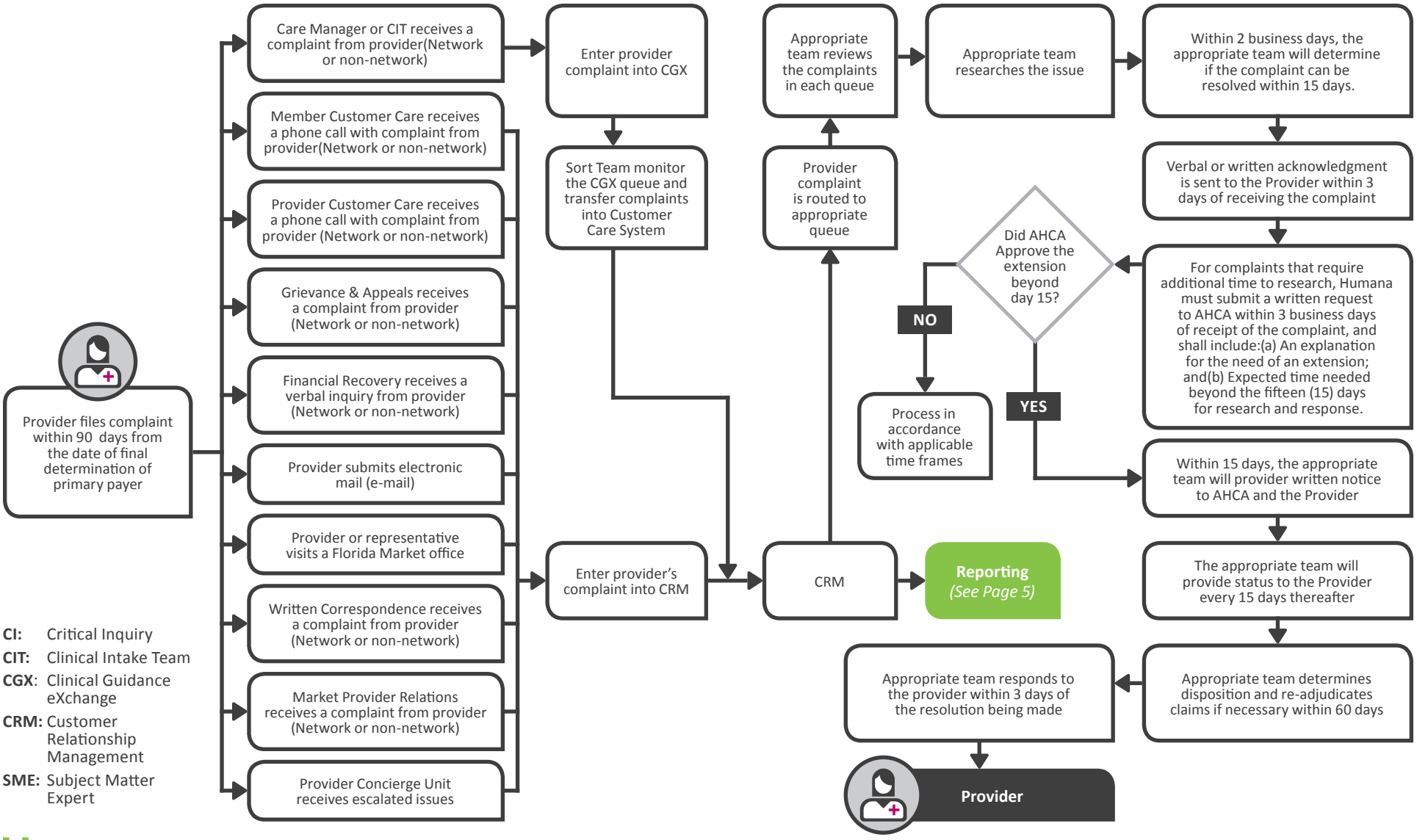
(b) A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and

(c) Prompt payment of final orders issued by the Agency related to claims arbitration case determinations.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

Attachment 16-1: Humana's Provider Dispute Resolution Process

Claims Related Provider Complaints

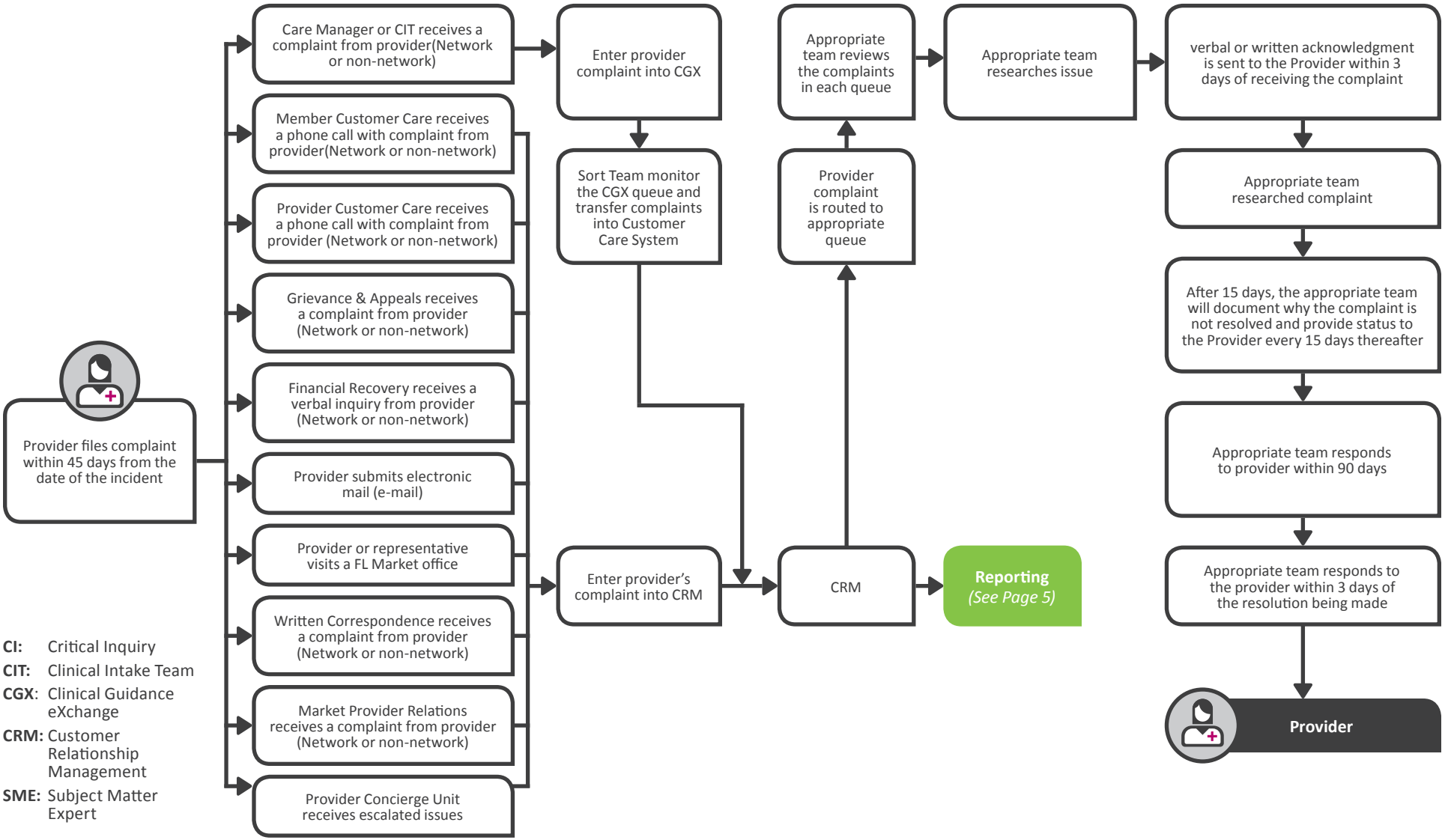


CI: Critical Inquiry
CIT: Clinical Intake Team
CGX: Clinical Guidance eXchange
CRM: Customer Relationship Management
SME: Subject Matter Expert

Humana.

Attachment 16-1: Humana's Provider Dispute Resolution Process

Non-Claims Related Provider Complaints



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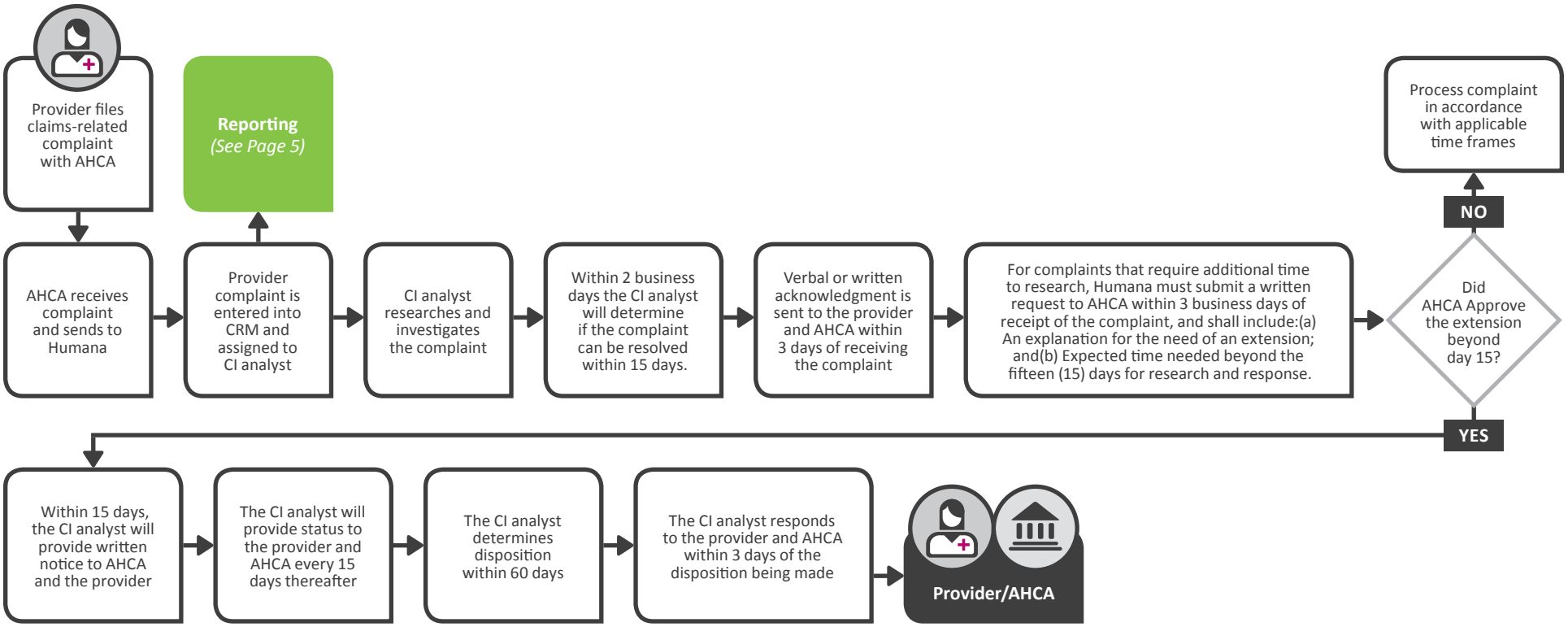
Attachment 16-1: Humana's Provider Dispute Resolution Process

Provider Claims Related Complaints received through AHCA



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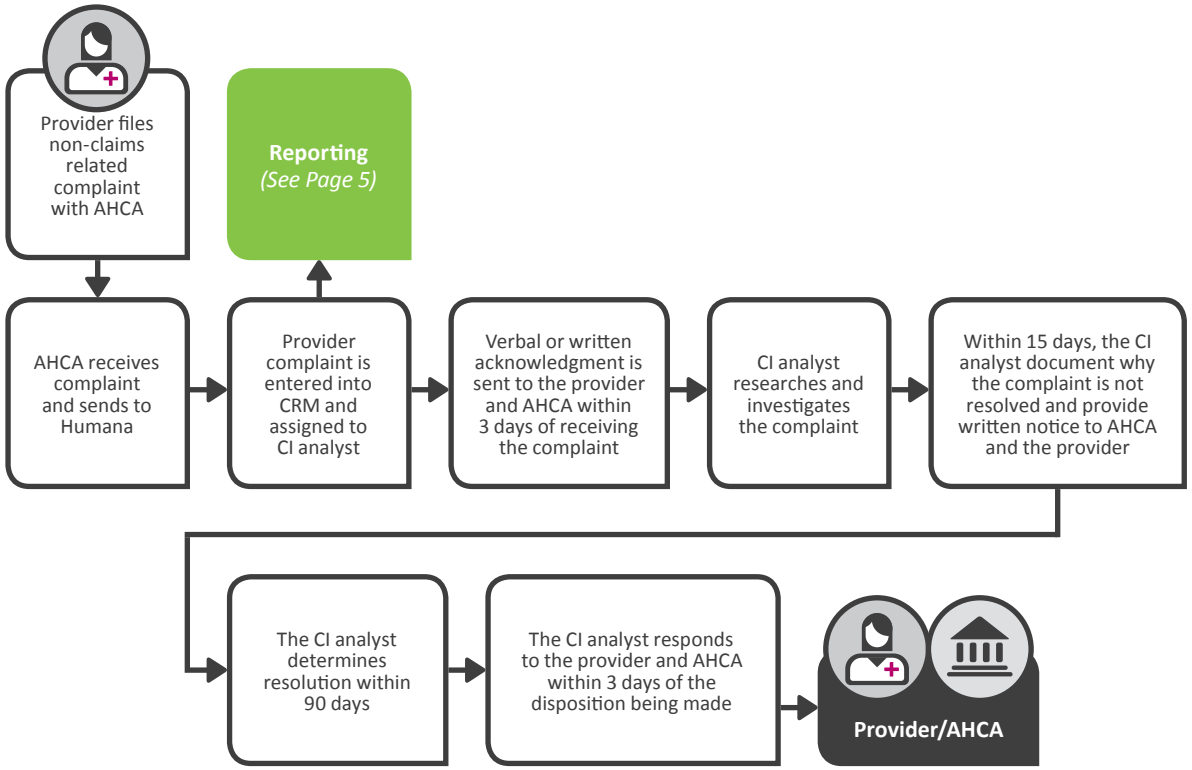
Attachment 16-1: Humana's Provider Dispute Resolution Process

Provider Non-Claims Related Complaints received through AHCA



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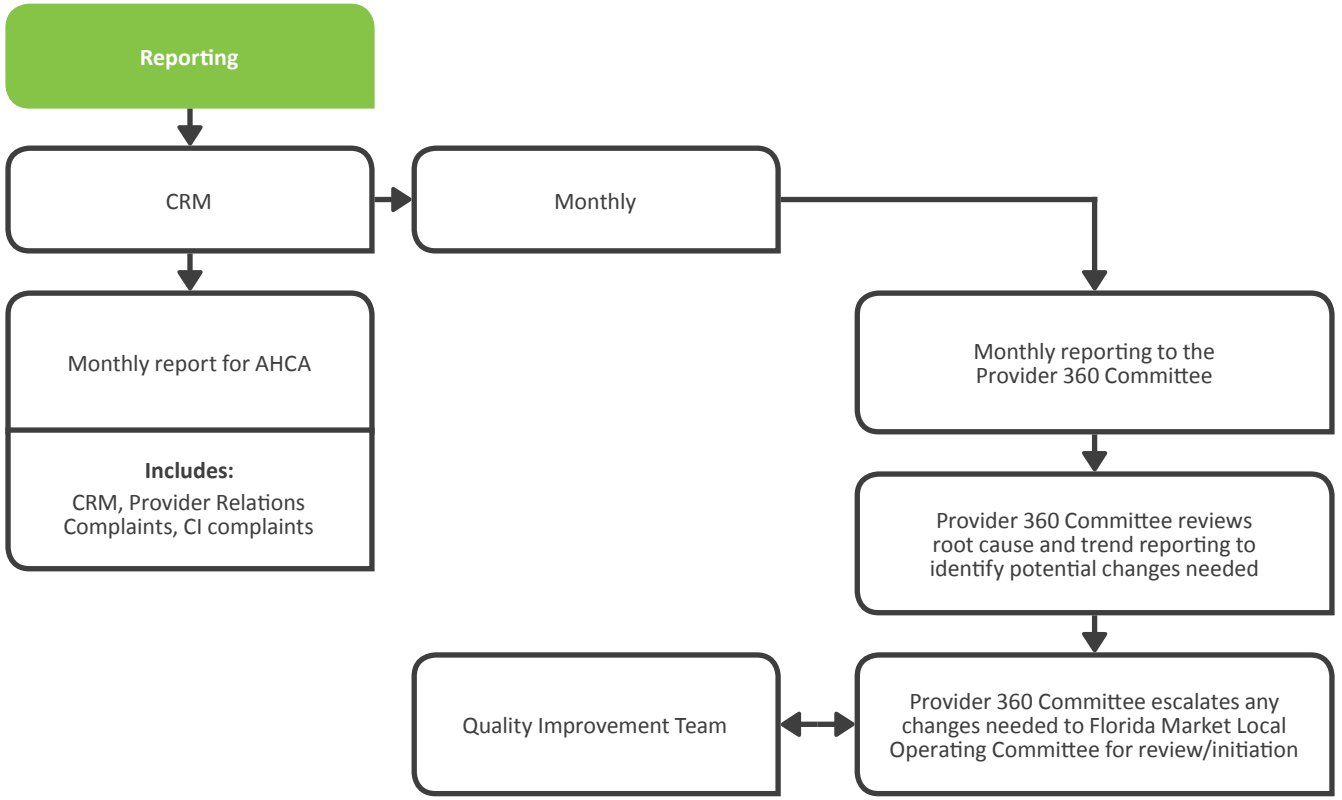
Reporting Process



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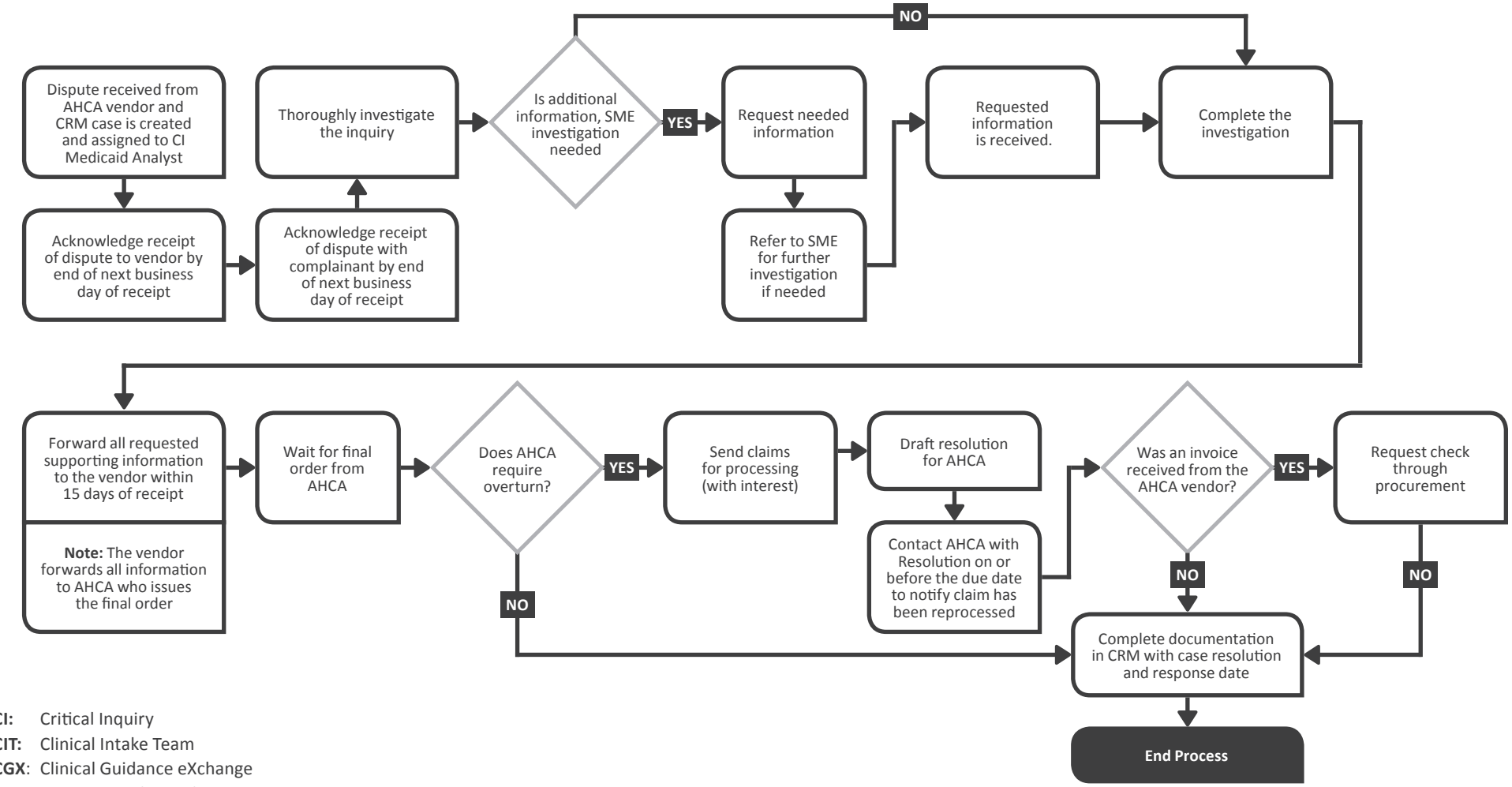
Attachment 16-1: Humana's Provider Dispute Resolution Process

AHCA's Provider Claims Dispute Resolution Program



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Humana.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 17 – Claims Processing and Payment Process (Statewide):

In a manner suitable for the provider community, the respondent shall submit key components of its claims processing and payment process, addressing both paper and electronic claims submissions for both participating and non-participating providers.

The response shall include detailed information on the metrics to be employed by the vendor to track timeliness and accuracy of claims adjudication and payment for claims submitted by participating providers and how these metrics will be used by line level and management staff to improve processes and provide for rapid cycle improvement.

The response shall also include a detailed description of how the respondent will make data and metrics regarding claims and payment available to the Agency and will ensure that network providers have access to real-time and trend data regarding claims processing and payment by the respondent and all applicable proposed subcontractors.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Humana's state-of-the-art claims processing systems meet all Federal and State requirements for accuracy and timeliness. Streamlined processes that do not add administrative burden to providers – with an emphasis on ease of navigation – are the foundation of our claims processing strategy. Humana processed one hundred sixty-four million (164,000,000) claims in 2016 for our commercial, Medicare, and Medicaid business. Five million eight hundred thousand (5,800,000) of those claims were for the Florida Medicaid programs. We understand that accurate and timely processing and payment of claims is essential to building and maintaining strong provider relationships.

Humana processes claims received from more than two hundred thousand (200,000) providers remitted through more than one hundred (100) clearinghouses. Humana has a strong reputation for successful "first pass" claims processing and payment. Humana vigorously tracks key claims payment metrics to ensure providers are paid in a timely fashion. Across all our government businesses, we pay more than ninety-nine percent (99%) of all claims within thirty (30) days and ninety-five percent (95%) of all claims within fourteen (14) days. Additionally, ninety-six percent (96%) of our Florida Managed Medical Assistance (MMA) and Long-Term Care (LTC) claims are electronic. Our metrics are achieved in part due to our established and tested processes and in part due to the collaboration and education our Provider Relations representatives and Claims departments offer our providers. We also have a structured mechanism to review trends in our claims metrics and report claims issues to our cross-functional Provider 360 Committee. The Provider 360 Committee is also an avenue for our Florida Market team and our corporate resources to discuss processes and performance to achieve our overarching claims goals.

Periodic system upgrades and improvements that drive efficiency, effectiveness, and interface with our providers are core to our approach. One recent improvement is our move to a new provider portal, Availity. As a partial owner of Availity, a national claims clearinghouse and claims management platform, and in partnership with other plans, we created Payer Space – a

multi-payer provider engagement portal tool to make Availity provider-friendly so that they can access the information and tools they need to run their businesses within their existing workflow across all their payers. Humana has been at the forefront of creating a streamlined process for providers to manage claims. Additionally, Availity offers providers access to real-time status updates on claims, including trended reports on claims.

Critical to the success of our claims processing and payment process is the timeliness and accuracy metrics established to conduct continuous performance monitoring. We have designed reports to closely monitor performance of systems and processes to measure against contractual and internally developed timeliness and accuracy goals. Our associates are guided to identify and resolve issues immediately. Claims dashboards are monitored and reviewed by our Medicaid Governance structure and cross-functional forums to ensure a validated and structured mechanism to maintain the integrity of our claims process. This rigor extends to all cross-functional capability critical to Medicaid's success, inclusive of claims processing and provider relationship management. Close monitoring of performance helps us identify any issues and pinpoint necessary process enhancements, changes in resource allocations, and opportunities for provider training.

To promote transparency in information sharing, Humana is making key components of internally-developed claims-level data and reporting accessible to the Agency. We are creating a secure Business Partner Portal to share these dashboards with AHCA for the new contract.

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1. The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims suitable for the public, including a description of the processes for claims submitted both on paper and electronically.

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Humana has designed our claims process and payment methodology to be streamlined and simplified. Our claims process and payment methodology is designed to:

1. Intake a claim from a mechanism of the provider's choosing, which encompasses more than one hundred (100) clearinghouses and billing agencies

2. Pay claims timely through a simple electronic fund transfer or check

3. Offer clear reasons for claims denials with an easy to access and use platform to view remittance files and resubmit denied claims

Our claims process and payment methodology has many back-end rules and edits in place to validate our payment to services rendered.

Humana's claims process and payment methodology is available to providers and the public in our Provider Manual and via easy to understand online videos on our publicly-facing website at https://www.humana.com/provider/. In addition, providers may request a printed copy of the Provider Manual. The claims information outlined in the Provider Manual includes the steps necessary to submit a claim for reimbursement, benefit limits, services which require prior authorization, copay procedures, and third party liability rules and requirements. All materials

have been developed to offer an easy-to-understand manual for our provider offices, including providers, billing staff, and other administrative staff so they can submit proper claims.

As part of Humana's efforts to streamline and simplify the claims submission process, we have retooled Availity, our provider engagement portal, to support providers in the submission of claims as well as throughout the path of a claim (e.g., claims status, payment, claim correction).

Humana's local Provider Relations representatives are also trained on our claims process. They receive rigorous training to develop an understanding of the claims process and the mechanisms we have designed to support accurate and timely processing. Humana's Provider Relations representatives conduct in-office training and follow-up to ensure that providers understand our claims process. The Provider Relations representatives are supported by additional claims associates, as needed.

Non-participating providers can find instructions on billing claims through our website and can call our Provider Relations Call Center for instructions. Our Availity webpage offers specific instructions for non-participating providers on the submission process for claims.

CLAIMS SUBMISSION

Humana's claims processing and payment process begins with a provider submitting an electronic or paper claim. Humana has worked with our providers to educate them on the complete, accurate, and timely submission of an 837 claims file.

Attachment 17-1 offers a diagram of our claims lifecycle process.

ELECTRONIC CLAIMS

If a provider bills electronically, the provider can use a large range of clearinghouses or billing agencies to submit the claim to Availity, our preferred clearinghouse that aggregates claims submitted by eighty percent (80%) of all our providers. Availity also serves as Humana's provider engagement portal and includes a feature to submit claims via direct data entry, a mechanism that is commonly utilized among our smaller LTC providers and is available at no-cost to our providers. We also work with ZirMed and other claims submission platforms to directly submit claims to our eHub platform. These platforms automate the claims conversion via the provider's practice management system to an 837 claims file we can then process.

When Humana receives a claim file from a clearinghouse or billing agency, Availity sends an electronic acknowledgement back to that entity, indicating our receipt of the claim. We acknowledge claims if there is a need for the provider to resubmit the claim. The 999 acknowledgement (a structured ANSI 999 X12 Acknowledgment for Health Care Insurance) offers notice to the submitter that the claim failed Health Insurance Portability and Accountability Act (HIPAA) compliance edits. A 277CA acknowledgement (a structured ANSI 277CA Health Care Claim Acknowledgement) offers a description for failed claims, which are payer-specific, outside of HIPAA compliance edits, providing the provider a clear understanding of reasons for rejections.

Humana has checks and balances in place at the front end of Availity to review the claim for more than one hundred (100) code checks to ensure that the claim has all the necessary fields

filled in and coded fields have valid values. The edits, inclusive of HIPAA level seven (7) edits, ensure that the 837 files submitted by our providers or through clearinghouses and billing agencies are not rejected when they enter our claims adjudication platform. As a result of these edits and front-end review of 837 claim files, we are able to reduce the number of claims denials a provider receives.

Humana has designed Availity, our provider engagement portal, to offer our providers a one-stop shop for claims submission and access to clinical member-level information, performance on care gaps and other quality metrics, authorization submission and status reviews, trainings, and more. Approximately sixty-five percent (65%) of our providers, across all lines of businesses, are registered and use the tools in Availity. As an added mechanism to support first pass of claims, Humana has developed the Claims Code Editor tool to allow providers to test the feedback they would receive for specific claim submission scenarios. The tool offers real-time guidance to providers with claims reject reasons so that providers can fix their 837 files before submission.

Our providers can access the status of any claim submitted to our platform via the Availity provider engagement portal. Providers can also resubmit claims and offer additional details for claims that have been rejected. Providers can download claims reports and filter by member ID and claims status and view amounts paid for each claim.

Throughout gradual and recent transition to Availity, Humana has developed a concerted strategy to help our paper claim submitting providers move to Availity's simple claims submission, a direct data entry form. In 2017, four percent (4%) of all claims submitted were paper claims, as compared to five percent (5%) percent in 2015 and 2016. We offer training to our providers, through a targeted outreach strategy to transition all providers to electronic claims submission.

Claims that successfully pass these and other edits are sent electronically to Humana for processing in our eHub system. All claims are subject to edits that confirm that the procedural and diagnosis codes are valid, the procedural codes are appropriate for the diagnosis code submitted, and the claim is in the correct format (e.g., a structured ANSI 837 X12 Health Care Claim transaction with HIPAA-compliant information). These are known as "HIPAA validation edits." Non-participating providers can submit claims through Availity or other clearinghouses and are processed with the same set of checks and balances.

PAPER CLAIMS

Providers that submit paper claims to Humana using a standard claims form, such as CMS-1500 or UB-04, mail their claims to the P.O. Box that is listed on the back of the member's identification (ID) card. Humana's vendor, Conduent, Inc., manages the paper claims process from the time the claim is received at the Humana P.O Box until the claim is received by eHub after being converted into an electronic format. Today, only four percent (4%) of all our Medicaid claims are submitted via paper.

Humana requires Conduent to retrieve mail from the P.O. Box two times a day between 6:00 am and 10:00 am EST. They open, sort, and scan all documents. Once the documents are sorted, Conduent scans each one and adds a date and time stamp number sequence called a document control number (DCN). Conduent then sends the scanned claim through an optical character recognition (OCR) scanner to extract the data needed by Humana to process the

claim. For claims that cannot be “read” by the OCR scanner, Conduent manually enters the required claims data into their system to accommodate a comprehensive transmission of all necessary details for the claims received. Data is therefore submitted in a format and with the fields Humana requires for claims processing. All paper claims are scanned and processed by Conduent within 24 hours of receipt. Upon receipt of a claim from Conduent, Humana responds with an acknowledgement of receipt which allows them to reconcile and ensure no claims are lost. Providers can also track the status of paper claims through the Availity provider engagement portal.

EHUB – HUMANA’S FIRST STAGE OF CLAIM PROCESSING

All claims, whether originally submitted electronically or on paper, are transmitted as an electronic claim from our clearinghouses and partners to Humana through eHub, Humana’s front-end claims system, where they are stored in their original state of receipt. eHub performs edits in addition to those applied by the clearinghouse or billing agency. These edits include but are not limited to:

- Validation of HIPAA level four (4) edits to validate for claims that are submitted via direct connections from clearinghouses and billing agencies

- Verification of member eligibility for services rendered

- Accurate completion of all key fields, including National Provider Identification (NPI) number, claim type, and others

- Identification of duplicate claims

Availity and eHub work in a complimentary fashion. We have designed Availity and eHub to apply level seven (7) and level four (4) HIPAA edits, respectively, to ensure all claims, regardless of the path of entry to our platform, are properly and thoroughly validated against HIPAA requirements. As noted above, claims received by eHub from Availity, ZirMed, and other claims submission platforms are subject to additional non-HIPAA related edits to address other considerations impacting our ability to successfully and accurately process claims. At every step in our process, we notify providers of claims that are rejected and provide supporting detail.

Claims that have passed eHub are then routed to our proprietary claims processing system, Claims Adjudication System (CAS). When CAS receives a claim from eHub, it sends an electronic acknowledgement back to eHub and maintains one hundred percent (100) percent traceability between systems to ensure no claim is lost.

Additionally, we have designed eHub to match all claims with authorizations if an authorization is required for the service being billed. If authorizations are not found, the 837 file is returned with a note to the provider requesting proof of authorization submission.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

ADJUDICATION

Adjudication is the stage in the claims process when Humana determines whether a claim can be paid and how much to pay the provider. The vast majority of claims that move through Humana's system are processed and paid without any manual intervention. Nearly ninety percent (90%) of all claims we process for our government businesses are automatically adjudicated and pass the first time through our edits.

CAS automatically assesses each claim to: identify the member; identify the provider; verify benefits; complete a series of automatic edits; verify that the member record shows no other insurance; and apply pricing. The following section details this process.

DETERMINING WHETHER A CLAIM CAN BE PAID
When CAS receives a claim from eHub, it determines whether the claim includes all the information necessary for adjudication and for our subsequent encounter submissions to the State. Edits include industry standard applications (e.g. McKesson ClaimsXten to verify accuracy of professional claim coding and iHealth verifies professional, outpatient, and DME claims) as well as internal Humana edits based on internal policies and contract and program parameters.

Edits verify:
- Provider match (e.g., "same provider" checks individual providers with group providers)
- Diagnosis and procedure code appropriateness
- Benefit eligibility and design
- Patient data and procedure and diagnosis code appropriateness (e.g., gender, age)
- Non-automated contract terms
- Manual pricing criteria
- Pricing
- Service authorization
- Duplicate claims

For non-par providers who do not have a single case agreement or contract, claims are pended. Our Provider Pend Group works with our Provider Relations team to load the provider's information into our system to ensure the claims can be processed.

Claims that pass these edits and that do not need further assessment are categorized as clean and are routed for payment. Clean claims may still pend for review.

Claims that are not clean either failed our edits or were rejected because we need additional information to process the claim. Humana may perform outreach to the provider to obtain necessary information to finalize these claims.

CAS finds claims with inconsistent data (such as type code, group number, or contracted provider number) and flags the claim as requiring manual processing. This is known as "pending" the claim. CAS may "pend" a claim for other reasons as well. Pended claims are assigned to our adjustors, who are highly trained within the type of pend reason or code they specialize in. Our Adjustors specialize in addressing our Florida Medicaid claims and are easily

able to identify trends and conduct root-cause analyses to correct issues. Our Adjustors conduct manual research and complete the adjudication guided by documentation.

If a claim fails the CAS edits, Humana may deny it and return the claim to the provider for correction and resubmission. Claims that are rejected are returned to our providers via Humana's Availity Provider Portal and through fax and mail remittance. Humana will clearly indicate to the provider what information is needed and the explanation of benefits so that the provider can readily make the correction and resubmit the claim. Humana never makes any changes to the information that a provider submits on a claim; only the provider can make any corrections and then resubmit the claim.

PRICING THE CLAIM (DETERMINING HOW MUCH TO PAY)
Prior to pricing the claim, the CAS platform verifies the service rendered is within the scope of their benefits. We then price the claim by comparing the total charge submitted for each claim with the total of individually entered amounts for each treatment or service within the claim. If the totals do not balance, the claim cannot be processed. The second step is pricing each service billed in the claim against the fee schedule for that provider and calculating the amount due to the provider. (If a claim has been pended, it may be manually priced by Adjustors using the same steps.) According to the contract and State statutory requirements, once the claim has been priced it is paid and sent to the Payments department for payment issuance.

PAYMENT

Claims that have been finalized will be processed for payment automatically. Prior to claim finalization, we conduct a prepay audit. The prepay audit process reviews an average of one point five percent (1.5%) to two percent (2%) of claims monthly. Selection of the claims are driven by rules that have been developed and coded into our prepay system. We have established rules to stop a claim from being processed that may contain errors. If the claim clears pre-payment, it is finalized and sent for payment. The audit process within our pre-pay area is end-to-end based on the rule that is being audited. Each auditor is assigned rules based on their prior background and experience. The auditor will examine the claim and confirm the appropriate step actions have occurred. The claim is examined from the point of receipt from the provider to completion for both the adjuster and the system.

If it does not clear the check, it is returned to the analyst who conducted the manual review.
If the provider has elected electronic funds transfer (EFT), Humana's Pay Pilot system assigns a payment trace number and pay-by-date and the payment will be automatically transmitted to the provider's bank account on that date. If the provider is not set up for EFT, we generate a paper check and mail it to the provider. Humana generates a Provider Explanation of Remittance (EOR) for both electronic and paper distribution. For electronic remittance, a provider can download the remittance from our provider portal at Availity, the provider's preferred clearinghouse or billing agency. Humana pays providers twice a week.

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2. The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process.
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Since 2016, we have paid more than ninety-five percent (95%) of clean claims within ten (10) days for our MMA services and more than ninety-three percent (93%) of clean claims within ten (10) days for our LTC services. These consistently high performance rates reflect our highly effective claims processing and payment reporting, monitoring, and evaluation mechanisms. Our processes and discussions are informed by conducting smart analytics of our data. Our data are reviewed in different forums and are made available to our Associates, Front Line Leads, Managers, and Executive Level Committees to track performance and identify process improvement opportunities.

We monitor: (1) our claims end-to-end through the lifecycle to ensure timeliness and accuracy; and (2) our claims processing system for capacity and to audit that the rules we have in place are effective. The reports and metrics described in this response achieve both these goals and ultimately ensure timely and accurate claims processing and payment.

BUSINESS INTELLIGENCE

Humana understands the importance of actionable data to effectively monitor and track claims. As such, we have invested heavily in business intelligence architecture to support and oversee our day-to-day functions. Humana's Enterprise Data Warehouse (EDW) and Medicaid Datamart form the foundation for claims analytics. Our Medicaid Datamart strengthens our data by applying logic and validation to our data. Business Intelligence teams use this platform to develop interactive applications and reports that support Associates in data discovery that lead to effective process management and improvement.

MEDICAID OPERATING DASHBOARD

In June 2016, Humana's Medicaid Performance Management and Reporting team launched a Medicaid Reporting Dashboard application on InfoMarket, Humana's home for reporting that is approved by our governing board for quality assurance. This dashboard provides an overview of the operational health of Humana's Medicaid plans over a thirty-six (36)-month period and captures claims processing and payment performance metrics. Summary dashboards guide conversation at cross functional meetings and executive level committees. The metrics measure our performance to support our overall assessment of processes and performance to achieving accuracy and timeliness standards. At a high level, the dashboard offers the volume of claims, our month-end inventory, and top pended and denied reasons. The Medicaid Reporting Dashboard has multiple filters and offers data at a point in time as well as trended data over the life of our contract. The tool also offers drill down capabilities at the line level to research and resolve issues and identify process improvement opportunities.

CLAIMS PERFORMANCE ANALYTICS CATALOG

The Business Informatics Shared Services team has developed a suite of interactive dashboards using QlikView software specifically for the Claims department to monitor claims key aspects of claims performance, including receipts, auto-adjudications, pend inventory, cycle time, and more. Associates can view trended data over a 12-month period and evaluate performance against thresholds and benchmarks to help inform process improvement opportunities.

Attachment 17-2 offers some visuals on our Business Intelligence Tools available to Claims Operations teams.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

CLAIMS LIFECYCLE PROCESS EVALUATION

Throughout the life of a claim, our systems record a comprehensive set of data elements. Teams across our claims organization use this data to develop measures and automated reporting that track key process steps to ensure we accurately process and pay claims timely. Our teams continuously monitor these operational reports to review process performance and are empowered by analytical tools to assess and resolve issues quickly. Listed below are examples of measures we monitor and that support efficient processing and payment.

RECEIPT OF CLAIM

During receipt of a claim, we have a set of key reports that monitor all initial processes that take place during and immediately after receipt of a claim. This includes monitoring mechanisms that: (1) validate all claims submitted were received; (2) reject any claims that were not submitted correctly; and (3) process claims that pass edits to our eHub platform. Key metrics we monitor are listed below:

- Unacknowledged claims within forty-eight (48) hours of receipt (837 Unacknowledged Claims): This metric allows us to monitor all claims correspondences for claims that have been received by eHub. We identify the number of claims received and validate against the number of acknowledgements sent. Claims that have not been acknowledged within forty-eight (48) hours of receipt are tracked for root cause and resolution, ensuring all claims receive an acknowledgement correspondence.

- Paper claims receipt and acknowledgment: Humana monitors the volume of claims acknowledgement receipts submitted to validate against Conduent claims submitted to eHub to identify claims that did not transmit. Every four (4) hours, Humana receives notification from Conduent of all claims submitted that have not been acknowledged. This report helps us validate the number of paper claims received is the same number of paper claims submitted.

- eHub HIPAA and payer-specific (999 and 277) rejects: On a real-time basis, we monitor the edits that are triggered by our eHub platform. Reports indicating HIPAA rejections of claims submitted are produced twice a day. Reports indicating other payer-specific rejections are produced six times a day. These reports and the reasoning for rejections are stored in our systems and communicated to providers. When our team receives inquiries from providers regarding rejected claims, these reports and cataloged notes allows us to retrieve the relevant data quickly, and promptly respond to the providers to support their proper submission.

- Claims transmission batch failure: On a daily basis, we review the claims process and identify any claims submission batches with a failed transmission into our eHub platform. If any batches fail, our eHub PSM team or clearinghouse ensures the batch file is corrected and successfully submitted.

To support monitoring of claims received, Humana has designed a Claims Audit Trail tool to investigate the routing of a particular claim and can provide information such as type of claim, eligibility status, the claim adjudication platform, and the time the claim was routed. This allows our Adjustors the ability to quickly assess potentially conflicted claims and conduct root causes analyses immediately.

CLAIMS PROCESSING SYSTEMS CAPACITY
We also have reports that monitor and assess our systems capacity for handling the volume of transactions and claims we have at any given moment, ensuring all claims are processed in a timely.

- eHub and CAS system claims volume: On a daily basis, we monitor the volume of claims routed to each of our claims processing and adjudication platforms. We trend the volumes to identify issues or gaps in the movement of claims from eHub to CAS, ensuring all claims are moving down the queue in the appropriate steps. Through this mechanism, we identify and resolve back-end technical issues to troubleshoot any barriers of submission to the adjudication platform. Additionally, daily and monthly reports, including yearly averages, are reviewed by leadership to assess for needs to increase resource and technology capacity.

- Availity capacity: This alert is routed to Humana from our Availity platform and notifies us of spikes in claims submission, where processing failure rates exceed thirty percent (30%) or more than one hundred (100) failed transactions. Our team receives these alerts on a real-time basis and on a daily basis. Based on this indication, we may submit communication to our subcontractors or providers alerting them of any slight delays we may foresee in processing their claims.

- eHub daily volume: On a daily basis, we review submission of claims, by clearinghouse or billing agency, to monitor claims submission deficiencies and overages. Special attention is paid to claims not received and claims submission patterns that significantly deviate from historical submission patterns. If the submission of claims deviates by twenty percent (20%) or more, we research the root cause of the deviation, test for special versus common cause variation, and take action, as needed.

CLAIMS PROCESSING
A strong end-to-end claims process consists of multiple systems designed to handle the particular rules and relevant logic by type of claim to effectively manage each claim throughout the claims process. Humana monitors this end-to-end process in a detailed manner. We use multiple reports to ensure that each claim received by Humana is successfully sent to the correct adjudication platform. In fact, we maintain a status record for all open claims for the purpose of real-time monitoring to offer status updates to providers on their claims in an easy to find fashion. We also maintain a historical record of all processed claims for ten (10) years, offering detailed explanation of the life of a particular claim and notes passed between our departments to resolve any issue associated with adjudicating the claim. Our primary workflow system, MACESS, offers this and more. MACESS is a workflow system that queues all pended claims to the appropriate and qualified team and associate.

- Claims aging: To support timeliness of payment, we monitor all pended claims in MACESS by age. We are able to, in real-time, assess the number of claims pended by reason it was pended, by team responsible, by type of claim, and more. Our Operations Manager, Front Line Leaders, and Team Leads can generate, refresh, and review these reports continuously to identify strategies to staff appropriate pend queues and to identify potential claims processing issues. These reports are also filtered by each contract requirement to assess how our claims are performing with regards to standards we have to achieve. We monitor the age of the claims

before it has passed the standard, to adequately staff each pended queue and prioritize claims that are at risk of aging, in our effort to address all claims and meet all contract requirements.

To ensure our edits for pending claims are working as designed and that the pending logic is an effective method to validate claims data, we generate a daily report to identify claims by pend code. The report allows us to ensure the claims pended by the logic are the types of claims the logic is designed to pend and review.

- Pended claims queue logic validation: To assess if claims are pending appropriately, we generate drill-down reports to review the detail and pend codes for all pended claims. Our Claims Operations manager, Front Line Leaders, and Team Leads review these reports on a daily and weekly basis to identify strategies to staff appropriate pend queues and to identify potential claims processing issues.

Humana also monitors two (2) claims adjudication and timeliness reports to identify opportunities for process improvements to our CAS system, including the edits and logic we have designed the system with. These reports offer trended views of data, allowing us to assess performance week over week for the month, quarter, and year range.

- Auto-adjudication abnormalities: To ensure claims that are auto-adjudicated are accurately adjudicated and to ensure that they are paid timely, we monitor a daily and weekly report of claims that are auto-adjudicating.

- Claims processing cycle time: On a weekly basis, we assess cycle time of all claims by various claim filters including clean claims, pended claims, dirty claims or electronic versus paper claim or medical claim, nursing facility claim, among other metrics.

Similar to the above mentioned reports, remittance files that are submitted and enter and exit our Electronic Remittance Advice (ERA) database are reviewed on a daily basis. We ensure that inbound and outbound electronic remit files are at least a ninety-five (95%) threshold for the previous day.

CLAIMS PAYMENT
- Payment cycle time: On a weekly basis, our CAS system generates a metric which informs our Claims Department of all claims that were paid in a given week, filtered by the claim type, and by age. This metric allows us to monitor how we are performing as compared to the contractual requirements and adjust any of our adjudication processes and claims processing edits, as necessary.

- Payment audit: On a monthly basis, we monitor all payments that were submitted to our providers against the amounts from our claims submission. This metric allows us to ensure that all payments were submitted accurately.

CLAIM AUDITS

Humana has instituted a process management control system for our claims operations that defines the claim process, quality controls, and monitoring plan. The control plan is an

important collaborative tool utilized by operations, auditing, and quality engineering associates to target improvement plans.

Humana also conducts five (5) types of audits to ensure all claims are focused on identifying, preventing and correcting errors. They include: performance guarantee audits, platform audits, focused audits, pre-disbursement audits, and performance management audits. Humana conducts an end-to-end claims audit of five hundred (500) claims on the CAS platform on a monthly basis. The sampling methodology for the platform audit includes a dollar-stratified random selection. Under this approach, our claims audit sample consists of a random selection of a pre-determined number of claims within each dollar stratum. Volume, frequency, standard deviation, and variance are considered for each stratum and in the sample size calculations.
Humana reviews and measures financial metrics, payment metrics, processing metrics, and overall accuracy.

- The financial error rate reflects the total payment of the claim that does not accurately reflect the amount of benefits payable

- The payment error rate reflects the number of claims adjudicated with financial errors

- The processing error rate reflects the number of claims that were not processed according to the policy and procedure and has no immediate financial impact but may have future financial implications. These errors may negatively impact the quality of service for the member, benefits for the claim, and fails to meet compliance to the contract. Examples include claims processed to the wrong member provider with the same TIN, claims processed against guidelines and recommendations, or if the claim amount went to the deductible or co-pay but should have denied.

- Monetary errors reflect errors that do result in financial impact and usually occur when there is an incorrect issuance of benefits leading to overpayment or underpayment. Examples include duplicate claim, coordination of benefits (COB) applied improperly, and a claim processed with incorrect provider ID.

When our audits uncover missed opportunities and improperly processed claims, we review the claim to understand if the error was made due to improper process documentation, adjustor error, or other reasons. Where process documentation improvement opportunities exist, we work with various leaders in our Claims department to update our policies and processes and retrain our adjustors on the new policies. For adjustor errors, Team Leads educate the adjustor on the error and monitor the adjustor closely to validate understanding.

For each sample claim that is audited, the following elements are reviewed: claim information, duplicates, eligibility, provider information, contract information, coordination of benefits and other insurance, benefits, co-payments and co-insurance and deductibles, pre-certification, pre-existing conditions, claims remarks, member remarks, claim check, I-health (to check for coding edits), claims member history, eHub, queue and adjuster unit audit trail, information recorded in other systems including MACESS, and use of internally developed process guidelines.

PREPAY AUDIT
The prepay audit process is designed to review a targeted population of claims that meet predetermined criteria. The criterion that is utilized is focused on the identification of claims that

are highly susceptible to error based on past experience. This is a proactive audit that is focused on identifying, correcting, and preventing errors prior to payment. The prepay audit process reviews an average of one point five percent (1.5%) to two percent (2%) of claims monthly. Selection of the claims is driven by rules that have been developed and coded into our prepay system. We have established rules to stop a claim from being processed that may contain errors.

The audit process within our pre-pay area is end-to-end based on the rule that is being audited. Each auditor is assigned rules based on their prior background and experience. The auditor will examine the claim based on logic to validate the appropriate step actions have occurred. The claim is examined from the point of receipt from the provider to completion for both the adjuster and the system. Reports are generated on a weekly and monthly basis that allows us to track dollars and claims in error through this audit process. The management oversight allows us to remove rules where the process, tools, or technology have been improved and monitoring is no longer required. Additional information is supplied by Financial Recovery, National Quality Audit, and a peer review process to identify additional opportunities for future rule determinations.

POST-PAY REVIEW

In addition to pre-payment adjudication processes, paid claims are assessed following payment to identify overpayments and underpayments. Retroactive review may be triggered by a provider inquiry, additional information received by our trading partners, or through automated processes generated when Humana receives updated enrollment and eligibility files. Humana runs queries monthly on all paid claims to identify claims that would have a likeness of being over or underpaid. In addition any retroactive changes to membership or provider contract changes are captured and claims are reviewed for appropriate payment.

Humana's Enterprise Financial Recovery system (EFR), a component of CAS, assesses paid claims for accuracy, and potential overpayment. Overpayments may be identified when Humana receives additional information from Medicare or Medicaid concerning an individual's eligibility or service status.

PERFORMANCE MANAGEMENT AUDIT

Our monthly performance management audit is an edit-driven claims audit covering a sample of ten (10) or more claims processed per month per adjuster (a minimum of two hundred (200) claims monthly) on the CAS platform. These audits are used to independently and objectively evaluate the quality of claims adjusters, to provide feedback and coaching for improvement and to capture trends for people, process, and technology enhancements.

The sampling methodology is a random audit which selects a minimum of one (1) to three (3) claims per week per adjuster. Samples are pulled on a weekly basis (at a minimum) to assist in timely completion of the audits and to ensure an equal distribution of sampled claims throughout the processing month. Claims are selected automatically utilizing a system-created random number generator. These audits are specific to our Florida comprehensive contract requirements.

SUMMARY

These reports help support issue identification and improve our claim processing and payment rates. Our teams and committees meet regularly and are organized around our performance and the processes we have in place to improve our performance. As evidenced, claims processing systems are complex and fed by several ancillary systems, which makes it imperative to be able to track, identify, and reconcile claims as they move through the system. Humana understands that claims processing is at the core of ensuring a strong provider experience.

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3. The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.

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Rapid-cycle improvement is a quality improvement methodology for accomplishing measurable and meaningful results in an accelerated timeframe, typically less than ninety (90) days. It requires the management of an organization to identify a specific opportunity for improvement, assign a team to gather data about the issue and assess it, select the improvement strategy, implement the strategy, and test whether the strategy was effective. In addition, the organization's management must be committed to supporting the process so that it happens in an expedited manner.

As described earlier, our Front-Line Leaders and Team Leads from responsible departments monitor key metrics to validate all claims are being processed accurately and are on track for timely payment. These metrics roll up into daily, weekly, and monthly dashboards that are reviewed and assessed by multiple departments, including the Claims Operations Department, Claim Process Organization, and Operational Risk Management Department. These departments have individual meetings to discuss areas of opportunity – where Humana's performance is lower than the threshold or where trend data indicates abnormalities. During these meetings, rapid-cycle improvements are immediately put in place, where possible and appropriate. Often times, this requires engagement with our MIS Team to fix a technical or systems issue and can be handled within a matter of days. Any claim issue impacting providers are discussed at our Provider 360 Committee.

As our Frontline Leaders and Team Leads identify outliers and unexpected performance through our multiple monitoring vehicles, they work with our Claims Rework team to support the identification of the claims issue. The Claims Rework team then works with our IT department or within the back-end logic of the claims processing platform to recreate the issue, identify a solution, test the solution, and implement the fix. This team plays a central role to claims with processing lags and issues and creates resolutions for the particular claim at hand to ensure timely processing and conducts root cause analytics to create a solution for the claim issue so that similar claims do not lag in the future.

Recognizing the need to support an end-to-end process to monitor these projects and to build rapid cycle improvement strategy into our Medicaid operations, this past year Humana enhanced its Medicaid governance framework, deploying new processes for risk identification,

and new pathways for issue escalation. As claims issues are identified, the Claims Process Owner raises the issue during the next local Market Operating Committee meeting, where the group determines how the issue should be escalated and resolved. The proposed resolution and issue is presented to our Triage team. This team assesses requests for process improvement and system enhancement projects, determines that additional work is required to determine root cause and resolve the issue, decides whether to approve the project, and if needed refers the proposed project to the Medicaid Operations Steering Committee for approval. Triage teams are comprised of consultants to the process (product or process owners, market representatives, corporate Medicaid and IT staff) and decision makers (governance process facilitator and implementation or process improvement leader).

The new governance structure will enhance claims performance improvement by creating a consistent process for providing progress and status updates and identifying risk and escalation procedures to senior management. We have developed tools to support our framework and to ensure all changes are tracked and meet objectives and goals. The new structure is supported by our Medicaid Implementation Team comprised of experienced process engineers and project managers, this team coordinates corporate and market resources to rapidly implement opportunities identified. Attachment 17-3 provides an overview of the Medicaid Governance framework.

Humana also recently launched the Florida-based Provider 360 Committee. The Provider 360 Committee plays an important role in rapid cycle improvement of claims processing and payment process. Led by local market leadership, the Committee includes a mix of market and corporate support areas, including our Compliance Officers, Provider Relations, Claims, digital, Provider Escalation and Provider Communications. The sole objective of the Provider 360 Committee is to review performance measures that contribute to our provider's experience with Humana. As needed process improvement opportunities will be presented to Triage and overseen via the Medicaid Governance framework.

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4. The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data.

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As described earlier, Humana understands the importance of data and the types of functionalities needed to make the data impactful. Humana has a multitude of QlikView and SSRS data packages that offer smart analysis of claims. As Humana enters the new contract, we will offer the Agency an on-line, secure portal to access these data platforms and more. Humana offers Business Partner Portals to clients across our organization. We will design a portal tailored to meet the reporting requirements of the contract.

The reporting portal will offer access to near real-time data on our claims process and will offer access to line-level claims detail. Claims data are backed-up nightly in our Enterprise Data Warehouse (EDW). On a nightly basis, the Government Partner Portal will be updated to offer as close to real-time and line-level information on all active claims we house in our system, wherever it may be in the claims lifecycle. Our QlikView and SSRS dashboards allow for information to be presented at an aggregate level with an ability to filter and drill-down to the

claims level. These tools will make our reports highly interactive. As an example, we can share and make available claims pend inventory reports. Where the Agency is interested in a specific metric, our SSRS capabilities allows for AHCA to access additional detail about that measure. Attachment 17-4 offers a sample of the types of reporting functionalities that can be made available.

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5. The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.
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Humana has developed a special partnership with Availity to make it easier for providers to care for patients and interact with our platform. As a cofounder and payer-owner, Humana has designed the Provider Engagement Portal to offer ease of use and reduce administrative burden providers are challenged with when trying to access information on their patients across insurance carriers. Humana has worked with Availity to design Payer Space, offering Humana-specific tools to our providers to reduce the administrative burden of analyzing data, tracking claims status, and other administrative functions.

Availity allows our providers to check eligibility, check benefits, submit and receive updates on referrals and authorizations, and submit and manage claims, among other functions. Availity helps practices access information about claims throughout the workflow in real-time. Availity's real-time transmission is mission critical to the delivery of our member's care and is designed to trigger key processes including prior authorization requests and eligibility of services.

Availity's Claims Status Inquiry Summary Page displays high-level information about claims, including date of service, claim number, date processed, check or EFT number, amount billed, and amount paid. Through the platform, providers can access detailed line-level information for each claim. Further, the platform offers all remittances for finalized claims and includes a financial summary. Providers can view claims processing and payment process status for all submitted claims over a time span, allowing them to view trended data and to filter by a member, claim type, claim status, and other indicators.

Providers can also correct claims through Availity, where they are routed to Humana's claims application and supplemental documentation can be submitted to provide additional information. Attachment 17-5 provides screenshots of how providers can access claims information on a real-time basis.

In addition to the data made available through this platform, Humana's Provider Engagement team meets with providers routinely and discusses claims and encounter performance. Our team can typically share county and specialty type benchmarks and performance on key metrics such as average volume of claims or encounters per member.

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6. The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor.
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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

As part of our contract with each subcontractor, Humana requires them to meet all AHCA claims processing requirements. A Humana Relationship Manager is assigned to each subcontractor and, in coordination with the key market stakeholders, Delegation Compliance, Regulatory Compliance, and Humana's Internal Audit Consulting Group (IACG), is responsible for managing the subcontractor relationship. We focus on monitoring and driving closure to any gaps to state contract and Humana-established performance standards, inclusive of operational, reporting, and compliance-related requirements.

Key metrics monitored across all our subcontractors who processes claims include, but are not limited to:

- Claims paid and denied
- Claims volume
- Average number of claims received per member
- Clean claims cycle time
- All claims cycle time

For subcontractors serving multiple Humana lines-of-business or markets, the Relationship Managers are dedicated to translating best practices and learnings across the broad Humana footprint. Subcontractor performance is assessed and escalated issues and opportunities are reviewed during regular Joint Operating Committee (JOC) meetings. The JOCs are attended by key market leadership, including the Florida Medicaid Vendor Oversight Manager. The Vendor Oversight Manager is responsible for monitoring the performance of all subcontractors in their collective contribution to Florida Medicaid's operational quality, inclusive of claims and claims-related areas Humana requires the subcontractor to develop a corrective action plan (CAP) to address significant gaps in performance. Through direct engagement in the Quality Improvement Committee (QIC), the Vendor Oversight Manager also contributes to the strategy and planning relative to all elements of subcontractor performance quality, including those relative to claims.

The following response provides an overview of our subcontractor's claims processing mechanism and the metrics they use to ensure accuracy and timeliness of payment. Our key subcontractors include: Access Behavioral Health (ABH) for behavioral health services, Beacon Health Options (Beacon) for behavioral health services, DentaQuest for dental services, DST Pharmacy Solutions for prescription drug claims processing, and LogistiCare for transportation.

While each of our subcontractors have mechanisms to offer insight to their providers on data and metrics, Humana collects all claims data from each of our subcontractors and reports this information to AHCA. Therefore, the Humana process for ensuring AHCA has access to claims metrics and performance (as outlined in #4 above) includes information on our subcontractors.

ACCESS BEHAVIORAL HEALTH (BEHAVIORAL HEALTH SERVICES)

Since 2001, Access Behavioral Health has been serving the mental health and substance abuse needs for Medicaid enrollees in northwest Florida. Access Behavioral Health contracts with an experienced provider network to offer comprehensive, community-based care.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. CLAIMS PROCESSING AND PAYMENT PROCESS – KEY COMPONENTS

Access Behavioral Health (ABH) providers upload electronic claims to an established file transfer protocol (FTP) site. Through an automated process, the FTP site periodically throughout the day. When a file is found on the FTP site, the automated process downloads the file into a folder for processing and sends an automated email notification is checked to ABH associates that a new file has been downloaded. Humana sends a daily eligibility feed to ABH.

The claims processing system recognizes new electronic files in the claims processing folder. The files are automatically imported into the claims system. A claim reciept date is populated with a file import date. The 999 response files are automatically generated into a specified outbound folder.

An automated process recognizes new files in the outbound folder. The automated process uploads the 999 response files to the FTP site. An automated email notification is sent to ABH staff when the process is completed. ABH staff run the claims adjudication process. Accounting staff process adjudicated claims for payment every Tuesday. Checks are cut for fee-for-service (FFS) claims and mailed to the provider. Remittance reports for FFS and encounter claims are created and uploaded to FTP site. Email notification is sent to the provider that a remittance report is available on the FTP site.

ABH receives paper claims via US mail, FedEx, UPS, and other carriers at the Lakeview Center mail room. ABH sorts mail directed to ABH claims on the day it is received. An ABH staff member retrieves the mail from the mail room Monday through Friday a minimum of once daily. On the same day claims are retrieved from the mail room, the claims are removed from envelopes, sorted by submitting provider, and stamped with the date received.

On the same day claims are retrieved from the mail room, claims are triaged for misroutes and submission errors. Claims for medical services not covered by ABH are rerouted to the appropriate health plan. Claims with submission errors are returned to the provider with a letter stating the specific reason why the claim cannot be processed as paid or denied. ABH keeps a log of the total number of claims passing triage and sent for processing.

ABH keys claims into the claims payment system. The claims payment system edits for member eligibility, valid diagnosis code, member benefit limit, timely filing (within three hundred sixty-five (365) days of date of service), valid service code, valid rendering provider, and prior authorization (If required).

If a claim fails these edits, it is denied. If a claim passes all the edits, ABH pays the claim. ABH acknowledges, pays, or denies paper claims within fifteen (15) days of receipt. Accounting staff process adjudicated claims for payment every Tuesday.

Checks are cut and mailed to the provider, or EFT payments are made to the provider every Tuesday. Remittance advices for all claims processed as paid or denied are mailed to providers every Tuesday. The remittance advice includes information on how to request a claim correction or file an appeal. If a claim is denied for reasons related to authorizations or non-covered services, a denial letter is also mailed to the member.

2. TIMELINESS AND ACCURACY METRICS
ABH employs proven metrics to track the timeliness and accuracy of its claims processing and payment. The metrics include claims turnaround time (TAT) reports and monthly paid claims review for procedural and financial accuracy.

3. RAPID CYCLE IMPROVEMENT
ABH uses two (2) monthly reports, the Claims TAT report and the Monthly Paid Claims Review to determine whether process improvements or system enhancements are needed. The trigger for rapid cycle improvement (RCI) based on the Claims TAT report is a score of less than fifty percent (50%) processed within seven (7) days, seventy percent (70%) within ten (10) days, or ninety percent (90%) within twenty (20) days for three (3) consecutive months. For the Monthly Paid Claims Review, the trigger for RCI is a score of less than ninety-eight percent (98%) for procedural accuracy or ninety-nine percent (99%) for financial accuracy for three (3) consecutive months.

ABH's RCI process begins with notification to key staff, including the ABH Director, the LCI Business Office Director (or designee), and the IT Director (or designee). A team is assembled and a specific goal for improvement is established. The team brainstorms the current process to determine the problem. Team members identify causes and alternative solutions using the statement, "If we do _____, then _____will happen." The team develops and implements an action plan. The team then re-measures the metric. If the outcome is successful, the improvement is standardized. If the outcome is unsuccessful, ABH restarts the process.

4. DATA AND METRICS AVAILABLE TO AHCA
ABH's claims processing and payment metrics and data will be made available via Humana's reporting portal referenced in evaluation criteria four (4).

5. REAL-TIME DATA TO NETWORK PROVIDERS
Information sent to providers with the remittance advice each time claims are paid or denied includes a direct phone number for claims questions and disputes. This phone number connects providers directly to the Lakeview business office where claims processors are available Monday through Friday 9:00 AM to 6:00 PM CST to answer questions about claims payment or denials. The phone line is set to ring at multiple locations so that all calls may be answered by a live person. A confidential voicemail option is available for high volume time periods and after hours.

BEACON HEALTH OPTIONS

Beacon Health Options (Beacon) serves as a national behavioral health services organization and processes claims for a majority of its clients, averaging more than twenty-two million (22,000,000) claims annually. In 2016, billed claims were submitted to Beacon totaling more than fourteen billion, eight hundred million dollars ($14,800,000,000). Beacon's proprietary FlexCare360 management information system supports managed behavioral health programs starting with the eligibility process through claims adjudication and payment. Humana provides a daily eligibility feed to Beacon.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1. CLAIMS PROCESSING AND PAYMENT PROCESS – KEY COMPONENTS

Claims Submission
Beacon accepts paper as well as electronic claims. Approximately eighty-eight percent (88%) of all claims are submitted electronically to Beacon. Providers may submit electronic claims through Beacon's web portal in FlexCare360 or an electronic data interchange (EDI) gateway. Once uploaded, electronic claims run through the FlexCare360 claims adjudication engine for processing. For electronic claims, about seventy-five percent (75%) of Beacon's providers use a clearinghouse and twenty-five percent (25%) use direct connections to Beacon's systems.

While submission of paper claims is discouraged, providers can submit them manually, using the national standard format CMS 1500 or UB-04 claim form. Beacon enters the data from these claims into scanned images that are prepared on the day of receipt. In addition, Beacon will create a file (known as an 837) from a paper claim. The scanned images and 837s are entered into Beacon's claims adjudication system, FlexCare360.

Beacon's web portal capabilities allows for claims submission and makes administrative requirements more efficient, user-friendly, and are at no-cost to providers. Any provider with internet access can use the web portal. Through eServices, the web portal, providers can enter claims and receive immediate confirmation of the transaction.

Claims Adjudication
FlexCare360 includes adjudication edits and logic for claims processing, including standard tables that contain HIPAA-compliant codes for diagnosis, procedure, decision, and place of service. FlexCare360 claims processing logic checks for erroneous payments, including duplicate payments, incompatibility between gender and procedure code-diagnosis edits, gender code-diagnosis edits, and payments for the service does not correspond with the pricing schedule on file for the date of service. It also recognizes and automatically denies claims that are duplicate submissions.

If a claim is found during the application of these edits and logic checks to have errors or to be missing required documentation, it will be denied and returned to the provider.

Claims Payment
Claims that pass all the edits and include all the required information are priced according to the provider's negotiated fees and approved for payment.

2. TIMELINESS AND ACCURACY METRICS
Beacon's Claims Supervisors closely monitor claims aging inventory reports daily to ensure work assignments are appropriately prioritized and claims are finalized timely to meet timeliness metrics. Claims staff review turn-around time reports monthly to identify and address where improvements are needed.

Beacon staff performs daily internal quality audits on claims accuracy using an auditing process that mirrors an external audit. There are various levels of audits conducted that focus on the financial outcome of the claim, and on policies and workflows used in the adjudication process. Claims are audited both pre- and post-payment to evaluate the abilities of Claim Processors to consistently meet individual and departmental goals. Each claim audit reviews forty-one (41) elements to check mechanical and financial accuracy. Examples of these elements include the

correct authorization was used, the correct provider record is selected for adjudication, the benefits have been applied correctly, the correct procedure codes have been entered, and the dates of service match the bill lines on the claim image.

Humana's Relationship Manager monitors Beacon's performance on claims processing and payment process on a monthly basis. In August 2017, Beacon processed ninety-seven percent (97%) of their clean claims within twenty (20) days.

3. RAPID CYCLE IMPROVEMENT
Beacon uses an accountable, data-supported continuous quality improvement (CQI) process to refine and improve claims processing across the organization. Beacon delineates thresholds and benchmarks, identifies responsible parties who are accountable to monitor and promote the change process, implements corrective action plans and monitoring procedures, and acts on the results of those plans. Through data collection, measurement, and analysis, Beacon identifies aspects of claims processing that demonstrate opportunities for improvement and prioritizes them for quality improvement activities that are implemented in an accelerated timeframe.

4. DATA AND METRICS AVAILABLE TO AHCA
Beacon's claims processing and payment metrics and data will be made available via Humana's reporting portal referenced in evaluation criteria four (4).

5. REAL-TIME DATA TO NETWORK PROVIDERS
Through Beacon's eServices web provider portal, providers can view aggregate claims information for their entire provider practice or organization, by month. Users can select Provider Reports and Claims Approval with Denial Report. The report displays a table chart and pie charts, showing the number and percentage of claims approved, and of claims denied for various reasons. These calculations are provided by member and by all claims, since any single member may have multiple claims. Providers can view full descriptions of the reasons for the denials of their claims in the portal.

DENTAQUEST (DENTAL SERVICES)

As a national dental health maintenance organization, DentaQuest has experience serving Medicaid, CHIP, and Medicare Advantage enrollees, and partners with over 60 health plans across the country. DentaQuest serves a total of twenty-four million (24,000,000) enrollees with a network of forty-eight thousand (48,000) dentists nationwide. DentaQuest has an overall clean claims accuracy rate of over ninety-nine percent (99%).

1. CLAIMS PROCESSING AND PAYMENT PROCESS – KEY COMPONENTS
Providers can submit dental claims to DentaQuest by three methods: paper (mail or fax), electronically via a clearinghouse, and electronically through direct data entry on DentaQuest's provider portal. Humana provides a daily eligibility feed to DentaQuest.

DentaQuest auto-adjudicates clean claims and authorizations that have been submitted electronically in real time. Providers can access determinations and payment amounts on-line the following business day. DentaQuest Customer Service is able to provide data on these real-time events immediately.

Claims are paid once a week on a day of the week determined by Humana. Claims that have been submitted and have completed processing prior to 5:00 PM EST on the date of payment will be included in the payment run.

2. TIMELINESS AND ACCURACY METRICS

DentaQuest tracks claim processing timeliness and accuracy through multiple reporting mechanisms. DentaQuest utilizes a first-in first-out prioritization of claims in queue. Additionally, DentaQuest reviews age of claims in queue reports on a daily basis to ensure the system is effectively prioritizing claims in queue. Turnaround time reporting is reviewed at a minimum on a monthly basis.

Claims are audited by DentaQuest's Quality Assurance team to ensure processing accuracy. Humana monitors DentaQuest's performance on claims processing and payment process using the standard determined by AHCA on a monthly basis. In August 2017, DentaQuest processed and paid ninety-one point eight percent (91.8%) of clean claims within ten (10) days and ninety-nine point four nine percent (99.49%) of clean claims within twenty (20) days; exceeding contract requirements by twenty-one point eight (21.8) and nine point four nine (9.49) percentage points, respectively.

3. RAPID CYCLE IMPROVEMENT

The age of claims in queue and turnaround time reports are used for problem identification and root cause resolution. Claims determined to be processed outside of service level agreements are reviewed for root cause and action plans are promptly implemented to prevent future occurrences. Humana's Relationship Managers monitor the performance monthly and engage in more frequent discussions, as needed.

4. REAL-TIME DATA TO AHCA

DentaQuest will provide a client web portal to AHCA through which it will have access to data in a transparent and user-friendly manner, along with a more robust menu of self-service reporting options. DentaQuest offers full access to standard reports as well as inquiry-based data through this web portal. Standard reports include claims paid by benefit type, claims paid by procedure class, paid by provider specialty, patient count, provider and network utilization, breakdown of procedure class, and trending metrics. Standard reports are posted on the web portal for review as needed. The client web portal also provides inquiry access, simple list reports for common administrative inquiries, and ad hoc reports as requested.

5. REAL-TIME DATA TO NETWORK PROVIDERS

DentaQuest works with its providers to ensure they understand the claims and payment processing guidelines. The DentaQuest provider manual located on their website and describes how providers can submit claims and monitor payment breakdown and delivery via the provider web portal. DentaQuest educates their providers on its web portal and the ease of filing claims, accuracy of processing claims, speed of claims payment, ability to track claims, and direct deposit.

DST PHARMACY SOLUTIONS (PHARMACY CLAIMS ADJUDICATION)

Humana Pharmacy Solutions® (HPS) is a wholly-owned subsidiary within the Humana Inc. diversified family of health and well-being solutions. Today, HPS provides Pharmacy Benefit

Management (PBM) services for more than ten million (10,000,000) enrollees across our book of business, including approximately seven million, four hundred twenty-two thousand, nine hundred thirty-two (7,422,932) Medicare lives, two million eight hundred fifty-three thousand, three hundred nine (2,853,309) Commercial lives and more than two hundred ninety-seven thousand, six hundred ninety (297,690) Medicaid lives. We process more than three hundred million (300,000,000) prescriptions annually and manage approximately eighteen billion dollars ($18,000,000,000) in prescription drug spend. HPS uses DST Pharmacy Solutions to conduct all functions related to the processing and management of claims. HPS provides twice daily eligibility feeds to DST Pharmacy Solutions.

1. CLAIMS PROCESSING AND PAYMENT PROCESS – KEY COMPONENTS

DST Pharmacy Solutions processes all claims submitted by the pharmacies in the network of Humana's subsidiary, Humana Pharmacy Solutions (HPS) and operates the pharmacy technical help desk on behalf of HPS. HPS requires that all pharmacy claims be submitted electronically at the point of sale using NCPDP standards.

When a claim is submitted to DST Pharmacy Solutions using NCPDP standards via a clearinghouse or through a direct connection, DST Pharmacy Solutions applies the first round of edits to the claim to ensure all required fields are filled in. If a claim clears the first round of edits, a second round of edits is applied. The second round checks the National Drug Code (NDC) file, the prescriber file, deductible information, whether the claim is a duplicate, and whether a prior authorization (if required) is on file. The claims processing system performs an average of one hundred fifty (150) edits in approximately one (1) second of processing time on each submitted claim. Some of these edits include eligibility, pharmacy, prescriber, drug, drug utilization review, benefits, authorizations, and deductible reviews. Some of these edits are "hard," that is, they will result in rejection of the claim if the information is not found or there is an error. Examples of hard edits include whether there is a valid member ID and a valid pharmacy ID. Other edits are "soft" and will not result in rejection; some hard edits allow a pharmacy to override the edit by entering the appropriate override code into the system. An example of this is that the DST Pharmacy Solutions system finds that the claim is being refilled before the allotted time. The pharmacy may know that this is due to a dosage change by the prescriber and can enter a code to override the hard edit.

Claim adjudication is done at the point of sale, giving the pharmacy an immediate electronic decision within fifteen (15) seconds on whether its claim can be paid and the payment amount. Humana adjudicates more than ninety-nine percent (99%) of pharmacy claims electronically in real time at the point of sale. If the pharmacy does not agree with the determinations on claim status and payment amount communicated via the DST Pharmacy Solutions provider portal, the pharmacy can "reverse" the claim and tell the member they cannot fill the prescription. The pharmacy can find out further information about why its claim was rejected from the DST Pharmacy Technical Help Desk.

If the claim is accepted and paid, the pharmacy is paid in a payment cycle run by DST four (4) times a month.

2. TIMELINESS AND ACCURACY METRICS

DST Pharmacy Solutions conducts an audit of a statistically significant sample of claims processed during a reporting period to assess whether the following claims processing rules were followed when adjudicating the claim: pricing, pharmacy, drug utilization review (DUR),

deductible, preauthorization, duplicate claim, member, prescriber, NDC, drug coverage, and customer and client claim edits. Humana also monitors total claims processed accuracy as a result of incorrect claims.

Since all claims coordinate through the same database, we are able to integrate and track all DUR, deductible, and prior authorizations accordingly. This seamless operation provides consistent claim adjudication and reporting services. More importantly, this unified approach provides enrollees with safe and comprehensive pharmaceutical care.

3. RAPID CYCLE IMPROVEMENT
Pharmacy claims are adjudicated in a pre-service environment which means that the patient cannot receive their prescription until the claim is successfully processed. Therefore, the DST RxNova system is very flexible and table-driven to allow for easy changes that influence the system logic. Rapid cycle improvement is imperative in a 24/7 processing environment like pharmacy.

4. DATA AND METRICS AVAILABLE TO AHCA
RxNova's™ claims processing and payment metrics and data will be made available via Humana's reporting portal referenced in evaluation criteria four (4).

5. REAL-TIME DATA TO NETWORK PROVIDERS
The RxNova™ proprietary claims processing system was developed to support automation and offer advanced analytics to create data visualization and real-time benefit checks with physician desktop communication at the point of care.

LOGISTICARE (TRANSPORTATION)

LogistiCare is the largest non-emergency medical transportation manager in the country. They operate in thirty-nine (39) states plus the District of Columbia, regularly serving State Agencies and Managed Care Organizations (MCO), and serve nearly nine hundred thousand (900,000) Humana enrollees.

1. CLAIMS PROCESSING AND PAYMENT PROCESS – KEY COMPONENTS
LogistiCare processes both paper and electronic claims. When a paper claim is received, LogistiCare opens the claim, finds the batch in LCAD (LogistiCare's electronic claims processing system), and enters the date, job number, and trip leg. These fields are automatically populated for electronic claims. Humana provides a daily eligibility feed to Logisticare. The system applies edits to verify the enrollee, date of service, pick up and drop off times, and the enrollee's signature for each leg of each trip. If any of these cannot be verified, the trip is denied and removed from the batch. LogistiCare pends some claims for manual processing.

When a claim has been approved for payment by the manager, a check is issued and mailed to the provider. Checks are issued every week for claims received the prior week.

2. TIMELINESS AND ACCURACY METRICS
LogistiCare has several system controls in place to manage the payment process along with additional backend controls or reports used to manage accuracy and timeliness. LogistiCare

reviews timeliness of payments on a monthly basis through its Prompt Payment report. To reduce the risk of overpayments, LogistiCare processes payments based on the lowest payment between the billed amount from the provider and the calculated amount in the LCAD system (which is generated from the base rate and mileage of the trip's level of service and distance based off Google Maps).

To maintain control over payment accuracy, prior to payment, the Claims team reviews all trips that had an override or payment above the calculated system rate to confirm that proper approval was obtained. Another control is the requirement of sign-off by multiple LogistiCare leaders (the General Manager of the operation, Senior Vice President of Division, and the CAO of LogistiCare) concerning rates used to calculate the trip prior to the rate being included in LCAD.

3. RAPID CYCLE IMPROVEMENT
LogistiCare's Prompt Payment report shows whether the company is paying for trips in a reasonable amount of time and within contract requirements. If LogistiCare finds that it is outside of the requirements, it evaluates the cause of the problem and adjusts processes "on the floor" or through the system to bring it back in compliance. LogistiCare also runs reports and queries to verify that trends in trips have not changed. If abnormalities are found, the company reviews the process and when needed, adjusts the process to eliminate the issues. Prior to all payment submissions, the Claims department reviews trips for overrides or any trips exceeding a certain dollar amount. If there are any discrepancies, the Claims department will work with Operations to confirm the issue and adjust the process accordingly for future periods.

4. DATA AND METRICS AVAILABLE TO AHCA
LogistiCare's claims processing and payment metrics and data will be made available via Humana's reporting portal referenced in evaluation criteria four (4).

5. REAL-TIME DATA TO NETWORK PROVIDERS
Providers have access to LogistiCare's Provider web portal which allows them to see when payment for a trip will be made and the dollar amount of the payment. Providers may also call LogistiCare's claims office to receive information about the status of their claims.

Evaluation Criteria:

1. The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.

2. The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process.

3. The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.

4. The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data.

5. The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.

6. The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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Claim Lifecycle

12.5M
Avg. medical claim receipts per month

PRE-ADJUDICATION

300K+ Providers

100+ Clearing Houses
1K+ Billing Agencies
Translate claims into 837 X12 format and perform HIPAA editing

Paper claim (837) to Conduent
Electronic claim (837)...to a clearing house ...to Availity

96% of medical claims are received electronically

8 Trading Partners
Interest/penalty timing starts when a claim hits the trading partner

Medical
ZirMed
experian, Availity
HumTrans
Conduent, Change Healthcare
Dental
EDI HealthGrp, Conduent, Change Healthcare Dental

eHub
First point where claims are rcvd by Humana. Central tracking of all electronic claims transactions

Pass HIPAA & Humana specific edits and member eligibility?
NO
YES

ADJUDICATION ON THE PLATFORMS

- Identify member & provider
- Verify benefits
- Complete series of edits
- Verify if COB applies
- Apply pricing
- Manually process if necessary

Payment Data

POST-ADJUDICATION

Members receive Explanation of Benefits (EOB) for all claims, and periodic SmartSummaries

1.8M members receive electronic EOBs instead of paper

54.77% of claim payment remits are sent to providers electronically

Providers may reconcile remits vs. payments

Clearing Houses / Billing Agencies

	Med	Dental
Availity	X	X
Chase	X	
EDI HlthGrp		X

eHub
Receive & validate remit data (835) for CAS claims

Paper remit if provider not set up for Electronic Remittance Advice (ERA)
Some providers access remit data on Availity.com

Banks
Humana banks send transactions to provider banks

Pay Pilot
Validate and process electronic funds transfers

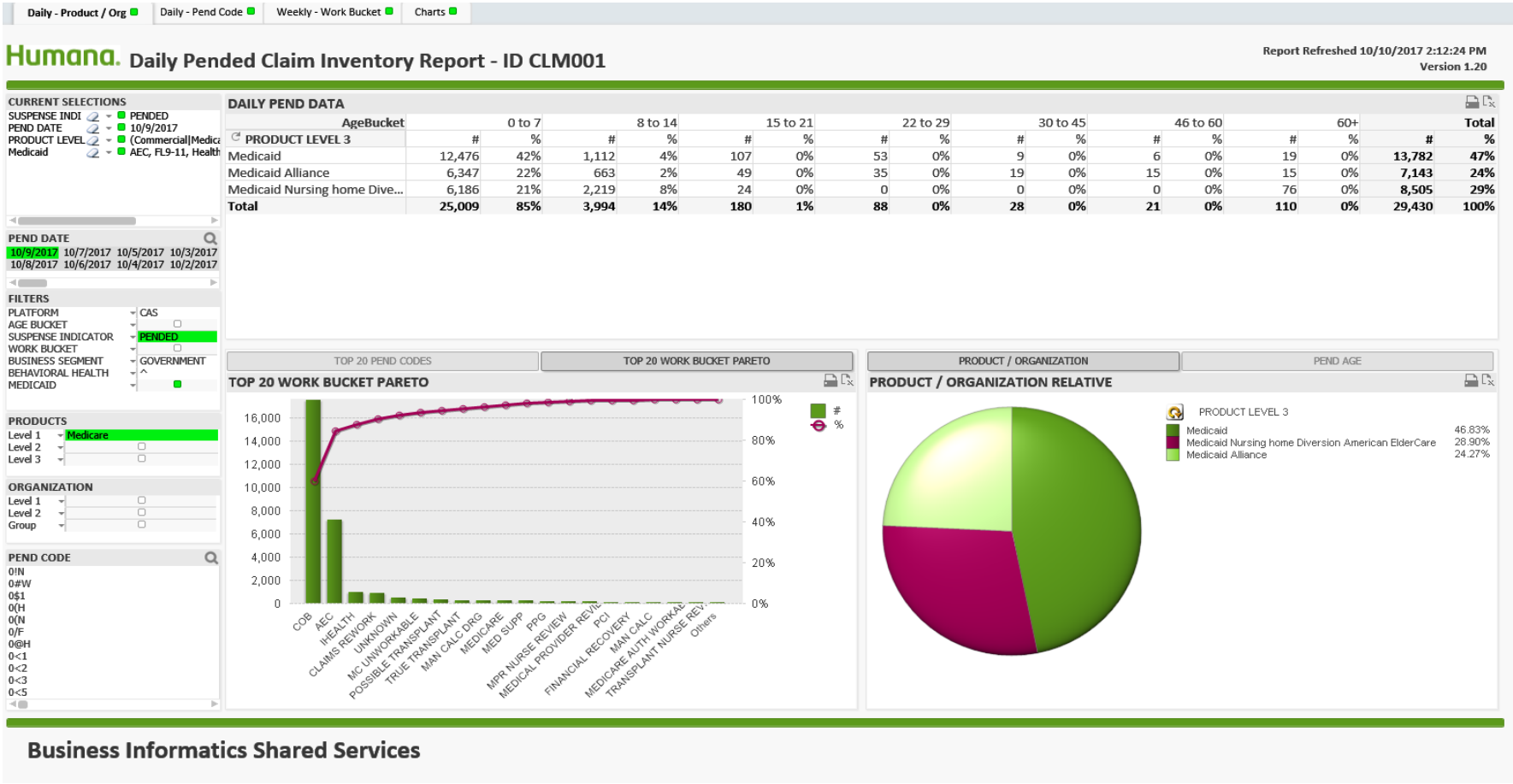
Paper check if provider not set up for Electronic Funds Transfer (EFT)

Payments

Humana

Attachment 17-2: Business Intelligence Tools

Attachment 17-2: Business Intelligence Tools



Daily - Product / Org | Daily - Pend Code | Weekly - Work Bucket | Charts

Humana. **Daily Pended Claim Inventory Report - ID CLM001**

Report Refreshed 10/10/2017 2:12:24 PM
Version 1.20

CURRENT SELECTIONS

SUSPENSE INDI	PENDED
PEND DATE	10/9/2017
PRODUCT LEVEL	(Commercial|Medica
Medicaid	AEC, FL9-11, Health

PEND DATE

10/9/2017 10/7/2017 10/5/2017 10/3/2017
10/8/2017 10/6/2017 10/4/2017 10/2/2017

FILTERS

PLATFORM	CAS
AGE BUCKET	
SUSPENSE INDICATOR	PENDED
WORK BUCKET	
BUSINESS SEGMENT	GOVERNMENT
BEHAVIORAL HEALTH	^
MEDICAID	

PRODUCTS

Level 1	Medicare
Level 2	
Level 3	

ORGANIZATION

Level 1	
Level 2	
Group	

PEND CODE

0!N
0#W
0$1
0(H
0(N
0/F
0@H
0<1
0<2
0<3
0<5

DAILY PEND DATA

AgeBucket	0 to 7		8 to 14		15 to 21		22 to 29		30 to 45		46 to 60		60+		Total	
PRODUCT LEVEL 3	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Medicaid	12,476	42%	1,112	4%	107	0%	53	0%	9	0%	6	0%	19	0%	13,782	47%
Medicaid Alliance	6,347	22%	663	2%	49	0%	35	0%	19	0%	15	0%	15	0%	7,143	24%
Medicaid Nursing home Dive...	6,186	21%	2,219	8%	24	0%	0	0%	0	0%	0	0%	76	0%	8,505	29%
Total	**25,009**	**85%**	**3,994**	**14%**	**180**	**1%**	**88**	**0%**	**28**	**0%**	**21**	**0%**	**110**	**0%**	**29,430**	**100%**

TOP 20 PEND CODES | TOP 20 WORK BUCKET PARETO

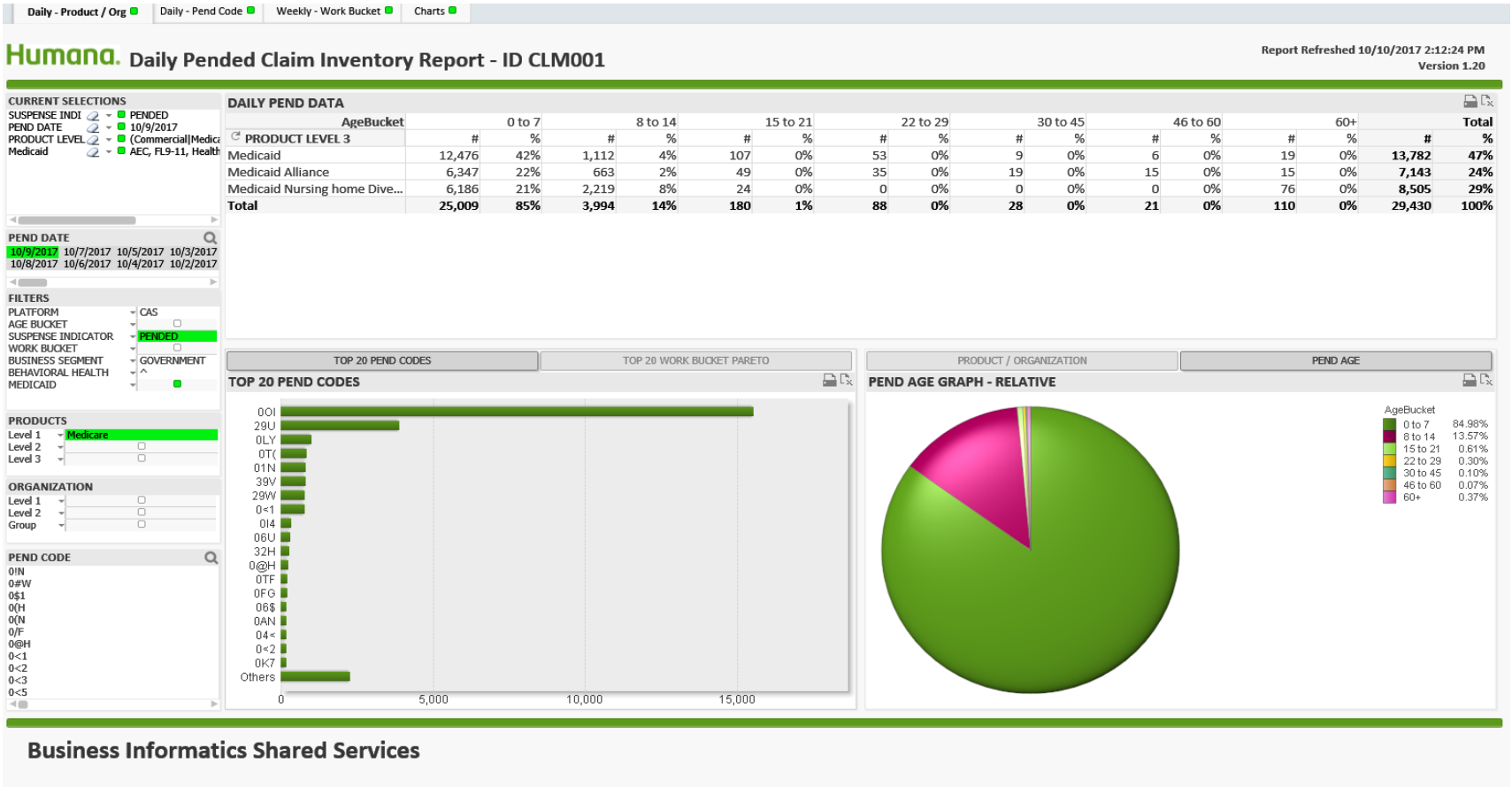
TOP 20 WORK BUCKET PARETO

PRODUCT / ORGANIZATION | PEND AGE

PRODUCT / ORGANIZATION RELATIVE

Business Informatics Shared Services

Attachment 17-2: Business Intelligence Tools



Daily - Product / Org | Daily - Pend Code | Weekly - Work Bucket | Charts

Humana. Daily Pended Claim Inventory Report - ID CLM001

Report Refreshed 10/10/2017 2:12:24 PM
Version 1.20

CURRENT SELECTIONS
SUSPENSE INDI: PENDED
PEND DATE: 10/9/2017
PRODUCT LEVEL: (Commercial|Medica
Medicaid: AEC, FL9-11, Health

PEND DATE
10/9/2017 10/7/2017 10/5/2017 10/3/2017
10/8/2017 10/6/2017 10/4/2017 10/2/2017

FILTERS
PLATFORM: CAS
AGE BUCKET
SUSPENSE INDICATOR: PENDED
WORK BUCKET
BUSINESS SEGMENT: GOVERNMENT
BEHAVIORAL HEALTH
MEDICAID

PRODUCTS
Level 1: Medicare
Level 2
Level 3

ORGANIZATION
Level 1
Level 2
Group

PEND CODE
0!N
0#W
0$1
0(H
0(N
0/F
0@H
0<1
0<2
0<3
0<5

DAILY PEND DATA

AgeBucket	0 to 7		8 to 14		15 to 21		22 to 29		30 to 45		46 to 60		60+		Total	
PRODUCT LEVEL 3	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Medicaid	12,476	42%	1,112	4%	107	0%	53	0%	9	0%	6	0%	19	0%	13,782	47%
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Medicaid Nursing home Dive...	6,186	21%	2,219	8%	24	0%	0	0%	0	0%	0	0%	76	0%	8,505	29%
Total	**25,009**	**85%**	**3,994**	**14%**	**180**	**1%**	**88**	**0%**	**28**	**0%**	**21**	**0%**	**110**	**0%**	**29,430**	**100%**

TOP 20 PEND CODES | TOP 20 WORK BUCKET PARETO

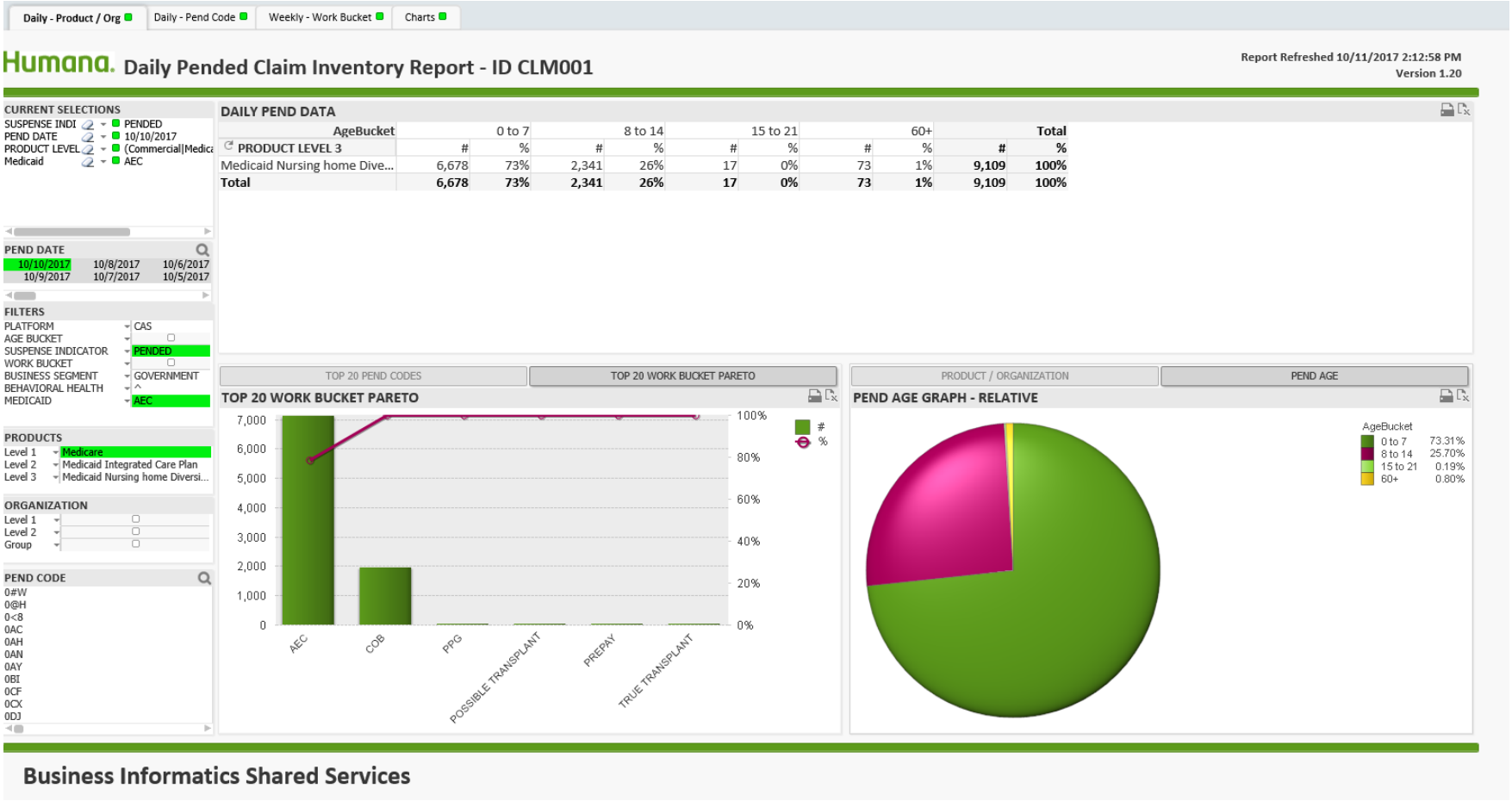
TOP 20 PEND CODES

PRODUCT / ORGANIZATION | PEND AGE

PEND AGE GRAPH - RELATIVE

Business Informatics Shared Services

Attachment 17-2: Business Intelligence Tools



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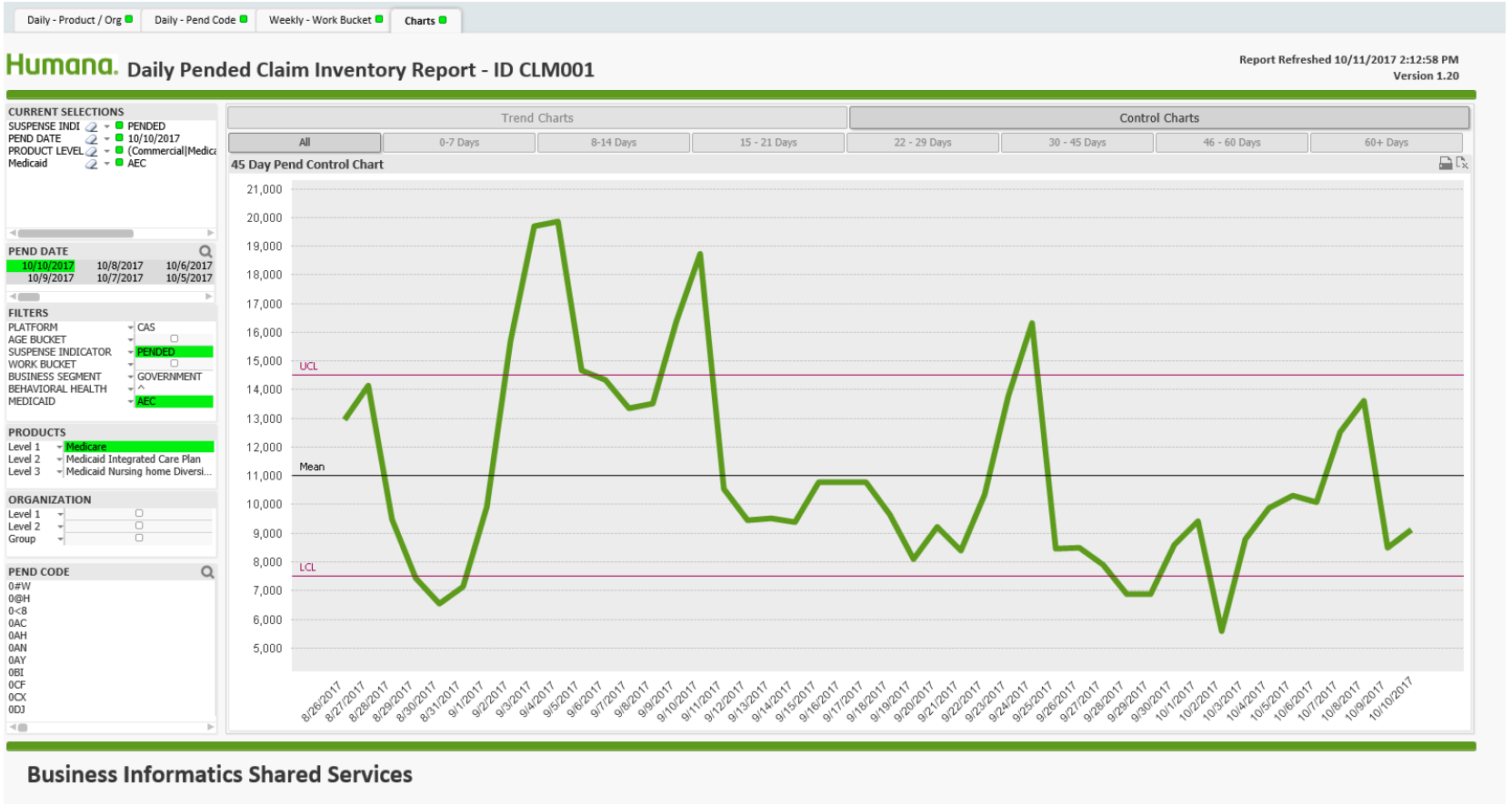

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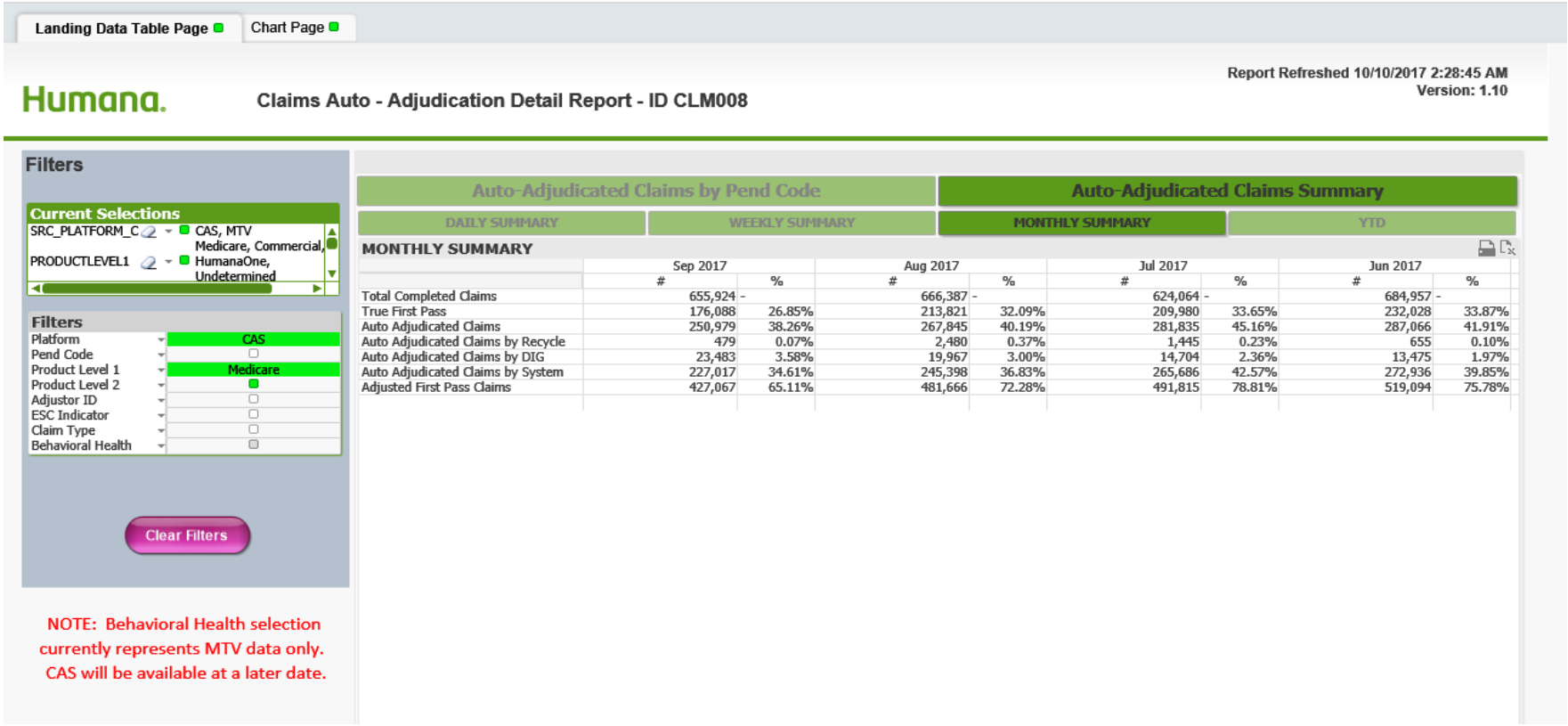


Landing Data Table Page | Chart Page

Humana.

Claims Auto - Adjudication Detail Report - ID CLM008

Report Refreshed 10/10/2017 2:28:45 AM
Version: 1.10

Filters

Current Selections

SRC_PLATFORM_C	CAS, MTV
PRODUCTLEVEL1	Medicare, Commercial, HumanaOne, Undetermined

Filters

Platform	CAS
Pend Code	
Product Level 1	Medicare
Product Level 2	
Adjustor ID	
ESC Indicator	
Claim Type	
Behavioral Health	

Clear Filters

NOTE: Behavioral Health selection currently represents MTV data only. CAS will be available at a later date.

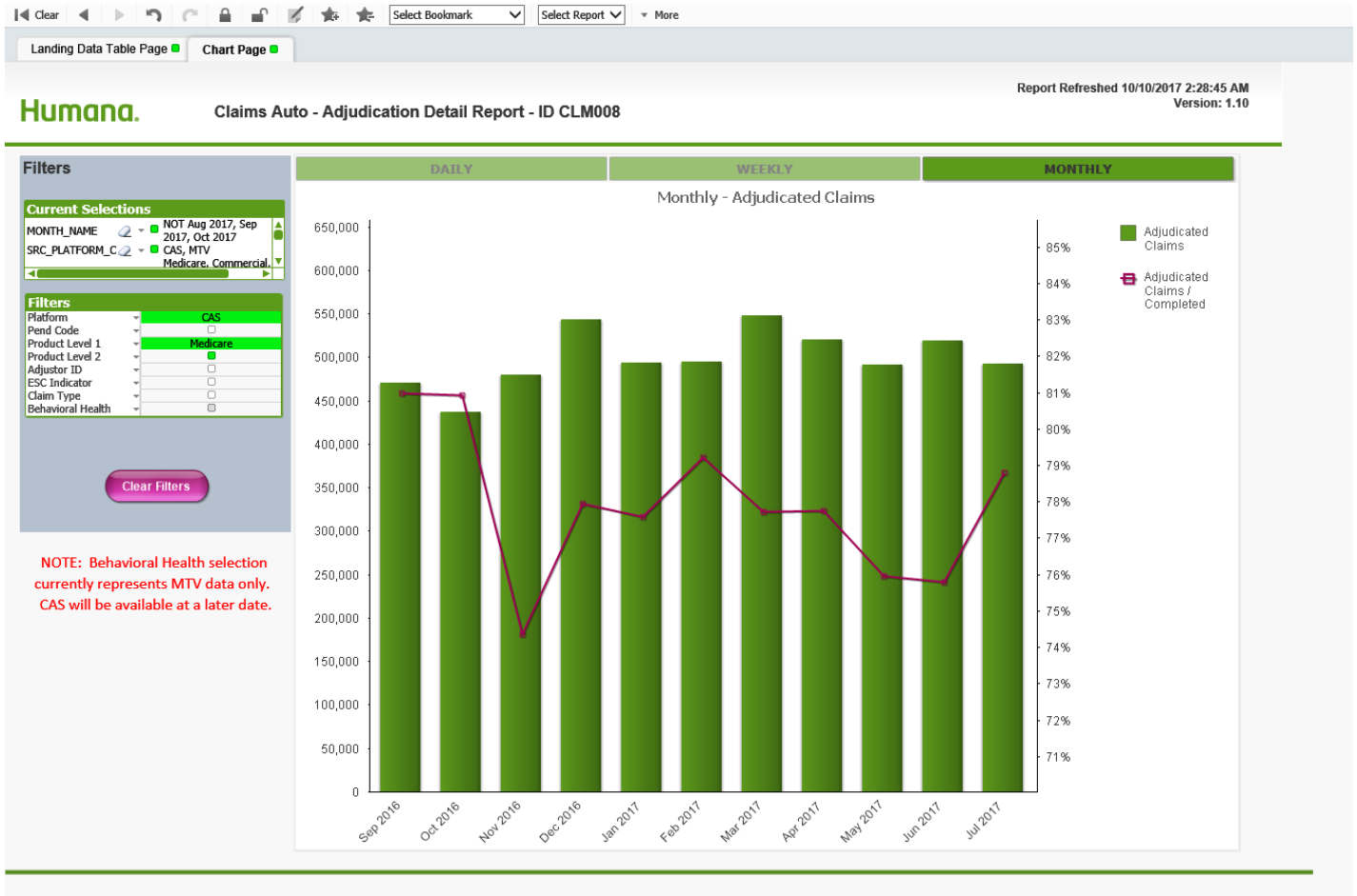
Auto-Adjudicated Claims by Pend Code | Auto-Adjudicated Claims Summary

DAILY SUMMARY | WEEKLY SUMMARY | MONTHLY SUMMARY | YTD

MONTHLY SUMMARY

	Sep 2017		Aug 2017		Jul 2017		Jun 2017	
	#	%	#	%	#	%	#	%
Total Completed Claims	655,924	-	666,387	-	624,064	-	684,957	-
True First Pass	176,088	26.85%	213,821	32.09%	209,980	33.65%	232,028	33.87%
Auto Adjudicated Claims	250,979	38.26%	267,845	40.19%	281,835	45.16%	287,066	41.91%
Auto Adjudicated Claims by Recycle	479	0.07%	2,480	0.37%	1,445	0.23%	655	0.10%
Auto Adjudicated Claims by DIG	23,483	3.58%	19,967	3.00%	14,704	2.36%	13,475	1.97%
Auto Adjudicated Claims by System	227,017	34.61%	245,398	36.83%	265,686	42.57%	272,936	39.85%
Adjusted First Pass Claims	427,067	65.11%	481,666	72.28%	491,815	78.81%	519,094	75.78%

Attachment 17-2: Business Intelligence Tools



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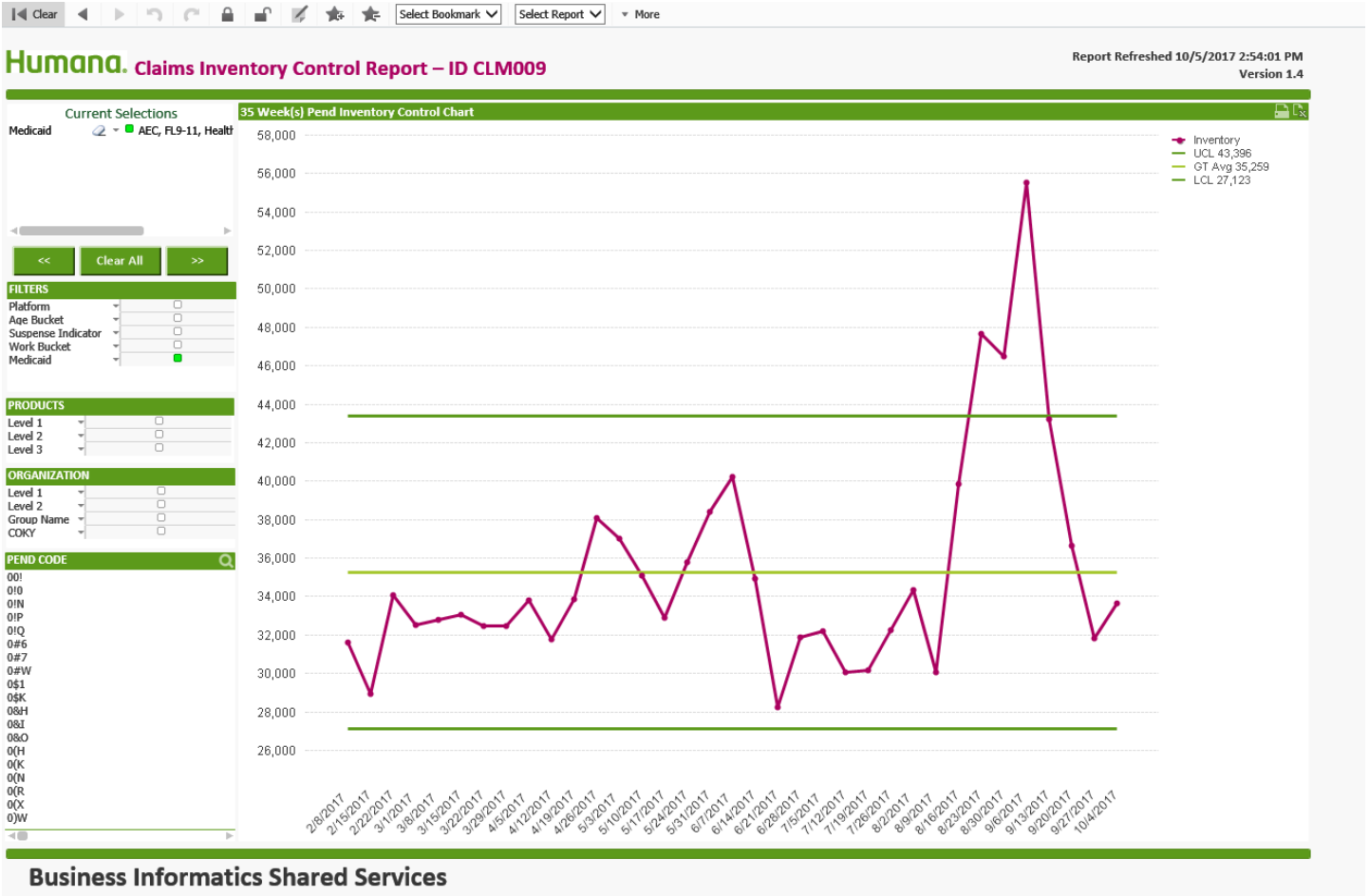

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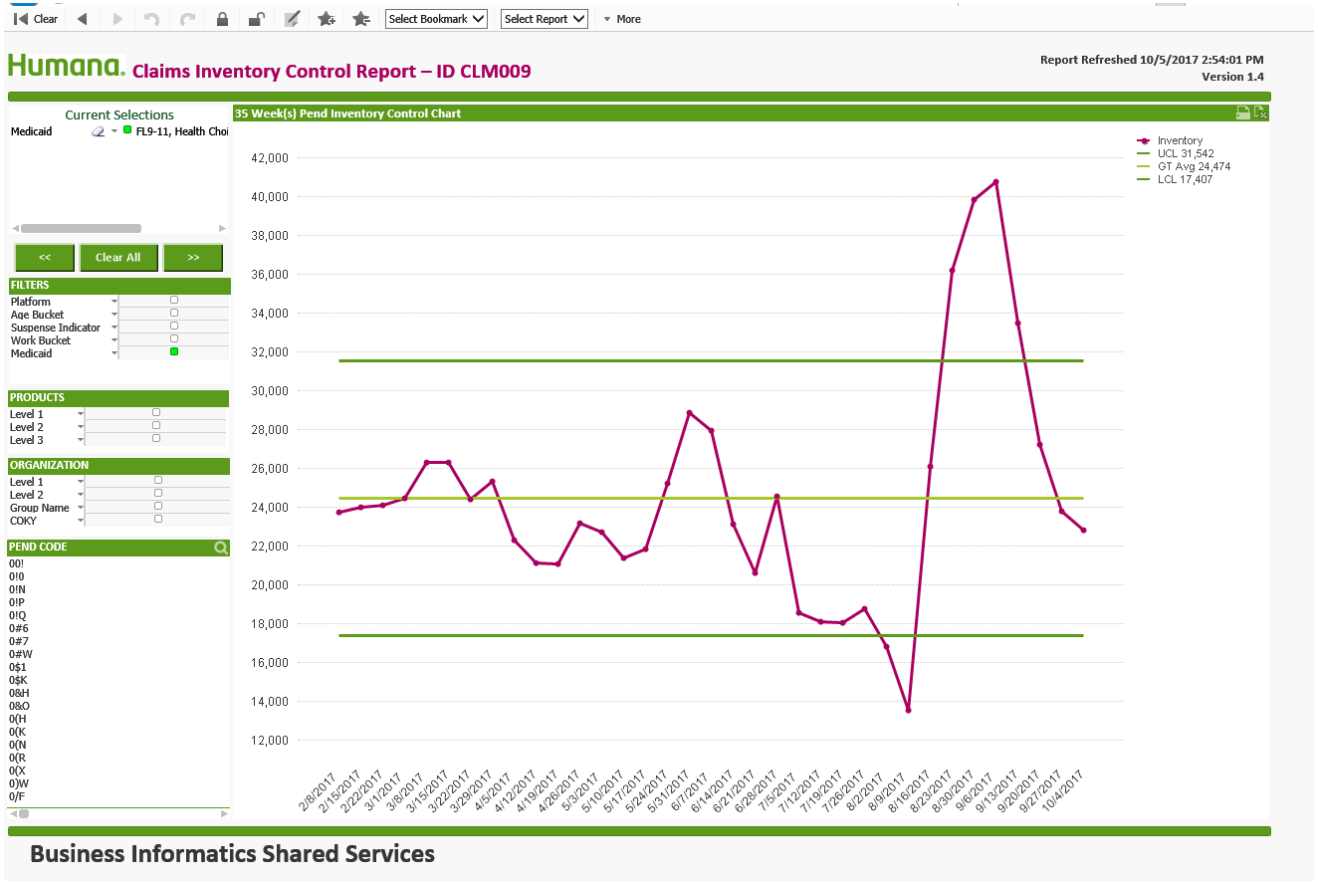

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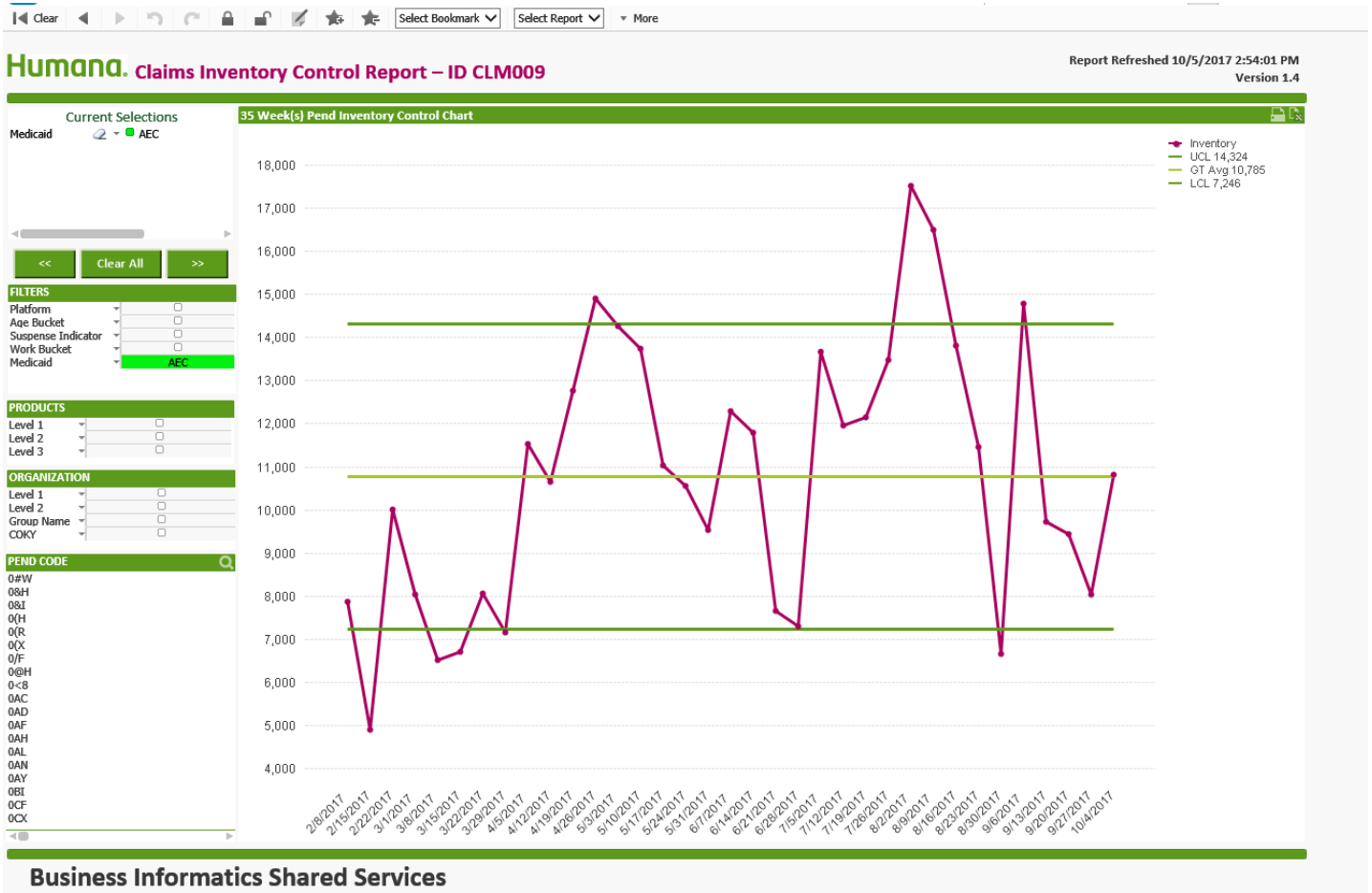

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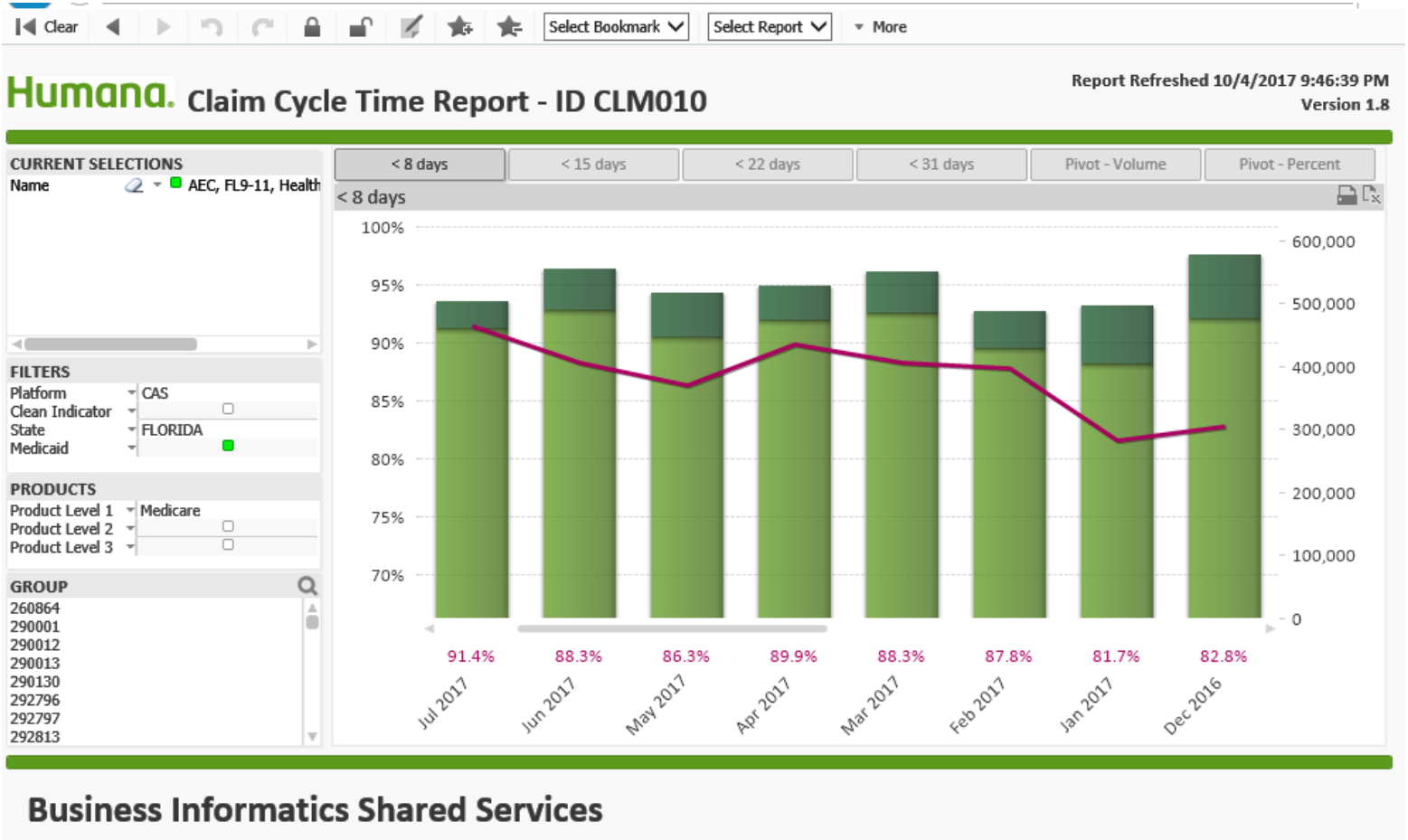

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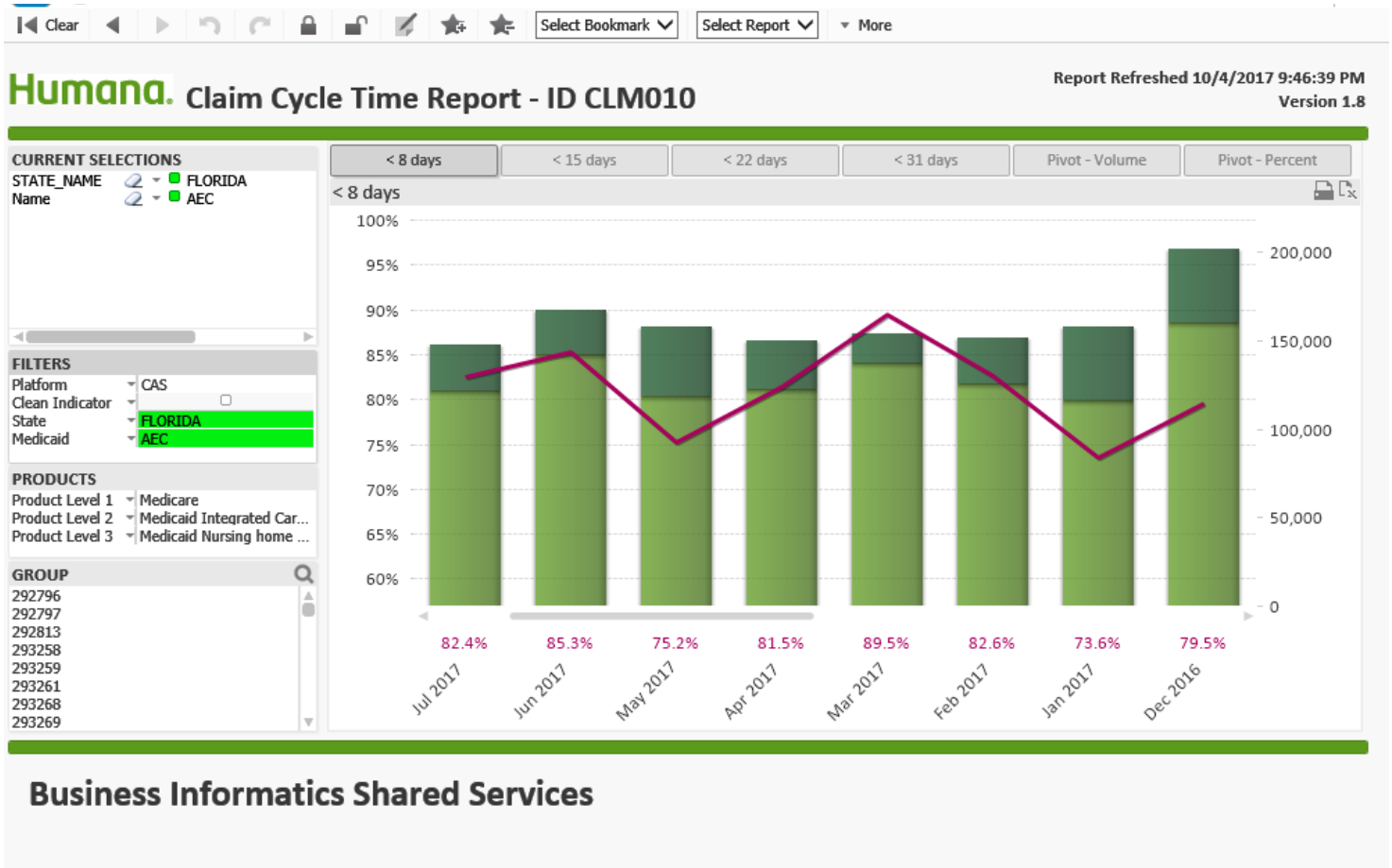


Attachment 17-3: Medicaid Governance Framework

Executive Steering

- Establish Medicaid strategy, goals, and objectives
  - Provide strategic leadership and oversight to Medicaid business
  - Pulse Operational Health - Market status updates, metric reviews, etc.
  - Resolve escalated issues and risks

Operations Steering

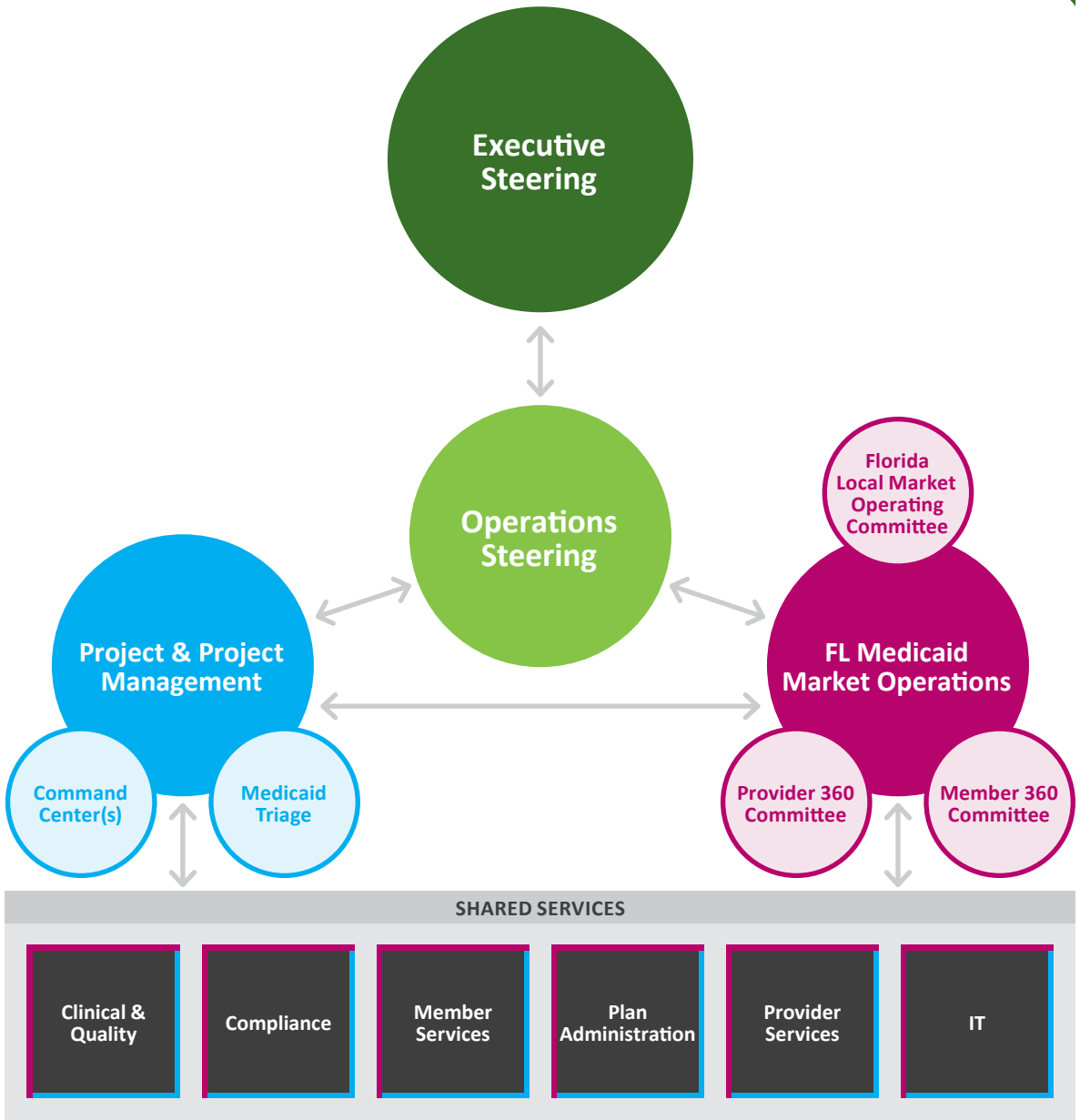
- Review, evaluate, and approve/reject all material Medicaid projects
  - To include IT and non IT related
  - To allocate funding and resources
- Resolve escalated issues and risks
- Communicate - Business Development status, cross-market synergies, strategic opportunities, and planned changes, etc.

Program & Project Management – Implementation & Process Improvement

- Support program implementations and facilitate Command Center (e.g. New Plans & Plan Expansions)
- Host Triage and evaluate process improvement (PI) opportunities:
  - Assess impact to current/future Implementations, market operations, delegate operations, etc.
  - Develop and prioritize business cases
- Present implementation programs and prioritized process improvement business cases to Operations steering
- Provide Program and Project Management support for approved initiatives
- Own and drive closure of all escalated project issues and risks

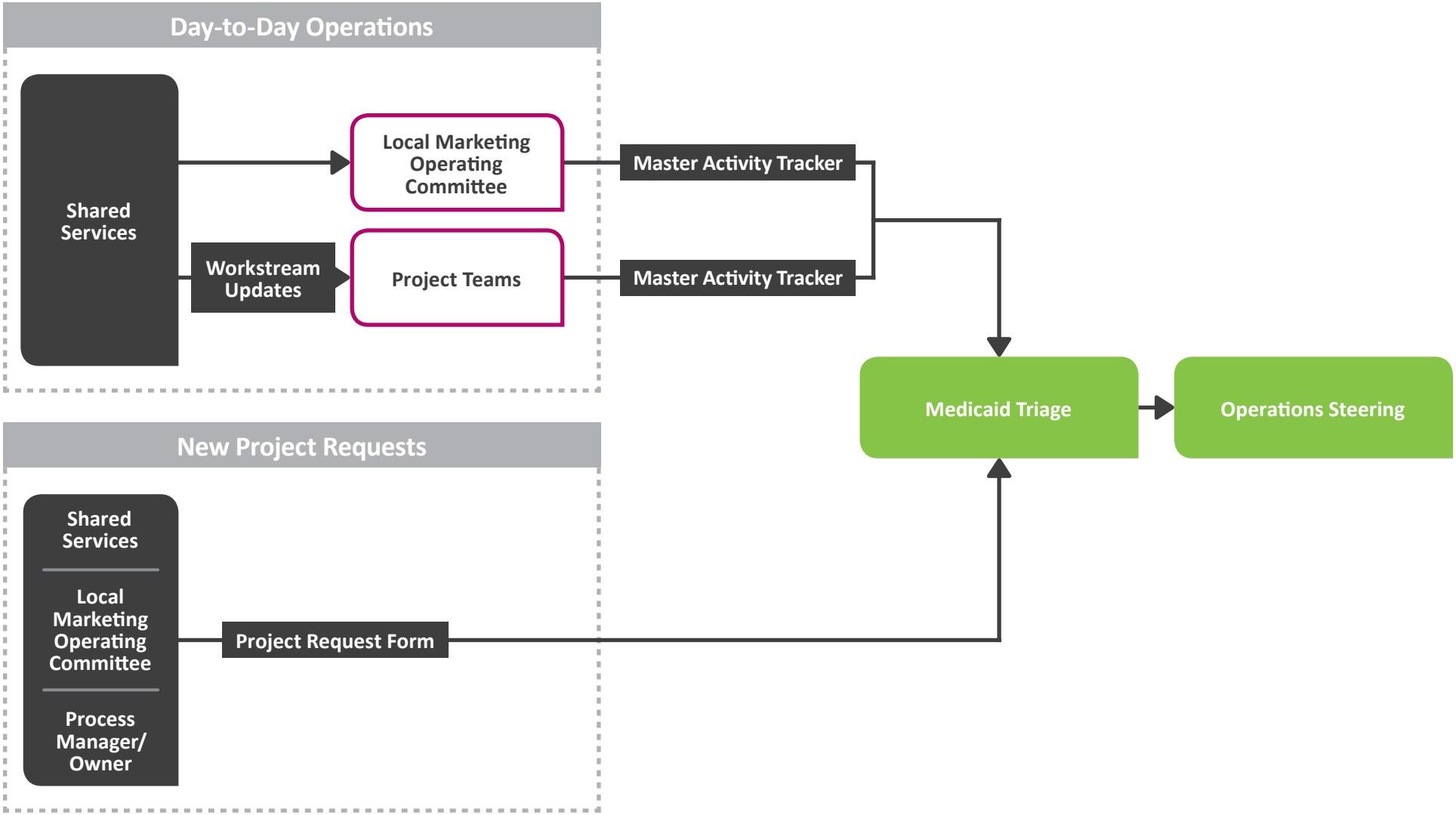
FL Medicaid Market Operations

- Host regular Market Operating and 360 Committee meetings with shared services, IT, and Corporate Medicaid Consultant (no less than bi-weekly)
  - Own and drive closure of all Market issues
  - Identify potential opportunities for process improvements and efficiency

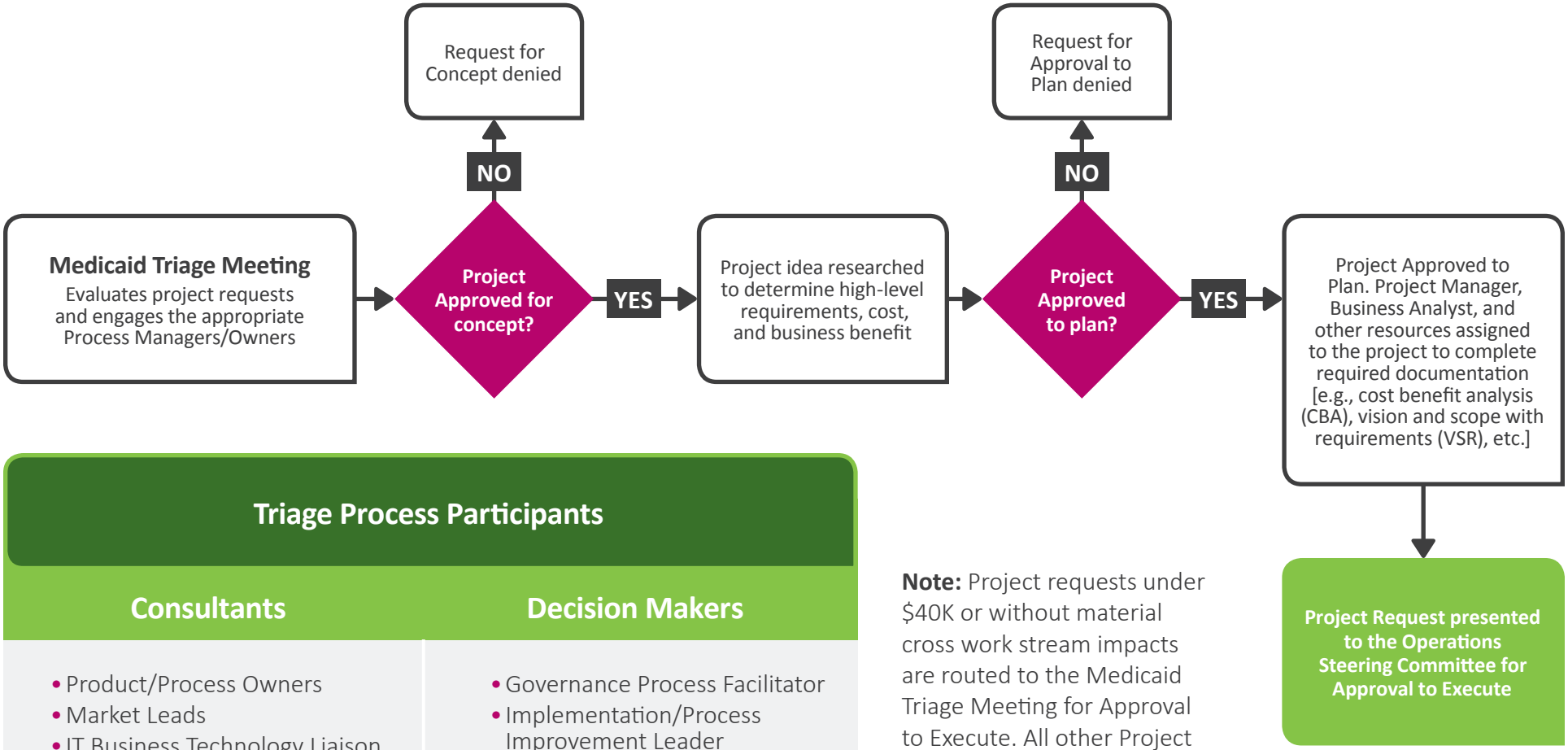


Humana

High Level Process



Triage Process

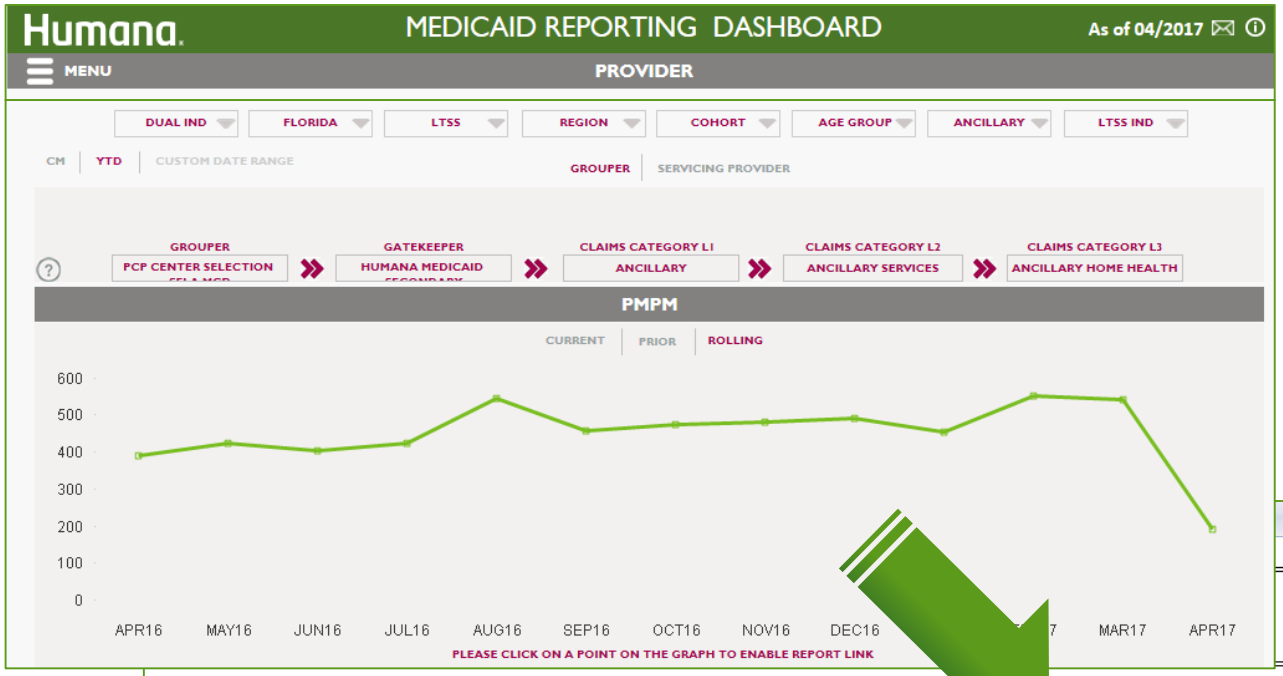


Triage Process Participants

Consultants	Decision Makers
• Product/Process Owners • Market Leads • IT Business Technology Liaison • Medicaid Corporate Consultant	• Governance Process Facilitator • Implementation/Process Improvement Leader

Note: Project requests under $40K or without material cross work stream impacts are routed to the Medicaid Triage Meeting for Approval to Execute. All other Project Requests are routed to the Operations Steering Committee for Approval to Execute.

Medicaid Reporting Dashboard – Guided Analytics



Giving analysts the ability to *drill down to* *claim level detail* in seconds…

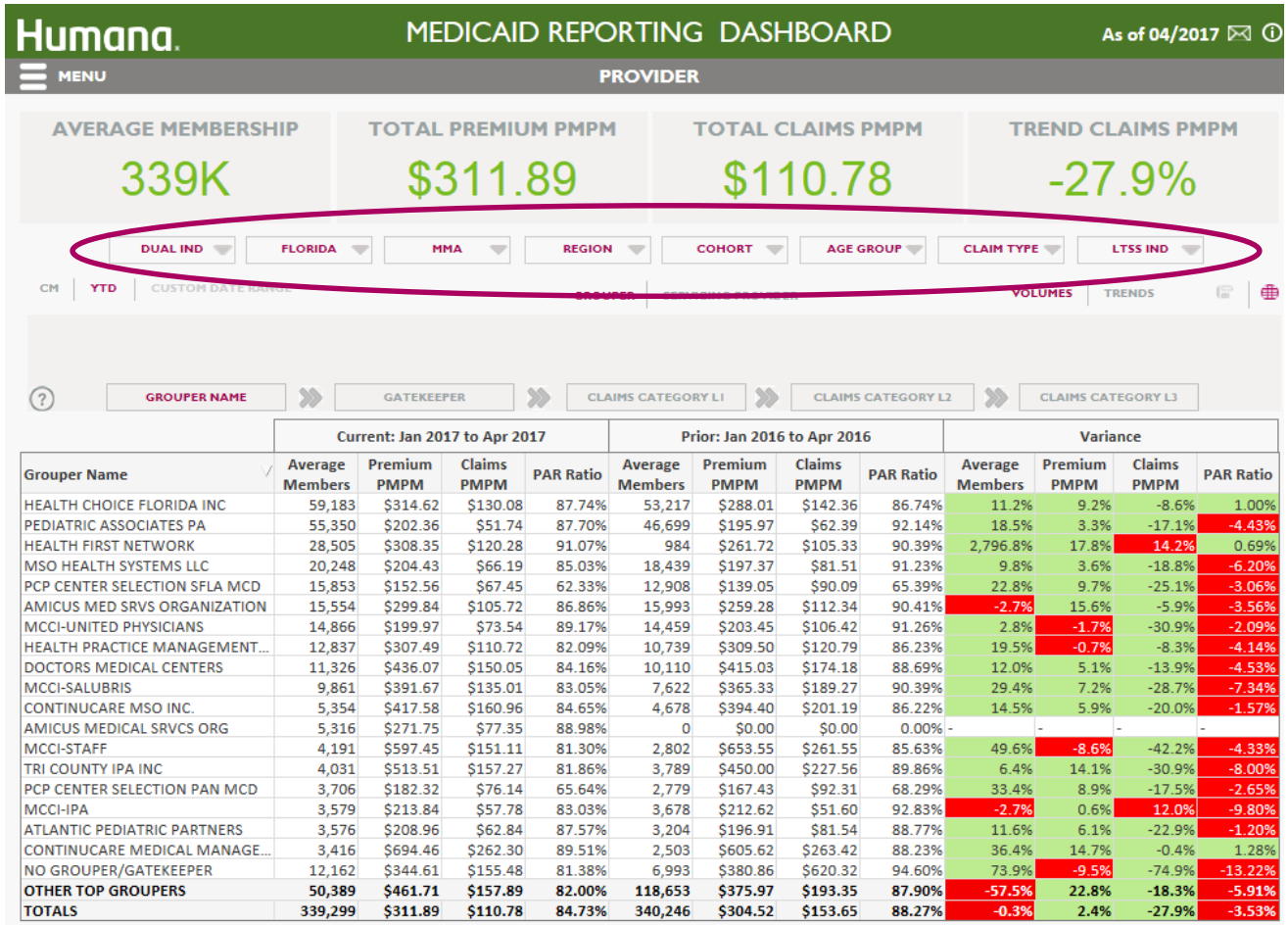
MEDICAID PROVIDER

* Humana Confidential for Internal Use Only

COV MTH DATE SKEY	STATE CD	PRODUCT CD	REGION NAME	SRC CLAIM NBR	MEMBER KEY	GROUPER LVL1 NAME	PROV ORG NAME	LCLM RSTMT FIN CAT CD DESC	LCLM RSTMT GRP LINE CD DESC	LCLM RSTMT CAT CD DESC	CLM BENEFIT PAR CAT CD	PYMT CAT CD	CPT
20170331	FL	LTSS	FL LTSS REGION 03 (OCALA)	492404167	29634885218	PCP CENTER SELECTION SFLA MCD	HUMANA MEDICAID SECONDARY	ANCILLARY SERVICES	ANCILLARY HOME HEALTH	ANCILLARY HOME HEALTH	P	C	
20170331	FL	LTSS	FL LTSS REGION 11 (MIAMI-DADE/MONROE)	494313473	29284401282	PCP CENTER SELECTION SFLA MCD	HUMANA MEDICAID SECONDARY	ANCILLARY SERVICES	ANCILLARY HOME HEALTH	ANCILLARY HOME HEALTH	P	C	
20170331	FL	LTSS	FL LTSS REGION 11 (MIAMI-DADE/MONROE)	494323271	29284401282	PCP CENTER SELECTION SFLA MCD	HUMANA MEDICAID SECONDARY	ANCILLARY SERVICES	ANCILLARY HOME HEALTH	ANCILLARY HOME HEALTH	P	C	
20170331	FL	LTSS	FL LTSS REGION 11 (MIAMI-DADE/MONROE)	498857898	29284421732	PCP CENTER SELECTION SFLA MCD	HUMANA MEDICAID SECONDARY	ANCILLARY SERVICES	ANCILLARY HOME HEALTH	ANCILLARY HOME HEALTH	P	C	
20170331	FL	LTSS	FL LTSS REGION 11 (MIAMI-DADE/MONROE)	509539287	29284422222	PCP CENTER SELECTION SFLA MCD	HUMANA MEDICAID SECONDARY	ANCILLARY SERVICES	ANCILLARY HOME HEALTH	ANCILLARY HOME HEALTH	P	C	

Medicaid Reporting Dashboard – Guided Analytics

1. Select from the primary filters.



	Current: Jan 2017 to Apr 2017				Prior: Jan 2016 to Apr 2016				Variance			
Grouper Name	Average Members	Premium PMPM	Claims PMPM	PAR Ratio	Average Members	Premium PMPM	Claims PMPM	PAR Ratio	Average Members	Premium PMPM	Claims PMPM	PAR Ratio
HEALTH CHOICE FLORIDA INC	59,183	$314.62	$130.08	87.74%	53,217	$288.01	$142.36	86.74%	11.2%	9.2%	-8.6%	1.00%
PEDIATRIC ASSOCIATES PA	55,350	$202.36	$51.74	87.70%	46,699	$195.97	$62.39	92.14%	18.5%	3.3%	-17.1%	-4.43%
HEALTH FIRST NETWORK	28,505	$308.35	$120.28	91.07%	984	$261.72	$105.33	90.39%	2,796.8%	17.8%	14.2%	0.69%
MSO HEALTH SYSTEMS LLC	20,248	$204.43	$66.19	85.03%	18,439	$197.37	$81.51	91.23%	9.8%	3.6%	-18.8%	-6.20%
PCP CENTER SELECTION SFLA MCD	15,853	$152.56	$67.45	62.33%	12,908	$139.05	$90.09	65.39%	22.8%	9.7%	-25.1%	-3.06%
AMICUS MED SRVS ORGANIZATION	15,554	$299.84	$105.72	86.86%	15,993	$259.28	$112.34	90.41%	-2.7%	15.6%	-5.9%	-3.56%
MCCI-UNITED PHYSICIANS	14,866	$199.97	$73.54	89.17%	14,459	$203.45	$106.42	91.26%	2.8%	-1.7%	-30.9%	-2.09%
HEALTH PRACTICE MANAGEMENT...	12,837	$307.49	$110.72	82.09%	10,739	$309.50	$120.79	86.23%	19.5%	-0.7%	-8.3%	-4.14%
DOCTORS MEDICAL CENTERS	11,326	$436.07	$150.05	84.16%	10,110	$415.03	$174.18	88.69%	12.0%	5.1%	-13.9%	-4.53%
MCCI-SALUBRIS	9,861	$391.67	$135.01	83.05%	7,622	$365.33	$189.27	90.39%	29.4%	7.2%	-28.7%	-7.34%
CONTINUCARE MSO INC.	5,354	$417.58	$160.96	84.65%	4,678	$394.40	$201.19	86.22%	14.5%	5.9%	-20.0%	-1.57%
AMICUS MEDICAL SRVCS ORG	5,316	$271.75	$77.35	88.98%	0	$0.00	$0.00	0.00%	-	-	-	-
MCCI-STAFF	4,191	$597.45	$151.11	81.30%	2,802	$653.55	$261.55	85.63%	49.6%	-8.6%	-42.2%	-4.33%
TRI COUNTY IPA INC	4,031	$513.51	$157.27	81.86%	3,789	$450.00	$227.56	89.86%	6.4%	14.1%	-30.9%	-8.00%
PCP CENTER SELECTION PAN MCD	3,706	$182.32	$76.14	65.64%	2,779	$167.43	$92.31	68.29%	33.4%	8.9%	-17.5%	-2.65%
MCCI-IPA	3,579	$213.84	$57.78	83.03%	3,678	$212.62	$51.60	92.83%	-2.7%	0.6%	12.0%	-9.80%
ATLANTIC PEDIATRIC PARTNERS	3,576	$208.96	$62.84	87.57%	3,204	$196.91	$81.54	88.77%	11.6%	6.1%	-22.9%	-1.20%
CONTINUCARE MEDICAL MANAGE...	3,416	$694.46	$262.30	89.51%	2,503	$605.62	$263.42	88.23%	36.4%	14.7%	-0.4%	1.28%
NO GROUPER/GATEKEEPER	12,162	$344.61	$155.48	81.38%	6,993	$380.86	$620.32	94.60%	73.9%	-9.5%	-74.9%	-13.22%
OTHER TOP GROUPERS	**50,389**	**$461.71**	**$157.89**	**82.00%**	**118,653**	**$375.97**	**$193.35**	**87.90%**	**-57.5%**	**22.8%**	**-18.3%**	**-5.91%**
TOTALS	**339,299**	**$311.89**	**$110.78**	**84.73%**	**340,246**	**$304.52**	**$153.65**	**88.27%**	**-0.3%**	**2.4%**	**-27.9%**	**-3.53%**

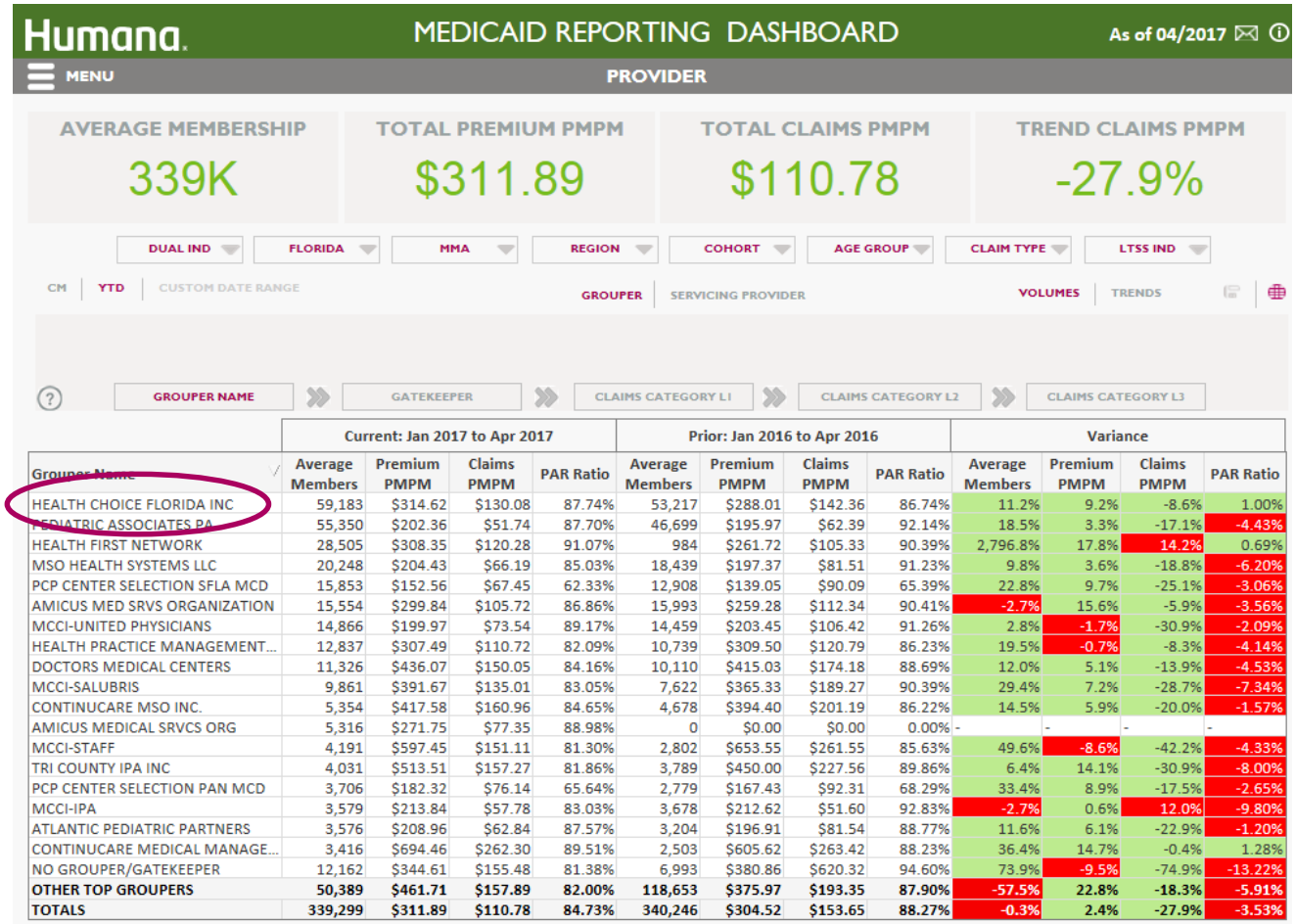
Current Selections:

State: FL

Product: MMA

Medicaid Reporting Dashboard – Guided Analytics

2. Select a GROUPER.



	Current: Jan 2017 to Apr 2017				Prior: Jan 2016 to Apr 2016				Variance			
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DOCTORS MEDICAL CENTERS	11,326	$436.07	$150.05	84.16%	10,110	$415.03	$174.18	88.69%	12.0%	5.1%	-13.9%	-4.53%
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CONTINUCARE MSO INC.	5,354	$417.58	$160.96	84.65%	4,678	$394.40	$201.19	86.22%	14.5%	5.9%	-20.0%	-1.57%
AMICUS MEDICAL SRVCS ORG	5,316	$271.75	$77.35	88.98%	0	$0.00	$0.00	0.00%	-	-	-	-
MCCI-STAFF	4,191	$597.45	$151.11	81.30%	2,802	$653.55	$261.55	85.63%	49.6%	-8.6%	-42.2%	-4.33%
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PCP CENTER SELECTION PAN MCD	3,706	$182.32	$76.14	65.64%	2,779	$167.43	$92.31	68.29%	33.4%	8.9%	-17.5%	-2.65%
MCCI-IPA	3,579	$213.84	$57.78	83.03%	3,678	$212.62	$51.60	92.83%	-2.7%	0.6%	12.0%	-9.80%
ATLANTIC PEDIATRIC PARTNERS	3,576	$208.96	$62.84	87.57%	3,204	$196.91	$81.54	88.77%	11.6%	6.1%	-22.9%	-1.20%
CONTINUCARE MEDICAL MANAGE...	3,416	$694.46	$262.30	89.51%	2,503	$605.62	$263.42	88.23%	36.4%	14.7%	-0.4%	1.28%
NO GROUPER/GATEKEEPER	12,162	$344.61	$155.48	81.38%	6,993	$380.86	$620.32	94.60%	73.9%	-9.5%	-74.9%	-13.22%
OTHER TOP GROUPERS	**50,389**	**$461.71**	**$157.89**	**82.00%**	**118,653**	**$375.97**	**$193.35**	**87.90%**	**-57.5%**	**22.8%**	**-18.3%**	**-5.91%**
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Current Selections:

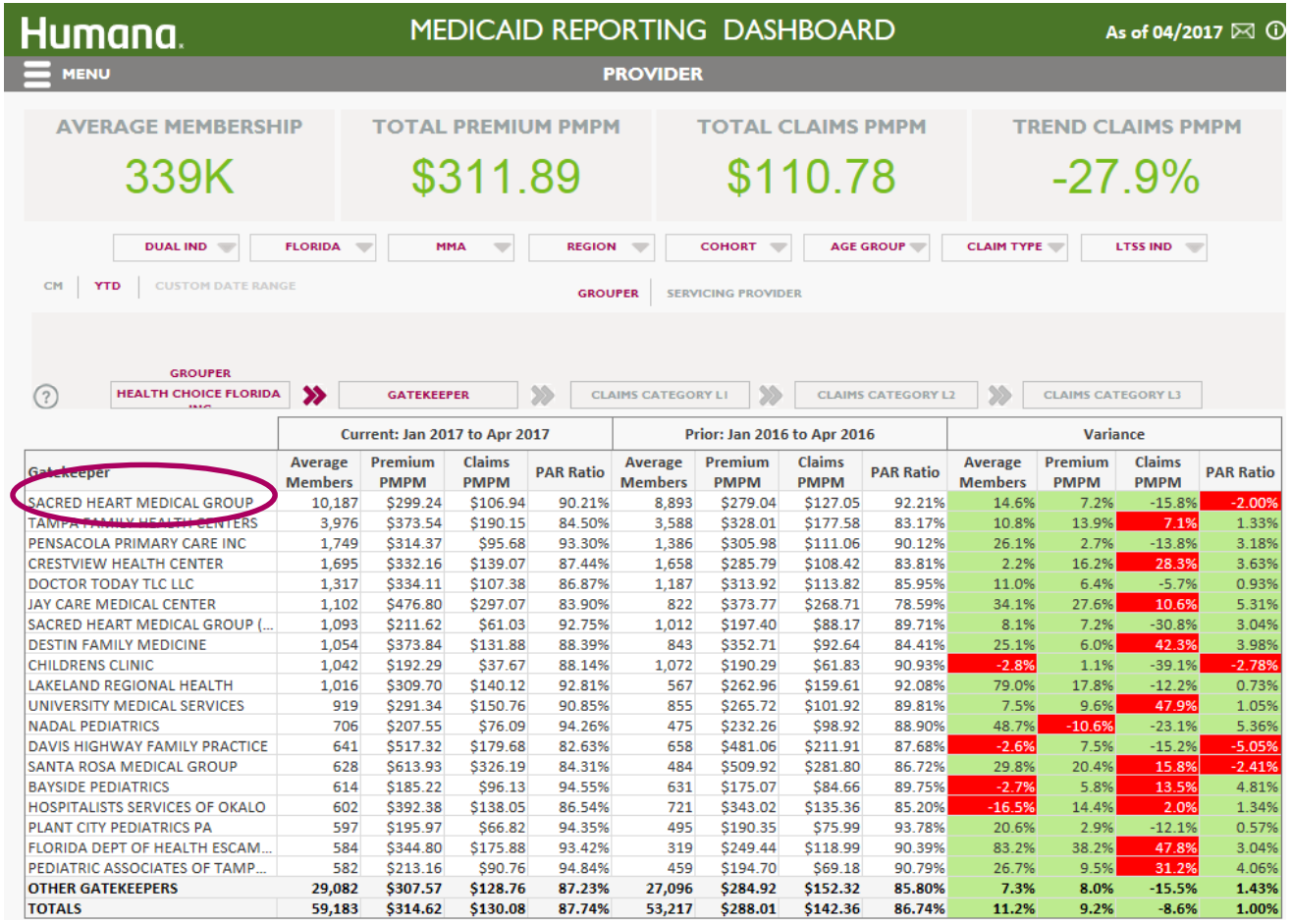
State: FL

Product: MMA

Grouper: Health Choice FL

Medicaid Reporting Dashboard – Guided Analytics

3. Select a GATEKEEPER.



	Current: Jan 2017 to Apr 2017				Prior: Jan 2016 to Apr 2016				Variance			
Gatekeeper	Average Members	Premium PMPM	Claims PMPM	PAR Ratio	Average Members	Premium PMPM	Claims PMPM	PAR Ratio	Average Members	Premium PMPM	Claims PMPM	PAR Ratio
SACRED HEART MEDICAL GROUP	10,187	$299.24	$106.94	90.21%	8,893	$279.04	$127.05	92.21%	14.6%	7.2%	-15.8%	-2.00%
TAMPA FAMILY HEALTH CENTERS	3,976	$373.54	$190.15	84.50%	3,588	$328.01	$177.58	83.17%	10.8%	13.9%	7.1%	1.33%
PENSACOLA PRIMARY CARE INC	1,749	$314.37	$95.68	93.30%	1,386	$305.98	$111.06	90.12%	26.1%	2.7%	-13.8%	3.18%
CRESTVIEW HEALTH CENTER	1,695	$332.16	$139.07	87.44%	1,658	$285.79	$108.42	83.81%	2.2%	16.2%	28.3%	3.63%
DOCTOR TODAY TLC LLC	1,317	$334.11	$107.38	86.87%	1,187	$313.92	$113.82	85.95%	11.0%	6.4%	-5.7%	0.93%
JAY CARE MEDICAL CENTER	1,102	$476.80	$297.07	83.90%	822	$373.77	$268.71	78.59%	34.1%	27.6%	10.6%	5.31%
SACRED HEART MEDICAL GROUP (...	1,093	$211.62	$61.03	92.75%	1,012	$197.40	$88.17	89.71%	8.1%	7.2%	-30.8%	3.04%
DESTIN FAMILY MEDICINE	1,054	$373.84	$131.88	88.39%	843	$352.71	$92.64	84.41%	25.1%	6.0%	42.3%	3.98%
CHILDRENS CLINIC	1,042	$192.29	$37.67	88.14%	1,072	$190.29	$61.83	90.93%	-2.8%	1.1%	-39.1%	-2.78%
LAKELAND REGIONAL HEALTH	1,016	$309.70	$140.12	92.81%	567	$262.96	$159.61	92.08%	79.0%	17.8%	-12.2%	0.73%
UNIVERSITY MEDICAL SERVICES	919	$291.34	$150.76	90.85%	855	$265.72	$101.92	89.81%	7.5%	9.6%	47.9%	1.05%
NADAL PEDIATRICS	706	$207.55	$76.09	94.26%	475	$232.26	$98.92	88.90%	48.7%	-10.6%	-23.1%	5.36%
DAVIS HIGHWAY FAMILY PRACTICE	641	$517.32	$179.68	82.63%	658	$481.06	$211.91	87.68%	-2.6%	7.5%	-15.2%	-5.05%
SANTA ROSA MEDICAL GROUP	628	$613.93	$326.19	84.31%	484	$509.92	$281.80	86.72%	29.8%	20.4%	15.8%	-2.41%
BAYSIDE PEDIATRICS	614	$185.22	$96.13	94.55%	631	$175.07	$84.66	89.75%	-2.7%	5.8%	13.5%	4.81%
HOSPITALISTS SERVICES OF OKALO	602	$392.38	$138.05	86.54%	721	$343.02	$135.36	85.20%	-16.5%	14.4%	2.0%	1.34%
PLANT CITY PEDIATRICS PA	597	$195.97	$66.82	94.35%	495	$190.35	$75.99	93.78%	20.6%	2.9%	-12.1%	0.57%
FLORIDA DEPT OF HEALTH ESCAM...	584	$344.80	$175.88	93.42%	319	$249.44	$118.99	90.39%	83.2%	38.2%	47.8%	3.04%
PEDIATRIC ASSOCIATES OF TAMP...	582	$213.16	$90.76	94.84%	459	$194.70	$69.18	90.79%	26.7%	9.5%	31.2%	4.06%
OTHER GATEKEEPERS	**29,082**	**$307.57**	**$128.76**	**87.23%**	**27,096**	**$284.92**	**$152.32**	**85.80%**	**7.3%**	**8.0%**	**-15.5%**	**1.43%**
TOTALS	**59,183**	**$314.62**	**$130.08**	**87.74%**	**53,217**	**$288.01**	**$142.36**	**86.74%**	**11.2%**	**9.2%**	**-8.6%**	**1.00%**

Current Selections:

State: FL

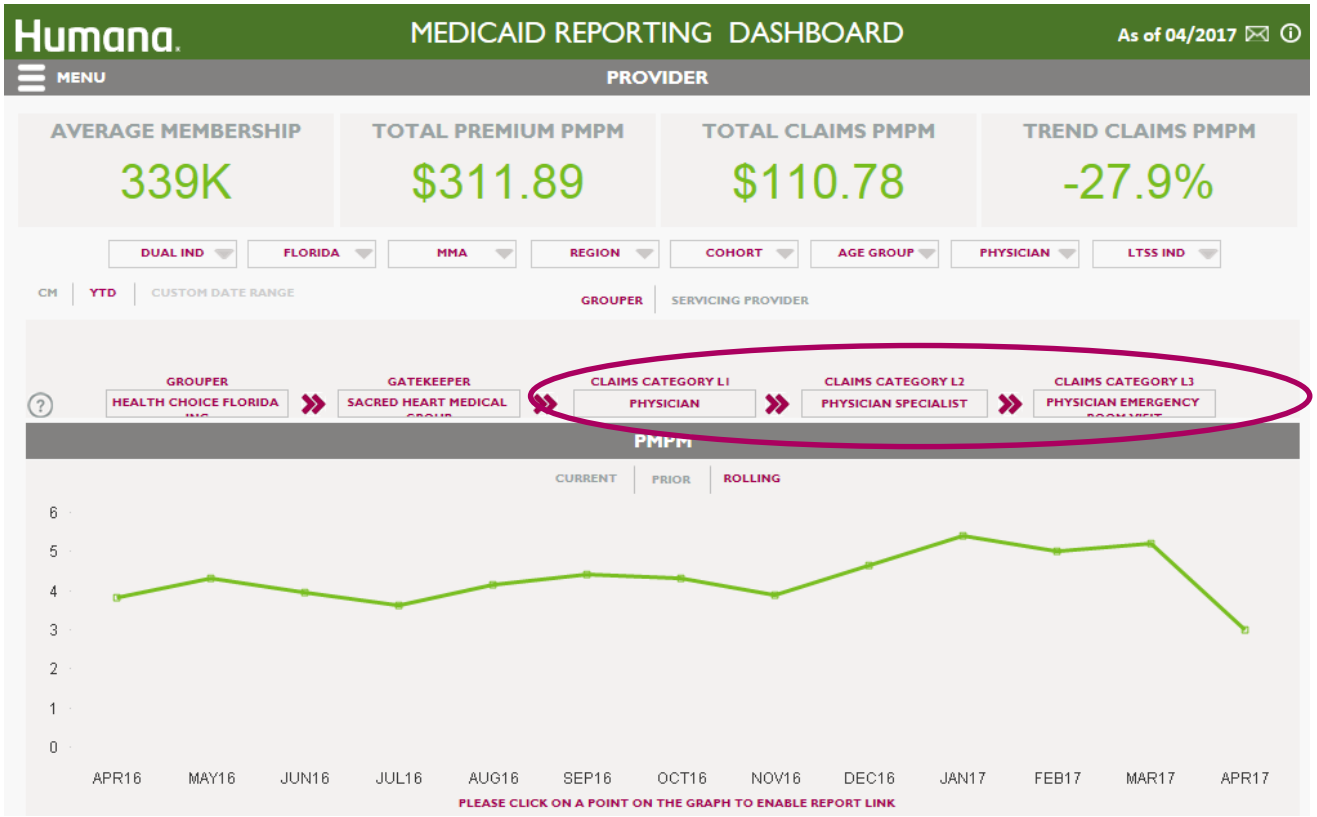
Product: MMA

Grouper: Health Choice FL

Gatekeeper: Sacred Heart

Medicaid Reporting Dashboard – Guided Analytics

4. Select the 3 CLAIMS CATEGORIES.



Current Selections:

State: FL

Product: MMA

Grouper: Health Choice FL

Gatekeeper: Sacred Heart

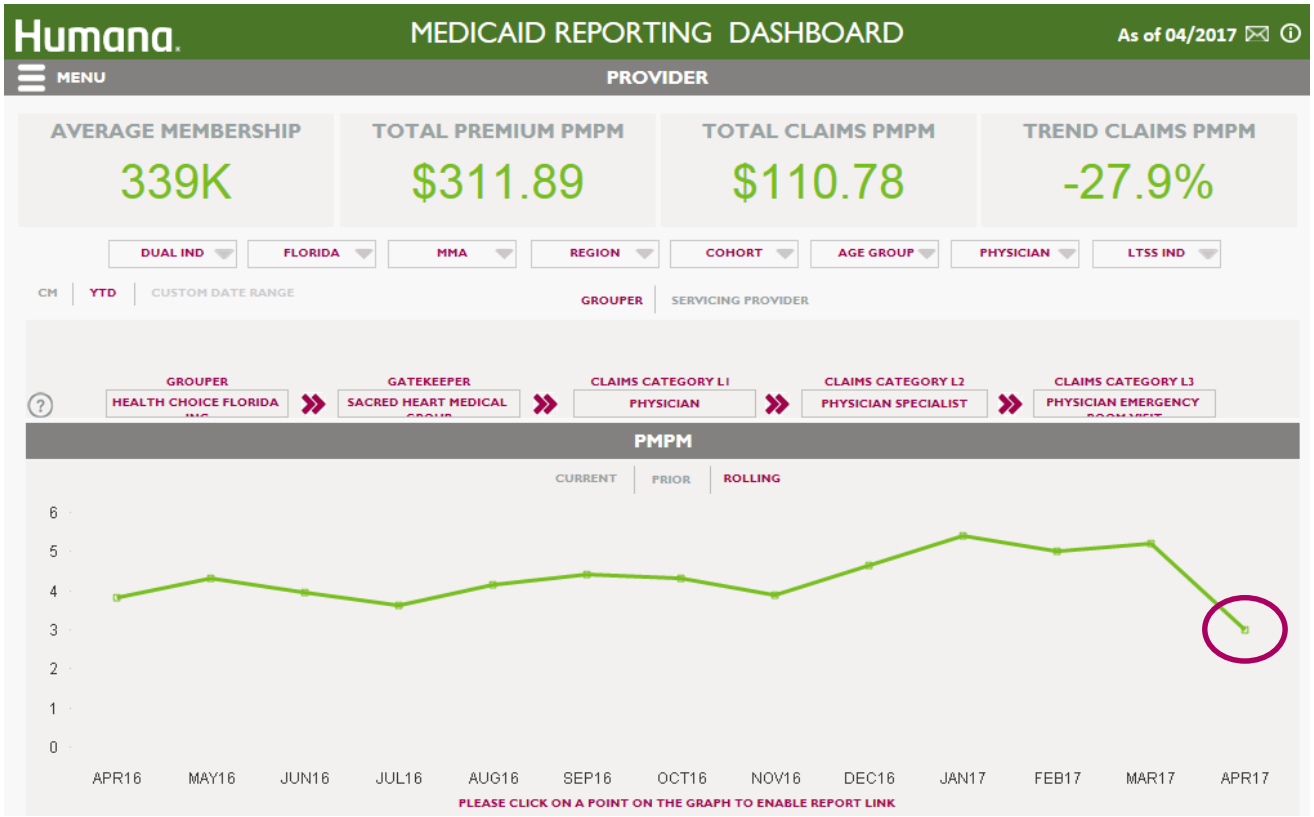
Claims Cat 1: Physician

Claims Cat 2: Physician Spec

Claims Cat 3: Physician ER

Medicaid Reporting Dashboard – Guided Analytics

5. Select a month in the graph to DRILL DOWN.



Current Selections:

State: FL

Product: MMA

Grouper: Health Choice FL

Gatekeeper: Sacred Heart

Claims Cat 1: Physician

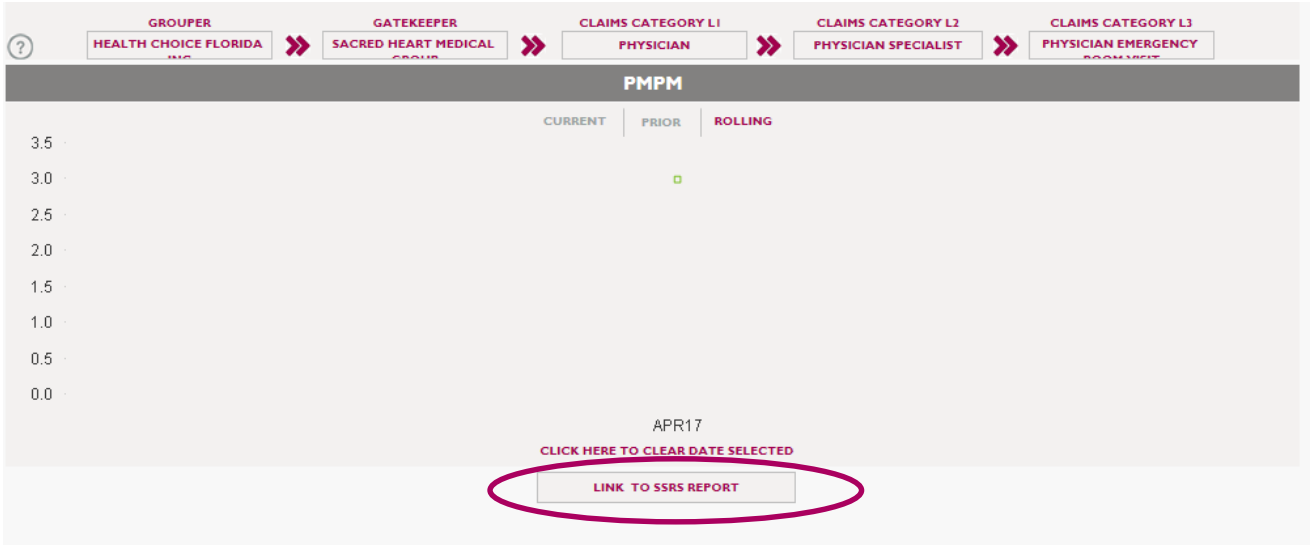
Claims Cat 2: Physician Spec

Claims Cat 3: Physician ER

Graph Month: April 2017

Medicaid Reporting Dashboard – Guided Analytics

6. Select “LINK TO SSRS REPORT”.



Current Selections:

State: FL

Product: MMA

Grouper: Health Choice FL

Gatekeeper: Sacred Heart

Claims Cat 1: Physician

Claims Cat 2: Physician Spec

Claims Cat 3: Physician ER

Graph Month: April 2017

The result is claim level detail!

COV MTH DATE SKEY	STATE CD	PRODUCT CD	REGION NAME	SRC CLAIM NBR	MEMBER KEY	GROUPER LVL1 NAME	PROV ORG NAME	LCLM RSTMT FIN CAT CD DESC	LCLM RSTMT GRP LINE CD DESC	LCLM RSTMT CAT CD DESC	CLM BENEFIT PAR CAT CD	PYMT CAT CD	CPT
20170430	FL	MMA	FL MMA REGION 01 (PANHANDLE)	700713642	25783594256	HEALTH CHOICE FLORIDA INC	Sacred Heart Medical Group	PHYSICIAN SPECIALIST	PHYSICIAN EMERGENCY ROOM VISIT	PHYSICIAN EMERGENCY ROOM VISIT	P	C	
20170430	FL	MMA	FL MMA REGION 01 (PANHANDLE)	701718327	31478326130	HEALTH CHOICE FLORIDA INC	Sacred Heart Medical Group	PHYSICIAN SPECIALIST	PHYSICIAN EMERGENCY ROOM VISIT	PHYSICIAN EMERGENCY ROOM VISIT	N	C	
20170430	FL	MMA	FL MMA REGION 01 (PANHANDLE)	699904086	20004087562	HEALTH CHOICE FLORIDA INC	Sacred Heart Medical Group	PHYSICIAN SPECIALIST	PHYSICIAN EMERGENCY ROOM VISIT	PHYSICIAN EMERGENCY ROOM VISIT	N	C	

Claim status

How to review and update your Humana claims on the Availity Portal

Humana®

Topics we'll cover today

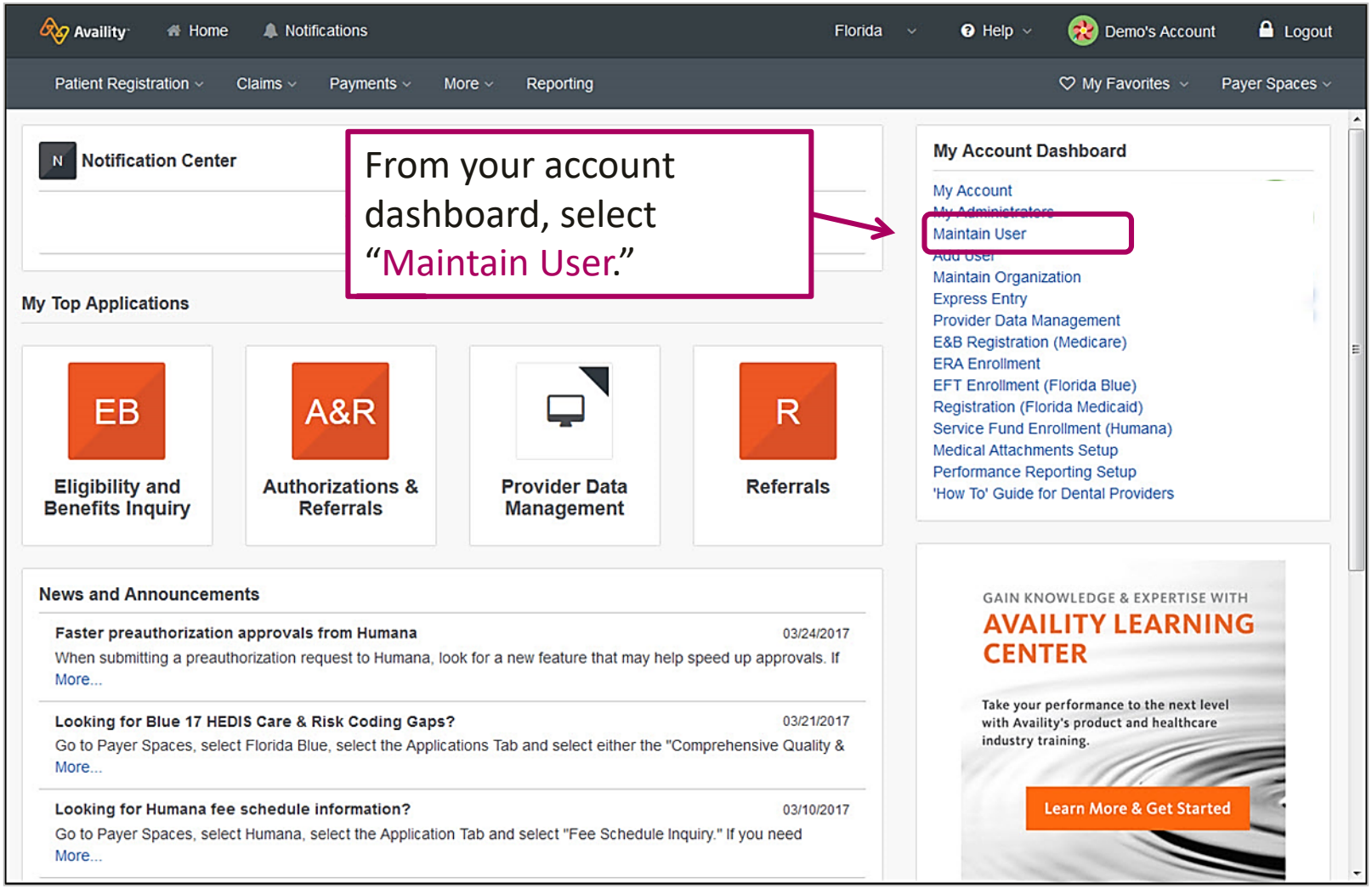
- About the claim status tool
- How to start your search
- How to review your search results
- How to review claim details
- How to send an attachment

About the claim status tool

About the new claim status tool

- **Customized** for Humana to help with common provider tasks and questions.

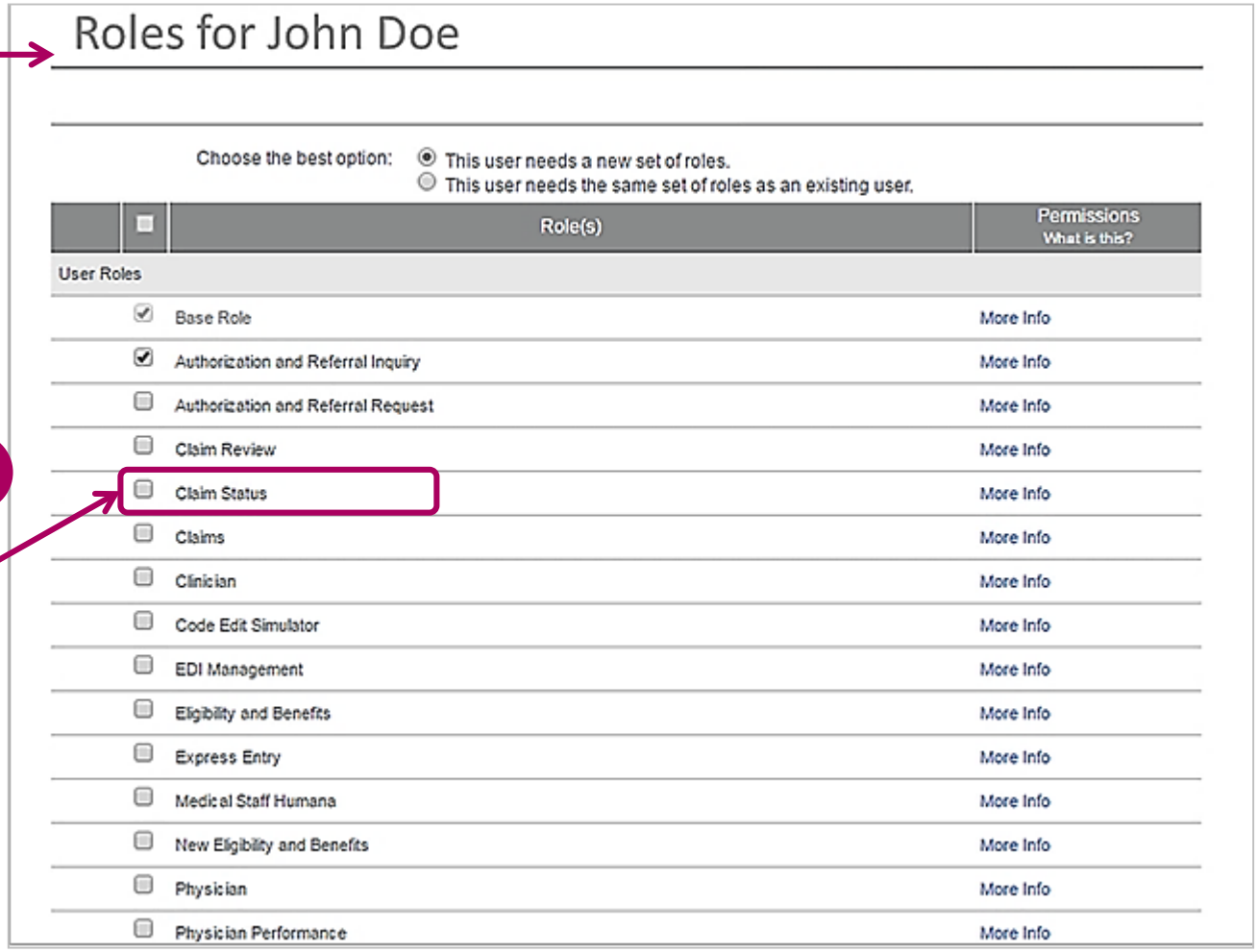
Granting access to the tool (administrators only)



Granting access to the tool (administrators only)

1. Go to the roles page for the user who needs this access.

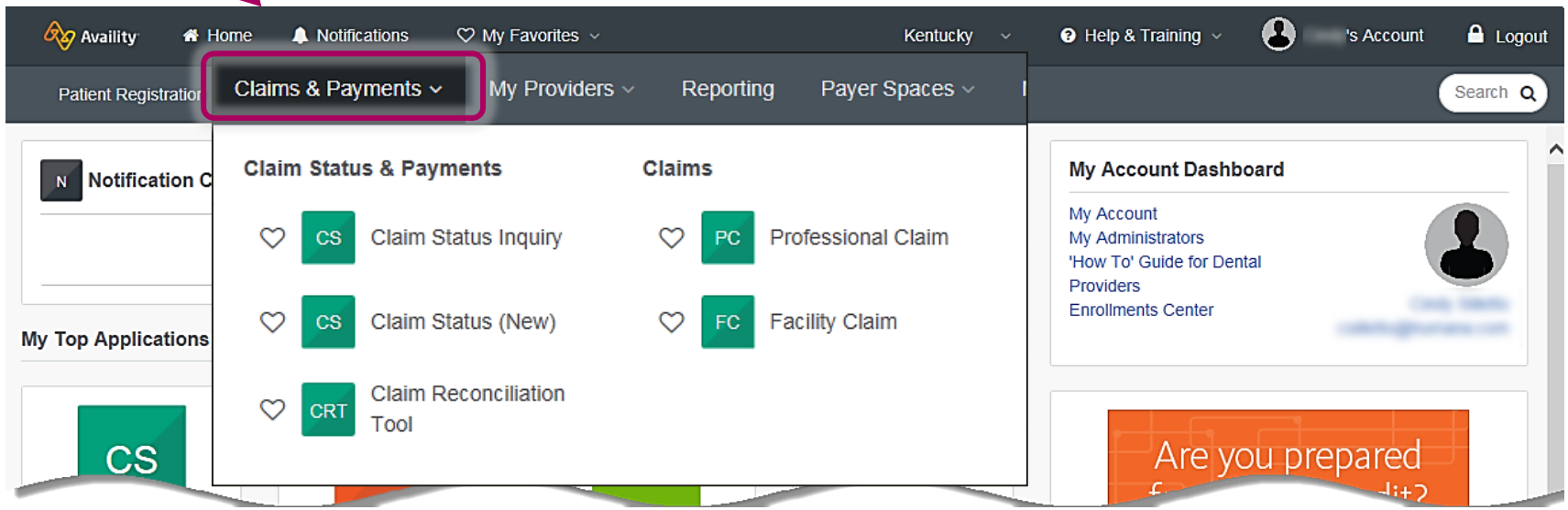
2. Select the "Claim Status" option.



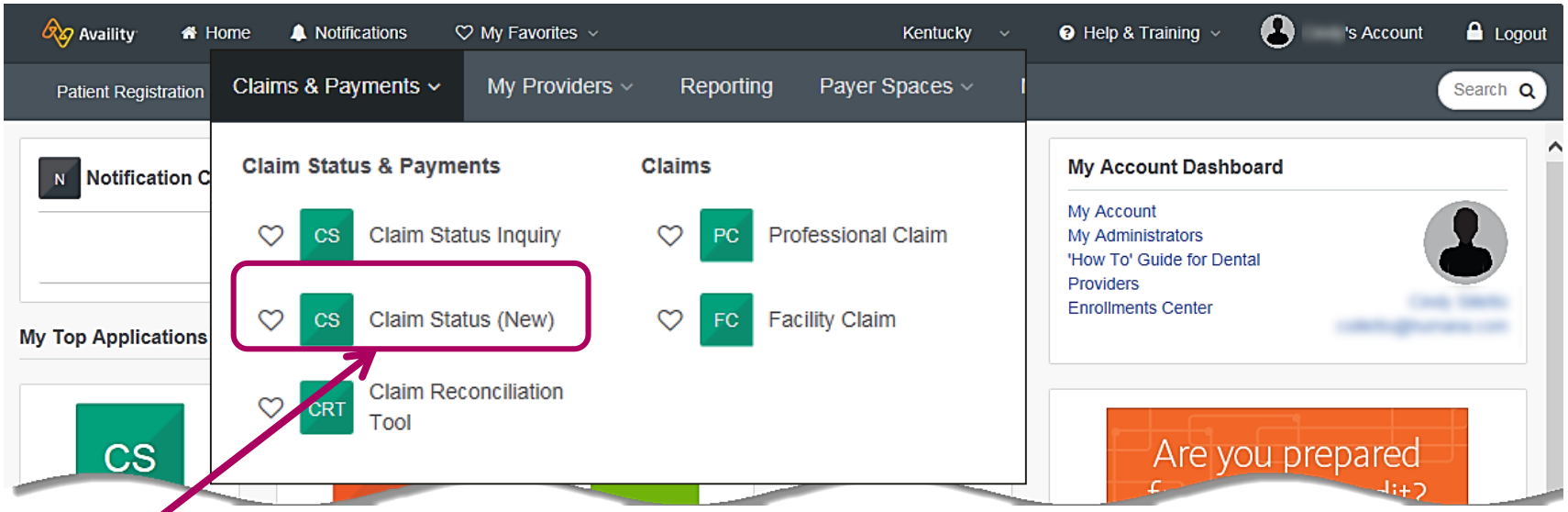
Starting your search

Finding the claim status tool

Select
"Claims & Payments."

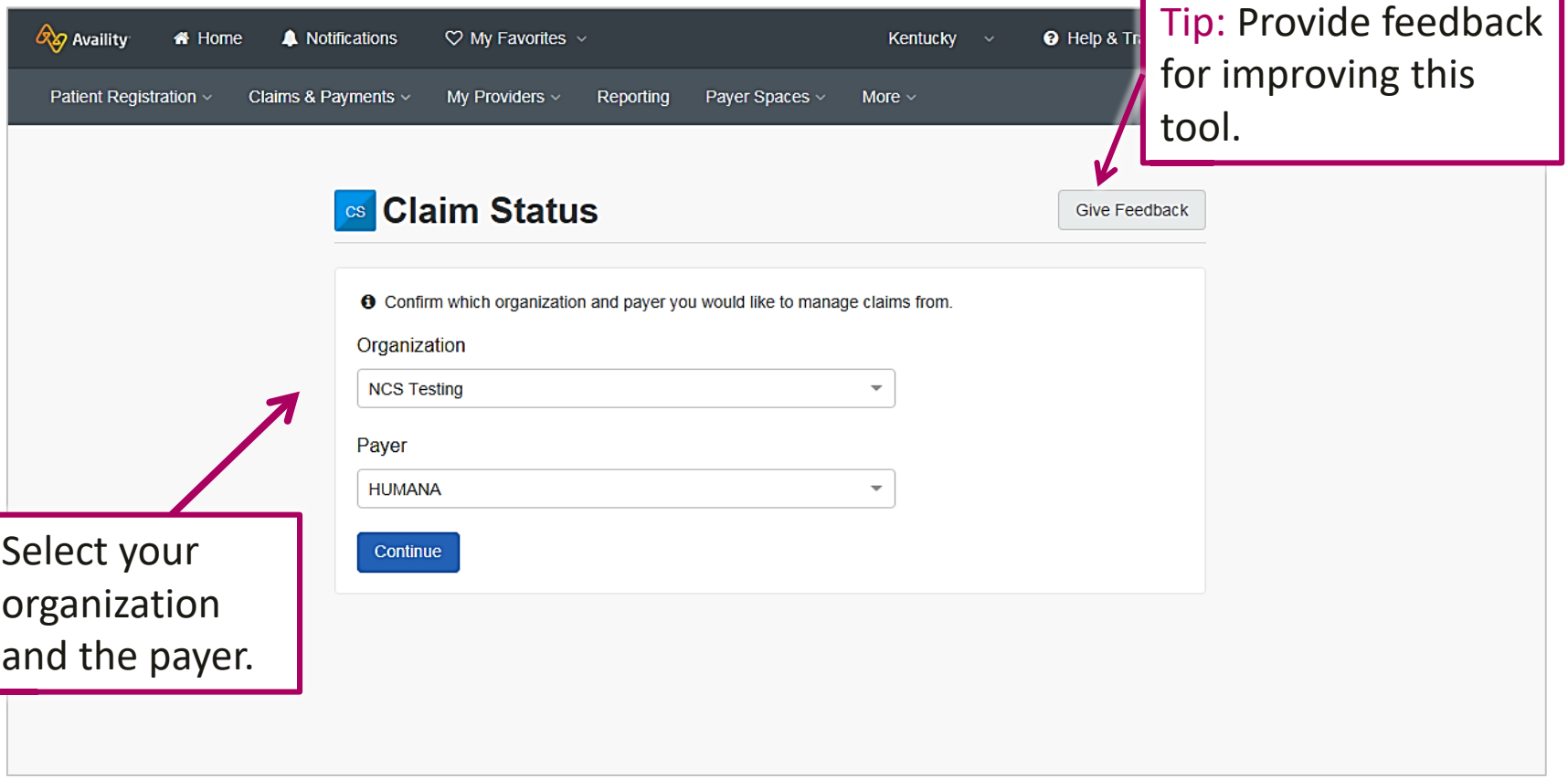


Finding the claim status tool

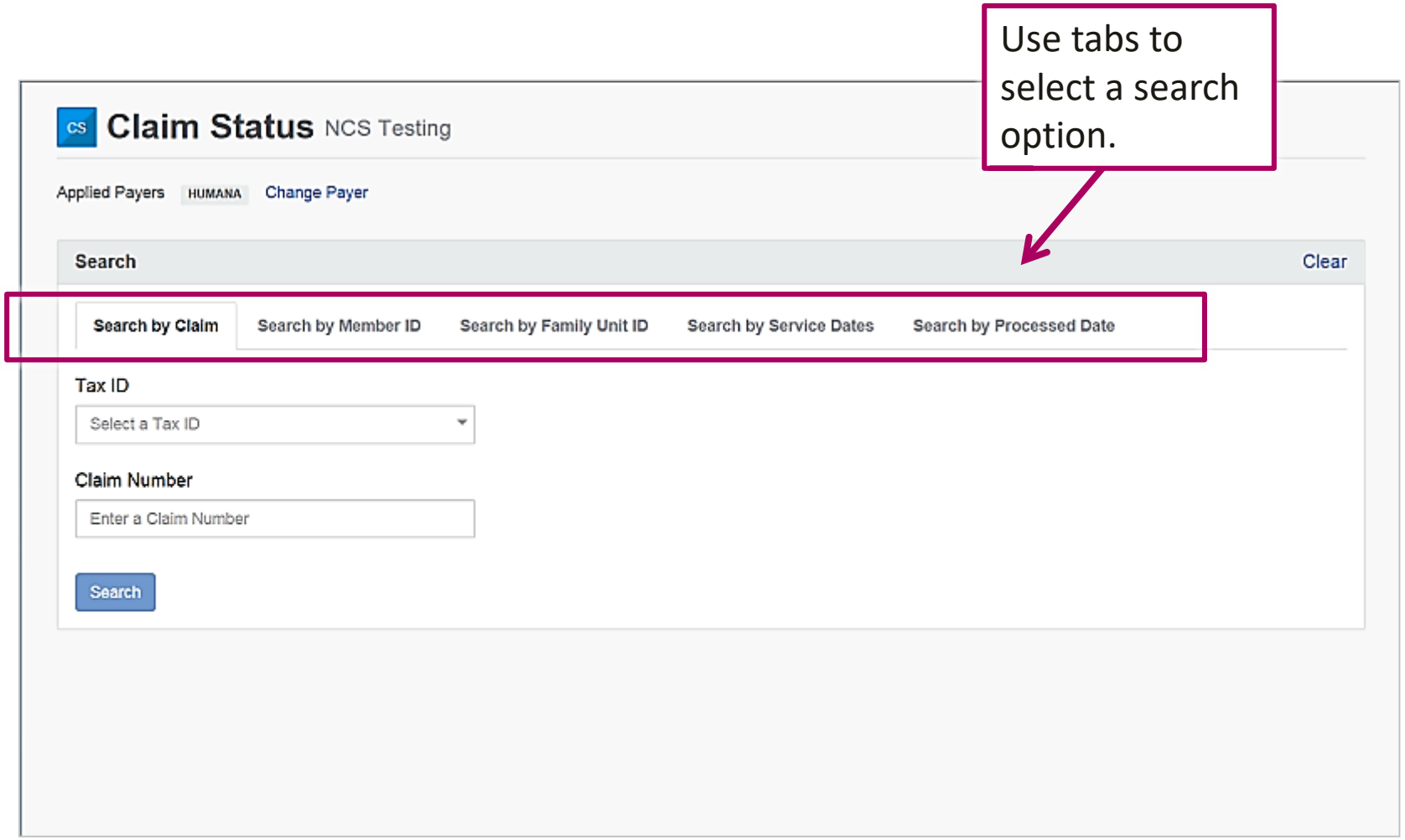


Select "Claim Status (New)."

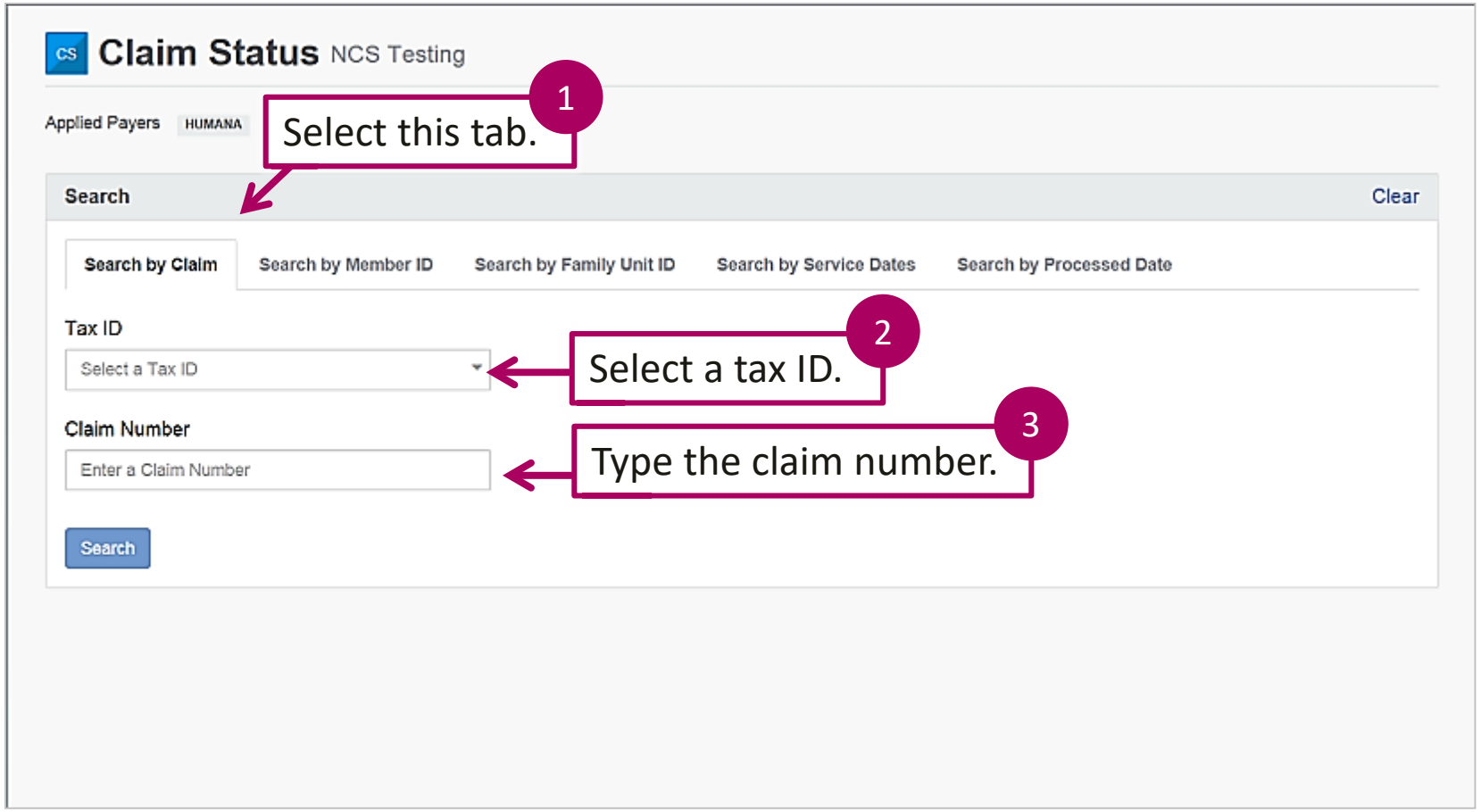
Selecting your organization and payer



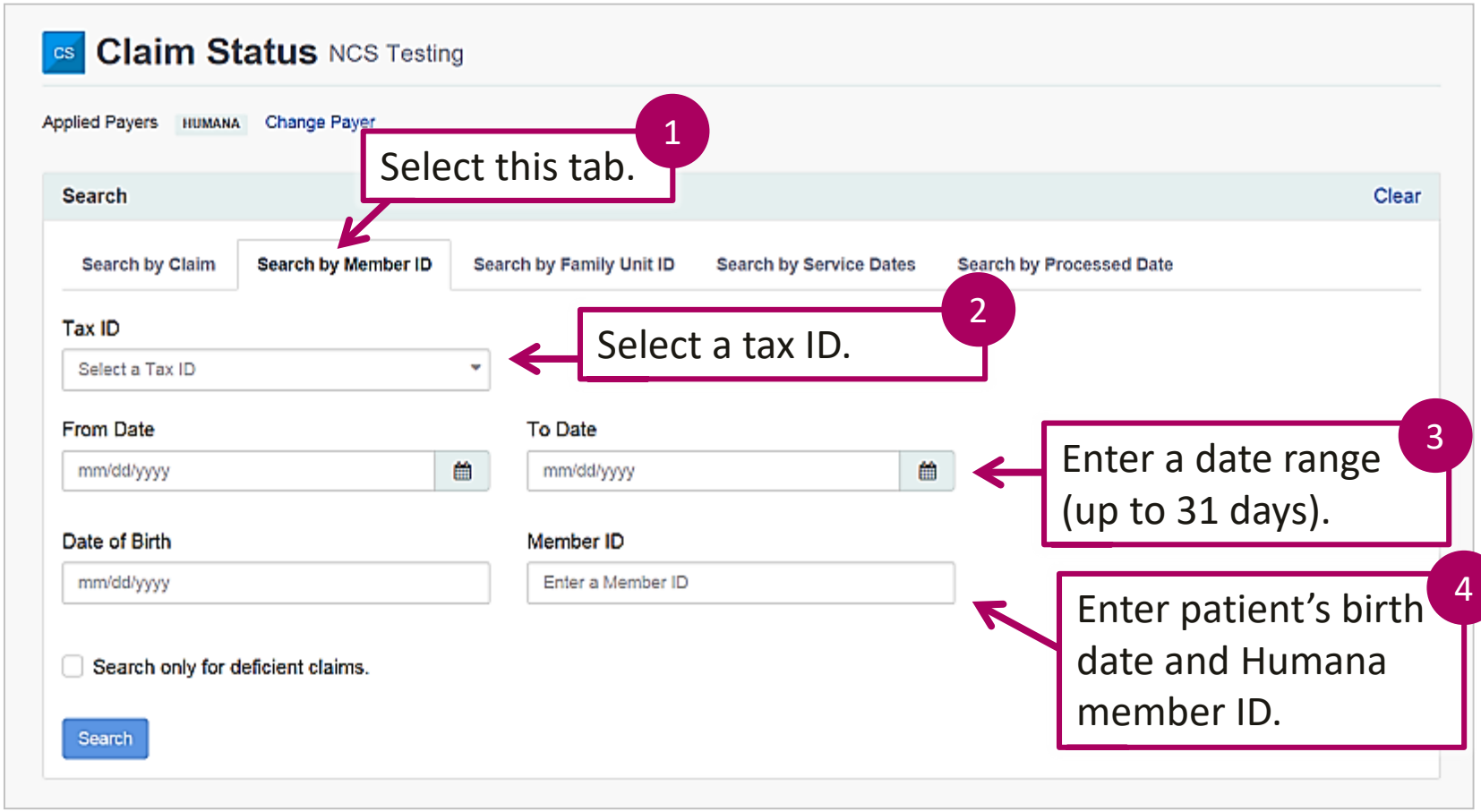
Choosing a search tab



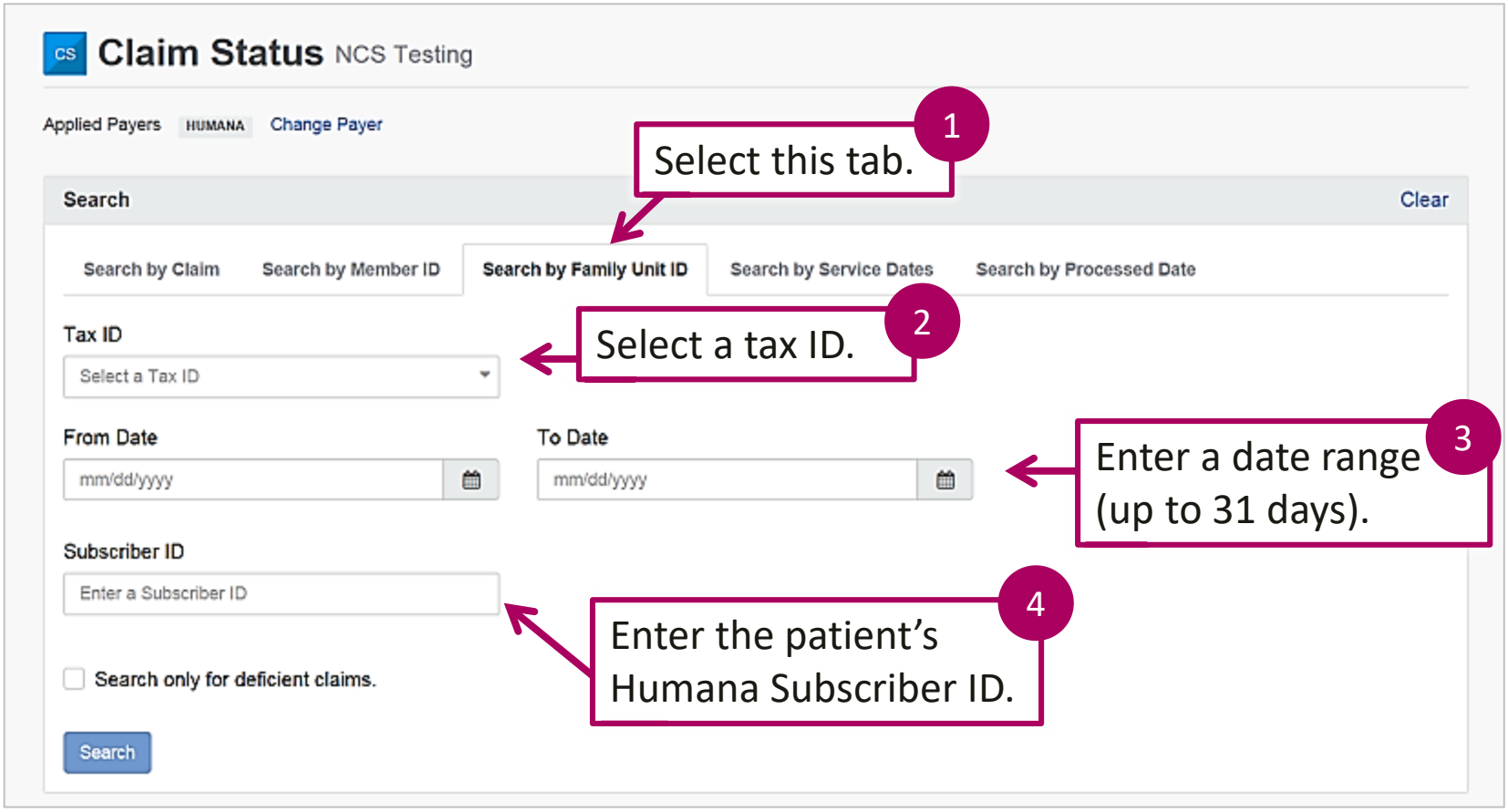
Searching by claim number



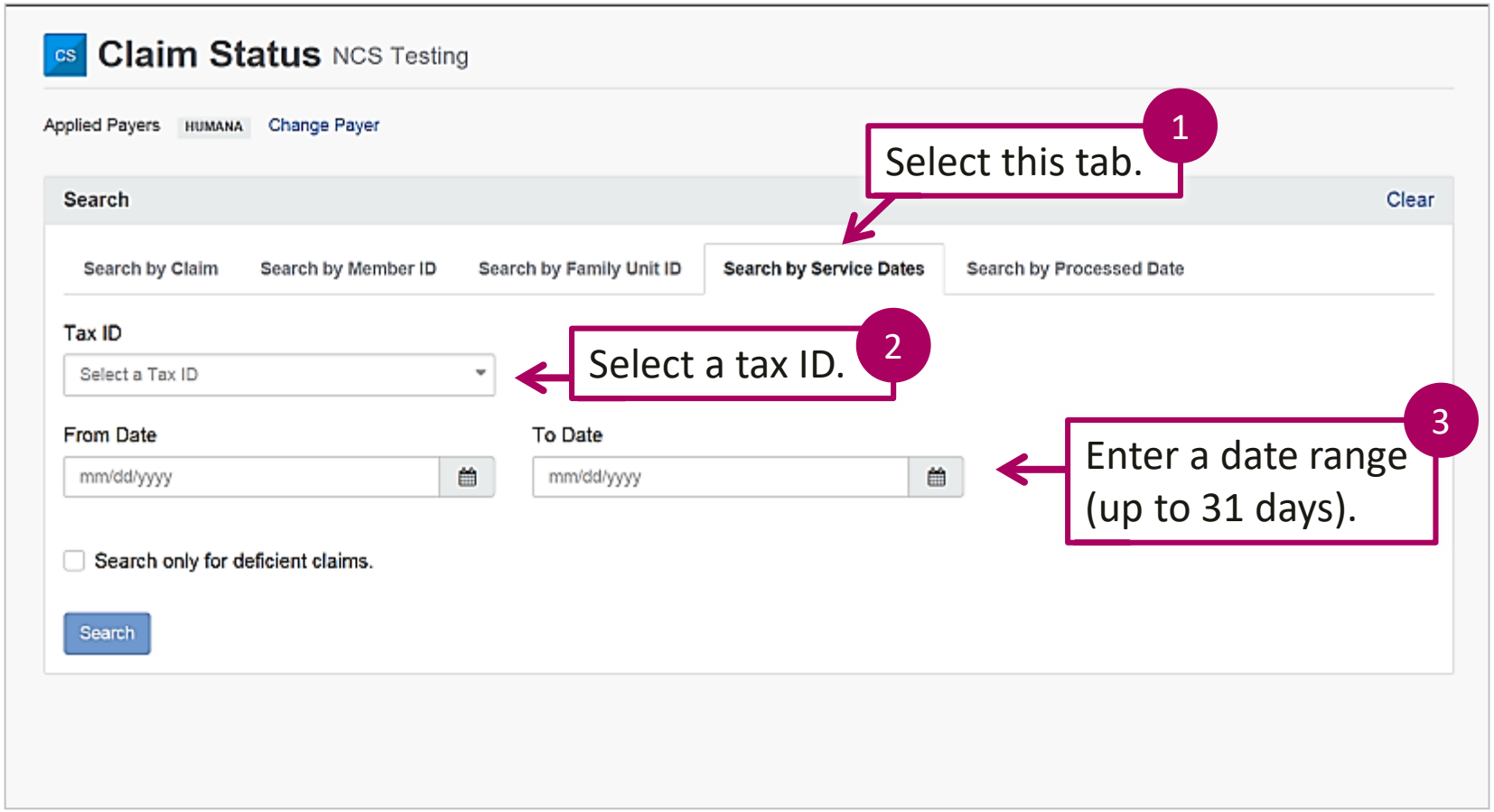
Searching by patient



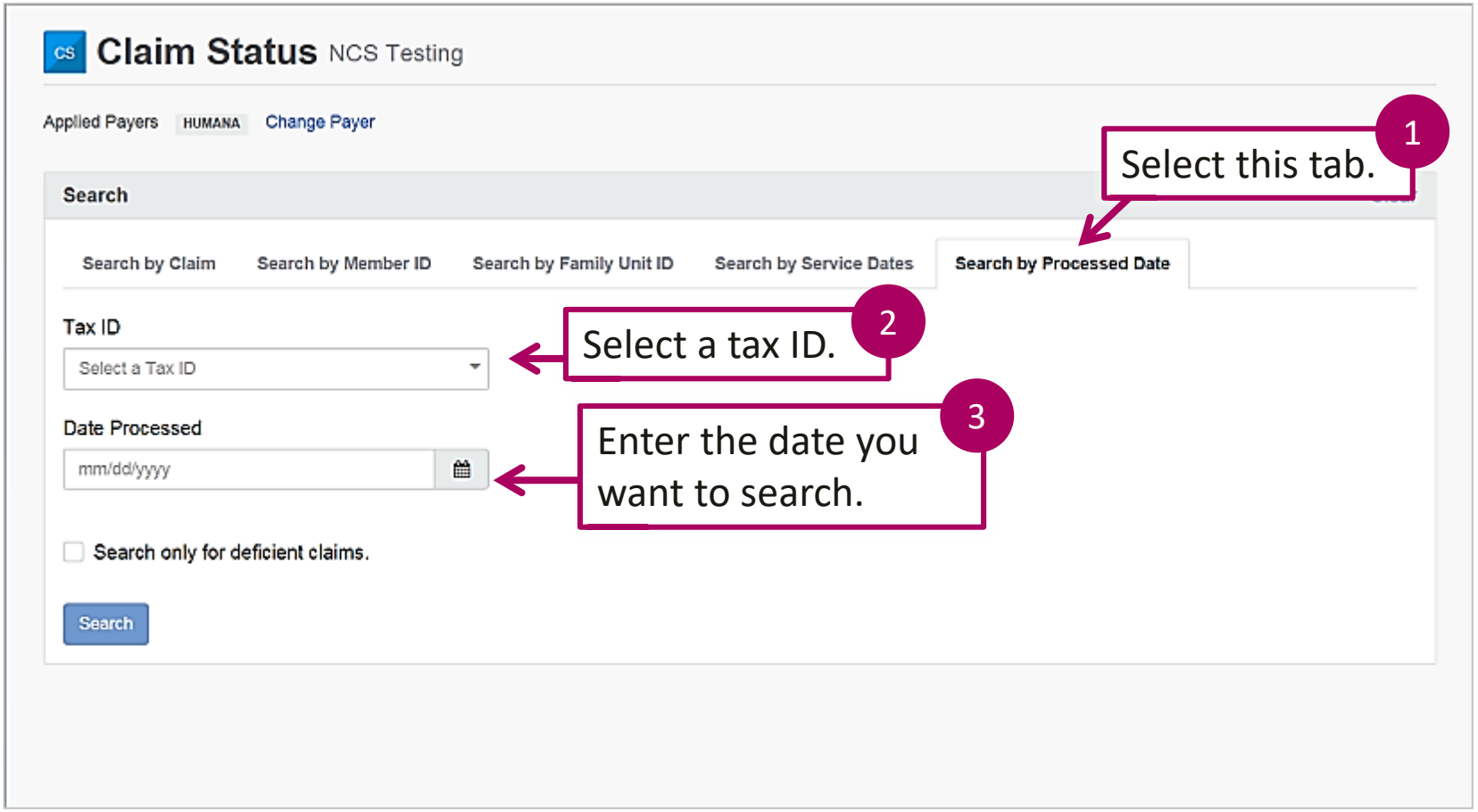
Searching by family unit



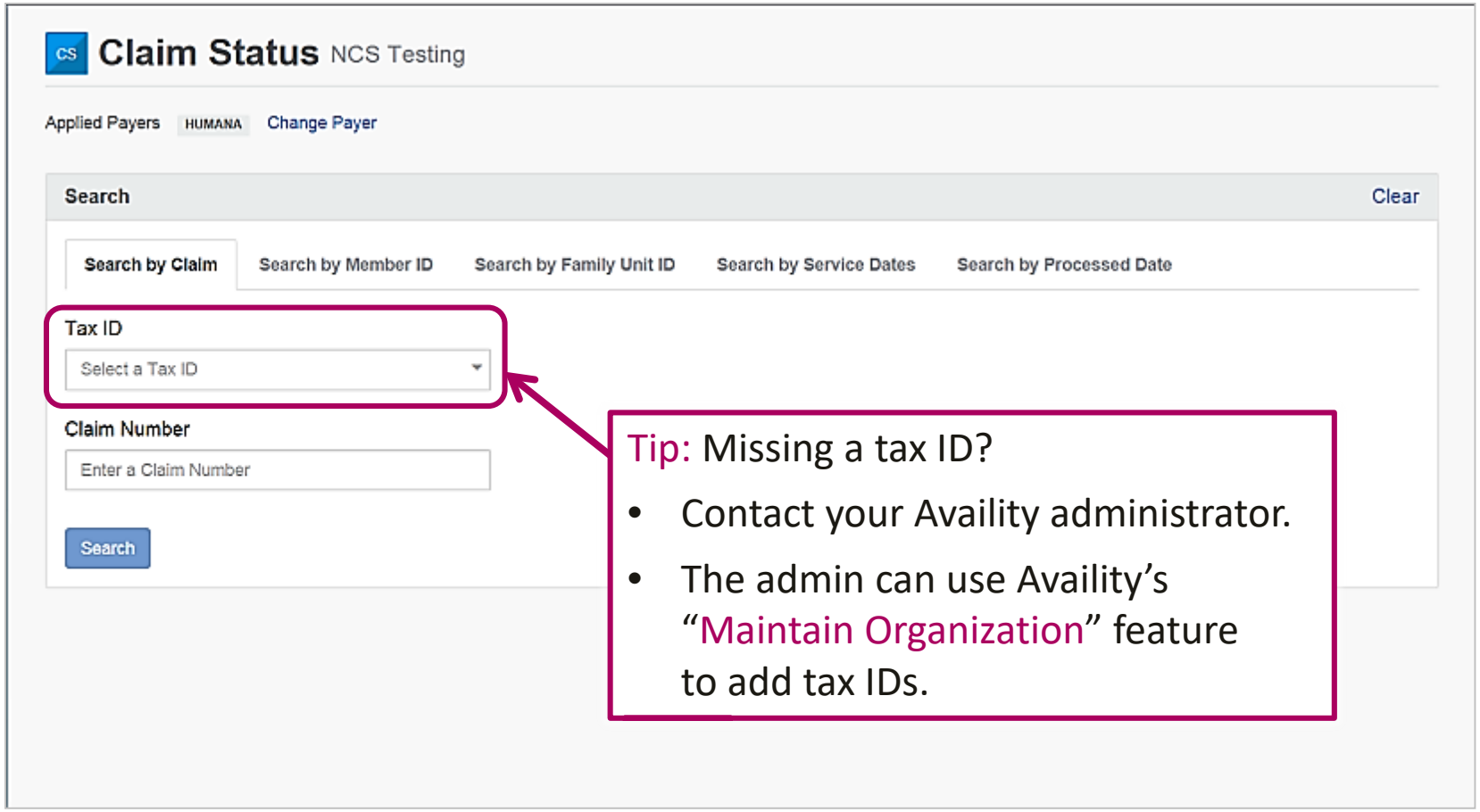
Searching by service dates



Searching by date Humana processed the claim



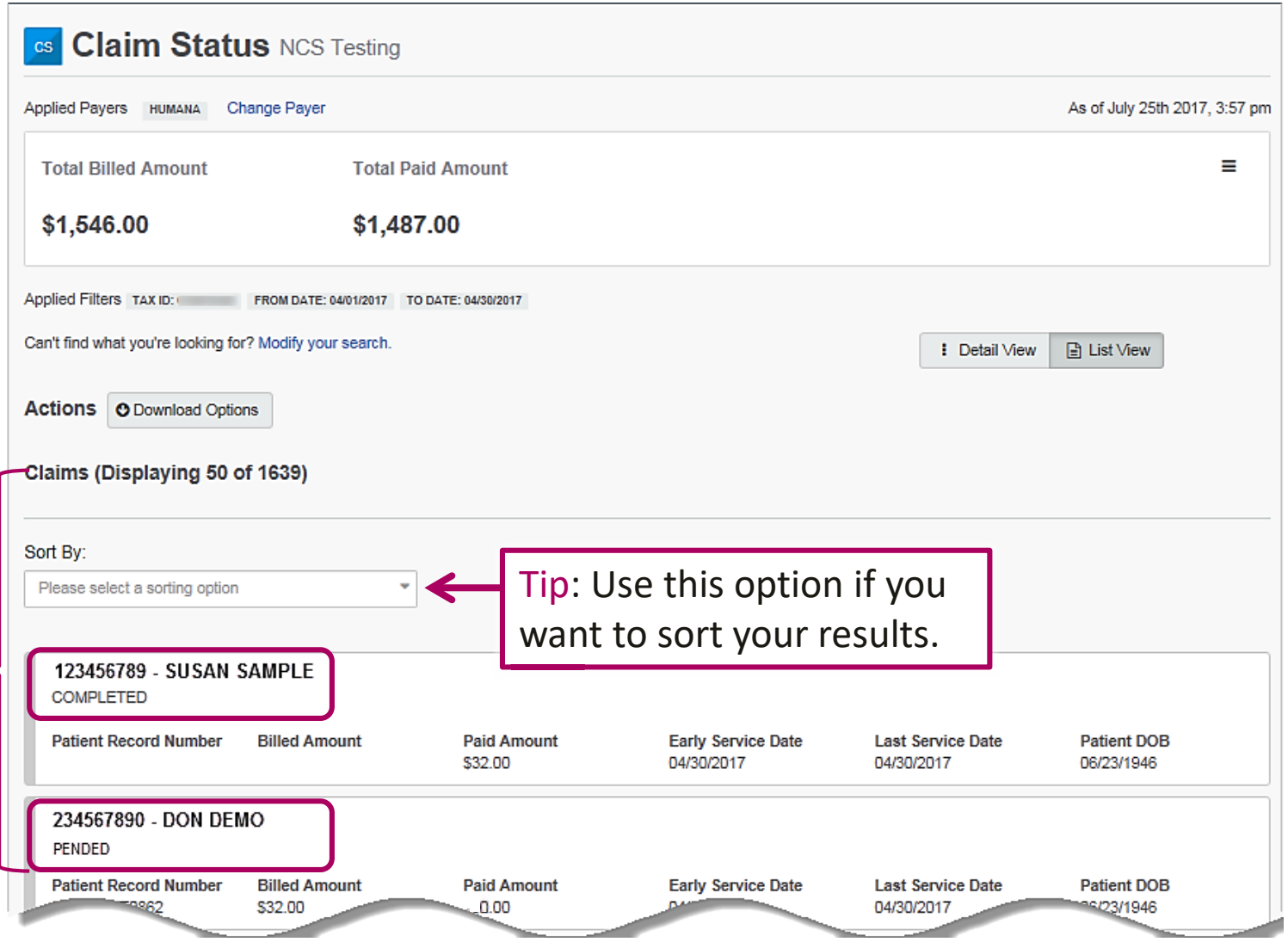
About tax IDs



Reviewing search results

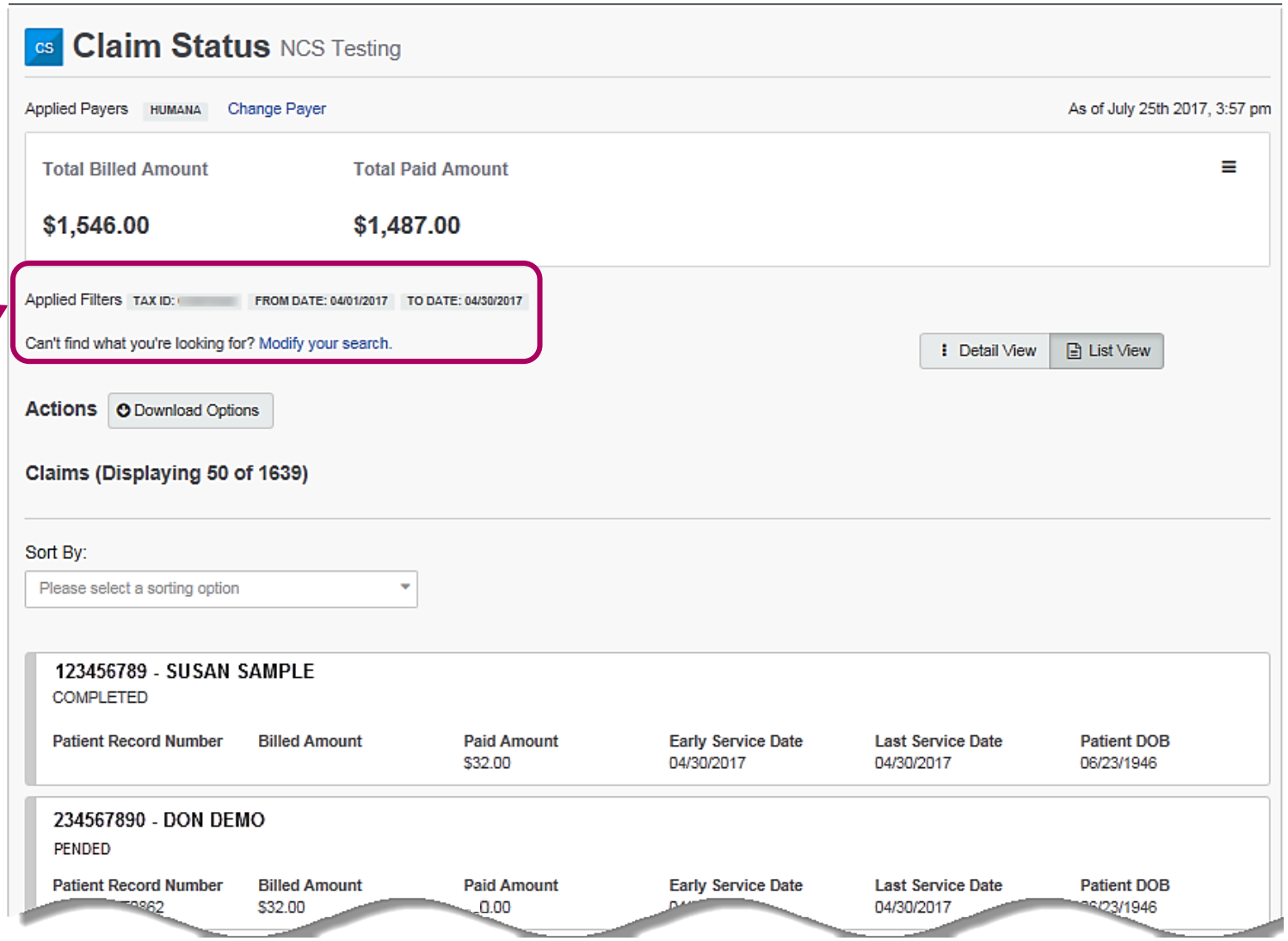
Viewing your search results

Claims that match your search.



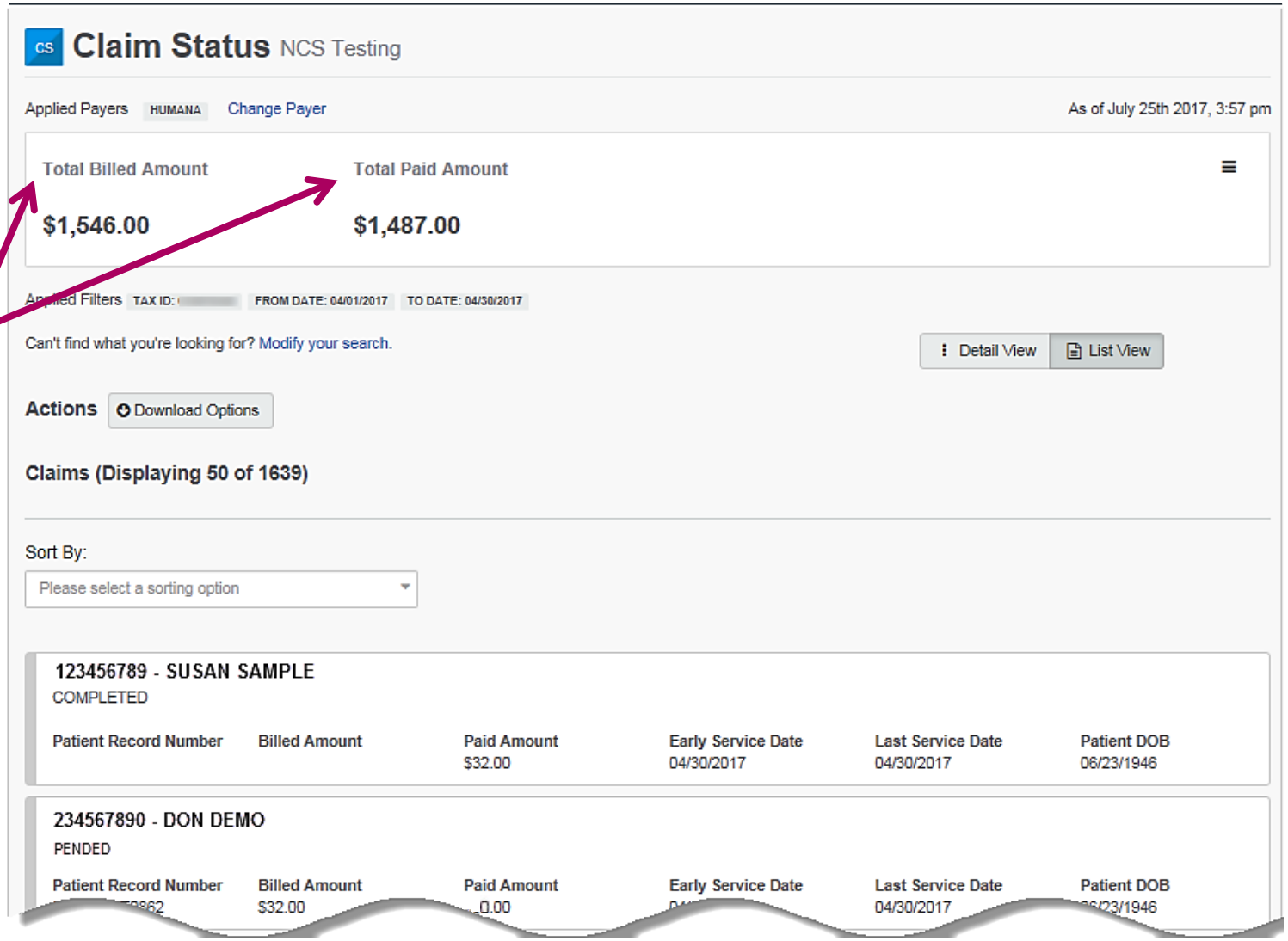
Tip: Changing your search

Review or modify your search selections here.



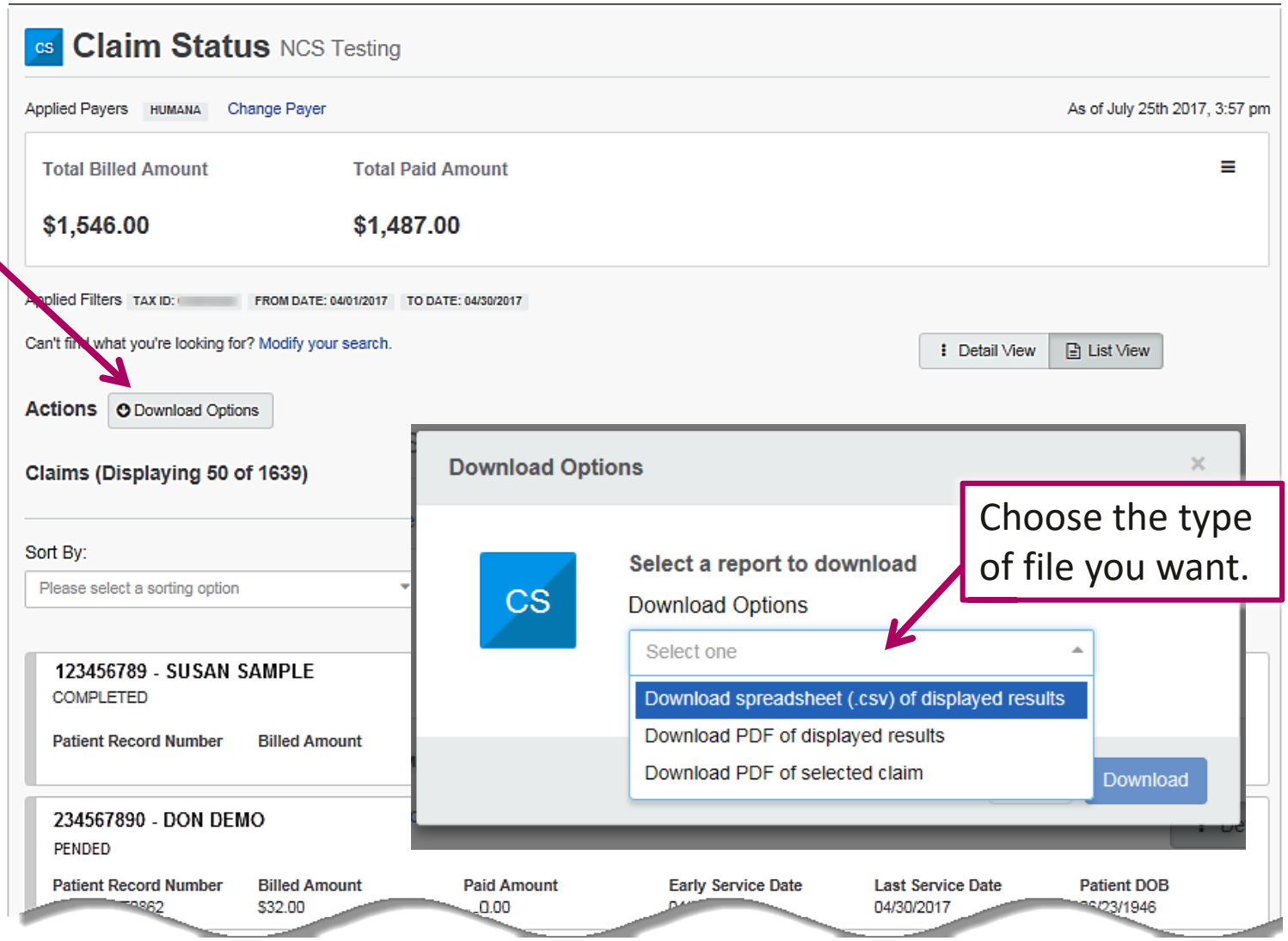
Viewing total amounts billed and paid

Displays the total amounts billed and paid to date for these claims.



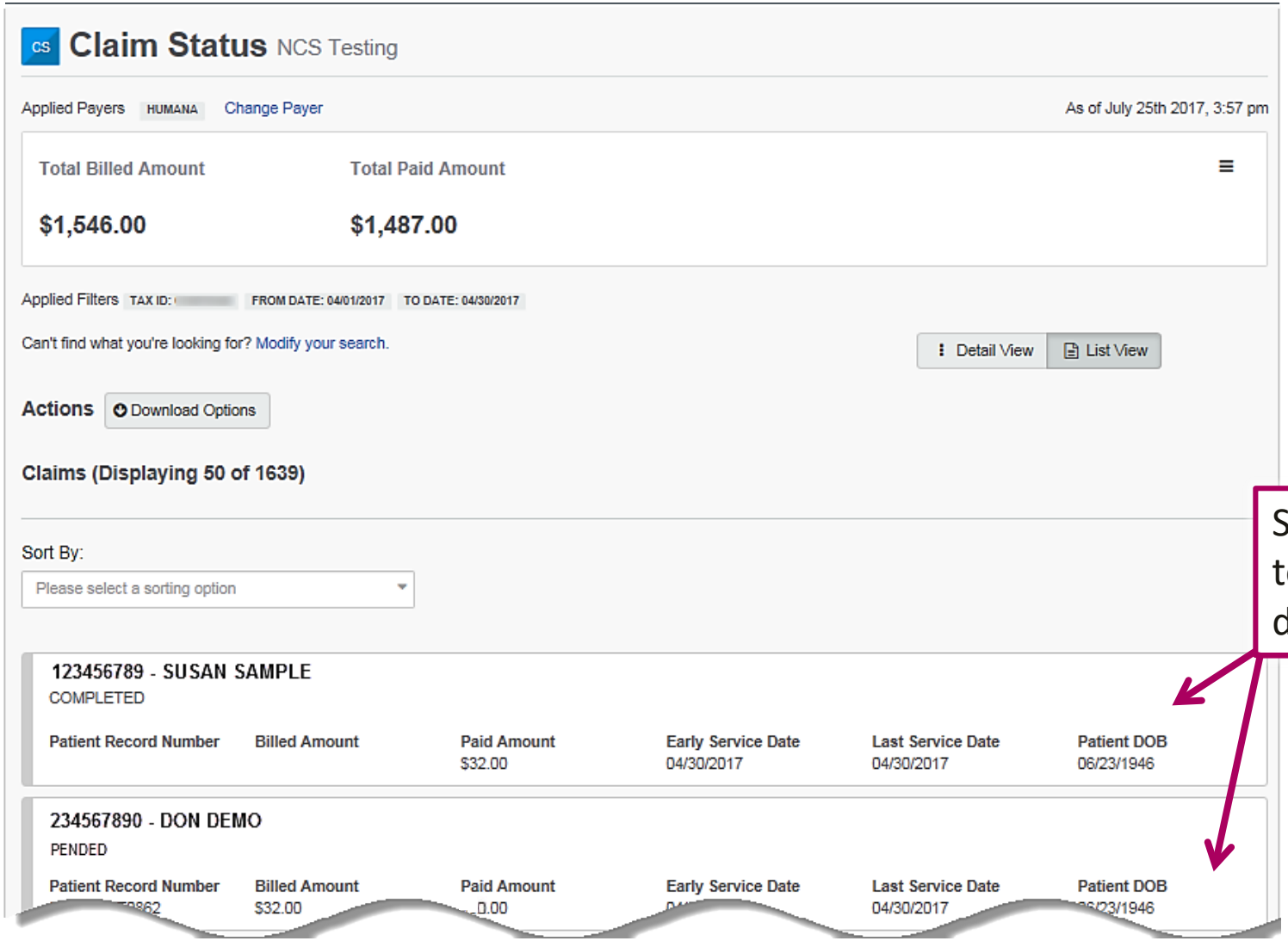
Downloading or printing your results

Select "Download Options."

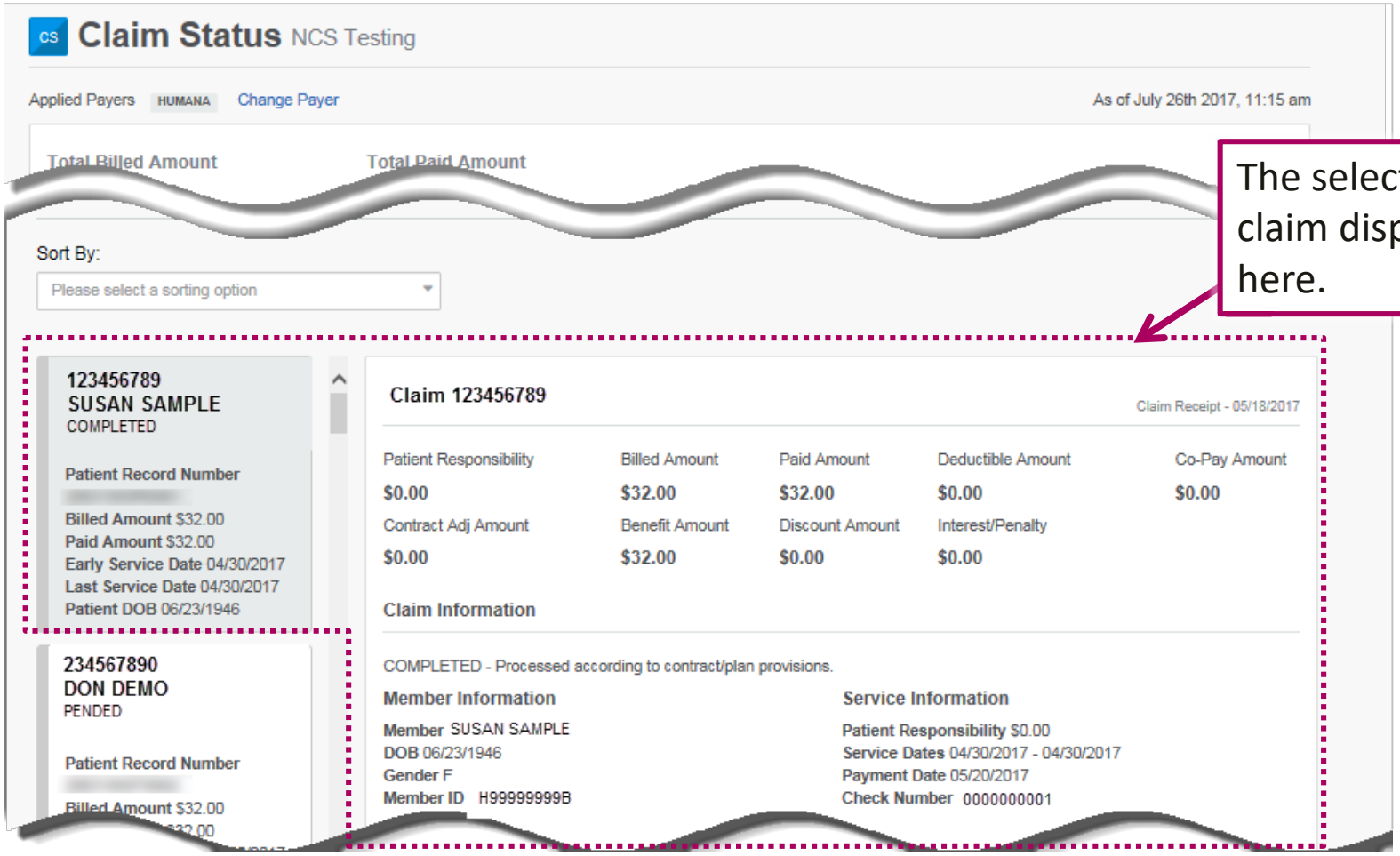


Reviewing claim details

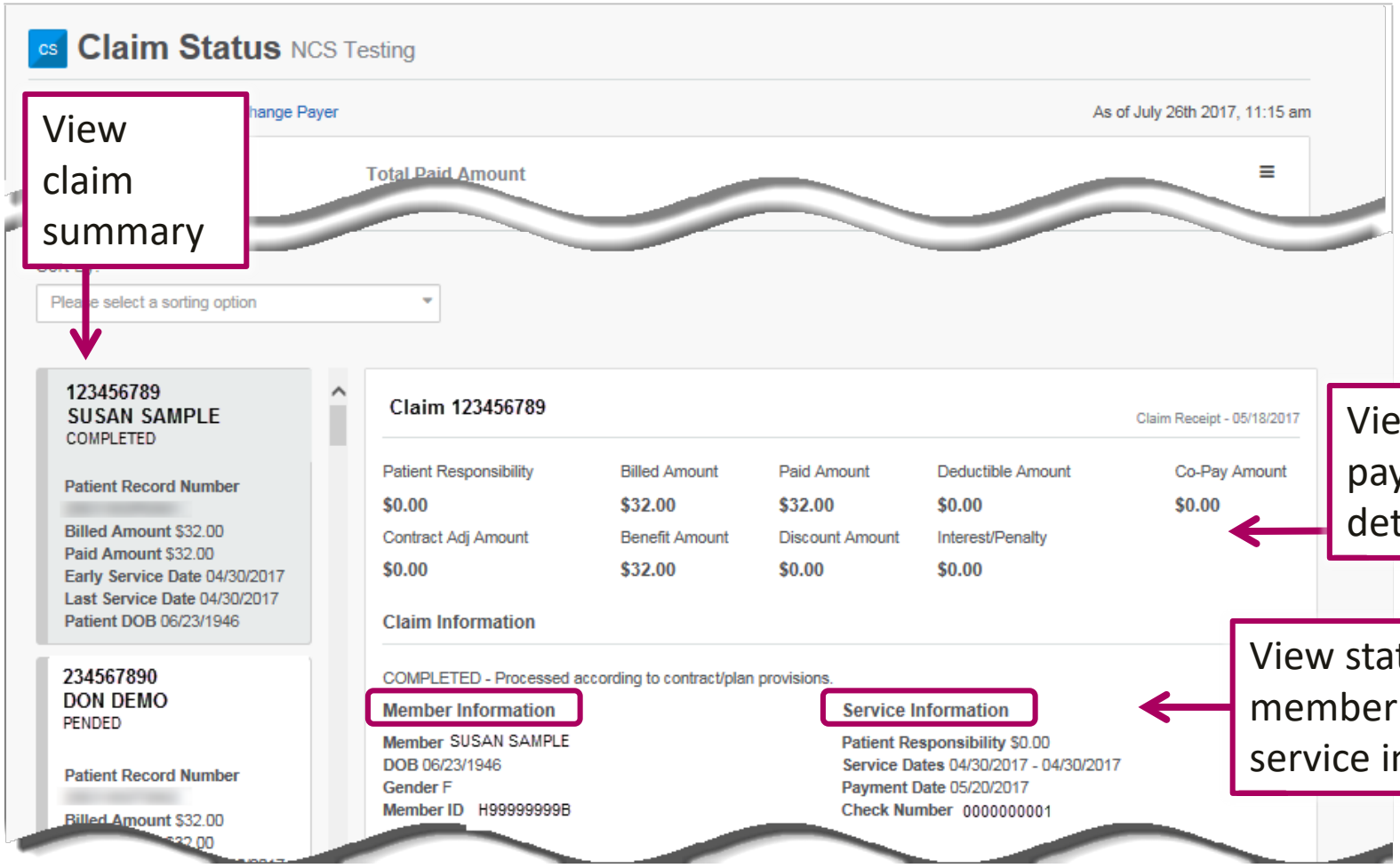
Opening the detail view of a claim



Viewing claim details: a “card” approach



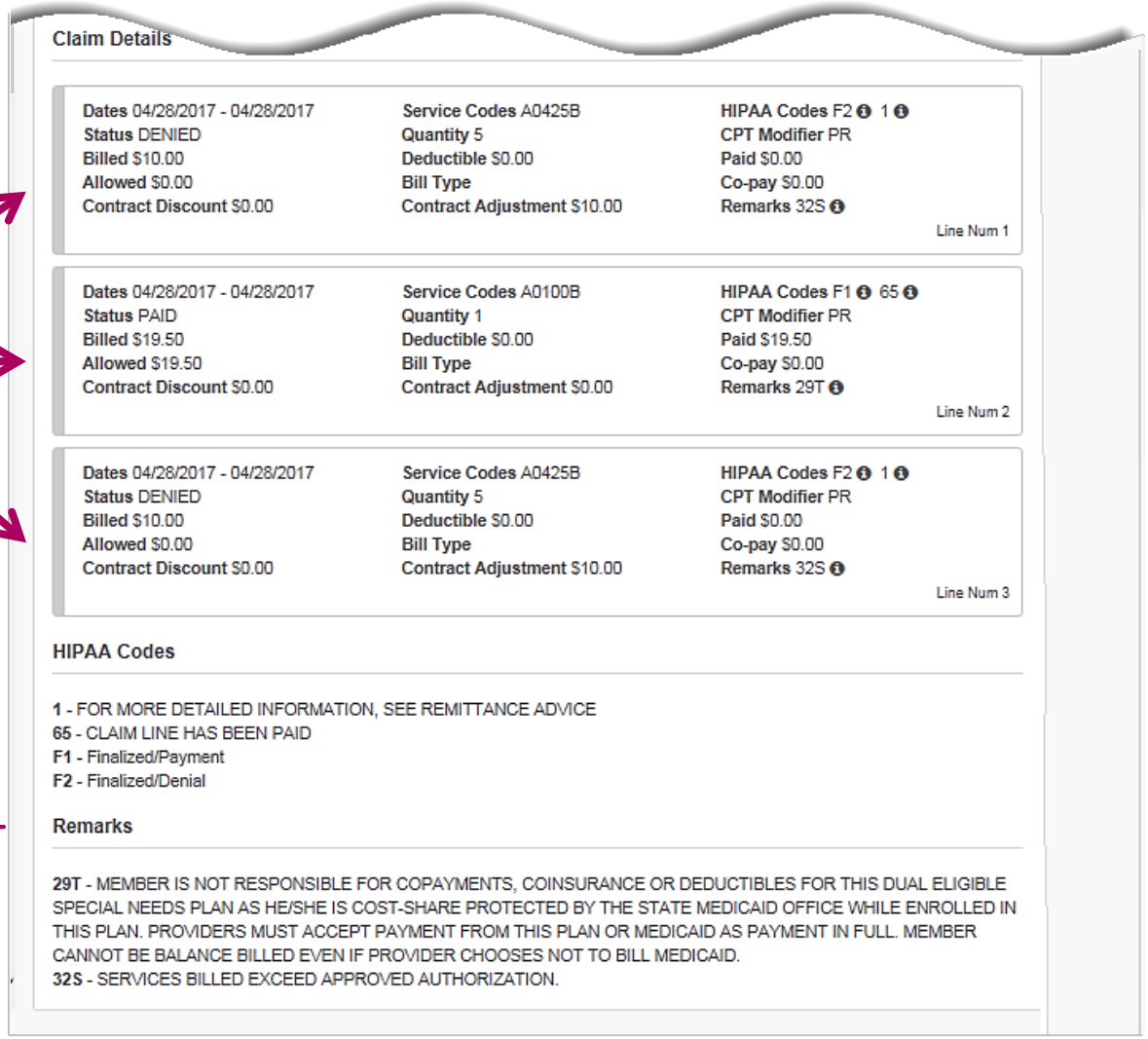
Viewing more claim details



Viewing claim line details

View details for each claim line, including HIPAA codes and remarks.

View definitions for HIPAA codes and remarks.



Claim Details

Dates 04/28/2017 - 04/28/2017	**Service Codes** A0425B	**HIPAA Codes** F2 1
Status DENIED	**Quantity** 5	**CPT Modifier** PR
Billed $10.00	**Deductible** $0.00	**Paid** $0.00
Allowed $0.00	**Bill Type**	**Co-pay** $0.00
Contract Discount $0.00	**Contract Adjustment** $10.00	**Remarks** 32S

Line Num 1

Dates 04/28/2017 - 04/28/2017	**Service Codes** A0100B	**HIPAA Codes** F1 65
Status PAID	**Quantity** 1	**CPT Modifier** PR
Billed $19.50	**Deductible** $0.00	**Paid** $19.50
Allowed $19.50	**Bill Type**	**Co-pay** $0.00
Contract Discount $0.00	**Contract Adjustment** $0.00	**Remarks** 29T

Line Num 2

Dates 04/28/2017 - 04/28/2017	**Service Codes** A0425B	**HIPAA Codes** F2 1
Status DENIED	**Quantity** 5	**CPT Modifier** PR
Billed $10.00	**Deductible** $0.00	**Paid** $0.00
Allowed $0.00	**Bill Type**	**Co-pay** $0.00
Contract Discount $0.00	**Contract Adjustment** $10.00	**Remarks** 32S

Line Num 3

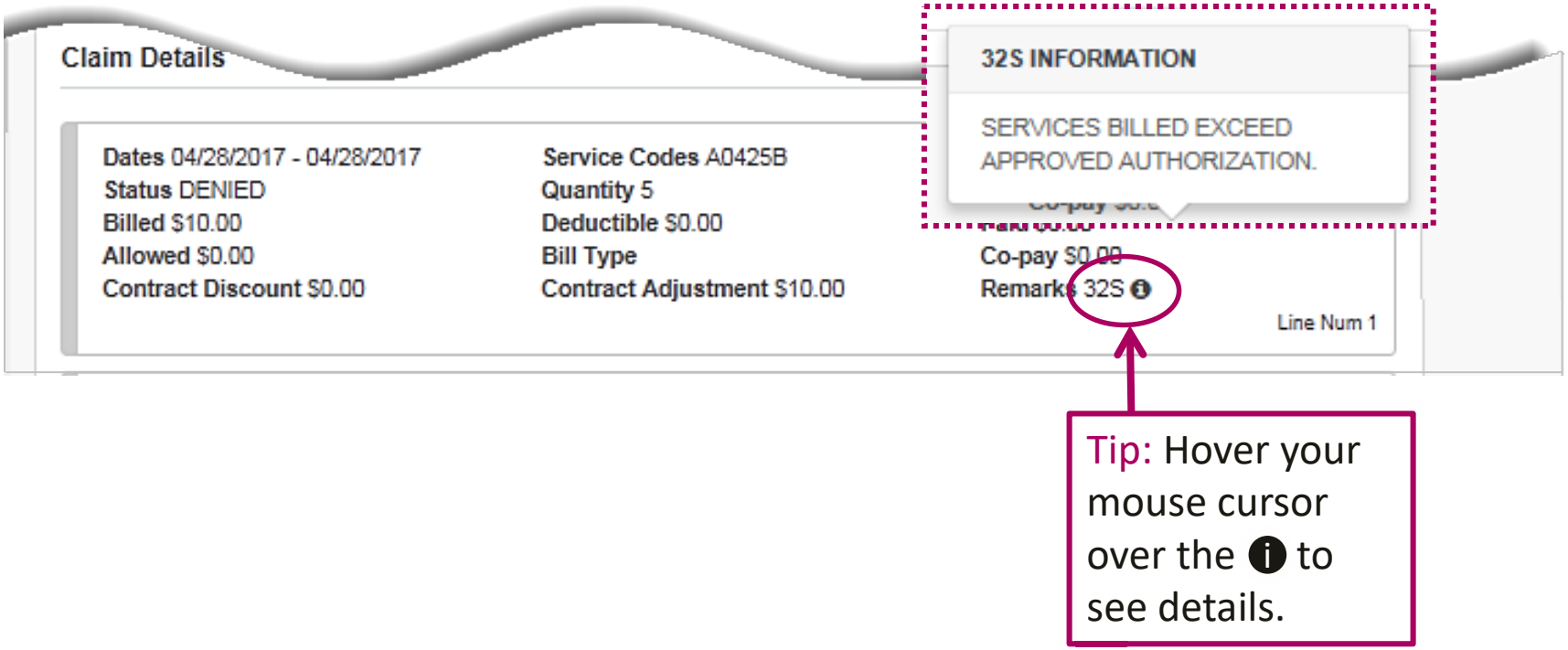
HIPAA Codes

1 - FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE
65 - CLAIM LINE HAS BEEN PAID
F1 - Finalized/Payment
F2 - Finalized/Denial

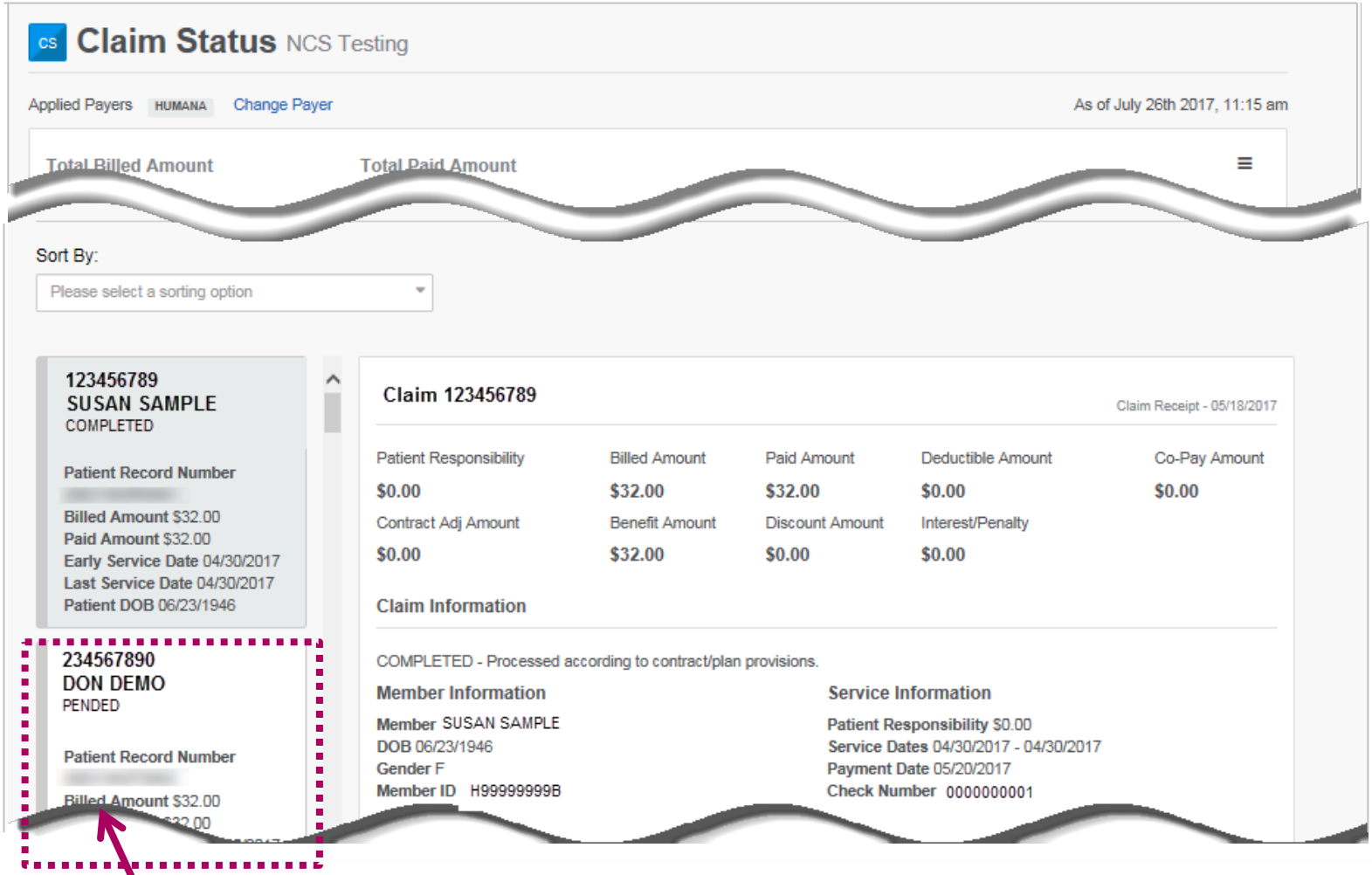
Remarks

29T - MEMBER IS NOT RESPONSIBLE FOR COPAYMENTS, COINSURANCE OR DEDUCTIBLES FOR THIS DUAL ELIGIBLE SPECIAL NEEDS PLAN AS HE/SHE IS COST-SHARE PROTECTED BY THE STATE MEDICAID OFFICE WHILE ENROLLED IN THIS PLAN. PROVIDERS MUST ACCEPT PAYMENT FROM THIS PLAN OR MEDICAID AS PAYMENT IN FULL. MEMBER CANNOT BE BALANCE BILLED EVEN IF PROVIDER CHOOSES NOT TO BILL MEDICAID.
32S - SERVICES BILLED EXCEED APPROVED AUTHORIZATION.

Tip: Viewing HIPAA codes and remarks as a mouseover



Viewing additional claims: a “card” approach

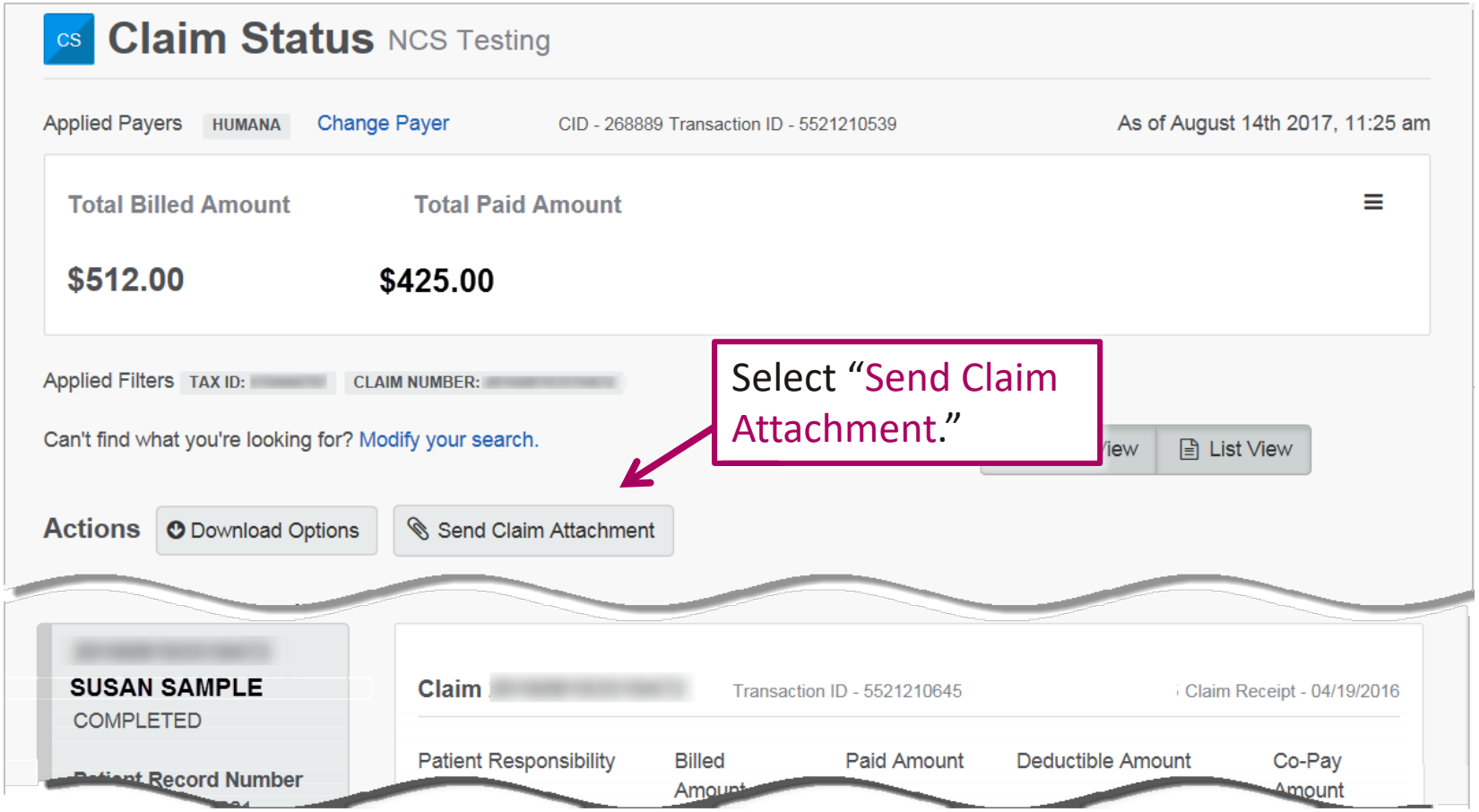


Tip: To view another claim from your search results, scroll and click the one you want.

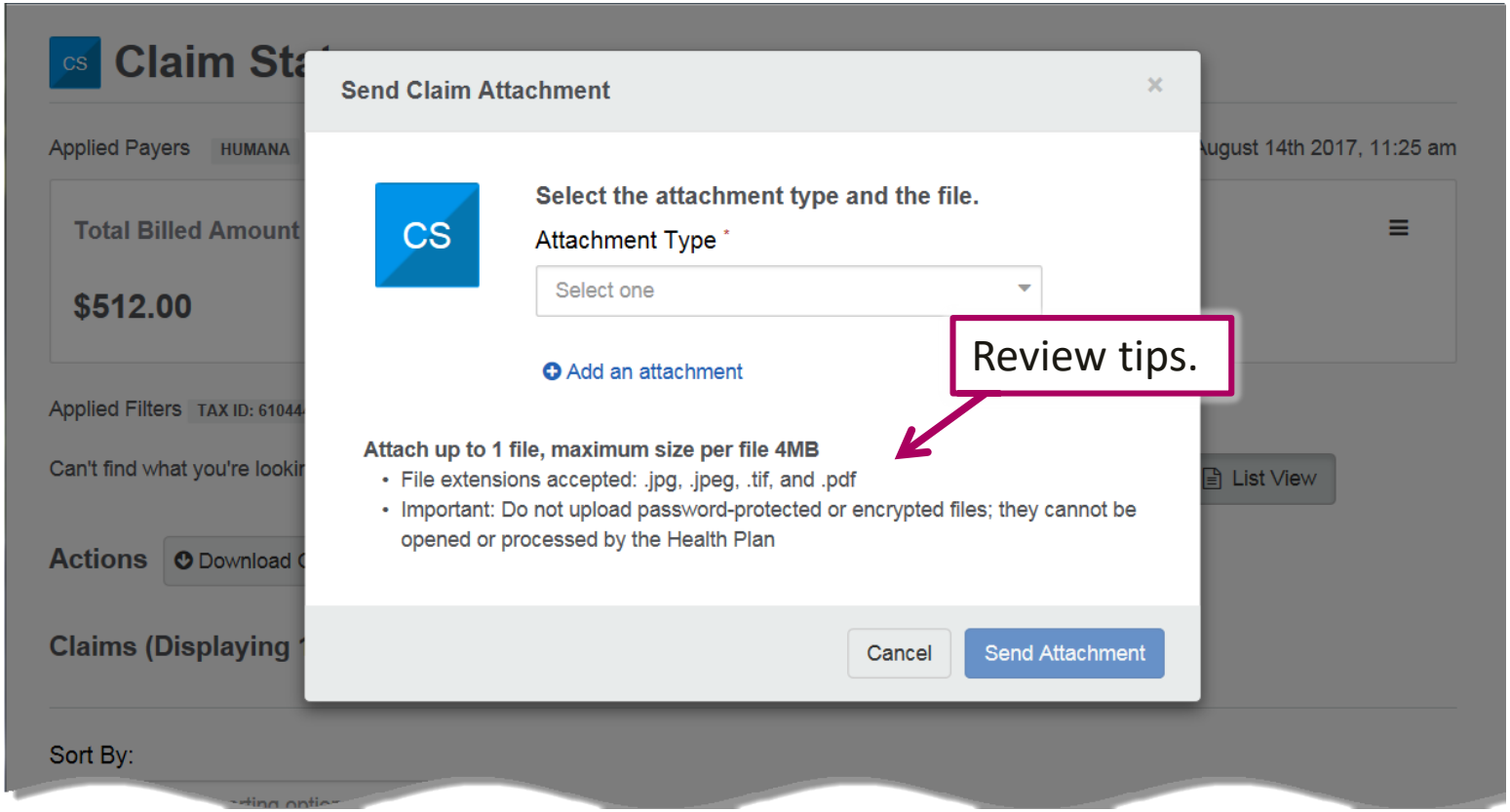
Sending an attachment

Humana®

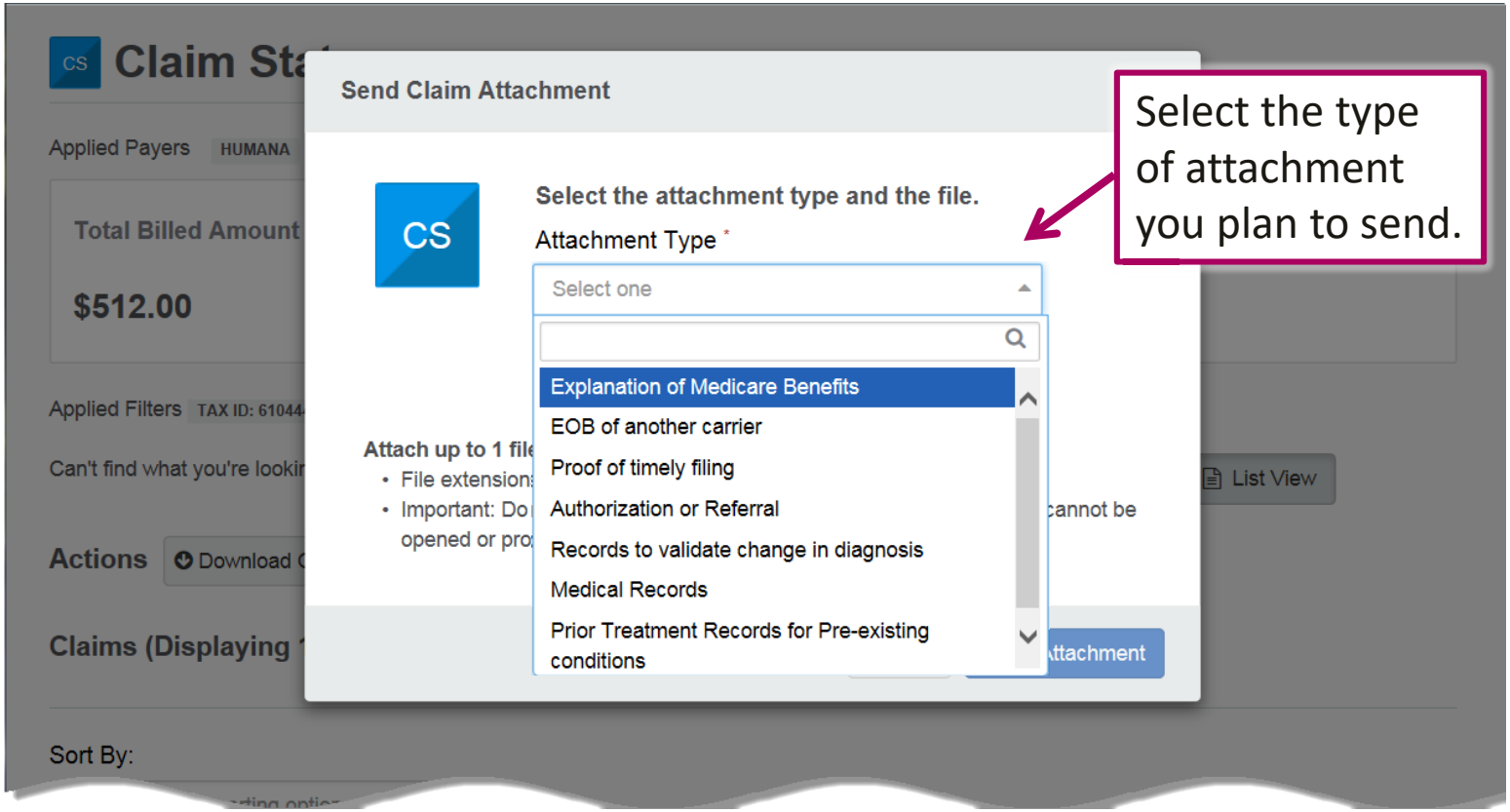
Locating the Send Claim Attachment button



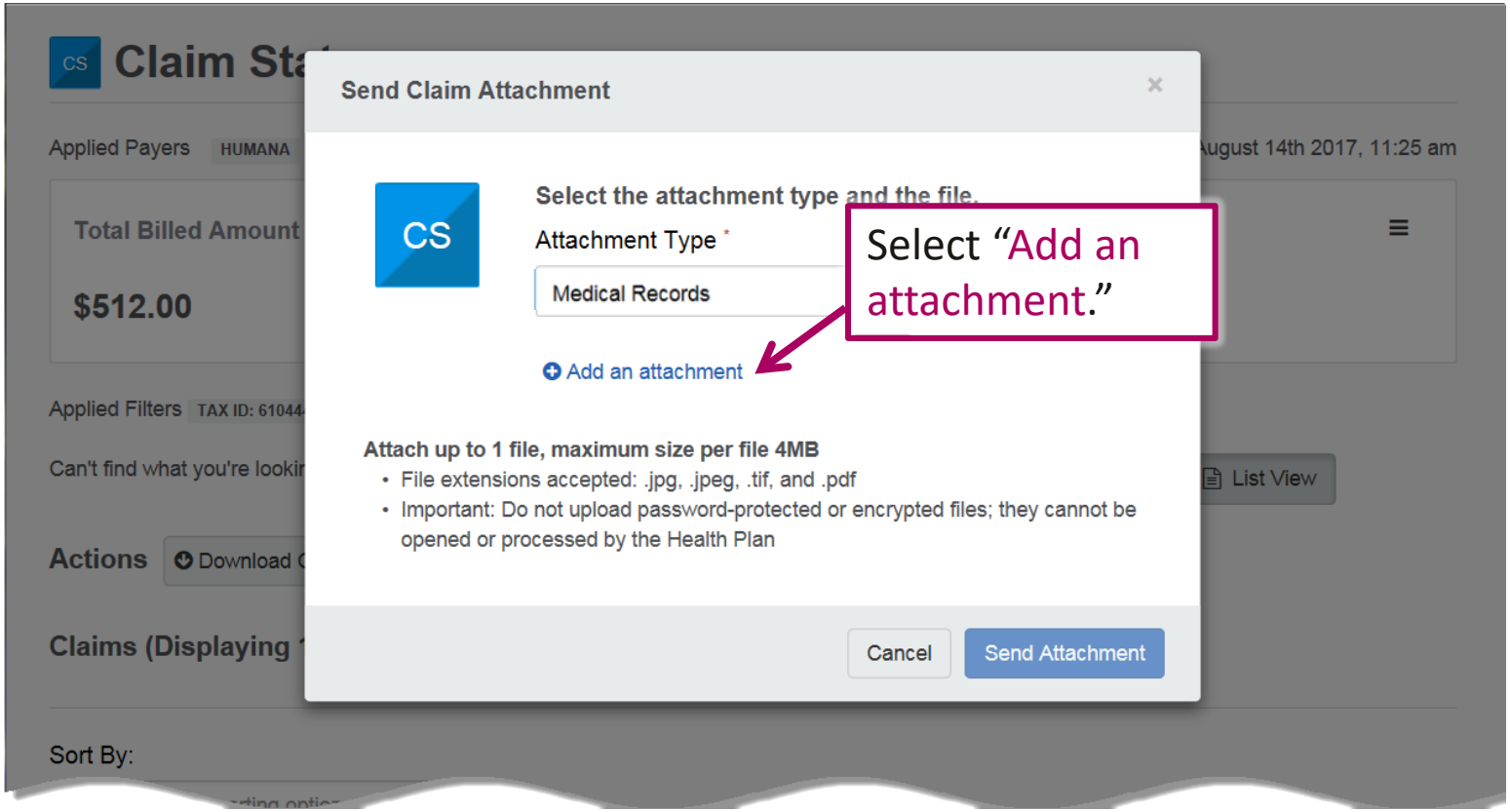
Reviewing attachment tips



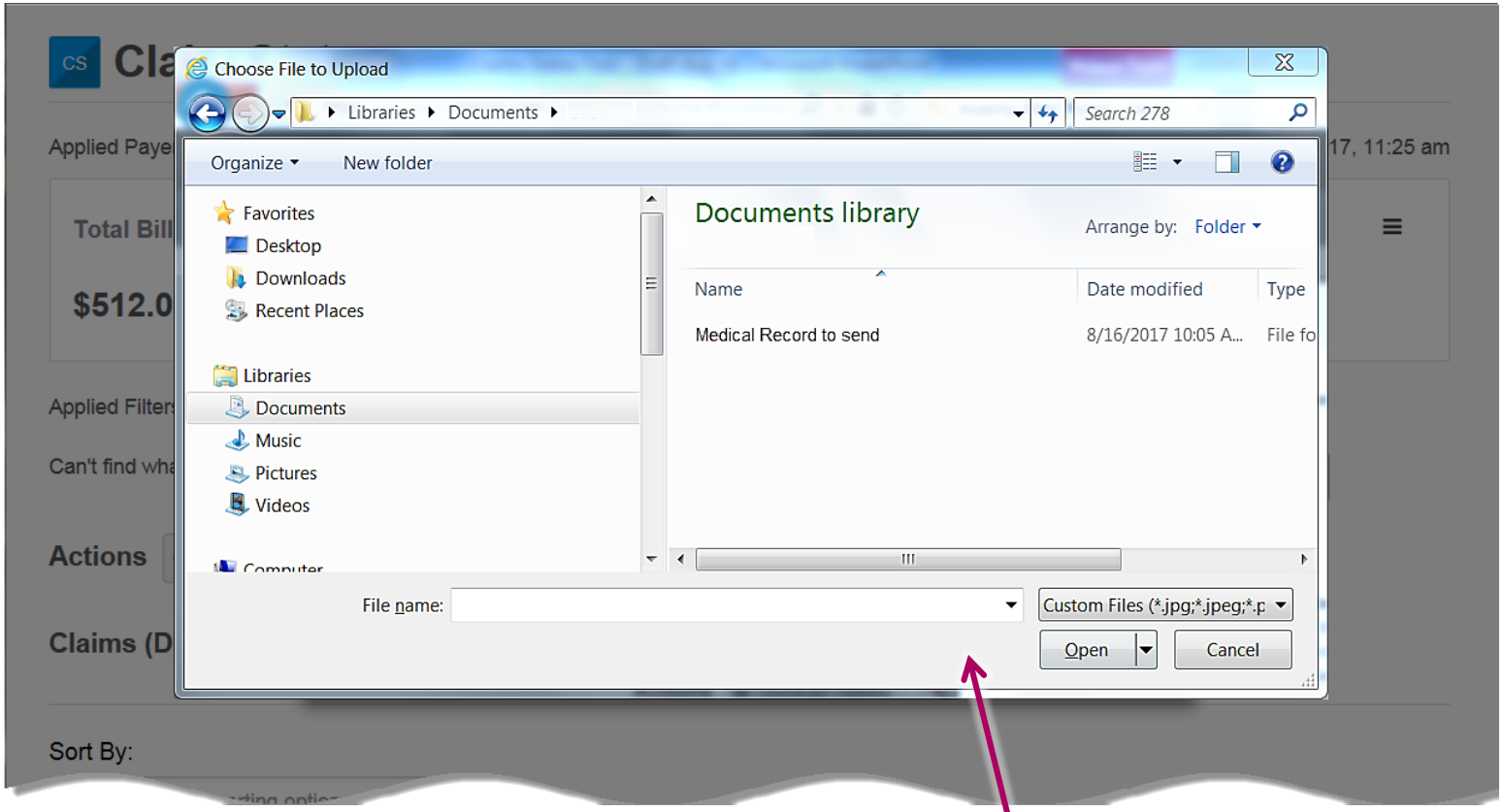
Selecting the type of attachment



Adding the attachment

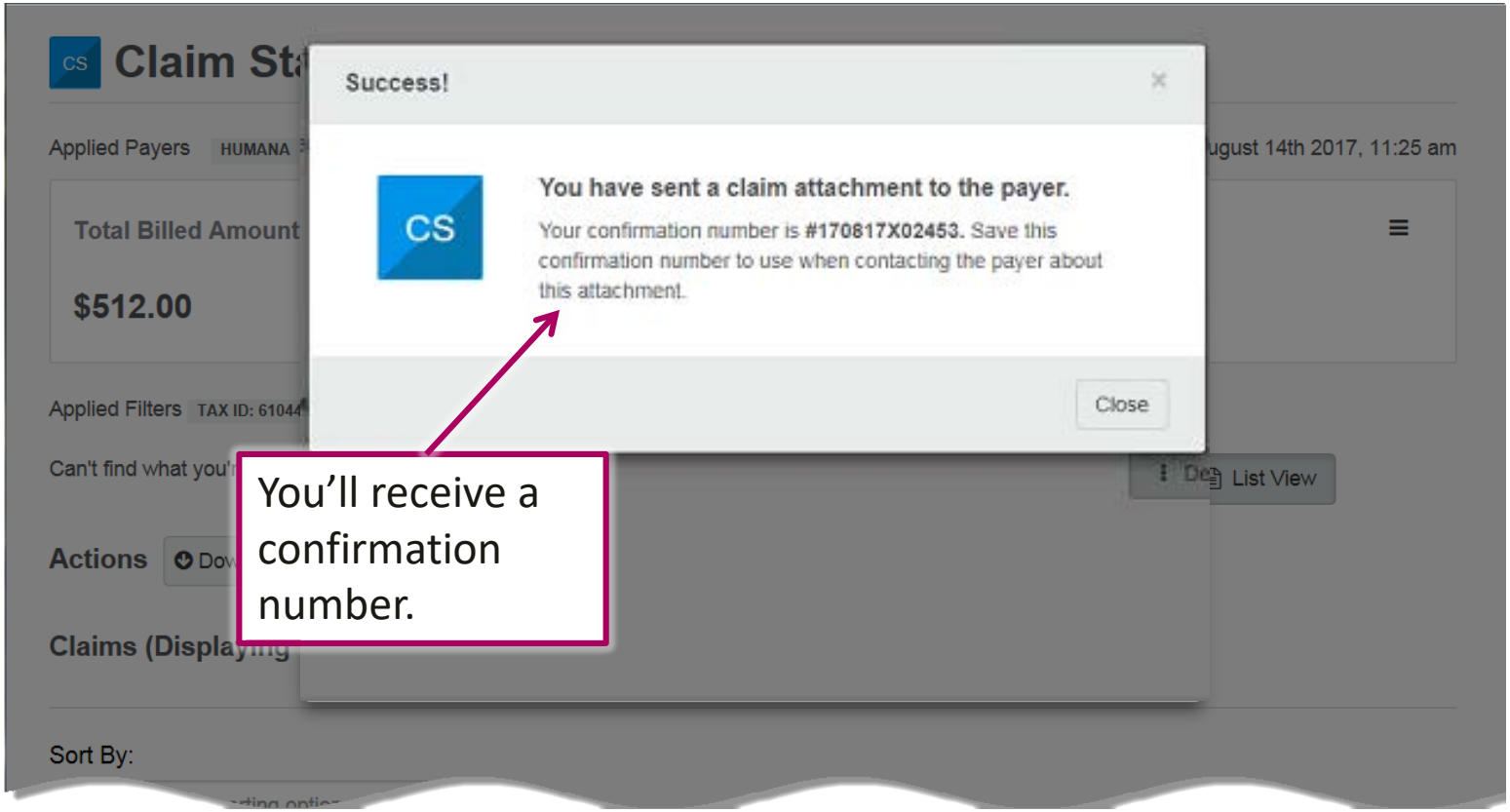


Uploading the attachment



Locate and select the file you want to send.

Confirming the attachment was sent



Tip: Once you've sent an attachment, the "Send Claim Attachment" button will no longer appear on the screen.

Helpful contacts and resources

Working with Humana online	**eBusiness team** www.Humana.com/ProviderSelfService
Availity Portal	**Availity Client Services** Phone: 1-800-AVAILITY (1-800-282-4548)
Other	**Humana customer service** Phone: 1-800-448-6262

E. DELIVERY SYSTEM COORDINATION

SRC# 18 – Utilization Management (Statewide):

The respondent shall describe the following related to its utilization management (UM) approach:

a. A description of the process used to determine whether a service should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid benefit.

b. A description of how the respondent will ensure consistent application of the review criteria for authorization decisions.

c. A description of how the respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.

d. A description of the approach used to determine whether a service will be needed short-term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the respondent's service authorization approach (if any exists) based on the length of time that the service will be needed.

e. To the extent that a service is needed long-term, a description of the strategies that the respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.

f. A description and example of how the respondent will detect, monitor and evaluate under-utilization, over-utilization and inappropriate utilization as well as processes to identify and address opportunities for improvement.

Response:

Humana uses a dynamic Utilization Management (UM) program to provide comprehensive delivery of health care services and to 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 and behavioral health, long-term services and supports (LTSS), and pharmaceutical management in all phases of the program. Our approach 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 for both acute and long-term facility stays. Our UM approach includes the following aspects:

- Prior Authorization List (PAL) and review processes

- Consistent review of UM decisions based on established national clinical guidelines and protocols

- Application of medical necessity criteria to ensure services are not arbitrarily reduced or denied

- Policies and procedures in place to analyze data to monitor and track utilization trends, including over- and under-utilization and inappropriate utilization

The Humana UM program includes evaluation of clinical utilization guidelines and criteria, patterns of utilization, analysis of population-based and evidence-based data, and the intervention of programs to positively affect health outcomes.

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1. The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.

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PRIOR AUTHORIZATION SERVICE DETERMINATION PROCESS

Humana's prior authorization program promotes quality of care and optimal treatment options for our enrollees while controlling costs to the healthcare delivery system. Ongoing review of utilization, financial and quality data, and the Agency for Health Care Administration (AHCA) fee schedule determines those services that require prior authorization for payment. We implement a PAL in our current comprehensive program in Florida. Attachment SRC 18-1 illustrates the Humana UM processes workflows for outpatient, inpatient, behavioral health, and dental service requests. We review and authorize LTSS services as they are added to the enrollee's plan of care.

PAL AND REVIEWED SERVICES LIST PROCESSES (RSL)

The PAL and RSL represent commonly reviewed services and medications that may require additional clinical information. The PAL conveys the service names that must have prior authorizations, while the RSL conveys the code-level information for those services included on the PAL.

For our Medicaid programs, providers must provide services according to the contractually required guidelines, including Federal Managed Medicaid Care Statutes as well as State Regulatory Guidance. We use MCG® (formerly known as Milliman Care Guidelines), a nationally-recognized medical review criteria, as the primary source for our UM policies. We also apply State-specific requirements for medical necessity, and all services are subject to review for coverage and medical necessity. Additionally, we request (but do not require) service notification for certain services, such as inpatient maternity for normal newborn deliver. This is done so we can refer enrollees to appropriate care management and disease management programs.

Humana uses specific metrics to determine whether to include a requested service in the PAL. These metrics include:

- Over-utilization and inappropriate utilization

- Potential quality of care issues
- Trend of services not meeting nationally-recognized criteria for medical necessity
- Current claims volume for the service
- Projected enrollee impact

The PAL team conducts service reviews to determine which services should be included on the PAL. The team includes representatives from the following departments:

- Clinical and Quality Leadership and teams
- Provider Network
- Clinical Strategies
- Clinical Intake Team (CIT)
- Grievance and Appeals
- Provider Communications
- Claims
- Product Build
- Plan Load

Any stakeholder (including network providers) can raise a PAL issue or propose an addition ro or removal from our PAL by filling out a request form. We also elicit provider feedback on our authorization processes using provider surveys and peer-to-peer discussions between providers and Humana Medical Directors regarding specific authorizations.

Once we have submitted a request, the PAL team follows the process illustrated in Attachment SRC 18-2.

Clinical leaders evaluate the PAL on a bi-annual basis for additions and removals based on utilization patterns and any quality of care issues present. Providers receive annual notification of the PAL via a mailing and receive a mail notification from Humana ninety (90) days in advance of any change to the list, however the PAL and RSL are always available on our website at https://www.humana.com/provider/medical-providers/education/claims/pre-authorization. Humana periodically communicates the corresponding procedures and required timeframes for prior authorizations. Attachment 18-3 illustrates our process for ongoing maintenance of the PAL.

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2. The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.

==========

Humana's UM program is evidence-based and guided by nationally-recognized clinical care criteria. We utilize MCG® and updated annually, as the foundation of all UM determinations. When necessary, we supplement the MCG® guidelines with clinically sound and reputable Clinical Practice Guidelines (CPG), which the Corporate Quality Improvement Committee (CQIC) reviews and approves annually. CPG provides a basis for written policies and procedures that reflect current standards of medical practice. We base these guidelines on community-based practice guidelines and literature established by national organizations generally accepted in their fields as experts such as the:

- 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)
- National Quality Forum (NQF)
- Guidelines.gov

We also utilize the Centers for Medicare and Medicaid Services (CMS) Medicare guidelines for our enrollees with Long-term Care (LTC) needs to determine appropriate coordination of care and benefits for Humana dual eligible enrollees. The LTC Case Managers (CMs) are responsible for case management of services and benefits specific to the enrollee. If necessary, the LTC CM will review Medicare benefits and guidelines to ensure enrollees receive necessary services.

We base all review and authorization decisions on the information collected at the time of the request. When conducting reviews, the utilization review associate accepts information from any reliable source that will assist in the certification process. Requests focus on the information required to render a review decision or assist with discharge planning. We use any information obtained during this process solely for the purposes of utilization management, quality management, discharge planning, case management, and claims payment.

Clinical associates and medical directors use these criteria, which apply for all care acuity levels. In no way are they to replace the clinical judgment of the clinical associates or the Medical Directors. UM review nurses approve services if they meet MCG® criteria.

Humana Medicaid Hierarchy of Criteria for Review of Medical Services (all apply):

1. MCG®
2. Medicaid Coverage Handbook and Medicaid Enrollee’s Contract
3. State-specific Medicaid Regulations
4. Humana Coverage Policies

Medical Directors use MCG® criteria as part of their cadre of information, and rely on clinical judgment to render a decision based on medical necessity. Medical Directors are the only clinical associates that can render adverse determination.

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

- Age
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Co-morbidity
- Progress of treatment

- Complications
- Psychosocial situations
- Home environment
- Cultural needs

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 such as surgicenters versus inpatient surgery

We understand there cannot be a one-size-fits-all approach to determining the appropriate services for all our enrollees. Humana applies an established set of UM guidelines and criteria along with enrollee-specific information to ensure we are flexible and meeting their needs.

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3. The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for plan staff and network providers).

==========

Humana’s shared national local structure allows us to use consistent and centralized national resources while maintaining flexibility to build policies and procedures to specifically meet local market needs. The Corporate Utilization Management Committee develops, implements, and maintains operational policies and procedures consistent with federal, state, regulatory, accrediting, and corporate guidelines. The Policy Sub Team Committee reviews new policies or policy revisions before sending to the Utilization Management Committee for final approval.

Currently in our Florida Comprehensive Medicaid operations, the Utilization Management Committee is responsible for developing and maintaining Florida-specific policies and procedures. The Florida Medical Director, the Health Services Director, and Utilization Management Director or the local Utilization Management Committee review and approve Florida-specific policies developed for processes specific to our comprehensive program at least annually, and revise as necessary.

UM ASSOCIATE TRAINING

To ensure we consistently apply review criteria for authorization decisions, Humana provides initial and ongoing education for its CMs, UM associates, and network providers regarding our UM program, including clinical guidelines and determination of medical necessity. All case management associates receive new hire and refresher training on UM processes. Upon completion of initial training, new associates team up with a peer for mentoring and continued

support. We also provide all CMs with a new hire orientation packet that includes Policies and Procedures regarding UM processes.

We notify associates when we review and revise policies and procedures and review them individually, as teams, or through special in-service updates. A shared site, Mentor, houses policies and procedures that link to the Health Services Organization (HSO) Guidance Exchange SharePoint site.

INTER-RATER RELIABILITY (IRR) AND EVALUATING CONSISTENCY OF UM DECISIONS
All medical necessity determinations are under the guidance of a licensed physician. Florida licensed healthcare associates, including but not limited to physicians, nurses, and other Florida licensed professionals, make UM decisions that require review.

Assessing consistency in the UM decision-making process is critical to uniform application of medical necessity by physicians and non-physician reviewers. Since non-physician reviewers cannot deny a request for services, it is essential that these associates know the criteria that will allow them to approve a request. Each year Humana conducts testing of these reviewers using methods endorsed by National Committee for Quality Assurance (NCQA). We create hypothetical cases that mimic the types of cases we typically present to our reviewers. Each case (question) has a clinical stem serving as the basis for a selection of choices by the reviewer (examinee). The hypothetical cases focus on the application of Medicaid policies and MCG® criteria, and we review the cases and preferred answers with examinees. Non-physician associates must obtain a passing grade of eighty percent (80%). If they score less than eighty percent (80%), they will re-take an examination. If they again score less than eighty percent (80%), they will undergo additional training.

In contrast, physician reviewers render decisions to approve or deny based on medical necessity, clinical judgment, and knowledge of clinical guidelines and practice patterns in local communities. To identify consistency of physician decisions we employ IRR using a multiple-choice examination based on de-identified cases or hypothetical questions. We then calculate a kappa statistic to evaluate the level of agreement on each item. We consider a kappa equal to or greater than zero point eight (0.8) good agreement; for items with a kappa less than zero point eight (0.8), the group of physician reviewers will review and discuss to improve the quality of our reviews.

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 in our Florida Comprehensive Medicaid program 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, behavioral health, and LTC nurses 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, identification of trends, and sharing of quality improvement ideas. The goal is to ensure consistent application of criteria, decision-making, and implementation of best practices among the UM clinical teams.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

ENGAGING PROVIDERS IN THE UM PROCESSES

The Humana UM program works with providers in the planning, implementation, coordination, and delivery of quality healthcare services. We accomplish this through:

- Adoption and establishment of medical necessity guidelines and criteria that promote quality and cost-effective care, which we make available to providers upon request or as appropriate

- Monitoring of healthcare services provided to enrollees

- Assessment, evaluation, and coordination of medically necessary care and the appropriateness of care requested and delivered using established approved written criteria to ensure efficient use of resources

- Promotion of fair and consistent benefit coverage

- Collaboration with local health delivery systems to align initiatives and facilitate program success

- Ensuring outcome-based, cost-effective care of individual enrollees given their current clinical situation and support systems available

- Providing proactive interface with practitioners and providers regarding discharge planning

- Acting as a referral source for identification of case management needs and identifying potential gaps in care

- Identification of enrollees with long-term or disease-specific care needs for case/disease management

Humana also provides education and training for its network providers to ensure that they understand Humana's policies regarding UM. Providers must have authorizations prior to providing services to Humana enrollees except in certain situations, such as emergency circumstances, where we do not require prior approval. The Provider Manual, which we deliver to all network providers, clearly outlines information related to UM. Humana also contractually requires its providers to conduct UM-related training for staff at their facility. Attachment 18-4 contains the excerpt of our provider training that pertains to preauthorization determinations.

DELEGATION OF UM FUNCTIONS AND OVERSIGHT

While Humana's UM program houses most UM functions, there are circumstances under which we would delegate certain UM functions to another entity, such as a subcontractor. For our Florida Comprehensive Medicaid Program, Humana will delegate behavioral health UM functions to our behavioral health subcontractors, Access Behavioral Health (in Regions 1 and 2) and Beacon Health Options (in Regions 3 through 11). (We delegate pharmacy prior authorization to an internal common parrent affiliate entity, Humana Pharmacy Solutions ® (HPS)).

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Although we may delegate the authority to perform a function, the responsibility for the function remains with Humana. We have aligned our policies involving delegation with those of the NCQA and CMS. Prior to approval of delegation, certain pre-delegation activities may include:

- Review of the proposed delegates' program description, work plan, and most recent evaluation

- Review of proposed delegates' policies and procedures

- Pre-delegation audit to determine if the proposed delegate can adequately perform the function(s) to be delegated

- Review of appropriate committee minutes

- Review of organizational chart and job descriptions

- Blinded medical record review, if applicable

- Completion of Humana Pre-Delegation Tool for the proposed delegated function

Humana reviews the contractual language, develops clear delineation of the agreed-upon activities, outlines the delegate's accountability for these activities, determines the type and frequency of reporting to Humana, and determines the process by which we will evaluate the delegation prior to the delegation of the requested UM function.

The contract language includes the following:

- The delegated activities and those activities retained by Humana

- Requirement that services be performed in accordance with Humana's and regulatory requirements and accreditation standards

- Notification to Humana of any material change in the entity's performance of delegated functions

- Sub-delegates shall be subject to the terms of the agreement between the delegate and Humana

- Type and frequency of required reporting to Humana

- Process by which delegation will be evaluated

- Remedies available to Humana, including development of a corrective action plan (CAP), suspension of the delegated function, or termination of delegation if the delegate does not fulfill its obligations

Oversight activities consist of onsite visits, audits, and review of required reports and all relevant documentation related to specific delegation functions for compliance to Humana, regulatory, and accreditation standards. We expect regular presentation to the Florida Quality Improvement

Committee (QIC) and appropriate sub-committee, with certain committees requiring a defined position as a member. We will require implementation of corrective action or quality improvement plans if delegates only partially meet these standards, with re-review and ongoing oversight conducted until they have corrected the identified deficiencies. Oversight of delegation activities is an ongoing process, and may include the following:

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

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4. The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced.

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Humana has long established and tested mechanisms in place to ensure we do not arbitrarily or inappropriately deny or reduce in amount, duration, or scope any services. Our medical necessity review processes and procedures take into account all aspects of an enrollee's individual healthcare needs to determine which services and care setting is most appropriate.
Humana performs medical necessity reviews for those services for which we require an authorization and that the primary care provider, behavioral health provider, or treating provider requests an initial or extension of the original authorization. The first step in making a coverage and medical necessity determination is to verify benefits existed at the time of service, and that the plan benefits include the services. Humana complies with all federal and state regulations as well as the contractual requirements for covered and excluded services.

Florida licensed healthcare professionals initiate the UM process by reviewing medical record documentation against standardized medical necessity criteria for treatment and verifying appropriate levels and intensity of care. Licensed healthcare professionals may include appropriately qualified practitioners, in accordance with Florida laws.

According to Florida code, "medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational

4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide

5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

“Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not in itself make such care, goods, or services medically necessary, or a medical necessity or a covered service.

Humana utilizes MCG® Care Guidelines and Clinical Utilization Guidelines as well as the State of Florida’s rule requirements to ensure that services are medically necessary. We provide the enrollee the fullest extent of their benefits and services as specified by the Medicaid program. We refer all requests, pre-service, concurrent or retrospective, that don’t meet initial medical necessity review criteria, to the Medical Director for determination. Only the Medical Director can make an adverse determination based on medical necessity, which includes:

- Decisions about covered medical benefits defined by the organization, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits

- Decisions about care or services that could be considered either covered or non-covered, depending on the circumstances, including decisions on requests for care that may be considered experimental

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

- Treating or ordering physicians are offered an opportunity to discuss adverse utilization decisions with a Humana physician reviewer either while decision is pending or within the applicable timeframes after the determination has been made

We make specific criteria available upon request to enrollees or providers at no cost. Humana Medical Coverage Policies are available on Humana.com. We make MCG® Care Guidelines and Technology Assessment Forum research available, either verbally or in writing, to providers and enrollees (upon request) and communicate the process to obtain criteria annually in the provider newsletter, YourPractice. We also inform providers and enrollees of the clinical rationale used as the basis for a medical necessity determination in individual adverse determination letters.

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d. A description of the approach used to determine whether a service will be needed short-term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the respondent’s service authorization approach (if any exists) based on the length of time that the service will be needed.

6. The adequacy of the respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long-term (ongoing maintenance services/therapies).
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As a Comprehensive Plan, Humana provides a broad range of short- and long-term services for our enrollees. We are experienced in handling care needs for the entire spectrum of our enrollees' needs, from birth to end of life. The process we use to manage requests for services is the same for both short- term and long-term services, as we review authorizations based on medical necessity and individual enrollee needs. Furthermore, we have designed these processes to allow enrollees to focus on their health needs by reducing their administrative burdens that would otherwise delay needed care and cause adverse outcomes. We utilize and apply UM protocols in our review of authorizations, while considering enrollees' individual needs and being flexible when applying those protocols. For example, we evaluate enrollee needs based on the presenting condition and anticipated future needs. If an enrollee needs an in-home ventilator for the foreseeable future, we do not require a reauthorization every thirty (30) days. We issue an ongoing authorization to remove the burden on the provider as well as to ensure that enrollee has continuity in ongoing services.

Our UM protocols also allow for exceptions in certain circumstances, such as chronic conditions and developmental delays. An enrollee with a chronic condition requiring ongoing treatment, such as dialysis, would receive a long-term authorization for dialysis treatments. Similarly, if a child has been diagnosed with a developmental delay in speech, we would supply a longer-term authorization for speech therapy for that enrollee, understanding that this child's condition may take many months or even years to resolve. Our goal is to ensure enrollees receive medically necessary services for the duration of time they require those services so we do not place undue burden on our providers or enrollees.

In the case of an enrollee who requires ongoing services that they or their family cannot manage themselves, the Humana UM nurse works collaboratively with a Humana CM who then assumes the role of management of care, working with the enrollee, enrollee's family and enrollee's providers, especially the primary care physician (PCP).

The CM initiates authorizations for LTC services as they add them into the enrollee's plan of care. We consider those services an ongoing authorization as long as the plan of care includes them. Humana CMs update enrollee plans at least annually or more frequently based on the changing service needs of the enrollee.

Similarly, when an enrollee who receives LTC requires services for an acute illness or condition, their CM will contact the UM nurses to initiate the authorization for the short-term services. To make these transitions seamless, the UM nurses and CM nurses call on ancillary services such as social workers and home health agencies.

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7. The adequacy of the respondent's approach at ensuring continuity of care, particularly as it relates to special needs populations.
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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana ensures that all our enrollees receive the care they need when they need it, regardless of whether they need their services short- or long-term. For those enrollees who require long-term authorizations for medically necessary services, including special needs populations such as those receiving private duty nursing (PDN), HIV waiver populations, and those with complex medical needs, we have the following mechanisms in place to reduce gaps in authorizations:

- Utilization management and case management interaction
- Plan of care development and ongoing review
- Discharge Planning
- In-home Provider Visits
- Enhanced Care Coordination for Special Needs Enrollees Under Age 21
- Continuity of Care Studies
- New Enrollee Continuity of Care Processes
- Provider Engagement

We identify those enrollees with special needs via data extraction from state files such as the 834 enrollment file, as well as through our risk severity model based on the enrollment files. We supplement that data with enrollee-specific information we obtain through Health Risk Assessments (HRA).

UM AND CASE MANAGEMENT INTERACTION. Humana's Case Management and UM associates work closely to ensure a seamless care delivery experience for our Medicaid enrollees. We understand the population, particularly those with special needs, requires timely and accurate service authorization decisions and conscientious follow up to ensure there are no gaps in care. Communication between our Case Management and Utilization Management associates is fluid and adapts to the needs of our enrollees. Our integrated Clinical Guidelines eXchange (CGX) platform gives CMS areal-time view of authorizations, allowing them to immediately update plans of care where necessary. For a long-term authorization of medically necessary covered services, Humana creates an ongoing authorization for a specified duration of time or number of treatments to complete the expected course of care.

PLAN OF CARE DEVELOPMENT AND ONGOING REVIEW. We maintain enrollee plans of care to ensure we document the most accurate service authorization information. The CM leads the development of the plan of care, keeping the enrollee and PCP as the primary contributors, followed by family and caregivers, and other specialty providers. The results of the comprehensive assessment forms the basis for the plan of care's individualized and prioritized goals and interventions. We develop the plan of care with prioritized goals and actions with timeframes for completion and the enrollee's documented progress toward achieving the goals, which the CM monitors, updates, and revises as needed. Examples of other key items included within the individualized plan of care process include:

- A communication plan with the enrollee including anticipated frequency of contacts

- A communication plan with the PCP and specialist to ascertain the needs the provider has identified and prioritized, including a process to ensure the plan of care developed by the health plan reflects the provider's treatment plan

- Specific services and benefits needed

- Preferences for care

- Need for add-on or extended benefits

- Services for enrollees with disabilities

- Identification of providers responsible for delivering services

- Identification of referrals made to specialists or providers and confirmation that the enrollee received these services

- Referrals to community, social, and recovery support agencies, including assisting enrollees in contacting the agency and validating the enrollee received the needed service

- A review of the new and updated plan of care with enrollee, family and caregiver (as needed), and the primary care provider and specialist, and actively seek input from them

- Contingency planning for changes in condition or caregiver availability and ability

- A plan for effective and comprehensive transitions of care between care settings

- Continual review and revision of the plan of care, which includes follow-up contact as needed with enrollee to ensure we adequately monitor the plan of care, including identification of gaps between recommended care and actual care provided

DISCHARGE PLANNING. CMs work to ensure we closely monitor enrollees (especially those at high risk) post-discharge and on an ongoing basis to ensure safe transition of those enrollees from inpatient settings to the home and community, as well as to reduce unnecessary hospital admissions. The CMs coordinate care for the enrollee by:

- Setting goals that promote coordinated care
- Assisting enrollees by scheduling PCP and Specialist appointments
- Assisting with transportation as needed
- Coordinating care within and across treatment settings
- Giving enrollees and families a single point of contact
- Facilitating care coordination across providers
- Communicating enrollee needs and care preferences to healthcare providers

In addition, the CM is responsible for managing an individualized transition plan for the enrollee, to include:

- Assessment of needs upon hospital admission

- Education of the enrollee and caregiver on their Humana benefits

- Assistance with scheduling a timely follow-up appointment(s), optimally within 7-14 days following discharge, or earlier if appropriate

- Assurance that enrollee needs are addressed prior to hospital discharge (such as home health services, securing discharge medications prior to discharge, transportation)

- Coordination surrounding effective communication between the facility, enrollee and caregiver, the enrollee's health home, and key stakeholders

- Assistance with the establishment of a health home if the enrollee does not have one

- Engagement into a care management program, as appropriate, if the enrollee is not already engaged

- Evaluation of plan effectiveness.

IN-HOME PROVIDER VISITS. If the enrollee is homebound and cannot access required care in the community, the CM may refer the enrollee to a home visiting provider to provide home-based health care to the enrollee post-discharge. This helps reduce the risk of readmissions and to ensure the appropriate services are occurring in the home. Through this service, we provide access to high-quality in-home medical care while focusing on educating enrollees on their disease state, and about the importance of compliance with their treatment plan and regular PCP visit(s).

ENHANCED CARE COORDINATION FOR SPECIAL NEEDS ENROLLEES UNDER AGE TWENTY-ONE (21). For enrollees under age twenty-one (21) who are in nursing facilities and meet criteria for transition from the nursing facility to home, the CM works collaboratively with the enrollee's multidisciplinary team (MDT) to transition the enrollee safely from the facility to the community, developing the transition plan within thirty (30) days prior to discharge. The transition plan includes Freedom of Choice forms and outlining the ongoing services and supports the enrollee needs to successfully reside in the community, including EPSDT services. EPSDT provision inclusion is a fundamental tenet of how we approach care delivery for our enrollees under the age of twenty-one (21).

During the first six (6) months following discharge from the nursing facility, the CM contacts the enrollee or enrollee's authorized representative at least twice per month, with at least one (1) of those meetings as a face-to-face (if the enrollee or enrollee's authorized representative agree). We also conduct quarterly face-to-face visits for our enrollees under the age of twenty-one (21) with private duty nursing (PDN) services. After the initial six (6)-month transition period, the CM continues to maintain monthly contact with the enrollee or enrollee's authorized representative.

CONTINUITY OF CARE STUDIES: We understand that our enrollees with special needs require coordination of care across various settings and levels of care. Humana facilitates care delivered seamlessly across a multitude of delivery sites and throughout the course of the disease process. We analyze data to determine areas where opportunities exist to improve continuity and coordination between settings of care, and in transitions of care from one provider to another.

Humana has medical continuity and coordination of care opportunities, which we complete for all NCQA-accredited states and include Medicare, Medicaid, and Dual Eligible enrollees. These include:

- Post-discharge survey – Improving Rate of Follow up appointment with physician
- Post-discharge survey – Improving Ease of Obtaining medications
- Post-discharge survey – Improving Coordination of home health care services
- Post-discharge survey – Increasing Understanding of discharge plans and instructions

Humana's Florida Medicaid health plan is NCQA-accredited and completes two (2) medical continuity of care opportunities.

- Improving Coordination between Hospital and Primary Physicians for enrollees with an inpatient stay (hospital discharge)

- Improving Communication of Mammogram Results to the Primary Physicians

NEW ENROLLEE CONTINUITY OF CARE (COC) PROCESSES. Humana ensures a new enrollee transitioning to Humana with ongoing authorizations continues to receive those services. We honor existing short- and long-term authorizations for new enrollees for up to sixty (60) days from enrollment; the enrollee continues to receive previously authorized care during that time even if the providers are outside of our network. During the sixty (60) days, Humana conducts a medical necessity review of the previously authorized services. If we deem the services medically necessary, Humana continues the authorization, ensuring no gaps in care or services. We attempt to transfer the enrollee to in-network providers. If deemed no longer medically necessary, Humana works with the enrollee and the CM to reduce, alter, or stop the authorization based on the needs of the enrollee.

PROVIDER ENGAGEMENT. Humana's model of provider engagement involves proactively working with the PCP to serve as a central point for coordination of care for long term authorizations for their patients. The PCPs are key participants in the referral process and typically initiate the orders for care considered either short or long term. Humana also assists PCPs in managing the total care of our enrollees by assisting with referrals if participating providers are unavailable or inadequate to meet the enrollee's medical need or if there are COC issues such that transferring care to a participating provider would jeopardize the enrollee's health.

Additionally, our provider payment model often involves considerable capitation-based contracting, which creates incentives for providers to keep enrollees stable and prevent the re-emergence of health crises that often result in readmissions in less coordinated settings.

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5. The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization).

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Humana understands the need to efficiently provide the highest quality of care for our enrollees. We strive to direct enrollees to the most appropriate level and type of care in a timely manner while improving our cost efficiencies. Our approach to using UM data rests on the foundation of established quality improvement tenets. We rely heavily on data to direct our activities that result in identifying barriers, root causes, and systemic problems that would otherwise lead to fragmented service delivery. The UM Program 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 barriers we identify. Trends may indicate improvement or reveal where we need to improve.

Data collected through Humana's UM program allow us to more effectively:

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

One of Humana's key differentiators is our 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 enrollee health outcomes. We pride ourselves on our scalability and we will continue to bring this strength to the Florida Statewide Medicaid Managed Care (SMMC) program. Based on our analysis of the Florida population, if we identify an initiative from one of our other lines of business (Medicare, Commercial or Duals) that we think will demonstrate measurable improvement in the health of Florida enrollees, we have the capabilities and resources to quickly and efficiently implement that initiative.

PROMOTING APPROPRIATE UTILIZATION

Humana draws 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. 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. For example, we provide daily emergency department visit reports to our engaged providers so they can conduct follow up with their enrollees who accessed the emergency department. 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 these data, our CMs can direct enrollees to the most appropriate care setting.

IDENTIFICATION OF AREAS FOR IMPROVEMENT

Humana is committed to ensuring we deliver evidence- and outcome-based approaches and cost-effective care of enrollees given our current clinical situation and support systems available. The Utilization and Case Management unit regularly reviews several reports to provide feedback and tracking in reference to the utilization activities. We collect data from various sources, including clinical reviews, aggregate claims, encounter and authorization data, and provider communications. The UM department develops indicators for identifying potentially inappropriate over- and under- utilization, which the UM and Quality Management Committees (QMC) approve.

The UM Committee receives utilization metric trends reports monthly. Humana's sophisticated Early Indicator Reporting (EIR) includes key utilization indicators. Utilizing the expanded capabilities our local-corporate structure provides, the Humana corporate actuarial team produces this user-friendly dashboard primarily from claims data with actuarial completion principles to incorporate data from the authorization system. This allows earlier recognition of key trends and earlier intervention than allowed if we relied strictly on claims data. For the most recent incurred periods (typically two (2) to three (3) months), we prefer to leverage authorization information from our CGX clinical system to prevent any claims processing noise (e.g., inventory build-up, provider billing delays) from introducing excess restatements. We have studied historical authorizations-versus-claims relationships to assess the provider "compliance" in reporting authorizations, where used. We base utilization projections for those incurred periods off the compliance-adjusted estimate of admission authorizations.

With the EIR, users can see overall performance at a glance and can drill down to specific data elements to quickly analyze data and identify root causes. For example, if overall admits per one thousand (1,000) enrollees is unusually high, the drill-down capability allows users to view by market segments and by age of the population. This report allows analysis of both month-to-month and year-over-year trends.

Attachment 18-5 contains an example of drill-down capability for current Medicaid reporting on an EIR report.

We establish metric targets based on existing utilization data tracking and trending to goals are also part of the analysis. If a metric appears to be unusually high or low, the actuarial team drills down to root causes, preparing additional ad-hoc reporting to present to the Medicaid Trend Committee. Depending on the root cause, we assign the appropriate Florida market or corporate team to complete a gap analysis and return to the UM committee with strategic and tactical recommendations.

When the root cause reveals a clinical issue, we include licensed clinical input in the action plan. Several corporate clinical strategy teams provide specialized inputs, such as for proactive care and messaging campaigns, acute strategies such as for emergency department utilization and post-discharge care coordination, and the Chronic Care Strategies teams.

The goal is to identify risk factors and facilitate the development of innovative management and treatment alternatives including specific medical management, case management and coordination, and disease management programs, which will efficiently and effectively improve health outcomes.

In addition to outcome metrics, operational metric dashboards allow clinical leaders to track and trend activities to drive to successful outcomes. One of the most critical metrics for clinical program success, particularly for Medicaid enrollees, is the timeliness of the intervention and effective engagement with our highest-risk enrollees. Dashboards allow leaders to drill down to specific segments and time periods to closely monitor clinical operational performance. For example, we see that the MomsFirst nurses were able to contact nearly seventy-five percent (75%) of the program-eligible enrollees for our Florida Medicaid plans in 2014. Once contacted, more than ninety-five percent (95%) percent of the enrollees agreed to engage with the nurse. Dashboards allow comparison between different clinical teams with the same programs in

different markets. The corporate team facilitates additional analysis to identify region-specific best practices and lessons learned, allowing ongoing improvement of existing initiatives. Below is a list of Humana's operational metric dashboards and reports.

- INPATIENT CENSUS REPORT - Daily detailed account of all 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) - As described above, monthly reporting of key utilization metrics such as: admits/1,000 by utilization type (Acute, Skilled Nursing Facility, Rehab, LTACH), inpatient days/1,000, Length of Service by type, emergency department 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 for Severity Score (updated monthly) and Readmission Model (updated daily from admission to discharge) integrated into CGX to trigger referrals for clinical programs; emergency department Predictive Model scores available by report monthly with expected integration into CGX during 2016

- AUTHORIZATION TIMELINESS REPORT - Monthly market-specific summary of authorization timeliness against target.

Humana also conducts ad-hoc reporting to drill down for root cause analysis in cases of under- or over-utilization. Examples of these reports include:

- READMISSIONS BY PROVIDER – Provides monthly tracking of fourteen (14)- and thirty (30)-day readmission rate for acute admissions, by line of business, product, DRG, and physician visit within fourteen (14) days of discharge date. The reporting dashboard allows us to drill down and identify areas for improvement.

- HIGH UTILIZER REPORT – Allows us to drill down into individual enrollees with high utilization by service type, e.g., ED, inpatient care, etc.

- INPATIENT DRILL DOWN – This report provides inpatient services by provider, type, and major diagnostic category.

We can also focus in on specific services and claims volume to identify areas where interventions may increase appropriate utilization of preventive services. We monitor and analyze utilization data to preemptively address potential high cost inpatient stays, as well as improve health outcomes.

MONITORING AND ADDRESSING OVER-UTILIZATION

Humana's UM Program incorporates numerous measures to monitor and evaluate progress toward meeting goals. Our UM analysts collect, analyze, trend, and monitor data on a systematic basis to facilitate corporate quality improvement and to address any potential or identified barriers. We have found that trends can be indicators of improvement or reveal where improvement is needed. Humana selects utilization indicators and monitors data and outcomes 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
- Emergency Room Visits per 1,000 enrollees
- Observation Rate
- Post-Discharge Care Coordination Referral Calls

ADDRESSING UNDERUTILIZATION

Humana's UM processes also identify areas where enrollees may underutilize key preventive or supporting services. Through review of utilization data, we can 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 underutilization for those enrollees in case management through CM, enrollee, and PCP interactions. 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 and CMs work together with the enrollees to determine if additional services are medically necessary and would benefit 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. Humana Quality Improvement Nurses (QINs) work with our providers to review utilization patterns and identify areas for improvement (such as closing gaps in preventive care) to promote appropriate utilization.

ENROLLEE STORY: INCREASING APPROPRIATE AND NECESSARY UTILIZATION

A young Humana enrollee with complex needs had been receiving twelve (12) hours of PDN. However, given the mother's full-time job, the mother felt overwhelmed when the PDN was not there. The Humana CM noticed the strain on the mother, and asked if she needed more help in the home. As a result, the CM assisted the mother in requesting more in-home services.

Following a review of the family's situation, and the enrollee's needs, Humana increased the amount of in-home nursing services for the enrollee, which increased the quality of life for the whole family.

ADDRESSING INAPPROPRIATE AND FRAUDULENT UTILIZATION

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). Health Services associates can refer to SIU either telephonically or via email.

Humana's SIU conducts reviews of clinical data to inform its potential Fraud, Waste and Abuse (FWA) cases. The SIU uses the CGX platform to search and view medical pre-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. Humana also performs data mining to search for unusual or impossible situations.

Three (3) Medical Directors currently assist SIU, and other Medical Directors will assist with certain specialties as follows:

- Ongoing education and guidance from a clinical perspective
- Review of all Medical Necessity reviews
- Review of all experimental and investigational reviews
- Clinician representation on peer-to-peer, provider education, and market calls
- Guidance on various cases and types of reviews for both clinical and SI;
- Attendance in the various meetings of the clinical team to promote consistency in reviews
- Clinical training sessions for SIU and clinical associates
- Clinical representation if needed for litigation or pre-litigation meetings with the legal department

Such engagement of clinicians requires significant collaboration between the Humana's SIU and clinical teams. Collaboration occurs over multiple fronts in addition to those listed above, including but not limited to: approval for Medical Necessity reviews, continuous review for cost-saving efficiencies and process improvements, new case set or meeting with investigative team to discuss cases, review and follow up on post pay cases; and monthly clinical training sessions for SIU and Clinical.

ADDRESSING UTILIZATION CONCERNS
Humana's 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 reports on inpatient utilization, which they use to identify enrollee-specific predictive scoring (readmission) to assist with proactive discharge planning and communication. The initial review process includes assessment of readmission history, compliance with provider visits, and case management alerts. 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 we identify utilization issues through this review process, including potential cases of FWA, we address them immediately.

IN THE MID TERM: We schedule regular meetings with the clinical team to discuss enrollees requiring complex medical management and discharge coordination, as well as those requiring LTSS. The team discusses enrollee utilization patterns and current clinical needs, including physical capabilities, their family structure and support system, and emotional state. We discuss potential problems identified using analysis of utilization patterns with the PCP. Upon discharge we refer the enrollee to internal and external programs to prevent avoidable rehospitalizations.

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 under- and over-utilization, the program solicits 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, home and community-based services (HCBS), case management and coordination, and disease management programs.

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8. The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

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CASE STUDY EXAMPLE

PROACTIVELY MONITORING AND ADDRESSING ED UTILIZATION

Humana continuously assesses the needs of our Florida enrollees. Our CMs work with our Medical Directors and with our primary care physicians (PCPs) to monitor over- and underutilization. As an example of how Humana has led the way in pioneering real-time emergency department data exchange between hospitals and health plans, we identified a real need to address inappropriate ED usage. Between 2014 and 2017, Humana developed partnerships with twenty-three (23) local hospitals to receive daily reports of ED encounters, reducing the months-long notification lag, customary of claims-based reporting, to within a few days of an enrollee's ED visit. Timely notification is essential to impacting non-urgent and non-emergent ED utilization.

Once we identify a non-urgent or non-emergent ED visit, our internal ED team began reaching out to the enrollee and enrollee's PCP. We contacted the enrollee to assess and educate them on the disease process, prevention, appropriate place of treatment including alternatives to ED for non-emergent needs, such as urgent care centers, and redirected them to their PCP for a follow-up appointment. If the ED team felt there were comprehensive needs, we referred the enrollee to case management or our behavioral health partner for behavioral health needs. The team notified the PCP and secured a follow-up PCP appointment to address any barriers to health. Using this process of timely notification, enrollee education, and provider collaboration, Humana achieved a significant reduction of ED visits pre- and post-outreach.

The success of Humana's initiative laid the foundation for the current Florida Health Information Exchange (HIE) Event Notification System (ENS), in which Humana partners with AHCA to contract with more than fifty (50) local hospitals to receive real-time emergency department data.

Evaluation Criteria:

1. The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.

2. The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.

3. The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for plan staff and network providers).

4. The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced.

5. The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization).

6. The adequacy of the respondent’s approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long-term (ongoing maintenance services/therapies).

7. The adequacy of the respondent’s approach at ensuring continuity of care, particularly as it relates to special needs populations.

8. The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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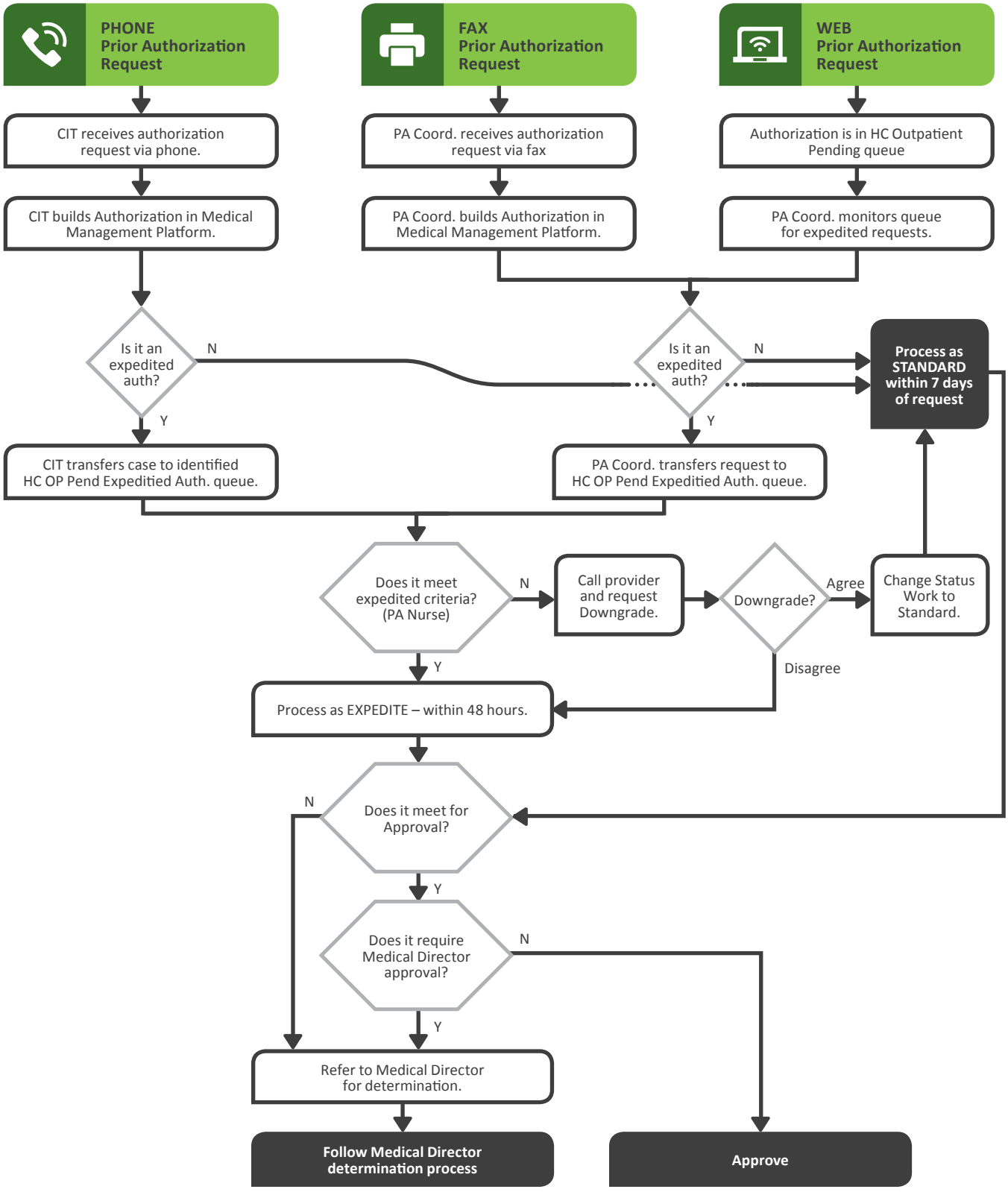
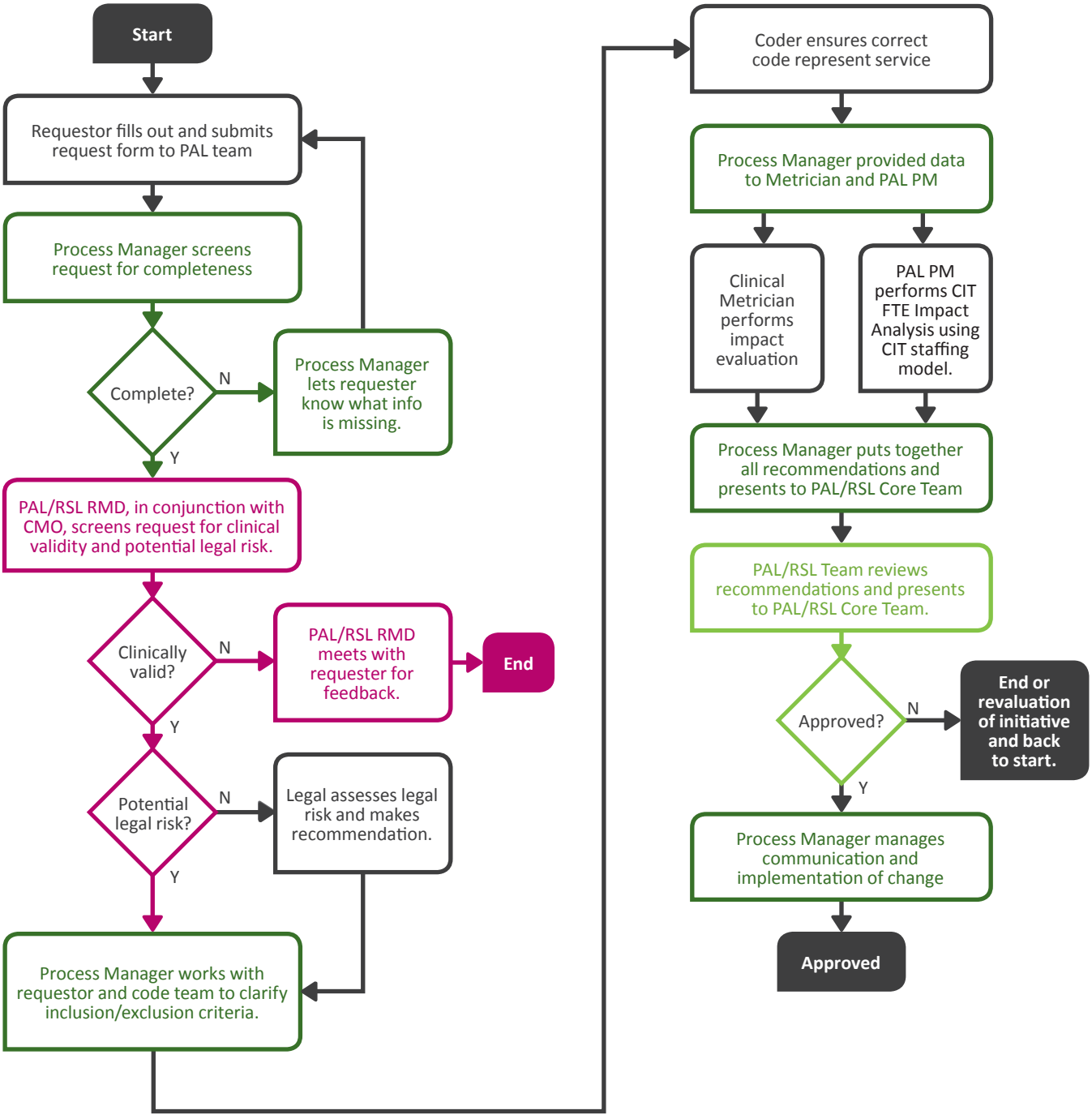
Attachment 18-1: Prior Authorization Referral Process

Current State 8/2016



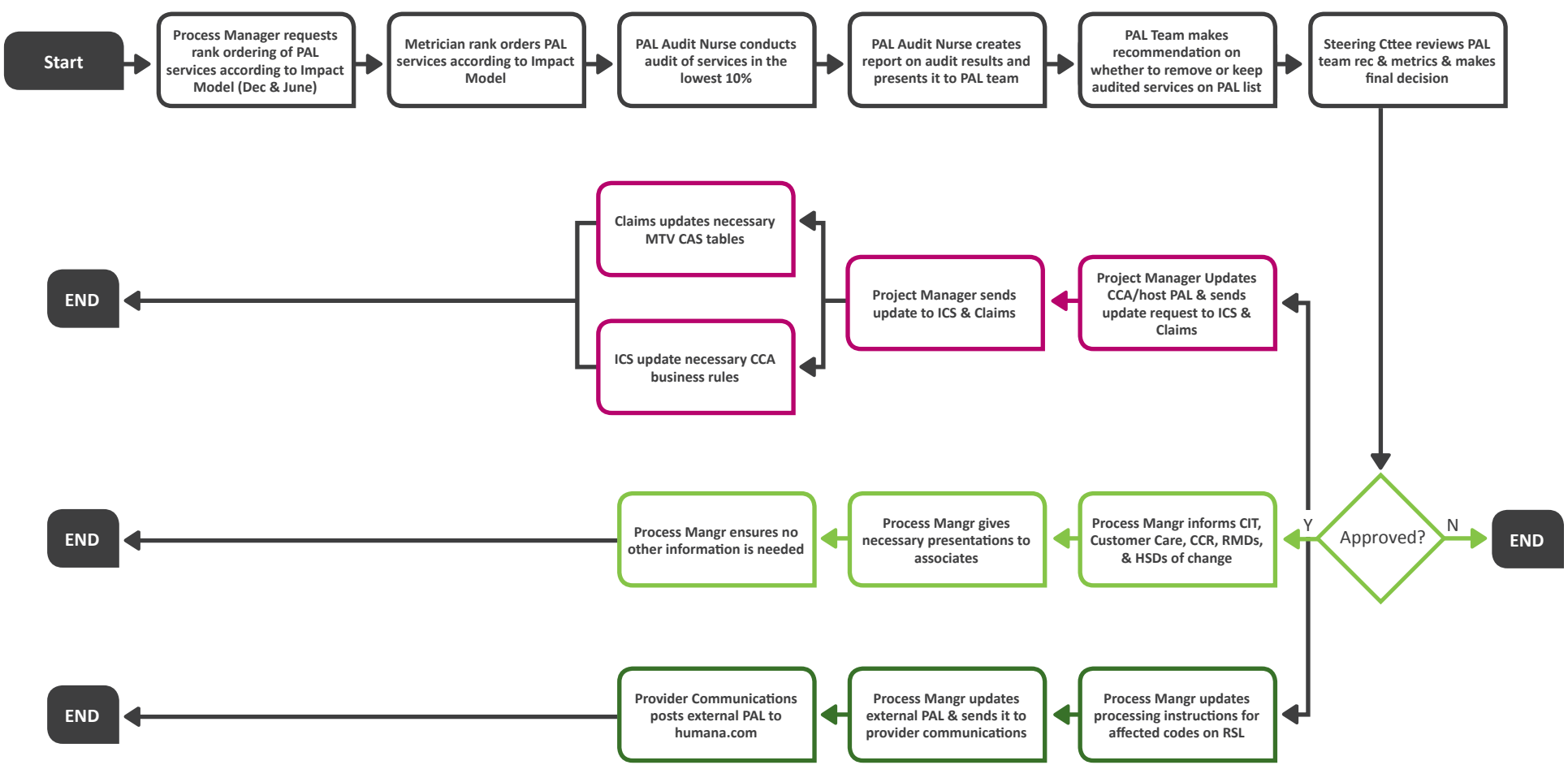
Attachment 18-2: PAL/RSL Change Intake Process



Color Key
PAL/RSL RMD
PAL/RSL Team
Process Manager
Other

Humana.

Attachment SRC 18-3: PAL/RSL Change Maintenance Process

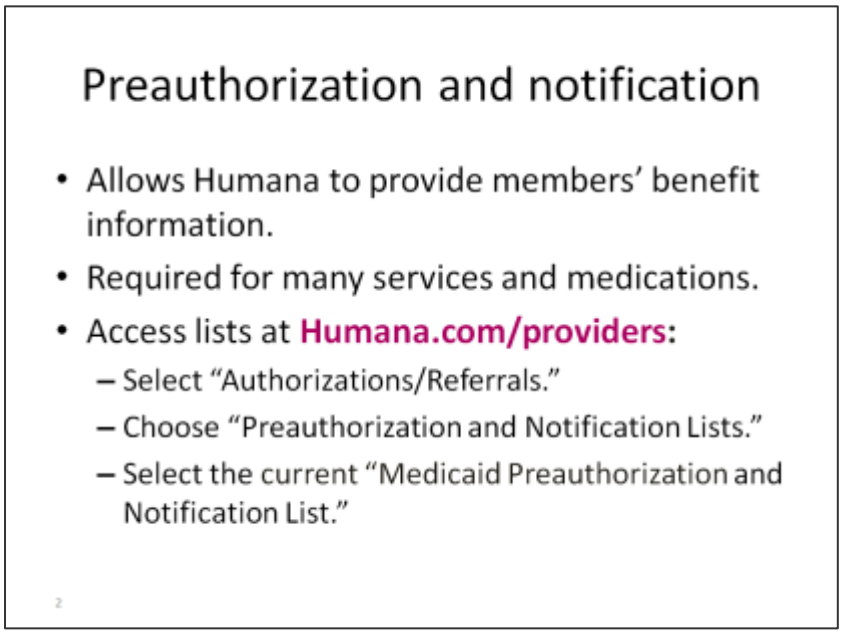


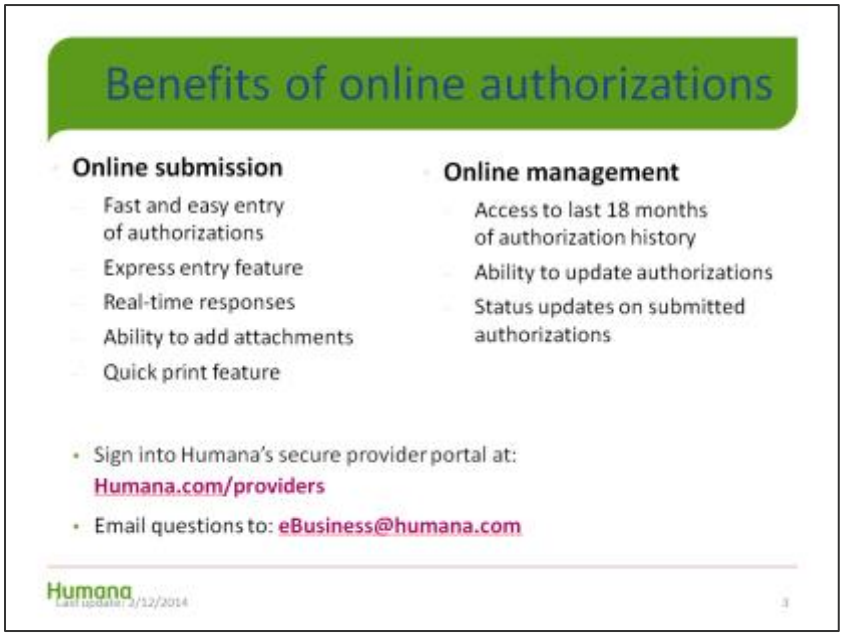
Color Key
ICS and Claims
CIT, Customer Care, CCR & RMDs, HSDs
External PAL & RSL
Other

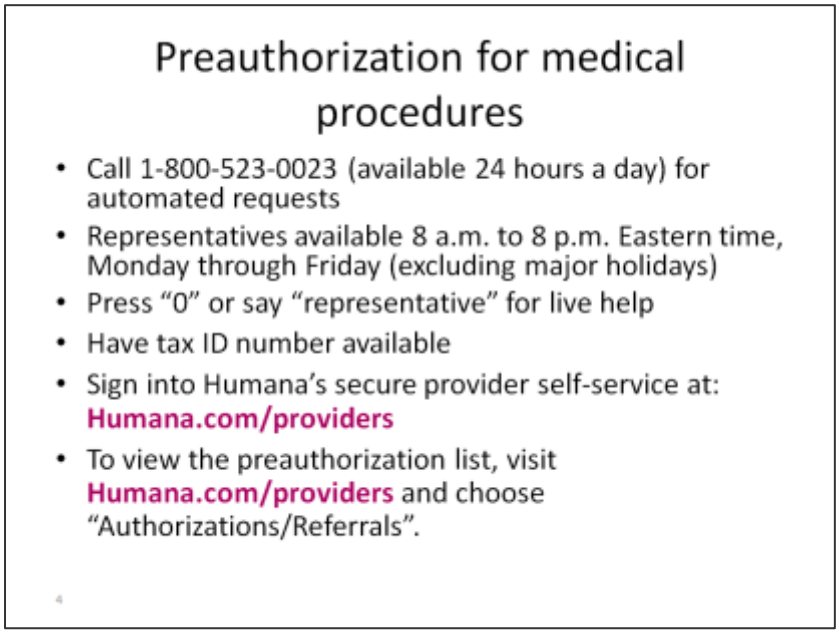
Humana.

Attachment 18-4: Humana Preauthorization and Notification Provider Training

Providers must have authorizations prior to providing select services to our enrollees. Humana contractually requires its providers to conduct utilization management-related training for staff at their facilities. Below is an excerpt from Humana's training requirements.

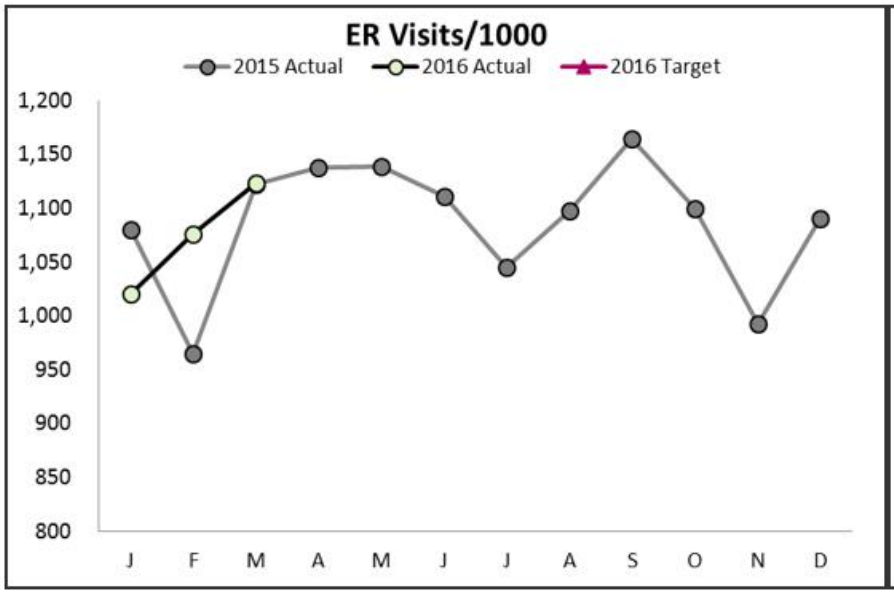


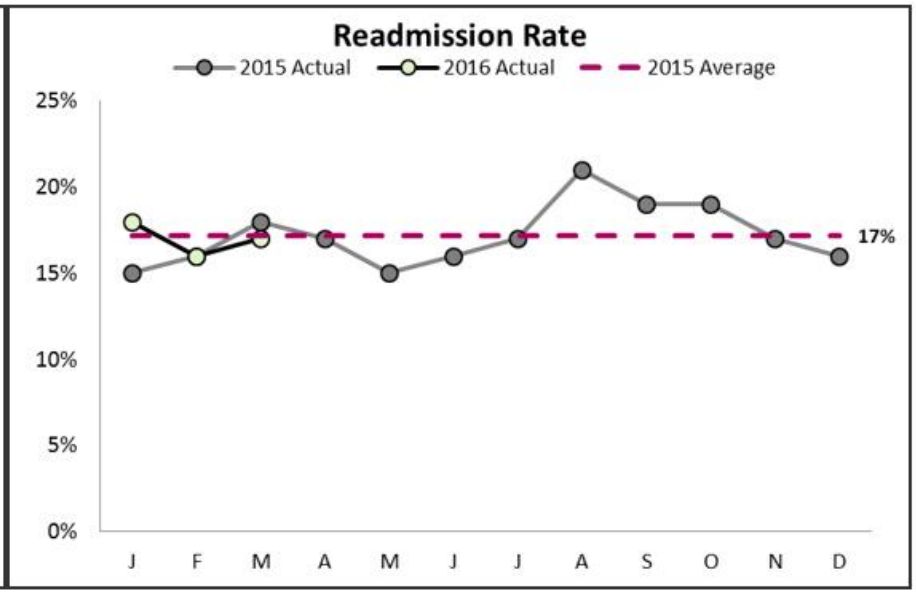

Benefits of online authorizations
Online submission
Fast and easy entry of authorizations
Express entry feature
Real-time responses
Ability to add attachments
Quick print feature
Online management
Access to last 18 months of authorization history
Ability to update authorizations
Status updates on submitted authorizations
Sign into Humana's secure provider portal at: Humana.com/providers
Email questions to: eBusiness@humana.com
Humana
Last update: 2/12/2014
3


Preauthorization for medical procedures
Call 1-800-523-0023 (available 24 hours a day) for automated requests
Representatives available 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding major holidays)
Press "0" or say "representative" for live help
Have tax ID number available
Sign into Humana's secure provider self-service at: Humana.com/providers
To view the preauthorization list, visit Humana.com/providers and choose "Authorizations/Referrals".
4

Drug prior authorization and notification
• Get forms at www.humana.com/pa or call 1-800-555-2546 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)
• For drugs delivered/administered in physician's office, clinic, outpatient or home setting (fee-for-service providers only):
– www.humana.com/medpa
– 1-866-461-7273 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)

Attachment 18-5: Sample Early Indicator Report (EIR)





Humana.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 19 – Utilization Management – Ease of Use (Statewide):

The respondent shall describe the following related to its utilization management systems:

a. A description of how the respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;

b. A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, subcontractors and the respondent (to the extent any UM functions are delegated);

c. A description of the respondent's experience meeting timeliness standards for service authorization requests;

d. A description of the approach that the respondent will use to educate enrollees and providers about the process for seeking authorization; and

e. A detailed workflow of how "special service" requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the plan to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbooks/coverage policy or the associated fee schedule.

Response:

==========

1. The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.

==========

Humana has developed innovative strategies using utilization data and metrics to better manage our enrollees' care while maintaining focus on efficient service delivery. We capitalize on our utilization data to determine which enrollees will benefit from care management, as well as to monitor if our enrollees are receiving the appropriate care.

Humana CareHub (hereafter referred to as CareHub), Humana's enterprise solution for complete program integration for our provider community and enrollees, is at the center of our Utilization Management (UM) system capacity. The CareHub Clinical Guidance eXchange (CGX) workflow system supports utilization and care management. As a fully integrated approach, this enterprise solution provides enhanced capabilities to monitor over- and under-utilization, identify candidates for care management/disease management programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention. All of the various sources of identification and referral (from predictive modeling to claims data and lab results) are integrated into our powerful CareHub platform, as shown in Attachment 19-1.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Our data mining capabilities are robust and automated due to the interoperability of our systems. The CareHub infrastructure utilizes technology solutions such as Atlas and Anvita clinical rules engines to drive timely and actionable data into an enterprise workflow for the Humana team. This includes automated processes to route enrollees to specific clinical programs and Case Managers, as well as to create Care Alerts consisting of evidence-based medicine Gaps-in-Care, Healthcare Effectiveness Data and Information Set (HEDIS), and drug-to-drug and disease interaction alerts. These automated processes ensure that there are no delays in authorizations or gaps in care for our enrollees.

FUNCTIONALITY INCLUDES:

- Management of automated referrals to clinical programs

- Clinical Program Care Management for management of an enrollee within the clinical program

- Assessments to evaluate an enrollee's condition and identify opportunities for improvement

- Plan of Care (POC) to manage an enrollee's problems, goals, and clinician interventions

- Documentation of all contact with enrollees and providers and the subsequent outcomes of these contacts

- Management of an enrollee's medications, allergies, and immunizations

AUTOMATED FEATURES SUPPORTING UM ACTIVITIES INCLUDE:
- Routing of authorizations within system to MD queue for clinical determinations

- Automated routing of new authorization requests to appropriate internal team through "My Work" queue management

- Sophisticated, layered, and highly nuanced automated business rules integrate with preauthorization list to automatically approve as appropriate or pend in "real-time" to appropriate clinical team for review

- Electronic capture of provider clinical information to support UM decisions

- UM letters, such as "Notice of Action," integrated within system

- Links to useful tools, such as MCG® guidelines and Customer Care system, create user efficiency

- Integration of discharge planning documentation and care management system with UM system

- User customizable interface allowing filtering and sorting to meet role need

- Individual work and team queues maximize productivity; leader queue management allows real-time visibility (e.g., for reprioritization or re-assignment of associates to meet compliance standards)

- Automated operational and compliance metrics capture; back-end database enables both automated and ad hoc reporting functionality

- Mobile and tablet compatible for onsite associates

AUTOMATED AUTHORIZATIONS

Authorization requests for inpatient and outpatient services to CareHub are processed and automatically fed to CareHub's analytics engine and claims platforms, providing seamless continuity of care for our enrollees. Information that is collected during the building of the authorization request (e.g., enrollee demographics, enrollee medical policy, the provider(s) performing the services, and the medical codes) is provided by the source platforms via real-time web services. Many of the views and functionality provided within CareHub are direct integrations and data representations of the source platforms. Real-time web services are used to drive effectiveness and efficiency by leveraging clinical rules engines to propel timely and actionable data into an enterprise workflow for the Humana associate. Attachment 19-2 provides an overview of our clinical systems, including how UM data is integrated into our automated clinical systems' workflows.

Through the use of various web portals (e.g., Eligibility and Benefits page, Availity Care Profile), messaging channels (e.g., email, fax, mail), and the CareHub CGX clinical workflow system, Care Alerts are generated and distributed to the Multidisciplinary Team (MDT), enrollees, providers, and clinical care teams. The CareHub infrastructure utilizes technology solutions, such as Atlas and Anvita clinical rules engines, to enable integration, collaboration, and data sharing throughout the healthcare delivery system. These Care Alerts consist of evidence-based medicine Gaps-in-Care, HEDIS, and drug-to-drug and disease interaction alerts.

Providers are notified of both gaps in care, as well as risk scores, through utilization reports provided by Humana Quality Improvement Nurses (QINs). For privacy reasons, these records will not include records from psychiatric, substance abuse or HIV-related treatment.

Humana's claims systems and customer service systems are fully integrated with the CareHub system. They share common files and common data coding standards. These applications are capable of the following:

- Supporting electronic enrollment, claims and encounters, and referrals

- Interpreting participant eligibility

- Identifying duplicate claims

- Assessing reasonableness of charges

- Automatically applying correct provider reimbursement methodologies

- Distinguishing participating from non-network providers

- Interpreting covered versus non-covered benefits

- Applying pre-existing conditions

- Determining medical appropriateness

- Recognizing up-coding and unbundling practices (and automatically re-bundling)

- Investigating coordination of benefits

- Detecting fraud and abuse

- Researching potential Medicare and Medicaid eligibility issues

- Assessing subrogation opportunities

- Applying penalties for non-compliance with medical management rules

- Applying a variety of cost sharing and other benefit calculations

- Storing and centralizing data that Customer Care representatives can use to answer questions from enrollees and providers

CareHub's integration server, CareHub Interchange, is implemented in an industry leading technology that provides pre-built interface adapters and message transformation tools to improve the timeliness of integration with other systems. The extent of integration limitations exists solely on that system's ability to provide an inter- and intra-system interface to the CareHub Interchange in a timely manner.

==========

2. The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.

==========

SYSTEM INTEGRATION

To reduce the burden on providers, subcontractors, and Humana associates, our systems are integrated through real-time user interfaces that receive information from multiple data sources. The core eligibility and claims processing systems feed data to the Operational Data Store (ODS) and the Enterprise Wide Database (EWD), which are then used to provide information to multiple systems and users throughout Humana. ODS is a DB2 database that houses consolidated data for operational use across the enterprise. ODS receives daily batch feeds from multiple sources. Data subjects include enrollee demographics, eligibility, and benefits

from Customer Interface, as well as medical and dental claims, authorizations, referrals, provider data, and accumulators fed from other systems across Humana. The database is available twenty-four (24) hours a day, seven (7) days a week. We supply our providers and subcontractors with the information housed in the ODS, enabling streamlined identification of enrollee benefits, as well as authorization information. Attachment 19-4 illustrates how our platforms are integrated through our advanced CGX platform.

Providers, vendors, and subcontractors can have access to enrollee eligibility and authorization information through numerous avenues. Enterprise Eligibility Services (EES) are web services that return eligibility and benefit data. Many consumer applications call EES or use ODS data, including MyHumana (Enrollee and Provider portals); Interactive Voice Recognition tools; Enrollee Services (CCP and GCP); Clinical Management; Secured Logons; eHub; Availity®; feeds to vendors; and enrollee communications.

Detailed descriptions of our software capabilities follow in the narrative below.

CAREHUB

Humana's integrated technology solutions are made available to team members through our cutting edge CareHub infrastructure. CareHub is Humana's clinical management platform that includes all of the clinical and care management documentation. This is where all designated care management associates – e.g., acute Case Managers, utilization management associates, Humana Case Managers, Community Health Educators, and Field Case Managers – can create and update enrollee records. Enrollee health status can be tracked through the Clinical Tools function, which collects important information, such as measurements, and generates trend reports for staff and enrollees. This is part of a menu of applications that ties all enrollee experiences (e.g. pharmacy encounters and communications, eligibility status, claims and utilization, power of attorney documentation) into a centralized electronic enrollee record repository.

The objective of the CareHub ecosystem is to improve enrollee outcomes and realize quality objectives by addressing gaps in care through integration at the point of care. Our CareHub infrastructure truly leverages technology to enhance clinical delivery. It utilizes technology solutions to enable integration, collaboration, and data sharing throughout the healthcare delivery life cycle.

CGX

The CareHub CGX clinical workflow system supports an integrated, comprehensive approach to utilization and care management. As a fully integrated approach, this enterprise solution provides enhanced capabilities to monitor over- and under-utilization, identify candidates for programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention. Our CGX system documents both medical and Long-term Care (LTC) information, enabling a full view of our comprehensive enrollees. Attachment 19-3 includes a screenshot from our CGX system illustrating our integrated views for our comprehensive enrollees.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

ATLAS

Atlas Clinical Rules Engine allows enrollee identification, stratification and routing for:
- Chronic Condition Management:
-- Diabetes – both disease management and education
-- Coronary Artery Disease – both disease management and education
-- Cancer – both disease management and education
-- End-stage Renal/Chronic Kidney Disease

- Asthma

- Transplant Management

- Rare Disease

- Emergency Department Care Management (Complex Care Management)

Attachment 19-4 Illustrates our Atlas Clinical Rules Engine.

ANVITA

Humana has established a first of its kind clinical infrastructure that truly optimizes technology to enhance enrollee understanding and clinical delivery by converting diverse enrollee data into real-time actionable insights that drive change and enable providers to deliver the most appropriate and effective services.

The Anvita engine and CareHub delivers personalized enrollee analyses identifying enrollees who are at risk for adverse medical events, including hospitalizations, are taking contraindicated therapies, are missing preventive services, have cost-saving interchange opportunities to lower costs, need electronic, automated prior authorization of expensive services, and have resolvable data gaps in their electronic record.

When deployed at the point of care, Anvita can identify, rank, and score competing treatments by safety, efficacy, and cost in real-time, using virtually all known clinical data. Anvita also has the ability to translate confusing industry terminology into consumer-friendly language, in real-time, to enable physicians and enrollees to have symmetrical views enabling shared decision-making.

AVAILITY®

Network providers in Florida have access to the Availity® web-based platform. Availity® is one of the leading health information networks in the country, optimizing information exchange between multiple healthcare stakeholders through a single, secure network. The Availity® Health Information Network encompasses business and clinical services, and supports nationwide real time and batch electronic data interchange via the Web and through business-to-business integration.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The Availity® Care Profile includes claims information associated with office visits and hospitalizations, diagnoses and associated procedures, prescription history, lab event history, radiology event history, immunization history and clinical messaging. This type of information is critically important when a first time enrollee presents, or during an emergency department visit, post-hospital discharge or natural disasters. Use of the Availity® Care Profile also improves enrollee safety, can eliminate duplicate and unnecessary procedures, and improves coordination and continuity of care. This enables more rapid closure of gaps in care for enrollees, greater opportunity for preventive care services and chronic condition management.

==========

3. The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests.

==========

Humana has vast experience reviewing and processing authorization requests across all lines of business. In the Florida Medicaid program, we have been working with providers and enrollees to process accurate and timely authorization decisions since 1997.

We believe that UM processes and service determinations should take place in a timely, efficient manner and have a minimum impact on network provider and enrollees. The Humana UM associates provide a Notice of Action regarding service authorizations within the following timeframes:

STANDARD (NON-URGENT)

Humana provides notice as expeditiously as the enrollee's health condition requires and within no more than seven (7) days following receipt of the request for service. An extension may be granted for an additional seven (7) calendar days if the enrollee or the provider requests an extension, or if Humana justifies a need for additional information and the extension is in the enrollee's best interest.

EXPEDITED AUTHORIZATIONS

An expedited authorization is required when a provider, or Humana determines, that following the standard timeline could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. An expedited decision must be made no later than forty-eight (48) hours after receipt of the request for service. Humana may extend the timeframe for expedited authorization decisions by up to two (2) additional business days if the enrollee or the provider requests an extension or if Humana justifies the need for additional information and how the extension is in the enrollee's interest.

CONCURRENT AND URGENT CONCURRENT REVIEWS

A concurrent review is any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. NCQA also considers a request made

while an enrollee is in the process of receiving care to be an urgent concurrent request if the medical care requested meets the definition of urgent, even if the organization did not previously approve the earlier care. Requests for ongoing inpatient care are always considered urgent; for this reason, we have nurses and physicians on call twenty-four (24) hours a day, seven (7) days a week three hundred sixty-five (365) days per year. Determinations for Urgent Concurrent reviews are made within twenty-four (24) clock hours one (1) day of Humana's receipt of the authorization request, when all necessary information to make a determination is available. When additional information is needed to make a determination, the request for the additional information must be made within twenty-four (24) clock hours one (1) day of Humana's receipt of the authorization request.

When additional information is requested, the total timeframe in which a decision must be made is three (3) calendar days from the date that Humana received the authorization request.

RETROSPECTIVE REVIEWS

Retrospective reviews occur after the service has occurred. Humana completes these reviews within thirty (30) days of the receipt of the initial request.
Humana meets the above-referenced standards with the following compliance rates:
- Standard authorizations – 98.5% compliant
- Expedited authorizations – 100% compliant
- Urgent Concurrent authorizations– 99% compliant
- Retrospective authorizations– 95% compliant

==========
4. The adequacy of the respondent's education and training plan providers on the service authorization processes.
==========

EDUCATING ENROLLEES ON PRIOR AUTHORIZATION PROCESSES

Humana ensures that our enrollees understand what referrals and prior authorizations are, and we help them navigate the process. The enrollee handbook includes the following information for our enrollees regarding prior authorizations:

- Services that DO NOT require authorization

- Direction to the Benefit Summary to determine what services might require prior authorization

- How to get services authorized and approved
-- Talk to PCP
-- Call Customer Care number on identification (ID) card
-- Talk to Case Manager

As the handbook states, enrollees are encouraged to call our Customer Care line whenever they have questions regarding benefits or authorization information.

EDUCATING PROVIDERS ON PRIOR AUTHORIZATION PROCESSES

Humana provides education and training for our network providers to ensure that they understand Humana's policies regarding utilization management. Providers must have authorizations prior to providing select services to Humana enrollees, except in certain situations, such as emergency circumstances, where prior approval is not required. Information related to utilization management is clearly outlined in the Provider Manual delivered to all network providers. Furthermore, Humana contractually requires our providers to conduct utilization management-related training for staff at their facilities. The prior authorization portion of the training includes the following:

- How to use online submission for prior authorization requests

- How to use the 24 hours a day, 7 days a week automated prior authorization line

- How to submit prior authorization requests via Humana's secure provider self-service at: Humana.com/providers

- How to view the prior authorization list via Humana.com/providers - choose "Authorizations/Referrals"

- How to access authorization forms at www.humana.com/pa or via phone

- How to access authorization requests and decisions via online portal

Please see Attachment 19-5 for the prior authorization excerpt from Humana's provider training.

We notify existing providers of any changes or enhancements to our prior authorization policies or processes via the Provider Manual and online through the provider portal.

==========

5. The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).

==========

TRANSPARENCY OF SERVICE AUTHORIZATION PROCESSES

Humana's service providers have full access to all utilization management information via the following resources:
- Provider training
- Provider manual
- Online portals (Availty, www.humana.com)

We make our UM review criteria available on the online provider portal, and providers can access the prior authorization list by either calling Customer Care or accessing the list via the provider portal.

==========
6. The extent to which the workflow describing the respondent's process for handling "special service" requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.
==========

Humana ensures that our youngest enrollees have access to the services they need; we honor all service requests that meet medical necessity criteria for our enrollees under the age of twenty-one (21). When processing special service requests for children under the age of twenty-one (21), to ensure we are consistent with EPSDT requirements, we only deny services if they do not meet Florida's definition of medical necessity. We do not review for benefit information. If we deem the service(s) medically necessary, regardless of its covered benefit status, we authorize the service(s). Attachment 19-6 includes our detailed workflow of how special service requests are processed for enrollees under the age of twenty-one (21).

Evaluation Criteria:

1. The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.

2. The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.

3. The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests.

4. The adequacy of the respondent's education and training plan providers on the service authorization processes.

5. The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).

6. The extent to which the workflow describing the respondent's process for handling "special service" requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

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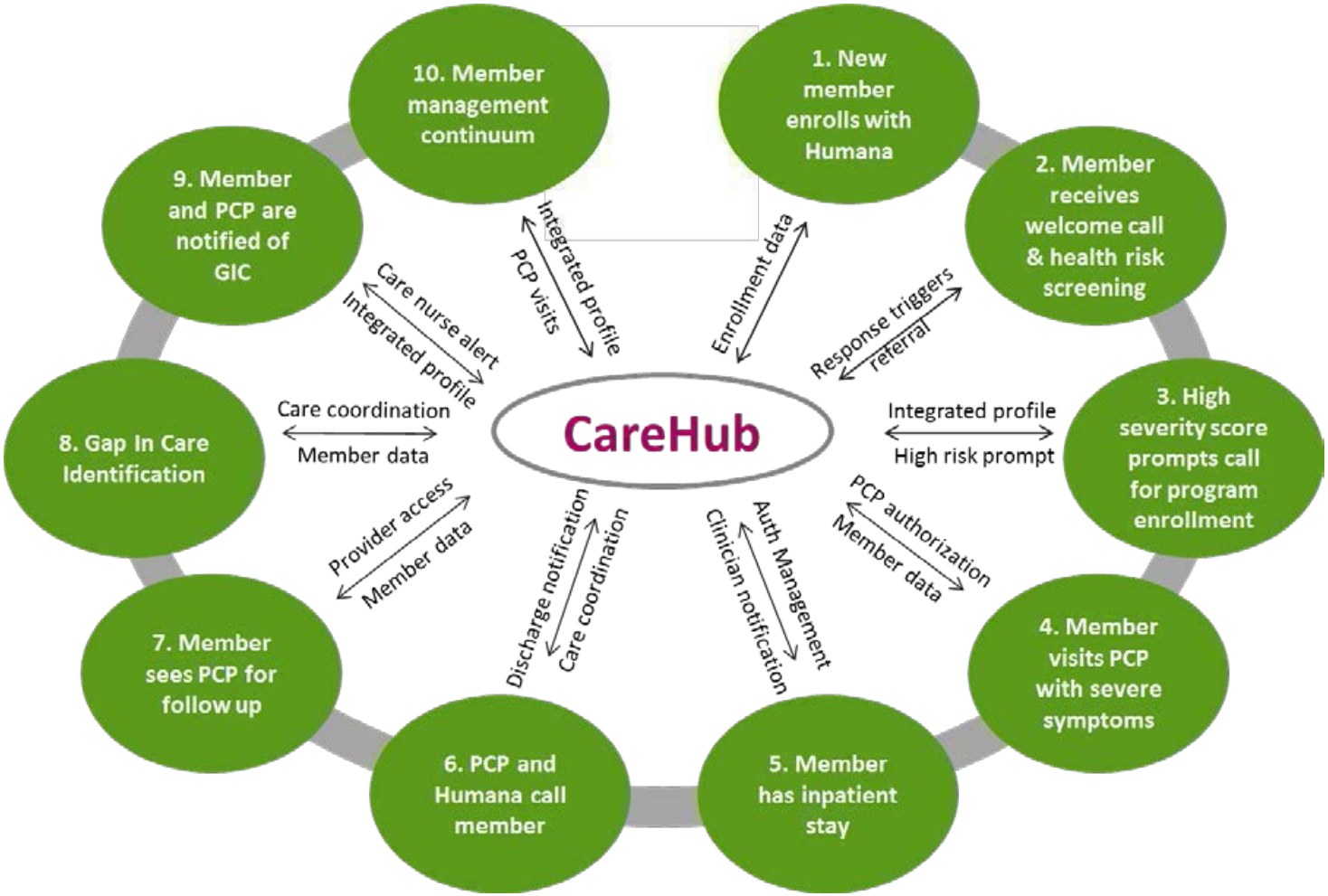
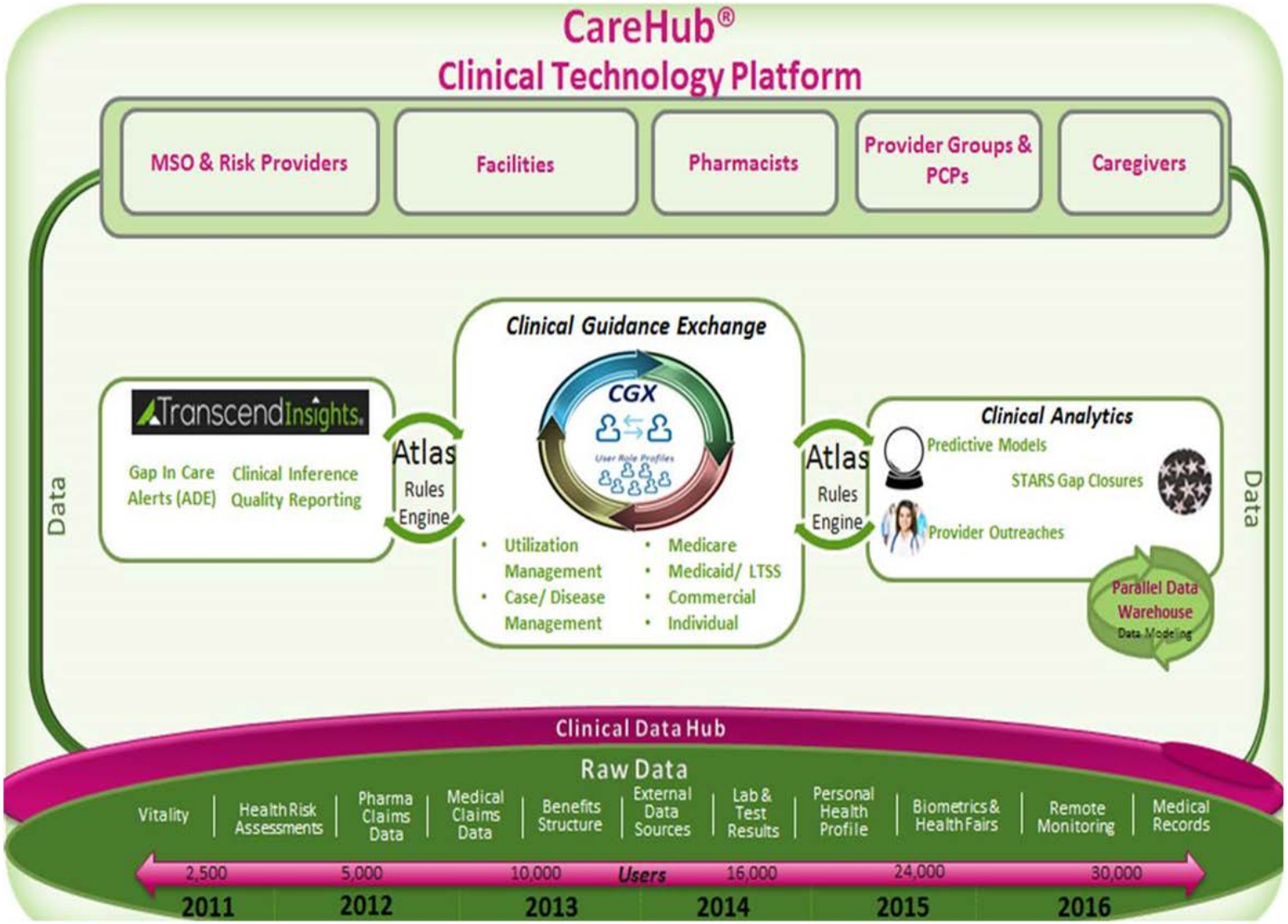
Attachment 19-1: Humana's CareHub Platform

CareHub is Humana's enterprise solution for complete program integration for our provider community and enrollees. The CareHub Clinical Guidance eXchange (CGX) workflow system supports an integrated approach to utilization and care management. All of the various sources of identification and referral – from Predictive Modeling to claims data and lab results – are integrated into our powerful CareHub platform, as seen below.



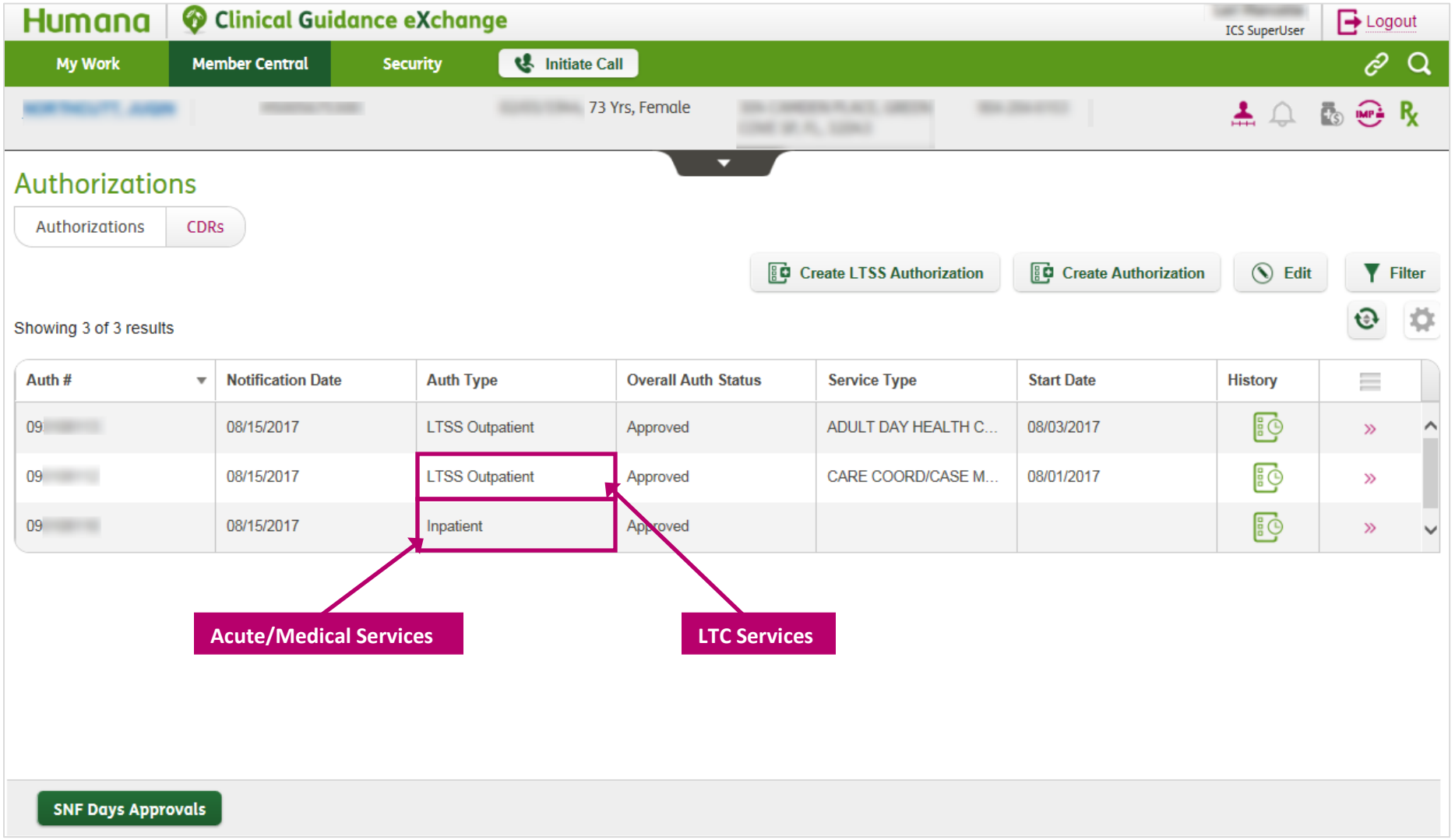
Attachment 19-2: Clinical Technology Platform Overview

Below is an overview of our clinical systems, including how UM data is integrated into our automated clinical systems' workflows.



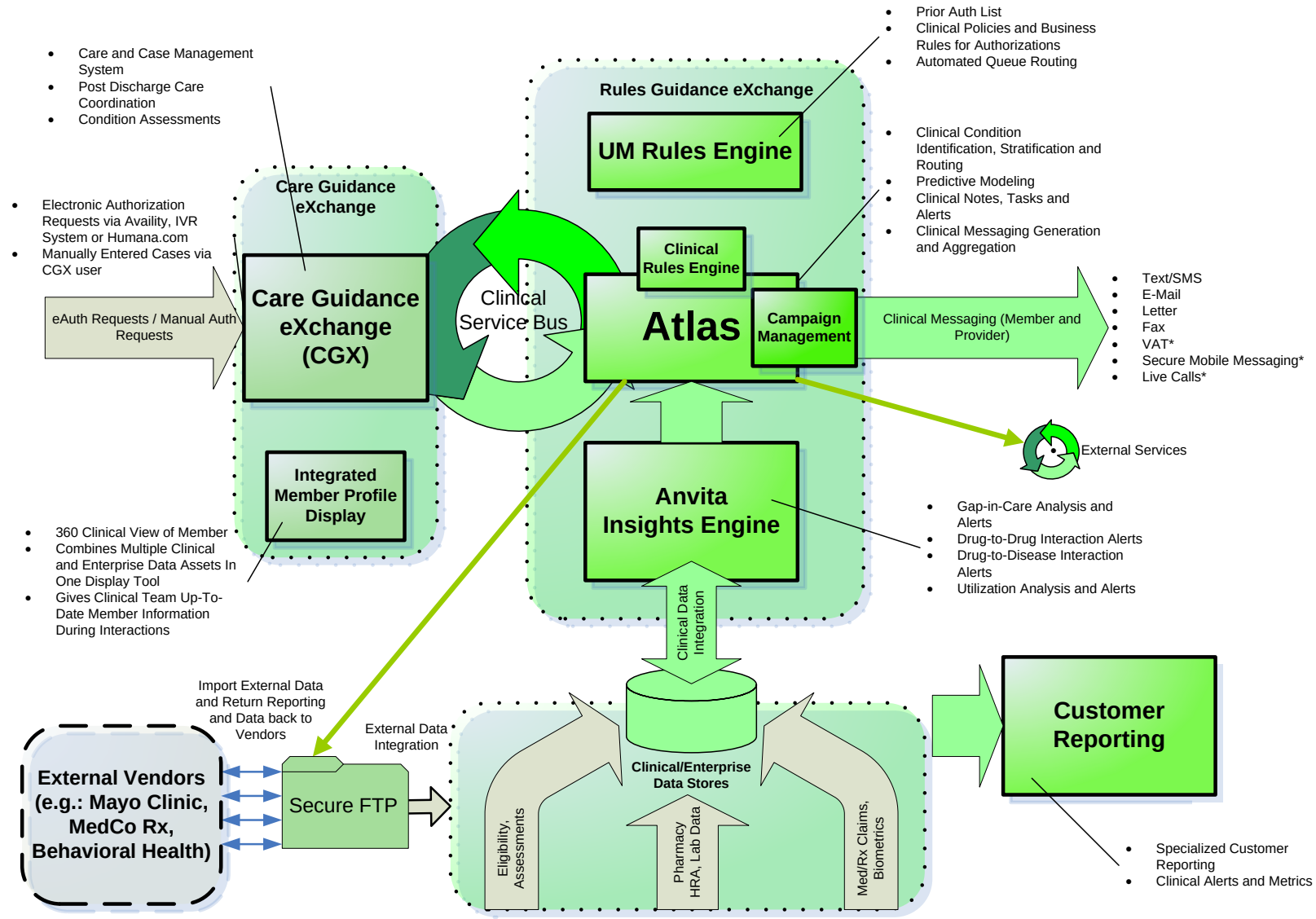
Attachment 19-3: LTC and Medical Services View from CGX Platform

Our Clinical Guidance eXchange (CGX) system documents include both medical and LTC information that allow us a full view of our comprehensive enrollees. Below is a screenshot from our CGX system illustrating our integrated views for our comprehensive enrollees.



Attachment 19-4: Humana Atlas Clinical Rules Engine

Our Atlas Clinical Rules Engine shown below allows for the identification, stratification and routing of a patient for various conditions.



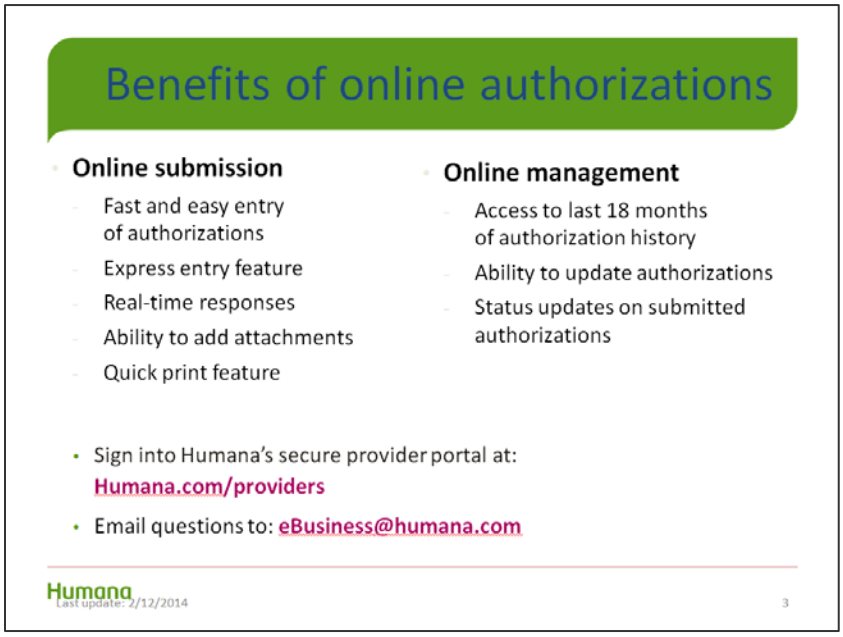
Attachment 19-5: Preauthorization and Notification Provider Training

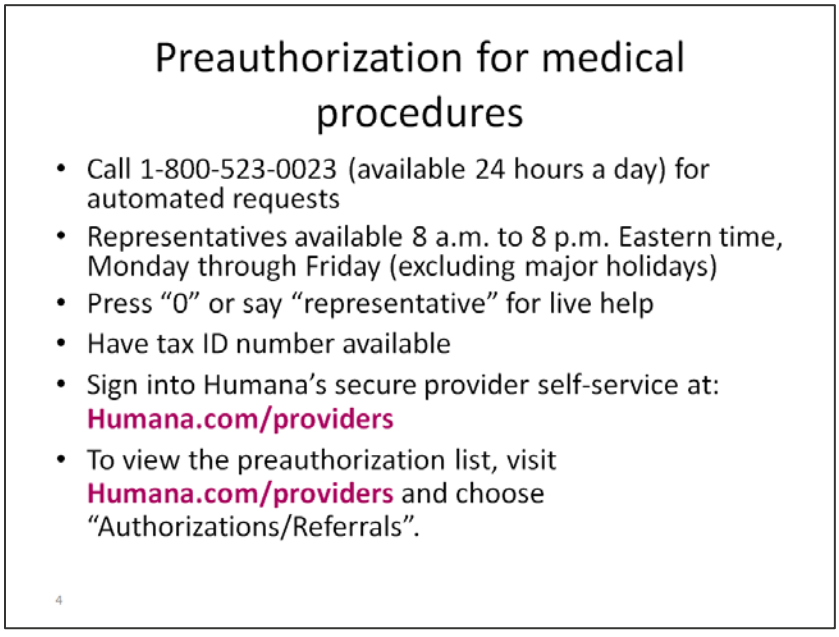
Providers must have authorizations prior to providing select services to our enrollees. Humana contractually requires its providers to conduct utilization management-related training for staff at their facilities. Below is an excerpt from Humana's training requirements.

Preauthorization and notification

- Allows Humana to provide members' benefit information.
- Required for many services and medications.
- Access lists at **Humana.com/providers**:
  - Select "Authorizations/Referrals."
  - Choose "Preauthorization and Notification Lists."
  - Select the current "Medicaid Preauthorization and Notification List."

2


Benefits of online authorizations
Online submission
Fast and easy entry of authorizations
Express entry feature
Real-time responses
Ability to add attachments
Quick print feature
Online management
Access to last 18 months of authorization history
Ability to update authorizations
Status updates on submitted authorizations
Sign into Humana's secure provider portal at: Humana.com/providers
Email questions to: eBusiness@humana.com
Humana
Last update: 2/12/2014
3

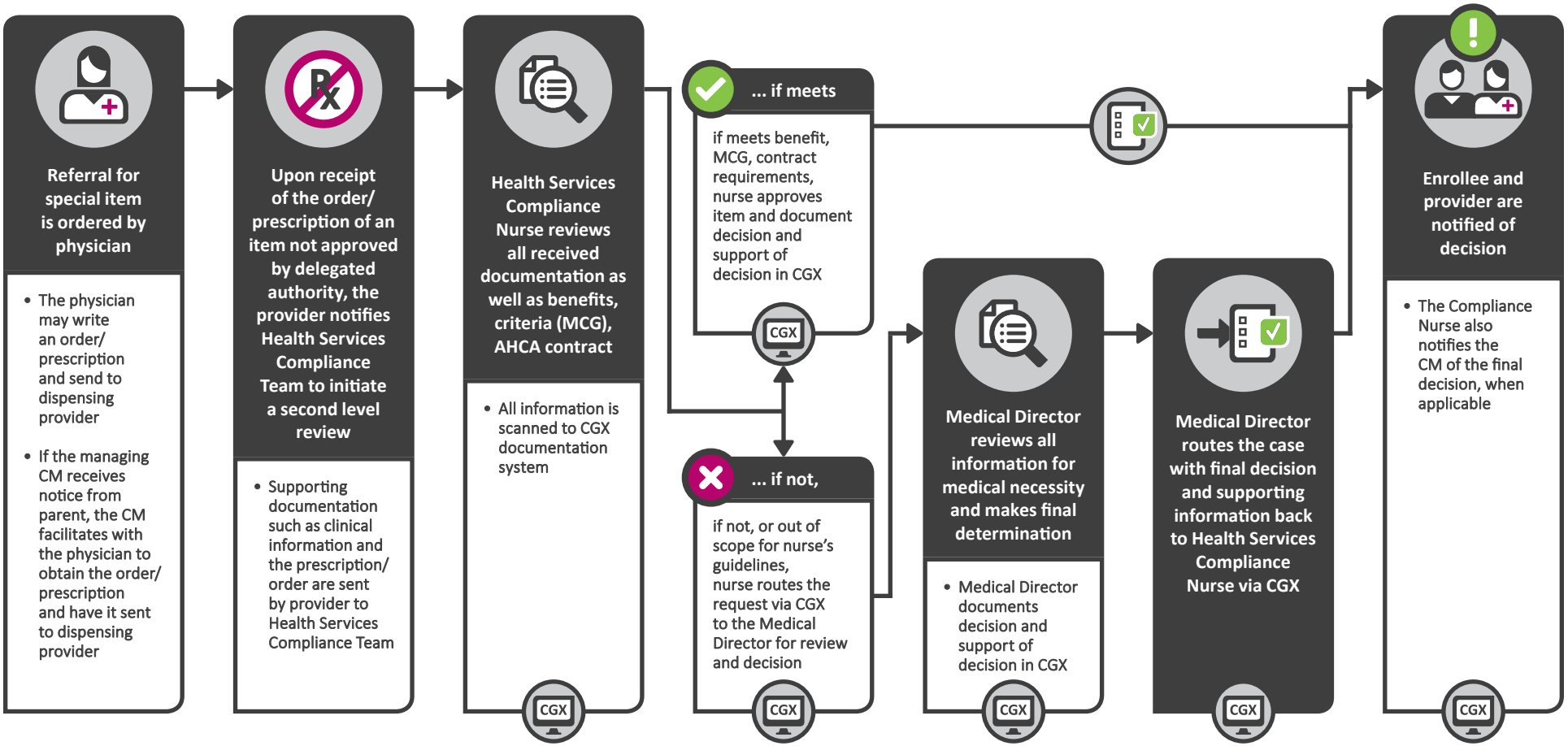

Preauthorization for medical procedures
Call 1-800-523-0023 (available 24 hours a day) for automated requests
Representatives available 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding major holidays)
Press "0" or say "representative" for live help
Have tax ID number available
Sign into Humana's secure provider self-service at: Humana.com/providers
To view the preauthorization list, visit Humana.com/providers and choose "Authorizations/Referrals".
4

Drug prior authorization and notification
• Get forms at www.humana.com/pa or call 1-800-555-2546 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)
• For drugs delivered/administered in physician's office, clinic, outpatient or home setting (fee-for-service providers only):
– www.humana.com/medpa
– 1-866-461-7273 (Monday through Friday, 8 a.m. to 6 p.m. Eastern time)
5

Attachment 19-6 – Special Service Requests for Enrollees under the Age of 21

Humana ensures our youngest enrollees have access to the services they need; we honor all service requests that meet medical necessity for our enrollees under the age of 21. When processing special service requests for children under the age of 21, to ensure we are consistent with EPSDT requirements, we **only** deny services if they do not meet Florida's definition of medical necessity.

CM = Case Manager
CGX = Clinical Guidance eXchange
MCG® = MCG (formerly Milliman Care Guidelines)
CPCM = Complex Case Manager



Humana.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 20 – Care Coordination (Statewide):

The respondent shall describe its approach for identifying, assessing, and implementing interventions for enrollees that present with the following:

- Complex medical and/or behavioral health needs;
- High service utilization;
- Intensive health care needs; and
- Consistently accessing services at the highest level of care.

The respondent's approach shall include:

a. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;

b. A description of minimum contact frequencies and contact type for each severity and/or risk level;

c. A description of the maximum caseloads for each case manager (ratio requirements) and support staff;

d. A description of evidence-based guidelines utilized in the care coordination approach, including interventions deployed to improve enrollee engagement and improve treatment adherence; and

e. A description of performance metrics used to evaluate the efficacy of the care coordination, including cost-savings, reduction in the use of higher cost services, etc.

Response:

Humana has been providing case management and care coordination for Medicaid populations and vulnerable subpopulations for decades. Our experience has shown us that an effective approach to identifying, assessing, and implementing interventions for high-risk enrollees must be multi-faceted and enrollee-driven while encompassing all levels of care. Our comprehensive case management program is dedicated to identifying, engaging, and managing our enrollees who require care coordination and case management services, and tailoring those services to the specific needs of the enrollee. Humana's process for identifying and monitoring the highest need and highest-risk enrollees integrates robust data analytics with specialized care coordination strategies. This approach allows us to proactively identify high-risk enrollees and preventively address emerging health issues.

We are committed to having well-trained and knowledgeable case management staff. In addition to hiring Case Managers (CMs) with specifically applicable experience (e.g., our pediatric CMs have pediatric-specific experience), Humana's Clinical Learning and Development (CLD) team provides a two (2)-week orientation that includes training on Medicaid, Humana's care and technology systems, ethics, cultural competency, motivational interviewing, and other computer-based training. After initial orientation, senior CMs mentor CMs for eight (8) weeks using onsite-office, field-based, and web-based training. This training

equips CMs to find and locate appropriate community resources to help resolve enrollee issues in a timely manner. They learn strategies to identify barriers to access to care, prioritize immediate needs, identify enrollee health literacy, and display empathy and emotional support. Humana provides a half-day monthly meeting of continuous education and training in addition to oversight, ensuring CMs have the most up-to-date care management information.

Humana maintains a “No Wrong Door” policy for identifying enrollees in need of regular care monitoring. We integrate all our various sources of identification and referral into our powerful CareHub platform, Humana’s innovative enterprise solution for complete program integration for Humana’s provider community and enrollees. This includes everything from predictive modeling to claims data and lab results. The CareHub Clinical Guidance eXchange (CGX) clinical workflow system supports an integrated approach to care coordination. As a fully integrated approach, this enterprise solution provides enhanced capabilities to identify enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention.

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1. The extent to which the respondent’s algorithm and risk stratification approach is well-defined and incorporates data elements other than diagnosis.

2. The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.

3. The extent to which the respondent’s approach includes the use of predictive modeling.
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Humana identifies and assesses an enrollee’s needs at both the time of enrollment and on an ongoing basis using multiple means, including but not limited to the sources listed below. Our data sources allow us to create a full picture of enrollee utilization and help us identify potential high utilizers, high-risk enrollees, and potential emerging risk factors upon initial enrollment and ongoing.

- Upon initial enrollment in Humana through:
-- Information from the enrollee’s 834 file
-- Prior authorizations and other continuity of care data and requests
-- New enrollee welcome calls
-- Health Risk Assessment (HRA)
-- Predictive modeling and risk stratification
-- Claims and encounter data that may be available from enrollee’s previous health plans and the Agency for Health Care Administration (AHCA)

- Ongoing identification through:
-- Data collected through Utilization Management (UM) or Case Management processes
-- Hospital admission and discharge data including Readmission Reports
-- Claims and encounter data
-- Ongoing face-to-face and telephonic contacts
-- High Utilizer Report (HUR)
-- Electronic Medical Record (EMR) access
-- Outlier Report

-- Pharmacy data
-- Electronic and automated reports
-- Twenty-four seven (24/7) nurse call line
-- Enrollee self-referrals
-- Referrals from caregivers, providers, and community agencies
-- Laboratory reports
-- Health management, wellness, and health coaching programs
-- Ongoing predictive modeling and risk stratification

The case management program maintains a "No Wrong Door" policy for potential care management referrals twenty-four (24) hours a day, including referrals from providers. We maintain a list of screening triggers for all internal and external staff to use as a guide to further maximize timely and accurate referrals to the case management program. In addition, because case management and disease management programs are effective tools to coordinate care for our enrollees, Humana includes a description of case management and disease management program opportunities for self-referral in the enrollee new materials and through our quarterly enrollee newsletter. We also disseminate information about these programs in provider materials.

Claims data analysis conducted through predictive modeling is a primary method we use to identify enrollees in need of case management and to determine the level of case management required. Humana seeks to obtain pre-enrollment claims and diagnosis history while the enrollee was in a different health plan or in fee-for-service (FFS) so we can thoroughly assess case management needs at time of enrollment. Our claims data inputs to our predictive modeling tools encompass all claims types: medical claims data, which include lab data, behavioral health claims data, and pharmacy claims data, which is available to us on a real-time basis. In Florida, we have partnered with independent labs to receive not only the claim for a completed test, but also the actual lab value.

It is important to highlight that an enrollee's life circumstances, such as socioeconomic status and environment and social service needs are also important determinants of the level of case management required. The additional data gathered through various avenues (e.g., Health Risk Screening results, internal and external referral sources) are crucial to incorporate into the identification and stratification process. We address an enrollee's whole physical, mental, and social health and seek to improve enrollees' health and social outcomes through a population health management approach.

The data mining by the CareHub CGX system is comprehensive and automated. This is where we integrate our predictive modeling tools. The CareHub infrastructure utilizes technology solutions such as Atlas and Anvita clinical rules engines to drive timely and actionable data into an enterprise workflow for the Humana team, including automated processes to route enrollees to specific clinical programs and CMs.

The backbone of our identification is advanced predictive modeling to detect enrollees who need support in the early stages of their condition, when we can have the greatest impact. By using medical and pharmacy claims data along with other data elements such as behavioral and socioeconomic input, this early identification allows our clinical programs to intervene before a major health event occurs. Sophisticated algorithms allow for precise stratification, and we queue enrollees in "risk rank order" for engagement, focusing on the highest-risk cases first.

This stratification does not determine the level of intensity of case management needed (e.g., low, medium, high, complex), but instead stratifies enrollees by severity score for prioritization of outreach. The enrollee's CM determines final case management intensity after outreach and comprehensive assessment.

The fact that our predictive models are based on our data and built on our systems enhances the validity, reliability, and flexibility of the models. Humana's predictive modeling capabilities have led the industry for years and we continue to innovate. Our approach is, in as close to real-time as possible, continually screening our enrollees for opportunities to make a difference. We then can reach out to the enrollee with the most appropriate level of support. Our proprietary predictive models include the following:

- Humana's MEDICAID SEVERITY SCORE PREDICTIVE MODEL is the primary predictive model used across the entire Medicaid population, not just on those who are hospitalized as with the Readmission Predictive Model described below, for example. Using this proprietary model, we incorporate a severity score generated from medical, behavioral health, and pharmacy claims into monthly reports that identify enrollees with high costs and clinically complex health conditions over a rolling 12-month period. The severity score is a predictor of future medical and pharmacy costs over the next 12 months. Use of this data allows Humana to identify enrollees with changing care needs, enroll them in case management, move them between acuity levels, and alter their level of case management intervention. All this occurs while we're gauging the stage of readiness of the enrollee to accept case management support.

- This innovative model addresses the challenges of modeling for a diverse group like those represented by Humana's Medicaid population. For such diverse populations, the large array of characteristics makes it difficult to score the enrollees under the same circumstances. Humana's model groups the individuals together based upon certain characteristics and builds individual models for each group. This 2-stage meta modeling is reliable, efficient, and provides increased accuracy.

- We then stratify the severity scores into complex, high, moderate, and low categories, which allows our case management team to identify the enrollees at greatest risk for a clinical event that could devastate them and their families. We prioritize case management processes to ensure that enrollees identified as complex or high risk receive intervention first, so we can mitigate potential crises or transition situations to whatever extent possible.

- Humana also calculates the READMISSION PREDICTIVE MODEL (RPM) to assess the probability of an enrollee's readmittance into a facility within thirty (30) days. The RPM is a true predictive modeling process, with inputs from more than 50 variables including demographics such as the enrollee's age and gender, previous medical and pharmacy claims including physician visits, admissions, days since last admission, Charlson Comorbidity Index (validated instrument regarding co-morbidities), and number of medications, as well as information regarding their current admission (procedure, diagnosis, bed type, length of stay (LOS), and discharge disposition). The process generates a numerical RPM score, which allows stratification and prioritization based upon the risk of all-cause readmission within thirty (30) days.

- Humana uses EMERGENCY DEPARTMENT PREDICTIVE MODELS that prospectively identify enrollees likely to use emergency departments, likely to become high emergency

department utilizers, and likely to use emergency departments for non-emergent reasons to provide the following benefits:

--Opportunity for proactive enrollee engagement and education to reduce barriers to optimal health management;

-- Referrals to clinical programs and alignment with support services; and

--Prevention of repeated ED visits as a substitute for primary care, often detrimental to enrollees with chronic conditions. This also helps create a stronger enrollee-physician care partnership.

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4. The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.

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Before determining the frequency and intensity of our care coordinaton services based on enrollee-specific needs, we engage in comprehensive assessment of our enrollees. We summarize our assessment and care planning approaches below and then follow with a description of contact frequencies and contact type.

ASSESSMENT AND CARE PLANNING

Every aspect of health care begins by assessing the enrollee's need for care. The assigned CM contacts enrollees with Managed Medical Assistance (MMA)-only benefits who are referrals for and accept participation in case management. The CM administers a comprehensive case management assessment within thirty (30) days of the enrollee's acceptance of participation. Our comprehensive case management assessment not only identifies health needs but also identifies potential barriers to care, such as an enrollee's lack of knowledge of their disease state, understanding of the PCP's treatment plan and importance of adhering to that plan, or challenges in meeting basic needs. These basic needs include the ability to afford food, housing, and transportation. Elements include:

- Enrollee's health status, including condition-specific issues

- Social and cultural dynamics, including an evaluation of activities of daily living and functional status

- Evaluation of caregiver resources including adequacy, involvement, and level of decision-making

- Cultural and linguistic needs, preferences, or limitations

- Life planning activities

- Mental health status, including psychosocial and cognitive functioning

- Clinical history, including a medication reconciliation

- Evaluation of available benefits within the organization and from community resources

- Evaluation for hearing and visual preferences or limitations

We assign a CM to all Comprehensive enrollees, those with both Long-term Care (LTC) and full MMA benefits through our plan. The CM assesses them face-to-face for long-term care services and support (LTSS) needs as well as for medical and behavioral health needs.

The additional information we gather through the assessment, which involves direct communication with the enrollee and caregiver or designee, enables the CM to make a final determination on acuity. With all factors in mind, including predictive model scores and information gathered during the comprehensive assessment, the CM assigns acuity based on clinical judgment.

Humana CMs actively manage enrollees, coordinating care between service settings and acuity levels. Our comprehensive case management program is multifaceted and encompasses Low Acuity Case Management, Medium Acuity Case Management, High Acuity Case Management, and Complex Acuity Case Management, described in greater detail later in this section.

We create an individualized POC for every MMA-only enrollee within thirty (30) days of his or her consent to case management. Comprehensive enrollees all receive case management and an individualized POC. The CM creates a Multidisciplinary Team (MDT) specific to the enrollee's needs. This may include the CM, the enrollee and enrollee representative, family and caregivers, the enrollee's PCP, and other applicable providers involved in the enrollee's care. The CM leads the development of the plan, keeping the enrollee and PCP as the primary contributors, followed by other MDT members. The results of comprehensive assessment form the basis for the plan's individualized and prioritized goals and interventions, which we develop with timeframes for completion and the enrollee's documented progress toward achieving their goals. CMs monitor, update, and revise the goals as needed. Each goal has a set of interventions and expected outcomes associated with it.

Examples of other key items included within the individualized care plan process include:

- A communication plan with the enrollee including anticipated frequency of contacts

- A communication plan with the PCP and specialist to ascertain the needs the provider has identified and prioritized, including a process to ensure the provider's treatment plan is reflected in the plan of care developed by the health plan

- Specific services and benefits needed

- Preferences for care

- Need for add-on or extended benefits

- Services for enrollees with disabilities

- Identification of providers responsible for delivering services

- Identification of referrals made to specialists or providers and confirmation that the enrollee received these services

- Referrals to community, social, recovery support agencies, including assisting enrollees in contacting the agency and validating the enrollee received the needed service

- A review of the new and updated care plan with enrollee, family, and caregiver as needed and the PCP and specialist and actively seek input from them

- Contingency planning for changes in condition or caregiver availability and ability

- A plan for effective and comprehensive transitions of care between care settings

- Continuous review and revision of the plan of care, which includes follow-up contact as needed with enrollee to ensure care plan is adequately monitored, including identification of gaps between recommended care and actual care provided

The primary objective of the plan of care is to identify and document the enrollee's problems, goals, and interventions to guide best practices, support enrollee expected goals and outcomes, and provide a tool for communication among the enrollee's MDT. While the CM initiates and updates the POC, other participants on the enrollee's care team, including the enrollee, actively contribute to the development and ongoing updates to the plan to ensure the enrollee achieves his or her physical, behavioral, and psychosocial goals.

FREQUENCY AND INTENSITY OF CARE COORDINATION SERVICES

The Humana case management model allows for differing levels of care coordination and follow-up with the enrollee, provider, and other stakeholders based on the acuity level of the enrollee.

- COMPREHENSIVE ENROLLEES: All Comprehensive enrollees receive case management. For these enrollees, the primary CMs are LTC specialists who are assisted by RN CMs acting in a consultative role for the medical component. CMs have at minimum monthly contact with these enrollees and quarterly face-to-face visits, regardless of their acuity level. We will enhance contact frequency based on enrollee's risk stratification and comprehensive needs assessment.

- ENROLLEES UNDER THE AGE OF 21 YEARS WHO ARE RECEIVING SERVICES IN A SKILLED NURSING FACILITY (SNF), RECEIVING PRIVATE DUTY NURSING (PDN) SERVICES IN THEIR FAMILY HOME, OR OTHER COMMUNITY-BASED SETTING: Whether a Comprehensive enrollee or MMA-only enrollee, contact frequency is at minimum monthly and includes quarterly face-to-face visits.

COMPLEX ACUITY

- The CM contacts complex acuity enrollees weekly.

- The criteria for stratifying an MMA-only enrollee as complex are as follows

-- At least two (2) hospitalizations within 30 days

-- Medical, educational, and psychosocial barriers that lead to emergency department or inpatient readmissions

-- Complex needs for care coordination.

We use the following referral guidelines to identify Comprehensive enrollees for complex case management:

-- Discussion with medical director required because of unmanaged health issues or the enrollee's inability to take or obtain medications

-- Complex health and medical management situations

-- High Utilization of emergency department or hospitalizations – two (2) or more hospitalizations within 6 months

-- End of life issues that require team approach

-- Transitions of care concerns to prevent unplanned nursing home placement

-- Home safety, durable medical equipment (DME), or fall prevention concerns

-- Change in cognition (e.g., dementia or decline in health or lack of caregiver support)

-- Caregiver struggling to assist the enrollee with his or her health issues or because of enrollee's decline in health

-- Increased need for case management – when the discussion becomes more clinical while liaising with an enrollee's PCP

-- Unresolved state complaints that require Medical Director intervention

-- Difficult transitions to the community setting

-- Complex discharge planning, enrollee decline during hospitalization now requesting extensive services

For enrollees with complex needs, we extend and formalize the role of the MDT to ensure that we regularly review such enrollees' care using a team approach. This ensures a person-centered care plan is in place and that we address and resolve any gaps in care. The MDT core participants for these enrollees may include the enrollee and caregiver, Medical Director, CM, Disease Management (DM) Nurse if indicated, Frontline Leader, and any other participants involved in the enrollee's care (e.g., PCP, specialists, behavioral health provider, Medicare

health plan). The CM collaborates with the MDT on a regular basis and presents their cases during a monthly Interdisciplinary Case Conference. We may hold unscheduled MDT meetings as needed to review any urgent or emergent situations.

HIGH ACUITY:
- The CM contacts these enrollees monthly.
- Stratification criteria are as follows:
-- At least 2 hospitalizations within the last 3 months
-- Medical, educational, and psychosocial barriers that lead to ED/inpatient readmissions
-- Ongoing needs for care coordination

MEDIUM ACUITY:
- The CM contacts these enrollees every other month.
- Stratification criteria are as follows:
-- At least 2 hospitalizations within the last 6 months
-- Barriers to educational and self-healthcare management
-- Require reinforcement about their plan of care

LOW ACUITY (SHORT-TERM, EPISODIC CLINICAL MANAGEMENT):
- The CM contacts these enrollees every 3 months
- Stratification criteria are as follows:
-- No hospital admissions, but has ED utilization of more than 2 visits in 30 days
-- Knowledge deficit of ED versus Urgent Care and PCP visits for follow-up care and sick visits

LOW ACUITY (NON-CLINICAL MONITORED AND PENDING HIGH UTILIZATION REPORT MONITORING STATUS):
- A case management assistant contacts these enrollees six (6) months following enrollment into case management, and then annually.
- Stratification criteria include the following:
-- No hospital admission within the last 6 months
-- Stable with mild or no symptoms
-- Understands their plan of care, but desires a CM for follow-up
-- Complies with plan of care and does not require assistance with care coordination

BEHAVIORAL HEALTH INTENSIVE CASE MANAGEMENT (ICM): We have designed Behavioral Health ICM to serve enrollees with the most complex behavioral health care needs. These enrollees are typically at the highest risk within the health population for negative clinical outcomes related to mental health and substance use issues and co-morbid medical issues.

The following criteria qualify an enrollee as eligible for ICM:
-- Rapid re-admission (within 60 days)
-- Frequent emergency department visits
-- Recent suicide attempt
-- Co-morbid medical condition with Behavioral Health and Substance Abuse Disorder that could result in exacerbation of the fragile medical status

The primary goals of the ICM program are to help individuals maintain or improve community tenure, regain optimal health, improve life functioning capability, and promote resiliency and recovery. Contact frequency for ICM is a minimum of 1 contact per month; however, enrollee

acuity will determine frequency. Ideally, once an enrollee engages in the ICM process and begins to stabilize, contact frequency will lessen but will continue to be at least once per month.

Humana's case management program uses both telephonic and face-to-face contact with enrollees. In addition to the quarterly face-to-face visits with comprehensive enrollees and enrollees under the age of twenty-one (21) who are receiving services in an SNF or receiving PDN services in their family home or other community-based setting, face-to-face visits also occur as part of the following initiatives:

- HIV-AIDS FIELD CASE MANAGEMENT (FCM). In June 2016, we implemented FCM for enrollees participating in our HIV/AIDS DM program who reside in Dade or Broward counties. Humana has 1 dedicated HIV/AIDS DM CM in Broward and one (1) in Dade who meet with their assigned enrollees wherever they need to: in the home, PCP office, hospital, or elsewhere. We initiated this program to enhance our case management services for this population, as we found that many enrollees with HIV/AIDS felt uncomfortable engaging over the phone. We selected Dade and Broward counties for this iniative because these counties are home to a large number of new infections.

- FIELD CM AND FIELD SOCIAL WORKER PILOTS. In July 2017, Humana introduced Field CM and Field Social Worker Pilots in Broward and Dade Counties for reducing utilization, reducing barriers to close gaps in care, and improving engagement of identified enrollees with complex needs. We designate a Field CM and a Field Social Worker in each of these counties to conduct field visits to the enrollee at the hospital and at PCP appointments (and, beginning in Phase Two of the pilot, in the enrollee's home). We identify enrollees eligible for a field visit through a variety of sources, including the following:
-- Complex Acuity
-- High Utilizer Enrollee (e.g., as identified via Frequent Admitter Report)
-- UM Nurse Referral (high risk for readmission)
-- Regional Medical Directors
-- Physician Referral
-- CM Referrals (Non-compliance with plan of care or PCP appointments, complex needs, knowledge deficit with psychosocial issue or barrier)

Hospital visit criteria include the following:
-- Enrollees non-compliant with PCP visits
-- High Utilizers
-- Knowledge deficit issues (e.g., medication issues)
-- Enrollee or PCP request (Supervisor approval needed)

- In addition to our Field CM pilots, we have recently instituted a field visit component for all our telephonic CMs throughout our MMA program. While the majority of enrollee contacts continue to be telephonic, each CM conducts at least 1 field visit per month at the hospital or PCP office to engage an enrollee identified for case management whom they have been unable to contact. For instance, if a high utilizer we have been unable to reach and engage in case management is hospitalized, there will be an alert in the system so that a CM may visit the enrollee in the hospital and try to engage them. Similarly, if a complex acuity enrollee is already engaged but would benefit from direct contact between the CM and the PCP, the CM can meet with the enrollee and the PCP at an office visit.

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4. The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.

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CASELOADS FOR MMA-ONLY ENROLLEES

Humana has maximum caseload requirements relative to Enhanced Care Coordination for Enrollees under the age of twenty-one (21). We assign CMs to children with special needs, including enrollees under the age of twenty-one (21) who are receiving skilled nursing facility (SNF) or PDN services. On May 21, 2015, AHCA approved a mixed caseload that does not exceed caseloads outlined in the contract and meets the following methodology:

- Each CM will carry a weighted caseload of no more than 15 enrollees where each enrollee residing in a Nursing Facility counts as 1, and each enrollee receiving services in the community counts as 15/40 (or 0.375)

- This methodology translates to the following mixed caseload formula: # of NF enrollees + (# of PDN enrollees X 0.375) = less than or equal to 15

For other CMs and support associates, we maintain targets that guide our process of assigning CMs to enrollees as follows:

- Telephonic CMs (including telephonic DM and OB CM nurses providing case management services to enrollees participating in these programs): Caseload Target of 70 enrollees.

- Field CMs (including HIV/AIDS DM CMs and pilot FCMs in Broward and Dade counties): Caseload Target of 40 to 45 enrollees.

- Telephonic social workers: Caseload Target of 100 enrollees.

- Field social workers (pilot in Broward and Dade Counties): Caseload Target of 40 to 45 enrollees.

- CM Assistants: Caseload Target of 150 enrollees.

All our CMs and support staff have a mix of enrollee severity levels in their caseloads. When assigning a new enrollee to a CM and support staff, we assess the current caseload to ensure that adding an enrollee at the enrollee's initially assigned case acuity level will not overload the CM or support associates.

CASELOADS FOR COMPREHENSIVE ENROLLEES

CM caseloads do not exceed a ratio of sixty enrollees to one (60:1) CM for enrollees who reside in the community, or a ratio of one hundred (100) enrollees to one (1) CM for enrollees who reside in a nursing facility. As all CMs are likely to have blended caseloads, we weight caseloads to ensure contractual compliance with caseload ratios. For example, a CM may have fifty (50) assigned enrollees residing in the community (who are weighted as one point six six (1.66) enrollees each) and sixteen (16) enrollees residing in a nursing home (who are weighted

at one (1) enrollee each), and not exceed the maximum weighted ratio of one hundred (100) enrollees.

Humana cross-trains all CMs on all contract performance provisions so we can assign any CM to enrollees with related needs. To ensure optimal case management assignment, we adjust case management staffing and caseloads as necessary based on not only the number of enrollees, but also the enrollees' acuity and intensity of case management interaction. For purposes of monitoring and managing specialty caseloads, we determine caseload acuity by assigning different weights to enrollees, as follows:

- Enrollees with special and complex needs (e.g., traumatic brain injury, AIDS, ventilator-dependent) will receive an acuity weight of 1:2.5. We will count any enrollee with such special needs as 2.5 enrollees in caseload calculations.

- We will assign an acuity weight of 1:2 to all other enrollees stratified into moderate and high acuity levels using our Acuity Stratification Tool. This means that we will count each moderate or high acuity level enrollee as 2 enrollees in caseload calculations.

- All other enrollees, including those in the low acuity level, will have an acuity weighting of 1:1

Frontline Leaders and Clinical administrators review caseload size and acuity monthly to ensure appropriate supervisory oversight by the Frontline Leaders. If through such analysis we find that we are exceeding caseload ratios or that caseloads have inappropriately high acuity levels, the Clinical administrator will coach the Frontline Leaders and develop work plans to ensure contract compliance.

CASE ASSIGNMENT OPTIMIZATION MODEL
Humana has recently invested in technology to improve care management compliance, efficiency, and the enrollee experience. By removing obstacles to providing care coordination to enrollees within the community we are increasing the time case managers spend with enrollees. Specifically, we have developed a case manager assignment program which utilizes linear algorithms to determine the most appropriate case manager to assign to each enrollee. The algorithm has been pairs with a user interface that allows the clinical management team to make future case manager hiring and membership distribution decisions that best serve our enrollees (see Attachment 20-1). Factors accounted for within the algorithm include: distance from casse manager to enrollee, prior assignment, state weighting, membership clustering, language preference, enrollment and term projections, and current model to optimal model thresholds. The utilization of advanced mathmatical clustering techniques combined with a linear program solver and enrollee directed inputs creates an industry leading practice for enrollee assignment. Travel savings resulting from use of this model are estimated to be as high as forty percent (40%) across all regions once the model is fully phased in. A handful of enrollees who require specialized training are excluded from the algorithm and assigned manually.

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5. The extent to which the respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.

6. The adequacy of the respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.
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Humana's Case Management programs incorporate the National Committee on Quality Assurance (NCQA) guidelines for accredited case management programs in each of the following areas NCQA addresses:

- Element A: Population Assessment
- Element B: Program Description
- Element C: Identifying Enrollees for Case Management
- Element D: Access to Case Management
- Element E: Case Management Systems
- Element F: Case Management Process
- Element G: Initial Assessment
- Element H: Case Management – Ongoing Management
- Element I: Experience with Case Management
- Element J: Measuring Effectiveness
- Element K: Action and Remeasurement

The interventions we employ to enhance enrollee engagement and improve treatment adherence are multi-faceted and incorporate evidence-based best practices. They include the following:

- MOTIVATIONAL INTERVIEWING: All of Humana's CMs and Case Management Assistants receive training on motivational interviewing skills designed to engage enrollees and help them decide if they are hesitant or apprehensive. Both initial training and ongoing coaching address communication techniques and behavior change strategies. Training includes role-play, observation, and hands-on learning exercises. They incorporate motivational interviewing into interactions and collaboration with enrollees to facilitate progress toward enrollee-centric goals, reduce ambivalence, and promote behavioral change. These motivational strategies may include open-ended questions, affirmations, reflective listening, and summarizing, among others.

- ADDRESSING CULTURAL DIVERSITY: Humana is committed to addressing cultural diversity through cultural competency training, through building a network and providing supports such as translation services that minimize barriers to care resulting from language and cultural barriers, and through disseminating culturally and linguistically appropriate materials to our enrollees. These efforts are particularly important to maximizing the appropriate utilization of certain services, such as prenatal and postpartum services, as cultural values and beliefs related to pregnancy often contribute to an enrollee's hesitancy to access services. Through our case management programs, we ensure we inform and link our enrollees to the translation services and community resources they need to facilitate their care.

- CASE MANAGEMENT PROCESS: Our CMs work with each enrollee and his or her caregiver to identify and address barriers to the POC, such as poor understanding of the treatment regimen or difficulty remembering to take medicines. In addition to using techniques such as motivational interviewing to engage the enrollee, difficulty in implementing behavior change

strategies for enrollees in complex case management will result in convening an MDT. During this meeting which all persons involved in the enrollee's care can address strategies for change.

- ENGAGING INDIVIDUALS WHO INITIALLY DECLINE TO ENGAGE: Our foremost priority is to respect the choices of every enrollee. Enrollees may exercise their right to decline or disengage from case management. For our most complex enrollees and LTC enrollees who have declined to engage or have disengaged, cases remain open. In these instances, CMs continue to monitor and receive alerts about the enrollee in the event of hospitalizations, changes to a condition, or any other health events. CMs offer the opportunity to engage or reengage, if the enrollee is willing, after a health event. Even if an enrollee doesn't experience a health event or change in condition, CMs reach out over the phone periodically or based on minimum contact requirements to offer case management services and to ensure the enrollee is receiving everything they need both medically and socially (unless the enrollee states he or she doesn't want contact from us).

- PEER SUPPORT: Humana recommends a system of care approach that embraces recovery and resiliency using peers. Both of our behavioral health partners, Beacon Health Options (Beacon) and Access Behavioral Health (ABH), incorporate peer support to enhance enrollee engagement and to address the unique needs of difficult to serve populations.

-- Beacon utilizes peer specialists who are trained in principles of recovery and resilience, wraparound services, and traditional peer support. Beacon connects enrollees to the National Alliance for Mental Illness (NAMI), which has peers throughout the state, and to community resources that offer peer specialists. Peer specialists support the enrollee's engagement in treatment, assist in navigating the service system, and identify natural supports. They also reach out to recently discharged individuals to assist in their transition, support their adherence to any follow-up appointments, and help them leverage their own strengths. Peer support specialists significantly enhance the impact of case management and broaden the array of support available to families. Their "lived experience" allows them to connect in a meaningful way, showing by example that recovery is attainable.

-- ABH launched Café PERC (Peer Education Resource Community) at Lakeview Center in 2012 as a clubhouse-model peer-support service organization (PSSO), where consumers of behavioral health services share information, socialization, and recreational activities with their peers. The café serves as a safe place where guests interact with one another in a comfortable, low-stress environment without fear of stigma or judgment. Lakeview's Behavioral Health Division assumed responsibility for Café PERC the following year, and ABH continues active involvement. ABH associates facilitated training in Region 1 for Peer Recovery Certification, which is a designation for behavioral health consumers to become trained to act as support and advocates for other behavioral health consumers. Currently, these associates work at Café PERC.

- FIELD CASE MANAGEMENT: As discussed earlier in the response, we have implemented HIV/AIDS field case management, field case management and field social worker pilots, and a field visit component for all our telephonic CMs throughout our MMA program. The primary objective of all of these initiatives is to improve engagement of identified enrollees with complex needs. Early results from our field case management program for HIV/AIDS indicate that this strategy has been effective. By successfully engaging these enrollees, guiding them to the appropriate care setting, and enrolling them in DM, Humana has reduced our average per

member per month (PMPM) cost for these enrollees by forty-eight percent (48%). Lower PMPM costs indicate better overall management of these enrollees, thereby improving overall outcomes.

- TELEMEDICINE: As discussed in detail in our response to MMA SRC #4, Humana and our behavioral health partners, Beacon and ABH, use telemedicine to meet enrollee access needs, particularly in challenging rural areas. We understand the value and endorse the use of telemedicine technologies as a component of an effective care management model. Telemedicine availability improves access to care, reduces emergency room use, and improves opportunity for detection and control of chronic diseases. For highly resistant and difficult to serve populations, the ability to connect enrollees to telemedicine providers is very beneficial; telemedicine availability reduces barriers related to time and distance that may interfere with enrollees' desire to engage in their care and their ability to adhere to treatment regimens. Humana, Beacon, and ABH all ensure that there are no limitations on telemedicine services if providers and practitioners who conduct telemedicine have the proper interactive electronic systems that protect the confidentiality of client information as well as audio and visual data transfer during the provision of telemedicine services.

- REAL-TIME ED ALERTS: Since 2014, Humana has developed relationships with Florida hospitals to receive daily reports of emergency department encounters to reduce the months-long notification lag to 1 day. Timely outreach and engagement of enrollees to educate and close gaps has been key to impacting unnecessary emergency department utilization. Humana is currently contracted with AHCA for the Florida Health Insurance Exchange's (HIE) Event Notification Service (ENS) for Regions 9, 10, and 11, which automates the notification process and has increased our provision of daily reports to facilities.

- EFFECTIVE TRANSITION PROCESSES: As described in our responses to MMA SRC #10 and LTC SRC #3, we have created processes that meet the needs of our enrollees and their families during transitions between care settings and levels of care. During these critical times, they are most likely to seek education and assistance with care coordination. Internal propensity-matched studies, which inform our post-discharge activities for all our enrollee populations, suggest that the closer the post-discharge intervention follows the discharge, the more likely the intervention will have a positive impact on quality of care and decrease inappropriate and costly readmissions. Engaging enrollees at these crucial points has resulted in decreasing readmission rates. In both 2015 and 2016, we significantly improved our readmission rate goal for our enrollees in complex case management, (by 7 percentage points between 2015 and 2016).

- PROACTIVE HEALTH INITIATIVES: Focusing on effective healthcare proactively during childhood helps establish patterns of lifelong healthcare engagement. Enrollees who establish patterns of engagement early are more likely to avoid the health risks associated with lack of regular preventive and prenatal care, for instance. Thus, we have developed the following initiatives centered on building positive provider-enrollee relationships during childhood.

-- Our welcome calls to all new female enrollees of childbearing age include a brief discussion of gynecological care. We ask the enrollee where she receives gynecological care and when her last visit was. If the enrollee states that she is not receiving gynecological care, we connect her to a CM to provide education on the importance of obtaining such care on a regular basis. This

not only helps to improve the enrollee's gynecological health, but also supports a healthy start to pregnancy and adequate prenatal care for those enrollees who later become pregnant.

-- For children, our provider network team and Quality Improvement Nurses (QINs) conduct to PCPs who have child enrollees who have yet to visit. We encourage the PCP to reach out to their enrollees to schedule a child health checkup. We also are initiating a Healthy Kids outreach campaign for school-aged children who have yet to have a PCP visit. This initiative reaches out to the parents/caregivers to encourage PCP visits for their child.

- INNOVATIVE COMMUNICATION METHODS: Humana offers a range of sophisticated and innovative technologies, including an extensive social media presence, text messaging platform, and numerous mobile applications. To align with AHCA's goals and to meet our enrollees where they are, Humana is developing and implementing a Medicaid-specific digital health strategy. Our strategy focuses on engaging hard-to-reach enrollees to ensure they are aware of and know how to use the breadth of resources we have available. It includes a redesigned health and well-being website, social media platforms as avenues for enrollee education and engagement, and mobile-friendly access to Humana resources. We provide detail on this strategy in our response to SRC #13.

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7. The efficacy of the respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.
==========

A key component of our CM program is evaluation. We continuously evaluate operational, humanistic, clinical, and economic outcomes to improve overall enrollee health and well-being. Below we summarize the sample metrics we use for each of these categories of evaluation and provide examples of recent results within each category.

Operational Outcomes:
-- Definition: Efficient operations, high participation rate, effective outreach
-- Sample Metrics: Program participation, outreach frequency
-- Recent Results: Of adult enrollees eligible for and reached regarding case management, 74% agreed to participate in the program

Humanistic Outcomes:
-- Definition: Positive trends in patient-reported indicators (subjective measures)
-- Sample Metrics: Participation satisfaction, improved quality of life, readiness to change
-- Recent Results: Humana conducts enrollee surveys to assess satisfaction among enrollees who participate in our CM programs. From August through September 2017, Humana conducted a survey to assess satisfaction among enrollees who participated in the Humana Complex Case Management Program. Evaluated measures included the program's impact on enrollees' likelihood to make changes in their health and enrollees' preparedness to manage their health, as well as overall CM ratings. Our most recent results are very positive. Every measure represented an improvement over the previous year. The percentages below reflect percent of enrollees who gave ratings of 4 or 5, on a scale of 1-5:
--- CM Rating – Overall: 82%
--- CM Rating – Knowledgeable: 88%
--- Likely to make change in how you take care of your health: 77%

--- Whether you feel more prepared to manage your own health: 77%
--- Helped You Achieve Healthcare Goals (new question in 2017): 82%

Clinical Outcomes:
- Definition: Achievement of clinical standards of care (objective measures).
- Sample Metrics: Increased treatment adherence, reduction in adverse events (e.g., emergency department visits, hospital stays).
- Recent Results: For adult and pediatric enrollees participating in our Case Management Programs between January 1, 2016, and June 30, 2017, we looked at annualized admissions per thousand (APT) and emergency department visits per thousand (EPT) in the 6 months prior to their enrollment in CM and in the 12 months following their enrollment in CM.

--- For adult CM enrollees, APT decreased 57% and EPT decreased 34% from the pre-CM enrollment period to the post-CM enrollment period.
--- For pediatric CM enrollees, APT decreased 61% and EPT decreased 32% from the pre-CM enrollment period to the post-CM enrollment period.

Please see Attachment 20-2 for additional detail.

Economic Outcomes:
- Definition: Healthcare cost savings
- Sample Metrics: Reduction in overall costs per participant per month
- Recent Results: For adult and pediatric enrollees participating in our Case Management programs between January 1, 2016, and June 30, 2017, we also looked at per member per month (PMPM) costs before and after CM enrollment. As with APT and EPT trends, average costs PMPM decreased significantly from the pre-CM enrollment period to the post-CM enrollment period, for both adult enrollees, who had a 37% decrease, and pediatric enrollees, who had a 62% decrease. Please see Attachment 20-2 for additional detail.

Evaluation Criteria:

1. The extent to which the respondent's algorithm and risk stratification approach is well-defined and incorporates data elements other than diagnosis.

2. The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.

3. The extent to which the respondent's approach includes the use of predictive modeling.

4. The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.

5. The extent to which the respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.

6. The adequacy of the respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.

7. The efficacy of the respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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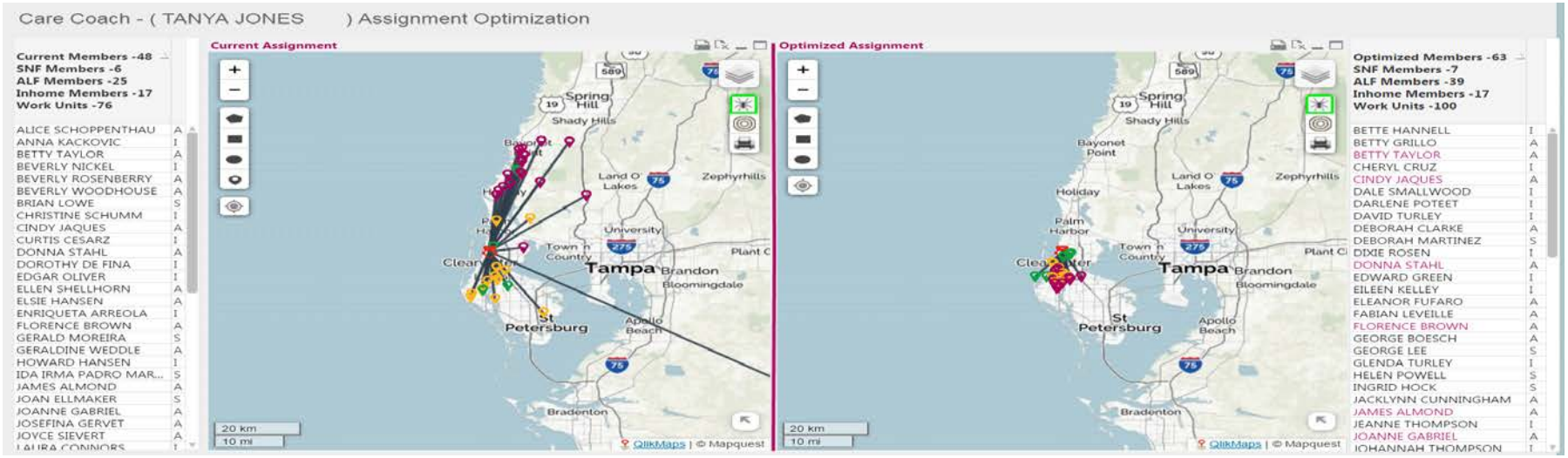
Attachment 20-1: Medicaid – Case Assignment Optimization Model

- Model has been delivered to the market with phased implementation beginning 3rd quarter 2017
- Estimated travel savings of 40% across all regions
- Phase 2 of the project will deliver ongoing assignment capabilities accounting for existing established Case Manager relationships - to be delivered 4th quarter 2017

Care Manager Example

Assignment Before Optimization

Assignment After Optimization



Humana.

Health Services Outcome Metrics

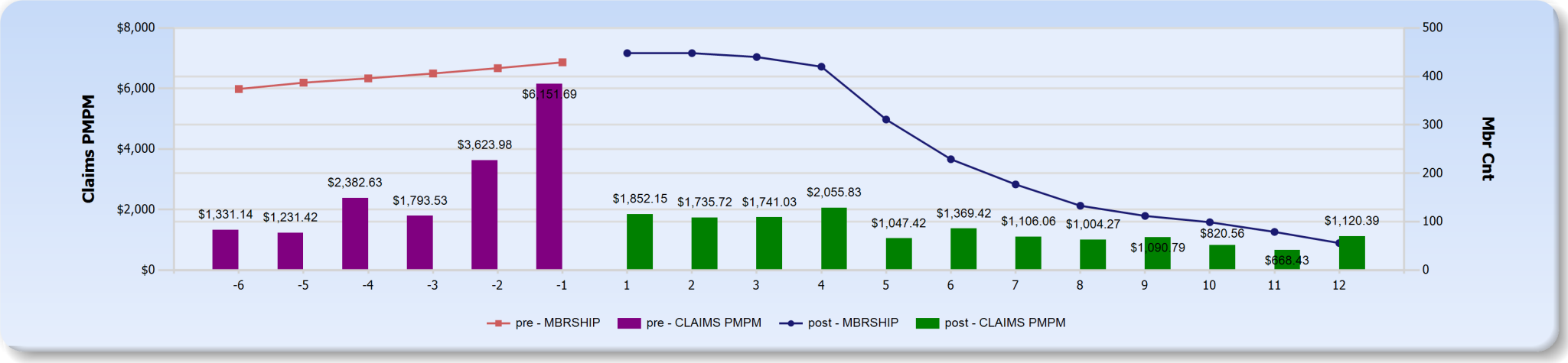
As at : 8/18/2017

Program Name : CASE MANAGEMENT

LOB : MEDICAID

Patient Type : ADULT

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	**PRE PMPM**	**POST PMPM- 12 Months Post**
-37.09%	$2,821.24	$1,774.85

APT Trend		
Trend	**6-Month Pre**	**12 - Month Post**
-56.89%	2,232	962

EPT Trend		
Trend	**6-Month Pre**	**12 - Month Post**
-33.72%	3,073	2,037

Humana.

Health Services Outcome Metrics

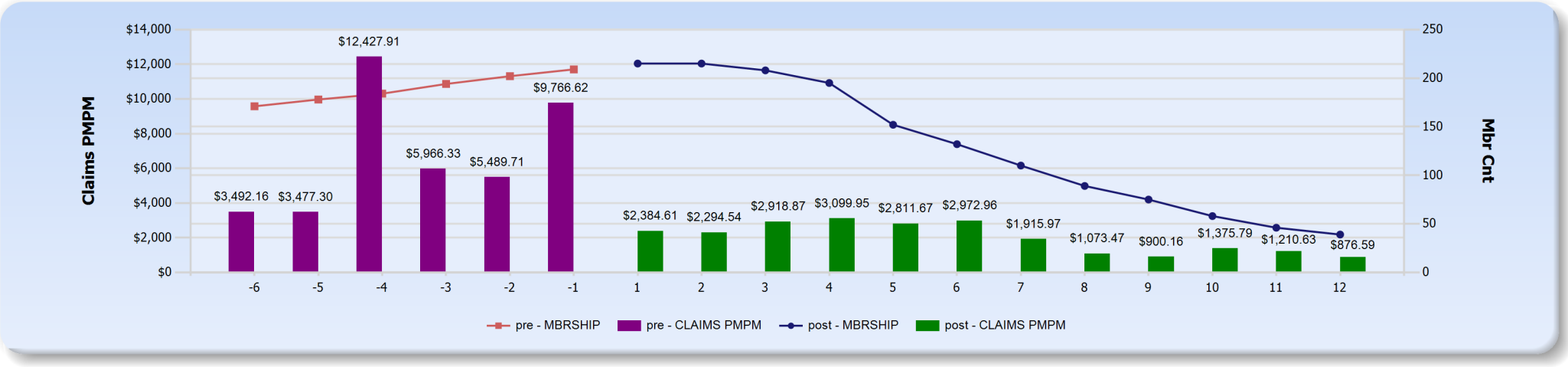
As at : 8/18/2017

Program Name : CASE MANAGEMENT

LOB : MEDICAID

Patient Type : PEDIATRICS

Note : This report includes Members Participating in the Programs between 1/1/2016 - 6/30/2017



Participating		
Trend	PRE PMPM	POST PMPM- 12 Months Post
-61.63%	$6,863.33	$2,633.67

APT Trend			
Trend		6-Month Pre	12 - Month Post
-60.97%		1,624	634

EPT Trend			
Trend		6-Month Pre	12 - Month Post
-31.69%		2,077	1,419

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 21 – Coordination of Benefits (Statewide):

The respondent shall describe the strategies utilized in care coordination with other plans and insurers (e.g., Medicare) to provide necessary services for its enrollees when the third party payer is the primary insurer. The respondent shall include information on its approach in the following circumstances:

a. Florida Medicaid does not cover the service, but it is available through the third party payer;

b. Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid;

c. The third party carrier benefit limit is exhausted and the service is now a Medicaid expense. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid; and

d. The service is not covered by the third party but is available through Florida Medicaid.

Response:

An effective coordination of benefits process eliminates gaps in care while minimizing service overlaps, reducing enrollee confusion, ensuring timely service authorization and payment, and preserving service coordination. Humana views effective coordination of benefits as a critical aspect of our partnership with AHCA and numerous other organizations around the state. We have developed a varied set of policies, procedures, and approaches that range from clinical management and care coordination to claims processing and service authorization.

Our approach to coordination benefits for our Florida Medicaid enrollees is informed by decades of experience serving them while also serving individuals across our broad base of plan types in Florida. Our operations in and relationships built through our Medicare Advantage, Medicaid, Tricare, commercial, and D-SNP plans offer additional insight into the range of benefits covered by these plans and the numerous ways these and other coverage packages should best interact with one another for the collective benefit of the individuals they each support. This is particularly impactful for individuals enrolled across multiple plans with Humana. Our care management systems enable us to swiftly and easily coordinate care and share information, insights, and plans of care (POCs) for these individuals.

Our response to this question will first provide our global approach to effective enrollee communication, processes for identifying non-covered services and streamlining authorization and payment, and service coordination. This includes provider communication and service provision for enrollees who are dually eligible for Medicare and Medicaid. We will then present our specific approach for each of the scenarios, in which we will detail how we will use our sophisticated care coordination platforms, streamlined authorization and payment systems, and broad methods of enrollee communication to coordinate benefits.

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2. The extent to which the respondent's approach includes (a) documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials)

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Our communication strategies are designed to reduce confusion and provide guidance to enrollees about the benefits available to them through Humana Medicaid and other third-party payers. We use four primary avenues to convey this information: our Welcome Calls; the enrollee handbook; communication from our Case Managers; and our Customer Care Specialists.

WELCOME CALLS

Beginning with the enrollment process, we seek to gather information about the enrollee's other sources of coverage so that we can provide information and support that is specifically applicable to the enrollee. During our Welcome Call (which is conducted for all new enrollees) we provide information about the services that are available through Humana Medicaid and request information about any other insurers or coverage they have (in case this information was not captured on the enrollment form). For those enrollees who indicate that they have coverage through another insurer, we explain that Humana and the other insurer will coordinate and guide the enrollee to also contact their other insurer for information about covered benefits. As needed, we provide contact information or offer to transfer enrollees to the appropriate parties with the other insurer.

ENROLLEE HANDBOOK

Our enrollee handbook (always easily accessible through our website or via mail upon request) contains information about Medicaid covered services, including specific information for dual eligible enrollees. The information for dual eligible enrollees describes, in easy-to-understand language, what it means to be dually eligible for Medicaid and Medicare and how dual eligible enrollees use their Humana medical plan. There is also information on choosing a provider, accessing Medicaid-covered services, and other valuable programs (e.g., Healthy Behaviors). With AHCA's approval, we will add similar information to our enrollee handbook that describes coordination of benefits for enrollees who are covered by other third party payers.

CARE MANAGEMENT

For our enrollees in LTC and MMA Case Management, our Case Managers use job aids and other templates to help them clearly explain and answer questions about coordination of benefits across the various third-party payers, such as Medicare, commercial, and Tricare. In addition, Humana's Case Managers serve as advocates for our enrollees to ensure that services needed by our enrollees are being provided. We contact the Case Managers of other payers and our enrollees' providers when needed to facilitate this coordination. This communication ensures that enrollees receive a unified message from all payers and providers about their benefits.

INBOUND CALLS TO CUSTOMER CARE

When an enrollee calls our Customer Care department to inquire about their benefits, the Customer Care Specialist can view the enrollee's profile in our Customer Relationship Management (CRM) system to determine if they have other coverage. Using this information, along with any other statements made by the enrollee, the Customer Care Specialist refers to the benefit grids (a comprehensive list of covered services, dollar and frequency limits, and approval requirements) to determine which benefits are covered by Humana Medicaid or a third-party payer. If the enrollee is inquiring about a benefit that is not covered by Humana Medicaid, our Customer Care Specialist will explain this and offer to transfer the enrollee to the other insurer using information in our database of contact information.

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2. The extent to which the respondent's approach includes (b) processes used to identify non-covered services by the primary insurer for individual enrollees
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We have five paths through which we can determine that an enrollee has a different primary insurer:

- Enrollee's 834 file, received from AHCA

- Florida Medicaid Managed Information System (FLMMIS)

- HealthNet

- Communication from enrollees or their providers, including through our Welcome Calls and during completion of the health risk assessment (HRA)

- Coordination of Benefits (COB) submissions from providers and other plans

We take care to document any information about an enrollee's other insurer in our Clinical platform, Clinical Guidance eXchange (CGX), and in our CRM system. As these systems are accessed by our Case Managers, Customer Care Specialists, and other enrollee-facing staff across our Medicaid, Medicare, and D-SNP plans in Florida, they reduce duplication of efforts, ensure earlier resolution of coordination of benefits inquiries, and enable us to swiftly answer enrollees' questions with information tailored to their situations.

Services that are not covered by the primary insurer may be identified through routine check-ins with our enrollees in Case Management or during a telephone call with our Customer Care Specialists. In either situation, we work with the enrollee and the enrollee's provider to obtain coverage from Humana Medicaid for the service if it is a covered benefit. Throughout this process, we have regular communication with the enrollee (either telephonically or face-to-face) in order to reduce confusion, ensure that the enrollee understands that service coverage will be maintained, and help the enrollee anticipate and prepare for any unavoidable changes in providers.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

During the HRA and POC process, our Case Managers collect information about services that are covered by a third-party payer and seek to obtain information about the length of the authorization and any benefit limits from the third-party payer. This is done so that we are prepared to evaluate medical necessity and assume responsibility for coverage of the service upon expiration of the authorization. In addition, Humana ensures our enrollees' POCs contain information about services covered through a third-party payer.

For those not enrolled in Case Management, we most frequently identify these services by the primary insurer through claims submissions. This process is detailed below.

MEDICAL CLAIMS

Upon receiving a request for benefits coverage, our associates review the claim to determine the appropriate Medicaid allowable and potential payment. We pay the claim using AHCA and Centers for Medicare and Medicaid Services (CMS) rules regarding coordination of benefits. If the enrollee is dually eligible for Medicaid and Medicare and Humana is the Medicare provider, our staff coordinate with Humana Medicare to process the claim with Medicare as the primary payer. If the enrollee has third-party coverage through another health insurer, we will redirect the provider to submit the coverage request to the other payer for primary payment. If the primary payment has already been made by the third-party payer, we review the payment for secondary coverage under the appropriate Medicaid allowable and covered benefits. All of this communication is documented in our Claims Adjudication System to provide an easily accessible record of the claim's status.

PHARMACY CLAIMS

Our pharmacy claims processing system, Argus, integrates information from our enrollment forms to indicate if an enrollee is covered by another third-party payer. When a retail pharmacy is checking coverage of a prescription, Argus recognizes whether or not Medicaid is the payer for that prescription. If the prescription should be covered by another payer, the pharmacist receives an error message. The pharmacist can then obtain the appropriate plan information from the enrollee. If the enrollee does not have information for their primary payer, the pharmacist or enrollee can contact our Customer Care department to request information about the other insurer. We then reach out to the enrollee's other insurer, as noted in their file, to determine the enrollee's coverage and effective dates, including this information in our system to avoid any future coordination of benefit issues.

For those enrollees who are enrolled in more than one Humana plan, this process is expedited. Our enrollees have a unique enrollee identification (ID) number, which is the same across all Humana plans. This feature enables pharmacy claims to be quickly routed to the appropriate insurer, whether it is Humana Medicare or Medicaid, without additional prompting to the pharmacy or enrollee.

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2. The extent to which the respondent's approach includes (c) processes used to streamline ongoing authorization and payment of services once the initial determination has been made

that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted.
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Humana employs a number of complementary processes aimed at ensuring that enrollees obtain timely and appropriate services when they cannot obtain a necessary service from their primary insurer or have exhausted a third-party benefit. Our Utilization Management department focuses on the expeditious authorization of the necessary service, working in tandem with our Case Management department, the enrollee, and (as appropriate) providers. We have additional processes in place to ensure that claims for these services will be paid upon submission, whether the service requires authorization, involves a new provider, or uses the standard procedures.

CONTINUITY OF CARE

Once a determination has been made that the service is not covered by the primary insurer or if the benefit from the third-party insurer has been exhausted, we adhere to continuity of care policies and procedures we have developed. These are designed to reduce and eliminate gaps in coverage for our enrollees. This includes incorporating those non-participating providers into our network (to the extent possible) in an effort to permit an enrollee to stay with their provider. If the provider is not already in our MMA network, we pay at the rate that the provider was receiving just prior to transfer, or at a lower rate if agreed upon by the provider during the 60-day continuity of care period (with exceptions for enrollees with certain conditions, such as transplant recipients). For our enrollees receiving LTC services, our Case Managers will collaborate with other insurers to obtain previous POCs to streamline this process. We will ensure that continuity of care is preserved until the needed services are authorized and incorporated into the enrollee's POC, at which time the enrollee will be transferred to a participating provider.

ONGOING AUTHORIZATION

When an initial determination has been made that a service is not covered by the primary insurer, or the benefit from the primary insurer has been exhausted, our primary goal is to ensure continuity of care for our enrollees, and to protect against any gaps in care. Through regular communication with our enrollees, their providers, and other health insurers, our Case Management department seeks to identify services that Florida Medicaid must cover in a timely, efficient manner. Using our database of health insurer contact information, we reach out to other insurers covering our enrollees to understand their benefit packages, including limits on covered benefits. This enables us to anticipate any services the enrollee may need that their primary insurer may not cover and to ensure that we have processes in place to assume responsibility for covered services upon the benefit limit being reached. Upon identification of these benefits, we arrange to obtain any needed authorizations and correct submission of the claim for continuation of the service so that there is no gap in coverage.

We recognize that, in many circumstances, we will not learn of a non-covered service until the enrollee is in urgent need of or is already receiving the service. In these circumstances, our authorization and payment processes are expedited where possible in order to protect against

gaps in care. For those services where Medicaid is the primary payer, we ensure that the authorization and payment of that service guarantees continuity of care for our enrollees. If the service does not require authorization, we communicate with the prescribing provider to confirm submission of the claim to Humana for coverage.

If the service requires authorization and Medicaid is the primary payer, our Utilization Management department reviews the authorization request in one of the following timeframes, according to the urgency of the service need:

- STANDARD (NON-URGENT): No more than seven (7) days following receipt of the request for service. An extension may be granted for an additional seven (7) calendar days if the enrollee or provider requests an extension, or if Humana justifies the need for an extension to AHCA.

- EXPEDITED AUTHORIZATIONS: These authorizations are required when a provider indicates, or Humana determines, that following the standard timeline could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. These decisions will be made no more than forty-eight (48) hours after receipt of the request for service, with the possibility of an extended timeframe if the enrollee or provider requests an extension or Humana justifies the need for additional information and how the extension is in the enrollee's best interest.

- CONCURRENT/URGENT CONCURRENT AUTHORIZATIONS: When an enrollee is currently receiving a benefit that is not covered by the third-party payer, or for which the third-party payer's benefit has been exhausted, Humana undertakes a concurrent or urgent concurrent authorization review. Requests for ongoing inpatient care are always considered urgent; we have nurses and physicians on call twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days per year to review these requests. Urgent concurrent review determinations are made within one (1) day of receipt of the authorization request by Humana when all necessary information to make a determination is available. When additional information is needed to make a determination, the request for additional information must be made within one (1) day of receipt of the authorization request by Humana. When additional information is requested, the total timeframe in which a decision must be made is three (3) calendar days from the date that Humana received the authorization request.

- RETROSPECTIVE REVIEWS: If we learn of a non-covered service after it has already occurred, we will undertake a retrospective review. Humana completes these reviews within thirty (30) days of the receipt of the initial request.

Our authorization process includes a determination of the length of authorization. For preventive services or services to treat an acute illness, we issue a short-term authorization. For those enrollees that have a continuing, ongoing need for a service – usually a minimum of three (3) months – we will issue a long-term authorization.

TIMELY PAYMENTS

Our sophisticated claims processing logic is designed to ensure timely payments after the service becomes a Medicaid expense. Humana's systems automatically process Medicare or

other insurer benefits in the claims systems as primary and Medicaid services as secondary, in line with Medicaid's role as the payer of last resort. If the third-party payer does not cover the service, or the benefit limit has been reached, our system will detect that there has been no payment or only a partial payment by the primary payer and will proceed to pay the claim in accordance with our AHCA-approved coordination of benefits guidelines.

If the service provider is not currently part of our Medicaid network, our Network Development and Claims departments facilitate any required provider integration into our claims system or special processing arrangements to ensure timely payment.

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3. The extent to which respondent's description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer.

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Humana has established special processes to improve care coordination for our enrollees with third-party coverage, including dual eligibility with Medicare. Our strategy includes enrollee and provider communication and education, proactive coordination and collaboration with other insurers, and sophisticated data systems that enable sharing between Humana's Medicaid and Medicare plans.

CARE COORDINATION

To reduce overlap in services and improve care coordination, our Case Managers work with other health insurers to understand their benefits package and coordinate the exchange of information to ensure coverage of benefits and continuity of care. We work with third-party payers to verify that they have any necessary prescriptions or authorizations from the provider and to guarantee coverage of benefits for our enrollees.

From our experience coordinating benefits across Florida's regions, we have learned that strong communication between health insurers is key to care coordination. As mentioned previously, Humana led the development of a database of contact information for health insurers across the state. This database allows our associates to quickly and easily contact their counterparts with other payers to identify non-covered services for our enrollees, communicate a unified message to our enrollees and their providers, and ensure any necessary authorization and coverage of the service in a timely manner. Under the next contract, Humana will work with other insurers to obtain updated contact information and disseminate the revised list to all payers.

Our Case Managers include any non-covered services that are being provided by a third-party payer in the enrollee's POC in CGX. As possible, they include the length of the authorization so that we can monitor for an expiring or denied service authorizations and intervene as appropriate. This intervention may include the issuance of our own service authorization so that there is no gap in care, or coordination with the provider to ensure the service authorization is issued as appropriate.

To further support care coordination across health insurers for our dual eligible enrollees, comprehensive enrollees, and enrollees receiving enhanced care coordination, our Case

Managers initiate contact with the enrollee's third-party insurer to determine if the enrollee already has a multidisciplinary team (MDT) in place. If the Case Manager determines that an MDT is already in place through another health insurer serving the enrollee, the Case Manager will become part of that team. If there is no MDT in place for an enrollee with complex needs, the Case Manager will create one to include the enrollee/caregiver, the enrollee's primary care provider (PCP), therapists/specialists serving the enrollee, facility representative for enrollees living in a facility, behavioral health provider(s) as applicable, and Case Managers from other health insurers serving the enrollee.

PROVIDER COMMUNICATIONS

As our providers are responsible for the submission of claims to the appropriate payer, their understanding of the COB process is essential to reducing confusion for the enrollee at the point of service, and for ensuring a seamless authorization and claims payment process. For these reasons, our Medicaid provider training processes and handbook explain coordination of benefits procedures as they relate to providers and discuss those standard and expanded benefits that are covered through Humana Medicaid. Our regular face-to-face visits with providers may also be used as an opportunity to share information and answer questions about coordination of benefits.

If we learn that a provider has inappropriately billed Medicaid for a non-covered service or has mistakenly accepted a copayment from an enrollee who is eligible for Medicaid coverage of copayments, we use it as an opportunity to educate that provider about COB and the importance of ascertaining the enrollee's coverage at the time of service by asking the enrollee for all insurance cards.

Claim denials, due to improper submission to Humana Medicaid as the primary payer, are also used as an opportunity to educate providers about COB. At an individual provider level, all denials include an explanation of denial and/or explanation of adjustment when applicable. We also review the most frequent reasons for denials, and use this information to design provider trainings that address improper claims submissions. Providers can contact our Claims Customer Service department with questions or concerns regarding the denial or partial denial of payment.

SERVICE PROVISION FOR DUAL ELIGIBLE ENROLLEES WHEN MEDICARE IS THE PRIMARY INSURER

For enrollees who are enrolled in a Humana Medicare plan, in addition to a Humana Medicaid plan, a number of factors ensure seamless care coordination, drive continuity, and minimize confusion while safeguarding against gaps or overlap in care:

- The enrollees' PCPs and other providers are in-network with Humana.

- All network providers receive Humana training and education that emphasizes the importance of communication, coordination, and integration of care.

- A single data repository houses enrollment, benefits, clinical, and care coordination data across Medicare, Medicaid, physical health, behavioral health, and LTC, streamlining reporting and data analytics.

- CGX, Humana's integrated clinical platform, enables Humana's enrollee-facing staff across plans to view all enrollee data in one system. Through CGX, our Case Managers can access records and care plan details across Medicare and Medicaid for our dual eligible enrollees who are also enrolled in Humana's Medicare Advantage or D-SNP plans. This data sharing facilitates regular communication between our Medicare and Medicaid Case Managers to preserve coordination and continuity of care.

We recognize that not all of our dual eligible enrollees will be enrolled in a Humana Medicare plan. Humana has experience coordinating care for thousands of dual eligible enrollees in our Florida Medicaid plans whose Medicare coverage is through FFS or an unaligned MA plan or D-SNP. As Medicare handles case management responsibilities for dual eligible enrollees, our care coordination approach shifts to focus on the ongoing provision of information and data to the Medicare plan. If the enrollee has a MDT, our Case Managers will invite the Medicare plan to participate in these meetings. We coordinate services for all of our enrollees and facilitate enrollee access to services, regardless of the ultimate funding source of these services.

For those dual eligible enrollees with a non-Humana Medicare plan, we work to identify their PCP during routine contacts or through a review of claims data. Our Case Managers reach out to, meet with, and create relationships with unaligned PCPs, including inviting these PCPs to enrollee MDT meetings. We also attempt to bring any unaligned PCPs in-network.

ENROLLEE STORY

Martha is a Humana LTC enrollee who Medicare coverage through another insurer. Martha required supplemental oxygen concentrators – equipment that is not covered by Medicare, but is covered by Medicaid. Upon identifying Martha's needs for these services, her Humana Case Manager set up a call with the Medicare plan to discuss how to obtain a prescription for these items, as Martha was homebound and could not visit her Medicare provider to obtain the prescription. After outreach by Martha's Humana Case Manager, the Medicare plan arranged for an in-home visit by the provider. Martha then received the supplemental oxygen concentrators, improving her quality of life. Through the coordination efforts of her Humana Case Manager, we were able to arrange coverage of these necessary items for Martha.

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1. The adequacy of the respondent's approach when:
a. Florida Medicaid does not cover the service, but it is available through the third party payer.

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Our approach to care coordination when Florida Medicaid does not cover the service, but the third-party payer does, includes:

- Communication to enrollees to help them understand their benefits

- Streamlined identification of non-covered services, with the goal of ensuring prompt coverage by the appropriate payer

- Communication with providers and other insurers to coordinate needed services for our enrollees in a timely manner

ENROLLEE COMMUNICATION

Beginning with an enrollee's initial enrollment in Humana Medicaid, we provide information about our covered benefits through our enrollee handbook and Welcome Call. For those enrollees in care management, we review this handbook and COB information during the initial face-to-face visit. During the Welcome Call and subsequent enrollee interactions that address COB, we explain that, if they do have coverage through another insurer, that insurer may cover other services, and that questions about those covered benefits and service authorizations should be directed to that insurer. As needed, we provide contact information for the other insurer.

If the enrollee contacts their Case Manager or our Customer Care department with questions about a benefit that is not covered by Florida Medicaid, we will determine if the enrollee has coverage through another insurer by checking their record in CGX, asking the enrollee directly, and confirming any information in FLMMIS and HealthNet. If the enrollee does have coverage through a third-party payer, we will warm transfer that enrollee to the other payer using our list of contact information for other insurers operating in Florida. In addition, we use this opportunity to explain to the enrollee how the COB process works, and what type of information they should share with their other insurer and their provider.

IDENTIFICATION OF NON-COVERED SERVICES

When our Claims department receives a claim, AHCA's fee schedule – which is loaded into our systems – is used to ascertain if the service is covered by Florida Medicaid. If not, the remittance advice issued to the provider explains the reason for the denial and states that non-covered items or charges are not the enrollee's responsibility.

CARE COORDINATION

When we learn that a service is being provided by a third-party payer, we note that information in CGX or in the enrollee's POC. This POC is shared with the PCP and the enrollee's other providers, facilitating greater coordination of the services being covered by all payers through the care team. We leverage this information to ensure that our enrollees receive the wrap-around support services covered by Florida Medicaid that complement those services provided by the third-party payer. For example, for those enrollees receiving dialysis through a third-party payer, we will make sure that the enrollee is attending dialysis through regular check-in. In addition, if that enrollee requires support when they get home from dialysis, we will arrange to have a companion there for them.

COMMUNICATION WITH PROVIDERS

Our provider handbook contains a list of covered services for Florida Medicaid enrollees. During provider training, we review these benefits and discuss COB. Providers are instructed to ensure collection of all insurance information from the enrollee at the point of service, and to submit claims to the primary insurer for timely and correct payment.

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b. Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid.

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When Medicaid is responsible only for coinsurance/copayment expenses, Humana's role focuses primarily on enrollee education and proper payment of claims. Through our Case Managers, we work to make sure that the enrollee knows that their primary insurance is responsible for payment of the service, while Medicaid will cover their coinsurance/deductible. By emphasizing the importance of providing all insurance cards to providers with our enrollees and educating providers on proper billing of coinsurance/copayment expenses for coverage by Medicaid, we ensure streamlined payment of these claims.

ENROLLEE COMMUNICATION

Upon enrollment in Case Management, our Case Managers educate our enrollees on COB, using a job aid to ensure consistency in communication. We inform dual eligible enrollees that Medicaid may pay for coinsurance/copayment expenses if the enrollee is a qualified Medicare beneficiary. For these enrollees, we stress the importance of making sure that their provider receives both their Medicare and Medicaid card in order to avoid any confusion about coinsurance/copayment expenses.

CLAIMS PAYMENT

We learn of our liability for coinsurance/copayment expenses as the secondary payer through the enrollment files received from AHCA and through the receipt of claims from the provider, after another insurer has made a primary payment. When we receive such a claim, we confirm that we are the secondary payer for the enrollee and review the claim for potential coverage of any copayment or coinsurance expenses, up to the Medicaid allowable.

We process these claims through the same systems used for all other claims, following AHCA and CMS rules for coordination of benefits. There are no differences in these processes if Medicare is the primary payer or if a commercial or other insurer is the primary payer.

CARE COORDINATION

Our provider training on COB discusses Medicaid coverage of coinsurance/copayment expenses for qualified enrollees. We emphasize the importance of asking all of their patients if they have Medicaid coverage, in addition to any other third-party payer.

If we learn of an enrollee who has been inappropriately billed for coinsurance or copayment, we will work to communicate with that provider – whether they are a Medicaid provider or not – the appropriate procedures for billing of coinsurance/copayment expenses for an enrollee who qualifies for Medicaid coverage of these expenses to avoid future issues.

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c. The third party carrier benefit limit is exhausted and the service is now a Medicaid expense.

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For many of our enrollees who have third-party coverage, especially those with chronic conditions or LTC needs, exhaustion of benefits may be common. This includes our enrollees covered through Medicare, which sets limits on services such as inpatient care. To ensure continuity of care for these enrollees, we have established procedures that facilitate streamlined authorization and payment of needed services.

ENROLLEE COMMUNICATION

Humana's enrollee handbook explains Medicaid covered services. With AHCA's permission, we will add language targeted to our enrollees who have both Medicare and Medicaid plans explaining that they are not responsible for any expenses that are covered under Medicaid, including office visits and hospital stays. For those enrollees who have other insurance, we explain that as long as their other insurance has been informed of their Medicaid status and the provider is aware of their Medicaid status, the balance of the claim will be sent directly to their Medicaid plan, which will cover the remainder of any medically necessary services. These messages will be reiterated in any other communication about coverage of these expenses with their Case Manager or the Customer Care Specialist.

AUTHORIZATION AND PAYMENT

We most often identify non-covered services through an automated claims submission. In this case, our system automatically reviews the claim for payment by the primary insurer. Upon determination that the claim is now a Medicaid expense, it is processed in accordance with our AHCA-approved procedures. Alternatively, we may become aware of a non-covered service after an explanation of benefits (EOB) from a third-party payer has been sent to us by a provider or enrollee. In this event, we will process the claim following our standard procedures.

While authorization is not required for claims when Medicaid is the secondary payer, we will ensure that ongoing authorization is streamlined using the processes described above.

CARE COORDINATION

Our Case Managers seek to identify services covered by a third-party payer that our enrollees currently receive, and to ascertain if and when the benefit limit will be reached through communication with the enrollee and the third-party payer. Using this information, our Case Managers obtain any necessary authorizations and coordinate with the provider to ensure that service provision is not interrupted when the third-party's benefit limit is reached.

We educate our providers so they understand that if a third-party benefit limit is exhausted, Medicaid may cover the remaining expense. We also emphasize that, for this reason, it is important to ask all enrollees if they have Medicaid coverage at the time of service provision to avoid any delay in claim processing and payment.

DIFFERENCE IN APPROACH FOR THOSE DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID

For those dual eligible enrollees who require case management services, the Medicare plan assumes medical case management responsibilities, with Humana maintaining case management responsibilities for LTC benefits. We continue to serve as advocates for these enrollees by ensuring that they have all necessary services, regardless of the payer. In the event that the Medicare limit for a covered service is exhausted, we collaborate with the provider, enrollee, and Medicare plan to assume responsibility for service coverage and prevent gaps in services/care.

Our approach to coverage of claims after the third-party carrier benefit limit has been exhausted does not differ for enrollees who are dually eligible for Medicare and Medicaid. However, we do ensure that our enrollee and provider communication materials provide guidance for enrollees with various types of coverage (Medicare, commercial plans, Tricare, etc.), highlighting the differences that enrollees and providers may expect for each.

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d. The service is not covered by the third party but is available through Florida Medicaid.

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Florida Medicaid covers a number of services which are not routinely included in many third-party insurance policies, such as home-based care. Additionally, Humana offers a range of expanded benefits, such as dental services and speech therapy for adults that may not be available through a third-party payer. We treat these services like all others in our benefits package, and are committed to ensuring their appropriate use by our enrollees. Enrollees can access these services through our provider network and use our enrollee portal and Customer Care line for assistance in finding a provider and setting up an appointment. For those enrollees engaged in care management, our Case Managers integrate these services into the care plan and facilitate case coordination.

ENROLLEE COMMUNICATION

Humana's enrollee handbook provides information on covered benefits that are covered by Florida Medicaid. In our handbook, we explain that the enrollee may receive the majority of their services through their other third-party payer, such as Medicare, and that Medicaid rules do not apply for those services covered by other insurers. However, if the other insurer does not cover the service required by the enrollee, and it is a Medicaid covered benefit, Humana will assume responsibility for that cost for those services that are determined to be medically necessary.
In addition, our Welcome Call and enrollee interactions with their Case Manager and our Customer Care Specialists provide additional opportunities to reduce confusion among our enrollees about services that are covered through Florida Medicaid. During our Welcome Call, we explain the benefits that are covered under Florida Medicaid, including hearing and vision. If the enrollee calls our Customer Care department or Case Manager with a question about covered benefits, our associates use the benefits grid to explain those benefits that are covered by Florida Medicaid, and encourage our enrollees to obtain a list of covered benefits from their other insurer. The enrollee can be warm transferred to the other insurer or the Case Manager will initiate contact with the other insurer to obtain the list of covered benefits in order to provide optimal assistance to the enrollee in understanding the COB process.

AUTHORIZATION AND PAYMENT

We identify services that are not covered through third-party payers through claims processing. When we note that a claim has been received for an enrollee who has another third-party payer, we ascertain that the claim has been denied by that third-party payer. Depending on the reason for the denial, we determine if Humana Medicaid will pay as the primary or secondary insurer, and process the claim accordingly.

Our service authorization and payment procedures reduce the amount of time between the request for coverage of a service and the time when the enrollee receives the service and the provider receives payment. When Florida Medicaid is the primary payer, we will authorize the service using our standard service authorization protocols, as described above.

CARE COORDINATION

Although the other payer may not be financially liable for the requested services, we communicate with the payer to ensure that they are nonetheless aware of the services being provided to facilitate the coordination of care. Our database of insurer contacts and participation on any MDT held by the enrollee's other insurer facilitate this communication. We use these forums to share information about the services covered by Florida Medicaid through Humana.

Evaluation Criteria:

1. The adequacy of the respondent's approach when:

(a) Florida Medicaid does not cover the service, but it is available through the third party payer.

(b) Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.

(c) The third party carrier benefit limit is exhausted and the service is now a Medicaid expense.

(d) The service is not covered by the third party but is available through Florida Medicaid.

2. The extent to which the respondent's approach includes:

(a) Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials).

(b) Processes used to identify non-covered services by the primary insurer for individual enrollees.

(c) Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted.

3. The extent to which respondent's description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

SRC# 22 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Statewide):

The respondent shall describe its approach to education and monitoring of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, including:

a. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.

b. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan (case management, utilization management, provider relations, etc.) as well as subcontractors.

c. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the plan and with subcontractors.

d. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the respondent's approach towards coverage of the EPSDT benefit.

Response:

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) plays an essential role in enabling Florida Medicaid enrollees under the age of twenty-one (21) to lead healthy lives by ensuring the availability of preventive services and screenings, and facilitating prompt access to medically necessary treatment for identified conditions. Our approach to EPSDT education and outreach incorporates both population-level and individual strategies that leverage data and the unique knowledge of our associates, providers, and community partners to design programs and interventions that will increase compliance with the EPSDT periodicity schedule. This outreach and education approach is complemented by our commitment to ensuring compliance with the EPSDT requirements throughout our plan – including providers and subcontractors – and the strong partnerships we have cultivated with external stakeholders over the past twenty (20) years serving Medicaid enrollees in Florida.

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1. The adequacy of the respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.

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Humana's approach to outreach and education combines written materials, targeted telephonic campaigns, and online resources with innovative community partnerships to bring multi-cultural, multi-lingual outreach activities to our enrollees. We complement these population-level approaches with targeted, data-driven individual outreach to identify and close gaps in EPSDT services among our enrollees.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

NEW ENROLLEE ONBOARDING

Our strategies to enhance enrollee education on the EPSDT requirements begin when the enrollee joins Humana. At this time, our Medicaid Administration Education and Satisfaction Unit (ESU) conducts New Enrollee Welcome Outreach Calls to each new enrollee or enrollee family. These calls cover topics including Primary Care Physician (PCP) selection, an abbreviated Health Risk Screening, and continuity of care. The ESU team educates the caregivers of our enrollees under twenty-one (21) on the importance of well-child visits, the intervals at which well-child visits should be scheduled, and the periodicity schedule for immunizations. We also connect enrollees and their caregivers with information about their PCP and assist enrollees in scheduling their upcoming Child Health Check-Up appointments.

To complement the Welcome Calls, we send each of our enrollees a packet of new enrollee materials. These materials include information about online resources, including our Provider Directory and Enrollee Handbook, that helps enrollees and their caregivers follow the periodicity schedule, learn about EPSDT benefits, and schedule appointments with pediatric PCPs. These enrollee materials are written at no more than a fourth grade reading level and are produced, at a minimum, in English and Spanish.

Our online Enrollee Handbook informs enrollees about the importance of the EPSDT program, the enrollee incentive and rewards program, and Humana's disease management and case management programs. Enrollees can refer to their Handbook for details regarding how to contact Humana for more information and referrals to specific programs. The Handbook also contains a chart that helps caregivers track their child's immunizations against the recommended schedule.

Humana's online Provider Directory is user-friendly and allows for searches by zip code, the first and last name of physicians, and specialty type. Enrollees can further filter their search results by gender of the physician; whether the practice is accepting new patients; practice affiliations; hospital affiliations; accreditations and certifications; and languages spoken at the practice. While our associates are always ready and willing to help our enrollees schedule an appointment with a PCP, this Provider Directory empowers our enrollees and their caregivers with additional information and tools to take control of their own care, including choosing their PCP and scheduling appointments.

MAILINGS AND PHONE CAMPAIGNS

We utilize mailings and inbound and outbound call campaigns to educate enrollees about upcoming EPSDT visits. We send reminder mailings for immunizations and EPSDT visits at one (1), three (3), five (5), eight (8), eleven (11), fourteen (14), seventeen (17), and twenty-three (23) months, and yearly thereafter. This outreach is designed to enhance the caregiver's understanding of the importance of timely Child Health Check-Up (CHCUP) visits.

Our Child Wellness Campaign targets caretakers with child wellness and benefit coverage education through e-mail, text messages, and outbound calls, including customized reminders based on the child's milestone (birthday, age group, back-to-school, or seasonal). Our outbound enrollee calling campaigns include both voice-automated and live calls to enrollee home phone

lines and cell phone lines. We conduct these calls in advance of the enrollee's next, periodic EPSDT visit to ensure that the visit is scheduled in accordance with the periodicity schedule. During these calls, Customer Care Specialists (CCS) ask about the enrollee's health status, inquire about the enrollee's engagement with their PCP, conduct a short questionnaire to screen for any immediate health needs, and provide referrals to care. If the Customer Care Specialist learns that the enrollee has not connected with their PCP, or has not scheduled their upcoming EPSDT visit, they will – with the caregiver's permission - conduct a three-way call to connect the enrollee with the PCP's office and help schedule an appointment for an annual CHCUP.

Text messaging offers an innovative avenue to reach our enrollees and their caregivers with important health information. Humana will pilot the mPulse HIPAA-compliant platform in Florida to extend our EPSDT outreach. Through mPulse, Humana will offer text messaging (or messaging through an app or web-based platform), push notifications, e-mail, and secure chat to communicate with our enrollees and their caregivers in real-time. In the initial pilot program, our team will send text messages to engage enrollees who are due or overdue for their annual wellness visit. These messages will include information on how to set up an appointment, appointment reminders, and directions to the appointment.

ENROLLEE NEWSLETTERS

Our quarterly enrollee newsletters are filled with educational information and useful news about our enrollees' health care coverage, social service programs, preventive health care, safety tips, and benefit updates. Our newsletters emphasize the importance of timely access to preventive care, including CHCUP. Humana realizes that healthy habits stem from the leadership of parents and guardians; as such, our newsletters are designed to address the needs of both the enrollee and their family. Recent topics covered in our newsletters include hygiene, dental care, the role of the PCP, and immunizations. An excerpt of our summer 2017 newsletter, which includes information on the importance of back-to-school wellness check-ups, can be found in Attachment 22-1.

DIGITAL OUTREACH

Our Digital Outreach strategy for EPSDT education and outreach includes our website, Enrollee Portal, and social media platforms.

Through our website, we provide valuable, easy-to-read information to our enrollees to learn more about covered EPSDT services. Our Florida SMMC enrollee website includes:

- The Enrollee Handbook, including EPSDT benefit information

- The most recent and historical quarterly enrollee newsletters

- Information about current seasonal and national health issues

- Important contact numbers, including the number for our Customer Care Department to help our enrollees schedule their no-cost yearly CHCUP

In addition to our public website, our secure Enrollee Portal empowers our enrollees and their caregivers to take greater responsibility for their health, including compliance with the EPSDT periodicity schedule. This portal, known as MyHumana, is accessible through a computer, mobile device, or the My Humana mobile application. Through MyHumana, enrollees and their caregivers can access their enrollee identification number, demographic information, PCP assignment and contact information, a summary of the enrollee's health status, and other health information. Additionally, when enrollees log onto MyHumana, they receive a gap-in-care alert that flags any missing preventive screenings. The MyHumana portal also enables enrollees to send secure messages to CCS for further assistance.

Our social media platforms also serve as an avenue to increase health literacy and educate our enrollees about their EPSDT benefits. Through our Corporate Social Media platforms (Facebook, Twitter, YouTube), and soon-to-be launched Medicaid Facebook page, we conduct campaigns about health care utilization and preventive screenings. These campaigns, designed by our award-winning Digital Center of Excellence Team, will leverage organic content in addition to content based on our enrollees' location, interests, behaviors, and demographics.

COMMUNITY-BASED OUTREACH AND EDUCATION

Our community-based outreach and education strategies reflect our commitment to meet our enrollees with important health information where they are. This means that we partner with community organizations, providers, and other stakeholders to deliver information face-to-face in places that are easily accessible and frequented by our enrollees and their caregivers. Today, we use four (4) approaches to reach our enrollees with these messages in the community: our Humana Storks program, our CHCUP events and Health Education sessions at provider offices, and health promotion events around the state.

CHCUP EVENTS WITH OUR PROVIDER NETWORKS

With our provider partners, we hold events around the state to encourage completion of the CHCUP among our enrollees. Through mailings, voice activated technology (VAT), and flyers, and through direct outreach from the provider office, we target our enrollees who have a current or upcoming care gap and who are assigned to the provider office where the event will be held. These enrollees are invited to call the provider office to schedule an appointment for services during this event, which also features fun, healthy, and interactive activities for our enrollees, such as face-painting, photo opportunities with "superheroes", and arts and crafts. We use these events as an opportunity to share important health information with our enrollees' parents and caregivers, including the importance of complying with the EPSDT periodicity schedule and treatment recommendations. In 2016, eight hundred thirty-six (836) enrollees attended these events, six hundred forty-seven (647) CHCUP services were provided, and four hundred ninety-two (492) HEDIS gaps were closed. In the words of one of our provider groups: "Having the opportunity to work with Humana was a very positive experience for our office and patients. Our patients really enjoyed the many fun, entertaining, and interactive activities provided, especially photos with their favorite superheroes! Due to the outreach provided, our office was successful in scheduling and providing quality care to many of our Humana enrollees. This Humana event was well-organized, fun, and productive. We look forward to working with Humana in the future."

HEALTH EDUCATION SESSIONS AT PROVIDER OFFICES
In addition to our CHCUP events, we partner with providers to lead educational sessions for our enrollees at their offices. We offer these events at a wide range of provider offices, including Federally Qualified Health Centers (FQHCs), OB/GYN, and pediatric offices, to reach our enrollees at the location where they most frequently receive health services. Past locations include Escambia Community Clinic (including their Mobile Dental Units), Genesis OB/GYN, Cantonment Family Practice, Tampa Family Health Centers, Big Bend Pediatrics, and Pediatric Associates of Tampa Bay. At these sessions, we cover topics that are of utmost importance to our enrollees and their caregivers, including asthma; nutrition, or diabetes; oral health; bullying; staying safe in the summer, including sun and swim safety; medicine safety and poison control; and holiday safety. In 2017, we have conducted almost four hundred (400) such events at provider offices, potentially reaching over eighty-seven thousand (87,000) enrollees.

HUMANA STORKS
Our commitment to educating our enrollees and their families about the importance of EPSDT visits begins at birth. Through our Humana Storks program, which recently debuted at two hospitals within the Memorial Healthcare System, our Enrollee Advocates greet new mothers in the hospital with a care package and information about how to access important health services for themselves and their babies. This information includes a vaccination schedule and a reminder to reach out to the pediatrician to make an appointment for their newborn's first Well-Child Visit.

HEALTH PROMOTION EVENTS IN THE COMMUNITY
As part of Humana's outreach efforts, we partner with community agencies and develop a calendar of health promotion events that our associates participate in throughout the year. Through these public events, our Enrollee Communication and Engagement team engages families outside of the provider's office to share important health information with Florida residents, including resources on CHCUPs.

Some of the community events that we participated in during 2016 included:

- March for Dimes March for Babies in Broward County

- Back to School in Hillsborough County

- Health Fair, held in conjunction with Central Florida Healthcare and Lakeland Primary Care

- Flipany Fun Run in Broward County

- Healthy Mothers/Healthy Babies is the New Hot! Health Fair in Broward County

- Ministerio Internacional El Rey Jesus CARE Community Resource Fair

- City of Miami Health Department Safe Summer Back to School Health Fair

- Jessie Trice Community Health Center Immunization Fair in Miami-Dade County

- City of Miami Police & 1804 INK Little Haiti Turkey Drive Health Fair

- United Way Center of Excellence – United Way Mini Health Fair

- Florida Department of Health/Miami-Dade – 3rd Annual Homestead/Florida City Health & Resource Fair

DESIGNING POPULATION-LEVEL STRATEGIES TO IMPROVE COMPLIANCE
On a monthly basis, our CHCUP Task Force Team meets to review EPSDT-related indicators, and to design and implement interventions that can improve our EPSDT results. These interventions are based on root-cause analysis, and are designed using the Plan-Do-Study-Act (PDSA) approach.

One such finding of these root-cause analyses was that there is a lack of understanding by enrollees and their caregivers regarding the importance of CHCUP visits and proper immunizations, resulting in missed screenings and immunizations. In addition, we determined that our PCPs faced challenges in documenting CHCUP visits: CHCUP services provided during a minor illness visit may not be properly recorded, leading to false missed gaps in the enrollee record. To resolve these barriers, we implemented a multi-pronged initiative that targeted enrollees, their caregivers, and providers through different channels to increase awareness of the importance of CHCUP services, and to ensure correct documentation of services in the enrollee record. These initiatives included:

- Targeted mailing, including an immunization card;

- Enhanced Welcome Calls process to provide assistance with scheduling appointments and transportation;

- Increased awareness and use of the Healthy Behavior Incentive Programs, including the Baby Well Visit Program and the Pediatric Well Visit Program;

- Enhanced Birthday Wellness VAT calls to remind enrollees to make an appointment for their yearly check-up/screening;

- Dissemination of CHCUP materials at targeted public events and educational enrollee events around the community; and

- Education for providers to remind them to record all screening services provided, including those provided during non-CHCUP visits.

Through the CHCUP Task Force Team's monthly meetings, these interventions are reviewed using the PDSA approach to identify progress towards measurable goals and isolate areas for improvement. Our enhanced Welcome Calls have demonstrated progress in helping more enrollees schedule PCP appointments: in July 2017, fifteen point three (15.3) percent of Welcome Calls resulted in a scheduled PCP appointment, as compared to twelve point seven (12.7) percent in April 2017.

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2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.

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Humana uses a rich set of advanced data analytics tools, through our Atlas Clinical Rule Engine, to identify enrollees who are not in compliance with their periodicity schedule and treatment recommendations. We provide this information to providers and case managers (CMs) through actionable reports that can be used to engage enrollees. We then deploy additional outreach and education strategies to engage enrollees who have missed an appointment or who have a gap in care, including targeted calls and mailings. In addition, the Healthy Behaviors program, through which our enrollees and their caregivers receive a gift card for attendance at well-child and well-baby visits, provides an extra incentive for our enrollees to adhere to the periodicity schedule.

USING DATA TO EMPOWER PROVIDERS TO CLOSE CARE GAPS

We provide all PCPs with a package of monthly HEDIS reports, sourced from claims data. This package details the PCPs' performance on a range of HEDIS metrics and compares their performance with that of their peers in the same region. In addition, we include a list of the enrollees who have CHCUP care gaps. To equip our providers with the information to take action on these results and improve compliance with CHCUP visits, we provide call lists with the contact information for enrollees who have care gaps and a list of recommended actions for enrollees who are non-compliant with preventive care screening or disease management visits. For example, Pediatric Associates – the largest pediatric primary care practice in our network, with locations around the state – uses this contact list to identify enrollees who may benefit from their case management outreach program. An example of this action report is included in Attachment 22-2.

These monthly HEDIS reports, delivered by our Provider Relations representatives, are supported by a clinical infrastructure that converts diverse patient data into real-time, actionable insights. Humana's clinical insights engine, Anvita, continually tracks each component of EPSDT compliance for our enrollees through bi-directional data feeds with our providers using submitted claims. Anvita automatically flags enrollees who are not compliant with the EPSDT and immunization periodicity schedules, and sends this information to our CMs and providers as Care Gap alerts.

Our proprietary web-based platform, Availity, serves as an additional data source for our providers to swiftly and easily identify care gaps among their enrollees, including missing EPSDT services and unfulfilled treatment recommendations. Through this portal, our providers can access: payment history and claim status to track EPSDT services provided; enrollee profiles that give a comprehensive view of screenings, check-ups, and treatments received; and monthly membership lists to track Humana enrollees. Because Availity combines information from all providers for each enrollee, one provider can determine whether an enrollee obtained follow-up treatments or screenings from another. This improves coordination and continuity of care between providers.

ENROLLEE OUTREACH TO IMPROVE COMPLIANCE WITH THE PERIODICITY SCHEDULE AND TREATMENT RECOMMENDATIONS

Upon identification of a care gap for an enrollee, we take additional actions to educate the enrollee about any missing EPSDT services and help them schedule an appointment with their PCP for care. A mailing is sent to the enrollee to remind them of the importance of the missed care gap and to share information about our enrollee incentive program, which rewards them for completing their CHCUP visits. In addition, this enrollee may be queued for a CHCUP call. This call – part of a campaign geared towards enrollees who have no well-child visit claims within the 6 month period after their birthday – serves as an opportunity to educate the enrollee/caregiver about the importance of EPSDT visits and to connect the enrollee and caregiver with their PCP to schedule an appointment. From January 1, 2017 to July 31, 2017, we reached almost twenty-three thousand five hundred (23,500) enrollees through these calls, and educated over sixteen thousand (16,000) about the importance of EPSDT services. Additionally, we have scheduled PCP appointments for over two thousand (2,000) enrollees through this ongoing campaign.

HEALTHY BEHAVIORS PROGRAMS

To encourage parents and caregivers to take their children and babies to their CHCUP appointments, we provide incentives through our Healthy Behaviors programs. Through the Baby Well Visit program, parents or guardians of infants who have been a Humana Medical Plan enrollee since birth can receive a ten (10) dollar gift card for each well-child visit completed between zero (0) and eighteen (18) months of age, up to three (3) visits. In our Pediatric Well Visit program, parents or guardians of Humana Medical Plan enrollees between the ages of two (2) and twenty-one (21) years can receive a twenty (20) dollar gift card for each yearly well-child visit.

Our CHCUP Task Force has introduced initiatives to increase enrollee awareness of the Healthy Behaviors program. As of September 2017, seven thousand eight hundred and seventy-four (7,874) enrollees have received the Pediatric Well-Visit reward and nine thousand four hundred and ninety (9,490) enrollees have received the Baby Well Visit reward.

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3. The adequacy of the respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.

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TRAINING FOR ASSOCIATES

We use an array of mediums to help our associates understand and implement federal and State EPSDT requirements throughout plan operations, including online, classroom, and field-based training; written materials, including policies and procedures and e-mail updates; and associate meetings to discuss updates to the requirements and best practices for compliance. Training on these requirements occurs upon hire and throughout each associate's tenure with Humana.

Humana associates who are responsible for implementing the EPSDT requirements – including those in Case Management, Utilization Management, Provider Relations, Quality Improvement, and Customer Care departments – complete online, on-boarding training upon hire,

complemented by field visits administered by our Clinical Learning and Development department (CLD) and clinical trainers. We will design a detailed EPSDT module that will be added to this mandatory training that will cover the federal and State EPSDT requirements and EPSDT operations throughout the plan. Additionally, we offer several online courses for our associates that provide further education on Medicaid, including “Medicaid Basics” and “Florida Medicaid Plan”, both of which cover the benefits available to our enrollees under our plan. Additionally, our “Florida Contract Training” e-learning course emphasizes the required Medicaid benefits, including EPSDT, and Humana expanded benefits.

Although some aspects of associate training are common to everyone, each department has its own training process and content tailored to the specific knowledge, skills, and abilities needed to perform each role. After the initial onboarding training, new CMs shadow experienced CMs on at least two field visits and one supervised meeting visit before their first unsupervised visit with an enrollee. This field training ensures that our Case Managers can apply the knowledge that they gained through our online and classroom education to their day-to-day responsibilities, including the EPSDT requirements.

Our associates receive ongoing and annual training designed to refresh their knowledge on the EPSDT requirements and other compliance measures, share best practices for ensuring compliance with these requirements, and discuss updates to policies and procedures. Humana’s clinical and quality assurance teams review of changes in our current training tools as AHCA or CMS issues new program requirements or changes to the EPSDT requirements. E-mail updates, associate meetings, and updates to policies and procedures are used to convey these changes to our associates, and the changes are also built into ongoing training sessions. These training sessions use an array of mediums, including WebEx, Microsoft Lync, and on-site classroom-based trainings.

TRAINING FOR SUBCONTRACTORS

Our subcontractor training closely resembles our associate training. Subcontractors are required to complete the same online on-boarding and annual training as our associates, and they receive further in-person training specific to their delegated duties. For subcontractors with responsibilities for utilization management or EPSDT service provision or referral – including Beacon Health Options, Access Behavioral Health, and Medical Care Consortium, Inc. – our Relationship Managers also use our monthly Local Operating Committee meetings to discuss the EPSDT requirements, and to share any updates to the requirements.

TRAINING FOR PROVIDERS

Our diverse set of providers in Florida calls for various training mediums to meet their needs and educate them on EPSDT compliance in an easy-to-understand fashion. Providers are educated on timely access standards and other EPSDT requirements through four (4) primary training modalities:

- Medicaid Provider Orientation: Humana’s Provider Relations teams conduct in-person or virtual orientations for all newly contracted providers within thirty (30) days of the effective contract date.

- Written Materials: The Florida Medicaid Provider Manual and the Florida Medicaid Addendum to the provider agreement are both shared with our providers to convey information about the EPSDT requirements in a written form. In addition, providers receive an annual letter to remind

them of the importance of CHCUP and the components of an EPSDT visit for each age group. The letter in Attachment 22-3 is an example of our written provider communication about EPSDT.

- Digital Education: Our provider website offers easy access to communications related to EPSDT, including the annual CHCUP letter, and education on the EPSDT requirements.

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4. The adequacy of the respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors.

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Our Quality Improvement Committee (QIC) is the hub of EPSDT compliance monitoring activities through our Florida Humana operations. Quarterly QIC meetings are attended by our Utilization Management, Case Management, Quality, Compliance, Provider Relations, Performance Management, and Risk Management departments. Each department shares their monitoring activities and results from the most recent quarter, specific to the EPSDT requirements referred to in 42 U.S.C. § 1396d(r)(5), all binding federal precedents interpreting it, and any other State and federal requirements. The monitoring approach used by each department is further described below. In addition to addressing or referring any immediate quality or compliance issues to the Compliance Oversight department, the QIC develops improvement projects to respond to overall plan trends in EPSDT in conjunction with the CHCUP Task Force.

MONITORING APPROACHES BY DEPARTMENT

UTILIZATION MANAGEMENT

Our Utilization Management (UM) department is responsible for the review of special services requests in accordance with the flowchart depicted in Attachment 22-4. Our UM Nurse Liaisons and/or Compliance Nurses review the request utilizing National Clinical Guidelines (NCGs), Humana's AHCA contract, and our enrollee handbook. If the request is out of scope with the guidance provisions, it is then routed to the Associate Medical Director. For EPSDT services, the Associate Medical Director's authorization decision is always based on medical necessity, not covered benefits.

To monitor the consistent application of our EPSDT criteria and compliance with the special services request flowchart, we employ three processes. The results of all three processes are shared at QIC meetings:

1. Review a sample of denial and appeal files for services provided to enrollees ages zero (0) to twenty-one (21) for compliance with the EPSDT requirements.

2. Conduct inter-rater reliability assessments for our physician and non-physician reviewers at least annually. This assessment measures the consistency with which our health care professionals involved in UM decision-making apply the EPSDT requirements.

3. Hold case conferences to monitor the quality of decision-making and criteria application skills of the reviews referred to a physician by a nurse reviewer, pharmacy reviewer, or claim examiner. These case conferences, in addition to ensuring compliance with the EPSDT requirements, allow us to identify any gaps in our clinical policies that have led to variation in our decision-making, as it relates to service authorizations.

CASE MANAGEMENT
Our Case Management department is responsible for ensuring EPSDT compliance for children enrolled in case management, including the identification of gaps in care, coordination of CHCUP visits, and resolution of any barriers to accessing care.

To monitor our Case Management department for compliance with the relevant EPSDT requirements, we audit a subset of care plans for our enrollees ages zero (0) to twenty-one (21) to ensure that they contain EPSDT services. Additionally, we sample those enrollees in CM who have an EPSDT care gap to ascertain that their CM has conducted the appropriate follow-up. As all communication with enrollees and their providers is documented in our clinical operating system, Care Guidance eXchange (CGX), we can ensure that the CM contacted both the enrollee to notify them of the care gap and the provider to schedule an appointment (if the enrollee gave permission to do so).

SUBCONTRACTOR OVERSIGHT
Our local Performance Management Office and Relationship Managers, in conjunction with our Delegation Compliance department, are responsible for subcontractor oversight as related to the EPSDT requirements. At our quarterly QIC meetings, the Performance Management Office provides an update on all EPSDT-related monitoring activities, including any possible non-compliance that has been detected and addressed.

All subcontractors are monitored for completion of required trainings, including modules on EPSDT. We ensure subcontractor compliance with the EPSDT requirements through annual delegation audits, reviews of service-level agreement performance, and regular Local Operations Committee meetings. Annual delegation audits are designed to evaluate each subcontractor's ability to meet delegation compliance requirements. These audits include a review and approval of each subcontractor's policies and procedures; program descriptions and work plans; forms, tools, and reports; file audits; and enrollee communications. We provide a template for all enrollee communications to assist our subcontractors in complying with communications-specific requirements. Additionally, for subcontractors with delegated UM responsibilities, we review authorizations of EPSDT services, including authorizations sent to Humana for review by the Medical Director.

PROVIDER RELATIONS
Our Provider Relations department is responsible for oversight of provider education, outreach, training, and ensuring that our network is compliant with the EPSDT requirements. To monitor compliance with the requirements among our providers, our Provider Relations department conducts site visits to evaluate compliance with AHCA's periodicity schedule and EPSDT requirements; documents the education it provides to our provider network on the EPSDT requirements; and ensures a sufficient network of EPSDT providers. This outreach includes education on the importance of tracking all EPSDT services provided for our enrollees, even those that are part of a minor illness visit (as opposed to a well-child visit), to ensure data accuracy. A report on these activities is provided at our quarterly QIC meetings.

We also conduct various audits to ensure our providers are maintaining accessibility standards. Appointment availability standards are measured through initial credentialing and re-credentialing site visits, complaint data, capacity reports, and provider self-reporting. Humana also physically audits appointment schedules on a random basis and at least annually during visits to provider offices, and conducts "secret shopper" surveys to assess appointment availability and wait times. Additionally, we conduct calls to PCP offices at least annually to ensure our enrollees have access to care during after-hours. The results of our 2016 After Hours Accessibility Audit found that we are within the AHCA Service Level Agreement requirement in every region in which we operate a MMA plan.

MEDICAID ADMINISTRATION DEPARTMENT
Legal and compliance reviews of our handbooks and other enrollee communications concerning EPSDT ensure that these materials contain clear information about the enrollee's right to appeal any decision, and the procedures for doing so.

MEDICAID ADMINISTRATION EDUCATION AND SATISFACTION UNIT (ESU)
Our ESU plays a key role in providing outreach and education for our enrollees on EPSDT services. Our ESU team conducts outbound calls to enrollees who have EPSDT care gaps, and assists those enrollees with gaps to schedule a CHCUP visit. The ESU prepares quarterly reports that demonstrate the percentage of all enrollees with an EPSDT care gap who receive an outbound call, the percentage who are educated about CHCUP visits, and the percentage of those enrollees who grant permission to the ESU team to schedule a PCP appointment.

ENROLLEE AND COMMUNITY ENGAGEMENT TEAM
Our Enrollee and Community Engagement team conducts EPSDT outreach and education activities throughout the state. This team provides quarterly reports on the number of activities conducted, the number of enrollees in attendance, and any related health outcomes (e.g., number of CHCUPs completed).

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5. The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.
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Humana has demonstrated our commitment to engaging with stakeholders in Florida to share and improve our approach towards coverage of the EPSDT benefit. Through our Community Engagement Teams, Medicaid Advisory Panel, involvement with professional associations, engagement with providers, and participation in community organizations, we will continue this commitment to transparency under the next contract. As we expand into other regions of the state, we will continue to engage with stakeholders from all regions who can inform and strengthen our EPSDT-related activities.

COMMUNITY ENGAGEMENT TEAMS
Humana's Medicaid Community Engagement Teams, launched in 2014, facilitate our efforts to support local organizations that serve our Florida Medicaid enrollees. These regionally-based teams work with a broad array of community partners to host health events, provide health education, and refer our enrollees for further support and resources. Our regular involvement with these partners facilitates the exchange of information and dialogue about ways to ensure

coverage of the EPSDT benefit among our enrollees, as these groups have unique insights into the communities they serve. Some of our partners who have been fundamental to improving our EPSDT program include:

- Region 1: Escambia County School District and Head Start

- Region 6: Polk County Boys and Girls Club and the Healthy Start Coalition

- Region 9: Bridges and Lake Worth West and Bridges at Northwood

- Region 10: Cypress Elementary School and Healthy Mothers, Healthy Babies of Broward County

- Region 11: Carol City Elementary School and Health Connect in Our School

MEDICAID ADVISORY PANEL
Our Medicaid Advisory Panel, first formed in 2013, brings together leaders from within Humana and from external stakeholders across the communities we serve. Our current members include representatives from hospitals, including Holtz Children's Hospital and North Shore Medical Center; Member Services Organizations, including Doctor's Medical Center, Pediatric Associates, and Broward Health; non-profit organizations, including Healthy Mothers Healthy Babies and Goodman JFS of Broward; and cultural groups, including Sant La Haitian Neighborhood Center in Miami-Dade. As we grow our presence across the state, we will seek to include leaders who represent all parts of the state on our panel to ensure transparency across our EPSDT operations.

During our meetings, we discuss EPSDT-related HEDIS measures, including any progress or challenges we have encountered in improving our rates. Our panel draws upon their depth of experience serving Florida's Medicaid population to provide advice and input on how to better reach these communities and improve compliance with well-child visits and immunizations. For example, we learned from a representative of our Haitian community that Creole-speaking enrollees were having difficulty understanding the highly technical language presented by other native Creole speakers during outbound calls to educate our enrollees about the EPSDT benefit. We presented this information to the department responsible for these outbound calls to design ways to better communicate this nuanced information to our Creole-speaking enrollees, including a thorough review of the translation of health information and other technical language.

In addition, the Medicaid Advisor Panel often raises issues from their day-to-day work in the community that they believe Humana can help to address. For example, after discussing high rates of emergency department utilization, we worked with external stakeholders on the Medicaid Advisory Panel to design an Emergency Department Utilization Pilot Project. With the connections we have established through the Advisory Panel – including representation from North Shore Medical Center in Miami and Palmetto General Hospital in Hialeah – we introduced a pilot project in which real-time information was sent to Humana and the PCP when an enrollee was admitted to the emergency department. In addition to addressing the acute issue that brought the enrollee to the emergency department, we are able to improve coverage of the EPSDT benefit by connecting our enrollees with their PCP, who can ensure that they receive all necessary EPSDT services during their follow-up visit.

Our panel further serves as a sounding board for our EPSDT outreach and education initiatives. For example, we collaborated with our panel members to extend the reach of our Children's Nutrition Campaign. Through connections forged by our panel, we formed a partnership with FLIPANY, an organization in South Florida that provides nutritional outreach to low-income families. FLIPANY helped us to bring local chefs to our enrollee events to demonstrate ways in which our families can eat healthy in an affordable manner. At our upcoming meeting in December 2017, we will share the results of the first year of our Humana Storks program, which targets mothers during the post-partum period to share information about the importance of well-child visits and adhering to the immunization schedule, and will solicit feedback from our panel about how we can continue to grow this initiative.

ENGAGEMENT WITH PROFESSIONAL ASSOCIATIONS

Humana regularly partners with external provider associations to understand their evolving concerns and develop collaborative solutions to better serve our Florida Medicaid enrollees, including in the area of EPSDT. This year, we have met with more than twelve (12) provider associations, including the Florida Medical Association, Florida Hospital Association, the Florida Obstetric and Gynecological Society, the Florida Chapter of the American Academy of Pediatrics, and the Florida Council for Community Mental Health Centers. Our attendance at conferences held by professional associations throughout Florida further strengthens our relationships with these external stakeholders. As these conferences allow us to interact with a broad swath of our providers, we can both share information about our EPSDT-related efforts and obtain feedback from our provider network and other community stakeholders about our ongoing work.

HUMANA ASSOCIATES' INVOLVEMENT WITH COMMUNITY ORGANIZATIONS

Humana associates participate in the leadership of community organizations across North, Central, and South Florida. These connections with community stakeholders allows us to respond to and incorporate ongoing community initiatives into our own work; identify best practices that we can use to strengthen our EPSDT operations; and share Humana's ongoing activities for feedback and recommendations. As we expand our presence throughout Florida, we will seek to engage with community partners in all regions.

Some of the committees and boards on which our associates and executive leadership currently serve are:

- Head Start Advisory Committee
- Healthy Start Coalition
- Student Health Advisory Committee of Hillsborough County
- Head Start Policy Council
- March of Dimes Board of Directors
- Florida Board of Nursing
- Impact Broward Advisory Committee
- Pediatric Council for the Florida Chapter of the American Academy of Pediatrics
- United Way of Broward County's Health Access Committee

CHILD HEALTH CHECK-UP EVENTS HELD WITH PROVIDER OFFICES

Our Child Health Check-Up events, held in partnership with provider offices, present us with a unique opportunity to present our EPSDT approach to our providers and enrollees. As we work

closely with our providers to plan and hold these events, they can provide feedback, advice, and input into our approach to coverage of the EPSDT benefit. Additionally, at the events themselves, Humana associates can interact with our enrollees and learn how to better help them maintain compliance with the EPSDT periodicity schedule. These events will continue to be a key avenue for ensuring transparency among these important external stakeholders under the next contract.

Evaluation Criteria:

1. The adequacy of the respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.

2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.

3. The adequacy of the respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.

4. The adequacy of the respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors.

5. The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment 22-1: Back-to-School Wellness Check-Ups Newsletter Excerpt

Humana realizes that healthy habits stem from the leadership of parents and guardians; as such, our newsletters are designed to address the needs of both the enrollee and his or her family. Recent topics covered in our newsletters include hygiene, dental care, the role of the PCP, and immunizations. An excerpt of our summer 2017 newsletter, which includes information on the importance of back-to-school wellness check-ups, can be found below.

CHECKUP

Back to school
Time for a checkup!

Kids may be enjoying summer fun but, before you know it, they'll be back in school

Make sure they have had their yearly checkup before the last-minute rush. Students of all ages must be up-to-date with their shots in order to go back to school. Talk to your child's doctor about the shots they should get.

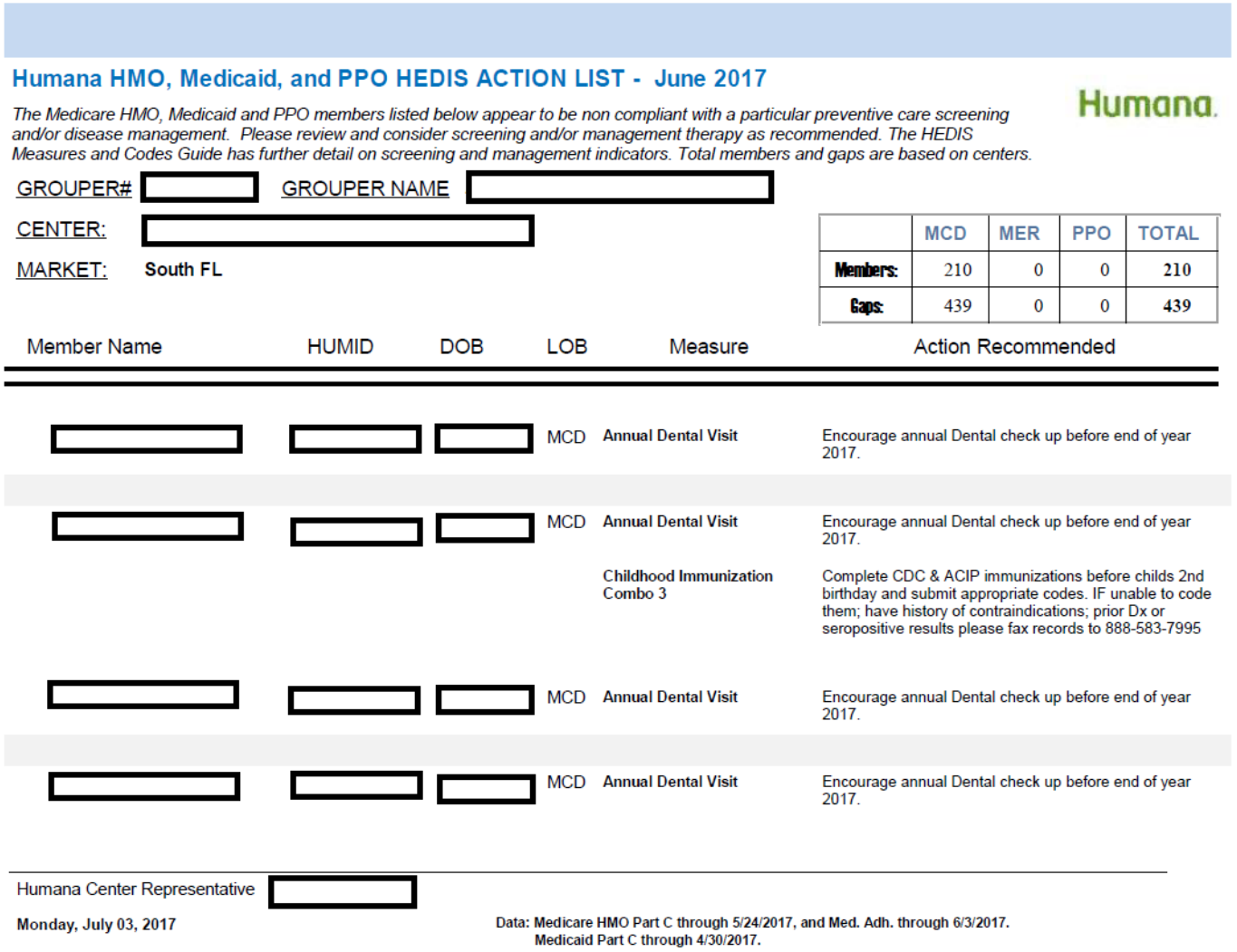
Your child's doctor can answer any questions you may have about shots and don't worry—if your child missed a shot, they can get caught up. Enjoy summer and have a healthy back-to-school season.

SOURCE

Humana.com/learning-center/health-and-wellbeing/healthy-living/immunizations-january-2012

Attachment 22-2: HEDIS Action Report

We provide all of our PCPs with a package of monthly HEDIS reports. This package details the PCPs' performance on a range of HEDIS metrics and compares their performance with that of their peers in the same region. An example of this action report is included below.



Humana HMO, Medicaid, and PPO HEDIS ACTION LIST - June 2017

Humana.

The Medicare HMO, Medicaid and PPO members listed below appear to be non compliant with a particular preventive care screening and/or disease management. Please review and consider screening and/or management therapy as recommended. The HEDIS Measures and Codes Guide has further detail on screening and management indicators. Total members and gaps are based on centers.

GROUPER# [redacted] GROUPER NAME [redacted]

CENTER: [redacted]

MARKET: South FL

	MCD	MER	PPO	TOTAL
Members:	210	0	0	210
Gaps:	439	0	0	439

Member Name	HUMID	DOB	LOB	Measure	Action Recommended
[redacted]	[redacted]	[redacted]	MCD	Annual Dental Visit	Encourage annual Dental check up before end of year 2017.
[redacted]	[redacted]	[redacted]	MCD	Annual Dental Visit	Encourage annual Dental check up before end of year 2017.
				Childhood Immunization Combo 3	Complete CDC & ACIP immunizations before childs 2nd birthday and submit appropriate codes. IF unable to code them; have history of contraindications; prior Dx or seropositive results please fax records to 888-583-7995
[redacted]	[redacted]	[redacted]	MCD	Annual Dental Visit	Encourage annual Dental check up before end of year 2017.
[redacted]	[redacted]	[redacted]	MCD	Annual Dental Visit	Encourage annual Dental check up before end of year 2017.

Humana Center Representative [redacted]

Monday, July 03, 2017

Data: Medicare HMO Part C through 5/24/2017, and Med. Adh. through 6/3/2017.
Medicaid Part C through 4/30/2017.

Attachment 22-3: Annual CHCUP Letter

We provide our providers with an annual letter to remind them of the importance of CHCUP and the components of an EPSDT visit. The letter below provides an example of our written provider communication about EPSDT.

Child Health Check-Up (CHCUP)

Information for physicians

The Child Health Check-Up (CHCUP) is a regularly scheduled comprehensive, preventive health screening service for children from birth through age 20. Child health checkups are performed according to a periodic schedule to help children have routine health screenings to identify and correct medical conditions before the conditions become more serious and potentially disabling. CHCUP is Florida's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Making the most of the visit while the child is in the office

Physician discretion in evaluating the degree of illness should determine if a child health checkup should be performed during a visit when the child is sick. A child health checkup should not be performed on an obviously sick child during which time findings may be distorted. The physician should treat the child for the illness and reschedule the checkup. If, in the physician's opinion, a checkup or well-child visit can be appropriately completed, the physician should treat or refer the child for the illness and bill the checkup or well visit.

What are the components of the child health checkup?

A child health checkup is composed of the following:

- Comprehensive health and developmental history, including assessment of past medical history, developmental history and behavioral health status
- Nutritional assessment
- Developmental assessment
- Comprehensive unclothed physical examination
- Dental screening, including dental referral, when required
- Vision screening, including objective testing, when required
- Hearing screening, including objective testing, when required
- Laboratory test, including blood lead testing, when required
- Appropriate immunizations
- Health education and anticipatory guidance
- Diagnosis and treatment
- Referral and follow-up, as appropriate

Importance of lead testing

Federal regulation requires that all children receive a blood test for lead at:

- 12 months old and 24 months old
- 36 months old and 72 months old for children who have not had a previous blood lead screening

How do the CHCUP measures compare to the various HEDIS® measures?

Both the CHCUP components and various Healthcare Effectiveness Data and Information Set (HEDIS®) measures address annual wellness visits for children: well-child visits in the first 15 months of life (W15); well-child visits in the third, fourth, fifth and sixth years of life (W34); adolescent well-care visits (AWC); adults' access to preventive/ambulatory health services (AAP); child and adolescent access to a primary care physician (CAP); an annual dental visit (ADV); and

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lead screening in children (LSC). The main difference is based on the child's continuous enrollment in the plan, as well as the measurement periods for both groups of measures.

With CHCUP measures, children are placed in the health plan's denominator (children meeting criteria for the service) once the child has been enrolled for 90 days or more. The measurement period is Oct. 1 – Sept. 30. HEDIS measures typically place children in the health plan's denominator once the child has been with the plan for 12 months. The measurement period for many HEDIS measures is Jan. 1 – Dec. 31.

Most procedure codes detailed below cover both CHCUP and HEDIS measures, depending on care rendered to the member.

Members on the HEDIS and CHCUP action lists you receive monthly and quarterly, respectively, may overlap based on the criteria detailed above in regard to continuous enrollment and measurement periods. In addition, compliance also may be met with one visit based on the time frame details listed.

What is Humana's approach to improve the CHCUP measures?

Humana is working to improve CHCUP measures through a variety of methods, including:

- Outreach to members using printed materials, online information and phone calls.
- Nurses who are working directly with physician practices to promote CHCUP and improve HEDIS scores.
- Member rewards programs through which eligible Medicaid members can earn rewards for receiving certain immunizations, screenings and well checkups.
- Health care providers may bill for a CHCUP and a sick visit on the same day.

Billing tips: CHCUP

To ensure you receive credit for performing CHCUP requirements, please use the correct codes when submitting encounters and claims. Please note: Health care providers can bill a sick visit in addition to the CHCUP visit and receive reimbursement for both.

Child health checkup age or description	Well-child ICD-9 codes	New patient CPT codes	Established patient CPT codes
Neonatal exam	NA	99460, 99461, 99463	NA
Two to four days for newborns discharged less than 48 hours after delivery	NA		
By 1 month	NA	99381	99391
2 months	NA		
4 months	NA		
6 months	NA		
9 months	NA		
12 months	NA	99382	99392
15 months	NA		
18 months	NA		
2 years to under 5 years	NA		
5 years to under 12 years	NA	99383	99393
12 years to under 18 years	NA	99384	99394
18 years to under 21 years	NA	99385 EP	99395 EP
Routine child health check	V20.2	99202-99205	99213-99215
Routine general medical exam	V70.0		
Other medical exam for administrative purpose	V70.3		

Health exam of defined subpopulation	V70.5		
Health exam in population survey	V70.6		
Other specified general medical exam	V70.8		
Unspecified general medical exam	V70.9		

ICD-9 codes were replaced by the following ICD-10 codes Oct. 1, 2015:

Z76.2 (Encounter for health supervision and care of other healthy infant and child)
Z00.121 (Encounter for routine child health examination with abnormal findings)
Z00.129 (Encounter for routine child health examination without abnormal findings)
Z00.110 (Health examination for newborn under 8 days old)
Z00.111 (Health examination for newborn 8 to 28 days old)
Z00.00-01 (Encounter for general adult medical examination without/with abnormal findings)
Z02.0 (Encounter for examination for admission to educational institution)
Z02.1 (Encounter for pre-employment examination)
Z02.2 (Encounter for examination for admission to residential institution)
Z02.3 (Encounter for examination for recruitment to armed forces)
Z02.4 (Encounter for examination for driving license)
Z02.5 (Encounter for examination for participation in sport)
Z02.6 (Encounter for examination for insurance purposes)
Z02.81 (Encounter for paternity testing)
Z02.82 (Encounter for adoption services)
Z02.83 (Encounter for blood-alcohol and blood-drug test)
Z02.89 (Encounter for other administrative examinations)
Z00.8 (Encounter for other general examination)
Z00.6 (Encounter for examination for normal comparison and control in clinical research program)
Z00.5 (Encounter for examination of potential donor of organ and tissue)
Z00.70 (Encounter for examination for period of delayed growth in childhood without abnormal findings)
Z00.71 (Encounter for examination for period of delayed growth in childhood with abnormal findings)

Notes: The child may enter the periodic schedule at any time. For example, if a child has an initial screening at age 4, then the next periodic screening is performed at age 5. This information may be found at http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1.

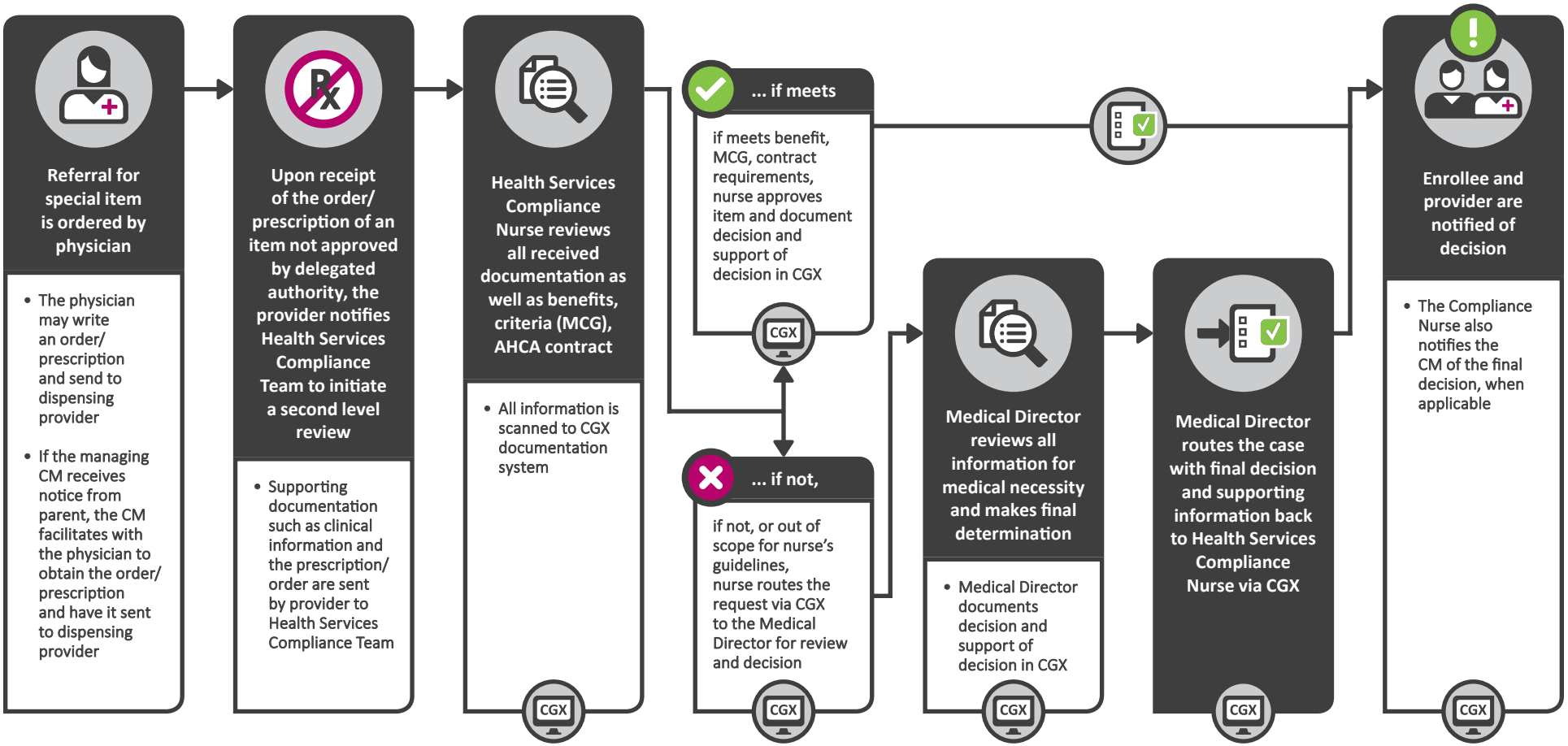
References

- http://pediatrics.aappublications.org/cgi/data/120/6/1376/DC1/1
- http://www.fdhc.state.fl.us/Medicaid/childhealthservices/chc-up/index.shtml
- http://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads//clm104c12.pdf
- WEB-NV-0016-13 Issued November 2013 by Amerigroup Community Care

Attachment 22-4: Special Service Requests for Enrollees under the Age of 21

Humana ensures our youngest enrollees have access to the services they need; we honor all service requests that meet medical necessity for our enrollees under the age of 21. When processing special service requests for children under the age of 21, to ensure we are consistent with EPSDT requirements, we **only** deny services if they do not meet Florida's definition of medical necessity.

CM = Case Manager
CGX = Clinical Guidance eXchange
MCG® = MCG (formerly Milliman Care Guidelines)
CPCM = Complex Case Manager



Humana.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 23 – Behavioral Health/Primary Care Integration (Statewide):

The respondent shall describe its proposed approach in promoting integrated behavioral health and primary care models, including:

a. Identification of integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness.

b. Identification of opportunities for improvement across the respondent's system of care (e.g., care management, provider network, utilization management, enrollee services) with the goal of advancing to more integrated care models.

c. Description of strategies the respondent will deploy to overcome the barriers/gaps identified to increase its capacity for providing integrated care models, including use of alternative payment models/financing strategies.

Response:

Historically, behavioral health (BH) and primary care have been fragmented, with limited coordination between primary care and BH providers. Evidence demonstrates that having multiple, mostly independent systems of care contributes to poorer health outcomes and higher costs. Although up to 80 percent (80%) of individuals with BH problems seek care in emergency departments (EDs) and primary care clinics, many primary care providers may lack the training needed to identify and treat BH needs. Additionally, individuals receiving treatment for a medical condition may develop a co-occurring BH need as a result of their medical condition (as the recent opioid epidemic in the United States demonstrates) and require specialized BH treatment. For those individuals who do receive treatment in behavioral health settings, they often do so in independent practices that have no formal referral processes with primary care settings. When patients are left to navigate the health system on their own, they may struggle to follow through with appointments, be unsure where to go for care, or feel uncomfortable or stigmatized seeking care outside of their normal BH or medical facility. As a result of these often separate and parallel systems, patient outcomes worsen and health care costs can skyrocket. Individuals with severe and persistent mental illness (SPMI) tend to die 25 years earlier than the general population, often due to untreated medical conditions. Additionally, the American Psychiatric Association found that spending for patients with co-occurring behavioral health needs is 2.5 to 3.5 times higher than for those without co-occurring needs, with most of that spending going to medical services [1].

Recognizing the benefit and necessity of integration to our enrollees, our providers, and the health system as a whole, Humana is committed to bringing integrated care to our network and care models in Florida. We place enrollees at the center of our system of care and support providers to introduce integration into their practices. In strengthening coordination and collaboration between providers and emphasizing integration throughout our system of care, we improve medication adherence and reduce BH or medical inpatient and ED visits, ultimately leading to better outcomes, higher quality of life, and lower avoidable costs.

Humana manages BH services in Florida Medicaid today through a longstanding integrated strategic partnership model, working with Beacon Health Options (Beacon) and Access Behavioral Health (ABH). This design enables us to implement best practices from each of our

partners' highly-specialized BH experience and capabilities in Florida and across the country. We have refined our BH partnership model over the years, continuously enhancing our operational and strategic integration points to become an increasingly cohesive organization. This ongoing effort will be further enhanced by AHCA's move towards a Comprehensive Plan model for the SMMC program. In our collective and joint experience serving Florida Medicaid enrollees, we have worked to overcome systemic challenges that affect the integration of BH and primary care, including providers' separate facilities and data systems. We will continue to pursue new opportunities to support providers' development of stronger primary and behavioral care integration, including an increased emphasis on community involvement, further integration of our BH partners into Humana's Clinical Guidance eXchange (CGX) platform, and the continued expansion of integrated telemedicine to serve enrollees with co-occurring needs in rural areas.

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1. The extent with which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care.

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Humana takes a person-centered, holistic approach to case management that encompasses all conditions enrollees may have. We work to bridge the BH, primary care, and social services divide by promoting communication and coordination among medical and BH case managers, primary care providers (PCPs), BH providers, enrollees with co-occurring conditions, caregivers, and community organizations. Our strategy, designed to incentivize and remove barriers to integration, is focused on three (3) key areas of our system of care:

1. Case Management
2. Enrollee Engagement and Care Planning
3. Integrated Care Continuum in our Provider Network

CASE MANAGEMENT

For those enrollees with complex medical, behavioral, or long-term services and supports needs, our innovative care team structure provides wrap-around support that covers all areas of their care, and helps the enrollee navigate the health system to access the services they need. This Multidisciplinary Team (MDT), led by a Humana case manager, encompasses a wide range of supports and integrates medical and behavioral expertise in support of the enrollee's care. Each MDT meets regularly to discuss enrollee needs and ensure proper service coverage. With the enrollee's consent, we facilitate open dialogue between behavioral and medical providers, with all providers invited to participate in MDT meetings.

Recognizing the unique needs of our enrollees, the frequency of coordination and discussion between medical and BH case managers is dependent upon the enrollee's needs and risk level, and is determined during the referral process. For enrollees with BH needs, a BH case manager supports the enrollee and medical case manager as part of the MDT, providing insight, condition-specific education, coordination with providers, and assistance with care planning, external resources, and referrals as indicated. At times, the enrollee's BH needs are more prominent - such as with enrollees who have conditions that are difficult to manage, such as

SPMI, schizophrenia, psychosis, or bipolar disorder. When these needs require more intensive case management, the MDT may agree that the BH case manager should lead the MDT process on behalf of the enrollee. These open lines of communication between case managers encourage increased collaboration, to the benefit of our enrollees with co-occurring disorders. Reflecting our person-centered, individualized approach to case management, our BH and medical case managers determine the type of collaboration that will most benefit each enrollee. This case management collaboration may include:

- Attendance at Humana case management meetings, as requested, to review goals and interventions, and to re-evaluate and update the enrollee's comprehensive care plan across physical and behavioral health issues

- Updates on enrollee adherence with treatment and after-care plans for both behavioral and medical conditions

- Identification of enrollees with multiple inpatient admissions or multiple ED visits for possible enrollment in additional case management

- Updates between case managers and healthcare providers on a regular basis. During the initial referral process, the referring party can indicate how often they would like updates on the enrollee's case

- Recommendations on care plan revision from the enrollee, case managers, and the enrollee's providers

- Receiving recommendations from the health care providers on next steps to improve the enrollee's health and well-being

- Providing updates based on agreed-upon timeframes, in line with the care plan

To facilitate this collaboration, we receive daily hospital inpatient census reports for Humana enrollees admitted for BH conditions. Humana case managers reference these reports to identify enrollees currently receiving or requiring medical case management who may be hospitalized for BH needs. Our BH case managers also provide weekly hospital discharge reports that provide Humana with a list of enrollees who were discharged in the previous week. In addition to discharge date and diagnosis, the report includes the provider name and date and time of the scheduled follow-up appointment. This data-sharing prompts follow-up from both medical and BH case managers to ensure that the enrollee receives the appropriate post-discharge care and support, including an appointment with the provider within seven (7) days of discharge and linkage with any necessary social services and community resources that can reduce the likelihood of re-admission.

With the collective experience and expertise of our clinical team, we are equipped to comprehensively and successfully manage even the most complex needs of our enrollees. Our regular, interdisciplinary Medical Advisement meetings give our medical and BH case managers a venue to seek physician advice or consultation on specific cases from across our entire organization. This interdisciplinary approach ensures that we are addressing all aspects of our enrollees' needs and goals to support a holistic approach to our enrollees' needs. Specifically, the Medical Advisement program provides an opportunity to:

- Assist with assessment, planning, facilitation, advocacy, and care coordination for enrollees

- Review the enrollee's clinical status to determine opportunities for improved coordination with the MDT, ongoing care and support needs, and connection to community resources

- Facilitate evidence-based recommendations for optimal case management planning

- Help develop an actionable case management plan or obtain clarification on direction to take within that plan

- Review identified barriers or gaps in care and identify ways to overcome these barriers to help improve an enrollee's care plan (e.g., using injectable, long-lasting medications to help enrollees with SPMI better adhere to their medications).

ENROLLEE ENGAGEMENT AND CARE PLANNING

Once an enrollee is identified to participate in case management, the MDT begins the process of engaging the enrollee in case management services, completing a comprehensive assessment of the enrollee's needs, and as a result, developing a person-centered, individualized plan of care (POC).

Our treatment planning processes do not seek to impose a prescriptive or "one size fits all" approach to our enrollees' care. Rather, we take the time to develop POCs that are built around the unique needs and goals of each individual we serve. For enrollees with co-occurring disorders who are enrolled in case management, our primary care and BH case managers participate in concurrent case management reviews and collaborate on the review of the enrollee's POCs with their providers.

For enrollees who receive comprehensive MMA and LTC services, this integration extends to their long-term care needs and benefits. Our innovative model of care includes the joint participation of primary care and BH providers on enrollees' MDT, facilitating the discussion of enrollees' needs in a holistic manner. The MDT is updated to include additional enrollees and key participants as enrollee needs change.

The health assessments conducted by both our medical and BH case managers encompass the enrollees' behavioral health, medical, and long-term services and support needs. In addition, we assess other aspects of enrollees' lives that influence their health, such as their natural support systems, access to community resources, and social determinants. The comprehensive nature of our assessments allows us to more quickly detect co-occurring conditions among our enrollees, and use these results to inform the POC and to request further screenings, assessments, and referrals that meet each enrollee's unique needs and goals.

Upon completion of the initial assessment, the medical case manager collaborates with the enrollee, their family or caregivers, the BH case manager, and the enrollee's primary care and specialty providers to develop a POC that encompasses all medical, BH, and long-term services required by the enrollee. This plan includes:

- Short-term goals to address the acute or immediate health status of the enrollee
- Long-term goals to achieve sustained health improvement and optimal health status
- Interventions planned to meet these goals
- Timeframes for re-evaluation (follow-up) and assessment of progress against the POC
- Identification of barriers to meeting goals, or complying with the POC
- Resources to be utilized to assist the enrollee in achieving short- and long-term goals
- Collaborative approaches for facilitating implementation of the POC, including coordination between medical and BH case managers

INTEGRATED CARE CONTINUUM IN OUR PROVIDER NETWORK

We support a continuum of innovative provider engagement models that facilitate integrated primary and behavioral health care. Recognizing that providers in our network have varying levels of readiness to engage in integrated arrangements, this spectrum allows us to engage all providers in an integration model that is appropriate for their current capacities while supporting them to move along the continuum towards more complex arrangements. This continuum is depicted in Attachment 23-1, and includes the following integration models, arranged from least to most integrated:

- Traditional Primary Care and BH Arrangements: In this traditional model, providers are only responsible for the services delivered within their practice. Humana encourages increased integration of primary and BH care in this model through support for screening, diagnosis, and treatment of less serious mental illnesses among PCPs, and identification of and referral to primary care services by BH providers, including Community Mental Health Centers (CMHCs).

- Value-Based Payment (VBP) Integration: The goal of our VBP arrangements is to improve quality and outcomes while reducing avoidable costs. In order to achieve this goal, both primary care and BH providers are incentivized to take greater accountability for our enrollees' entire spectrum of needs, including those that they may not treat themselves. Payments are linked to their performance on a range of outcome measures, including ED visits and inpatient admissions for both medical and BH issues.

- Formalized Partnership: Primary care and BH providers in this model sign Humana's Collaborative Care Agreement to improve coordination and communication between their practices. This agreement provides a framework for better communication and safe transitions of care between PCPs and BH providers. PCPs and BH providers agree to share consultation notes and other data about their patients in a HIPAA-compliant manner and with the permission of enrollees.

- Co-Location: In the co-location model of integration, PCPs and BH providers are co-located at the same facility. We recognize that transportation and time constraints are real challenges for many Medicaid enrollees, and co-location helps enrollees adhere to their primary care-to-BH referrals. In addition to facilitating seamless referrals, co-location models encourage regular collaboration and data sharing between providers to support care coordination for enrollees with co-occurring conditions.

- Fully-Integrated Health Home: In the fully-integrated health home model, our providers build upon the co-location model to provide wrap-around services that support enrollees using a

team-based approach. These services include: comprehensive case management; care coordination and health promotion; comprehensive transitional and follow-up care from inpatient to other settings; individual and family support; referral to community and support services; and use of health information technology to link services.

- Comprehensive Health System: The final integration model on Humana's continuum of programs is built around health systems that include both PCPs and BH providers. Just as in the fully-integrated health home model, health systems often have many different provider types co-located at the same site. The key difference in the health system model is that primary and BH providers are part of the same overarching provider group. As a result, primary and BH providers are fully integrated, with systems and processes designed from the ground-up to support full integration across all services offered. This model allows our enrollees to truly use a "one-stop shop" for all of their health care needs.

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2. The extent to which the respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. The respondent must also describe the data sources.
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Humana works proactively with our provider network to develop the capabilities and partnerships that will enable them to deliver integrated care. We provided a brief summary above of our integrated care continuum and will provide further detail in this section, including examples from our current provider network. Using transactional electronic claims data, we are able to track patient outcomes for our providers engaged in these models. Additionally, as detailed below, our provider network collects data from a variety of sources, including pre- and post-surveys and medical record reviews, to provide data on patient outcomes, patient satisfaction, and cost-effectiveness.

Our continuum includes:
1. Traditional primary and BH arrangements
2. Value-based purchasing
3. Formalized partnerships
4. Co-location models
5. Fully-integrated health homes
6. Comprehensive health systems

TRADITIONAL PRIMARY AND BH ARRANGEMENTS

We recognize that not all network providers are prepared to engage in a more sophisticated integration model. Humana is committed to supporting our network providers who operate under traditional arrangements to advance primary care and behavioral health integration, while providing incentives for them to move along the integration continuum into more advanced models of integration.

In the traditional arrangement of primary care and behavioral health, providers largely operate within their own area, with only limited data sharing and periodic communication with providers outside of their practice. We believe that even in this traditional model, PCPs and BH providers

can do more to support integration. We provide the tools and support that our providers need to deliver integrated care for our enrollees, including:

- Joint Visits: Humana Provider Relations representatives conduct joint visits with representatives from our BH partners to educate PCPs on BH measures, including how to drive improvement, and how to undertake appropriate referrals for BH services. For example, these visits are used as an opportunity to support PCPs to implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach for substance abuse. This model of treatment is designed to support PCPs in screening for substance abuse and provide brief interventions that are tailored to the needs of the patient. For those deemed to be at a moderate level of risk, the PCP is empowered to use motivational interviewing techniques to raise awareness of the condition and encourage behavior change. Additionally, the PCP may provide further assessment, education, and coping mechanisms. For those patients who are determined to be at high risk, the PCP provides a referral to a BH provider.

- Toolkits: With the right information and training, PCPs can screen enrollees for BH conditions and provide appropriate referrals. PCP toolkits provided by our BH partners (Attachment 23-2 and Attachment 23-3) in hard copy and online contain resources, contact information, diagnostic and prescribing references, and information on how to bill for BH services provided by PCPs. In addition, PCPs can share fact sheets and self-management strategies from the toolkits with enrollees. These toolkits also include behavioral health screening tools that are specifically designed for the primary care setting, including the Patient Health Questionnaire (PHQ-9) for depression; the CAGE to screen for alcohol abuse; the CRAFFT for adolescent substance use; the Edinburgh Postnatal Depression Scale for postpartum depression; and the Generalized Anxiety Disorder 7-item (GAD-7) scale for anxiety disorders. All screening tools are also available on our behavioral health partners' websites for 24/7 access.

- Model Protocols for Collaboration: PCPs and BH providers who do not have experience with integrated models may be unsure of how to initiate a collaborative relationship. Therefore, in addition to face-to-face support offered by our Provider Relations representatives, we also provide model protocols to our PCPs and BH providers that describe how they can consult with one another and conduct joint clinical reviews.

- Consent Forms and Registries: Respect for our enrollees' privacy and confidentiality is of utmost importance. Therefore, we provide sample forms and protocols to our providers to secure consent from their patients to allow communication between PCPs and BH providers. We also provide sample registries to help providers identify and track enrollees who are affected by one or more chronic conditions.

- Case Consultation: We operate toll-free hotlines through which PCPs consult with a board-certified psychiatrist about BH issues, including psychopharmacology, treatment alternatives, and when to refer for a psychiatric assessment. Additionally, our case managers and PCPs contact licensed BH clinicians, employed by our BH partners, to obtain short-term case consultation services, including referrals for further treatment.

- Community Engagement: To further promote education for PCPs on referrals for BH services, our BH partners participate in county-wide monthly meetings. These meetings include BH providers, medical providers, school systems, faith-based groups, and representatives from child welfare, the court system, and juvenile justice. The goal of these meetings is to ensure that

there are no gaps in coordination of care between behavioral and medical providers. These monthly meetings are accompanied by quarterly regional meetings that promote sharing across counties.

To measure collaboration between PCPs and BH providers in traditional arrangements, our quality teams assess the frequency of communication between enrollees' medical and BH providers through medical record audits. During regular monitoring visits of our BH providers, staff check for evidence of communication, including evidence of an assessment of any medical diagnoses, signed information releases allowing practice staff to contact the enrollee's other providers, and records of conversations with PCPs or other providers. These results are then trended and presented to BH providers to review their performance and to ensure that the integration of primary and behavioral health care is promoted. Additionally, during our regular Joint Operating Committee meetings between Humana and our BH partners, we review the results of these medical record audits and discuss possible avenues for supporting and improving integration between providers.

VALUE-BASED PURCHASING INTEGRATION

Our VBP models are designed to improve health outcomes by incentivizing providers to take more accountability for the full spectrum of our enrollees' care, including primary and behavioral health. More than 167,000 of our Florida Medicaid enrollees are attributed to PCPs in Global Risk arrangements. Ten (10) of our largest BH providers are contracted through VBP arrangements as well. These arrangements range from quality rewards programs to capitated arrangements in which providers assume global risk.

Most of our Florida Medicaid enrollees' PCPs are now engaged in global risk arrangements. In global risk arrangements, rather than reimbursing providers on a fee-for-service basis, PCPs and specialists receive a single capitated monthly payment to manage the care of our enrollees. This model incentivizes PCPs to reduce preventable events, such as hospital admissions, through proactive and preventive care. As a result, PCPs in global risk arrangements work closely with BH providers to ensure enrollees adhere to referrals and treatment plans for co-occurring conditions.

Using our claims data, we are able to assess our providers' performance under various risk arrangements. This data demonstrates that Humana's Florida Medicaid providers in "Full Value" risk arrangements outperform their non-risk counterparts in terms of quality, outcomes, and cost. In 2016, the risk providers had significantly higher quality scores on metrics related to preventive health, well child visits, and diabetes management. As a result of their strong performance, these providers also have strong outcomes – Humana's Florida Medicaid risk providers are averaging twenty-five point three percent (25.3%) fewer emergency department visits per one thousand (1,000) enrollees and seventeen point four percent (17.4%) fewer hospital admits per one thousand (1,000) enrollees. By reducing preventable events like these and helping enrollees access care in appropriate settings, Florida risk providers have fourteen point seven percent (14.7%) lower inpatient medical expenses and reduce pharmacy expenses by eleven point four percent (11.4%).

As one example of a VBP arrangement supporting integrated care in our current network of Florida Medicaid providers, Humana has a Global Risk VBP arrangement with Pediatric

Associates, a practice with locations in Broward County, Jacksonville, Miami-Dade County, Palm Beach County, St. Lucie, and Tampa. More than fifty-six thousand (56,000) of our Florida Medicaid enrollees are attributed to Pediatric Associates providers. The Global Risk arrangement encourages providers to screen for behavioral health conditions among our enrollees, such as Attention Deficit/Hyperactivity Disorder (ADHD). Pediatric Associates providers screen enrollees for this condition, provide guidance on parenting, school performance, and treatments (both those with and without medication), and offer a host of resources on its website for parents about ADHD and its management. This Global Risk arrangement complements and strengthens Pediatric Associates' formalized partnership with Chrysalis Health for BH referrals and data-sharing, the next step on our continuum.

FORMALIZED PARTNERSHIPS

In the Formalized Partnerships model, provider groups sign a commitment to one another, agreeing to share enrollees' consultation notes and test results on an ongoing basis to facilitate improved integration of primary care and BH services. Patient-centered medical homes (PCMHs), with their capabilities to provide supportive services that help our enrollees navigate the health system, are well-suited for this integration model; as such, Humana encourages them to sign Collaborative Care Agreements with key local BH providers, and has a team in Florida that is delegated to help providers obtain PCMH certification. Attachment 23-4 contains a sample Collaborative Care Agreement.

Chrysalis Health, a behavioral health treatment provider in our network that serves children and adults throughout the state of Florida, has a formalized partnership with Pediatric Associates, the largest provider of pediatric health care in the United States. As more than eighty percent (80%) of Chrysalis's patients are under the age of twenty-six (26), this partnership facilitates integrated physical and behavioral health care for children and young adults. Joint policies permit pediatricians to manage mild and low-risk behavioral health needs, while the behavioral health needs of enrollees who are moderate and high-risk are managed by a psychiatrist. The formal partnership forged by Chrysalis Health and Pediatric Associates includes:

- Primary-behavioral care coordination
- Integrated electronic health records
- Integrated treatment planning
- Psychiatric consultation for physicians
- Shared assessment tools
- Shared responsibility for managing medical and behavioral health
- Protocols for regular communication
- Joint policies for collecting, sharing, and reporting joint outcomes
- Warm hand-offs from behavioral health when stabilization is achieved

All outcomes from this partnership are stored in Chrysalis Health's electronic health records, and include data collected from pre- and post-testing; Daily Living Activities scores; treatment plan goal completion; reports from clients, guardians, and providers; and any other information collected from health plans and other partners. Outcomes from calendar year 2016 include:

- Seventy-five percent (75%) of patients improved their condition and/or symptoms during the course of treatment

- Sixty-two point seven (62.7%) of patients eliminated substance use, and twenty-three point nine (23.9%) reduced use

- Ninety-five (95%) of patients were free from psychiatric hospitalization while receiving services

At several sites, Chrysalis Health and Pediatric Associates have even co-located to offer primary and behavioral health at the same location. This co-located model represents the next progression on our Integrated Care Continuum.

CO-LOCATION

In the co-location model, PCPs and BH providers work together at the same location. This model has several benefits, including: reduced travel and wait times; greater routine health maintenance; seamless coordination of medical and BH care; and establishment of a relationship with a PCP for our enrollees with BH needs. Co-location supports both the addition of BH providers to primary care settings, and the addition of PCPs to BH settings. There is robust evidence that for individuals with depression and anxiety disorders, integration of behavioral health into primary care settings (with the PCP serving as the primary provider) is an effective pathway to better care and treatment for both medical and behavioral health conditions. For those individuals with SPMI or substance use disorders (SUD), the integration of primary care into behavioral health settings (with the BH provider serving in the primary provider role) serves as a more effective model of care, as these individuals may encounter difficulty in juggling multiple appointments or fear stigma outside of the BH clinic. We seek to include both of these models in our provider network.

Our network today demonstrates the feasibility and success of the co-location model. Chrysalis Health and Pediatric Associates, have co-located to jointly offer primary and BH services at several sites. Gracepoint, an integrated community mental health center serving our enrollees in the Tampa Bay area, co-locates staff within the Florida Hospital ED. By screening individuals under the Baker and Marchman Acts, which govern involuntary admissions of persons with BH needs in Florida, while they are in the ED, Gracepoint's staff can ensure that our enrollees receive the care they need more quickly. Additionally, Gracepoint's Care Coordination Team (CCT) coordinates behavioral and medical services for high utilizers, engaging these individuals in Gracepoint's Central Receiving Facility (CRF), as well as the Crisis Stabilization Unit, Detox, hospital ED, and the community. Gracepoint has tracked outcomes for those patients who received services from the CCT. There was a decrease from eighty-eight (88) CRF admissions pre-CCT intervention to sixty (60) CRF admissions post-CCT among enrollees who were discharged from the CRF between December 2016 and April 2017. This was accompanied by an estimated fifty-two percent (52%) reduction in costs for these patients, based on actual submitted claims for all funding sources.

We plan to pursue the credentialing of at least one BH therapist in all Federally Qualified Health Centers (FQHCs) in accordance with guidelines issued by the Centers for Medicare and Medicaid Services. In our current network, Escambia Community Clinic (ECC), a leading FQHC in region 1, has adopted the co-location model. Today, ECC's main clinic in Pensacola employs a Licensed Clinical Social Worker (LCSW) and a Family Psychiatric-Mental Health Nurse Practitioner to provide behavioral health care. Two of ECC's pediatric clinics have added a

LCSW to work with children and families. Chautauqua Health Care Center, also in Region 1, has placed a LCSW in the Walton County Health Department to see Humana enrollees while they are receiving medical services.

To expand access to primary care for individuals with SMI or SUD, and reduce barriers to diagnosis and treatment of medical needs, some of our BH providers have integrated medical clinics into their locations. Lakeview Center CMHC in Region 1 has partnered with ECC to bring on-site medical care into their main center and their clinic in Century. A medical nurse practitioner employed by the Peace River Center (PRC) in Region 6 provides medical services for individuals at New Beginnings Transitional Housing and Substance Use Recovery Program for Men operated by Tri-County Human Services in Polk County. Additionally, PRC provides licensed BH therapists who work at medical centers around Region 6, including Lakeland Regional Health, Family Practice Clinic; Florida Department of Public Health – Polk County Medical Clinics; Lakeside Pediatrics; and Lakeland Pediatrics. In all of these arrangements, PRC's co-located staff use electronic health records and provide summary reports and data on the care they provide to the medical or behavioral health clinic's staff, in compliance with HIPAA requirements.

FULLY-INTEGRATED HEALTH HOME

Fully-integrated health homes provide comprehensive, coordinated care for Medicaid enrollees who have complex needs, including co-occurring medical and behavioral health conditions. Moving beyond simple co-location of providers, this approach provides patient-centered care through a team of professionals who span different areas of health care system, with a focus on case management, community referrals, and wrap-around supports for the enrollee and their family. Fully-integrated health homes have often added case managers and social workers to provide this extra care for our enrollees. These individuals play a crucial role in helping our enrollees navigate the health system for both their medical and behavioral health needs.

Two examples from our current provider network demonstrate the value of the fully-integrated health home model in caring for enrollees with co-occurring conditions. In Region 6, Peace River Center operates a comprehensive, integrated behavioral health home serving Polk, Highlands, and Hardee Counties. PRC's BHH model provides both BH and primary care services, supported by care management, care coordination, health and wellness assessments and promotion, transitional care, individual and family support, and referral to community and social services, as needed. While mainly operating as a BH service provider, PRC also employs medical nurse practitioners and internal medicine physicians who provide medical and behavioral health services to PRC clients. To support integration and communication throughout the health home, PRC uses electronic health records for all documentation.

In Region 10, Henderson Behavioral Health has incorporated on-site PCPs for integrated primary care through the HILL (Helping Individuals Live Longer) Project. The HILL Project provides primary medical care and wellness activities to enrollees who receive services at Henderson Behavioral Health and serves as their health home. This model of service provides medical exams, lab tests, coordination of follow-up medical services, and an onsite wellness program. The program adheres to the principles of informed choice, recovery-focused and person-centered care and incorporation of evidence-based practices in routine care. The focus

of HILL Project service delivery is a person-centered, integrated approach to the medical care of enrollees with BH needs.

THE GOALS AND OBJECTIVES OF THE HILL PROJECT ARE TO:

- Increase the delivery of a coordinated array of medical, self-help, social, supportive, and rehabilitative services designed around the needs and desires of the individual.

- Improve the physical health of individuals with SPMI who are at-risk for co-occurring behavioral health and primary care conditions.

- Assist enrollees in taking an active role in their health and well-being.

- Assist in the coordination of primary, specialty, and behavioral health services.

- Increase individual and family input and participation in the recovery planning process.

THE SUPPORTS AND SERVICES PROVIDED BY THE HILL PROJECT INCLUDE:

- Primary Medical Care - A primary care physician and medical assistant are available one day per week at each of the adult outpatient facilities. Their focus is on assessing, diagnosing, and reducing the symptoms of primary medical issues, and making referrals for specialty care and wellness activities.

- Care Coordination - Every effort is made to coordinate the primary medical appointment with ongoing Henderson psychiatric, rehab, or case management services, as well as assisting individuals to link with specialty care services in the community as needed.

- Peer Support Wellness - The peer support specialist assists enrollees with their wellness by providing individual coaching and support to implement change strategies that improve healthy living habits. Smoking cessation, healthy eating habits, exercise, and healthy living groups are scheduled throughout the year for participants in the program.

- Integrated Services - Primary services are coordinated with outpatient BH services.

At each visit, Henderson BH collects data on each individual served through the HILL Project, including blood pressure, body mass index, waist circumference, breath carbon monoxide, fasting plasma glucose or HgbA1C, and cholesterol. In addition, behavioral health and substance use screening results are tracked over time for evidence of changes in risk factors. These results demonstrate the feasibility and impact of the integrated health home model. These data were aggregated to Henderson BH's reporting as a condition of its grant from the Substance Abuse and Mental Health Services Administration to launch the HILL Project [2].

- Of the participants who assessed for behavioral health and substance use risk factors that impact overall health, ninety-two percent (92%) reported stability in risk factors or demonstrated improvement in one or more factor.

- 81% of individuals seen during this reporting period demonstrated stability in healthy ranges or improvement in blood pressure readings.

- 85% of individuals seen during this reporting period demonstrated stability in healthy ranges or improvement in A1c readings, an indicator of blood glucose readings over time.

- 70% of individuals seen during this reporting period demonstrated stability in healthy ranges or improvement in cholesterol readings.

- During the first half of this grant period, the HILL Project has a retention rate of 93%, reflecting patient satisfaction.

COMPREHENSIVE HEALTH SYSTEM

In the Comprehensive Health System model, PCPs and BH providers operate under the umbrella of a single health system. With fully integrated services and fiscal accountability, the comprehensive health system model represents the most advanced version of integration. With one health system responsible for all facets of the enrollee's medical and BH care, providers use the same information systems and engage in regular dialogue and discussion to manage the enrollee's case in a holistic manner.

Citrus Health Network, both a community mental health center and Federally Qualified Health Center (FQHC), is an example of a comprehensive health system in our current provider network. While Citrus Health was founded to serve individuals with mental and behavioral health conditions, they have expanded their services to include primary care and social services in order to deliver a truly holistic approach. Today, Citrus Health employs PCPs and BH providers, who work side-by-side in several locations across South Florida to provide integrated care. This arrangement to integrate behavioral health has led to strong clinical quality performance. According to data from the Health Resources and Services Administration, in both 2015 and 2016 for example, Citrus Health was in the top-ranked quartile of national health centers across disease management measures related to diabetes management, controlling high blood pressure, and coronary artery disease [3]. In addition, Citrus Health increased the percentage of patients who were screened for clinical depression and had a follow-up plan from nineteen point one percent (19.1%) in 2015 to seventy-six point nine percent (76.9%) in 2016 [4].

==========
3. The extent to which the respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the respondent will implement across its systems to increase capacity for providing integrated care.
==========

In addition to the provider arrangements described above, our experience implementing an integrated care model in Florida has helped us to identify opportunities for improving the delivery of integrated primary care and BH services across our system of care. Humana is committed to continuous self-evaluation and improvement of our operations, with the goal of providing the best experience for our enrollees. To this end, we collaborate with our community partners through our Medicaid Advisory Panel, community events, and stakeholder listening tours to gain their insight and input into our integrated care model, and to identify opportunities to better meet the BH and medical needs of our enrollees. Under the next contract, we will draw upon our lessons learned, strong provider network, and partnerships with stakeholders to

continue delivering innovations that increase our capacity for providing integrated care. Specifically, we have designed initiatives to respond to the following identified opportunities for improvement:

- Medical and Behavioral Integration in Community Settings
- Improving System Capabilities
- Training for Providers and Humana Associates to Support Primary Care and BH Integration
- Integrated Care Teams Across our Comprehensive Plan
- Telemedicine to Improve Access to Behavioral Health Services in Rural Areas

MEDICAL AND BEHAVIORAL INTEGRATION IN COMMUNITY SETTINGS

BRINGING CARE COORDINATION TO SCHOOLS

The average school counselor ratio per student in low-income communities is three (3) times the federal guidelines; at the same time, four (4) in ten (10) students have a behavioral health disorder. In collaboration with the largest school districts in Florida, we will support Motivational Coaches of America (MCUSA) to place trained Service Members on school campuses to initiate multi-tiered support systems targeting student behavioral and academic early warning indicators. Trained coaches work on school campuses all day for one hundred eighty (180) academic days, providing a mix of evidence-based interventions, prevention, and primary care coordination for Humana enrollees with identified behavioral health needs. Humana is exploring an enhancement of this program by assigning a primary care provider to visit the schools with MCUSA and deliver truly integrated behavioral and primary health services.

MCUSA's proven model has demonstrated significant improvements in school campus climate and culture in five key areas: improved attendance, reductions in disciplinary referrals, increases in instructional time, improved school safety, and greater child-school connectivity.

- 98% improvement in submitting homework assignments
- 93% improvement in parent/child relationships
- 88% decrease in self-harming behavior
- 97% decreases in rates of alcohol and substance abuse
- 87% increase in school engagement
- Additional 60,000 days of attendance in one school district in the 2015-16 school year

This innovative school-based program will allow us to meet our enrollees where they are, and to deliver services that address their social, behavioral, and wellness needs in a holistic manner. Through our partnership with Motivational Coaches of America (MCUSA), we will expand our school-based behavioral health care presence to serve Humana enrollees ages six (6) to twenty (20) in Miami-Dade, Palm Beach, Escambia, Orange, Duval, Hillsborough, Pasco, Broward, Jefferson, and Clay counties. By incorporating primary care, we can enhance the program and integrate primary and behavioral health.

SUPPORTING THOSE WITH SPMI THROUGH ASSERTIVE COMMUNITY TREATMENT

Individuals with SMI may struggle to keep appointments, adhere to their medications, and obtain medical care, due to their condition. These difficulties can be compounded by homelessness, food insecurity, and a multitude of other challenges that they encounter in their day-to-day lives.

To better support these enrollees and engage them in both medical and behavioral health care in an integrated model, we employ the Florida Assertive Community Treatment (FACT) approach. The FACT program provides the care, coordination, and community support that our enrollees need to live successful, healthy lives. By focusing on basic needs, including housing, medical care, and income, enrollees are empowered to address their BH needs and adhere to treatment. FACT uses a team model, comprised of psychiatrists, nurses, social workers, substance abuse treatment specialists, vocational rehabilitation counselors, and peer counselors, covering all aspects of enrollees' needs. Using this team-based approach, FACT reaches enrollees in the community and helps them to obtain medical care and cope with life's day-to-day demands. Under the next contract, we will continue to apply and expand this approach to coordinate integrated care for our enrollees with the most complex behavioral health needs.

IMPROVING SYSTEM CAPABILITIES

Lack of data can often be an impediment to the improved integration of behavioral health and primary care services. By bridging this data gap, we can support PCPs and BH providers in our network to better monitor and coordinate care for our enrollees with co-occurring conditions. For example, by informing our PCPs of BH admissions among their patient panel, we empower our medical providers to follow-up with enrollees and ensure that they see their BH provider upon discharge, decreasing re-admissions. Additionally, with the right information, our PCPs and BH providers are enabled to jointly help enrollees who are taking medications for psychiatric conditions to adhere to the medication and manage any medical side effects. For example, through our Antidepressant Medication Management quality initiative, we provide PCPs and BH providers with a monthly action list containing contact information for those enrollees prescribed antidepressants who are due for a follow-up visit.

Today, we receive automated, daily inpatient census reports and weekly discharge reports for our enrollees admitted for BH inpatient care. These reports provide Humana's clinical teams with updated information about our enrollees' date of admission and treating physician. We use this information to both track enrollee utilization and to identify clinical aftercare programs that may be beneficial to enrollees post-discharge. With the enrollee's permission, we share this discharge information with their medical and BH providers to encourage further follow-up.

To further close this information gap between our medical and behavioral health case managers, we will build out our Behavioral Health Clinical and Case Management capabilities in our CGX system during 2018. In addition to our standing meetings and daily census reports, this integration will enable both our medical and behavioral health case managers to obtain a seamless view of our enrollee's needs, including their providers, care plans, and contact information, leading to better communication, coordination, and integration for our enrollees with co-occurring medical and behavioral health needs.

IMPROVING TRAINING FOR PROVIDERS AND HUMANA ASSOCIATES

PCPs are often the first line of care for our enrollees, and their main point of interaction with the health care system. Therefore, it is essential that all PCPs, including pediatric PCPs, are

equipped with tools and knowledge to identify BH conditions and refer to the appropriate providers. We will continue our ongoing initiatives to deliver provider support and training for improved integration of BH and primary care, including our joint site visits with BH partners, while growing our approach to incorporate best practices and evidence-based approaches.

To help our own associates understand interplay between primary and behavioral health services, along with the social determinants that impact enrollees' health, we utilize a training course called "Medicaid – Closing the Gaps." This training will be integrated into our associate on-boarding in Florida. The course defines social determinants of health, calls attention to various environmental, cultural, and social challenges that may impact our enrollees and their abilities to engage in health management, and discusses how we can take these into account when we are designing new programs, talking to our enrollees, coordinating care, building systems, and more.

OPERATING AS A COMPREHENSIVE PLAN

Through our experience as a Comprehensive Plan, we have developed unique capabilities to support the integration of primary care and BH. Coordinating enrollees within a comprehensive plan design which incorporates medical, behavioral, and LTC benefits helps us identify enrollees with BH care needs and provide integrated, comprehensive care. Our MDT approach facilitates communication and reduces fragmentation between Humana's case managers, BH case managers, providers across all specialties, and the enrollee, ensuring that the full spectrum needs are accommodated.

We are prepared to facilitate service delivery for comprehensive enrollees with BH needs. For example, enrollees diagnosed with a SPMI who reside in an Assisted Living Facility (ALF) may require additional care coordination support to ensure access to behavioral health services. Our BH partner, Beacon Health Options, was selected by AHCA to join with Apalachee Center and the President of the Florida ALF Association to establish meetings throughout the State of Florida to work with health plans, providers, ALF owners, and managing entities to develop a System of Care for enrollees with SMI living in ALFs. The intimate involvement of our BH partner in the development of the System of Care will ensure that our processes to integrate and coordinate care for these enrollees reflect best practices in the state, while facilitating improved collaboration with ALF providers and owners.

SUPPORTING INTEGRATION IN RURAL AND UNDERSERVED AREAS THROUGH TELEPSYCHIATRY

Humana will continue its investment in expanding the reach of telepsychiatry services. We see an opportunity to integrate primary and behavioral health services by supporting PCPs who are interested in building telepsychiatry capabilities in their practices. Telepsychiatry also provides an opportunity to improve coverage of BH services in rural and other underserved areas. By allowing PCPs and enrollees to quickly and easily access services from a licensed psychiatrist that are equivalent to in-person care in diagnostic accuracy, treatment effectiveness, and patient satisfaction (according to the American Psychiatric Association), we can meet the behavioral health needs of our enrollees in a timely, low-cost manner. Additionally, telepsychiatry can be used as an avenue to answer the PCP's questions, further integrating primary care and

behavioral health. In our network today, over 650 of providers in our current BH network are authorized to provide telemedicine service. Some of these providers include Lakeview Center CMHC and Chautauqua Healthcare Services in Region 1; BayCare in Region 6; and Changing Tree Wellness Center in Region 9.

To extend the reach of our current telepsychiatry capabilities, we will continue to expand our network of providers who are authorized to provide telepsychiatry. Additionally, Humana will adopt the Project ECHO model. This model revolutionizes how community providers manage specialty health conditions, such as substance use disorders, with the goal of disseminating knowledge previously held only by specialists. Through this model, community-based providers are better equipped to treat specialty conditions, particularly in those areas where access to care is limited. To bring this model to our enrollees in Florida, we will establish specialist teams, known as ECHO hubs, who will be linked with primary care or other community clinicians through interactive videoconferencing. Initially focusing on those enrollees with opioid use disorders, this hub would be led by a senior psychiatrist and addictionologist, along with an interdisciplinary team of providers, including a pharmacist, nurse, behavioral health counselor, and a peer. This approach would result in expanded access to ambulatory treatment, with a focus on Medication-Assisted Treatment (MAT); improved knowledge and skills among community practitioners, equipping them to treat opioid use disorders with MAT; and improved integration of BH treatment in primary care settings.

Footnotes

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[1]http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus#/#2

[2]https://www.integration.samhsa.gov/pbhci-learning-community/Henderson_Behavioral_Health.pdf

[3] https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&state=fl&year=2016&bid=0438180

[4] https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=0438180&state=FL&year=2016

Evaluation Criteria:

1. The extent with which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care.

2. The extent to which the respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. The respondent must also describe the data sources.

3. The extent to which the respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the respondent will implement across its systems to increase capacity for providing integrated care.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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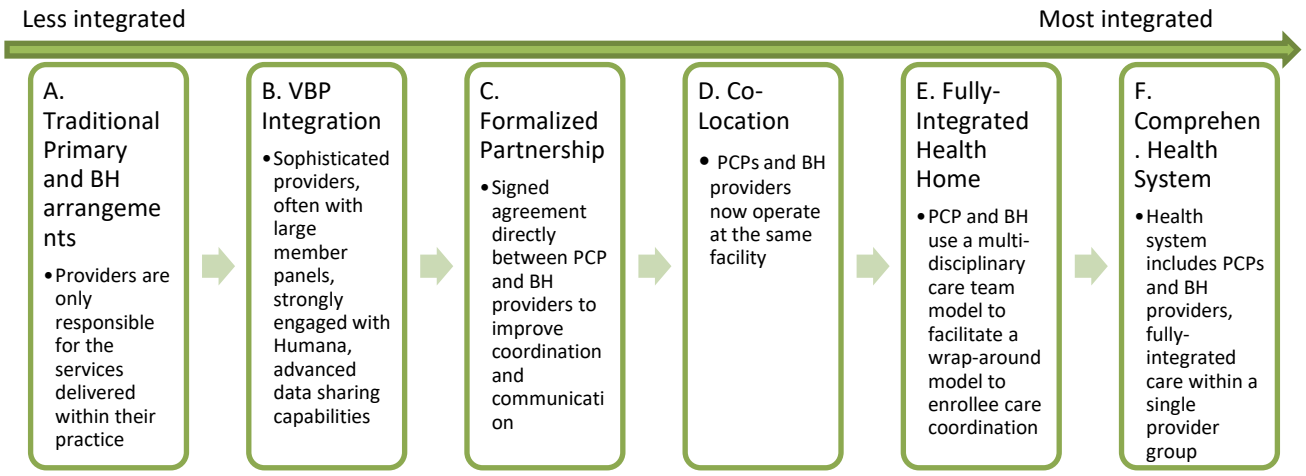
Attachment 23-1: Continuum of Primary Care and Behavioral Health Integration

Humana supports a continuum of innovative provider engagement models that facilitate integrated primary and behavioral health care. Recognizing that providers in our network have varying levels of readiness to engage in integrated arrangements, this spectrum allows us to engage all of providers in an integration model that is appropriate for their current capacities while supporting them to move along the continuum towards more complex arrangements. This continuum is depicted below.



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Beacon Health Options' PCP Toolkit

A Resource for Identification, Screening, Treatment and Referral of Members with BH conditions

Beacon is committed to leading the integration of medical and behavioral health services to improve patient outcomes

As the **first line of defense for behavioral health issues**, primary care physicians play a critical role in the proper **identification and treatment** of behavioral health conditions.

As a collaborative healthcare partner, **Beacon supports PCPs through information sharing and support** so that they have the tools and resources they need to successfully treat their patients.

Beacon's toolkit has been developed to support our ongoing collaborative initiatives with Primary Care Practices.

PCP toolkit development process incorporated input from both PCPs and Behavioral Health physicians

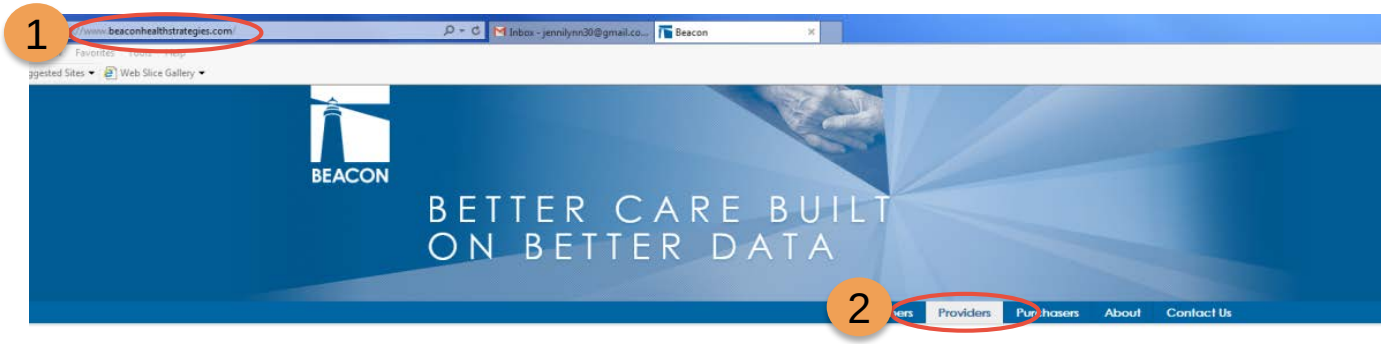
- **Primary research targeting PCPs to determine:**
  - Who is presenting to their practice with BH conditions?
  - What conditions are they seeing most frequently?
  - How do they currently treat BH conditions?
  - How do they refer patients for BH services?
  - What additional resources would be helpful in treating their patients?
- **Secondary research of existing resources for BH conditions**
  - Information gathered targeting up-to-date clinical guidelines, member-facing resources, and standard screening tools for BH conditions
- **Rigorous review of material included in the toolkit**
  - Reviewed by consulting NP for relevance/usefulness to PCP practice
  - VP of Medical Affairs reviewed for clinical appropriateness and accuracy
- **Moving forward:**
  - Ongoing monitoring and maintenance to ensure relevance of clinical material
  - Managed in house by Quality Department

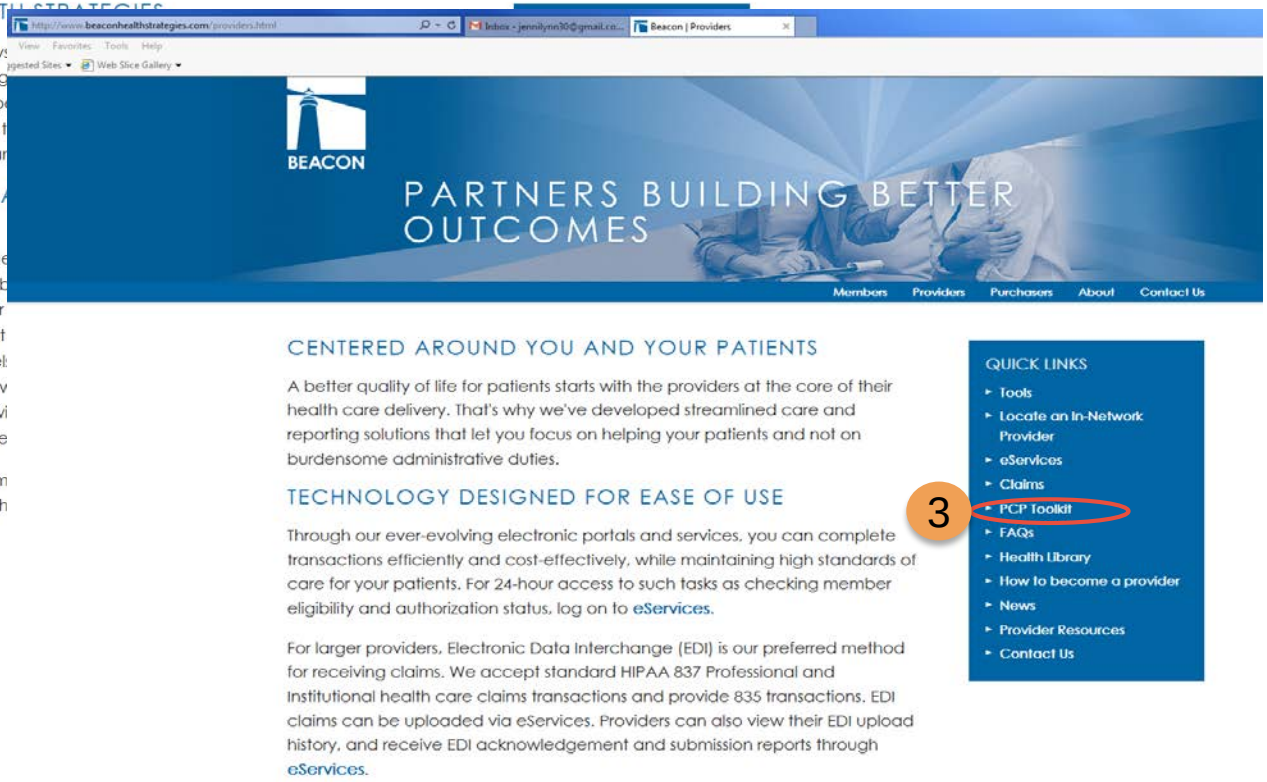
Beacon's toolkit has been developed to support our ongoing collaborative initiatives with Primary Care Practices.

PCP Toolkit components

Member resources	Diagnostic references	Screening tools	Prescribing references	Beacon access
Reference: Fact sheets	Reference: APA guidelines	Reference: PHQ-2/9	Reference: Prescription dosing range and side effects	Toll free number or web-based access to Beacon physicians for diagnostic, prescription, etc.
Reference: Self-management strategies	Reference: DSM diagnostic criteria	Reference: GAD-7	Reference: Treatment algorithms	

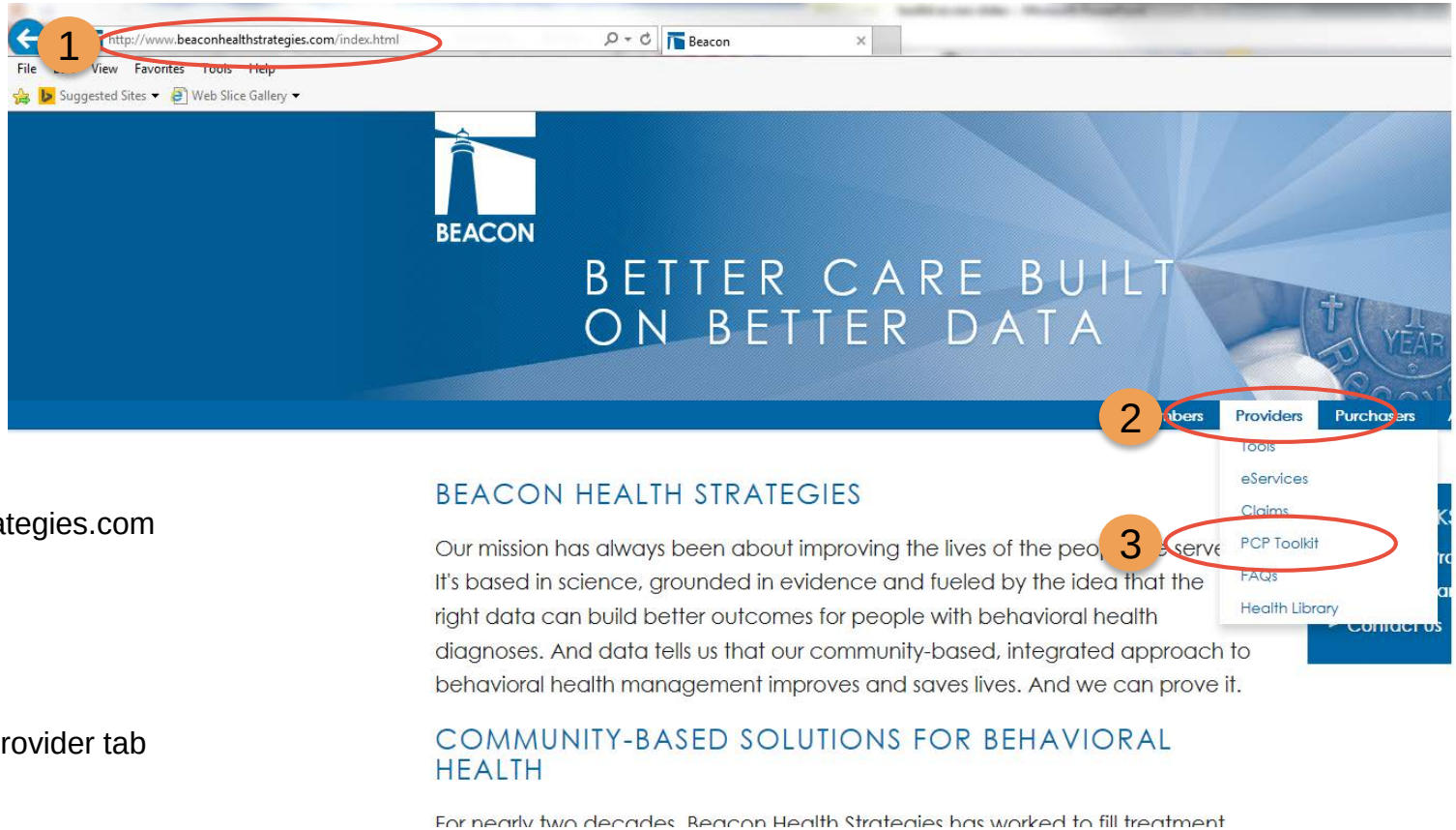
PCPs can access the toolkit from Beacon's provider page





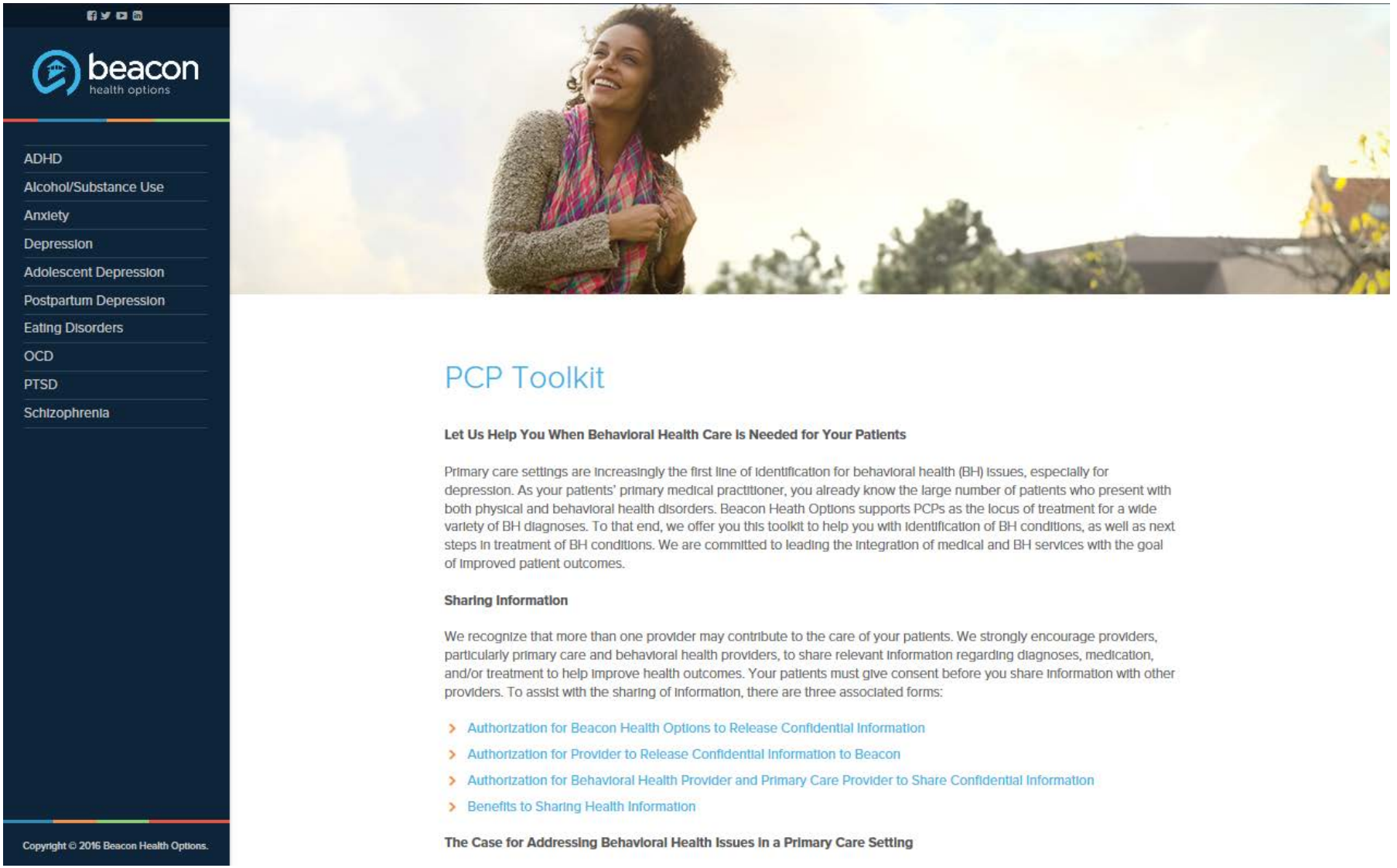
1. Go to beaconhealthstrategies.com
2. Click on the "Providers" tab
3. Click on PCP toolkit in the blue Quick Links box

The toolkit is accessible directly from Beacon's homepage

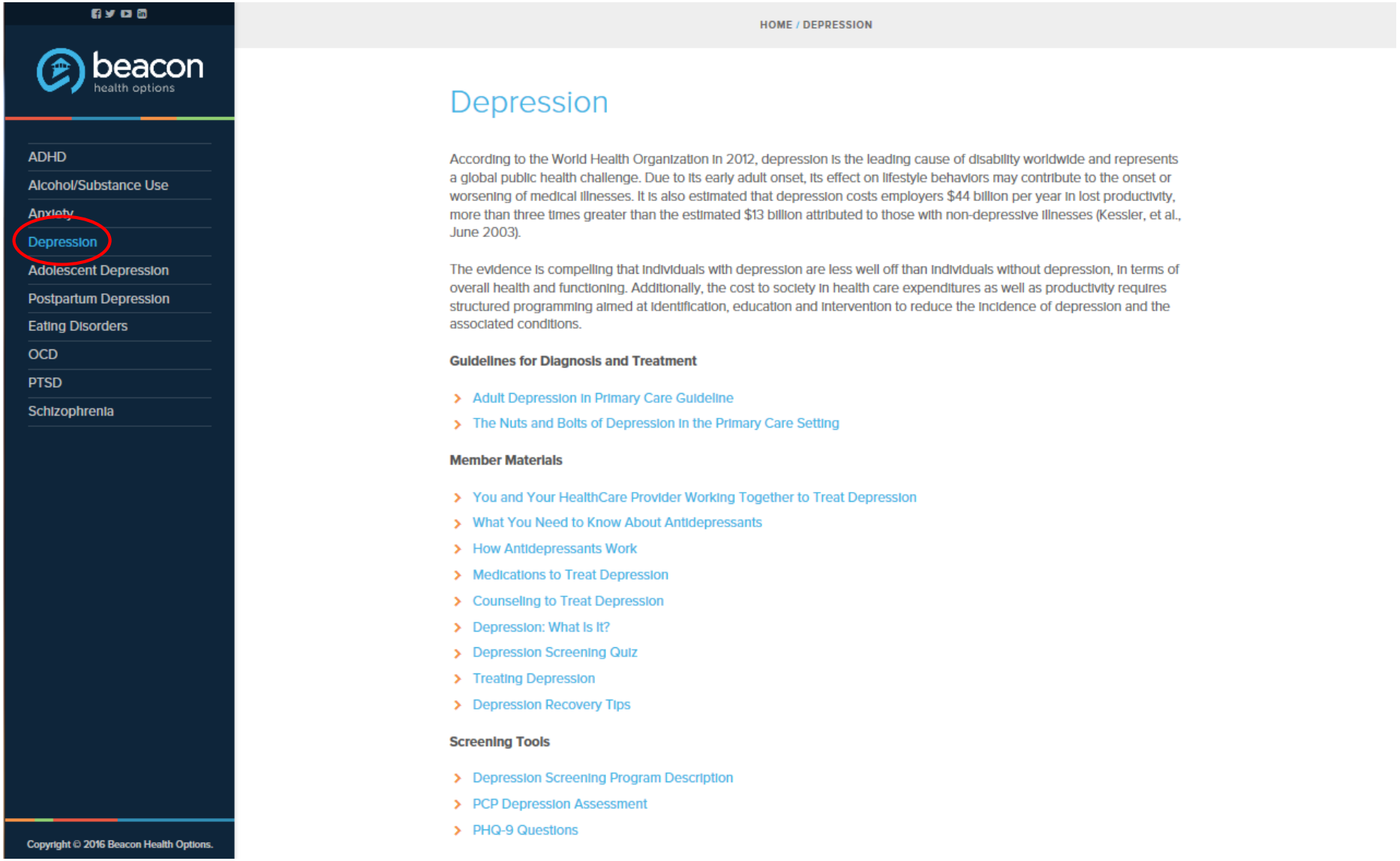


1. Go to beaconhealthstrategies.com
2. Hover over the Provider tab
3. Click on PCP toolkit

PCP toolkit homepage provides general information about Beacon support for PCPs in addressing behavioral health issues.



Each BH condition page includes resources for PCPs and members



Depression-related materials include

- **Guidelines for Diagnosis and Treatment**
- **Member Materials**
- **Screening Tools**

Depression Guidelines:

ICSI
Institute for Clinical Systems Improvement

Health Care Guideline:

Adult Depression in Primary Care Guideline

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. With successive editions over the past 60 years, it has become a standard reference for clinical practice in the mental health field. In May 2013, the most recent edition, DSM-5, was published. It is the product of more than 10 years of effort by hundreds of international experts in all aspects of mental health.

The sixteenth edition of the Adult Depression in Primary Care Guideline uses DSM-5 as a reference. Throughout the guideline, both ICD-9-CM codes and ICD-10-CM codes are identified (the latter scheduled for adoption in October 2014). This reflects how DSM-5 classifications of mental health disorders were harmonized with the World Health Organization's *International Classification of Diseases* (ICD).

Depression-related member materials include:

Depression treatment tracking tools

You and Your Healthcare Provider:
Working Together to Treat Depression

WHAT TO EXPECT WHEN YOU ARE BEING TREATED FOR DEPRESSION

Depression is a treatable, medical illness. It is important to find the treatment that works best for you. Antidepressants are commonly prescribed medications to treat depression. When you are taking antidepressants, you need to talk with your provider about how you feel, so you can work together to make changes, as needed. Because antidepressants take time to work, some people stop taking them because they think they are not helping, or because they have side effects.

THINGS TO REMEMBER

- It may take more than one trial to find the right medication for you.
- Medications are started at a low dose and slowly increased to reduce the chance of side effects.
- If you experience side effects, such as headache, fatigue, heartburn or stomach upset, talk with your provider before stopping your medication. Most side effects will go away over time as you continue taking the medication.
- Medications do not work right away, but may take about a month to be effective.
- Many medications are most helpful if taken for at least six months.
- It is important to see your medication prescriber within the first three months of taking your medication, and beneficial to see your therapist at least twice.
- Some over-the-counter, herbal or natural supplements may interact with your medication, so inform your prescriber if you are taking them.
- Drinking alcohol can worsen depression and interfere with the medication or cause dangerous reactions.
- If you have questions about your medication, call your provider.
- If you have suicidal thoughts or feelings, **call 911**, go to your nearest emergency room, or call your local Emergency Service Provider (ESP, Crisis Team).

My Treatment Tracker

HEALTHCARE PROVIDERS

Provider Name	Provider Telephone #	Upcoming Appointment	Upcoming Appointment	Upcoming Appointment

CURRENT MEDICATIONS

Name	Dosage	How Often	Date Started

OTHER SUPPORTS

Name	Number

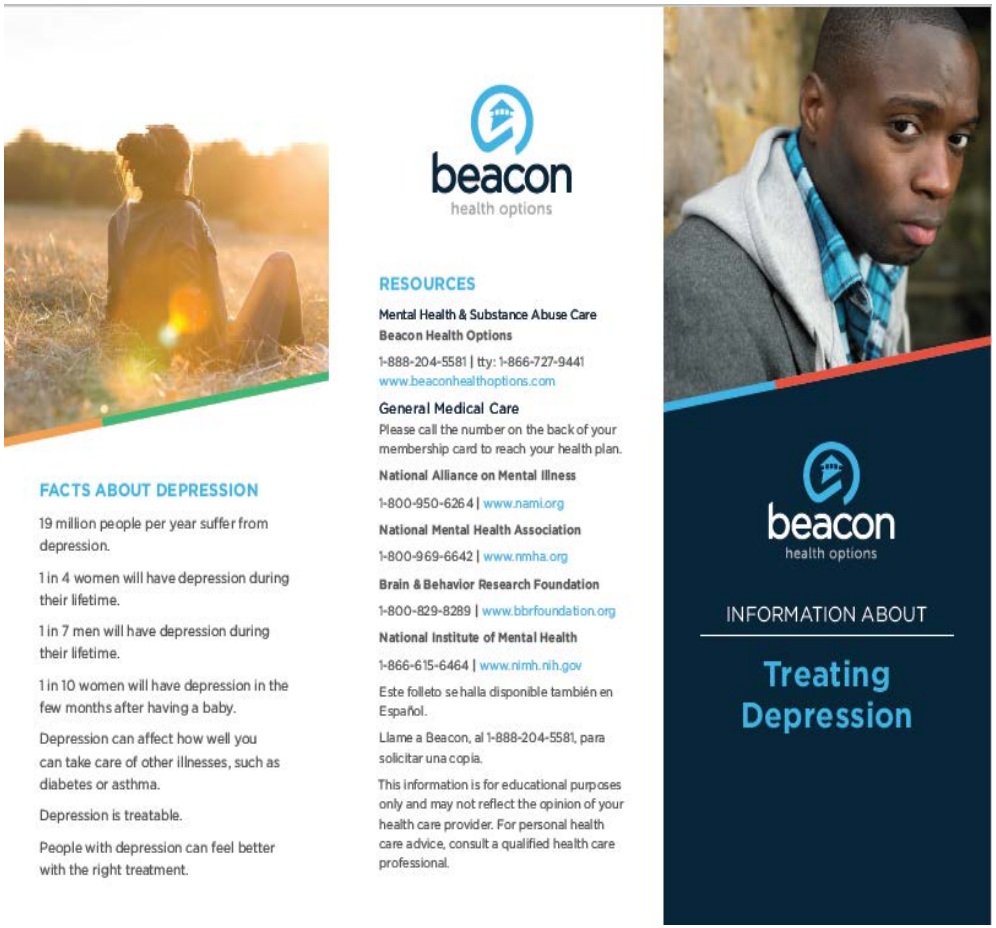
ACTIVITIES TO IMPROVE MY MOOD

Activities	Activities

I will try to bring this form with me to each appointment so that it can be updated

Depression-related member materials include:

Brochures



FACTS ABOUT DEPRESSION

19 million people per year suffer from depression.

1 in 4 women will have depression during their lifetime.

1 in 7 men will have depression during their lifetime.

1 in 10 women will have depression in the few months after having a baby.

Depression can affect how well you can take care of other illnesses, such as diabetes or asthma.

Depression is treatable.

People with depression can feel better with the right treatment.

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RESOURCES

Mental Health & Substance Abuse Care
Beacon Health Options
1-888-204-5581 | tty: 1-866-727-9441
www.beaconhealthoptions.com

General Medical Care
Please call the number on the back of your membership card to reach your health plan.

National Alliance on Mental Illness
1-800-950-6264 | www.nami.org

National Mental Health Association
1-800-969-6642 | www.nmha.org

Brain & Behavior Research Foundation
1-800-829-8289 | www.bbrfoundation.org

National Institute of Mental Health
1-866-615-6464 | www.nimh.nih.gov

Este folleto se halla disponible también en Español.

Llame a Beacon, al 1-888-204-5581, para solicitar una copia.

This information is for educational purposes only and may not reflect the opinion of your health care provider. For personal health care advice, consult a qualified health care professional.

beacon health options

INFORMATION ABOUT

Treating Depression

WHAT IS DEPRESSION?

Depression is an illness that can affect your body, mood and thoughts. Depression is when you feel sad or down most of the time. It is not a passing " blue mood."

Some Signs of Depression are:

- Feeling worried
- Feeling restless or nervous
- Feeling guilty, worthless, or hopeless
- Feeling "empty"
- Sleeping too little or too much
- Eating too little or too much
- Loss of energy
- Loss of interest or pleasure in things you like to do
- Having problems thinking or making decisions
- Having thoughts of death and suicide
- Having health problems that don't get better, such as headaches or stomach aches

If you often have these kinds of thoughts or problems, it could be a sign of depression. If you have signs of depression, you can talk with your doctor, nurse, or a counselor.

Without treatment, the symptoms of depression can last for weeks, months, or even years.

TREATMENT FOR DEPRESSION

Counseling
Most people who have depression get better with counseling, medication, or both. Counseling can be done individually or in a group and can help improve your mood. It can also help you figure out what brings on your depression and help you find ways to get better.

Medication
There are several different types of medicines to help with depression including medicines called anti-depressants. Your doctor or nurse will work with you to choose the one that's right for you. Usually, it takes between four (4) and eight (8) weeks for the medicine to work and for you to feel better. It is important to take it the way your doctor or nurse tells you to. Your doctor or nurse will most likely tell you to take the medicine for at least six (6) months. Some people take medicine for much longer.

If you are in treatment, experts recommend that you see your counselor at least three (3) times for the first three (3) months of your treatment.

If you take medicine for your depression, you should see the doctor or nurse who gave you the medicine at least one (1) time in the first three (3) months.

Remember to keep your appointments and take your medication exactly as your doctor or nurse tells you, even if you are feeling better. Always tell your doctor or nurse exactly how you are feeling.

Ask Yourself...
If you think you or someone you know might have depression, here are two questions that may help you talk with a doctor, nurse, or counselor:

1. Over the past two weeks, have you felt down, depressed, or hopeless?
2. Over the past two weeks,have you felt little interest or pleasure in doing things?

If you answered yes to either of these questions:

- It is important to talk to your primary care doctor, nurse, or go to see a counselor.
- A doctor or nurse can also rule out health problems that look like signs of depression.

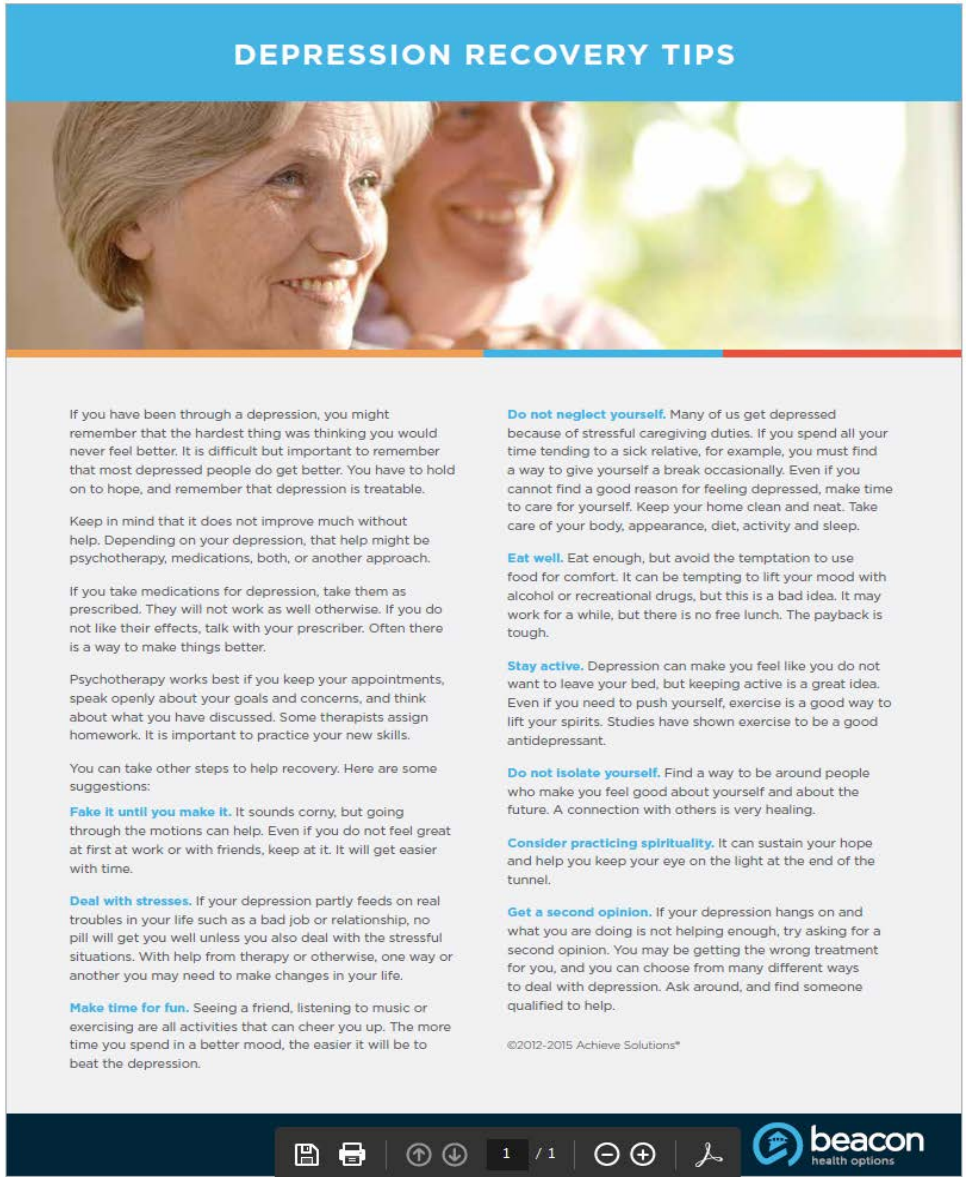
If you have thoughts of hurting yourself, call 911, go to the emergency room, or get help right away from a doctor, nurse, or counselor. This can be a very dangerous situation that needs treatment immediately.

Treatment can Help
If you are not in treatment and want counseling or medication, you can go to a counselor, doctor or nurse, and you don't need a referral. If you need help finding someone in your area, please call Beacon Health Options at 1-888-204-5581, or TTY: 1-866-727-9441.

Beacon Health Options | Treating Depression | beaconhealthoptions.com | 1.888.204.5581

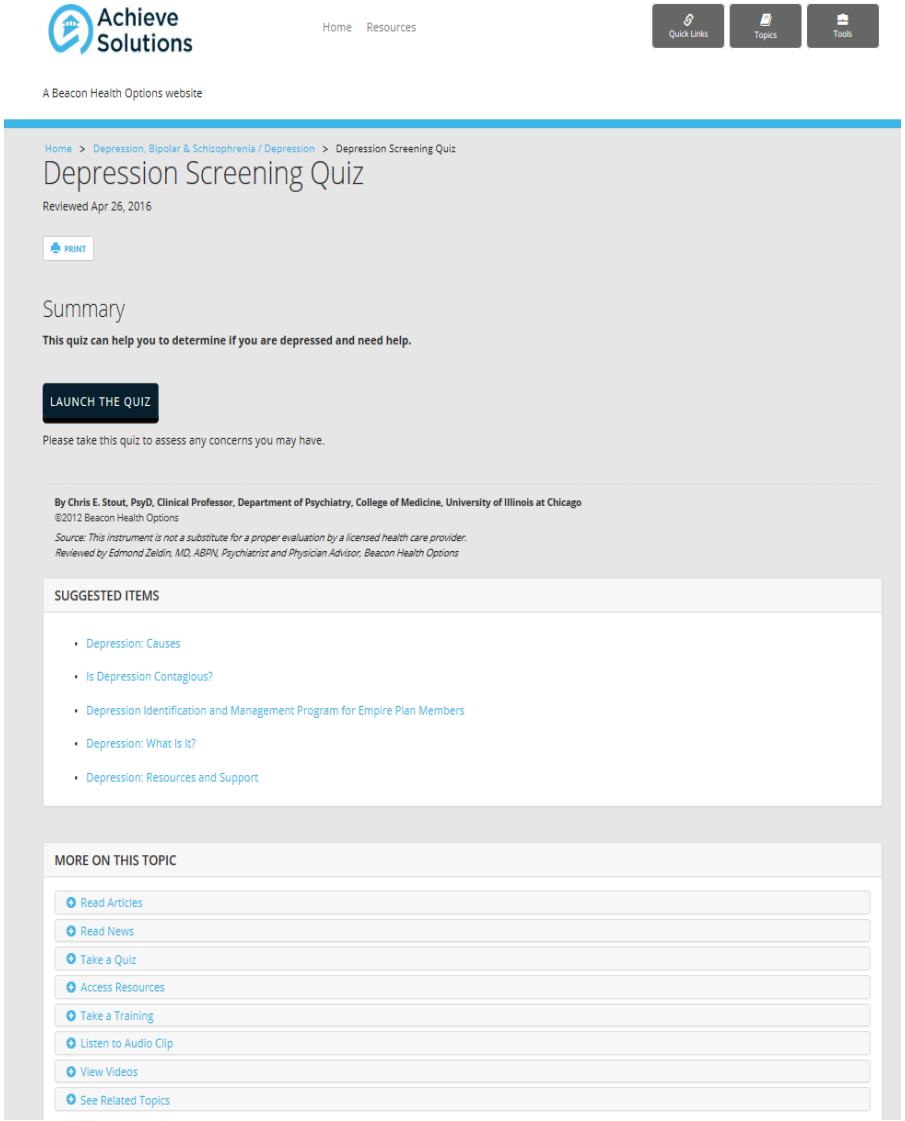
Depression-related member materials include:

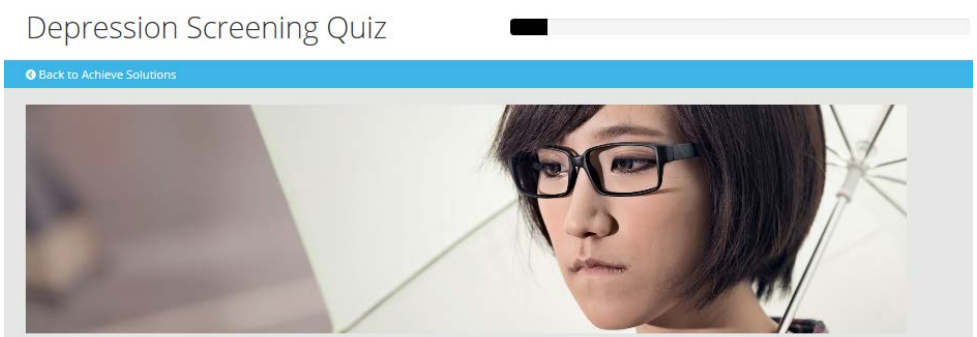
Bulletins

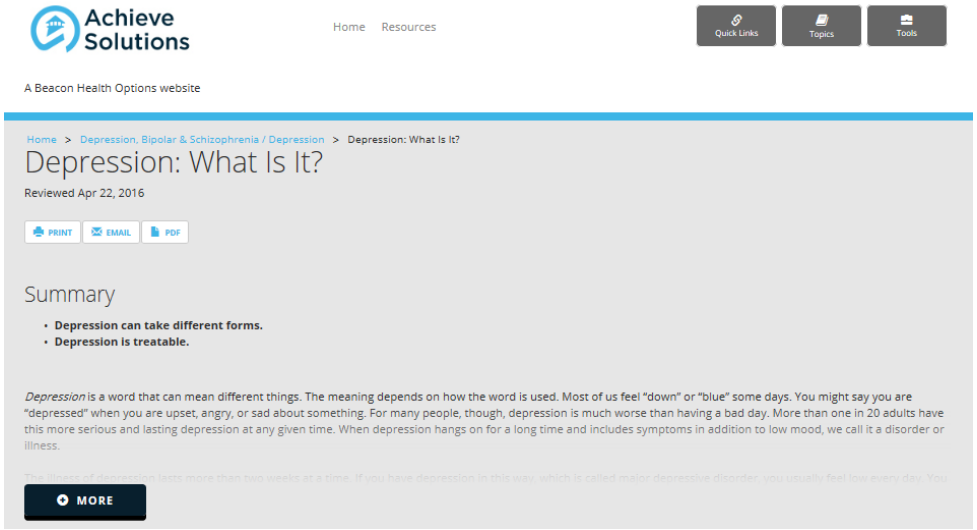


Depression-related member materials include:

Interactive Member Tools and Articles







Beacon's Depression Screening Program includes Screening Tools and Interpretive support

DEPRESSION ASSESSMENT

USE THIS GUIDE AS A REFERENCE TOOL TO SCREEN FOR CLINICAL DEPRESSION AND SUICIDE RISK.

RISK FACTORS FOR CLINICAL DEPRESSION

- Previous depressive episode or family history of depression
- Multiple or unexplained physical symptoms
- Chronic pain or chronic illness
- Recent serious loss or stressful life events
- Increase in substance use

REMEMBER

Always ask about alcohol and substance use/abuse.

TWO QUESTION SCREEN

During the past month, have you often been bothered by:

1. Little interest or pleasure in doing things? ☐Yes ☐No
2. Feeling down, depressed or hopeless? ☐Yes ☐No

If one or both responses are **"Yes,"** proceed to a more detailed assessment tool such as the PHQ-9, available at **www.beaconhealthstrategies.com.**

If the response is **"No"** to both questions, the screen is negative.

This guide is adapted from the MacArthur Initiative on Depression in Primary Care Physician Toolkit. Additional information on assessment and treatment guidelines are available on the MacArthur Initiative website: www.nimh.nih.gov/health/topics/depression/index.shtml

DSM 5 DIAGNOSTIC CRITERIA FOR DEPRESSION

For major depressive disorders, at least 5 of the following symptoms must be present most of the day, nearly every day, and for at least two weeks.

- **Depressed mood**
- **Markedly diminished interest in usual activities**
- Significant increase/loss in appetite/weight
- Insomnia/hypersomnia
- Psychomotor agitation/retardation
- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Difficulty with thinking, concentrating, or making decisions
- Recurrent thoughts of death or suicide.

REMEMBER

At least one of the first two bolded symptoms must be present.

SUICIDE RISK ASSESSMENT

If you make a depression diagnosis, you must also assess the patient for suicide risk. Remember: questions about suicidal ideation do not promote suicidal action.

If a patient reports current suicidal thoughts with planning, get emergency behavioral health services immediately or call 911.

Risk factors are not predictors of suicide. The following mnemonic aid **SAD PERSONS** may be used to assess for risk factors associated with suicide.

Sex (more women attempt suicide, more men succeed)
Age (bimodal age distribution <19 and/or >45)
Depression (especially with anxiety/panic)
Previous attempts
ETOH (alcohol or other substance abuse)
Rational thinking loss (psychosis)
Social Supports (none or limited)
Organized plan
No spouse
Sickness (chronic or debilitating illness)

TREATMENT OPTIONS

Consider starting a trial of antidepressant medication and/or a mental health referral for psychotherapy.

Call Beacon Health Strategies at **888.204.5581** for a referral to a behavioral health provider. For additional treatment options, visit **www.nimh.nih.gov/health/topics/depression/index.shtml**.

This guide is adapted from the MacArthur Initiative on Depression in Primary Care Physician Toolkit. Additional information on assessment and treatment guidelines are available on the MacArthur Initiative website: www.nimh.nih.gov/health/topics/depression/index.shtml

Depression Screening Tools:

- ***PHQ-2***: The sole purpose of PHQ-2 is to screen for depression, encompassing only the first two questions of the PHQ9, identifying the degree to which an individual experienced depressed mood and anhedonia over the past two weeks.
- ***PHQ-9***: The PHQ-9 is used to screen for depression, but is also valid for the assessment of depression severity. Thus, when used successively during a treatment episode, the PHQ-9 is a practical means to quantitatively monitor the patient's response to depression treatment.
- ***PHQ-A***: The PHQ-A is a modified version of the PHQ-9 sensitive to the adolescent experience of depression that is an acceptable and efficient tool for early detection and recognition of mental disorders in this high-risk group.

Thank you

Humana®

Medical and Behavioral Health Integration

A Behavioral Health Support Toolkit for Primary Care

2016

Humana.

Medicaid is currently the largest source of financing for behavioral health services in the nation. Recent data released by the Government Accountability Office show that more than half of Medicaid-only enrollees in the top 5 percent of expenditures had a mental health condition.[1] Approximately 71 percent of enrollees with high expenditures who had a substance-use disorder also lived with one or more co-occurring mental health conditions.[1] Increased costs and poor health outcomes among Medicaid recipients constitute the need for an integrated system of care that can properly identify, assess and address behavioral, medical and psychosocial needs.

Humana Family recognizes this need and is dedicated to foster and grow the relationship between primary care and behavioral care through its medical and behavioral health integration program. We hope this document helps support physicians in their efforts to efficiently address the behavioral health and substance abuse needs of our Humana Family members.

With the growing need for care integration, it is our intent to provide information to bridge efforts and increase collaboration for the treatment of members in our community.

For inquiries, please contact Humana Customer Service at 1-800-477-6931.

[1]Physical and Mental Health Integration: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/physical-and-mental-health-integration/physical-and-mental-health-integration.html

Meet your Humana Family Behavioral Health Support Team!

Access Behavioral Health (ABH) has been providing behavioral and substance abuse services to Medicaid recipients in northwestern Florida since 2001. ABH offers a wide variety of behavioral health and substance abuse services for both adults and children utilizing a comprehensive and community-based system of care.

Humana Family has contracted with ABH to address the behavioral health needs of Humana Family members and support the collaboration of primary care, behavioral care and the health plan to deliver necessary services and avoid gaps in care. We encourage physicians to reach out to us for behavioral health and substance abuse support for Humana Family members.

Humana Family Covered Benefits

- ✓ Inpatient hospital services for behavioral health conditions
- ✓ Outpatient hospital services for behavioral health conditions
- ✓ Outpatient medication management
- ✓ Outpatient substance abuse

ABH's Mission:
To help people overcome life's challenges by connecting them to hope and recovery.

Referring Patients to ABH

If a physician identifies a behavioral health need, such as a member with severe depression, anxiety, history of serious mental illness or substance abuse, the physician can refer the member to ABH for coordination of care by calling ABH customer service toll free at 1-866-477-6725, or by accessing our TDD/TYY services through the Florida Relay number at 1-800-955-1339. Referrals also may be faxed to 1-850-469-3597.

Information about available behavioral health programs and a full list of in-network providers are available on the ABH website at www.abhfl.org.

Provider Hotline Available for Psychiatric Questions

Humana Family and ABH strongly support communication between primary care physicians and behavioral health providers. We encourage physicians to address questions related to antidepressants, antipsychotics or general behavioral/substance abuse treatment to ABH's medical director for a peer consult.

Dr. Ed Mobley: 1-866-477-6725
Email: ed.mobley@bhcpns.org
(Please include "PCP Consultation" in the email's subject line)

Behavioral Health Performance Measures

It is our goal to collaborate with behavioral health care providers, primary care physicians and the health plan to improve behavioral health performance measures, as outlined by the Healthcare Effectiveness Data and Information Set (HEDIS) and the Florida Agency for Healthcare Administration (AHCA). Given the high rates of medical and behavioral comorbidity, and overall chronic illness, it is imperative that there is an open line of communication between all parties involved in a member's care when addressing such measures. (Please see pages 4 to 11 for the details of the measures.)

For additional questions regarding performance measures, please contact the ABH Director of Quality Management at 1-866-477-6725.

Thank you for assisting in our efforts to continually improve the quality of care and services to our members.

Antidepressant Medication Management (AMM)

Primary care physicians know that antidepressants are frequently prescribed in the primary care setting. They also know that patients often don't take their medications as prescribed. To improve adherence, it is important to educate the patient regarding common side effects, how long the side effects may last and how to manage those side effects.

Primary care physicians need to encourage patients to schedule their medication management appointments after their initial psychiatric evaluation and before they leave your office.

Measure description	Service needed	What to report
Percentage of members 18 years old and older who were diagnosed with a new episode of major depression, were treated with antidepressant medication and remained on an antidepressant medication treatment.	• Encourage and monitor compliance with antidepressant medications for members 18 years old and older, newly diagnosed with major depression.	**Codes to identify major depression**: **ICD-10-CM diagnosis**: F32.0 – F32.4. F32.9, F33.0 – F33.3, F33.41, F33.9 **Outpatient, intensive outpatient and partial hospitalization**: **CPT**: 90791, 90792**,** 90801 – 90819, 90821 – 09829, 90832 – 90840, 90845, 90847, 90849, 90853, 90857, 90862, 90867 – 90870, 90875, 90876, 98960 – 98962, 99078, 99201 – 99205, 99211 – 99215, 99217 – 99223, 99231 – 99233, 99238, 99239, 99241 – 99245, 99251 – 99255, 99341 – 99345, 99347 – 99350, 99384 – 99387, 99394 – 99397, 99401 – 99404, 99411, 99412, 99510 **HCPCS**: G0155, G0176, G0177, G0409 – G0411, G0463, H0002, H0004, H0031, H0034 – H0037, H0039, H0040, H2000, H2001, H2010 – H2020, M0064, S0201, S9480, S9484, S9485, T1015

AMM Action Checklist:

Behavioral health management	Description of requirement	Date completed
☐ Antidepressant medication management	Encourage and monitor compliance with antidepressant medications for members **18 years old and older**, newly diagnosed with major depression.	____/____/_____

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Failure to adhere to medication as prescribed can have a major impact on the course of illness and treatment outcomes in patients with schizophrenia. Even relatively short gaps in medication coverage increase the risk of relapse. It is important for primary care physicians and behavioral health providers to be vigilant for signs of adherence problems. To improve adherence, it is important to educate the patient regarding common side effects, how long the side effects may last and how to manage those side effects.

Measure description	Service needed	What to report
Percentage of members 19 to 64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period	• Adhere to the antipsychotic medication treatment regimen for all members 19 to 64 who are diagnosed with schizophrenia during **2016** • Consider medications within the following drug classes per the AHCA formulary: - Phenothiazine antipsychotics (oral) - Psychotherapeutic combinations (oral) - Psychotherapeutics combinations (oral) - Thioxanthenes (oral) - Long-acting injections	**Pharmacy claims for appropriate antipsychotic medications** **Codes to identify schizophrenia** **ICD-10-CM diagnosis**: F20.0 – F20.3, F20.5, F20.81, F20.89, F20.9, F25.0 – F25.1, F25.8 – F25.9 **ICD-10-CM diagnosis codes to identify required exclusions**: **Dementia:** F01.50 – F01.51, F02.80 – F02.81, F03.90 – F03.91, F04, F10.27, F10.97, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0 – G30.1, G30.8 – G30.9, G31.83

SAA Action Checklist:

Behavioral health management	Description of requirement	Date completed
☐ Adherence to antipsychotic medications for individuals with schizophrenia	Encourage and monitor compliance with antipsychotic medications for members **19 to 64 years of age** with schizophrenia	____/____/_____

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Antipsychotics can effectively treat psychiatric disorders in children and adolescents, but some of these medications increase the risk for weight gain and diabetes. Young people with metabolic disorders are at greater risk of negative outcomes. Therefore, it is important to closely monitor young people taking antipsychotics. It is important to educate parents/guardians and ensure annual blood tests are performed.

Measure description	Service needed	What to report
Percentage of children and adolescents 1 to 17 years old who had two or more antipsychotic prescriptions and had metabolic testing during the measurement year	• At least one blood glucose or HbA1c test in **2016** for all eligible members **and** • At least one LDL-C or cholesterol test in **2016** for all eligible members	**Pharmacy claims for antipsychotic medications** **Code to identify glucose test:** **CPT**: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951 **LOINC:** 10450-5, 14753-8, 14754-6, 14756-1, 14757-9, 14759-5, 14764-5, 14765-2, 14771-0, 1492-8, 1494-4, 1496-9, 1499-3, 14995-5, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 25666-9, 26554-6, 30251-3, 30265-3, 30267-9, 32320-4, 40285-9, 40286-7, 41024-1, 49134-0, 51597-3, 55351-1, 55381-8, 6749-6, 74774-1, 9375-7 **Code to identify HbA1c test:** **CPT**: 83036, 83037, 3044F, 3045F, 3046F **LOINC**: 17856-6, 4548-4, 4549-2 **Code to identify LDL-C test:** **CPT**: 80061, 83700, 83701, 83704, 83721, 3048F, 3049F, 3050F **LOINC**: 12773-8, 13457-7, 18261-8, 18262-6, 2089-1, 49132-4, 55440-2 **Code to identify cholesterol test:** **CPT**: 82465, 83718, 84478 **LOINC**: 2085-9, 2093-3, 2571-8, 5932-9

APM Action Checklist:

Behavioral health management	Description of requirement	Date completed
☐ Metabolic Monitoring for Children and Adolescents on Antipsychotics	One blood glucose or HbA1c test and one LDL-C or cholesterol test for children/ adolescents **1 to 17** years old who had two or more antipsychotic prescriptions before Dec. 31, 2016.	Glucose/HbA1c: ____/____/____ LDL-C/Cholesterol: ____/____/____

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

The practice of prescribing antipsychotics to children and adolescents has rapidly increased in recent years. Antipsychotics have serious side effects, including weight gain, diabetes and metabolic disturbance. Primary care physicians need to refer patients to behavioral health providers for consultation when prescribing antipsychotics to children and adolescents.

Measure description	Service needed	What to report
Percentage of children and adolescents 1 to 17 years of age who were on two or more concurrent antipsychotic medications during the measurement year	• Eligible members who are on **two or more** concurrent antipsychotic medications for at least **90 consecutive days**	**Pharmacy claims for antipsychotic medications** • First Generation Antipsychotic Medication • Second Generation Antipsychotic Medication

APC Action Checklist:

Behavioral health management	Description of requirement	Date completed
☐ Use of multiple concurrent antipsychotics in children and adolescents	Monitor members 1 to 17 years of age who were on antipsychotic medications	____/____/_____

Follow-up Care for Children Prescribed ADHD Medication (ADD)[1]
Initiation and Continuation Phase

Attention deficit hyperactivity disorder (ADHD) is one of the most commonly diagnosed childhood behavioral health disorders. The treatment of childhood ADHD works best with a team approach that includes care collaboration between behavioral health psychiatrists, clinicians, pediatricians, teachers, parents/legal guardians and other health care professionals. It is important to educate the patient's parents or guardians on medication adherence and medication management visits, which are essential to monitor the child's progress.

Performance measure	Service needed	What to report
Percentage of children 6 to 12 years old newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed	**For members with newly prescribed attention deficit disorder (ADD)/ADHD medications:** • An in-person outpatient visit within 30 days of prescription fill **and** • Two additional in-person outpatient follow-up visits between days 31 and 300 of prescription fill	**Codes to identify visits**: **CPT**: 90791 – 90792, 90801– 90802, 90804 –90819, 90821 – 90824, 90826 – 90829, 90832 – 90840, 90845, 90847, 90849, 90853, 90857, 90862, 96150 – 96154, 98960 – 98962, 99078, 99201 – 99205, 99211 – 99215, 99217 – 99223, 99231 – 99233, 99238 – 99239, 99241 – 99245, 99251 –99255, 99341 – 99345, 99347 – 99350, 99381 – 99384, 99391 – 99394, 99401 – 99404, 99411, 99412, 99510 **HCPCS**: G0155, G0176, G0177, G0409 – G0411, G0463, H0002, H0004, H0031, H0034 – H0037, H0039, H0040, H2000, H2001, H2010 – H2020, M0064, S0201, S9480, S9484, S9485, T1015

ADD Action Checklist:

Behavioral health management	Description of requirement	Date Completed
☐ Follow-up management for children with newly prescribed ADD/ADHD medications	• In-person outpatient visit within 30 days of prescription fill • Two additional in-person outpatient follow-up visits between days 31 and 300 of prescription fill	Initial: ____/____/_____ Follow-up: ____/____/_____ ____/____/_____

Follow-up after Hospitalization for Mental Illness (FHM) [2]
7 days and 30 days

Effective discharge planning from an acute-care facility helps facilitate continuous and coordinated behavioral health care treatment for patients. Timely follow-up after an inpatient psychiatric hospitalization promotes continuity of behavioral health care.

Measure description	Service needed	What to report
Percentage of discharges for members 6 years old and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit with a mental health practitioner within 7 and 30 days	• An outpatient visit within **7 days of discharge** and • An additional outpatient visit within **30 days of discharge**	**Code to identify mental health diagnosis:** **ICD-10-CM diagnosis**: F20.0 – 3, F20.5, F20.81, F20.89, F20.9, F21 – F24, F25.0 – 1, F25.8 – 9, F28 – F29, F30.10 – 13, F30.2 – 4, F30.8 – F31.0, F31.10 – 13, F31.2, F31.30 – 32, F31.4 – 5, F31.60 – 64, F31.70 – 78, F31.81, F31.89, F31.9 – F32.5, F32.8 – 9, F33.0 – 3, F33.40 – 42, F33.8 – F34.1, F34.8 – 9, F39, F42, F43.0, F43.10 – 12, F43.20 – 25, F43.29, F43.8 – 9, F44.89, F53, F60.0 – 7, F60.81, F60.89, F60.9, F63.0 – 3, F63.81, F63.89, F63.9, F68.10 – 13, F68.8, F84.0, F84.2 – 3, F84.5, F84.8, F84.9, F90.0 – 2, F90.8 – F91.3, F91.8 – 9, F93.0, F93.8 – F94.2, F94.8 – 9 **Codes to identify visits**: **CPT****: 90791, 90792, 90832 – 98034, 90836 – 90840, 90847, 90849, 90853, 90867 – 90870, 90875 – 90876, 90960, 99078, 99201 – 99205, 99211 – 99215, 99217 – 99223, 99231 – 99233, 99238, 99239, 99241 – 99245, 99251 – 99255, 99341 – 99345, 99347 – 99350, 99383 – 99387, 99393 – 99397, 99401 – 99404, 99411, 99412, 99510 **HCPCS****: G0155, G0176, G0177, G0409 – G0411, G0463, H0002, H0004, H0031, H0031 HO, H0031 HO GT, H0031 TS, H0031 HN, H0031 HN GT, H0032, H0032 TS, H0034 – H0037, H0039, H0040, H0046, H0046 GT, H2000, H2000 HP, H2000 HP GT, H2000 HO, H2001, H2010 – H2020, H2019 HR, H2019 HR GT, H2019 HQ, H2019 HO, H2019 HN, H2010 HO, H2010 HO GT, H2010 HE, H2010 HE GT, H2010 HQ, H2020 HA, H2030, M0064, S0201, S9480, S9484, S9485, T1015, T1015 GT, T1015 HE, T1023 HE ***Follow-up visits identified by these CPT and HCPCS codes must be with a mental health practitioner.*

FHM Action Checklist:

Behavioral health management	Description of requirement	Date completed
☐ Follow-up after hospitalization for mental illness	Confirm follow-up outpatient visit with a mental health practitioner within **7 days and 30 days of discharge**.	____/____/_____ ____/____/_____

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)[1]

Identifying individuals with alcohol and other drug disorders (AOD) is an important first step in the process of care; however, identification often does not lead to the initiation of care. The measure is designed to ensure that treatment is initiated once the need has been identified.

Many times the PCP is the first professional to encounter a patient with alcohol or other drug abuse issues. The following is a list of PCP interventions:

- Assess the patient about his or her alcohol use and other drug use. Screen for program, if applicable. (Please refer to page 12 for the recommended screening tools.)
- Make sure that the diagnosis is listed in the chart and on the patient's claims.
- Encourage the patient to follow through. Schedule a follow-up visit.
- Refer the patient to ABH for appointment scheduling with a behavioral health provider.

Performance measure	Service needed	What to report
Percentage of adolescent and adult members (13 years old and older) with a new episode of alcohol or other drug dependence (AOD)	• **Initiation of treatment:** Initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization **within 14 days of diagnosis** *See the patient for this diagnosis.* **and** • **Engagement of treatment**: Initiate treatment (as stated above) and have two or more additional services with a diagnosis of AOD **within 30 days of the initial visit** *See the patient for this diagnosis.*	*One of the following diagnosis codes must be billed for the initiation and the engagement visits, in addition to the requirements listed in Option 1, Option 2 or Option 3.* **ICD-10-CM Diagnosis**: F10.10, F10.120 – 121, F10.129, F10.14, F10.150 – 151, F10.159, F10.180 – 182, F10.188, F10.19 – 20, F10.220 – 221, F10.229 – 232, F10.239, F10.24, F10.250 – 251, F10.259, F10.26 – 27, F10.280 – 282, F10.288, F10.29, F10.920 – 921, F10.929, F10.94, F10.950 – 951, F10.959, F10.96 – 97, F10.980 – 982, F10.988, F10.99, F11.10, F11.120 – 122, F11.129, F11.14, F11.150 – 151, F11.159, F11.181 – 182, F11.188, F11.19 – 20, F11.220 – 222, F11.229, F11.23 – 24, F11.250 – 251, F11.259, F11.281 – 282, F11.288, F11.29, F12.10, F12.120 – 122, F12.129, F12.150 – 151, F12.159, F12.180, F12.188, F12.19 – 20, F12.220 – 222, F12.229, F12.250 – 251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120 – 121, F13.129, F13.14, F13.150 – 151, F13.159, F13.180 – 182, F13.188, F13.19 – 20, F13.220 – 221, F13.229 – 232, F13.239, F13.24, F13.250 – 251, F13.259, F13.26 – 27, F13.280 – 282, F13.288, F13.29, F14.10, F14.120 – 122, F14.129, F14.14, F14.150 – 151, F14.159, F14.180 – 182, F14.188, F14.19 – 20, F14.220 – 222, F14.229, F14.23 – 24, F14.250 – 251, F14.259, F14.280 – 282, F14.288, F14.29, F15.14, F15.150 – 151, F15.159, F15.180 – 182, F15.188, F15.19 – 20, F15.220 – 222, F15.229, F15.23 – 24, F15.250 – 251, F15.259, F15.280 – 282, F15.288, F15.29, F16.10, F16.120 – 122, F16.129, F16.14, F16.150 – 151, F16.159, F16.180, F16.183, F16.188.

		F16.19 – 20, F16.220 – 221, F16.229, F16.24, F16.250 – 251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120 – 121, F18.129, F18.14, F18.150 – 151, F18.159, F18.17, F18.180, F18.188, F18.19 – 20, F18.220 – 221, F18.229, F18.24, F18.250 – 251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120 – 122, F19.129, F19.14, F19.150 – 151, F19.159, F19.16 – 17, F19.180 – 182, F19.188, F19.19 – 20, F19.220 – 222, F19.229 – 232, F19.239, F19.24, F19.250 – 251, F19.259, F19.26 – 27, F19.280 – 282, F19.288, F19.29 **<u>Physician Codes</u>** **Option 1 –** *At least one code must be billed.* **CPT**: 98960 – 98962, 99078, 99201 – 99205, 99211 – 99215, 99217 – 99220, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99384 – 99387, 99394 – 99397, 99401 – 99404, 99408, 99409, 99411, 99412, 99510 **HCPCS**: G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034 – H0037, H0039, H0040, H2000, H2001, H2010 – H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012, T1015 **UB revenue**: 0510, 0513, 0515 – 0517, 0519 – 0523, 0526 – 0529, 0900, 0902 – 0907, 0911 – 0919, 0944, 0945, 0982, 0983 **<u>Behavioral health codes</u>** **Option 2 –** *At least one CPT code plus a POS code must be billed.* **CPT**: 90791, 90792, 90832 – 90834, 90836 – 90840, 90845, 90847, 90849, 90853, 90875, 90876 **and** **POS**: 03, 05, 07, 09, 11 – 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72 **Option 3** – *At least one CPT code plus a POS code must be billed.* **CPT**: 99221 – 99223, 99231 – 99233, 99238, 99239, 99251 – 99255 **and** **POS**: 52, 53

IET Action Checklist:

Behavioral health management	Description of requirement	Date completed
☐ Initiation and engagement of alcohol and drug dependence treatment	Initiate treatment through an inpatient alcohol or other drugs admission, outpatient visit, intensive outpatient encounter or partial hospitalization **within 14 days of diagnosis**. **And** Have two or more additional services with a diagnosis of AOD **within 30 days of initial visit.**	Initial: ____/____/_____ Follow-up: ____/____/_____ ____/____/_____

Screening Tools

There are several hundred screening tools that are available today to aid clinicians with the identification of patients with alcohol problems. Many are presented in the guide, *Assessing Alcohol Problems: A Guide for Clinicians and Researchers*, 2nd Edition, which may be accessed online at http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/index.htm.

Following are several brief recommended screenings:

CAGE

C Have you ever felt that you should **cut down** on your drinking or drug use?
A Have people **annoyed** you by criticizing your drinking or drug use?
G Have you ever felt **guilty** about your drinking or drug use?
E **Eye opener**: Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Note: CAGE can identify alcohol problems over the lifetime. Two positive responses are considered a positive test. Further assessment is warranted.

T-ACE

T **Tolerance**: How many drinks does it take to make you feel high?
A Have people **annoyed** you by criticizing your drinking or drug use?
C Have you ever felt you ought to **cut down** on your drinking or drug use?
E **Eye-opener**: Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

Note: T-ACE, which is based on CAGE, is valuable for identifying a range of use, including lifetime use and prenatal use, based on the DSM-III-R criteria. A score of two or more is considered positive. Affirmative answers to questions A, C or E = one point each. Reporting tolerance to more than two drinks (the T question) = two points.

Alcohol Use Disorders Identification Test (AUDIT)

Please circle the answer that is correct for you.

1. **How often do you have a drink containing alcohol?**

Never | Monthly or less | Two to four times a month | Two to three times per week | Four or more times a week

2. **How many drinks containing alcohol do you have on a typical day when you are drinking?**

1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more

3. **How often do you have six or more drinks on one occasion?**

Never | Less than monthly | Monthly | Two to three times per week | Four or more times a week

4. **How often during the last year have you found that you were not able to stop drinking once you had started?**

Never | Less than monthly | Monthly | Two to three times per week | Four or more times a week

5. **How often during the last year have you failed to do what was normally expected from you because of drinking?**

Never | Less than monthly | Monthly | Two to three times per week | Four or more times a week

6. **How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session**?

Never | Less than monthly | Monthly | Two to three times per week | Four or more times a week

7. **How often during the last year have you had a feeling of guilt or remorse after drinking?**

Never | Less than monthly | Monthly | Two to three times per week | Four or more times a week

8. **How often during the last year have you been unable to remember what happened the night before because you had been drinking?**

Never | Less than monthly | Monthly | Two to three times per week | Four or more times a week

9. **Have you or someone else been injured as a result if your drinking?**

No | Yes, but not in the last year | Yes, during the last year

10. **Has a relative, friend, doctor or other health care worker been concerned about your drinking?**

No | Yes, but not in the last year | Yes, during the last year

Note: The Alcohol Use Disorders Identification Test (AUDIT) can detect alcohol problems experienced in the last year. A score of 8+ on the AUDIT generally indicates harmful or hazardous drinking. Questions 1-8 = 0,1,2,3 or 4 points. Questions 9 and 10 are scored 0, 2 or 4 only.

Psychotropic Medication Clinical Guidelines

Medication management is a collaborative effort between all prescribing practitioners. It is our goal to provide the necessary tools to support current guidelines for the use of psychotherapeutic medication among children and adults. Listed below are resources to obtain *Florida's Best Practice Psychotherapeutic Medication Guidelines for Children* and *Florida's Best Practice Psychotherapeutic Medication Guidelines for Adults.*

Questions regarding these guidelines may be directed to ABH Medical Director Ed Mobley at 1-866-477-6725.

You may also visit https://medicaidmentalhealth.org.

Clinical guidelines	Resource link
2015 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults	http://www.medicaidmentalhealth.org/_assets/file/Guidelines/Web_2015-Psychotherapeutic%20Medication%20Guidelines%20for%20Adults_Final_Approved1.pdf
2015 Florida Psychotherapeutic Medication Guidelines for Children and Adolescents	http://www.medicaidmentalhealth.org/_assets/file/Guidelines/2015%20Florida%20Best%20Practice%20Medication%20Child-Adolescent%20Guidelines_online2.pdf

Website: www.abhfl.org

Medical and Behavioral Integration
Additional Resources

For more resources regarding medical and behavioral integration, please visit:

http://www.integration.samhsa.gov/about-us

http://www.samhsa.gov/health-care-health-systems-integration

http://www.fdhc.state.fl.us/Medicaid/SBIRT/index.shtml

Collaborative Care Agreement

This Collaborative Care Compact (Care Compact) is entered into between the Primary Care Provider ("PCP") and the Behavioral Health Specialist ("Specialist").

The purpose of this Primary Care-Specialty collaboration is:

- To provide optimal health care for our patients.
- To improve the quality, cost, and efficiency of health services.
- To provide a framework for better communication and safe transition of care between primary care and behavioral health/specialty care providers.

Both providers signing this document agree to:

- Provide safe, effective, and timely patient care.
- Maintain effective communication between the PCP and the specialist to eliminate the waste and excess cost of healthcare.
- Mutually respect each other with the purpose of sustaining a professional relationship and working collaboration.
- Offer proper care at the right time and place.
- Share the patient's consultation notes and relevant test results on an ongoing basis.

NOW THEREFORE, the parties hereto agree as follows:

By signing this agreement, both parties will abide by the Primary Care Provider-Behavioral Health Collaborative Care Agreement.

	Behavioral Health Provider	Primary Care Provider
Address		
Signature		
Name		
Title		
Date		

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 24 – Transportation (Statewide):

The respondent shall describe its experience and approach for coverage of non-emergency transportation services by providing the following:

a. A description of the software capabilities utilized to facilitate ease in scheduling and tracking of enrollee pickup adherence;

b. Strategies for determining the most appropriate mode of transportation; and

c. Providing data on the following performance metrics for calendar year 2016:

- **(1)** Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
- **(2)** Percentage of missed trip requests (failed to pick up the enrollee);
- **(3)** Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
- **(4)** Percentage of urgent care requests fulfilled within three (3) hours of the request; and
- **(5)** Number of transportation related complaints and grievances per 1,000 enrollees.

d. A description of how the respondent uses the performance metric data above to identify areas in need of improvement and implements successful strategies that improve the provision of service.

Response:

Medicaid enrollees, particularly those who live in rural areas or who have special needs, often experience heightened challenges in reaching the services they need due to a lack of reliable transportation. This can result in enrollees delaying or foregoing necessary preventive visits, missing prescription medication refills, and seeking care for acute conditions at hospital emergency departments rather than more appropriate, non-emergent care settings.

For these reasons, reliable and safe transportation services delivered by professional and courteous transportation providers is essential to improving the health outcomes of our enrollees. Through our contracts with Access2Care and LogistiCare, Humana provides Non-Emergency Transportation (NET) services to our enrollees who have no other means of transportation available to all covered Medicaid services, including enhanced benefits and services covered through Medicaid fee-for-service. Technological innovations from our NET providers continue to advance ease of access for our enrollees, including an improved ability to track vehicles and ensure timely pick-up and drop-off. Through our standardized questionnaires for enrollees requesting transportation, we ensure that they use the right level of NET for their medical needs, and that those enrollees with the highest level of need (including the frail, elderly, children with special needs, and pregnant women) receive the NET services they require. Our case managers take an active approach to arranging NET for these enrollees, including scheduling NET on their behalf. Additionally, we guarantee the high-quality performance of all of our providers through dedicated joint and local operating committees and quality oversight procedures. These efforts have resulted in demonstrable achievements. In

calendar year 2016, ninety-nine point nine percent (99.9%) of NET trips were complaint-free and only zero point zero zero three percent (0.003%) of trip requests were missed.

Our longstanding partnerships with both LogistiCare and Access2Care provide our enrollees with greater access to high-quality NET services. Under the next contract, we will continue to provide a high standard of care through innovative technologies, attention to enrollee satisfaction, and dedicated quality oversight.

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1. The adequacy of the respondent's software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence.

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We have invested in innovative software that will continue to ensure the highest quality transportation experience for our enrollees. These innovations permit our enrollees, their designated caregivers, providers, and Humana associates to easily and efficiently schedule trips over the phone, through a mobile application, or through an online portal. Additionally, investments in driver and enrollee applications increase convenience, accessibility, and enrollee control over routine tasks while improving enrollee pick-up adherence.

USING SOFTWARE TO FACILITATE SCHEDULING

The systems and intake processes used by our transportation partners aim to provide maximum efficiency in scheduling with minimum error. Our enrollees, their case managers, and providers can schedule transportation via dedicated phone lines, our online portals, or a smartphone app. These options, each designed to facilitate ease in scheduling, allow enrollees to quickly access the level of transportation that best meets their needs.

SCHEDULING VIA DESIGNATED PHONE LINES

Our enrollees and case managers can schedule transportation 24/7 via designated NET phone lines. Contact information for these phone lines is included in the enrollee handbook and on our enrollees' plan ID cards. Our subcontractors use a state-of-the-art Automatic Call Distribution (ACD) phone reporting system that works in concert with our web-based trip assignment system. This system records and aggregates critical performance and quality-related information on an hourly, daily, weekly, and monthly basis, allowing us to quickly identify areas of improvement and meet the needs of the enrollee and those dedicated to serving them. In addition, the scheduling process can be accelerated by utilizing previously stored enrollee selections, drop-down lists, and radio buttons to capture enrollee information and eliminate potential data entry errors.

ENROLLEE ONLINE PORTAL

We are committed to expanding the range of tools our enrollees can use to schedule their trips. One of these is the online enrollee portals operated by our transportation partners, through which our enrollees have twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five (365) days per year access to online ordering and trip management functions. This easy-to-use platform provides enrollees and their designated caregivers with increased control and discretion over their NET options. Enrollees are able to schedule, modify, or cancel their trips, view pick-up times, retrieve health plan contact information, obtain online user guides, and

authorize additional users (for example, a child or legal guardian) to act on their behalf to perform trip management functions.

HEALTH PLAN PORTAL
Humana associates can use the secure Health Plan portal to view scheduled trips, access reports, and respond to complaints filed by enrollees. In addition, we can perform user administration functions on behalf of our enrollees, an important feature for those enrollees who may lack access to the internet or cannot use the portal independently.

NET PROVIDER PORTALS
The NET Provider Portal is an easy-to-use, online platform that allows the NET provider network to more easily manage scheduling requests, thus ensuring greater access for our enrollees, and decreasing the number of missed or late trips. Through this portal, NET providers can view, accept, and reject trips, manage resources, such as drivers and vehicles, and track their accounts receivable, billing, and claims. In addition, providers can download trip information to meet specific reporting criteria, or upload to their own dispatch systems.

ENROLLEE APP
Today, more and more Medicaid enrollees own smartphones, tablets, and other handheld electronic devices. Our enrollees can download a free mobile application to their iOS or Android device to better manage their NET benefit.

This intuitive, user-friendly mobile app empowers enrollees to complete basic requests, independently, using their iOS or Android mobile device. The app guides users through questions to determine the most appropriate level of service for their needs and uncover any special needs (e.g., wheelchair or stretcher services). After a request is submitted, the enrollee is assigned a request ID number (which is stored in the app) and the reservation is sent to the local operations center for processing. Once the trip is assigned, the enrollee can view the confirmed trip through the app and through the enrollee online portal.

The mobile app may support a range of functions, including:

- Enrollment: Provides the functionality for enrollees to sign up for NET services and verify their eligibility

- Add a Member: Allows enrollees to add family members and other authorized users to their account to manage NET requests

- Account Management: Enables change of enrollee profile information, such as the enrollee's phone number or e-mail address

- Make/Change/Cancel Reservations: Enables enrollee management of reservations

- Manage Interactions: Allows in-app communication with drivers and transportation providers

- Ride Assist: Allows our enrollees to use their mobile device to check on the status of their ride

- Ready for Pick-Up: Enables our enrollees to use their mobile device to notify us when they are ready for a return pick-up, as an alternative to calling the Ride Assist Line

- View Pick-Up /Drop-Off: GPS timestamps enable verification of pick-up and drop-off times and locations

- View Schedule and Alerts/Notifications: Allows enrollees to view their scheduled trips, track the location of the ride, and receive notification if it is going to be late or early

- Post-Trip Surveys: Allows enrollees provide immediate feedback upon completion of a ride and rate the trip on a scale of one (1) to five (5)

USING SOFTWARE TO TRACK ENROLLEE PICKUP ADHERENCE

Humana is committed to continually refining our operations to minimize uncertainty, reduce enrollee wait times, and increase transparency. To this end, our subcontractors have introduced mobile applications for drivers. These applications allow continual, real-time oversight of drivers for on-time performance. Data can be collected on user wait times, on-time performance, incidents, management practices, and system usage. This real-time data is used by both Humana and our transportation subcontractors to foster better network performance, contribute to cost savings, and improve the enrollee experience.

Through this app, our transportation routers can remotely track vehicles in real-time on a browser-based map and quickly view vehicles operating on schedule, delayed vehicles, and vehicles available for recovery or urgent trip requests. With this information, we can take proactive measures to quickly activate recovery vehicles and limit late pick-ups and no-shows. Data from the GPS tool is used to optimize trip time estimations and maximize routing efficiency, helping us limit commute times. In addition, trips made through the call center, enrollee mobile application, and enrollee portal can be assigned to drivers via the app.

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2. The extent to which the respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee's individual needs.

3. The extent to which the respondent's approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.

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Humana's objective in providing NET services is to ensure that transportation issues do not create a barrier to enrollees obtaining health care. Our goal is to provide a wide array of transportation assistance that will meet the diverse transportation needs of our enrollees in the least costly, most medically-appropriate way. Enrollees with the greatest needs for NET, including those with special needs and pregnant enrollees who need to reach prenatal care, are informed of the benefit, know how to use it, and receive the support they need from Humana associates to use the service. At one end of the spectrum is the enrollee who is able to walk, lives close to a public transit stop, and has a series of appointments with a provider who is also close to a public transit stop. For this enrollee, provision of bus passes may be the least costly, most appropriate solution to ensuring appointments are kept. At the other end of the spectrum is a bed-ridden or disabled individual who requires not only a wheelchair, a lift-equipped vehicle,

or stretcher van to get to his or her follow-up appointment, but also needs an attendant to accompany him or her. Our transportation scheduling processes are designed to ensure that the least expensive, most appropriate mode of transport is assigned, based on the enrollee's medical condition and their destination.

Our comprehensive assessments, conducted upon enrollment into case management or disease management, address gaps and barriers to care that our enrollees may be facing, including transportation. For those enrollees who report transportation gaps, our case managers and Customer Care specialists can assist them in calling the appropriate subcontractor to begin transportation arrangements. In addition, our case managers and Customer Care specialists monitor for indications that an enrollee may need transportation assistance, such as one or more missed appointments, and uses it as an opportunity to link the enrollee with our transportation subcontractors.

When an enrollee calls the NET Customer Care line to schedule transportation, our Customer Care specialists first verify their eligibility. After the enrollee's eligibility has been confirmed, the NET Customer Care specialist obtains details of the enrollee's request, including trip date and time, and the name, address, and telephone number of their destination. To ensure that we assign the most appropriate transportation mode for each enrollee's individual medical needs, enrollees are asked a series of questions about their health and mobility, including the enrollee's ability to walk, use of a mobility device, proximity to mass transit spots (on both pick-up and drop-off locations), and availability of other forms of transportation, including a friend or family member's vehicle. For those transportation requests submitted by the case manager on behalf of the enrollee, the case manager will use the results of our comprehensive health risk assessment to inform the best choice of transportation for that enrollee. To expedite future service requests, enrollees' responses are stored in the scheduling system, allowing for quick and easy verification that the information is still up-to-date and accurate with each new transportation request.

After the request has been entered, a "Trip Optimization" algorithm is applied to assign the most appropriate vehicle type and service level for the individual enrollee, based on rules established by Humana and the enrollee's response to these questions. Our system considers the following baseline factors when determining suitability of a particular mode of transportation:

- The enrollee's access to a vehicle and ability to afford fuel. This may indicate the suitability of gas reimbursement.

- The enrollee's ability to travel independently, which may be limited because of age or any permanent or temporary debilitating mental or physical condition. This may preclude the use of mass transit, and indicate the need for an enrollee to travel with a caregiver.

- The availability of public transportation in the enrollee's area or community (including the accessibility of the enrollee's destination) and whether the enrollee must walk more than three-quarters of a mile to or from the public transportation stop.

- The availability of on-demand response providers in absence of public transit.

- The compatibility of a public transportation schedule with the enrollee's appointment times.

- The enrollee's ability to ambulate independently or use a wheelchair and type of wheelchair.

- Any special needs of the enrollee requiring coordination with other providers such as attendants for minors, the elderly, and enrollees with disabilities or other special needs.

PROMOTION OF MORE COST-EFFECTIVE MODES OF TRANSPORT
For those enrollees for whom a more cost-effective mode of transportation is appropriate, our NET Customer Care specialists educate the enrollee about their options, including the benefits of each. For example, we explain that enrollees often enjoy the benefits associated with receiving bus passes, such as having the ability to use the pass until its expiration to get to the grocery store, pharmacy, and other locations, in addition to their medical appointment. Additionally, the mileage reimbursement option, which allows enrollees with access to a vehicle through a family member, friend, or neighbor to receive coverage of fuel, provides additional flexibility in the enrollee's schedule, as they have more control over when they leave and arrive at their destination.

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4. The adequacy of the respondent's performance related to:
a. Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
b. Percentage of missed trip requests;
c. Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
d. Percentage of urgent care requests fulfilled within three (3) hours of the request;
e. Number of transportation-related complaints and grievances per 1,000 enrollees.
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Data from our current MMA and LTC plans in Florida are displayed below. This data is based upon verified, paid trips. We have included data from each month of calendar year 2016 to show our consistent performance over time, in addition to the overall total.

NET FOR HUMANA LTC ENROLLEES, CALENDAR YEAR 2016

Percentage of trips where the enrollee arrived to their scheduled appointment on-time:

Total Monthly Average 2016: 79.7%
January: 75.6%
February: 78.3%
March: 79.5%
April: 80.0%
May: 79.7%
June: 80.5%
July: 80.6%
August: 80.7%
September: 79.7%
October: 79.6%
November: 80.4%
December: 80.3%

Percentage of missed trip requests (failed to pick up the enrollee):

Total Monthly Average 2016: 0.01%
January: 0.03%
February: 0.00%
March: 0.02%
April: 0.01%
May: 0.01%
June: 0.01%
July: 0.00%
August: 0.01%
September: 0.02%
October: 0.01%
November: 0.04%
December: 0.01%

Percentage of hospital discharge requests fulfilled within 3 hours of the request: Not applicable, as this type of transportation is not a covered LTC benefit.

Percentage of urgent care requests fulfilled within three (3) hours of the request:

Total Monthly Average 2016: 98.8%
January: 100.0%
February: 100.0%
March: 100.0%
April: 100.0%
May: 100.0%
June: 100.0%
July: 100.0%
August: 100.0%
September: 97.6%
October: 100.0%
November: 92.9%
December: 100.0%

Number of transportation-related complaints and grievances per 1,000 enrollees:

Total Monthly Average 2016: 0.17
January: 0.41
February: 0.10
March: 0.05
April: 0.26
May: 0.15
June: 0.15
July: 0.10
August: 0.25
September: 0.30
October: 0.10
November: 0.10
December: 0.00

NET FOR HUMANA MMA ENROLLEES, CALENDAR YEAR 2016

Percentage of trips where the enrollee arrived to their scheduled appointment on-time:

Total Monthly Average 2016 2016: 88.2%
January: 88.2%
February: 88.0%
March: 89.8%
April: 89.2%
May: 88.6%
June: 88.7%
July: 89.0%
August: 88.2%
September: 86.6%
October: 87.0%
November: 87.7%
December: 87.8%

Percentage of missed trip requests (failed to pick up the enrollee):

Total Monthly Average 2016: 0.31%
January: 0.45%
February: 0.35%
March: 0.24%
April: 0.31%
May: 0.22%
June: 0.22%
July: 0.24%
August: 0.38%
September: 0.31%
October: 0.31%
November: 0.33%
December: 0.35%

Percentage of hospital discharge requests fulfilled within three (3) hours of the request:

Total Monthly Average 2016: 91.3%
January: 79.6%
February: 89.7%
March: 85.7%
April: 87.8%
May: 92.3%
June: 91.5%
July: 92.1%
August: 90.5%
September: 95.8%
October: 96.2%

November: 92.1%
December: 97.6%

Percentage of urgent care requests fulfilled within 3 hours of the request:

Total Monthly Average 2016: 96.6%
January: 93.1%
February: 96.3%
March: 94.1%
April: 97.3%
May: 97.0%
June: 97.1%
July: 98.0%
August: 97.0%
September: 97.2%
October: 96.7%
November: 95.8%
December: 98.1%

Number of transportation-related complaints and grievances per 1,000 enrollees:

Total Monthly Average 2016: 0.13
January: 0.11
February: 0.10
March: 0.11
April: 0.14
May:0.14
June: 0.15
July: 0.09
August: 0.20
September: 0.18
October: 0.16
November: 0.10
December: 0.10

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5. The extent to which the respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.

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Humana is committed to ensuring that all of our transportation partners meet or exceed all quality metrics. Our subcontractor oversight structure uses the performance metric data, captured in the reports detailed below, to guide our quality management activities. Through regular interactions with our NET subcontractors, including biweekly or monthly Local Operating Committees (LOCs) and Joint Operating Committees (JOCs), we collaborate to review this data and any received complaints to identify strategies for improvement, including investments in technology and refined processes. These interventions are rooted in the commitment of Humana and our NET subcontractors to provide a high-quality transportation experience that brings our enrollees to their destination in a safe and timely manner.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

REPORTING TO HUMANA

The robust reporting capabilities of our transportation subcontractors, as required by our contracts, provide Humana with a view of transportation program operations from multiple perspectives. These reports allow both Humana and our subcontractors to pinpoint areas for improvement and to design projects that can ensure a better NET experience for our enrollees. The reports produced by our transportation subcontractors draw from a wide variety of sources, including trip logs, enrollee surveys, complaints, claims, quality metrics, and transportation provider performance. These reports include the metrics listed above, in addition to:

- Call center metrics: Number of calls received, average answer time, number of abandoned calls, average abandonment time, and average call time

- Quality reports: Complaints by type (provider late, provider no-show, provider issue, other)

- Trip detail reports.

-- Trip summary report: Details the number of trips that have been requested, cancelled, and completed, as well as trips that are open. This report also includes utilization data by enrollee and vehicle type.

-- Complaint report: Details complaints filed by enrollees, transportation providers, medical providers, and facilities. This report provides dates, descriptions, and resolutions of these complaints.

-- Refusal report: Details all refusals for service, providing enrollee name, date of refusal, and reason for refusal.

-- Transportation provider accident report: Details accidents by NET provider, providing dates, driver names, enrollee names, cause of accident, injuries (if any), and actions taken.

-- Network provider report: Provides complete provider files.

-- Transportation quality assurance report: Details on-time performance, complaint ratio, and any late re-routes.

DEDICATED QUALITY MANAGEMENT AND SUBCONTRACTOR OVERSIGHT

Humana has implemented a rigorous oversight program for our subcontractors, comprised of corporate and market-level teams that are dedicated to the management of our subcontractors. Our Delegated Vendor Performance Oversight program is responsible for our subcontractor quality management activities. The goals and objectives of this program include:

- Monitoring the facilitation and delivery of appropriate care and services to enrollees
- Monitoring the response to enrollees' needs and practitioner requests

- Monitoring subcontractors' adherence to contractual provisions and Service Level Agreements (SLAs)
- Identifying opportunities for improvement in the delivery of care and services to enrollees
- Collaboratively developing corrective action plans, as appropriate
- Monitoring for timely submission of contractual reporting
- Reviewing financial solvency for subcontractors with financial risk arrangements
- Monitoring adherence to policies concerning Protected Health Information
- Detecting inappropriate utilization patterns
- Monitoring for appropriate credentialing and network adequacies
- Escalating operational and financial non-performance to the Delegated Vendor Oversight Committee (DVOC), Quality Improvement Committee (QIC), and senior leadership, as needed
- Collaborating with Delegation Compliance at the corporate level to validate that all delegated functions are in compliance and are meeting Humana's expectations based on SLAs

Monitoring and oversight of our NET subcontractors is performed on a day-to-day basis by our Florida-based Delegate Relationship Managers (DRM). In addition to the reports provided by our subcontractors on a monthly basis and ongoing communication to address any issues or questions that may arise, our DRMs oversee the performance of our NET subcontractors via our LOCs. Regular Operational Working Sessions, held on a biweekly or monthly basis, provide a structured forum for our DRMs, compliance officers, and the Director of Vendor Performance to meet with our NET subcontractors to review data, discuss trends, and identify opportunities for improvements with our subcontractors' own quality improvement teams. We also discuss any enrollee complaints that may have been filed in the last month, and the steps that our vendors are taking to address them. This close working relationship with our subcontractors, facilitated at the local level, provides us with a unique oversight and quality improvement role, allowing Humana to ensure the best possible NET services for our enrollees.

These calls also provide a forum for our subcontractors to share important lessons learned with Humana. For example, it was noted by the subcontractor during a LOC meeting that a select group of enrollees had to travel more than fifty (50) miles to reach a specialist. Humana used this information to explore ways to build their network in this region to bring our care closer to our enrollees' homes.

Our DRMs and LOCs are supported by our Director of Vendor Performance, who holds monthly operational meetings with all DRMs to review vendor performance, identify opportunities for improvement, develop corrective interventions, and follow-up on progress. A summary of subcontractor performance is presented at the DVOC. The DVOC is tasked with oversight of all of our delegated services at a market level, including NET. Through ongoing, objective, and systematic monitoring, including review and follow-up of corrective action plans, review of subcontractor activity performance reports, and the establishment of delegation oversight mechanisms, the DVOC ensures the quality performance of our NET subcontractors. The DVOC reports its findings and activities to our QIC.

STRATEGIES TO DRIVE PERFORMANCE ON KEY INDICATORS

Through our regular conversations with our NET subcontractors, we have designed and implemented strategies to consistently improve our performance on key metrics. In the section

below, we provide examples of the interventions that we have introduced to continually provide the best NET experience for our enrollees.

INCREASING ENROLLEE ON-TIME TRIPS AND REDUCING MISSED TRIP REQUESTS
Data on the percentage of trips where the enrollee arrived to their scheduled appointment on-time and the percentage of missed trip requests are shared with NET providers in the form of a performance score card. This scorecard benchmarks their performance compared to other providers, factoring in tracked complaints, on-time performance, credentialing compliance, cancellations, re-routes, no shows, and the number of trips provided. Using GPS technology, every trip is date- and time-stamped, providing transparent accounting for the performance of our NET providers.

When transportation providers do not maintain high-quality scores, per their contracted metrics with LogistiCare and Access2Care, our subcontractor teams meet with the provider to discuss areas where their performance falls below our quality standards and establish an agreed upon action plan to resolve issues in a prescribed timeframe. These plans include a variety of interventions that are responsive to the identified issues, such as provider re-training and vehicle re-inspection. We find that performance typically improves after implementation of the action plan. However, if we do not see the requisite level of improvement within the designated timeframe, we use a progressive improvement plan to provide a structured process to address critical deficiencies and improve and prevent a recurrence of undesirable incidents or performance issues. These steps include a verbal warning and provider education, a written warning and a decrease in the number of trips assigned to the provider, suspension and final written warning, and termination.

To improve our performance on these metrics, GPS technology is used to enable continual, real-time monitoring of on-time performance of our vehicle fleet. If we see a vehicle is at risk of a delayed arrival, we can proactively take action to ensure that the enrollee arrives in time for their scheduled appointment, including dispatching another vehicle nearby that can reach the enrollee more quickly. Furthermore, we can use data from the GPS tool to estimate trip times and maximize routing efficiency to limit enrollee commute times. This results in an improved enrollee experience, better on-time performance and cost savings.

INCREASING HOSPITAL DISCHARGE REQUESTS FULFILLED WITHIN THREE HOURS
We use data on the percentage of hospital discharge requests fulfilled within three (3) hours of the request to guide the development of strategies to ensure timely pick-ups for our enrollees. Two such strategies are our dedicated facility phone line and integration of our transportation scheduling system with hospital discharge software.

DEDICATED FACILITY PHONE LINE

To ensure timely service delivery for hospital discharge and urgent care requests, LogistiCare provides a dedicated line for facilities that is answered by specially-trained transportation staff. This toll-free number, which operates twenty-four (24) hours a day, seven (7) days a week, expedites the trip request process for medical facility staff. Through this line, hospital personnel receive prompt scheduling assistance in support of their discharge planning. Furthermore, LogistiCare's Utilization Review Department Specialists provide specialized management of standing order and demand response trip requests from ordering practitioners and serve as an

in-house advocates for, and liaisons to, healthcare facilities. Our review of hospital discharge requests by facility helps us to identify those facilities that could most benefit from this in-house support.

INTEGRATION WITH HOSPITAL DISCHARGE SOFTWARE

To further expedite the hospital discharge planning process, requests for NET can be made through naviHealth hospital discharge software if the participating facility uses this tool. This software, which is in use at LogistiCare's call centers, allows hospital staff to request discharge NET services without having to place a call to LogistiCare. Upon receipt of the request from a hospital LogistiCare will finalize the request through normal verification processes and provide details of the trip in naviHealth.

INCREASING URGENT CARE REQUESTS FULFILLED WITHIN THREE HOURS

Our subcontractors have implemented specialized processes to improve our performance on this metric. When an urgent care request is received through the NET call center, the request is routed to the Transportation department, where they are prioritized for scheduling and manually assigned to either an in-network or demand provider able to meet the level of service and timeframe required. To identify providers who can complete the request within the three hour window, we leverage our subcontractors' GPS capabilities through which we can see where our transportation provider vehicles are, in relation to a pick-up location. This system enables us to visually identify an available vehicle in the vicinity and meet the enrollee's request in a timely manner.

In addition to designing strategies to improve our performance on this metric, we use our data on the urgent care requests to identify the reasons why enrollees are submitting urgent care requests. For example, if enrollees are regularly submitting requests at short notice for routine appointments, we will educate them on their options to schedule appointments ahead of time through our designated phone line, enrollee portal, or mobile app.

REDUCING NUMBER OF TRANSPORTATION-RELATED COMPLAINTS AND GRIEVANCES

Humana and our NET subcontractors are committed to capturing and fully investigating all complaints received. This information is subsequently used to improve how we serve our enrollees. Our company-wide focus on quality improves our programs, and as a result, improves the enrollee experience. Our commitment to quality is recognized by the industry's highest standard: Access2Care and LogistiCare have received full URAC Accreditation for quality in all of their operations, and ninety-nine point nine percent (99.9%) of NET trips taken by Humana enrollees are complaint-free.

COMPLAINT INTAKE AND RESOLUTION

Our strategies to reduce the number of transportation-related complaints and grievances are rooted in a strong complaint intake and resolution process. All of our NET Customer Care specialists are trained on the complaint intake process and are able to receive and log complaints twenty-four (24) hours per day, seven (7) days per week, three-hundred sixty-five (365) days per year via the same toll-free number our enrollees call to schedule a trip. Customer

Care specialists log all complaints into the software system. A verbal acknowledgement is given to enrollees during intake, and an acknowledgement is generated within one business day.

While we encourage the formal filing of complaints by our enrollees, we recognize that informal complaints may also be received by our case managers or other personnel that warrant response and further discussion with the subcontractor. For example, our case manager may be called by the enrollee or their caregiver when the transportation provider is late for pick-up. In this instance, the case manager contacts our NET partner immediately to find another mode of transport, logs the complaint, and documents all information in Clinical Guidance eXchange (CGX) for our records. As with formal complaints, any informally-filed complaint that is not resolved by close of business on the business day following receipt becomes a grievance, and is elevated to Humana's Grievance and Appeals department. At our regular, internal quality meetings, these informal complaints are further shared and discussed, with trends identified and elevated to the DRM. The DRM brings these identified trends to the next LOC meeting with the subcontractor, where we discuss causes for the complaints and how they can be prevented in the future, including solutions related to network adequacy, technology, scheduling, and provider training.

In addition to Humana's own procedures for complaint resolution, both subcontractors have a designated team that responds to complaints from our enrollees. This response team works directly with all departments, in addition to other functional teams, to investigate complaints, uncover root causes, identify a targeted or high-risk list, and provide retrospective monitoring of these enrollees to improve their experience. The goal of this team is to enhance the overall NET program and provide the highest level of customer service. Any complaints that are not resolved by close of the next business day are elevated to Humana's Grievance and Appeals Department for resolution, with further support from our transportation partners. Grievances will be resolved as expeditiously as possible and no later than ninety (90) calendar days from the day of receipt by Humana.

All significant events are analyzed and brought to Humana's Grievance and Appeals department for further review, in conjunction with the subcontractor. Significant events are unexpected occurrences that demonstrate a real or potential threat to enrollee care or staff safety. We are committed to effectively managing such events, and corrective actions can vary from re-education up to termination of provider subcontractor agreements.

Our NET subcontractors share complaint-related information with Humana via monthly dashboard reporting and in near-real time via the secure online portal. Through our regular review of the portal, Humana staff can provide feedback on the complaint management process and recommend changes. We review complaints received during our regular LOC meetings with our transportation subcontractors. During these discussions, we review how the complaint was resolved and how future complaints of that kind can be prevented. We also use information on complaints received and resolved to design performance improvement projects to guarantee enrollee satisfaction with NET services.

IDENTIFICATION OF QUESTIONS AND CONCERNS THROUGH ENROLLEE SURVEYS

Our subcontractors' enrollee surveys allow us to proactively identify and address any questions or concerns that an enrollee may have that have not yet been registered as a complaint or

grievance. The results of the more than ten thousand (10,000) enrollee surveys conducted per quarter (which are shared with Humana during our LOC meetings) provide rich insights into our enrollees' experience with our transportation subcontractors. Based upon the findings of the surveys, we track our subcontractors' performance over time and design performance improvement projects to improve enrollee satisfaction. As an example, below are the results of LogistiCare's 2017 third (3rd) quarter results, among Humana's Florida Medicaid enrollees. We have seen a steady improvement in these results since the First (1st) quarter of 2017:

- 88.21% found it easy to request transportation
- 88.96% reported that the vehicle they rode in met their needs
- 88.37% arrived on time to their appointment
- 93.29% found their driver to be courteous

Evaluation Criteria:

1. The adequacy of the respondent's software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence;

2. The extent to which the respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee's individual needs.

3. The extent to which the respondent's approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.

4. The adequacy of the respondent's performance related to:

- **(a)** Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
- **(b)** Percentage of missed trip requests;
- **(c)** Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
- **(d)** Percentage of urgent care requests fulfilled within three (3) hours of the request; and
- **(e)** Number of transportation related complaints and grievances per 1,000 enrollees.

5. The extent to which the respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 25 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Deshea is 25 years old. She was auto-assigned to your plan and enrolled effective January 1, 2019. Deshea's enrollment information did not include a telephone number and listed a local area homeless shelter as her last place of residence. She left the shelter on December 27, 2018, and the shelter does not know her current whereabouts.*

The respondent shall describe the process it will use to attempt to contact Deshea by March 29, 2019.

Response:

PRE-ENROLLMENT

PRIOR TO DESHEA'S EFFECTIVE ENROLLMENT DATE
Notification of Deshea's eligibility comes to Humana via the 834 enrollment file from the Florida Agency for Health Care Administration (AHCA) on December 17, 2018 with a January 1, 2019 effective date. This file feed is an automated electronic transmission into our Customer Interface (CI) enrollment system. Deshea's eligibility information loads within 24 hours and flows into our downstream systems within 72 hours of enrollment receipt. The downstream systems include Humana's [1] CareHub Clinical Guidance Exchange (CGX) and [2] Customer Relationship Management (CRM).

IDENTIFICATION AND TIMELY INITIAL CONTACT WITH DESHEA
With the upload of Deshea's eligibility information into our systems, an electronic transmission triggers Humana's Enrollment team to mail welcome materials to Deshea. Before mailing the materials to Deshea, our system utilizes an automated validation process to ensure the address provided on the 834 file is complete for automated mailings. Within five days, the welcome materials were mailed to the address for her on the 834 file. Welcome materials mailed to Deshea contained the following items:

- Welcome letter to include an enrollment notice, where to locate the current enrollee handbook online, and how Deshea can receive a printed version of the handbook if desired

- Enrollee identification card

- Customer Service, 24/7 Nurse line phone numbers

- Continuity of Care form with a self-addressed and stamped return envelope

- Health Risk Assessment (HRA) form with a self-addressed and stamped return envelope. This form gathers key information on Deshea to determine if case management and/or disease management would be appropriate, such as chronic conditions, pregnancy, and care needs

- Release of Information form

UPON-ENROLLMENT

STRATIFICATION WITH MEDICAID SEVERITY PREDICTIVE MODEL
Concurrent with the initial outreach process, Deshea's new eligible enrollee information (such as claims, pharmacy, demographic, diagnosis, and pregnancy indicators) is run within the first thirty days of enrollment, and monthly thereafter, through our proprietary Medicaid Risk Score algorithm. This score provides guidance for enrollees with high risk factors and triggers them for case management or disease management outreach and participation efforts. Humana can improve care quality and health outcomes by stratifying enrollees by future risk and high utilization potential, and identify enrollees appropriately for case management. If Deshea is not eligible for case management or disease management, our Medicaid Severity Predictive Model will continue to run in the system background to assess changes in condition that may make her eligible for outreach by case or disease management case managers.

PREGNANCY INDICATORS
With Deshea's young age, she is within child bearing years. Humana's Medicaid Administration Education Satisfaction Unit (ESU) understands the importance of early identification and continuous care within the perinatal period and makes every effort to identify pregnant enrollees through many channels, including welcome calls, review of HRAs, community relationships, and efforts with the local Healthy Start program. If identified as pregnant, upon contact, Deshea would be enrolled in our Florida Medicaid plan are invited to enroll in Humana Obstetrics' Moms First program or they can opt to enroll in the Healthy Start case management program. Humana coordinates our case management efforts with the local Healthy Start Case Manager to prevent duplication of services. In addition, Humana established a file sharing relationship with Healthy Start, which assists in early identification of pregnant enrollees.

DISEASE MANAGEMENT REFERRAL REPORT
Medicaid enrollees such as Deshea are also queried through claims data that is inclusive of medical ICD-10 codes and pharmacy National Drug Code (NDC) codes related to any of the five proposed diseases; a report known as the "Potentials Report" is then generated. This report is pulled on a monthly basis by the Disease Management case manager and the identified enrollees are contacted by letter and telephonically within 7-10 days of identification.

DAY 1: DESHEA IS IDENTIFIED AS UTC; SERGIO INITIATES ATTEMPTS TO LOCATE

Although most enrollees have permanent residences, at times Humana is assigned enrollees, such as Deshea, who do not have permanent residences or known phone numbers and are very difficult to find. To specifically focus on such enrollees, we developed an Unable to Contact (UTC) process comprised of specially trained Humana associates dedicated to locating enrollees in the most effective and timely manner. In this instance, we assign Deshea's case to Sergio, a UTC Customer Care Specialist (CCS) within ESU. With his extensive communication tools, resources, and training, Sergio is able to begin the UTC process upon Deshea's effective enrollment date, in order to exhaust all reasonable methods to attempt to find her and identify

her care needs or concerns, as well as to connect her with the most appropriate providers, services, and community partners.

Sergio receives an automated alert of Deshea's UTC status in CGX. He reviews her file and learns she is a 25 year old female who has been auto-assigned to our plan. Unfortunately for Sergio, Deshea's file does not include a telephone number. Per Humana's process, for enrollees like Deshea who have a missing or invalid telephone number, an individual case file is created within CGX, triggering a UTC alert within the system. Upon activation of the UTC alert, Deshea's file forwards to an automated UTC queue within CGX to be managed by Sergio. Sergio's Florida-based UTC team manages the UTC queue for all Florida Medicaid enrollees who do not have a valid telephone number or a valid address. Given the system's "first-in first-out" approach, Sergio receives Deshea's case file in real time. Right away, he begins working on multiple avenues to attempt to locate her. Sergio is experienced in situations like Deshea's, given the significant number of individuals who enroll or are enrolled with inaccurate or incomplete contact information.

Proceeding with the initial steps to locate Deshea, Sergio begins with a search for a valid telephone number and address for Deshea within Humana's system. He reviews CGX to identify whether there is any historical claims information, provider or pharmacy data, or additional contact information. If Sergio were able to find such information for Deshea, he would attempt calls to any identified providers to obtain Deshea's current contact details. In this case, Deshea has no historical information on file.

DAY 2 – 19: SERGIO'S SHELTER OUTREACH

Sergio notes that the enrollee materials mailed pre-enrollment were returned as undeliverable (when this happens, an associate from ESU captures this information within CRM to note the returned mail). Sergio further notes the address as a homeless shelter in the area he knows. Sergio also knows that Humana provides Florida shelters with the latest information and enrollee-facing materials to distribute to our enrollees on a continual basis. These materials educate enrollees on our services and assistance we can provide, including a contact number that will route to Sergio or one of his associates if the enrollee needs assistance. Humana also delivers Humana Homeless Enrollee Survival Kits to homeless shelters for our enrollees. While partnering with the shelters in Deshea's community, Sergio knows the staff would provide a kit to Deshea if she were to visit, and would request that Deshea contact Humana to discuss her plan benefits. The Humana Homeless Enrollee Survival Kit includes items such as:

- First Aid supplies, like antiseptic wipes, hand sanitizer, ointment, and adhesive bandages

- Sunscreen and lip balm

- ID/Wallet Card for enrollee to complete with name, address, phone number, doctor, medical conditions, and emergency contact information

- Toothbrush and toothpaste

- List of available community support resources

- Humana ER Utilization Magnet

- Blanket

- Drawstring backpack

- Nail clippers

- Humana's contact information in multiple languages

This relationship development with the shelters, combined with Sergio's experience working with them through UTC and other community related activities, enables Sergio to make efficient and effective contact with the shelter listed as Deshea's address. He calls and speaks with the shelter manager, Alice. Alice tells Sergio that Deshea has not visited the shelter since December 27 and that she has no current information on her whereabouts. Alice makes a note to leave a message on the shelter communication board asking Deshea to contact Humana. Sergio also contacts a few other local homeless shelters, but has no luck in locating Deshea. Sergio had been hopeful he'd be able to locate a valid address for Deshea, as that would allow him to generate an automated mailing of a UTC postcard. However, knowing the current address is to a homeless shelter and that Deshea is no longer there, he ensures the postcard is not sent.

Sergio then connects with Humana's Florida Community Outreach teams to see if Deshea accessed any of these community services upon enrollment. Humana actively participates in Florida Health Fairs and Town Halls, in addition to partnering with Florida's Community Medical Automated Community Connection to Economic Self Sufficiency (ACCESS) Centers, where Deshea could check her eligibility and discuss her benefits with representatives from the State upon request. These representatives can also offer assistance in finding a Primary Care Physician (PCP), as well as determining eligibility for food (Food Assistance Program) and cash (Temporary Cash Assistance Program). Unfortunately for Sergio, the community outreach teams don't have any information on Deshea either.

Sergio is also mindful that a provider is auto-assigned to enrollees who do not choose one upon enrollment and can easily check the system for this information, as Humana's system proactively auto-assigns a PCP through our provider partnership model in situations like this. Sergio contacts Deshea's assigned PCP office and learns Deshea has not contacted the office since her enrollment date and they have no prior patient history. Sergio documents this information in CRM to note his call for future reference.

DAY 20-89: SERGIO'S CONTINUED EFFORTS AND COMMUNITY ENGAGEMENT

Sergio utilizes online search engines, such as the LexisNexis database, as well as social media channels, for government records such as death certificates and correctional facility admissions as additional possible paths for obtaining contact information. An online record of Deshea does not turn up; however, Sergio is aware of Humana's partnerships with community clinics, such as Federally Qualified Health Clinics and Community Mental Health Clinics, which have proven helpful in locating people in the past based on activities like visits to emergency departments. If Deshea visits one of these local centers, the representatives will provide guidance to Deshea on

Humana's behalf and encourage her to contact Humana regarding her plan benefits. Humana's Florida Medicaid Community Outreach team stays connected to these organizations to provide them with Humana enrollee education information regarding health and financial literacy, provider and enrollee cultural competency, food insecurity, and additional barriers to health.

Sergio continues the extensive research, location, and outreach methods outlined above and at least every two weeks reviews internal systems to identify if any new contact information has been obtained, such as a pharmacy claim or a medical visit.

HIE-ENS DAILY EMERGENCY DEPARTMENT UTILIZATION NOTIFICATIONS

For continuous monitoring of Deshea, Humana receives a daily Health Information Exchange-Electronic Notification System (HIE-ENS) file notifying us if Deshea were to visit an emergency department. This file would include her current contact information obtained during the visit. This HIE-ENS file would then alert our Utilization Management (UM) team of her emergency department visit and trigger for outreach. Additionally, the UM team would view Deshea's UTC status in the system. This collaborative effort allows for outreach to Deshea sooner, after being identified by these services.

DAY 90: THE END OF DESHEA'S INITIAL 90 DAYS

Deshea's initial 90 days of enrollment come to a close and Sergio is still unsuccessful in locating her. He is also unable to find an accurate current address or phone number, and no new medical or pharmacy data has been uploaded into the system.

Sergio closes Deshea's formal 90 day UTC case within Humana's CGX and CRM systems, knowing our engagement efforts will continue well past the ninety day period.

POST 90 DAYS: ENROLLEE OUTREACH AND MONITORING

For Deshea, Humana's Healthcare Effectiveness Data and Information Set (HEDIS) campaigns are also utilized by ESU in an attempt to locate her post ninety days of initial plan enrollment. These campaigns include:

- Annual Wellness Visit – ESU attempts to follow up with Deshea if she does not get timely screenings and is more than two months behind in the periodicity schedule. If this new activity reveals a valid phone number, ESU contacts Deshea and offers to assist with scheduling her appointments and transportation.

- Birthday Campaign – Every month, ESU identifies all enrollees with a birthday for that particular month. This information is compiled to complete an automated call, encouraging enrollees like Deshea to visit her PCP to receive a health assessment and preventive care. If Deshea had children covered by our plan, ESU will also ask if the children have been to the doctor for their yearly health assessment, helping Deshea schedule the appointment and transportation if necessary.

- Dental Campaign – Humana's Medicaid Quality Team reviews data from our dental partners regarding HEDIS measures and relays this information to ESU on enrollees who are compliant

for that measure. In this case, ESU would attempt to contact Deshea since she is non-compliant providing updated number or address information is found.

- Concierge Campaign – ESU attempts to contact an enrollee after nine consecutive months of enrollment, with an upcoming open enrollment period within the next couple of months. Since open enrollment is different for every Medicaid enrollee, this is an ongoing process for ESU. The team performs outreach attempts starting month nine of enrollment, extending through months ten, eleven, and twelve. This particular call campaign ends the first month (month 1) of the new plan year eligibility for that enrollee.

ADDITIONAL INFORMATION: OTHER RELEVANT HUMANA UTC PROCESSES

Unfortunately, Sergio was not able to locate Deshea within his formal 90 day UTC process period, in part, due to her specific set of circumstances. However, Sergio understands that there are many others for whom these tactics may have yielded a more positive outcome.

Below, we have outlined some additional information that is helpful to understand to gain a fuller picture of Humana's UTC approach. This information relates to alternate processes to locate UTC enrollees when more information is available and training that is provided for our UTC Specialists. Specifically below, you will find detail on:

- Humana's UTC Specialist Training
- Humana's Process for New Enrollees with a Valid Telephone Number

UTC SPECIALIST TRAINING

Humana provides extensive training to Sergio as a UTC specialist. This comprehensive training includes four weeks of classroom training, covering motivational interviewing, cultural competency, and enrollee rights. After four weeks of classroom training, he is mentored by senior CCSs and Quality Specialists (QS). Sergio's mentoring includes shadowing and then oversight and feedback, with every call reviewed for quality assurance and application of scoring criteria. This training includes strategies on finding enrollees without a valid telephone number or address, as well as mail returned undeliverable to an enrollee, or enrollee mail returned to Humana with a completed health risk assessment.

This training equips Sergio to locate and contact appropriate community resources, to help resolve enrollee issues in a timely manner. This helps Sergio and his colleagues learn to utilize strategies to identify indicators of access-to-care barriers, prioritization of immediate needs, detection of enrollee health literacy issues, and to display empathy and provide emotional support. Humana's ESU uses Spanish, English, French, Creole, and other languages mirroring the enrollee's spoken language, to address communication barriers. CCSs such as Sergio are the first Humana touchpoint with enrollees, initiating a relationship that can be built upon to empower the enrollee to be successful. Humana hosts a monthly meeting for CCSs to incorporate continuous education methods, which includes a question and answer training session and forum where they share lessons learned with each other. Along with monthly training, QSs support the CCS team by performing quality assurance reviews of Humana's new enrollee welcome calls each month, to assess the performance and completion of all procedures required to effectively inform new enrollees of their plan benefits. The evaluation includes the monitoring of Humana's Health Insurance Portability and Accountability Act

(HIPAA) requirements, communication and interaction skills, accuracy and accountability, and documentation of enrollee information. CCSs also adhere to all Telephone Consumer Protection Act (TCPA) and Do Not Call regulations if a valid number is found.

PROCESS FOR NEW ENROLLEES WITH A TELEPHONE NUMBER

Upon enrollment, all enrollee files that include a valid phone number are loaded into the Humana Autodialer for automated telephonic outreach. The Autodialer is programmed to call enrollees with a phone number six times within the first thirty days of eligibility. If the call is answered by the enrollee, our automated system transfers the call to ESU to conduct a welcome call. This call includes completion of an HRA to determine needs, a review of available benefits, confirmation of current providers, confirmation of receipt of the enrollee handbook and plan identification card, and the collection of any updated demographic information. If an enrollee exhibits an urgent medical need or concern, the ESU CCS personally transfers them and introduces them to the Humana Clinical Access Team for immediate assistance by a Registered Nurse. If someone other than the enrollee answers the call, the ESU CCS will leave a non-PHI general message requesting they contact Humana at their earliest convenience.

Trained to identify the needs of our enrollees during welcome calls, ESU helps to close care gaps and target resources that match individualized needs. An ESU Quality Specialist supports this team by performing quality assurance reviews of welcome calls monthly to assess the performance and completion of all procedures required to effectively inform the new enrollee of their plan benefits. The evaluation includes the monitoring of Humana's HIPAA requirements, communication and interaction skills, accuracy and accountability, and documentation of enrollee information.

CONCLUSION

Humana realizes that successfully engaging new enrollees requires timely and consistent outreach throughout eligibility, not just during the first ninety days. We work with a variety of community and social service organizations, including homeless shelters and community mental health groups, as well as physician and hospital partnerships and social media channels, all with the aim of finding solutions to complex health and well-being issues. By exhausting all options for engagement through extensive internal and external search, continuously monitoring for health care changes, and improving our processes through innovative strategies, enrollees like Deshea can receive a simplified and streamlined experience. This provides various pathways into case management services for a holistic and dedicated approach to health and well-being.

Footnotes

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[1] CareHub is Humana's enterprise solution for complete program integration for our provider community and enrollees. CGX supports an integrated, comprehensive approach to medical, behavioral health, pharmacy, utilization, and care management. Full system integration allows our care team the capability to identify potential enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify opportunities for intervention.

[2] CRM is Humana's documentation system for enrollee support activities, providing message optimization, enrollee-centric prioritization, data mining and reporting, and enhanced processes for quality management to streamline the flow of data to other internal systems.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

(a) Identification of strategies for identifying new enrollees; and

(b) Description of the sources of data/information that will be utilized to identify enrollees with special health care needs or circumstances.

2. The extent to which the respondent describes its process for contacting enrollees, including the data sources.

3. A description of how network providers and community partners will be engaged in the identification process.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment SRC 25-1: Deshea's Visual Story Guide

We have provided this document as a visual guide to our response. The key timelines from our core response are duplicated here in a format intended to supplement and enable a comprehensive review of Humana's approach to Deshea.

About Deshea:

Deshea is a 25-year-old female, newly eligible MMA Medicaid enrollee with auto-assignment into the Humana plan, with a January 1, 2019 effective date of eligibility. Her enrollment information did not include a telephone number and listed a local area homeless shelter as last place of residence. Deshea left the shelter on December 27, 2018 and the shelter does not know her current whereabouts.

Key Components of Care

- **Unable to Contact (UTC)** process focuses specifically on locating Deshea in the most effective and timely manner possible
- **Real-time information updates** via Humana's CGX and CRM to automate UTC alerts, assignment, and status for Deshea
- **Dedicated, knowledgeable UTC Customer Care Specialist (CCS)** engages community, provider, & social services supports to exhaust every outreach effort and identify Deshea's care needs and concerns
- **Florida Medicaid Community Outreach teams** to connect to organizations, share information
- **Post-90 Day Outreach and Monitoring throughout Eligibility** to continue timely and consistent outreach to locate and engage Deshea

Deshea's Support System

- **Sergio** — UTC CSS
- **Alice** — Shelter Manager
- **Florida Community Outreach teams**
- **ESU Continued Outreach & Monitoring Post-90 days**

Deshea's Timeline:

1 — Pre-Enrollment:
Notification of Deshea's eligibility comes to Humana on December 17, 2018. Her information loads within 24 hours and flows into our downstream systems within 72 hours of enrollment receipt. The downstream systems include CGX and CRM.

2 — Pre-Enrollment: Timely Initial Contact
Our system validates Deshea's mailing address from her 834 file. Within five days, we mail new enrollee materials to the address for her on the 834 file.

3 — Day 1 – Ongoing: Enrollment Identification through Predictive Modeling
Humana runs Deshea's eligibility information through our Medicaid Risk Score algorithm within the first thirty days of enrollment, and monthly thereafter.

4 — Day 1: UTC Designation
Returned shelter mail indicates Deshea isn't at the shelter. A UTC alert is triggered within the system. Sergio, a UTC CCS, begins location and outreach attempts for Deshea.

5 — Day 1: Attempting to Locate Using Internal Systems
Sergio looks through Humana's system to try to locate contact info, reviewing CGX for historical claims, data, etc. No information is on file for Deshea.

6 — Days 2-19: Shelter & Community Engagement
Sergio calls the and speaks with Alice, the shelter's manager. She has not seen Deshea since Dec. 27, 2018. Sergio then connects to Humana's Florida Community Outreach teams to see if she has accessed community services upon enrollment.

7 — Day 20: Community Engagement
Sergio uses online search engines, databases, social media, and government records for possible paths to contact Deshea.

8 — Day 20-90: Continued Search & Close Formal UTC case
Sergio continues extensive research and every two weeks reviews all available internal systems. After 90 days of no contact, he closes Deshea's formal 90-day UTC case.

9 — Post-90 Days: Enrollee Outreach & Monitoring
Humana's Education & Satisfaction Unit (ESU) continues attempts to locate Deshea using HEDIS campaigns such as annual wellness visits follow-up, birthday campaigns, dental and concierge campaigns.

F. OVERSIGHT AND ACCOUNTABILITY

SRC# 26 – Subcontractor Oversight (Statewide):

The respondent shall list any proposed subcontractors to which it will delegate the management of: provision of covered services, utilization management, provider networks or paying providers. The respondent shall describe how it will oversee and monitor the performance of subcontractors in general, as well as any specific oversight planned for certain subcontractors, including any corresponding service level agreements. The respondent shall include in its response the schedule and type of monitoring and how findings are reported, remediated, and used for process improvements.

Response:

While Humana has responsibility for and will continue to perform a majority of the functions required by the SMMC, we also understand the importance of choosing and maintaining high quality subcontractor relationships where functional support is appropriate. We have thoughtfully and deliberately contracted with entities that share Humana's goal of providing the most effective and efficient care to Florida enrollees. We have been successfully delegating select services as part of our Florida Medicaid program for the last twenty (20) years. Humana subcontractors provide specialized services and support to enrollees and providers in varying capacities across several categories:

- Managing the provision of covered services,
- Performing utilization management,
- Maintaining high quality provider networks, and
- Paying providers.

Humana is committed to working with partners experienced in serving Medicaid enrollees and delivering services on behalf of our organization to improve enrollee outcomes and quality of life. We carefully evaluate our subcontractors by conducting pre-assessment reviews prior to contracting and delegation to ensure we satisfy all compliance standards. The pre-assessment is conducted in addition to all assessments and audits required by regulations and contract obligations at the time of delegation. We will provide results of subcontractor monitoring to the Agency's Contract Manager fourteen (14) business days after the end of each month or as specified by the Agency. We understand that if a subcontractor's performance does not meet the Agency's performance standard according to the Agency's monitoring report or the subcontractor's monitoring report, an improvement plan must be submitted to the subcontractor and the Agency within fourteen (14) business days of the deficient report.

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1. The extent to which the respondent provides a list of subcontractors it proposes to use under the SMMC Program for the delegation of work as described above.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

PROPOSED SUBCONTRACTORS

Humana proposes to use the subcontractors listed below and in Attachment 26-1 Subcontractor List in our Florida Comprehensive Medicaid program to delegate management of: provision of covered services [Florida Statute 409.973], utilization management, provider networks, and paying providers. Each subcontractor will be subject to the contracting, monitoring and oversight processes described here prior to providing any services or goods in support of the SMMC.

PROVISION OF COVERED SERVICES:
- 20/20 Eye Care Network, Inc. (Vision Services)

- Access2Care, LLC (Non-Emergency Medical Transportation Services)

- American Eldercare, Inc. (Administration of LTC Program)

- Audiology Distribution, LLC, d/b/a HearUSA (Hearing Services)

- Bay Care Medical Group (Credentialing)

- Beacon Health Strategies LLC (Behavioral Health Services)

- Coordinated Medical Specialists Podiatry (Provider Services - Claims Processing, Network Management)

- DentaQuest of Florida, Inc. (Dental Services)

- Dermatology Network Solutions (Provider Services - Claims Processing, Network Management)

-Doctor on Demand, Inc. (Telemedicine Services/Virtual Physician Consultation)

- Doctor's Professional Service Consultants (Provider Services - Claims Processing, Network Management)

- Evolve Emod, LLC (Home Modification Network Manager)

- First Quality Home Care, Inc. (Supplemental Case Manager Staffing)

- Florida Chiropractic Institute (Chiropractic Services)

- Florida Health Sciences Center, Inc., d/b/a Tampa General Hospital (Credentialing)

- Guardiantrac, LLC, d/b/a GT Independence (Participant Direction Option Services)

- Gulf Coast Jewish Family and Community Services, Inc. (Supplemental Case Manager Staffing)

- Health First Network, Inc. (Provider Services - Credentialing, Network Management)

- Humana Insurance Company (Provider Services - Claims Processing, Customer Service, Front End Operations, Billing and Enrollment, UM Review, Administrative Functions, Case Management)

- Humana Pharmacy, Inc., d/b/a PrescribeIT RX (Administration of OTC Benefit)

- iCare Health Solutions, LLC (Vision Services)

- Independent Living Systems, LLC (Post Discharge Meal Delivery, Nutrition Counseling)

- JMG Specialty Physicians (Credentialing)

- Laboratory Corporation of America Holdings a/k/a LabCorp (Lab Services)

- Lakeland Regional Health Systems, Inc. (Credentialing)

- Lakeview Center, Inc., d/b/a Access Behavioral Health (Behavioral Health Services)

- LanguageSpeak, Inc. (Translation Services)

- LogistiCare Solutions, LLC (Non-emergency Medical Transportation Services)

- Manatee County Rural Health Services (Credentialing)

- Martin Memorial Physician Corporation, d/b/a Martin Medical Group (Credentialing)

- Mednax Services Inc. (Credentialing)

- MotionPoint Corporation (Translation Services)

- Nemours Children's Clinics/Nemours Foundation (Credentialing)

- One HomeCare Solutions LLC (Home Health Services/DME Services)

- Orange Health Solutions, Inc., d/b/a Citra Health Solutions (f/k/a Sirona Health) (After Hours Nurse Triage Services)

- Orthopedix Network, Inc. (Provider Services - Claims Processing, Network Management)

- Pediatric Associates (Credentialing)

- Premier Eye Care, LLC (Vision Services)

- Public Partnerships, LLC (Participant Direction Option Services)

- Quest Diagnostics Incorporated (Lab Services)

- Shands HealthCare Network-Gainesville (Credentialing)

- Shands Jacksonville Medical Center (Credentialing)

- Ubiqus Reporting Inc., d/b/a LanguageWorks (Translation Services)

- University of Miami School of Medicine (Credentialing)

- University of South Florida/USF College of Medicine (Credentialing)

- United Language Group (Translation Services)

- Variety Children's Hospital, d/b/a Nicklaus Children's Hospital (Credentialing)

- Village Health Disease Management LLC (Renal Care Management)

- Whole Health Networks, Inc., f/k/a Healthways Whole Health Networks, Inc. (Provider Services Claims Processing, Credentialing, Network Management)

UTILIZATION MANAGEMENT:
- American Eldercare, Inc. (Administration of LTC Program)

- Beacon Health Strategies LLC (Behavioral Health Services)

- Continuecare Managed Care, Inc. (Utilization Management)

- DentaQuest of Florida, Inc. (Dental Services)

- Humana Insurance Company (Provider Services - Claims Processing, Customer Service, Front End Operations, Billing and Enrollment, UM Review, Admin Functions, Case Management)

- Lakeview Center, Inc., d/b/a Access Behavioral Health (Behavioral Health Services)

- Medical Care Consortium, Inc. (Utilization Management)

- One HomeCare Solutions LLC (Home Health Services/DME Services)

- Premier Eye Care, LLC (Vision Services)

- Village Health Disease Management LLC (Renal Care Management)

PROVIDER NETWORKS:
- 20/20 Eye Care Network, Inc. (Vision Services)

- Access2Care, LLC (Non-Emergency Medical Transportation Services)

- American Eldercare, Inc. (Administration of LTC Program)

- Audiology Distribution, LLC, d/b/a HearUSA (Hearing Services)

- Beacon Health Strategies LLC (Behavioral Health Services)

- Coordinated Medical Specialists Podiatry (Provider Services - Claims Processing, Network Management)

- DentaQuest of Florida, Inc. (Dental Services)

- Dermatology Network Solutions (Provider Services - Claims Processing, Network Management)

- Doctor's Professional Service Consultants (Provider Services - Claims Processing, Network Management)

- Evolve Emod, LLC (Home Modification Network Manager)

- Florida Chiropractic Institute (Chiropractic Services)

- Guardiantrac, LLC, d/b/a GT Independence (Participant Direction Option Services)

- Health First Network, Inc. (Provider Services - Credentialing, Network Management)

- Humana Insurance Company (Provider Services - Claims Processing, Customer Service, Front End Operations, Billing and Enrollment, UM Review, Admin Functions, Case Management)

- iCare Health Solutions, LLC (Vision Services)

- Laboratory Corporation of America Holdings a/k/a LabCorp (Lab Services)

- Lakeview Center, Inc., d/b/a Access Behavioral Health (Behavioral Health Services)

- LogistiCare Solutions, LLC (Non-emergency Medical Transportation Services)

- One HomeCare Solutions LLC (Home Health Services/DME Services)

- Orthopedix Network, Inc. (Provider Services - Claims Processing, Network Management)

- Premier Eye Care, LLC (Vision Services)

- Public Partnerships, LLC (Participant Direction Option Services)

- Quest Diagnostics Incorporated (Lab Services)

- Whole Health Networks, Inc., f/k/a Healthways Whole Health Networks, Inc. (Provider Services Claims Processing, Credentialing, Network Management)

Paying Providers:

- 20/20 Eye Care Network, Inc. (Vision Services)

- Access2Care, LLC (Non-Emergency Medical Transportation Services)

- American Eldercare, Inc. (Administration of LTC Program)

- Audiology Distribution, LLC, d/b/a HearUSA (Hearing Services)

- Beacon Health Strategies LLC (Behavioral Health Services)

- Coordinated Medical Specialists Podiatry (Provider Services - Claims Processing, Network Management)

- DentaQuest of Florida, Inc. (Dental Services)

- Dermatology Network Solutions (Provider Services - Claims Processing, Network Management)

- Doctor's Professional Service Consultants (Provider Services - Claims Processing, Network Management)

- DST Systems, Inc., d/b/a DST Pharmacy Solutions, f/k/a Argus Health (Pharmacy Claims Processing)

- Florida Chiropractic Institute (Chiropractic Services)

- Guardiantrac, LLC, d/b/a GT Independence (Participant Direction Option Services)

- Humana Insurance Company (Provider Services - Claims Processing, Customer Service, Front End Operations, Billing and Enrollment, UM Review, Admin Functions, Case Management)

- iCare Health Solutions, LLC (Vision Services)

- Lakeview Center, Inc., d/b/a Access Behavioral Health (Behavioral Health Services)

- LogistiCare Solutions, LLC (Non-emergency Medical Transportation Services)

- One HomeCare Solutions LLC (Home Health Services/DME Services)

- Orthopedix Network, Inc. (Provider Services - Claims Processing, Network Management)

- Premier Eye Care, LLC (Vision Services)

- Public Partnerships, LLC (Participant Direction Option Services)

- Whole Health Networks, Inc., f/k/a Healthways Whole Health Networks, Inc. (Provider Services - Claims Processing, Credentialing, Network Management)

Humana proposes to also utilize the following administrative subcontractors (e.g. print, fulfillment):
- Conduent Incorporate d/b/a Xerox Commercial Solutions (Administrative Services)
- Decision Support Systems, d/b/a DSS Research (Administrative Services)
- Dunwoody Technology Services Group (Administrative Services)
- EC Services, LLC (Administrative Services)
- Hinduja Global Solutions, Inc. (Administrative Services/Provider Services)
- New Leaf Business Solutions (Administrative Services)
- Photofax, Inc. (Administrative Services)
- Pride Healthcare, LLC (Administrative Services)
- Silverlink Communications (Administrative Services)
- Talk2Rep, Inc. (Administrative Services)
- Verscend Technologies, Inc. (Administrative Services)

SUBCONTRACTOR SELECTION AND ENGAGEMENT PRACTICES

When Humana Florida Operations identifies a need requiring the engagement of a subcontractor, a responsible Relationship Manager is identified to facilitate the subcontractor selection process. We first clarify internal requirements and then competitively select the most ideal subcontractor(s) positioned to meet our needs. Once selected, fully qualified, and contractually engaged, the Relationship Manager establishes the necessary relationship touch points.

The six (6) step process employed by Humana to guide the selection of a subcontractor is described below and in Attachment 26-2 Medicaid Relationship Management Six Step Process:

1. Internal Analysis:

- Spend Trend – Historic and anticipated spend, usage and related transactions associated with the target purchase are evaluated.

- Service Need – Key stakeholders are identified to clarify scope of services to be provided by the subcontractor.

2. External Analysis:

- Potential Service Providers – To include incumbents (if deemed appropriate), those providing similar services across the Humana lines of business, and additional candidates identified via market research.

3. Sourcing Process:

- Assessment criteria are established, inclusive of price, capability, quality/compliance, customer service, and innovation. These criteria are weighted.

- Request for Proposal (RFP) or Request for Quote (RFQ)– A request for proposal is developed, describing Humana, the service need, State Contract references, service requirements, and the timeline for responding. Subcontractors respond directly to the Director of Medicaid Operations

or Market team managing the bid. Please see Attachment 26-3 Participant Direction Option Services RFP, from June 2017, as an example.

4. Negotiations and Contracts:

- Respondent Evaluations – Each respondent is assessed via a Financial Due Diligence (FDD) process. Please see Attachment 26-4 Financial Due Diligence Summary for an example of the result the completed FDD process.

- References – References obtained from each respondent are contacted to collect additional information. We seek to obtain three (3) references per potential subcontractor.

- Selection – All respondents are evaluated based on the assessment criteria, feedback from references, best and final pricing, and the preference of the stakeholders.

5. Implementation:

- Pre-Delegation Audit – If the subcontractor is a new relationship, a pre-delegation audit is conducted by the Delegation Compliance team. Without their confirmation, the engagement does not progress.

- Business Continuity (BC) Planning and Disaster Recovery (DR) – While standard BC and DR expectations are established by contract, the selected subcontractor's BC and DR strength will be formally assessed via on-site and desk audits based on the criticality of this service relationship and the level of risk of an inadequate BC or DR program.

6. Relationship Management:

- The Relationship Manager will monitor and influence service provider performance in an ongoing manner in coordination with, and support of, or led by the Florida Market.

SUBCONTRACTOR QUALIFICATION AND CONTRACTING PROCESS

Humana holds every subcontractor to compliance with all applicable requirements of the SMMC Program Scope of Services. All service level agreements (SLAs) and applicable contract requirements are flowed to each subcontractor within the executed agreements specific to the performed activities.

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3. The extent to which the respondent uses and monitors for service level agreements consistent with the SMMC Program Scope of Services.
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SERVICE LEVEL AGREEMENTS

While it is always the intent of Humana to have vendor compliance and performance be voluntary and automatic, we have found that requiring certain performance with attendant consequences drives desired behavior. Humana customizes SLAs to each set of subcontractor activities and services and then actively negotiates the requirements into each subcontract. SLAs address those items important to Humana in provision of the services related to the contract and the Humana statement of work. For example, our call center SLAs are the current contract requirements reduced to individual line items with the metric, definition, standard, penalty, and measurement period identified. This is done for each area of activity of the subcontractor related to the services provided. Areas of focus include enrollment and eligibility, customer service, mail and correspondence, case management, quality measures (such as Healthcare Effectiveness Data and Information Set (HEDIS)), complaints and grievances, claims processing, provider network, reporting and file transfer, legal requirements such as Health Insurance Portability & Accountability Act (HIPAA) and privacy controls, and any additional state and federal requirements.

Certain performance metric service levels may be more or less stringent than the related service levels described in the SMMC. Such differences are intended solely to reduce the cost of tracking and monitoring service levels, simplify administration, and diminish conflict in application. It is important to note that the SLAs are in addition to, and separate from, the provisions in every subcontract for the subcontractor to comply strictly with each requirement of the SMMC.

Humana and the subcontractor agree on the form and content of each report for each service level metric, and the subcontractor self-reports on the agreed timing, typically monthly. SMMC required reports may be used for certain metrics, but others are developed as necessary. Humana always retains the right to audit and analyze the subcontractor's calculations.

SLAs are discussed at each Joint Operating Committee (JOC) meeting as described further below. Penalties are assessed and collected in accordance with the settlement process documented in each subcontract. The detailed statement of work negotiated with subcontractors and the Medicaid Addendum, which tracks all of the requirements of the Agency for Health Care Administration (AHCA) checklist, are additional requirements of the contracting process.

DELEGATION PROCESS

After the Market has received approval for contracting from the local Florida Contract Approval Committee for any value based arrangements, Delegation Compliance is the next stop for the Market in the qualification process. First, a Request for Delegation (RFD) (Attachment 26-5 Request for Delegation) must be completed and submitted to the Delegation Compliance unit to trigger the need for evaluation and documentation. For claims and clinical delegations, approval must also be sought from the national Delegation Council.

The Overall Delegation Approval Process map (Attachment 26-6 Overall Delegation Approval Process) provides a detailed snapshot of the rigorous delegation process. The Delegation Policy (Attachment 26-7 Delegation Policy) describes the oversight process requirements for any activity or function that has been delegated by Humana to another entity. Humana remains responsible for the performance and compliance of any delegated function.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Upon receipt of the RFD, Delegation Compliance carefully evaluates our subcontractors by conducting pre-assessment reviews prior to contracting and delegation to ensure we satisfy all compliance standards. The pre-assessment is conducted in addition to all assessments and audits required by regulation and contract obligations at the time of delegation.

After a subcontractor completes the certification process, additional specific requirements particular to the delegated services are established in a written delegation agreement supplementing the main subcontract (Attachment 26-8 Delegated Services Addendum). However, not all subcontractor contracts require a contract addendum. The written agreement setting forth the subcontracted activities and related obligations includes the following information:

- Activities to be performed by the subcontractor
- Process by which Humana evaluates the subcontractor's performance
- Remedies available to Humana if the subcontractor does not fulfill its obligations (CAPs, penalties, or revocation)
- Required reports to be created and submitted to Humana
- Responsibilities retained by Humana

The delegation document specifically addresses instructions and requirements for functions, reporting, regulatory standards, corrective action plans (CAPs) and penalties, quality improvement, auditing, and the grievance and appeal process based upon the type of direct impact of the subcontracted services. For example, there are delegation attachments for Utilization Review and Management of Medical or Behavioral Health Services, Complex Case Management, Disease Management, Quality Improvement for Behavioral Health Services, and Claims Processing. However, the Delegation Compliance team will create documentation and establish monitoring processes for any function that is delegated in accordance with the SMMC requirements, such as network management.

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2. The adequacy of the respondent’s oversight structure, including the extent of executive level staff participation.

4. The adequacy of the respondent’s approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.

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SUBCONTRACTOR OVERSIGHT STRUCTURE

Humana’s robust subcontractor oversight structure is coordinated across multiple teams at national and local levels. At the national level, well established delegation policies and procedures ensure consistency across Humana. We require subcontractors to adhere to a formal Compliance Policy (Attachment 26-9 Compliance Policy) which contains written standards of conduct for healthcare providers and subcontractors supporting us. In Florida, local executive leadership oversees the operations and performance of our subcontractors, applying those national policies and procedures in a way that is more specifically applicable to local operations. Finally, in direct response to State process and contract requirements, the Florida Subcontractor policy and procedure has been implemented.

This Florida structure is formalized in Attachment 26-10 Florida Medicaid Subcontractor Monitoring and Oversight procedure and Attachment 26-11 Medicaid Delegate Relationship Management policy.

The Humana Florida Market has designed the local monitoring and oversight structure described here, incorporating all existing company-wide resources, to address specific activity as required by SMMC and regulation. This will ensure world-class subcontractors are selected and maintained for Florida Medicaid.

As part of the subcontracting effort, Humana requires every subcontractor to meet all AHCA performance requirements related to its services. A Humana Relationship Manager is assigned to each subcontractor, and in coordination with other key market stakeholders, is responsible for managing the subcontractor relationship. Driving closure of any gaps to the contract and Humana SLAs, inclusive of operational, reporting, and compliance-related requirements, is a key focus area.

Following are the teams, departments and committees materially contributing to vendor oversight:

LOCAL SUBCONTRACTOR OVERSIGHT
- Florida Director, Vendor Performance Oversight
- Relationship Managers
- Joint Operating Committee (JOC)
- Florida Market Operations

NATIONAL SUBCONTRACTOR OVERSIGHT
- Clinical Vendor Oversight
- Delegation Compliance
- Delegation Council
- Enterprise Procurement and Vendor Services (EPVS) and IT Strategic Vendor Services (ITSVS)
- First Tier, Downstream, Related Entity (FDR) Compliance
- Fraud, Waste, and Abuse (FWA) and Special Investigations Unit (SIU)
- Internal Audit Consulting Group (IACG)
- Medicaid Finance
- Medicaid Strategic Partnerships and Implementation
- National Network Operations (NNO)
- Privacy Office
- Regulatory Compliance

LOCAL AND NATIONAL OVERSIGHT COMMITTEES
- Florida Contract Approval Committee
- Delegated Vendor Oversight Committee (DVOC)
- Medicaid Compliance Committee
- Quality Improvement Committee (QIC)

In addition to these teams and committees, there are other established enterprise-wide functions that support, monitor, and provide guidance related to vendor oversight. Our

Grievance and Appeals, Risk Management, and Legal Departments manage these functions. Notably, our Legal team includes attorneys specialized in CMS/Medicaid regulatory matters who counsel in direct support of the Florida Medicaid Comprehensive plan.

LOCAL SUBCONTRACTOR OVERSIGHT STRUCTURE
Florida Director, Vendor Performance Oversight
The Florida Director, Vendor Performance Oversight reports to the Vice President, Dual Eligible and Medicaid Programs and provides executive-level oversight of the subcontractor and delegated function process. The Florida Director, Vendor Performance Oversight, together with Relationship Managers whose duties are described below, is responsible for subcontractor relationship maintenance and for monitoring subcontractors' performance in accordance with State Contract and Humana-specific requirements.

Relationship Manager
Relationship Managers are responsible for the monitoring of subcontractor performance within their designated operational areas. If a subcontractor demonstrates a significant gap in meeting established SMMC or Humana-specific performance targets, the Relationship Managers, together with the Florida Director, Vendor Performance Oversight, collaborate in the development of CAPs. For subcontractors serving multiple Humana lines of business or markets, the Relationship Managers are especially dedicated to translating best practices and learnings across the broad Humana enterprise.

In accordance with our Medicaid Delegate Relationship Management policy (Attachment 26-11 Medicaid Delegate Relationship Management), each Relationship Manager is to ensure that the following actions and activities are accomplished.

FIRST-TIER DOWN-STREAM-RELATED ENTITY (FDR) ASSESSMENT
- Complete and submit the Risk Ranking Questionnaire to the FDR Committee for review.
- Confirm and follow the requirements for third parties determined to be FDRs.

DELEGATION COORDINATION
- Submit a completed Request for Delegation form to Delegation Compliance to initiate a pre-delegation audit.
- Confirm and follow the delegation recommendation from Delegation Compliance (Go/No Go).

CONTRACTING
- Complete required due diligence (e.g. financial, business continuity, systems and physical security, etc.) to identify and mitigate potential risk.

- Negotiate all required contract documents and related provisions, working with contract drafting, legal, and compliance subject matter experts (SMEs) to streamline the language, limit duplications, and eliminate conflicting language, to include, but not be limited to:

-- SLAs, reflecting relevant contract performance requirements and Humana operating standards, inclusive of penalties and incentives, as appropriate;

-- For the specific delegated functions, a Delegation Addendum and attachments;

-- A current state-specific Medicaid Addendum (aka Medicaid Omnibus Agreement);

-- A Business Associate Agreement, as applicable;

-- An IT Security Agreement, as applicable.

- Facilitate final reviews and contract execution, internal-to-Humana, including the operational lead(s), and with the subcontractor.

- In partnership with state-facing market lead(s), obtain state agency approval for the initial relationship and relationship changes, as required.

ON-GOING RELATIONSHIP OVERSIGHT
- Identify and engage the operational lead(s) associated with the subcontractor to establish and maintain a shared understanding of expectations and accountability for compliance oversight.

- Assist with compliance oversight, as needed (e.g. Delegation, FDR, IACG, EIP).

- In partnership with teams who monitor and report certain measures internal-to-Humana and to external entities, ensure the subcontractor takes the necessary action to create information, communicate, and manage to key metrics (e.g. compliance, operational, contractual SLAs, etc.) associated with the services being provided.

- In partnership with operational market lead(s), schedule and participate in regular operational pulse meetings.

- Schedule and host formal joint steering committee (JSC) meetings to:

-- Align on compliance challenges/opportunities (e.g. Grievance and Appeals (G&A), Risk Management, Internal Audit Consulting Group (IACG), Delegation, First-Tier-Down Stream-Related Entity (FDR), Enterprise Information Protection (EIP), Privacy, Legal, Regulatory Compliance, related audit findings and Corrective Action Plans (CAPs), etc.).

-- Pulse performance trend over time (e.g. SLAs, key compliance metrics).

-- Identify/address operational and performance barriers.

-- Pursue opportunities to maximize business benefit.

-- Explore cross-market translation opportunities.

- Document and publish notes and next actions from all JSCs.

- Participate in all key audits associated with the third party to facilitate full performance transparency and coordinated follow up.

- Support escalation of performance issues including penalty assessments, de-delegation evaluations, breach investigations.

- Engage the appropriate SMEs (e.g., Legal, Privacy, EIP, Delegation, Regulatory Compliance, IACG, FDR, clinical/operational leads) to assist in addressing issues or exploring opportunities to maximize relationship value.

Because the Relationship Manager is directly dedicated to subcontractor performance, this ensures that the subcontractor is able to meet our standards for care and customer service, the standards of the Department of Insurance, requirements of state and federal regulatory agencies, and applicable accrediting agencies (e.g., the NCQA).

JOINT OPERATING COMMITTEE (JOC)
Regular JOC meetings are held with individual subcontractors and relevant staff where performance is assessed, and issues and opportunities are escalated. The agendas address compliance challenges and opportunities (e.g. G&A, Delegation, FDR, Privacy, Regulatory Compliance, related audit findings, and CAPs); track performance trend over time (e.g. SLAs, key compliance metrics); identify and address operational and performance barriers; pursue opportunities to maximize business benefit; and explore cross-market translation opportunities. The JOCs are attended by key market leaders, including Florida Medicaid Operations and the Florida Director, Vendor Performance Oversight.

The JOCs meet regularly based on the need and the direct impact of the relationship. JOCs ensure:
- Subcontractors comply with applicable state and federal Laws.

- Tasks related to the subcontract are performed in accordance with the terms of the AHCA Contract.

- Subcontractors remain eligible for participation in the Medicaid Program.

- Subcontracted durable medical equipment subcontractors are in compliance with the Any Willing Provider statute.

- Opportunities to minimize risk and maximize value in the service of enrollees and the Plan are explored and supported.

FLORIDA MARKET OPERATIONS
The Humana Florida Market Operations team is comprised of the Florida Director, Vendor Performance Oversight, Ancillary and Network Contract team, Medicaid Provider Network team, and the Specialty Contract team. Florida Market Operations identifies the subcontractor need and initiates the process to engage the subcontractor, including following the subcontractor selection and engagement process previously described. Florida Market Operations also identifies a Relationship Manager, and partners with Delegation, Regulatory, and FDR Compliance teams to establish the necessary oversight of the subcontractor. In partnership with the respective Relationship Managers for each subcontractor, the Florida Market Operations team is responsible for the following tasks to ensure compliance by subcontractors:

- Review of SLAs performance;

- Participation in all audits of the subcontractor to facilitate coordinated follow up;

- Escalation of performance issues;

- Reports findings, corrective action plans, and follow up to the DVOC;

- Engagement of the appropriate subject matter experts, including our legal department, Privacy department, Regulatory Compliance, Delegation Compliance, FDR Compliance, EIP, and IACG, as needed;

- Assists with resolution of escalated enrollee and provider complaints;

- In conjunction with the subcontractor, identify and align on challenges and improvement opportunities.

Additionally, Florida Market Operations ensures:
- Subcontractors comply with applicable state and federal laws;

- That subcontractors are eligible for participation in the Medicaid Program;

- Tasks related to the subcontract are performed in accordance with the terms of the State Contract; and

- Delegated durable medical equipment (DME) subcontractors are in compliance with Florida Statute § 409.975(1)(d) and the Agency Guidance Statement about Durable Medical Equipment Contracts in the Managed Medical Assistance Program.

NATIONAL SUBCONTRACTOR OVERSIGHT STRUCTURE AND PROCESSES

CLINICAL VENDOR OVERSIGHT
Clinical Vendor Oversight and Trend Management reports through the Vice President, Clinical Operational Oversight to the Segment President for Healthcare Services. This team conducts a monthly dashboard meeting and quarterly business reviews of Utilization Management subcontractors. The monthly dashboard meeting reviews subcontractor budgets and tracks and reviews metrics related to quality and operations generally. The quarterly business review delves deeper into an individual subcontractor's operational performance. Both the monthly dashboard and the quarterly business reviews are sent to Delegation Compliance for review, follow up, and implementation of any necessary CAPs.

DELEGATION COMPLIANCE
The Delegation Compliance team is a centralized team based in Humana's national office and conducts operational compliance oversight of subcontractors performing claims, clinical health services, credentialing, and any other delegated function on behalf of Humana. This team:

- Evaluates all delegation requests submitted to Delegation Compliance to initiate a pre-delegation audit;

- Performs an audit prior to delegation of these functions to assess capability to perform the function in a compliant manner;

- Based on the audit results, provides recommendation for subcontractor delegation and delegation documentation to be executed by the subcontractor;

- Conducts annual audits against function-specific compliance standards and routinely monitors each delegate; and

- Initiates corrective actions when instances of noncompliance are identified and notifies Market Operations.

DELEGATION COUNCIL
In recent years, several Centers of Excellence were created at Humana, including the Provider Development Center of Excellence (PD CoE). The mission of the PD CoE is to develop and deploy best practices and capabilities that assist enrollees, market and network leaders, owned entities and Humana's MSO, in creating successful value-based provider relationships with a focus on improving the provider experience and achieving Humana's path-to-value goals.

The Delegation Council is a monthly leadership forum created by the PD CoE for Markets to evaluate strategic and operational impacts of potential clinical and claims delegation and to provide organizational visibility into new subcontracted arrangements for all lines of business. At each monthly forum, the Council reviews proposals to consider whether delegation is in the best interest of our enrollees, providers, and Humana, and to help minimize negative operational impacts.

Members of the Delegation Council include representatives from Provider Development, Provider Process & Services, Integrated Clinical Solutions, Service Fund, Retail Segment, Group Segment, Delegation Compliance, the Legal Department, and Market Representation proposing the group or vendor.

ENTERPRISE PROCUREMENT AND VENDOR SERVICES (EPVS) AND INFORMATION TECHNOLOGY STRATEGIC VENDOR SERVICES (IT SVS)
The EPVS team sources enterprise administrative goods and services and is responsible to lead the contracting for certain Florida Medicaid goods and services such as print, fulfillment, and translation services. As gatekeeper, EPVS directs and provides management oversight for these relationships by facilitating vendor performance through SLAs and other contract requirements.

IT Strategic Vendor Services (IT SVS) provides IT subcontractor selection, negotiation and management focused on best-in-class engagements which comply with myriad healthcare requirements and regulations. IT SVS is responsible for software compliance monitoring, IT subcontractor relationship management, research and guidance, and is a liaison with contract management. Florida Market needs for enterprise or custom software and services begins with engagement of IT SVS.

FIRST TIER, DOWNSTREAM, RELATED ENTITY (FDR) COMPLIANCE
The First Tier, Downstream, Related Entity (FDR) Compliance team reports up through Licensure and Business Partner Compliance to the Enterprise Vice President for Compliance. It is a centralized unit based in the Humana national office. To identify Florida delegate FDRs for monitoring and compliance with CMS requirements, the FDR Compliance team reviews the Risk Ranking Questionnaire (Attachment 26-12 Risk Ranking Questionnaire) completed by

Delegation Compliance and evaluates the information through the FDR Identification Committee. The FDR Identification Committee consists of compliance representatives, Medicaid operations leaders and CMS counsel. The committee meets weekly to determine whether the presented subcontractor services are or are not assigned FDR status. FDR Compliance monitors and performs periodic audits of FDRs, monitors compliance program self-assessments, and screens FDRs against the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists monthly. The team also initiates corrective actions when instances of non-compliance with FDR program requirements are identified.

The FDR Compliance team communicates compliance program expectations, training requirements, and methods of reporting suspected or detected compliance and FWA issues involving an FDR. Non-compliance or FWA occurrences are escalated to the appropriate business area and others.

FRAUD, WASTE AND ABUSE (FWA) AND SPECIAL INVESTIGATIONS UNIT (SIU)
Humana recognizes that the prevention, detection, and investigation of fraud on the government or the company, waste of funds, and abuse of benefits or services are essential to maintaining the integrity of the healthcare system and ensuring compliance with federal and state laws and regulations.

Humana has robust procedures and systems in place for responding to suspected internal, subcontractor, provider, and enrollee FWA non-compliance in managed care programs. Humana conducts timely investigations of potential noncompliance identified in the course of self-evaluations and audits of subcontractors, and corrects such problems immediately, reducing the potential for recurrence and ensuring ongoing compliance with state and federal requirements for all product offerings. Humana has developed policies and procedures to ensure a timely and reasonable inquiry is made into potential fraud or misconduct. In addition, Humana reports identified instances of fraud or misconduct to the appropriate regulatory body, based on the associated Humana line of business, and all associates must consistently adhere to all applicable Humana policies, regardless of operational needs, financial concerns, level or degree of influence, or any other business factor.

In addition, Humana holds healthcare providers, subcontractors, and business partners responsible for maintaining their own comprehensive plan for detecting, correcting, and preventing FWA. The FWA team verifies healthcare providers, subcontractors, and business partner FWA plans annually.

Humana is actively involved with anti-fraud organizations such as the National Health Care Anti-Fraud Association, the Healthcare Fraud Prevention Partnership, and the Midwest Anti-Fraud Insurance Association. Humana cooperates with federal, state, and local authorities in the investigation of potential FWA when appropriate.

The purpose of the Special Investigations Unit (SIU) is to reduce fraudulent activity by pursuing potential leads, initiating research, educating Humana associates and customers, partnering with law enforcement and government agencies, while working with competitors in the active detection of FWA.

SIU is Humana's primary investigative arm and is responsible for complex cases of fraud and abuse. SIU processes include data analytics to identify trends, fraud, schemes, and potential

fraudulent activity that may warrant further investigation. SIU investigates fraud at all levels—from associates to providers to subcontractors to enrollees.

SIU also participates in the Enterprise Investigations Consortium (EIC) which is designed to encourage information sharing and collaboration among the various investigative groups within Humana. When appropriate, allegations may be referred to other investigative groups pursuant to the transfer standard set forth by the EIC investigations policy.

SIU implements an Anti-Fraud Plan which continuously monitors all lines of business for potential FWA activity. SIU monitors the activities of associates, enrollees of its health plans and insurance policy holders, healthcare providers and business partners.

INTERNAL AUDIT CONSULTING GROUP (IACG)
The Internal Audit Consulting Group (IACG) reports to the Segment Vice President in Finance Management and provides independent consulting and advisory services that evaluate and improve the effectiveness of risk management, control, and governance processes. IACG guides management on the appropriate level of risk taking necessary to achieve objectives. IACG will conduct on-site audits and desk reviews at the request of a Relationship Manager to audit the critical processes of a subcontractor (including Humana's oversight of those processes), focusing on areas of greatest risk and exposure. In response to deficiencies, Issues and Opportunities (IOPs) are documented and tracked to closure.

MEDICAID FINANCE
The Medicaid Finance team consists of Operational and Corporate teams. Both report through the Segment Vice President, Finance Management to the Chief Financial Officer. The team provides financial support about subcontractors serving the Florida market. Corporate is the controller function managing accruals, reserves, audit reporting, and like activities. Operational manages financial reporting, P&L ownership, administration, trend analysis, and contract analysis.

MEDICAID STRATEGIC PARTNERSHIPS AND IMPLEMENTATION
The Medicaid Strategic Partnerships and Implementation team reports through Medicaid operations to the Vice President, Dual Eligible and Medicaid Programs. The team provides relationship management for subcontractors with a cross-Medicaid market presence. This includes facilitating performance oversight and coordinating with the key stakeholders within the Florida Market, attendance at the JOCs and DVOC participation. The team is also responsible for implementing new and expanded plan capability leaning on the Medicaid Governance structure.

NATIONAL NETWORK OPERATIONS (NNO)
National Network Operations (NNO) reports up to the Vice President for Provider Development Leadership and operates at the national level. NNO has promulgated policies and procedures for all enterprise provider activity, including national health systems administration, health plan management, provider contracting and administration, and certain national vendor contracts.

PRIVACY OFFICE

The Privacy Office reports through Privacy, Ethics and Corporate Policy to the Enterprise Vice President for Compliance. The Privacy Office ascertains whether contracted business associates of Humana are in compliance with the terms of their Business Associate Agreements, including HIPAA and HI-TECH.

REGULATORY COMPLIANCE

The Regulatory Compliance team is a centralized team based in the Humana national office and in the field. Two (2) Compliance Officers on this team are dedicated to the Florida Medicaid plan. In addition to other business functions, this team assists Delegation Compliance with issues identified through the oversight and monitoring channels. Regulatory Compliance also institutes and monitors CAPs as needed and escalates issues to the DVOC and JOC, whose meetings they regularly attend. The Florida Compliance Officers for Managed Medical Assistance (MMA) and Long-term Care (LTC) monitor metrics, SLA performance, operational and performance barriers, and issues of non-compliance by external subcontractors. This is achieved by reviewing and analyzing company and provider or subcontractor documents and reports, attending various operational and functional meetings, and through consultation with the Relationship Managers. Upon identification of an issue by the Florida Compliance Officers, an audit or CAP may be conducted.

LOCAL AND NATIONAL OVERSIGHT COMMITTEES

FLORIDA CONTRACT APPROVAL COMMITTEE (CAC)

The Florida market structure provides for Florida to have its own dedicated CAC as a subset of the national CAC. Monthly meetings (more often as needed) bring all new third party engagements before the committee for approval. The Florida CAC must approve any new engagement to ensure provider and vendor contracting representatives in Florida are adhering to Humana contracting standards and that non-standard contracts have undergone appropriate approvals and reviews prior to contract execution. The Florida CAC is made up of representatives from Senior Director/VP Network, Finance, Law, Medicare/Medicaid President (or designee), Service Fund, and Medical Director.

DELEGATED VENDOR OVERSIGHT COMMITTEE (DVOC)

The Delegated Vendor Oversight Committee (DVOC) is a Florida Market-based committee authorized by the QIC to monitor Humana's delegated services. The DVOC charter (Attachment 26-13 DVOC Charter 2017) provides for the committee to monitor the Medicaid plan's subcontracted services and perform oversight of quality and service activities delivered and managed by subcontractors. The DVOC operates in alignment with the Florida Medicaid Subcontractor Monitoring and Oversight procedure (Attachment 26-10) and Medicaid Delegate Relationship Management policy (Attachment 26-11).

The committee receives regular updates about subcontractor performance and activities from the Relationship Managers are assigned to each subcontractor performance via regularly held JOC meetings with the subcontractors. The JOC meetings are designed to review the previous period's subcontractor performance as compared to SLAs and contract provisions. JOC meetings are led by the Relationship Managers and attended by the Florida Director, Vendor Performance Oversight, and Business Owners from designated areas are invited participants. The DVOC reviews JOC notes and next actions, compliance reporting, and audit feedback. The

DVOC is chaired by the Florida Director of Vendor Performance Oversight and meets quarterly and more frequently as needed.

The DVOC is charged to:
- Establish appropriate subcontractor oversight mechanisms, procedures, and tools.

- Review subcontractor activity, performance metrics, and audit results.

- Make recommendations and approve CAPs as appropriate.

- Review annual Utilization Management (UM) program descriptions and evaluations for subcontractors with delegated UM.

- Review and follow up on CAPs progress and/or completion.

- Perform annual evaluation of the Delegated Vendor Performance Oversight program (Attachment 26-14 Delegated Vendor Performance Program) and makes recommendations for enhancements.

The DVOC submits the quarterly meeting minutes to the QIC, which in turn incorporates the DVOC minutes into a report presented to Corporate QIC and to the Board of Directors.

MEDICAID COMPLIANCE COMMITTEE
The nationally led Medicaid Compliance Committee, comprised of leaders and their reports from all Medicaid teams, including operations, compliance, clinical, and provider, meets each month. The purpose of the Medicaid Compliance Committee is to provide a forum to present, review, analyze and make recommendations on issues pertaining to Medicaid. Discussion of metrics facilitates the closure of external and internal CAPs and other notifications of non-compliance. All subcontractors, including those that are corporate-owned, fall within the scope of the monthly Medicaid Compliance Committee meeting.

QUALITY IMPROVEMENT COMMITTEE (QIC)
The QIC is a multidisciplinary committee that includes our Chief Medical Officer (CMO) and our Florida Medicaid President, who oversees Florida Medicaid operations. The QIC meets quarterly and provides oversight of Quality Improvement program activities and clinical recommendations for our Florida Medicaid plan. This authority is delegated to the QIC by the Corporate QIC and the Internal Board of Directors Executive Committee.

The Florida Director, Vendor Performance Oversight presents performance trends and relates insights of the Relationship Managers to the QIC, as captured by the JOCs and DVOC. The QIC employs the subcontractor-related data provided to best inform quality strategy and plans.

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5. The adequacy of the respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.

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CLAIMS SUBCONTRACTORS

If audits or reviews reveal a claims subcontractor is at a moderate risk level for financial insolvency, the responsible Relationship Manager or performance team will remediate. Relevant data will be captured, assessed, and proactively remediated to potential risks or failure points for subcontractor's ability to meet the contract requirements. The FMEA tool is effective at engaging a subcontractor to thoughtfully assess risks and issues, as well as implementing triggers to successfully identify risks and issues throughout the life of the subcontract. This process is discussed in greater detail in the Financial Monitoring and Oversight section of this narrative.

CORRECTIVE ACTION PLANS

The local Florida Operations team participates in all key audits associated with each subcontractor to facilitate full performance transparency and coordinated follow-up. The respective Relationship Managers escalate performance issues including penalty assessments, de-delegation evaluations, and breach investigations by engaging the appropriate SMEs to correct any issues.

The Humana Delegation Compliance unit issues a CAP when a delegate fails to meet established compliance thresholds, State Contract requirements, subcontract requirements, accreditation organization standards, or other state or federal regulatory requirements. Specific deficiencies triggering and resulting in CAPs may include:

- Failure to achieve an adequate overall audit score;
- Failure to achieve a required threshold for any single-item score; or
- Failure to meet compliance thresholds for critical elements as specified on the standardized audit tool during pre-delegation, an annual delegation audit, or contract review.

A CAP contains:
1. The identified issues and deficiencies;
2. Root cause analysis;
3. The corrective actions required; and
4. The timeframes for performance of the corrective actions and achieved results.

The delegate's performance under the CAP is monitored by Delegation Compliance. Monitoring frequency is dependent upon the potential risks identified, and will occur until the delegate has achieved the required results. If a delegate fails to achieve the required results within the timeframe provided, the delegate's results will be referred to the appropriate committee, Florida Market leadership, compliance leadership, or Relationship Manager for additional evaluation and final determination on appropriate and necessary next steps. These may include additional corrective measures, cancellation of a particular subcontracted function, or termination of the delegated services agreement. Decisions to terminate subcontractors lie with the contract owners and Relationship Managers, with input from multiple stakeholders.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

AUDITS

FDR COMPLIANCE AUDITS

The Humana FDR Compliance team Subcontractor Monitoring Schedule is submitted to AHCA each year in accordance with State Contract requirements. This schedule documents planned auditing and monitoring activity of FDR relationships supporting Humana's contract with the State. Subcontractors are screened against the OIG/GSA exclusion lists monthly, with a small subset being monitored on an ad-hoc basis through Organization Compliance Program self-assessments. OIG/GSA screenings are essential for subcontractors to remain eligible for participation in the Medicaid program. FDR Compliance audits with a frequency required by regulatory or accrediting bodies, as well as those audits with a discretionary frequency.

INTERNAL AUDITS

IACG will engage, at the request of the respective Relationship Manager or Florida Market leader, to audit the critical processes of the subcontractor, including Humana’s oversight of those processes. With an eye on process stability and efficiency, the IACG will focus on areas of greatest risk and exposure. Specifically, IACG performs risk-based audits addressing process issues with a focus on the contract, CMS, and other regulatory requirements. In response to deficiencies, Issues and Opportunities (IOPs) are identified, documented and tracked to closure.

NATIONAL ANNUAL DELEGATION AUDITS

To ensure ongoing compliance, all subcontractors are be evaluated at least annually against state, federal, and accreditation standards. The audits are performed by Delegation Compliance on all delegates utilizing customized audit tools built to conduct onsite reviews of the subcontractor. All delegated functions of a subcontractor are audited for compliance with the subcontract and with state, federal, and accreditation standards and requirements. The audit also covers a careful review of the subcontractor’s financial solvency and established letters of credit.

The reviews include the following:
- Policies and procedures
- Forms, tools, and reports
- Program descriptions and work plans
- Sub-delegation agreements
- Audit of contracted sub-delegates
- Financial solvency
- File audit
- Letters of credit

Results of the annual delegation audit are discussed with the Florida Market operations leaders, recorded on a standardized audit tool, and then scored to determine the delegate’s ability to meet compliance requirements. The audit tool provides data sources which would trigger a CAP.

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6. The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

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FINANCIAL MONITORING AND OVERSIGHT

FINANCIAL DUE DILIGENCE

The Financial Due Diligence process (FDD) is a standard vendor onboarding process used by our EVPS team to investigate and rate via scorecard a new vendor's financial status prior to entering into an agreement, although FDD is also available for other uses.

Humana partners with Tata Consultancy Services (TCS), who completes the FDD analysis after receiving a subcontractor's financial statements. The analysis is supplemented through online financial information searches and by direct contact with the subcontractor. Once relevant financial information is obtained, TCS completes the appropriate public or private entity FDD template (Attachment 26-15 EVPS Financial Due Diligence SOP) to calculate a health score, which is shared with the FDD requestor. The FDD requestor uses the health score to complete the Financial Due Diligence Summary Report (Attachment 26-4) which feeds the Financial Solvency Risk Report, triggering the FMEA tool.

The FDD process is offered by EVPS to other areas of Humana seeking financial analysis due to concerns over a subcontractor's financial risk, the need to evaluate subcontractors during a Request for Proposal (Attachment 26-3 Participant Direction Option Services RFP), a significant business change or event, or as part of the annual monitoring of subcontractor financial risk. An FDD Strategy Manager or other Humana associate, such as a Relationship Manager, may request an FDD at any time on a new or existing subcontractor, delegate, or provider engaged outside the administrative services procurement process.

FINANCIAL SOLVENCY REVIEW PROCESS AND RISK REPORT

In addition to the other Market, national, and compliance oversight described here, monitoring and oversight of all claims subcontractors is enhanced by a rigorous Financial Solvency Review process that includes a Financial Solvency Risk Report (Risk Report) (Attachment 26-16 Financial Solvency Risk Report). The Risk Report is updated quarterly by the Financial Solvency Task Force containing one hundred twenty-five (125) representatives across Risk Management, Internal Audit, Senior Products, National Network Operations, Delegation Compliance, Finance, and Market Operations.

Two (2) months prior to every quarterly Financial Solvency Task Force meeting, Delegation Compliance requires Market finance teams to obtain the most recent financial documents from subcontractors for upload to Humana's internal system to complete the Risk Report.

All Market Finance Directors and Relationship Managers with a claims subcontractor receiving a high or moderate risk score on the Risk Report are prepared to discuss the matter in detail during the quarterly Financial Solvency Task Force meetings. Market Finance Directors and Relationship Managers leave the meeting with action items to be completed to mitigate any

risks. Delegation Compliance follows up on the action items with the Market Finance Directors and Relationship Managers regularly after the meeting.

The Florida Market team will treat the Risk Report as a primary data source of financial solvency risks to trigger a remediation plan for a subcontractor where warranted. Leveraging existing processes, resources, and a proven Six Sigma-based tool, we will proactively capture, assess, and remediate financial solvency risks for UM and Paying Provider delegates.

CONCLUSION

Careful monitoring and rigorous oversight of subcontractors on many levels across the enterprise, with effort and focus driving State Contract requirements at the local Florida Market level aligns with the Humana commitment to improving quality and outcomes for our enrollees. The relationships with our subcontractors support our Perfect Experience goal, which is dedicated to delivering a personalized well-being journey that inspires those we serve to embrace us as a health partner for life.

Evaluation Criteria:

1. The extent to which the respondent provides a list of subcontractors it proposes to use under the SMMC Program for the delegation of work as described above.

2. The adequacy of the respondent's oversight structure, including the extent of executive level staff participation.

3. The extent to which the respondent uses and monitors for service level agreements consistent with the SMMC Program Scope of Services.

4. The adequacy of the respondent's approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.

5. The adequacy of the respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.

6. The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Attachment 26-1: Subcontractor List

Subcontractor	Description	Covered Services	UM	Provider Network	Paying Providers
20/20 Eye Care Network, Inc.	Vision Services	X		X	X
Access2Care, LLC	Non-Emergency Medical Transportation Services	X		X	X
American Eldercare, Inc.	Administration of LTC Program	X	X	X	X
Audiology Distribution, LLC (d/b/a HearUSA)	Hearing Services	X		X	X
Bay Care Medical Group	Credentialing	X			
Beacon Health Strategies LLC	Behavioral Health Services	X	X	X	X
Continucare Managed Care, Inc.	Utilization Management		X		
Coordinated Medical Specialists Podiatry	Provider Services - Claims processing, Network Management	X		X	X
DentaQuest of Florida, Inc.	Dental Services	X	X	X	X
Dermatology Network Solutions	Provider Services - Claims processing, Network Management	X		X	X
Doctor on Demand, Inc.	Telemedicine Services/Virtual Physicians Consultation	X			
Doctor's Professional Service Consultants	Provider Services - Network Management, Claims Processing	X		X	X
DST Systems, Inc. (d/b/a DST Pharmacy Solutions) (f/k/a Argus Health)	Pharmacy Claims Processing				X
Evolve Emod, LLC	Home Modifications	X		X	
First Quality Home Care, Inc.	Case Management	X			
Florida Chiropractic Institute	Chiropractic Services	X		X	X
Florida Health Sciences Center, Inc. (d/b/a Tampa General Hospital)	Credentialing	X			
Guardiantrac, LLC (f/k/a GT Independence)	Participant Direction Option Services	X		X	X
Gulf Coast Jewish Family and Community Services, Inc.	Case Management	X			
Health First Network, Inc.	Provider Services - Credentialing, Network Management	X		X	
Humana Insurance Company	Provider Services - Claims Processing, Customer Service, Front End Operations, Billing and Enrollment, UM Review, Admin Functions, Case Management	X	X	X	X
Humana Pharmacy, Inc. (d/b/a PrescribeIT RX)	Administration of OTC Benefit	X			
Humana Pharmacy Solutions, Inc.	Pharmacy Benefits Management Services				X
iCare Health Solutions, LLC	Vision Services	X		X	X

Independent Living Systems, LLC	Post Discharge Meal Delivery, Nutrition Counseling	X			
JMG Specialty Physicians	Credentialing	X			
Laboratory Corporation of America Holdings	Lab Services	X		X	
Lakeland Regional Health Systems, Inc.	Credentialing	X			
Lakeview Center, Inc. (d/b/a Access Behavioral Health)	Behavioral Health Services	X	X	X	X
LanguageSpeak, Inc.	Translation Services	X			
LogistiCare Solutions, LLC	Non-Emergency Medical Transportation Services	X		X	X
Manatee County Rural Health Services	Credentialing	X			
Martin Memorial Physician Corporation (d/b/a Martin Medical Group)	Credentialing	X			
Medical Care Consortium, Inc.	Utilization Management		X		
Mednax Services Inc.	Credentialing	X			
MotionPoint Corporation	Translation Services	X			
Nemours Children's Clinics/Nemours Foundation	Credentialing	X			
One HomeCare Solutions LLC	Home Health Services/DME Services	X	X	X	X
Orange Health Solutions, Inc. d/b/a Citra Health Solutions (f/k/a Sirona Health)	After Hours Nurse Triage Services	X			
Orthopedix Network, Inc	Provider Services - Claims Processing, Network Management	X		X	X
Pediatric Associates	Credentialing	X			
Premier Eye Care, LLC	Vision Services	X	X	X	X
Public Partnerships, LLC	Participant Direction Option Services	X		X	X
Quest Diagnostics Inc.	Lab Services	X		X	
Shands HealthCare Network-Gainesville	Credentialing	X			
Shands Jacksonville Medical Center	Credentialing	X			
Ubiqus Reporting Inc. (d/b/a LanguageWorks)	Translation Services	X			
University of Miami School of Medicine	Credentialing	X			
University of South Florida/USF College of Medicine	Credentialing	X			
United Language Group	Translation Services	X			
Variety Children's Hospital, (d/b/a Nicklaus Children's Hospital)	Credentialing	X			
Village Health Disease Management LLC	Renal Care Management	X	X		
Whole Health Networks, Inc. (f/k/a Healthways Whole Health Networks, Inc.)	Provider Services - Claims Processing, Credentialing, Network Management	X		X	X

Medicaid Six Step Process: Source Selection & Relationship Management

Internal Analysis

- Analyze spend
- Analyze usage and transactions
- Analyze/engage stakeholders and users
- Analyze products, services, and related contracts
- Identify cross-Line of Business needs & relationships
- Broadly define scope, specifications, requirements

External Analysis

- Identify potential partners/providers
- Evaluate markets for same services or products
- Perform benchmarking analysis

Sourcing Process

- Refine scope, specifications, and requirements
- Develop the partner engagement strategy
- Develop evaluation tool/model
- *Initiate a Request for Proposal or a Request for Quote based on the expectations of the participating third parties**

Negotiations And Contracts

- Evaluate all respondents via financials(e.g. financial due diligence (FDD)), references, written responses
- Narrow subcontractor/ provider pool to a "short list" for further negotiations
- Lead final negotiation/make selections
- Finalize terms, conditions, Service Level Agreements (SLAs), and performance requirements
- Complete all required FDR Submissions
- Draft and Execute required Contracts
- Gather required approvals, including those required by the impacted state(s)

Implementation

- Implement the new/revised relationship, to include, but not be limited to, the following:
  - Project Plan
  - Comprehensive Stakeholder Engagement
  - Communications Strategy
  - Engagement Training/Support
- Initiate metrics reporting and tracking

Relationship Management

- Initiate robust relationship management process in partnership with the service provider and market operational lead(s)
- Participate in regular Operations Touch Points
- Schedule, Host, and document Joint Operating Committee Meetings
- FL: Contribute to DVOC Subcontractor Oversight

Humana

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**** If the process and expectations are solidly defined and set, third parties under evaluation need only submit a quote. If not, a request for proposal, to gather process/approach recommendations, is in order. (out of box vs custom)***

Humana Inc.
Request for Proposal
For
Participant Direction Option (PDO) Support Services

RFP Date: June 6, 2017
RFP Due: June 20, 2017

Contact: Deborah Beavin
Director, Medicaid Operations
502.580.2941
DBeavin@Humana.com

500 West Main
Louisville, KY 40202

Corporate Profile

Humana Inc., headquartered in Louisville, Ky., is a leading health and well-being company focused on making it easy for people to achieve their best health with clinical excellence through coordinated care. The company's strategy integrates care delivery, the member experience, and clinical and consumer insights to encourage engagement, behavior change, proactive clinical outreach and wellness for the millions of people we serve across the country.

RFP Purpose

Humana has chosen your organization to participate in the competitive evaluation of Participant Direction Option (PDO) Services in support of its Long-Term Care enrollees in Florida. Responses to this Request for Proposal (RFP), as assessed against Humana's needs, will drive next steps.

Humana wishes to identify a partner capable of meeting all requirements of Humana Medicaid in the provision of PDO Services to our members and, in doing so, will be a strong partner in driving continuous improvement and demonstrating operational excellence.

From Humana's FL Medicaid Contract:

- ***Participant Direction Option (PDO)*** — A service delivery enrollee option that enables long- term care enrollees to exercise decision-making authority and control over allowable services and how those services are delivered, including the ability to hire and fire service providers. An enrollee choosing participant direction accepts responsibility for taking a direct role in managing his/her care.

- ***Participant Direction Option Services (PDO Services)*** — The services an enrollee may choose for the participant direction option. They include: adult companion care, attendant care, homemaker services, intermittent and skilled nursing, and personal care services.

RFP Response Instructions

Please provide responses to all RFP questions, as provided in Exhibit B, and any supplementation information via email to Deborah Beavin (Dbeavin@Humana.com) by 5pm eastern, Tuesday, June 20. All questions regarding this RFP are to be directed to Deborah Beavin using the above contact information.

A bidders' conference with all participants will be hosted 3pm eastern, Tuesday, June 13 to ensure all questions have been addressed.

Humana will request a formal presentation from all finalists identified through the RFP process. The participants and dates for these forums will be hosted between June 21 and June 30.

RFP Schedule

Please provide responses to all RFP questions, as provided in Exhibit B, and any supplementation information via email to Deborah Beavin (DBeavin@Humana.com) by 5pm eastern, Tuesday, June 20.

RFP Request Date	5pm eastern, Tuesday, June 6
Bidders' Conference	2pm eastern, Tuesday, June 13 *Note: Written questions are due to Deborah Beavin (dbeavin@humana.com) by noon eastern, Monday, June 12*
RFP Responses Due	5pm eastern, Tuesday, June 20
RFP Finalist Presentations	June 27 through June 30
Finalize Selection	Friday, July 21

Exhibits

- Exhibit A Plan Requirements and References (Page 4-10)
- Exhibit B Service Requirements (Page 11-33)
- Exhibit C Request for Proposal Questionnaire (Page 34)
- Exhibit D List of Required Documents (Page 35)

RFP Cancellation/Non Award

Humana reserves the right to cancel this RFP, or to make no award of a contract pursuant to this RFP. RFP respondents shall bear all of their own costs related to this RFP.

Rejection of Proposals

Proposals which do not conform to the requirements of this RFP may be rejected by Humana. Proposals may be rejected for reasons, which include, but are not limited to, submission of the RFP response after the submission deadline.

EXHIBIT A
PLAN REQUIREMENTS AND REFERENCES

Section V. Covered Services

A. Required Benefits

2. Specific Services to be Provided

a. Comprehensive LTC Managed Care Plans are responsible for implementing and managing the Participant Direction Option (PDO) for enrollees with LTC benefits, as defined in Section I, Definitions and Acronyms, and as specified in the LTC Exhibit.

1. Participant Direction Option (PDO)

a. General Provisions

(1) The Managed Care Plan is responsible for implementing and managing the Participant Direction Option (PDO) as defined in Attachment II, Section I,

Definitions and Acronyms. The Managed Care Plan shall ensure the PDO is available to all Long-term Care enrollees who have any PDO-qualifying service on their authorized care plan and who live in their own home or family home.

(2) An enrollee's plan of care shall include one or more of the following services in order for the enrollee to be eligible to participate in the PDO: adult companion care, attendant nursing care, homemaker services, intermittent and skilled nursing, or personal care. The enrollee may choose to participate in the PDO for one or more of the eligible PDO services, as outlined in their authorized care plan.

(3) Enrollees who receive PDO services shall be called "participants" in any PDO specific published materials. The enrollee shall have employer authority. An enrollee may delegate their employer authority to a representative. The representative can neither be paid for services as a representative, nor be a direct service worker. For the purposes of this section, "enrollee" means the enrollee or their representative.

(4) The Managed Care Plan shall develop PDO-specific policies and procedures that shall be updated at least annually and shall obtain Agency approval prior to distributing PDO materials to enrollees, representatives, direct service workers, and case managers.

(5) The Managed Care Plan shall operate the PDO service delivery option in a manner consistent with the PDO Manual and the PDO Participant Guidelines provided by the Agency.

(6) The Agency will provide templates for the following to the Managed Care Plan: PDO Consent Form, PDO Representative Agreement, PDO Participant Guidelines, and PDO Pre-Screening Tool.

(7) The Managed Care Plan shall maintain books, records, documents, and other evidence of PDO-related expenditures using generally accepted accounting principles (GAAP).

(8) The Managed Care Plan shall submit a PDO report monthly as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. The Managed Care Plan shall provide ad-hoc PDO related information, records, and statistics, at the request of the Agency within the specified timeframe.

(9) The Agency will conduct PDO satisfaction surveys on at least an annual basis and shall provide results to the Managed Care Plan for use in quality improvement plans.

(10) The Managed Care Plan shall cooperate with, and participate in, ongoing evaluations and focus groups conducted by the Agency to evaluate the quality of the PDO.

b. Training Requirements

(1) The Managed Care Plan shall ensure all applicable staff receives basic training on the PDO service delivery option

(2) The Managed Care Plan shall designate staff to participate in PDO training conducted by the Agency.

(3) The Managed Care Plan shall ensure an adequate number of case managers are trained extensively in the PDO. This extensive PDO training, beyond the general PDO informational training, is provided to case managers who serve enrollees and consists of training specific to PDO employer responsibilities, such as: completing federal and state tax documents, interviewing potential direct service workers, developing Emergency Back-up Plans, training direct service workers, completing the PDO Pre-Screening tool, evaluating direct service worker job performance, and completing and submitting timesheets. The Managed Care Plan shall maintain records of employee training in the employee's file.

(4) The Managed Care Plan shall provide PDO-trained staff as part of the enrollee and provider call centers to be available during the business hours specified in this Contract.

c. PDO Case Management

(1) The case manager is responsible for informing enrollees of the option to participate in the PDO when any of the PDO services are listed on the enrollee's authorized care plan.

(2) The Managed Care Plan shall assign a case manager trained extensively in the PDO within two business days of an enrollee electing to participate in the PDO delivery option.

(3) In addition to the other case manager requirements in this Contract, all case managers are responsible for:

(a) Documenting the PDO was offered to the enrollee, initially and annually, upon reassessment. This documentation shall be signed by the enrollee and included in the case file;

(b) Referring Managed Care Plan enrollees, who have expressed an interest in choosing the PDO, to available case managers who have received specialized PDO training.

(4) In addition to the other case manager requirements in this Contract, case managers who have received extensive PDO training are responsible for:

(a) Completing the PDO Pre-Screening Tool with each enrollee and prospective representative;

(b) Ensuring enrollees choosing the PDO understand their roles and responsibilities;

(c) Ensuring the Participant Agreement is signed by enrollees and included in the case file;

(d) Facilitating the transition of enrollees to, and from, the PDO service delivery system;

(e) Ensuring PDO and non-PDO services do not duplicate;

(f) Training enrollees, initially, and as needed, on employer responsibilities such as: creating job descriptions, interviewing, hiring, training, supervising, evaluating job performance, and terminating employment of the direct service worker(s);

(g) Assisting enrollees as needed with finding and hiring direct service workers;

(h) Assisting enrollees with resolving disputes with direct service workers and/or taking employment action against direct service workers;

(i) Assisting enrollees with developing emergency back-up plans including identifying Plan network providers and explaining the process for accessing network providers in the event of a foreseeable or unplanned lapse in PDO services;

(j) Assisting and training enrollees as requested in PDO related subjects.

d. Enrollee Employer Authority/Direct Service Workers

(1) Enrollees may hire any individual who satisfies the minimum qualifications set forth in Section VI, Provider Network, including but not limited to neighbors, family members, or friends. The Managed Care Plan shall not restrict an enrollees' choice of direct service worker(s) or require them to choose providers in the Managed Care Plan's provider network.

(2) The Managed Care Plan shall inform enrollees, upon choosing the PDO, of the rate of payment for the PDO services. If the rate of payment changes for any PDO service, the Managed Care Plan shall provide a written notice to the applicable enrollees and direct service workers, at least thirty (30) days prior to the change.

(3) The Managed Care Plan shall ensure the enrollees update their Participant/Direct Service Worker Agreement indicating any changes in rate of payment.

(4) The Managed Care Plan shall provide instructions to the enrollee regarding the submission of timesheets.

(5) The Managed Care Plan shall ensure the Participant/Direct Service Worker Agreement includes, at a minimum, include the following:

(a) Service(s) to be provided;

(b) Hourly rate, the range for which may change from time to time as established and managed by Humana;

(c) Direct service worker work schedule;

(d) Relationship of the direct service worker to the enrollee;

(e) Job description and duties;

(f) Agreement statement; and

(g) Dated signatures of the case manager, enrollee, and direct service worker.

(6) The Managed Care Plan shall pay for Level II background screening for at least one representative (if applicable) per enrollee and at least one direct service worker for each service per enrollee, per Contract year. The Managed Care Plan shall receive the results of the background screening and make a determination of clearance, adhering to all requirements in Chapters 435 and 408.809 F.S.

(7) The Managed Care Plan shall monitor over and under use of services based on payroll and an enrollee's approved plan of care and provide reports to the Agency, or its designee.

e. Fiscal/Employer Agent

(1) The Managed Care Plan shall be the Fiscal/Employer Agent (F/EA) for PDO enrollee's or may sub-contract this function. Should any of the F/EA duties be sub-contracted, the Managed Care Plan shall provide enrollees with at least thirty (30) days' notice informing them that the Managed Care Plan shall utilize a subcontractor to perform certain F/EA duties.

(2) The Managed Care Plan shall meet all applicable PDO-related Federal and State requirements and shall be operated in accordance with Section 3504 of the Internal Revenue Code, per Revenue Procedure 70-6 and Section 3504 Agent Employment Tax Liability proposed regulations (REG-137036-
08) issued by the IRS on January 13, 2010.

(3) The Managed Care Plan remain abreast of all federal and state F/EA requirements and tax forms, and shall ensure all materials distributed to enrollees, representatives, direct service workers, and case managers are current, and in accordance with the appropriate federal and state regulations.

(4) The Managed Care Plan shall have a separate Federal Employer Identification Number (FEIN) that is used only for purposes of representing enrollees as employers. This FEIN should not be used to file or pay taxes for the Managed Care Plan's staff.

(5) The Managed Care Plan shall complete the following payroll and F/EA tasks:

(a) Develop a pay schedule and distribute it to all enrollees at least annually;

(b) Collect and process timesheets submitted by the enrollee. Resolve any timesheet issues with the enrollee and/or direct service worker;

(c) Disburse payroll (no less than twice per month) by direct deposit or pre- paid card to each direct service worker who has a complete and current Hiring Packet on file and has provided services to an enrollee as authorized in the enrollee's plan of care and the Participant/ Direct Service Worker Agreement by the published pay date;

(d) Maintain payroll documentation for all direct service workers;

(e) Compute, maintain, and appropriately withhold all employer and direct service worker taxes pursuant to federal and state law. All payments that are not in compliance with federal and state tax withholding, reporting, and payment requirements shall be corrected within two (2) business days of identifying an error;

(f) Process applicable direct service worker garnishments, liens, and levies in accordance with state and federal garnishment rules. Submit payments and reports to applicable agencies per garnishment instructions;

(g) Deposit direct service worker aggregate payroll deductions per federal and state tax deposit requirements. Federal Income Tax, Social Security and Medicare and enrollee Federal Social Security and Medicare (FICA) taxes in the aggregate per deposit frequency required by an F/EA. (See IRS publication 15-A, located at www.irs.gov/);

(h) Deposit employer aggregate tax deductions per federal and state tax deposit requirements. Federal Unemployment Tax (FUTA) shall be deposited in the aggregate per F/EA deposit frequency. (See IRS publication 15-A, located at www.irs.gov/);

(i) Refund over-collected FICA for direct service workers who earn less than the Federal FICA threshold for the year (See IRS Publication 15, Circular E for threshold information);

(j) File a single IRS Form 941, Employer's Quarterly Tax Return in the aggregate on behalf of all enrollees represented by the Managed Care Plan. Form 941 is completed using the Managed Care Plan's separate F/EA, FEIN. Wages and taxes reported represent total, aggregate wages and taxes for all enrollees represented by the Managed Care Plan. Schedule B should be completed per rules. The Managed Care Plan shall also complete and submit Schedule R with the Form 941.

Schedule R disaggregates each enrollee's employer wages and federal tax liability;

(k) Adjust Forms 941 as applicable by completing and filing IRS Form 941- X.

(l) File a single IRS Form 940, Employer's Annual Federal Unemployment Tax Return in the aggregate on behalf of all enrollees represented by the Managed Care Plan. Form 940 is completed using the Managed Care Plan's separate FEIN. Wages and FUTA tax reported represent total, aggregate wages and taxes for all enrollees represented by the Managed Care Plan. Note: Even Managed Care Plans incorporated with a nonprofit 501c3 status SHALL file and pay FUTA on behalf of enrollees;

(m) Process and distribute IRS Forms W-2 to the direct service workers and submit them electronically according to IRS Form W-2 instructions, per IRS rules and regulations;

(n) Track payroll disbursed to all direct service workers and provide reports as may be required by the Agency or its designee in accordance with this Contract;

(o) Provide written notification to the case manager and enrollee if utilization is less than 10% of the monthly hours as approved on the authorized plan of care for more than one (1) month;

(p) Obtain workers' compensation coverage for the enrollee's direct service workers, if required by Florida statute or rule (see, e.g., Chapter 440, F.S., and Rule 69L, F.A.C.), which shall be funded by the Managed Care Plan;

(q) Comply with, and support enrollee compliance with, state workers' compensation audits as applicable;

(r) Prepare for and support enrollee preparation for unemployment claim proceedings, as

applicable;

(s) Maintain records in compliance with Fair Labor Standards Act requirements for employers;

(t) Ensure a payroll system with maximum data integrity in which direct service workers are not paid above authorized hours as prescribed in the enrollee's plan of care and the Participant/Direct Service Worker Agreement;

(u) Respond to requests for direct service worker employment verification;

(v) Perform all duties regarding disenrollment of an enrollee from the PDO, including final federal and state tax filings and payments and revocation of accounts, numbers, and authorizations previously obtained by the

Managed Care Plan. This includes retiring the FEIN and State Unemployment Tax Account (SUTA) Number;

(w) Provide a transitioning enrollee's new plan with the enrollee's FEIN and SUTA numbers.

f. PDO Monitoring

The Managed Care Plan shall monitor for compliance with PDO requirements, and shall report to the Agency or its designee upon request for an annual F/EA Quality Assessment and Performance Review, including:

(1) Whether timesheets are signed by the enrollee (or enrollee's authorized representative, if applicable) and the direct service worker;

(2) Utilization of services based on payroll and an enrollee's approved plan of care;

(3) Whether services, duties, and hours listed on the Participant/Direct Service Worker Agreement are in compliance with the authorized plan of care;

(4) Whether direct service workers are qualified pursuant to the PDO Participant Guidelines and the PDO Manual, prior to providing services to an enrollee;

(5) Duplication of PDO and non-PDO services.

Table 2

PDO Provider Qualifications

Long-term Care Plan Benefit	**Qualified Service Provider Types**	**Minimum Provider Qualifications**
Adult Companion	Individual	None *

Attendant Nursing Care	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Homemaker	Individual	None *
Intermittent/ Skilled Nursing	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Personal Care	Individual	None*

*Individuals of the enrollee's choosing may provide PDO services so long as they meet the minimum provider qualifications as above and are age eighteen (18) years and older. PDO providers are also required to sign a Participant/Direct Service Worker Agreement and obtain a satisfactory Level II background screening.

Section XIV. Reporting Requirements

A. Managed Care Plan Reporting Requirements

1. Required Reports

The Managed Care Plan shall comply with all reporting requirements set forth in this Contract, including reports specific to Comprehensive LTC Managed Care Plans as specified in the Summary of Reporting Requirements Table below and the Managed Care Plan Report Guide.

Summary of Reporting Requirements		
Report Name	**Plan Type**	**Frequency**
Participant Direction (PDO) Roster Report	All LTC Plans	Monthly

EXHIBIT B
SERVICE REQUIREMENTS

Statement of Work

THIS STATEMENT OF WORK IS EFFECTIVE FOR THE RFP AND HUMANA RESERVES THE RIGHT TO ADJUST DESCRIPTIONS AND REQUIREMENTS BASED ON RESPONSES AND NEGOTIATIONS AND ENGAGEMENT OF ACTUAL SERVICES.

A. Definitions:

1. **AHCA** means Florida Agency for Healthcare Administration which issued the State Contract; also referred to as the "State".
2. **Case Manager** means the MCO personnel responsible to manage the Participant's Plan of Care .
3. **COMPANY** means [PDO Service Provider], the vendor performing PDO services in accordance with the Schedule.
4. **Direct Service Worker** means the employee hired by the Participant to perform PDO Services.
5. **Enrollment Packet** means that set of documents approved or provided by the State which contains the items listed in Section C.2(b).
6. **FEA** means fiscal employer agent.
7. **Hiring Packet** means the set of documents approved or provided by the State which contains the items listed in Section C.3(a).
8. **Humana Services** means services performed by COMPANY for the benefit of individuals enrolled under the State Contract.
9. **IRS** means the Internal Revenue Service of the United States.
10. **LTC** means Long Term Care.
11. **LTSS** means long term services and supports.
12. **MCO** means Managed Care Organization. Humana is an MCO.
13. **P&P(s)** means Policy and Procedure documents developed by Humana and provided to COMPANY that describes the procedures to be followed regarding certain activities in support of the Services. Such P&Ps shall be incorporated as if fully set forth herein.
14. **Participant** means the long term care recipient whose Plan of Care provides for PDO Services.
15. **Participant Directed Option (PDO)** means a service delivery enrollee option that enables long term care enrollees to exercise decision-making authority and control over allowable services and how those services are delivered, including the ability to hire and fire direct service workers.
16. .**Participant Directed Option (PDO) Services** means the services an enrollee may choose for the Participant Directed Option. They include adult companion care, attendant care, homemaker services, intermittent and skilled nursing, and personal care services.
17. **Participant Packet** means the set of forms and documents provided or approved by the State which contains the items listed in Section C.4 (b).
18. **PDO Participant Guidelines** mean the document prepared or approved by the State which provides information to the Participant regarding MCO, COMPANY, and Participant responsibilities with respect to PDO Services, and the hiring and management of Direct

Service Workers.

19. .**Personnel** means all employees, agents, officers, managers, providers and subcontractors of COMPANY.
20. **Plan of Care** means the care plan of the Participant as authorized by the State and as implemented by the MCO Case Manager**.**
21. **Region** means the designated geographical area within which Humana is authorized by the State Contract to furnish covered services to enrollees.
22. **Representative** means an individual officially designated as required by the State to represent the Participant in implementing PDO Services. An enrollee may delegate employer authority to a Representative. The representative can neither be paid for services as a representative, nor be a direct service worker.
23. **State Contract** means the Statewide Medicaid Managed Care contract including Medical Managed Assistance and Long Term Care by and between Humana and the State of Florida through AHCA.
24. **Supports Broker(s)** means the dedicated Personnel employed by COMPANY to assist Participants with managing their PDO Services and Direct Service Workers.
25. **System** means the proprietary computer applications and software, including hardware/storage owned or licensed by COMPANY and used by COMPANY to manage information described in this SOW. It also includes systems which Participants and Direct Service Workers may access to manage and perform activity, such as schedule workers, submit time cards and requests for payment. This definition includes multiple systems and platforms owned or licensed by COMPANY.
26. **The State** means the state of Florida and/or ACHA.

B. Purpose:

Humana has contracted with AHCA to provide Medicaid LTC services to eligible Florida enrollees. Humana must ensure the PDO is available to all LTC enrollees who have any PDO-qualifying service on their authorized Plan of Care and who live in their own home or family home. An enrollee's Plan of Care must include one or more of the PDO Services in order for the enrollee to be eligible to participate in the PDO. COMPANY shall provide the required services for providing the PDO in the State Contract to identified Participants, including without limitation assisting Participants with self-directing the employment of individuals to provide PDO Services, and to perform financial management and support broker services (the "Services") all as set forth herein.

C. Description of Services:

1. Personnel

a) In accordance with the State Contract and consistent with Humana P&Ps, COMPANY shall have sufficient staff, qualified by training, experience and certification/licensure to conduct the functions. COMPANY shall have professional support staff necessary to conduct daily business in an orderly manner, directly available during agreed upon business hours for Participant communication and assistance. COMPANY shall maintain sufficient professional support staff, available to handle urgent inquiries from Humana, Participants and Representatives.

b) **COMPANY** shall have a centralized executive administration, and must ensure adequate staffing and information systems capability to ensure **COMPANY** can appropriately manage financial transactions, record keeping, data collection, and other administrative functions, including the ability to submit any financial, programmatic, encounter data or other information required by the Schedule.

c) If Humana notifies **COMPANY** that any of its Personnel performing Services has failed to meet any standard of Humana or the State, **COMPANY** shall immediately take reasonable corrective action, including but not limited to, removing such person from performing any Services for Humana as appropriate. Any request for replacement of **COMPANY** Personnel by Humana shall be in writing and will be administered in accordance with applicable law.

d) **COMPANY** shall maintain and show reasonable evidence of adequate back-up force and supervisory staff to assist with sick days, vacations and disasters or any other emergency. **COMPANY** shall comply in all respects with the staffing due diligence requirements of the State Contract, including, but not limited to, timely background checks, drug screens, and fingerprint submissions.

e) Every month, COMPANY shall check current staff and Direct Service Workers against the federal List of Excluded Individuals and Entities (LEIE) and the federal System for Award Management (SAM) (includes the former Excluded Parties List System (EPLS) or their equivalent), to identify and report to Humana any excluded parties.

f) COMPANY shall ensure all applicable Personnel receives basic training on Humana's PDO Service delivery option. COMPANY shall designate staff to participate in PDO training conducted

by the State.

g) COMPANY shall ensure an adequate number of Personnel are trained extensively in the PDO. This extensive PDO training, beyond the general PDO informational training, must be provided to Personnel who serve Participants and consists of training specific to PDO employer responsibilities, such as completing federal and state tax documents, interviewing potential Direct Service Workers, training Direct Service Workers, evaluating Direct Service Worker job performance, and completing and submitting timesheets. COMPANY shall maintain records of Personnel training in each individual's employee file.

h) Supports Brokers

i) COMPANY shall maintain Supports Broker staffing sufficient to achieve the service levels described herein. The Supports Broker staff serving Humana Participants shall be exclusively dedicated to Humana.

ii) COMPANY shall use best efforts to have Supports Brokers in close proximity to the geographic location of Participants. In any event, Supports Brokers shall make themselves available for in person meetings as hereinafter set forth.

iii) All Supports Brokers shall have the proper and required skill, and training background to perform duties described herein in an effective and efficient manner. All Supports Brokers shall be fluent in English and Spanish. All Supports Brokers shall be trained on PDO activities within fifteen (15) days of hire.

iv) In addition to the PDO training materials developed by Humana for Case Managers, COMPANY and its Supports Brokers shall assist with development and updating of "Train the Trainer" materials as mutually agreed.

2. <u>Participant Initial PDO Enrollment Activities</u>

a) Case Managers will determine if Participants are eligible for PDO Services within the Plan of Care. If a Participant is eligible, the Case Manager will send to the Participant the Enrollment Packet for completion. When COMPANY is selected, Humana will send the completed Enrollment Packet to the COMPANY Supports Broker for that Region by secure e-mail [or fax] within two (2) business days of receipt from Participant.

b) The Enrollment Packet will contain information necessary for COMPANY to begin delivering Services to Participants, including but not limited to:

- Participant applicable Plan of Care provisions,
- Employer of Record Information Form,
- Level II Background Screening Form
- PDO Consent Form,
- PDO Representative Agreement,
- IRS Form 2678,
- IRS Form 8821,
- Florida Business Tax Application,
- Florida Department of Revenue Power Of Attorney and Declaration of Representative Form,

- Florida Department of Revenue Reemployment Tax Application for Agent Registration,
- Florida Enrollment and Authorization for e-Services Program,
- IRS Form SS-4.

This list is subject to change in accordance with requirements of the State.

c) COMPANY shall, within twenty-four (24) hours of receipt of the Enrollment Packet, log all information into its System and contact the Participant by telephone ("Welcome Call") to introduce Participant to the program and confirm basic information, in particular, whether Participant has already identified potential Direct Service Workers or whether Participant needs assistance to recruit Direct Service Workers.

d) In the event COMPANY is initially unable to contact Participant, COMPANY shall make at least three (3) attempts over the five (5) following business days to contact Participant, and thereafter report to Humana immediately if unable to contact.

e) COMPANY shall advise Participants of the COMPANY toll free customer service telephone number for assistance with filling out forms and other employer assistance.

3. <u>Participant Identified Direct Service Worker</u>

a) If a Participant has identified potential Direct Service Worker(s), the Case Manager will leave a Direct Service Worker Hiring Packet with Participant, or COMPANY will send the Hiring Packet to the Participant within three (3) calendar days of a request from Humana or the Participant. The Direct Service Worker Hiring Packet will contain:
   - COMPANY Direct Service Worker Information Form
   - MCO/Plan Customer Service Contact Information
   - COMPANY Direct Service Worker Payroll Schedule D
   - USCIS Form I-9,
   - Authorization Form by Direct Service Worker for Direct Deposit
   - Form W-4
   - Criminal Record Check Consent Form
   - AHCA Affidavit Of Compliance With Background Screening Requirements
   - COMPANY/Participant/Direct Service Worker Agreement(s)
   - Return envelope

This list is subject to change in accordance with requirements of the State.

b) The Case Manager will contact the COMPANY Supports Broker by telephone to advise if the Participant previously identified a potential Direct Service Worker. The Supports Broker shall make contact with the Participant no later than seventy-two (72) hours after contact from a Case Manager.

c) The Supports Broker shall thereafter attempt further contact on the twentieth (20th) day, and every three (3) business days thereafter, until the earlier of: (i) three (3) unsuccessful contact attempts, (ii) the Participant indicates that he/she is no longer interested in enrolling in PDO Services, or (iii) receipt of completed Direct Service Worker Hiring Packet materials.

d) Following three (3) unsuccessful attempts to contact the Participant, or notice from the Participant that he/she does not wish to continue in PDO, the Supports Broker shall notify the Case Manager

who will make final determination whether to continue efforts to enroll Participant in PDO Services or dis-enroll Participant from the program. COMPANY shall not suspend attempts to enroll Participant in PDO Services without the Case Manager's prior authorization.

4. Direct Service Worker Recruitment Assistance Services

a) When a Participant requests assistance in recruiting Direct Service Worker(s), prior to performing the tasks described in 3(a) – (c), above, the COMPANY Supports Broker shall schedule a recruiting program meeting with the Participant to provide the Participant with information and education on recruiting techniques, interviewing and hiring. Such meeting shall take place in person at such time and place as reasonably requested by the Participant.

b) COMPANY shall provide the following Direct Service Worker Recruitment Assistance Services and materials:
   i) Provide the Participant Packet within three (3) business days, containing the following:
      - COMPANY Direct Service Worker Payroll Schedule D
      - Self Determination Time Sheet and Instructions for Completion
      - Fax Coversheet for Self-Directed Service Recipients
      - Caregiver Online Directory Letter and Application
      - Florida New Hire Reporting Form
      - PDO Participant Guidelines (if not yet received)
   ii) Assist the Participant with developing job description(s);
   iii) Educate the Participant about interviewing techniques, how to identify Direct Service Workers within their own networks and nontraditional recruiting channels;
   iv) Assist the Participant in developing and placing Direct Service Worker recruitment ads if the cost of such advertising is reimbursable under Medicaid. COMPANY will contact the Participant within two (2) business days of the recruiting program meeting to confirm ad placement, and again within twelve (12) days thereafter to monitor recruitment ad responses. The Supports Broker shall obtain Case Manager approval prior to placement of any recruitment ad with a cost greater than $250.00.

5. Direct Service Worker Candidate Eligibility Testing

a) Participants may hire any individual who satisfies the minimum qualifications set forth in Table 2 of Section VI, Provider Network, of the State Contract (Appendix 1 hereto), including but not limited to neighbors, family members, or friends. There shall be no restriction on a Participant's choice of Direct Service Worker(s) and they may not be required to choose providers in Humana's network.

b) Upon identification of Direct Service Worker candidates by Participants and receipt of all required candidate-completed forms, COMPANY shall, on Participants' behalf, perform eligibility testing of candidates. Such eligibility testing shall comply with the requirements of State (specifically Chapter 435 and S. 408.809, Florida Statutes) and federal law, as well as requirements of applicable P&Ps.

c) COMPANY shall ensure that Level II criminal background screening and fingerprinting have been performed for Direct Service Worker(s) pursuant to Chapter 435 and Section 408.809, F.S.

d) COMPANY shall verify all direct Service Worker qualifications in accordance with applicable P&Ps.

e) COMPANY shall verify all direct Service Worker qualifications as specified by the State and shall further verify Direct Service Workers' information (i.e., citizenship or legal alien verification documentation), and social security numbers with the Social Security Administration's Social Security Verification Service.

f) COMPANY shall contact either Participant or potential Direct Service Worker(s) to confirm that potential Direct Service Worker has completed all required screening (including 10 panel drug screening and fingerprinting) not later than two (2) weeks following receipt of candidate-completed forms. COMPANY shall conduct two (2) follow-up calls to either Participant or potential Direct Service Worker(s) and if potential Direct Service Worker(s) has not completed required screening, COMPANY shall contact the Case Manager for further instructions.

g) COMPANY shall comply with all State requirements for determining eligibility of Direct Service Worker(s) for employment under PDO. For all ineligible candidates:
   i) COMPANY shall, on behalf of the Participant, provide all legally required documentation to the potential Direct Service Worker(s) (e.g., Fair Credit Reporting Act notices).
   ii) In the event potential Direct Service Worker(s) fail eligibility testing, COMPANY shall notify the Case Manager AND the Participant within three (3) business days of notification of such failure. Following such failure, the Supports Brokers shall seek the advice and consent of Case Manager prior to assisting the Participant with further searches for potential Direct Service Workers.

6 Participant / Direct Service Worker Orientation Meeting

a) Within five (5) business days of a potential Direct Service Worker passing eligibility testing, the Supports Broker shall coordinate a meeting between the Participant and/or Representative, the Direct Service Worker and Humana Case Manager at such time and place as reasonably requested by the Participant ("Direct Service Worker Orientation Meeting"). The Direct Service Worker Orientation Meeting must be an in-person, face-to-face meeting. If necessary as pre-approved by the Case Manager, COMPANY shall provide telephone orientation to Direct Service Workers, Representatives and others who could not participate in the in-person, face-to-face meeting.

b) COMPANY shall comply with all State and Humana requirements for Direct Service Worker Orientation Meetings.

c) During the Direct Service Worker Orientation Meeting, COMPANY shall:

   i) Secure the completion and/or execution of all documents necessary for Direct Service Worker PDO Services that includes payroll taxes, workers compensation coverage (if required) and other employment related expenses.

   ii) Communicate the program parameters (as set forth in the Plan of Care received from the Case Manager) to Participants and Direct Service Workers.

   iii) Confirm that the Participant and Direct Service Worker have agreed upon a wage rate that conforms to Humana guidelines and State program requirements for wage rates, and confirm that the wage rate is documented in the Participant/Direct Service Worker Agreement. (Humana will inform Participants, upon choosing the PDO, of the rate of payment for the PDO Services.

If the rate of payment changes for any PDO Service, Humana will provide the thirty (30) day written notice to the affected Participants and Direct Service Workers as required by the State Contract and notify COMPANY.) COMPANY shall ensure any updates to rates are documented in the Participant/Direct Service Worker Agreement.

iv) Complete and obtain signatures on the required Hiring Packet forms, including the Participant/Direct Service Worker Agreement.

v) COMPANY shall ensure the Participant/Direct Service Worker Agreement includes the following minimum provisions.

1. PDO Service(s) to be provided;
2. Hourly rate;
3. Direct Service Worker work schedule;
4. Relationship of the Direct Service Worker to the Participant;
5. Job description and duties;
6. Agreement statement;
7. Dated signatures of the Case Manager (or COMPANY), Participant, and Direct Service Worker.

vi) Deliver the following State-required training to Direct Service Worker(s):

1. Overview of PDO in HCBS and self-direction of health care tasks;
2. Caring for elderly and disabled populations;
3. Abuse and neglect identification and reporting;
4. Critical Incident reporting;
5. Submission of timesheets, required documentation and withholdings.

vii) Deliver the following State-required training to Participants initially and on an as needed basis:

1. Understanding the role of Participants and Representatives and PDO in HCBS and self-direction of health care tasks;
2. Understanding the role of the Case Manager and COMPANY;
3. Creating job descriptions
4. Interviewing, hiring, training, and supervising Direct Service Workers;
5. Abuse and neglect identification and reporting;
6. Being an employer, evaluating worker performance and managing Direct Service Workers;
7. Fraud and abuse;
8. Performing administrative tasks such as reviewing and approving time sheets;
9. Scheduling workers and back-up planning;
10. Terminating employment of Direct Service Workers.

d) COMPANY will coordinate a minimum of one (1) face-to-face Participant/Direct Service Worker Orientation Meeting between the Participant, Supports Broker and each Direct Service Worker.

7. <u>Direct Service Worker Training</u>

a) With respect to Direct Service Worker training, in addition to that described in 7(c) vi, above, COMPANY shall:

i) deliver written training materials;

ii) refer Direct Service Workers to appropriate training providers (e.g., American Red Cross for

CPR);

iii) refer Direct Service Workers to certification and licensing locations when COMPANY cannot perform any required certifications;

iv) confirm by telephone with Direct Service Workers that training materials have been received and that Direct Service Workers understand the content of such materials;

v) respond to Direct Service Worker questions relating to training.

c) Efforts to contact, deliver, and initiate necessary training to Direct Service Workers shall be completed no later than fifteen (15) days from hire.

d) COMPANY shall provide all training materials to Direct Service Workers and will collect any required certifications in the Eligibility Testing phase.

e) COMPANY shall document and maintain information on certification renewals and shall follow up with Direct Service Workers to ensure renewals are timely obtained. In the event Direct Service Worker certifications lapse, COMPANY shall administer such processes as reasonably requested by Humana and/or required by the State.

8 Employment Oversight and Performance Services

a) COMPANY shall include within the PDO Participant Guidelines information related to Direct Service Worker discipline and provide telephone support to Participants for Direct Service Worker discipline issues through COMPANY'S customer call center. Such support shall include information relating to documentation of performance issues and proper termination procedures.

b) COMPANY shall assist Humana in enforcing CMS regulations relating to fraud, waste and abuse by observing potential indicators of Participants' failure to manage employer responsibilities and communicating evidence of such indicators to Case Managers. Indicators include but are not limited to:

i) extreme utilization patterns, including under use of services or high concentration of utilization over a short period;

ii) statements or actions by Participants or Direct Service Workers that indicate fraudulent activity or violation of program rules.

c) All Participant- and Direct Service Worker-facing materials required for PDO Services shall be in form and content as required by the State and Humana. The State and Humana shall provide or preapprove all documentation used by COMPANY in performance of Services. Members who receive PDO Services shall be called Participants in any PDO specific published materials. All documentation created or used by COMPANY for Services must display an AHCA code number.

d) Materials shall be reviewed and updated by the parties annually, or more frequently if required by the State. All materials shall be available in hard copy format, either hand delivered to the Participant or Direct Service Worker or sent by U.S. Mail, or e-mailed if directed by Participants or Direct Service Workers. Delivery timeframes shall meet all State PDO program requirements. Materials may also be provided at COMPANY's website.

e) COMPANY developed materials, whether paper or electronic, shall be in English and Spanish. Translation services for other languages shall be made available by COMPANY for other

languages at a Participant's or Case Manager's request.

f) In the event COMPANY receives notice of a Direct Service Worker termination (either voluntarily or by Participant), COMPANY shall communicate such information to the Case Manager by telephone, together with a follow up e-mail, within thirty (30) minutes of actual notice, in order for Humana to meet the State's requirement that backup services to the Participant be provided within three (3) hours. After normal business hours, COMPANY shall implement such messaging or automatic routing processes as are required to direct Participants to a live agent.

9. Payroll Services

COMPANY shall complete the following payroll and FEA tasks:

a) COMPANY shall perform all employer payroll processing and payments to Direct Service Workers on behalf of Participants in compliance with all state, federal and local laws, rules and regulations.

b) COMPANY shall obtain an individual Federal Employer Identification Number ("FEIN") used only for purposes of representing Participants as employers.

c) COMPANY shall complete or assist Participants with completion of all forms and documents included in the Enrollment Packet.

d) COMPANY shall distribute the pay schedule to all Participants at least annually.

e) COMPANY shall collect and process timesheets submitted by the Participant and resolve any timesheet issues with the Participant and/or Direct Service Worker.

f) COMPANY shall disburse payroll (no less than twice per month) by direct deposit or pre- paid card to each Direct Service Worker who has a complete and current Hiring Packet on file and has provided PDO Services to a Participant as authorized in the Plan of Care and the Participant/ Direct Service Worker Agreement by the published pay date.

g) COMPANY shall establish payroll withholding accounts as required by law and shall prepare and timely file all payroll and withholding reports due to state, federal and local government agencies.

h) COMPANY shall respond to correspondence and questions from state, federal and local tax authorities in a timely manner and comply with all deadlines and requirements according to regulation and/or instructions included in the correspondence. COMPANY shall receive and respond to correspondence from taxing authorities sent directly to Participants or Case Managers in the same manner.

i) COMPANY shall train Direct Service Workers on proper completion of timesheet service descriptions tied to proper service codes so as to properly evidence reimbursements due from CMS or other government agencies. COMPANY will maintain edits within its timekeeping system to allow only descriptions which match Medicaid CMS codes.

j) COMPANY shall ensure Direct Service Workers are only paid for approved PDO Services actually performed.

k) COMPANY shall ensure that Participants and Direct Service Workers understand that no additional fringe or other benefits, including overtime, will be approved or paid by the State.

l) COMPANY shall process applicable Direct Service Worker garnishments, liens, and levies in accordance with state and federal garnishment rules. Company shall submit payments and reports to applicable agencies per garnishment instructions.

m) COMPANY shall provide Human Relations functions, such as processing requests for Direct Service Worker verification, at a Participants' request.

n) COMPANY shall prepare for and support unemployment claims proceedings on terminated Direct Service Workers.

o) COMPANY shall prepare and timely submit all reports to the Florida Department of Economic Opportunity and other federal and state employment-related reports (e.g., EEOC-1 if applicable).

p) COMPANY shall obtain workers compensation insurance without markup, for a Participant's Direct Service Worker if required by Florida statute or rule (see, e.g., Chapter 440, F.S., and Rule 69L, F.A.C.)and if approved as part of the Plan of Care.

q) COMPANY shall assist with processing workers compensation claims and field inquiries on Participants who have no coverage.

r) COMPANY shall compute, maintain, and appropriately withhold all Participant employer and Direct Service Worker taxes pursuant to federal and state law. All payments that are not in compliance with federal and state tax withholding, reporting, and payment requirements shall be corrected within two (2) business days of identifying an error. COMPANY shall contain a provision in any written agreements with Participant indemnifying and holding Participants harmless from any failure of COMPANY to properly withhold or remit taxes.

s) COMPANY shall respond timely and lawfully to third-party requests for verification of employment status of a Direct Service Worker.

t) COMPANY shall deposit Direct Service Worker aggregate payroll deductions in accordance with federal and state tax deposit requirements. Federal Income Tax, Social Security and Medicare and participant Federal Social Security and Medicare (FICA) taxes in the aggregate shall be deposited in accordance with deposit frequency requirements of a fiscal employer agent. (IRS publication 15-A, located at www.irs.gov/)

u) COMPANY shall deposit Participant's employer aggregate tax deductions in accordance with federal and state tax deposit requirements. Federal Unemployment Tax (FUTA) in the aggregate shall be in accordance with fiscal employer agent deposit frequency. (IRS publication 15-A, located at www.irs.gov/)

v) COMPANY shall refund over-collected FICA for Direct Service Workers who earn less than the Federal FICA threshold for a calendar year. (IRS Publication 15, Circular E).

w) COMPANY shall file a single IRS Form 941, Employer's Quarterly Tax Return in the aggregate on behalf of all Participants. Form 941 is completed using COMPANY's separate FEA, FEIN.

Wages and taxes reported represent total, aggregate wages and taxes for all Participants. Schedule B must be completed in accordance with the rules. Company shall also complete and submit Schedule R with the Form 941. Schedule R disaggregates each Participant's employer wages and federal tax liability.

x) COMPANY shall adjust Form 941 as applicable by completing and filing IRS Form 941- X.
y) COMPANY shall file a single IRS Form 940, Employer's Annual Federal Unemployment Tax Return, in the aggregate on behalf of all Participants. Form 940 is completed using COMPANY's separate FEIN. Wages and FUTA tax reported represent total, aggregate wages and taxes for all Participants.

z) COMPANY shall distribute IRS Forms W-2 to each Direct Service Worker and submit them electronically according to IRS Form W-2 instructions, in accordance with IRS rules and regulations.

aa) COMPANY shall track payroll disbursed to all direct service workers and provide reports as may be required by the Agency or its designee in accordance with this Contract
bb) COMPANY shall comply with, and support Participant compliance with, state workers compensation audits as applicable.

cc) COMPANY shall maintain records in compliance with Fair Labor Standards Act requirements for employers.

10. <u>Direct Service Worker Payment / Claim Processing</u>

a) COMPANY shall maintain books, records, documents, and other evidence of PDO-related expenditures using generally accepted accounting principles (GAAP).

b) COMPANY shall ensure a payroll System with maximum data integrity in which Direct Service Workers are not paid above authorized hours as prescribed in the Plan of Care and the Participant/Direct Service Worker Agreement.

c) COMPANY will use timesheet forms and templates as approved by the State and Humana.

d) COMPANY shall accept timesheets submitted by fax or scanned documents sent by email. COMPANY shall accept timesheets sent through the US mail and will educate Direct Service Workers on delays which may be caused by untimely mailed timesheets.

e) COMPANY shall review all submitted timesheets for:
   i) Mathematical accuracy. Inaccuracies will be rejected for correction and required to be resubmitted; however, COMPANY shall correct timesheets and confirm, telephonically or by other means, such corrections with Participants.
   ii) Proper time period. COMPANY shall not compensate for dates-of-service more than ninety (90) days old unless approved by Humana in writing.
   iii) Overlapping timesheets, i.e., more than one Direct Service Worker with the same service or one Direct Service Worker with multiple entries for the same service on the same day or time. COMPANY will reconcile and reject or pay as appropriate.
   iv) Proper service codes.
   v) Signature by the Direct Service Worker and Participant, including a statement by the Direct Service Worker attesting that the Participant was provided the PDO Services in accordance with the information contained on the timesheet. Timesheets shall be rejected and

signatures obtained for resubmittal. No verbal approvals shall be allowed.

f) COMPANY shall resolve all timesheet discrepancies within the then-current payroll cycle. If the discrepancy cannot be remedied within the current cycle, COMPANY shall timely notify the Direct Service Worker that payment or correction will be in the next payroll cycle. COMPANY may be required by Humana to issue payroll checks off the payroll cycle in certain circumstances set forth herein.

g) COMPANY will timely advise Direct Service Workers of all rejections of timesheets or payment requests in a timely manner and by telephone to the extent practical. COMPANY shall request correction and resubmission.

h) COMPANY shall forward any invoices received in error from non-Direct Service Worker vendors of Participants to the Humana Case Manager within one (1) day of receipt and provide concurrent notification by telephone or e-mail.

i) COMPANY shall make payments to Direct Service Workers [on a bi-weekly basis] by: (i) ACH or (ii) debit card transfers, at Humana's direction.

j) In the event of an overpayment or underpayment to a Direct Service Worker, COMPANY shall make the proper correction consistent within wage and hour standards and concurrently report the error and resolution to Humana if the error is over five hundred dollars ($500.00). COMPANY shall correct the error on the next payment cycle from discovery.

k) In the event COMPANY incorrectly bills Humana (or other party at the request of Humana), COMPANY shall credit (or charge) Humana to correct such error immediately upon discovery, and provide information on the circumstances surrounding such credit or charge. COMPANY shall be responsible, at its own expense, to pursue any third party recovery to which it is entitled.

l) Humana shall have the right to recover from COMPANY all Direct Service Worker payments made in error by COMPANY for a period of five (5) years from the date of payment to the Direct Service Worker. Such right will survive termination of the Agreement between COMPANY and Humana.

m) COMPANY shall comply with all state laws applicable to unclaimed property and escheatment, including reasonable efforts to locate payees and re-issue payments prior to escheatment, filing all required reports and making all required remittances and deposits.

11. <u>Utilization Management</u>

a) Humana shall have primary responsibility for all utilization management ("UM") requirements of the State Contract, including Plan of Care development and authorization of services and benefits.

b) Services are (currently) authorized in Participant Plans of Care in ninety (90) day increments, subject to change by State requirements. COMPANY shall compare PDO Services reported in Direct Service Worker timesheets to those authorized in Participant Plans of Care. COMPANY shall compare Direct Service Worker timesheets to the Participant service authorization in the Plan of Care and will notify Participants when the amount of PDO Services claimed exceeds the amount of services authorized on a prorated (authorization to date) basis. COMPANY will not

compensate Direct Service Workers for PDO Services in excess of the authorized amount or for services that were not authorized without the prior approval of Humana.

c) COMPANY shall provide to Humana such reports relating to PDO Services and hours authorized and paid as required by the State and/or Humana to satisfy State reporting requirements or facilitate Humana's oversight of PDO Services. Such reports shall adhere to format, frequency and timing as mutually agreed by COMPANY and Humana and include, but are not limited to:
   i) Monthly comparison, by Participant, of hours and PDO Services paid to hours and PDO Services authorized
   ii) Written notification to the Case Manager and Participant if utilization is less than 10% of the monthly hours as approved on the authorized Plan of Care for more than one (1) month. Iii) Written notification to Case Managers if hours or PDO Services paid in any payroll period are 25% below, or 10% above, hours and PDO Services authorized.

d) COMPANY and Humana agree that format, frequency and timing of reports may be modified in accordance with policy and procedures for utilization management as agreed by the parties.

12. <u>Participant Disenrollment or Transfer</u>

a) In the event Humana receives formal notification from either the State or the Participant that the Participant has elected to cease receiving PDO Services, Humana will provide notice to COMPANY. COMPANY will confirm the termination date of Participant's participation in PDO Services, as well as Direct Service Worker termination dates, in writing to Case Manager.

b) In connection with the disenrollment in PDO, COMPANY shall perform all duties regarding disenrollment of the Participant from PDO, including final federal and state tax filings and payments and revocation of accounts, numbers, and authorizations previously obtained for closing the Participant records with COMPANY. This includes retiring the FEIN and State Unemployment Tax Account (SUTA) Number. COMPANY shall provide all such documentation to Humana.

c) In the event Case Manager receives a request from Participant to transition to a PDO service provider other than COMPANY ("Alternate PDO"), Case Manager will provide written or verbal notice to COMPANY COMPANY shall thereafter initiate contact with Alternate PDO within three (3) business days. COMPANY shall exchange with Humana and Alternate PDO all necessary information, including complete Participant and Direct Service Worker records. Such exchange wshall be within five (5) days of notification by Humana and in such manner and format as reasonably requested by COMPANY and Alternate PDO. COMPANY shall take such other steps as are necessary to facilitate Participant's transition to Alternate PDO, including coordinating submission of payroll taxes with Alternate PDO, and providing Participant's Alternate PDO or new Plan with Participant's FEIN and SUTA numbers.

13. <u>Customer Service and Service Center Operations</u>

a) COMPANY shall operate a support center (the "Service Center") to respond to Participant, Direct Service Worker and Case Manager inquiries, whether by telephone or written correspondence (email, fax or letter) which shall be staffed (including coverage for vacations and sick days) in such manner as to maintain the service levels as otherwise agreed to by COMPANY and Humana.

b) The Service Center shall maintain a toll-free telephone number dedicated exclusively to the PDO

program.

c) The Service Center shall have hours of operation from Monday through Friday, 8 AM to 7 PM eastern time. The Service Center may be closed on State and national holidays, but shall not be closed on any day which is not recognized as a State holiday.

d) COMPANY will follow all P&Ps for escalation of issues during telephone calls with Participants and Direct Service Workers.

e) COMPANY shall maintain sufficient Spanish-speaking agents to assure that call service levels achieved for Spanish-speaking callers are not less than those required by the standard service level commitments. Other languages shall be supported by a third party interpreting service engaged by COMPANY or as directed by Humana.

f) Subject to the requirements of the Complaint process set forth in the following section, all correspondence received by letter, email, or fax from or regarding Participants or Direct Service Workers shall be logged as received in COMPANY's systems and responded to within three (3) business days.

g) In accordance with the State Contract, AHCA will conduct PDO satisfaction surveys on at least an annual basis and provide results to Humana for use in quality improvement plans. Humana will share with COMPANY the results pertaining to COMPANY. COMPANY shall cooperate with, and participate in, ongoing evaluations and focus groups conducted by AHCA to evaluate the quality of the PDO.

h) In addition to any member satisfaction or CAHPS survey issued by the State or Humana, COMPANY shall develop and mail written satisfaction surveys to each Participant and Case Manager receiving Services during the twelve months prior to the survey date. Such surveys will be performed annually. Survey instruments shall be developed by COMPANY and approved by Humana (and the State where required). Survey results shall be compiled by COMPANY and reported to Humana within sixty (60) days after collection. COMPANY may offer online access to the survey instrument. Written and online surveys shall be ADA compliant (sight and hearing impaired) and shall be available in English. COMPANY will translate written surveys into other languages upon Participant or Case Manager request.

14. <u>Complaints, Grievance & Appeals</u>

a) Humana shall have responsibility for processing Participant Grievances and appeals. Humana shall have responsibility for handling Participant Complaints for denied services.

b) Under the State Contract, a Complaint is any oral or written expression of dissatisfaction by an enrollee submitted to COMPANY and resolved by close of business the following business day. Possible subjects for Complaints include, but are not limited to, the quality of services provided, aspects of interpersonal relationships such as rudeness of COMPANY Personnel, failure to respect the enrollee's rights, administration, claims practices or provision of services that relates to the quality of care rendered pursuant to the State Contract. A Complaint is the lowest level of challenge and provides COMPANY an opportunity to resolve a problem without it becoming a formal Grievance. Except for the

items set forth in section i), above, COMPANY shall handle all other Participant Complaints in accordance with these provisions.

c) COMPANY shall address, log, track and trend all Complaints, regardless of the degree of seriousness or whether the Participant expressly requests filing the concern. The COMPANY log of Complaints shall include date received, complainant and Participant name(s), Medicaid ID number, nature of complaint, whether complaint is EPSDT related, type of complaint, date of disposition, description of resolution and final disposition. COMPANY shall submit the information in this Complaint log with its required monthly reporting and submit the actual log at any time upon the request of Humana or AHCA.

d) COMPANY Personnel shall have all necessary and proper training to effectively support Humana's resolution of Complaints, Grievances and appeals, including training on how to determine when such matters constitute a Participant Complaint, Grievance or appeal to be directed to Humana. COMPANY shall provide Humana with proof of completion of training on the issues upon request.

e) If a Member Complaint is not resolved within 24 hours of receipt, it becomes a Grievance. All Grievances shall be identified in COMPANY's Participant record and notified to the Humana Florida Medicaid Grievance Department for attention within twenty-four (24) hours of receipt at the following numbers, telephone- 1-800-477-6931; fax- 1-800-949-2961 using the form supplied by Humana.

f) COMPANY shall respond to all requests for information by Humana in support of the Complaint, Grievance and Appeal process as follows: within twenty-four (24) hours for standard requests, or as required to address/respond to AHCA Critical Inquiry cases.

g) Humana shall have responsibility for administering Participant medical necessity appeals. COMPANY shall promptly respond to all requests for information by Humana to enable prompt response to such appeals within the timeframes established by the State Contract, e.g. seventy-two (72) hours for expedited appeal requests and seven (7) calendar days for standard appeal requests. These times are subject to change by AHCA on a case by case basis.

h) Reporting Requirements: COMPANY shall provide to Humana the specific monthly reports as noted in the State Contract and required by the Florida Market and COMPANY's Delegation Compliance consultant at Humana. Monthly reports shall be submitted by COMPANY in proper format within eight (8) days following the end of each calendar month.

i) Reporting requirements, including timing, may change based upon revised or new State and federal legislation and NCQA standards requirements during the Agreement term.

j) Critical Incidents: COMPANY shall follow all State and federal laws, rules and regulations, including State Contract requirements with respect to reporting suspected Participant abuse and neglect. COMPANY shall provide to Humana all incident and event details (Critical or Adverse Incident Report) by completing all required fields in the Critical Incident

portal, Riskonnect, within twenty-four (24) hours of the incident or receipt of a report by a third party. Critical Incident details shall be captured in the Critical Incident Portal within twenty-four (24) hours of learning of such events. Reports shall include at a minimum the Participant's identity, description of the incident and outcomes including current status of the Participant. COMPANY shall cooperate fully with Humana Risk Managers to provide information, follow up and participation in resolution to ensure all Critical and Adverse Incidents have been properly resolved and documented.

k) Direct Service Worker Complaints. COMPANY shall respond to all concerns or inquiries from Direct Service Workers, whether telephonic or written, within three (3) business days of receipt. COMPANY shall resolve such concerns or inquiries at the time of initial Direct Service Worker contact. COMPANY will notify the Case manager of Direct Service Worker complaints within twenty-four (24) hours of receipt.

15. Reporting and Data File Exchanges

a) In addition to any reports, files or documents identified in other sections of this Schedule, COMPANY shall provide the following reports, files and documents on the frequency and to the persons or entities identified below. Details of report formats will be mutually agreed by COMPANY and Humana.

b) This report list may change and is at all times subject to the requirements of the State Contract, including PDO monthly report(s) as specified in Section XIV, Reporting Requirements and the Managed Care Plan Report Guide. COMPANY shall provide ad-hoc PDO related information, records, and statistics, as reasonably requested by Humana, plus any information requested by the State, and within any specified timeframes.

Report Title	Delivered To:	Frequency
1. Participant enrollment and disenrollment – report of changes in enrollment	Humana	Monthly
2. Participant report – comparison of authorized services to actual services	Participant	Monthly, by the 21st calendar day of each month
3. Participant report – comparison of authorized services to actual services by Participant	Humana	Monthly, by the 21st calendar day of each month
4. Payroll register – details of payments to Direct Service Workers, by Direct Service Worker	Humana	Bi-weekly, within one (1) business day of payroll
5. 837 Healthcare claims file	Humana	Bi-weekly, within three (3) business days of payroll

6. Participant enrollment roster – report of Participants enrolled in Program on the last day of the month, with attestation	Humana	Monthly, by 10th calendar day of each month

16. Payroll Funding/Reimbursement

a) COMPANY will receive from Humana a monthly Participant election file; COMPANY shall include in its payroll register only costs for services of Participants that appear on the Participant election file.

b) COMPANY shall submit its bi-weekly payroll register, in the form of a HIPAA 837- compliant claims file, to Humana for reimbursement.

c) Additional requirements of the payroll funding process may be required based on System processes.

17. General Requirements of COMPANY as FEA and Supports Provider

a) Humana shall provide enrollees any required notices of the State Contract informing them that Humana is utilizing a subcontractor to perform FEA duties.

b) COMPANY shall meet all applicable PDO-related federal and State requirements and shall be operated in accordance with Section 3504 of the Internal Revenue Code, per Revenue Procedure 70-6 and Section 3504 Agent Employment Tax Liability proposed regulations (REG-137036-08) issued by the IRS on January 13, 2010.

c) COMPANY remain informed of all federal and state FEA requirements and tax forms, and shall ensure all materials distributed to Participants, Representatives, Direct Service Workers (and Case Managers as applicable) are current, and in accordance with the appropriate federal and state regulations.

d) COMPANY shall have a separate Federal Employer Identification Number ("FEIN") that is used only for purposes of representing Participants as employers. This FEIN must not be used to file or pay taxes for COMPANY's staff.

e) COMPANY shall provide to Humana a copy of its Fiscal Intermediary Service Organization license required under 641.316 F.S. or Insurance Administrator license required under 626, Part VII F.S.. COMPANY shall alternately provide acceptable evidence that it is not required to maintain such licenses to operate in the State.

18. Performance Standards

a) CMS and the State have defined specific requirements for performance and established liquidated damages, penalties and sanctions for failure of Humana to comply with such requirements including but not limited to those described in the State Contract. COMPANY shall be responsible to pay Humana for incurred liquidated damages, penalties or sanctions

which have been levied by CMS or the State against Humana when the actions or inactions of COMPANY are the proximate cause.

b) In addition to responsibility for State or CMS penalties in Section A, above, COMPANY shall implement procedures and tools needed to measure its performance under the Performance Standards set forth below. The parties will also implement tracking and measurement reports for each of the performance standards ("Tracking Reports"). COMPANY shall provide the Tracking Reports of all metrics on the fifteenth (15th) day of the month following the reporting period, for example, on November 15 for performance during the month of October. In the event the 15th falls on a weekend, or on a Humana or COMPANY holiday, the Tracking Reports will be provided by close of business the next business day. The formats of all Tracking Reports will be in accordance with the descriptions set forth in the Performance Standards below, and as mutually agreed by the parties. The reporting and related deadlines are not intended to supersede any State-required reports or their related deadlines described in the Delegation Addendum. Humana shall have the right at all times to analyze and audit COMPANY's calculations.

c) Upon receipt of the Tracking Reports and calculations, Humana shall have ten (10) calendar days to accept or propose adjustments to COMPANY reporting and calculations. If Humana proposes adjustments to COMPANY reporting or calculations, COMPANY shall have five (5) calendar days following receipt of Humana's response to accept or reject Humana's adjustments. Following acceptance by Humana of the final calculation, COMPANY shall remit, or allow Humana to deduct from amounts owed to COMPANY, funds equal to the final calculation within five (5) business days.

d) There will be a one half percent (0.5%) reduction of the COMPANY payment during each month for each Performance Standard not met.

e) In the event of COMPANY's failure to achieve a service level described herein, Humana shall have the right to request COMPANY to: (a) provide Humana with a report detailing the cause of, and procedure for correcting, such failure within ten (10) business days of request; as well as reasonable evidence that such failure will not reoccur. This shall be in addition to any and all other rights, remedies, credits and damages to which, in a particular instance, Humana shall be entitled. Reoccurrence of the same failure in consecutive months shall constitute a default under the Agreement.

#	Section of AHCA or Humana Contract	Metric	Definition	Performance Standards	Measurement Period
1	IV.B.2.h(1)	Telephone Response Time	The average speed of answer (ASA) shall not exceed thirty (30) seconds.	Ninety five (95%) percent of Participant and Direct Service Worker calls not to exceed ASA of 30 seconds	Monthly

2	IV.B.2.h(2)	Call Blockage Rate	The call blockage rate for direct calls shall not exceed one half of one percent (0.5%)	Ninety five (95%) percent of telephone calls shall not exceed 0.5%	Monthly
3	IV.B.2.h(3)	Abandoned Call Rate	The average call abandonment rate for direct calls shall not exceed three percent (3%). A system, which places calls in queue may be used but the wait time in the queue shall not exceed sixty (60) seconds	Abandoned calls shall not exceed three (3%) percent.	Monthly
4	Humana SOW	Referral Packet Delivery	Ensure that Participant has received Referral Packet within five (5) business days of COMPANY obtaining the signed consent form.	Deliver Referral packets within five (5) business days ninety eight (98%) percent of the time	Monthly
5	Humana SOW	Employee Candidate Eligibility Testing	Confirm that potential Direct Service Worker has completed all required screening (including 10 panel drug screening and fingerprinting) not later than two (2) weeks following receipt of candidate-completed forms.	Confirm screening completion within two (2) weeks ninety five (95%) percent of the time	Monthly
6	Humana SOW	Participant / Employee Orientation Meeting	Coordinate Orientation Meeting with all required attendees within five (5) business days of potential employee passing eligibility testing.	Coordinate meeting within five (5) business days ninety five (95%) percent of the time	Monthly
7	V.A.6.b.1	Direct Service Worker Training	Direct Service Workers will receive all initial training no later than fifteen (15) days from hire.	Complete Direct Service Worker training within fifteen (15) days from hire ninety five (95%) percent of the time	Monthly

8	Humana SOW	Backup Services Notice	Report Direct Service Worker termination notices received by telephone, and follow up e-mail within thirty (30) minutes of actual notice in order for Humana to provide timely backup services	Report terminations to Humana within thirty (30) minutes of actual notice ninety nine (99%) percent of the time	Monthly
9	Humana SOW	PDO Transition	Provide complete Participant and employee records to Humana and Alternate PDO within five (5) calendar days of transfer notification	Provide necessary information within five (5) calendar days of notice ninety eight (98%) percent of the time	Monthly
10	V.A.6.a.8	Participant Budget Report	GT shall provide Humana with the Participant Budget report (comparison of authorized services to actual services, and comp. of authorized services to actual services by Participant) monthly by the twenty-first (21st) calendar day of each month.	Deliver report by the twenty-first (21st) calendar day of each month.	Monthly
11	XI.C.8.b	Eligibility Database Update	GT shall update its eligibility/enrollment databases within twenty-four (24) hours after receipt of said files.	Update database ninety-nine (99%) of time within twenty four (24) hours of receipt of file(s).	Monthly
12	Humana SOW	Participant Grievances	For Participant contacts unable to be resolved in 24 hours, log as a grievance and transmit to Humana within the same 24 hours of receipt	Grievances transmitted timely 99% of the time	Monthly
13	Humana Operating Consistency Requirement	Reporting – Timeliness and Accuracy – State Required Reports	Provide a complete and accurate report to Humana on its due date as stated in Delegation and Statement of Work documents	Timely delivery of complete and accurate report 100% of the time	Per occurrence

14	XI.D.4.a	System Issue Notification	Within one (1) hour of discovery, notify Humana of any problem that may or is jeopardizing the availability and performance of System functions and the availability of information, including any problems affecting scheduled exchanges	Notify Humana within one (1) hour of discovery one hundred (100%) percent of the time	Per Occurrence
15	XI.D.5	System Issue Resolution	Unscheduled System unavailability caused by the failure of systems and telecommunications resolved and the services restored within forty-eight (48) hours of declaration of System unavailability.	Resolve issue within forty eight (48) hours of declaration one hundred (100%) percent of the time	Per Occurrence
16	Humana SOW	COMPANY Participant Survey - Satisfaction	Number of Participants that "strongly agree" or "agree" with survey question, "Overall, the services that I am receiving from COMPANY are better than I expected."	95.0% of total respondents "strongly agree" or "agree"	Annually
17	Humana SOW	COMPANY Case Manager Survey - Satisfaction	Number of Humana Case Managers that "strongly agree" or "agree" with survey question, "Overall, the services that I am receiving from COMPANY are better than I expected."	95.0% of total respondents "strongly agree" or "agree"	Annually

Appendix 1

PDO Provider Qualifications of the State Contract

Long-term Care Plan Benefit	Qualified Service Provider Types	Minimum Provider Qualifications
Adult Companion	Individual	None *
Attendant Nursing Care	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Homemaker	Individual	None *
Intermittent/ Skilled Nursing	Registered Nurse (RN), Licensed Practical Nurse (LPN)	Licensed per Chapter 464, F. S.*
Personal Care	Individual	None*

*Individuals of the Participant's choosing may provide PDO Services so long as they meet the minimum provider qualifications as above and are age eighteen (18) years and older. PDO providers are also required to sign a Participant/Direct Service Worker Agreement and obtain a satisfactory Level II background screening.

EXHIBIT C
REQUEST FOR PROPOSAL QUESTIONNAIRE

1. Please provide a proposal for services required as set forth in Exhibit B.

2. Please propose pricing for FL Medicaid LTC members participating in the PDO service program:
   Note: Pricing is to be fixed for the term of the resulting contract.
   a. Administrative Fees as a Per Member Per Month Fee, Tiered by Participant Count:
      - 1-300
      - 301-600
      - 601-900
      - 901-1200
      - 1201-1500
      - 1501-1800
      - 1801-2100
      - 2101-above

   b. Background Check and Drug Screens

EXHIBIT D
LIST OF REQUIRED DOCUMENTS

1. Top-level organizational chart with a list of all your management personnel
2. Copies of all most recent state, federal, and local government agency performance evaluations
3. Current financial statement with:
    a. Income statement
    b. Balance Sheet
    c. Statement of Cash Flows
    d. State of Retained Earnings and Notes to Financial Statements
    e. Two most previous fiscal years ended audited financial reports. If you are a publicly held multi-divisional organization, provide your divisional statements as well.
4. Member satisfaction survey results for the past two years
5. Provider satisfaction survey results for the past two years
6. Sample management reports, inclusive of utilization reports

Document sterilized to provide example form

Information Technology Strategy & Operations
Strategy, Best Practices & Standards

Financial Due Diligence Summary

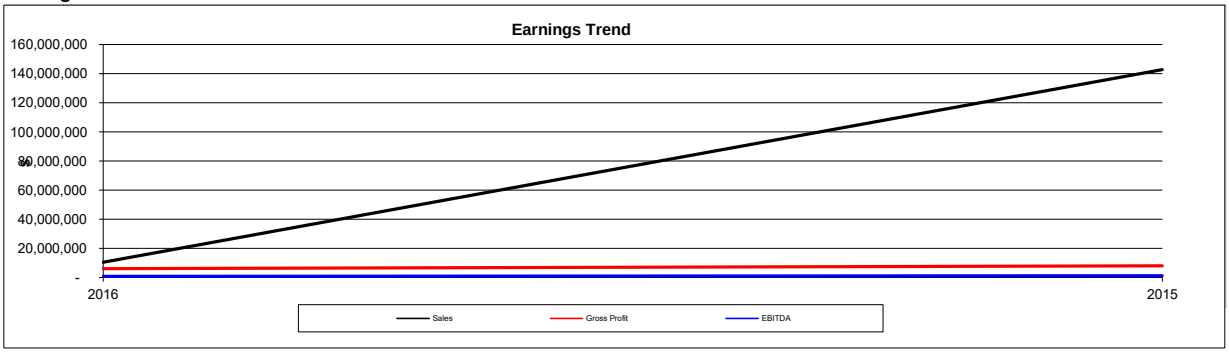
(For Private Company)

Rating: 12 (See Table Below)

Overview	Date
	Completed by:

Company Name:		
Address		
BIN:		
Parent Company:		
Were 1+ years of reports provided?		
Was a letter from Auditor attached?		
Comments:		
Line of Business:		
Year Started:		
No of Employees:		
Major Clients:		
Major Competitors:		

Ratings



Financial Info in: Thousands

Financial Statements	FYE2016	FY2015		
Comments:				
Annual Gross Revenue:	PRIVATE COMPANY			
Net Income (Loss)				
Cash on Hand:				
Long-term Debt:				
R&D Expenditures:				
Financial Ratios:				

Current Ratio:	2.05	
Monthly Burn Rate:	N/A	How many years current cash on hand can support Net Loss.

	2016	2015
Cash Flow Schedule (000's):		

Overall Rating:	12			
Explanation:	Altman Z-Score:	14.39	Altman Z-Score Rating	Survival
Low Risk (13-15)	Current Ratio:	2.05	Current Ratio Rating	CAUTION
Mod-Low Risk (10-12)	Cash Burn Rate:	N/A	Cash Burn Rate Rating	Good
Moderate Risk (7-9)	Gross Profit Margin:	6%	GPM Rating	Not Increasing
High-Mod Risk (4-6)	Revenue Growth:	1263%	Revenue Growth Rating	Increasing
High Risk (1-3)	Days Sales Outstanding	11.90	DSO Rating	Good
	Mo Cash Burn Rate	N/A	Mo Cash Burn Rate	Good
			EBITDA Trend	Good

Source:

Related Articles/Websites:

Disclaimer: The rating assigned to the vendor is the opinion of IT Finance based on available financial and company specific information. The rating is not designed to determine whether or not Humana should enter into a relationship with the vendor. Instead, it is intended to assess the risk associated with the financial position of the vendor in question.

***This report contains CONFIDENTIAL information regarding the named company. This information is for Humana use only.**

Green = Low Risk Yellow = Moderate Risk Red = High Risk

Attachment 26-5: Request for Delegation

REQUEST FOR DELEGATION (RFD)

Review the Delegation Tool Box to determine if entity needs to go to CAC before submitting RFD

Please indicate if this is a new delegate ___ or a change to a current delegation___ or Repapering only___

Entity Information Provide the correct and full legal entity name and DBA as this information is used to verify that the potential delegate is eligible to participate in the Medicare and/or Medicaid product:	
Entity Name:	DBA:
Mailing Address: City: State: Zip:	
Tax ID:	
Entity Contact Name: **Check here if the contact name is the same for all functions: ____** If no, please include contact name under each function below.	Date contact can be made:
Email Address:	Phone Number:
Entity Compliance Officer Contact Name:	Title:
Email Address:	Phone Number:

Delegation Requested for the Following Lines of Business:
NOTE: If delegating multiple functions and lines of business vary by function, please indicate the appropriate line of business for each function.

__Commercial: __All __HMO __ PPO __ Humana One __ POS __ EPO __ Exchange

__Medicare: __All __HMO __ PPO __ POS __ FFS

__Medicaid: __All __Medical __ LTSS __ Dual List applicable State(s):

Requested Delegated Functions:

__Credentialing:

__Provider Delegation __Facility Delegation

Sub-delegation: __Yes __ No Sub-Delegate/MSO Name:

Entity Contact Name: Telephone: Email:

Contract Approval Committee (CAC) Date Approved:
Please obtain the financial guarantee and send a copy to delegationcompliance@humana.com

__Claims: __Part A/inpatient __ Part B/outpatient Sub-delegation: __Yes __ No __ Part A __ Part B

Sub-Delegate/ MSO Name:

What types of claims will be processed?

__Fully capitated __ Paid claims __ Denied claims

Entity Contact Name: Telephone: Email:

CLINICAL HEALTH SERVICES:

__Utilization Management: __Part A/inpatient __ Part B/outpatient

Sub-delegation : __Yes __ No __ Part A __ Part B Sub-Delegate/ MSO Name:

Entity Contact Name: Telephone: Email:

__Disease Management:

List programs Entity will provide:

Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name:

Entity Contact Name: Telephone: Email:

__Complex Case Management

Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name:

Entity Contact Name: Telephone: Email:

__Patient Centered Medical Home- PCMH

Is the Provider accredited by NCQA? __Yes __ No

__Network Management Services

Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name:

Entity Contact Name: Telephone: Email:

__Special Needs Plan-Model of Care:

__ Dual Eligible __ Chronic __ Institution

Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name:

Entity Contact Name: Telephone: Email:

__Other (Additional delegated functions not listed above. Please provide description below.)

Delegated Function:

Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name:

Entity Contact Name: Telephone: Email:

Functions specific to Behavioral Health (BH) Delegation:

Contract Approval Committee (CAC): Date Approved:
Please obtain the financial guarantee and send a copy to delegationcompliance@humana.com

__Claims: __Part A __ Part B Sub-delegation : __Yes __ Part A __ Part B __ No

Sub-Delegate/ MSO Name:

What types of claims will be processed?

__Fully capitated __ Paid claims __ Denied claims

Entity Contact Name: Telephone: Email:

__Utilization Management: __Part A __ Part B

Sub-delegation : __Yes __ Part A __ Part B __ No Sub-Delegate/ MSO Name:

Humana

LBPC Delegation & Vendor Compliance

Delegate Contact Name: Telephone: Email:
__Credentialing: __Provider Delegation __Facility Delegation Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name: Delegate Contact Name: Telephone: Email:
__Quality Improvement: Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name: Delegate Contact Name: Telephone: Email:
__Network Management Services Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name: Delegate Contact Name: Telephone: Email:
__Other (Additional delegated functions not listed above. Please provide description below.) Delegated Function: Sub-delegation: __Yes __ No Sub-Delegate/ MSO Name: Delegate Contact Name: Telephone: Email:

Documents required prior to the execution of the Delegation Services Addendum and Attachments

Obtain the participating provider downstream contract template from delegate and send to: **dscontracts@humana.com**

If Entity is subdelegating a function other than Credentialing, a copy of the executed Business Associate Agreement and executed agreement between the Delegate and Subdelegate needs to be sent to **delegationcompliance@humana.com**

Send executed participation agreement (base) to **delegationcompliance@humana.com**

Offshore Contracting: If RFD is for Credentialing Delegation only you may skip this section.	
Will the Delegate utilize or subcontract with an off shore vendor (vendor located outside of the United States or United States territory) to meet contractual obligations to Humana?	**Type in yes or no**
If yes, what is the name of the offshore vendor?	

If the answer to above is "Yes", the delegate is to complete the required First Tier, Downstream and Related Entities (FDR) Offshore Contracting Information and Attestation Form. Use the following link to download the form http://go/offshore. The form includes instructions for the delegate. If the answer above is "No," then no further action is required.

Humana Information:	
	Submission Date:

Humana

LBPC Delegation & Vendor Compliance

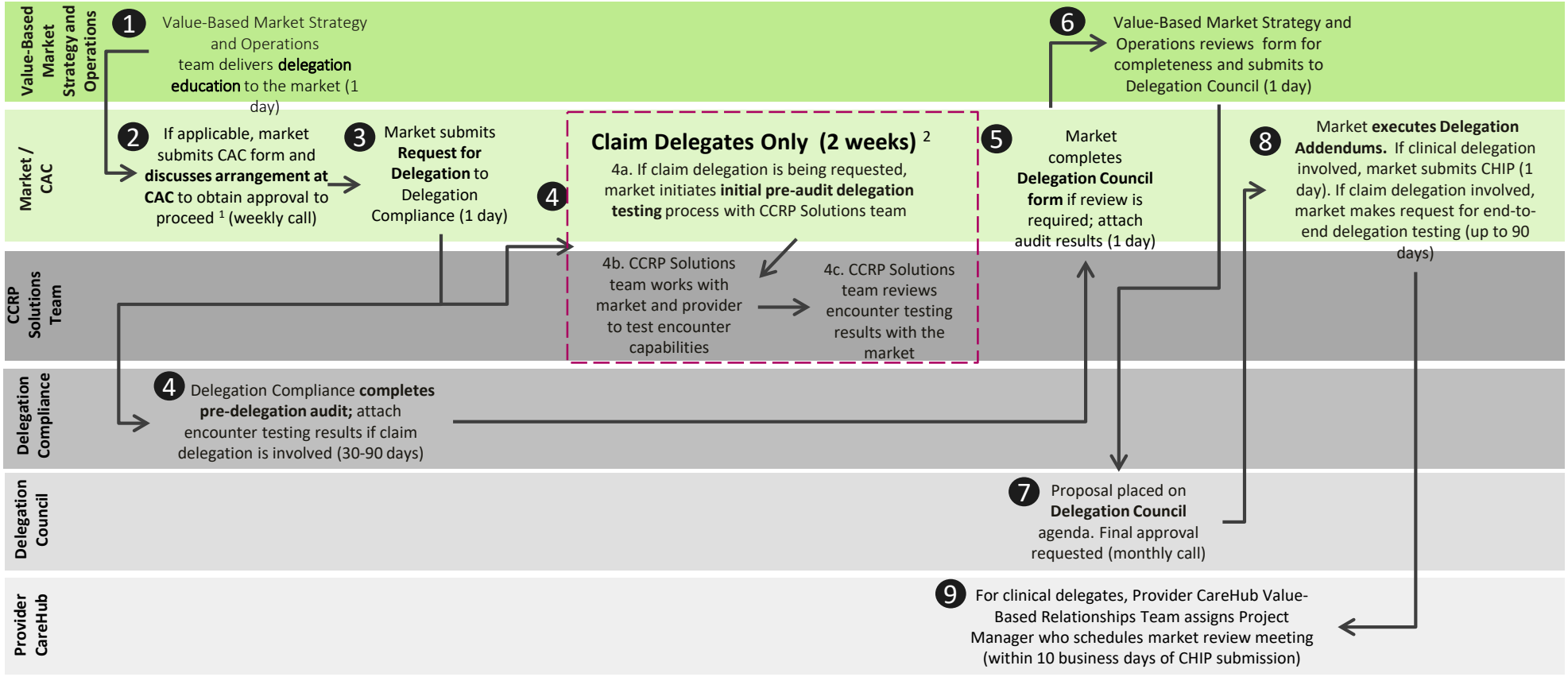
Humana Contractor Name:		
Market: **Please specify each market that will be involved!**	Plan ID/Contract Number:	**Delegation Target Effective Date:**
Network Relations Director:		

Submit completed form to Humana Delegation Compliance via email: delegationcompliance@humana.com

To be completed by Delegation Compliance:	
Delegate Federal/State Exclusion Screening:	
Delegate Name on Exclusion Listings: __Yes __ No ___N/A Entity an established Delegate **Subdelegate Federal/State Exclusion Screening:__** N/A Sub delegate Name on Exclusion Listings: __Yes __ No	
Completed By:	Date:

Overall Delegation Approval Process

This graphic outlines the overall delegation approval process.



1) Please refer to CAC process to determine if contract needs to be presented to CAC. The base contract may be executed after CAC approval; delegation contingent on successful completion of the pre-delegation audit and approval process. 2) This step is not required for CarePlus

Delegation Policy

Humana

Humana Policy and Standards

Creation Date:	September, 1996	**Accountable Dept:**	10906- Licensure and Business Partner Compliance
Publication Date:	July 18, 2016	**Business Domain:**	02 Governance and Compliance
Last Review ed:	July 18, 2016	**Business Area:**	13.05 Delegation

Scope:

This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Statement:

This policy describes the oversight process for any activity or function for the Medicare, Medicaid, Marketplace Exchanges (FFM, SBM, SHOP, SPM), commercial and specialty lines of business that have been delegated by Humana to another entity. Humana remains responsible for the performance and compliance of any function that is delegated. Functions that may be delegated include, but are not limited to:

- Claims Processing
- Claims Repricing
- Credentialing
- Clinical Health Services for medical and behavioral health
  - Utilization Management (UM)
  - Complex Case Management (CCM)
  - Disease Management (DM)
  - Quality Improvement (QI)
- Special Needs Plan (SNP)

The following standards are part of this Delegation Policy:

- Pre-Delegation Audit
- Annual Delegation Audit
- Corrective Action Plan
- Delegation Services Addendum and Delegation Attachments
- Provisions for Protected Health Information (PHI)
- Sub-Delegation
- Termination of Delegation
- Additional Delegated Functions

Definitions:

Additional Delegated Functions- Any additional activity or function that has been delegated by Humana.

Annual Delegation Audit- Method to evaluate an entity's contractual, regulatory and accreditation organization compliance and performance capacity annually.

Claims Processing- The process to receive, investigate and an act on a claim filed by a provider or an insured. It involves multiple administration and customer service layers that include review, investigation, adjustment, and remittance of payment or denial of a claim. Delegation of claims processing is whereby Humana delegates all of these processes to another entity.

Complex Case Management- Coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Concurrent- A review for an extension of a previously approved, ongoing course of treatment or number of treatments.

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Corrective Action Plan- Issued to a delegated entity when they fail to meet established thresholds of compliance.

Credentialing- The process of obtaining and reviewing the documentation provided by the applicant and/or obtained during the process for the purpose of determining participation privilege status in the health plan.

Delegated Entity- An entity contracted to perform a function on behalf of Humana.

Delegation- A formal process whereby a health plan gives a qualified contracted provider group the authority to perform certain business functions on its behalf.

Delegation Attachment- A legal document that covers the specific performance requirements based on the function being delegated.

Delegation Council- A cross-functional group to review and vet proposals that involve clinical or claim delegation

Delegation Services Addendum- An additional document not included in the main part of the contract. It contains additional terms, obligations and information regarding the delegation of specific functions to an entity.

Disease Management- A multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions.

Pre-Delegation Audit- Method to evaluate an entity's compliance and performance capacity prior to the execution of a delegation contract.

Pre-service Review- A service that an organization must approve, in whole or in part, in advance of a member obtaining medical care or services.

Post Service- Assessing appropriateness of medical services on a case-by-case or aggregate basis after services was provided.

Sub-Delegation- An entity contracted with a delegated entity to perform a function on behalf of the delegate.

Utilization Management- A formal evaluation (pre-service, concurrent, or post service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.

Acronyms:

BAA- Business Associate Agreement

CAC- Contract Approval Committee

CAP- Corrective Action Plan

FFM- Federally-Facilitated Marketplace

HIPAA- Health Insurance Portability and Accountability Act

HITECH- Health Information Technology for Economic and Clinical Health Act

SBM- State-Based Marketplace

SHOP- Small Business Health Options Program

SNP- Special Needs Plan

SPM- State Partnership Marketplace (partnership of state and federal agencies)

Related Documents: N/A

Standard: Pre-Delegation Audit

Purpose: To evaluate the entity's capability to perform the requested delegated functions on behalf of Humana in a contractually compliant manner.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been recommended for delegation by a Humana contractor to perform an activity or function on Humana's behalf.

Requirement: The Delegation Compliance department will perform a pre-delegation audit prior to any function being delegated to a prospective entity upon receipt of the Request for Delegation form and the Predelegation Questionnaire (claims delegation only). The pre-delegation audit will include evaluation of a prospective delegate's compliance and performance capacity which will include a review and approval of the following applicable items of the prospective delegate:

- Delegation Council review of proposed clinical health services and claims delegation
- Contract Approval Committee (CAC) approval for claims delegation
- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Audit of contracted sub-delegate's program including policies, procedures and program documents
- Letters of accreditation
- Financial solvency
- File audit
- Federal/state exclusion screenings
- Offshore contracting

If a delegate requests a change of a subcontractor at any point, Humana's Delegation Compliance department will review and approve the subcontractor's policies, procedures and program documents, either directly or by review and approval of the delegate's audit of the proposed sub-delegate. These reviews will be conducted prior to contracting and require the subcontractor to comply with all Humana, federal, state and accreditation requirements.

Results of the pre-delegation audit are recorded on a standardized audit tool and then scored to determine the prospective delegate's ability to meet compliance requirements. Approval or rejection of the prospective delegate's pre-delegation audit will be based on the following compliance thresholds:

- Prospective delegates with a pre-delegation audit score of less than 70% must be referred to the appropriate committee, market leadership, compliance leadership, or business owner for additional evaluation and final determination on the entity's ability to meet Humana requirements to assume a delegated function.

- Prospective delegates with a pre-delegation audit score of 70%- 94% or those missing critical elements may only be approved if a Corrective Action Plan (CAP) is implemented. Refer to the Corrective Action Plan standard.

- Prospective delegates with pre-delegation audit score of 95% or higher may be approved without requiring a CAP, although potential opportunities for improvement should be documented and communicated to the delegate

Definitions: N/A

Related Documents: N/A

Standard: Annual Delegation Audit

Purpose: To review annually the functions of a delegated entity against contractual, state, federal and accreditation organization standards and requirements to ensure compliance.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to

perform an activity or function on its behalf.

Requirement: The Delegation Compliance department will perform an annual delegation audit to evaluate a delegate's continued ability to meet delegation compliance requirements, which will include a review and approval of the following applicable items of the delegate:

- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Audit of contracted sub-delegate's program including policies, procedures and program documents
- Letters of accreditation
- Financial solvency
- File audit
- Confirming no offshore contracting

If a delegate requests a change of a subcontractor at any point, Humana's Delegation Compliance department will review and approve the subcontractor's policies, procedures and program documents, either directly or by review and approval of the delegate's audit of the proposed sub-delegate. These reviews will be conducted prior to contracting and require the subcontractor to comply with all Humana, federal, state and accreditation requirements.

Results of the annual audit are recorded on a standardized audit tool and then scored to determine the delegate's ability to meet compliance requirements. Approval or rejection of the delegates annual delegation audit scores will be based on the following compliance thresholds:

- Delegates with annual delegation audit scores of 70% or less must be referred to the appropriate committee, market leadership, compliance leadership or business owner for additional evaluation and final determination on appropriate and necessary next steps which may include; additional corrective measures, cancellation of a particular delegated function by termination of a delegation attachment, or termination of the delegation services addendum.

- Delegates with annual delegation audit scores of 70%-94% may only be approved if a Corrective Action Plan (CAP) is implemented. Refer to Corrective Action Plan standard.

- Delegates with annual delegation audit scores of 95% or higher may be approved without requiring a CAP, although potential opportunities for improvement should be documented and communicated to the delegate.

Definitions: N/A

Related Documents: N/A

Standard: Corrective Action Plan

Purpose: To formally identify and document any contractual, regulatory or accreditation organization performance requirements or other issues, provide an explanation of how the delegate is determined to be non-compliant and provide a plan of action to bring the delegate into compliance.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: The Delegation Compliance department will issue a Corrective Action Plan (CAP) when the delegate fails to meet established compliance thresholds, contractual requirements, or other requirements. Specific deficiencies resulting in a CAP include, but are not limited to:

- Failure to achieve an overall audit score of 95%, or
- Failure to achieve a single-item score of equal to or greater than 70%, or
- Failure to meet compliance thresholds for critical elements as specified on standardized audit tool, during a pre-delegation, annual delegation audit, or contractual review.

A CAP should contain:

1. The identified issues and deficiencies
2. The corrective actions required, and
3. The timeframes for performance of the corrective actions and achieved results.

The delegate's performance under the CAP will be monitored by Delegation Compliance. Monitoring frequency is dependent upon the potential risks identified, and will occur until the delegate has achieved the required results.

If a delegate fails to achieve the required results within the timeframe provided, the delegate's results will be referred to the appropriate committee, market leadership, compliance leadership or business owner for additional evaluation and a final determination on appropriate and necessary next steps, which may include; additional corrective measures, cancellation of a particular delegated function by termination of a delegation attachment, or termination of the delegation services addendum.

Definitions: N/A

Related Documents: N/A

Standard: Delegation Services Addendum and Delegation Attachments

Purpose: To establish a legally enforceable contractual arrangement between Humana and an entity that outlines the legal obligations mutually agreed upon between the parties to the agreement.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: Upon approval of delegation pursuant to the pre-delegation audit standard, Humana and delegate must execute Humana's Delegation Services Addendum and Delegation Attachment for each delegated function. The written Delegation Services Addendum and Delegation Attachment(s) must:

- Be mutually agreed upon.
- Describe the activities and the responsibilities of Humana and the delegated entity.
- Requires at least semiannual reporting by the delegated entity to Humana.
- Describe the process by which Humana evaluates the delegated entity's performance.
- Describe the remedies available to Humana if the delegated entity does not fulfill its obligations, including revocation of the Delegation Attachments.
- Retain for Humana the right to approve, suspend and terminate any delegated or sub-delegated function, including but not limited to the termination of individual practitioners, providers and provider sites where credentialing decision making is delegated.
- Retain for Humana pre-approval rights for any proposed sub-delegation.
- Contractually require that delegate shall provide sufficient oversight of the subcontractor to ensure that the subcontractor shall comply with all of the terms and conditions of the Delegation Services Addendum and attachments, or allow Humana to perform direct oversight of sub-delegate..
- Require delegate to comply with Humana, state and federal law and accreditation organization requirements.
- For Qualified Health Plans (QHP): Delegate must comply with 45 CFR 156.340 and permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of 45 CFR 156.340 until 10 years from the final date of the agreement period.

The Delegation Compliance department will maintain the Delegation Services Addendum with applicable Delegation Attachment(s).

Definitions: N/A

Related Documents: 45 CFR 156.340

Standard: Provisions for Protected Health Information (PHI)

Purpose: To protect the confidentiality, integrity, and availability of electronic PHI when it is stored, maintained, or transmitted.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: If a delegation arrangement involves the use of protected health information (PHI), Humana and delegate must execute Humana's Business Associate Agreement (BAA). The BAA should be mutually agreed upon and describe the following information:

- A list of allowed uses of PHI.
- A description of delegate safeguards to protect the information from inappropriate use or further disclosure.
- A stipulation that the delegate will ensure that sub-delegates have similar safeguards.
- A stipulation that the delegate will provide individuals with access to their PHI.
- A stipulation that the delegate will inform the organization if inappropriate uses of the information occur.
- A stipulation that the delegate will ensure that PHI is returned destroyed or protected if the delegation agreement ends.
- All other requirements under HIPAA/HITECH Act statutes and regulations.

The Business Associate Agreement (BAA) should be maintained by the Humana's Privacy Office and a copy of the BAA to the Delegation Compliance department.

Definitions: N/A

Related Documents: N/A

Standard: Sub-Delegation

Purpose: To establish requirements if a delegate choses to sub-delegate any activities that are currently delegated to them by Humana.

Scope: This standard governs the sub-delegation by any delegate of a delegated function

Requirement: The delegate will request Humana's approval to sub-delegate any portion of the delegated functions or activities. The delegate will demonstrate to Humana a plan for adequate oversight of the sub-delegate or request oversight by the Delegation Compliance department prior to approval of the sub-delegate.

If Humana approves the sub-delegation, the delegate will provide Humana documentation of a written sub-delegation agreement (and, as applicable, a Business Associate Agreement) that:

- Is mutually agreed upon.
- Describes the activities and the responsibilities of the delegate and the sub-delegated entity.
- Requires at least semiannual reporting of the sub-delegated entity to the delegate.
- Describes the process by which the delegate evaluates the sub-delegated entity's performance.
- Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement.
- Allows Delegation Compliance access to all records and documentation pertaining to monitoring and oversight of the sub-delegates delegated activities.

If it retains oversight responsibilities, the delegate will provide:

- Evidence of annual oversight of sub-delegated entity.

Definitions: N/A

Related Documents: N/A

Standard: Termination of Delegation

Purpose: To mitigate any risks the delegate may impose on Humana due to failure to comply with regulatory, contractual and other compliance requirements.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: A delegate's failure to perform or comply with the terms of the Delegation Services Addendum and attachments will result in Delegation Compliance referring the delegate's noncompliance or unacceptable performance status to the appropriate committee, market leadership, compliance leadership, or business owner recommending termination of delegation. Specific deficiencies that may lead to termination include:

- Failure to comply with state and federal laws, rules and regulations.
- Failure to comply with Humana or accreditation organization standards.
- Failure to cooperate with Humana's delegation audit process.
- Failure to comply with any term of the Delegation Services Addendum or delegation attachment(s).
- Failure to comply with the terms of any implemented Corrective Action Plan.
- Failure to submit accurate and timely delegation reports, as specified in the Delegation Services Addendum and attachments.
- Placement on any federal/state government programs exclusion lists.

Either the termination of the Delegation Services Addendum and/or a rescission of the delegated function/service should be initiated.

Definitions: N/A

Related Documents: N/A

Standard: Additional Delegated Functions

Purpose: To identify functions that could be delegated to an entity that would be out of scope for the Delegation Compliance department to oversee and/or monitor.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: The following additional activities or functions may be delegated by operational areas within Humana when the operational area assumes responsibility for oversight of that function or activity:

- Network Management
  - Provider access and availability
  - Provider contracting

Oversight of these additional activities or functions should meet the requirements of Humana's Delegation Policy and all standards therein.

Definitions: N/A

Related Documents: N/A

Owner:	Devin Prather	**Executive Team Member:**	Greg Catron
Accountable VP / Director:	Marla Sanders		

Disclaimer:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by a particular issue, to allow for consistency, Humana will follow the most stringent requirement.
This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/standard) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/standard) supersedes all other policies, standards, guidelines, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source to ensure no modifications have been made.

Non-Compliance:

Failure to comply with any part of Humana's policies, standards, guidelines, and procedures may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over any and all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Policy Source site of Humana's secure intranet (Humana Self-Service).

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DELEGATION SERVICES ADDENDUM

This **Delegation Services Addendum (Addendum)** is made part of and incorporated into the **<Insert Type>** Participation Agreement entered into between **<Insert Name of the Humana or ChoiceCare entity>** (**Delegator**), and **<Insert Name>** (**Delegate**) which was effective **<Insert Effective date of Base Agreement>** (Agreement). This Addendum is intended to supplement the terms and conditions of the Agreement and to the extent that this Addendum conflicts with the terms and conditions of the Agreement, including any prior amendments, addenda, exhibits, or attachments, this Addendum controls the relationship between the parties.

The following Attachments are included with this Addendum and incorporated by reference herein:

CONTRACTOR NOTE: Include only those Attachments that are appropriate for the Provider entity you are Delegating services to and delete the inapplicable Attachments **– REMOVE THIS TEXT BEFORE SENDING TO DELEGATE**.

A. Delegation of Credentialing Services Attachment
B. Delegation of Utilization Review and Utilization Management Services Attachment
C. Delegation of Complex Case Management Attachment
D. Delegation of Disease Management Attachment
E. Delegation of Quality Improvement Services for Behavioral Health Services Attachment
F. Delegation of Claims Processing Attachment
G. FDR Compliance Program Requirements Attachment
H. Process Integration Attachment
I. IT Security Agreement Attachment
J. Business Associate Agreement Attachment

ARTICLE I
DEFINITIONS

Any capitalized term in this Addendum or any of its Attachments not defined herein shall have the same meaning as set forth in the Agreement.

1.1 **Accreditation Organization** means any nationally recognized organization that accredits managed care organizations including without limitation to the National Committee of Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), and the Joint Commission (TJC) or other nationally recognized Accreditation Organization approved by Delegator.

1.2 **Subcontractor(s)** means any third party which has entered into an agreement with **Delegate** to perform part or all of **Delegate's** duties and/or obligations under this Addendum.

ARTICLE II
DELEGATE'S OBLIGATIONS

In order to fulfill the purposes and objective of this Addendum, the **Delegate** agrees:

2.1 To accept the obligation to perform all delegated functions and activities described in this Addendum and in each Attachment which are each incorporated by reference into the Agreement.

2.2 To comply with **Delegator's** policies, procedures, and program requirements, Member's Plan (coverage agreement), and all applicable state and federal laws, rules and regulations and instructions including but not limited to the CMS Standards for Downstream and Delegated Entities, (45 CFR 156.340) and Accreditation Organization requirements pertaining to all functions and activities described in each Attachment.

a. **Delegate** agrees to monitor all providers, employees and Subcontractors supporting any exchange Plan, Medicare and/or Medicaid lines of business for debarments and exclusions from federal and state government programs. This must be conducted upon initial hire or contract and on a monthly basis thereafter. Accurate records of such monitoring activity must be maintained and retained for a period of a minimum of ten (10) years. Any provider, Subcontractor or employee found excluded from any exchange, Federal and state government program must be removed from providing direct or indirect services for Medicare/Medicaid or other state or federal governmental program Members immediately and shall be reported promptly to the **Delegator**.

b. **Delegate** further agrees to make available to **Delegator,** its designee or any state or federal governmental agency all documents, including but not limited to logs, files, committee meeting minutes and reports required within the timeframe determined by the auditor.

2.3 To furnish, at no expense to **Delegator**, any and all staffing and systems necessary to receive from and transmit to **Delegator**, or its designee, all required data, and will allow access to and provide to **Delegator,** or its designee, all data required by state and federal laws, rules and regulations, and **Delegator** or Accreditation Organization standards including without limitation any documentation, records, files or data necessary to perform the functions delegated under this Addendum.

2.4 That upon the termination of performance of delegated function under this Addendum, and/or the expiration, non-renewal or termination of the Addendum, regardless of the cause, any files, records and documentation or quality copies of such files and documentation pertaining to **Delegator's** Members or providers which are necessary for **Delegator** to resume responsibility for the delegated function will be made available to **Delegator** upon request.

2.5 To prepare and maintain all appropriate records which involve transactions relating to any services delegated hereunder in accordance with prudent and professional record-keeping procedures and as required by applicable federal, state, or local laws, rules, or regulations and **Delegator** or Accreditation Organization standards.

2.6 That, in the event that **Delegator** is financially penalized or incurs any administrative fine or penalty imposed by any state or federal agency or Accreditation Organization as a direct result of **Delegate's** or any of its employees or Subcontractor's failure to adhere to the applicable state or federal laws or regulations, or the standards and procedures described herein, **Delegator** will forward to **Delegate** documentation of such financial penalty and/or sanction, and **Delegate** shall reimburse **Delegator** the full amount of such financial penalty imposed, including without limitation any attorneys' fees incurred as a result of such action and penalty by a state or federal agency within thirty (30) calendar days of receipt of the documentation.

2.7 That notwithstanding anything to the contrary herein, this Addendum may not be construed to limit in any way the authority or responsibility of **Delegator** to comply with all state and federal laws, rules and regulations, and Accreditation Organization requirements to which **Delegator** is subject.

2.8 To promptly notify **Delegator**, or its designee, in writing of any confirmed quality or risk issues of which **Delegate** may become aware of as it relates to the services delegated hereunder.

a. **Delegate** shall notify and provide documentation to **Delegator** within the next business day of any corrective action plan and/or sanctions, fines or other penalties imposed on or incurred by **Delegate**, or if applicable its Subcontractor, following any review by a regulatory agency or Accreditation Organization.

b. **Delegate** agrees any material change in **Delegate's** performance of delegated functions shall be submitted to **Delegator** for review and approval by **Delegator** prior to the effective date of the proposed changes.

2.9 That **Delegator** may request a change or revision to the **Delegate**'s programs and/or processes at any time as necessary to reflect changes in regulatory, **Delegator's** and/or Accreditation

Organization requirements. Required changes or revisions will be provided to **Delegate** in writing, to be effective within ninety (90) calendar days, or such lesser period of time as may be required by applicable regulatory and/or Accreditation Organization requirements to which **Delegator** is subject. **Delegate** shall provide evidence of implementation to **Delegator** as directed.

ARTICLE III
ACCESS, AUDIT AND OVERSIGHT

Delegate agrees that state, federal and Accreditation Organization regulations or standards require **Delegator** to maintain oversight of the delegated functions furnished by **Delegate**. Such oversight shall, at a minimum, include:

3.1 **Delegator's** or its designee's right to conduct on-site visits at least annually, or more frequently if deemed necessary by **Delegator**, upon not less than ten (10) business days prior notice, or such shorter notice as may be imposed on **Delegator** by a state or federal regulatory agency or Accreditation Organization.

3.2 **Delegator**, **Delegator's** designee, federal, state, and local governmental authorities having jurisdiction, and/or Accreditation Organization to audit any and all documents and materials including, but not limited to, books, contracts, computer and other electronic systems, related to services rendered under this Addendum. **Delegate** shall also permit review of **Delegate's** policies and procedures, programs, annual plans, annual evaluation of previous year's programs, reports, and meeting minutes that have been approved by the **Delegate's** administrative/quality committee, and **Delegate's** performance/compliance under each Attachment.

3.3 Permission for **Delegator**, **Delegator's** designee, federal, state and local governmental authorities having jurisdiction, and/or Accreditation Organization's right to conduct a site visit and/or audit at any site at any time where **Delegate** performs delegated functions under the terms of this Addendum. Any such audit shall be permitted during the term of this Addendum and for a period of ten (10) years thereafter (or any greater period required by applicable law). This section shall survive the termination of this Addendum, regardless of the cause of termination;

3.4 Submission to **Delegator** of periodic reports. These reports shall be provided in accordance with the applicable delegated function attachment and at such other times as **Delegator** shall request or as **Delegator** shall deem necessary or appropriate to ensure that **Delegator** is fully apprised of **Delegate's** activities;

3.5 That **Delegate** agrees to retain all data, information, records, and documentation related to its performance of each delegated function under this Addendum for the longer of ten (10) years following the date of service or the period required by applicable state law.

3.6 **Delegate's** obligation to cooperate and comply with any Corrective Action Plan (CAP) established by **Delegator** in the event there is any breach of this Addendum or non-compliance with state or federal law, Accreditation Organization requirements or **Delegator's** policies and procedures. Corrective action may include, without limitation, intensifying the frequency and number of audits, the temporary loss of delegated rights under this Addendum or the termination of this Addendum.

3.7 **Delegate's** agreement that notwithstanding anything to the contrary herein, **Delegator**, in its sole discretion, or any state or federal regulatory authority, retains the right to approve, modify, suspend or revoke at any time all, or any portion, of functions and/or activities delegated hereunder.

3.8 **Delegate's** acknowledgement and agreement that **Delegator** reserves the right to perform assessments to review the effectiveness of **Delegate's** ability to perform the assigned delegated

functions and compliance with established criteria. **Delegator** shall provide at least ten (10) business days prior written notice before conducting any onsite assessment.

3.9 That notwithstanding anything to the contrary herein, **Delegator**, in its sole discretion, or any state or federal regulatory authority, retains the right to approve, modify, suspend or revoke at any time all or any portion of functions and/or activities delegated hereunder.

ARTICLE IV
SUB-DELEGATION

4.1 If **Delegate** sub-delegates any portion of the delegated functions to a Subcontractor, **Delegate** will require by contract that those functions shall be pre-approved by **Delegator** and be subject to the terms of this Addendum and will be provided in accordance with **Delegator's** policies, procedures and program requirements and all state and federal regulatory and/or Accreditation Organization requirements applicable to **Delegator**.

4.2 Such sub-delegation shall not relieve **Delegate** of its obligations under this Addendum. **Delegate** acknowledges and agrees that all of its obligations under this Addendum shall apply equally to any Subcontractor that provides any services under this Addendum, and **Delegate** represents and warrants that **Delegate** shall take all steps necessary to cause such Subcontractor to comply with the terms of this Addendum.

4.3 If **Delegate** sub-delegates any portion of the delegated functions, then **Delegate** will provide to **Delegator** documentation, and demonstrate a plan for adequate oversight of, Subcontractor prior to any sub-delegation and annually thereafter, or will provide to **Delegator**, in writing **Delegate's** request and acknowledgement that **Delegator** will perform oversight of all sub-delegated functions.

4.4 **Delegate** agrees to require by contract that Subcontractor acknowledge and agree that **Delegator** retains the right to perform evaluation and oversight of the Subcontractor, and will review or audit as required by law or if deemed necessary by **Delegator.**

4.5 The **Delegate** will provide **Delegator** with documentation of a written sub-delegation agreement and Business Associate Agreement that:

a. Is mutually agreed upon;
b. Describes the responsibilities of the **Delegate** and Subcontractor;
c. Describes all sub-delegated activities;
d. Requires at least semi-annual reporting to the **Delegate**;
e. Describes the process by which the **Delegate** will regularly evaluate the Subcontractor's performance;
f. Describes the remedies, including revocation of the sub-delegation agreement, available to the **Delegate** if the Subcontractor does not fulfill its obligations.

4.6 If **Delegate** sub-delegates any portion of the delegated functions to a Subcontractor, then **Delegate** will require by contract that Subcontractor agrees to indemnify and hold **Delegator** and its affiliates and their respective agents, employees, and/or officers harmless from any and all claims, losses, liabilities, damages, injunctions, lawsuits, fines, penalties, demands and/or expenses of any kind or nature, including without limitation attorneys' fees, arising out of or in relation to Subcontractor's performance of the sub-delegated functions.

4.7 The **Delegate** agrees to monitor the Subcontractor for federal and state government programs exclusions on a monthly basis for Medicare/Medicaid providers and will maintain accurate records of such monitoring activity. Any provider, Subcontractor or employee found excluded from any exchange, Federal and/or state government program must be removed from providing direct or indirect services for Medicare/Medicaid or other governmental program Members immediately and shall be reported to the **Delegator**.

4.8 The **Delegate** agrees to monitor to ensure that the Subcontractor performs the federal and state government exclusion checks for their employees and contracted entities on a monthly basis and will

maintain accurate records of such monitoring activity. Any provider, Subcontractor or employee found excluded from any exchange, Federal and/or state government program must be removed from providing direct or indirect services for Medicare/Medicaid or other governmental program Members immediately and shall be reported to the **Delegate** who in turn shall report to the **Delegator**.

ARTICLE V
TERM AND TERMINATION

6.1 This Addendum shall commence at 12:01 AM on the Effective Date specified below and shall continue in full force and effect for an initial term of twelve (12) months. This Addendum shall continue in full force and effect for additional twelve (12) month periods unless terminated in accordance with the terms outlined in the Agreement or this Addendum.

6.2 Notwithstanding anything to the contrary in this Addendum, the Attachments, or the Agreement, performance under this Addendum may be terminated without cause by either party upon written notice provided to the other party no less than ninety (90) calendar days prior written notice or by mutual agreement.

6.3 Notwithstanding anything else in this Addendum, the Attachments, or the Agreement any breach related to Delegate's accreditation, licensure, and/or quality assurance issues shall be considered non-curable. Furthermore, a determination by Delegator that Delegate's continued performance of the delegated functions and/or activities under this Addendum may adversely affect the health, safety or welfare of any Member or bring Delegator or its provider networks in to disrepute, shall be considered non-curable.6.4 Notwithstanding any other provision in the Agreement, this Addendum or any Attachment, **Delegator** may terminate this Addendum, or any Attachment immediately and automatically without additional notice in the event **Delegator** determines that there has been any change or limitation that materially affects **Delegate's** ability to adequately deliver the services delegated hereunder, or for any of the reasons outlined in the Agreement. .

The Effective Date of this Addendum is: **<Insert Date>** .

Each party to this Addendum represents that it has full power and authority to enter into this Addendum and the person signing this Addendum on behalf of either party represents that he/she has been duly authorized to enter into this Addendum.

Delegate	**Delegator**
By: _____	By: _____
Signature of Delegate	Signature of Delegator
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date

DELEGATION OF DISEASE MANAGEMENT ATTACHMENT

This **Delegation of Disease Management Attachment** ("DM Attachment") is hereby made part of and incorporated into the Agreement and the Delegation Services Addendum, entered into between **<Insert Name of the Delegator Humana entity>** (**Delegator**), and **<Insert Name>** (**Delegate**) on **<Date>.** This DM Attachment is intended to amend the terms and conditions of the Addendum and to the extent that this DM Attachment conflicts with the terms and conditions of the Agreement or the Addendum, including any prior agreements, addenda, exhibits, or attachments, this DM Attachment controls the relationship between the parties.

ARTICLE I
DELEGATE'S OBLIGATIONS

Delegate agrees that it shall:

1.1 Acknowledge and agree that **Delegate**'s policies and procedures are subject to **Delegator's** review and written approval prior to any delegation of Disease Management (DM) functions.

1.2 Accept the responsibility and the obligation for performing all DM delegated functions and activities specified in **TABLE 1**, which is attached hereto and incorporated by reference herein, as they relate to services rendered to Members assigned to physicians, employees, Subcontractors and independent contractors.

1.3 Acknowledge and agree that clinical assessments of Members are required to be performed by licensed registered nurses (RN) in accordance with nurse practice guidelines and licensure requirements.

1.4 Comply with **Delegator's** policies, procedures, and program requirements and all applicable state and federal laws, rules and regulations and Accreditation Organization requirements pertaining to DM and the delivery of medical and related health care services.

1.5 Demonstrate **Delegate's** DM program plan, previous plan evaluation, and subsequent revisions have been approved by **Delegate's** internal quality/utilization management (UM) committee.

1.6 Not provide incentives to deny, limit, or discontinue Medically Necessary services. Nothing contained in this DM Attachment or the Agreement is intended by **Delegator** to be a financial incentive or payment, which directly or indirectly acts as an inducement for the **Delegate** to limit Medically Necessary services.

1.7 Retain all Member-related information and records created for a period of not less than ten (10) years.

1.8 Acknowledge that **Delegator** retains all other DM functions not specified as the **Delegate's** responsibility in this DM Attachment.

ARTICLE II
ACCESS, AUDIT, AND OVERSIGHT

Delegate agrees that it shall:

2.1 At least annually, or more frequently if deemed necessary by **Delegator**, and then upon not less than ten (10) business days prior notice, or such shorter notice as may be imposed on **Delegator** by a federal or state regulatory agency or Accreditation Organization, allow **Delegator**, its designee, and any state or federal entity or Accreditation Organization to access all DM documentation, processes, policies, systems, and files in order to perform an audit review of the **Delegate's** policies and procedures, program plan, QI/UM Committee meeting minutes that have been approved by the **Delegate's** QI/UM Committee, and **Delegate's** performance/compliance under this DM Attachment. In-person or telephonic/virtual meetings with participation of both **Delegator** and the **Delegate** will be held to discuss results of audits or reports on an as needed basis.

2.2 Submit to **Delegator**, with respect to delegated functions, all required reports and analyses, as indicated in **TABLE 2**, which is attached and hereby incorporated by reference, along with identified problems, corrective actions initiated, and outcomes.

a. All reports and subsections of reports must be specific to line of business and offering **Delegator**'s affiliate, and all reporting formats must be pre-approved by **Delegator**.

b. The analysis of data must address identified opportunities for improvement with dates that documented interventions were implemented. The next scheduled report must address follow up activities, outcomes and/or status.

c. **Delegate** agrees to provide any and all reports requested by **Delegator** within timeframes identified by **Delegator** to ensure **Delegator** meets all new and revised **Delegator,** CMS, Federal, State and Accreditation Organization reporting requirements.

2.3 Acknowledge and agree that **Delegator** maintains the ultimate responsibility for the sufficiency and appropriateness of the DM programs and retains the right to implement a Corrective Action Plan (CAP), suspend or terminate any of this DM Attachment at any time **Delegate** fails to meet or comply with **Delegator**'s policies, procedures, and program requirements and all applicable state and federal laws, rules and regulations and Accreditation Organization requirements.

2.4 Should the **Delegate** be placed on a CAP, the **Delegate** will have fourteen (14) calendar days to provide a written response describing how they will meet the requirements found to be noncompliant including prospective date of compliance.

2.5 **Delegate** will be subject to a capitation payment penalty as indicated in the table below for any outstanding issues noted on a CAP:

Outstanding Corrective Action Plan	**0 to 3 months**	**4-6 months**	**7-9 months**	**10-12 months or greater**
Payment Penalty	**0%**	**1% per month until CAP resolved**	**2% per month until CAP resolved**	**3% per month until CAP resolved**

ARTICLE III
MEMBER APPEALS AND GRIEVANCES/COMPLAINTS

3.1 **Delegator's** Member expedited and standard complaints/appeals/grievances are not delegated. **Delegator** maintains all Member rights and responsibility functions. **Delegator** will handle all Member appeals/ grievances/complaints for denied services including expedited and standard complaints/appeals/grievances made by a physician/practitioner on behalf of the Member.

3.2 **Delegate** will redirect any complaint/grievance and appeal received verbally or in writing to the **Delegator** within one (1) Business Day.

3.3 **Delegate** will fax all expedited appeals/grievances/complaints to **Delegator** immediately upon notification/receipt.

For Expedited and Standard Member Appeals and Grievances/Complaints:

Medicare:
Telephone- 1-800-867-6601 Fax- 1-800-949-2961
Medicaid:
Telephone- 1-800-764-7591 Fax- 1-855-336-6220

Commercial and Exchange:

Telephone- 1-888-259-6767 Fax- 1-920-339-2112

FL Medicaid only:
Telephone- 1-800-477-6931 Fax- 1-800-949-2961

ARTICLE IV
TERMINATION

4.1 Notwithstanding anything to the contrary in this DM Attachment, the Addendum, or the Agreement, performance under this DM Attachment may be terminated without cause by either party upon written notice provided to the other party no less than ninety (90) calendar days preceding the termination date or by mutual agreement.

4.2 Notwithstanding anything else in this DM Attachment, any breach related to **Delegate's** accreditation and/or licensure, quality assurance issues or alleged breach regarding termination by **Delegator** in the event **Delegator** determines that **Delegate's** continued performance of the delegated functions and/or activities under this DM Attachment may affect adversely the health, safety or welfare of any Member or bring **Delegator** or its provider networks in to disrepute, shall be considered non-curable.

The **Effective Date** of this Disease Management DM Attachment is: **<Insert Date>** .

TABLE 1
DISEASE MANAGEMENT FUNCTIONS

DELEGATED DISEASE MANAGEMENT ACTIVITIES	DETAIL FUNCTION FOR DELEGATOR	DETAIL FUNCTION FOR DELEGATE
Delegate's Disease Management Programs List the DM Programs: Congestive Heart Failure (CHF) Chronic Obstructive Pulmonary Disease (COPD) Coronary Artery Disease (CAD) Diabetes End-Stage Renal Disease (ESRD)		Disease Management Programs will be based on adopted Clinical Practice Guidelines.
DM Program		**Delegate's** DM Program/s will be based on nationally recognized clinical practice guidelines and describe the chronic illness/es of those Members served by the program, the types of services offered including the scope of services, (interventions, communications, self-care training) and a description of the types of measures that are used to assess program performance, including significant outcomes (clinical, satisfaction and costs).
DM Program Participation Criteria		**Delegate** establishes criteria for participation, describes how it monitors the progress of its DM participants, how frequently this occurs.
Identification of Members who qualify for DM programs	**Delegator** will assist **Delegate** in providing reporting data as requested by **Delegate**	The **Delegate** systematically identifies Members who qualify for each of its DM programs at least monthly using multiple referral and data sources including but not limited to claims, encounters, pharmacy, laboratory results, health appraisals, utilization management, case or care management, health management such as wellness or health coaching programs, electronic health records, physician referrals and Member self-referrals.
Program content requirements		Each DM program must address the following: 1. condition monitoring to include: a. self-monitoring; b. medical testing; c. regular clinical and laboratory assessment; d. surveillance of pharmacological management; e. lifestyle management; and f. assessing whether a Member understands a condition. 2. adherence to treatment plans and prescribed medication; 3. medical and behavioral comorbidities and other health conditions such as cognitive deficits and physical limitations; 4. health behaviors; 5. psychosocial issues; 6. depression screening 7. providing information about the Member's condition to caregivers who have the Member's consent including: a. the condition and treatment plan; b. self-management tools; c. DM program and staff resources; and d. community resources; 8. encouraging patients to communicate with their practitioners about their health conditions and treatment; and

DELEGATED DISEASE MANAGEMENT ACTIVITIES	DETAIL FUNCTION FOR DELEGATOR	DETAIL FUNCTION FOR DELEGATE
		9. additional resources external to the **Delegate.**
Member communications		The **Delegate** will provide the eligible Members the following written information about the program: 1. how to use the services; 2. how Members become eligible to participate; and 3. how to opt in or opt out.
Member interventions		**Delegate** will document evidence Member interventions have been performed based on disease stratification and assessment.
Practitioner communications		The **Delegate** will provide practitioner with the following information about the DM program: 1. instructions on how to use DM services; and 2. how the **Delegate** works with practitioner's patients in the program.
Member continuity of care (COC)		The **Delegate** will integrate information from various systems to facilitate access to Member health information for COC: A health information line; a DM program; a case management program; a UM program; and a wellness program.
Appropriate policies and procedures		**Delegate** must have documented policies and procedures that meet National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) requirements, as applicable.
Member experience with disease management	Approve Member satisfaction survey prior to **Delegate** use	The **Delegate** annually evaluates the satisfaction with its disease management services by: 1. Obtaining and analyzing Member feedback: a. the overall program; b. helpfulness of the program staff; c. usefulness of the information disseminated; and d. Member's experience in adhering to treatment plans 2. Analyzing Member feedback and inquiries by conducting a quantitative analysis of data to identify patterns in Member feedback, and conducts a causal analysis if stated goals were not met.
Measure effectiveness of DM Program		The **Delegate** must track a minimum of one performance measure for each DM program. Each measure: 1. addresses a relevant process or outcome; 2. produces a quantitative result; 3. is population based; 4. uses data and methodology that are valid for the process or outcome being measured; and 5. has been analyzed in comparison with a benchmark or goal. The **Delegate** monitors clinical outcomes and measures and tracks performance measures against goals. Results are analyzed; improvement plans are initiated, if warranted. Outcomes in health status for Members are documented.

TABLE 3
DOCUMENTATION REQUIREMENTS

Documentation Required	DM File	DM Log
Type of DM Program		X
Line of business	X	X
Member Identification number	X	X
Member name	X	X
Primary Care Physician name	X	
Names of all involved healthcare professionals including contact information	X	
Date enrolled in DM program	X	X
Member diagnoses	X	X
Clinical history including medications	X	
Disease stratification level and assessment	X	X (stratification level only)
Development of care plan with ongoing documentation	X	
Interventions	X	
Identification of barriers to meeting goals and complying with the plans	X	
Development of schedules for follow-up and communication with Members	X	
Development and communication of member self-management plans	X	
Assessment of progress against disease management plans and goals, and modification as needed	X	
Date DM program terminated	X	X

TABLE 2
REQUIRED DISEASE MANAGEMENT REPORTS

All reports are to be sent using the secured email procedure and sent to your assigned delegation compliance consultant.

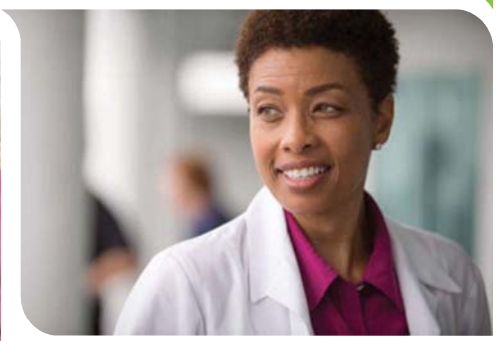
MANDATORY REPORTS	FREQUENCY	DETAIL
DM Annual Programs	Annually	
Previous year DM Programs effectiveness evaluations	Annually	
Member DM Program Satisfaction Survey	Annually	
Aggregated numbers of all quarterly report data	Annually	
Reporting for each delegated DM program of opt-in and opt-out active Member participation rates.	Quarterly Annually	Report opt-in participation rates: Total eligible population and by condition Number of Members referred to the program and opted in % Members enrolled and actively managed Report opt-out participation rates: Total eligible population and by condition Active participation number % Members opt-out active participation rate
Reporting of enrolled Members into **Delegate's** DM programs. See **Table 3** for log requirements.	Quarterly Annually	At a minimum, the annual report is to be submitted to the **Delegator**
Hospital admissions/readmissions for enrolled DM Members • Admissions per each DM program/each total DM program membership • Readmissions per each DM program/each total DM program membership • ER visits per each DM program/each DM program membership	Quarterly	
Member DM Program Satisfaction Survey	Annually	Determine performance goals for the Member satisfactory survey and conduct a causal analysis if stated goals were not met.

Note: Reporting requirements may change based upon revised or new state and federal legislation, **Delegator** and NCQA standards requirements during the term of this Attachment.

All reports and subsections of reports must be LOB and **Delegator** market specific.
The analysis of data and identified opportunities for improvement must include documentation of interventions implemented. Outcomes and/or status should be documented in the next scheduled report. **Reporting formats must be pre-approved by Delegator.**
Monthly – 30 days following the end of the month
Quarterly – 60 days following the end of the quarter
Annually – March 15

Compliance Policy

for Contracted Health Care Providers and Business Partners



It is important that I read this and, if I'm an administrator, provide this information or a materially similar document to all employees and business partners who support Humana's Medicare and/or Medicaid products as a part of our relationship.

Overview

Humana has compliance program requirements for those supporting its business: your organization, its employees and downstream entities. These requirements include, but are not limited to, the core elements of Humana's Compliance Program outlined in the Table of Contents on the next page. Your organization may be required to provide assurance that it understands and incorporates these components into its own compliance program or that it has a materially similar program.

Humana®

GHHH7DVHH 0816

Effective January 2017

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Introduction

Purpose

One of Humana's objectives is "to help people achieve lifelong well-being." In pursuit of this ideal, Humana is committed to maintaining high ethical standards in the conduct of its business. The key to upholding these standards is through the daily decisions and actions of every Humana associate. We also require highly ethical conduct from our business relationships. Your strong commitment to compliance is the foundation of our business relationship.

The purpose of this policy is to aid our health care providers and business partners in fully understanding Humana's strong organizational commitment to conducting business ethically, with integrity, and in compliance with applicable laws, regulations and requirements. Humana requires of its health care providers and business partners a similar commitment to ethical conduct and assurance that they, and their employees and downstream entities supporting Humana business, comply with the guiding principles outlined within this policy.

Organization

This policy relays Humana's compliance requirements and expectations of its health care providers and business partners and addresses the requirements of the Centers for Medicare & Medicaid Services (CMS) pertaining to an effective compliance program and fraud, waste and abuse prevention, detection and correction. In addition, this policy references state- and product-specific requirements. The seven core elements of an effective compliance program are categorized into the following sections within this document: Framework, Communication, Oversight and Investigation. Under each of these sections is a description of Humana's elements-related requirements and processes, along with an outline of Humana's expectations of health care providers and partners in a "Health Care Provider and Business Partner Impact" segment.

Responsibility

Humana maintains ultimate responsibility for the effectiveness of its compliance program. As part of this responsibility, Humana requires all health care providers and business partners to adhere to and maintain policies to address the principles outlined in this document.

This can be achieved by your organization in any of the following ways:

a) Adopting all of the following: this Policy, Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners (standard of conduct), and CMS' fraud, waste and abuse (FWA) training and general compliance training; OR

b) Adopting the CMS FWA training and general compliance training document and maintaining internal policies that:

   i. Are materially similar to this Policy and Ethics Every Day for Contracted Health Care Providers and Business Partners; and

   ii. Align with the guiding principles and requirements of these documents listed above; OR

c) Completing the exception process if the requirement is not applicable

   » Exception requests must be made in writing to and receive approval from Humana's Enterprise Compliance Department.

In addition, Humana has ongoing monitoring, auditing and reporting processes to assess health care provider and business partner compliance. Humana updates this policy when there are material regulation, policy or guidance changes, and at least annually.

Notable changes (with page number)

This overview has been provided to list the key points of notable changes and the sections in which they are detailed.

(Cover)

It now clarifies the required audience for this document.

Definitions (2)

Clarified that examples of Health Care Providers and Business Partners also include delegated and non-delegated health care providers, as well as delegated entities. These are in addition to other examples previously and currently listed.

Materials Distributed to Contracted Health Care Providers and Business Partners (3)
Effective Training and Education (5)

Both sections now clarify that key compliance program materials and training documents:
- must be provided to employees and subcontractors performing administrative functions and/or providing health care services in support of Humana's Medicare and/or Medicaid products; and
- are publicly acessible on Humana's Website.

Methods for Reporting Suspected or Detected Noncompliance to Humana Humana (6)

This section now includes a fax number in addition to other listed methods.

Oversight (7)
Investigation, Discipline and Correction (8)

Both of these sections now clarify that, when applicable, organizations supporting Humana must issue corrective actions and track them to closure.

Conflict of Interest (7)

This section now clarifies that a conflict of interest internal disclosure policy must be in place.

Appendix A: Resources (8)

This section now clarifies that the CMS Compliance Program Policy and Guidance link includes regulations and select CMS memoranda serving as the basis for requirements; and provides materials and a CMS contact email address to leverage for training and support.

Added information about Humana having an electronic Compliance Toolkit containing supplemental materials to support organizations' compliance program enhancement and maturity. A contact has been provided for emailing related inquiries.

Appendix B: Summary of Applicable Laws and Regulations (9)

Added CMS link and information about marketing guidelines related to Medicare products.

Appendix B: Summary of Applicable Laws and Regulations (10)

This section now has an overview of the Foreign Corrupt Practices Act (FCPA) and a link to the applicable government site with additional information.

Definitions

Associate – Refers to a Humana employee.

Audit – Refers to a formal review of compliance with a particular set of internal (e.g., policies and procedures) and/or external (e.g., laws and regulations) standards used as base measures.

Centers for Medicare & Medicaid Services (CMS) – An agency within the U.S. Department of Health and Human Services that is responsible for the administration of the federal Medicare and Medicaid programs and the federally-facilitated marketplace for the exchange product (FFM).

Conflicts of Interest – Personal, familial or business relationships that could amount to, but are not limited to:

- Competing with any of Humana's product offerings
- Providing services to a competitor of Humana
- Interfering with the performance of work duties

Please refer to Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners for examples.

Downstream Entity – An organization or individual that enters into an acceptable written arrangement below the level of the arrangement between Humana and a First Tier Entity. This continues down to the level of the ultimate provider of a service or product. Example: A management services organization contracted directly with Humana is a First Tier Entity. The hospitals and health care providers contracted with the management services organization as part of its network are downstream entities.

FDR - A first tier, downstream or related entity of Humana. This is a contracted entity that supports Humana business. Please refer to the separate definitions of First Tier, Downstream and Related Entity, as well as Health Care Providers and Business Partners, for clarifications.

FDR Employees and Downstream Entities – Individuals employed by, contracted with, or otherwise supporting an FDR, who are acting on behalf of Humana, either directly or indirectly. These include, but are not limited to, FDR employees, employed and contracted health care providers and pharmacists, board members, pharmacy and therapeutic committee members, volunteers, consultants and any contracted individuals.

First Tier Entity – An organization or individual that enters into an acceptable written arrangement with Humana to provide administrative or health care services. This includes any person or entity that is contracted by Humana to perform work in support of administration or delivery of Humana products and/or services. Additionally, when Medicare or Medicaid is involved and Humana is the Sponsor, the agreement must be acceptable to CMS. Example: A call center contracted directly with Humana is a first tier entity.

Health Care Providers and Business Partners – Any non-associate contracted, directly or indirectly, to perform a business function or provide goods or a service for or on Humana's behalf. These may also be referred to as first tier, downstream and related entities (FDRs). Some examples of business partners are health care providers, pharmacies, sales agents, sales agencies, vendors, suppliers, contractors and delegates.

Some examples of business partners are delegated and non-delegated health care providers, delegated entities, pharmacies, sales agents, sales agencies, vendors, suppliers, contractors and delegates.

Vendors and suppliers of administrative goods and services are considered Business Partners.

Humana – Refers to Humana Inc. and its wholly owned subsidiaries.

Monitoring – Reviews that are repeated regularly during the normal course of operations. These activities may occur to confirm:

- Ongoing compliance even in the absence of identified problems; or
- Corrective actions are undertaken and effective

Related Entity – Any entity that is related to Humana by common ownership or control and meets one of the following criteria:

- Performs some of Humana's management functions under contract or delegation; or
- Furnishes services to enrollees under an oral or written agreement; or
- Leases real property or sells materials to Humana at a cost of more than $2,500 during a contract period

Volunteer – Any individual who performs work for Humana related to the Medicare or Medicaid program, but is not employed by or contracted with Humana in any fashion, and not otherwise compensated for their work. An example is an unpaid student intern.

Key takeaways from this policy

Humana is committed to ethically conducting business and complying with this Policy and all laws, rules and regulations referenced in the appendices. This policy is aligned with the seven elements of an effective compliance program outlined by CMS:

Section I – Framework

Element I: Written Policies, Procedures and Standards of Conduct

- **Materials Distributed to Contracted Health Care Providers and Business Partners:** This Policy, a standards of conduct document (Ethics Every Day for Contracted Health Care Providers and Business Partners), and CMS' fraud, waste and abuse (FWA) training and general compliance training. Compliance with all the above documents is required and corresponding training on their subject matter must be provided to employees and subcontractors performing administrative functions and/or providing health care services in support of Humana's Medicare and/or Medicaid products. These documents are accessible from a public page on Humana's website: http://www.Humana.com/fraud
  - » Organizations performing any function for Humana may meet the distribution requirements for the two Humana policies by using materially similar policies. However, only the CMS training material on FWA and general compliance may be used to meet the training requirements for those two topics.
- **Record Retention:** Documentation and records integral to meeting Policy requirements and activities must be maintained for a minimum of 10 years.
- **Requirements of Contracted Health Care Provider and Business Partners Subcontracting any of their Contractual Obligations:**
  - » Notify Humana when it seeks to subcontract any work in support of Humana so that Humana can issue its approval or rejection of the proposed relationship.
  - » Maintain written agreements with any subcontractors supporting functions the contracted health care provider or business partner is contracted to perform for Humana.
  - » Provide performance and compliance oversight of their subcontractors to assure they are meeting related requirements outlined in any contracts related to Humana as well as the Policy.

Element II: Compliance Officer, Compliance Committee and High Level Oversight

- Humana has designated personnel accountable for overseeing compliance responsibilities.
  - » Contracted health care providers and business partners must also have designated resources to fulfill compliance obligations.

Section II – Communication

Element III: Effective Training and Education

- This must be in place for Humana and its contracted health care providers and business partners on compliance, addressing fraud, waste and abuse, and, where applicable, Medicaid-related subject matter. The education must be formally tracked and conducted by contracted health care providers and business partners within 90 days of initial contract/employment and annually thereafter.

Element IV: Effective Lines of Communication

- Humana employees and its contracted health care providers and business partners are given access to its compliance officer for feedback and multiple methods for reporting suspected or detected noncompliance. Such reporting is required of all who support Humana's business. More than one available method offers anytime access, while all are confidential and allow for follow-up.
- Humana prohibits intimidation or retaliation against anyone making a good faith report of suspected violations of the Policy. Contracted health care providers and business partners are required to have and publicize one or more reporting options with these features and/or publicize Humana's reporting options, as well as comply with the prohibition on intimidation and retaliation.

Element V: Well-Publicized Disciplinary Standards

Humana and its contracted health care providers and business partners are required to widely publicize disciplinary standards and the requirement to report suspected violations.

Section III – Oversight

Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks

- **Monitoring and Auditing Work Plans:** Humana has these in place to assess compliance with this Policy and related requirements. Contracted health care providers and business partners are also required to have these plans and conduct corresponding oversight.
- **Exclusion Lists:** Screening employees and subcontractors against the Office of Inspector General (OIG) and Genersal Service Adminsitration (GSA) exclusion lists must be conducted by Humana and contracted health care providers and business partners prior to hire/contract and at least monthly thereafter and, and records of screening activities must be retained for 10 years. An individual or entity appearing on either list must be promptly removed from supporting Humana business.
- **Conflicts of Interest:** Statements of Humana associates' suspected conflicts are obtained by Humana within 90 days of hire, upon any related change or addition, and annually thereafter. Contracted health care providers and business partners must obtain these statements annually, and when there is a related change or addition, from those performing functions for them. Identified conflicts must be removed or approval to allow them must be granted. Humana reserves the right to request and review this information, as well as require a conflict to be removed, up to the person or entity supporting Humana ceasing to perform functions to meet contractual obligations to Humana.

Section IV – Investigation, Discipline and Correction

Element VII: Procedures and System for Prompt Response to Compliance Issues

Humana investigates suspected violations, takes applicable disciplinary action and implements any necessary, subsequent corrections to prevent future violations. Associates, as well as contracted health care providers and business partners, must also cooperate with any investigation and initiate disciplinary actions when applicable.

I. Framework

Written Policies, Procedures and Standards of Conduct

Humana has two principle documents at the core of its compliance program:

- Humana's standards of conduct, which outlines ethical expectations and can be accessed online from the Corporate Governance section of the Investor Relations page on **Humana.com**. There is also a closely-aligned document titled Ethics Every Day for Contracted Health Care Providers and Business Partners. It can be accessed on www.Humana.com/fraud.
- The Enterprise Compliance Plan outlines the fundamental elements of Humana's compliance program, including
  - » Required policies;
  - » Compliance officer and Compliance Committee requirements;
  - » Compliance and fraud, waste and abuse (FWA) training content and requirements;
  - » Communication and compliance officer access requirements;
  - » Behavior monitoring and disciplinary standard expectations;
  - » Requirements for monitoring and assessment of compliance with state and federal requirements and identification of compliance risks; and
  - » Requirements for identifying, responding to and correcting compliance issues.

Numerous policies, standards and procedures exist to support the Enterprise Compliance Plan. The core policies that apply to relationships with health care providers and business partners as they relate to compliance are outlined in this document.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected either to adopt the following for their employees and downstream entities:

a) Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners (standards of conduct)
b) This compliance policy
c) CMS' FWA training and general compliance training

Or to adopt the CMS FWA training and general compliance training and maintain their own, materially similar:

a) Version of Humana's standards of conduct for contracted health care providers and business partners
b) Policies that support the requirements and activities in this document

Supporting procedures may be developed and maintained for certain required activities. All health care providers and business partners are required to have appropriate policies and procedures in place to address FWA.

Record Retention

Health care providers and business partners must maintain documentation and records for requirements and activities outlined in this policy for a minimum of 10 years.

Your Relationships With Downstream Entities

Though Humana is ultimately responsible for any functions performed to support its business, there are also certain requirements that health care providers and business partners must adhere to when entering into a relationship with a downstream entity. The health care provider or business partner must:

- Notify Humana for approval to subcontract any services inside or outside of the United States
- Maintain compliant written agreements with downstream entities
- Maintain adequate oversight of the functions performed downstream
- Confirm that downstream entities adhere to core compliance requirements, including all requirements outlined in this document (such as providing compliance and FWA training to, and conducting exclusion screening of, their employees and those supporting the downstream entities, and monitoring and auditing of any further downstream entities)

Compliance Officer and Compliance Committee, and High Level Oversight

Humana has a chief compliance officer (CCO) who is a full-time Humana associate. The CCO:

- chairs the Enterprise Compliance Committee;
- on behalf of the Enterprise Compliance Committee, reports directly to the Audit Committee of the Board of Directors; and
- reports indirectly to the chief executive officer (CEO), and reports administratively to the senior vice president and general counsel.

Humana has a separate compliance officer for Medicare and Medicaid who is also a full-time Humana associate and reports directly to Humana's chief compliance officer, has direct access to report any compliance matters to the Audit Committee of the Board of Directors or chief executive officer, and provides quarterly updates to the chief compliance officer on the Company's Fraud, Waste, and Abuse Program. The Medicare and Medicaid compliance officer chairs the Medicare and Medicaid Compliance Committee.

The CCO, chairman of the board and CEO, and the board of directors provide overall leadership and governance for the Enterprise Compliance Plan.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to have a designated compliance resource accountable for overseeing the organization's compliance responsibilities, including those outlined in this document. The personnel assigned must be adequately educated, trained, and qualified to perform compliance functions. Humana is not prescriptive regarding specific qualifications; however, organizations may choose to consider qualifications such as formal education, on the job training, industry experience, compliance experience, continuing education, conferences and seminars in determining adequacy.

II. Communication

Effective Training and Education

Humana requires its associates to annually review its standards of conduct. In addition, associates and members of the board of directors receive compliance and FWA training within 30 days of hire or election and annually thereafter. Associates working in areas of identified substantial risk receive specialized and focused training. These areas include, but are not limited to the following: Claims, Correspondence, Customer Service, Critical Inquiry, Billing and Enrollment, Sales, Underwriting, Grievance and Appeals and Pharmacy.

Health care providers and business partners are required to review Ethics Every Day for Contracted Health Care Providers and Business Partners and to complete the CMS general compliance and FWA training within 90 days of contract and annually thereafter. They are also required to provide standards of conduct and the CMS general compliance and FWA training to employees and any downstream entities performing administrative functions and/or providing health care services in support of Humana's Medicare and/or Medicaid products. Health care providers and business partners may use their discretion in how training is administered; examples include classroom training, online training modules, or attestations that these audiences have read and received standards of conduct and/or compliance policies and procedures. Instructions for accessing the CMS general compliance and FWA training document are available in Appendix A. Regardless of the method used for training, health care providers and business partners are required to provide proof to Humana that the requirement has been met through completion of an acceptance statement and maintenance of documentation of the time, attendance topic, certifications of completion and test scores of any tests administered (if applicable).

Required Training and Education

All employees and downstream entities of health care providers and business partners are required to receive:

- CMS general compliance training (including Medicare compliance training, if applicable)
- CMS FWA detection, correction and prevention training

(Individuals with Humana system access are required to complete Humana's training(s) for FWA and general compliance and are not required to receive additional or separate training from your organization for that content.)

- Applicable, job-specific compliance training
- Training required in a particular state or by a Humana Medicaid and/or government contract may include, but is not limited to:
  - » Cultural competency training
  - » Health, safety and welfare education training
  - » Medicaid training
  - » Humana orientation training

Sufficient understanding of training received must be demonstrated to the health care provider or business partner prior to performing any functions included under a Humana contract, which may be accomplished through knowledge checks or other means. Humana will provide training content support and monitor completion of required training to those who have Humana system access.

Required Training Timelines

All health care providers and business partners without Humana system access must train on compliance and FWA within 90 days of hiring an employee or contracting with a representative, or downstream entity and annually thereafter. Those employees or downstream entities who receive Humana system security access are required to take Humana's training on ethics and compliance, including FWA, within 30 days of receiving such access and annually thereafter. Additionally, job-specific training must be provided by health care providers and business partners and completed within 30 days of hire or contract to properly perform the functions required.

Deemed Status

Humana recognizes that certain health care providers are deemed to have met FWA education and training requirements through:

- Enrollment into the Medicare program; or
- Accreditation as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

In the case of organizations with multiple locations, such as chain pharmacies, each individual location must be enrolled in Medicare Part A or B to be deemed.

Entities and individuals with deemed status for FWA training are still required to complete the CMS general compliance training.

Noncompliance With Humana's Training Requirements

The following will occur in the event that any employee or downstream entity of a health care provider or business partner is found to be noncompliant with respect to Humana's training requirements or an individual's singular actions demonstrate noncompliance with Humana's compliance expectations:

- Humana will give the organization written notice
- The health care provider or business partner must immediately remove and replace, at its own expense, such employee or downstream entity from supporting Humana-contracted work

If the health care provider or business partner discovers the noncompliance with training requirements, then the health care provider or business partner must remove and replace the employee or downstream entity and notify Humana. In the event that the health care provider or business partner fails to immediately remove and replace the noncompliant employee or downstream entity, as requested by Humana, then Humana may take disciplinary action. This can include a formal corrective action plan, up to termination of the contracted work upon written notice.

Changes Impacting Training

Humana will notify health care providers and business partners when there are changes to a process in a specific contract that require immediate, job-specific training and require the health care provider or business partner to act immediately to provide such training to its employees and any downstream entities.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Complete CMS's general compliance and FWA training within 90 days of contract and annually thereafter.
- Provide compliance policies and standards of conduct to employees and any downstream entities within 90 days of hire or contract and annually thereafter.
- Provide CMS's general compliance and FWA training to employees and any downstream entities within 90 days of hire or contract and annually thereafter. Training documentation should include the time, attendance, topic, certificates of completion (if applicable) and test scores of any tests administered.
- Verify as deemed via a contract between the health care provider and CMS, or a business partner and CMS, which, among other things, affirms the FWA training requirement has been met. Otherwise, remove and replace any employees and any downstream entities who do not receive FWA training within 90 days of hire or contract.
- Provide specialized compliance training on issues posing FWA risks based on an individual's job function when appropriate.

Effective Lines of Communication

Humana communicates with its associates through the company intranet to provide continual awareness of the importance of compliance. Humana also communicates regularly with its health care providers and business partners through a variety of methods, including contracts, administration manuals, newsletters, the Partner Compliance Portal, **Humana.com**, policy communication and annual compliance and FWA training.

Access and Availability of Compliance Officer

The Chief Compliance Officer, J. Gregory Catron, is available to address any suggestions or comments on maintaining ethical behavior, or identifying and preventing fraudulent or criminal misconduct. Associates, health care providers or business partners may contact Mr. Catron through the Ethics Office or call the Help Line at **1-877-5-THE-KEY (1-877-584-3539)**.

Mr. Catron is based in Humana's corporate headquarters: 500 West Main St., Louisville, KY 40202.

Requirement to Report

All Humana associates, members of the governing body, health care providers, and business partners are required to report compliance concerns and suspected or actual compliance and FWA violations to Humana.

Methods for Reporting Suspected or Detected Noncompliance to Humana

Suspected or detected violations of Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners or any related law or policy must be immediately reported by health care providers, business partners, or their employees or downstream entities to Humana through one of these methods:

- Telephonic: Ethics Help Line, **1-877-5-THE-KEY (1-877-584-3539)**
- Online: Ethics Help Line Web reporting site **www.ethicshelpline.com**
- Email: **ethics@Humana.com** (Ethics Office)

Suspected or detected FWA violations may also be reported directly to Humana's Special Investigations Referral department by calling **1-800-614-4126**, emailing **siureferrals@Humana.com**, or faxing **1-920-339-3613**.

Key Features of These Communication Options

- Intake Neutrality: Non-Humana personnel (employed by a separate and independent company) staff the Ethics Help Line.
- Anonymous Reporting: Communication to the Ethics Help Line or Ethics Help Line Web reporting site can be made anonymously. Humana requests that if a reporter desires to remain anonymous, he/she provide enough information to allow Humana to investigate the issue.
- Prohibition Against Intimidation and/or Retaliation: Humana strictly prohibits intimidation and/or retaliation against any health care provider or business partner, or their employees or downstream entities, who, in good faith, reports a detected or suspected violation of ethical standards or FWA.
- Status Update: Regardless of the reporting method used, the individual reporting a suspected or detected violation will receive a confidential identification number that will allow for follow-up on the status of the issue reported, along with a recommended follow-up date.

Health Care Provider and Business Partner Impact

Health care providers and business partners may train their employees and downstream entities on their own ethics and compliance reporting processes; however, the reporting system must meet the following requirements:

- Maintain confidentiality (to the greatest extent possible)
- Allow for anonymity if desired
- Be available 24 hours a day
- Emphasize the policy of non-intimidation and non-retaliation for good faith reporting of compliance concerns, FWA and participation in the compliance program
- Emphasize that reports must be made to Humana

In addition, health care providers and business partners are expected to:

- Widely publicize the methods for reporting compliance and FWA concerns and the non-retaliation policy throughout facilities (examples include: posters, table tents, mouse pads, key cards and other prominent displays)
- Reinforce Humana's policy of non-intimidation and non-retaliation
- Report compliance concerns and suspected or actual compliance and FWA violations to Humana

III. Oversight

Monitoring and Auditing Work Plan

Humana maintains an Anti-Fraud Plan for continuous monitoring of potential fraud, waste, and abuse activity. Humana monitors and audits the activities of associates, members of its health plans and insurance policies, health care providers and business partners. In addition, health care providers and business partners are responsible for maintaining their own comprehensive plan for detecting, correcting, and preventing fraud, waste, and abuse.

Humana also conducts monitoring and auditing activities for its relationships with health care providers and business partners. The activities monitored and audited may include, but are not limited to, both operational performance and compliance requirements applicable to the functions performed and as described throughout this document.

Humana has developed separate monitoring and auditing work plans to address the risks associated with the health care provider and business partner relationships. The implemented work plans enable Humana to determine the nature, timing and extent of the monitoring and auditing process to be performed by Humana.

In order to monitor a health care provider or business partner's compliance obligations, Humana may periodically request the health care provider or business partner to complete a self-assessment, questionnaire or survey, submit documentation, and/or attest to applicable policy, procedure and compliance requirements. Humana may also perform an on-site or desktop audit, which may include inspection of the facilities, systems, books, procedures, audit work plans and results and records that relate to the services provided under the contractual agreement. Health care providers and business partners shall provide timely turnaround of these requests in accordance with the time period specified by Humana.

Disciplinary actions could result from Humana's conducted monitoring and auditing initiatives. These could include, but are not limited to: mandatory (re)training, corrective action plans tracked to closure or contract termination.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Monitor for fraud, waste, and abuse within their organizations and downstream entities
- Comply with any monitoring or auditing requests from Humana
- Develop and implement monitoring and auditing work plans for any functions supporting Humana business that the health care provider or business partner has further contracted to downstream entities

Exclusion Lists

Individuals and entities acting on behalf of Humana, either directly or indirectly, that appear on either the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (OIG) or the General Services Administration list of excluded parties contained within the System for Award

Management (GSA) may not support any Humana business function. All health care providers and business partners, and their employees and downstream entities, are required to be screened against both the OIG and the GSA prior to hire or contract and monthly thereafter, and accurate records of such monitoring activity must be retained for a minimum of 10 years.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Query both the OIG and GSA for all employees and downstream entities prior to hire or contract and monthly thereafter
- Promptly remove any individual or entity appearing on either of these lists from any work related to Humana business functions
- Promptly report any such exclusions and actions to Humana

Conflicts of Interest

Humana requires each associate to complete a conflict of interest statement certifying that the individual is free from any conflicts of interest in performing his/her job function. Similarly, employees and downstream entities of Humana's health care providers and business partners must have a policy to internally disclose any conflicts of interest annually and upon any change or addition to this status.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Communicate to their employees and downstream entities that any conflict of interest must be disclosed annually and upon receipt of any changes or additions
- Review potential conflicts of interest and either remove the conflicts or, if appropriate, grant approval to continue work despite the conflicts

IV. Investigation, Discipline and Correction

Violation of Humana's Ethics Every Day for Contracted Health Care Providers and Business Partners and other policies and procedures could compromise Humana's integrity and reputation. A violation may also result in a required corrective action, termination of contract and/or reporting of the violation to appropriate regulatory and/or law enforcement authorities.

Humana initiates investigations of any reports of suspected or detected violations of Ethics Every Day for Contracted Health Care Providers and Business Partners and Humana policies and procedures, as well as suspected FWA, as quickly as possible, but not later than within two weeks of identifying the suspected or detected issue. All reported issues are treated confidentially to the greatest extent possible and documentation is maintained.

In the event that corrective actions are imposed on a health care provider or business partner, Humana will monitor and/or audit the health care provider or business partner to confirm that corrective actions have been implemented. Monitoring and auditing following implementation of the corrective action will also occur, as appropriate, to facilitate effective corrective actions.

Health Care Provider and Business Partner Impact

Health care providers and business partners are expected to:

- Widely publicize the disciplinary standards, including the duty and expectation to report noncompliant and unethical behavior and suspected FWA
  - » Examples include: newsletters, regular presentations and department staff meetings, communications with downstream entities, general compliance training, intranet site, posters prominently displayed throughout employee work and break areas, and cafeteria table tents.
- Take prompt disciplinary action when there is noncompliant or unethical behavior by their employees or downstream entities or FWA is discovered, and report such action to Humana. This may include issuing corrective action plans that must be tracked to closure.
  - » Humana reserves the right to take additional action if deemed necessary.
- Cooperate fully with any investigation of an alleged violation and/or remedial actions.

Appendix A: Resources

CMS Medicare Parts C and D Fraud, Waste, and Abuse Training and General Compliance Training	1) Navigate to the link below; 2) Scroll to the "Downloads" section; 3) Click on "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training"; 4) The CMS document contains options for accessing the training material, including Web links to review the content and/or download PDF versions. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
OIG Special Advisory Bulletin on Exclusion	Issued in May 2013, this answers common questions on this topic, including screening frequency, liability, how exclusions can be violated, and the administrative sanctions OIG can pursue against those who violated an exclusion http://oig.hhs.gov/exclusions/files/sab-05092013.pdf
CMS Compliance Program Policy and Guidance	This site: lists compliance program regulations and includes select CMS memoranda serving as the basis for requirements; and provides materials and a CMS contact email address to leverage for training and support. The Related Links section of this Web page includes Chapters 9 of the Prescription Drug Benefit Manual and 21 of the Medicare Managed Care Manual https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ComplianceProgramPolicyandGuidance.html
Ethics Every Day for Contracted Health Care Providers and Business Partners	**http://apps.Humana.com/marketing/documents.asp?file=1112774**
Compliance Program Toolkit	Humana offers an electronic Compliance Toolkit to support healthcare providers and business partners in compliance program enhancement and maturity. Submit related inquiries to: partnercompliance@humana.com

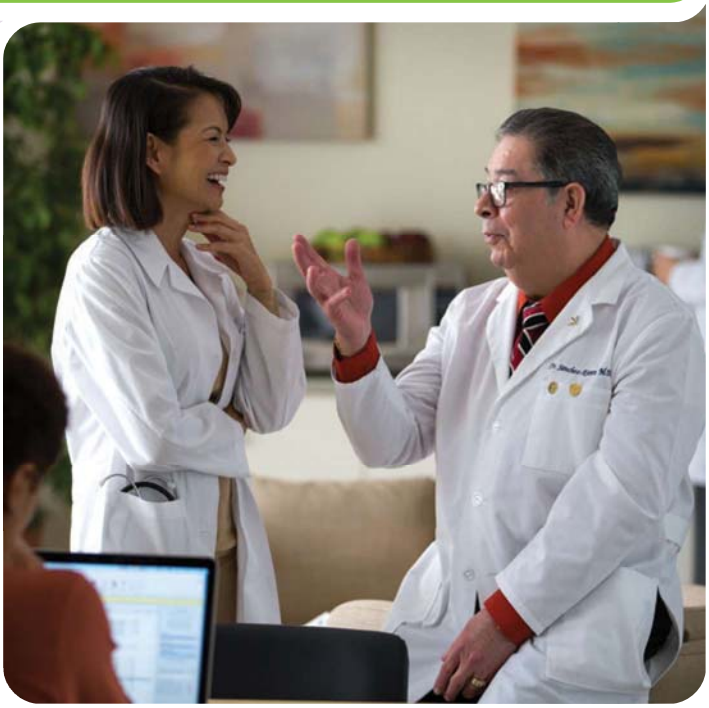
Appendix B: Summary of Applicable Laws and Regulations

Note: Depending on the function your organization performs, not all of the following laws and regulations may be applicable to it.

Title XVIII of the Social Security Act	Passed in 1965, the Social Security Act included Title XVIII, which became known as Medicare. Title XVIII includes Part A, which provides hospital insurance for the aged and disabled, and Part B, which provides medical insurance. To address the Part A and Part B benefits, Medicare offers a choice between an open-network single payer health care plan (known as Original Medicare) and plans administered by private companies approved by Medicare (Medicare Advantage, or Medicare Part C), where the federal government pays for private companies to administer health coverage. Medicare Part D covers outpatient prescription drugs exclusively through plans offered by Medicare-approved private insurance companies. Part D plans can either be stand-alone prescription drug plans or through included in a Medicare Advantage plan that offers prescription drugs. Humana offers part C and D plans. Therefore, the laws and regulations related to Part C and D plans, many of which are listed in the link below, impact your relationship with Humana. http://www.ssa.gov/OP_Home/ssact/title18/1800.htm
Regulations governing Medicare Parts C and D, and Medicaid, where applicable, found at 42 C.F.R. §§ 422 and 423 respectively	CCMS has outlined compliance program guidelines in its Prescription Drug Benefit Manual, Chapter 9 and Medicare Managed Care Manual, Chapter 21. That combined manual is an interpretation of the compliance program requirements and related provisions in 42 C.F.R. Parts 422 and 423 for Medicare Advantage Organizations (MAO) and Medicare Prescription Drug Plans (PDP). As a result, Humana's compliance program incorporates the seven elements of an effective program as outlined by CMS. 42 C.F.R. § 422.503: http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div8&view=text&node=42%3A3.0.1.1.9.11.5.4&idno=42 42 C.F.R. § 422.504: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=c41f978c39319dbc1d0a601eba47dee%200&ty=HTML&h=L&r=SECTION&n=se42.3.422_1504 42 C.F.R. § 423.504: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=808d3484cc31371f557c19a256928842&ty=HTML&h=L&r=SECTION&n=42y3.0.1.1.10.11.5.5
Medicare Managed Care Manual, Chapter 3 – Medicare Marketing Guidelines	The Marketing guidelines reflect CMS' interpretation of the marketing requirements and related provisions of the Medicare Advantage and Medicare Prescription Drug Benefit rules (42 C.F.R. Parts 422 and 423). For specific information on marketing guidelines related to Providers, please refer to section 70.11 titled "Marketing in the Health Care Setting". https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html
Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119)	This extensive act is most known for the increased rights and protections it establishes for consumers, but it has many provisions, known as titles. The core elements of this act include, but are not limited to, the following: • Where/how to purchase coverage is being expanded • New benefits are offered for those eligible for coverage • There are shifts in who is eligible for receiving and retaining coverage and under what arrangements • Organizations offering insurance, like Humana, are subject to greater accountability The act will change payment (amounts) and reimbursement(s) for certain benefits, as well as increase the ability to appeal claims, which may impact enrollment and claims processing. This could ultimately affect your relationship with Humana and/or how your organization maintains records and/or tracks payments. There are other titles that could also impact your organization, although not directly in regard to Humana. Therefore, the act is available here for review: http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf
Federal Acquisition Regulation	This regulation prohibits gifts with greater than $15 fair market value from being given to, or received from, the government. The exceptions are: • Modest items of snacks and refreshments (such as soft drinks, coffee and donuts) offered other than as part of a meal if made available to everyone in attendance • Promotional or marketing materials (e.g., pens, pencils, note pads and calendars) valued at $15 or less • Tokens of appreciation (e.g., command coins or patches) with the command's/unit's logo, valued at $15 or less
Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191)	Per the U.S. Department of Labor, HIPAA was initially passed in 1996 to "improve portability and continuity of health insurance coverage." As a result, there are more consumer protections regarding options for coverage. http://aspe.hhs.gov/admnsimp/pl104191.htm Later "rules," or provisions, were passed in 2001 and 2003 to protect the privacy, confidentiality and security of individually identifiable health information. This includes the establishment of security standards for electronic protected health information. Your organization, as well as Humana, is required to have sufficient safeguards regarding this type of information, including who may access it, how much of it may be accessed by any individual and how it is retained and transmitted. http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html http://www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html

False Claims Acts (31 U.S.C. §§ 3729-3733	This act gives the federal government leverage against persons/entities involved in fraudulent activities with the government. This allows financial liability in the form of a civil penalty and damages to be imposed for submitting, or causing someone to submit, a false or fraudulent claim for government payment. http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37- subchapIII-sec3729.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37- subchapIII-sec3730.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37-subchapIII-sec3731.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37- subchapIII-sec3732.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title31/pdf/USCODE-2011-title31-subtitleIII-chap37- subchapIII-sec3733.pdf
Federal Criminal False Claims Statutes (18 U.S.C. §§ 287,1001)	Section 1001 applies to anyone whose action(s) related to any claim(s) for government payment consist(s) of any of the following: • Falsifying, concealing, or covering up by any trick, scheme or device a material fact related to any claim(s) for government payment; • Making any materially false, fictitious or fraudulent statement or representation; • Making or using any false writing or document knowing it contains any materially false, fictitious or fraudulent statement or entry. Section 287 states that whoever makes or presents to the government a claim knowing that it is false, fictitious or fraudulent shall be imprisoned and subject to fines. The government is required to establish all of the following in regard to the action(s) of a false claim(s) case defendant. He/she: • Made or presented a false, fictitious or fraudulent claim to a department of the United States; • Knew the claim was false, fictitious or fraudulent; and • Did so with the specific intent to violate the law or with awareness that what s/he was doing was wrong. http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-partI-chap15-sec287.pdf http://www.gpo.gov/fdsys/pkg/USCODE-2011-title18/pdf/USCODE-2011-title18-partI-chap47-sec1001.pdf
Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))	This federal statute prohibits any individual or entity from knowingly and deliberately offering, giving or receiving money or something of value in exchange for referrals of health care goods or services that will be paid for in whole or in part by a federal health care program, such as Medicare or Medicaid. http://www.ssa.gov/OP_Home/ssact/title11/1128B.htm#f
The Beneficiary Anti-Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))	This federal statute declares that any person who gives or offers to give anything of value* to a Medicare or Medicaid beneficiary that the person knows or should know is likely to influence a beneficiary's choice of a particular health care provider, practitioner or supplier to buy or rent a Medicare or Medicaid covered item from the provider, practitioner or supplier may be liable for civil money penalties of up to $10,000 for each wrongful act. http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXI-partA-sec1320a-7a.pdf * The OIG stated in guidance that there is a "nominal value" exception that allows a health care provider to give: • A gift to a beneficiary as long as the gift has a retail value of $10 or less • Multiple gifts each with retail value of $10 or less over a 12-month period, as long as the total retail value of the gifts does not exceed $50 Any such gift must not be in cash or cash equivalents, so it should not be a gift card or gift certificate. Types of gifts and their value(s) are detailed in a Special Advisory Bulletin from the OIG: http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf
Prohibitions against employing or contracting with persons or entities that have been excluded from doing business with the federal government (42 U.S.C. §1395w-27(g)(1)(G)	The expectations of CMS and Humana in regard to screening government exclusion lists have been outlined in the oversight section on page 9 of this policy and in this federal provision: http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXVIII-partC-sec1395w-27.pdf
Foreign Corrupt Practices Act (FCPA)	This federal statute prohibits giving any type of gift, payment, entertainment, gratuity or anything of value to a foreign official, political candidate, political party, party official, public international organization, their employees or their representatives or entities working with them for the purpose of obtaining, retaining or directing their business to any person for the purpose of influencing an official act or decision or securing an improper advantage. The FCPA has specific criminal and civil penalties for violations: fines for the responsible organization, suspension or debarment from participation in federal programs and fines and imprisonment for individuals convicted of such conduct. https://www.justice.gov/criminal-fraud/foreign-corrupt-practices-act

Civil monetary penalties of the Social Security Act (42 U.S.C. § 1395w-27 (g))	This provision of the Social Security Act describes the penalties that can be assessed to organizations that offer Part C and/or Part D plans should CMS determine they do not meet the requirements outlined in their contract(s) with CMS. Your organization is impacted by this act if it supports and/or sells any of Humana's Medicare Advantage or Prescription Drug products. Examples of such impactful provisions include, but are not limited to: • Enrolling an individual in any such plan without the prior consent of the individual or the individual's designee • Failing to re-enroll an eligible individual • Denying or discouraging an eligible individual from plan enrollment • Noncompliance with marketing restrictions surrounding these plans • Failing substantially to provide medically necessary items and services that are required (under law or contract) {to an individual covered under the contract http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXVIII-partC-sec1395w-27.pdf
Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn)	This statute: • Prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception* applies • Prohibits the entity from presenting, or causing to be presented, claims to Medicare (or billing another individual, entity or third party payer) for those referred services * Specific exceptions have been established, and the federal government has the authority to create regulatory exceptions for financial relationships that do not pose a risk of program or patient abuse. Please refer to the following link for a list of the established exceptions and additional information: https://www.cms.gov/PhysicianSelfReferral/
Fraud and Abuse, Privacy and Security Provisions of the Health Insurance Portability and Accountability Act, as modified by HITECH Act	This act could be considered an extension of HIPAA, as it enabled the U.S. Department of Health and Human Services to promote and expand the adoption of health information technology. It addresses: • Use of electronic health records, including incentives for adopting them and requirements around their disclosure • How to secure protected health information appropriately • When and to whom notifications should made in regard to data breaches of unsecured protected health information (PHI) http://www.healthit.gov/policy-researchers-implementers/health-it-legislation-and-regulations
Fraud Enforcement and Recovery Act of 2009	This act improves the enforcement of various kinds of fraud related to federal assistance and relief programs, the recovery of funds lost to these frauds, and for other purposes. It increased resources for investigation and prosecution of fraud cases and made recovery under the False Claims Act, 31 USC § 3729 statute easier. http://www.gpo.gov/fdsys/pkg/PLAW-111publ21/pdf/PLAW-111publ21.pdf
CMS Data Use Agreement	Humana's Compliance Policy and Ethics Every Day for Contracted Health Care Providers and Business Partners incorporate the overarching aspects of the CMS Data Use Agreement to facilitate the proper safeguarding of all data, including CMS-related data, by Humana and health care providers and business partners, regardless of whether support is provided for Humana's Part C and/or Part D offerings. The overarching components of the CMS Data Use Agreement are as follows: **Disclosure**, use, or reuse of the data covered by the agreement between CMS and Humana must only be for the purpose(s) specified within the agreement, unless CMS provides appropriate authorization for any other purpose(s). • Any individual's access to the data must only be on a need-to-know basis • Data access must be limited to the minimum amount of data and minimum number of individuals necessary to achieve the purpose stated in the agreement **Sufficient Data Safeguards** for the storage and disclosure of data/information must be established from the following perspectives: administrative, technical and physical. Together these measures assure data confidentiality is protected and that unauthorized use or access to it is prevented. **Handling of Suspected or Detected Breaches** • This matter is addressed in the Effective Communications section of this policy under "Methods for Reporting Suspected or Detected Noncompliance to Humana" A signed CMS Data Use Agreement provides CMS with assurance of compliance with the requirements of the Privacy Act, the Privacy Rule, and CMS data release policies when CMS data is utilized by anyone outside of CMS. The agreement must be completed and updated when applicable by Humana. Upon CMS' receipt of the completed agreement, CMS provides Humana with, and/or access to, data containing, but not necessarily limited to, protected health information and individual identifiers from CMS' Systems of Record. It is your responsibility to consult with your legal counsel to determine when/if there are instances that the CMS Data Use Agreement applies to your organization.
All sub-regulatory guidance produced by CMS and HHS such as manuals, training materials, HPMS memos, and guides	Vast guidance resources are available on the following websites: **CMS:** https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html **U.S. Department of Health and Human Services:** http://www.hhs.gov/ http://www.hhs.gov/regulations/index.html



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GHHH7DVHH 0816

Florida Medicaid Subcontractor Monitoring & Oversight

Humana

Humana Procedure

Creation Date:	September 26, 2017	**Accountable Dept:**	50606 Florida Medicaid Administration
		Business Domain:	FL Medicaid
		Business Area:	Delegation Oversight

Summary of Changes: New document

Scope: This Procedure applies to the Florida Medicaid Market and the oversight of Subcontractor/Vendor performance.

Statement: The purpose of this Procedure document is to establish a process for monitoring and oversight of contracted subcontractors/vendors who render services on behalf of Humana Health Plan. The Procedure is written in accordance with the Agency for Health Care Administration (the Agency) state contract FP023, Amendment 14 requirements (State Contract).

Definitions:
Subcontractor – Any entity contracted by or subsidiary or affiliate of the Health Plan that performs services or fulfills any of the requirements listed in the State Contract.

Delegated Vendor – Any entity performing functions on behalf of the Health Plan that are listed in the State Contract. These include but are not limited to utilization management, case management, claims processing, network management and credentialing.

Related Document(s): Medicaid Delegate Relationship Management Policy; Delegated Vendor Performance Oversight Program Description; Delegated Vendor Oversight Committee Charter; Subcontractor Lifecycle

Procedure: Florida Medicaid Subcontractor Monitoring & Oversight

Description: Humana oversees Florida subcontractors/vendors through a company-wide coordinated approach across multiple teams, including Florida Market Operations, Delegation Compliance, First Tier Downstream Related entity (FDR) Compliance, and Regulatory Compliance. The monitoring and oversight of subcontractors/vendors results are reported to the Delegated Vendor Oversight Committee (DVOC). The oversight activities are managed in compliance with active Florida Medicaid State Contract requirements, NCQA accreditation standards, and all applicable laws, rules, and regulations.

Narrative:

Florida Market Operations

The local Florida Market Operations team includes Delegate Relationship Managers (DRM) responsible for the procurement of subcontractors/vendors. The DRM develops the contract and engages Delegation Compliance at the corporate level, if any functions are to be delegated. In addition, the Florida Market Operations team:

- Holds subcontractors/vendors accountable for compliance with State Contract requirements and Service Level Agreements (SLAs).

- In conjunction with the subcontractor/vendor, the Florida Market Operations team will identify and align on challenges and improvement opportunities.

- Reports findings, corrective action plans, and follow up to the DVOC.

- Monitors the performance trend of subcontractors/vendors overtime (e.g. SLAs, key compliance metrics, etc.).

- Reports results of the monitoring to the Agency's Contract Manager, fourteen (14) business days after the end of each month or as specified by the Agency. The reports shall be based on the Agency supplied format.

- If the subcontractor/vendor's performance does not meet the Agency's performance standards according to the Agency's monitoring report or the subcontractor/vendor monitoring report, an improvement plan must be submitted to the subcontractor/vendor and the Agency within fourteen (14) business days of the deficient report.

- Assesses and reviews the operational health of subcontractors/vendors with Humana and subcontractor/vendor leadership during regularly held Joint Operational Committee (JOC) meetings, and uses this forum to ensure:
  - Subcontractors/vendors comply with applicable state and federal Laws;
  - Subcontractors/vendors are eligible for participation in the Medicaid Program;
  - Tasks related to the subcontract are performed in accordance with the terms of the State Contract;
  - Delegated durable medical equipment (DME) subcontractors are in compliance with Florida Statute § 409.975(1)(d) and the Agency Guidance Statement regarding Durable Medical Equipment Contracts in the Managed Medical Assistance Program.

- Assists with resolution of member and provider complaints, including:
  - Billing and claims issues;
  - Coordinating appropriate pre- and post-contracting activities with the Delegation Compliance team, if the subcontractor/vendor will be delegated for any functions (e.g., claims, credentialing, utilization management, and network management).

- Participates in all key audits associated with the subcontractor/vendor to facilitate full performance transparency and coordinated follow up.

- Supports escalation of performance issues including penalty assessments, de-delegation evaluations, breach investigations, and like issues.

- Engages the appropriate subject matter experts (SMEs) (Legal, Privacy, Enterprise Information Protection (EIP), Delegation Compliance, Regulatory Compliance, Internal Audit Consulting Group (IACG), FDR Compliance, Clinical/Operational leads) to assist in addressing issues or exploring opportunities to maximize relationship value.

Delegation Compliance

The Delegation Compliance team is a centralized team based in Humana's corporate office and conducts operational compliance oversight of subcontractors/vendors performing claims, clinical health services, credentialing, and any other delegated function on behalf of Humana. This team:

- Evaluates all delegation requests submitted to Delegation Compliance to initiate a pre-delegation audit.

- Performs an audit prior to delegation of these functions to assess capability to perform the function in a compliant manner.
- Based on the audit results, provides recommendation for subcontractor/vendor delegation.
- Conducts annual audits against function-specific compliance standards and routinely monitors each delegate.
- Initiates corrective actions when instances of noncompliance are identified and notifies Market Operations.

FDR Compliance

Humana's FDR Compliance team is a centralized team based in Humana's corporate office. The FDR Compliance team conducts oversight activities related to compliance program requirements such as:

- Evaluates the FDR Risk Ranking Questionnaire completed by the business owner.
- Tracks the universe of subcontractors/vendors.
- Performs periodic audits against compliance program standards, periodic monitoring of compliance program self-assessments completed by subcontractors/vendors, and reviews subcontractors/vendors against the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists monthly.
- Initiates corrective actions when instances of noncompliance with compliance program requirements are identified and notifies Market Operations.

Regulatory Compliance

The Regulatory Compliance team is a centralized team based in both Humana's corporate office and the field. This team assists with oversight and monitoring activities such as:

- Assists Delegation Compliance and FDR Compliance with desk reviews and audits as needed.
- Assists with issues identified through other oversight and monitoring channels.

Delegated Subcontractor/Vendor Performance Oversight

This team is Florida Market-based and includes a Director, Vendor Performance Oversight, who is dedicated to subcontractor/vendor performance oversight. The Director works closely with all entities listed within this Procedure to ensure subcontractor/vendor performance remains compliant with the State Contract requirements and agreed upon SLAs between the subcontractor/vendor and Humana.

Delegated Vendor Oversight Committee (DVOC)

The DVOC is a Florida specific committee responsible for the monitoring of delegated vendors who render services on behalf of Humana Health Plan. The DVOC is chaired by the Director, Vendor Performance Oversight and meets quarterly at minimum and more frequently as needed. The DVOC reports to the Quality Improvement Committee. The DVOC is charged to:

- Establish appropriate delegation oversight mechanisms, procedures and tools.
- Review vendor activity, performance metrics, and audit results.
- Make recommendations and approve corrective action plans as appropriate.

- Review annual Utilization Management (UM) program descriptions and evaluations for vendors with delegated UM.
- Review and follow up on corrective action plan progress and/or completion.
- Perform annual evaluation of the Delegated Vendor Performance Oversight program and makes recommendations for enhancements

Owner:	**Irene Lord**	**Executive Team Members:**	**John Barger, Alan Wheatley**
Accountable VP / Director:	**Jaimie White**		

Disclaimer:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by a particular issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This Procedure is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This Procedure supersedes all other policies, standards, guidelines, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source to ensure no modifications have been made.

Non-Compliance:

Failure to comply with any part of Humana's policies, standards, guidelines, and procedures may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over any and all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this Procedure may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Policy Source site of Humana's secure intranet on HI! (Sites/View Full Site Directory/Tools and Resources/Policy Source).

Medicaid Delegate Relationship Management

Humana

Humana Policy and Procedure

Creation Date:	February 23, 2017	**Accountable Dept:**	50115 Medicaid/LTSS/Duals Operations
Publication Date:	March 10, 2017	**Business Domain:**	02 Governance and Compliance
Last Review Date:	March 9, 2017	**Business Area:**	04.11 Vendor Compliance

Summary of Changes: New document

Scope: This policy applies to anyone responsible for Medicaid Delegate Relationship Management, including selection, contracting, and on-going relationship oversight of third parties and internal-to-Humana legal entities which have been delegated certain plan-required services.

Statement: The purpose of this policy is to clarify the expectations and accountabilities of an individual who is the responsible Medicaid Delegate Relationship Manager.

Definitions: See below

Related Document(s): Delegation Policy

Procedure: Medicaid Delegate Relationship Management

Description: Each individual responsible for the relationship management of third party and internal-to-Humana legal entities delegated to perform certain plan-required services is to ensure that the following actions and activities are accomplished.

Narrative:

First Tier-Down Stream-Related Entity (FDR) Assessment

- Ensure the Risk Ranking Questionnaire is completed and submitted to the FDR Committee for review.
- Confirm and follow the requirements for third parties determined to be FDRs.

Delegation Coordination

- Submit a completed Request for Delegation form to Delegation Compliance to initiate a pre-delegation audit.
- Confirm and follow the delegation recommendation from Delegation Compliance (Go/No Go).

Contracting

- Complete required due diligence (e.g. financial, business continuity, systems and physical security, etc.) to identify and mitigate potential risk.
- Negotiate all required contract documents and related provisions, working with contract drafting, legal, and compliance SMEs to streamline the language, limit duplications, and eliminate conflicting language, to include, but not be limited to:
  - Performance Requirements (aka service level agreements (SLAs)), reflecting relevant contract performance. requirements and Humana operating standards, inclusive of penalties and incentives, as appropriate;
  - For the specific delegated functions, a Delegation Addendum and attachments;
  - A current state-specific Medicaid Addendum (aka Medicaid Omnibus Agreement);
  - A Business Associate Agreement (BAA), as applicable;
  - An IT Security Agreement (ITSA), as applicable.
- Facilitate final reviews and contract execution, internal-to-Humana, including the operational lead(s), and with the Delegate.

- In partnership with state-facing market lead(s), obtain state agency approval for the initial relationship and relationship changes, as required.

On-Going Relationship Oversight

- Identify and engage the operational lead(s) associated with the Delegate to establish and maintain a shared understanding of expectations and accountability for compliance oversight.
- Hold Delegates accountable for compliance.
- In partnership with operational market lead(s), participate in regular operational pulse meetings.
- Assess and review the operational health of Delegates with Humana and Delegate leadership during formal periodic meetings and use these occasions to:
    - Align on compliance challenges/opportunities (e.g. Grievance and Appeals (G&A), Risk Management, Internal Audit Consulting Group (IACG), Delegation, First-Tier-Down Stream-Related Entity (FDR), Enterprise Information Protection (EIP), Privacy, Legal, Regulatory Compliance, related audit findings and Corrective Action Plans (CAPs), etc.).
    - Pulse performance trend over time (e.g. SLAs, key compliance metrics).
    - Identify/address operational and performance barriers.
    - Pursue opportunities to maximize business benefit.
    - Explore cross-market translation opportunities.
- Document and publish notes & next actions from the formal periodic leadership meetings.
- Participate in all key audits associated with the third party to facilitate full performance transparency and coordinated follow up.
- Support escalation of performance issues including penalty assessments, de-delegation evaluations, breach investigations.
- Engage the appropriate SMEs (e.g., legal, privacy, EIP, delegation, regulatory compliance, IACG, FDR, clinical/operational leads) to assist in addressing issues or exploring opportunities to maximize relationship value.

Assessment of Future Service Sources

- Participate in future service evaluations and competitive evaluations for the services provided, inclusive of insourcing assessments.

Definitions:

- **Business Associate Agreement (BAA)** - A contract document containing terms, obligations, and information regarding between the Delegate, as a HIPAA business associate, and Humana, as a HIPAA-covered entity, as established via HIPAA.
- **CMS –** Centers for Medicare & Medicaid Services.
- **Delegated Entity or Medicaid Delegate –** An entity contracted to perform one or more functions, as required of Humana Medicaid under a state Medicaid contract, on behalf of Humana Medicaid.
- **Delegation –** A formal process whereby a health plan gives a qualified entity the authority to perform certain business functions required of Humana by the state Medicaid contract.
- **Delegation Addendum –** A contract document containing terms, obligations, and information regarding the delegation of specific functions to an entity.
- **HIPAA - Health Insurance Portability and Accountability Act.**
- **IT Security Agreement (ITSA)** - A contract document containing terms, obligations, and information regarding information technology-related security requirements.
- **Medicaid Addendum or Medicaid Omnibus Agreement –** A contract document containing terms, obligations, and information regarding requirements of First Tier, Downstream, or Related Entities, as established and governed by CMS, in the service of Medicaid enrollees in a given state
- **Pre-Delegation Audit –** Method to evaluate an entity's compliance and performance capacity prior to the execution of a Delegation Addendum.

Related Documents: Delegation Policy

Owner:	Deborah Beavin	**Executive Team Member:**	John Barge and Alan Wheatley
Accountable VP / Director:	Jeff Layman		

Disclaimer:

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2016 FDR Compliance Risk Ranking Questionnaire – Final 6/17/2016

The Risk Ranking Questionnaire (RRQ) must be completed prior to the execution and/or modification of a contract that supports Medicare Advantage, Prescription Drug Plan, and/or Medicaid products. The completed RRQ is submitted to the FDR Compliance Team which is responsible for determining if the entity (partner) is a first tier, downstream or related entity (FDR) based, on the scope of work.

Definition:

A **first tier entity** is any party that enters into a written arrangement with a Humana entity to provide administrative or health care services to a Medicare or Medicaid eligible individual under a Humana Medicare Advantage, Medicare Prescription Drug Benefit, Medicaid or Dual Medicare-Medicaid plan.

A **downstream entity** is any party that enters into a written arrangement with persons or entities involved with a Humana Medicare Advantage, Medicare Prescription Drug Benefit, Medicaid or Dual Medicare-Medicaid plan, below the level of the arrangement between Humana and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

A **related entity** is any entity that is related to Humana by common ownership or control and:

- Performs some of the health plan management functions under contract or delegation;
- Furnishes services to Medicare, Medicaid or Dual Medicare-Medicaid enrollees under an oral or written agreement; or
- Leases real property or sells materials to Humana at a cost of more than $2,500 during a contract period.

Scope:

FDRs include entities performing functions that support the administration or delivery of Medicare Advantage, Medicare Prescription Drug Benefit, Medicaid and/or Dual Medicare-Medicaid health care services or benefits (including mandatory and optional supplemental benefits) offered by Humana, and continues down to the level of the ultimate provider of administrative or health services. These definitions do not apply to any other products (i.e., Medicare supplement and commercial products).

FDRs include delegated entities, suppliers, providers, pharmacies and delegated sales agents. The Centers for Medicare and Medicaid Services (CMS) govern relationships associated with service to Medicare and Medicaid members. In the questions below the following terms apply:

- Humana refers to Humana Inc. and any Humana subsidiaries
- Supplier refers to the entity contracted with Humana and any subcontractors supporting the contracted entity

The contracting business partner must complete the required information below to determine if FDR reporting to CMS is required for this transaction and whether any Medicare or Medicaid addenda are required for the contract. This form must be completed for all new contracts and also in the event that an existing contract is modified for any reason.

For any questions, contact partnercompliance@humana.com

Item	Guidance	Response
Name of partner:	Legal name on the agreement	
The Centers for Medicare and Medicaid Services (CMS) govern relationships associated with service to Medicare and Medicaid members. Are the services procured under this contract in support of the Centers for Medicare and Medicaid Services, such as Humana Medicare Advantage, Dual Medicare/Medicaid, Medicaid only, or Prescription Drug Benefit products or services?	Respond Yes, if the partner will be supporting Medicare , Medicaid or Duals services on behalf of Humana. Procurement is responsible for executing a Medicare addendum and informing FDR Compliance of the contract effective date. If the response is No, the remaining questionnaire does not need to be completed or forwarded to FDR Compliance.	
If you answer yes to the above because the services support Medicaid, indicate all applicable states:	Select each state that applies: FL, IL, VA, KY, All. Procurement will need to execute the appropriate Medicaid addendum for each state indicated and inform FDR Compliance of the contract effective date(s). Contact Ryan Keith if questions on addenda for KY, IL, VA. Contact Nicole Hines for questions on FL addenda.	
Humana Affiliated Legal Entity that is Contracting with the partner:	The name on the agreement of the Humana legal entity contracting with the partner.	
Humana business area contracting with this partner:	Humana business (*aka Component*) area initiating the contract.	
Humana business area process owner:	The operational business owner responsible for managing and oversight of the contracted scope of work.	
Humana business contract owner:	Person in the operational business area responsible for the overall contract.	
Procurement lead	Name of the person in procurement responsible for processing the partner contract.	
List the functions and services provided by the partner: Actuarial Support, Advanced Care Planning, Audits/Surveys – Required, Behavioral Health, Care Management, Claims Administration, Processing and Coverage Adjudication, Claims Review, Clinical Health Services, Clinical Outreach, Complex Case Management, Coordination of Benefits, Credentialing, Customer Inquiry, Customer Service, Dental, Diagnostic Lab Testing, Disease Management, Drug Utilization Review, Enrollment, Financial Recovery/Subrogation, Fiscal Intermediary Services, Grievance and Appeals, Health Care Services, Health Risk Assessment,	List all functions that apply from the options imbedded. If the function or service you need is not listed please specify.	

Home Health, Hotline Operations, Marketing, Medical Record Retrieval, Medical Record Review, Medicare Risk Adjustment, Medication Intake, Therapy, Member Eligibility Verification, Member Pharmaceutical Counseling and Education, Network Management, Payroll Services¸ Pharmacy Benefits Management, Population Health Management, Practice Management Services, Prescription Drug Fulfillment, Print and Mail Fulfillment, Provider Relations, Quality Improvement, Quality Management, Sales Functions, Special Needs Plan, Transportation Services, Unable to Contact, Utilization Management, Utilization Review, Wellness and Rewards Program		
Scope of Work:	Include a full and detailed description of the scope of work (functions and services). This can be taken from the draft contract, SOW, schedule or Executive Summary as needed. Attach the actual or draft SOW or forward to partnercompliance@humana.com if available, even if in draft format.	
Service Level Agreement (SLA):	Please include proposed service level agreements for this SOW.	
Is this a direct contract with Humana (First Tier)?	Yes, if the contract is between Humana and the partner. Be advised that if any time the contractor subcontracts any of the Humana work, FDR compliance must be notified.	
If no, explain the subcontractor relationship (Downstream):	Indicate who the subcontractor has contracted with directly.	
Is the partner partially or wholly owned by Humana (Related Entity)?	Respond Yes or No If Yes, Indicate partial or wholly owned.	
Partner's internal compliance point of contact resource Name	Name	
Partner's internal compliance point of contact resource Title	Title	
Partner's internal compliance point of contact resource Email	Email	
Partner's internal compliance point of contact resource Phone	Phone	
Physical location where contracted work will be performed Line 1	Line 1	
Physical location where contracted work will be	Line 2	

performed Line 2		
Physical location where contracted work will be performed City	City	
Physical location where contracted work will be performed State	State	
Physical location where contracted work will be performed Zip Code	Zip Code	
Risk Criteria Questions:		
1. Does the partner provide a delegated function for Humana?	Choose all that apply: • Credentialing Operations; • Claim Operations; and/or • Clinical Health Services (Delegation refers to a function that is being performed entirely by a partner other than Humana, overseen by Delegation Compliance and requires a Delegation Agreement. For example: Credentialing; Claim Processing; Utilization Management; Disease Management; Behavioral Health; Quality Improvement; Complex Case Management).	
2. Does the contracted work require direct interaction with members?	Respond Yes or No Direct interaction can be face-to-face, over the phone or through written correspondence.	
3. Does the contracted work require access into Humana systems?	Respond Yes or No This includes employees or contractors of the partner having access to any internal Humana systems.	
4. Does the partner have access to Humana member's health and/or financial information?	Respond Yes or No	
5. Is Humana member's health and/or financial information stored outside of Humana systems or locations in support of this contract?	Respond Yes or No	
6. Does the partner make health plan decisions on Humana's behalf?	Respond Yes or No *Most responses will be "No" to this question. If decision making is based upon Humana policy or procedure, answer "no". For example, if an partner makes decisions, but the decision is directed or dictated by Humana policy, procedure or defined criteria, the response is no.*	
7. Does the partner perform a critical function and also perform a substantial portion of the function for Humana as a whole?	Respond Yes or No Consider to what degree Humana business functions would be adversely impacted in the event the relationship with this partner was disrupted, ended unexpectedly, or the contracted work was not performed properly. For example: The partner performs at least 80% of the work for all of Humana. Critical functions include those core to the operation of a	

	health plan, such as billing; eligibility; enrollment; claims processing; call center operations, etc.	
8. Does the function(s) impact the member's ability to receive care under a Humana benefit plan?	Respond Yes or No Defaults to No if the partner is a Claims or Credentialing delegate. FDR Compliance Intake Consultant will confirm this response for each Clinical Health Services delegate.	
9. Does the function(s) impact member's ability to access pharmaceutical drugs under a Humana benefit plan?	Respond Yes or No	
10. Will the partner utilize or subcontract with an off shore vendor (vendor located outside of the United States or United States territory) to meet contractual obligations to Humana?	Respond Yes or No If Yes, Procurement will engage Humana Enterprise Information Protection (EIP) to complete a due diligence review of the off shore vendor. This information must be reported to CMS, by FDR Compliance, within 30 days of the contract signature date. Be advised that if at any time the off shore arrangement changes: new off shore arrangement added, change in location or change in scope of work, the FDR Compliance Team must be notified immediately.	
11. If yes, what is the name of the off shore vendor?	Include the name of the vendor providing the off shore support.	
Person completing this form:	Name	
Email of person completing this form:	Email	
Date the form is completed:	Date	

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Committee: Delegated Vendor Oversight Committee (DVOC)

Charter Statement:
The Delegated Vendor Oversight Committee (DVOC) is a Florida based decision-making committee that monitors the health plan's delegated services and performs oversight of quality and service activities delivered and managed by contracted vendors.

Purpose:
- Provide oversight of delegated vendor activities that relate to utilization management, credentialing, customer services (member and provider), contract compliance, and claims processing and payment. This is accomplished through a comprehensive, Plan-wide system of ongoing, objective, and systematic monitoring (oversight program).
- The Director, Vendor Performance Oversight, in conjunction with the Delegate Relationship Managers (DRM), is responsible for vendor relationship maintenance and the monitoring of delegated vendor performance in accordance with the contract requirements.
- The Business Owners from their respective areas are responsible for the monitoring of vendor performance related to their designated areas. If the vendor fails to meet the established performance targets, Business Owners, in conjunction with the DRMs, are responsible for the recommendation and the development of corrective action plans (CAPs). Delegation Compliance, Regulatory Compliance and Internal Audit Consultant Group shall be consulted in the CAP development. One or more of these teams must be engaged to invoke a formal CAP. All CAPs are captured in, triggered, and issued from, the central partner repository, Enterprise Solution Point (ESP).
- Opportunities for vendor performance improvement/enhancement are identified and resolved during the Joint Operational Committee (JOC) meetings with the vendors, and the outcomes are presented to the DVOC. JOC meetings are led by the Delegate Relationship Manager and as appropriate, the Business Owners are invited participants. If issues are being escalated, the Business Owner is required to attend the JOC meeting.
- The oversight program will ensure that delegated services meet the health Plan standards for care and customer service, as well as the standards of the Department of Insurance, requirements of state and federal regulatory agencies, and applicable accrediting agencies such as the National Committee for Quality Assurance (NCQA).
- The DVOC reports its findings to the Quality Improvement Committee (QIC).

Scope:
- Establish appropriate delegation oversight mechanisms, procedures, and tools.
- Oversight of delegated services by the review of vendor activity, performance metrics, and reports.
- Review of pre-delegation and annual delegation audit findings.
- Recommendations for the issuance of Corrective Action Plans (CAPs) as appropriate.
- Review of vendors' annual QI/UM Workplans, Program Descriptions, and Evaluations (as applicable).
- Review of JOC meeting minutes.
- Review and follow up on CAP activities.
- Determine and implement mechanisms to improve vendor collaboration and performance.

Structure and Operation:
- The members of the DVOC act as an oversight committee and receive regular reports from all Delegate-specific subcommittees that are responsible for monitoring activities.
- The DVOC is a Business Owner committee with at least one (1) representative from each department involved with the Delegate to monitor performance. A representative from the Corporate Delegation Compliance team shall attend the DVOC.
- The Director, Vendor Performance Oversight (or designee) is the standing chairperson for the DVOC.
- The DVOC meets at a minimum four (4) times per year and on an ad hoc basis as necessary.

Quorum: All members are voting members; a minimum of four (4) members must be present for a quorum.

Decision Authority:
Except where decision making authority is retained by others as stated herein, the DVOC is authorized by the health Plan QIC to make all decisions related to vendor oversight. Decisions are made by consensus and DVOC members are responsible to raise any concerns or issues at the DVOC meetings.

Committee Data/Document Responsibilities:
- The chairperson or a designee maintains detailed records and minutes of all DVOC meetings, presentation documents, dashboards, reports, CAPs, and logs decisions made by the Committee.
- The DVOC submits meeting minutes to the QIC for approval at least four (4) times per year, which in turn incorporates the DVOC minutes into a report presented to the Corporate Board of Directors. Committee minutes are completed, signed, and dated by the recorder within fifteen (15) calendar days of the meeting, and are signed and dated by the chairperson within five (5) business days following approval of the minutes at the next meeting of the Committee.

Evaluation:
- The DVOC submits a written summary in the form of an evaluation of the outcomes and effectiveness of the DVOC program to the QIC on an annual basis.
- The DVOC reviews the charter annually.

9/21/17

Delegated Vendor Performance Oversight Program Description

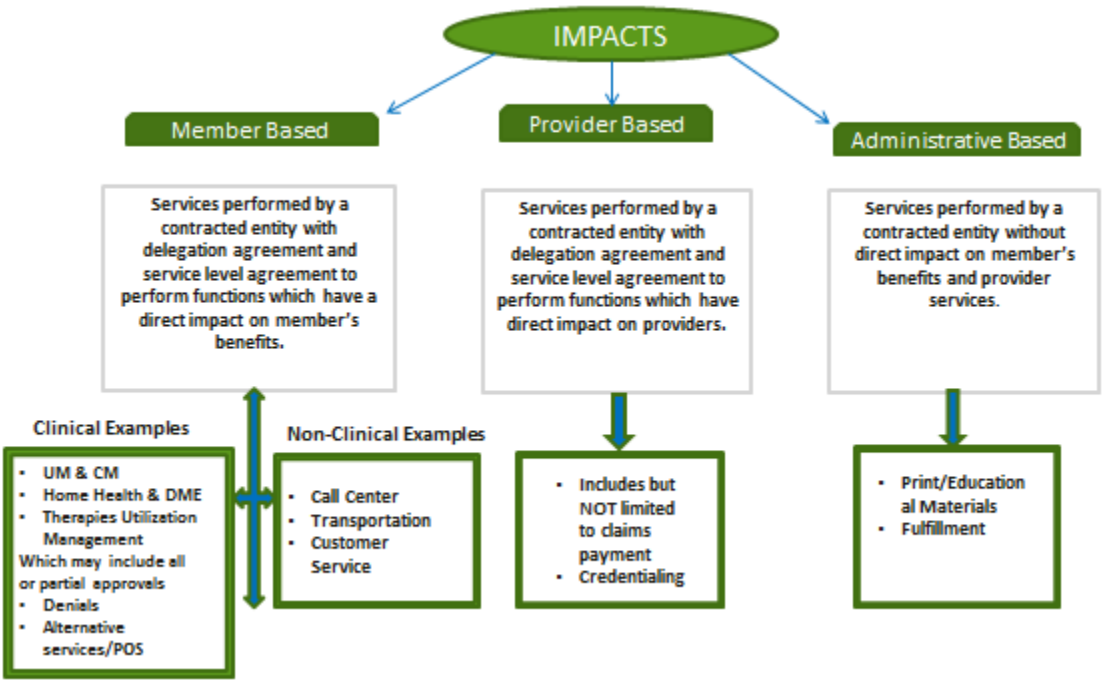
2017

Humana.

Delegated Vendor Performance Oversight
Program Description

I. Introduction and Overview

The Delegated Vendor Performance Oversight program, a Florida based program, sets forth the monitoring and oversight of functions delegated to subcontractors. The delegated functions are divided into three (3) pillars with corresponding impacts.



The monitoring and oversight of the delegated functions entails coordination and collaboration with subcontractors rendering services on behalf of the Humana Plan. Humana remains responsible for the performance and compliance of any function that is delegated. The following functions that may be delegated are:

- Utilization Management (UM)
- Complex Case Management (CM)
- Disease Management (DM)
- Behavioral/Mental Health
- Dental Health
- Provider Credentialing
- Network Management
- Claims Payment
- Ancillary Services (Therapies, Home Health, DME, Specialty Networks)
- Other function(s) as identified

A comprehensive monitoring approach incorporating market-based and corporate teams is utilized to ensure subcontractors are in compliance with all contract provisions. Humana undertakes the following actions in its subcontractor monitoring and oversight:

- Pre-Delegation Audit
- Delegation Services Agreement, including specific Service Levels Agreement (SLA) and Attachments
- Annual Delegation Audit (NCQA Standards where applicable, and contractual provisions)
- Ad hoc audit if warranted by subcontractor's performance
- Corrective Action Plans
- Protected Health Information (PHI) protection
- Financial contingency plan for subcontractors with financial risk
- Termination of Delegation

Refer to Delegation Policy (Business Domain: 02 Governance and Compliance, Attachment A) for a full description of each action.

The monitoring and oversight of subcontractors with delegated functions is performed by the Delegate Relationship Managers (DRM). The DRMs are assigned to each subcontractor and oversee the performance of subcontractors via regularly held joint operational meetings with the subcontractors and receipt of regular reporting as stated in the contract. The Joint Operational Committee (JOC) meetings are designed to review the previous period's subcontractor performance as compared to SLAs and contract provisions. JOC meetings are led by the DRM and attended by the Director, Vendor Performance Oversight, and Business Owners from designated areas are invited participants. In addition, the Director, Vendor Performance Oversight holds periodic operational meetings with all DRMs to review subcontractors' performance, identify opportunities for improvement, develop corrective interventions and identify progress made. Summaries of subcontractor performance are presented at the Delegated Vendor Oversight Committee (DVOC) which reports to the Quality Improvement Committee (QIC).

II. Goals and Objectives

The goals and objectives of the subcontractor monitoring and oversight program include:

- To monitor the facilitation of the delivery of appropriate care and services to enrollees
- To monitor the response to enrollee needs and practitioner requests
- To monitor subcontractor adherence to SLAs and State contract provisions
- To identify opportunities for improvement in the delivery of care and services to enrollees
- To collaboratively develop corrective actions plans as appropriate
- To monitor for timely submission of contract required reporting

- To review the financial solvency of subcontractors with financial risk arrangements
- To monitor adherence to PHI protection requirements
- To detect inappropriate utilization patterns (UM and Claims)
- To monitor for appropriate credentialing and network adequacies
- To escalade operational and financial non-performance to the DVOC, QIC, and senior leadership
- To collaborate with Delegation Compliance to validate that all delegated functions are compliant and meet Humana expectations based on SLAs

III. Scope

Humana partners with subcontractors to provide health care and related services to enrollees. The partnerships are based on contract provisions and performance expectations stated in the SLAs. To ensure that each subcontractor adheres to or exceeds these expectations, Humana has implemented a rigorous oversight program with corporate and market based teams responsible for subcontractor performance.

IV. Accountability and Structure

The DVOC is a governing entity which reports to the QIC. All subcontractor performance issues are presented to the DVOC for review and approval of necessary interventions and corrective actions in the event of a subcontractor's non-compliance with SLAs and contract provisions. The oversight of subcontractors is performed by three entities:

1. Delegate Relationship Managers (DRM) – A front line of Humana associates who work closely with the subcontractors. They are responsible for the due diligence of subcontractors and consistent oversight of operational performance according to the SLAs and contract provisions. DRMs hold joint operational meetings with the subcontractors and report any findings which need to be escalated to the DVOC. *Refer to Medicaid Delegate Relationship Management Policy (Business Domain: 04.11 Vendor Compliance, Attachment B)* for role details.
2. Corporate Delegation Compliance – This organization is responsible for pre-delegation, annual, and ad hoc audits of subcontractors. The audits are performed in accordance with State contract provisions, NCQA Standards, and SLAs. The audit results are presented to the DVOC for recommendations of interventions as appropriate.
3. Delegated Vendor Performance Oversight unit – comprised of a director and coordinator. The role of this unit include the following:
    a. In conjunction with DRMs, facilitates the coordination of oversight and monitoring activities
    b. Reviews operational performance of subcontractors for adherence to contract provisions and SLAs
    c. In conjunction with the DRMs, develops interventions and corrective action plans as necessary to improve performance and subcontractors compliance

d. Participates in joint operational meetings with subcontractors; review performance and recommend improvements
e. Reviews for under/overutilization trends and addresses with subcontractors
f. Works with subcontractors to participate in the support of Humana's goals to improve health care outcomes (HEDIS campaigns, Plan initiatives, integration and specialty programs)
g. Establishes vendor specific performance goals based on enrollee health outcomes
h. Works closely with the Network Contracting Directors to monitor for financial solvency for subcontractors with financial risk
i. Performs any other subcontractor monitoring or oversight activity necessary to ensure exceptional performance and compliance

To ensure comprehensive oversight, communication, and timely implementation of interventions, the Director, Vendor Performance Oversight holds periodic operational meetings with the DRMs. The focus of the meetings is the review and analysis of the prior period subcontractor performance against SLAs and other contract requirements, and subsequent development of corrective interventions as appropriate. The results and actions identified during the monthly meetings are presented to the DVOC.

V. Delegated Vendor Oversight Committee (DVOC)

The DVOC is a committee that monitors the health plan's subcontractor delegated services and performs oversight of quality and service activities delivered and managed by subcontractors.

Purpose

- Provide oversight of delegated vendor activities that relate to utilization management, credentialing, customer service (member and/or provider), contract compliance, and claims processing and payment. This is accomplished through a comprehensive, Plan-wide system of ongoing, objective, and systematic monitoring (oversight program).
- The Director, Vendor Performance Oversight in conjunction with the DRMs is responsible for the vendor relationship maintenance and the monitoring of delegated vendor performance in accordance with the contract requirements.
- The DRMs are responsible for the monitoring of performance for assigned vendors. DRMs collaborate with the Business Owners from respective areas to obtain recommendations and assist with the development of corrective action plans (CAPs) if the vendor fails to meet the established performance targets. The CAPs are created in partnership with Delegation Compliance, Regulatory Compliance and Internal Audit Consultant Group. One or more of these teams are required to be engaged to invoke a formal CAP. All CAPs are issued and captured from the central partner repository, Enterprise Solution Point (ESP). Opportunities for vendor performance improvement and enhancement are identified and resolved during

the Joint Operational Committee (JOC) and other meetings with the vendors, and the outcomes are then presented to the DVOC.

- The oversight program will ensure that delegated services meet the health Plan standards for care and customer service, as well as the standards of the Department Of Insurance, requirements of state and federal regulatory agencies, and applicable accrediting agencies such as National Committee for Quality Assurance (NCQA).
- The DVOC reports its findings to the Quality Improvement Committee (QIC).

The scope of the DVOC includes, but is not limited to:

- Establish appropriate delegation oversight mechanisms, procedures, and tools
- Oversight of delegated services by the review of subcontractor activity performance metrics/reports
- Review of pre-delegation and annual delegation audit findings
- Recommendation for the issuance of CAPs as appropriate
- Review of annual program descriptions, and evaluations for subcontractors with delegated Utilization Management (UM)
- Review and follow up on CAP progress and completion
- Perform annual evaluation of the Delegated Vendor Performance Oversight Program and make recommendations for enhancements

The DVOC membership comprises of DRMs, Network Contracting Directors, the Medical Director, and representatives from operational areas within the Plan. The committee is chaired by the Director, Vendor Performance Oversight and meets quarterly at minimum and more frequently as needed.

VI. Annual Evaluation

Humana evaluates the Delegated Vendor Performance Oversight Program annually to ensure it remains current and appropriate, including the program structure, scope and level of senior leadership involvement. The evaluation and any enhancements are presented to the DVOC for approval.

Standard Operating Procedure

Financial Due Diligence (FDD)

INTRODUCTION

1.1 Purpose of this Document

This Operating Procedure Manual details the step by step process of financial information collection, financial data entry and completion of the **Financial Due Diligence Process (FDD) scorecard.** It is intended to be used as a training and reference tool for staff that will be deployed in the above process. It is used in conjunction with the Training Manual & User Manual to promote understanding and reduce the learning curve for new staff as deployed in the process.

1.2 Process Scope

General Scope:

1.2.1 IN SCOPE

- Investigate & rate via scorecard a new vendor's financial information, prior to contracting.

2 TERMS & DEFINITIONS

S. No	Term	Definition
1.	EPVS	Enterprise Procurement & Vendor Services. Humana's site to access SharePoint and Project requests
2.	SLA	Service Level Agreement
3.	KPI	Key Performance Indicators
6.	SharePoint	Humana's intranet. EPVS has a departmental site on Humana's SharePoint
7.	Outlook ("Vendor Info" mail box)	Separate folder inside the Outlook email which includes the emails sent by a Humana representative
8.	Requestor	Humana representative that will submit a request into the system to be processed.
9.	FDD	Financial Due Diligence

3 SLA & KPI

Supplier will complete the FDD template within 2 (two) business days of receiving vendor's financial statements.

4 STEP BY STEP PROCEDURE

4.1 Detailed activity table

Step #	Activities	Expected Result	Action Required, If no Result	Fig Ref No:
Financial Due Diligence is required in order to investigate and rate via scorecard a new vendor's financial situation, prior to signing product/service contracts. Note that FDD's may be requested on an existing vendor.				
1.0	Supplier Analyst will receive an FDD request through the FDD SharePoint EPVS Secure Site (submitted by an EPVS associate or a Business unit). Supplier Analyst will enter the FDD SharePoint EPVS Secure Site once a day to check if there are any Financial Due Diligence requests under the **"Open"** status. If there is a new FDD request, then Supplier Analyst will start working on it keeping the comments section updated. **FDD site link:** go/fddstatus			1
2.0	Supplier Analyst will investigate the Vendor's financial information. If the vendor is a **public company** Supplier Analyst will be able to find their financial information from online sources such as **Google Finance, Yahoo Finance, Nasdaq, Reuters.com, morningStar.com, USATODAY.com, Marketwatch.com or Scotttrade.com, SEC.gov**. This can be achieved by inserting the vendor's name in such sites. (Please refer to figure #1). Supplier Analyst will update the comment section in go/fddstatus with date of email sent to vendor.	Find new vendor's financial information online.	Contact the vendor and request their financial information be sent via email to your project email.	2

Step #	Activities	Expected Result	Action Required, If no Result	Fig Ref No:
2.1	If the new vendor is a **private company**, an automated email will be sent to vendor contact requesting the necessary financial information. If vendor is unresponsive, then Supplier Analyst will need to request vendor's financial information via email, sending follow up emails every 3 business days. If the vendor does not respond to the 3rd follow up, then Supplier Analyst will mark the vendor as "Unresponsive" as explained in 1.0 above. The financial information to be requested is **3 years** of vendor's **audited financial statements** including **Income Statement, Balance Sheet and Statement of Cash Flow**. The vendor will be notified that this request is for internal use only and that the information will not be shared with anyone and once analysis is completed, the information the vendor provided will be destroyed. If the vendor will not provide audited financial statements, Supplier Analyst will complete the Financial Due Diligence Summary to report an Overall Rating of "Red", noting that requested financial information was not made available. If the vendor provides unaudited reports, the vendor will receive a ranking that is one level lower than the scorecard calculates. (Ex: green rating would = yellow rating).	Receive new vendor's financial information via project email.	Contact the vendor and request their financial information be sent via email to your project email.	
2.2	Once all the financial information has been obtained from the vendor or from the financial website, start completing the applicable FDD template:	Complete the information required in the FDD template		 Private Comp FDD Template u Public Company Template updat

Step #	Activities	Expected Result	Action Required, If no Result	Fig Ref No:
3.0	The FDD Template contains multiple sections: Template section: • **Date of Financial review** The date in which the Supplier Analyst completed the FDD template. • **Address** This information is found in the Company Profile tab in provided websites. • **BIN# (Bank Identification Number)** This number will be provided by vendor upon set-up in iSupplier. It is not needed for this form. • **Parent Company and Comments** If provided, enter on this form. Not all companies have a Parent Company. Leave blank if not available. • **Line of Business** For Public companies, this information will be available on the online finance site (such as Yahoo Finance or Google Finance). For Private Companies Supplier Analyst will need to check the documentation provided by the vendor or check the vendor website. (See fig. 3) • **Year Started**	Enter all the information required for each section within the FDD Template.		3

Step #	Activities	Expected Result	Action Required, If no Result	Fig Ref No:
3.1	• **Current Stock Price** For public companies, Supplier Analyst can obtain this information from the Summary tab in Yahoo finance. For private companies, this information should be in the documentation provided by the new Vendor. • **Market Cap** For private companies, Supplier Analyst can obtain this information from the Summary tab in Yahoo finance. • **No of Employees** This information can be obtained from the Business Summary (above), otherwise, it may be found on the vendor's website. • **1Y target estimate** The Supplier Analyst can obtain this information from the webpage as shown above. • **Major Clients** The Supplier Analyst can obtain this information from the Vendor's website. • **Major Competitors** This information may be obtained from the Competitors tab in Yahoo Finance.			

Step #	Activities	Expected Result	Action Required, If no Result	Fig Ref No:
	• **Financial Statements Tab** To complete the Financial Statements Tab of the FDD template, the Supplier Analyst will need to go to the Financials Tab in Yahoo Finance. • **Balance Sheet table** On the Balance sheet table of the FFD template, match the lines with the balance sheet in Yahoo finance and fill in the blanks. • **Cash Flow** On the Cash Flow table of the FFD template, match the lines with the cash flow in Yahoo finance and fill in the blanks. • **Income Statement** On the Income Statement sheet table of the FFD template, match the lines with the income statement sheet in Yahoo finance and fill in the blanks.			4 5 6

Step #	Activities	Expected Result	Action Required, If no Result	Fig Ref No:
4.0	Once Supplier Analyst has completed all the fields with the information, they will save the template and update the **"Supplier health Score"** column for FDD Rating with result of financial analysis. Supplier Analyst will email the FDD Rating to the requester upon completion and save a copy on the EPVS SharePoint site in the following location: http://teams.humana.com/sites/procurement_team/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fsites%2Fprocurement%5Fteam%2FShared%20Documents%2FSupplier%20Compliance%20Data%2FFinancial%20Due%20Diligence&FolderCTID=0x0120009FE081E54AFF0442838C3A978FBA5A5C&View={7BDAE0C5-C819-461F-803F-0D96C35BE30A} or follow this path to the correct folder: Team Documents > Supplier Compliance Data > Financial Due Diligence (Note: If the FDD Rating is based on publicly available financial information, the Financial Due Diligence Summary will include the underlying financial information. If FDD Rating is based on information provided by the prospective vendor, the Financial Due Diligence Summary will not reflect the underlying financial information)	Upload the Financial due Diligence information to Share Point.		
	****IMPORTANT NOTE: ONCE Supplier ANALYST HAS COMPLETED THE FDD TEMPLATE AND HAS THE OVERALL RATING AVAILABLE, MAKE SURE TO CONVERT TO PDF THE SUMMARY TAB AND SHARE THE PDF DOCUMENT WITH REQUESTOR TO AVOID DISCLOSING ANY VENDOR'S CONFIDENTIAL INFORMATION****			

FIGURE1

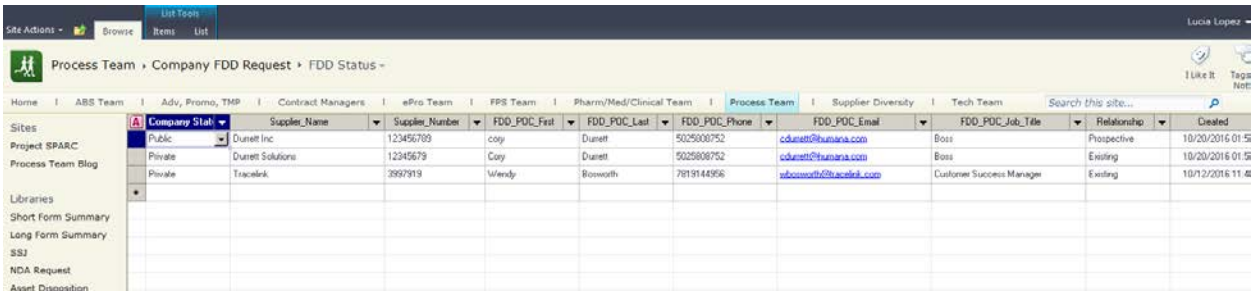
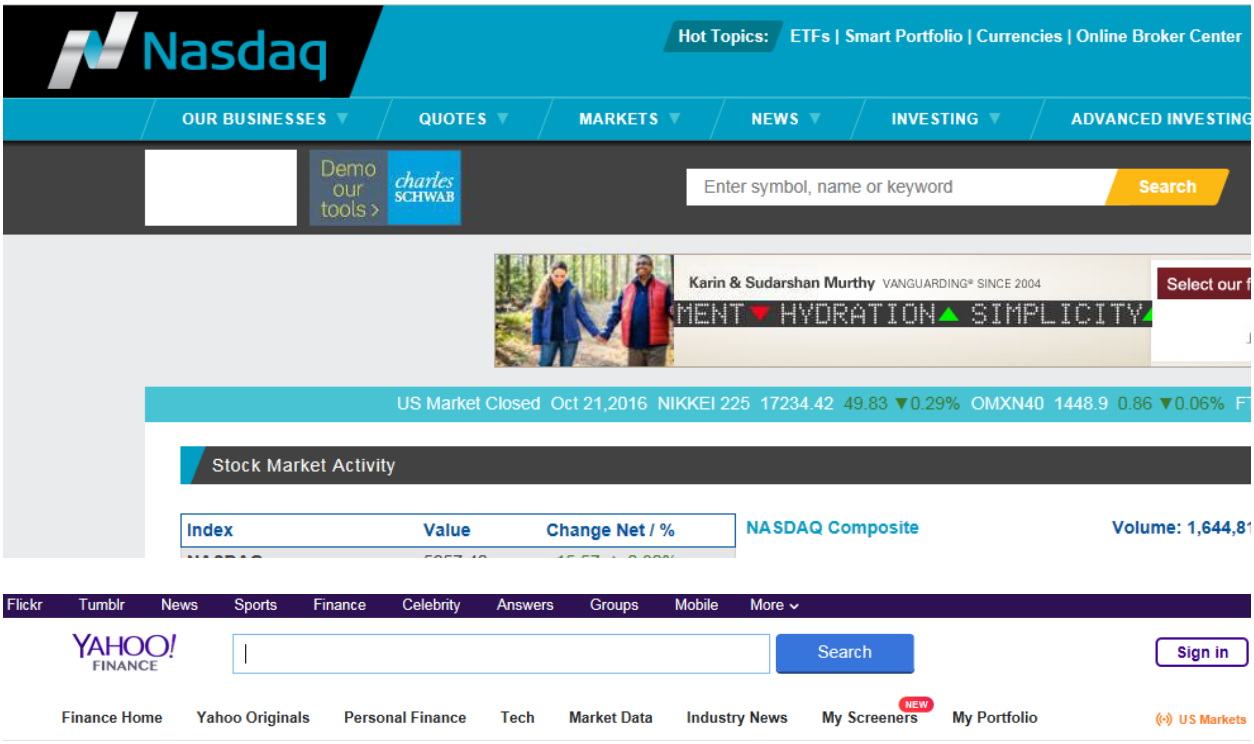
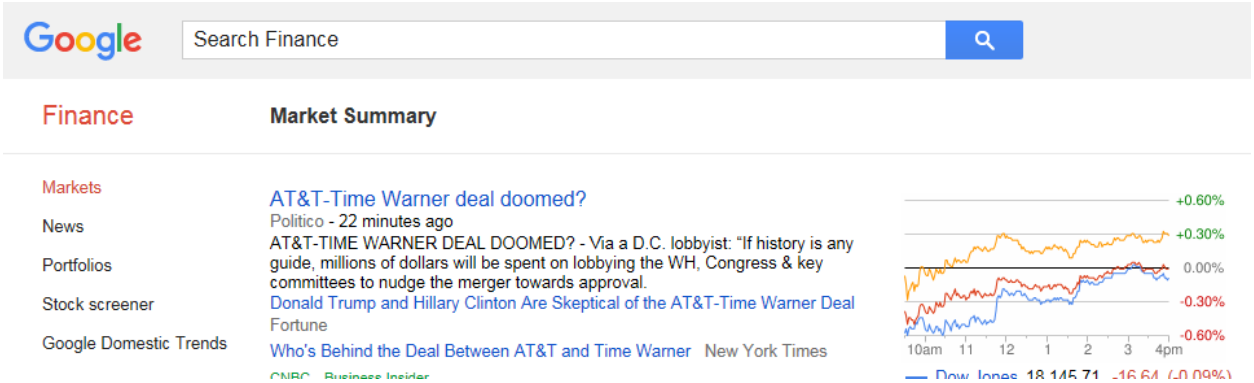


FIGURE2

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Finance
Market Summary
Markets
News
Portfolios
Stock screener
Google Domestic Trends
AT&T-Time Warner deal doomed?
Politico - 22 minutes ago
AT&T-TIME WARNER DEAL DOOMED? - Via a D.C. lobbyist: "If history is any guide, millions of dollars will be spent on lobbying the WH, Congress & key committees to nudge the merger towards approval.
Donald Trump and Hillary Clinton Are Skeptical of the AT&T-Time Warner Deal
Fortune
Who's Behind the Deal Between AT&T and Time Warner New York Times
+0.60%
+0.30%
0.00%
-0.30%
-0.60%
10am 11 12 1 2 3 4pm

MORNING BRIEFING: Another Time Warner deal. What could possibly go wrong? VIEW MORE
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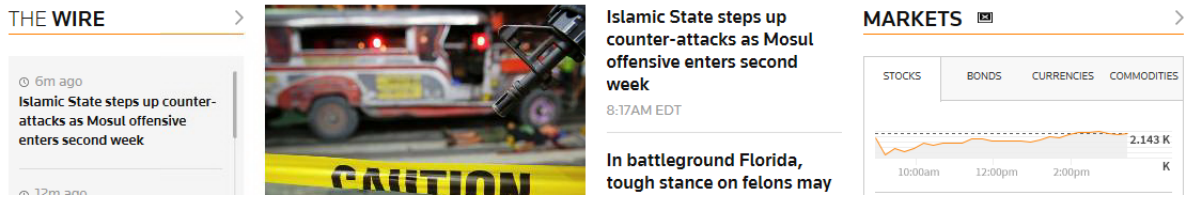
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6m ago
Islamic State steps up counter-attacks as Mosul offensive enters second week
Islamic State steps up counter-attacks as Mosul offensive enters second week
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In battleground Florida, tough stance on felons may
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CURRENCIES
COMMODITIES
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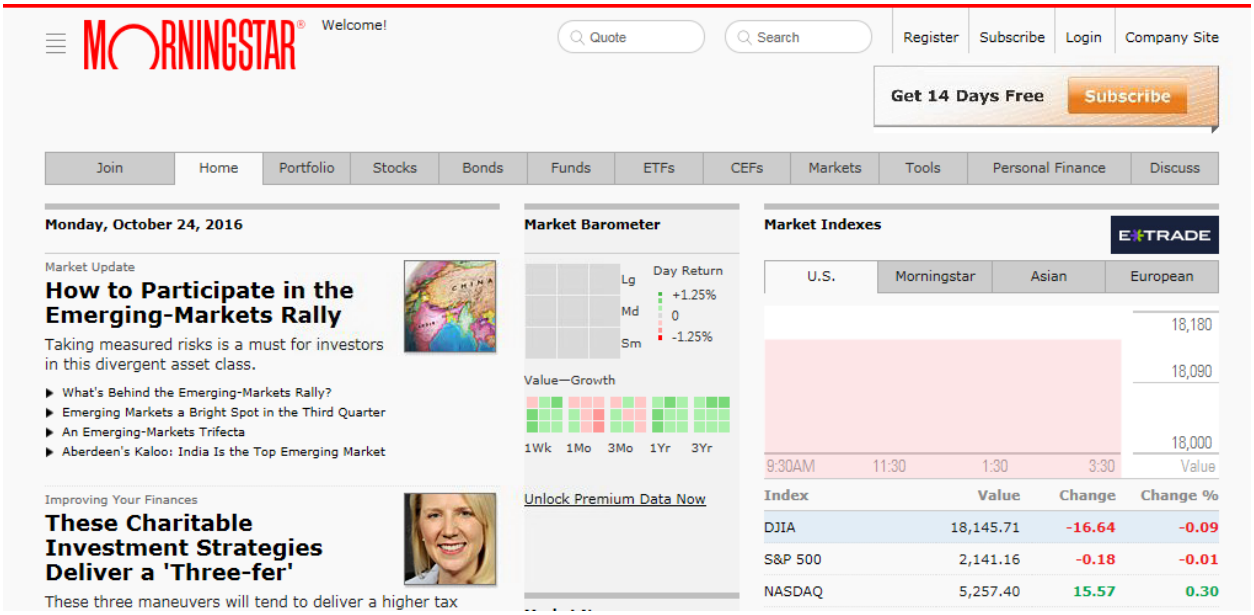
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Bonds
Funds
ETFs
CEFs
Markets
Tools
Personal Finance
Discuss
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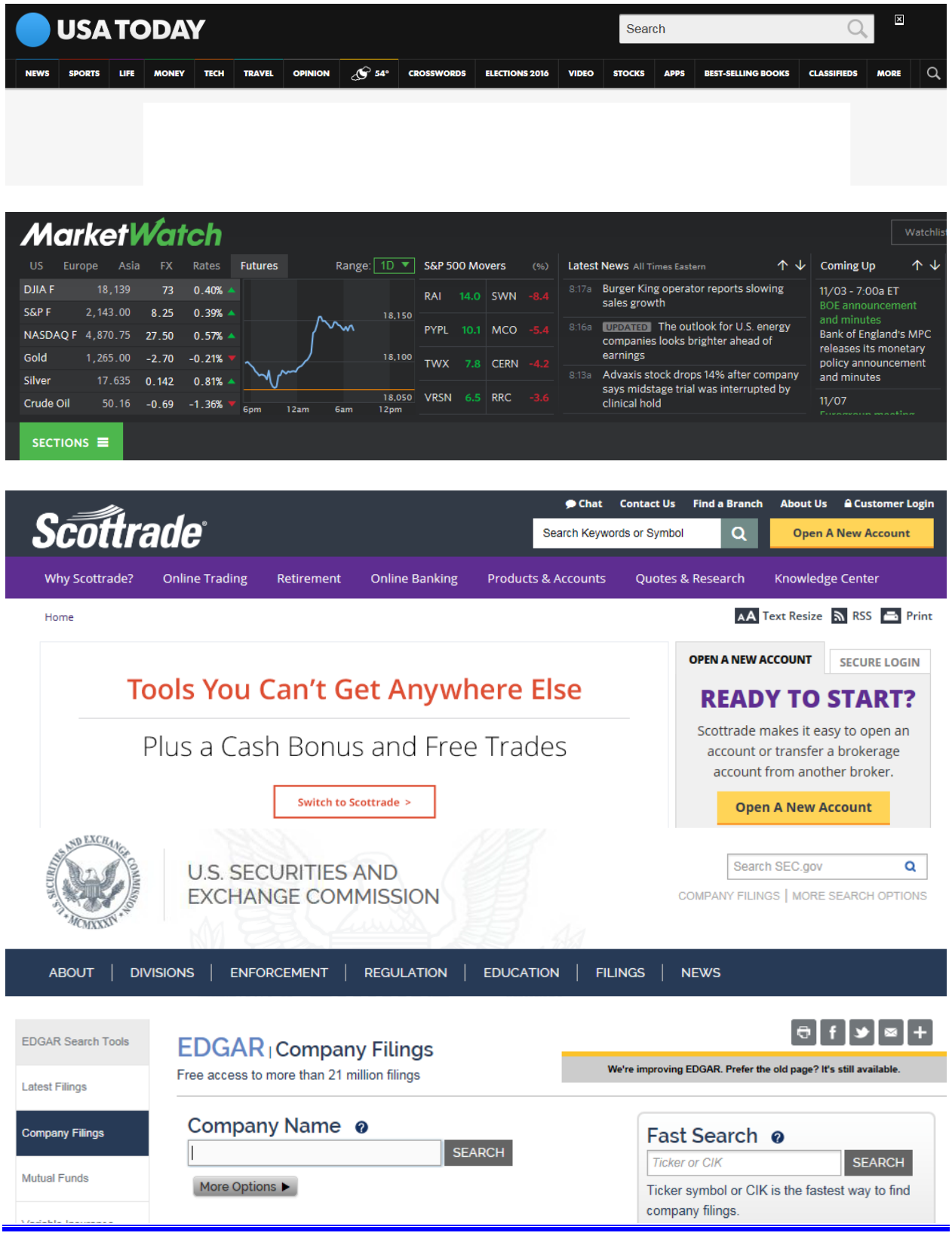
Market Update
How to Participate in the Emerging-Markets Rally
Taking measured risks is a must for investors in this divergent asset class.
What's Behind the Emerging-Markets Rally?
Emerging Markets a Bright Spot in the Third Quarter
An Emerging-Markets Trifecta
Aberdeen's Kaloo: India Is the Top Emerging Market
Improving Your Finances
These Charitable Investment Strategies Deliver a 'Three-fer'
These three maneuvers will tend to deliver a higher tax
Market Barometer
Lg
Md
Sm
Day Return
+1.25%
0
-1.25%
Value—Growth
1Wk 1Mo 3Mo 1Yr 3Yr
Unlock Premium Data Now
Market Indexes
E*TRADE
U.S.
Morningstar
Asian
European
18,180
18,090
18,000
9:30AM 11:30 1:30 3:30
Value
Index Value Change Change %
DJIA 18,145.71 -16.64 -0.09
S&P 500 2,141.16 -0.18 -0.01
NASDAQ 5,257.40 15.57 0.30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MarketWatch
US Europe Asia FX Rates Futures Range: 1D
DJIA F 18,139 73 0.40%
S&P F 2,143.00 8.25 0.39%
NASDAQ F 4,870.75 27.50 0.57%
Gold 1,265.00 -2.70 -0.21%
Silver 17.635 0.142 0.81%
Crude Oil 50.16 -0.69 -1.36%
6pm 12am 6am 12pm
S&P 500 Movers (%)
RAI 14.0 SWN -8.4
PYPL 10.1 MCO -5.4
TWX 7.8 CERN -4.2
VRSN 6.5 RRC -3.6
Latest News All Times Eastern
8:17a Burger King operator reports slowing sales growth
8:16a UPDATED The outlook for U.S. energy companies looks brighter ahead of earnings
8:13a Advaxis stock drops 14% after company says midstage trial was interrupted by clinical hold
Coming Up
11/03 - 7:00a ET BOE announcement and minutes
Bank of England's MPC releases its monetary policy announcement and minutes
11/07
SECTIONS
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Search Keywords or Symbol
Open A New Account
Why Scottrade? Online Trading Retirement Online Banking Products & Accounts Quotes & Research Knowledge Center
Home
Text Resize RSS Print
Tools You Can't Get Anywhere Else
Plus a Cash Bonus and Free Trades
Switch to Scottrade >
OPEN A NEW ACCOUNT
SECURE LOGIN
READY TO START?
Scottrade makes it easy to open an account or transfer a brokerage account from another broker.
Open A New Account
U.S. SECURITIES AND EXCHANGE COMMISSION
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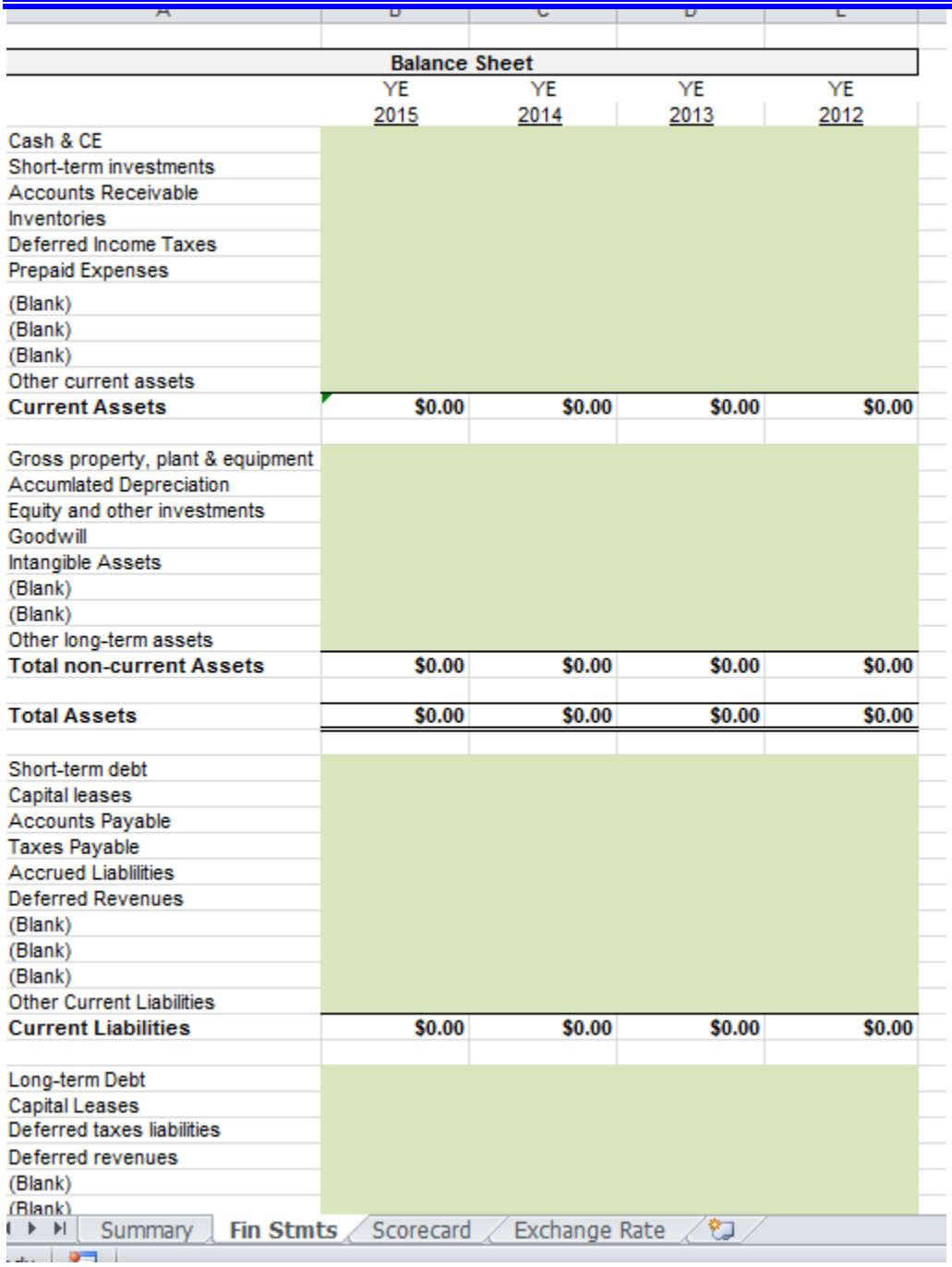
COMPANY FILINGS | MORE SEARCH OPTIONS
ABOUT DIVISIONS ENFORCEMENT REGULATION EDUCATION FILINGS NEWS
EDGAR Search Tools
Latest Filings
Company Filings
Mutual Funds
EDGAR | Company Filings
Free access to more than 21 million filings
We're improving EDGAR. Prefer the old page? It's still available.
Company Name
SEARCH
More Options
Fast Search
Ticker or CIK
SEARCH
Ticker symbol or CIK is the fastest way to find company filings.

FIGURE 3

Overview	Date
	Completed by:

Company Name:	
Address	
BIN:	
Parent Company:	
Were 3+ years of reports provided?	no
Comments:	
Line of Business:	
Year Started:	
Public/Private:	Public
Current Stock Price	Market Cap:
One year target estimate (52 Week Range)	
No of Employees:	
Major Clients:	
Major Competitors:	

FIGURE 4



Balance Sheet				
	YE 2015	YE 2014	YE 2013	YE 2012
Cash & CE				
Short-term investments				
Accounts Receivable				
Inventories				
Deferred Income Taxes				
Prepaid Expenses				
(Blank)				
(Blank)				
(Blank)				
Other current assets				
Current Assets	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Gross property, plant & equipment				
Accumlated Depreciation				
Equity and other investments				
Goodwill				
Intangible Assets				
(Blank)				
(Blank)				
Other long-term assets				
Total non-current Assets	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Total Assets	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Short-term debt				
Capital leases				
Accounts Payable				
Taxes Payable				
Accrued Liablilities				
Deferred Revenues				
(Blank)				
(Blank)				
(Blank)				
Other Current Liabilities				
Current Liabilities	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Long-term Debt				
Capital Leases				
Deferred taxes liabilities				
Deferred revenues				
(Blank)				
(Blank)				

Summary | Fin Stmts | Scorecard | Exchange Rate

FIGURE 5

Cash Flow Statement				
	2015	2014	2013	2012
Net Income	$0.00	$0.00	$0.00	$0.00
Cash - Operating				
Cash - Investing				
Cash - Financing				
Cash - Other				
Change in Cash	$0.00	$0.00	$0.00	$0.00

FIGURE 6

Income Statement

	2015 Act	2015 Ann	2014	2013	2012
REVENUE					
Revenue		$0.00			
Cost of Revenue		$0.00			
(Blank)		$0.00			
Gross Profit	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
OPERATING EXPENSES					
Research & Development		$0.00			
Sales, General and administrative		$0.00			
Restructuring, merger and acquisition		$0.00			
(Blank)		$0.00			
(Blank)		$0.00			
(Blank)		$0.00			
Other Operating Expenses		$0.00			
Total Operating Expenses	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Operating Income or Loss (EBITDA)	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Interest Expense		$0.00			
Other Income/Expense		$0.00			
EBT	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
OTHER EXPENSES					
Depriciation & Amortization		$0.00			
Operations		$0.00			
Non Recurring		$0.00			
(Blank)		$0.00			
(Blank)		$0.00			
EBIT	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
Provision for Income Taxes		$0.00			
Minority Interest		$0.00			
NI (Loss) Cont Ops	$0.00	$0.00	$0.00	$0.00	$0.00
Discontinued Ops		$0.00			
Net Income/(Loss)	$0.00	$0.00	$0.00	$0.00	$0.00
Cash Dividends		$0.00			
		$0.00			
Increase in RE	$0.00	$0.00	$0.00	$0.00	$0.00

Attachment 26-16: Financial Solvency Risk Report

Criteria & Scoring Methodology

Risk Reporting Criteria				
Assessment	Lower Risk – Green Light	Moderate Risk – Yellow Light	Higher Risk – Red Light	Weighted Scoring
Scoring Value	0	1	2	Risk x Weight and then sum all = Risk Score
Overall Risk Score	0-24	25-48	49-70	
Compliance				
Interest Payment Accuracy	100%	80% - 99.9%	< 80%	2
Member Denial Accuracy	95% or >	90% - 94.9%	< 90%	3
Cycle Time	95% or >	70% - 94.9%	< 70%	7
Financial Solvency				
Cash Flow	Positive	Zero	Negative	4
Net Income	Positive	Zero	Negative	5
Total Liabilities to Total Assets	Positive	Zero	Negative	6
Current Ratio	1	.9 - .99	< .9	8

Risk Report

Delegate Name	Florida (FL) UM + PP	FL PP	National UM + PP	FL UM + PP	FL PP
Market	FL	FL	NTL	FL	FL
Total Medicare Membership					
Total Commercial Membership					
Total Medicaid Membership					
Monthly CAP Payments					
Interest Payment = 2	NA	NA	NA	NA	NA
Membership Denial Accuracy Weight = 3	100.0%	93.3%	82.0%	97.0%	NA
Increase (Decrease) in Cash Flow Weight = 4					
Net Income/Loss Weight = 5					
Total Assets					
Total Liabilities					
Total Assets – Total Liabilities Weight = 6					

Cycle Time Weight = 7	100.0%	100.0%	100.0%	93.0%	100.0%
Current Assets					
Current Liabilities					
Current Ratio Weight = 8	2.00	4.59	0.44	4.19	0.96
Overall Risk Score	0	3	32	7	16
Line/Letter of Credit or Guarantee Information					
LOC Amount					
Expires					
Comments					
Period Ending Date of Financials					
Type of Financials	Audited Financials	Audited Financials	Audited Financials	Audited Financials	Audited Financials
Q = Quarterly or A = Annual					
Last Claims Audit Date					

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 27 – Subcontractor Oversight (Statewide):

The respondent shall submit a sample contingency plan it would enact in the event a subcontractor to which the plan has delegated authority to manage utilization and pay providers on behalf of the plan, files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Response:

Humana understands the importance of contingency planning, especially in situations where we use subcontractors to manage utilization and pay providers on behalf of the plan. Subcontractors sometimes file for bankruptcy or become otherwise unable to continue operations because of a lack of financial resources. While we consider financial solvency and organizational reliability when selecting subcontractors, uncertain market conditions can lead to insolvency or bankruptcy and become a potential failure point for many organizations.

That's why we coordinate our robust subcontractor oversight structure across multiple teams at both national and local levels. As part of this effort, Humana requires every subcontractor to meet all Agency for Health Care Administration (AHCA) performance requirements related to its services. We assign a Humana Relationship Manager to each subcontractor, who in coordination with other key market stakeholders, is responsible for managing the subcontractor relationship. If our subcontractor oversight process reveals a claims and utilization subcontractor is at a risk level for financial insolvency that is of concern, the relationship manager will develop a subcontractor-specific contingency plan. This plan will identify alternative external services options and evaluate internal business solutions. Unless the situation requires a more expedient resolution, relationship managers develop alternative plans within sixty (60) days of identifying a problem that include all pertinent evaluation points such as enrollee impact, provider experience, staffing plans, alternative subcontractor evaluation, system evaluations, timeframe, and internalization of subcontractor capabilities.

In the unlikely event that our proactive process does not identify an imminent closure and we receive notice of a subcontractor bankruptcy or deemed insolvency, we immediately convene all affected areas and support teams to:

- Develop a specific strategy absent a formal bankruptcy declaration
- Follow laws and regulations around letters of credit outstanding
- Understand the subcontractor's liability with respect to its downstream payees

We recognize continuity of care is of the utmost importance, which is why we invoke appropriate claims payment processes to ensure the flow of services or goods while taking care that the subcontractor or unpaid provider is not perpetrating fraud. To the extent we would not be hindered by a bankruptcy stay or subcontractor agreement as debtor in possession, we engage with the subcontractor early and as often as possible to obtain accounts payable and other relevant information regarding unpaid claims of providers and suppliers touching Humana enrollees. These subcontractor activities may also include requesting visibility into providers' accounts to establish valid claims, negotiation of unpaid claim amounts, manual adjudication of those claims, joint checks made payable to the subcontractor and the provider or supplier, and

confirming with enrollees that they have received the goods or services evidenced by the claims.

The Florida Market President will work with the legal department to consult and understand which business activities can continue with the subcontractor. This may include taking immediate actions against the subcontractor, interacting with enrollees and providers, collecting debt, and monitoring any asset disposition. We will engage outside counsel on proper timing to represent us in bankruptcy court proceedings and to provide counsel on state and federal insolvency matters. We will also consult with Humana Medicaid Finance and other national finance teams to address letter of credit draws, other guarantees, or assets we might access for incurred and unreported claims.

Ultimately, as we complete the work to verify and pay claims on the front end, our teams and processes also all provide the standard fraud detection and management activities, which we describe in detail below.

==========
1. The extent to which the respondent has outlined the data sources it would use to trigger the respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.
==========

The Financial Solvency Risk Report (Risk Report), an output of Humana's rigorous Delegate Financial Solvency Review Process, will serve as the primary data source of potential triggers to invoke the Subcontractor Contingency Plan for Florida's claim subcontractors. Humana can accelerate implementation of the contingency plan using a combination of processes, tools, and resources including:
- Delegate Financial Solvency Review Process and Risk Report
- Failure Modes and Effects Analysis (FMEA) Tool
- Florida Market Directors
- Relationship Managers
- Florida Director, Vendor Performance Oversight
- Deterioration related to contract compliance

DELEGATE FINANCIAL SOLVENCY REVIEW PROCESS AND RISK REPORT

The established Delegate Financial Solvency Review Process ensures that Humana regularly monitors the financial solvency of all subcontractors who process claims. In 2004 we developed a Solvency Task Force (STF) to discuss financial results of claim subcontractors after Humana paid significant claims costs when a subcontractor became insolvent. The STF includes representatives from Risk Management, Internal Audit, Senior Products, National Network Operations, Delegation Compliance, Finance, and Florida and other Market Operations.

The STF uses a scoring methodology that assigns audit scores and financial results a risk value of low, moderate, or high, which we then multiply by the weighted score for that category. We add the score for each category to calculate the risk score classified as low, moderate, or high risk. The Financial Solvency Risk Report includes information on the number of enrollees,

capitation payments, and financial guarantees. The Risk Report will serve as the primary data source for implementing the Subcontractor Contingency Plan. Attachment 27-1: Risk Report has subcontractor names and other confidential information removed.

Delegation Compliance, in collaboration with the Financial Solvency Committee, evaluates the financial stability of the provider group/entity prior to delegation, quarterly and annually. While we update the financial information for all subcontractors annually, we receive information on a rolling basis. For example, a subcontractor's audits may be submitted during one (1) quarter and financial statements in another. We evaluate all subcontractors quarterly to ensure we capture and evaluate all financial information updates regularly. Delegation Compliance collects the following information, which Market Finance Directors review and report to the Financial Solvency Committee.

RISK REPORT DATA SOURCE COLLECTION INCLUDES:

- Most recent audit report and supporting financial statements, including income statements, cash flow, and balance sheets. If not publicly available, we request the audited financial statements from the subcontractor;

- Opinion page from the independent auditor's report, which we will request if not publicly available;

- Working capital position (short-term financial health status);

- Current ratio (current assets divided by current liabilities), which we calculate in the Risk Report;

- Utilization management denial rates; and

- Contract compliance metrics, which vary by subcontracted category.

RISK REPORT TRIGGERS FOR THE CONTINGENCY PLAN
The goal of the Risk Report is to illuminate moderate and high risks. We strive to remediate moderate risks before they become high risks. The established Risk Report captures and scores the following compliance and financial solvency information:
- Negative Net Income/Net loss
- Negative Cash Flow
- Total Liabilities exceeding Total Assets
- Current Ratio less than 1
- Checks to the provider that are not cashed within 30 days of issued date
- Checks that are post dated
- Large changes in utilization denial rates
- Letter of Credit status
- Interest Payment Accuracy rating of less than 99.9%
- Member Denial Accuracy of less than 95%
- Cycle Time of less than 95%
- Cash Flow at 0
- Net Income at 0
- Total Liabilities to Total Assets rating of 0

- Current Ratio of less than 1
- Validity of Letter of Credit

Today, if any of the above reflects negatively on a subcontractor's financial standing, we will notify the subcontractor via a financial solvency corrective action plan (CAP). While this CAP process will continue, we will enhance it through the proactive capture and management of financial insolvency triggers of our Subcontractor Contingency Plan.

PROACTIVE MANAGEMENT OF MODERATE RISKS
Our goal is to proactively manage moderate risks to prevent them from becoming high risks. Our process indicating moderate risk will trigger the contingency plan and the Failure Modes and Effects Analysis (FMEA) tool will capture all relevant data.

LEVERAGING RISK REPORT TRIGGERS TO INVOKE THE CONTINGENCY PLAN
The FMEA tool will capture these risk data triggers and inform the contingency plan.

FAILURE MODES AND EFFECTS ANALYSIS TOOL (FMEA)

Informed by the Risk Report, Humana will apply the FMEA tool to capture, assess, and proactively remediate exposure to potential risks or failure points, and to serve as a subcontractor contingency planning tool.

Based on Six Sigma methodology, FMEA is a system for analyzing a service to identify potential failures in terms of severity, frequency, and detection.
- Severity – How severely the error affects enrollees or the business
- Occurrence – How often the error occurs
- Detection – How likely it is that the error will be detected

Subject matter experts evaluate the three (3) criteria above and assign scores of one (1) through ten (10), with one (1) being the best and ten (10) being the worst. We multiply the individual scores to produce a Risk Priority Number (RPN), which we then rank from highest to lowest. The team evaluates the highest RPNs to identify the root cause, and then develops and communicates solutions to reduce or eliminate the risk associated with each failure.

Attachment 27-2: FMEA Tool Example shows how the tool will be integral to the Subcontractor Contingency Plan as we use it to thoughtfully assess risks and plan for success. The following leaders will take ownership of the internal and external processes and communications to ensure we use the FMEA tool to its fullest:

The Market President, who oversees, Florida will be responsible for overseeing the ongoing utilization and management of the Contingency Plan FMEA tool. At monthly operational meetings (as needed) and quarterly Delegated Vendor Oversight Committee (DVOC) meetings, the Director, Delegated Vendor Oversight will provide status on the financial solvency issues, review corrective interventions, and report results as defined in the FMEA tool.

RELATIONSHIP MANAGERS FOR FLORIDA SUBCONTRACTORS

Relationship Managers for the Florida subcontractors will be accountable for meeting with individual subcontractors and providing the governance required by Florida Medicaid. Each Relationship Manager will be accountable for managing the contingency plan, inclusive of participation in the quarterly financial solvency committee. They will use the FMEA tool to support conversations around the moderate risks in compliance and financial solvency. Relationship Managers will report the risk discussions to their Florida Market Directors, who will oversee updates to the FMEA tool. If an issue arises, the Florida Market Director attends the monthly operational meeting to address the issue.

FLORIDA DIRECTOR, DELEGATE VENDOR OVERSIGHT

The Florida Director, Delegate Vendor Oversight is a natural focal point to collectively and collaboratively monitor and address performance needs in partnership with Relationship Managers and Florida Medicaid operations leads. The Director, Delegate Vendor Oversight also serves as the Delegated Vendor Oversight Committee (DVOC) Chair. As such, this individual will be well positioned to engage Humana's Internal Audit Consulting Group (IACG) on a periodic basis to assess the impact and effectiveness of the contingency plan process. The IACG is a consulting practice providing independent, objective assurance, consulting, and business advisory services that evaluate and improve the effectiveness of risk management, control, and governance processes.

==========

2. The extent to which the respondent outlines a communications strategy in the contingency plan.

==========

The Communication Plan (Attachment 27-3) describes our communication strategy in the contingency plan. This plan provides details regarding how we will communicate internally and externally with our enrollees, providers, and downstream subcontractors should a subcontractor file for bankruptcy or otherwise become unable to continue operations because of a lack of financial resources. Relationship Managers provide ongoing communication and serve as a point of contact for downstream subcontractors. Specifically, Relationship Managers answer frequently asked questions; provide claim submission and fee-for-service contracting process information; and offer contracting opportunities as part of our continuity of care plan to downstream subcontractors. The Florida Account Executive, Medicaid Administration, serves as the liaison between AHCA and Humana.

The Subcontractor Contingency Plan and FMEA tool will leverage the communication plan while adding proactive moderate risk identification, assessment, and planning. The FMEA will also capture internal and external communications and action items.

In addition, through established monitoring and oversight practices, use of the FMEA tool, and planned interventions, Humana will ensure ongoing communications with subcontractors. The monthly reviews will spot insolvency issues and improve our capacity to proactively remediate issues. Established escalation processes in DVOC and the Quality Improvement Committee (QIC) further improve our responsiveness to address financial insolvency matters.

LEVERAGING PAST EXPERIENCE

In our experience with a subcontractor who filed for bankruptcy or was otherwise unable to continue operations because of a lack of financial resources our communication strategy included contact with enrollees, providers, and the subcontractor. Relationship Managers, both then and now, are accountable for subcontractor relationships, communications, and ongoing support.

We developed and disseminated enrollee and provider communications to direct them on next steps and provide them with contact numbers. We placed copies of these communications in Humana's Contract Management System for access by all Humana care centers to ensure the centers knew how to direct both enrollees and providers calling in about the situation. We also provided enrollee and provider call center teams with a message wheel, a tool designed to help the care center teams maintain a consistent message to all callers. We provided timely and accurate communication and information to our enrollees and providers across all platforms.

To secure our own contracts, we coordinated with the subcontractors' contracted providers. We coordinated with hospitals and enrollees for continuation of care needs, including proactively identifying enrollees who needed critical ongoing care such as oxygen tanks. We contacted hospitals weekly to coordinate the home healthcare required by discharged individuals and to provide them with our updated network. These actions ensured our enrollees were guaranteed continuity of care.

We worked with the subcontractor to acquire all open authorized reports identifying enrollees at risk for current, open services. We worked with the Clinical Intake team and Health Services to ensure authorization processes, including authorization extensions, were in place to avoid enrollee service disruption. We also put a system business rule in place for ninety (90) days to allow services without an authorization, specific to providers who were newly contracted directly with Humana and going through the contract loading process.

Humana's strong experience in relationship management and established communication processes will contribute to the success of Florida's proactive contingency plan for claim subcontractors.

==========

3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.

==========

Humana's Contingency Plan includes ways to ensure we pay providers in situations where there are open authorizations. The Delegation Services agreement (Attachment 27-4) establishes a contractual arrangement between Humana and an entity that sets forth the legal obligations both parties mutually agree upon. The delegated claims attachment specifically states the subcontractor's obligations regarding claims performance, access, audit and oversight.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SUBCONTRACTOR OBLIGATIONS

Humana requires a subcontractor to provide a financial guarantee prior to implementing any delegation of claims processing, including but not limited to a letter of credit, to ensure the subcontractor's continued financial solvency and ability to adjudicate and process claims. We also require subcontractors to process and pay claims to maintain a surplus account to meet their obligations.

In addition, Humana requires subcontractors to provide financial information upon request, as proof of their continued financial solvency. Financial information submitted must include recent audited financial statements (balance sheet, statement of operations, and cash flow statement) if the subcontractor has not been audited. The subcontractor's chief financial officer or owner must certify the accuracy of the documents by signing the financial statements.

Subcontractors also agree to permit any regulatory agency to examine, at any time, information the agency deems relevant to determine financial solvency or to review their ability to continue to perform the subcontracted services.

CLAIMS PERFORMANCE REQUIREMENTS

Subcontractors are obligated to pay contracted providers under the terms of the contract between the subcontractor and the provider. Subcontractors agree within the delegation documents that Humana maintains the ultimate responsibility for the accuracy of claims processing and adjudication for enrollees, and retains the right to implement a Corrective Action Plan (CAP), suspend, or terminate any portion in the event there is a breach of the Claims Attachment or noncompliance with state or federal law, accreditation organization requirements, or subcontractor's policies, procedures and claims performance requirements.

CLAIMS, ACCESS, AUDIT, AND OVERSIGHT

Humana ensures that subcontractors establish, enforce, and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations. The Delegation process will monitor metrics, Service Level Agreements (SLAs), tracking, and reconciliation, along with the quarterly risk assessment process. Subcontractors agree that we can monitor the accuracy, quality, timeliness, and effectiveness of their claims adjudication and processing functions and activities through periodic reviews and audits. This includes requested access to any and all source documentation, and all other documents, processes, procedures, systems, and other information related to enrollee claims processed, paid, denied, or pending.

If Humana issues a CAP, the subcontractor has fourteen (14) calendar days to provide a written response describing how it will meet the requirements found to be noncompliant, including the prospective date of compliance, which they must remediate within ninety (90) days or less. The subcontractor will be subject to a capitation payment penalty each month until the CAP is resolved.

Our Florida Medicaid Subcontractor Monitoring and Oversight procedure establishes subcontractor monitoring and oversight activities by the Medicaid Market, including:

- Holding subcontractors accountable for compliance with State Contract requirements and SLAs;

- Reporting findings, CAPS, and follow up to the DVOC;

- Monitoring the performance trend of subcontractors over time;

- Reporting monitoring results to AHCA's Contract Manager, fourteen (14) business days after the end of each month or as specified;

- Participating in all key audits associated with the subcontractor to facilitate full performance transparency and coordinated follow up;

- Supporting escalation of performance issues including penalty assessments, de-delegation evaluations, breach investigations, and like issues; and

- Engaging the appropriate subject matter experts to assist in addressing issues or exploring opportunities to maximize relationship value.

PROVIDER CONTRACT REQUIREMENTS

Humana includes an exculpatory clause, which survives provider contract termination, in all contracts regarding breach due to insolvency. This clause ensures that our enrollees will not be held liable for the subcontractor's debts.

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4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

==========

At Humana, we proactively seek to prevent fraud, waste, and abuse (FWA) in every interaction. FWA expectations, training, and requirements are part of our core on-boarding process for all new and existing parties with which Humana engages, including subcontractors. In addition to our essential standards, as set forth in our Compliance Policy for Contracted Health Care Providers and Business Partners, our contingency plan includes extensive FWA oversight, monitoring, and strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations because of a lack of financial resources.

At the time we receive notice of an imminent closure, insolvency, or bankruptcy of a subcontractor, we immediately convene all affected areas and support teams to:

- Develop a strategy absent a formal bankruptcy declaration
- Understand laws and regulations around letters of credit outstanding

- Understand the subcontractor's liability with respect to its downstream payees

Because continuity of care in accordance with state law is critically important, we also invoke sophisticated claims payment processes to ensure the flow of services or goods while ensuring that the subcontractor or unpaid providers do not perpetrate fraud. To the extent we are not hindered by a bankruptcy stay or subcontractor agreement as debtor in possession, we would engage with the subcontractor early and as often as possible to obtain accounts payable and other relevant information regarding unpaid claims of providers and suppliers touching Humana enrollees. These subcontractor activities may also include requesting visibility into providers' accounts to establish valid claims, negotiation of unpaid claim amounts, manual adjudication of those claims, joint checks made payable to the subcontractor and the provider or supplier, and confirming with enrollees that they received the goods or services evidenced by the claims.

We consult the market attorney for the relationship state and other subject matter experts in the legal department to understand which business activities can continue to take place with the subcontractor, including immediate actions we can take to move against the subcontractor, interact with enrollees and providers, collect debt, and monitor any asset disposition. We engage outside counsel on proper timing to represent us in bankruptcy court proceedings and provide counsel on state and federal insolvency matters. We also immediately consult Humana Medicaid Finance and other national finance team members to address letter of credit draws and other guarantees or assets we might access for incurred and not reported claims.

COMPLIANCE POLICY

Our Compliance Policy for Contracted Health Care Providers and Business Partners, which we provide to all subcontractors, communicates our strong organizational commitment to conducting business ethically; provides training requirements and schedules (e.g., ethics, FWA, compliance); and describes communication lines and disciplinary actions. We require our healthcare providers and business partners to comply with the guiding principles set forth within this policy.

Humana requires healthcare providers and business partners to review our Ethics Every Day for Contracted Health Care Providers and Business Partners policy, and to complete the Centers for Medicare and Medicaid Services (CMS) general compliance and FWA training within ninety (90) days of the effective date of the contract, and annually thereafter.

In addition, we also expect healthcare providers and business partners, within ninety (90) days of the effective date of the contract and annually thereafter, to:

- Provide compliance policies and standards of conduct to associates and any downstream entities;

- Provide CMS's general compliance and FWA training to associates and any downstream entities. Training documentation should include the time, attendance, topic, certificates of completion (if applicable), and test scores of any tests administered;

- Verify they have met the FWA training requirement. Otherwise, remove and replace any associates and any downstream entities that did not complete the FWA training; and

- Provide specialized compliance training on issues posing FWA risks based on an individual's job function when appropriate.

ETHICS EVERY DAY

Our Ethics Every Day for Contracted Health Care Providers and Business Partner policy for contracted healthcare providers and business partners outlines our ethics expectations. The document defines ethics at Humana and provides information regarding resources, Ethics Office contact information, FWA, conflicts of interest, privacy, and laws/regulations. Please see Attachment 27-7: Ethics Every Day for more details.

FINANCIAL SOLVENCY CONTINGENCY PLAN

The contingency plan includes strategies to prevent provider FWA when subcontractors are facing financial insolvency issues. The contingency plan will draw information from our departments that combat FWA. We have multiple departments that work together to combat FWA. While all departments collaborate internally, they each manage their own case work independently.

SPECIAL INVESTIGATIONS UNIT (SIU) AND PROVIDER PAYMENT INTEGRITY (PPI)

Humana has developed procedures for reporting instances of FWA reviewed by the SIU and PPI departments to external agencies as required by each agency. The Claims Cost Management (CCM) Compliance team supports both Special Investigations Unit (SIU) and Provider Payment Integrity (PPI) to ensure all regulatory reporting is completed in a timely and compliant manner, and that each department stays abreast of changes to federal and state regulations. The CCM Compliance team, with support from Humana's law department, is also responsible for responding to subpoenas and requests for information from government agencies as they pertain to FWA reviews.

SIU serves as Humana's primary investigative arm and is responsible for complex cases of fraud and abuse. Its processes include data analytics to identify trends, fraud, schemes, and potential fraudulent activity that may warrant further investigation. The SIU investigates fraud at all levels, from providers to agents to enrollees.

SIU also implements an Anti-Fraud Plan, which continuously monitors all lines of business for potential FWA activity. SIU monitors and audits the activities of associates, enrollees of its health plans and insurance policies, health care providers, and business partners. In addition, healthcare providers and business partners are responsible for maintaining their own comprehensive plan for detecting, correcting, and preventing FWA. Humana also conducts monitoring and auditing activities for its relationships with healthcare providers and business partners. The activities monitored and audited may include but are not limited to both operational performance and compliance requirements applicable to the performed functions we describe throughout this response.

Humana is actively involved with anti-fraud organizations, such as the National Health Care Anti-Fraud Association, the Healthcare Fraud Prevention Partnership, and the Midwest Anti-Fraud Insurance Association. Humana cooperates with federal, state, and local authorities in the investigation of potential FWA when appropriate.

Humana's PPI department uses complex data analytics including outlier analysis, trending, and link analysis to identify potential fraud, waste, and abuse. PPI reviews all leads for FWA, and routes each allegation to the appropriate area for further review. PPI routes fraud allegations, for example, to Humana's SIU department to investigate. The department also conducts pre-payment and post-payment audits to identify potential overpayments. In the event PPI substantiates FWA, it may refer the provider to the appropriate government agencies. PPI also provides recommendations for process and system improvements to proactively prevent overpayments.

RISK ADJUSTMENT INTEGRITY UNIT (RAIU)
The RAIU ensures integrity within the government programs administered by Humana, as it relates to risk adjustment. Its focus is detection and investigation of FWA in Humana's provider network that involve capitated payment models. The RAIU performs investigations on case referrals from various sources, including but not limited to internal and external legal counsel, SIU, Hotline, and Outlier Data Analysis.

OTHER DEPARTMENTS
The contingency plan also collects information from the following departments, which work independently, collectively, and with the previously mentioned SIU, PPI, and RAIU teams to combat FWA.

- Humana Claims Cost Management (CCM) oversees the following four (4) platforms to monitor claims, encounter payments, and limit exposure to FWA:
-- Expense Mitigation, the flagship platform, monitors more than three point four (3.4) million claims each year.
-- Value-Based Payment Monitoring detects FWA among providers submitting encounter and risk adjustment data.
-- Revenue Preservation identifies enrollees for whom CMS is improperly compensating Humana.
-- Underpayment Distribution enables us to quickly reprocess incorrect expense recoveries and claims underpayments that our provider partners identify.

- Clinical Integrity Review (CLI) is responsible for medical services substantiation and clinical necessity auditing, recovery, and loss prevention.

- Medical Coding Integrity Review (CI) updates medical coding standards validation, billing abuse and waste detection, and proactive billing correction.

- Coordination of Member Benefits (COB) reviews proactive benefit coordination for enrollees who have Humana as their secondary insurance coverage.

- Service Fund Integrity Review (SFI) is responsible for provider service fund payment issue detection, recovery and loss prevention.

- Subrogation Capture (SUB) identifies, investigates, and coordinates payments with third-party medical liability holders.

SUMMARY

Humana strives to partner with subcontractors that adhere to our established compliance thresholds, contract requirements, and other requirements set forth in this response. This helps us provide our enrollees with a simplified experience, one focused on integrated care delivery for improved quality and outcomes. The contingency plan requirements, along with our continued processes, tools, and resources, will set the expectations for subcontractor governance to ensure effective service delivery without added noise and complexity. With Humana's proven track record of successful service delegation to subcontractors for the current Florida Medicaid Managed Medical Assistance (MMA) and Long-Term Care (LTC) contracts, these rigorous strategies will continue to safeguard against financial insolvency for the new Florida contract.

Evaluation Criteria:

1. The extent to which the respondent has outlined the data sources it would use to trigger the respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.

2. The extent to which the respondent outlines a communications strategy in the contingency plan.

3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.

4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment 27-1: Financial Solvency Risk Report

Criteria & Scoring Methodology

Risk Reporting Criteria				
Assessment	Lower Risk – Green Light	Moderate Risk – Yellow Light	Higher Risk – Red Light	Weighted Scoring
Scoring Value	0	1	2	Risk x Weight and then sum all = Risk Score
Overall Risk Score	0-24	25-48	49-70	
Compliance				
Interest Payment Accuracy	100%	80% - 99.9%	< 80%	2
Member Denial Accuracy	95% or >	90% - 94.9%	< 90%	3
Cycle Time	95% or >	70% - 94.9%	< 70%	7
Financial Solvency				
Cash Flow	Positive	Zero	Negative	4
Net Income	Positive	Zero	Negative	5
Total Liabilities to Total Assets	Positive	Zero	Negative	6
Current Ratio	1	.9 - .99	< .9	8

Risk Report

Delegate Name	Florida (FL) UM + PP	FL PP	National UM + PP	FL UM + PP	FL PP
Market	FL	FL	NTL	FL	FL
Total Medicare Membership					
Total Commercial Membership					
Total Medicaid Membership					
Monthly CAP Payments					
Interest Payment = 2	NA	NA	NA	NA	NA
Membership Denial Accuracy Weight = 3	100.0%	93.3%	82.0%	97.0%	NA
Increase (Decrease) in Cash Flow Weight = 4					
Net Income/Loss Weight = 5					
Total Assets					
Total Liabilities					
Total Assets – Total Liabilities Weight = 6					

Cycle Time Weight = 7	100.0%	100.0%	100.0%	93.0%	100.0%
Current Assets					
Current Liabilities					
Current Ratio Weight = 8	2.00	4.59	0.44	4.19	0.96
Overall Risk Score	0	3	32	7	16
Line/Letter of Credit or Guarantee Information					
LOC Amount					
Expires					
Comments					
Period Ending Date of Financials					
Type of Financials	Audited Financials	Audited Financials	Audited Financials	Audited Financials	Audited Financials
Q = Quarterly or A = Annual					
Last Claims Audit Date					

Attachment 27-2: FMEA Tool

Contingency Plan Guidelines

Contingency Planning via Failure Modes Effects Analysis (FMEA) – FMEA Guidelines

Purpose

In the context of Subcontractor Contingency Planning, FMEA is a system for analyzing a service to identify potential failures in terms of severity, frequency, and detection.

- Severity – How severely the error affects Customers, Enrollees, or the business
- Occurrence – How often the error occurs
- Detection – How likely it is that the error will be detected

An FMEA can be used to evaluate all potential points of failure or just those with the greatest probability of failure.

Process

- Gather process Subject Matter Experts (SMEs) including those familiar with the service(s) in question, including downstream SMEs who can provide helpful input.
- Evaluate the three criteria scales at the bottom of the template and agree on how the 1, 5, 10 scores will apply for each of the three criteria (Use "Criteria Scoring" tab to document)
- It is OK to use any number between 1 and 10 if team agrees that is appropriate
- Agree on the score to assign for each error and each criteria, based on your agreed-to scoring criteria

Results

- The Risk Priority Number (RPN) auto-calculates = Severity X Occurrence X Detection Scores
- When all errors have been scored, sort table by RPN highest to lowest
- Evaluate highest error risks and determine which ones are best to address

Next Steps

- Identify the root cause of the highest error RPNs using cause and effect or 5 Whys tools
- Establish solutions to reduce or eliminate the risk associated with each failure

Contingency Plan (FMEA)

FL ITN NOTE: The Failure Mode and Effects Analysis tool will be utilized by Relationship Managers to proactively manage financial solvency risks for each claim delegate. For example purposes, this FMEA lists all seven (7) risk elements that are scored in the quarterly Financial Solvency Risk Report, an output of the Humana Delegate Financial Solvency Review Process. The "Potential Issue or Risk" column shows the Moderate Risk metric from the risk report that triggers the Contingency Plan and use of the FMEA tool.

Subcontractor Name: We-Pay-Providers

Service Description: Claims delegate

Delegated Services: Paying Providers

Relationship Manager: HUM Relationship Manager

Prepared By: HUM Relationship Manager

Planning Date: 12-Sep-17

Process or Process Step	Interest Payment Accuracy (Compliance)	Enrollee Denial Accuracy (Compliance)	Cycle Time (Compliance)	Cash Flow (Financial Solvency)	Net Income (Financial Solvency)	Total Liabilities to Total Assets (Financial Solvency)	Current Ratio (Financial Solvency)
Potential Issue or Risk	Not making state-required Interest Payments on-time 80% - 99.9% of the time, a Moderate Risk	Enrollee Denial Accuracy is met 90% - 94.9% of the time, a Moderate Risk	Cycle Time falls between 70% to 94.9%, a Moderate Risk	Cash Flow is reported as Zero, a Moderate Risk	Net Income is reported as Zero, a Moderate Risk	Total Liabilities to Total Assets is reported as Zero, a Moderate Risk	Current Ratio is reported from 1 - .9, a Moderate Risk
Severity: How Severe would the business impact be?	2	3	7	4	5	6	8
What are the potential causes of the Issue or Risk?	Lack of contract or regulatory requirements, system issues, not enough funds to pay interest	Lack of contract or regulatory requirements, system issues, not enough funds to pay interest	Lack of contract or regulatory requirements, system issues, not enough funds to pay interest	Depends on cash on hand or in bank account; Subs should have a multiplier of cash on hand per claims if dealing with claims; If no claims,	Would need previous years to ensure current year of no profit is an anomaly or if some other major financial	less than 0.5, assets financed through equity; greater than 0.5, assets financed through debt. More debt, more risk of bankruptcy	Want this to be higher than 1. Lower, a company appears to not be able to meet their financial obligations and/or have a receivables issue

				would want to see multiple years of cash flow to see a pattern; One-time actions such as stock buy-back could swing a cash flow statement, but would not indicate a problem with the company	transaction occurred		(slow/non collection)
Occurrence: How often does the Issue or Risk occur?	1	1	1	1	1	1	1
What are the existing controls that prevent the Issue or Risk?	Delegate Financial Solvency Risk Report	Delegate Financial Solvency Risk Report	Delegate Financial Solvency Risk Report	Delegate Financial Solvency Risk Report	Delegate Financial Solvency Risk Report	Delegate Financial Solvency Risk Report	Delegate Financial Solvency Risk Report
Detection: How well can the Failure Mode(s) be detected?	5	5	5	5	5	5	5
Calculated Risk Priority Number (Severity x Occurrence x Detection)	10	15	35	20	25	30	40
What are the actions for reducing the Occurrence or Improving Detection? (Note: the severity will never change)	Language within the delegation agreement requiring compliance with contractual or regulatory requirements; Language within the agreement requiring review	Language within the delegation agreement requiring compliance with contractual or regulatory requirements; Language within the agreement requiring review	Language within the delegation agreement requiring compliance with contractual or regulatory requirements; Language within the agreement requiring review	Touch base with Delegation Compliance; Coordinate with contract liaison/relationship manager if there is a potential issue	Touch base with Delegation Compliance; Coordinate with contract liaison/relationship manager if there is a potential issue	Touch base with Delegation Compliance; Coordinate with contract liaison/relationship manager if there is a potential issue	Touch base with Delegation Compliance; Coordinate with contract liaison/relationship manager if there is a potential issue

	of claims payment process through oversight audits	of claims payment process through oversight audits	of claims payment process through oversight audits				
Who is responsible for implementing the recommended actions?	Delegation Compliance	Delegation Compliance	Delegation Compliance	Delegation Compliance	Delegation Compliance	Delegation Compliance	Delegation Compliance
What actions/ communications are being taken?	Annual oversight audits including a review of interest payment accuracy	Annual oversight audits including a review of member denial accuracy	Annual oversight audits including a review of cycle time and monthly cycle time monitoring	Request letters of credit in response to issues identified, as appropriate	Request letters of credit in response to issues identified, as appropriate	Request letters of credit in response to issues identified, as appropriate	Request letters of credit in response to issues identified, as appropriate
Severity: How Severe would the business impact be?	2	3	7	4	5	6	8
Occurrence: How often does the Issue or Risk occur?	1	1	1	1	1	1	1
Detection: How well can the Failure Mode(s) be detected?	5	5	5	5	5	5	5
Calculated Risk Priority Number (Severity x Occurrence x Detection)	10	15	35	20	25	30	40

Contingency (aka FMEA) GRADING CRITERIA

FMEA Category	1	5	10
Severity			
Occurrence			
Detection			

EXAMPLE

FMEA GRADING CRITERIA – Enrollee-centered Service

FMEA Category	1	5	10
Severity	Impacts just a few enrollees	Impacts a material subset of membership (~25%) in a given geography	Impacts more than half of all enrollees in a given geography
Occurrence	Rarely, if ever	Periodically	Often
Detection	Automatically detected	Detected through routine oversight	Identified through a complaint or grievance

Attachment 27-3: Communication Plan

Subcontractor Contingency Communication Plan

Accountable Business Area	Communicate What	Purpose	Frequency/ Duration	Communication to	Communication Methods
Humana (Internal)					
Provider Contracting	Subcontractor Issue and Contingency Plan Informational Email	Inform leadership of subcontractor issue and contingency activation plan	Once	Business Leaders	Email
Provider Contracting	Contingency Plan Activation Kick-off	Inform reason for contingency plan activation, identify stakeholders, share project schedule, and assign impact analysis and business area specific action plan	Once	Provider Contracting, Hospital Contracting, MSO Operations, Health Services, Service Fund, Finance and Medicaid Operations	Meeting
Provider Contracting	Impact Analysis and Business Area Action Plan	Opportunity for each impacted business area to share impact and action items to mitigate risk	Once	Provider Contracting, Hospital Contracting, MSO Operations, Health Services, Service Fund, Finance and Medicaid Operations	Meeting
Provider Contracting	Impact Analysis and Business Area Action Plan Updates	Opportunity for each business to provide updates and collaborate with other impacted areas	Biweekly	Provider Contracting, Hospital Contracting, MSO Operations, Health Services, Service Fund, Finance and Medicaid Operations	Meeting
Provider Contracting	Contingency Activation Project Closure and Lessons Learned	Close out termination and transition project and document lessons learned to be incorporated on the next contingency plan activation	Once	Provider Contracting, Hospital Contracting, MSO Operations, Health Services, Service Fund, Finance, and Medicaid Operations	Meeting
AHCA					
Medicaid Operations	Inform of Subcontractor Termination	Initial communication to inform AHCA of subcontractor termination, cause of termination, enrollees impacted, and contingency plan (continuity of care)	Once	AHCA Contracting Manager and other AHCA contacts as needed	Call and Email
Medicaid Operations	Contingency Plan Status Update	Opportunity to provide status update of contingency plan progress (continuity of care, network adequacy, and communication enrollee/provider/downstream subcontractors) and obtain feedback/requests from AHCA	Weekly	AHCA Contracting Manager and other AHCA contacts as needed	Call or email

Attachment 27-3: Communication Plan

Enrollees					
Provider Contracting	Inform of Subcontractor Termination	Inform enrollees of termination, effective date, and continuity of care process, including Humana contact assistance number	Once	All impacted enrollees	Letter and Email
Health Services	High Risk Enrollee Continuity of Care Outreach	Opportunity for Case Management team to call enrollees and assist with subcontract transition (if needed), and avoid unnecessary hospitalization	Once and additional outreach if needed	High risk enrollees in Humana Case Management program	Call
Providers					
Provider Contracting	Subcontractor Termination Informational Letter	Inform providers, hospital and SNFs of termination, effective date, continuity of care/new process	Once	Providers, Hospitals, and SNFs	Letter, Fax, Email
Provider Contracting	Subcontractor Termination FAQs	Additional information on termination, lines of business and provider types affected, contingency plan by region, patient continuation of care process and contacts, and downstream claims submission process	Once	Providers, Hospitals, and SNFs	Letter, Fax, Email
MSO Operations, Hospital Contracting, and Provider Contracting	MSO/Provider Outreach	Inform provider offices, including front line staff of termination and continuity of care/new process, and opportunity to identify issues, gaps and educational needs during the transition	Once and additional outreach as needed	Providers, Hospitals, and SNFs	Outreach
Downstream Subcontractors					
Provider Contracting	Subcontractor Termination Informational Letter for Downstreams	Inform subcontractor downstreams of termination, effective date, and continuity of care process (fee-for-service)	Once	Downstream providers contracted by Humana subcontractor being termed	Letter, Fax, Email
Provider Contracting	Subcontractor Termination FAQs for Downstreams	Provide a Humana contact point of contact and inform downstreams of claim submission and fee-for-service contracting process	Once	Downstream providers contracted by Humana subcontractor being termed	Letter, Fax, Email
Provider Contracting	Contracting Outreach	Contact downstreams to offer contracting opportunity as part of our continuation of care plan	Once and additional outreach as needed	Downstream providers contracted by Humana subcontractor being termed	Outreach

DELEGATION SERVICES ADDENDUM

This **Delegation Services Addendum (Addendum)** is made part of and incorporated into the **<Insert Type>** Participation Agreement entered into between **<Insert Name of the Humana or ChoiceCare entity>** (**Delegator**), and **<Insert Name>** (**Delegate**) which was effective **<Insert Effective date of Base Agreement>** (Agreement). This Addendum is intended to supplement the terms and conditions of the Agreement and to the extent that this Addendum conflicts with the terms and conditions of the Agreement, including any prior amendments, addenda, exhibits, or attachments, this Addendum controls the relationship between the parties.

The following Attachments are included with this Addendum and incorporated by reference herein:

CONTRACTOR NOTE: Include only those Attachments that are appropriate for the Provider entity you are Delegating services to and delete the inapplicable Attachments **– REMOVE THIS TEXT BEFORE SENDING TO DELEGATE**.

A. Delegation of Credentialing Services Attachment
B. Delegation of Utilization Review and Utilization Management Services Attachment
C. Delegation of Complex Case Management Attachment
D. Delegation of Disease Management Attachment
E. Delegation of Quality Improvement Services for Behavioral Health Services Attachment
F. Delegation of Claims Processing Attachment
G. FDR Compliance Program Requirements Attachment
H. Process Integration Attachment
I. IT Security Agreement Attachment
J. Business Associate Agreement Attachment

ARTICLE I
DEFINITIONS

Any capitalized term in this Addendum or any of its Attachments not defined herein shall have the same meaning as set forth in the Agreement.

1.1 **Accreditation Organization** means any nationally recognized organization that accredits managed care organizations including without limitation to the National Committee of Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), and the Joint Commission (TJC) or other nationally recognized Accreditation Organization approved by Delegator.

1.2 **Subcontractor(s)** means any third party which has entered into an agreement with **Delegate** to perform part or all of **Delegate's** duties and/or obligations under this Addendum.

ARTICLE II
DELEGATE'S OBLIGATIONS

In order to fulfill the purposes and objective of this Addendum, the **Delegate** agrees:

2.1 To accept the obligation to perform all delegated functions and activities described in this Addendum and in each Attachment which are each incorporated by reference into the Agreement.

2.2 To comply with **Delegator's** policies, procedures, and program requirements, Member's Plan (coverage agreement), and all applicable state and federal laws, rules and regulations and instructions including but not limited to the CMS Standards for Downstream and Delegated Entities, (45 CFR 156.340) and Accreditation Organization requirements pertaining to all functions and activities described in each Attachment.

a. **Delegate** agrees to monitor all providers, employees and Subcontractors supporting any exchange Plan, Medicare and/or Medicaid lines of business for debarments and exclusions from federal and state government programs. This must be conducted upon initial hire or contract and on a monthly basis thereafter. Accurate records of such monitoring activity must be maintained and retained for a period of a minimum of ten (10) years. Any provider, Subcontractor or employee found excluded from any exchange, Federal and state government program must be removed from providing direct or indirect services for Medicare/Medicaid or other state or federal governmental program Members immediately and shall be reported promptly to the **Delegator**.

b. **Delegate** further agrees to make available to **Delegator,** its designee or any state or federal governmental agency all documents, including but not limited to logs, files, committee meeting minutes and reports required within the timeframe determined by the auditor.

2.3 To furnish, at no expense to **Delegator**, any and all staffing and systems necessary to receive from and transmit to **Delegator**, or its designee, all required data, and will allow access to and provide to **Delegator,** or its designee, all data required by state and federal laws, rules and regulations, and **Delegator** or Accreditation Organization standards including without limitation any documentation, records, files or data necessary to perform the functions delegated under this Addendum.

2.4 That upon the termination of performance of delegated function under this Addendum, and/or the expiration, non-renewal or termination of the Addendum, regardless of the cause, any files, records and documentation or quality copies of such files and documentation pertaining to **Delegator's** Members or providers which are necessary for **Delegator** to resume responsibility for the delegated function will be made available to **Delegator** upon request.

2.5 To prepare and maintain all appropriate records which involve transactions relating to any services delegated hereunder in accordance with prudent and professional record-keeping procedures and as required by applicable federal, state, or local laws, rules, or regulations and **Delegator** or Accreditation Organization standards.

2.6 That, in the event that **Delegator** is financially penalized or incurs any administrative fine or penalty imposed by any state or federal agency or Accreditation Organization as a direct result of **Delegate's** or any of its employees or Subcontractor's failure to adhere to the applicable state or federal laws or regulations, or the standards and procedures described herein, **Delegator** will forward to **Delegate** documentation of such financial penalty and/or sanction, and **Delegate** shall reimburse **Delegator** the full amount of such financial penalty imposed, including without limitation any attorneys' fees incurred as a result of such action and penalty by a state or federal agency within thirty (30) calendar days of receipt of the documentation.

2.7 That notwithstanding anything to the contrary herein, this Addendum may not be construed to limit in any way the authority or responsibility of **Delegator** to comply with all state and federal laws, rules and regulations, and Accreditation Organization requirements to which **Delegator** is subject.

2.8 To promptly notify **Delegator**, or its designee, in writing of any confirmed quality or risk issues of which **Delegate** may become aware of as it relates to the services delegated hereunder.

a. **Delegate** shall notify and provide documentation to **Delegator** within the next business day of any corrective action plan and/or sanctions, fines or other penalties imposed on or incurred by **Delegate**, or if applicable its Subcontractor, following any review by a regulatory agency or Accreditation Organization.

b. **Delegate** agrees any material change in **Delegate's** performance of delegated functions shall be submitted to **Delegator** for review and approval by **Delegator** prior to the effective date of the proposed changes.

2.9 That **Delegator** may request a change or revision to the **Delegate**'s programs and/or processes at any time as necessary to reflect changes in regulatory, **Delegator's** and/or Accreditation

Organization requirements. Required changes or revisions will be provided to **Delegate** in writing, to be effective within ninety (90) calendar days, or such lesser period of time as may be required by applicable regulatory and/or Accreditation Organization requirements to which **Delegator** is subject. **Delegate** shall provide evidence of implementation to **Delegator** as directed.

ARTICLE III
ACCESS, AUDIT AND OVERSIGHT

Delegate agrees that state, federal and Accreditation Organization regulations or standards require **Delegator** to maintain oversight of the delegated functions furnished by **Delegate**. Such oversight shall, at a minimum, include:

3.1 **Delegator's** or its designee's right to conduct on-site visits at least annually, or more frequently if deemed necessary by **Delegator**, upon not less than ten (10) business days prior notice, or such shorter notice as may be imposed on **Delegator** by a state or federal regulatory agency or Accreditation Organization.

3.2 **Delegator**, **Delegator's** designee, federal, state, and local governmental authorities having jurisdiction, and/or Accreditation Organization to audit any and all documents and materials including, but not limited to, books, contracts, computer and other electronic systems, related to services rendered under this Addendum. **Delegate** shall also permit review of **Delegate's** policies and procedures, programs, annual plans, annual evaluation of previous year's programs, reports, and meeting minutes that have been approved by the **Delegate's** administrative/quality committee, and **Delegate's** performance/compliance under each Attachment.

3.3 Permission for **Delegator**, **Delegator's** designee, federal, state and local governmental authorities having jurisdiction, and/or Accreditation Organization's right to conduct a site visit and/or audit at any site at any time where **Delegate** performs delegated functions under the terms of this Addendum. Any such audit shall be permitted during the term of this Addendum and for a period of ten (10) years thereafter (or any greater period required by applicable law). This section shall survive the termination of this Addendum, regardless of the cause of termination;

3.4 Submission to **Delegator** of periodic reports. These reports shall be provided in accordance with the applicable delegated function attachment and at such other times as **Delegator** shall request or as **Delegator** shall deem necessary or appropriate to ensure that **Delegator** is fully apprised of **Delegate's** activities;

3.5 That **Delegate** agrees to retain all data, information, records, and documentation related to its performance of each delegated function under this Addendum for the longer of ten (10) years following the date of service or the period required by applicable state law.

3.6 **Delegate's** obligation to cooperate and comply with any Corrective Action Plan (CAP) established by **Delegator** in the event there is any breach of this Addendum or non-compliance with state or federal law, Accreditation Organization requirements or **Delegator's** policies and procedures. Corrective action may include, without limitation, intensifying the frequency and number of audits, the temporary loss of delegated rights under this Addendum or the termination of this Addendum.

3.7 **Delegate's** agreement that notwithstanding anything to the contrary herein, **Delegator**, in its sole discretion, or any state or federal regulatory authority, retains the right to approve, modify, suspend or revoke at any time all, or any portion, of functions and/or activities delegated hereunder.

3.8 **Delegate's** acknowledgement and agreement that **Delegator** reserves the right to perform assessments to review the effectiveness of **Delegate's** ability to perform the assigned delegated

functions and compliance with established criteria. **Delegator** shall provide at least ten (10) business days prior written notice before conducting any onsite assessment.

3.9 That notwithstanding anything to the contrary herein, **Delegator**, in its sole discretion, or any state or federal regulatory authority, retains the right to approve, modify, suspend or revoke at any time all or any portion of functions and/or activities delegated hereunder.

ARTICLE IV
SUB-DELEGATION

4.1 If **Delegate** sub-delegates any portion of the delegated functions to a Subcontractor, **Delegate** will require by contract that those functions shall be pre-approved by **Delegator** and be subject to the terms of this Addendum and will be provided in accordance with **Delegator's** policies, procedures and program requirements and all state and federal regulatory and/or Accreditation Organization requirements applicable to **Delegator**.

4.2 Such sub-delegation shall not relieve **Delegate** of its obligations under this Addendum. **Delegate** acknowledges and agrees that all of its obligations under this Addendum shall apply equally to any Subcontractor that provides any services under this Addendum, and **Delegate** represents and warrants that **Delegate** shall take all steps necessary to cause such Subcontractor to comply with the terms of this Addendum.

4.3 If **Delegate** sub-delegates any portion of the delegated functions, then **Delegate** will provide to **Delegator** documentation, and demonstrate a plan for adequate oversight of, Subcontractor prior to any sub-delegation and annually thereafter, or will provide to **Delegator**, in writing **Delegate's** request and acknowledgement that **Delegator** will perform oversight of all sub-delegated functions.

4.4 **Delegate** agrees to require by contract that Subcontractor acknowledge and agree that **Delegator** retains the right to perform evaluation and oversight of the Subcontractor, and will review or audit as required by law or if deemed necessary by **Delegator.**

4.5 The **Delegate** will provide **Delegator** with documentation of a written sub-delegation agreement and Business Associate Agreement that:

a. Is mutually agreed upon;
b. Describes the responsibilities of the **Delegate** and Subcontractor;
c. Describes all sub-delegated activities;
d. Requires at least semi-annual reporting to the **Delegate**;
e. Describes the process by which the **Delegate** will regularly evaluate the Subcontractor's performance;
f. Describes the remedies, including revocation of the sub-delegation agreement, available to the **Delegate** if the Subcontractor does not fulfill its obligations.

4.6 If **Delegate** sub-delegates any portion of the delegated functions to a Subcontractor, then **Delegate** will require by contract that Subcontractor agrees to indemnify and hold **Delegator** and its affiliates and their respective agents, employees, and/or officers harmless from any and all claims, losses, liabilities, damages, injunctions, lawsuits, fines, penalties, demands and/or expenses of any kind or nature, including without limitation attorneys' fees, arising out of or in relation to Subcontractor's performance of the sub-delegated functions.

4.7 The **Delegate** agrees to monitor the Subcontractor for federal and state government programs exclusions on a monthly basis for Medicare/Medicaid providers and will maintain accurate records of such monitoring activity. Any provider, Subcontractor or employee found excluded from any exchange, Federal and/or state government program must be removed from providing direct or indirect services for Medicare/Medicaid or other governmental program Members immediately and shall be reported to the **Delegator**.

4.8 The **Delegate** agrees to monitor to ensure that the Subcontractor performs the federal and state government exclusion checks for their employees and contracted entities on a monthly basis and will

maintain accurate records of such monitoring activity. Any provider, Subcontractor or employee found excluded from any exchange, Federal and/or state government program must be removed from providing direct or indirect services for Medicare/Medicaid or other governmental program Members immediately and shall be reported to the **Delegate** who in turn shall report to the **Delegator**.

ARTICLE V
TERM AND TERMINATION

6.1 This Addendum shall commence at 12:01 AM on the Effective Date specified below and shall continue in full force and effect for an initial term of twelve (12) months. This Addendum shall continue in full force and effect for additional twelve (12) month periods unless terminated in accordance with the terms outlined in the Agreement or this Addendum.

6.2 Notwithstanding anything to the contrary in this Addendum, the Attachments, or the Agreement, performance under this Addendum may be terminated without cause by either party upon written notice provided to the other party no less than ninety (90) calendar days prior written notice or by mutual agreement.

6.3 Notwithstanding anything else in this Addendum, the Attachments, or the Agreement any breach related to Delegate's accreditation, licensure, and/or quality assurance issues shall be considered non-curable. Furthermore, a determination by Delegator that Delegate's continued performance of the delegated functions and/or activities under this Addendum may adversely affect the health, safety or welfare of any Member or bring Delegator or its provider networks in to disrepute, shall be considered non-curable.6.4 Notwithstanding any other provision in the Agreement, this Addendum or any Attachment, **Delegator** may terminate this Addendum, or any Attachment immediately and automatically without additional notice in the event **Delegator** determines that there has been any change or limitation that materially affects **Delegate's** ability to adequately deliver the services delegated hereunder, or for any of the reasons outlined in the Agreement. .

The Effective Date of this Addendum is: **<Insert Date>** .

Each party to this Addendum represents that it has full power and authority to enter into this Addendum and the person signing this Addendum on behalf of either party represents that he/she has been duly authorized to enter into this Addendum.

Delegate	**Delegator**
By: _____	By: _____
Signature of Delegate	Signature of Delegator
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date

DELEGATION OF CLAIMS PROCESSING FOR MEDICAL and BEHAVIORAL HEALTH SERVICES (remove BH services if not applicable)

ATTACHMENT

This **Delegation of Claims Processing Services Attachment** ("Claims Attachment") is hereby made part of and incorporated into the Agreement and the Delegation Services Addendum, entered into between **<Insert Name of the Humana entity>** (**Delegator**), and **<Insert Name>** (**Delegate**) effective on **<Date>**. This Claims Attachment is intended to amend the terms and conditions of the Addendum and to the extent that this Claims Attachment conflicts with the terms and conditions of the Agreement or the Addendum, including any prior agreements, addenda, exhibits, or attachments, this Claims Attachment controls the relationship between the parties.

ARTICLE I

DELEGATE'S OBLIGATIONS

Delegate agrees that it will:

1.1 Acknowledge and agree that **Delegate**'s policies and procedures are subject to **Delegator's** review and written approval prior to any delegation of claims processing functions.

1.2 Accept responsibility and the obligation for all claims processing functions delegated hereunder for those services rendered to Members.

1.3 Be solely responsible for acquiring, operating, and maintaining any equipment or software necessary in performing its duties hereunder.

1.4 Conduct claims adjudication and processing in accordance with **Delegator's** policies, procedures, and program requirements, Member's Plan, state and federal laws, rules, and regulations, and the requirements of all regulatory bodies or Accreditation Organizations to which **Delegator** is subject, including but not limited to all privacy and electronic data security laws or regulations, and/or as required by **Delegator**.

1.5 Represent and warrant that **Delegate's** claims processing processes are compliant with the most current American Medical Association (AMA) Current Procedural Terminology (CPT®) code sets, Healthcare Common Procedure Coding System (HCPCS) code sets, International Classification of Diseases, 10th Edition/Revision (ICD-10) code sets (and future ICD revisions when effective), Centers for Medicare & Medicaid Services (CMS) guidelines and national coverage determinations (NCDs), and the CMS National Correct Coding Initiative (NCCI).

1.6 Acknowledge and agree that **Delegator** retains the right and final authority to pay any claims for its Members regardless of the delegation of any such functions or activities to **Delegate**.

1.7 Acknowledge and agree that any amounts authorized by **Delegate** for payment by **Delegator** may be charged against **Delegate's** funding.

1.8 If required by state and/or federal law, rule or regulation, **Delegate**, at all times during the term of this Addendum, shall obtain, and maintain in good standing a Third Party Administrator (TPA) license/certificate or other state required license/registration/certification. **Delegate** shall provide **Delegator** a copy of the appropriate license/registration/certification number(s) prior to execution of this Addendum and upon renewal thereafter.

1.9 Provide a financial guarantee, acceptable to **Delegator** prior to implementation of any delegation of claims processing, including, but not limited to, a letter of credit, to ensure its continued financial solvency and **Delegate's** ability to adjudicate and process claims hereunder.

1.10 **Delegate** shall submit to **Delegator**, financial information, upon request, as proof of their continued financial solvency. Financial information submitted should include the following:

a. Recent audited financial statements (balance sheet, statement of operations, statement of cash flows and notes to the financial statements). If the audited financial statements

are over six (6) months old, provide current internal financials with projections (e.g. 6 month-ended financials or quarterly reports).

b. If **Delegate** has not been audited, **Delegate** is to provide recent internally prepared financial statements (balance sheet, statement of operations and cash flow statement).

c. **Delegate's** chief financial officer and/or owner will certify/attest to their correctness by adding his/her signature to the financial statements provided to **Delegator**.

1.11 **Delegate** agrees to permit any regulatory agency to examine, at any time, information the agency deems relevant to determine the financial solvency of the **Delegate** or to review the **Delegate's** ability to meet its responsibilities in connection with any function delegated to **Delegate** by **Delegator**.

1.12 **Delegate** will submit claim/Encounter data in the format defined in the Process Integration Attachment (eConnectivity).

1.13 Acknowledge that **Delegator** retains all other claim processing functions not specified as the **Delegate's** responsibility in this Claims Attachment.

ARTICLE II
CLAIMS PERFORMANCE REQUIREMENTS

Delegate agrees, and represents and warrants that it will meet, at a minimum, the following claims adjudication and processing performance requirements. **Delegate** must:

2.1 Accurately and timely process at least ninety-five percent (95%) of the total of all delegated claims according to **Delegator's** claims processing standards and requirements and in accordance with state and federal laws, rules and regulations and/or the requirements of any regulatory or Accrediting Organization to whom **Delegator** is subject.

2.2 Pay any and all statutory interest or other penalties on claims in accordance with applicable state and federal requirements.

2.3 Maintain an accuracy rate of at least ninety-nine percent (99%) of total dollars paid, for any given calendar month for all claims processed and adjudicated.

2.4 Comply with all state, federal and Accreditation Organization requirements to which **Delegator** is subject with respect to any denial or appeal of claim payment in all communications made to Members. Use **Delegator** prepared Member letter or Explanation of Benefits (EOB) templates for all delegated lines of business as indicated.

2.5 Provide claims processing results to **Delegator** on a monthly basis as required by **Delegator's** Delegation Compliance Department using the submission form supplied by **Delegator**.

2.6 If processing claims for payment for services rendered to any Medicare Advantage Members, **Delegate** must comply with all rules and requirements for the processing of Medicare Advantage claims established or implemented by the Centers for Medicare and Medicaid Services ("CMS") including, but not limited to, the following:

a. the **Delegate** must make correct claim determinations, which include developing the claim for additional information, when necessary, for:

1. Services obtained from a non-contracted provider and reasonable reimbursement when the services were authorized by a contracted provider or the **Delegate;**

2. Ambulance services dispatched through 911;

3. Emergency services;

4. Urgently needed services;

5. Post-stabilization care services;
6. Renal dialysis services that Medicare Members obtain while temporarily out of the service area; and
7. Services for which coverage has been denied by the **Delegate** but found to be services the Member was entitled to upon appeal.

b. Ninety-five percent (95%) of "Clean Claims" (as defined by CMS) from nonparticipating providers must be paid within thirty (30) calendar days of receipt.

c. Pay any CMS mandated interest amounts on all Clean Claims which are paid to nonparticipating providers later than thirty (30) calendar days from date of receipt.

d. Pay or deny all other claims received by nonparticipating providers within sixty (60) calendar days of receipt.

2.7 The **Delegate** is obligated to pay contracted providers under the terms of the contract between the **Delegate** and the Provider.

2.8 **Delegate** agrees that **Delegator** maintains the ultimate responsibility for the accuracy of claims processing and adjudication for Members and retains the right to implement a Corrective Action Plan (CAP), suspend, or terminate any portion of this Claims Attachment in the event there is a breach of this Claims Attachment or noncompliance with state or federal law, Accreditation Organization requirements or **Delegator's** policies, procedures and claims performance requirements.

ARTICLE III
CLAIMS ACCESS, AUDIT AND OVERSIGHT

3.1 **Delegate** shall allow **Delegator**, or its designee, to monitor the accuracy, quality, timeliness, and effectiveness of **Delegate's** claims adjudication and processing functions and activities hereunder through periodic reviews and audits. Accordingly, upon request at any time during the term of this Claims Attachment, **Delegate** will provide **Delegator**, or its designee, access to any and all source documentation, and all other documents, processes, procedures, systems and other information related to Member claims processed, paid, denied, or pended hereunder.

3.2 Submit to **Delegator**, with respect to delegated functions, all required reports and analyses including but not limited to the contents in **TABLE 1,** which is attached hereto and incorporated by reference herein, along with identified problems, corrective actions initiated, and outcomes.

a. All reports and subsections of reports must be specific to line of business and offering **Delegator's** affiliate, and all reporting formats must be pre-approved by **Delegator**.
b. **Delegate** agrees to provide any and all reports requested by **Delegator** within timeframes identified by **Delegator** to ensure **Delegator** meets all new and revised **Delegator**, CMS, Federal, State and Accreditation Organization reporting requirements.

3.3 Should the **Delegate** be placed on a CAP, the **Delegate** will have fourteen (14) calendar days to provide a written response describing how they will meet the requirements found to be noncompliant including prospective date of compliance, which must be remediated within ninety (90) days or less.

3.4 **Delegate** will be subject to a capitation payment penalty as indicated in the table below for any outstanding issues noted on a CAP:

Outstanding Corrective Action Plan	**0 to 3 months**	**4-6 months**	**7-9 months**	**10-12 months or greater**
Payment penalty	**0%**	**1% per month**	**2% per month**	**3% per month**

		until CAP resolved	**until CAP resolved**	**until CAP resolved**

ARTICLE IV
MEMBER APPEALS AND GRIEVANCES/COMPLAINTS

4.1 **Delegator's** Member appeals/grievances/complaints are not delegated. **Delegator** maintains all Member rights and responsibility functions. **Delegator** will handle all Member appeals / grievances / complaints regarding claims payment and payment denials including any appeal / grievances / complaints made by a provider on behalf of the Member.

4.2 **Delegate** will fax all Member appeals/grievances/complaints to **Delegator** within one (1) business day.

. **For Expedited and Standard Member Appeals and Grievances/Complaints**:

Medicare:

Telephone- 1-800-867-6601 Fax- 1-800-949-2961

Medicaid:

Telephone- 1-800-764-7591 Fax- 1-855-336-6220

Commercial and Exchange:

Telephone- 1-888-259-6767 Fax- 1-920-339-2112

Florida Medicaid:

Telephone- 1- 800-477-6931 Fax- 1- 800-949-2961

ARTICLE V
PARTICIPATING AND NON-PARTICIPATING PROVIDER DISPUTE/RECONSIDERATION

MEDICARE

5.1 **Delegator** will handle all non-participating physician, practitioner, hospital, and other health care professional and/or provider claim payment and payment denial disputes or request for reconsideration.

5.2 Delegate will handle all physician, practitioner, hospital, and other health care professional and/or provider claim payment and payment denial disputes or requests for reconsideration for Participating Providers.

5.3 **Delegate** shall instruct non-participating providers to submit their claim payment and payment denial disputes or requests for reconsideration directly to:

Humana

P.O. Box 14601

Lexington, KY 40512-4601

5.4 **Delegator's** payment dispute/reconsideration determination will be final and processed by **Delegate** as directed.

5.4 **Delegate** will follow the most current CMS MA Payment Guide for Out of Network Payments.

COMMERCIAL

5.5 **Delegate** will handle all physician, practitioner, hospital, and other health care professional and/or provider claim payment and payment denial disputes/appeals/grievances for Participating and non-participating Providers except as otherwise required by state or federal law.

MEDICAID

5.6 **Delegate** will handle all physician, practitioner, hospital, and other health care professional and/or provider claim payment and payment denial disputes/reconsiderations for Participating and non-Participating Providers as required by state and federal law.

ARTICLE VI

TERMINATION

6.1 Notwithstanding anything to the contrary in this Claims Attachment, the Addendum, or the Agreement, performance under this Claims Attachment may be terminated without cause by either party upon written notice provided to the other party no less than ninety (90) calendar days preceding the termination date or by mutual agreement.

6.2 Notwithstanding anything else in this Claims Attachment, any breach related to **Delegate's** accreditation and/or licensure, quality assurance issues or alleged breach regarding termination by **Delegator** in the event **Delegator** determines that **Delegate's** continued performance of the delegated functions and/or activities under this Claims Attachment may affect adversely the health, safety or welfare of any Member or bring **Delegator** or its provider networks in to disrepute, shall be considered non-curable.

6.3 If delegated for claims payment, the **Delegate** is obligated to pay claims incurred up to the date of termination. The run-off period to pay claims post-termination will be determined by the **Delegator** and shall continue until the last outstanding claim has been paid. The **Delegate** shall continue with the Mandatory Monthly Claims Reporting noted in the Claims Attachment, Table 1, until all applicable claims are paid.

The **Effective Date** of this Claims Attachment is: **<Insert Date>** .

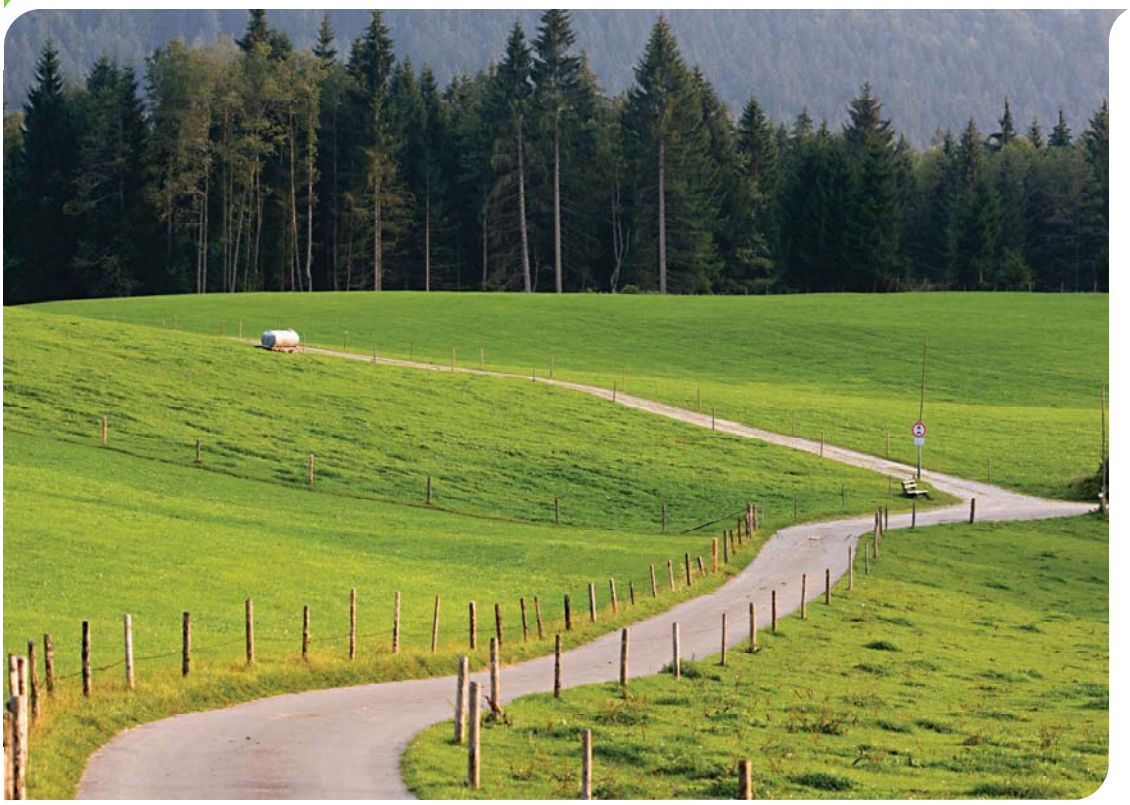
MANDATORY REPORTS	FREQUENCY	DETAIL
Delegator Monthly Claims Report	Monthly	Template will be provided to **Delegate**
Non-participating Provider Disputes	Monthly	Template will be provided to **Delegate** or **Delegator** will review **Delegate** template
Medicare Part C Reporting (Requirements can be found in the Medicare Part C Specification Documents)	Quarterly	**This must be reported 8 days following the end of the quarter**
Note: Reporting requirements may change based upon revised or new **Delegator,** state and federal legislation during the term of this Attachment. The Mandatory Reports listed above are in addition to required reports communicated throughout other contract documents.		

CLAIMS REPORT TABLE 1

All reports and subsections of reports must be line of business (LOB) and **Delegator** market specific. Reporting templates not provided by **Delegator** are subject to review and approval.
Monthly – 15th of the following month **Quarterly** – April 15, July 15, October 15, January 15

Ethics Every Day

for Contracted Health Care Providers and Business Partners



It is important that I read this and, if I'm an administrator, provide this information or a materially similar document to all employees and business partners who support Humana's Medicare and/or Medicaid products as a part of our relationship.

I am the key to integrity

I have help

From my manager, my organization, Humana and the Ethics Help Line **(1-877-5-THE-KEY)**, I have the support I need if I encounter sticky situations.

I know what to do

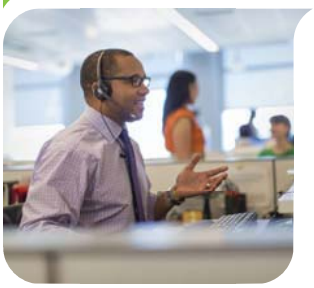
The guidelines in this book, along with Humana's policies and resources, help me understand and follow the rules.

I am safe from retaliation

When I suspect a violation, I know I will not get in trouble for speaking up.

Humana®

We are all the key to integrity



Humana's dream is underscored by Humana's values:

- Inspire health
- Cultivate uniqueness
- Rethink routine
- Pioneer simplicity
- Thrive together

We encourage your organization to consider these perspectives in its approach to the ongoing fulfillment of obligations to Humana.

Dear Valued Contracted Health Care Providers and Business Partners:

We appreciate all you do to maintain the highest ethical standards in your business interactions. Your actions enable us to do the same, while also contributing in a meaningful way to our combined success. We value our mutually beneficial relationship and are grateful for your partnership.

Our dream is to help people achieve lifelong well-being. Part of realizing that dream is a steadfast commitment to act with integrity and achieve the highest ethical standards, something we have been doing since Humana was founded more than 50 years ago. The values we share and clear ethical principles help us all make good decisions every day, allowing us to deliver a perfect experience for everyone we do business with. It takes all of us working together, living our values, taking ownership of our actions, and following the state and federal legal requirements that govern our industry to create that perfect experience in the right way.

In this spirit, we offer you, your employees and contracted business partners an important part of our Enterprise Compliance Program: Ethics Every Day for Contracted Health Care Providers and Business Partners. This document outlines our program's standards of conduct requirements for you.

Our Enterprise Compliance Program will help you with troubling or confusing matters, or you can reach out to your leader, another leader outside your team or the independently staffed Ethics Help Line (1-877-5-THE-KEY or www.ethicshelpline.com).

Thank you for your continued participation as a contracted health care provider or business partner. With all of us working each day to be the key to integrity, we can deliver a perfect experience. When we do the right thing in the right way for the right reasons, we thrive together.

Sincerely,

Kurt J. Hilzinger

Chairman of the Board

Bruce Broussard

President and
Chief Executive Officer

J. Gregory Catron

Vice President,
Associate General Counsel
and Chief Compliance Officer

Staying on track

The bottom line

The locations of the key requirements from each section of this document are listed below.

I am required to:	Where addressed
Make ethical decisions	1
Report suspected noncompliance with the Standards of Conduct or any applicable law or regulation	1, 2 and 3
Be familiar with the concepts of fraud, waste and abuse (FWA)	4
Not make business decisions motivated by personal considerations or relationships	5
Refrain from discussing, giving or offering anything of value, including employment, to anyone on Humana's behalf, unless permitted by law or Humana policy	5
Treat Humana customers with respect and make every effort to protect their health, safety and welfare	6
Not intimidate or retaliate against anyone I interact with in performing my role for Humana	7
Protect Humana information	8
Follow all applicable laws, rules and regulations	9

Those in a leadership role also are required to:	
Foster an ethical and compliant culture	1
Not employ or contract with ineligible parties	4

Violations	
Suspected violations will be investigated	7
Disciplinary actions will be taken when violations occur	7

Notable changes
(with page number)

This overview has been provided to list the key points of notable changes and the sections in which they are detailed.

Cover page
It now further clarifies the required audience for this document.

Key terms (ii)
Clarified that examples of Health Care Providers and Business Partners also include delegated and non-delegated health care providers, as well as delegated entities. These are in addition to other examples previously and currently listed.

I have help (3)
The Resources sub-section now lists a fax number as an additional option for reporting suspected violations that are referred to Humana's Special Investigations Unit.

Privacy or security breaches (3)
Clarified what a breach can be.

Conflicts of interest (5)
Clarified that uncertainty over whether a conflict exists means the matter should be disclosed for evaluation.

Gifts, favors, job opportunities and entertainment (5)
Disclosed that Humana has policies which outline allowable gifts for Medicare or Medicaid beneficiaries.

Investigation of suspected violations (7)
Clarified that those disclosing their identity when reporting a suspected violation may be contacted for additional information.

Disciplinary standards (7)
This section now includes a clarification that corrective action plans, when issued, are tracked to completion.

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Humana is ultimately responsible for ensuring the actions of those who support Humana business, including the actions of contracted health care providers and business partners, are compliant with applicable laws, rules and regulations.

Key terms

I will see the terms below throughout this document, and they are defined as follows:

Associate – A Humana employee.

Compliance Policy – The Compliance Policy for Contracted Health Care Providers and Business Partners, a detailed listing of Humana's compliance requirements for health care providers and business partners and how to meet them, along with overviews of, and links to, resources and applicable laws and regulations.

Health care providers and business partners – Any non-associate contracted, directly or indirectly, to perform a business function or provide goods or a service for or on our behalf. These may also be referred to as first tier, downstream and related entities (FDRs). Some examples of business partners are delegated and nondelegated health care providers delegated entities, pharmacies, sales agents, sales agencies, vendors, suppliers, contractors and delegates.

- Vendors and suppliers of administrative goods and services are considered business partners.

Humana (or the company) – Refers to Humana Inc. and its wholly owned subsidiaries.

Terms specific to fraud, waste and abuse (FWA):

Abuse –Includes any action(s) that may, directly or indirectly, result in one or more of the following:

- Unnecessary costs to the health care system, including the Medicare and Medicaid programs
- Improper payment
- Payment for services that fail to meet professionally recognized standards of care
- Services that are medically unnecessary

Abuse involves payment for items or services when there is no legal entitlement to that payment and the entity supporting Humana (e.g., a health care provider or supplier) has not knowingly and/or intentionally misrepresented facts to obtain payment.

Abuse cannot always be easily identified, because what is "abuse" vs. "fraud" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Fraud – Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. § 1347).

Waste – Overutilization of services or other practices that, directly or indirectly, results in unnecessary costs to the health care system, including the Medicare and Medicaid programs. Waste is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Our expectations

These principles are intended as guides that reflect the collective good judgment and common sense of us all, not a comprehensive set of rules or legal advice.

Q. What should I do if my supervisor or manager asks me to do something I think violates this document or related policies or is illegal?

A: Immediately report the request to a level of management above your supervisor or manager, Humana's Ethics Office or the Ethics Help Line. The matter will be investigated promptly so you receive proper guidance.

The Bottom Line
Leaders must foster an ethical and compliant culture.

Who should read this document

This document is for everyone who performs a business function or provides a service for or on our behalf. It is not limited to those who define themselves as health care providers or business partners, but includes their employed and contracted staff and organizations serving them.

Our principles

This document is closely aligned to the standards of conduct (Ethics Every Day) distributed to associates and available on Humana's website: http://phx.corporate-ir.net/External.File?item=UGFyZW50SUQ9MTg5MjY0fENoaWxkSUQ9LTF8VHlwZT0z&t=1

Both versions reaffirm our commitment to integrity as the cornerstone of behavior for anyone who acts on our behalf. This means anyone from a board of director to the CEO to the part-time temporary worker, regardless of whether the person is an employee.

The guidelines in this document are meant to help all of us better understand what we believe to be in the best interest of our constituencies, including customers, members, patients, clients, associates, shareholders, those with whom we do business and the public at large. As a result, we will provide value, service and guidance to become the role model for the health care industry.

Therefore, it's important to conduct ourselves in an ethical, legal and above-board manner. The quality of health care providers' and business partners' products and services affects the quality of Humana's products and services. Understanding this commitment and willingness to raise ethical concerns are essential to the well-being of Humana's customers, members, patients and clients, as well as the success of both your organization and Humana.

Keep in mind

No matter what the situation:

- Remember the ripple effect — your actions have an impact on everyone around you
- Don't forget it's OK to ask — if something doesn't feel right, use the resources identified in this policy to share your concerns

Our ethical principles are the framework for the Compliance Policy, which also integrates requirements outlined in Medicare Managed Care Manual, Chapter 21, and Prescription Drug Benefit Manual, Chapter 9 guidelines published by the Centers for Medicare & Medicaid Services (CMS). Please refer to the Compliance Policy for how to align ethical behavior with compliance requirements.

Leaders' responsibility

We expect leaders to set the example:

- Provide sufficient information to those supporting your organization to comply with laws, rules and regulations to meet obligations to Humana
- Foster a culture that encourages everyone to communicate concerns when they arise
- Never sacrifice ethical and compliant behavior in the pursuit of business objectives
- Have business ethics requirements for your organization, including a formal program for ethics, compliance and ongoing related training; you also may adopt this document

I know what to do

Four powerful principles steer us away from mistakes we never intended to make:

1 **Honesty and respect to all:** Act fairly and honestly with those who are affected by your actions, and respect and value those you serve by treating them the way you and they would want to be treated.

2 **Compliance with laws and focus on quality:** Comply not only with the letter of all applicable laws, regulations and regulatory guidance, but also with the spirit of the law, regulation or regulatory guidance. Act in such a manner that the full disclosure of all facts related to any activity would reflect favorably on the company or you. Ensure everything is done right the first time and every time.

3 **Responsibility for actions:** Adhere to the highest ethical standards of conduct in all business activities and act in a manner that enhances Humana's standing as a corporate citizen and ethical competitor within the business community. Pursue no business opportunity that requires violation of these principles. Communicate openly, place customers' needs first and act appropriately, according to Humana's values.

4 **Responsibility for reporting violations:** All of us are responsible for reporting suspected ethical or compliance violations and issues. Humana promotes relationships based on mutual trust and respect and provides an environment in which a company practice can be questioned without fear of adverse consequences.

It is important to report to Humana any questionable activity because ethical violations are not always the result of an intentional disregard of ethical standards.

Questions to ask yourself

If you're confronted with a situation that you're unsure how to handle, use these questions to guide your actions:

- Am I following approved company practices?
- Am I causing harm to someone?
- Can I defend my actions to my leader, coworkers, associates and the public?
- Am I appropriately protecting information about the company from disclosure to external or internal parties?
- Am I protecting the information of our customers, members, patients, clients, associates and shareholders?
- Am I living up to my personal code of behavior?
- Will my actions give the appearance of being illegal or unethical?
- Will my actions bring discredit to any co-workers, associate or the company if disclosed to the public?

Phrases you hear, read or think may signal a problem:

"It's just between you and me ..."

"Well, maybe just this once ..."

"Nobody will ever know."

"It doesn't matter how it gets done as long as it gets done."

"Everyone does it."

"What's in it for me?"

"Don't contact the Ethics Help Line."

"Remember, we didn't have this conversation."

"If they don't ask, don't tell."

The Bottom Line

I must make ethical decisions and report suspected noncompliance.

I have help

I can choose the option I feel most comfortable using.

An abundance of resources is available to make you feel comfortable speaking up.

Sometimes it's hard to report concerns or admit you don't know something. That's why Humana makes it easy to be heard.

Resources

For raising issues, asking questions and reporting suspected violations:

- **Leader:** Ask your leader for advice
- **Other leadership:** Speak to the next level of leadership
- **Humana's Ethics Office:** Contact via email at **ethics@Humana.com**
- **Ethics Help Line:** Call 1-877-5-THE-KEY (1-877-584-3539) or visit **www.ethicshelpline.com**
  - Available 24 hours a day, seven days a week
  - Calls are confidential and can be made anonymously
  - Calls will not be traced or otherwise identified
  - Staffed by trained, external non-Humana representatives
  - Reports are documented and forwarded to Humana's Ethics Office for review and determination of action, including referrals to internal departments for investigation
- **Special investigations referral:** Report suspected incidents of fraud, waste and abuse to SIU: **1-800-614-4126**, **siureferrals@Humana.com**, or fax 1-920-339-3613 or Contact the Ethics Help Line

Privacy or security breaches*

A Humana business partner with a signed Business Associate Agreement with Humana that identifies improper disclosure of or access to information or systems related to Humana, including, but not limited to, beneficiary or member information, must report it to Humana within five days of discovery. All information that should be included in the breach report is outlined in the Business Associate Agreement.

Mail: Humana Inc.
Privacy Office
500 W. Main St.
Louisville, Kentucky 40202

Fax: 502-508-3700

Email: **privacyoffice@Humana.com**

* Due to the nature of these issues, reporting them anonymously is not an option.

The Bottom Line

I must report suspected noncompliance.

Fraud, waste and abuse (FWA)

The detection, correction and prevention of FWA are essential to maintaining a health care system that is affordable for everyone. State and federal law enforcement agencies are increasingly focused on investigating health care FWA.

Examples of FWA include but are not limited to:

- Defrauding or attempting to defraud the health care system
- Lying, using false pretenses or making false statements or promises to get money from the health care system
- Using the identifying information of another person to defraud the health care system
- Misusing resources or services, which results in unnecessary costs to the health care system
- Taking any action that leads to a payment from the health care system that is improper, for substandard care or for medically unnecessary services

Even if you don't intentionally lie or misrepresent facts, you could still be committing fraud, waste and abuse if you are paid by the health care system but are not actually entitled to the money.

Requirement to report FWA

Everyone who performs a function that in some way supports Humana business is required to report suspected FWA to one of the designated contacts in the "I have help" section on the previous page.

Humana has zero tolerance for any activity that constitutes fraud, waste or abuse.

For more information on FWA, including additional examples, use the Web link below to access CMS' Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training*
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

* As with all concepts discussed in this document, the CMS training also applies to Humana's Medicaid line of business.

The Bottom Line
I must be familiar with FWA concepts.

Ineligible parties

The government requires us to refrain from contracting with or employing those who have engaged in certain types of activities. Such parties include health care providers and business partners, their employees and those they contract with to perform functions to meet obligations to Humana that have been or are:

- Convicted of a criminal offense related to health care
- Listed as excluded or otherwise ineligible for participation in federal health care programs*
- Identified and listed on the Executive Order 13224 – Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit, or Support Terrorism
- Listed on either the Department of Health and Human Services' Office of Inspector General or the General Services Administration exclusion list*
- Convicted of any felony involving dishonesty or a breach of trust (Violent Crime Control and Law Enforcement Act of 1994)

These individuals and their employees and those they contract with to perform functions to meet obligations to Humana are ineligible for any contractual relationship with Humana.

The Bottom Line
Those in leadership roles must not employ or contract with ineligible parties.

* There may be instances where some person or entity was previously listed as excluded, but that status has been removed. In such a case, Humana should be contacted so it can determine whether the involved party(s) may support Humana.

Conflicts of interest

Having a conflict of interest is not necessarily a violation of this document, but failing to disclose the conflict to your organization is a violation. Humana's healthcare providers and business partners and those supporting them must disclose any conflicts of interest annually and if their status changes. If you are unsure of whether a relationship is a potential conflict of interest, you should disclose it so that it may be evaluated.

The Bottom Line
I must not make business decisions motivated by personal considerations or relationships.

Possible conflicts of interest

Personal, familial or business relationships that could interfere with your organization's ability to meet contractual obligations to Humana may be conflicts of interest.

Additionally, Humana associates must not engage in activities that compete with any of Humana's lines of business nor invest in entities they select, manage or evaluate as an entity supporting Humana. Health care providers and business partners must be sensitive to these relationships and avoid creating situations that could encourage a Humana associate to violate these policies.

A good general rule is to avoid any action or association that would be embarrassing to you, your organization or Humana if it were disclosed to the public, or that would be perceived as a potential conflict of interest or appear as improper.

Gifts, favors, job opportunities and entertainment

Please refer to the Compliance Policy for anti-kickback and anti-inducement provisions that outline the kinds of items that can be given away, their value limits and to whom.

Email the Ethics Office at ethics@Humana.com with questions about gift cards and gift limits, including on a state or local level.

Health care providers and business partners:

- Should never offer or provide, directly or indirectly, anything of value – such as a job, cash, bribes or kickbacks – to any Humana associate, representative, customer or government employee.
- Are expected to understand Humana's business entertainment policies before offering or providing any Humana associate or representative any business entertainment. Business entertainment should never be offered to a Humana associate or representative under circumstances that create an appearance of impropriety.

Accepting or giving gifts, favors, travel and entertainment may create a conflict of interest with your obligations to Humana and may constitute a violation of law.

Gift giving or receiving that involves health care providers or business partners, is limited to $50 fair market value or less. Giving gifts to Medicare or Medicaid beneficiaries has stricter guidelines and limitations outlined in Humana policies. This also includes, but is not limited to, meals, favors, travel, tickets or entertainment, prizes, drawings, raffle winnings, gratuities and awards.

Gifts of money or cash equivalent are never permissible.

The Bottom Line
I must refrain from discussing, giving or offering anything of value, including employment, to anyone on Humana's behalf, unless permitted by law or Humana policy.

Working with Humana customers

Cultural competency

Health care providers and business partners who interact with Humana customers, including beneficiaries, must do so in a culturally competent manner. This includes:

- Understanding cultural differences and economic disparities in the populations you work with as part of your responsibilities for Humana
- Being knowledgeable about how to work with people from a variety of cultural and economic backgrounds and sensitive to any ongoing clinical challenges that may be in addition to the reason for their seeking treatment or guidance
- Being aware of your own cultural biases

To access interpretation services for Humana beneficiaries, call Humana or request the member provide the phone number listed on the member's Humana identification card.

Safety and welfare

Health care providers and business partners must make every effort to protect the health, safety and welfare of the customer. This includes being aware of the signs and symptoms of the following:

- **Abuse** – e.g., physical, sexual or emotional
- **Neglect** – e.g., conduct that could or does result in serious physical or emotional injury
- **Exploitation** – e.g., use of a position of trust to knowingly deceive or intimidate, or deprive of resources, funds or assets

Certain populations, such as the elderly and disabled, are at increased risk for these situations.

Reporting suspected abuse, neglect or exploitation

If a Humana customer is ever in immediate danger, call 911 or local police.

States may require me to immediately report suspected abuse, neglect and exploitation directly to the appropriate state agency(s). Additionally, any signs of the above must be reported to the Humana Care Manager, who will determine the appropriate next steps.

The Bottom Line

I must treat Humana customers with respect and make every effort to protect their health, safety and welfare.

I am safe from retaliation

We strictly prohibit intimidation and/or retaliation against any associate or health care provider or business partner who, in good faith:

- Reports an actual or suspected violation of ethical standards, Humana policies or procedures and applicable laws, rules or regulations

or

- Participates in the investigation of a suspected or detected violation

If you suspect such behavior, you must report it to the Ethics Help Line.

Investigation of suspected violations

Humana promptly investigates any reported issues suspected of being violations of this document, Humana policies or procedures, or applicable laws, rules or regulations. All reported issues are treated as confidentially as possible, yet you may be contacted to provide additional information if you provided your name at the time of reporting. If contacted, you are expected to cooperate fully in any investigation of an alleged violation. If you want to remain anonymous when reporting an issue, please provide as much information as possible, at the time of reporting, to allow Humana to thoroughly investigate the issue.

When Humana determines it is appropriate, Humana will report any violations of the requirements in this document or Humana policies, Medicare program noncompliance, Medicaid program noncompliance, violations of law, criminal misconduct, any instances of abuse, neglect or exploitation, or FWA to the Centers for Medicare & Medicaid Services (CMS), CMS designees, other regulatory agencies, including state Medicaid agencies and/or law enforcement, as applicable.

The Bottom Line

- I must not intimidate or retaliate against anyone I interact with in performing my role for Humana
- Suspected violations will be investigated

Disciplinary standards

The Bottom Line

Disciplinary actions will be taken when violations occur.

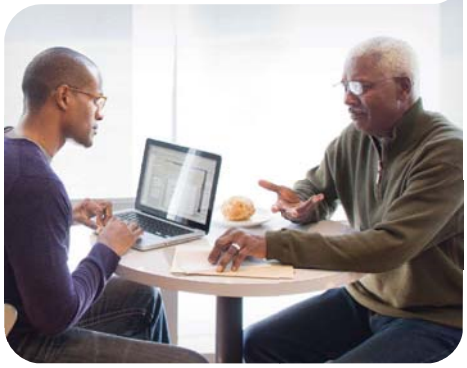
Violation of this document and other policies and procedures could compromise Humana's integrity and reputation, and result in criminal or monetary penalties or disciplinary action. This disciplinary action may include, but is not limited to, retraining, issuance of a corrective action plan that is tracked to completion or termination of your organization's contract and, based on the violation, the matter being reported to the appropriate authorities.

Health care providers and business partners should promptly take appropriate disciplinary actions for employees and business partners found to be in violation, up to and including termination of contract or employment, and report such action to Humana. Humana may take additional action if deemed necessary.

The following are examples of conduct that may result in disciplinary action:

- Authorization or participation in actions that violate this document or Humana policies
- Failure to report a suspected violation of this document or Humana policies
- Refusal to report a suspected violation of this document or Humana policies
- Refusal to cooperate in an investigation of an alleged violation of this document or Humana policies
- Failure by a violator's supervisor or manager to detect and report a violation of this document or Humana policies, if such failure reflects inadequate supervision or lack of oversight
- Intimidation of, or retaliation against, an individual for reporting or participating in the investigation of a violation or suspected violation of this document or Humana policies
- Intentionally making a false accusation

Integrity of company information



We are committed to:

- Safeguarding information used to perform functions for or related to Humana. This includes following the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the more recent Health Information Technology for Economics and Clinical Health Act (HITECH), as should Humana health care providers and business partners. Links to these regulations are in the Compliance Policy.
- Providing accurate and truthful information in any transaction — it is required.
  - Of particular note, health care providers are responsible for submitting truthful, complete and accurate data to Humana.
  - For instance, when you submit risk adjustment data to Humana, Humana expects that it is always truthful, complete and accurate and that all diagnoses are appropriately documented in the medical record.

Policies and procedures

This commitment is reinforced by internal controls and procedures designed to detect and prevent, report, investigate and track inappropriate usage and disclosure of information, as well as illegal activities, in compliance with the Foreign Corrupt Practices Act.

Health care providers and business partners are expected to have policies and procedures in place to affirm the integrity of their organizations' information. Examples include:

- Privacy and security training program for employees and business partners
- Confidentiality agreements, where applicable
- A procedure for the required return/destruction of protected health information (PHI) if an agreement involving the support of Humana is terminated
- A procedure for restricting the marketing of PHI

If asked, health care providers and business partners have an obligation to provide accurate and complete information to auditors about the status of financial, operational and compliance risks and controls related to their business with Humana.

Health care providers and business partners must safeguard Humana information.

For those having a BAA with Humana: Please refer to the separate Humana Privacy and Security Policy Guidance document that is provided with the BAA for more information on this topic.

Your concerns

Health care providers and business partners, or those who perform functions for them, who believe they have been asked to withhold information from auditors, or question the accuracy of any information, are required to immediately call the Ethics Help Line at 1-877-5-THE-KEY or report their concern at www.ethicshelpline.com.

Unauthorized disclosure

Humana's written approval must be acquired by organizations designated as business associates before any confidential Humana information may be provided to any contractor, including subcontractor and independent contractor, outside of the United States. Unauthorized disclosure of, or access to, confidential information, within or outside of an organization, may result in termination of contract and also may result in civil and criminal penalties.

The Bottom Line

I must protect Humana information.

Reporting a privacy or security breach*

If I am a Humana business partner with a signed Business Associate Agreement (BAA) with Humana, any identified breach by my organization must be reported to Humana within five days of discovery via one of the methods outlined in the "I have help" section on page 3. All information that should be included in the breach report is outlined in the BAA.

* Due to the nature of these issues, reporting them anonymously is not an option.

Applicable laws and regulations

Humana's Compliance Policy provides more information on applicable laws and regulations that impact the relationship that my organization and I have with Humana.

Direct clarification requests to: compliance@Humana.com.

Corporate social responsibility

Our proactive commitment extends beyond compliance, as we are dedicated to making business decisions to improve the health and well-being of our members, our associates, the communities we serve and our planet.

For more information: Humana.com/about/corporate

Overview

There are many laws and regulations that impact Humana's operations that you and your organization should be familiar with to sufficiently fulfill contractual obligations to Humana. They involve but are not limited to:

- Prohibitions on inducing referrals or recommendations related to an item, service or plan enrollment paid for in whole or in part under a federal or state health care program. This could take many forms, such as gifts, rebates, etc.
- Filing or conspiring to file false claims.
- Retaliating against someone who reports suspected misconduct.
- Improperly using cash value options of a covered product to facilitate money laundering or finance terrorist activity.
- Requirements and restrictions regarding doing business with the government, with accrediting agencies, and foreign governments, contractors or consultants.
- Receiving contractor bid or proposal information that would give Humana an unfair competitive advantage.
- Giving, discussing or offering anything of value, including employment, to a procurement official.

Humana's compliance department should be informed of any allegation of a violation or citations alleging a violation from a governmental regulatory agency. The person receiving the notification should direct the request to Humana's Compliance department. This requirement also applies to health care providers and business partners if a violation occurs that involves Humana business. Email the applicable information to **compliance@Humana.com**.

Health care providers and business partners, their employees and those they contract with to perform functions to meet obligations to Humana must never:

- Destroy or alter any document or record in anticipation of a request for the document or record by a government agency or court
- Lie or make false or misleading statements to any government investigator
- Persuade or attempt to persuade anyone to provide false or misleading information to a government investigator

Humana's policy is to avoid even the appearance of impropriety. Related violations committed by health care providers, their employees or those they contract with to perform functions to meet obligations to Humana are punishable by fines and imprisonment, loss of government contracts and/or suspension or exclusion from participating in federal procurement opportunities.

Environmental commitment

Humana is committed to conducting its business operations in an environmentally responsible manner and in compliance with all applicable laws and regulations. Health care providers and business partners are expected to support this commitment by:

- Operating in full compliance with both the letter and spirit of environmental, health and safety laws and regulations applicable to their businesses, including the integration of sound environmental, health and safety practices into their everyday activities
- Reporting any environmental, health and safety concerns in connection with their Humana business dealings
- Identifying opportunities to improve their environmental, health and safety programs
- Implementing emergency preparedness plans, if necessary

The Bottom Line

I must follow all applicable laws, rules and regulations.

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We thrive together

We stay in the know and understand the consequences of our actions.

We expect our leaders to set the example.

Humana®

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 28 – System Modification Protocol (Statewide):

The respondent shall describe, in detail the following change control IT processes:

a. How the respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems,

b. How the respondent will accommodate Agency-directed IT modifications; and

c. How the respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

For each of the descriptions, the respondent shall also include the expected timeframes for making modifications, the prioritization process employed, the communication processes used for planned or unplanned changes, as well as status updates provided to employees, Agency staff, and providers. The descriptions shall also address testing procedures, production control procedures, and any applicable claims/encounter reprocessing for historical or retroactive system changes.

Response:

Humana has one of the most effective and efficient Management Information Systems in the industry. Our technology facilitates operational transaction processing, data collection, workflow, reporting, and analytics. We place considerable focus on the importance of IT as the backbone of our core business functions. As such, we have made significant IT investments to provide efficient and effective delivery of services to our members. Humana's integrated IT platform differentiates us within the industry—it is managed in-house and receives positive feedback from auditors. Our IT systems have served our Florida Medicaid operation's needs since 1997, with continuous investment to maintain and evolve their capabilities. As a national company with various lines of businesses, we serve more than fourteen (14) million members in medical benefits plans and nearly seven (7) million members in specialty plans. We are adept at designing technology solutions to meet the always evolving needs to support high quality care.

Our capabilities will meet or exceed the requirements of this contract and our applications are well-integrated to support the workflows necessary to manage enrollee and provider interactions and improve every aspect of our care, quality, and business processes.

Humana continually invests in our IT platform and recognizes the crucial role it plays in ensuring successful operations. Over the current contract administration we have streamlined our clinical capabilities for our Medical Managed Assistance (MMA) and Long-Term Care (LTC) members in our Care Management platform so that the Care Coordinators and Utilization Management teams have a 360° clinical view of the member, including authorizations and referrals, care plans, and health assessments and have also developed insightful reporting and data analytics capabilities (e.g., Medicaid DataMart, Clinical DataMart, and Business Intelligence tools) to support our performance goals and to offer a proactive approach to operational performance. These major IT improvements were built to enhance and replace existing capabilities without disrupting access to our legacy platforms or other core systems. Our process and people,

managed by our Medicaid Governance Committee, exemplify our success in achieving systems changes.

In 2016, we were awarded the InfoWorld/Forrester Enterprise Architecture Award, recognizing Humana as one of five companies globally who are leading the way by approaching Enterprise Architecture (EA) with speed, responsiveness, and agility. Humana was singled out by InfoWorld, which reported, “Humana’s EA practice identified synergies across the strategic focus areas, which became the genesis of a Future State Architecture (FSA). The FSA is composed of business-oriented domains, which provide a logical collection of business processes, data subjects, systems, and services that enable competency, as enterprise services, and Application Programming Interface (API)”.

Information Week has recognized Humana IT as an Elite 100 company in back-to-back years (2015 and 2016) as the most innovative user of technology. Humana has several IT leaders who have been recognized for their leadership excellence in the Computerworld Premier 100 technology lists. In 2017, Humana was ranked in the Top 15 on the Computerworld list of the “Best Places to Work in IT.”

We have invested heavily in IT systems over the past few years and recently refreshed our technology roadmap to continue to make significant investment in the coming years. We are one of the top global companies in regards to IT, and we are committed to keeping pace with the changing healthcare environment through continued innovation and investment.

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a. How the respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems.

==========

INITIATION AND COORDINATION OF CORE SYSTEMS MODIFICATIONS

We have a defined and structured process to identify, assess, and implement technology updates and solutions.

Internal systems changes are continuously identified through multiple means which include, but are not limited to regulatory and contractual changes, internal trend analyses, operational functions performance to internal and external benchmarks, enterprise architecture capabilities, compliance with operational metrics, independent audit results, strategic roadmaps; and review of emerging technologies. As an example, our Compliance department routinely monitors our Florida performance against benchmarks and supports the operational business to identify system change requests to improve performance.

Annually, our Business Technology leadership evaluates our current system and recommends a plan for the coming year. These projects are also submitted and evaluated with the same rigor and planning to ensure a carefully designed and an effective implementation.

In addition to our internal assessments, we have hired Deloitte, a national leader in conducting IT assessments and due diligence, to perform a full systems capability assessment to determine

our functionalities compared to national standards. Deloitte has reviewed our systems twice in the past four years and has helped inform future system enhancements. They found our Medicaid IT platform to be performing in line with, and exceeding the industry standard. We leverage Deloitte's feedback to identify projects to enhance our systems and continue to keep pace with technology advancements.

Regardless of the channel used to identify a project or requests for modifications, each is clearly documented to define the intent and purpose behind the request and how the change is designed to support the delivery of service to our members.

CORE SYSTEMS MODIFICATION REQUESTS AND CHANGE CONTROL PROCESS

Humana has a systematic and thoughtful process to ensure all system changes, especially those impacting core systems, are vetted, prioritized, and maintained through an end-to-end change control mechanism. All project requests for core systems modifications are vetted through our Medicaid Governance Committee through which business area owners and Medicaid IT leadership report.

The Medicaid Governance Committee structure includes a tiered approach to vetting and approving IT projects or changes. All new project requests for core systems modifications are submitted by the business area owners. New projects requests are reviewed by the Medicaid Implementation team and Business Technology leadership to ensure the requests for change are well defined for presentation during the weekly Medicaid Operations Triage meeting. All modifications impacting core systems are thoroughly reviewed during the assessment of the modification. We also assess and monitor all systems modifications requested of our subcontractors. The Medicaid Operations Triage meeting includes associates from our IT team who can validate the appropriateness of the change, the impact on other systems, and the level of effort required. As an outcome of this meeting, all requests are reviewed and approved for detailed planning, or are declined. Attachment 28-1 lists the workflow of our project initiation process, including the triage and approval process.

As part of the governance process, each potential project is assessed for its value and prioritized based on the lens of regulatory compliance, member experience, strategic alignment, and operational process. Projects are scored for each lens and ranked to provide the Governance team guidance on how to prioritize efforts to ensure we are applying resources to the most impactful changes.

Projects which are approved for planning are then assigned an Information Technology Project Manager and a Business Analyst to define the lT impacts for each requirement. The team works collaboratively across disciplines to provide the best solution for the request. Once requirements are approved, the Information Technology Project Manager submits requests to the Enterprise Release Management (ERM) team to discuss the project on the weekly ERM Impacts call. On this call, the project's impact on other systems, including Humana's core systems and any subcontractor systems, is reviewed and discussed in detail. Segment President Review Committee meetings are held to review change requests, ensuring the downstream impacts are assessed by each area's leader.

Attachment 28-1 explains the project intake and approval process. Strategic changes or large projects are vetted for approval through our Medicaid Operations Steering Committee, which includes our market and corporate leadership teams.

RELEASE PLANNING – PRIORITIZATION PROCESS

All internal modifications are completed within one (1) to nine (9) months. The timeframe depends on the IT estimates, number of systems impacted, IT capacity, and business need. Projects that represent a compliance risk to contractual standards are addressed prior to other requests. To support the planning of the systems change and the release of changes to our production environments, we work across our departments and within our IT teams to prioritize projects and plan the release. As soon as targeted deployment dates are determined, the IT Project Manager creates a Production Turn Task to identify the planned release date, impacted applications, and the project features and capability being delivered. The ERM team assigns implementation dates based on the magnitude of the changes needed and the impact on our members and providers. The ERM team receives input from the relevant IT leaders to determine if the implementation dates are appropriate and achievable. While Humana's ERM team plans and establishes a schedule for integrated software releases at least eighteen (18) months in advance, the timelines can be mitigated by holding accelerated meetings for the scope, requirements, and design phases. On a monthly basis, the ERM team produces and publishes a heat map report, illustrating the volume of planned changes with impact to critical, shared systems. The Segment President Release Committee (SPRC), comprised of Business Technology and Business Segment leaders, uses this report to prepare for the monthly SPRC meeting. During this meeting, associates share operational risks for technology changes to shared systems and validate that operational risks identified in previous meetings have been mitigated. The SPRC team also reviews the schedule of major infrastructure projects deploying in the coming months and checks in on the status of current projects. Attachment 28-2 explains the IT Project Intake and Release Planning Process.

COMMUNICATION PROCESS

Humana Medicaid resources proactively monitor the status of all change requests or systems change projects. Progress is reviewed during weekly meetings. These meetings offer an avenue to provide a status update of each project and identify barriers to IT leadership. We communicate project issues impacting members, providers, or the Agency. Further, we ensure transparency by informing our stakeholders of the issue and the anticipated impact, including timeframes.

IT PROCESSES ADDRESSING INTERNAL MODIFICATIONS FOR CORE SYSTEMS

All our IT projects are tracked and monitored through the Systems Development Life Cycle (SDLC) project management framework using agile and waterfall methodologies and following Project Management best practices. Attachment 28-3 and 28-4 provides a diagram of the SDLC process Humana utilizes for the agile and waterfall approaches. The methodology used is dependent on the level of iterations needed, scope of project, and constant need to test and retest. Most systems changes impacting clinical systems use the agile process to allow for

faster turnaround times. The assigned IT Project Manager (PM) is in continuous contact with the IT development teams and at least weekly reviews progress, issues and risks. The IT PM provides weekly project status updates to Medicaid leadership and escalates any issues or risks for visibility and assistance with resolution.

TESTING APPROACH

Application and business teams leverage a wide range of testing methodologies. The following practices are widely used across the enterprise:

- Functional testing is based on an analysis of the specification of the functionality of a component or system.

- Non-functional testing reviews the attributes of a component or system that do not relate to functionality (e.g., reliability, efficiency, usability, maintainability, and portability).

- Integration testing is performed to expose defects in the interfaces and in the interactions between integrated components or systems. This includes the testing of interfaces to external organizations (e.g., Electronic Data Interchange, Internet).

- Performance testing evaluates the degree to which a system or component accomplishes its designated functions within given constraints regarding processing time and throughput rate, based on service-level agreements and business expectations.

- Security Testing reviews the attributes of software products that impair its ability to prevent unauthorized access, whether accidental or deliberate, to programs and data.

- Regression testing of a previously existing program or application following modification is conducted to ensure that defects have not been introduced or uncovered in unchanged areas of the software as a result of the changes made. It is performed when the software or its environment is changed.

- User Acceptance is formal testing with respect to user needs, requirements, and business processes conducted to determine whether or not a system satisfies the acceptance criteria and to enable the user, customers, or other authorized entities to determine whether or not to accept the system.

- Test cases are created to verify each requirement for a product, including functional, non-functional, and structural requirements. Test cases are also created to verify existing functionality through regression. Traceability is established between requirements and related test cases to ensure thorough testing coverage. Defects are created when the product or system is not behaving as desired. Test cases, defects, and traceability are documented in the Test Management System of record.

- After final testing approvals are received, each IT development team submits their turns to move the changed code into production. The Enterprise Change Management team reviews each turn for all the critical applications and provides approval to turn on the release date. Humana has monthly releases which are monitored by the Enterprise Release Manager

assigned to the release. The Release Manager provides regular updates during the release day and ensures all the applications are validated in production after the turn and all issues found during post production validation are resolved.

ENTERPRISE CHANGE MANAGEMENT OVERSIGHT

The Enterprise Change Management team is responsible for evaluating risk and preparedness for all technology changes across Humana and our subcontractors. The Enterprise Change Management team facilitates Change Approval Board meetings multiple times each week to ensure high and medium risk infrastructure and security changes as well as changes impacting critical systems are operationally ready for deployment. As part of the operational readiness review, the following artifacts for change are reviewed and discussed: evidence of testing (e.g. lower environment testing, pilot) step-by-step implementation plan step-by step back-out plan robust post-production validation plan monitoring plan; load testing plan and communication plan.

Changes that do not meet Change Management process standards are rejected and controls are in place to ensure they do not reach production.

After successful deployment of the changes in production, the projects move to warranty phase where the processes are monitored in production and any issues are logged as Incident tickets. The issues are resolved by the IT development teams as part of a ninety-day (90-day) warranty. After the end of the warranty phase, the monitoring of all processes is done by Production Support Management teams.

After the end of the warranty period the IT project is closed. A lessons learned meeting is organized by the IT PM with all project team members. In this forum, all lessons learned are shared by the IT PM, in support of future implementations.

SUBCONTRACTOR CORE SYSTEM MODIFICATIONS

Humana maintains a strong relationship with our subcontractors and ensures the same level of detailed planning and oversight of any changes made to our subcontractors' systems to ensure our members' ability to access care. We have a Relationship Manager assigned to each of our subcontractors, who meets with the subcontractor on a routine (typically monthly) basis to discuss performance. Planned updates to both Humana's and the subcontractors' systems are discussed during these meetings and are tracked to validate that there is no downstream impact, from the planning phase through testing and implementation. We conduct thorough regression testing with our subcontractors upon any core systems change to test and validate that updates to file formats, software updates, and system modifications have not resulted in defects in the way information is interchanged.

Our IT platform is built to seamlessly exchange the appropriate levels of information with our subcontractors' core systems. All of our subcontractors exchange data with Humana in a nightly batch feed. Key subcontracted functions critical to our members' experience are performed on Humana's platform so as to avoid any delay in sharing of key data elements and allow for full

clinical integration. Subcontractors are required to align with our business impact analysis and other interim assessments and to ensure our systems interact correctly.

CONTINUAL INVESTMENT TO MAINTAIN CORE SYSTEMS

Humana's technology strategy is directly linked to the business strategy and enterprise priorities. Our strategy considers industry and technology trends, organizational positioning, and capabilities that will offer the greatest differentiation in the rapidly evolving market. Humana has the resources, abilities and capacity to not be a traditional health insurance transactional processor, but rather an integrated care delivery organization that stays ahead of the curve and proactively enacts on technology changes to make appropriate systems modifications.

Our technology roadmap consists of six areas of greatest differentiation: seamlessly integrated clinical, population health, differentiated member experience, 360-degree views, turning insights into action, and platform for innovation. To fund the strategy and focus our efforts, we have been investing nearly two hundred million ($200M) annually.

With AHCA's support and guidance, Humana has implemented capabilities to systematically support a comprehensive plan for enrollees having both MMA and LTSS. We have made system changes to ensure our back-end operations function seamlessly for our enrollees as they access services, and with providers as they engage with our members. As an example, we have streamlined our processing of MMA and LTSS claims and encounters on our enterprise platform. Clinical operations are also performed on our integrated care management platform, which provides the 360-degree view of all Care Management activities. Our Care Management platform is already set up with the necessary rules to trigger appropriate workflows. These enhancements align Humana ideally to serve as a Comprehensive plan under the updated SMMC program model.

We also have a proactive approach to the maintenance of our core systems and applications. Our core enterprise applications, including but not limited to, our Enrollment Systems, Provider Systems , Claims Adjudication System (CAS), our Encounter Processing Engine (Edifecs), our Clinical Program (Clinical Guidance eXchange (CGX)), and Enterprise Data Warehouse (EDW), are tested during each major system release to validate that there are no negative downstream impacts. We also maintain these core enterprise applications with regular testing and monitoring throughout the year. We continually run reports of these applications or systems to assess for capacity, appropriate functioning (e.g., workflow triggers), and security.

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b. How the respondent will accommodate Agency-directed IT modifications

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PRIORITIZATION OF AGENCY-DIRECTED IT MODIFICATIONS

Agency-directed IT modifications follow the same process as outlined above. Humana assigns Agency-directed IT modifications the highest level of priority and drives our systems change process to implement within ninety (90) days. Our corporate resources offer expertise and

capabilities to make changes to IT systems timely. Over the current contract term, we have worked with AHCA and complied with the timeframes for systems change turnaround.

Our process for Agency-directed modifications is designed to be responsive to the request and guided by the timeline established by AHCA for the change. We follow a process similar to the systems change processes, from intake to prioritization and all the way to production and testing, to mitigate adverse events, but within the timeframe requested by AHCA. Further, our Regulatory Compliance department continuously monitors and reviews our contract and any amendments to identify any need for IT modifications.

All Agency-directed modifications are reviewed by our Medicaid Governance Committee and assigned an IT Project Manager and Business Analysts. Agency-directed IT modifications which need to be implemented in shorter time frames will be processed quickly through the intake process and offline approval.

CASE STUDY: EXPRESS ENROLLMENT REQUEST FROM AHCA

Humana partnered with AHCA to implement Express Enrollment. At the end of 2015 we supported implementation of the Mid-Month Express Enrollment in partnership with AHCA to ensure that enrollees receive benefits upon enrollment, removing the lag time between becoming Medicaid eligible and accessing plan benefits. Our expertise, resources, and scale enabled us to quickly assess the requirements and form a team to complete the project without any error within two (2) months.

TESTING WITH THE AGENCY

We utilize our internal systems integration testing and user acceptance testing on all Agency-directed modifications to prepare for and prevent issues or negative impacts. We will continue to work with AHCA by utilizing their test files, when provided, prior to go-live.

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c. How the respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

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Humana follows industry standard best practice Information Technology Information Library (ITIL) processes for production issues management. Humana has an end-to-end Incident Management process to identify, track, and manage all IT issues to full resolution for both internal and external stakeholders. Humana's Network Operations Center (NOC), IT Command Center (ITCC), Production Support Management (PSM), and Central System Support (CSS) teams work together on a twenty-four (24) hours a day, seven (7) days a week schedule to address all IT issues with appropriate urgency based on impact and priority. All issues are tracked in our Computer Associates (CA) Service Desk platform, a best-in-class issue management tool. The CA Service Desk tracking ensures our extensive planning, validation, and testing processes are followed. Tickets are routed to the appropriate incident resolution teams and are then prioritized based on impact to our providers, members, and to AHCA. Our associates work the individual tickets, providing updates within the CA Service Desk tool until

the issues are resolved. The updates are then communicated back to the impacted parties. Production issues with widespread impacts are addressed with a troubleshooting conference call.

Routine reports are run on enrollment, claims, premium, clinical, provider, pharmacy, and financial data. Our IT Command Center hosts a daily meeting to provide a business-driven, centralized location for escalation of issues, risk identification with key dates for fixes, discussion of events and remedies, and communication and change management.

Humana has significant reporting and analytics capabilities within its ITIL processes. These reporting and analytics capabilities allow us to closely monitor and manage any issue trends, and to ensure excellent service levels for issue resolution.

In addition to ITIL processes for tracking, communicating and resolving IT production issues, Humana has invested significantly in system monitoring and alerting capabilities to track issues as they are happening or before they actually cause impacts to members, partners, or internal users. We have twenty-four (24) hours a day, seven (7) days a week support staff for both the hardware and software components of our operations. We also have a robust environment monitoring platform which provides real-time information on the status of our most important systems.

COMMUNICATION PROCESS

Humana has dedicated resources within our Florida Medicaid Operations team responsible for communicating necessary IT issues within the timeframes and frequency required. Our systems are purposefully structured to interact with compliance and regulatory agencies (e.g., CMS, AHCA) and to produce data and reports in required formats to interact with those agencies. All business areas have teams for monitoring production issues, prioritizing and implementing fixes. Our Provider Communications and Member Communications teams are engaged to draft communication notices to offer details of the project, including a timeframe for any continue anticipated interruptions. The content is submitted to AHCA for approvals, as necessary, and is internally vetted by Risk Management, Privacy, Regulatory Compliance, and our Legal departments. Communications impacting members and providers are shared via email, fax blasts, post mail, and our website, including our provider and member portals.

As described earlier, our Relationship Managers assigned to each of our subcontractors meet with the subcontractor on a routine (typically monthly) basis to discuss performance. During these meetings, system issues deriving from the subcontractor's platform or those impact their platform are discussed to ensure files are being shared correctly and timely, and to validate that our members and providers do not experience any downtime with accessing care or providing services. These issues are tracked by our Relationship Managers, who also bring in our IT team to support and inform further conversations and decisions to remediate system impact issues. Production issues impacting providers, members, or AHCA are communicated timely.

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The descriptions shall also address any applicable claims/encounter reprocessing for historical or retroactive system changes.

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In the event we identify a systems production issue impacting the processing of our claims or encounters, we identify the date and time stamp of the origination of the issue and use our archived and historical system to reprocess all claims processed from that period. Our IT team identifies the issue, conducts research, and stands up a project that flows through the same testing rigor described earlier in our response. We also validate the claims that have been identified as needing to be reprocessed and confirm the new method in which the claims are to be processed (e.g., the change in the system). We verify all key mechanisms, including the fee schedule, authorization process, and provider network files in advance of reprocessing these claims. Our systems are fully capable of reprocessing all affected data while avoiding any incorrect or duplicate payment.

CASE STUDY: CLAIMS REPROCESSING DUE TO SYSTEMS CHANGE

Recently, we identified that select claims passing through Conduent (our contractor responsible for receiving paper claims and converting them to an electronic format) were acting as encounters, causing the claims to go unpaid. Our Claims team and IT team worked together to identify the root cause of this issue and worked with our claims front-end team to test similar cases in our test environment. We then developed a test strategy, created an interim fix to ensure claims that were processed incorrectly were paid on time, completed user acceptance testing, and fixed the issue within three (3) weeks of initially identifying the problem.

Humana's systems change mechanism has been well thought-out and is considerate of the impact these changes could have on our members, providers, and the Agency. Our goal is to ensure transparency with AHCA and offer routine updates for any systems issues. Finally, our MIS platform is sophisticated and is built with the strategy, tools, and mechanisms to maintain a proactive approach to addressing system changes, limiting our need to be reactive to system issues.

Evaluation Criteria:

1. The adequacy of the respondent's IT processes addressing internal modifications for its core systems and subcontractor's systems.

2. The extent to which the respondent's IT processes documented for implementing Agency-directed modifications is less than ninety (90) days.

3. The adequacy of the respondent's processes documented for handling production IT system issues.

4. The adequacy of the respondent's communication process used when system issues/updates are identified and resolved by the respondent and/or its subcontractors throughout the change control process.

5. The adequacy of the respondent's approach to system internal testing to ensure the respondent's and/or subcontractors' system changes/updates are accurate.

6. The adequacy of the respondent's approach to integration testing to ensure the respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.

7. The adequacy of the respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment 28-1: Medicaid Governance – Project Intake and Approval

Executive Steering

- Establish Medicaid strategy, goals, and objectives
  - Provide strategic leadership and oversight to Medicaid business
  - Pulse Operational Health - Market status updates, metric reviews, etc.
  - Resolve escalated issues and risks

Operations Steering

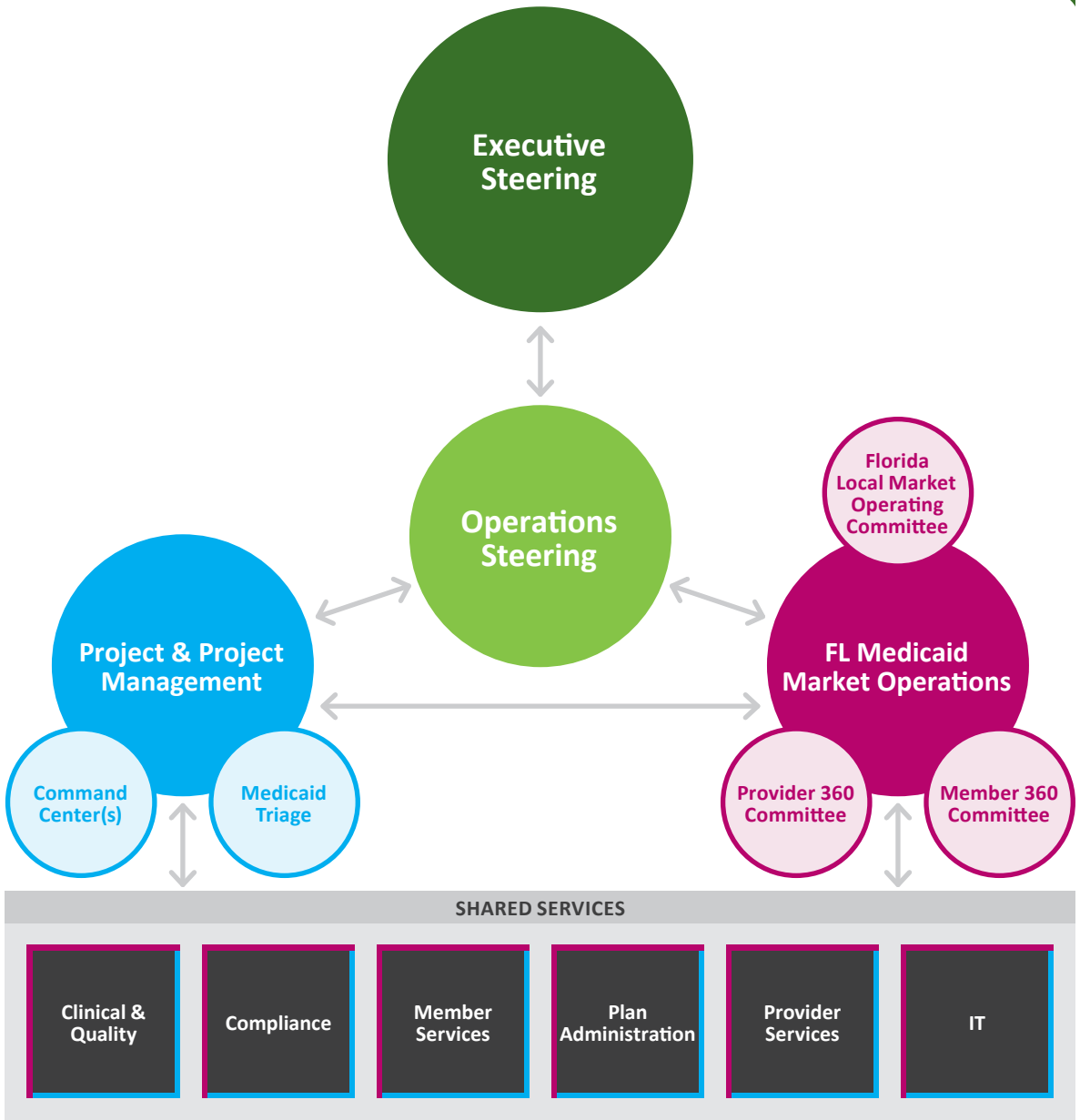
- Review, evaluate, and approve/reject all material Medicaid projects
  - To include IT and non IT related
  - To allocate funding and resources
- Resolve escalated issues and risks
- Communicate - Business Development status, cross-market synergies, strategic opportunities, and planned changes, etc.

Program & Project Management – Implementation & Process Improvement

- Support program implementations and facilitate Command Center (e.g. New Plans & Plan Expansions)
- Host Triage and evaluate process improvement (PI) opportunities:
  - Assess impact to current/future Implementations, market operations, delegate operations, etc.
  - Develop and prioritize business cases
- Present implementation programs and prioritized process improvement business cases to Operations steering
- Provide Program and Project Management support for approved initiatives
- Own and drive closure of all escalated project issues and risks

FL Medicaid Market Operations

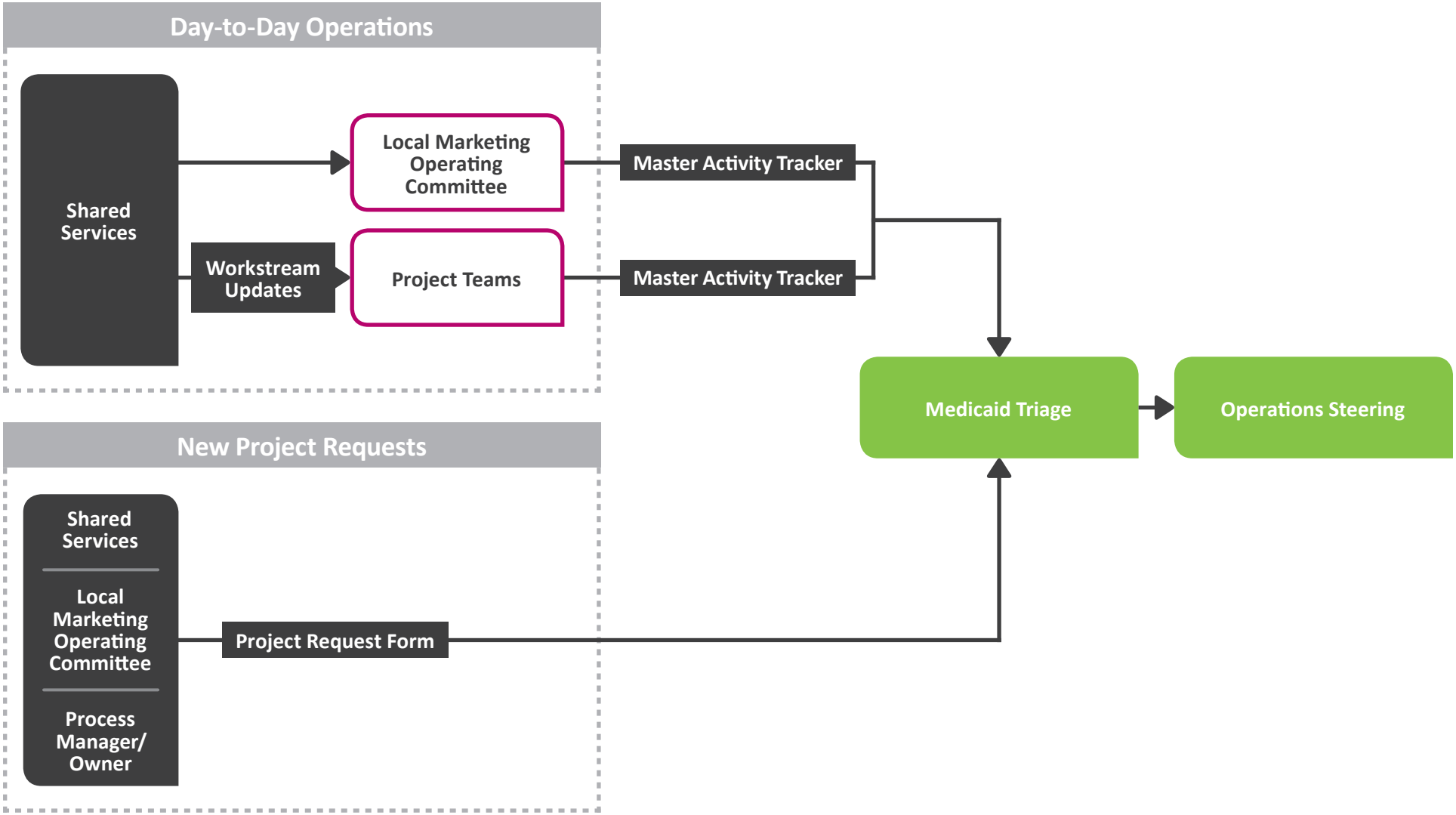
- Host regular Market Operating and 360 Committee meetings with shared services, IT, and Corporate Medicaid Consultant (no less than bi-weekly)
  - Own and drive closure of all Market issues
  - Identify potential opportunities for process improvements and efficiency



Humana

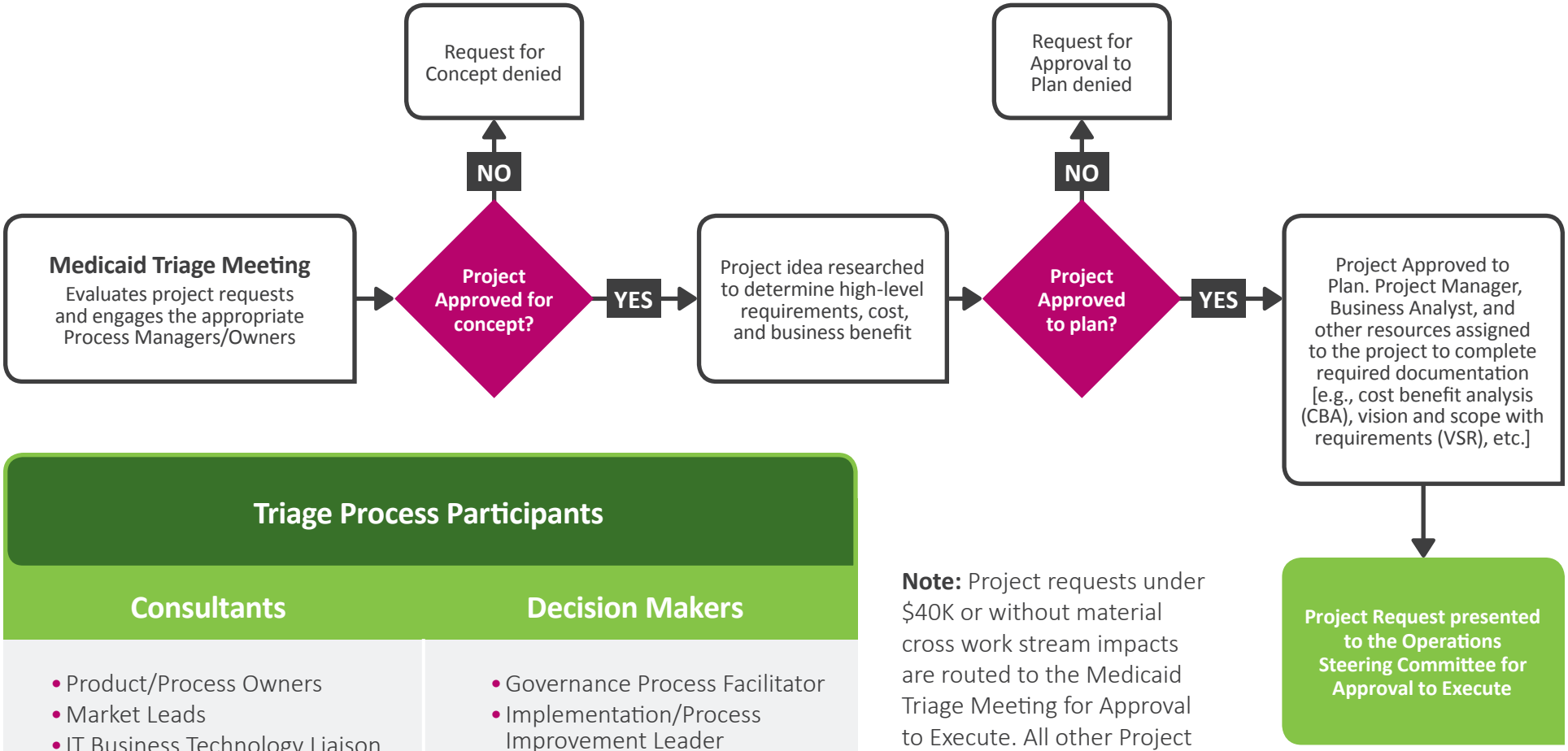
Attachment 28-1: Medicaid Governance – Project Intake and Approval

High Level Process



Attachment 28-1: Medicaid Governance – Project Intake and Approval

Triage Process

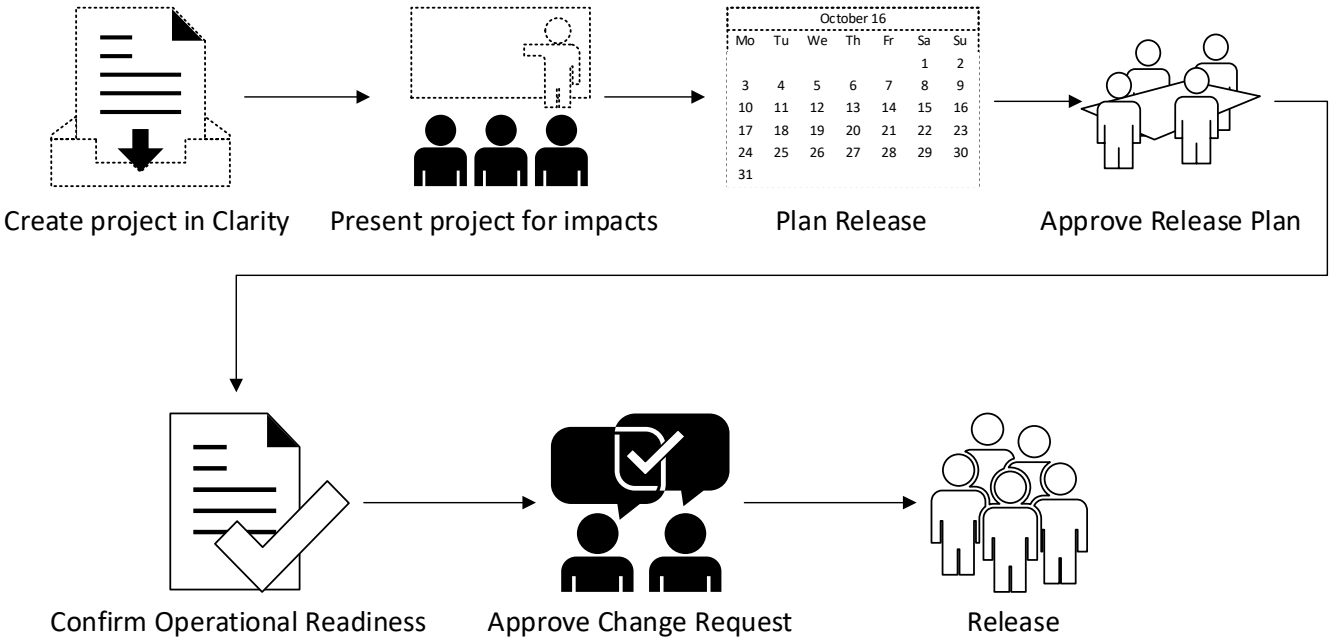


Triage Process Participants

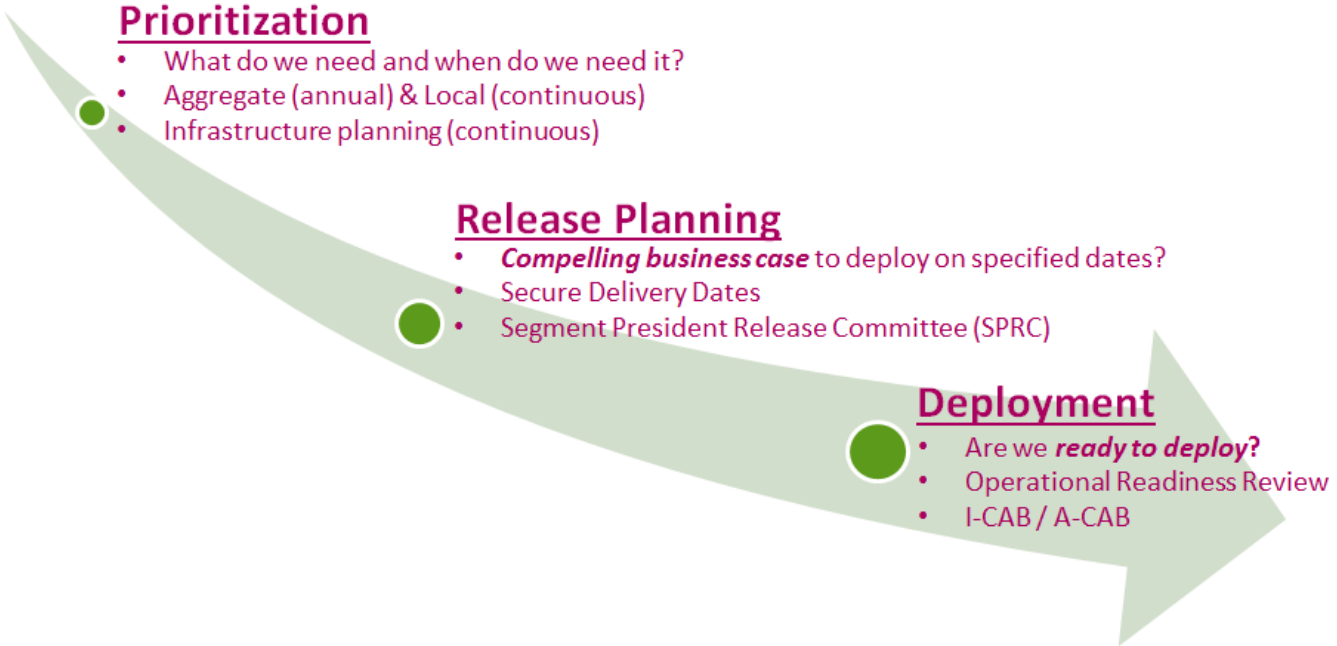
Consultants	Decision Makers
• Product/Process Owners • Market Leads • IT Business Technology Liaison • Medicaid Corporate Consultant	• Governance Process Facilitator • Implementation/Process Improvement Leader

Note: Project requests under $40K or without material cross work stream impacts are routed to the Medicaid Triage Meeting for Approval to Execute. All other Project Requests are routed to the Operations Steering Committee for Approval to Execute.

Attachment 28-2: Implementation Change Initiation Process



Release Planning



Attachment 28-3: Systems Development Life Cycle – Agile

Process ID: SDLC 3.0
Effective Date: 2017.04

Systems Development Life Cycle - Agile

Pre-SDLC

Intake

Activities
- Complete Intake Form

Artifacts
- Intake Form

Approvals
- Intake Approval

Initiation

Concept

Activities
- Create Project in Clarity
- Create IT Project Site

Artifacts
- High Level Business Opportunity & Vision Statement
- High Level Cost and Benefit
- Conceptual Architecture Document (CAD)

Planning

Activities
- Product & Release Planning
- Plan Release
- Initiate Project Planning
- Assign Architect
- Plan Impacts
- Engage IT Service Providers
- Complete Budget Plan

Artifacts
- Vision & Scope
- Project Architecture Document (PAD)

Approvals
- Vision & Scope (ITPS)
- Budget Plan (Clarity)
- CBA Financial (Clarity)
- Approved for Development (AFD) (Clarity)

Develop

Sprints 0-n

Activities
- Create/Edit EAPM Entry
- Sprint & Release Planning
- Review Operational Readiness
- Develop Systems
- Conduct Peer Review
- Developer Security Scan Analysis
- Request Security Scanning
- Request Test Data
- Perform System & Integration Testing
- Confirm Release
- Sprint Demo & Retrospective

Artifacts
- Product Backlog
- Project Assessment (PA)
- Sprint Backlog
- Detailed Design Artifacts
- Data Flow Diagram (DFD)
- Test Strategy
- Testing Traceability Matrix (UAT)
- Test Cases (UAT)
- Testing Traceability Matrix (SIT)
- Test Plan
- Test Cases (SIT)

Approvals
- Architecture Artifacts (ITPS)
- SIT Complete (ITPS)

Per Release

Deploy

UAT

Activities
- Perform User Acceptance Testing

Approvals
- UAT Complete (ITPS)
- Final Security Review (ITPS) (Conditional)

Implementation

Activities
- Review Production Readiness
- Execute Production Turn
- Complete Functional Value Measurement Form

Operations & Maintenance

Activities
- Perform Warranty Maintenance
- Mark Project Complete

Full SDLC projects – All activities, artifacts, and approvals are required unless otherwise noted.
Tailored SDLC projects – In addition to the mandatory darker-shaded items for SOX-audit compliance, choose activities, artifacts, and approvals appropriate for the project.

Attachment 28-4: Systems Development Lide Cycle - Waterfall

Process ID: SDLC 3.0
Effective Date: 2017.04

Systems Development Life Cycle - Waterfall

	Pre-SDLC	Initiation		Develop				Deploy		
	Intake	Concept	Planning	Requirements	Design	Build	SIT	UAT	Implementation	Operations & Maintenance
Activities	Complete Intake Form	Create Project in Clarity Create IT Project Site	Initiate Project Planning Plan Release Assign Architect Plan Impacts Engage IT Service Providers Complete Budget Plan	Elicit Requirements Review Operational Readiness	Create/Edit EAPM Entry Request Test Data	Develop Systems Conduct Peer Review Developer Security Scan Analysis	Perform System & Integration Testing Confirm Release Request Security Scanning	Perform User Acceptance Testing	Review Production Readiness Execute Production Turn Complete Functional Value Measurement Form	Perform Warranty Maintenance Mark Project Complete
Artifacts	Intake Form	High Level Business Opportunity & Vision Statement High Level Cost and Benefit Conceptual Architecture Document (CAD)	Vision & Scope Project Architecture Document (PAD)	Requirements Project Assessment (PA) Test Strategy Testing Traceability Matrix (UAT) Test Cases (UAT)	Data Flow Diagram (DFD) Detailed Design Artifacts Testing Traceability Matrix (SIT) Test Cases (SIT) Test Plan					
Approvals	Intake Approval		Budget Plan (Clarity) CBA Financial (Clarity) Vision & Scope (ITPS) Approved for Development (AFD) (Clarity)	Requirements (ITPS) Architecture Artifacts (ITPS)			SIT Complete (ITPS)	UAT Complete (ITPS) Final Security Review (ITPS) (Conditional)		
				Per Release						

Full SDLC projects – All activities, artifacts, and approvals are required unless otherwise noted.
Tailored SDLC projects – In addition to the mandatory darker-shaded items for SOX-audit compliance, choose activities, artifacts, and approvals appropriate for the project.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 29 – Encounter Data Submission (Statewide):

a. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.

b. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.

c. The respondent shall demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.

d. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.

e. The respondent shall include documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.

f. The respondent shall submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

Response:

Humana understands the importance of encounter data to support identification of provider performance and track actual cost of care. As such, we manage the submission of all encounters internally across all our providers and subcontractors and do not delegate this function. Humana is a national expert and is one of the top performing managed care organizations when it comes to the submission of accurate and timely encounter data. We have been submitting encounter data to government authorities, including both Medicare and State Medicaid programs, for more than twenty (20) years. We have a long history working with the Centers for Medicare and Medicaid Services (CMS) for encounter submissions including being one of the first plans to be certified for encounter submissions to CMS for Virginia and Illinois Dual Demonstration plans. Further, we are called upon by CMS on a routine basis to support their standard development processes for encounter processing.

To date in 2017, we have not found any variance that has required us to request supporting documentation from the Agency for Health Care Administration (AHCA). Humana's encounter data submission process includes electronic editing systems, quality checks, quality control procedures, tracking tools, metrics, and the compliance oversight mechanisms necessary to

ensure that our encounter data submissions meet the State's standards for accurate, complete, and timely encounter data submissions. The key to our ability to consistently meet the State's requirements for accurate and complete encounter data submission metrics is our electronic editing process. By requiring that all claims submitted to us (paper as well as electronic), and all encounter files from our sub-capitated providers and subcontractors, pass the same electronic edits, we can ensure that only those encounters in which the required fields are accurately and fully populated are submitted to the state and that the documentation and coding of encounters are consistent throughout all records, regardless of the data source or provider type.

To ensure that we comply with the State's timeliness standards, we closely track and trend our performance through daily, weekly, and biweekly reports. We have effective processes for analyzing and responding to any internal report or data received from the State that signals negative trends, including procedures for rapid issue escalation and resolution. Over the past three years, Humana has improved our encounter data submission accuracy and timeliness performance for our Florida Managed Medical Assistance (MMA) and Long-term Care (LTC) contracts. Today, we are consistently meeting overall encounter submission timeliness standards at levels between ninety-six percent (96%) and ninety-nine percent (99%). Further, we have already streamlined the submission of encounters for our MMA and LTC providers by leveraging one internal process to create, submit, and monitor encounters.

As part of Humana's IT strategy, we are investing in reviewing and upgrading our encounter data submission architecture. Humana understands the importance of continuous reduction of encounter rejections. This project will offer additional automation to manual processes and is designed to improve the accuracy and timeliness of encounter submissions to the Agency. The project focuses on reviewing the encounter errors from our Florida Medicaid encounter submissions and will determine how our architecture and mapping of encounter elements can be enhanced to improve submissions.

As a transparent partner, Humana is committed to vigorously monitoring and continuously improving our encounter data submission processes, including compliance with the State's findings and updated standards. Humana will continue to maintain and improve our strong performance in accurately and timely submitting encounters to the State.

Below we outline processes in detail in response to this SRC. The accompanying flowcharts can be found (as will be directly referenced later) in the attachments that follow this response.

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1. The adequacy of the respondent's process to ensure accurate, timely and complete encounter data.

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NON-PHARMACY ENCOUNTERS

ACCURATE ENCOUNTER DATA SUBMISSIONS

Accurate encounters begin with properly received and processed claims. Our network providers are required in their contracts to submit complete claims based on industry standard clean claim guidelines. We require our subcontractors to include similar contract provisions with their providers. These guidelines are enforced through our clearinghouse partners. We educate our

providers about requirements for submitting accurate claims and encounters at the time of onboarding, on our website, through web-based trainings, through our provider manuals, provider communications/newsletters, in-person meetings with our contract management associates, Provider Relations representatives, and through our provider customer service center.

FRONT-END EDITS

Our high accuracy rate for encounters is in part a result of the front-end claims editing performed by our clearinghouses and our Electronic Hub (eHub), which serves as the gateway to the submission of data into our Claims Adjudication System (CAS). These processes enable us to isolate and address quality issues prior to the receipt of claims and encounters by CAS. With a few exceptions, all claims, including paper claims and encounters from sub-capitated providers and subcontractors, must pass the edits in eHub. These edits include both the state-mandated edits (e.g., key fields including Medicaid registration ID, dollar amount paid, etc.), and edits specific to Humana (e.g., NPI number). Dental encounters are submitted to Humana by our subcontractor, DentaQuest, and must clear the edits in DentalXChange, our dental clearinghouse partner, and subsequently eHUB.

Claims and encounters that do not pass our Health Insurance Portability & Accountability Act (HIPAA) edits have acknowledgements returned to the provider and subcontractors via our clearinghouses, indicating errors that need correction. They can then review and correct failed files electronically for resubmission.

EDIFECS ENCOUNTER SUBMISSION PLATFORM EDITS

Humana has customized the Edifecs Transaction Management (TM) software to begin the creation of encounters. Edifecs' customized rules allow Humana to combine the 837 files we receive from providers and subcontractors with the outbound 835 files we send to providers and subcontractors in accordance with Florida's companion guide and the standard X12 implementation guide.

After creating an encounter, the Edifecs software validates that the encounter is HIPAA X12 compliant. Any encounters with errors are corrected prior to submission to the State. Encounters are then batched based on State specifications, file-naming conventions are added, and the encounters are uploaded to our file transfer site. All acknowledgments received from the State are loaded into the Edifecs system for tracking. Encounters identified on acknowledgements as having errors are added to the exception worklist in the Edifecs software for error resolution. Brief documentation describing the Edifecs software and how it supports accurate and timely encounter submission is provided in Attachment 29-1.

OTHER STRATEGIES TO IMPROVE ACCURACY

Humana's Encounter submission team analyzes the errors in Edifecs and identifies who is responsible for researching and resolving the State's denial reasons. This team has a cumulative seventy-eight (78) years of expertise in performing encounters-related functions. This team also reviews claim-associated acceptance and rejection rates to ensure accuracy and increase acceptance rates. We use our assessment of errors and AHCA's denial rates to target providers for education, identify associates for additional training, and recommend system edits and process improvements.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our systems are designed to ensure that encounters and claims are processed with appropriate Current Procedural Terminology (CPT) and Diagnosis (DX) codes as seen on AHCA's Data Submission report card. The high scores given to Humana on the submission of Diagnosis, Procedure and Revenue codes, as well as Date Span Adjustments and Duplicates, proves Humana's ability to send accurate and timely encounter data to AHCA.

TIMELY SUBMISSION OF ENCOUNTER DATA

Humana closely tracks the timeliness of our encounter submissions. Our overall encounter submission timeliness has been consistently exceeding the requirement of ninety-five percent (95%) due to several system enhancements and operational processes we have implemented as well as through an array of reporting tools that offer real-time results. Over ninety-six percent (96%) of the time, we have exceeded the state requirement for ninety-five percent (95%) of encounters to be submitted within seven (7) days of adjudication. In rare instances when we are unable to meet the standard, Humana maintains transparency by proactively communicating any issues and the path to resolution for identified deficiencies.

One of the ways in which Humana ensures the timeliness of its encounter submissions is through our encounter reporting system. The system generates reports that help us monitor the aging of our encounter queue and generates an alert when we are at risk of missing an upcoming State timeliness standard.

Humana utilizes a daily reporting tool that identifies encounters in jeopardy of falling out of compliance for submissions. The report allows for adequate distribution of work based on timeliness, where those encounters closest to failing state requirements are prioritized for same day resolution.

We validate the accuracy of our reporting by comparing our own data with the results in AHCA's weekly timeliness reports. If we find a discrepancy, we request supporting information from AHCA to help us assess the reason. To date in 2017, we have not found a variance that has required us to request supporting documentation from AHCA.

COMPLETE ENCOUNTER SUBMISSIONS

During the extraction and creation of trigger files, IT alerts indicate any record that failed during this process (i.e. uploading to Transaction Manager (TM)). A trigger file is based on claims processed in CAS. Necessary stakeholders are notified and immediate action is taken to address any failed processes. After encounters reach TM, monitoring is done to track the status and to ensure encounter submissions to AHCA occur. Our reporting, based on the encounter and service line counts, indicates the volume of encounters received into the Edifecs system that have not yet been submitted to AHCA. The Florida Encounters Submission team will monitor volume and ensure complete and timely submission.

To ensure that we include complete data in our encounter submissions, we have implemented HIPAA level edits for data integrity and validity to evaluate the data being submitted in the encounter files we receive from our providers and subcontractors. Prior to submission to AHCA, we validate that all necessary claim and encounter fields, in particular the key fields identified by AHCA, are populated with values of the appropriate range and type and have the proper layout. We maintain multiple reports that monitor the status of all encounters to ensure complete encounter submissions.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

PHARMACY ENCOUNTERS

Humana uses a wholly-owned subsidiary, Humana Pharmacy Solutions (HPS), as our Pharmacy Benefits Manager (PBM). HPS contracts with a claims adjudication platform called DST Pharmacy Solutions. DST Pharmacy Solutions adjudicates all pharmacy claims at the point of sale, rejecting claims that do not meet point of sale processing requirements. DST Pharmacy Solutions sends Humana a feed of paid claims daily, which are then sent to our Enterprise Data Warehouse (EDW). The Humana Pharmacy Encounter team automatically picks up this feed and creates the National Council for Prescription Drug Programs (NCPDP) encounter data file, ensuring all required fields are completed and in the required format. This is translated into an encounter data file that we transmit to the State's vendor, Magellan, four (4) times a week.

One recent success of the Humana Pharmacy Encounter team was the automation of our encounter processing mechanism in 2016. To achieve this automation, we examined every guideline from the AHCA manual and D.0 file layout and worked with our Information Technology team to develop, test, and deploy an encounter file based on the Agency's requirements. We have automated the process in which the encounter data elements are captured from the submitted claims information and the end-to-end process to generate and submit the file to Magellan, ensuring that all data submitted is accurate, timely, and complete.

In fact, our Pharmacy Encounters team has held leadership positions at NCPDP and informs discussions and decisions at a national level. We also continuously monitor NCPDP updates and readily engage with the organization in implementing their guidance.

Our pharmacy encounter submission process includes daily tracking and monitoring of our submissions to Magellan, response reports from AHCA, and resubmissions. We track timely submission of pharmacy encounter data through our monthly Timeliness Audit report. This report tracks our compliance with the State's timeliness requirements. We also trend our compliance month by month in our Timeliness Metric report. We have consistently surpassed the contractually established encounter completeness, accuracy, and timeliness metrics.

We track the accuracy of our encounter submissions through our Encounter Submission and Error Tracking report, which identifies the volume of errors in our encounter submissions and trends our improvement opportunities. We monitor that we are submitting an encounter for every pharmacy claim through a completeness report.

To ensure that we resubmit all encounters that have been rejected by Magellan, we have implemented an automatic trigger process that resubmits an encounter when it was rejected due to a system timeout by Magellan. Additionally, when we do not receive all encounters back from Magellan following submission, our system searches for those encounters and automatically resubmits them.

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2. Demonstrated knowledge of the combination of key fields needed to identify services.

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Our high rate of encounter acceptance by AHCA for both non-pharmacy and pharmacy encounters is strong evidence of our knowledge of the key fields needed to identify services. To

ensure correct and complete submission of encounter data to AHCA, Humana has developed a series of front-end edits to ensure all key fields are complete and accurately distinguished based on institutional, professional, and dental services.

During submission of claims and encounter data, Humana's electronic Hub (eHub) and CAS ensure all fields are entered and pass edits to ensure the data is valid. Claims and encounter data submitted with incomplete or inaccurate data fields are rejected and are not processed further. Humana converts claims data and validates encounters submitted from our sub-capitated providers and subcontractors to match against all key fields required for correct submission, including a review of the revenue field, diagnosis field, and procedure code field. Claims that pass this validation go through McKesson's claim auditing platform (Claims Xten) edits, our correct coding mechanism, and are then passed to the Encounters Submission team.

During the final creation of the outbound encounter, Humana's customized Edifecs Transaction Management Solution runs the encounters through contract level editing. We conduct relational coding and map our revenue code, diagnosis code, and procedure code to cross-walk an institutional, professional, or dental encounter. These edits contain HIPAA-level validation to ensure structurally sound encounters and valid data. We have also added business level edits to comply with key Florida-specific requirements and to match the Companion Guide. If an encounter fails to meet these base requirements, then the encounter is placed on our internal exception worklist for review and correction. These checks ensure that the required key fields are submitted accurately to the state. For our claims data, this is accomplished by using eHub and CAS platform edits combined with the edits applied by the clearinghouses assuring key fields are populated.

Humana's Encounter Submission team has extensive experience, knowledge and understanding of the companion guide, user guide, report guide and the State's Web Portal. The team thoroughly reviews and documents all updates and changes made to the Companion Guide identifying any logic or system impacts that will ensure that the changes are in line with the submission and processing requirements defined by AHCA. Team members also attend internal X12 trainings as well as the industry recognized annual X12 and Workgroup for Electronic Data Interchange (WEDI) conferences to maintain up-to-date knowledge and clarity of EDI standards.

Humana also conducts clinical audit reviews and encounter validation to ensure our providers are submitting data accurately, including coding data elements. Clinical audit reviews are used as a mechanism to educate our providers and discuss opportunities for improvement across clinical and administrative performance. Records are matched to submitted claims or encounters to validate for accurate submission.

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3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

NON-PHARMACY ENCOUNTERS

Upon receipt of claims data from our clearinghouses, Humana's eHub verifies the entry of all key fields necessary for complete encounter submissions that ensures a proper 5010 compliant submission format. Our clearinghouses are contractually required to meet HIPAA edits and standards, including edits to validate for correct coding. Our preferred clearinghouse and trading partner, Availity, performs the highest level of HIPAA edits (HIPAA level seven), well above the AHCA HIPAA level requirements, reviewing fields such as CPT, ICD-9, ICD-10, CDT, NDC, status codes, adjustment reason codes, and their appropriate use for the transaction. ZirMed, another clearhouse, performs HIPAA level five edits and reviews for CPT, ICD-9, ICD-10, CDT, NDC, status codes, adjustment reason codes, and their appropriate use for the transaction.

We also have a quality certification check with our clearinghouses, through which we receive reports from the clearinghouses on the provider data submissions that have been rejected, which informs our strategy on provider education and engagement.

Humana uses the editing logic for key fields to ensure the data is accurately populated during encounter data submissions. The list below describes select editing logic we have in place.

- Recipient Medicaid ID – The enrollee's Medicaid ID is added to the encounter at the time of generation based on the enrollee's Medicaid ID currently stored in our Enrollment system.

- Provider Medicaid ID – Humana submits the NPI (National Provider Identifier) included on the claim in encounter submissions for all providers who are able to bill with an NPI. For those providers who do not have an NPI, Humana crosswalks their information to the Medicaid ID stored in our claims platform for submission on the outbound encounter.

- Claim type – Claim types are confirmed during HIPAA validation at the claims clearinghouses and in Humana's claim platform. If the claim type is not correct, the claim will be rejected and no encounter will be generated.

- Place of service – The place of service is confirmed during HIPAA validation at the clearinghouses. If the place of service is incorrect, the clearinghouse returns the claim to the sender. Humana performs a secondary review in our eHub platform to ensure the correct place of service is included for the service being billed and the provider. If the place of service is not correct, no encounter will be generated since the claim is rejected initially.

- Revenue code – Revenue codes are confirmed during HIPAA validation at the claims clearinghouses. If the clearinghouse finds an incorrect revenue code, it returns the claim to the sender. Humana performs a secondary review in our eHub platform to ensure the correct revenue code is included for the service being billed and the provider. If the revenue code is not correct, the claim will be rejected and no encounter will be generated.

- Diagnosis code – Diagnosis codes are confirmed during HIPAA validation at the clearinghouses. If the clearinghouse finds an incorrect diagnosis code, it returns the claim to the sender. Humana performs a secondary review in our eHub platform to ensure the correct diagnosis code is included for the service being billed and the provider. If the diagnosis code is not correct, the claim will be rejected and no encounter will be generated.

- Amount paid – Humana utilizes standard X12 matching and balancing logic for applying the correct paid amount to the service lines for encounters or fee-for-service claims. Encounters and claims received from a sub-capitated provider, fee-for-service providers and subcontractors are subject to up-front HIPAA validation edits to confirm the population of the paid amount field.

- Procedure code – Procedure codes are confirmed during HIPAA validation at the clearinghouses. If the clearinghouse finds an incorrect procedure code, it returns the claim to the sender. Humana performs a secondary review in our eHub platform to ensure the correct procedure code is included for the service being billed and the rendering provider. If the procedure code is not correct, the claim will be rejected and no encounter will be generated.

PHARMACY ENCOUNTERS

For pharmacy encounters, our claims adjudication vendor applies extensive edits at the point of sale to ensure that all claims meet appropriate standards for claim processing. In the event we are missing an AHCA required field, the encounter is held until the data has been populated.

As mentioned before, our Pharmacy Encounters team developed an automated process to ensure all encounter data fields are populated per the guidance in the Agency's companion guide. We have designed our systems to pull the appropriate data elements from our claims and to include quality control mechanisms to support the accuracy of encounter data submissions.

The Pharmacy Encounters team also reviews encounters bi-weekly to assess performance on encounter submissions to Magellan and to discuss fluctuations and errors. During these meetings, we develop action plans to resolve issues.

Pharmacy claims require the submission of all key encounter data elements, ensuring all key fields are identified for pharmacy encounters. These key fields are matched to the field submitted on the claim and include: Transaction Code, Service Provider Id, Date Of Service, Cardholder Id, Prescription/Service Reference Number, Product/Service Id, Number Of Refills Authorized, Prescriber Id, Segment Identification, Compound Ingredient Quantity, Date Of Birth, Patient Gender Code, Medicaid Id Number, Quantity Dispensed, Other Payer Date, Internal Control Number, Other Payer Amount Paid (First Occurrence), Other Payer-Patient Responsibility Amount, Ingredient Cost Submitted, Dispensing Fee Submitted, Usual And Customary Charge, Compound Ingredient Drug Cost, and Gross Amount Due.

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4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.

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NON-PHARMACY ENCOUNTERS

Humana can ensure that encounters are coded consistently across providers and provider types because all claims and encounter submissions for all types of providers and subcontractors must clear the same edits in the claims clearinghouses and our eHub. The HIPAA level 7 edits

that most of our claims and encounters are processed through identify and reject data for incorrect coding at the front-end.

Additional edits are applied by our claims platform. We periodically update our policies and claims payment systems to align with correct-coding initiatives, as well as these national benchmarks and industry standards:
- Centers for Medicare & Medicaid Services (CMS) guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT®)
- Health Care Common Procedure Coding System (HCPCS)
- International Classification of Diseases, 9th Edition (ICD-9) and 10th Edition (ICD-10)

These updates support Humana's continuing efforts to process claims accurately. Thus, the same logic, edits, and rules concerning coding are applied to all claims and encounters before we prepare our encounter submission file for AHCA. Systematic creation of encounters ensures that data fields are coded consistently based on source data from the originally submitted claim. Any time encounter processing is changed, there is extensive testing to validate the changes.

In addition to edits to ensure consistent coding, Humana has a proactive approach to conduct provider outreach. Humana’s Provider Reporting, Communication and Education Department develops various provider communications to promote accurate and consistent coding. This includes condition-specific coding guidelines and industry best practice materials, which are shared with providers and office associates by request or as the need arises. The educational materials are sourced from organizations such as CMS, American Heart Association, Mayo Clinic, and ICD-10-CM Official Guidelines for Coding and Reporting. Examples of condition-specific coding guidelines include Depression and Adult Wellness Visit. Attachment 29-2 and Attachment 29-3, respectively, include the materials we have developed and share with our providers to educate them on the coding for these conditions and tests. These materials may be delivered electronically as well as in person by our local Provider Relations representatives or peer-to-peer, as appropriate, by the local market Medicaid Medical Director.

Additionally, Humana has developed a coding improvement process in which recommendations are given to providers guiding them on commonly missed data points including diagnosis codes, coding specificity, and more. The coding improvement plan also suggests best practices to improve coding for specific conditions. The plan is reviewed and specific coding issues are addressed by our Provider Relations team. The template improvement plan and our best practices guidance for diagnosis coding can be found in Attachment 29-4.

PHARMACY ENCOUNTERS

Humana’s pharmacy data submitted at point of sale are rejected if the codes entered are not valid. We also ensure that pharmacy encounters are coded consistently by applying edits at the point of sale. Once Humana receives these claims, Humana creates the encounter submission file based upon the AHCA NCPDP guidelines to ensure accuracy. Our automated and systematic creation of encounters ensures that encounter fields are coded consistently based on source data from the claim. Any time the encounter processing is modified, there is extensive testing to validate the changes.

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5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.

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NON-PHARMACY ENCOUNTERS

Humana ensures the consistency of volume, categorization, dollar amount, and dates for encounters across data sources by requiring that all medical claims and encounters from providers and subcontractors clear HIPAA, State, and Humana edits. Only after a claim or encounter has passed the required edits, is it moved to the next stage, Edifecs, to be converted into an encounter that Humana submits to the Agency.

Humana has an encounter reconciliation program to ensure Humana receives all claims and codes timely and accurately from providers. This is measured by completing a reconciliation process between the provider and Humana. The reconciliation process summarizes claims and code data processed, isolates data not received by Humana, and identifies any gaps in the data. Humana and the provider collaborate on the results of the process, identify gaps in data, and the provider resubmits as needed. Humana and the provider will remedy any identified issues for accurate and timely submissions in support of future processing.

Because the 837 has to go through a series of edits from the provider to the clearinghouse to Humana, there is the possibility of dropped or truncated claims within various provider practice management systems. The encounter reconciliation program gives claim and code level analysis to determine averages and benchmarking based on overall claim performance. Furthermore, we request a collection of claims data for a specified period of time, referred to as a “shadow file,” from our providers and Medical Service Organizations (MSO). The shadow file is used to measure accuracy of all provider claims submitted to, and received by, Humana.
The reconciliation model compares shadow file data to Humana’s received data to determine potential data gaps. There is matching logic behind the reconciliation model to determine a match or a non-match. During the process, Humana looks at specific key data fields including provider tax ID, date of service (DOS), enrollee ID, diagnosis codes, Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes and claim ID.

Additionally, we reconcile at a claim, service line, and diagnosis code level. The results of the reconciliation process are shared with the provider. If any gaps are identified, Humana and the provider work together to locate and resubmit claims and identify and address any system issues among the provider, the clearinghouse, and Humana. The date of service, shadow claims, matching claims, claim outage, claim outage percentage, shadow diagnosis codes, matching diagnosis codes, outlier diagnosis codes, and percentages are included in the summary report shared with the healthcare provider.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

PHARMACY ENCOUNTERS

Humana ensures that encounters (volume, categorization, dollar amounts, and dates) are consistent across all pharmacies in our network by requiring our claims adjudication subcontractor (DST Pharmacy Solutions) to apply the same edits to all pharmacy claims.

We also conduct an analysis of total claims paid, volume, and categorization of claims and our encounters to ensure they align and do not have any discrepancies.

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6. The completeness of the respondent's flowcharts describing its encounter data submission process.
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Please refer to Attachment 29-5, Non-Pharmacy Encounters Data Flow Chart, for a flow chart depicting the medical encounter data submission process.

Please refer to Attachment 29-6, Pharmacy Encounters Data Flow Chart, for a flow chart depicting the pharmacy encounter data submission process.

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7. The adequacy of the respondent's mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.
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NON-PHARMACY ENCOUNTERS

As previously discussed, Humana utilizes a customized version of the Edifecs TM platform to execute, manage and monitor encounter submissions with State agencies. The system provides a comprehensive view of an encounter's life cycle and serves as the platform in which the status of an encounter can be observed and any rejections are addressed for resolution through our multi-prong approach. At any point in time, our approach may include one or more of the following activities:

- Prioritizing error correction efforts performed by our in-house, experienced Encounter Data Improvement team

- Collaborating with our corporate and market provider outreach and education teams

- Including agenda topics during our periodic AHCA/DXC Technology (DXC) meetings held in Florida

- Continuing to identify and improve the logic within our systems and processes

The above are all supported and driven through our robust reporting that gives clear end-to-end tracking, trending, and monitoring of non-pharmacy encounter initial submission as well as

resubmissions. The source of our reporting is derived through a combination of our Enterprise Data Warehouse (EDW) and the Edifecs data repository. All encounter data resides within our IT systems. A particular component of our reporting focuses significantly on ensuring the completeness, accuracy, and timeliness of our encounter submissions.

Humana continues to establish and refine internal error correction steps as well as monitoring aging processes, that focus on ensuring errors are resolved accurately the first-time while also being submitted within the State requirements.

As a true partner, we also openly participate in face-to-face discussions with AHCA/ DXC to further understand the nature of certain errors and to identify best practices for resolution.

TIMELINESS

Our reporting tools are a key asset to our operating success. As part of our strategy, we strive to maintain effective internal performance reporting tools that are based on best-practices. Over the course of the last two (2) years, our timeliness reports have evolved and offer greater insight into where operational process and IT improvements can be implemented to drive improvements. When an unusual result is identified (e.g. an impact greater than one percent (1%)), the team will conduct research and verify if the results are in line with expectations, assess whether it is due to a one-time event, and/or determine if corrective action is necessary. The timeliness reports are coupled with error inventories that focus on ensuring the company's error resolution efforts are prioritized to optimize our submission timeliness results.

Humana employs the use of multiple reports to ensure that we meet the State's requirements for timely initial submissions (submitted within seven (7) days of the adjudication date). Our reports specifically delineate our submission activity between initial submissions and resubmissions. We also organize our rejection inventories of internal business/compliance edits, TA1 errors, 999 rejections and 835 rejections. Further, our reports monitor the progression of an encounter from inception to final acceptance with the state based on Edifecs' activity states. The reporting combines the activity state and error information to deliver alerts and prioritization of inventories to ensure that contract timeliness requirements are being met. We are also able to forecast and determine when non-compliance is expected. This allows Humana the opportunity to deliver timely notice to the Agency.

ACCURACY

One key element of our strategy and success is a focus on data accuracy as demonstrated by a drive towards the highest level of acceptance on initial encounter submission. During instances in which a rejection occurs, our Encounter Submission and Data Improvement teams utilizes several reporting tools that provide an organized view of all rejections based on the encounter's status, exception type, aging, workability and specific errors. The teams utilize these reports on a daily basis to assign work to Louisville-based Data Improvement associates and to determine if other efforts are needed. We also monitor our rejection and acceptance rates to determine if results exceed minimum tolerance standards, identify unusual trends, give feedback and training to associates, and identify process improvements that can yield increased efficiency.

An accurate encounter begins with properly received and processed claims. EHub and CAS have numerous edits that ensure accuracy of data. In addition to the validity of data there is built-in logic to identify duplicates. The logic is split into two (2) categories: exact duplicates and near exact duplicates. For exact duplicates, logic will consider the claim an exact duplicate and

reject. The second category is near exact duplicate, which pends the claim as a possible duplicate allowing the associate to further interrogate the claim to confirm duplication. The logic looks for key fields when determining duplicate data (e.g., enrollee, procedure code, provider, and date of service).

In addition to eliminating duplicate claims, the Edifecs Transaction Management system reviews all requests for new encounters to determine if a previous encounter is still pending acknowledgment. If an encounter is waiting for acknowledgement, the Edifecs system will stop the request from completing to prevent duplicate data from being sent to AHCA.
Additionally, the array of reports and analytics we conduct gives transparency and actionable information on how we can improve the accuracy of our reports and continually feeds into process improvements in our effort to meet and exceed AHCA's encounter data standards.

COMPLETENESS
Humana oversees the end-to-end encounter process through reporting that provides a view from all systems, reflecting the beginning processes of claims adjudication all the way to the final encounter submission. Our processes and supporting reports monitor all encounters to ensure the completeness of our submissions based on our adjudication processes and State agency requirements. IT alerts are designed to notify key associates immediately when certain IT processes fail. Also, meetings with IT occur weekly, at a minimum, to discuss status and any upcoming changes. We are able to utilize this information, coupled with our reporting, to ensure that our submission processes operate with the highest level of effectiveness and efficiency.

PHARMACY ENCOUNTERS

TIMELINESS
Humana tracks the timeliness of our pharmacy encounters to ensure that we meet the State's requirements. We do so using a monthly report that includes all encounters and claims other than those that have been resubmitted (those claims are not subjected to the seven (7) day window). Within the monthly report, we divide claims into two (2) groups -- within the seven (7) day window and outside the seven (7) day window. We use our monthly timeliness audit report to ensure that if anything is not meeting the seven-day timeframe, we understand the root cause why. We notify AHCA of any special circumstances that we know would cause claims to be processed outside of the seven (7) day window.

ACCURACY
Our Encounter Submission and Error Tracking daily report allows us to track how well we did per submission and over time. It includes the volume of errors and trending of our improvements (clearing of errors). It also includes the program, date of submission, volume of submission, total accepted, total rejected, rejection percent (passing percent) and total error count by submission overall. In 2017 to date, our encounters acceptance rate for MMA services has consistently been above ninety-nine-point five percent (99.5%).

COMPLETENESS
Our Rx Flow Completeness report is a monthly report that compares paid claim detail from DSP to what has been submitted to Magellan via the NCPDP encounter file. This report helps us ensure all encounters have successfully been submitted to the State. Humana has a multi-year

record of one hundred percent (100%) compliance for submission of all paid pharmacy encounters to the State.

PREVENTING DUPLICATE PHARMACY ENCOUNTERS
Humana's pharmacy claims adjudication vendor, DPS, has software logic that identifies all duplicates and rejects them at the point of service. Occasionally, a duplicate pharmacy encounter is not caught by this logic. The only situation in which this would occur is where a prescriber has called in a prescription to the pharmacy for, as an example, thirty (30) pills, but the enrollee decides to pick up less than the total count, for example, only fifteen (15) days of medication. Pharmacy claim reversals result in a corresponding encounter reversal if they happen in different cycles, e.g. the original encounter has already been sent when the pharmacy reversal occurs.

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8. The adequacy of the respondent's encounter data submission historical compliance ratings.
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Our complaince rating history for the past three (3) years is provided in Attachment 29-7. 29-7a includes compliance ratings that are reflective of timely encounter submissions data as provided by AHCA. 29-7b offers additional internal compliance ratings related to encounter submissions.

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9. The adequacy of the respondent's ability to implement timely corrective actions to compliance ratings, if indicated.
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Humana is able to implement timely internal corrective actions to compliance findings through internal CAPs, conducted via Enterprise Solution Point (ESP). ESP is Humana's Governance, Risk, and Compliance tool, which tracks important contractual information, including but not limited to: internal CAPs and business impacts from regulatory changes. Humana leverages the ESP workflow to manage and capture internal corrective action details such as root cause analysis and plans for remediation. Contract and regulatory requirements are documented in ESP and routed to the appropriate impacted business owners, operational leaders, compliance associates, and senior management for acknowledgement, documentation of the impact, implementation monitoring (as appropriate), gathering and storing attestations, and housing of metrics for compliance monitoring. Escalation occurs to ensure timeliness.

This system is designed to make the efforts of our frontline business leaders more simple, efficient, transparent, and effective with regard to managing processes, risks, controls and compliance.

Humana develops a monthly Operational Risk Management Medicaid Compliance Metrics Dashboards and Medicaid Integrated Compliance scorecard to coordinate and facilitate Medicaid Compliance Committee Meetings. Meeting invitees include leaders that are critical to the escalation process: Medicaid Operational Leadership including CEO and President of our Corporate Medicaid structure, Medicaid Market Leadership, Medicaid Segment VP and President, Regulatory Compliance VP, and the Operational Risk Management VP. During these meetings, we review the Medicaid Integrated Scorecard, which includes encounter performance metrics. During the review of each operational area, we discuss new issues,

concerns, and barriers. Respective owners also offer updates on historical issues, concerns, and barriers. In addition to the highlights, each component area reports on their overall status.

Should a request for a corrective action be received from AHCA, our Regulatory Compliance Department manages and oversees the response. In ESP, our Compliance Associates creates an Issue and Opportunity (IOP) entry and assigns responsibility for initiating and implementing an Improvement Action Plan (IAP) to the responsible business owners. The IAP describes what the responsible business owners will do to address the IOP along with an expected completion date. Our Compliance Associates continually monitor the progress of the IAP and will intervene should a business owner not meet the expected completion date or experience any other obstacle. Compliance Officers facilitate remediation with both the business owner and appropriate leadership. If necessary, the issue can be addressed through an accelerated escalation process to senior leadership. This ensures that the issue can be completely and timely addressed according to AHCA's direction. Our Risk Compliance Associates and associates monitor this process through completion and until AHCA's approval is received. Should status reports or additional information be required by AHCA, our compliance team will work with the business to provide reporting and information in the format and timeframe that AHCA requires.

AHCA has not issued a corrective action for Humana for non-pharmacy or pharmacy encounter submission issues during the current contract.

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10. The adequacy of the tools and methodologies used to determine compliance

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NON-PHARMACY ENCOUNTERS

Ramp Manager is Humana's encounter quality assurance tool. The tool allows us to test the logic and updates made to reflect Companion Guide changes before it goes into production. Humana then tests dummy encounter data to validate accurate and timely processing, ensuring compliance. Attachment 29-8 offers our policy and procedure on how we use our proprietary Ramp Manager tool to support the submission of compliant encounter data. Examples of customized edits include, but are not limited to:

- Skilled Nursing Facility
- Atypical Provider
- Coordination of Benefits (COB)/Balancing
- Provider level compliance edits

Humana utilizes various reporting tools aligned with the AHCA methodology for determining compliance with the contract. Results are routinely provided by AHCA outlining our compliance rates with the initial submission compliance timeliness measure. Humana generates reports internally for determining results for additional operational and compliance oversight. Our reports are generated on a varying schedule ranging from daily, weekly, or monthly depending on their particular purpose and use. Some key reports utilized include:

- Expected vs. Actual Submission Compliance Report (daily) - Utilized to monitor, track, and trend Humana's initial submission activities and response statuses by contract type. This report

forecasts and analyzes compliance for timeliness and is aligned to mimic results received on weekly Encounter Timeliness Report provided by AHCA. Our report allows us to quickly analyze and determine why any changes to our compliance score are happening.

- Florida Status Summary report (weekly) - Provides a current status of the complete submission process on a weekly basis that rolls-up based on a monthly summary. This report monitors the completeness and trends volume of encounters received into our Edifecs system against our submissions to AHCA. This report is also utilized to monitor submission compliance for timeliness and accuracy.

- Encounter Initial Submission and Response Report (daily) - Monitors the completeness, timeliness, and accuracy of encounters received into the Edifecs system compared to first-pass submissions to AHCA.

- Enterprise Solution Point Metrics Report (monthly) - Drives operational efficiency by monitoring and reporting compliance timeliness and completeness on a daily basis. Provides senior leadership with oversight of the company's compliance results and any action plans in place to improve processes.

Examples of these reports are attached at Attachment 29-9.

PHARMACY ENCOUNTERS

Humana utilizes the following tools to determine compliance of its pharmacy encounters with the State's requirements:

Our Monthly Timeliness Audit Report tracks compliance with the State's timeliness requirements. We also trend our compliance month by month in our Timeliness Metric report.
Our Encounter Submission and Error Tracking report tracks the volume of errors in our encounter submissions and trends of our improvements (clearing of errors). It includes the program, date of submission, volume of submission, total accepted, total rejected, rejection percent, passing percent, person submission, and total error count by submission and overall. We monitor this report every business day.

Our RX Flow Chart Control Point 3 Completeness report is a monthly report that compares paid claim detail from DPS to what has been submitted to Magellan via the NCPDP encounter file. This report helps ensure all encounters have successfully been submitted to the State.
To ensure that we resubmit all encounters that have been rejected by Magellan, we have implemented an automatic retrigger process that resubmits an encounter when it was rejected due to a system timeout by Magellan. Additionally, when we do not receive all encounters back from Magellan following processing, our system searches for these encounters and automatically resubmits them.

Examples of these reports are attached at Attachment 29-10.

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11. The adequacy of the respondent's process for converting paper claims to electronic encounter data.

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NON-PHARMACY ENCOUNTERS

In 2017, only four percent (4%) of our Medicaid claims were submitted in paper form. We accept paper claims as a CMS 1500, UB-04, and other form types. If a provider bills by paper, the provider mails their claim to a P.O. Box that is listed in the Humana provider manual. Our vendor, Conduent, retrieves, opens, and sorts the mail. Once a claim has been sorted, it is then scanned, and passes through a quality check at the Scan Quality Control area. A five percent (5%) audit is performed daily on all the sorting for quality assurance. The image is then transmitted to the Optical Character Recognition (OCR) team to begin the process of gathering the claim data. The claim data is then placed in a proprietary template and is passed to the First Pass team for review of the OCR data of critical fields and any other field that Humana requests. Conduent translates data submitted in a CMS 1500 and UB-04 forms and submits it to eHub as a pseudoi-837 file. Paper claims submitted in other formats are processed manually by our Associates.

If the scanning cannot be done electronically, because for example, the handwriting on the claim cannot be read by the OCR process, a Conduent employee will manually enter the information from the claim into the template. The data entry team also performs a second review of the claim data that is processed through the First Pass team, along with specific fields as requested by Humana. To ensure accuracy of the manually keyed data, a routine random audit of five percent (5%) of the claim fields is performed daily at Conduent. Conduent then converts the data into an X12 837 file and transmits to Humana in real time, utilizing the current infrastructure of the EDI systems, for maximum efficiency in passing data to the adjudication platforms. On average, this process takes less than twenty-four (24) hours.

Although we have a well-developed process for accepting paper claims, Humana realizes the benefits of electronic submissions. Humana completes ongoing outreach to providers who are submitting paper claims to give them guidance on how to submit electronically. This includes options for them to use Humana's clearinghouses to manually enter the claims through direct data entry if they are not able to create an electronic 837.

PHARMACY ENCOUNTERS

Less than zero-point-zero three percent (0.03%) of pharmacy claims and encounters were submitted via paper in 2017. Paper claims can be submitted by the pharmacist or the enrollee. The paper claims are scanned into DST Pharmacy Solutions where each is converted to an electronic claim. We require the pharmacists in our network to bill electronically.

A pharmacy or enrollee paper claim is a claim that is received in paper form to Humana's P.O. Box or via fax. The paper claims received through the P.O. Box are then scanned by our mail vendor, Conduent. We process paper claims using the Universal Claims Form. Upon receipt, a

claims processor enters the claims using the DST 3270 claims processing system. This takes them from paper to electronic form.

Once the claim is entered and pays, the claim(s) will be paid to the pharmacy using the negotiated rate for that pharmacy on file. The negotiated price includes any negotiated pricing mechanism, e.g. Wholesale Acquisition Cost (WAC), Maximum Allowable Cost (MAC), Floor Price. Payment should be reflected on the pharmacies Financial 835 record they receive each month.

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12. The adequacy of the respondent's approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.

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NON-PHARMACY ENCOUNTERS

Humana continuously tracks and trends encounter submission issues that could result in invalid encounter data being submitted to AHCA. We implement internal system enhancements to better support business logic updates whenever we receive notice that AHCA has updated the Companion Guide or revised the contract.

ENCOUNTER ERROR RESOLUTION APPROACH
Correcting encounter errors for resubmission to AHCA begins daily with reviewing the Encounters Status and Reject 835 Response report which tracks and trends the encounter rejects received from AHCA.

Our Encounter Submission team assesses the report to understand the types of rejections received and identify the errors based on volume and error type. We then determine the steps needed to correct the errors for resubmission.

Claims that are pended due to internal edits or AHCA rejects are reviewed by Humana's Data Improvement team. The user will access Humana's customized Edifecs TM software which allows us to track the status of all encounters. Users are able to access each encounter via the user interface and are able to see both a business version and the X12 version. All encounter versions that have been sent to an outside agency are linked together, so the users are able to review each iteration. All original outbound batches are stored in the system for users to view at any time. This system serves as a data source to assist with research and resolution of errors and identification of future enhancements.

Encounter acknowledgements received from AHCA are loaded to the software to update the status of the encounter. The software also automatically creates an exception report for users to work if an error is received. This allows the user to make encounter-related corrections quickly in the system. Any corrected encounters are automatically added to the next round of outbound batches. Humana also makes all error corrections in the Edifecs TM tool. The Edifecs TM tool tracks each time an encounter is processed and the success of that submission. A weekly Error Corrections Success report is generated which allows us to monitor and track the end result of a submission. The report is used by the Encounter Data Improvement and the Encounter

Submission team to perform quality checks, develop process and procedure improvements and isolate matters requiring possible escalation. The report assigns a status to the encounter:

- Successful - Progressed to be submitted, next level exception or completed.

- Different Errors - Next exception is the same as the previous exception type, but different errors.

- Regressed - Next exception is of a lower level exception type.

- Unsuccessful - Next exception returned the same exact errors as the previous one.

- Exception Loop - Identifies claims with a history of exceptions, a possible pattern between errors.

These corrections are linked back to the original encounter to allow for long term audit tracking. The software and all the data is kept in house at Humana, so we have control of the data to optimally support reporting and analytics. The Efifecs TM software allows for Humana to send encounter original, adjustments and voids to the agency to ensure accurate and complete encounter submissions.

Errors that fall outside of the Encounter Data Improvement area are categorized, presented, and vetted during a weekly team meeting. A plan of action is created and next steps are identified. The error is assigned to an Analyst to begin scope development and root cause analysis. The Analyst documents and presents the findings of his/her analysis during the weekly team meeting. The analysis is then referred to a Consultant for validation. The validated analysis determines how we will proceed with resolving the error.

The Consultant then reaches out to the respective area to begin working towards resolution, including, but not limited to, kickoff meetings, desk procedure updates, and drafting heads-up communications. After an error resolution has been implemented, the Consultant develops a test plan to ensure the accuracy of error resolution.

Humana has worked with the Agency to identify encounter errors and improve the reporting process and mechanism. As a transparent partner, we have participated in offering data to conduct validation studies and to support ad-hoc projects. Below are some examples where we employed this encounter error resolution approach.

BUSINESS LOGIC MODIFICATIONS
While reviewing the Encounters Status and Reject 835 Responses report, Humana identified a significant increase in N703 denials, indicating that certain claims previously submitted were resubmitted in error. The encounters were submitted with either the incorrect ICN or without an ICN. After an internal review and clarification from DXC, it was determined that a system fix could be implemented to resolve the error. After the system fix was implemented, the encounters were reprocessed and resubmitted to AHCA. The report later indicated an eighty-three percent (83%) decrease in N703 errors from March 2016 to November 2016.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

FINANCIAL CLASS CODE (FCC) UPDATE

In reviewing the 835 Error report, we searched for increases in M56 rejection errors (FCC). From our past experience and root cause analyses, we identified that the FCC logic was not mapped correctly and it was subsequently causing incorrect encounter data. As a result of Humana's internal process of categorizing and assigning tasks to develop error resolutions, we have reduced our FCC error rate by twelve-point six percent (12.6%); today this error code is at zero point six percent (0.6%).

PRESENT-ON-ADMISSION (POA) INDICATOR

The N434 (POA) rejection was identified due to the present-on-admissions indicator being missing or invalid. The definition of the error led us to inquire about how the provider was submitting the POA per 5010 HIPAA Compliant Standards as well as AHCA guidelines. We decided to place an edit at the front end of claims to not accept any claims with missing or invalid POA. The issue was submitted through the Ongoing Escalation process for validation and the Claims Process Organization to ensure the research was accurate. The edit was placed to prevent further N434 rejections from AHCA.

CROSSOVER CLAIMS

As an example of Humana's encounter knowledge and partnership, in December of 2015, AHCA asked Humana to consider being a Beta Test Site for crossover claims. Humana knew that the request would require new processes and reporting, technical support, and provider outreach. With more than twenty (20) years of experience with Medicaid Encounter Submissions and as a proven industry leader, we believed we had sufficient knowledge, technical support, and experience to assist AHCA with Beta testing. The Beta Test process required Humana to: conduct file transfer of enrollee eligibility, identify other payer information (e.g., coordination of benefits), engage and provide oversight to the clearinghouse, give routine feedback and status updates, test validation; and conduct provider outreach.

Our efforts, in coordination with AHCA and CMS, resulted in a successful transition that went into production in October 2016. We received very positive feedback for our efforts from both AHCA and CMS, and were acknowledged as being one (1) of the two (2) test sites that went in production successfully.

To address the administrative burden of submitting, waiting, receiving approvals on cross-over claims from both CMS and from Humana separately, we implemented an initiative to streamline the process for our providers so that the claims must be submitted only once. Humana coordinates the transmission of the provider claim along with COB data to Emdeon using Medicaid COBA ID, which is shared with our systems for processing. This process creates efficiencies within the systems between payers and reduces the administrative and monitoring burden on our nursing facility providers.

ENHANCEMENT OPPORTUNITIES OF ENCOUNTER SUBMISSIONS

Humana has a team of associates that meet weekly to strategize on proactive approaches to implement process improvements. We understand the importance of error resolution. The team is also focused on proactively identifying issues and introducing enhancements to prevent or mitigate future errors. Humana utilizes numerous tools that allow us to stay well informed of future changes and possible impacts.

One example is by using the Florida Medicaid Health Alert, whereby our Associates receive an email generated alert that notifies Humana of "late-breaking" healthcare information. Each alert is treated with importance. A Consultant is responsible for reading each alert to determine potential impact. As an example, Humana received communication from AHCA, via their Florida Medicaid Health Care Alert emails, indicating outpatient encounters would be denied if not submitted with the correct HCPC/CPT codes. This communication was taken to our committee for review to determine if any system changes were needed to ensure encounters with the correct HCPC/CPT codes were not rejected in error. Fortunately, Humana's planned system updates to our Enhanced Ambulatory Patient Grouping (EAPG) logic comprehensively addressed any changes necessary to meet the new requirements. The alert provided confirmation that we were moving in the same direction as AHCA. When it was time for implementation, the impact for Humana was minimal and the related process changes were implemented efficiently and timely.

ESCALATION PROCESS FOR ENCOUNTER ISSUES

Humana has an established escalation team, the Claims Process Organization (CPO) team, which reviews encounter issues. The team is comprised of Claim Subject Matter Experts, Encounter Submission Experts, and IT system support. This diverse team of experts identifies the root causes of errors, brings encounter issues to the attention of management level associates across the enterprise, and develops quick efficient fixes for all the impacted areas of the organization.

The escalation process for encounters starts when the Florida Medicaid encounter team identifies an issue that needs to be addressed at a higher level and refers the issue to the CPO leader and Encounters Process Manager. This Associate adds the issue to the agenda for the weekly meeting that includes associates from different departments such as Claims, Medicare/Medicare Risk Assessment, eHub, Provider Connect, and Humana Medicaid Market team. The goal of these meetings is to determine whether the issue can be resolved with a system enhancement to eHub or CAS. If an electronic change would not be sufficient to address the error in question, the Encounter Submission team is asked to assess whether a manual process would correct the issue.

PHARMACY ENCOUNTERS

When we receive a response file from Magellan, we review and research all errors. Our IT team and business owners assess whether any of the errors can be remedied via Humana code changes. Any issues that are a result of data-related errors (e.g., pharmacy registration) are escalated through the Florida market and compliance leadership for swift resolution.

==========

13. The adequacy of the tool to ensure that all encounters are submitted.

==========

NON-PHARMACY ENCOUNTERS

As previously discussed, Humana utilizes a customized version of the Edifecs Transaction Management platform to execute, manage, and monitor encounter submissions with our

contracted state agencies. Edifecs is the only vendor with a single solution for submission, tracking, and error correction that allows Humana to manage our data internally. The system gives a comprehensive view of an encounter's life cycle and serves as the platform in which the status of an encounter can be observed and any rejections are addressed for resolution through our multi-prong approach. We have tailored Edifecs with customized edits.

Humana has two (2) reports to ensure that all medical encounters are submitted, the Initial Submission Report and the Expected versus Actual Report. The Initial Submission report is a weekly tool that shows the number of claims and encounters received by Edifecs from CAS and DentaQuest (which represents the total number of our encounters) and the percentage of those encounters submitted to the state on a timely basis (within seven days following the date of adjudication by the Plan). The Expected versus Actual report is a tool that tracks for each week our initial submission compliance within seven (7) days of the adjudication date, lists the total encounters submitted that passed 999 compliance edits, and indicates the 835 status. Both tools show our performance on these metrics over time. Samples of these reports are provided in Attachment 29-9.

To ensure that we submit an encounter for every service provided to an enrollee during the applicable reporting period, prior to transmitting our encounter file to AHCA, we run a report that compares the number of encounters in the file with the number of expected encounters based on our claims payments.

To verify that that our subcontractors and provider groups have submitted complete encounters for all the services they provided to our enrollees, we conduct annual audits during which we review a sample of the subcontractor's or provider's claims against their encounter submissions over the prior year. If an audit shows that one or more encounters were not submitted, Humana issues a corrective action plan. Sub-capitated providers are incentivized to submit complete encounters because their capitation rate is reduced if the error file is found to be incomplete.

As a result of our tools and monitoring mechanisms, we have been consistently surpassing our initial completeness submission rate above ninety-five percent (95%).

PHARMACY ENCOUNTERS

Humana uses our monthly RX Flow Chart Control Point 3 Completeness report to monitor that an encounter is submitted for every pharmacy claim we have paid. The report pulls the latest claim picture from our submission tables and checks to see if there are any outstanding claims that need to be submitted. The results are then narrowed to include only the current claim picture and claims that were not internally voided.

Evaluation Criteria:

1. The adequacy of the respondent's process to ensure accurate, timely, and complete encounter data.

2. Demonstrated knowledge of the combination of key fields needed to identify services.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.

4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.

5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.

6. The completeness of the respondent's flowcharts describing its encounter data submission process.

7. The adequacy of the respondent's mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.

8. The adequacy of the respondent's encounter data submission historical compliance ratings.

9. The adequacy of the respondent's ability to implement timely corrective actions to compliance ratings, if indicated.

10. The adequacy of the tools and methodologies used to determine compliance.

11. The adequacy of the respondent's process for converting paper claims to electronic encounter data.

12. The adequacy of the respondent's approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.

13. The adequacy of the tool to ensure that all encounters are submitted.

Score: This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 5 points each.

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Edifecs Transaction Management

DATA SHEET

Gain deep insight into the end-to-end healthcare transaction lifecycle

As soon as a transaction is received by a healthcare organization, it begins a complex journey, spanning multiple systems, through which it is acknowledged, processed, and modified at several points in its lifecycle – often with limited or no visibility by operations staff. Healthcare organizations that lack visibility into their transaction lifecycles will spend unnecessary time, resources and expense processing transactions and supporting partners.

Edifecs Transaction Management (TM) provides a secure, end-to-end view of the healthcare transaction lifecycle to internal users and trading partners to enable better business decision-making, monitor performance against internal and external SLAs, enhance claims first-pass rates, and improve customer satisfaction.

WHY EDIFECS TRANSACTION MANAGEMENT?

- Supports the unique needs of the healthcare market by leveraging pre-built templates for common transaction processing scenarios
- Leverages commercial off-the-shelf components that lower costs to implement and maintain IT infrastructure
- Is a market-proven solution used by a majority of the nation's Blue plans and major commercial insurance plans

Capabilities

WITH EDIFECS TRANSACTION MANAGEMENT, OPERATIONS AND CUSTOMER SUPPORT STAFF CAN:

- Configure trading partner transaction processing by defining partners within the community, transactions supported and partner-specific processing rules. Support and manage large partner communities with shared master agreements and Edifecs Ramp Management add-on for partner self-testing.
- Analyze Service Level Agreements (SLAs) and troubleshoot deviations using visual dashboards and reports.
- Search and manage a variety of file formats including HIPAA, NCPDP and proprietary file formats. View HIPAA transactions in a business-friendly view or in a paper-based format.
- Secure transaction access by departments or transaction types through granular, role-based access control.
- Audit transaction lifecycle activity using archived original file, history, internal events and third-party processing events, along with other linked transactions.
- Issue alerts and notifications about business or processing exceptions and track responses to support resolution. Publish events to internal or partners systems.

Benefits

As shown in Table 1, Edifecs Transaction Management improves operations and transaction visibility resulting in more informed decision-making, better monitoring of performance against SLAs, enhanced claims first pass rates and improved customer satisfaction.

BENEFITS	SUPPORTING FEATURES
Make Better Operational and Business Decisions	▪ Generate scheduled or on-demand reports with summary or detailed analysis on operations and business activity. ▪ Create reporting on metrics including trending and threshold comparisons. ▪ Run balancing reports, such as comparing claims received vs. those sent to core processing systems. ▪ Use ad hoc reporting to support business analysis related to special projects or new initiatives, or use ad hoc queries for quick access to information. ▪ Configure automated alerts to trigger when processing exceptions occur.
Monitor Performance against Internal and External SLAs	▪ Report on external SLAs such as turnaround times on claims and request response times. ▪ Report on internal SLAs such as such as percent of claims originating on paper vs. electronic form. ▪ Use automated alerts when processing SLA-related exceptions such as excessive time to process transmissions or excessive timeouts on response transactions. ▪ Auto-generate notifications or interim responses when processing time exceeds expectations. ▪ Run balancing reports such as comparison of claims received to claims sent to core processing systems. ▪ Configuration notifications for processing exceptions, including full tracking and resolution via the Exception Management Module to ensure successful processing of individual items during run-time.
Improve Claims First-Pass Rates	▪ Run scheduled or on-demand reports on key metrics such as most frequently occurring errors or partner with most rejected claims. ▪ Use ad hoc reporting to support analysis such as determining the root cause of claim rejections. ▪ Send reports to partners or make reports accessible via web portal to facilitate error resolution. ▪ Provide partners with self-service testing via Ramp Management Add-on to ensure partners can create compliant claims.
Improve Delivery of Customer Support	▪ Provide a secure self-service portal (stand-alone or integrated into existing portal) that lets internal and partner users view transactions and related information in business-friendly formats. ▪ Configure and leverage granular, role-based control to secure transactions and views by department or line of business. ▪ Use contextual search based on transaction type to quickly find and display business and transaction information. ▪ Use an integrated, three-pane view containing data structure, content, and error listing to provide convenient access to original data sent or received. ▪ Create partner reports that can be auto-generated and delivered directly (through FTP, SFTP, email, etc.) or made available through partner portal. ▪ Schedule reports that include key metrics and information monitored by support organizations. ▪ Create on-demand reports that allow internal users to quickly access information. ▪ Use “Browse and Attach” feature to let low-volume partners upload transaction files for processing.

Table 1: Benefits and Features of Edifecs Transaction Management

edifecs

An industry leader since 1996, Edifecs provides healthcare software solutions that improve operational performance by streamlining the exchange of information among health plans, hospitals, and other healthcare organizations, while enabling compliance with current mandates such as HIPAA, Operating Rules and ICD-10. Today, more than 250 healthcare customers use Edifecs technology to unify transactions from any information channel source and input mechanism, while automating manual business processes such as enrollment, claims and payments management. Edifecs is currently recognized as one of the 100 Fastest Growing Private Companies in the state of Washington, 100 Best Places to Work in the state of Washington, an Inc. 5000 fastest-growing private company and one of the 500 Fastest Growing Companies in North America by Deloitte. Edifecs is headquartered in Bellevue, WA. For more information, please visit http://www.edifecs.com

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Depression

ICD-10-CM
Documentation and coding guidelines

Humana 2653ALL0916-A

Disclaimer

This presentation is intended for both physicians and office staff. The information contained in this presentation and responses to the questions asked are not intended to serve as official coding or legal advice. All coding must be considered on a case-by-case basis and supported by medical necessity and the appropriate documentation in the medical record.

Topics

1. Definition
2. Causes and risk factors
3. Complications
4. Best documentation practices
5. Coding examples

Definition

Major depression is a mental disorder, marked by a depressed mood and loss of interest or pleasure in all activities that last for at least two weeks and represents a change from previous functioning.

American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – Text Revision (DSM-5)

DSM-5 criteria for diagnosis of major depression or major depressive disorder

Criterion A:

Five (or more) of the symptoms below during same two-week period that are a change from previous functioning, and at least one of the symptoms is either:

- **Depressed mood**
- **Loss of interest or pleasure**

Does not include symptoms clearly attributable to another medical condition

- Depressed mood most of the day
- Markedly diminished interest or pleasure in all/almost all activities
- Significant weight loss or gain, or decrease or increase in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to concentrate or indecisiveness
- Recurrent thoughts of death, suicidal ideation or plan for committing suicide

DSM-5 criteria for diagnosis of major depression or major depressive disorder

Criterion B:

Symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Criterion C:

Episode is not attributable to the physiological effects of a substance or to another medical condition.

Criteria A-C represent a major depressive episode

Note:

- Responses to a significant loss may include Criterion A symptoms and could resemble a depressive episode.
- Such symptoms may be understandable or appropriate to the loss; however, the presence of a major depressive episode in addition to the normal response to significant loss should be considered.
- Exercise of clinical judgment is inevitably required.

DSM-5 criteria for diagnosis of major depression or major depressive disorder

Criterion D:

Major depressive episode not better explained by:

- Schizoaffective disorder
- Schizophrenia
- Schizophreniform disorder
- Delusional disorder
- Other specified and unspecified schizophrenia spectrum disorders
- Other psychotic disorders

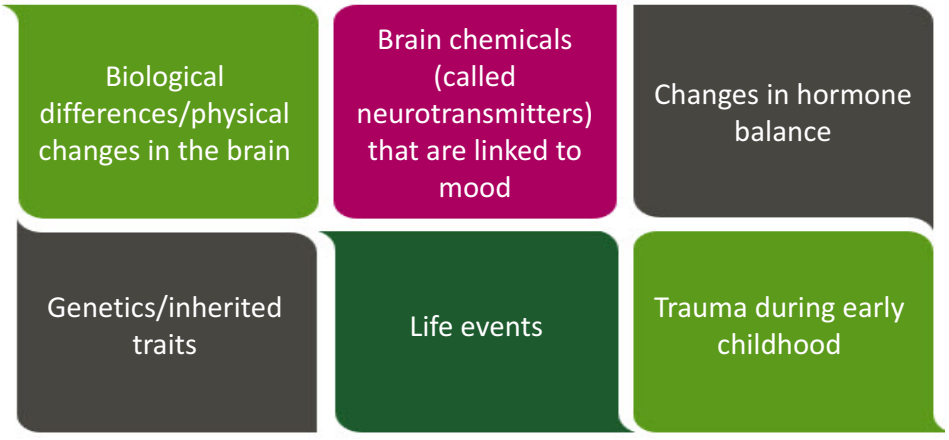
Criterion E:

There never has been a manic or hypomanic episode

(Does not apply if substance-induced or attributable to physiological effects of another medical condition)

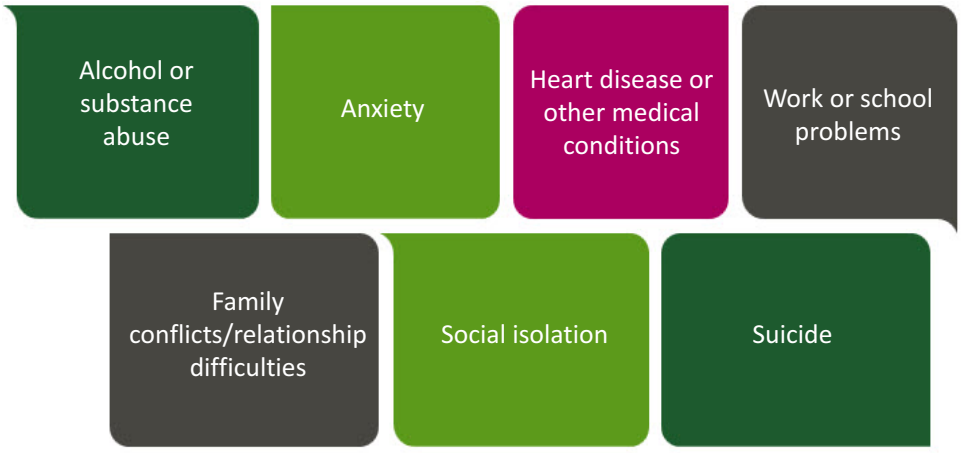
Causes and risk factors

The exact cause of depression is not known. Many factors may play a role. These include, but are not limited to:



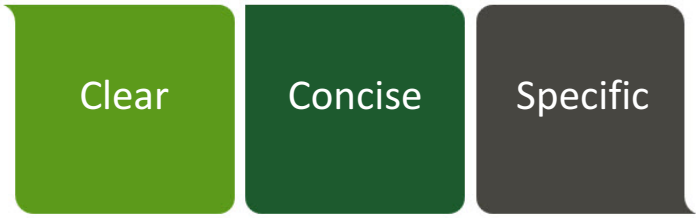
Complications

Major depression left untreated can cause complications such as:



HHS and CMS "Evaluation and Management Services" guide

Documentation that is:



May lead to:

- Accurate diagnosis code assignment
- Appropriate and timely health care provider payment for furnished services

Centers for Medicare & Medicaid Services (CMS) documentation guidelines

CLEAR

- Communicate to all readers the documenter's intent.

CONCISE

- Use key coding terms.
- Avoid use of abbreviations, acronyms or truncated words.

CONSISTENT

- Use caution when documenting in medical record templates or electronic medical records that may inadvertently insert inconsistent information.

COMPLETE

- In the final assessment, describe to the highest level of specificity all medical conditions that were evaluated and treated during the encounter.
- Include all chronic conditions impacting patient care, treatment or management.
- Include a timely provider signature with printed and legible name and credentials.

LEGIBLE

- Medical record documentation must be legible to any objective reader.

Documentation tips for health care providers

S **Subjective** section of office note:

- Document the presence or absence of any current symptom related to major depressive disorder.
- If there are no current symptoms, this section should show the patient was asked about symptoms.

O **Objective** section of office note:

- Document any positive associated physical exam finding.
- If there are no related exam findings, this section should show that the patient was evaluated for related findings.

A **Final** assessment**:**

- Spell out each diagnosis in full with current status.
- Avoid the use of abbreviations, acronyms or truncated words.

P **Treatment** plan**:**

- Clearly link major depressive disorder to medications that are being used to treat the condition; also include this information in the medications list.
- Document referrals to specialists or other providers.
- Indicate when you plan to see the patient again.

Documentation tips for providers

ICD-10-CM classifies "depression" without further description as major depression.

Remember to document all of the following:

- **Episode:** single or recurrent
- **Severity:** mild, moderate or severe
- **Presence or absence of:** psychosis or psychotic features
- **Remission status:** partial or full

Major depressive disorder

Use fourth and fifth characters for further specification

Major depressive disorder, single episode:

- F32.Ø Major depressive disorder, single episode, mild
- F32.1 Major depressive disorder, single episode, moderate
- F32.2 Major depressive disorder, single episode, severe without psychotic features
- F32.3 Major depressive disorder, single episode, severe with psychotic features
- F32.4 Major depressive disorder, single episode, in partial remission
- F32.5 Major depressive disorder, single episode, in full remission

Major depressive disorder, recurrent episode

- F33.Ø Major depressive disorder, recurrent, mild
- F33.1 Major depressive disorder, recurrent, moderate
- F33.2 Major depressive disorder, recurrent, severe without psychotic features
- F33.3 Major depressive disorder, recurrent, severe with psychotic symptoms
- F33.4- Major depressive disorder, recurrent, in remission
- F33.4Ø Major depressive disorder, recurrent, in remission, unspecified
- F33.41 Major depressive disorder, recurrent, in partial remission
- F33.42 Major depressive disorder, recurrent, in full remission
- F33.8 Other recurrent depressive disorders (document the specific "other" recurrent depressive condition, as in "recurrent brief depressive episodes")
- F33.9 Major depressive disorder, recurrent, unspecified

Documentation tips for providers

Avoid using unclear abbreviations, such as MDD.

- MDD can have more than one meaning, such as manic depressive disorder.
- Major depressive disorder should be spelled out clearly.

Code assignment is based solely on the provider's clinical judgment.

- Only diagnosis codes for the exact diagnosis documented in the medical record can be assigned.
- Coders cannot make assumptions based on signs and symptoms.

Coding example
Depression, unspecified code

Final diagnosis	Depression
ICD-10-CM code(s)	F32.9 Major depressive disorder, single episode, unspecified
Rationale	F32.9 is an unspecified code, assigned for both depression and major depression.

Coding example
Major depressive disorder

Final diagnosis	Single episode severe major depression with psychotic behavior
ICD-10-CM code(s)	F32.3 Major depressive disorder, single episode, severe with psychotic features
Rationale	F32.3 is assigned for major depressive disorder, single episode, severe with psychotic behavior.

Coding example
Recurrent depressive episode

Final diagnosis	Recurrent depressive episode
ICD-10-CM code(s)	F33.9 Major depressive disorder, recurrent, unspecified
Rationale	The alphabetic index of ICD-10-CM – episode, depressive, recurrent – codes to F33.9. Verification of the code in the tabular list shows code F33.9 represents major depressive disorder, recurrent, unspecified.

Coding example
Unclear documentation

Past medical history	History of major depressive disorder
Final diagnosis	MDD
ICD-10-CM code(s)	Unable to code. Query physician for clarification.
Rationale	MDD can represent major depressive disorder or manic depressive disorder. Provider clarification is needed before code assignment.

Coding example
Reactive psychotic depression

Final diagnosis	Reactive psychotic depression
ICD-10-CM code(s)	F32.3 Major depressive disorder, single episode, severe with psychotic features
Rationale	The alphabetic index of ICD-10-CM – depression, reactive, psychotic – codes to F32.3. Verification of the code in the tabular list shows code F32.3 represents major depressive disorder, single episode, severe with psychotic features.

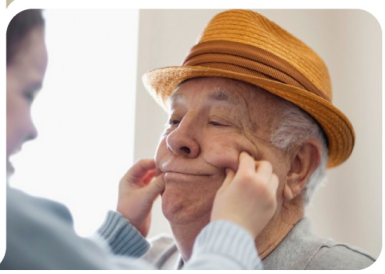
Thank you

References

- Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – Text Revision (DSM-5)
- Mayo Clinic
- ICD-10-CM Official Guidelines for Coding and Reporting
- 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide

Annual Wellness Visits (AWVs)

Documentation and coding basics



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Humana 2962ALL0517-A

Agenda

1. Purpose of an Annual Wellness Visit (AWV)
2. Coding an AWV
3. Documenting an AWV
4. Takeaways

Purpose of an AWV

What is an AWV?

The AWV is a face-to-face **visit** to:

- **Review all chronic conditions**
  - Update a patient's problem list
- **Plan for needed health services for the upcoming year**
  - Review a patient's quality measures
- **Counsel the patient**
  - Ensure the patient is taking advantage of all free services and screenings available

Preventive and wellness care

- In 2011, less than half of adults age 65 years old or older were up to date with core preventive services despite regular checkups.
- Older adults who obtain clinical preventive services and practice healthy behaviors are more likely to remain healthy and functionally independent.

Components of the Annual Wellness Visit

A Annual health status review

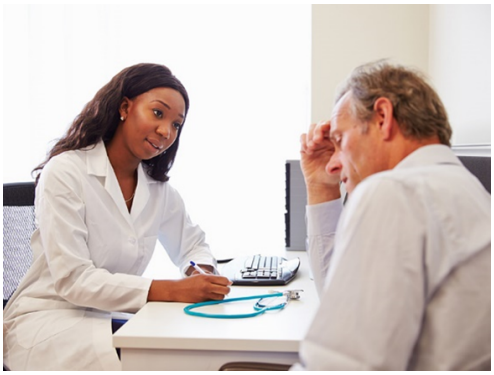
W Wellness planning

V Counseling visit

Annual health status review

Administer health risk assessment (HRA)

- Collect self-reported information from the patient, including self-assessment of health status.
- Identify psychosocial and behavioral risk factors.



Annual health status review

Acquire patient information and update medical history

- Confirm whether documented medical conditions are active or resolved.
- Document the date of any major medical events, accidents or surgical interventions.
- List all physicians and suppliers participating in the care of each condition.
- Review functional status, safety and potential risk factors for depression.

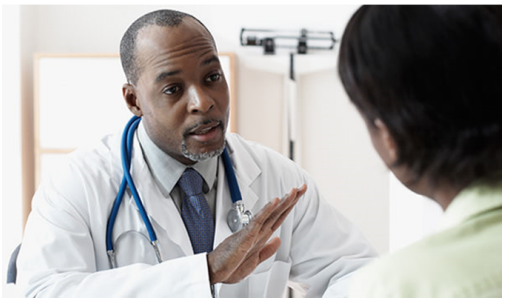
Assess patient

- Assess cognitive status by direct observation.
- Acquire height, weight, body mass index (BMI) and blood pressure measurements.

Wellness planning

Review patient quality measures

- Spend some time focusing on quality measures during the visit.
- Follow up later in the year with an annual preventive physical exam.
- Attach quality measures to either the AWV or the annual preventive exam.



Counsel patient

1. Ensure the patient is taking advantage of all free services and screenings available.

2. Following up later in the year with an annual preventive physical exam to confirm patient follow-through with referrals and screening recommendations.

Coding an AWV

Humana

Current Procedural Terminology (CPT®) coding for an Annual Wellness Visit

- G0438 and G0439 are the correct Healthcare Common Procedure Coding System (HCPCS) codes for an Annual Wellness Visit.
- This service could be submitted with the appropriate initial or periodic comprehensive preventive medicine code – ***but only if all components of these services are performed.***
  - Many elements of the Annual Wellness Visit overlap with an annual physical exam.
  - Completing the AWV on a separate date of service maximizes a patient's opportunity for preventive care.

Humana

CPT coding for an Annual Wellness Visit

Annual Wellness Visits with problem-oriented exams

- **If a patient presents with a problem at the AWV that requires a physician exam/assessment**, a problem-oriented evaluation and management (E/M) service will be covered at the same visit (99201 – 99205; 99211 – 99215).
  - The problem-oriented portion of the visit must be significant, separately identifiable and medically necessary to treat the patient's illness or injury or to improve the functioning of a malformed body member.
  - Ensure the documentation is complete and both types of visits are fully documented.
  - Use modifier -25 on the problem-oriented E/M service code.

Diagnosis coding for an Annual Wellness Visit

- Any appropriate diagnosis code may be used with the Annual Wellness Visit.
- Diagnose all conditions reviewed or updated during the visit:
  - If a face-to-face encounter has occurred
  - If an assessment includes the status of each active condition as stable, unstable, improved, worsening, active or resolved
- Because the AWV is not an examination, do not use:
  - `Z00.00` – Encounter for general adult medical examination without abnormal findings
  - `Z00.01` – Encounter for general adult medical examination with abnormal findings

Coding Annual Wellness Visits

- AWVs include a comprehensive review of a patient's medical status.
- A certified coder can review the selected diagnosis codes for accuracy and specificity prior to the visit being submitted for payment.

Diagnosis coding for additional services ordered

- Ordering additional preventive services in conjunction with the Annual Wellness Visit is allowed.
- Refer to the CMS publication "Medicare Preventive Services" for detailed information on requirements related to covered preventive services and screenings:
  - CPT/HCPCS codes
  - ICD-10 codes
  - Frequency
  - Eligibility requirements

Documenting an AWV

Humana

Documenting an Annual Wellness Visit

Documentation requirements are specific

- Provide all components of the AWV prior to submitting a claim for the AWV.
- Acquire patient's history, including a health risk assessment.
- Perform required assessments.
- Counsel the patient.

Humana

Review chronic conditions

Update the patient's final diagnostic statement

- Assess each condition in the problem list and list all current coexisting conditions in the final assessment, final impression or final diagnosis list.
- Verify that the diagnoses in the final diagnosis list accurately and specifically reflect the patient's current condition.

Help from Humana

Humana Medicare risk adjustment (MRA) educators are available to meet with practices and help them understand documentation requirements of Annual Wellness Visits outlined by Medicare.

Takeaways

- The AWV is a planning visit.
- The AWV is:
  - An annual health status review
  - A wellness-planning visit (quality review)
  - A counseling visit
- MRA learning facilitators are available to help.

Coding Improvement Plan

<Insert managed service organization (MSO)/provider name — site/center number>

<Insert current month, current year>

ELEMENT	IMPROVEMENT ACTIVITIES	RESPONSIBILITY	NOTES
Medical record elements:			
Legibility	❑ Clear, concise, consistent, complete and legible	Physician	
Provider signature and credentials	❑ Rendering provider name(s) and credentials clearly identified on each progress note ❑ Signature and date by rendering provider within 30 days of date of encounter		
Final diagnosis/ impression/assessment	❑ All conditions or diagnoses evaluated and managed during each patient visit ❑ All coexisting conditions or diagnoses that impacted patient care, treatment or management during each patient visit ❑ Current status of each condition (improved, stable, worsening, in remission, followed by specialist, etc.) ❑ Manifestations or complications clearly linked to the underlying diagnosis in a cause-and-effect relationship ("associated with," "complicated by," "secondary to," "due to," etc.) ❑ "Status" conditions (ostomy status, dialysis status, amputation status, major organ transplant status, etc.)		
Treatment plan	❑ Current and specific plan of treatment clearly documented for each diagnosis		
Best practices	See "**Best Documentation Practices for Diagnosis Coding**" for additional guidance on: ▪ Legibility ▪ Patient demographics ▪ Page numbering ▪ Provider signature and credentials ▪ Abbreviations and acronyms ▪ Timelines and dates ▪ Historical versus current ▪ Consistency ▪ Final diagnostic statement ▪ Specificity ▪ Confirmed versus uncertain ▪ Status conditions ▪ Supporting documentation ▪ Treatment plan		

Coding Improvement Plan

<Insert managed service organization (MSO)/provider name — site/center number>

<Insert current month, current year>

ELEMENT	IMPROVEMENT ACTIVITIES	RESPONSIBILITY	NOTES
Coding:			
Diagnosis code assignment	❑ Diagnosis codes from a complete, signed and dated progress note for each individual visit. Code assignment based on: ▪ A diagnosis coding manual that corresponds to the encounter date of service ▪ Industry-standard coding guidelines. Examples: ○ ICD-9-CM or ICD-10-CM Official Guidelines for Coding and Reporting (Located in front of coding manual or most up-to-date version at www.cdc.gov.) ○ American Hospital Association (AHA) Coding Clinic Guidelines	Coder	
Coding specificity	❑ ICD-9-CM: Three- to five-digit numeric codes are assigned with appropriate fourth and fifth digits ❑ ICD-10-CM: Three- to seven-character alphanumeric codes are assigned with appropriate fourth, fifth, sixth and seventh characters		
Condition-specific improvement opportunities:			
Humana coding guidelines	See separate condition-specific coding guidelines for additional detail	Physician and coder	
Angina	❑ All applicable descriptors (acute, chronic, nocturnal, stable, unstable, etc.) ❑ Current status (controlled by medication, stable, worsening, improved, etc.) ❑ Clearly linked to any condition-specific medications, procedures and/or recommended lifestyle changes		
Aortic aneurysm	❑ Current signs or symptoms (thrill, bruit, increased growth, etc.) ❑ Specific location along the aorta (abdominal, thoracic, thoracoabdominal, etc.) ❑ Current status (stable, enlarging, specific measurements, etc.) ❑ Current treatment plan (date of past or future ultrasound, referral to vascular surgeon, etc.)		

Coding Improvement Plan

<Insert managed service organization (MSO)/provider name — site/center number>

<Insert current month, current year>

ELEMENT	IMPROVEMENT ACTIVITIES	RESPONSIBILITY	NOTES
Atrial fibrillation	❑ All applicable descriptors (chronic, paroxysmal, persistent, permanent, etc.) ❑ Signs and symptoms (irregular rhythm, tachycardia, shortness of breath, fatigue, etc.) ❑ Current status (controlled by antiarrhythmic medication, stable, worsening, improved, etc.) ❑ Historical with risk of recurrence versus current ❑ Specific and concise treatment plan with clear linkage between atrial fibrillation and any medication used in the management of atrial fibrillation: ▪ Antiarrhythmic or rate control medications used to treat the atrial fibrillation itself ▪ Long-term preventive anticoagulant medications (to prevent complications caused by blood clots) ○ Specify purpose of long-term anticoagulant therapy, i.e., stroke prevention in patient with • current atrial fibrillation; versus • history of atrial fibrillation at risk for recurrence		
Cerebrovascular accident (CVA)	❑ Clear differentiation between acute CVA in progress versus past CVA (coded differently) ❑ CVA described to highest degree of specificity (e.g., ischemic, embolic, thrombotic, hemorrhagic; specific location, including artery or region of brain affected, laterality; etc.) ❑ Neurologic deficits caused by acute or past CVA clearly linked to CVA (“with,” “due to,” “secondary to,” “associated with,” “related to,” etc.) and described to the highest level of specificity ❑ Documentation consistent and not contradictory (For example, a completely normal neurologic exam would contradict a final diagnosis of “left hemiparesis, due to past CVA.”) ❑ Clear and concise current treatment plan for CVA and any related neurologic deficit		

Coding Improvement Plan

<Insert managed service organization (MSO)/provider name — site/center number>

<Insert current month, current year>

ELEMENT	IMPROVEMENT ACTIVITIES	RESPONSIBILITY	NOTES
Chronic kidney disease (CKD)	❑ Clearly stated cause is specifically linked to CKD in a cause-and-effect relationship ("due to," "caused by," "associated with," etc.) ❑ Specific stage of CKD documented in the final assessment or final impression ❑ Current status (stable, worsening, improving, etc.) ❑ Specific and concise treatment plan ❑ Notation of dialysis status with the specific dialysis regimen and/or the presence of an arteriovenous (AV) fistula for the purpose of dialysis		
Deep venous thrombosis (DVT)	❑ All applicable descriptors (acute, subacute, chronic, "history of," etc.) ❑ Location (laterality and specific vein involved) ❑ Current signs or symptoms (pain, swelling, redness, warmth, diagnostic testing results, etc.) ❑ Simple DVT versus DVT with thrombophlebitis ❑ Specific and concise treatment plan, including purpose of long-term anticoagulant therapy: ▪ Part of active treatment of a current acute, current subacute or current chronic DVT; versus ▪ Prophylactic treatment of a historical DVT with the goal of preventing a recurrence		
Diabetes mellitus and manifestations	❑ Type of diabetes (due to underlying cause, drug or chemical induced, Type 1, Type 2, "other" type clearly described) ❑ Current status of diabetes control (controlled, uncontrolled, out of control, etc.) ❑ Manifestations linked to diabetes unless specified that they are due to another cause ▪ Best practice: Use the descriptor "diabetic" for every complication. ❑ All associated diabetic complications described to the highest level of specificity with any related sign and symptom ❑ Clear and concise treatment plan ❑ Linkage to current medications ❑ Specific insulin regimen (final assessment clearly and specifically states "long-		

Coding Improvement Plan

<Insert managed service organization (MSO)/provider name — site/center number>

<Insert current month, current year>

ELEMENT	IMPROVEMENT ACTIVITIES	RESPONSIBILITY	NOTES
	term current use" or "temporary use of insulin" as applicable) ❑ Cause of secondary diabetes specifically stated		
Drug dependence	❑ Specifically noted as "use," "abuse" or "dependence" ❑ Specific drug or substance involved ❑ Described to the highest level of specificity with any related signs, symptoms, complications, behavioral disorders, etc.		
Fractures	❑ Specific site (body part, particular bone and location along the bone, laterality, etc.) ❑ Current associated signs and symptoms, including diagnostic imaging results ❑ Episode of care (initial, active treatment versus follow-up aftercare) ❑ Cause (pathologic with clear linkage to disease process versus trauma, including injury details) ❑ Current status (improving, stable, healed, etc.) ❑ Specific and concise treatment plan		
Major depression	❑ All applicable descriptors (mild, moderate, severe, with or without psychotic features, etc.) ❑ Episode of care clearly documented (single or recurrent) ❑ Associated signs and symptoms ❑ Specific diagnosis with descriptors spelled out in full in the final impression (no abbreviations) ❑ Current status (stable, in partial or full remission, controlled, etc.) ❑ Specific and concise treatment plan		
Morbid obesity/body mass index (BMI)	❑ Height, weight and BMI ❑ Current, associated physical exam findings (obese, morbidly obese, overweight, etc.) ❑ Overweight or obesity diagnosis documented to the highest level of specificity (morbid obesity, severe obesity, extreme obesity, overweight, etc.) ❑ Associated diagnosis(es) that caused the overweight or obesity diagnosis		

Coding Improvement Plan

<Insert managed service organization (MSO)/provider name — site/center number>

<Insert current month, current year>

ELEMENT	IMPROVEMENT ACTIVITIES	RESPONSIBILITY	NOTES
	(excess calorie intake, drug induced, diabetes induced, etc.) using terms that show the cause-and-effect relationship ("due to," "secondary to," "related to," etc.) ❑ Coexisting diagnoses impacted by the overweight or obesity diagnosis ❑ Current obesity diagnosis not described as "history of" ❑ Specific treatment plan for the obesity condition (referral to nutritionist, patient education, plan for return follow-up, etc.)		
Neoplasm	❑ Histological type (adenocarcinoma, squamous cell, etc.) or behavior (benign, malignant, uncertain, unspecified) ❑ Exact location, including the site within a body part (such as inner, outer quadrant of right breast) ❑ Primary, secondary or carcinoma in situ (confined to original site/no spread) ❑ All sites or locations clearly identified as primary or secondary ❑ Current neoplasm not described as "history of" ❑ Historical neoplasm not documented as if current ❑ Neoplasm in remission described as "in remission" ❑ Clear and concise treatment plan ▪ Documentation indicates whether treatment directed at primary, secondary or in situ malignancy ▪ Goal of current treatment plan clearly noted (active treatment of current neoplasm versus monitoring of historical cancer to check for recurrence) ▪ Purpose of adjuvant therapy clearly stated (curative, palliative or preventive)		
Pressure ulcer	❑ Site/location and stage ❑ Specific description (size in centimeters; undermining, sinus tracts or tunneling; wound base description; absence or presence of drainage – amount, color, consistency, odor; pain; description of area up to 4 cm from edge of the wound – measure in centimeters and describe characteristics – light pink, deep red,		

Coding Improvement Plan

<Insert managed service organization (MSO)/provider name — site/center number>

<Insert current month, current year>

ELEMENT	IMPROVEMENT ACTIVITIES	RESPONSIBILITY	NOTES
	purple, macerated, calloused; etc.). ❑ Specific and concise treatment plan (devices such as foam pads or mattresses; wound care instructions; prescriptions for ointments, creams or other medications; planned debridement; etc.)		
Rheumatoid arthritis	❑ Validate patient-reported diagnosis by review of prior medical records, past and current diagnostic test results and specialist reports with notation of findings in the patient record ❑ Signs and symptoms (joint pain and/or deformity, warmth, redness, swelling; rheumatoid nodules) ❑ Associated conditions or manifestations of rheumatoid arthritis clearly linked ("with," "due to," "secondary to," "associated with," "related to," etc.) ❑ Terms such as "apparently," "likely," "consistent with" or "probable" are not to be used when rheumatoid arthritis is a confirmed diagnosis ❑ Spelled out in full in the final diagnosis, as there are other meanings for the abbreviation "RA" (e.g., refractory anemia) ❑ Drug therapy (e.g., disease-modifying antirheumatic drug [DMARD] therapy, immunosuppressants) with clear linkage of the medication to the rheumatoid arthritis diagnosis		
Seizure disorder	❑ Type (simple, complex, partial, generalized, absence, myoclonic, atonic, tonic-clonic, grand mal, etc.) ❑ "Seizure" specified as seizure disorder, versus single seizure, versus recurrent seizures ❑ Current status (controlled, stable, improved, worsening, historical with no recurrence, etc.) ❑ Specific and concise treatment plan ❑ Clearly linked to any medications prescribed to treat the condition		

Coding Improvement Plan

<Insert managed service organization (MSO)/provider name — site/center number>

<Insert current month, current year>

ELEMENT	IMPROVEMENT ACTIVITIES	RESPONSIBILITY	NOTES
Sick sinus syndrome	❑ Current associated signs and symptoms ❑ Current status (stable, worsening, controlled by pacemaker, etc.) ❑ Pacemaker issues or problems versus normally functioning pacemaker ❑ Specific and concise treatment plan ▪ Condition clearly linked to medications prescribed to treat the condition (including documentation that antiarrhythmic medication is being used to control fast heart rate, when applicable) ▪ Planned diagnostic testing		
Compliance program:			
Conducting internal monitoring and auditing	Program recommendations to include: ❑ Conduct reviews of coding and chart documentation ❑ Implement compliance and practice standards ❑ Develop and communicate medical record documentation and coding standards in accordance with Centers for Medicare & Medicaid Services (CMS), Humana and ICD-9 or ICD-10 guidelines ❑ Use certified coders	MSO	
Follow-up review post-education	❑ Conduct training and education ❑ <Insert number>-month re-review ❑ Develop performance standards and follow up for results less than the established acceptable standard of 85 percent or greater	Humana provider data validation	

Provider office representative/physician:		**Title:**		**Date:**	
MSO representative:		**Title:**		**Date:**	
Humana representative:		**Title:**		**Date:**	

Best Documentation Practices for Diagnosis Coding

The "Evaluation and Management Services Guide" issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:
"Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings and observations about the patient's health history. Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time."

Medical record documentation of patient diagnoses that is clear, concise and described to the highest level of specificity leads to:

- Quality patient care with better outcomes
- Accurate diagnosis code assignment
- Appropriate and timely health care provider payment for furnished services

Key points

Legibility
The entire medical record must be legible. Remember this basic rule: If it is not documented, it was not done. Likewise, if it is not legible, it cannot be read. If it cannot be read, it cannot be proven that the diagnoses are supported and appropriate medical services were performed. An illegible record is of no use in assigning diagnosis codes or determining the medical services performed.

Patient demographics
Each page of the medical record should include, at a minimum, the date of service and the patient's name and date of birth. Also include the patient identification number, if applicable.

Page numbering
Each page for each date of service should be numbered.

Best practice

- *Page 1 of 3*
- *Page 2 of 3*
- *Page 3 of 3*

If numbered in this way, it will be clear to an objective reviewer whether the record for a particular date is complete.

Health care provider signature and credentials

- Only authorized personnel may document in the medical record, and each person must be clearly identified with full name and credentials.
- All entries must be signed and dated in a timely manner by the health care provider who performed the service. Signatures should be identified by a printed, legible name and credentials.
- Signature stamps are not accepted by CMS.
- Electronic signatures must be authenticated by the health care provider. For a signature to be valid, the following criteria must be met:
    - Services provided or ordered must be authenticated by the ordering practitioner.
    - Signatures are to be handwritten or electronic (stamped signatures are not acceptable).
    - Signatures should be legible.

  Reference: CMS Medicare Program Integrity Manual (Publication [Pub.] 100-08), Chapter 3, Section 3.3.2.4

Abbreviations and acronyms

- Limit the use of abbreviations and acronyms, or avoid them altogether.
- Use only industry-standard abbreviations and acronyms. Keep a current list on file from a respected source.
- Realize some standard abbreviations and acronyms have multiple meanings. The meaning of the abbreviation or acronym often can be determined based on context, but this is not always true.

Best practice

- *The initial notation of a diagnosis should be spelled out in full with the abbreviation in parentheses, such as "myocardial infarction (MI)" or "rheumatoid arthritis (RA)."*
- *Subsequent mention of the condition can be made using the abbreviation.*
- *The diagnosis should again be spelled out in full in the final impression or plan.*

Timelines and dates

Specific dates and timelines provide important information and can affect diagnosis code assignment (see second example below regarding myocardial infarction).

- Post-hospitalization or post-operative follow-up office visits:

  Vague: "Patient was recently discharged from the hospital."

  Vague: "Patient is here for hospital follow-up."

  Specific: "Patient was discharged from the hospital on 1/15/20xx after admission for ____."

  Specific: "Patient was discharged from the hospital two weeks ago after admission for _____."

  Vague: "Post-op visit for recent splenectomy."

  Specific: "Patient is here for first post-op visit for splenectomy performed on 3/25/20xx."

- "Recent" myocardial infarction (MI) is a vague description that does not specify whether the patient experienced an acute myocardial infarction within the last four weeks (coded as acute MI) versus a myocardial infarction that is older than four weeks with no current symptoms (coded as historical MI).

  Vague: "Follow-up office visit for recent myocardial infarction."

  Specific: "Patient was discharged from ABC Medical Center on 2/25/20xx after inpatient admission for acute myocardial infarction."

  Specific: "Patient was discharged from ABC Medical Center one week ago after inpatient admission for acute myocardial infarction."

Historical versus current

- Do not use the descriptor "history of" to describe a current or chronic condition that is still present, active or ongoing.
- Do not use the descriptor "history of" to describe a current condition that is in remission. Describe the condition as "in remission."
- Do not document a condition as current if it is historical only. For example: A patient with a history of prostate cancer that has been eradicated in the past presents to the office for an evaluation, examination and prostate-specific antigen (PSA) lab test to monitor for recurrence. The assessment section should not state "prostate cancer," but rather "history of prostate cancer." The related plan should state, "Will continue to monitor PSA every six months to check for prostate cancer recurrence."

Consistency

Use caution when using record templates or electronic medical records that are conflicting or contradictory. Examples of conflicting or contradictory documentation include:

- The final assessment states right hemiparesis due to prior cerebrovascular accident, but the neurologic review of systems (ROS) and neurologic examination are noted as completely normal.
- The chief complaint states the patient presents for evaluation of chest pain, and the final assessment states acute angina. However, the review of systems states, "Patient denies any episodes of chest pain."
- The office notes refer to the patient as both "he" and "she," creating a consistency issue.

Specificity

Describe each condition to the highest level of specificity, such as:

- with or without exacerbation
- with or without complications
- acute versus chronic
- severity – mild, moderate, severe
- stages or types
- controlled or uncontrolled
- underlying cause
- location or site, including laterality, specific site within a body part (upper outer quadrant, lower inner quadrant, etc.), distal, proximal, etc.

Examples:

Chronic kidney disease (CKD) – Specify stage I-V or end-stage renal disease (ESRD).

- Even if lab values and/or the glomerular filtration rate (GFR) are documented, the record must clearly specify the stage of CKD. Medical coders are not allowed to assign a stage of CKD based on the documented GFR.

Diabetes mellitus (DM) – specify:

- Type (Type 1, Type 2, secondary to − specify causal condition)
- Status of diabetes control (controlled or out of control)
- With or without complications or manifestations (fully describe each complication or manifestation)

If there are complications or manifestations of diabetes mellitus, you must clearly and directly link diabetes to those complications or manifestations using terms such as "with," "due to," "secondary to," "associated with" and "related to." Avoid the use of punctuation marks (e.g., slashes and commas) to separate diabetes and its manifestations, as they may not clearly indicate a causal relationship.

Best practice

- *Document each complication of diabetes with the descriptor "diabetic," as in "diabetes mellitus Type 2, controlled, with diabetic neuropathy."*

Confirmed versus uncertain
Avoid use of terms that imply uncertainty (such as “probable,” “apparently,” “likely” or “consistent with”) to describe diagnoses or conditions that are confirmed. Always document the signs and symptoms in the absence of a confirmed diagnosis.

Status conditions
Document status conditions when applicable (e.g., ostomy status, dialysis status, amputation status, major organ transplant, etc.).

Final diagnostic statement
This is the section of the record where you state your final assessment or final impression of the patient’s current diagnoses based on all other information you gathered as you evaluated the patient on an individual date of service. In your final diagnostic statement, you should include:

- All conditions or diagnoses that impacted the patient’s care on this date
- All conditions or diagnoses you evaluated and managed on this date
- All comorbid or coexisting conditions that impacted patient care, treatment or management on this date
- Current status (improved, stable, worsening, etc.) of each diagnosis or condition

Supporting documentation
Keep in mind that the previous sections of the record should provide supporting documentation for each condition or diagnosis listed. For example:

- Related signs and symptoms and physical exam findings should be listed.
- Medication lists should document the drug name, dosage with times and/or frequency and the condition(s) for which the drug has been prescribed.
- Results of diagnostic testing should be documented.

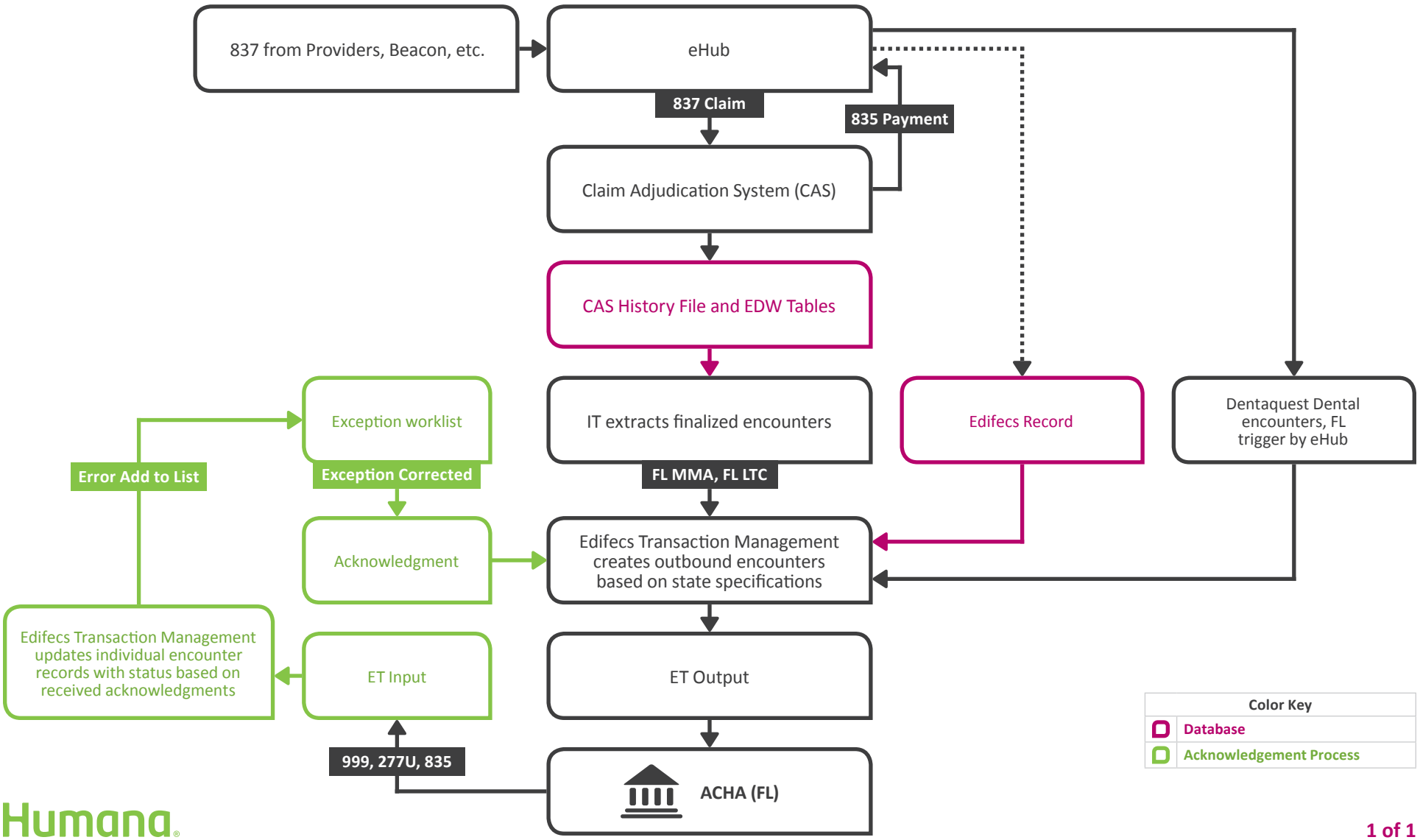
Treatment plan
Your current plan of treatment for each diagnosis should be clearly documented and specific. Examples should include dietary recommendations, medication changes, scheduling of diagnostic testing, specific patient education or counseling provided, continued monitoring and other factors that affect diagnosis. If referrals are made or consultations requested, the office note should indicate to whom or where the referral or consultation is made or from whom consultation advice is requested. Document when you plan to see the patient again, even if on an as-needed basis only.

A final note

Industry-standard diagnosis coding guidelines require medical coders to apply a strict literal interpretation to your medical record documentation. Coders are not allowed to “connect the dots,” make assumptions or presume to know the health care provider’s intent. Coders cannot apply a clinical interpretation to information within the record, such as diagnostic test results or physical exam findings. Accurate diagnosis code assignment is dependent on the health care provider clearly describing each medical diagnosis to the highest level of specificity.

Attachment 29-5: Encounter Submission Process Flow

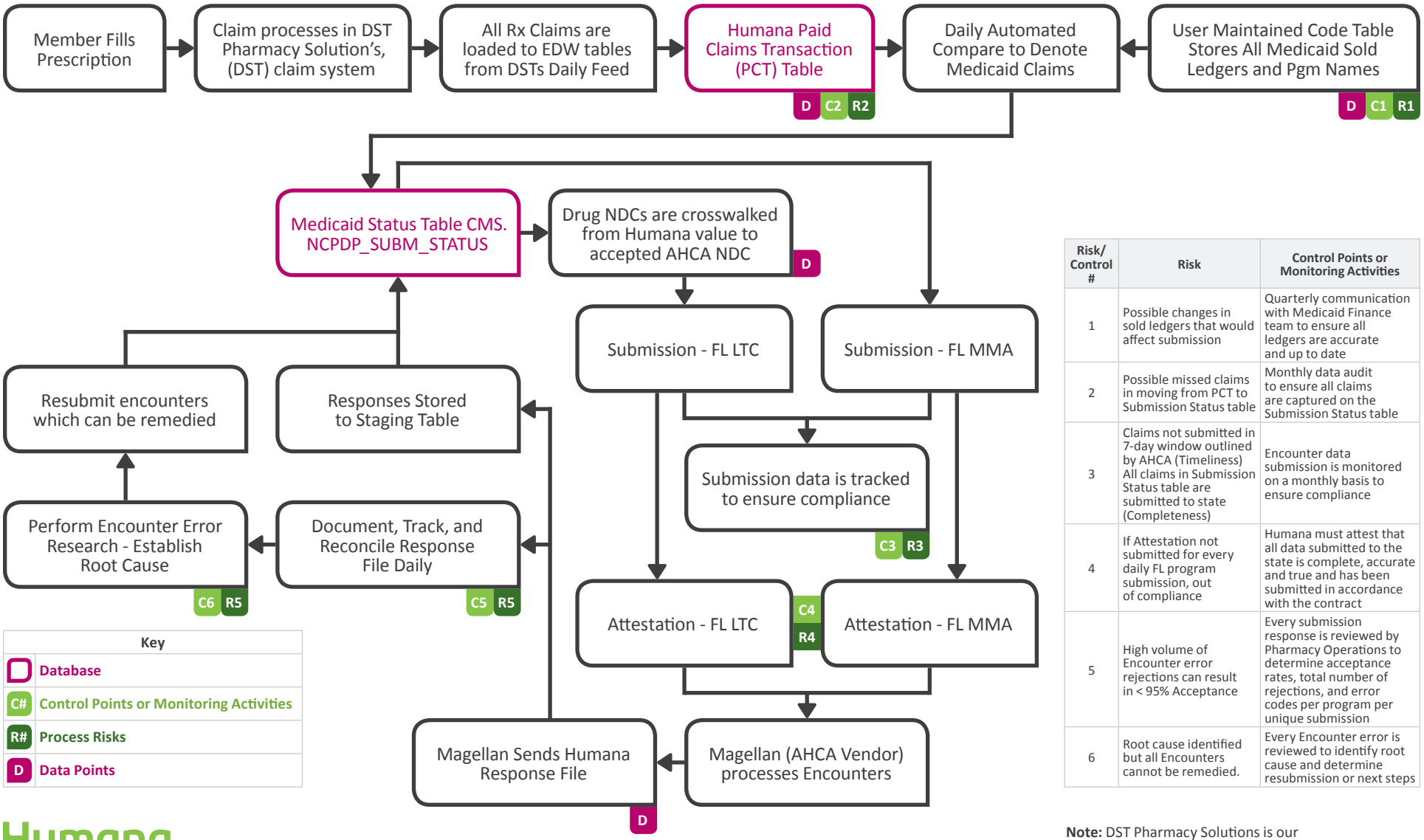
Non-Pharmacy Encounter Submission Process



Humana.

Attachment 29-6: Encounter Submission Process Flow

Pharmacy Encounter Submission Process – Compliance



Risk/ Control #	Risk	Control Points or Monitoring Activities
1	Possible changes in sold ledgers that would affect submission	Quarterly communication with Medicaid Finance team to ensure all ledgers are accurate and up to date
2	Possible missed claims in moving from PCT to Submission Status table	Monthly data audit to ensure all claims are captured on the Submission Status table
3	Claims not submitted in 7-day window outlined by AHCA (Timeliness) All claims in Submission Status table are submitted to state (Completeness)	Encounter data submission is monitored on a monthly basis to ensure compliance
4	If Attestation not submitted for every daily FL program submission, out of compliance	Humana must attest that all data submitted to the state is complete, accurate and true and has been submitted in accordance with the contract
5	High volume of Encounter error rejections can result in < 95% Acceptance	Every submission response is reviewed by Pharmacy Operations to determine acceptance rates, total number of rejections, and error codes per program per unique submission
6	Root cause identified but all Encounters cannot be remedied.	Every Encounter error is reviewed to identify root cause and determine resubmission or next steps

Note: DST Pharmacy Solutions is our Pharmacy Claims Processing Partner

Attachment 29-7: Encounters Data Submission Compliance Ratings

29-7a: AHCA Encounter Submission Compliance Ratings

Week/Year	MMA Compliance Rating	LTC Compliance Rating	AHCA Corrective Action
11/23/2015 -11/29/2015	91.03%	99.84%	No
11/30/2015 - 12/06/2015	75.38%	98.90%	No
12/7/2015 - 12/13/2015	91.15%	98.98%	No
12/14/2015 - 12/20/2015	94.15%	99.67%	No
12/21/2015-12/27/2015	24.33%	83.77%	No
12/28/2015-1/3/2016	39.40%	71.23%	No
1/4/2016-1/10/2016	42.46%	66.50%	No
1/11/2016-1/17/2016	39.71%	79.23%	No
1/18/2016-1/24/2016	39.85%	75.25%	No
1/25/2016-1/31/2016	52.23%	90.06%	No
2/1/2016-2/7/2016	81.27%	81.75%	No
2/8/2016-2/14/2016	50.14%	99.11%	No
2/15/2016-2/21/2016	44.30%	80.27%	No
2/22/2016-2/28/2016	59.76%	60.80%	No
2/29/2016-3/6/2016	50.73%	78.34%	No
3/7/2016-3/13/2016	87..81%	99.23%	No
3/14/206-3/20/2016	82.96%	78.78%	No
3/21/2016-3/27/2016	83.91%	84.58%	No
3/28/2016-4/3/2016	69.01%	85.89%	No
4/4/2016-4/10/2016	67.00%	97.62%	No
4/11/2016-4/17/2016	91.44%	86.22%	No
4/18/2016-4/24/2016	81.32%	90.32%	No
4/25/2016-5/1/2016	65.99%	81.10%	No
5/2/2016-5/8/2016	66.98%	96.04%	No
5/9/2016-5/15/2016	86.66%	82.27%	No
5/16/2016-5/22/2016	81.27%	89.69%	No
5/23/2016 - 5/29/2016	62.81%	80.63%	No
5/30/2016 - 6/05/2016	63.75%	97.87%	No
6/6/2016 - 6/12/2016	82.77%	85.99%	No
6/13/2016 - 6/19/2016	51.20%	72.57%	No
6/20/2016 - 6/26/2016	75.47%	80.85%	No
6/27/2016 - 7/3/2016	61.91%	98.27%	No
7/4/2016-7/10/2016	66.30%	89.00%	No
7/11/2016-7/17/2016	75.98%	84.82%	No
7/18/2016-7/24/2016	92.22%	97.32%	No
8/1/2016-8/7/2016	62.03%	98.13%	No
8/8/2016-8/14/2016	91.66%	85.30%	No
8/15/2016-8/21/2016	51.11%	74.17%	No
8/22/2016-8/28/2016	83.31%	96.25%	No
8/29/2016 - 9/04/2016	96.60%	98.75%	No
9/5/2016-9/11/2016	96.60%	98.75%	No
9/12/2016-9/18/2016	89.20%	79.54%	No
9/19/2016-9/25/2016	96.31%	78.72%	No
9/26/2016-10/2/2016	97.93%	99.73%	No
10/3/2016-10/9/2016	97.30%	99.27%	No
10/10/2016-10/16/2016	96.69%	99.04%	No
10/17/2016-10/23/2016	97.16%	99.61%	No
10/24/2016-10/30/2016	97.72%	99.44%	No

Attachment 29-7: Encounters Data Submission Compliance Ratings

Week/Year	MMA Compliance Rating	LTC Compliance Rating	AHCA Corrective Action
10/31/2016-11/6/2016	75.42%	95.95%	No
11/7/2016-11/13/2016	73.70%	90.98%	No
11/14/2016-11/20/2016	98.33%	99.48%	No
11/21/2016-11/27/2016	98.29%	99.68%	No
11/28/2016-12/4/2016	97.17%	99.36%	No
12/5/2016-12/11/2016	92.42%	98.38%	No
12/12/2016-12/18/2016	97.31%	98.47%	No
12/26/2016-1/1/2017	97.26%	98.26%	No
1/2/2017-1/8/2017	95.54%	93.21%	No
1/9/2017-1/15/2017	96.92%	84.78%	No
1/16/2017-1/22/2017	96.16%	97.81%	No
1/23/2017-1/29/2017	98.96%	99.59%	No
1/30/2017-2/5/2017	94.94%	99.20%	No
2/06/2017 - 2/12/2017	97.56%	99.44%	No
2/13/2017-02/19/2017	98.41%	98.38%	No
2/20/2017-2/26/2017	99.61%	97.57%	No
2/27/2017-3/5/2017	98.73%	99.58%	No
3/6/2017-3/12/2017	81.74%	95.13%	No
3/13/2017-3/19/2017	75.23%	93.71%	No
3/20/2017-3/26/2017	79.31%	95.50%	No
3/27/2017-4/2/2017	97.53%	98.06%	No
4/3/2017-4/9/2017	99.22%	98.14%	No
4/10/2017-4/16/2017	97.28%	99.04%	No
4/17/2017-4/23/2017	98.76%	99.35%	No
4/24/2017-4/30/2017	98.58%	96.82%	No
4/30/2017-5/6/2017	99.11%	98.96%	No
5/8/2017-5/14/2017	99.22%	98.14%	No
5/15/2017-5/21/2017	99.19%	97.93%	No
5/22/2017-5/28/2017	99.00%	99.41%	No
5/29/2017-6/4/2017	98.74%	97.35%	No
6/5/2017-6/11/2017	98.78%	98.02%	No
6/12/2017-6/18/2017	97.94%	97.26%	No
6/19/2017-6/25/2017	98.51%	97.24%	No
6/26/2017-7/2/2017	99.14%	96.74%	No
7/3/2017-7/9/2017	99.41%	98.54%	No
7/10/2017-7/16/2017	72.19%	70.98%	No
7/17/2016-7/24/2017	99.22%	99.10%	No
7/25/2017-7/30/2017	98.94%	98.85%	No
7/31/2017-8/6/2017	91.27%	97.58%	No
8/7/2017-8/13/2017	98.63%	99.53%	No
8/14/2017-8/20/2017	98.82%	98.78%	No
8/21/2017-8/27/2017	98.81%	99.40%	No
8/28/2017-9/3/2017	98.43%	99.77%	No
9/4/2017-9/10/2017	99.24%	99.66%	No
9/11/2017-9/17/2017	98.44%	99.55%	No
9/18/2017-9/24/2017	95.25%	97.24%	No
9/25/2017-10/1/2017	99.15%	99.78%	No
10/2/2017-10/8/2017	99.38%	99.58%	No

Attachment 29-7: Encounters Data Submission Compliance Ratings

29-7b: Encounter Submission Internal Compliance Ratings

1. Internal Compliance Rating Metrics and Definitions

Reference ID	Title	Details	Numerator Prompt	Denominator Prompt
CLM-09-FL	Encounter Accuracy – EDI Edits	Ninety-five percent of the records in an encounter batch submission must pass X12 EDI edits and MMIS edits	Number of encounter submissions accepted without EDI compliance edits for the reporting period	Total number of encounter submissions for the reporting period
CLM-10-FL	Encounter Accuracy – NCPDP Edits	Ninety-five percent of the records in an encounter batch submission must pass NCPDP edits and the pharmacy benefits system edits	Number of encounter submissions accepted without NCPDP compliance edits for the reporting period	Total number of encounter submissions for the reporting period
CLM-12-FL	Pharmacy Encounter Submissions	Pharmacy encounter data shall be submitted no later than seven days following the date on which the Managed Care Plan adjudicated the claims.	Number of pharmacy encounters sent by the 15th day of the month after the date-of-service month for the reporting period	Total number of pharmacy claims made on or after 12/01/2011 for the reporting period
CLM-13-FL	Non-Pharmacy Encounter Submissions	Non-pharmacy encounter data shall be submitted no later than seven days following the date on which the Managed Care Plan adjudicated the claims.	Number of non-pharmacy encounters sent within 60 calendar days following the end of the month in which the plan paid for claims for services for the reporting period	Total number of non-pharmacy claims made for the reporting period
CLM-05-LTC	Submission of Encounter Data	All encounter data must be submitted to the agency	Number of encounters submitted to AHCA	Total number of encounters for the reporting period
CLM-06-LTC	Encounter Accuracy – EDI Edits	Ninety-five percent of the records in an encounter batch submission must pass X12 EDI edits and MMIS edits	Number of encounters passing X12 EDI edits and MMIS edits after submission	Total number of X12 encounters submitted for the reporting period
CLM-07-LTC	Encounter Accuracy - NCPDP Edits	Ninety-five percent of the records in an encounter batch submission must pass NCPDP edits and the pharmacy benefits system edits	Number of encounters passing NCPDP and pharmacy benefits system edits after submission	Total number of NCPDP encounters submitted for the reporting period
CLM-17-LTC	Timely Initial Encounter Submissions	Encounter data shall be submitted no later than seven days following the date on which the Managed Care Plan adjudicated the claim	Total amount of encounters submitted within 7 days of adjudicating the claim within the reporting period	Total amount of claims adjudicated during the reporting period
CLM-10-FLLT	Encounter Accuracy – EDI Edits	Ninety-five percent of the records in an encounter batch submission must pass X12 EDI edits and MMIS edits	Number of encounter submissions that pass EDI and MMIS edits for the reporting period	Total number of encounters submitted for the reporting period
CLM-18-FLLT	Encounter Submissions	Encounter data shall be submitted no later than seven days following the date on which the Managed Care Plan adjudicated the claims.	Total number of encounter data submitted within 7 days of adjudicating the claim for the reporting period	Total number of adjudicated claims for the reporting period

Attachment 29-7: Encounters Data Submission Compliance Ratings

	2. Medical Managed Assistance (FP023) Encounter Submission Internal Compliance Ratings							
	Metric: CLM-09-FL		Metric: CLM-10-FL		Metric: CLM-10-FL		Metric: CLM-13-FL	
Month/Year	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action
Jul-14	100%	No	100%	No	100%	No	100%	No
Aug-14	100%	No	100%	No	100%	No	100%	No
Sep-14	100%	No	97%	No	100%	No	98%	No
Oct-14	100%	No	95%	No	100%	No	97%	No
Nov-14	100%	No	97%	No	100%	No	99%	No
Dec-14	99%	No	97%	No	100%	No	100%	No
Jan-15	98%	No	96%	No	100%	No	98%	No
Feb-15	97%	No	96%	No	100%	No	92%	No
Mar-15	96%	No	96%	No	100%	No	96%	No
Apr-15	96%	No	82%	No	100%	No	95%	No
May-15	92%	No	97%	No	100%	No	91%	No
Jun-15	97%	No	97%	No	100%	No	99%	No
Jul-15	98%	No	97%	No	100%	No	98%	No
Aug-15	97%	No	97%	No	100%	No	99%	No
Sep-15	96%	No	96%	No	100%	No	98%	No
Oct-15	99%	No	97%	No	100%	No	98%	No
Nov-15	99%	No	98%	No	100%	No	99%	No
Dec-15	99%	No	98%	No	100%	No	99%	No
Jan-16	99%	No	96%	No	100%	No	99%	No
Feb-16	99%	No	98%	No	100%	No	83%	No
Mar-16	98%	No	98%	No	100%	No	99%	No
Apr-16	98%	No	99%	No	100%	No	98%	No
May-16	99%	No	99%	No	100%	No	99%	No
Jun-16	99%	No	99%	No	100%	No	99%	No

Attachment 29-7: Encounters Data Submission Compliance Ratings

	2. Medical Managed Assistance (FP023) Encounter Submission Internal Compliance Ratings							
	Metric: CLM-09-FL		Metric: CLM-10-FL		Metric: CLM-10-FL		Metric: CLM-13-FL	
Month/Year	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action
Jul-16	71%	No	99%	No	100%	No	100%	No
Aug-16	96%	No	99%	No	100%	No	76%	No
Sep-16	100%	No	100%	No	100%	No	99%	No
Oct-16	100%	No	98%	No	100%	No	100%	No
Nov-16	99%	No	81%	No	100%	No	100%	No
Dec-16	100%	No	90%	No	100%	No	100%	No
Jan-17	100%	No	92%	No	100%	No	100%	No
Feb-17	99%	No	87%	No	100%	No	99%	No
Mar-17	100%	No	86%	No	49%	No	100%	No
Apr-17	100%	No	100%	No	99%	No	100%	No
May-17	100%	No	100%	No	100%	No	100%	No
Jun-17	100%	No	100%	No	100%	No	100%	No
Jul-17	100%	No	100%	No	97%	No	100%	No
Aug-17	100%	No	100%	No	90%	No	100%	No

	3. Long-Term Care (FP023) Encounter Submission Internal Compliance Ratings					
	Metric: CLM-10-FLLT		Metric: CLM-10-FLLT		Metric: CLM-18-FLLT	
Month/Year	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action
Jul-14	95%	No	100%	No	N/A	N/A
Aug-14	96%	No	100%	No	N/A	N/A
Sep-14	93%	No	100%	No	N/A	N/A
Oct-14	96%	No	100%	No	N/A	N/A

Attachment 29-7: Encounters Data Submission Compliance Ratings

	3. Long-Term Care (FP023) Encounter Submission Internal Compliance Ratings					
	Metric: CLM-10-FLLT		**Metric: CLM-10-FLLT**		**Metric: CLM-18-FLLT**	
Month/Year	**Internal Compliance Rating**	**AHCA Corrective Action**	**Internal Compliance Rating**	**AHCA Corrective Action**	**Internal Compliance Rating**	**AHCA Corrective Action**
Nov-14	94%	No	100%	No	98%	No
Dec-14	97%	No	100%	No	97%	No
Jan-15	96%	No	100%	No	95%	No
Feb-15	96%	No	100%	No	97%	No
Mar-15	93%	No	100%	No	100%	No
Apr-15	94%	No	100%	No	100%	No
May-15	97%	No	100%	No	98%	No
Jun-15	98%	No	100%	No	100%	No
Jul-15	98%	No	100%	No	100%	No
Aug-15	95%	No	100%	No	100%	No
Sep-15	97%	No	100%	No	100%	No
Oct-15	83%	No	100%	No	100%	No
Nov-15	66%	No	100%	No	100%	No
Dec-15	61%	No	100%	No	100%	No
Jan-16	79%	No	100%	No	100%	No
Feb-16	99%	No	100%	No	100%	No
Mar-16	93%	No	100%	No	100%	No
Apr-16	29%	No	100%	No	100%	No
May-16	89%	No	100%	No	100%	No
Jun-16	99%	No	100%	No	100%	No
Jul-16	64%	No	100%	No	100%	No
Aug-16	100%	No	100%	No	100%	No
Sep-16	100%	No	100%	No	100%	No
Oct-16	100%	No	100%	No	100%	No

Attachment 29-7: Encounters Data Submission Compliance Ratings

	4. Long-Term Care (FP003) Encounter Submission Internal Compliance Ratings							
	Metric: CLM-05-LTC		Metric: CLM-06-LTC		Metric: CLM-07-LTC		Metric: CLM-17-LTC	
Month/Year	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action
Jul-15	100%	No	96%	No	100%	No	83%	No
Aug-15	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable	Data Unavailable
Sep-15	100%	No	99%	No	Data Unavailable	Data Unavailable	100%	No
Oct-15	99%	No	99%	No	100%	No	100%	No
Nov-15	100%	No	96%	No	99%	No	100%	No
Dec-15	100%	No	99%	No	96%	No	100%	No
Jan-16	99%	No	99%	No	94%	No	99%	No
Feb-16	98%	No	99%	No	99%	No	87%	No
Mar-16	99%	No	83%	No	98%	No	99%	No
Apr-16	100%	No	77%	No	99%	No	100%	No
May-16	100%	No	66%	No	99%	No	100%	No
Jun-16	99%	No	93%	No	100%	No	100%	No
Jul-16	97%	No	95%	No	100%	No	99%	No
Aug-16	99%	No	94%	No	100%	No	93%	No
Sep-16	100%	No	96%	No	100%	No	100%	No
Oct-16	81%	No	96%	No	0%	No	100%	No
Nov-16	99%	No	98%	No	0%	No	100%	No
Dec-16	89%	No	97%	No	0%	No	99%	No
Jan-17	94%	No	97%	No	9%	No	100%	No
Feb-17	100%	No	97%	No	68%	No	100%	No
Mar-17	96%	No	96%	No	85%	No	100%	No
Apr-17	91%	No	96%	No	100%	No	100%	No
May-17	100%	No	96%	No	100%	No	100%	No

Attachment 29-7: Encounters Data Submission Compliance Ratings

	4. Long-Term Care (FP003) Encounter Submission Internal Compliance Ratings							
	Metric: CLM-05-LTC		Metric: CLM-06-LTC		Metric: CLM-07-LTC		Metric: CLM-17-LTC	
Month/Year	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action	Internal Compliance Rating	AHCA Corrective Action
Jun-17	94%	No	96%	No	100%	No	99%	No
Jul-17	100%	No	97%	No	100%	No	100%	No
Aug-17	100%	No	91%	No	100%	No	100%	No

Humana	***Desktop Procedure Ramp Manager***		
Original Issue Date: 07/30/2014	***Procedure Number: FLM-PCDR-001***	***Page 1 of 4***	
Subject: Ramp Manager	***Original Approval Date: 07/30/2014***	***Revision Approval Date: N/a***	
Change Summary:	*Original issue*		

Purpose of Procedure:

Ramp Manager is an application that provides interactive, self-service tools to verify accuracy of encounters transactions against the Florida Medicaid Companion Guides. Ramp Manager is hosted by EDIFECs in an environment customized for Florida Medicaid transaction activities.

Line of Business Procedure Applies to:

- Florida Medicaid

Procedure Definitions:

- Define key terms or acronyms

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Humana	Desktop Procedure Ramp Manager	
Original Issue Date: 07/30/2014	Procedure Number: FLM-PCDR-001	Page 2 of 4
Subject: Ramp Manager	Revision Approval Date: N/A	

Ramp Manager

1. **Download File from Edifecs**

   a. Logon to Edifecs via *TM Dual Prod*

   b. Navigate to the *Transmissions* page

   c. Direction field click on *Outbound*

   d. Enter in Partner- State of Florida LTSS, State of Florida Medicaid or State of Florida Medicaid F03

   e. Select the type of search (last 24 hrs., last 30 days)

   f. Click on *Search*

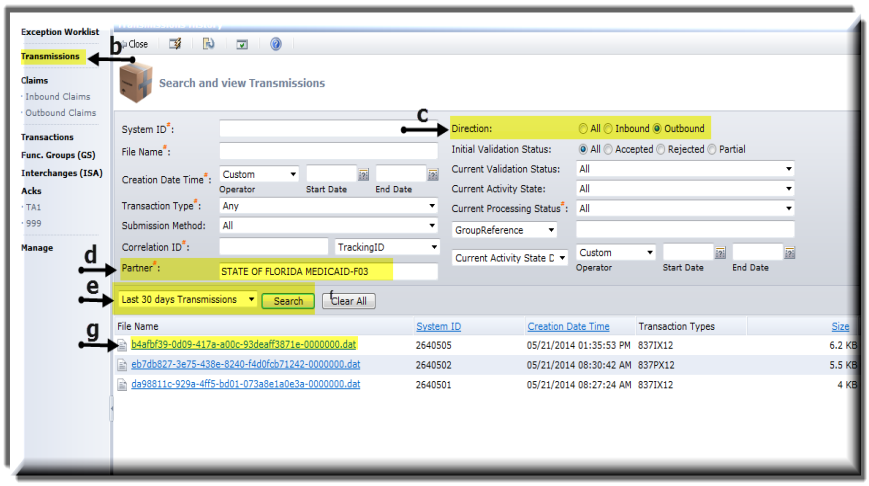
   g. Results are displayed on the bottom of the page, Click the *File Name* to open

   h. Locate the *Transaction Type* on the *General* tab and note if it is 837I, 837P or 837D

   i. Navigate to the *Attachments* tab

   j. Click on *File Name*

   k. Save document to a drive on your computer



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Humana	Desktop Procedure Ramp Manager	
Original Issue Date: 07/30/2014	Procedure Number: FLM-PCDR-001	Page 3 of 4
Subject: Ramp Manager	Revision Approval Date: N/A	

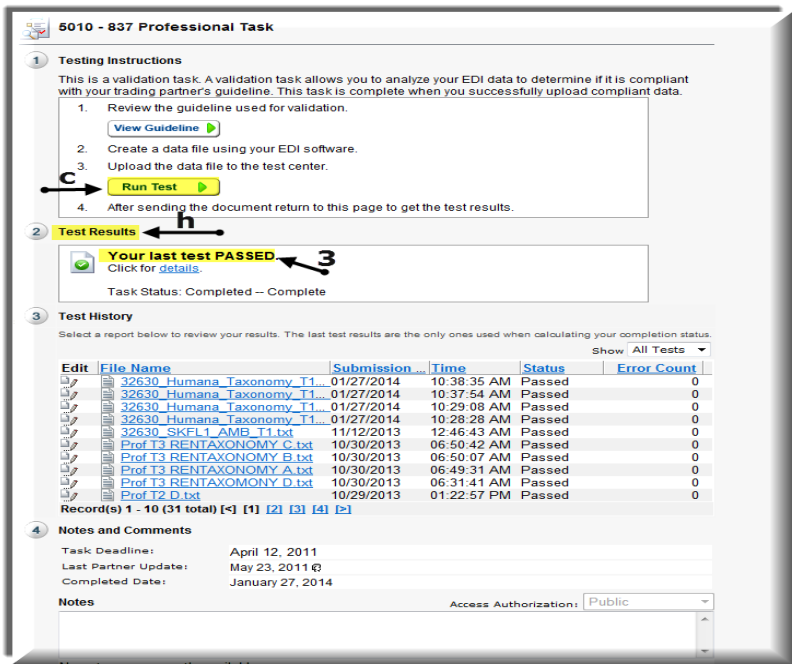
2. **Logon to Florida's Edifecs site**

   https://sites.edifecs.com/index.jsp?flmedicaid

   a. Click on *5010-Testing Program- All Transactions* in the top navigation bar
   b. In the Task field select type of encounters to be tested *5010-837 Dental Task, 5010-837 Institutional Task or 5010-837-Professional Task*
   c. Click on *Run Test*
   d. A "Welcome to Validation Test Wizard" screen will pop up click *Next*
   e. Click on *Browse* and locate the file from step 1.
   f. Click on *Next*
   g. Click *Finish*
   h. In the Test Results field will process the file, once complete it will advise if the file Passed or Failed

3. **Did Test Pass or Fail**

Passed	Failed
Allow Edifecs to submit encounters	Click on *Error Report* to open, review errors and determine if they need to be corrected



References:

FLM-PLCY-001 Encounter Submissions

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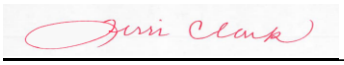
Humana	Desktop Procedure Ramp Manager	
Original Issue Date: 07/30/2014	Procedure Number: FLM-PCDR-001	Page 4 of 4
Subject: Ramp Manager	Revision Approval Date: N/A	

Approvals

Original Version

	7/30/2014
Signature	Date
Signature	Date
Signature	Date
Signature	Date
Signature	Date

Revisions

Signature	Date
Signature	Date
Signature	Date
Signature	Date
Signature	Date

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Attachment 29-9: Encounter Reports

Medicaid Encounter Submission, Florida Status Report

Submitter ID	Week Starting	Submissions									835 Status		Expected Compliance	Actual Compliance	Expected vs. Actual Submission Compliance Report
		Initial	Initial Redo	Redo	Initial 999	999 Resub	Revalidate 835	Other Resub	Total Resub	Total Submissions	ICN70	ICN71			
F03	9/3/2017	242,575	1	33,859	3,151	1,862	0	8	35,729	**281,456**	242,810	33,961	**99.00%**	**99.12%**	Initial Submission Compliance Within 7 Days of Adjudication Date
F03	9/10/2017	172,439	1,081	69,318	1,711	28,335	45	23	97,721	**272,952**	172,050	69,310	**97.93%**	**98.05%**	Total Submissions Passing 999 Compliance Edits
F03	9/17/2017	208,383	556	293	1,996	16,909	0	180	17,382	**228,317**	207,066	15,701	**99.02%**	**98.39%**	Populates how many encounters can be submitted timely by service line
F03	9/24/2017	272,652	869	20,444	957	1,359	0	27	21,830	**296,308**	270,911	20,661	**99.19%**	**98.91%**	
F03	10/1/2017	297,087	35	199	3,503	724	459	47	1,429	**302,054**	0	0	**99.34%**	**99.37%**	
F03	10/8/2017	59,503	125	65,632	1,762	552	4,320	186	70,690	**132,080**	0	0	**96.59%**		
F04	9/3/2017	110,273	0	9	1,174	29	0	0	38	**111,485**	108,602	38	**99.62%**	**99.73%**	
F04	9/10/2017	75,933	89	822	1,224	26	0	0	848	**78,094**	75,394	804	**99.49%**	**99.64%**	
F04	9/17/2017	118,572	18	0	1,696	9	0	68	77	**120,363**	114,785	10	**99.43%**	**99.41%**	
F04	9/24/2017	106,607	46	709	873	10	0	0	719	**108,245**	103,843	673	**99.72%**	**99.79%**	
F04	10/1/2017	109,772	0	64	941	10	0	4	78	**110,791**	0	0	**99.61%**	**99.64%**	
F04	10/8/2017	22,400	401	1,275	26	0	0	12	1,287	**24,114**	0	0	**95.76%**		

Medicaid Encounter Submission, Florida Status Report

Submitter ID	Received Yr.Mth	Encounters Submitted	Lines Submitted	Encounter Initial Submission Compliance	Line Initial Submission Compliance
F03	2017.09	256,390	769,877	99.57%	99.75%
	2017.08	419,285	1,269,048	99.79%	99.77%
	2017.07	440,679	1,334,119	99.89%	99.88%
	2017.06	455,362	1,311,359	99.71%	99.73%
	2017.05	501,306	1,465,115	99.55%	99.51%
	2017.04	486,121	1,416,407	96.46%	95.69%
	2017.03	523,085	1,572,451	99.73%	99.59%
	2017.02	469,205	1,442,230	99.64%	99.34%
		15,388,654	**44,249,865**	**97.12%**	**96.74%**
F04	2017.09	75,506	377,937	99.93%	99.94%
	2017.08	113,196	530,825	99.67%	99.85%
	2017.07	101,477	478,602	99.87%	99.65%
	2017.06	104,345	480,808	99.37%	99.39%
	2017.05	98,098	521,277	99.61%	99.61%
	2017.04	90,708	417,822	90.54%	94.64%
	2017.03	100,654	482,431	99.64%	99.59%
	2017.02	99,737	410,232	99.86%	99.85%

Initial Submission Compliance

Encounter Compliance Rate	**99.64%**
Line Compliance Rate	**99.78%**

325,738	**324,577**	**979,546**	**977,396**

Submitter ID	Received Yr.Month	Claim Received Date	Submission Date	Claims Received	Encounters Submitted Timely	Lines Received	Lines Submitted Timely
F03	2017.09	2017.09.02	(blank)	1	0	1	0
			2017.09.02	12680	12677	49328	49325
			2017.09.05	20	20	119	119
		2017.09.01	2017.09.02	8992	8984	28144	28131
			2017.09.12	1	0	166	0
			2017.09.25	1	0	3	0
			2017.09.20	1	0	1	0
			2017.09.05	11	11	20	20
		2017.09.04	(blank)	1	0	1	0
			2017.09.11	1	0	1	0
			2017.09.05	13	13	66	66
			2017.09.04	29932	29901	93202	93122
			2017.09.06	53	53	123	123
		2017.09.06	2017.09.11	68	10	92	21
			2017.09.12	1	0	1	0
			2017.09.14	8	0	25	0
			2017.09.07	57	57	262	262
			2017.09.06	29009	29001	82228	82204
			2017.09.09	1	1	1	1
			2017.09.19	1	0	1	0
		2017.09.07	(blank)	10	0	34	0
			2017.09.11	34	34	38	38
			2017.09.12	21	1	31	11
			2017.09.07	4342	4342	18707	18707
			2017.09.09	32	32	72	72
			2017.10.02	64	0	75	0
		2017.09.08	2017.09.11	3	3	28	28
			2017.09.12	16	16	29	29
			2017.09.09	5835	5830	20241	20220
		2017.09.09	(blank)	2	0	12	0
			2017.09.12	29	29	72	72
			2017.09.09	8389	8373	29080	29028
		2017.09.11	(blank)	2	0	8	0
			2017.09.11	33346	33142	86447	86106
			2017.09.14	45	45	105	105
			2017.09.13	33	33	60	60
			2017.09.16	1	1	1	1
			2017.09.25	1	0	1	0
			2017.10.07	1	0	1	0
			2017.09.19	7	0	13	0
			2017.10.02	1	0	1	0
		2017.09.12	2017.09.12	3419	3419	13236	13236
		2017.09.13	2017.09.14	41	41	130	130
			2017.09.13	18304	18299	50363	50357
			2017.09.16	33	33	79	79
		2017.09.14	(blank)	2	0	21	0
			2017.09.14	5848	5840	23116	23087

Attachment 29-9: Encounter Reports

Submitter ID	Received Yr.Month	Claim Received Date	Submission Date	Claims Received	Encounters Submitted Timely	Lines Received	Lines Submitted Timely
F03	2017.09		2017.09.16	11	11	38	38
			2017.09.19	1	1	4	4
		2017.09.18	2017.09.23	1	0	2	0
			2017.09.26	1	0	16	0
			2017.09.21	1	1	25	25
			2017.09.20	21	21	50	50
			2017.09.19	41	41	176	176
			2017.09.18	28143	28118	83805	83727
		2017.09.19	2017.09.21	1	1	1	1
			2017.09.20	4	4	5	5
			2017.09.19	3104	3104	9490	9490
		2017.09.20	2017.09.20	1629	1628	5931	5929
		2017.09.21	(blank)	2	0	9	0
			2017.09.23	13	13	58	58
			2017.09.21	10923	10914	33896	33873
		2017.09.22	(blank)	1	0	7	0
			2017.09.23	7752	7747	24453	24435
			2017.09.25	28	28	118	118
			2017.09.26	1	1	6	6
		2017.09.23	(blank)	4	0	5	0
			2017.09.23	22871	22338	51621	51011
			2017.09.26	13	13	74	74
			2017.09.27	2	2	5	5
		2017.09.25	(blank)	18	0	28	0
			2017.09.25	18704	18667	55145	54986
			2017.09.26	29	29	126	126
			2017.09.27	61	61	129	129
			2017.09.28	34	34	97	97
			2017.09.30	2	0	2	0
		2017.09.26	2017.09.26	2469	2469	9205	9205
		2017.09.27	2017.09.27	28026	28024	72304	72294
			2017.09.28	32	32	127	127
			2017.09.30	6	6	22	22
		2017.09.28	(blank)	5	0	13	0
			2017.09.28	15882	15878	42875	42849
			2017.10.02	1	1	28	28
			2017.09.30	24	24	103	103
		2017.09.29	(blank)	2	0	2	0
			2017.10.07	4	0	7	0
			2017.10.03	13	13	84	84
			2017.10.02	36	36	135	135
			2017.09.30	13647	13639	53606	53588
		2017.09.30	(blank)	3	0	6	0
			2017.10.07	5	0	15	0
			2017.10.03	4	4	21	21
			2017.10.02	11	11	45	45
			2017.09.30	11439	11422	39840	39772

Enterprise Solution Point Metrics (ESP) Report (Monthly)

Provides the ongoing compliance status for all encounters received into the Edifecs/ TM system for submission purposes and whether the initial encounter submission occurred within 7 days of adjudication.

Attachment 29-9: Encounter Reports

EDI Edits

Encounter Compliance Rate	**99.59%**
Line Compliance Rate	**98.81%**

				325,983	**25,281**	**1,230**	**299,472**	**979,803**	**93,531**	**10,564**	**875,708**

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09	2016.08.17	2017.09.12	6	0	0	6	Submitted	0	0	10
			2017.09.11	4	0	0	4	Submitted	0	0	5
			2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.16	3	0	0	3	Submitted	0	0	5
			2017.09.14	1	0	0	1	Submitted	0	0	1
			2017.09.13	2	0	0	2	Submitted	0	0	2
			2017.09.23	1	0	0	1	Submitted	0	0	1
		2016.08.19	2017.09.11	1	0	0	1	Submitted	0	0	2
		2016.09.12	2017.09.12	1	0	0	1	Submitted	0	0	2
			2017.09.11	1	0	0	1	Submitted	0	0	1
			2017.09.25	1	0	0	1	Submitted	0	0	1
		2017.01.13	2017.09.12	1	0	0	1	Submitted	0	0	2
		2017.02.06	2017.09.11	1	0	0	1	Submitted	0	0	2
		2016.08.01	2017.09.07	1	0	1	0	Submitted	0	1	0
		2016.08.24	2017.09.12	2	0	0	2	Submitted	0	0	4
			2017.09.11	7	0	0	7	Submitted	0	0	9
			2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.16	2	0	0	2	Submitted	0	0	2
		2016.07.27	2017.09.12	2	0	0	2	Submitted	0	0	3
			2017.09.11	1	0	0	1	Submitted	0	0	1
			2017.09.14	1	0	0	1	Submitted	0	0	1
		2016.09.05	2017.09.16	1	0	0	1	Submitted	0	0	1
		2016.09.09	2017.09.11	1	0	0	1	Submitted	0	0	1
			2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.16	1	0	0	1	Submitted	0	0	1
		2016.10.08	2017.09.11	1	0	0	1	Submitted	0	0	1
		2016.10.13	2017.09.11	1	0	0	1	Submitted	0	0	1

Attachment 29-9: Encounter Reports

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09	2016.11.30	2017.09.12	1	0	0	1	Submitted	0	0	2
			2017.09.11	3	0	0	3	Submitted	0	0	3
			2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.16	1	0	0	1	Submitted	0	0	2
		2017.02.10	2017.09.26	1	0	0	1	Submitted	0	0	2
		2017.02.25	2017.09.12	1	0	0	1	Submitted	0	0	2
			2017.09.16	1	0	0	1	Submitted	0	0	2
		2017.03.11	2017.09.12	1	0	0	1	Submitted	0	0	2
			2017.09.25	2	0	1	1	Submitted	0	2	2
			2017.09.13	1	0	0	1	Submitted	0	0	2
		2017.03.15	2017.09.12	1	0	0	1	Submitted	0	0	2
		2017.02.23	2017.09.16	1	0	0	1	Submitted	0	0	2
		2017.02.24	2017.09.11	2	0	1	1	Submitted	0	1	2
		2017.02.27	2017.09.11	1	0	1	0	Submitted	0	2	0
		2017.03.02	2017.09.11	1	0	0	1	Submitted	0	0	2
		2017.04.01	2017.09.25	3	0	0	3	Submitted	0	0	3
			2017.09.26	3	0	0	3	Submitted	0	0	5
		2017.04.15	2017.09.25	4	0	0	4	Submitted	0	0	6
			2017.09.26	2	0	0	2	Submitted	0	0	3
		2017.04.24	2017.09.12	1	0	0	1	Submitted	0	0	1
			2017.09.11	2	0	0	2	Submitted	0	0	2
			2017.09.25	2	0	0	2	Submitted	0	0	3
			2017.09.26	2	0	0	2	Submitted	0	0	4
			2017.09.13	2	0	0	2	Submitted	0	0	3
		2017.05.08	2017.09.12	1	0	0	1	Submitted	0	0	1
		2017.05.15	2017.09.26	1	0	0	1	Submitted	0	0	1
			2017.09.13	1	0	0	1	Submitted	0	0	1
		2017.05.16	2017.09.26	1	0	0	1	Submitted	0	0	1
		2017.05.18	2017.09.25	6	0	0	6	Submitted	0	0	8
			2017.09.26	3	0	0	3	Submitted	0	0	5
		2017.05.22	2017.09.26	1	0	0	1	Submitted	0	0	2
		2017.05.29	2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.26	2	0	0	2	Submitted	0	0	3

Attachment 29-9: Encounter Reports

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09	2017.02.02	2017.09.16	1	0	0	1	Submitted	0	0	2
		2017.06.07	2017.09.25	5	0	0	5	Submitted	0	0	6
			2017.09.26	3	0	0	3	Submitted	0	0	5
		2017.06.12	2017.09.25	2	0	0	2	Submitted	0	0	3
			2017.09.26	2	0	0	2	Submitted	0	0	2
			2017.09.14	1	0	0	1	Submitted	0	0	1
		2017.06.16	2017.09.25	2	0	0	2	Submitted	0	0	2
		2017.06.17	2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.26	2	0	1	1	Submitted	0	2	1
		2017.06.21	2017.09.25	3	0	0	3	Submitted	0	0	3
			2017.09.26	4	0	0	4	Submitted	0	0	6
		2017.06.23	2017.09.25	3	0	0	3	Submitted	0	0	4
			2017.09.26	3	0	0	3	Submitted	0	0	4
		2017.04.28	2017.09.25	1	0	0	1	Submitted	0	0	2
		2017.06.19	2017.09.13	1	0	0	1	Submitted	0	0	1
		2017.06.28	2017.09.12	5	0	0	5	Submitted	0	0	10
			2017.09.11	2	0	0	2	Submitted	0	0	3
			2017.09.16	2	0	1	1	Submitted	0	2	1
			2017.09.26	2	0	0	2	Submitted	0	0	3
			2017.09.14	2	0	0	2	Submitted	0	0	4
			2017.09.27	1	0	1	0	Submitted	0	2	0
			2017.09.13	3	0	0	3	Submitted	0	0	6
		2017.07.07	2017.09.25	2	0	0	2	Submitted	0	0	2
			2017.09.26	2	0	0	2	Submitted	0	0	2
			2017.09.27	1	0	0	1	Submitted	0	0	2
		2017.07.10	2017.09.12	1	0	0	1	Submitted	0	0	1
			2017.09.11	2	0	0	2	Submitted	0	0	2
			2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.16	1	0	0	1	Submitted	0	0	2
			2017.09.27	1	0	0	1	Submitted	0	0	1
		2017.07.17	2017.09.25	2	0	0	2	Submitted	0	0	3
			2017.09.26	3	0	0	3	Submitted	0	0	4
			2017.09.13	1	0	1	0	Submitted	0	1	0

Attachment 29-9: Encounter Reports

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09	2017.07.19	2017.09.11	1	0	0	1	Submitted	0	0	1
			2017.09.25	4	0	0	4	Submitted	0	0	6
			2017.09.26	1	0	0	1	Submitted	0	0	2
			2017.09.27	1	0	0	1	Submitted	0	0	2
		2017.07.20	2017.09.11	1	0	0	1	Submitted	0	0	1
			2017.09.13	1	0	0	1	Submitted	0	0	1
		2017.08.03	2017.09.13	1	0	0	1	Submitted	0	0	1
		2017.08.05	2017.09.25	1	1	0	0	Submitted	1	0	0
		2017.08.10	2017.09.12	3	1	1	1	Submitted	2	1	1
			2017.09.25	1	1	0	0	Submitted	1	0	0
			2017.09.16	1	0	1	0	Submitted	0	1	0
			2017.09.13	2	0	0	2	Submitted	0	0	2
			2017.09.20	1	1	0	0	Submitted	1	0	0
		2017.08.11	2017.09.11	1	1	0	0	Submitted	1	0	0
			2017.09.13	1	1	0	0	Submitted	1	0	0
		2017.08.12	2017.09.11	1	0	0	1	Submitted	0	0	1
		2017.08.24	2017.09.25	1	0	1	0	Submitted	0	1	0
		2017.08.25	2017.09.11	1	0	0	1	Submitted	0	0	2
			2017.09.25	1	0	1	0	Submitted	0	2	0
			2017.09.14	1	0	0	1	Submitted	0	0	17
			2017.09.05	2	0	0	2	Submitted	0	0	30
		2017.08.26	2017.09.25	66	0	1	65	Submitted	0	6	176
			2017.09.16	1	0	0	1	Submitted	0	0	1
			2017.09.28	2	0	0	2	Submitted	0	0	4
		2016.08.10	2017.09.12	1	0	0	1	Submitted	0	0	2
			2017.09.11	2	0	0	2	Submitted	0	0	2
		2016.11.25	2017.09.12	1	0	0	1	Submitted	0	0	1
			2017.09.13	1	0	0	1	Submitted	0	0	1
		2017.02.08	2017.09.12	1	0	0	1	Submitted	0	0	2
			2017.09.11	1	0	0	1	Submitted	0	0	1
		2017.06.26	2017.09.25	5	0	0	5	Submitted	0	0	8
			2017.09.26	2	0	0	2	Submitted	0	0	3
		2017.07.03	2017.09.25	5	0	0	5	Submitted	0	0	6

Attachment 29-9: Encounter Reports

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09		2017.09.26	1	0	0	1	Submitted	0	0	1
		2017.07.14	2017.09.12	1	0	0	1	Submitted	0	0	2
			2017.09.11	3	0	0	3	Submitted	0	0	4
			2017.09.16	1	0	1	0	Submitted	0	1	0
			2017.09.14	1	0	1	0	Submitted	0	1	0
			2017.09.13	1	0	0	1	Submitted	0	0	1
		2017.08.02	2017.09.12	2	2	0	0	Submitted	4	0	0
		2017.08.09	2017.09.12	2	0	0	2	Submitted	0	0	2
			2017.09.11	2	0	0	2	Submitted	0	0	3
			2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.13	1	0	0	1	Submitted	0	0	1
		2017.08.19	2017.09.25	1	0	0	1	Submitted	0	0	3
		2017.08.31	2017.09.25	1	0	0	1	Submitted	0	0	15
			2017.09.02	18	0	1	17	Submitted	0	1	68
		2017.09.02	2017.09.05	20	0	3	17	Submitted	0	8	111
			2017.09.02	12680	2	38	12640	Submitted	37	546	48745
		2017.09.08	2017.09.12	16	0	1	15	Submitted	0	1	28
			2017.09.11	3	0	0	3	Submitted	0	0	28
			2017.09.09	5835	0	47	5788	Submitted	0	380	19861
		2017.09.11	2017.09.11	33346	0	95	33251	Submitted	0	818	85629
			2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.16	1	0	0	1	Submitted	0	0	1
			2017.09.14	45	0	6	39	Submitted	0	6	99
			2017.09.13	33	0	3	30	Submitted	0	3	57
			2017.09.19	7	0	0	7	Submitted	0	0	13
		2017.09.12	2017.09.12	3419	2	0	3417	Submitted	5	0	13231
		2017.09.21	2017.09.21	10923	3	58	10862	Submitted	46	497	33353
			2017.09.23	13	0	1	12	Submitted	0	6	52
		2017.09.23	2017.09.26	13	0	1	12	Submitted	0	3	71
			2017.09.27	2	0	0	2	Submitted	0	0	5
			2017.09.23	22871	1	57	22813	Submitted	2	336	51283
		2017.09.25	2017.09.25	18704	35	47	18622	Submitted	129	537	54479
			2017.09.26	29	0	0	29	Submitted	0	0	126

Attachment 29-9: Encounter Reports

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09		2017.09.27	61	0	2	59	Submitted	0	3	126
			2017.09.28	34	0	0	34	Submitted	0	0	97
			2017.09.30	2	2	0	0	Submitted	2	0	0
		2017.09.07	2017.09.12	21	0	0	21	Submitted	0	0	31
			2017.09.11	34	0	3	31	Submitted	0	5	33
			2017.09.09	32	0	31	1	Submitted	0	69	3
			2017.09.07	4342	0	11	4331	Submitted	0	83	18624
		2017.09.29	2017.09.30	13647	13583	64	0	Submitted	52979	627	0
		2016.08.31	2017.09.11	1	0	0	1	Submitted	0	0	2
			2017.09.16	1	0	0	1	Submitted	0	0	1
			2017.09.13	2	0	0	2	Submitted	0	0	2
		2016.09.02	2017.09.14	1	0	0	1	Submitted	0	0	1
		2017.04.03	2017.09.25	4	0	0	4	Submitted	0	0	5
			2017.09.26	3	0	0	3	Submitted	0	0	5
			2017.09.21	1	0	0	1	Submitted	0	0	2
		2017.05.10	2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.26	1	0	0	1	Submitted	0	0	2
		2017.07.13	2017.09.12	1	0	0	1	Submitted	0	0	1
			2017.09.11	2	0	0	2	Submitted	0	0	3
			2017.09.25	1	0	0	1	Submitted	0	0	1
			2017.09.26	1	0	0	1	Submitted	0	0	1
			2017.09.14	1	0	0	1	Submitted	0	0	1
			2017.09.13	2	0	1	1	Submitted	0	1	2
		2017.09.27	2017.09.27	28026	9	84	27933	Submitted	63	607	71634
			2017.09.28	32	0	3	29	Submitted	0	5	122
			2017.09.30	6	3	3	0	Submitted	14	8	0
		2017.09.28	2017.09.28	15882	0	41	15841	Submitted	0	507	42368
			2017.09.30	24	23	1	0	Submitted	90	13	0
		2017.02.15	2017.09.12	1	0	0	1	Submitted	0	0	2
		2017.03.09	2017.09.25	2	0	0	2	Submitted	0	0	3
		2017.02.04	2017.09.12	1	0	0	1	Submitted	0	0	2
		2017.04.19	2017.09.25	2	0	0	2	Submitted	0	0	2
			2017.09.26	1	0	0	1	Submitted	0	0	1

Attachment 29-9: Encounter Reports

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09	2016.09.08	2017.09.12	1	0	0	1	Submitted	0	0	2
		2017.05.05	2017.09.25	1	0	0	1	Submitted	0	0	2
			2017.09.26	1	0	0	1	Submitted	0	0	1
		2017.06.10	2017.09.25	2	0	0	2	Submitted	0	0	3
			2017.09.26	3	0	0	3	Submitted	0	0	6
		2017.06.15	2017.09.25	2	0	0	2	Submitted	0	0	2
			2017.09.26	2	0	0	2	Submitted	0	0	3
		2017.07.01	2017.09.16	1	0	0	1	Submitted	0	0	2
			2017.09.14	1	0	0	1	Submitted	0	0	2
		2017.07.08	2017.09.25	1	0	0	1	Submitted	0	0	1
		2017.07.12	2017.09.11	3	0	0	3	Submitted	0	0	3
			2017.09.25	1	0	0	1	Submitted	0	0	2
		2017.07.28	2017.09.14	1	1	0	0	Submitted	2	0	0
		2017.07.31	2017.09.12	1	0	0	1	Submitted	0	0	2
			2017.09.25	1	0	0	1	Submitted	0	0	2
		2017.08.07	2017.09.25	1	0	0	1	Submitted	0	0	1
		2017.08.14	2017.09.11	1	0	1	0	Submitted	0	1	0
		2017.08.17	2017.09.25	1	0	0	1	Submitted	0	0	1
		2017.08.30	2017.09.05	1	0	0	1	Submitted	0	0	4
			2017.09.02	30	0	1	29	Submitted	0	1	45
		2017.07.24	2017.09.12	1	0	0	1	Submitted	0	0	1
			2017.09.11	1	0	0	1	Submitted	0	0	7
			2017.09.25	2	0	0	2	Submitted	0	0	3
			2017.09.26	1	0	0	1	Submitted	0	0	1
		2017.07.26	2017.09.12	1	0	0	1	Submitted	0	0	1
			2017.09.11	2	0	0	2	Submitted	0	0	2
			2017.09.26	1	0	0	1	Submitted	0	0	1
		2017.09.06	2017.09.12	1	0	0	1	Submitted	0	0	1
			2017.09.11	68	0	3	65	Submitted	0	3	89
			2017.09.14	8	0	2	6	Submitted	0	17	8
			2017.09.09	1	0	0	1	Submitted	0	0	1
			2017.09.07	57	0	2	55	Submitted	0	10	252
			2017.09.19	1	0	0	1	Submitted	0	0	1

Attachment 29-9: Encounter Reports

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09		2017.09.06	29009	8	80	28921	Submitted	44	234	81950
		2017.09.19	2017.09.21	1	0	1	0	Submitted	0	1	0
			2017.09.19	3104	1	6	3097	Submitted	3	26	9461
			2017.09.20	4	0	0	4	Submitted	0	0	5
		2017.09.30	2017.09.30	11439	11393	46	0	Submitted	39287	553	0
		2017.07.05	2017.09.14	1	0	0	1	Submitted	0	0	2
		2016.11.24	2017.09.12	2	0	0	2	Submitted	0	0	4
			2017.09.11	2	0	0	2	Submitted	0	0	2
			2017.09.16	1	0	0	1	Submitted	0	0	1
			2017.09.13	1	0	0	1	Submitted	0	0	2
		2017.09.01	2017.09.12	1	0	0	1	Submitted	0	0	166
			2017.09.25	1	0	0	1	Submitted	0	0	3
			2017.09.05	11	0	1	10	Submitted	0	1	19
			2017.09.02	8992	1	51	8940	Submitted	44	380	27720
			2017.09.20	1	0	1	0	Submitted	0	1	0
		2017.09.09	2017.09.12	29	0	6	23	Submitted	0	6	66
			2017.09.09	8389	8	30	8351	Submitted	57	302	28721
		2017.09.18	2017.09.26	1	0	0	1	Submitted	0	0	16
			2017.09.21	1	0	1	0	Submitted	0	25	0
			2017.09.19	41	0	9	32	Submitted	0	58	118
			2017.09.23	1	0	0	1	Submitted	0	0	2
			2017.09.20	21	0	0	21	Submitted	0	0	50
			2017.09.18	28143	120	123	27900	Submitted	367	1399	82039
		2017.09.22	2017.09.25	28	0	1	27	Submitted	0	1	117
			2017.09.26	1	0	0	1	Submitted	0	0	6
			2017.09.23	7752	18	40	7694	Submitted	155	339	23959
		2017.04.22	2017.09.11	1	0	1	0	Submitted	0	1	0
		2017.05.25	2017.09.25	6	0	0	6	Submitted	0	0	7
			2017.09.26	2	0	0	2	Submitted	0	0	3
		2017.07.27	2017.09.11	1	0	1	0	Submitted	0	1	0
		2017.08.18	2017.09.12	1	0	0	1	Submitted	0	0	1
			2017.09.25	1	0	0	1	Submitted	0	0	1
		2017.09.04	2017.09.11	1	0	0	1	Submitted	0	0	1

Attachment 29-9: Encounter Reports

Submitter ID	Submitted Yr.Month	Received Date	Submission Date	Encounters				Lines			
				Submitted	Encounters Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejection Errors (999)	Submitted	Awaiting Response	EDI Compliance Rejection Errors (999)	Submitted w/o EDI Compliance Rejections Errors (999)
F03	2017.09		2017.09.05	13	0	2	11	Submitted	0	6	60
			2017.09.06	53	0	1	52	Submitted	0	3	120
			2017.09.04	29932	22	90	29820	Submitted	49	943	92210
		2017.09.13	2017.09.16	33	0	0	33	Submitted	0	0	79
			2017.09.14	41	0	5	36	Submitted	0	20	110
			2017.09.13	18304	12	64	18228	Submitted	26	731	49606
		2017.09.14	2017.09.16	11	0	4	7	Submitted	0	11	27
			2017.09.14	5848	24	39	5785	Submitted	106	391	22619
			2017.09.19	1	0	0	1	Submitted	0	0	4
		2017.09.20	2017.09.20	1629	0	1	1628	Submitted	0	3	5928
		2017.09.26	2017.09.26	2469	2	0	2467	Submitted	13	0	9192

Enterprise Solution Point Metrics (ESP) Report (Monthly)

Provides the ongoing compliance status of passing the AHCA 999 compliance edits only for those encounters in which a response from AHCA has been received.

Attachment 29-10: Medicaid Pharmacy Encounter Submission, Florida Status Report

Program Submission	Received Yr.Mth	Encounters Received	Resubmitted Encounters	Encounters Excluded on State's Request	Total Encounters Submitted	Charges	Accepted Encounters	Encounters Acceptance Pct	Denied Encounters	Encounter Denial Pct	Remaining Claim Inventory	Remaining Inventory Pct
FL MMA	2017.09	267,610	2	0	267,612	$17,016,089.00	266,429	99.56%	1,183	0.44%	0	0%
	2017.08	339,961	291	0	340,252	$19,681,058.00	339,262	99.71%	989	0.29%	0	0%
	2017.07	189,754	106	0	189,860	$17,967,198.00	189,311	99.71%	549	0.29%	0	0%
	2017.06	278,258	155	0	278,413	$19,121,065.00	277,649	99.73%	745	0.27%	0	0%
	2017.05	301,465	38	0	301,503	$19,867,945.00	300,662	99.72%	841	0.28%	0	0%
	2017.04	268,571	58	0	268,629	$18,922,376.00	267,618	99.62%	1,011	0.38%	0	0%
	2017.03	305,232	56	0	305,288	$20,553,601.00	304,389	99.71%	899	0.29%	0	0%
	2017.02	277,053	53	0	277,106	$18,084,242.00	276,008	99.60%	1,098	0.40%	0	0%
	2017.01	301,648	105	0	301,753	$19,135,853.00	300,581	99.61%	1,172	0.39%	0	0%
		2,529,552	**864**	**-**	**2,530,416**	**170,349,427**	**2,521,909**	**99.66%**	**8,487**	**0.34%**	**0**	**0%**
FL Expanded Benefit	2017.09	28,620	0	5,875	22,745	$18,168.00	22,714	99.86%	31	0.14%	0	0%
	2017.08	44,132	3	7,492	36,643	$23,231.00	36,582	99.83%	53	0.14%	0	0%
	2017.07	26,285	0	6,969	19,316	$20,206.00	19,287	99.85%	29	0.15%	0	0%
	2017.06	36,117	11	7,585	28,543	$21,495.00	28,478	99.77%	65	0.23%	0	0%
	2017.05	39,216	3	6,405	32,814	$18,989.00	32,758	99.83%	56	0.17%	0	0%
	2017.04	33,173	0	6,878	26,295	$20,150.00	26,238	99.78%	57	0.22%	0	0%
	2017.03	392,583	13,510	7,405	398,688	$19,678.00	286,743	71.92%	111,945	28.08%	0	0%
	2017.02	122,338	5	7,102	115,241	$16,705.00	64,823	56.25%	50,418	43.75%	0	0%
	2017.01	84,792	5,944	6,700	84,036	$17,514.00	47,688	56.75%	36,348	43.25%	0	0%
		807,256	**19,476**	**62,411**	**764,321**	**$176,136.00**	**565,311**	**93.71%**	**199,002**	**6.29%**	**0**	**0%**

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

SRC# 30 – Encounter Submission for Sub-Capitated, Subcontracted, Non-Pay and Atypical (Statewide):

The respondent shall describe how it will work with providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to ensure the accuracy, timeliness and completeness of encounter data.

Response:

Humana understands the importance of complete and accurate encounter data and the role each data field plays in validating services and quality of care provided. We have built a team of experts that understands the challenges providers face, the importance of the electronic data interchange (EDI), and the strategies necessary to ensure accurate data. Our associates attend and are active participants at national conferences and associations, including the Workgroup for Electronic Data Interchange (WEDI), which discusses and develops standards. Over the past three (3) years, we have delivered this expertise in collaboration with our Provider Relations team to educate our providers in Florida about the importance of the data they submit to Humana. As an example, we have worked with our providers to improve Florida Medicaid Management Information Systems (FMMIS) registration and submission of accurate provider identification (ID) information in our encounter data.

Humana's ability to meet the Agency for Health Care Administration's (AHCA) encounter data requirements depends upon our providers fully understanding their obligations to submit accurate, timely, and complete encounter data, and their willingness to consistently meet those obligations. Consequently, we recognize the importance of educating providers regarding claims and encounters is ongiong. We offer a variety of delivery methods to ensure that information is accessible, convenient, and accomodates all of our provider types. The training formats used include face-to-face orientation and monthly meetings, Humana's Provider Handbook, Quarterly Provider Newsletters, materials available on our Availity provider portal and website, and ongoing support available from our Provider Relations Representatives. We prepare our highly trained provider Customer Care associates to answer questions about encounter submission requirements. We also provide one-on-one outreach to providers, particularly our atypical providers.

As the only statewide Long-term Care (LTC) plan, we have built experience in working with our LTC providers to educate them on encounter data. In the past three (3) years, we have developed strong relationships with our LTC providers to educate them on claims submission and to develop an understanding of encounter data. We have also worked with our sub-capitated Managed Medical Assistance (MMA) providers to encourage complete submission of encounter data.

Our provider trainings and communications notify providers that we will subject claims and encounters data submissions to electronic edits, and that we may reject and return claims and encounters that are incorrectly coded, lack key information, or otherwise fail to meet our requirements to the provider with an explanation of the reason for rejection. Prior to entering into a contract with a subcontractor, we carefully review our encounter data submission requirements with the company's associates.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana has processes in place to ensure the completeness of our encounter submissions to AHCA. Prior to submitting our weekly encounter file to AHCA, we run a report that compares the number of encounters in the file with the number of expected encounters based on our claims payments. We verify that our capitated subcontractors and providers have submitted encounters for all the claims they paid through an annual audit, during which we review a sample of the provider's claims against their encounter submissions. If that audit shows that the capitated provider or subcontractor failed to submit even one encounter, Humana issues a corrective action plan (CAP). We also penalize capitated providers and subcontractors by adjusting their capitation payments based on their encounter submission performance.

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1. The adequacy of the respondent's approach to ensure that all network providers, including sub-capitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.

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Over the past year, we have been working with our providers to enforce the correct and complete submission of provider IDs in encounter and claims data. Our strategy consists of three (3) components.

First, during the credentialing phase, Humana requires the submission of provider IDs and validates the providers' registration on the Florida Medicaid Management Information System (FMMIS). We recently implemented this verification requirement as part of our approach to address this systemically. In the past six (6) months, one hundred percent (100%) of our newly credentialed providers were verified and validated for FMMIS registration, reducing claims and encounter error rates. We do not offer providers who are not registered with FMMIS a contract with Humana.

Second, for our providers we contracted with prior to our FMMIS registration credentialing requirement, we have been developing and disseminating educational materials to encourage providers to register with FMMIS and receive a provider ID. We stress the importance of this information using regular provider updates and offer guidance on how to register with FMMIS. We also offer resources they can access at any point, including videos, materials, and our Provider Relations call center, to walk providers through FMMIS training.

We target our educational strategy to focus on our providers identified in our Encounter Error Reports from the State. If a provider is not registered or if their registration has expired, Humana's Medicaid Risk Adjustment (MRA) Team validates that the provider is not pending registration and researches AHCA's search engine to research for different variations of the provider's name, for example. As needed, our MRA Team and Provider Relations Team conduct telephonic outreach and site visits to discuss claims and encounter issues, including Medicaid ID reject reasons.

For non-participating providers, during approval of service, we identify if the provider has an active Medicaid ID number. If we determine that the provider does not have an active Medicaid ID number, we complete the registration on behalf of the provider and have the provider sign a Managed Care Organization (MCO) Treating Provider Registration Form, which we submit to AHCA prior to services being rendered.

Humana works with our providers to process the FMMIS registration on their behalf. We work to complete the enrollment documentation and submit it to AHCA on behalf of the provider as needed. Should issues arise with the enrollment process, we work with the provider to address and reconcile the matter and ensure they receive a valid provider ID.

Third, we are in the process of implementing an automated edit in our Claims Adjudication System (CAS) to validate the submission of provider IDs with the AHCA file. This enhancement will deny claims and encounters submitted by our providers with missing or incorrect provider IDs. We are rolling out this strategy after ensuring we have adequately communicated this change and educated our providers.

This edit will cross-walk to the AHCA Provider Network Validation (PNV) file and automatically pend claims that contain missing and incorrect Medicaid ID numbers for possible rejection, thus reducing our claims errors and overall encounter error submission rates. We will validate non-participating provider IDs through similar logic.

To prepare our providers for our new CAS edit, we provided advance notice using alerts on our Humana provider portal and through provider updates. In addition, Humana's Provider Relations teams conducted outreach to providers using phone calls, face-to-face visits, and provider training sessions. Upon implementation of this edit, Humana envisions a substantial reduction in our encounters rejecting for missing or incorrect provider IDs. Further, we will implement a proactive outreach and education strategy upon identifying providers not registered with FMMIS, as the claim or encounter is submitted and thereby denied.

SUBCONTRACTORS

Humana's Encounter Team also hosts weekly meetings with our subcontractors to review their contracted providers not registered with FMMIS. We share reports of missing and incomplete encounter data, as a result of incomplete data submitted by the subcontractor, with our Relationship Managers who oversee our subcontractors' performance. The Relationship Managers monitor and track these issues to completion.

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2. The adequacy of the respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.

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TRADITIONAL CLAIMS AND ENCOUNTER EDUCATION

Humana understands the importance of educating our providers about our requirements for accurate and complete encounters. Our provider onboarding training materials for all new providers include information about our claims and encounter submission requirements. We supplement the initial training with refresher trainings, provider updates and alerts, and one-on-one instruction on how to address claim and encounter errors, including correcting coding

omissions and mistakes. Humana's "Making It Easier for Providers" series includes on-demand presentations on Humana's claims processing and payment policies.

Our Provider Customer Service Center plays a central role in educating providers about Humana's claims and encounters requirements. Our highly trained representatives can answer specific questions about claims and encounters requirements, the reason a provider's claim or encounter submission was rejected, and the status of payment of a claim. Each associate receives eight (8) full weeks of training on claims and encounters, including technical training on our electronic claims processing and payment system (e.g., CAS). Associates have access to Humana's claims processing and payment system so they can research the reason why the provider's claim or encounter submission was rejected. They refer providers to the Humana website for claims-specific provider education materials.

TARGETED OUTREACH
When a provider or subcontractor contacts us after a claim or encounter rejection or we notice that a provider's encounter errors have been more frequent, we view this as an opportunity to reach out to the provider or subcontractor to provide additional training on how to meet encounter requirements. Our Provider Relations team may contact the provider and offer to visit them.

As part of Humana's enterprise-wide strategy to correct and complete submission of claims and encounter data, our Medicaid Risk Adjustment Team has developed a proactive education strategy. In fact, we have dedicated Learning Facilitators who are responsible for educating our providers on documentation and coding. We base education on approved Coding Guidelines. Attachment 30-1 offers a sample of the best practice guidelines our Learning Facilitators use to discuss diagnosis coding.

We base an additional strategy that complements our enterprise-wide strategy on the work of our Provider Data Validation Audit (PDVA) team. The PDVA team conducts provider audits, identifies providers who need education on accurate and complete submission of claims and encounter data, and places these providers on a Coding Improvement Plan (CIP). We identify providers for a CIP if their encounter and claims submission scores fall below the benchmark goal of ninety percent (90%).

REAL-TIME EDUCATION AND FEEDBACK THROUGH ADVANCED CODE EDITOR
Additionally, we are developing, piloting, and testing a Humana-specific tool on Availity's Payer Space platform called Advanced Code Editor. This tool offers code edits and checks to validate complete and accurate submission of claims and encounter data submitted through Availity. The tool immediately identifies claims and encounters that are not accurate, notifying the provider in near real-time with rejections along with reasons for these rejections. One edit we recently implemented is the PCD-ICD-10-CM Primary Diagnosis Only (PDO). The PDO rule identifies certain Z codes and categories that may only be reported as the principal or first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined.

Humana has a list of additional edits scheduled for implementation after thorough testing to support accurate and complete submission of claim and encounter data from our providers, supporting Humana's complete and accurate submission of encounter data to AHCA. Examples

include edits to identify invalid modifier codes and inappropriate diagnosis combinations. This tool also offers education to our providers on their claims submission.

ATYPICAL PROVIDERS

Atypical providers are often small businesses that may have limited experience in claims billing, and may need more education and support to submit claims that include accurate and complete encounter data. Most atypical providers in Humana's network are LTC providers. Humana has established a special Provider Relations team to work closely with our LTC providers one-on-one, either in-person or over the phone, to review the reasons why the provider's claim was rejected and to provide step-by-step instructions on how to submit correct claims, including using correct procedure codes, and how to resubmit claims that have been rejected.

To support our atypical providers in their submission of complete and accurate claims and with the goal of achieving first pass success, we developed a direct data entry tool in Availity that guides these providers on all the key fields required to generate the 837 file and ensure complete submission of the claims and encounter data. While we initially built this platform on Humana.com, we have since moved it to our provider engagement portal, Availity, to streamline our providers' access to claims status, clinical information, guidance, and more.

SUB-CAPITATED PRIMARY CARE MEDICAL GROUPS

During contract negotiations with sub-capitated primary care medical groups, our Provider Contracting team reviews the contract requirements for monthly encounter data submissions with the provider and emphasizes the importance of submitting complete and accurate encounters. The onboarding training that our Provider Relations team conducts for all new sub-capitated providers and their associates includes a segment on the reasons for encounter rejections. We reinforce this information and provide updates on new encounter submission requirements in our refresher training. We also require that at least one (1) representative from each sub-capitated medical group take our online training program that covers encounter submission requirements and attest that he or she has completed the training.

The Provider Relations team targets outreach to sub-capitated primary care medical providers that repeatedly submit incomplete or inaccurate encounter data. They meet with the provider to help them identify the cause of the problem, which might be that the provider has started using a new vendor to prepare their encounters, and provide guidance on encounter submissions. The team documents the content of the meeting with the provider's associates and requires the provider to sign an acknowledgement that they have received the training.

SUBCONTRACTORS

Prior to executing a contract with a prospective subcontractor and conducting testing of the entity's ability to produce accurate and complete encounters, Humana meets one-on-one with the entity to walk through the encounter submission requirements in the Delegated Entity Companion Guide for Delegated Encounters, or "Companion Guide". Designed to ensure all data fields are populated and accurate, the Companion Guide offers guidance on the requirements of transactions and data submitted to Humana.

We require our subcontractors to submit their encounter data to our clearinghouses. The clearinghouses and our electronic claim and encounter editing platform, eHub, identifies encounters that do not include the key field combinations, have incorrect coding, or contain other encounter errors, and rejects them. A claim rejection is usually an effective incentive to

encourage our providers and subcontractors to take steps to meet our encounter data requirements.

Additionally, as part of the contracting process, we establish key measures and performance thresholds that reflect our contract with AHCA to ensure our subcontractors perform to the same expectations we are accountable for, thereby driving timely, accurate, and complete submission of claims and encounters. Humana meets with key subcontractors monthly to discuss performance across all functions, including claims and encounters. We also take the appropriate steps to educate our subcontractors during onboarding on encounter submissions. Attachment 30-2 includes our encounter education materials we develop and offer our providers to inform them on the importance of encounters and coding validation.

PHARMACIES
Humana Pharmacy Solutions (HPS) owns and manages our pharmacy network. We educate our pharmacists about the requirements for submitting a complete and accurate claim in our Pharmacy Manual and through published payer sheets. In addition, we require our pharmacists to complete a self-guided online training program that highlights the State's requirements for claims. These requirements include the elements needed for a complete and accurate encounter. HPS is an affiliate to Humana Medical Plan, Inc., sharing the same parent (Humana, Inc.).

NON-PARTICIPATING PROVIDERS
Humana does not mandate training of non-participating providers on encounter requirements. We direct non-participating providers to our non-secured provider portal at Humana.com to learn about Humana's claim processing and payment requirements. This portal includes detailed guidance about requirements for claims to pass our electronic edits. Providers can also speak directly with a Provider Customer Service associate to discuss their questions about claim and encounter requirements.

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3. The adequacy of the respondent's approach to ensuring that all providers, including sub-capitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the respondent's approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.
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To ensure all our providers, sub-capitated providers and subcontractors submit accurate and complete encounters, Humana has developed front-end edits to ensure we reject claims and encounters when the amount or cost of Medicaid service is not complete. We remit the rejection with an explanation of the reason for the rejection so the provider understands that they must resubmit the claim or encounter with this information for processing. The encounter submissions by Humana's subcontractors must clear these edits, beginning with the submission to our preferred clearinghouse, Availity, and the submission into our electronic platform, eHub. We reject claims and encounters with this missing field upfront.

We also use our Provider Bulletin and other communication mechanisms to educate our providers on the importance of complete submission of encounter and claims data.

SUBCONTRACTORS
Our Claims and Encounters Teams works with our Relationship Managers and subcontractors to support our subcontractors' understanding of complete claims and encounter submission. Our internal teams work together to share encounter data performance on completeness metrics and conduct re-education, as needed.

PHARMACIES
Humana manages its own pharmacy network and uses DST Pharmacy Solutions, a claims processing subcontractor, to handle the processing and payment of claims. We have configured DST's claim processing and adjudication software with the necessary edits to validate that the amount or cost of the Medicaid service provided by the pharmacy is the amount actually paid to the pharmacy and does not include other administrative costs. All pharmacy claims, regardless of the source, adjudicate through DST. The criteria and reviews that process through our clinical analysis apply to retail, specialty, and mail service. Since all claims coordinate through the same database, we are able to integrate and track all drug utilization review (DUR), deductible, and prior authorizations accordingly.

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4. The adequacy of the respondent's approach to educating and supporting providers who submit paper claims.

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SUPPORTING PROVIDERS WHO SUBMIT PAPER CLAIMS

Humana understands the administrative challenges that our smaller providers in particular face in submitting claims. Over the past three (3) years, we have worked with our providers to educate them on the complete and proper submission of clean paper claims. All providers, including those that submit paper claims, receive orientation training on the requirements for claims to pass our electronic claims edits. Humana works closely with providers that submit paper claims, and monitors their claim denial rates. Our Provider Relations teams reach out to those providers that bill by paper and have higher-than-average claims denials to hold one-on-one phone training sessions and consultations with them. The training includes instructions on how to correct a denied claim. For those providers that speak only Spanish, we have Spanish-speaking Provider Relations representatives to help them directly with understanding Humana's claim and encounter requirements.

Our Provider Customer Service Center maintains an important role in educating and supporting providers that submit paper claims. This is particularly true for small or atypical providers who are not comfortable with the claims process. Our Provider Customer Service Center associates have sufficient training and experience in answering provider questions about claims and encounters so that they can explain the complexities of the Humana claims processing and payment system in terms that providers can easily understand. We also thoroughly train them

on the soft skills that are important in communicating with a provider who may be angry or upset because of a rejected claim. If the provider does not speak English, we will offer the provider the opportunity to use the translation services of our interpretation and translation vendor, or possibly be transferred to one of our Call Center associates who speak Spanish.

SUPPORTING PROVIDERS TRANSITION FROM PAPER TO ELECTRONIC CLAIMS SUBMISSION

Humana has an enterprise-wide strategy to transition our providers to electronic claims submission. Since 2015, we have reduced paper claims submission from five percent (5%) to four percent (4%), and have transitioned six thousand (6,000) paper claims to electronic submission on a monthly average (when comparing our 2016 performance to our 2017 performance to date). Our dedicated eBusiness Consulting team maintains a targeted outreach strategy and engages with providers one-on-one to support their transition to electronic claims. The eBusiness Consulting team targets our providers that have had high volume of phone calls to our Provider Call Center, high volume of paper checks, and high paper claims and encounters. The team initially engages the providers with an email and follows up with a phone call. Providers who submit a high volume of claims via paper also receive in-person sessions. We provide information to all providers on weekly webinars, designed specifically for our Florida providers, hosted by the team to discuss the claims submission process and to ask any questions. This far in 2017, our eBusiness consulting team has held more than nine hundred (900) webinars and more than seventeen thousand (17,000) interactions with providers to date.

Additionally, with our transition to Availity, we have designed a similar direct data entry form on the provider portal, making information on the status of the claim and remittance information for all claims available in one centralized location. Provided at no cost to our providers, Availity simplifies the entry of claims data for our providers and supports the completeness and accuracy of claims and encounter data, helping us achieve contractual requirements. Another feature we have designed with Availity is the submission of supplemental information electronically for paper claims that have been rejected because of a lack of information. To reduce the communication time we often face with paper claims, we alert our providers of the missing information via mail and via the online provider engagement portal while offering an electronic means to submit supplemental information to reprocess the claim.

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5. The adequacy of the respondent's approach to encouraging providers, particularly sub-capitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.

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SUB-CAPITATED PRIMARY CARE MEDICAL GROUPS

Our Medicaid Finance department reviews encounter detail data for our sub-capitated medical groups annually to validate accuracy of our capitation rates. We contact providers who do not submit complete encounter data to indicate the discrepancy between services rendered and capitation rate provided to identify whether quality improvements need to be in place, or if the provider's office needs additional education on encounter data submission.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana maintains strong oversight of our sub-capitated primary care medical groups. We meet with them on a routine basis and review reports to assess performance. We meet with our Primary Care Providers (PCPs) monthly and review several performance reports, including their encounter rate. Our Provider Relations representatives discuss the PCPs' encounter rates as compared with the county average to identify root causes for low encounter rate submissions. If a sub-capitated medical group's encounter error rate is high, our Provider Relations team works with the provider one-on-one to identify where education is needed and offer our expertise in fixing the error rate.

We determine capitation rates based on the encounter data submitted by our sub-capitated providers. When providers fail to submit complete and accurate encounter data in a timely fashion, their routinely assessed capitation rates will not reflect the actual cost of services they provide enrollees. To improve our validation of complete encounter submissions from our sub-capitated providers, we will conduct a more frequent review of encounter detail data and the capitation payments. Through this mechanism, we plan to track and trend quarterly claim and service counts as well as the average claims paid amount. The report will highlight significant variances between capitation payments and encounters.

Additionally, our sub-capitated providers enroll in either our Quality Capitation Bonus program or the MMA Physician Incentive Plan (MPIP), in which providers receive their bonus or award in each of these programs based on submitted encounters. These programs naturally incentivize providers to submit complete and accurate encounter data so they qualify for the bonus or reward designed in these programs. To this end, when they do not submit encounter data elements, the provider will not receive the bonus they have worked toward. Continuously, we educate and engage with our sub-capitated providers to ensure they understand that it is in their best interest to ensure completeness, accuracy, and timeliness of encounter data submission. When providers consistently fail to submit encounter data in a complete, accurate, and timely fashion, Humana conducts enrollment freezes and imposes liquidated damages.

SUBCONTRACTORS

Humana maintains oversight of subcontractor encounter accuracy, completeness, and timeliness metrics. We have developed a new position to ensure local oversight of our subcontracted functions. The Vendor Performance Leader will be responsible for monitoring performance of all subcontractors in their performance on the Florida Medicaid contract, including performance on data submitted to Humana. The Provider Relations Network Leadership supports our Vendor Oversight team. Relationship Managers work with our subcontractors on a regular basis to address areas of opportunity.

The Vendor Performance Leader reviews vendor performance on encounter data for completeness, accuracy, and timeliness of submission, and shares these reports with our subcontractors during Joint Operating Committee (JOC) meetings, and internal reporting to the Quality Improvement Committee (QIC). We put in place Corrective Action Plans (CAPs) where performance falls under the expected Service Level Agreement (SLA).

We require our subcontractors to submit their encounter data to one (1) of our two (2) preferred clearinghouses, Availity or ZirMed. These clearinghouses, together with our electronic claims receiving platform, eHub, identify encounters that do not include the necessary key field combinations, have incorrect coding, or contain other encounter errors, and reject them upfront.

As described earlier, we establish key measures and performance thresholds with our subcontractors to reflect our contract with AHCA as a strategy to ensure our subcontractors perform to the same expectations to which we are accountable. While a rejection is usually an effective incentive to encourage our subcontractors to implement corrective steps to meet our encounter requirements, we also apply any penalty received because of the performance of our subcontractor's data downstream to that entity.

ATYPICAL PROVIDERS
Our Provider Relations team works closely with atypical providers to ensure that they understand our requirements for claims payment and complete encounter data. Humana's strategy to work with our atypical providers focuses on engaging with our Spanish-speaking providers and targeted education for our atypical providers to support re-education on problematic areas related to submission of encounter data.

Because some of our atypical providers in South Florida speak only Spanish, we have assigned three (3) Spanish-speaking Provider Relations representatives in that region to help these providers submit accurate, correct, and complete claims and encounter data. Recently, Humana held a special in-person training session in Spanish on claims requirements for atypical providers in South Florida.

Our eBusiness Consulting team conducts targeted training, focused on our atypical providers, to identify our providers who have had high call volumes, high error rates, and low electronic submissions. The team then conducts email and telephonic outreach to work with these atypical providers to address these issues.

NON-PARTICIPATING PROVIDERS
Humana encourages non-participating providers to submit accurate, timely, and complete encounter data by making our claims submission requirements publicly available through our non-secure provider portal website. Our claims processing system includes front-line edits to ensure accurate and complete submission of data to create an encounter. We reject claims upfront when all the required data fields are incomplete or inaccurate. In addition, our Provider Customer Services associates are also available to help non-participating providers understand our encounter submission requirements.

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6. The adequacy of the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.
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As described throughout this response, we have multiple teams that engage with our providers, including sub-capitated, subcontractors, atypical, and non-participating providers. This is done to educate them about the importance of accurate, complete, and timely submission of encounters. To ensure timely submission of revised encounter data, we have developed a process and defined roles for our associates to support this function.

When Humana receives 835 encounter retections from the State, our Edifecs system captures all retections and centralizes the information to create actionable reports to resolve the encounter issue. We categorize errors into three (3) queues and disseminate to the appropriate resources for timely resolution: errors that can be resolved internally are handled by encounters

teams, errors that require outreach to providers for resolution are directed to Provider Realtions representatives, and errors that require resolution by subcontractors are overseen by Relationship Managers and Delegation Compliance.

We communicate summary reports with our Florida Medicaid Corporate Governance Committee and our Local Joint Operating Committee to identify additional opportunities. Whenever a provider submits an inaccurate or incomplete encounter to Humana, the provider receives a letter from us stating that we have rejected the encounter because of missing information. The letter specifies which information is missing and directs the provider to revise and resubmit. We deny any encounters submitted past the timely filing deadline.

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7. The adequacy of the respondent's approach to work with providers to comply with correct coding.
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Humana works with providers to comply with correct coding in several ways. First, CAS has correct coding edits to identify improper coding and will deny claims. Remittance files made available to providers via Availity explain the specific coding error that resulted in the denial, offering education to the provider. Our Provider Relations team also receives a report of errors, including coding errors, to inform their education strategy.

Humana has a proactive approach to provider outreach on encounter coding. Humana's Provider Reporting, Communication, and Education department develops various provider communications to promote accurate and consistent coding. This includes condition-specific coding guidelines and industry best practice materials, which we share with providers and office associates. We source educational materials from organizations such as the Centers for Medicare and Medicaid Services (CMS), American Heart Association, Mayo Clinic, and ICD-10-CM Official Guidelines for Coding and Reporting. Examples of condition-specific coding guidelines include depression and adult wellness visit. We may deliver these materials electronically as well as in person using our local Provider Relations representatives or peer-to-peer, as appropriate, by the local market Medicaid Medical Director.

Humana has developed a coding improvement process in which we give providers plans to guide them on commonly missed data points including diagnosis codes and coding specificity. The coding improvement plan also suggests best practices to improve coding for specific conditions. Our Provider Relations team reviews the plan and addresses specific coding issues. Provider Relations associates also share the State's clinical coding guidelines with providers and encourage them to follow the guidelines. In our provider newsletter and provider updates, we include recent releases from the State on coding issues and discuss coding errors we have seen in claim submissions. In addition, our coding experts provide detailed physician-based training on correct coding, and we offer peer-to-peer review with physicians on coding issues.

==========
8. The adequacy of the respondent's approach to ensure that all encounters are included in submissions.
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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana uses a customized version of the Edifecs Transaction Management platform to execute, manage, and monitor encounter submissions with our contracted State agencies. Edifecs is the only subcontractor with a single solution for submission, tracking, and error correction that allows Humana to manage our data internally.

Humana has an encounter reconciliation program to ensure we receive all claims and codes that providers submit accurately and timely. We measure this by completing a reconciliation process between the provider and Humana. The reconciliation process summarizes claim and code data processed, isolates data not received by Humana, and identifies any gaps in the data. Humana and the provider collaborate on the results of the process, identify gaps in the data, and the provider resubmits as needed. Humana and the provider will remedy any identified issues for accurate and timely submissions in support of future processing.

Since the 837 has to go through a series of edits from the provider to the clearinghouse to Humana, there is the possibility of dropped or truncated claims within various provider practice management systems. The encounter reconciliation program provides claim- and code-level analysis to determine averages and benchmarking based on overall claim performance. Furthermore, we request a collection of claims data for a specified period of time, a "shadow file," from our providers and Management Service Organization. We use the shadow file to measure accuracy of submission of all provider claims submitted to, and received by, Humana. The reconciliation model compares shadow file data to Humana's received data to determine potential data gaps. There is matching logic behind the reconciliation model to determine a match or a non-match. During the process, Humana looks at specific key data fields, including provider tax identification, date of service, enrollee identification, diagnosis codes, Current Procedural Terminology/Healthcare Common Procedure Coding System codes, and claim identification.

Additionally, we reconcile at a claim-, claim line-, and diagnosis code-level. We share results of the reconciliation process with the provider and if we identify any gaps, Humana and the provider work together to locate and resubmit any missing claims. We also work together to identify and address any system issues among the provider, the clearinghouse, and Humana. The summary report we share with the healthcare provider includes the date of service, shadow claims, matching claims, claim outage, claim outage percentage, shadow diagnosis codes, matching diagnosis codes, outlier diagnosis codes, and percentage.

Evaluation Criteria:

1. The adequacy of the respondent's approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.

2. The adequacy of the respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.

3. The adequacy of the respondent's approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes

the adequacy of the respondent's approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.

4. The adequacy of the respondent's approach to educating and supporting providers who submit paper claims.

5. The adequacy of the respondent's approach to encouraging providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.

6. The adequacy of the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.

7. The adequacy of the respondent's approach to work with providers to comply with correct coding.

8. The adequacy of the respondent's approach to ensure that all encounters are included in submissions.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

SRC# 31 – Fraud and Abuse/Compliance Office (Statewide):

The respondent shall describe its compliance program including the compliance officer's level of authority and reporting relationships. The respondent shall describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. The respondent shall include a résumé or curriculum vitae for the compliance officer. The respondent shall also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

Response:

"Our dream is to help people achieve lifelong well-being. Part of realizing that dream is a steadfast commitment to act with integrity and maintain the highest ethical standards. The values we share and a set of clear ethical principles help us make good decisions, allowing us to deliver a perfect experience for everyone we do business with." – Greg Catron, Humana's Chief Compliance Officer

Humana is fully committed to a culture of compliance that shapes every aspect of how we operate. Our Chief Compliance Officer, associates, and corporate advisors, along with our Florida compliance officers, exercise active oversight and informed judgment on behalf of the organization, and our oversight program ensures that every subcontractor we work with also adheres to our strict compliance standards. Our culture of compliance begins with our national leadership and (as described in our Compliance Plan) our overall compliance and accountability-centered mindset extends to associates, enrollees, shareholders, healthcare providers, subcontracted business partners, the community, and government agencies.

Best Documentation Practices for Diagnosis Coding

The "Evaluation and Management Services Guide" issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:

"Clear and concise medical record documentation is critical to providing patients with quality care and is required in order for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings and observations about the patient's health history. Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time."

Medical record documentation of patient diagnoses that is clear, concise and described to the highest level of specificity facilitates:

- Quality patient care with better outcomes
- Accurate diagnosis code assignment
- Appropriate and timely health care provider payment for furnished services

Key points

Legibility

The entire medical record must be legible. Remember this basic rule: If it is not documented, it was not done. Likewise, if it is not legible, it cannot be read. If it cannot be read, it cannot be proven that the diagnoses are supported and appropriate medical services were performed. An illegible record is of no use in assigning diagnosis codes or determining the medical services performed.

Patient demographics

Each page of the medical record should include, at a minimum, the date of service and the patient's name and date of birth. Also include the patient identification number, if applicable.

Page numbering

Each page for each date of service should be numbered.

Best practice

- *Page 1 of 3*
- *Page 2 of 3*
- *Page 3 of 3*

If pages are numbered in this way, it will be clear to an objective reviewer whether the record for a particular date is complete. If the printed pages are inadvertently separated, page numbers allow the medical record to be reassembled in proper order.

Health care provider signature and credentials

- Only authorized personnel may document in the medical record, and each person must be clearly identified with full name and credentials.
- All entries must be signed and dated in a timely manner by the health care provider who performed the service. Signatures should be identified by a printed, legible name and credentials.
- Signature stamps are not accepted by CMS.
- Electronic signatures must be authenticated by the health care provider. For a signature to be valid, the following criteria must be met:
    - Services provided or ordered must be authenticated by the ordering practitioner.
    - Signatures are to be handwritten or electronic (stamped signatures are not acceptable).
    - Signatures should be legible.

  Reference: CMS Medicare Program Integrity Manual (Publication [Pub.] 100-08), Chapter 3, Section 3.3.2.4

Abbreviations and acronyms

- Limit the use of abbreviations and acronyms, or avoid them altogether.
- Use only industry-standard abbreviations and acronyms.
- Realize some standard abbreviations and acronyms have multiple meanings. The meaning of the abbreviation or acronym often can be determined based on context, but this is not always true.

Best practice

- *The initial notation of a diagnosis should be spelled out in full with the abbreviation in parentheses, such as "myocardial infarction (MI)" or "rheumatoid arthritis (RA)."*
- *Subsequent mention of the condition can be made using the abbreviation.*
- *The diagnosis should again be spelled out in full in the final impression or plan.*

Timelines and dates

Specific dates and timelines provide important information and can affect diagnosis code assignment (see second example below regarding myocardial infarction).

- Post-hospitalization or post-operative follow-up office visits:

  Vague: "Patient was recently discharged from the hospital."

  Vague: "Patient is here for hospital follow-up."

  Specific: "Patient was discharged from the hospital on 1/15/20xx after admission for ____."

  Specific: "Patient was discharged from the hospital two weeks ago after admission for _____."

  Vague: "Post-op visit for recent splenectomy."

  Specific: "Patient is here for first post-op visit for splenectomy performed on 3/25/20xx."

- "Recent" myocardial infarction (MI) is a vague description that does not specify whether the patient experienced an acute myocardial infarction within the last four weeks (coded as acute MI) versus a myocardial infarction that is older than four weeks with no current symptoms (coded as historical MI).

  Vague: "Follow-up office visit for recent myocardial infarction."

  Specific: "Patient was discharged from ABC Medical Center on 2/25/20xx after inpatient admission for acute myocardial infarction."

  Specific: "Patient was discharged from ABC Medical Center one week ago after inpatient admission for acute myocardial infarction."

Historical versus current

- Do not use the descriptor "history of" to describe a current or chronic condition that is still present, active or ongoing.
- Do not use the descriptor "history of" to describe a current condition that is in remission. Describe the condition as "in remission."
- Do not document a condition as current if it is historical only. For example: A patient with a history of prostate cancer that has been eradicated in the past presents to the office for an evaluation, examination and prostate-specific antigen (PSA) lab test to monitor for recurrence. The assessment section should not state "prostate cancer," but rather "history of prostate cancer." The related plan should state, "Will continue to monitor PSA every six months to check for prostate cancer recurrence."

Consistency

Use caution when using record templates or electronic medical records (EMR) that might introduce conflicting or contradictory information. Many EMR systems default to "normal" values that may conflict with previous "abnormal" entries.

Examples of conflicting or contradictory documentation include:

- The final assessment states right hemiparesis due to prior cerebrovascular accident, but the neurologic review of systems (ROS) and neurologic examination are noted as completely normal.
- The chief complaint states the patient presents for evaluation of chest pain, and the final assessment states acute angina. However, the review of systems states, "Patient denies any episodes of chest pain."
- The office notes refer to the patient as both "he" and "she," creating a consistency issue.

Specificity

Describe each condition to the highest level of specificity, such as:

- with or without exacerbation
- with or without complications
- acute versus chronic
- severity – mild, moderate, severe
- stages or types
- controlled or uncontrolled
- underlying cause
- location or site, including laterality, specific site within a body part (upper outer quadrant, lower inner quadrant, etc.), distal, proximal, etc.

Examples:

Chronic kidney disease (CKD) – Specify stage I-V or end-stage renal disease (ESRD).

- Even if lab values and/or the glomerular filtration rate (GFR) are documented, the record must clearly specify the stage of CKD. Medical coders are not allowed to assign a stage of CKD based on the documented GFR.

Diabetes mellitus (DM) – Specify:

- Type (Type 1, Type 2, secondary to – specify causal condition)
- Status of diabetes control, as in "well controlled" or "uncontrolled due to hyperglycemia" (ICD-10-CM considers "uncontrolled" to be a diabetic complication and requires the physician to specify "uncontrolled" as either hyperglycemia or hypoglycemia)
- With or without complications or manifestations (fully describe each complication or manifestation)

If there are complications or manifestations of diabetes mellitus, best practice is to clearly and directly link diabetes to those complications or manifestations using terms such as "with," "due to," "secondary to," "associated with" and "related to." Avoid the use of punctuation marks (e.g., slashes and commas) to separate diabetes and its manifestations, as they may not clearly indicate a causal relationship.

Best practice

- *Document each complication of diabetes with the descriptor "diabetic," as in "diabetes mellitus Type 2, well controlled, with diabetic neuropathy."*

Confirmed versus uncertain

Avoid use of terms that imply uncertainty (such as "probable," "apparently," "likely" or "consistent with") to describe diagnoses or conditions that are confirmed. Always document the signs and symptoms in the absence of a confirmed diagnosis.

Status conditions

Document status conditions when applicable (e.g., ostomy status, dialysis status, amputation status, major organ transplant, etc.).

Final diagnostic statement

This is the section of the record where the health care provider states the final assessment or final impression of the patient's current diagnoses based on all other information gathered as the patient was evaluated on an individual date of service. The final diagnostic statement should include:

- All conditions or diagnoses that impacted the patient's care on this date
- All conditions or diagnoses evaluated and managed on this date
- All comorbid or coexisting conditions that impacted patient care, treatment or management on this date
- Status of each condition that currently exists (not historical), such as improved, stable, worsening, in remission, etc.

Supporting documentation

Keep in mind that the record should provide supporting documentation for each condition or diagnosis listed. For example:

- Related signs and symptoms and physical exam findings should be listed
- Medication lists should document the drug name, dosage with times and/or frequency and the condition(s) for which the drug has been prescribed
- Results of diagnostic testing should be documented

For chronic conditions that are being followed by a different health care provider, supporting documentation would be a simple notation to that effect. For example, "Chronic obstructive pulmonary disease (COPD), under treatment by pulmonologist."

Treatment plan

Your current plan of treatment for each diagnosis should be clearly documented and specific. Examples should include dietary recommendations, medication changes, scheduling of diagnostic testing, specific patient education or counseling provided, continued monitoring and other factors that affect diagnosis. If referrals are made or consultations requested, the office note should indicate to whom or where the referral or consultation is made or from whom consultation advice is requested. Document when it is planned to see the patient again, even if on an as-needed basis only.

A final note

Industry-standard diagnosis coding guidelines require medical coders to apply a strict literal interpretation to the health care provider's medical record documentation. Coders are not allowed to "connect the dots," make assumptions or presume to know the health care provider's intent. Coders cannot apply a clinical interpretation to information within the record, such as diagnostic test results or physical exam findings. Accurate diagnosis code assignment is dependent on the health care provider clearly describing each medical diagnosis to the highest level of specificity.

Humana's Encounter Series

The Basics of Encounters

As we move closer to the proposed ICD-10 compliance date of Oct. 1, 2015, one of Humana's top priorities is to minimize disruption to our provider groups for claims delegation and to reduce potential financial impact to revenue streams. We are committed to continue delivering accurate and timely claims payment and processing of submitted encounters.

We want providers to know why submitting accurate, complete and timely claims and encounter data is critical to financial and operational continuity for them and Humana.

What is an encounter?

- An encounter is a unique type of claim.
- Encounter data are used to determine the member's health status.
- Encounter data are submitted by Humana's provider groups.

What is the difference between a claim and an encounter?

- Encounter data contain the same provider, member, service and diagnosis information that a claim does.
- A claim generates a payment or a denial; an encounter does not.
- Encounters are the responsibility of the provider under the capitation agreement.

Why is an encounter so critical?

- Encounters are used for HEDIS® (Healthcare Effectiveness Data & Information) reporting as well as being a primary driver for risk adjustment scoring.
- Encounters must contain **all diagnosis codes** for which the member was treated and/or monitored during his or her visit.
- Encounters enable accurate and complete reporting of risk adjustment data to the Centers for Medicare & Medicaid Services (CMS) for reimbursement.

Important Risk Information

Risk adjustment applies to every Medicare Advantage (MA) plan member.

A member's health status is determined through diagnosis codes. These codes are tied to hierarchical condition categories (HCC) that determine a member's risk score, and risk scores directly impact CMS reimbursement.

If encounters do not describe a member's condition accurately, there may be a negative impact to a member's risk score. Risk scores are higher for members with greater levels of illness. If diagnosis codes are missing on a member's encounter, then risk score assigned to the member may be understated.

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What is a hierarchical condition category (HCC)?

You may be wondering how HCCs influence a member's risk score. HCCs represent categories of health conditions, which can be chronic and acute. Diagnosis codes are mapped to HCCs for conditions, such as diabetes or congestive heart failure. It also is important to note that a member can have multiple HCCs. Each HCC is assigned a value that contributes to a member's risk score. CMS controls the mapping of these diagnosis codes to the appropriate HCC.

What is the encounter flow process?

The flow of data from physician to Humana contains several intermediaries that perform key functions.

Type	Physician	Practice Management System (PMS)	Intermediary / Billing Service	Provider Group	Billing Service/ Clearinghouse	Clearinghouse
Description	Medical practitioner that performs the service on the claim and ensures that all diagnosis codes are on the claim	Management software used to schedule, administer claims and to code ICD codes for member's visit (may also generate 837s)	Service/ company that generates the 837 or performs billing related functions on behalf of the physician	Company that performs select administrative tasks on behalf of Humana, such as claim adjudication	Service/ company that generates the initial validation of encounter file; may also perform billing-related functions on behalf of the provider group	Service/ company that performs front-end validation of encounter file and transmits responses back to submitter and sends encounter to Humana
Example	Any contracted Physician	Cerner	Emdeon	IPA/MSO/MG/TPA	Transunion	Availity

Provider groups submit encounters to document the treatments provided to members. Unlike fee-for service (FFS) claims, encounters do not generate a payment when processed. The diagnosis and procedure codes on the encounter support Humana managed care programs, confirm that gaps in quality measures have been closed and provide data to calculate Medicare risk scores, which affect capitation rates, member premiums and plan benefits.

The term delegate represents entities that may be referred to as claims delegate or provider group, as well as delivery system (DS), independent practice association (IPA), management service organization (MSO), medical groups (MG), physician hospital organization (PHO), third-party administrator (TPA) and other entities to which Humana delegates its claim adjudication function.

Contact Information

The ICD-10 deadline is right around the corner; therefore, providers need to be prepared. Humana encourages providers to start testing and measuring associated risks that may impact their practices.

For more information about encounters or ICD-10, please email IPAICD10Inquiries@humana.com.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Incorporating the Office of Inspector General's (OIG) guidance, we have built our Compliance Plan on a strong code of conduct for our associates and contractors across all lines of business, and have structured it to adhere to all relevant federal and State requirements. We are committed to compliance with the contractual and regulatory requirements of our programs. The following details our compliance efforts, compliance structure, and experience in identifying and mitigating subcontractor fraud, and internal fraud, waste and abuse.

Our Compliance Plan is comprised of seven (7) key elements:

1. Written Policies, Procedures and Standards of Conduct
2. A Corporate Commitment to Oversight: Compliance Officers and Compliance Committee
3. Effective Training and Education for all Employees and Contractors
4. Effective Lines of Communication
5. Well-Publicized Disciplinary Standards and Strong Enforcement Mechanisms
6. Routine Monitoring and Auditing
7. Corrective Action: Procedures and System for Prompt Response to Compliance Issues

1. WRITTEN POLICIES, PROCEDURES AND STANDARDS OF CONDUCT
Humana establishes standards of conduct within Ethics Every Day, our comprehensive ethics and compliance training program. Ethics Every Day is supported by an extensive policy library with written guidelines which:

- Provide direction as to how to identify, manage, and report potential issues

- Describe how potential issues are investigated and resolved by the organization

- Include a policy of non-intimidation and no-retaliation for good-faith participation in the compliance program. This includes, but is not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate regulatory officials.

We are committed to complying with all federal or state laws, rules, and regulations associated with the privacy of protected health, financial, and personal information described below and in detail in our Compliance Plan. Since regulatory and other requirements change over time, we review compliance policies annually and revise policies as appropriate. The Policy Governance Committee, chaired by the Privacy Officer (who reports to the Chief Compliance Officer), gives oversight for this annual review process.

Finally, we conduct an annual assessment to evaluate the overall performance and effectiveness of the Compliance Plan, introducing modifications to the Plan as deemed necessary or appropriate per the assessment results.

2. A CORPORATE COMMITMENT TO OVERSIGHT: COMPLIANCE OFFICERS AND COMPLIANCE COMMITTEE
Humana's Board of Directors is ultimately responsible for our compliance with all state and federal requirements, and with ensuring the effectiveness of the compliance program. Our Board of Directors has delegated compliance program oversight to the Audit Committee of the

Board, which oversees our Compliance Plan. Both the Board of Directors and the Audit Committee receive quarterly reports about compliance matters throughout the organization.
We have an established Chief Compliance Officer who, in recognition of the importance of this position, also serves as a Vice President of Humana, Inc. The Chief Compliance Officer works in conjunction with several other key senior executive level positions, including our Medicare and Medicaid Compliance Officer and Chief Risk Officer. The Medicare and Medicaid Compliance Officer reports quarterly to the Corporate Compliance Committee and Audit Committee.

We have also appointed a highly experienced Compliance Officer (CO) at the Florida Medicaid market level who oversees the Florida implementation of our Compliance Plan, ensures compliance with federal and State regulations, and acts as a point of contact for our Florida Medicaid compliance operations. This CO has deep expertise in with the Florida Medicaid program, both in Long-term Care (LTC) and Managed Medical Assistance (MMA). In addition, the CO is also able to use additional associates, with significant regulatory compliance experience, in addressing our market-directed compliance efforts. The Florida CO has direct access to our Chief Executive Officer and Board of Directors, submits quarterly Florida-market specific reports to the Audit Committee, and receives steady support from our broader national compliance structure.

3. EFFECTIVE TRAINING AND EDUCATION FOR ALL EMPLOYEES AND CONTRACTORS
Effective compliance and Fraud Waste and Abuse (FWA) training is a cornerstone of Humana's Compliance Plan, and is administered in a curriculum called Ethics and Compliance Training. This required training is completed annually by all Humana associates, including the Chief Executive Officer, all senior leaders, the Board of Directors, and contingent labor, including all subcontractors. Additionally, our new associates, senior leaders, and members of the Board of Directors (including temporary workers) are required to complete Ethics and Compliance Training within thirty (30) days of hire or start date and are required to complete the "Ethics Every Day" training annually thereafter. Employees of entities we acquire are required to complete the Ethics and Compliance Training within sixty (60) days of acquisition close date, and complete the "Ethics Every Day" training annually thereafter.

4. EFFECTIVE LINES OF COMMUNICATION
As mentioned above, the Corporate Compliance Committee, which includes the Chief Executive Officer (CEO), governs the Corporate Compliance Program, updating the Audit Committee of the Board of Directors when necessary. Senior management is fully engaged in the compliance program, and Humana's CEO stands behind the Chief Compliance Officer to ensure that all necessary resources and support are available to operate an effective program. The CEO participates in, and is a member of, the Corporate Compliance Committee, which also receives quarterly reports from the Medicare and Medicaid Compliance Officer, along with the Audit Committee.

Humana has an "open door" policy when it comes to reporting FWA. Any Humana associate can safely report concerns of compliance. Our compliance hotline is well-publicized and prominently featured on our website and numerous other materials. Our website also includes a link for anyone to report any suspected FWA. All reports can be made confidentially via the phone, website, or email, which is well-publicized during our required training. Market-based compliance officers, market-based leadership, and associates who oversee subcontractors

have direct lines of communication with the CEO and the Audit Committee of the Board of Directors in a culture that is free of fear of retaliation.

5. WELL-PUBLICIZED DISCIPLINARY STANDARDS AND STRONG ENFORCEMENT MECHANISMS

To support our compliance culture and the expectation that all associates report any compliance issue or unethical behavior, we maintain well-publicized disciplinary standards, described in our internal policies, and a comprehensive guide for ethical conduct, Ethics Every Day. Reported violations are thoroughly investigated and resolved. Violations of law or company policy or behavior that is not aligned with our standards of ethics and integrity may constitute critical offenses, justifying immediate disciplinary action up to, and including, termination of employment. Subcontractors must abide by the same policies. Disciplinary action for any violation(s) committed by subcontractors could include, but is not limited to, mandatory (re)training, corrective action plans, or contract termination.

6. ROUTINE MONITORING AND AUDITING

Humana has many internal departments engaged in the identification of compliance risks. Monitoring occurs through the effort of the following teams:

- Human Resources
- The Ethics Office
- The Privacy Office
- Regulatory Compliance
- Delegation Compliance
- First Tier, Downstream, and Related Entities (FDR) Compliance
- The Internal Audit Consulting Group
- The Enterprise Information Protection team
- The Special Investigations Unit (SIU)
- Provider Payment Integrity (PPI)
- Risk Adjustment Integrity Unit (RAIU)
- Pharmacy department
- Insurance Risk Management

We also engage various independent review organizations, including nationally-recognized experts such as Deloitte Consulting, LLP, to assist with compliance risk identification. Each of the departments listed above has subject matter expertise to monitor and assess adequate control systems and risks associated with ongoing and one-time processes. This activity ensures that reporting mechanisms are in place, fully functional, and that serious deficiencies are reported to the appropriate authorities.

Compliance events are communicated to the Compliance Officers, reviewed by appropriate leadership, and communicated to senior management on a monthly basis through the Integrated Compliance Scorecard and our compliance dashboard, which are both discussed in detail below. When appropriate, the Enterprise Compliance team voluntarily self-reports identified violations to government agencies.

7. CORRECTIVE ACTION: PROCEDURES AND SYSTEMS FOR PROMPT RESPONSE TO COMPLIANCE ISSUES

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana has procedures and systems in place for responding to compliance issues in managed care programs as they are raised, both with respect to potential internal fraud and abuse as well as with identifying subcontractor fraud. We utilize a continuous improvement mindset implemented through our Enterprise Solution Point (ESP) system, which is an enterprise-wide tool for improving the management processes, risk, controls, and compliance. This integrated solution begins with policies and procedures, coupled with an audit and assessment framework, to continuously improve the management process as efficiently as possible. To that end, we conduct timely investigations of potential compliance problems identified in the course of self-evaluations and audits. These problems are corrected promptly and thoroughly to reduce the potential for recurrence and to ensure ongoing compliance with state and federal requirements for all product offerings. We have also developed policies and procedures to facilitate timely and reasonable inquiry into potential fraud or misconduct. We voluntarily self-report identified instances of fraud or misconduct to the appropriate regulatory body internal-to-Humana, based on the associated line of business, and all associates are expected to ensure policies are consistently followed, regardless of operational needs, financial concerns, level or degree of influence, or other business factors.

ONGOING PARTNERSHIP WITH AHCA

Humana considers one of our biggest successes related to compliance to be our strong partnership with Agency for Health Care Administration (AHCA) and its other local partners. As an example, several years ago when AHCA Medicaid Program Integrity (MPI) suggested holding quarterly meetings outside of the AHCA offices at plan locales, we offered to host the first meeting of all the plans. Similarly, when AHCA sought input to perfect its own audit tool and process, we dedicated time to ensure that we assisted AHCA by meeting with them and providing input about our auditing process and tool used in recognition of this partnership. This ongoing successful partnership with AHCA is a critical component to the success of our compliance program in Florida.

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1. The extent to which the respondent's compliance program complies with all State and federal requirements.

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HUMANA'S CORPORATE-LOCAL APPROACH TO PROGRAM COMPLIANCE

Humana's efforts to ensure our compliance program complies with all current state and federal requirements are multi-level and comprehensive. On the corporate enterprise level, Humana's Chief Compliance Officer (CCO) oversees numerous associates charged with ensuring our associates and contractors comply with Federal laws, regulations, policies, and guidance. We are also actively involved with multiple national anti-fraud organizations including, but not limited to, the National Health Care Anti-Fraud Association (NHCAA) and the Special Investigations Unit Anti-Fraud Coalition (SIUAC). We are also founding members of an innovative public-private partnership, the Healthcare Fraud Prevention Partnership, formed by the Department of Health and Human Services (HHS) following passage of the Affordable Care Act (ACA). These partnerships, coupled with participation in numerous industry conferences, have helped us confirm our compliance with current Federal requirements and allow us to stay ahead of

inappropriate or illegal trends and schemes as they are emerging. We ensure the knowledge we learn from our partners is incorporated into our day-to-day operations, and distributed to our associates nationally.

In Florida, we have been an active partner with AHCA to prevent and detect fraud, waste and abuse. We have built upon our broad and longstanding experience operating as a Comprehensive Plan in Florida Medicaid to appoint a CO and additional experienced compliance associates. Our CO and Florida compliance associates lead our compliance program integrity efforts with the assistance from our SIU and PPI units. Similar to our federal activities, our Florida associates participate actively in State and local workgroups, calls, and discussions, including quarterly meetings and calls with AHCA and Florida anti-fraud task forces. This participation, along with the expertise of our Florida CO and compliance associates, ensures we remain current with Florida laws and regulations and AHCA's policies and requirements.

ENSURING COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS
Humana's compliance endeavors are described in detail in our Compliance Plan, which includes a detailed description of the laws and regulations that apply to our operations including policies related to gifts and gratuities to government employees and conflicts of interest. Examples of the federal laws incorporated into our Compliance Plan include:

- The Medicaid Act, 42 U.S.C §1932 et seq.,
- The Medicaid Program, 42 CFR Part 400, et al. Medicaid Program
- The Medicaid Managed Care Rule, 42 CFR Part 438
- False Claims Act, Civil and Criminal, 31 USC §37§29-3733 and 18 USC §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b(b)
- Physician Self-Referral Statute (Stark), 42 USC § 1395nn
- Criminal Health Care Fraud 18 USC §1347
- Regulatory Safe Harbors, 42 CFR § 1001.952
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191
- HIPPA Privacy, Security and Administrative Simplification Regulations, 45 CRF Parts 160 and 164

Our CO also monitors compliance-related laws and regulations specific to the State of Florida, including Title Social Welfare,Chapter 409 - Social and Economic Assistance of the Florida Statute, specifically Parts III and IV, along with the corresponding regulations.

Various executives and groups within Humana review the compliance plan at least annually, and often more frequently. This includes our CEO, Board of Directors and Audit Committee. We are required to submit this plan to AHCA for approval annually. AHCA approved our most recent submission in August of 2017 with a favorable response.

TOOLS TO MONITOR COMPLIANCE WITH STATE AND FEDERAL REQUIREMENTS
There are several tools and resources we use to monitor our compliance with State and federal requirements, including:

- Enterprise Solution Point
- Metrics and Scorecards to monitor and track activities
- Contract Management Unit Implementation

- Active Risk Ranking System
- Aggressive Internal Audit Efforts
- Compliance Training

Enterprise Solution Point (ESP)
Our ESP system allows us to tailor all of our required reports to meet state and federal contractual requirements. The ESP dashboard allows us to view metrics relating to internal compliance (ethics training, and internal audits), as well as metrics related to compliance with our contract with AHCA. ESP also houses compliance-related policies and procedures to ensure our associates are operating under the same guiding principles across the organization.

Metrics and scorecards to monitor and track activities
On a regular basis, we track and report on compliance for Florida Medicaid operations, allowing compliance associates and leadership to examine our compliance status and the success of our efforts. Several units within Humana analyze this information to provide a full view across the organization including, for example, our Quality Improvement Committee, utilization management associates, and our market review teams, among others.

Our Medicaid Integrated Compliance Scorecard is compiled monthly by Operational Risk Management and is comprised of two (2) parts: 1) a point-in-time assessment of compliance for each contract; and 2) compliance metrics including current compliance measurements for the reporting month. The results are trended and showcase a realistic view of business operations, taking into consideration normal and unusual occurrences. Discussion of the metrics facilitates the closure of external and internal corrective action plans and other notifications of non-compliance.

On top of the standing monthly meeting and metric reporting described above, we also produce regular reports to examine and ensure compliance for specific areas. These regular reports include, but are not limited to, the following:

- Monthly reports of enrollees and providers

- Monthly compliance reports

- Weekly compliance reports help to confirm cases were closed timely in compliance with the Medicaid Grievance and Appeals compliance regulations

- Daily open critical inquiry (CI) inventory summaries on open and pending statuses with their due dates, created dates, owner information, and more

- Bi-weekly AHCA CI inventory reports detail the inventory and reason code management dealing with Florida Medicaid cases, tracking all received cases for the year and giving a summary of open and pending cases

- Weekly acknowledgement reports to determine which cases were acknowledged in a timely manner for Medicaid Grievance and Appeals in relation to Medicaid rules

- Discretionary payment reports giving the number of discretionary payments made, including the overturn amount and the reason

Contract Management Unit Implementation
A standing agenda item for the Operational Risk Management meeting is High-Risk Implementations, which are any risks associated with a new regulation or contract provision. As necessary, discussion is held to identify any risks, barriers, or gaps that would impede timely implementation of the new regulation or contract provision.

Active Risk Ranking System
Our monthly compliance dashboard displays performance on metrics using criteria that include the following considerations: criticality to key business processes; seasonality impact; and at-risk or under-performance for the reporting period. This monitoring tool allows us to identify and address potential AHCA compliance issues by gathering data across the following primary business functions: claims, clinical, enrollee services, grievances and appeals, and provider network. Compliance scorecards and dashboards are published to senior leaders across Humana, including the Chief Compliance Officer, Medicare and Medicaid Compliance Officer, Segment VP and President, Medicaid, and other senior leaders who are responsible for oversight of Medicaid across Humana.

Medicaid Regulatory Compliance leverages findings from ongoing monitoring activities and Risk Assessment Subcommittees to perform an annual compliance risk assessment. Informed by the risk assessment, a work plan is developed to outline monitoring and auditing activities that will take place during the year, including those items that are at a higher risk-ranking. This work plan, created annually, encompasses activity that will take place in Medicaid Service Operations, Customer Service and Resolution, Pharmacy Operations, and Healthcare Delivery. The work plan is reviewed regularly by the Chief Compliance Officer and updated by Compliance leaders throughout the year.

Aggressive Internal Audit Efforts
Regulatory Compliance monitors adherence to the AHCA Contract and regulatory requirements. The requirement “owner” within Humana for each requirement, this individual’s leadership, Medicaid operations and leadership, operational risk management associates, and enterprise compliance associates are engaged in this monitoring activity. On a monthly basis, these groups present the performance of these key contract requirements to our compliance and executive leadership.

The Humana Medicaid Compliance Committee meets each month, is chaired by the Medicare and Medicaid Compliance Officer, and includes representatives from Compliance, Legal, Internal Audit, and Medicaid Operations, among others. The purpose of the Medicaid Compliance Committee is to provide a forum to present, review, analyze, and make recommendations on issues pertaining to our Medicaid programs. The agenda includes discussion of pressing compliance issues in each Medicaid program, including Florida Medicaid. The Medicaid Integrated Compliance Scorecard drives the discussion, providing the opportunity to monitor and report out Medicaid compliance risks.

Compliance Training
Our thorough strategies for ensuring compliance with federal and state laws are coupled with a strict Standards of Conduct policy which applies to all Humana associates and contractors. All our associates and contractors are required to complete training within thirty (30) days of their employment with Humana and annually thereafter. This training includes details about our

expectations for adhering to the law and discusses the consequences for those who violate those expectations.

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2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program.

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The success of Humana's compliance program is due, in significant part, to the emphasis we place on compliance throughout every facet of our organization. Our "culture of compliance" begins with strong leadership at the top of the organization that consistently emphasizes that compliance is an unwavering expectation for all associates and contractors. Our senior-most leadership – Humana President and CEO, Bruce Broussard -- and the Audit Committee of the Board of Directors, play an active role in oversight of our compliance functions. Attachment 31-1 presents our Medicaid Regulatory Compliance Organizational Chart, depicting key Florida-based and corporate-level leadership responsible for compliance and demonstrates their clear access to leadership.

Our enterprise- wide commitment to compliance has led to strong relationships with our partners at AHCA and CMS. We have capitalized on our Local-Corporate compliance oversight model to establish a clear leadership structure for our on-the-ground compliance operations in Florida, supported by our robust national compliance monitoring resources.

FLORIDA COMPLIANCE LEADERSHIP

COMPLIANCE OFFICER

Humana's Florida SMMC Comprehensive Plan compliance efforts are led by our Florida-based Compliance Officer (CO), Linda Lawrence, whose resume is provided in Attachment 31-2. Ms. Lawrence has been with Humana since 1985. Linda's thirty-two (32) years of work history with Humana provide her with extensive knowledge and experience of the business. She was a medical center administrator before joining the Compliance team where she has served for the past twenty-five (25) years. She has worked in both the Commercial and Medicare areas in addition to Medicaid, and has been dedicated to Medicaid for the last eight years.

Ms. Lawrence will continue to be supported by her experienced compliance associates, including Shannon Childers. Ms. Childers has been with Humana for nearly four (4) years and has extensive experience in both the financial industry as an analyst and as a practicing attorney. Specifically, Ms. Childers has represented clients on Medicaid and Medicare reimbursement complaints, including both enrollees and providers, giving her a valuable perspective on how Medicaid functions from their perspectives. In addition, Ms. Childers brings years of experience in financial roles and a strong understanding of types of reports to run and anomalies to look for in identifying fraud, waste, and abuse and monitoring operational compliance.

We believe that compliance must be a partnership with the state to truly be successful. To that end, Ms. Lawrence and her associates have provided strong leadership in Florida to ensure that our compliance efforts are as successful as possible. We have led or participated in numerous

meetings with AHCA and worked diligently to build a strong relationship to foster compliance across the state. Our compliance associates have either led or participated in at least fifteen (15) regular AHCA Medicaid Program Integrity (MPI) meetings to ensure an effective relationship with AHCA, as well as the other health plans, when it comes to detecting and resolving instances of fraud, waste and abuse. This cooperative effort allows all parties to share information quickly to prevent or respond to issues and mitigate the associated risk. The Florida Compliance Officer reports to our Medicare and Medicaid Compliance Officer; however, our compliance associates have the ability to escalate compliance matters directly to the CEO and the Audit Committee of the Board of Directors.

NATIONAL COMPLIANCE LEADERSHIP

CHIEF COMPLIANCE OFFICER
Humana's Chief Compliance Officer is responsible for our Compliance function – which includes federal and State Regulatory Compliance, Delegation Compliance, Ethics, Privacy, National Regulatory Implementation, and Enterprise Policy Management and Compliance Training – and has authority to report out directly to the Chairman of the Board, the CEO, and the Audit Committee of the Board of Directors. Humana holds each of its operational areas accountable for the daily adherence to the Compliance Plan, making various leaders accountable to the Chief Compliance Officer.

CHIEF RISK OFFICER
In September 2017, we took a progressive step in the healthcare industry by creating a Chief Risk Office, uniting our risk and compliance organizations to ensure easier collaboration while maintaining strong partnerships across our operations. While this type of position is common in other industries, such as the banking industry, this position is unique for a healthcare organization. We believe the introduction of the Chief Risk Office will be a significant step forward in optimally serving our enrollees and the organizations and agencies with whom we partner, including AHCA. Leading this joint organization is the newly created position of Senior Vice President and Chief Risk Officer. This leader reports directly to our President and CEO and serves as a member of Humana's Management team while overseeing the development of the company's Chief Risk Office. The Chief Risk Officer sets direction and establishes policy in the areas of enterprise risk management and compliance, while building a strategy and a culture that manages risk appropriately and establishing a consistent definition of risk across the enterprise. This enables the organization to drive connections and collaboration throughout the business to ensure timely and proactive discovery as well as faster mitigation of risks and their causes.

MEDICARE AND MEDICAID COMPLIANCE OFFICER
Humana's Chief Compliance Officer and Chief Risk Officer are supported by a Medicare and Medicaid Compliance Officer who reports directly to our Chief Compliance Officer and has full direct access to report any compliance matters to the Audit Committee of the Board of Directors or our CEO, including quarterly updates on fraud, waste and abuse and our Compliance Program. The Medicare and Medicaid Compliance Officer's responsibilities and authority are delineated in the Compliance Program.

Our Medicare and Medicaid Compliance Officer reports quarterly, in writing or in person, to the Audit Committee of Humana's Board of Directors about Compliance issues, including Florida

Medicaid issues as they arise. Generally, the Medicaid Compliance reports include significant issues of non-compliance, audit schedules and results, liquidated damages/Corrective Action Plans, root causes of compliance challenges and plans to mitigate these incidences, and any other compliance matters that warrant the attention of the Board of Directors. The goal of these reports is to allow the governing body to exercise reasonable oversight with respect to implementation and effectiveness of the compliance program.

COMPLIANCE COMMITTEE
The Compliance Committee, chaired by the Medicare and Medicaid Compliance Officer, oversees the Medicaid FWA Control Program. The FWA Control Program is designed to meet federal and state laws, rules and regulations, including fraud, waste, and abuse detection, correction, and prevention guidelines that apply to Humana and its FDR entities.

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3. The extent to which there are sufficient staff to implement the compliance program.
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Our commitment to compliance is substantial, fully operational, and supported by significant resources. This includes financial resources, human resources, and state-of-the-art information systems. As described in detail above, we have developed a strong leadership structure that combines local Florida compliance expertise, with extensive national resources. The enterprise function is supported by more than one hundred twenty (120) Full Time Equivalent (FTE) associates across our compliance organizational structure; however, this does not provide a full picture of our dedication to our compliance functions. We also have numerous individuals who work for our Claims Cost Management (CCM) department, which includes our SIU and PPI Unit, all of which play an essential role in compliance efforts, but who are accounted for separately. Further, we have numerous associates who deliver compliance-related functions within each department, such as our quality or case management departments, who are accounted for under those functions. Included in Attachment 31-1 is our Compliance Structure.

As described above, associates at both our state market level and at our national enterprise level have clearly defined responsibilities and work together to fill out the full staffing allocated to our compliance functions.

FLORIDA COMPLIANCE STAFF

At the State level, the Regulatory Compliance (RC) associates, specifically the Florida Compliance Officer (CO), has responsibility for oversight of contract requirements, whether of an administrative or operational nature. Oversight is completed with the assistance of many associates through document and data reviews, Joint and Local Operational Committee meetings, audits, and ad-hoc meetings. RC associates are engaged in all phases of these activities with the appropriate support and oversight that is needed by the function or business area. Some areas are well established and run with minimal need for support, while others are in a transitional or developmental phase and thus require more involvement. Additionally, it is our philosophy that each associate is responsible for compliance with ethical standards as well as the stipulated contract requirements of their respective work area. Our functional departments typically identify an individual who is charged with monitoring their area's compliance with Medicaid requirements.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Our Florida compliance associates have support and oversight at both the local and national level, relying on the experience within the large set of associates supporting our ongoing compliance. When there are special projects or audits, additional associates may contribute to support the area that is under review or in need of assistance. This may include anything from reviewing responses, locating policy and procedure documentation, or researching contract or federal and State requirements. Often, regulatory compliance makes requests across departmental lines so Humana associates work together to provide a thorough response and data extract. This is applicable to requests both planned or ad-hoc. Examples include but are not limited to: Special Feed Encounter requests, complaint handling, MPI self-audits or specific provider audits, on-site reviews, university studies, and CMS studies.

NATIONAL COMPLIANCE STAFF

Our Enterprise Compliance team provides regulatory interpretations, clarification, and effective, timely guidance to achieve:

- Comprehensive business and contract-based controls driven by regulations, policies, processes and systems

- A framework for risk and compliance assessment, identification, and mitigation in a preventive and preemptive manner

- Timely identification of risk and compliance vulnerabilities and gaps in policies and procedures for meeting laws, rules, and regulations

Humana's Medicaid Regulatory Compliance team adds additional resources and oversight at the national level to:

- Manage relationships with regulatory agencies through various communication points

- Serve as a contact with regulatory agencies, including primary contact with Medicaid Program Integrity

- Function as lead for regulatory audits

- Provide guidance to business areas upon implementation of new regulations by our Contract Management Unit

- Assist business areas in interpretation and clarification of regulations or processes

- Assess risk and perform monitoring and auditing of high-risk operational processes

- Provide oversight and direction of the established Compliance Program

- Provide oversight and direction of the established Fraud, Waste and Abuse Program

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

ADDITIONAL RESOURCES CONTRIBUTING TO COMPLIANCE EFFORTS

DELEGATION COMPLIANCE

As delegated functions are subject to the same federal and state regulations, we are ultimately responsible for the performance of any delegated business function. Delegation Compliance evaluates the capability of an entity to determine if they are able to perform delegated functions prior to contracting. In addition to the pre-delegation assessment, Delegation Compliance conducts audits of delegated entities on at least an annual basis, or more frequently if required by regulations or contractual requirements. Our annual audits include both a policy review and a file review and may be conducted on-site. In addition, our Delegation Compliance and Market Clinical associates (including our Quality Improvement Committee (QIC), if relevant) conduct ongoing monitoring through a series of mandatory reporting requirements. Periodic evaluation of a delegated entity's performance is also completed at regional delegation or operational oversight committees.

MONITORING AND AUDITING OF FDRS

We conduct monitoring and auditing activities for our relationships with First Tier, Downstream, and Related Entities (FDRs) that support Humana's Medicaid programs. The activities monitored and audited may include, but are not limited to:

- Operational performance, as outlined in executed contracts. This oversight is conducted by operations teams and/or operational business owners.

- Compliance Program requirements, as described throughout our Compliance Policy for Contracted Health Care Providers and Business Partners. This oversight is conducted by a collaborative effort between the FDR Compliance team and operations areas.

To facilitate these initiatives, we separate monitoring and auditing work plans to address the risks associated with these FDR relationships. We submitted a copy of our Subcontractor Monitoring Schedule to AHCA for 2017 and are currently preparing our plan for 2018. This work plan documents planned auditing and monitoring of FDR relationships. The FDR team uses a variety of tools to monitor compliance, including a self-assessment questionnaire, survey, document reviews, on-site or desktop audits, which may include inspection of the facilities, systems, books, procedures, audit work plans and results, and records that relate to the services provided under the contractual agreement.

INTERNAL AUDIT CONSULTING GROUP

The Internal Audit Consulting Group (IACG) Annual Audit Plan outlines specific areas to be monitored by the IACG. The Annual Audit Plan is implemented through audits, assessments, consulting engagements and investigations of the identified areas. With an eye towards process and stability, the IACG performs risk-based process audits with a focus on contractual obligations, CMS and other regulatory requirements, and other areas of risk.

SPECIAL INVESTIGATIONS UNIT AND PROVIDER PAYMENT INTEGRITY — FRAUD, WASTE AND ABUSE

The Claims Cost Management (CCM) Compliance team is responsible for detection, prevention, and recommendation of process improvement for our publicly funded healthcare programs, including Medicaid. CCM works in conjunction with the SIU and PPI to ensure all regulatory

reporting is completed in a timely and compliant manner, and that each department stays abreast of changes to federal and state regulations. The CCM Compliance team, with support from the law department, is also responsible for responding to subpoenas and requests for information from government agencies as they pertain to fraud, waste and abuse reviews.

SPECIAL INVESTIGATIONS UNIT (SIU)
Our SIU is responsible for all investigations related to fraud and abuse. The SIU Anti-Fraud Plan, which is approved by AHCA annually, details the processes taken by Humana's SIU for the detection, investigation, and prevention of suspected fraud and abuse. SIU receives referrals from various sources, including, but not limited to, hotline calls, data-mining results, fraud detection software, and government agencies. SIU investigates these referrals to determine if the suspected fraud and abuse activities have occurred. If an allegation is substantiated, SIU may refer the provider to the appropriate government or law enforcement agency (or agencies) and may also recommend action up to, and including, termination from Humana's network. SIU also gives recommendations for process improvements to proactively address potential fraud risks identified in our business practices.

PROVIDER PAYMENT INTEGRITY
The PPI unit conducts reviews and audits related to waste and abuse, along with handling all written inquiries related to overpayments. PPI utilizes complex data analytics including outlier analysis, trending and link analysis to identify potential fraud, waste, and abuse. The PPI reviews all leads for fraud, waste and abuse, and routes each allegation to the appropriate area for further review. Fraud allegations, for instance, are routed to our SIU department for investigation. Our PPI also conducts pre-payment and post-payment audits to identify potential overpayments. In the event PPI substantiates waste or abuse, it may refer the provider to the appropriate government agencies. PPI also gives recommendations for process and system improvements to proactively prevent overpayments.

RISK ADJUSTMENT INTEGRITY UNIT (RAIU)
The RAIU is responsible for investigating instances of FWA in our provider network that impact the integrity of risk adjustment submissions. RAIU performs investigations on case referrals from various sources, including, but not limited to, internal and external legal counsel, SIU, Hotline and Outlier Data Analysis.

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4. The extent to which the respondent's compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

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Humana has high standards for identifying and resolving fraud and abuse for our associates and we maintain the same high standards for our subcontractors. We have an oversight structure that is company-wide and coordinated across multiple teams at both the local and national level. For Florida, our CO and compliance associates are deeply engaged with CCM, SIU and PPI as well as other teams, such as Delegation Oversight, to ensure subcontractor fraud, waste and abuse (FWA) is identified and addressed. This includes changes in our processes whenever necessary to prevent future FWA. Additionally, detailed information about our general subcontractor oversight policies and processes is found in SRC 26.

IDENTIFYING INTERNAL FRAUD AND ABUSE

Humana's culture of compliance is predicated upon open lines of communication and a workplace free from fear of retaliation. We widely publicize our Hotline, including on our website, and actively encourage associates and contractors to report suspected instances of fraud and abuse, but also waste and areas of improvement. All instances of suspected FWA may be reported anonymously. We make this widely known and feature it prominently in our annual all-associate training. These efforts are intended to ensure that all our associates and contractors feel comfortable in assisting in our FWA efforts, including those related to our internal operations. Our Florida CO may receive reports of FWA directly from associates. The CO then refers the report to the appropriate associates within Humana to resolve. The CO asists as necessary but does not lead the investigation.

Additionally, we have a large team of individuals specifically dedicated to identifying fraud and abuse. Specifically (and as described in greater detail in SRC 32 and above) our Claims Cost Management (CCM) team is responsible for detection, prevention, and recommendation of fraud, waste and abuse. To assist in efforts related to investigating healthcare fraud, we also have a Special Investigations Unit (SIU). The SIU, which has been operational since 1985, has investigated thousands of cases of FWA internally and related to our subcontractors across all our lines of business, including commercial, Medicare, and Medicaid managed care. The SIU maintains a thorough anti-fraud program that includes drafting and implementing an annual Anti-Fraud Plan that describes general oversight and auditing of internal functions and subcontractors and this plan is supplemented with investigations that result from hotline calls, detection from our on-going analytical tools, and requests or referrals from our federal and state partners, including AHCA.

Along with the SIU, our anti-fraud work is supplemented by the PPI unit, which conducts reviews and audits related to provider FWA, including pre-payment audits that focused on proper payments and reduction of waste. Additionally, our RAIU is specifically focused on investigating instances of FWA within the provider network which affect the integrity of our risk adjustment submissions. In addition to reactive detection efforts, we also have a proactive approach to detection of FWA. This is led by our Fraud Research, Analytics and Concepts (FRAC) team. The FRAC utilizes data mining along with other analytical tools to review claims, patterns of services and numerous other data points to detect trends, identify outliers and anomalies. The FRAC team is broad in scope and includes review of providers, pharmacies, enrollees and associates.

IDENTIFYING SUBCONTRACTOR FRAUD AND ABUSE

While our FWA investigation efforts are thorough and include our subcontractors, we also have a dedicated process related to our subcontractors. Our process for ensuring robust compliance by our subcontractors, led by our Delegation Oversight department, begins with a careful screening program to allow only those who are qualified and able to meet our expectations to provide services to us, our state partners, and our enrollees. Each subcontractor must complete a pre-delegation audit prior to selection. Once selected, our subcontractors are required to complete annual compliance and ethics training that includes training about a wide variety of topics including compliance obligations, privacy and security and reporting

requirements. We give all our subcontractors our Compliance Policy and our subcontracts specifically require cooperation with our compliance efforts.

The last step in our fraud and abuse detection efforts related to our subcontractors is our on-going monitoring of their performance. Our structure allows for robust oversight. Specifically we have established nationwide policies for our subcontractors to ensure consistency across our organization. In Florida, our local executive leadership oversees our Florida subcontractors on a day-to-day basis, implementing the policies and procedures established nationally.
Our compliance experience has resulted in the development of several internal departments that coordinate to identify subcontractor fraud across all lines of business. These departments use our technology systems, standardized reporting, and weekly, monthly, quarterly, and annual data sharing and root-cause analysis meetings to prevent, identify, investigate, and resolve suspected fraud and abuse cases. We require that all subcontracted lines of business that support our Medicaid plans ensure they have the following in place for their employees and those who support them:

- Standards of Conduct
- Sufficient Compliance Program policies and procedures
- Effective training on general compliance and fraud, waste, and abuse
- OIG and GSA exclusion screening

ADDRESSING SUBCONTRACTOR FRAUD AND ABUSE

On the national level, our Contract Management Unit (CMU) tracks contract compliance (including subcontract compliance), and facilitates our corporate subcontractor compliance committees, including coordination of our audit activities and readiness assessments. We monitor and address subcontractor fraud via the following mechanisms:

Florida-Based Mechanisms:

- We utilize Joint Operating Committee (JOC) meetings as a mechanism with providers and subcontractors to interactively discuss and resolve issues or concerns. JOC meetings may be scheduled monthly, every other month, or quarterly depending on the needs of the provider network or Humana. All subcontractors must participate in a JOC at least annually or more frequently depending upon the services the subcontractor provides and the scope of the relationship. For example, a printing vendor may only have one (1) JOC each year while a large provider may be required to participate in these formal meetings more frequently. JOC meetings also give us with an opportunity to communicate updates on contractual and program changes or offer technical assistance. Florida's two (2) compliance officers regularly attend JOCs and, in fact, were charter members of our JOC, participating actively in document reviews and other activities.

- The Florida Market Operations team initiates the subcontractor contract and engages Delegation Compliance if any functions will be delegated. The Florida Market Operations team also identifies the Relationship Manager for each subcontractor to ensure clear lines of communication and accountability. This team is accountable for subcontractor compliance, reviewing service-level agreement performance and convening JOC meetings. This team will

also assist with resolution of complaints or issues and works in partnership with the Florida CO to support each other's efforts.

- Our Delegated Vendor Oversight Committee (DVOC), which is based in Florida, monitors the quality of the services delivered or managed by subcontractors and meets quarterly. This key committee monitors the subcontractors support Florida Medicaid and ensures that all delegated entities and subcontractors meet our standards of care, customer service standards, as well as Department of Insurance (DOI) standards, and State and federal regulatory requirements, along with accrediting agencies such as National Committee for Quality Assurance (NCQA). The DVOC also reports to our Quality Improvement Committee (QIC) to ensure sufficient internal communication and continuous improvements in quality of care. In addition, we have a centralized Delegation Compliance Committee that is responsible for coordination of, among other functions, claims payment and utilization and meets at least quarterly.

Enterprise-Wide Mechanisms:

- Delegation Compliance is a centralized national team that conducts operational compliance oversight for subcontractors performing claims, clinical health services, or credentialing services. This team initiates corrective actions when instances of noncompliance are identified and notifies the Florida Market Operations team. Florida's compliance officers participate in Delegation Compliance meetings and assist with related functions such as providing review, guidance, interpretation, and other types of oversight. Delegation Compliance works closely with the Florida Compliance Officers to ensure subcontractors' performance meets or exceeds contract requirements and related laws, regulations, and AHCA procedures.

- FDR Compliance is a centralized national team that conducts oversight activities related to compliance program requirements. Similar to Delegation Compliance, this team initiates corrective actions when instances of noncompliance by FDRs are identified and notifies the Florida Market Operations team. FDR Compliance monitors compliance with auditing standards and checks subcontractors against federal exclusion lists monthly.

- Regulatory Compliance also supports the Florida Market Operations team and other compliance teams with oversight and issues identified as needed. It also assists Delegation and FDR Compliance with desk reviews and audits as needed.

- The Medicaid Compliance Committee, discussed above, meets monthly to present, review, analyze, and make recommendations on issues pertaining to Florida Medicaid. The Medicaid Integrated Compliance Scorecard includes metrics on the compliance status, including those related to subcontractors. The results are used to identify trends and implement improvements.

HUMANA TEAMS DEDICATED TO PHARMACY FRAUD AND ABUSE

Because of our experience related to risks associated with pharmacy services, we have dedicated teams to monitor and address potential pharmaceutical fraud and abuse. Humana Pharmacy Solutions (HPS) utilizes our cross-functional teams, external software products, project management techniques, issue tracking processes, and other resources and systems to accomplish and measure our contracted Point of Sale (POS) accuracy and performance. Claim reviews occur through desktop, onsite, telephone, and overpayment review processes and

include reviewing accuracy of pharmacy provider claim submission, as well as pharmacy provider compliance with applicable laws, regulations, contractual agreements, and our policies. The Pharmacy Audit department also conducts outreach and investigations related to potential pharmacy waste and abuse situations identified through data analysis, complaints, or allegations. Issues identified through audit processes and investigations are resolved through provider education, claim correction, claim recovery, corrective action plans, terminations or referral to our SIU for further investigation.

The Pharmacy Fraud Waste and Abuse & Prevention team monitors and audits the pharmacy network to prevent fraud, waste and abuse, promote appropriate claims processing according to Humana and CMS guidelines, and correct overpayment and underpayment of claims. Across Humana we conduct a minimum of five thousand (5,000) pharmacy desk top audits annually. We also conduct a minimum of two thousand (2,000) pharmacy onsite audits annually.

Another component of the pharmacy auditing and monitoring plan is the implementation of point of sale edits to promote appropriate claims processing. Through the pharmacy audit process, we often become aware of trends in inappropriate billing practices that could be prevented through point of sale claim system edits and makes adjustments across our subcontractors to improve performance.

CASE STUDY: IDENTIFYING FRAUD IN FLORIDA
AHCA's Medicaid Program Integrity Unit (MPI) contacted our Special Investigations Unit (SIU) about suspicious billing activity from an assisted living facility in the Miami area. MPI identified the irregularities through a combination of data mining efforts and observations made during an inspection of one of the related facilities. The issue identified was that the assisted living facility continued to bill for services after an enrollee had been discharged.

SIU opened an investigation into the matter. The preliminary investigation of the allegations established that there were more entities that needed to be considered as being complicit in the concerns noted by MPI in their initial allegation. Irregularities in addresses related to the suspects were identified by the assigned Investigator. A Humana SIU Investigator made contact with MPI to convey plan findings and concerns. The plan suggested that collaboration and coordination of investigative efforts would be beneficial to our mutual interests. MPI invited us to participate in site visits of the suspect locations, including those formerly unknown to MPI.

Site visits revealed substantial violations. Each of the facilities was over legal capacity. There were substantial administrative deficiencies. The address that we gave to MPI was established as a property owned by the suspect and operating as an unlicensed assisted living facility and adult day care campus. In another instance, a person in the care of the suspect was found entirely unattended in a facility operated by the suspect.

The collaborative investigation produced evidence which prompted an immediate response from Florida's Department of Children and Families (DCF). DCF relocated eight (8) individuals to an appropriate facility where they would be certain to receive adequate care in a licensed facility by qualified clinicians. Though we did not receive formal notice of the final action, it was related that AHCA intended to revoke the provider's license, for cause, effectively eliminating the opportunity for the suspect to reenter the industry. MPI intended to recommend substantial financial penalties for the violation. Florida's MFCU began a criminal investigation into the matter which is still active.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which the respondent's compliance program complies with all State and federal requirements.

2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program.

3. The extent to which there are sufficient staff to implement the compliance program.

4. The extent to which the respondent's compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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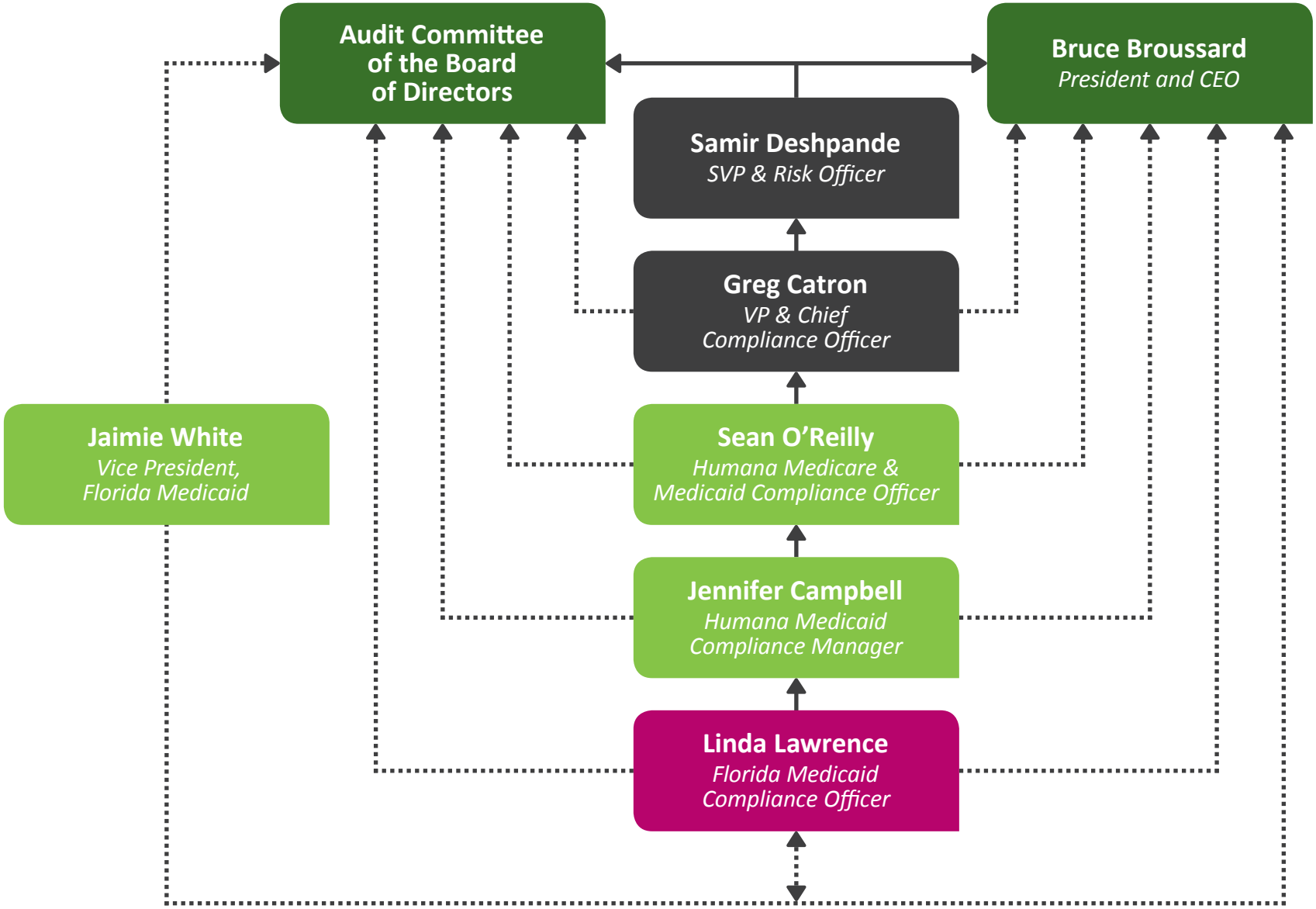
Attachment 31-1: Fraud & Abuse / Compliance Office – Organizational Chart



Humana.

Attachment 31-1: Fraud & Abuse / Compliance Office – Organizational Chart

Humana Compliance Structure

National Regulatory Implementation

Commercial & Specialty Regulatory Compliance

- State Regulatory Compliance
- Department of Insurance Interface
- External Reviews
- Market Conduct Exams

Medicare & Medicaid Regulatory Compliance; Medicare Compliance Officer

- Regulatory Compliance
- CMS Account Management
- External Audits
- Medicare/Medicaid Compliance Committee
- FWA Oversight
- Compliance Audit & Assessment
- Medicaid RFPs
- Medicaid State Agency Interface
- CMS Interface

Delegation & Vendor Oversight/Licensing & Reporting

- Delegation & Vendor Oversight
- Licensure
- Reporting
- Sales Allegation Investigation
- FDR Oversight

Privacy, Ethics & Corporate Policy; Chief Privacy Officer

- Privacy Complaints & Incident Investigations
- Privacy Risk Assessment
- Monitoring Activities
- Ethics
- Corporate P&P Development

Claims Cost Management

- Special Investigations Unit (SIU)
- Provider Payment Integrity (PPI)
- Risk Adjustment Integrity Unit (RAIU)
- Clinical Integrity Review (CLI)
- Medical Coding Integrity Review (CI)
- Coordination of Member Benefits (COB)
- Service Fund Integrity Review (SFI)
- Subrogation Capture (SUB)

Attachment 31-2: Resume

Linda Lawrence

Upon Award: Compliance Officer, Florida Medicaid Market

Qualifications

- Expertise in managing compliance and regulatory requirements for the managed care industry with 30+ years' experience working in the healthcare industry
- Experience working in the Florida Medicaid market, specifically coordinating compliance and training and mitigating risks
- Managed suite of on-site specialty providers, and an urgent walk-in clinic servicing approximately 15,000 Medicare and Commercial members

Professional Experience

1985–Present Humana's Compliance Officer, Florida Medicaid Market

- Manages Humana's relationship with regulatory agencies and provides guidance for complying with regulatory requirements for the statewide Medicaid Managed Care Program including both Managed Medical Assistance (MMA) and Long-Term Care (LTC) as administered by the Florida Agency for Health Care Administration (AHCA)
- Conducts audits on operational activities/reports results/implements and monitors corrective actions
- Interacts with regulatory agencies
- Participates in company and external work groups/committees
- Directs regulatory exams
- Provides consultation and direction for government products.

Past Positions

- Regulatory Compliance Director, Medicare & Medicaid
- Compliance Coordinator
- Training Coordinator
- Medical Center Administrator
- Systems Technician
- Senior Field Service Coordinator
- Field Service Coordinator

Education and Certifications

- Bachelor of Science in Professional Studies from Barry University

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 32 – Fraud and Abuse Special Investigations Unit (SIU) (Statewide):

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, including verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

Response:

HUMANA'S COMMITMENT TO FRAUD, WASTE, AND ABUSE DETECTION AND PREVENTION

Detecting and preventing fraud, waste, and abuse (FWA) is essential to maintaining a health system that is cost effective for everyone and trusted by enrollees. As discussed in detail in SRC#31, Humana's culture of compliance begins with our Board of Directors and executive leadership and permeates every aspect of our business. We expect our employees and contractors to adhere to a strict standard of conduct that includes comprehensive ethical standards, and we require annual training to ensure these expectations are understood and agreed to. Our comprehensive Compliance Plan delineates our expectations and an approach to ensure organizational compliance. This includes a commitment to detecting, identifying, mitigating, and preventing fraud, waste, and abuse (FWA).

Humana has extensive experience preventing, detecting, and mitigating FWA. Because Humana has been providing publicly financed healthcare services since the mid-1980s, we have deep content knowledge related to FWA. Our Special Investigations Unit (SIU), which was formed in 1985, has led these efforts.

In addition to being experienced in FWA efforts, Humana is actively involved with multiple anti-fraud organizations, and is a founding member of the Healthcare Fraud Prevention Partnership (HFPP), established as a result of the passage of the Affordable Care Act (ACA). We also routinely work with other organizations such as the National Health Care Anti-Fraud Association (NHCAA), Special Investigations Unit Anti-Fraud Coalition (SIUAC), and other regional and local organizations. In fact, Humana's SIU director, Christa Jewsbury, is a member of the Board of Directors of the NHCAA. These partnerships, along with our recurring meetings with Agency for Health Care Administration (AHCA) and the Department of Justice (DOJ) led anti-fraud task force, ensure that we remain apprised of current laws and regulations, as well as trends in the industry and newly emerging schemes to monitor.

As a Medicaid provider in the State of Florida since 1997, Humana works on a daily basis at all levels of our organization to serve as a true partner to AHCA with a commitment to efficiency and resource optimization. Humana has numerous compliance and SIU-related staff located in Florida to ensure an active and engaged presence in the State. Along with prioritizing our partnership with AHCA to detect and prevent FWA, we actively works with other managed care organizations (MCOs) to share information on suspected cases of FWA. Through this process,

Humana simultaneously leads efforts to mitigate potential fraud and learns from others' experiences.

Strong partnerships, a clear communication and accountability structure, sophisticated information technology systems, mandatory and regular training of our workforce, and additional investments by Humana ensure rapid and complete clinical reviews support our comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment. These efforts are described in detail below.

HUMANA'S FRAUD, WASTE AND ABUSE FRAMEWORK

Humana has a comprehensive FWA framework in place to prevent and correct fraud risk events. Fraud risk events can be malicious, unintentional, or simply the result of a misunderstanding. Through this framework, we work to prevent, identify, and rectify potential cases related to: corruption (kickbacks and bribes); insurance and billing issues (billing for services not performed, fraudulent claims, misrepresentation); reporting issues (false timesheets, misrepresentation of financial information); strategic items (budgetary expansion, intercompany payments, improper incentive structures); and theft and losses (direct payments via cash, accounts payable, theft or misrepresentation). Humana's goal is to achieve risk and resource optimization that contributes to our care and supports delivery objectives in a sustainable and ethical manner. This risk and resource optimization translates into efficiencies for the State as well. Our framework is based upon four (4) essential tools:

- A Compliance Plan that is comprehensive, AHCA-approved, reviewed annually (and modified as needed), and clear on Humana's expectations. These expectations include standards of conduct and ethics, and required training for all employees and contractors.

- An Anti-Fraud Plan that is reviewed annually and modified as needed, approved by AHCA. This plan clearly describes Humana's strategic efforts at detecting FWA internally and amongst our providers and subcontractors.

- Sufficient numbers of highly qualified staff at the national enterprise level and State market level to monitor relevant developments, and engage in active FWA detection and prevention activities. These include a Regulatory Compliance Officer and an additional Compliance Officer that serve Florida's Medicaid enrollees.

- State-of-the art technology that provides tools and platforms to proactively detect FWA and track ongoing investigations.

The overarching organization within Humana responsible for program integrity is Claims Cost Management (CCM). To proactively monitor claims and encounter payments, as well as to limit exposure to FWA, CCM oversees the following four (4) platforms:

- Expense Mitigation, the flagship platform, monitors more than three point four (3.4) million claims each year

- Value-Based Provider (VBP) Monitoring monitors FWA among providers submitting encounter and risk adjustment data

- Revenue Preservation identifies enrollees for whom the Centers for Medicare and Medicaid Services (CMS) is improperly compensating Humana

- Underpayment Distribution enables us to quickly reprocess incorrect expense recoveries and claims underpayments identified by our provider partners

While these systems proactively monitor for FWA, Humana also maintains multiple groups that work to aggressively investigate new areas of risk. While these departments within CCM work together, they each manage their own case work independently:

- The Special Investigations Unit (SIU) is responsible for all investigations related to fraud and complex abuse

- The Provider Payment Integrity (PPI) unit conducts all reviews and audits related to waste and abuse, along with handling all written inquiries related to overpayments

- The Risk Adjustment Integrity Unit (RAIU) is responsible for investigating instances of FWA in Humana's provider network that impact the integrity of risk adjustment submissions

- Clinical Integrity Review (CIR) is responsible for medical services substantiation and clinical necessity auditing, recovery, and loss prevention

- Medical Coding Integrity Review (MCIR) updates medical coding standards validation, billing abuse and waste detection and proactive billing correction

- Coordination of Enrollees' Benefits (COB) reviews proactive benefit coordination for enrollees who have Humana as their secondary insurance coverage

- Service Fund Integrity Review (SFIR) is responsible for provider service fund payment issue detection, recovery, and loss prevention

- Subrogation Capture (SUB) identifies, investigates, and coordinates payments with third-party medical liability holders

Humana's AHCA-approved annual Anti-Fraud Plan guides our efforts related to FWA detection and investigation, which is led by the SIU, our primary investigative arm. Our processes include data analytics to identify trends, fraud, schemes, and potential fraudulent activity that may warrant further investigation. Humana's SIU goals include, but are not limited to:

- Maintaining an anti-fraud program to protect Humana and government funds from potential fraud

- Conducting thorough and effective investigations into alleged fraud or abuse

- Educating providers regarding billing and documentation errors identified during the course of investigations

- Coordinating with the Pharmacy Audit Team to investigate egregious cases of pharmacy-related FWA

- Recommending termination of Humana's contractual arrangements with providers, agents, brokers, enrollees, and other business entities when appropriate

- Recovering or denying payment for claims deemed to be fraudulent or inappropriately billed

- Reporting suspected fraudulent acts to the appropriate federal or State government agency or law enforcement agency, as required

- Cooperating, if requested, with federal or State officials in civil or criminal matters as a witness for Humana and/or attesting to the validity of information provided by Humana

- Training Humana associates in detecting, preventing, and reporting suspected fraudulent activities

The SIU investigates claims-related fraud at all levels from subcontractors and delegated entities, providers, enrollees, and associates. When warranted, the SIU collaborates on investigations with law enforcement at the federal, State, and local levels. SIU reports any suspected or confirmed fraud or abuse regarding Florida Medicaid to AHCA within fifteen (15) days after review and approval of confirmed suspicion of FWA from our internal Government Referral Panel. Since 2015, through our pre-pay and post-pay recovery efforts, Humana's SIU prevented approximately seven hundred thirty-six thousand ($736,000) in fraud and abuse related payments. This number represents a small part of our efforts to prevent FWA. PPI audits of waste and abuse have identified approximately seven million, seven hundred forty-two, two hundred seventy-five ($7,742,275) saved in addition to the SIU provider specific investigations. PPI's audits of waste and abuse do not include general billing errors identified.

To ensure consistency and a fair and proper review of all investigations, the Government Referral Panel was established to review all cases that the SIU or other departments have identified as meeting State or federal agency requirements for reporting to a relevant agency or regulatory body. This panel was created to consider cases and ensure that criteria are met to refer a case on to the appropriate government agency. This innovative approach to streamline and operate efficiently in referring cases appropriately enables Humana, AHCA and other agencies to pursue cases with merit. Investigators bring cases to the Government Referral Panel when a case has met one of the following milestones:

- Completed post-pay audit that resulted in findings

- Confirmation of multiple instances services not rendered

- Referral was received from a government agency and Humana's Medicaid exposure fits within the scope of that allegation

- Any indication that the provider is a phantom provider

- Other evidence of credible fraud

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The Government Referral Panel ensures that the case has been properly investigated and that the referral has clear language, meets the relevant requirements for referral, and is consistent with best practices. As a result, this process produces better quality referrals for Florida's Medicaid Program Integrity (MPI) unit to send directly to the Medicaid Fraud Control Unit (MFCU), offering more actionable information and additional details to support next steps. This process ensures that MPI's time is not wasted reviewing referrals that are unsubstantiated or not a FWA issue.

Humana's SIU is supported by the Enterprise Investigations Consortium (EIC) and is comprised of key executives representing the Operations, Medical, Compliance, Finance, and Legal departments. The Committee provides oversight, prioritization, and direction to the investigative process and associated corrective actions conducting investigations into fraud, waste, abuse, criminal activity, ethics, and compliance concerns. The EIC's role in FWA prevention and detection rests in the identification of opportunities for investigations, training, development, and process improvement across Humana. Additionally, the EIC provides guidance and collaboration with various investigative groups across Humana.

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1. The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.

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Humana employs a comprehensive, enrollee- and logic-driven process to prevent, detect, and respond to patterns of FWA. Our approach to prevent and detect fraud, abuse, and overpayment relies on the combination of sophisticated data systems and analytics operated by highly skilled associates coordinated through oversight bodies. It includes the implementation of specific FWA detection mechanisms, including: identification of potential aberrations in service utilization through comparison of approved services and enrollee needs documented in the plan of care (POC); monitoring of medical, behavioral health, and pharmacy utilization metrics; and robust data analytics from encounter submission to claim payment. While our automated systems identify these data points, our associates and contractors continuously analyze this data for risks.

Humana's Fraud Research, Analytics and Concepts (FRAC) team conducts a variety of processes to proactively detect FWA. This involves the review of information provided through a variety of sources, including communication from government agencies, industry associations, internal referrals, provider partner referrals, and other private payers. These processes also include risk assessment and data analysis to determine which potential fraudulent activities require further investigation. This sophisticated combination of controls and automated approaches are designed to efficiently prevent and detect potential or suspected fraud and abuse and overpayment.

Our FWA process is also based upon the use of good data. We use data mining to identify trends, such as gaps in payment or common overpayments and outliers. Some data markers indicating FWA are:

- Outlier Analysis
- Trend Analysis

- Anomaly Detection
- Statistical Analysis
- Rules-Based Anomaly Detection

As a result of data mining and audit queries, on average CCM:

- Audits more than three (3) million claims per year

- Identifies opportunities to recover claims overpayments on approximately thirty percent (30%) of audited claims

- Recovers or prevents loss on approximately five percent (5%) of total claims paid across our lines of business

Humana's automated Claims Adjudication System (CAS) supports FWA detection, through various systems edits, as it is designed with both pre- and post-payment algorithms to scan all claims for overpayment, double payment, and fraudulent payments. Because our system also scans claims post-payment, Humana is able to recoup payments after they have been made if we later deem them improper. In addition to scanning claims for payment-related measures, CAS also uses robust algorithms to look for impossible points in care. For example, a male cannot have a live-birth C-section, so CAS will not permit payment if a claim is received for such a scenario.

Humana also uses state-of-the-art software applications to construct analytical, statistical, and predictive models that identify and detect FWA. Models can be focused on specialty or type of services. Data is selected based upon detailed investigation on identified risk and research into potential fraud schemes impacting potential models. The tools include, but are not limited to:

- SAS Analytics Software: SAS is a strong data analytics engine used to analyze identified FWA claims, search for claim payment aberrancies, and calculate FWA recoveries. Our Data Analyst generates a case file that includes written and statistical information, which aids the SIU in presenting our case to our internal Investigation Committee, law enforcement, providers and/or their attorneys. This detailed investigative report may be used by the SIU in any legal efforts (e.g., litigation, arbitration, and mediation), as well as in provider dispute resolution and recoupment efforts. SAS Analytics software is used in monthly increments depending on the topic.

- Qlikview: Qlikview enables Humana to build dynamic models that can accept data from multiple sources. Qlikview processes large amounts of data, and through the use of a variety of visualizations, dynamically identifies interesting and suspicious billing patterns.

- Centrifuge®: Centrifuge® uses advanced link analysis, complemented by charts, timelines, and geospatial views, to discover relationships and significant insights that are not always obvious in the claims data, often more quickly than other technology. This program enables analysts to more easily combine data from disparate sources and interact with large data sets using multiple visual representations of that data in a single integrated workspace. Centrifuge® links analyses and data visualizations to help find provider fraud patterns.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

ADDITIONAL FWA CONTROLS: HUMANA'S HIGHLY-QUALIFIED STAFF

Even the best automated processes are unable to prevent or detect all cases of FWA. Consequently, Humana has developed a highly skilled and trained staff to perform manual audits at all levels, including at the individual provider level. Numerous controls are built in to all aspects of Humana's operational management, from day-to-day operations for claims processing and data analysis to ongoing maintenance of systems employee training requirements. These controls include, but are not limited to:

- Florida Medicaid Compliance Staff: There are two experienced Florida Compliance associates dedicated to Medicaid to ensure robust, comprehensive, focused compliance efforts. Our Compliance Officer is the designated point of contact and responsible for the pulse of compliance for all regulatory and operational functions and responsible for oversight in accordance with our current contract with AHCA.

- Associate Education: Every Humana associate – including the Chief Executive Officer, all senior leaders, the Board of Directors, full and part-time employees, and business partners (first tier, downstream and related entities [FDRs]) – is required to complete annual web-based ethics and compliance training. The training includes a FWA module with information on the Federal False Claims Act, Anti-kickback, and Whistleblower Protection, as well as examples of various types of healthcare FWA and potential fraud indicators. All associates must complete ethics and compliance training annually and are given our Ethics Every Day resource, which includes our standards of conduct, to keep and refer to on an ongoing basis.

- Provider Education: Via the Provider Network team, the provider website, and the provider manual, providers receive information regarding FWA. We have also posted visual reminders, such as signs and posters, throughout Humana's offices to remind providers of our compliance and FWA efforts, including posting of our hotline number.

- Enrollee Education: Enrollees receive information regarding FWA, including how to contact the SIU. Information is located in the enrollee handbook, Humana's website, and Explanation of Benefits (EOBs) and enrollees are encouraged to report suspicious activity through our well-publicized hotline.

- Regulatory Monitoring: Humana monitors federal and State enforcement actions and Office of Inspector General work plans for new and/or recurring trends. Humana also monitors our associates, providers and vendors for OIG-excluded individuals and entities.

- Provider Network Maintenance: Humana monitors our provider network excluded and suspended providers and AHCA-terminated providers, and confirms the credentialing of providers and facilities.

- Delegation Oversight: Humana ensures subcontract provisions are inclusive of federal, State and Humana-related requirements. The Delegated Vendor Oversight Committee monitors Humana's delegated services and performs oversight of quality and service activities delivered/managed by vendors. Florida Medicaid has a dedicated Director of Vendor Performance who oversees vendor compliance and coordinates with the SIU.

- Claims Administration: Humana performs ongoing monitoring of claims system validation rules, conducting detailed reviews of service claims at both pre-payment and post-payment points.

- Utilization Management: Humana monitors hospital utilization and care management records daily, using Case Managers as gateways to the healthcare system via prior authorization requirements.

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2. The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.

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Ensuring prudent use of Medicaid funds is of the upmost importance to Humana. As a result, we employ several methods to verify that our enrollees receive approved and appropriate care at the point of service. Humana has partnered with Sandata Technologies LLC to utilize electronic visit verification (EVV) with innovative technology, including geo-mapping combined with mobile technology, across several states, including Florida, for our Medicare Advantage line of business. Humana has also developed and is currently testing our own technology to support internal Case Managers through a mobile application that verifies and logs the Case Manager's visits to enrollees via geo-location. Prior to implementation of this contract, Humana plans to develop additional EVV processes to serve our Medicaid plans and institute an enterprise-wide approach to ensuring that we can prevent and detect potential or suspected fraud and abuse and overpayment.

In compliance with the 21st Century Cures Act and as AHCA builds its guidance for managed care organizations to integrate EVV technology into care delivery and FWA prevention, Humana is committed to ensuring that the following elements of any EVV technology are included within our process:

- Data capture, compatibility, and aggregation
-- Regardless of the EVV platform used, data capture across providers will comply with minimum data requirements to be set forth by Humana based on AHCA guidelines. Through our contracting process, provider data systems will be required to offer compatibility with Humana's systems and comply with Humana's strict privacy and authentication requirements. Humana will also require providers to comply with our timelines for rapid use in claims payments and adjudication.

- EVV point of service capabilities
-- All subcontracted home-based care providers must ensure that their EVV capabilities allow for point of service verification with the support of scheduling, tracking, and/or other capabilities that support active and real time prevention and identification of potential fraud and abuse. Humana will require the use of GPS EVV as the primary capture method with Interactive Voice Response (IVR) as a backup.

- EVV system capacity requirements and integration
--Humana EVV vendors must ensure their systems have the capacity to handle a full patient load with twenty-four (24) hours a day, seven (7) days a week, data refresh and backup capabilities. Data regarding services delivered to Humana enrollees is the property of Humana.

EVV vendor capability must allow for seamless data integration with Humana's information systems.

- EVV Analytical Capabilities
-- Humana will develop analytical tools to match EVV data (e.g., geolocation, service dates, service times) with authorization, claims, and related services. Output will be included within claims overpayment rejection/recoupment processes, identification of missed services, and integrated into our FWA systems.

Any provider wishing to subcontract with Humana for home-based and personal care services will be required to comply with Humana's requirements for point of service verification as outlined above. While Humana is currently building our EVV capacity internally, we will explore whether to develop a contractual relationship with an EVV aggregator once we have received AHCA's requirements regarding EVVs.

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3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.
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Humana has numerous controls in place to support clinical reviews and SIU investigations of potential cases of fraud and abuse and overpayment. Those controls include: prior authorizations; utilization management; subcontract and provider contract provisions; provisions from the provider manual and the enrollee manual; and standards for a code of conduct. Humana further relies on clinical reviews of utilization and care management to detect potential FWA cases and escalate those cases to SIU for further investigation.

Humana's CCM Medical Record Audit Team conducts a wide range of coding and medical records audits to identify potential FWA. CCM has a team of medical personnel including Medical Directors, Registered Nurses, Nurse Practitioners, Certified Coders, and Pharmacists, which cover dozens of specialties. This audit team uses proprietary tools to automate selections, record requests, and records management, and streamline audit processes. This team also works very closely with the SIU and if an auditor or investigator identifies a potential case of fraud in the course of an audit, it is immediately referred to the SIU for further investigations.

For all new referrals, Humana's SIU conducts an initial review to determine:

- If a reasonable inquiry should be initiated, at which time the referral will be opened as a case and assigned to an investigator for a further investigation

- If a provider should be placed on a watch list

- If the referral should be closed with education provided to the individual who submitted the referral

- If the referral should be closed with no further action

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Each referral and case is inherently unique. However, SIU Investigators often employ similar investigative techniques to complete a case review. SIU's investigative techniques include, but are not limited to:

- Verifying the allegation validates a reasonable inquiry to be opened

- Reviewing medical, dental, and/or pharmacy claim information

- Interviewing enrollees, providers, and/or pharmacies

- Requesting and reviewing copies of medical or dental records from providers or prescriptions/signature logs from pharmacies

- Sending and reviewing enrollee questionnaires or Rx verification letters

- Researching non-Humana resources (i.e., Internet resources)

- Requesting and reviewing provider or pharmacy network contracts

- Requesting and reviewing enrollee benefit plan documents

- Requesting or conducting pharmacy desk-top or on-site audits and reviewing results

- Reviewing enrollee eligibility

- Reviewing provider licensure information

- Monitoring providers (participating and non-participating) who:
-- Demonstrate a pattern of falsified encounter data and service reports
-- Demonstrate a pattern of overstated reports or up coding
-- Alter, falsify or destroy record documentation
-- Make false statements
-- Misrepresent medical information to justify referrals or billing
-- Charge enrollees for covered services
-- Bill for services not rendered
-- Fail to render medically necessary services they are obligated to provide according to their contract or pursuant to government regulation

All incoming referrals are tracked in our proprietary tool, Fraud Investigations Tracker (FIT), which we built in-house to provide a more robust tracking system for our investigations and to enhance Humana's ability to fulfill our compliance and reporting goals. When it is fully implemented, we anticipate the FIT will set a new industry standard for case documentation while actively integrating with key business systems to enhance data supporting our investigations. As the case progresses, the investigative steps are documented in the appropriate activity in the FIT and electronic copies of all documents pertaining to the case are attached. Details of relevant case documentation can be viewed by SIU and can be extracted for reporting from the Electronic Data Warehouse (EDW). If the SIU Triage team does not open a case upon reviewing a new referral, the reason(s) are documented and the referral is rejected, but continues to be stored in FIT for future retrieval if needed.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana's SIU is comprised of staff with various backgrounds including data analytics, clinical credentials, and investigative training. The SIU staff consists of the following:

- LEADERSHIP: Director: Manages team's case load efficiently and effectively and ensures team operates in accordance with Humana and SIU policies, processes, standards, and procedures. Also ensures the team has appropriate access to resources, tools, and business areas necessary to accomplish objectives.

- TRIAGE TEAM: Investigators review referrals, regardless of source, to determine whether the case has merit and prioritizes those cases requiring immediate action.

- INVESTIGATIVE LEADS: Ensure Investigators are managing their cases effectively and in accordance with Humana and SIU's policies, processes, standards, and procedures. Effectively investigate and manage complex and non-complex fraud allegations.

- INVESTIGATOR: Investigate potential fraud related to providers, enrollees, agents and others who may be committing healthcare fraud. Identify fraud schemes and trends within their assigned line of business, geographic region, or across specialties.

- INVESTIGATIVE RESEARCHER: Research background information and compile initial case facts for the Investigator. Obtain and research additional information as requested by the Investigator.

- BUSINESS CONSULTANTS: Develop a project plan for each assigned project including a timeline of activities to be performed. Understand the business impacts to the SIU department when there are processes or IT changes/update.

- CONSULTANTS: Manage projects appropriately, prioritizing to ensure deadlines are met. Identify impacts to other areas. Engage impacted areas and work through process changes/updates.

- FACILITATOR: Develop training plans and training content, facilitate training sessions, and support consultants on updates to policies, procedures, and process flows. Manage projects appropriately, prioritizing to ensure deadlines are met.

- SPECIALIST: Assist with gathering and assembling information as needed to respond to inquiries, appeals, and general correspondence. Handle and route correspondence related to SIU investigations as appropriate.

- CLAIM COST MANAGEMENT COMPLIANCE ANALYST: Review State and federal regulations to ensure SIU is aware of and relying on most current regulations. Complete and submit required federal and State government reporting. Coordinate and act as point of contact for federal and State audits impacting SIU and/or Claim Cost Management.

- ADMINISTRATIVE ASSISTANT/OFFICE SUPPORT: Scan, load, and work faxes. Pick up and deliver mail. Provide support to the department as needed.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Following an initial referral and review, SIU's Triage Team identifies the appropriate investigative or audit group at Humana. If further investigation is warranted, the case is then assigned to an Investigator based on the primary product line impacted as well as geographic region. The Investigators or Investigative Leads are responsible for conducting an investigation into potential violations of federal and state criminal, civil, administrative laws, rules and regulations, as well as any misconduct related to the payment or delivery of claims.

In addition, the SIU is also supported by a dedicated clinical team of approximately eighty (80) clinicians. These clinicians are comprised of Medical Directors, Registered Nurses, Nurse Practitioners, Certified Coders, Chiropractors, Pharmacists, and other specialties. The SIU may also access clinicians throughout Humana should a particular scheme arise involving a specialty with which our dedicated team does not have expertise. SIU is currently supported by three (3) Medical Directors, and other Medical Directors are available to assist with certain specialties as follows:

- Ongoing education and guidance from a clinical perspective

- Review of all medical necessity reviews

- Review of all experimental and investigational reviews

- Clinician representation on peer-to-peer, provider education, and market calls

- Guidance on various cases and types of reviews for both the SIU investigators and the clinical team

- Attendance in the various meetings of the SIU clinical team to promote consistency in reviews

- Clinical trainings sessions for SIU investigators and clinical team

- Clinical representation if needed for litigation or pre-litigation meetings with the Legal department

This significant collaboration between the Humana's SIU and clinical teams has also led to continuous review for cost saving efficiencies and process improvements; new case set/meeting with investigative team to discuss cases; review and follow up on post-pay cases; and monthly clinical training sessions for SIU and clinical staff.

CLINICAL REVIEWS ALSO INFORM POTENTIAL FWA CASES

Humana's Utilization Management and Care Management programs have policies in place to immediately identify utilization problems. Daily reports on hospital admissions and care management activity are reviewed to address all identified service utilization concerns. Because services for Long-Term Care (LTC) enrollees and certain MMA services must be authorized by a designated Case Manager, Humana's Case Managers serve as gatekeepers to the healthcare system and are in a unique position to quickly identify possible fraud and abuse cases, and are trained to act on them. Our Case Managers are trained upon hire and receive refresher training

at least annually regarding compliance and FWA in order to further our culture of compliance. Any potential cases are addressed immediately and forwarded to Humana's SIU.

On a monthly basis, LTC Case Managers must submit attestations to Humana's SIU, that to the best of their knowledge, information, and belief, that any missed services or suspected fraud and abuse reported by enrollees during the monthly contact were assessed and referred to the SIU, if appropriate.

Humana's SIU also conducts reviews of clinical data to inform potential FWA cases. Humana's Clinical Guidance eXchange (CGX) houses enrollee medical prior authorization data. The SIU uses the CGX platform to search and view medical prior authorization data after security approval is obtained and HIPAA training has been completed. The SIU searches CGX by authorization number and enrollee identification number. Once an authorization is located, the system provides authorization dates, approval status, relevant nurse documentation of the clinical timeline, and nurse phone call logs. Humana also performs data mining to search for unusual or impossible situations. Specifically, the data teams look for overuse and abuse of durable medical equipment, a common area of concern particularly for LTC. If SIU detects an issue, it ensures that payment is stopped or recouped if applicable.

SIU may notify Humana Market Medical Officers, market network contracting management or Medical Directors across our operations of investigations that are ongoing or completed on non-participating (out-of-network) providers, or discuss with them for input on handling these cases in the event the provider is being considered for contracting.

Humana's Florida Compliance Officer and enterprise compliance staff attend a monthly meeting and ad hoc meetings as necessary with the SIU and PPI to ensure information is shared and that communication channels remain open. Attendees at this meeting discuss open cases, operational needs and changes, and review the SIU Compliance Dashboard. Staff from SIU and PPI, along with the Florida Compliance Officer, attend quarterly in-person meetings and quarterly interim calls with AHCA's MPI.

Finally, SIU is responsible for communication with law enforcement officials. SIU reports cases of suspected fraud activity within 15 days of confirmation of a suspected case by the Government Referral Panel, or as required by federal and State laws, rules and regulations, to the appropriate law enforcement and/or the appropriate government agencies.

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4. The extent to which respondent uses innovative technology for the purposes of verifying home-based visits and services.

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Humana has taken important steps toward using innovative technology for the purpose of verifying home-based services and reducing the risk of fraud waste and abuse.

Humana has invested heavily in technology to improve care management compliance, efficiency and the enrollee experience. By removing obstacles to providing care coordination to members within the community we are increasing the time case managers spend with enrollees and appropriately documenting contractual components of the visit. Specifically, we have developed a case manager assignment program that utilizes linear algorithms to determine the

most appropriate care manager to assign to each enrollee. The algorithm has been paired with a user interface that enhances the clinical management team's ability to make future care manager hiring and membership distribution decisions best serving our enrollees. Factors accounted for within the algorithm include: distance from case manager to enrollee, membership clustering, language preference, enrollment and term projections, and current-to-optimal model care manager reassignment thresholds. The utilization of advanced mathematical clustering techniques combined with a linear program solver and enrollee directed inputs creates an industry leading practice that reduces the risk of internal fraud.

Secondly, Humana has implemented a state-of-the-art Care App, a mobile application for use by our case managers. The Care App is designed to provide users with the ability to display member demographic information and input information regarding the visit. This technology further advances efficiencies within the care model, increases compliance, and reduces the occurrence of fraud. For example, a case manager can retrieve their next appointment, pull up the contact information for the member or member's caregiver, and call the member or caregiver directly from the application. Once the appointment is confirmed, the application provides point-to-point directions to the member's location. The application also enables the care manager to scan documents directly into Humana's clinical platform and electronically capture signatures on contractual documents and to demonstrate compliance with care management requirements. Furthermore, the Care App is designed to electronically verify home and facility based visits via a check in and check out system. Case managers are checked into enrollees locations based on geo fencing around member locations. Upon exiting the location, the care manager is prompted to check out of the visit. The care manager confirms the system generated data elements from the visit, including the name of the enrollee visited, time exited, and the tasks completed. The electronic verification of the visit is maintained regardless of the action by the case manager. With this app, we aim to utilize dashboards and relevant analytics to monitor home-based visits, including for purposes of verifying care coordination delivery and monitoring FWA.

We have coupled these technology advancements with a new communication model that stems from our Medicaid Governance Structure that identifies risks and opportunities. The governance structure, technology investments, and our communication strategies result in thoughtful redundancies to verify home visits and services.

In addition, Humana's efforts to implement the 21st Century Cures Act (Cures Act) are well underway. For example, we have procedures in place to report providers in accordance with Title V of the Cures Act. We also have effort underway to comply with AHCA's desire to implement EVV capability for both personal care and home health services effective January 1, 2019. As we await AHCA's guidance on the end-to-end EVV data management approach for Managed Care Organizations (MCOs) relevant to the services in question, we have established procedures to integrate the resulting requirements into our operating model. As set out in the Cures Act, we understand this to include the ability to capture the required six (6) data elements (e.g. date, location, type of service, individual providing the service, individual receiving the service, and service time beginning and end) and, via a systematic match of the EVV detail to its related claim and authorization, address services not supported by EVV detail to further reduce FWA exposure. Furthermore, the data captured will support drill-down analytical capability to identify anomalies and patterns to address provider performance issues, under and over utilization of enrollee-specific services, authorizations without resulting service, and potential FWA exposure. Wishing to maximize the accuracy of data collected and the resulting

impact on FWA, we plan to stress the adoption of Global Positioning System (GPS) location detail, as opposed to Interactive Voice Response (IVR), as the primary location-related data source. We look forward to the future guidance from AHCA to ensure that we continue to work in lock-step.

Evaluation Criteria:

1. The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.

2. The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.

3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.

4. The extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

SRC# 33 – Disaster Recovery Requirements (Statewide):

The respondent shall demonstrate its capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section X.D.4.h.**

Response:

Humana understands the critical nature of effective Disaster Recovery (DR) Plans and Business Continuity (BC) Plans. We have designated multiple teams to strategically support our disaster recovery functions. The Crisis Management, BC, DR, and Emergency Response teams maintain responsibility for preparing for threats and disasters. Our Enterprise Resiliency Office (ERO) serves as the central office for collaboration among these teams. Annually, the ERO facilitates various Business Impact Analyses (BIAs) to establish the criticality of business functions and supporting applications for our enrollees. The ERO shares results with executive leadership for their review and to make adjustments, if needed. The DR team uses the results of the BIAs to apply recovery tiers to each application and adjust the DR Plans, as needed.

We have Agency for Health Care Administration (AHCA) approved plans in place that meet all current requirements, including for the restoration of critical applications of software and master files for hardware backup in the event production systems are disabled or destroyed. We also have an integrated process to update those plans when requirements, information systems, or policies and procedures change. In instances when Humana experiences equipment failure or disasters, we have back-up systems which protect our data and information technology (IT) systems and rely on an off-site host for disaster recovery communications.

All production servers are housed in Humana's primary hardened data center, twenty (20) miles south of our corporate headquarters in Louisville, Kentucky. Our secondary data center is located in Simpsonville, Kentucky. This makes them easily accessible by the IT associates who are responsible for DR and BC plan maintenance. The secondary data center offers redundancy and can be activated remotely. We have back-ups of critical systems in both our primary data center and our secondary data center. Both our primary and secondary data centers are state-of-the-art facilities. Our Kentucky-based primary and secondary data centers are protected from the weather-related events impacting the State of Florida, ensuring our systems are live and protected from these disturbances. During Hurricane Irma, our associates experienced no downtime when accessing software applications and data stored in hardware servers and databases, allowing us to offer our enrollees the attention they needed.

Through our experience serving Florida Medicaid enrollees since 1997, we understand the communication processes and triggers AHCA expects of its contractors during disaster events. We have built in touchpoint tasks in our Crisis Management and Crisis Communication Plans. These touch points support specific contractually compliant timings of communications throughout a crisis or significant event including, but not limited to, our Contract Manager notifying AHCA of system outages every hour until they are resolved. We use an externally hosted communication system to support crisis and emergency notification to key leaders, Crisis Management team (CMT) members, and associates. To ensure that we are always prepared for potential disaster or crisis events, our Executive Management team participates in Crisis Exercises approximately every six (6) months.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

PREVENTIVE STRATEGY TO ELIMINATE DATA AND SOFTWARE RISK

To prevent and ward off man-made disasters, we have maintained a preventive strategy to eliminate data and software risk. All hardware and system software on which the applications run are upgraded regularly, as new upgrades are released. Mainframe and its operating systems are upgraded per IBM standards; Humana continues to use only best-in-class hardware (Mainframe and Unix Servers) and systems software developed by IBM. Similarly, our Windows servers and Microsoft core software, used for application development, are upgraded regularly before the support for the old version is no longer available.

As an added safeguard against hacking and other electronic disasters, we employ McAfee VirusScan Enterprise, VirusScan Enterprise for Linux, McAfee Management Optimized for Virtual Environments (MOVE), and McAfee Endpoint Security on all machines that could interact with our network. We use a suite of products from FireEye (HX, NX, and EX), which looks for compromised hosts, indicators of compromise (IOCs), and phishing attacks across our environment. We also use a web filter proxy from Zscaler that has virus detection and mitigation capabilities, as well as Cisco/SourceFire network intrusion prevention sensors that monitor for issues including, but not limited to, web attacks, viruses, malicious code, and drive-by downloads. These measures help to prevent our systems from experiencing any unanticipated electronic disaster.

DISASTER RECOVERY TEAM CAPABILITY AND EXPERIENCE

Our corporate DR Program team facilitates creation and maintenance of DR Plans. The DR team has five (5) full time consultants and one (1) Team Manager. The team has twenty-seven (27) years of cumulative experience in DR and BC at Humana and nearly fifty (50) years of overall experience in DR. The team includes experts with training in material science and engineering and enterprise content management. The team also includes experts certified in BC Planning, Project Management Professional, and IT Infrastructure Library.

Our DR team is structured to rely on the expertise, insight, and active participation from a variety of sources to proactively plan for the successful recovery of production following an event or disaster. Multiple business areas form our DR team so that we have a well-rounded approach. The DR team includes, but is not limited to, members from the: DR Program team, Crisis Management team, Data Center Operations Administration team, Network Services team, Production Control team, Database Administration team, Configuration and Change Management team, Storage Management team, Performance and Capacity Management team, Systems and Software team, Application Engineering teams, Corporate Communications team, Enterprise Information Security teams, and Security Administration team.

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1. The adequacy of the respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.

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Our DR planning revolves around safeguarding our data and computers, and ensuring we have plans in place for application recovery. Our DR plans address scenarios including, but not limited to: destruction of computer or software systems, interruption or failure of network based systems, operating hardware, or software, interruption of transactions in live and archival systems caused by operational errors, malicious acts; and weather-related events that affect our

data or computers. We conduct disaster recovery tests throughout the year, hosting tests at our secondary data center as well as at remote facilities, to test various scenarios.

Humana employs a proactive approach to DR by staying ahead of any anticipated or unanticipated disasters. To achieve this, we build, test, and continuously update DR plans for each software application, including third-party software to which we subscribe. As such, all applications have DR plans. Each IT Application Owner and Technical Services Owner is responsible for documenting, maintaining, and testing his or her application recovery plan or plans. The DR team assists the plan owners with recovery planning and testing, as needed, and serves as experts on industry best practices and business and regulatory compliance. The DR Program team facilitates planning sessions, consults, and conducts testing validation for Humana's DR Plans. The DR Program team also coordinates with the Tactical team, the Operational team, and the Local Market Crisis Event Management team in these processes.

STANDARDS TO RESTORE APPLICATION OF SOFTWARE AND CURRENT MASTER FILES
Humana follows all applicable federal and State laws and regulations. Humana will provide backup and recovery to meet security, privacy andother regulatory standards for both systems and data. At the broadest level, our DR Plan ensures that IT systems containing, using, processing, or storing protected health information, protected financial information, and protected personal information have a documented DR plan defining how the organization continues its role if service, use, or access to its computer resources is disrupted for an extended period of time. Our systems adhere to the following standards:

- Gramm-Leach-Bliley Act (1999)

- Privacy Act (1974)

- HIPAA, 45 CFR Parts 160, 162 and 164, Health Insurance Reform: Security Standards

- ISO/IEC 27002:2013, Information Security Management – Code of Practice

- ISO/IEC 27001:2013, Information Security Management System

- ISO/IEC 22301:2012, Societal Security – Business Continuity Management Systems – Requirements

- ISO/IEC 24762:2008 Guidelines for Information and Communications Technology Disaster - Recovery Services

- Sarbanes-Oxley Act of 2002, SOX

- CoBiT V5, Control Objectives Management Guidelines Maturity Model, DS4 Ensure Continuous Service

- PCI/DSS Security Standard V3 issued October 2008, Credit Card Security

- ITIL Version 3 Service Design Volume Section 4.5

- NFPA 1600, Standard on Disaster / Emergency Management and Business Continuity / Continuity of Operations Programs

These baseline standards protect critical infrastructure such as computer operations, networks, power, security, and telecommunications. Critical systems use real-time mirroring to our secondary data center, while non-critical systems, databases, and files are backed up nightly. Data are replicated at the file level in the event some subset of replicated data becomes corrupt.

APPROACH TO HARDWARE BACKUP AND PRODUCTION SYSTEM FAILURE
To ensure protections of our systems, all data and soft copies of files are kept on servers housed outside the state of Florida, avoiding potential disasters from weather events in the state. We keep three (3) copies of our production systems—the primary copy supporting on-going operations, a backup of this at our main data center, and a redundant backup at our secondary data center.

Humana maintains a private, encrypted data link between the primary and secondary data centers. Data that are critical to our operations are stored at both data centers automatically, rather than relying on the primary data center to push data to the secondary one. Backups are performed on a daily basis, at a minimum. We are fully capable of recovering and operating from the secondary data center in the event the primary data center is not available. We have a robust infrastructure for the maintenance of all applications and systems that are critical to business functions. These applications and systems are duplicated in both data centers. Data is replicated between both data centers via a private, secure high-capacity connection, so the data never leaves our secure areas. Backups of critical servers and critical data at the file level are completed nightly by the enterprise back up team in the event that a subset of the replicated data becomes corrupt. During any IT disaster in which our primary data center is not functional, our secondary data center serves as the primary data center until restoration is complete. Development, testing, and implementation of new technologies and applications are suspended during crisis and significant events so that all available resources can be dedicated to resuming normal operations.

We perform yearly tests of our DR Plans. Most of these tests are conducted at the secondary data center using an in-house DR strategy. However, some testing for remote facilities are conducted from contracted vendor facilities. These tests provide the ideal settings under which updates to DR Plans can be made. During tests, we track responses to notifications to join calls, team responsiveness and validation steps. Our latest DR Plan test conducted on August 28, 2017, demonstrated our ability to meet the recovery time objectives. All testing results are documented and maintained for future review.

DR Plans are stored in hard (paper) and soft (electronic) copies. DR Plan owners maintain hard copies of the plans at their homes and at their desk for quick access. The DR team also uses a company-wide shared site as the primary repository to store copies of the recovery plans; the servers used to store these files are designated as critical and have never experienced a disaster. As an additional precaution, DR Plans are loaded onto twenty (20) laptops and updated monthly. Mainframe application recovery plans are replicated alongside copies of the applications, and all are replicated at our secondary data center.

Our Security Office is responsible for physical access at both primary and secondary data centers. The Security Operations Group is responsible for protecting computer hardware,

software, and data against unauthorized access from threats such as viruses, Trojan horses, hacking, and other events such as a denial of service attack. The Security Administration Group is responsible for granting logical access to computer information systems based on data owner approvals. The Enterprise Information Security Organization has a compliance group responsible for routine monitoring of data systems for compliance with the regulatory security requirements. Our security teams have two hundred fifty-one (251) associates, averaging seven (7) years of tenure at Humana.

We maintain all files, including our disaster recovery plans, for our Florida Medicaid plan on physical servers for at least eleven (11) years, exceeding the AHCA retention requirement.

MAINTAINING DISASTER RECOVERY AND BUSINESS CONTINUITY PLANS FOR EXECUTION

Our Corporate Operational team supports the Florida Medicaid market with DR and BC plans. The corporate team works directly with the Florida Medicaid Market Vice President and includes several dedicated BC Liaisons within the Enterprise Resiliency Office who are responsible for coordinating with our Florida associates during any crisis or significant event. Our business and technical associates' response to events is coordinated using their BC and DR Plans.

The Enterprise Resiliency Office works with our Florida business and engages Situational Awareness teams that have responsibility for monitoring and acting during incidents and disasters by offering response plans, including cyber responses, BC Plans, DR Plans, emergency response plans, and crisis communication plans.

EXECUTING DISASTER RECOVERY PLANS

In the event of a disaster, the core recovery teams and Executive Management make an initial assessment of the damages after a crisis or significant event occurs. This group then decides on a course of action, including activation of appropriate DR plans. Our integral partners, including AHCA, are notified per contractual requirements.

Events may also be reported through a variety of methods, including automated incident reporting. Data Center Operations issues are typically reported through the corporate Help Desk (CSS) or through the Network Operations Control Center (NOC), both of which operate twenty-four (24) hours a day, seven (7) days a week. The NOC maintains an escalation contact list that includes the DR team Manager for major events. Our latest test had all required managers in communication via a secure telecommunications line within ten (10) minutes.

Our Crisis Communications Plan includes directions on communicating with enrollees, providers, and AHCA. We notify AHCA of significant system outages every hour, as required by the Contract.

SUBCONTRACTOR DISASTER RECOVERY AND BUSINESS CONTINUITY PLANS

We ensure that all subcontractors have appropriate DR and BC Plans that adhere to Florida's requirements. The ERO established a third Party Risk and Resiliency Program to monitor subcontractor risk and resolution strategies. Critical subcontractors provide their DR Plans and BC Plans to demonstrate compliance with AHCA's contract. In addition, each critical subcontractor annually provides updated plan(s) and evidence of their BC and DR exercises.

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2. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract.

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Access to software, current master files, and backups of production systems is critical to our successful systems availability. Our secondary data center is maintained and continuously monitored, as described earlier, with careful attention to ensure we can backup and restore information. Our DR Plan is based on the assumption of catastrophic loss of the main corporate data center in Louisville and includes a tiered approach (based on criticality) for recovery. DR Plans are updated annually or more often, based on the information we gain from our experienced associates, industry insights, and our robust testing processes. Our leadership team operates in compliance with regulatory requirements in establishing criticality (e.g., if a system must be recovered within twenty-four (24) hours, this will be considered critical). The final DR Plan is approved by the DR team.

Humana meets and often exceeds CMS Essential Functions Guidelines in limiting service interruption to a period of twenty-four (24) hours in a disaster event. Our DR Plan establishes roles and responsibilities for documenting disaster recovery and application recovery procedures for computer infrastructure and its supporting networks, applications, and communications in the event of a disaster at the primary data center. We perform annual tests to validate that Humana can meet both the twenty-four (24) hour Recovery Time Objective and the Recovery Point Objective of near zero data loss for Critical systems.

To best support our expansive lines of business, we have established a strong and highly skilled IT team and crafted effective BC Plans. This allows us to effectively respond with the necessary expertise and resources to limit service interruptions. Our recovery strategies are based on a tested process that allows for expedient recovery for applications and services that are critical to delivering and ensuring access to care. Our DR Plan is designed to ensure that our enrollees have access to clinical services and our associates have access to appropriate clinical systems.

BUSINESS CONTINUITY

BC planning ensures we have the necessary resources to satisfy our obligations to AHCA, our enrollees, and our providers. We utilize a tiered approach to our disaster response based on an event's anticipated severity. The process we use to determine which version of the BC Plan to use is detailed below under "Events Management." Our ERO facilitates the execution of recovery during crisis and significant events. Our Florida Market Plan directors are responsible for executing the Florida Market BC Plans. The Florida Market Plan directors report to our President of Florida Medicaid Market Operations. During Crisis and Significant events, our President of Florida Medical Operations facilitates the Florida Market's communication with the CMT.

EVENTS MANAGEMENT

The CMT maintains the Crisis Management Plan (CMP). The CMP guides the CMT on how to handle crises and significant events, with particular guidance for events that are expected to last forty-eight (48) hours or longer. Attachment 33-1 gives an overview of our organizational structure for Crisis Management.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana.com displays actions we take for Medicaid enrollees based on CMS disaster guidance to protect our enrollees. These actions include, but are not limited to, overriding refill timelines, paying out-of-network claims for impacted enrollees, and waiving prior-authorization requirements for impacted enrollees. During crises and significant events, we will look to partner with CMS and AHCA to swiftly implement additional disaster-specific mitigation activity, if necessary.

Business impacting events are reviewed by the ERO for severity of impact on our enrollees and providers, and are then categorized as incident, local market or nationwide crisis, and significant events.

The following paragraphs describe the actions we take for each event severity level:

- Incident: Events categorized as an incident reflect situations where there is minimal, if any, impact to our enrollees accessing or providers delivering care. An example includes minor access to care impacts. Our Emergency and Incident Response team responds to these situations.

- Local Market Crisis or Nationwide Crisis: Nationwide crises would affect Humana's operations in multiple locations. Events categorized as Local Market or Nationwide Crisis events reflect situations where access to care does not pose long-term health risks. The BC and CMTs support Market Leaders in our response efforts to provide a timely action to these situations. Examples of Local Market Crises include weather related disasters in a specific regional area that prevent our employees from accessing our offices. In these situations, the business areas have developed processes that redirect work to other sites, if possible. All production servers are housed in Humana's hardened data center in Louisville, Kentucky; as such, they are not vulnerable to weather-related events in Florida. The servers are accessible from any location within Humana's nationwide private data network.

- Significant Events: Events are identified as significant when we are limited or unable to access critical care systems, resulting in critical care issues that could pose long-term health risks. The Significant Event Management (SEM) team manages significant events, with ERO Crisis Management providing support and guidance. Our CMT is also activated during any significant event. The ERO team works with our business and technical operations in Florida and engages Situational Awareness teams that have responsibility for monitoring and acting during incidents and disasters by offering response plans, which include cyber responses, business continuity plans, disaster recovery plans, emergency response plans, and crisis communication plans.

Access-to-care and critical-to-operations applications and services are stored and backed up at our primary data center and are duplicated at our secondary data center. Data replication occurs via a secure, private network between both data centers, so the data never leaves corporate secure facilities. Backups of critical servers and data are done nightly at the file level to mitigate data loss in the event some subset of the replicated data becomes corrupt.

DR Plan testing, which is the main avenue used to measure time to bring systems back up, occurs throughout the year. The testing drives toward full recovery in a timely fashion. From 2008 to 2016 we have been able to reduce our real-world simulation test recovery times by more than thirty-eight percent (38%).

Humana uses an external mass communication system to support Crisis Management that can be accessed remotely to notify associates of the BC and DR plans to use for the event. Emergency notification can be sent to thousands of associates in just minutes and can be one-way (to the emergency personnel only) or two-way (requesting the recipient to press a number to join a teleconference, provide a status on personnel safety, or give them a number to call for more details). Additionally, the tool provides a report showing the key personnel who have responded. We even utilize this system during annual DR tests and during our semi-annual Crisis Management exercises.

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3. The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract.

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Humana has extensive records backup to ensure our systems remain operable during adverse events. We retain three (3) copies of our critical systems to mitigate issues if one of the copies is damaged or destroyed. The production copy and one (1) backup are stored in our primary data center, and a redundant backup copy is stored in our secondary data center. Changes and updates to the data are pushed between the two (2) data centers automatically via a secure, private, encrypted corporate data link. Backups of critical servers and critical data at the file level are taken nightly by the application teams in the event some subset of the replicated data becomes corrupt. Data replication for applications defined as Tier 1 (catastrophic/must have) occurs between both data centers so the data never leaves corporate secure facilities. This allows for compliance with the AHCA Contract and for us to satisfy the requirements of our DR Plan.

Our DR team reviews our DR Plan annually or more frequently (when needed). The DR Plan covers the recovery of computer systems, hardware, and software applications our market plan and corporate teams need access to. The DR Plan outlines the overall recovery plan strategy and defines roles and responsibilities for all DR planning. Humana's DR Plan will continue to be made available to AHCA. Our comprehensive Corporate DR Plan follows all state and federal laws and regulations. In the event that there is a conflict between state and federal laws, we follow the more stringent requirements. Recovery team owners are responsible for maintaining, testing, and executing, when needed, their DR Plans.

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4. The adequacy of the respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract.

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DISASTER RECOVERY

Humana's DR Plans are designed to guide our associates to recover systems. They are written with the level of detail needed to allow trained IT resources to understand and implement recovery activities at alternative locations. These plans are reviewed annually and are updated as any system or application change is made.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

BUSINESS CONTINUITY

BC Plans ensure we have the necessary resources to satisfy our obligations to AHCA, our enrollees, and our providers. All BC Plans include accommodations for alternate-site operations in the event our primary sites are inoperable. BC Plans are also stored off-site with managers on their laptops and on a dedicated secure network drive site that is accessible through a virtual private network. Our key market and corporate business leaders maintain hard copies of the BC Plans are kept in their offices and homes, ensuring access to physical access to these plans in the event of system or electricity failures.

Humana maintains unique BC Plans for each business area that are tailored to address events and support the restoration of day-to-day operations, based on business criticality established by business leaders. These plans include operating from alternative locations for critical business functions.

Our BC Plans offer the day-to-day operational guidance to carry out critical operational functions. BC Plans begin with a recovery strategy that includes recovery approaches based on business criticality. BC Plans are built on the assumption that the event could occur during or after business hours, the relevant Humana facilities are inaccessible for an extended period of up to six (6) months, and key business area associates are not able to assist in recovery. As a result, BC Plans are written with the level of detail necessary so that associates or managers with similar skill sets can execute the plan.

The BC Plan has the following steps:

1. Notification and activation, to notify key individuals impacted and begin to act on key elements of the plan

2. Assessment, to determine disruption scope and initiate recovery

3. Recovery site, to maintain a temporary recovery site if needed

4. Process recovery, to restore day-to-day operations

5. Salvage efforts, to clean up abandoned site and retrieve records

6. Return to permanent facility, to restore day-to-day operations at the permanent site

Business Continuity Plans are executed by plan Directors, with support from the Enterprise Resiliency Office during Local Market, Nationwide Crisis, and Significant Events. Plan Directors maintain overall responsibility for business functions and attest to the BC Plan for its approval. The BC team works with Managers, Supervisors, and Subject Matter Experts to create, update, and test the BC Plan. Final approval for BC Plans occurs when the plan is submitted with attestations that the plan meets specific requirements. Mission and Business Critical BC Plans are updated after tests and events.

The CMT maintains the Crisis Management Plan (CMP). The CMP directs the CMT on how to handle all events, with guidance for events that could impact our enrollees, providers, associates, and stakeholders (e.g., AHCA).

The Business Continuity team oversees the development of tools for the creation of plans and the facilitation of the business impact analyses. These analyses help identify critical applications, the recovery time objectives, and key information provided to the Disaster Recovery teams.

The Tactical team comprises Directors and Vice Presidents. This team's primary responsibilities during a recovery include emergency response, cyber response, BC, DR, and crisis communication. The Tactical team reports to the Operational and Local Market Crisis Event Management teams.

Our corporate Operational team and Local Market Crisis Event Management team are made up of Segment Presidents and Enterprise Vice Presidents. Higher level events, especially those that have the potential to cause a maximum of twenty-four (24) hours of disruption are escalated to this level. When an event could exceed twenty-four (24) hours of disruption, the Significant Event Management team is immediately called into action. This team is comprised of the Chief Executive Officer and direct reports. It is responsible for strategically guiding the enterprise though the Disaster Recovery process to minimize disruption during, or as a result of, a major event.

To restore day to day operations, Humana's telecom systems have remote login capability that allows business associates to login at alternate work locations or from their homes to take calls. Associates have this remote capability because they are assigned to a specific skillset that aligns to the incoming phone numbers. For example, our Critical Inquiry team (CIT) associates working from various Humana locations or from their home can take CIT calls virtually anywhere, as they are assigned the CIT skillset. This remote login and work at home capability helps to provide continuity of CIT services should Humana experience a facility interruption.

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5. The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.

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As a result of our comprehensive system security protections, Humana has never experienced a loss of data due to a system or program failure or destruction. We maintain backups of critical applications and systems, which are updated nightly. Our data centers are accessible via Humana's secured virtual private network, allowing us to maintain operational functionality, regardless of time or place, because our associates can access their files in a secure manner remotely. Humana's secondary data center is located in Simpsonville, Kentucky, and is always privy to the information found within our primary data center. The secondary data center is fed data through our high-capacity data link and includes real-time mirroring for critical systems. As an additional precaution, we have two (2) backup power sources – large battery banks and generators – for our data centers.

Our Primary Data Center is protected by our security teams, a barbed wire fence, and drop-gate parking entrances. Both data centers require that visitors have a Humana Associate Identification (ID) to enter. Visitors who do not have a Humana Associate ID are required to register with the security office, are issued a temporary ID, and are escorted by a security member or associate at all times. The Associate ID or temporary ID is required to enter and exit

the centers. Both data centers are Tier 3 certified, which means that they require no shutdowns for equipment replacement and maintenance, have exterior walls built to withstand one hundred fifty (150) mile-per-hour winds, and are fully enclosed (without windows for the area storing data).

The Storage Management team provides storage capability for all computer processing needs. The team is responsible for providing mainframe disk and tape storage for production operations and replicating production data in real time, which is then transmitted to the secondary data center where data is also stored on disk. They also provide open systems storage for servers based on the amount of data to be stored on each server. During emergency events, the Storage Management teams work closely with the open system vendors to expand the storage as required at the alternative processing site, either on a temporary or permanent basis. The software management team also has responsibility for replicating critical system production data in near real time and transmitting the data to our secondary data center where the data is stored on a disk.

The accountable systems and software teams have responsibility for mainframe system level software, including installation, servicing, and ongoing maintenance. The team also provides all production operating system images to the recovery teams.

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6. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date.

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Humana's tenure in healthcare and within the Florida market has enabled us to develop the relevant expertise needed to ensure our DR processes are thorough and up-to-date. Our Contract Management Unit will ensure that all necessary updates to our BC and DR Plans align with the Contract and are finalized no later than thirty (30) days prior to the resulting contract's effective date.

Our Contract Manager is ultimately responsible for the submission of our enterprise DR plan to AHCA. Our Contract Manager works with our BC Plan liaison to support BC and DR planning to ensure we plan for potential impacts to our enrollees. Since we joined the Florida Medicaid program in 1997, we have always submitted our Enterprise DR Plan to AHCA in a timely fashion.

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7. The adequacy of the respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.

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Humana prioritizes opportunities identified in our DR plan updates to support business function priorities and AHCA's requirements, as well as to adhere to national standards. Any updates and changes we determine through this process are always made in the best interest of the Agency and our enrollees and providers. Our Contract Manager shares updates to our DR

Plans with AHCA annually or as DR Plan changes are made. Changes occur after tests or events and as new protocols are established.

Humana meets and often exceeds CMS Essential Functions Guidelines and maintains responsibility for related DR costs. Annually, or as needed, Humana will assess AHCA business functional recovery requirements or new service offerings and compare them to CMS Essential Functions. When AHCA's recovery requirements do not align with CMS' Essential Functions, our Senior Leadership reviews any additional requirements or variation in requirements and will amend and update our plan in the best interest of the Agency. Our Contract Manager shares updates we are making to our Enterprise DR Plans to the Agency in a timely manner and at no additional cost to the Agency.

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8. The adequacy of the respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times.

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Humana has made our DR Plan available to the Agency at all times and will continue to make the DR Plan available at all times. We will submit the DR annually and at any time AHCA requests.

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9. The adequacy of the respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency.

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Humana performs annual simulation tests on our DR Plans. These tests provide the ideal settings under which updates to DR Plans can be made. The test scope includes recovery of the infrastructure, functionality, data, and applications supporting national Humana and local Florida Medicaid business at the secondary data center in Simpsonville.

During tests, we track responses to notifications to join calls, team responsiveness, and validation steps. Our DR Plan tests are used to validate successful operations and provide scenarios to serve as experience to test the effectiveness and comprehensiveness of our DR Plan. Our latest test, on August 27, 2017, demonstrated we met the recovery time objectives.

Special tests are conducted whenever major revisions are made to the recovery plans or significant changes have occurred to software, hardware, or data communications environments. When practical, the test exercises may use tabletop, walkthrough, technical, backup media restore, simulated, or automated test exercises to walk through a recovery plan.

The DR Program Manager is responsible for coordinating and documenting all testing and testing results. The DR Program team monitors testing, gathers evidence of testing documentation, identifies gaps in the existing DR Plans being tested, and works with the test teams to update plans accordingly. Test results will be documented in the Executive Summary report. The Executive Summary test report is given to Executive management shortly after testing is completed and posted to the DR SharePoint site. Follow-up focus meetings are held with participating teams to discuss lessons learned and identify where specific changes must be made to the individual team plans and give teams with test objectives for the next test exercise.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

We have established minimum criteria to complete these tests and set new objectives each year to ensure we consistently achieve improved objectives and are aligned with the priorities established by the field and by AHCA. As referenced earlier, over the past eight (8) years we have been able to reduce our real-world simulation test recovery times by more than thirty-eight percent (38%). We take the knowledge gained in these exercises and apply it to update all of our DR Plans.

Humana will continue to submit a summary report of our DR exercise and results to AHCA on an annual basis. This validates our capability to meet our recovery time objectives.

Evaluation Criteria:

1. The adequacy of the respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.

2. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract.

3. The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract.

4. The adequacy of the respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract.

5. The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.

6. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date.

7. The adequacy of the respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.

8. The adequacy of the respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

9. The adequacy of the respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment SRC 33-1. Business Continuity Organizational Structure and Severity Levels

Attachment SRC 33-1. Business Continuity Organizational Structure and Severity Levels

Trade Secret as defined in Section 812.081, Florida Statutes

G. STATUTORY REQUIREMENTS

SRC# 34 – Statutory Community Partnerships (Regional):

The respondent shall describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees, including:

a. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.

b. Partnerships with local community organizations focused on addressing the following social determinants of health:

(1) Access to Food;
(2) Employment;
(3) Housing Stability;
(4) Education; and
(5) Exposure to Crime/Violence.

c. Participation in both grass-roots and grass-tops provider initiatives.

Response:

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The respondent shall describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees.
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Partnerships with local organizations and providers are critical to improve the health and quality of life for the Medicaid enrollees that depend on them. This is particularly true for programs supporting the complex care and social supports needs of vulnerable subpopulations covered in Florida's Statewide Medicaid Managed Care (SMMC) program. There are countless organizations that have provided foundationally important work for decades in communities across Florida. Humana is committed to enhancing these existing support structures rather than supplanting them with overly prescriptive national models. Partnerships with local community organizations also help us more effectively remove access to care barriers. We have built this approach on the understanding that success requires working within current system infrastructures and collaborating with community partners to support programs and initiatives centered on a common goal to improve the health, well-being, and quality of life for Florida enrollees.

Humana has formed community partnerships deliberately and gradually through strong, historical experience across the State, where we currently serve more than two point two five (2.25) million enrollees across Medicaid, Medicare, and Commercial health plans. Humana's

more than ten thousand (10,000) Florida-based associates are highly engaged in their communities, with more than thirty-three thousand six hundred (33,600) volunteerism hours logged in 2016. In fact, Humana encourages associates to give back to their communities by offering paid time off for volunteerism. We've built community partnerships with nearly three hundred (300) different local organizations, in addition to hundreds of long-established, highly-engaged relationships with locally-based providers. Separately, the Humana Foundation, a 501(c)(3) entity with a governing and grant-making body separate from Humana Inc. market leadership, has contributed more than four point one million dollars ($4.1M) to a variety of local Florida non-profits over the last five (5) years, further demonstrating the company's overarching commitment to the communities we serve. Most recently, in the immediate aftermath of Hurricane Irma, the Humana Foundation donated one million dollars ($1M) to the American Red Cross and one hundred thousand dollars ($100,000) to Feeding America partners throughout Florida for relief efforts.

Humana's corporate "Bold Goal" captures the spirit of our approach to community partnerships: to make the communities we serve twenty percent (20%) healthier by 2020. Achieving this goal is only possible through a deep company leadership commitment to community engagement coupled with strong relationships with local organizations that help enrollees adopt healthy behaviors and address the many social determinants of health and wellness. Jaimie White, President of Florida Medicaid Operations, as well as John Barger, Humana's Vice President of National Medicaid and Dual-Eligible Programs, have demonstrated a commitment to achieving this goal by serving on Humana's Florida Bold Goal Board of Directors to align their leadership and expertise with community health priorities.

In 2015 Humana's corporate Bold Goal team, housed under the Office of the Chief Medical Officer, launched Bold Goal markets in Florida, including Broward County, Tampa, and Jacksonville. To truly understand these communities, the Bold Goal team conducted in-depth analyses of each community's specific social determinants of health, prevalent chronic conditions, provider landscapes, and access barriers. In each of these regions, Humana helped convene and establish a local Health Advisory Board, which brings dozens of local stakeholders together to collaborate and find solutions to improve the local systems of care. The Health Advisory Boards hold quarterly meetings to foster collaboration among community organizations. Our leaders, in collaboration with critical community stakeholders, explore and validate opportunities for enhanced clinical and community partnerships, then remove barriers and align resources for support. During the Health Advisory Board meetings, the group charters and leads subcommittees to implement high-impact opportunities throughout the year. The response from organizations in these communities has been remarkable: one hundred seventy-five (175) local organizations have already signed on as Bold Goal Health Advisory Board members across Broward County, Jacksonville, and Tampa, and the list continues to grow.

BROWARD COUNTY HUMANA BOLD GOAL HEALTH ADVISORY BOARD MEMBERS

Aging and Disability Resource Center of Broward County
American Ambulance
American Cancer Society
American Heart Association
American Parkinson Disease Association
Ann Storck Center

Boys and Girls Clubs of Broward County
Broward County Government
Broward County Public Schools
Broward Health
Broward Regional Health Planning Council
Broward Sheriff's Office
Brown and Brown
City of Fort Lauderdale
City of Hallandale Beach
City of Lauderdale Lakes
County Health Rankings and Roadmaps
Deliver Lean
Faison Group Benefits, Inc.
Feeding South Florida
Florida Introduces Physical Activity and Nutrition to Youth
Florida Department of Health - Broward County
Florida International University
Gelin Benefits Group
Goodman Jewish Family Services
Health Foundation of South Florida
Health Practice Management
HealthSouth
Healthy Mothers Healthy Babies Coalition of Broward County
Henderson Behavioral Health
Hispanic Unity of Florida
Holy Cross Hospital
Hope Outreach Center, Inc.
Impact Broward
Keiser University
Kindred Healthcare, Inc.
Light of the World Clinic
Lighthouse of Broward
LogistiCare
March of Dimes
Med-Care Diabetic and Medical Supplies
MediFit
Mental Health Association of Southeast Florida
Non-Profit Executive Alliance of Broward
Nova Southeastern University
Novo Nordisk
Premier MHS
Rahul Free Clinic
Red Tree Health
Riverland Medical Center
RMA Medical Group of Florida
Sanofi
South Florida Symphony
United Way of Broward County
Urban League of Broward County

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

YMCA of South Florida

JACKSONVILLE HUMANA BOLD GOAL HEALTH ADVISORY BOARD MEMBERS

Accountable Health
Advize Health LLC
Agape Community Health Centers
American Cancer Society
American Diabetes Association
American Heart Association
American Lung Association
Baptist Health
Boys and Girls Clubs of NE Florida
Carewire
Citra Health Solutions
City of Jacksonville
Coalition to End Senior Hunger
Cora Health
Crucial Care
Davita Dialysis
Department of Defense Building Healthy Military Families
Duval County Medical Society
Duval County Medical Society Foundation
Duval County Public Schools
Edward Waters College
Eldersource
Eldersource Institute
Family Care Partners
Feeding Northeast Florida
First Coast YMCA
Florida Beverage Association
Florida Department of Health, Duval County
Florida Renal Administrators Association
Florida State College at Jacksonville
Florida Suicide Prevention Coalition
Healogics
Health Designs
Health Planning Council of NE Florida
Hunger Fight
Hylant
Jacksonville Transportation Authority
Jacksonville University
JaxChamber
Lifely Insights
Lutheran Family Services
Mayo Clinic
MCCI
Mental Health America

MomentStrong, LLC
National Park Service
New York Life
Nonprofit Center of NE Florida
Northeast Florida AHEC
NovoNordisk
Nview Health
PGA Tour
Pondus Health
Quest Diagnostics
Sanofi
St. Vincent's Healthcare
Sulzbacher Center
The Community Foundation of NE FL
The Hylant Group
Timucuan Parks Foundation
Tivity Health
University of Florida (UF) College of Medicine
UF Health Disparities Institute
UF Health Jacksonville
UF Extension office
United Way of Northeast Florida
University of North Florida
Vision is Priceless
Volunteers in Medicine
Wecarejacksonville
WJCT

TAMPA BAY HUMANA BOLD GOAL HEALTH ADVISORY BOARD MEMBERS

All Children's Hospital
Allegany Franciscan Ministries
American Diabetes Association
American Heart Association
Baycare Health Systems
Centre for Women
Depression and Bipolar Support Alliance of Tampa Bay
Feeding Tampa Bay
Florida Department of Health in Hillsborough County
Florida Department of Health in Pasco County
Florida Department of Health in Pinellas County
Florida Hospital Carrollwood
HART - Pasco
HCA Largo Medical Center
Healthy St. Petersburg
Hillsborough County Public Schools
Hillsborough County Department of Aging Services
JSA Healthcare

Meals on Wheels of Tampa
MehraVista
Metropolitan Ministries
Moffitt Cancer Center
Neighborly Care Network
Pinellas County Urban League
Pinellas Hematology and Oncology, PA
Prevent Blindness - Florida Affiliate
Publix
Sanofi
SEER Analytics
Senior Connection Center
Suncoast Health Council
Tampa Bay Healthcare Collaborative
Tampa Bay Network to End Hunger, Inc.
Tampa General Hospital
Tampa Housing Authority
Tampa Metropolitan Area YMCA
UF/Institute of Food and Agricultural Sciences Extension Hillsborough County
UF/Institute of Food and Agricultural Sciences Extension Pinellas County
United Way Suncoast
University of South Florida (USF) Health
USF College of Arts and Sciences
Vincent House
Walgreens
YMCA of St. Petersburg
YMCA of the Suncoast
YMCA of Tampa

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a. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.

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Humana emphasizes the importance of volunteerism and community involvement for all our associates and executives. By directly working with local organizations, we have a better understanding of our communities and enrollees' needs. Similarly, Humana offers these local health organizations our senior executives' leadership and expertise, which creates mutually beneficial partnerships. Our senior executive staff, through their leadership on the Florida Bold Goal Board of Directors and numerous other local health boards, councils, and commissions, helps to build extensive community partnerships. Our leaders care deeply about improving the health of their local communities, and they independently participate on Florida boards and councils that align with their individual interests. Below is a list of several Florida-based leaders and the organizations with which they are involved:

Jaimie White, President, Florida Medicaid Operations
- Board of Directors, Anne Storck Center
- Board of Directors, The FOOT Foundation – Florida Orthotics and Prosthetics Outreach Team
- Governance Board Member, Healthy Start Coalition of Escambia County

- Board of Directors, Humana Bold Goal Tampa

John Barger, Segment Vice President, Humana Dual Eligible and Medicaid Programs
- Board of Directors, Florida Hunger Action Alliance in partnership with Feeding Tampa Bay
- Board of Directors, Humana Bold Goal Tampa

Dr. Ian Nathanson, MD, Florida Medicaid Medical Director
- Pediatric Council Member, Florida Chapter of the American Academy of Pediatrics
- Board of Trustees, American College of Chest Physicians
- Decision Skills Committee Chair, Maintenance of Certification for the American Board of Pediatrics

Liz Webster, Florida Medicaid MMA Clinical Director
- Board of Directors, South Florida March of Dimes
- Florida Board of Nursing

Natalia Aresu, Director, Florida Medicaid LTC
- Advisory Committee Member, Impact Broward

Ela Alarcon-Cabrera, Clinical Director, Florida Medicaid LTC
- Board Member, Health Council of South Florida

Fernando Valverde, Florida Regional President
- Dean's Advisory Committee Member, Florida International University College of Medicine
- Board of Governors for all twelve (12) State Universities in Florida
- St. Thomas University Science Board

Kurt Strohmeyer, South Florida Medicaid Community Engagement Director
- Board of Directors, Florida Introduces Physical Activity and Nutrition to Youth (FLIPANY)
- Board of Directors, Humana Bold Goal Broward County

Katie Fleetwood, North Florida Medicaid Community Engagement Director
- Voting Member, Homeless Coalition of Polk County

Melissa Blum, Bold Goal Integration Leader
- Health Access Committee Member, United Way of Broward County
- Health Access Committee Member, Broward Regional Health Planning Council
- TOUCH Partner Leadership Team Member, Broward Regional Health Planning Council
- Broward County Nutrition and Fitness Task Force Member, Florida Department of Health

MEDICAID COMMUNITY ENGAGEMENT

In 2014 Humana launched Community Engagement Teams specifically focused on supporting local organizations that can help Humana’s Florida Medicaid enrollees. These regionally-based teams collaborate with community partners and providers, host health events, present health education sessions at conferences, and most importantly, help our Medicaid enrollees and their families connect with local resources to address all aspects of their health. As one example, we forged a partnership between Escambia County School District and Escambia County

Community Clinic to bring a mobile dental clinic into more than twenty (20) local schools. As a result, more than one thousand one hundred forty (1,140) children have received dental services. To forge relationships like these, Humana's Community Engagement teams serve on local health committees and build strategic partnerships, including the following:

HEALTH AND HUMAN SERVICE BOARDS, COUNCILS, AND COMMITTEES
Aging and Disability Resource Center (ADRC) Monthly Partners Committee
Alliance for Aging New Face of Aging Committee
Alliance for Aging Board of Directors
Bridges of Pahokee and Riviera Beach, Community Events Committee
Diabetes Coalition of Palm Beach County, Outreach Committee
Escambia County Council PTA and Florida State PTA, Health and Safety Committee Chairperson
Estate Planning Council, Committee Member
Florida Assisted Living Association (FALA) Board of Directors
Florida Assisted Living Association (FALA) Conference and Education Committee
Florida Assisted Living Association (FALA) Governance Committee
Head Start Advisory Committee, Gold Star Volunteer
Head Start Policy Council
Healthy Start Coalition
Hillsborough County Board of Commissioners Back 2 School Coalition
Homeless Coalition of Polk County
Helping Youth in Pensacola Endure (HYPE), Board Member
Junior League of Pensacola
Mentor at West Perrine Park
Palm Beach County HIV Care Council, Committee Member
Promoting Health in Homeless Shelters
Student Health Advisory Committee of Hillsborough County
The Beautiful Gate, Outreach Committee
The Urban League of Broward, Bold Goal committee
Tobacco Free Florida
United Way Children's Week Committee
United Way Loaned Executive Program
United Way Senior Day Committee
Volusia Flagler Coalition, Board Member
Wellness Committee Rotary Club of Perrine-Cutler Ridge/Palmetto Bay
West Palm Mental Health Coalition, Outreach Committee
Women's Health and Education Network of Palm Beach County, Outreach Committee

KEY PARTNERSHIPS
90 Works
All People's Day, Inc.
Autism Pensacola
Barbara Carey-Shuler Manor
Barry University
Bella Foundation
Beth-El Farmworker Ministries
Bezerra de Menezes Spiritist Association
Boys and Girls Clubs

Bridges at Lake Worth West
Bridges at Northwood
Brito Medical Center
Broward and Palm Beach Area Refugee Task Force
Broward Aware
Camillus House of Dade County
Carol City Elementary School
CarrFour Supportive Housing
City of Greenacres
City of Homestead
City of Refuge Compassion Pantry
City of West Palm Beach
Community Drug and Alcohol Council
Coral Way United Methodist Church
Council on Aging
Covenant Seventh-Day Adventist Church
Cypress Elementary School
Dayton Medical Center
Deerwood Bonita Lake Parks
Department of Elder Affairs
Devereaux
Dios con Nosotros
Downtown Lakeland Partnership
Escambia County School District
Extended Hands
Florida International University
Florida Introduces Physical Activity and Nutrition to Youth (FLIPANY)
Florida Medical Center
Gang Alternative Inc.
Gathering Place
Glazer Children's Museum
Goldson Spine Rehabilitation
Good Neighbor Thrift Stores and Food Pantries
Goodman Jewish Family Services of Broward
Housing Opportunities, Mortgage Assistance, Effective Neighborhood Solutions, Inc. (HOMES)
Haitian American Nurses Association of Florida
Harding Village
Head Start
Health and Hope Clinic
Health Connect in Our School
Healthy Mothers, Healthy Babies of Broward County
Healthy Start Coalition
Hillcrest Health Care and Rehab Center
Hillsborough County Parks and Recreation
Jessie Trice Community Health Center
Juvenile Diabetes Research Foundation
Lakeland Housing Authority
Lauderdale Manor Learning Center
Leukemia and Lymphoma Society

LiveWell Northwest Florida
Lynn Cancer Institute
Lynn University
Manna Food Bank
Miami Dade College
Miami Dade Homestead College Campus
Minority Association at Barry University
National Black Police Association
National Coalition of 100 Black Women
North Miami Police Department
North Miami SDA Church
Norwood Elementary PTA
Omega Power and Praise Ministry Inc.
Opa Locka Community Development Corp.
Pass the Blessings Foundation Inc.
Payne Chapel
Polk County Boys and Girls Clubs
Polk County Parks and Recreation
Psoriasis Foundation
Reimagine Milton
Salvation Army
Sant La
Southwest Miami Senior High School
St. Rose of Lima Catholic Church
Stand Among Friends
Start Off Smart
Students Working Against Tobacco
The ARC
The City of North Miami Parks and Recreation Department
The Epilepsy Foundation of Florida
Tobacco Free Florida Committee
United Haitian Baptist Church
United Way
University of Miami Miller School of Medicine, Department of Community Service
University of West Florida – University of Florida Extension Programs
Westgate CRA
Winter Haven Chamber of Commerce
YMCA
Zion Hope Missionary Baptist Church of Miami

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b. Partnerships with local community organizations focused on addressing the following social determinants of health:

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Social determinants, including economic and environmental factors, can play as big a role in enrollees' health as their access to high quality primary care providers (PCP) and hospitals. Fortunately, there are strong local organizations throughout Florida dedicated to improving their communities. Many of these organizations are focused on a single issue within one (1) specific

community, which puts them in the best position to lead progress on the issue. Across the company, Humana builds partnerships with these organizations to provide a variety of support, including:

- Launching collaborative events: Our Medicaid Community Engagement Teams have helped organize, coordinate, and present at more than two hundred (200) health fairs and events in 2017.

- Volunteerism: In 2016 alone, Humana associates logged more than thirty-three thousand six hundred (33,600) volunteer hours in Florida.

- Making connections with other organizations: Humana's Bold Goal Health Advisory Boards build strategic partnerships between hundreds of local organizations.

- Corporate Philanthropy: The Humana Foundation, a 501(c)(3) entity with a governing and grant-making body separate from Humana Inc. market leadership, has contributed more than four point one million dollars ($4.1M) to local Florida non-profits since 2012.

Our partnerships with local community organizations are critical to address a broad range of social determinants that drive health and well-being, including food insecurity, employment, housing stability, education, and exposure to crime and violence.

(1) ACCESS TO FOOD

Studies by Feeding America suggest that food insecurity affects one (1) in seven (7) Americans. Humana has been studying Florida's food insecurity challenges in collaboration with the University of South Florida, Feeding Tampa Bay, Bank of America, Community Foundation of Tampa Bay, and Mosaic. Using the Centers for Disease Control and Prevention's (CDC) four (4)-question Healthy Days survey, our findings suggest that enrollees who experience food insecurity struggle with twice as many "Unhealthy Days" as food-secure enrollees. "Unhealthy Days" refer to the number of days in a month during which the individual feels unwell mentally or physically. Thus, through our food security programs, we aim to mitigate one of the strongest influences on enrollees' health.

Together with our community partners, we have launched initiatives and supported food drive events to work toward alleviating food insecurity issues for many individuals across Florida. Food insecurity has a powerful influence on an individual's health, and Humana focuses heavily on partnering with local community organizations to address it. Below are examples of how we have worked to alleviate food insecurity through partnerships with Florida community organizations.

HURRICANE IRMA DISASTER RELIEF

Food insecurity is already a serious health concern throughout much of Florida, which disasters like hurricanes magnify even further. When Hurricane Irma left a widespread path of destruction across Florida, Feeding America worked quickly and diligently with local food banks to meet the critical food needs of Floridians affected by the storm. Immediately following Hurricane Irma, the Humana Foundation donated one hundred thousand dollars ($100,000) to Feeding America partners in South Florida, Tampa Bay, and Northeast Florida for hurricane relief efforts. Feeding

America used these funds to supply critical items such as water, produce, snack foods, ready-to-eat products, personal hygiene items, and cleaning supplies.

FEEDING AMERICA FOOD INSECURITY PILOT

In 2016, Humana collaborated with Continucare Medical Centers, Feeding America, and Feeding South Florida to conduct a pilot program to address food insecurity. When enrollees came for a doctor's visit, the Continucare associates evaluated them to determine whether they experienced food insecurity. They referred individuals who screened positive to meet with Feeding South Florida, with representatives onsite at the clinic. Feeding South Florida helped them enroll in Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Child (WIC), and other applicable assistance programs, and provided information about local food pantries. To address their most immediate needs, food insecure patients then received a care package of food.

The results from this program show how programs like this can impact enrollees' well-being by identifying those who experience food insecurities and helping them identify options for obtaining affordable food options. In this pilot program, we screened five hundred thirty (530) enrollees over a three (3)-week period. Of those screened, two hundred forty-six (246), or forty-six percent (46%), screened positive for food insecurity so we referred them to meet with Feeding South Florida. Of the two hundred forty-six (246) referred: two hundred eleven (211), or eighty-six percent (86%), accepted the referral and met with Feeding South Florida; one hundred ninety-eight (198), or ninety-four percent (94%), accepted an emergency box of food; and one hundred seventy-six (176), or eighty-three percent (83%), were referred to local food pantries or other agencies. Furthermore, seventy-eight point three percent (78.3%) of the dual-eligible enrollees screened were food insecure – a significantly higher percentage than that of Medicare Advantage (MA) enrollees screened.

Following the success of this pilot program, Humana launched large-scale, long-term food insecurity programs in both South Florida and Tampa that not only support enrollees in signing up for resources that provide ongoing food assistance, but also allow food-insecure patients to receive a package of food designed to last a full month. These programs, which went live in May 2017, build on the foundation of the pilot and expand geographic reach by extending into additional medical centers.

FOOD PANTRY VOLUNTEERISM AND SUPPORT

Humana's Community Engagement team works onsite with the City of Refuge food pantry on a weekly basis to provide health education. Last year, as the 2016 holiday season approached, the pantry director was concerned about a food shortage after Thanksgiving. The director also noted the pantry needed to replace a broken refrigerator to hold its annual Christmas giving event. To meet the need, the Humana team organized an office-wide initiative, and in two (2) weeks, we collected and donated more than three thousand seven hundred (3,700) non-perishable food items to the pantry. As a result, two (2) truckloads of food went to volunteers at the City of Refuge Compassion Food Pantry in Polk County in December. Our Community Engagement team also found a gently used refrigerator for sale. After speaking with the seller about the pantry's need, the seller offered to donate and deliver the appliance to the pantry free of charge. As a result, more than three hundred (300) families received dinner at the Christmas giving event.

OUTREACH CENTER REFERRALS

The Helping Other People Everyday (HOPE) Outreach Center is a South Florida agency that supports families with a variety of services, including a food pantry, after-school enrichment programs for children, senior companionship, and financial support for low-income families. In 2016 alone, the HOPE Outreach Center provided nearly one hundred (100) tons of food to their neighbors in Broward County. Humana has a longstanding partnership to help this local organization improve its community by fighting food insecurity. When we identify enrollees as food insecure, we connect them with the HOPE Outreach Center. To support their operations, Humana has provided fundraising sponsorships, which help cover costs for their food pantry. Additionally, our South Florida team participates at public events for the HOPE Outreach Center throughout the year.

NUTRITIONAL EDUCATION FOR CHILDREN
Humana has an ongoing partnership with Florida Introduces Physical Activity and Nutrition to Youth (FLIPANY), an organization that educates and empowers youth and adults through nutrition and physical activity programs while advocating for policy changes that benefit low-income families. FLIPANY has been a stalwart partner by participating in two (2) educational health initiatives, the Children's Nutrition and Women's Health Campaigns events, at which they have provided nutritional education to our enrollees and community members. Humana sponsors FLIPANY's annual charity event and participates in many of its initiatives. For example, Humana provides preventive health education at FLIPANY's annual Fun Run Marathon.

HOLIDAY FOOD DRIVES
Many families depend on free and subsidized school lunches for their children. When schools close for holiday breaks, many children experience food insecurity. Over Thanksgiving break in 2016, Humana partnered with the Miami-Dade Police Department to support the Little Haiti Turkey Drive, a local event to address food insecurity over the holidays. Held at a local community center, Humana volunteers helped distribute more than 500 turkeys to families in need at the event. The event helped families avoid food insecurity over the holiday break.

(2) EMPLOYMENT

Employment is a critical social determinant of health. Studies have shown that unemployment tends to lead individuals to practice poor health habits such as smoking and excess drinking, and to adopt overly sedentary lifestyles. Mortality rates and susceptibility to various long-term diseases also increase in the unemployed population.

Given this, reducing unemployment is a clear priority. By working with local job boards and organizations that interact with populations more prone to dealing with unemployment, we aim to educate enrollees about employment opportunities and to provide access to more resources for individuals seeking employment.

COMMUNITY PARTNERS PROMOTING STABILITY AND EMPLOYMENT
Humana's North Florida Medicaid Community Engagement Team works with the following organizations to address both employment and housing stability:

- Crisis Center of Tampa Bay: The Crisis Center of Tampa Bay is a twenty-four (24) hour-a-day, three hundred sixty-five (365) days-a-year facility that helps individuals with various crises they

may face, including situational problems such as unemployment, medical emergencies, and domestic violence.

- Salvation Army: The Salvation Army is a faith-based organization that works to help communities and individuals facing issues, including addiction, hunger, and homelessness, all common effects resulting from unemployment and instability.

- Metropolitan Ministries: Metropolitan Ministries cares for the homeless and individuals or families at risk of becoming homeless. This organization provides individuals with crisis stabilization services and aims to improve longer-term prospects regarding housing stability, employment, and education.

- 90Works: 90Works aims to educate and help people overcome unemployment, homelessness, and other issues by teaching self-sufficiency.

URBAN LEAGUE EMPLOYMENT INITIATIVES
In 2015, the Humana Foundation contributed three hundred thousand dollars ($300,000) to the Urban League of Broward County. The mission of the Urban League movement is to enable African Americans to secure economic self-reliance, parity, power, and civil rights. Its key areas of service are jobs, education, housing, and health. Through training, career building, and job placement services, the Urban League equips individuals with skills needed to enter or re-enter the workforce. In addition to engaging with the Humana Foundation on a separate grant initiative, the Urban League of Broward County is also an active member of Humana's Bold Goal Health Advisory Board. It is evident that the Urban League's employment initiatives present Broward County residents and SMMC enrollees with strong opportunities for employment, education, and self-improvement.

CAREER FAIRS
The Humana Medicaid Community Engagement Team has both sponsored and participated in the South Florida City of West Palm Beach Annual Young Adult Job and Resource Fair. The event provides an opportunity for employers to help young adults find job opportunities in their community, encouraging employers to focus on hiring adults ranging in ages from seventeen (17) to twenty-five (25) years old, particularly during the summer months. We also participated at the 2017 Career and Resource Fair, sponsored by the West Palm Beach VA Medical Center, in September. This event introduced veterans to community partners and organizations that will provide information on jobs and community services. These career fairs help young adults and veterans find gainful employment, which can set a foundation for a stable life and improve overall well-being.

(3) HOUSING STABILITY

Housing stability is a critical social determinant, impacting mental, social, and physical health. According to Johns Hopkins University, housing is also the greatest recurring expense for Americans. Stable housing supports education for children and employment for adults. It also helps case managers (CMs) maintain communication and support for individuals in need. We help enrollees build trusting relationships with their primary care providers (PCPs) over time, but without stable housing individuals may need to change providers frequently. Humana has built partnerships with many local shelters and organizations that help individuals in need of stable

housing. Humana offers financial support to underfunded organizations that are fighting to end homelessness, and we work closely with these organizations to help our enrollees and their families find and maintain a stable home.

FINANCIAL SUPPORT TO END YOUTH HOMELESSNESS

In 2014, the Humana Foundation made a three hundred fifty-thousand dollar ($350,000) grant to Starting Right Now. Humana's partnership with Starting Right Now reflects our strong support for its mission to end youth homelessness. Starting Right Now provides a stable home for young homeless individuals and provides one-on-one mentoring focused on educational achievement, obtaining employment, life skills, and financial literacy. Through this partnership the Humana Foundation aims to improve housing stability so that individuals can ultimately achieve their well-being goals.

COMMUNITY ENGAGEMENT EVENTS

Humana finds opportunities to support our enrollees by interacting with community through participation at local health fairs and other community engagement events. For example, we organized a health fair in October 2016 in coordination with Central Florida Healthcare and Lakeland Primary Care. We invited more than one thousand (1,000) enrollees to attend the fair, with education booths hosted by community organizations representing food pantries, family resources, dentists, transportation organizations, homeless coalitions, and more. Two (2) particularly resonant stories stand out from the event:

- An enrollee approached the Homeless Coalition's table searching for help. Her son had been homeless for months, living in the wooded area of rural Polk County. By the end of the day, we had arranged for a safe pickup and temporary housing for the young man.

- An enrollee and her two (2) young children had been involved in a domestic violence issue earlier in the week, and were looking for support and a safe place to stay. The Homeless Coalition connected the family with a shelter specializing in domestic violence cases.

AFFORDABLE HOUSING DEVELOPMENT

Humana's Medicaid Community Engagement Team has sponsored and supported Housing Opportunities, Mortgage Assistance, Effective Neighborhood Solutions, Inc. (HOMES) over the last three (3) years. More specifically, we have supported their annual Funky Fun Run, a fundraising event that attracts public participation from the surrounding neighborhoods. HOMES has used fundraising from the event to build four (4) housing projects for at-risk teens transitioning into adulthood. Local businesses say these developments have contributed to a reduction of crime in the surrounding neighborhoods.

FUNDRAISING FOR EMERGENCY, TRANSITION, AND PERMANENT HOUSING

Humana provides continued financial support to Camillus House through its annual fundraising galas. Camillus House provides fully integrated services through various programs including: Continuum of Housing (emergency, transitional, and permanent housing), Compassionate Healing (substance abuse and mental health treatment), Compassionate Hospitality (food, clothing, showers, outreach, case management, rent assistance), and Camillus Health Concern (providing primary health care services to adults and children).

FLORIDA COALITION FOR THE HOMELESS

Humana will exhibit at the 2017 Florida Institute on Homelessness and Supportive Housing Conference, sponsored by the Florida Coalition for the Homeless (FCH). The FCH's mission is

to work collaboratively with chapter organizations throughout the State to prevent and end homelessness in Florida. It uses a Continuum of Care model that systematically provides training and resources to all its member organizations, with designated lead agencies in each region.

(4) EDUCATION

Education is both a key social determinant of health and a critical factor in an individual's overall socioeconomic well-being. Many Medicaid beneficiaries have lower levels of educational attainment than the general population. They also face significant socioeconomic obstacles as a result, and greater challenges in returning to education. Humana helps enrollees overcome these barriers through education support initiatives.

FINANCIAL SUPPORT FOR LOCAL EDUCATION FOUNDATIONS
The Humana Foundation seeks to improve community health and well-being by supporting non-profit partners that address social determinants of health, such as education. Since 2013, the Humana Foundation has contributed thirty thousand dollars ($30,000) and twenty-five thousand dollars ($25,000) to the Pinellas Education Foundation and the Hillsborough Education Foundation, respectively. The Pinellas Education Foundation is composed of community leaders who undertake initiatives to improve the quality of public education, while the Hillsborough Education Foundation works to bring vital resources not funded by taxes to students in the form of scholarships, grants, and supplies. The Foundation's contribution will positively impact the area's children's likelihood of greater educational achievement.

BACK TO SCHOOL EVENTS
For the second year in a row, Humana engaged the community by participating in five (5) back to school events in Hillsborough County. In partnership with the Back to School Coalition, we assisted families in need of school supplies, resources, and immunizations during each event. This year, we collected donations of school supplies so every child who attended these events went home with a backpack containing the school supplies necessary to successfully begin his or her first day of school. Humana also provides health benefits to Hillsborough County and Pinellas County school district employees. Additionally, we coordinated individual volunteer opportunities for associates to participate in organizing and distributing supplies.

EDUCATION SESSIONS ON HEALTH AND SOCIAL DETERMINANTS
Humana supports the local partners below by regularly visiting them to lead health education presentations. Presentation topics include asthma, nutrition, access to care, oral health, bullying, summer safety (sun, swimming, etc.), medicine safety, and poison control. Humana supports and partners with the following organizations and their respective health education programming:

- The Aylstock, Witkin, Kreis, and Overholtz (AWKO) Justice Foundation

- At Hungry for Justice, a community project impacting hungry children in the community at monthly events, we showcase how to make healthy meals. Each family leaves with the ingredients to make the meals at home.

- Marcus Pointe Food Pantry and Schools – Humana leads recurring presentations on varied health education topics.
- Woodland Heights, Cobb, Fricker Centers and Boys and Girls Club – at after school programs, Humana hosts health education sessions.

- Family Fundamentals and Success by Six – Humana collaborates on community-wide events focused on health disparities. Events include: “Ready, Set, Learn,” Santa's Workshop, and Storybook Adventure.

- Devereux – Humana leads presentations on topics designed to foster positive parent-child relationships.

- Beth-El Farmworker Ministry – We tailor Humana’s health education presentations specifically to the needs of migrant workers.

(5) EXPOSURE TO CRIME/VIOLENCE.

Exposure to crime and violence has been proven to significantly impact individuals’ lives in both very specific and very broad ways. Domestic violence, abuse, gang-related activity, and other forms of crime and violence create insecurity within households and communities, which has a direct negative impact on overall health. Humana supports local organizations working to reduce crime and violence in communities, as well as organizations that offer support for families that have been victims of abuse.

PARTNERSHIPS WITH LOCAL SHELTERS AND SAFE HAVENS
The Spring of Tampa Bay provides sanctuary and services to abused adults and their children. The Spring’s programs and services help victims of domestic violence rebuild their lives and raise awareness to prevent domestic violence from occurring. Humana partners with The Spring to help enrollees suffering from domestic violence find a safe place to live, counseling and support, and more. The Spring also offers an accredited onsite school for resident children.

FINANCIAL SUPPORT FOR YMCA
In 2016 the Humana Foundation contributed more than fifty-seven thousand dollars ($57,000) to the YMCA of South Palm Beach County. This YMCA allows all community residents to participate in its programs, regardless of their ability to pay fees. They offer programs for all ages, from child care to teen fitness clinics to senior wellness classes. This is part of the Foundation’s efforts to support organizations that give young people a safe, positive environment. Separate from the Humana Foundation’s grant contribution to the YMCA of South Palm Beach County, Humana Inc.’s Bold Goal Health Advisory Board includes active participation from the following YMCA regional chapters: YMCA of St. Petersburg, YMCA of the Suncoast, YMCA of South Florida, and First Coast YMCA.
PARTICIPATION IN EVENTS TO PREVENT CRIME AND VIOLENCE
In support of the North Miami Police Department’s North Miami Police Athletic League (PAL) Families and Communities Together (F.A.C.T) Festival, the Medicaid Community Engagement team participated at this educational event for families and children. The event’s purpose was to provide the community awareness of various community social services while bringing neighboring families together to prevent and curb crime and juvenile violence. Held at the police station with more than four hundred (400) attendees, the event included dental, chiropractic,

and other health providers in attendance. Families received a meal and school supplies for their children.

CRIME WATCH SPONSORSHIPS
The Community Engagement Team is sponsoring the Citizens' Crime Watch of Miami-Dade through its Forty-Second (42nd) Annual Awards Ceremony honoring crime watchers and law enforcement. This program educates residents in various housing systems regarding crime watch and prevention, building strong working relationships with the local police departments.

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c. Participation in both grass-roots and grass-tops provider initiatives.
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GRASS-ROOTS PROVIDER INITIATIVES

With decades of experience building highly-engaged relationships with Florida providers, Humana regularly participates in grass-roots provider initiatives to deliver preventive health services and education in settings that improve enrollees' engagement and experience. Humana identifies and supports these initiatives through ongoing provider engagement, as well as Medicaid Advisory Panels.
ONGOING PROVIDER ENGAGEMENT
Humana continually learns from its provider partners and builds upon our longstanding provider relationships in Florida. For the SMMC program, we have developed a robust and comprehensive provider network capable of meeting enrollees' needs across the care spectrum. To most effectively serve our providers, our Provider Engagement team regularly meets with them to gauge their concerns about the SMMC program, Humana, and our enrollees. Moreover, by aligning the incentives of enrollees, providers, and community resources, Humana offers SMMC enrollees and providers a differentiating level of service coordination. Humana has aligned incentives through a continuum of value-based payment (VBP) models. We understand providers are at different stages in VBP readiness. As a result, we can meet providers where they are and help them grow in our VBP spectrum. Today, Humana has more than eight-hundred thousand (800,000) Florida enrollees, nearly two hundred thirty thousand (230,000) of whom are Medicaid-eligible, attributed to providers engaged in VBP arrangements. These arrangements have improved health outcomes for our enrollees and increased reimbursement for providers while reducing avoidable costs.

MEDICAID ADVISORY PANELS
Humana hosts Medicaid Advisory Panels to share new initiatives with key stakeholders in the community and to receive feedback from these organizations on how best to serve our enrollees. Our regional Medicaid Advisory Panels are comprised of medical service organizations, hospitals, non-profit organizations, and community agencies that serve the Medicaid population. For example, our South Florida Medicaid Advisory Panel includes representation from:

- Healthy Mothers Healthy Babies
- Sant La
- Goodman JFS of Broward
- Beacon Value Options

- Holtz Children's Hospital
- Broward Health
- Doctor's Medical Center
- Pediatric Associates

The provider partnerships forged through ongoing provider engagement and Humana's Medicaid Advisory Panels create opportunities for Humana to participate and support both grass-roots and grass-tops provider initiatives. Humana has many examples of programs borne out of these provider partnerships, including:

- Health Education Sessions at Provider Offices
- Humana Storks
- Children's Dental Clinics in Escambia Schools
- Provider-Hosted Health Fairs

HEALTH EDUCATION SESSIONS AT PROVIDER OFFICES

Humana's Community Engagement teams lead education sessions at local provider offices aimed at promoting awareness of general health education, chronic condition management, and understanding social factors' impacts on health. The provider groups at which we conduct these education sessions include: Escambia Community Clinic, Genesis OBGYN, Healthmark Clinic, Dr. Guentzel Internal Medicine, Sacred Heart, Destin Family Medical, Garcia Medical, Santa Rosa Community Clinic, Cantonment Family Practice, Central Florida Health Centers, Tampa Family Health Centers, Big Bend Pediatrics, Pediatric Associates of Tampa Bay, and Heart of Florida Regional Medical Center. Presentation topics include:

- Asthma
- Nutrition (Diabetes, Healthy Eating)
- Oral Health
- Bullying
- Summer and Swimming Safety
- Medicine Safety and Poison Control
- Holiday Safety (Gifts, Choking, and Fireworks)

HUMANA STORKS

In 2016, we launched the Humana Storks program in collaboration with several Memorial Healthcare System hospitals to improve the health and well-being of new mothers and their babies. When one of our Medicaid enrollees gives birth, we deploy a Member Advocate to the hospital with the purpose of educating the new mother regarding how to access health services that will ensure the best outcomes for herself and her newborn. The Member Advocate brings a care delivery package for the new mother, including a diaper bag, diapers, and a toy for the baby – see Attachment 34-1 for a photo of the care delivery package. The care package also includes health education information regarding the importance of scheduling timely appointments for dental and medical services, lead screenings, and vaccinations.

Response to this initiative has been very positive. One of our advocates recalls a recent Storks visit. The new mother stated, "I can't believe my insurance is bringing me a gift!" The Humana Member Advocate reviewed information regarding the hospital discharge, health education for new babies, and details for our MomsFirst case management program. MomsFirst program helps mothers with all aspects of their postpartum care, including finding pediatricians,

scheduling appointments, arranging transportation, and finding classes on parenting and childcare. The new mother immediately asked, "How soon can I sign up my baby?" By pairing an in-person, high-touch visit with the new mother care package, the Humana Storks program increases engagement in MomsFirst, which improves the health of new mothers and babies.

CHILDREN'S DENTAL CLINICS IN ESCAMBIA SCHOOLS

Escambia Community Clinics (ECC) is a federally qualified health center (FQHC) that includes pediatric, dental, and family practice providers. One of our Regional Community Engagement Leaders sits on the local parent-teacher association (PTA) board. In a meeting she held with ECC, they discussed children in underserved communities who were not receiving critical preventive dental care. This conversation led to a school-based collaboration with ECC, which included building a mobile dental clinic. Our community engagement leader worked with the local school district to help children obtain convenient access to dental services at their schools, including oral health exams and sealants. The results of this collaboration have been impressive: More than one thousand one hundred forty (1,140) children have received approximately two thousand six hundred (2,600) total services since August 2016.

Through Humana's support, more than twenty (20) schools have participated in the initiative, including: Gibson Head Start Center, Myrtle Grove Head Start Center, Lincoln Park Head Start Center, Sherwood Head Start Center, OJ Semmes Head Start Center Global Learning Academy, NB Cook, CA Weis, Lincoln Park, Ferry Pass, Pleasant Grove, Myrtle Grove, West Pensacola, Scenic Heights, Cordova Park, McArthur, Ensley, Oakcrest, Montclair, OJ Semmes, and Sherwood.

Humana is building on the success of this collaboration with ECC by expanding into additional schools. We are also partnering with community centers in these areas that offer free programs including after-school day care, summer camps, and more.

PROVIDER-HOSTED HEALTH FAIRS

Humana has partnered with many providers to launch a series of seasonal family-oriented health fairs to improve health access and literacy and close Health Effectiveness Data Information Set (HEDIS) care gaps at select high-volume provider offices. To share some examples, we have hosted holiday parties for children to visit Santa as well as Hawaiian-themed luaus. These events foster goodwill within the community by creating an experience that allows the health plan to give back to families in need. These events target dozens of HEDIS measures related to preventive healthcare, including adult body mass index (BMI) assessment, breast cancer screening, children and adolescent access to primary care, diabetes care measures, and well child measures.

In 2016, Humana led these events across eleven (11) provider locations. Campaign partners included Boca Pediatric Group, Continucare, Doctor's Medical Center, Independent Living Systems, and Pediatric Associates. Through these events, more than eight hundred (800) Medicaid enrollees and their families visited their PCPs, closing nearly five hundred (500) HEDIS gaps as a result. Enrollees and providers alike have had very positive responses to the events.

"Having the opportunity to work with Humana was a very positive experience for our office and patients. Our patients really enjoyed the many fun, entertaining, and interactive activities provided, especially photos with their favorite Superheroes! Due to the outreach provided, our

office was successful in scheduling and providing quality care to many of our Humana enrollees. This Humana event was well organized, fun, and productive. We look forward to working with Humana in the future," said Suzanne Kayal of Boca Pediatric Group.

"We are happy to be partnering with Humana. I have seen our HEDIS scores improve and I believe that is largely due to the enrollee campaign events," said Barbara Ensenat of Continucare.

GRASS-TOPS PROVIDER ENGAGEMENT

In addition to working with individual providers and practices, Humana participates in grass-tops provider initiatives in collaboration with Statewide provider associations. Humana engages provider associations across the State to better understand their key concerns and participate in collaborative solutions. In 2017 we met with many stakeholders whose relationships play a key role in the Florida Medicaid system to help us gather feedback, including:

- Florida Medical Association
- Florida Hospital Association
- Obstetric and Gynecological Society, Florida Chapter
- American Congress of Obstetricians and Gynecologists, Florida Chapter
- American Academy of Pediatrics, Florida Chapter
- Home Care Association of Florida
- Florida Alliance of Home Care Services
- Florida Health Care Association
- LeadingAge
- Florida Assisted Living Association
- Florida Council for Community Mental Health Centers
- Florida Council on Aging
- Florida Alcohol and Drug Abuse Association

For example, we've learned about initiatives to reduce unnecessary Caesarean sections (C-sections) and unintended pregnancies through our partnership with the Florida chapter of the American Congress of Obstetricians and Gynecologists (ACOG). ACOG is a charter member of the Florida Perinatal Quality Collaborative (FPQC), which leads multiple initiatives to advance high-quality, evidence-based perinatal care. Through our grass-tops engagement with ACOG, Humana participated in several of these initiatives:

- Humana is excited to help promote FPQC's "Promoting Primary Vaginal Deliveries" (PROVIDE) Initiative. The goal of the PROVIDE Initiative is to improve maternal and newborn outcomes and reduce unnecessary C-section deliveries by applying evidence-based interventions to promote primary vaginal deliveries at Florida delivery hospitals. We are emailing the FQPC alerts to the managed care departments of our participating hospitals and promote the initiative through our other communications with the hospitals.

- We have also promoted FPQC's Long-Acting Reversible Contraception (LARC) Initiative, sending out FPQC LARC alerts to our participating hospitals. The goal of the LARC Initiative is to reduce unintended pregnancies by working with participating Florida hospitals to improve hospital policies, procedures, and collaboration to increase rates of postpartum LARC usage.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana is committed to continuing to collaborate with Statewide initiatives to achieve our shared goal of reducing the number of unintended pregnancies.

Grass-top provider initiatives like these contribute to our goals of investing in and partnering with local community health resources, addressing social determinants of health, increasing access to care, and improving health outcomes.

Evaluation Criteria:

1. The extent to which the respondent provides details on how their local community partnerships, activities and initiatives support the local system of care.

2. The extent to which the respondent has senior executive leadership staff who will be assigned to the resulting Contract who also participate on local health and human service related boards, councils, and commissions.

3. The extent to which the respondent has partnerships with local agencies that focus on addressing social determinants of health.

4. The extent to which the respondent jointly develops and incorporates change from grassroots and grass-tops provider initiatives.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

Attachment 34-1: Humana Storks

Launched in 2016, the Humana Storks program aims to improve the health and well-being of new mothers and their babies. When one of our Medicaid members gives birth, a Member Advocate is deployed to the hospital with the purpose of educating the new mother regarding how to access health services that will ensure the best outcomes for herself and her newborn. The Member Advocate brings a care delivery package for the new mother, including a diaper bag, diapers, and a toy for the baby. Health education information regarding the importance of scheduling timely appointments for dental and medical services, lead screenings and vaccinations is also included in the care package.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 35 – Organization Commitment to Quality (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall describe its organizational commitment to quality improvement, including active involvement by the respondent's medical and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

Response:

CORE COMMITMENT TO QUALITY IMPROVEMENT

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

At Humana, our commitment to quality improvement is a core value that guides our day-to-day behaviors, decisions, and actions. We understand and appreciate that high-level management engagement in the Quality Improvement Plan (QIP) is essential to maintaining a robust and centralized company-wide approach to quality. Our organizational commitment to quality improvement starts at the highest executive level and flows throughout our operations, integrating input from management and associates to directly serve our enrollees.

Our performance and experience meeting quality standards in Florida demonstrate our commitment to quality:

- Humana ranked second in quality among Florida's Medicaid plans, according to the National Committee for Quality Assurance (NCQA) [1].

- Humana's Florida Medicaid plan has been NCQA-accredited since 1994. We are in the process of seeking an additional NCQA certification for Long-term Care (LTC) Case Management.

- We have devoted significant resources to support enterprise-wide Medicaid compliance and quality improvement. Our QIP associates work within Florida and at the corporate level to develop, implement, and maintain a successful program.

HUMANA QIP ASSOCIATES' EXPERIENCE (AS OF AUGUST 2017)

- Total Quality Full-Time Equivalents (FTEs) – one hundred eighty-seven (187) associates

- Percent clinical (MD, RN, LPN) – seventy-five percent (75%)

- Percent with quality certifications – twenty percent (20%)

- Average number of years in managed care quality – nine (9) years

- Average years in clinical – twenty-eight (28) years

- Total combined number of years in Humana managed care quality – one thousand five hundred forty-two (1,542) years

- Total combined years in clinical – three thousand six hundred fifty-five (3,655) years

QUALITY IMPROVEMENT PROGRAM (QIP) OVERVIEW

HUMANA'S QUALITY MISSION STATEMENT
To provide our diverse Medicaid population with coordinated quality care and the necessary tools and information to enable enrollees to improve their health and achieve lifelong wellbeing.

Our QIP monitors, analyzes, evaluates, and facilitates improvements in the delivery, quality, and appropriateness of healthcare services for Humana enrollees, including those with special needs. The overarching goals of our program are to:

- Achieve Excellence in Quality Compliance and Accreditation

- Enhance Cultural Competency, Enrollee Safety Programs, and Continuity and Coordination of Care

- Promote Best Practices and Process Innovation; and

- Create a Work Environment that Exemplifies Humana's Values

Our QIP provides the framework for integrated organizational activity in pursuit of enrollee health outcome and service experience improvements, setting the stage for lifelong well-being. It defines the structure, policies, processes, and methods we use to determine meaningful activities and influence desired outcomes in areas related to the delivery of care.

We base our QIP structure upon state and federal regulations, state contract requirements, accreditation standards, national healthcare agency guidelines, and organizational values and priorities. It aligns with the Centers for Medicare and Medicaid Services (CMS) Quality Strategy, which incorporates the Institute for Healthcare Improvement's Triple Aim, the current National Quality Strategy (NQS), and the National Prevention Strategy (NPS). By incorporating the CMS Quality Strategy into the program, Humana supports delivering consistent high-quality care and promoting efficient outcomes in the healthcare system.

Key program components include, but are not limited to:

- Written policies and procedures for Quality Improvement (QI), Utilization Management (UM), and Continuous Quality Improvement (CQI) that we periodically assess for effectiveness

- Health Information System that supports the collection, integration, tracking, analysis, and reporting of data

- Designated associates with expertise in QI, UM, and Care Management

- Monitoring clinical outcomes

- Reports that we evaluate, indicated recommendations that we implement, and feedback we provide to providers and enrollees

- Conducting and maintaining provider profiling

- Reports to the Quality Improvement Committee (QIC) and AHCA on results, conclusions, recommendations, and implemented system changes

- Annual Performance Improvement Projects (PIPs)

- Integration of the results from annual PIPs, performance measure rate monitoring, and compliance with federal and state standards

- Evaluating the impact of the QIP.

Humana's approach to program deployment reflects our CQI philosophy. We employ the four-step method of PDSA (plan-do-study-act) for the management and control of key processes and indicators. When applying this model, we:

- Use sound management and measurement methodologies to conduct quality measurement and evaluate pertinent data;

- Institute meaningful corrective action that addresses identified barriers; and

- Measure the results, evaluate the effectiveness of actions, and modify the approach as needed.

We confirm objectives annually and provide guidance for achieving quality and improving performance. Collaboration and coordination of resources at both Humana's corporate and local Florida levels helps us accomplish our QIP goals. This collaboration includes the following:

1. QIP policy and procedure development;

2. QIP data collection and preliminary analysis;

3. Healthcare Effectiveness Data and Information Set (HEDIS) process compliance oversight, data collection, and reporting;

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) process compliance oversight, data collection, and reporting;

5. Clinical and medical necessity review criteria development and maintenance;

6. Predictive modeling construct deployment and refinement;

7. Over- and under-utilization monitoring;

8. Clinical practice guideline development and maintenance;

9. Enrollee and Patient Safety Program development and maintenance, with local markets contributing state-specific initiatives as appropriate;

10. Clinical Disparities and Cultural Diversity Program development and maintenance;

11. Enrollee and provider incentive program development and maintenance; and

12. Credentialing, re-credentialing and peer review activities, with local markets providing input as appropriate.

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1. The extent to which the respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.
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QUALITY IMPROVEMENT LEADERSHIP AND OVERSIGHT

Our Florida Medicaid Medical Director is responsible for all clinical aspects of our Florida QIP. He leads and oversees day-to-day operations, directs performance improvement initiatives, conducts quality of care reviews, and monitors overall plan performance.

The Medicaid Medical Director serves as Chairperson of the Florida Medicaid Quality Improvement Committee (QIC). The QIC is a multidisciplinary committee that includes our Chief Medical Officer (CMO) and our President, Florida Medicaid Operations (i.e. our plan CEO), who oversees our Florida Medicaid program. The QIC meets quarterly and provides oversight of the QIP activities and clinical recommendations for our Florida Medicaid plan. The CQIC and Internal Board and Executive Committee delegate this authority to the QIC.

The Medicaid Medical Director also chairs the Peer Review Committee (PRC), which is responsible for reviewing potential quality of care issues, determining the severity of the issue, and recommending appropriate quality improvements or corrective actions. The PRC is responsible for developing individual provider quality improvement plans, where indicated, and reviewing progress toward resolution. Physicians and other healthcare professionals participate on the PRC, but only physicians have voting privileges. The PRC reports to the local Florida Quality Management Committee (QMC), which the Medicaid Medical Director also chairs. The QMC is responsible for reviewing Florida-specific preventive health and clinical study initiatives and focused studies. We also report peer review functions in the QMC.

QIP IMPLEMENTATION

Our President, Florida Medicaid Operations and our Florida Medicaid Medical Director lead and oversee quality improvement initiatives, attending various meetings on ongoing initiatives to improve quality across our Florida Medicaid operations. Our President of Florida Medical Operations is involved in daily operations of our Florida Medicaid program, including the promotion and support of quality programs that we must integrate across our organization to truly make an impact on enrollee care outcomes. Our Presidnet of Florida Medical Operations participates in the following meetings:

- CAHPS Intervention Meeting
- Florida Child Health Check Up (CHCUP) Corrective Action Plan (CAP) Task Force
- Antidepressant Medication Management PIP Intervention Team Meeting
- Pediatric Dental Services PIP Intervention Team Meeting
- Postpartum Care and Well-Child Visit PIP Intervention Team Meeting
- Electronic Health Record (EHR) PIP Intervention Team Meeting

Our Medicaid Medical Director is a member of the CQIC, and has oversight and approval of all activities of the QIC and QMC, providing seamless oversight of the development of our QIP methodology at both the national and local Florida level.

Attachment 35-1 contains an excerpt of our CAHPS, CHCUP, and PIP meeting attendee list. As illustrated by the highlighted yellow portion, our Florida Medical Director, as well as our President, Florida Medicaid Operations, is involved in all clinical functions across our QIP initiatives.

In addition, the President, Florida Medicaid Operations, and Florida Medicaid Medical Director are voting members at our Florida comprehensive QIC meetings.

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2. The adequacy of the respondent's approach to incorporating quality improvement activities into the culture and operations of the organization.

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"Quality is everyone's responsibility and therefore requires everyone's involvement through enterprise-wide collaboration, personal accountability and speaking up when quality does not meet our standards." - Bruce Broussard, Humana President & CEO

At Humana, we measure quality improvement throughout all operational areas, as evidenced by our NCQA accreditation and the quality scores we have achieved from NCQA and CMS, which require that a comprehensive, organization-wide commitment to quality measurement and continuous quality improvement demonstrably occurs.

We strive to ensure a cohesive and effective enterprise-wide approach to quality improvement through the following:

- Comprehensive approach to quality improvement, monitoring, and analysis of medical, behavioral, and LTC services quality of care

- Our President, Florida Medicaid Operations, and Medicaid Medical Director lead and manage the ongoing quality improvement process

- Cohesive corporate and local plan quality management structure, enhancing our Florida QIP with our nationwide QIP's robust support and resources

- Quality Committee structure incorporating cross-department input and feedback

- Robust quality data analytics capabilities, enabling us to monitor, track, and improve quality of care for our enrollees.

Our multidisciplinary program integrates all business units to promote enrollee safety, quality of care, and effective service delivery including departments involved in clinical care (utilization management, case management, and disease management), as well as all other non-clinical operational functions (enrollee services, provider relations, claims processing, compliance and reporting, marketing, and outreach).

We have built our QIP structure and infrastructure upon our corporate-local model described in the following narrative.

COMPREHENSIVE QUALITY IMPROVEMENT PROGRAM INFRASTRUCTURE

THE HUMANA ADVANTAGE
We combine the experience, resources, and scalability of a National Quality Program with our local Florida experience and insight to deliver a uniquely robust QI Program customized for Florida Comprehensive enrollees.

Corporate leadership on the CQIC, delegated by the Board of Directors, provides operational oversight for QIP activities and recommends policy decisions by planning, analyzing, and evaluating quality improvement activities. On an on-going basis, the local market QIC reports accomplishments, barriers, and improvement initiatives. We have a strong and dedicated committee structure that:

- Involves executive leadership by assessing and identifying improvement opportunities stemming from QIP activity and communication to appropriate owners;

- Promotes ongoing integration of quality activities throughout the organization;

- Engages actively practicing network providers in the QIP and process by bringing first-hand recommendations geared to assist providers and motivate enrollees; and

- Uses clinical and non-clinical teams to develop, implement, and monitor QIP initiatives to identify successes and failures.

The quality committee structure and program encompasses all levels of management and associates (executive, middle, and front-line), provider partners, community groups, and

enrollees. The committees identify opportunities and develop and implement interventions with the goal of improving the health and well-being of our enrollees.

Please see Attachment 35-2, which is an organizational chart illustrating Humana's departments and committees involved in quality improvement.

CORPORATE OVERSIGHT OF FLORIDA COMPREHENSIVE QI PROGRAM

Our corporate Internal Board and Management Team (the Board), which has ultimate responsibility for the QIP, has delegated oversight authority to the CQIC. Humana's President and Chief Executive Officer has direct involvement in the Board of Directors and is intimately involved in quality issues presented to the Board.

The Chairperson of the CQIC presents reports to the Internal Board and Management Team in person on behalf of the Committee once per quarter. Following approval, we house the reports on the Quality Operations Compliance and Accreditation (QOCA) SharePoint site.

Members of the Internal Board and Management Team include:

- President and Chief Executive Officer
- Executive Vice President and Chief Operating Officer
- Senior Vice President and Chief Medical Officer
- President, Employer Group Segment, and Government
- Senior Vice President and Chief Consumer Officer
- President – Clinical Care Services
- President – Humana Pharmacy Solutions
- Senior Vice President and Chief Strategy Officer
- Senior Vice President and Chief Human Resources Officer
- Senior Vice President and Chief Financial Officer
- Senior Vice President and Chief Innovation Officer
- Senior Vice President and Chief Information Officer
- Senior Vice President and Chief of Quality
- Senior Vice President, Corporate Affairs
- Senior Vice President, Medicare Operations
- Senior Vice President and General Counsel
- President, Retail Segment

OFFICE OF THE CHIEF MEDICAL OFFICER (OCMO) QUALITY TEAM
The Quality team of the OCMO is responsible for identifying opportunities to improve clinical quality. The team develops and executes strategies to improve clinical quality and collaborates with leaders to ensure we align clinical quality goals and metrics across the organization. The team also supports various programs throughout Humana by providing clinical insight and thought leadership for quality initiatives, including identifying quality measures. The OCMO Quality team facilitates the Clinical Quality Metrics Alignment Governance team.

THE CLINICAL QUALITY METRICS ALIGNMENT GOVERNANCE TEAM manages and maintains meaningful measures that affect enrollees while reducing variability in measure selection, collection burden, and cost. Objectives include:

- Maintaining a manageable repository of meaningful clinical quality measures that matter across the enterprise through an ongoing review process that includes research, assessment, and redesign

- Monitoring industry and enterprise trends and priorities, regulatory and compliance guidelines, specialty metrics, value-based reimbursement strategies, and national quality strategy to continuously evolve metrics and ensure alignment

- Determining the framework, methodology, governing principles, and criteria for key quality metrics

- Reviewing new and existing clinical quality metrics the business and work teams present; using a methodology to ensure we ground measures in evidence-based medicine and credible organization support, ultimately resulting in improved health outcomes.

THE CORPORATE CHIEF OF QUALITY has ultimate responsibility for the oversight of the overall Corporate QIP and is accountable for the following aspects including, but not limited to:

- Chairs Clinical Quality Measure Alignment Committee (CQMA) on Enterprise-wide quality measure alignment, standardization, and simplification of quality measures

- Chairs the CQIC

- Chairs the Corporate Recommendation Review Committee (CRRC)

- Chairs the Physician Clinical Practice Guideline Committee.

CORPORATE COMMITTEES

THE CORPORATE QUALITY IMPROVEMENT COMMITTEE (CQIC) oversees the quality improvement program, as delegated by the Internal Board and Management Team. The CQIC uses a centralized approach to the QIP by forming one corporate committee that assumes the responsibility for the QIP of Humana. Chaired by the Corporate Chief of Quality, the CQIC reports to the Internal Board and Management Team on a quarterly basis.

The CQIC oversees the establishment and integration of the QIP across all departments and measurement of quality activities on a regular basis. It also provides operational oversight for the QIP activities and recommends policy decisions. The CQIC provides a forum for members to engage in review, coordination, and direction of the Quality Improvement program. Organization-wide representation of the CQIC includes representatives from:

- Accreditation
- Appeals and Grievances
- Behavioral Health
- Claims
- Clinical Policy
- Clinical Programs

- Clinical Strategy
- Commercial Product UM
- Compliance
- Consumer Messaging
- Credentialing
- Customer Care
- Disease Management
- Medicare/Medicaid Product UM
- National Network Operations
- Pharmacy
- Provider Communications
- Provider Contracting
- Quality Operations, Compliance and Accreditation
- Risk Management
- Specialty Benefits
- Medicaid Improvement

THE CORPORATE CREDENTIALING COMMITTEE is responsible for review and assessment of practitioners using appropriate standards for credentialing, recredentialing, and de-credentialing. The committee presents credentialing and recredentialing data to the CQIC, and is responsible for maintaining a high-quality network of providers.

The Humana Medical Director chairs the Credentialing Committee, which meets monthly. It includes credentialing representatives and practicing network physicians.

CORPORATE RECOMMENDATION REVIEW COMMITTEE (CRRC) has a direct role in the quality of care our network providers deliver to enrollees. The CRRC makes the final decision for Humana on provider termination recommendations for quality of care received through the peer review process. The CRRC may affirm, modify, or reverse the recommendation, or remand the matter back to the Peer Review Committee for additional evidence. The Corporate Chief of Quality chairs the CRRC, which is mostly composed of physicians and reports to the CQIC. Members may include:

- Corporate Chief of Quality
- Humana Medical Directors
- Director of Quality Operations, Compliance, and Accreditation
- Director of National Network Operations or Vice President of Provider Center of Excellence

CLINICAL OPERATIONS UTILIZATION MANAGEMENT COMMITTEE provides oversight of clinical compliance activities impacting Clinical Operations. This committee supports more effective collaboration between leaders of all Clinical Services Programs performing utilization management and includes representatives from Risk, Legal, and Compliance. The Committee conducts review and analysis of clinical compliance-related metrics, nurse inter-rater reliability assessment activities, Corrective Action Plans (CAPs), regulatory updates, compliance-related process and workflow changes, and quality monitoring and evaluation of effectiveness of the program. The committee reports to CQIC.

CLINICAL PRACTICE GUIDELINE PHYSICIAN COMMITTEE (CPGC) is chaired by the Corporate Chief of Quality and is comprise of Humana physicians specializing in cardiology,

family practice, OB/GYN, oncology, and behavioral health, among other specialties. The CPGC reviews selected guidelines and presents its recommendations to the CQIC for annual approval.

HEALTH SERVICES ORGANIZATION (HSO) NATIONAL UTILIZATION MANAGEMENT COMMITTEE is accountable for facilitating a process for monitoring the care that hospitals, skilled nursing facilities (SNFs), home health, and ancillary services provides. The committee reviews utilization data and related statistics to identify trends and recommend improvement strategies. The committee also reviews and approves the HSO Policies and Procedures at least annually and when needed as changes occur.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE is responsible for reviewing and making decisions about the appropriate use of drugs, biologicals, and select non-drug pharmacy-related products. The P&T Committee reviews policies that guide exceptions and other utilization management processes, including Drug Utilization Review program, QIP, quantity limits, generic substitution, and therapeutic interchange. This charge may be relevant in many contexts including, but not limited to, clinical edits, drug utilization review, consumer programs, contracting, and networks. Ultimately, the goal of the Committee is to confirm that we make proper decisions regarding drug access and the overall value of the benefit as it pertains to drugs, biologics, and select non-drug products.

PROTECTED HEALTH INFORMATION AND VENDOR ETHICS (PHIVE) COMMITTEE is a corporate committee created to protect the privacy of Humana enrollees and direct the ethical behavior of subcontractors. The PHIVE Committee reviews the handling of identifiable and de-identifiable enrollee data and monitors interaction with subcontractors to promote the highest ethical standards. The PHIVE Committee meets monthly and reports to the CQIC. Members of the PHIVE Committee may include representatives from:

- Privacy Officer (chair)
- Pharmacy Solutions
- Physician Review
- Market Vice President
- Law Department
- Regulatory Implementation
- National Network Operations
- Technical Services Group
- Clinical Programs and Services
- Risk Management

THE MEDICAL PIPELINE COMMITTEE'S charter is to discover and research new and emerging medical technologies with the purpose of developing a strategy, determining the expected financial impact around these new technologies, and distributing information to other departments throughout Humana. Medical technologies include, but are not limited to, medical devices, professional society recommendations, CMS coverage updates, and laboratory and genetic testing. The committee currently refers information to the following departments: Technology Assessment Forum, Provider Contracting, Lab Pay Zero Initiative [2], Quality Operations, Compliance and Accreditation, Pharmacy, Healthcare Economics, Claims, Product Development, and Medicare. The committee meets at least quarterly and publishes an update of activities we distribute throughout the company. The Committee also issues alerts around

technologies that may be of an urgent nature and result in high utilization or high financial impact. Medical Pipeline Committee members may include representatives from:
- Clinical Policy Development
- Technology Assessment Forum
- Healthcare Economics
- Genetic Guidance Program
- Additional representatives as appropriate

LOCAL OVERSIGHT OF FLORIDA COMPREHENSIVE QIP

FLORIDA COMMITTEE STRUCTURE
Humana's Florida QIP leverages the longstanding, robust experience of the Corporate Quality Improvement Committee (CQIC). The CQIC provides oversight for the Florida committees using the Quality Improvement Status Report. Our Florida program incorporates both clinical and service activities into the Quality Improvement process and has clinical committees that perform peer review and analysis of market-specific data and initiatives.

FLORIDA MEDICAID QUALITY IMPROVEMENT COMMITTEE (QIC) provides oversight of the quality improvement program activities and clinical recommendations for the Florida Medicaid plan. The CQIC and the Internal Board and Executive Committee delegate authority to the QIC.

The Florida QIC facilitates comprehensive integration of operational processes across medical and LTC services by planning, analyzing, and evaluating quality improvement activities. The Committee promotes objective and systematic monitoring and evaluation of consumer and client health services and facilitates compliance with regulatory requirements. The Florida QIC meets quarterly and reports to the CQIC through the legal entity report.

The Florida Medicaid Medical Director serves as Chairperson and presides at meetings of the Florida Comprehensive QIC. Illustrating cross-functional participation, the following departments are represented at QIC meetings:

- Case Management and Disease Management
- Utilization Management
- Network Development and Operations
- Provider Relations
- Florida Medicaid Medical Director
- Quality Operations Compliance and Accreditation
- Customer Care
- Performance Improvement
- Quality Improvement
- Finance
- Pharmacy
- Risk Management
- Compliance
- Grievances and Appeals
- Vendor Performance Delegation

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

QUALITY MANAGEMENT COMMITTEE (QMC) is responsible for recommending, reviewing, and evaluating aspects of preventive and clinical care of our Florida program. The QMC reviews Florida-specific preventive health and clinical study initiatives, and/or focused studies. The committee also handles peer review functions. Humana has empowered the QMC to develop appropriate corrective actions and quality improvement interventions. A Humana Medical Director or a physician designee chairs the QMC, which includes physician members who are actively practicing in the provider network. The QMC meets three (3) times per year, or as often as needed. Members of the QMC may include representatives from:

- Medical Director (chair)
- Quality Operations, Compliance, and Accreditation
- Clinical Programs
- Practicing Network Physicians
- Additional representatives as appropriate

PEER REVIEW COMMITTEE (PRC) is responsible for reviewing potential quality of care issues, determining the severity of the issue, and recommending quality improvements or corrective actions as appropriate. The PRC is responsible for developing individual provider quality improvement plans, where indicated, and reviewing progress toward resolution. Physicians and other healthcare professionals participate on the PRC, but only physician members have voting privileges. A Humana Medical Director chairs the PRC. It meets as needed to complete timely reviews of clinical quality concerns. The PRC reports to the local Florida Quality Management Committee. Members of the PRC may include:

- Humana Medical Director
- Quality Operations, Compliance, and Accreditation Divisional Director or manager and support associates
- Practicing Network Physicians (e.g., primary care and specialties)
- Additional representatives as appropriate.

DELEGATION COMMITTEE is responsible for coordination and review of Florida delegated activities related to quality management or improvement, credentialing, claims payment, enrollee rights and responsibilities, and utilization as appropriate. Responsibilities of the Delegation Committee include review and approval of reports from delegated entities and recommendations for corrective actions as necessary. The Delegation Committee meets at least quarterly, and we report all delegation activities annually through the CQIC.
Members of the Delegation Committee may include:

- Humana Medical Director
- Representative, Network, or Provider Relations
- Representative, Quality Operations, Compliance, and Accreditation
- Representative, Utilization Management
- Representative, Customer Care
- Representative, Compliance
- Representative, Delegation Oversight

RISK MANAGEMENT AND SAFETY COMMITTEE has oversight of the Risk Management Program. It identifies corrective measures needed to eliminate or control recognized safety and health hazards and recommends improvements. The committee acts upon referrals for risk

issues generated both internally and externally. The Manager of Risk Management is the Chair of the Risk Management Committee, which meets a minimum of three (3) times a year, or more frequently as needed. The committee reports quarterly to the Humana Internal Board and Management Team. Members of the Risk Management/ Safety Committee may include representatives from:

- Quality Operations, Compliance, and Accreditation
- Human Resources
- Health Services
- Workplace Solutions

QI PROGRAM CONTENT

Humana bases its QIP on the concept of Continuous Quality Improvement (CQI), whereby we execute a planned sequence of systematic and documented activities aimed at both resolving identified variances and improving processes. The program includes the following elements:

- Performance Improvement Projects (PIPs)

- Over-utilization and under-utilization measures

- Annual analysis of plan demographics including clinical, geographical, and cultural to identify high-risk populations, areas of network need, enrollee education opportunities, and performance improvement opportunities

- Access and availability issues including after-hours availability of Primary Care Physicians (PCPs)

- Quality and appropriateness of care furnished to children with special health care needs

- Continuity and coordination of care

- HEDIS measures including CAHPS surveys, as required by state, federal, or other agencies

- Annual effectiveness review of QIP

- Other non-clinical areas of performance (such as Customer Care call statistics and other enrollee services functions, marketing and outreach, claims processing timeliness and accuracy, provider satisfaction)

PERFORMANCE MONITORING FEATURES OF THE QIP

PERFORMANCE MONITORING AND EVALUATION PROCESSES ACROSS THE ORGANIZATION

The QIP is broad in scope to monitor and evaluate the quality of care and service our enrollees receive. The annual Quality Improvement Work Plan (QIWP) delineates targeted goals and objectives based on the strengths and weaknesses we identify in the previous year's Annual

Evaluation report. From there we establish goals and benchmarks using nationally recognized data, such as NCQA Quality Compass or State Medicaid identified goals. The QIC reviews continued follow-up and trending at defined frequencies captured in committee minutes, the annual QI Evaluation, and QIP Status Reports that we submit quarterly to the CQIC. Approved annually by the QMC, the QIC and the CQIC, we update the QIWP as needed to assess progress of initiatives. The QIWP includes:

- Specific activities to take and key indicators to monitor in the upcoming year, with data tracked and trended monthly, quarterly, or annually

- Opportunities for improvement identified from root cause analysis findings, enabling recognition of meaningful interventions

We complete a formal evaluation of the previous year's QIP annually as an assessment of the program's effectiveness. The evaluation outlines accomplishments, includes limitations or barriers to meeting objectives, and provides conclusions and recommendations for the upcoming year. The evaluation addresses the structure and functioning of the QIP, processes in place, and the outcome or results of QI activities. The QIC and the CQIC approve the evaluation.

KEY QIWP CLINICAL METRICS:
- Performance Measures including HEDIS, Agency for Healthcare Research and Quality (AHRQ), Child Health Check-Up, Agency-Defined
- CAHPS Surveys
- Performance Improvement Projects
- Provider Outcome Data
- Clinical Program Outcomes
- Performance Assessment Report
- Practice Guidelines Monitoring
- AHRQ Patient Safety Indicators

KEY QIWP OPERATIONAL METRICS:
- Customer Care Metrics
- Claims Timeliness and Accuracy
- Grievance and Appeals Management
- Assessment of Enrollee Complaints
- Under/Over-Utilization
- Health Services Organization Medical Management Metrics
- Subcontractor Performance

The Quality Improvement Work Plan prioritizes activities, assisting in determining resource needs. It also serves as a foundation for ongoing management of the QI process. We report the results, re-measures, actions taken, assessment, analysis, and barriers in the Florida QIC and in the Quality Improvement Evaluation (QIE).
Work plan requirements include:

- Approval by the Florida QIC and the QMC

- Updates as often as necessary and at least annually based on conclusions and recommendations identified in the preceding year's QIE

- Serving as a working document, which we update as priorities and projects change

- Including input and reflecting activities from all operational areas

- Facilitating continuity of previously identified issues, particularly those of the prior year

The QI Work Plan includes the following:
- Program scope
- Quality of clinical care
- Quality of service
- Safety of clinical care
- Enrollees' experience
- Yearly objectives
- Yearly planned activities
- Timeframe within which each activity is to be achieved
- The associate responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

We have included an excerpt from our QI Work Plan in Attachment 35-3.

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3. The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.
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Humana has established mechanisms within our QIP to identify potential issues before they arise and to address any problems immediately.

PROACTIVE PROCESSES AND STRATEGIES TO MONITOR QUALITY

PERFORMANCE MONITORING
Ongoing performance monitoring is the key to assessing the quality of services and measuring the effectiveness of our QIP, which ultimately improves the health and well-being of our enrollees. Humana proactively monitors our performance relating to quality of care using the following mechanisms:

- Ambulatory Medical Record Review
- Continuity of Care Studies
- Assessment of Satisfaction
- Case Management
- Communication and Collaboration on Behavioral Health Issues
- Enrollee Satisfaction Surveys
- HEDIS – Clinical and Preventive Health Initiatives
- Peer Review Process

- Performance Improvement Projects (PIPs)

AMBULATORY MEDICAL RECORD REVIEW: Humana clinical associates conduct annual medical record audits in randomly selected physician offices using a standard chart review tool. We also conduct medical record audits of facility provider sites every two (2) years. The Quality Operations Compliance and Accreditation department takes further actions as warranted. At a minimum, the record should comply with the standards set forth by AHCA and any federal regulatory standards.

Humana conducts an annual review of medical records for a sample of providers that provided Healthy Start services to our Medicaid enrollees. We use a standardized Humana Medical Record Documentation Review Tool (MRDR) for OB provider records, obstetrical delivery records, pediatric provider records, and hospital/birthing center records to complete the reviews. Practice sites include individual offices, clinics, multi-provider practices, and facilities.

The purpose of the review is to evaluate compliance with specific medical record documentation components, as delineated in the Provider Administration Manual and supported by CMS and the State of Florida. We communicate the outcomes and scores to the provider, along with any recommended corrective actions to improve performance. The purpose of the audit is to ensure our Medicaid providers comply with the guidelines set forth by the AHCA's contracted services as well as the requirements and recommendations made in Humana's Provider Manual.

Humana conducts medical and case record reviews of all provider sites that have a pattern of complaints or poor-quality outcomes. We conduct medical record audits at any provider sites with more than five (5) quality of care referrals in the last six (6) months.

CONTINUITY OF CARE STUDIES: Humana strives to facilitate medical care delivered seamlessly across a multitude of delivery sites and throughout the course of the disease process. We analyze data to determine areas where opportunities exist to improve continuity and coordination between settings of care, and in transitions of care from one provider to another.

Humana has corporate medical continuity and coordination of care (COC) studies that we complete for all NCQA-accredited states that include Medicare, Medicaid, and Dual Eligible enrollees. These studies include:

- Post-discharge survey – Improving rate of follow up appointment with physician
- Post-discharge survey – Improving ease of obtaining medications
- Post-discharge survey – Improving coordination of home health care services
- Post-discharge survey – Increasing understanding of discharge plans and instructions

Humana's Florida Medicaid CMO is NCQA-accredited and completes two (2) medical COC studies.

- Improving Coordination between Hospital and Primary Physicians for enrollees with an inpatient stay (hospital discharge)

- Improving Communication of Mammogram Results to the Primary Physicians.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

ASSESSMENT OF SATISFACTION: We conduct annual provider and enrollee satisfaction surveys to measure performance and compare survey results with the prior year to identify opportunities for improvement.

CASE MANAGEMENT
Case Management is a proactive method to identify quality issues before they arise. Through regular communication with enrollees and providers, Case Managers (CMs) can assess the quality and level of care being provided, and address any issues preemptively or immediately upon identification. We also provide case management programs for enrollees with chronic health care issues or complex care coordination needs for Medicaid enrollees diagnosed with asthma, congestive heart failure, diabetes, HIV/AIDS, hypertension, and dementia and Alzheimer's who have verbally agreed to participate in a Disease Management program. The program's aim is to provide enrollees with holistic care through telephone-based or, when available, in-person consultations by case managers. We have designed the program to keep enrollees' well-being at the forefront in many ways, including:
- Optimizing utilization of their healthcare benefits
- Improving their self-case management skills
- Preventing unnecessary hospital stays and emergency room visits

COMMUNICATION AND COLLABORATION ON BEHAVIORAL HEALTH ISSUES: Humana collaborates with two (2) behavioral health delegates to monitor and improve care coordination between medical care and behavioral health care. Analyses includes, but is not limited to, preventive behavioral health screening opportunities, HEDIS results, and management of co-existing medical and behavioral health disorders.

ENROLLEE SATISFACTION SURVEYS:
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS): We conduct CAHPS and CAHPS simulation surveys for our Florida enrollees. We base improvement actions upon individual market survey results and incorporate them into corporate improvement initiatives.

HUMANA ENROLLEE EXPERIENCE SURVEY: We are exploring developing a specialized Medicaid Enrollee Experience Survey for our Florida Medicaid program. Currently, Humana Medicare and dual eligible members are eligible to receive an Experience Survey following a visit in the prior sixty (60) days to any PCP or other advanced primary care provider.

The survey has thirteen (13) questions in total: Seven (7) of those core questions relate to topics on the CAHPS survey and six (6) relate to topics on the Health Outcomes Survey (HOS). After they complete those questions, the survey asks the enrollee to rate the likelihood that they would recommend the provider they saw to a friend or family member on a zero to ten (0-10) scale. We keep all enrollee responses confidential and share the aggregated survey data with provider groups to create a better enrollee experience.

TOPICS COVERED IN THE SURVEY QUESTIONS:

OFFICE EXPERIENCE
1. Ease of scheduling your appointment
2. Your wait time in the office today

3. Ease of getting a referral for specialist care

GETTING MEDICATIONS, TESTS, AND OTHER CARE
4. Ease of getting doctor-prescribed medications through your drug plan
5. Ease of getting doctor-recommended treatments and care through your health plan

COORDINATION OF CARE
6. Physician reviewed medications with you
7. Physician discussed specialist care you've received since your last visit

PHYSICIAN-ENROLLEE DISCUSSION
8. Physician or health provider discussed balance and risk falling in your home
9. Physician or health provider gave you treatment options for balance or risk of falling
10. Physician, nurse, or health provider discussed urine leakage
11. Physician, nurse, or health provider discussed options to treat urine leakage
12. Physician or health provider recommended exercise program
13. Physician or health provider discussed mental or emotional health issues like stress, depression, or anxiety

HEDIS – CLINICAL AND PREVENTIVE HEALTH INITIATIVES: We develop clinical quality initiatives to improve preventive care rates and to address specific conditions relevant to the population and as a result of review from specific areas of concern. There are many efforts underway to improve the HEDIS measure rates, including two (2) components to improve the final scores:
- Guiding the enrollee or physician to secure appropriate recommended services
- Facilitating production of accurate data produced that captures services we measure

PEER REVIEW PROCESS: Monitoring and identifying important aspects of care and resolving potential quality concerns are key to achieving desired health outcomes. The Quality Operations, Compliance, and Accreditation Department reviews potential quality concerns and refers concerns to a Humana Medical Director Peer Review Committee (PRC), as appropriate. We may identify potential quality concerns through enrollee complaints and grievances, ambulatory medical record review, external agency review requests, Humana clinical program referrals, in-patient medical record review, under-utilization reports, claims-based reports of certain safety indicators, and Utilization Management (UM) review. We implement improvement actions as warranted by the case findings.

PERFORMANCE IMPROVEMENT PROJECTS (PIPS): With guidance and approval from AHCA and the External Quality Review Organization (EQRO), Humana has developed PIPs for Medicaid enrollees. We create PIPs when we identify opportunities for improvement as well as in collaboration with AHCA and the EQRO. Upon data collection and analysis, we implement provider and enrollee-focused interventions.
Humana currently conducts the follow PIPs under the guidance of AHCA and the EQRO:

1. Improving Timeliness of Prenatal Care and Well-Child Visits in the First Fifteen (15) months of Life – Six (6) or More Visits

2. Preventive Dental Services for Children

3. Electronic Health Record with Meaningful Use

4. Integrating Primary Care and Behavioral Health in Antidepressant Medication Management medication review

5. Person-Centered Care Planning

ONGOING PROCESSES AND STRATEGIES TO IDENTIFY QUALITY OF CARE ISSUES

EVALUATION AND TRENDING
The QIP's broad scope enables us to monitor and evaluate enrollees' quality of care and service. We track, monitor, and take action on the following:

- Trending data monthly, quarterly, and annually as delineated in the QIWP and baseline measurements established

- Opportunities for improvement and barriers, conducting root cause analysis as needed

- Interventions to select and implement as appropriate

- Continued follow-up and trending through committee minutes, the annual QIE, and QIP Status Reports submitted quarterly to the CQIC

DATA SOURCES
Our information systems collect, analyze, integrate, and maintain data to support our QIP. We proactively review data including, but not limited to: UM data, HEDIS measures, encounter data, and enrollee and provider satisfaction data to identify areas where potential quality of care issues may arise. Humana achieves systematic measurement and assessment of performance using multiple data systems. We evaluate these systems annually to verify that we have adequate resources to meet the needs of the program. Our data resources and current analytics capabilities enable Humana to assess quality of care and ensure enrollees receive the right care, at the right place, at the right time. Attachment 35-4 depicts how we use multiple data sources to find insight and inform actions.

Our integrated system resources enable focus on promoting the overall health of our enrollees, while closing care gaps and improving quality care outcomes. Attachment 35-5 illustrates our dynamic approach to improving health outcomes for our enrollees.

ROOT CAUSE ANALYSIS
Root cause analysis (RCA) is a process through which an auditor can identify why an issue occurred, versus only identifying or reporting on the issue itself. RCA benefits the organization by identifying the underlying causes of an issue. This provides the basis to resolve the true issue that could impact the organization again in the future.

We see RCA as a crucial part of our quality improvement process. As an internal auditing process, RCA allows us to fully understand an issue in our organization and create a comprehensive solution to resolve the issue and prevent recurrence. Our QMC reviews trends identified in committee data at each meeting, and conducts root cause analysis on the trends.

Following this discussion, we present a high-level variance summary report to the CQIC that includes topics requiring further discussion, recommendation, and resolution. The CQIC then adapts operational policies to fit the solutions created through this analysis.

Using a nationally recognized, standardized approach, Humana applies the four (4)-step management method of PDSA (plan-do-study-act-adjust) for the monitoring, control, and continuous improvement of processes. Detailed steps include, but are not limited to:
- Monitoring system-wide issues
- Identifying opportunities for improvement
- Determining the root cause of problems identified
- Exploring alternatives and developing a plan of action
- Activating the plan, measuring the results, evaluating effectiveness of actions, and modifying the approach as needed

We have extensive experience using data and analytics to identify opportunities for improvement, and to monitor, evaluate, and improve quality of care and services to Medicaid enrollees. The Humana analytics team in conjunction with the QI department is experienced in data collection and monitoring. We provide a series of defined dashboard reports that allow analysis and trending of data to guide in formulating appropriate and meaningful PIPs to undertake.

PIPs help us measure performance, apply interventions to improve performance, evaluate performance, and conduct periodic follow-up to measure effectiveness of interventions and outcomes. We select projects based on high volume and high-risk conditions prevalent in this population and that have the potential for significant impact on health outcomes. We report the status and results of PIPs using the Agency's EQRO-required tools and processes. PIPs include the following components:

- Assessment of performance improvement
- Data collection and analysis
- Ongoing interventions and measurement of performance
- System interventions, including establishment or alteration of practice guidelines
- Systematic and periodic follow-up on the effect of the interventions
- Performance assessment using quality indicators that are:

-- Able to achieve demonstrable improvement

-- Based on systematic ongoing collection and analysis of valid and reliable data

-- Capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies or those outcomes

-- Objective, clearly, and unambiguously defined, and based on current clinical knowledge or health services research

Both PIPs and Corrective Action Plans (CAPs) play important roles in Humana's efforts to drive performance improvement in targeted areas. We can resolve many quality issues through specific actions such as outreach to a provider, dissemination of information to the enrollee, or other such corrective actions.

We develop PIPs with guidance from AHCA, the EQRO, and internal guidance upon identification of opportunities for improvement. When we identify an opportunity for system-wide improvement because of a negative trend or the like, we implement PIPs and CAPs as a structured and formal mechanism for resolving the situation.

Depending on the issue, we may implement CAPs with a provider who is failing to meet standards, or as part of QI initiatives designed to improve contract performance.

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4. The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.

5. The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.

6. The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable events or improving birth outcomes.

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Humana has vast experience identifying areas for improvement and developing and implementing successful initiatives to improve outcomes. When implementing our quality improvement initiatives, we follow the PDSA data-driven improvement cycle to track performance, identify areas for improvement, perform root cause analysis, implement interventions, and reassess performance following the interventions.

The results from our quality improvement initiatives below illustrate the efficacy of our interventions and our ability to meaningfully improve quality. Following are two examples of our Florida Medicaid Plan's completed quality improvement projects:

- South Florida Real-Time Emergency Department Initiative
- Field Case Manager HIV/AIDS Initiative

COMPLETED QUALITY INITIATIVE #1: SOUTH FLORIDA REAL-TIME EMERGENCY DEPARTMENT INITIATIVE

BACKGROUND AND INITIATIVE DETAILS

Reducing unnecessary emergency department utilization improves the quality and continuity of care for enrollees while reducing unnecessary costs. As a state-defined potentially preventable event, unnecessary or inappropriate emergency department utilization increases costs for the Florida's Medicaid Program and affects health outcomes for Florida Medicaid enrollees.

In 2013 we identified a need for up-to-date, real-time emergency department data to more effectively monitor and track enrollee emergency department utilization. Real-time data enabled us to conduct timely outreach to enrollees who use the emergency department, engaging them in care management, disease management, or accessing care in the most appropriate setting.

Our clinical team worked with our provider network and IT teams to contract with the following facilities:
North Shore: 2/1/2013
Palmetto: 6/17/2013
All Tenet Facilities: 6/9/2014
All Broward Health Facilities: 10/24/2014
Pediatric Associates (from the Memorials): 8/3/2015
All Memorial Facilities: 9/15/2015

INTERVENTIONS
- Receive, assign, and process daily, real-time emergency department information from various sources including paper referrals, daily reports, and an electronic encounter queue in our clinical platform Clinical Guidance eXchange (CGX)

- Notify PCPs of enrollee emergency department visits, verifying contact information and obtaining enrollees' permission to schedule follow-up appointments

- Provide discharge instructions via fax to PCP when accessible (North Shore, Palmetto)

- Contact, assess, and educate enrollees concerning disease management, prevention, and the most appropriate place for effective treatment

- Engage Provider Relations as necessary to address barriers

- Refer to Case Management and/or disease management, and behavioral health services, as needed for comprehensive care management

OUTCOMES
The outreach highlighted in the following results includes contacting, assessing, and educating enrollees to improve their quality of care.

Initial Outcomes Noted (Early 2014)
- North Shore Hospital:
-- Pre-outreach ED visits: 996
-- Post-outreach ED visits: 516
-- Indicates a forty-eight percent (48%) decrease in utilization with enrollees reached.

- Palmetto Hospital:
-- Pre-outreach ED visits: 401
-- Post-outreach ED visits: 147
-- Indicates a sixty-three percent (63%) decrease in utilization with enrollees reached.

Outcomes (2015)
- All Participating Facilities:
-- Pre-outreach ED visits: 4,829
-- Post-outreach ED visits: 867
-- Indicates an eighty-two percent (82%) decrease in utilization with enrollees reached.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

ONGOING INITIATIVES

Following the success of the South Florida Real-Time Emergency Department Initiative, we built upon our experience reducing unnecessary emergency department visits by partnering with AHCA in the Event Notification System (ENS). The ENS provides real-time electronic exchange of hospital utilization data, including emergency department visits.

COMPLETED QUALITY INITIATIVE #2: FIELD CASE MANAGER HIV/AIDS INITIATIVE

BACKGROUND AND INITIATIVE DETAILS

Using nurses in the field for home visits can help close gaps in engaging Florida enrollees with HIV/AIDS in our Disease Management (DM) program. Meeting enrollees at their homes helps facilitate conversations that help enrollees build trust with Humana, openly discuss the disease, and break down barriers they have in educating them on disease management.

Analyzing claim, utilization, and clinical outcome data, Humana identified a need to engage our HIV/AIDS enrollees more effectively, seeking more active participation in our HIV/AIDS DM program. While we had moderate success engaging members into this DM program using our telephonic approach, we had feedback from many enrollee and the nurses performing the telephonic outreach that because of the sensitive nature of the diagnosis, many members were reluctant to engage over the phone. We developed our Field Case Manager (FCM) HIV/AIDS Initiative to address this need.

Our FCMs contact the enrollee telephonically, requesting permission to meet face to face. If the enrollee agrees, the FCMs conduct a “drive-by” within the community so they can make in-person introductions and begin the enrollee engagement process. We meet enrollees at the place of their choosing, such as their home or PCP’s office.

INTERVENTIONS

- Find enrollee in the community
- Meet with enrollee at his or her home or PCP’s office
- Introduce enrollee to the DM Program and describe its benefits
- Complete a General Survey
- Address any immediate medical needs
-- Set up PCP appointment or provide enrollee with information to call
- Address immediate educational needs
-- Medication education regarding the importance of adherence
-- Assist enrollee with filling medication pill boxes to help enrollee take medication on time
- Address any immediate social needs
-- Link into care with social workers
- Address any immediate behavioral needs
-- Link into care with behavioral health (BH) services
- Identify any other immediate enrollee needs
- Introduce Disease Management Nurse who will be taking over the care telephonically
-- Link the enrollee via telephone to the DM Nurse for a quick introduction
-- Provide enrollee with DM Nurse information on a business card for future contact
-- Schedule next meeting with enrollee to hold by telephone with the DM Nurse

OUTCOMES
We have had success reaching and engaging enrollees via the FCM HIV/AIDS initiative. The following data illustrates enrollee engagement for the first and second years.

6/1/15 through 5/31/16
Eligible: 315
Unable to Contact: 109
Reached: 206
Reach Rate: 65.40%
Participating: 171
Engagement Rate: 83.01%
Participation Rate: 54.29%

6/1/16 through 5/31/17
Eligible: 336
Unable to Contact: 105
Reached: 231
Reach Rate: 68.75%
Participating: 204
Engagement Rate: 88.31%
Participation Rate: 60.71%

We were better able to manage enrollees' condition and improve outcomes through successful enrollee engagement, guiding them to the appropriate care setting and enrolling them in DM. Better management and improved outcomes led to improved health and well-being for the participating enrollees as well as an average per member per month (PMPM) forty-eight percent (48%) cost reduction.

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[1] http://healthinsuranceratings.ncqa.org/2017/search/Medicaid/FL

[2] Through the Lab Pay Zero Initiative, a provider agrees that payment for in-office laboratory services rendered to members is limited solely to those specified on Humana's National Lab Table 2988. Medical Pipeline Committee identifies emerging point-of-care tests and notifies Lab Pay Zero about these emerging tests.

Evaluation Criteria:

1. The extent to which the respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.

2. The adequacy of the respondent's approach to incorporating quality improvement activities into the culture and operations of the organization.

3. The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.

4. The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.

5. The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.

6. The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable events or improving birth outcomes.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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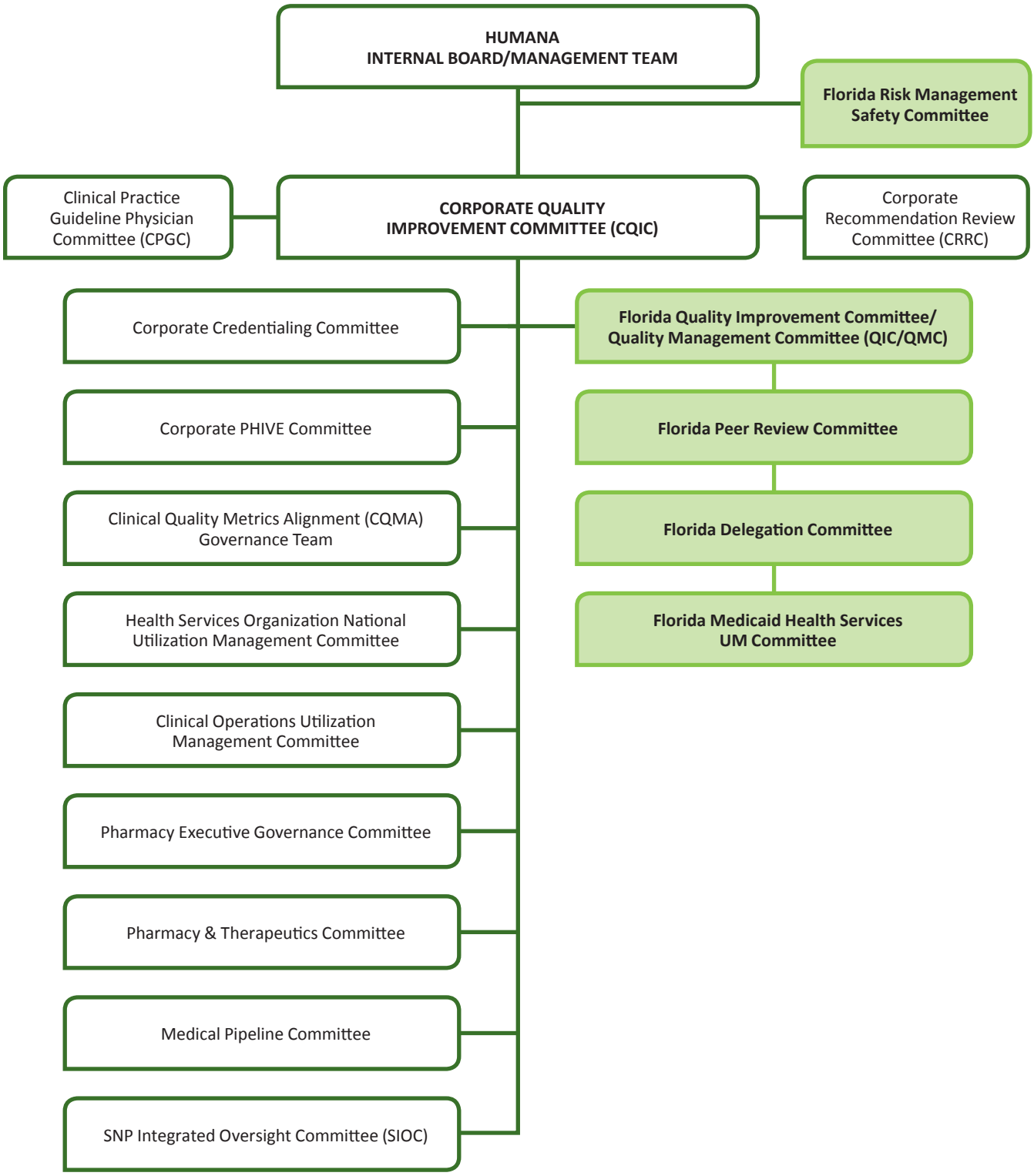
Attachment 35-1: Humana's CAHPS, CHCUP and PIP Meeting Attendee List

As demonstrated by the highlighted sections below, our Florida Medical Director, as well as the President, Florida Medicaid Operations (Plan CEO) are involved in all clinical functions across our quality improvement project initiatives, an excerpt of which are included below.

	CAHPS Intervention Meeting	FL MMA CHCUP CAP Task Force	AMM PIP Intervention Team	PDENT PIP Intervention Team	PPC W15 PIP Intervention Team	EHR PIP Intervention Team
President, Florida Medicaid Operations	X	X	X	X	X	X
Florida Medicaid Medical Director	X	X	X	X	X	X
Director South Florida Pharmacy/Senior Products			X			
Beacon Health Options Program Director			X			
DentaQuest Account Representative				X		
Analyst Quality Systems Integration		X				
Project Manager Health Services South Florida			X		X	
Medicaid Market, Account Services Executive	X	X	X	X	X	X
Beacon Health Options			X			
DentaQuest				X		
Strategic Consultant Medicaid/LTSS/Duals			X			
Strategic Consultant, QRS & Medicaid Improvement	X		X	X	X	X
Quality Improvement Manager, Sr MSO Operations	X	X	X	X	X	X
Strategic Consultant Medicaid Administration			X	X	X	X
Consultant, Stars QRS and Medicaid Improvement	X					
Analyst QSI		X				

Attachment 35-2: Humana Quality Organizational Chart

Below is an organizational chart illustrating Humana's departments and committees involved in the pursuit of quality (committees noted in green boxes operate locally in Florida).



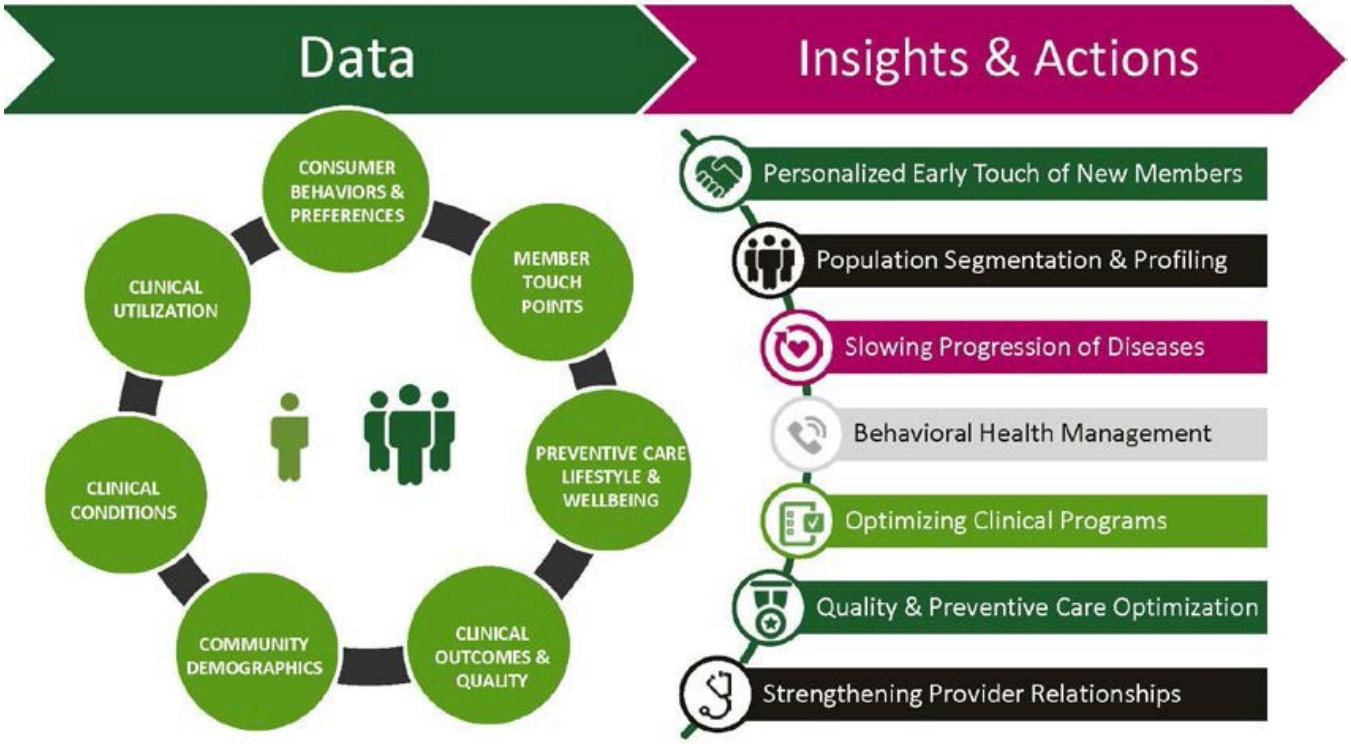
Attachment 35-3: Humana QI Work Plan

The Quality Improvement Work Plan prioritizes activities and assists in determining resource needs; it also serves as a foundation for ongoing management of the QI process. The results, re-measures, actions taken, assessment, analysis, and barriers are reported in the Florida Medicaid Quality Improvement Committee (FL QIC) and in the Quality Improvement Evaluation (QIE). Below is an excerpt from the Quality Improvement Work Plan.

Indicator	Scope	Objective/Description	Goal/Benchmark/Source	Responsible Person/Committee	Frequency/Reported
Process for Resolving Provider Quality Issues	Providers	Review/revise documents and update to accreditation standards.	QMS computer system	Corporate Quality Operations Manager Quality Operations Divisional Director QMC Medicaid Quality Operations Manager	Annually
Quality and Clinical Operations, Compliance and Accreditation (QOCA) Monthly Reports	Medicaid Market	Identify and provide updates in regards to: Audit Results, Quality Issues, MRDR/CHCUP, HR Issues, Quality Issues and Well-Being.	Information obtained at the market level and no goals or benchmarks needed.	Medicaid Quality Operations Manager	Monthly
Risk Management	Members Providers Associates	Monitor and analyze significant events/incidents. Identify safety concerns and establish prevention strategy.	Quarterly Review	Risk Manager Risk Management Committee FL MMA QIC QMC	Quarterly
Security Agreements and Ethics Education	Associates	Facilitate associate understanding of security and ethics principles.	100% trained and signed	Human Resources Leadership	Annually Ongoing
CLINICAL PROGRAMS – DISEASE MANAGEMENT PROGRAMS					
Asthma Program	Members	Monitor participation	Track and trend for a year before establishing a goal or target.	Director of Case Management and Disease Management FL MMA QIC	Semi-Annually
Congestive Heart Failure Program	Members	Monitor participation	Track and trend for a year before establishing a goal or target.	Director of Case Management and Disease Management FL MMA QIC	Semi-Annually
Diabetes Program	Members	Monitor participation	Track and trend for a year before establishing a goal or target.	Director of Case Management and Disease Management FL MMA QIC	Semi-Annually
HIV/AIDS	Members	Monitor participation	Track and trend for a year before establishing a goal or target.	Director of Case Management and Disease Management FL MMA QIC	Semi-Annually
Hypertension Program	Members	Monitor participation	Track and trend for a year before establishing a goal or target.	Director of Case Management and Disease Management FL MMA QIC	Semi-Annually
Moms First	Pregnant female members	Monitor participation	Track and trend for a year before establishing a goal or target.	Director of Case Management and Disease Management FL MMA QIC	Semi-Annually
COLLABORATION					
Continuity of Medical/Behavioral Health	Members Providers	A joint meeting (Beacon and Humana) monitors and improves coordination between medical and behavioral healthcare focusing on: facilitating exchange of information between PCP and BH specialists; improving HEDIS anti-depression medication management; enhancing management of members with coexisting medical and behavioral disorders; and developing and monitoring BH preventive programs. Summary reports submitted semi-annually. Annual documents include: PIPs, QIE, QIPD and QIWP.	Maintain open communication and collaborate to work toward improving outcome.	Medicaid Quality Operations Manager FL MMA QIC QMC	Monthly Meeting Summary Reports Semi-Annually Annual documents - March 15th

Attachment 35-4: Quality Improvement – Data Initiating Insights and Actions

Humana has information systems that are designed to collect, analyze, integrate, and maintain data to support the quality improvement program. Humana measures and promotes quality throughout all operational areas, as evidenced by our NCQA Commendable Accreditation status and our quality rankings. The graphic below depicts how we utilize multiple data sources to feed our insight and actions.



Attachment 35-5: Enabling Population Health through Integrated Quality & Data Processes

Our integrated system resources enables focus on promoting the overall health of our enrollees, while closing care gaps and improving quality care outcomes. The graphic below illustrates our dynamic approach to improving health outcomes for our enrollees.

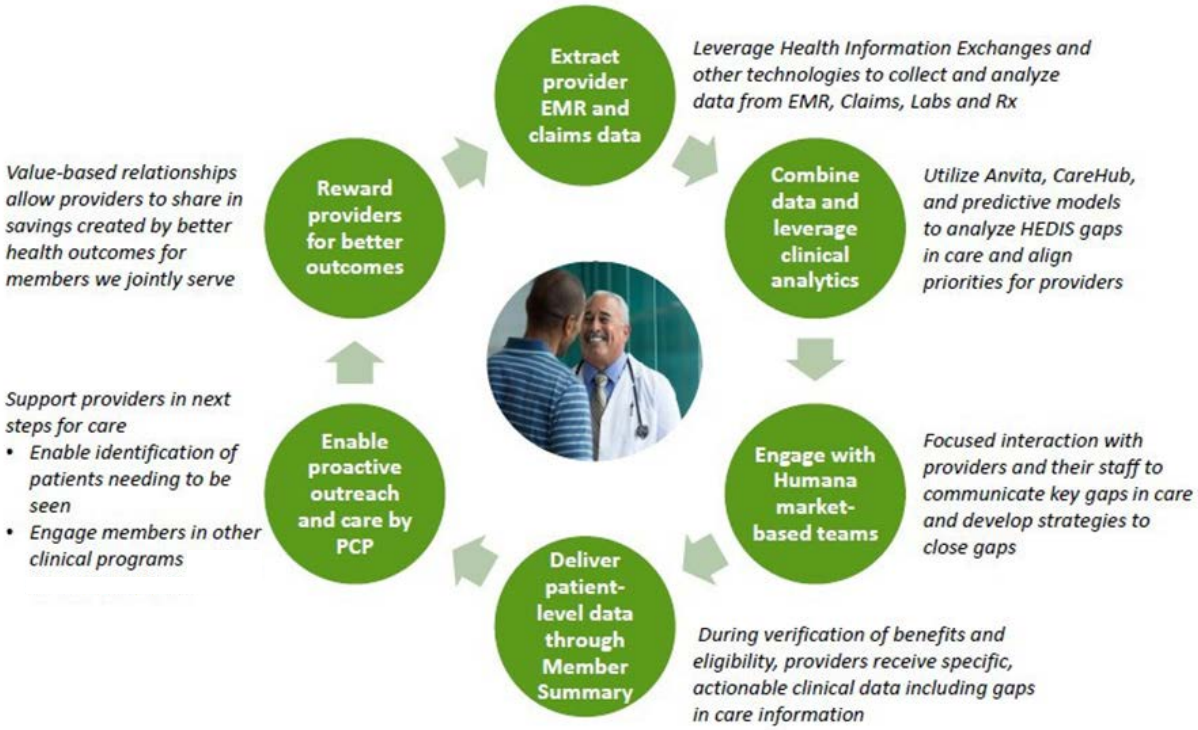


EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 36 – Health Plan Accreditation (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall specify its current accreditation status by a nationally recognized accrediting body. This shall include the name of the accrediting body, the most recent date of certification, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (i.e., provisional, conditional, etc.). The respondent shall attach documentation that supports this information.

Response:

Humana Medical Plan, Inc.'s (HMP) Florida Medicaid HMO currently holds National Committee for Quality Assurance's (NCQA) full, three-year accreditation from October 26, 2016 to October 26, 2019. HMP's accredation status is at the level of Accredited. We bring our longstanding experience and commitment to quality in our Florida Medicaid operations and will continue to improve the quality of care for our enrollees across the state of Florida. Please refer to Attachment 36-1 for a copy of our most recent NCQA accreditation certificate issued August 31, 2017. HMP has been NCQA accredited for twenty-three (23) years.

In our most recent NCQA health plan accreditation survey, HMP received perfect scores one hundred percent (100%) in the standard categories of Credentialing and Recredentialing as well as Members' Rights and Responsibilities. We scored ninety-eight percent (98%) or higher in the Quality Management and Improvement, Utilization Management, Member Connections, and Network Management standard categories.

Humana brings more than fifty-five (55) years of experience caring for Medicare and Medicaid enrollees. Our experience and compassion for these populations are rooted in our commitment to provide the highest quality care to our enrollees. We strive to meet and exceed nationally recognized standards to ensure our enrollees receive the most effective care and support to meet their individual needs.

Evaluation Criteria:

1. Evidence that the respondent has:

(a) Full health plan accreditation by a nationally recognized accrediting body; e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); or

(b) Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or

(c) No health plan accreditation or denied accreditation.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Score: This section is worth a maximum of 5 raw points as outlined below:

(a) 5 points for full health plan accreditation.

(b) 3 points for partial/conditional health plan accreditation.

(c) 0 points if health plan accreditation denied or no accreditation.

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NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Humana Medical Plan, Inc. (Florida)

Medicaid HMO

ACCREDITED NCQA HEALTH PLAN ACCREDITED

an accreditation status of

ACCREDITED

for service and clinical quality that meet or exceed

NCQA's rigorous requirements for consumer

protection and quality improvement.

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oh
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

August 31, 2017
DATE GRANTED

October 26, 2019
EXPIRATION DATE

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

RESPONDENT NAME: Humana Medical Plan, Inc.

A. RESPONDENT BACKGROUND/EXPERIENCE

No SRCs in this Category for MMA.

B. AGENCY GOALS

MMA SRC# 1 – Potentially Preventable Events (Regional):

The respondent shall describe its organizational commitment to quality improvement as it relates to reducing potentially preventable events. More specifically, the respondent shall describe its overall approach and specific strategies that will be used to ensure a reduction in potentially preventable hospital admissions and readmissions, a reduction in the use of the emergency department for non-emergent/urgent visits, and a reduction in the use of unnecessary ancillary services during hospitalization and outpatient visits. The respondent's approach shall also include:

- A description of the respondent's assessment (using available data sources) of hospital utilization rates and the potential for improvement;
- A description of performance benchmarks for each area of focus;
- A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings; and
- A description of evidence-based interventions and strategies that will be used to target super-utilizers, particularly related to pain management and behavioral health conditions.

Response:

Humana's goal to improve the overall health and well-being of enrollees and their communities drives our commitment to quality improvement. We use a wide range of locally driven clinical programs and quality improvement initiatives to reduce preventable emergency department visits, hospital admissions, and readmissions. Clinical data analytics inform these initiatives to improve the exchange of data between providers. We improve engagement using incentives for both providers and enrollees. Our ability to successfully reduce preventable events requires tailored programs based on a deep understanding of regional barriers and opportunities.

OPPORTUNITIES TO REDUCE PREVENTABLE EVENTS IN REGION 1
As a current Statewide Medicaid Managed Care (SMMC) Comprehensive Plan in Region 1 serving more than fifty-four thousand (54,000) enrollees, Humana has developed a specialized understanding of its populations. The greatest opportunities for improvement related to reducing potentially preventable events include a few areas of focus. Specifically, given the generally rural nature of Region 1, access to providers, particularly level three (3) or four (4) medical centers, is a major issue. Humana has noticed that our enrollees in Region 1 often seek care in other regions, such as Region 2, or out of state in Alabama, because of provider availability. These dynamics lead to an increased number of out-area-authorizations for these enrollees, increasing the need for intensive case management and care coordination to manage the

increased health needs of these individuals. Enrollees in more rural areas often delay seeking care because of barriers such as provider access and lack of transportation. We have learned that close collaboration with local health centers in Region 1 is essential to ensure necessary preventive and primary care for our Region 1 enrollees. Increasing access for these more rural populations require innovative strategies to bring care to enrollees where they are, encourage them to actively engage in primary care, and devise out-of-network care options to meet the needs of the population.

- The large farming industry in Region 1 also presents a unique challenge in the form of a higher number of migrant workers. These individuals work seasonally across the region and throughout the State, creating a challenge in terms of case management and care coordination.

- Region 1 also has a high incidence of readmissions because of behavioral health (BH) conditions. A BH condition is the number one (1) cause for potentially preventable readmissions in the region. [1]

We have organized the remainder of our response as follows, addressing the specific needs and challenges in Region 1:

- Identifying high-risk enrollees and super-utilizers
- Data analytics used to monitor and reduce potentially preventable events
- Humana's Foundation for Reducing Potentially Preventable Events: Strong Provider Partnerships
- Reducing preventable hospital admissions and readmissions in Region 1
- Reducing preventable emergency department visits in Region 1
- Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits in Region 1
- Strategies targeting BH conditions and pain management

IDENTIFICATION OF HIGH-RISK ENROLLEES AND SUPER-UTILIZERS
The first step to reduce preventable events is identifying at-risk enrollees before they inappropriately access care or immediately following a preventable event occurrence. Humana's process for identifying and monitoring high-risk enrollees integrates data analytics with specialized care coordination protocols. This approach allows us to proactively identify high-risk enrollees, preventively address emerging health issues, and immediately contact enrollees identified as accessing care inappropriately.

We use a variety of quantitative and qualitative measures to identify high-utilizer and high-risk enrollees, which allows us to create a full picture of enrollee utilization and potential emerging risk-factors. These sources include:

- Predictive modeling data
- Utilization and cost data
- Health Risk Assessments (HRAs) and survey tools
- Clinical assessments
- Multidisciplinary Team (MDT) meetings
- Specialist physicians
- Enrollee self-identification

- Caregiver identification
- Program referrals (e.g., Physicians, Care Managers, Utilization Managers, BH, Pharmacy, or Medication Therapy Management (MTM), etc.)

We assign an initial acuity level for each enrollee based on clinical and utilization data available in our Clinical Guidance eXchange (CGX) clinical management system. CGX is a proprietary system used by our medical management team to capture authorization and case management activities.

We use proprietary predictive modeling tools and care management hierarchy algorithms to identify enrollees who would benefit from enrollment in our case management programs, with the goal of optimizing quality outcomes in the delivery of healthcare services. We include more on our predictive modeling capabilities later in this response.

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Humana's Data Analytic Capabilities used to Monitor and Reduce Potentially Preventable Events

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Humana collects and analyzes data from various sources, including clinical reviews, aggregate claims, encounter and authorization data, and provider communications to reduce preventable events. The Utilization Management (UM) department develops indicators for identifying potentially inappropriate over- and under-utilization, which the UM and Quality Management Committees (QMC) approve. The Utilization and Case Management unit regularly reviews reports to provide feedback and tracking in reference to utilization activities.

Humana builds data into operational metric dashboards for leaders to track and trend clinical activities. One of the most critical metrics for clinical program success, particularly for Medicaid enrollees, is the timeliness of the intervention and effective engagement with highest-risk enrollees. Dashboards allow leaders to drill down to specific segments and time periods to closely monitor clinical operational performance. Dashboards include comparisons between clinical teams in different markets to identify region-specific best practices and lessons learned, which helps drive ongoing improvement of existing initiatives. Below is a list of Humana's operational metric dashboards and reports.

- Inpatient Census Report - Daily detailed account of all 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) - A monthly reporting of key utilization metrics such as admission rates by utilization type (Acute, Skilled Nursing Facility (SNF), Rehabilitation, Long-Term Acute Care Hospital (LTACH)), length of stay, and rate of emergency department utilization.

- Provider Utilization Profiling - Quarterly provider-level report of claims and encounter data to analyze under- and over-utilization and provide peer-to-peer analysis

- Predictive Model Reporting - Severity Score reports, Readmission Model reports, and emergency department Predictive Model reports integrated into CGX to trigger referrals for clinical programs

- Authorization Timeliness Report - Monthly market specific summary of authorization timeliness

At the enrollee-level, Humana also conducts routine reporting to drill down for root cause analysis in cases of under- or over-utilization. Examples of these reports include:

- Readmissions by Provider - Monthly tracking of fourteen (14) and thirty (30)-day readmission rates for acute admissions

- High Utilizer Report - Drill down into individual enrollees with high utilization by service type, e.g., emergency department and inpatient care

- Inpatient Drill Down - Inpatient services by provider, type, and major diagnostic category

At the population level, Humana has established a logic-driven process to monitor, identify, and respond to patterns of over- and under-utilization. These processes identify potential aberrations in service utilization by comparing the approved services and the enrollees' needs documented in the plan of care (POC) with utilization parameters. We analyze data sets for medical, BH, and pharmacy utilization. We also review frequency of selected procedures, emergency department visits, inpatient measures from Health Effectiveness Information Data Set (HEDIS), and certain Consumer Assessment of Healthcare Providers and Systems (CAHPS) enrollee satisfaction information to monitor for over or under UM trends. We select unique utilization indicators to monitor for each enrollee. Examples include but are not limited to the following:

- Acute care admissions per one thousand (1,000) enrollees per year
- Inpatient days per one thousand (1,000) enrollees per year
- Readmission rates within thirty (30) days
- Emergency department visits per one thousand (1,000) enrollees per year
- Observation days per one thousand (1,000) enrollees per year
- Post-discharge care coordination referral call

By continuously re-evaluating these data sets, we can uniquely assess each enrollee for risk factors and proactively take steps to prevent emerging health issues that may lead to unnecessarily high utilization of services as well as poor outcomes. These data sets also facilitate discussions with our clinical leaders and provider partners by benchmarking regional provider data relative to peer groupings.

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Humana's Foundation for Reducing Potentially Preventable Events: Strong Provider Partnerships

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ENGAGEMENT OF PRIMARY CARE PHYSICIANS (PCPS)

Humana's provider engagement model places PCPs at the forefront of managing enrollees' care while subsequently controlling over-utilization of emergency department, inpatient, and outpatient services. Our PCPs guide Humana enrollees' care management in conjunction with Humana case managers (CMs); this leads to effective case management, coordination of care, and the reduction of duplicative services. Our PCPs also communicate with inpatient physicians during an inpatient stay to avoid duplication of ancillary services.

REWARDING HIGH-QUALITY CARE
In Florida, Humana is deeply committed to improving outcomes through highly engaged value-based purchasing (VBP) provider models in our Medicaid, Medicare, and commercial plans. We now have more than eight hundred thousand (800,000) Florida Medicaid and Medicare enrollees attributed to local VBP-engaged PCPs. We support our providers using data analytics and in-person assistance from our Provider Relations representatives and others to improve results among our Florida Medicaid enrollees, including the reduction of potentially preventable events.

Our engaged PCPs in Region 1 receive monthly reports on their enrollee utilization patterns. Humana's Provider Relations Representatives and providers review the high-risk enrollees and centers that need additional support regarding performance, utilization patterns, preventable emergency department visits (percent of non-urgent), and inpatient and outpatient utilization.

Humana's Florida Medicaid providers in full-risk arrangements outperform their non-risk counterparts in quality, outcomes, and cost. In 2016 the risk providers had significantly higher quality scores on metrics related to preventive health, well-child visits, and diabetes management. As a result of their strong performance, these providers also have strong outcomes: Humana's Florida Medicaid risk providers average twenty-five point three percent (25.3%) fewer emergency department visits per one thousand (1,000) enrollees and seventeen point four percent (17.4%) fewer inpatient admissions per one thousand (1,000) enrollees. By reducing preventable events like these and helping enrollees access care in appropriate settings, Florida risk providers have fourteen point seven percent (14.7%) lower inpatient medical expenses and have reduced pharmacy expenses by eleven point four percent (11.4%).

Our strong provider partnerships are at the foundation of the approaches to preventing potentially preventable events we discuss throughout the remainder of this response.

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Humana's Approach to Reducing Potentially Preventable Hospital Admissions and Readmissions

Assessment of hospital utilization rates and the potential for improvement;
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According to AHCA's Spring 2017 Quarterly SMMC Report, the top three (3) reasons for potentially preventable admissions in Region are: 1) Chronic Obstructive Pulmonary Disease (COPD), 2) Congestive Heart Failure (CHF) and 3) Other Pneumonia. An effective case

management program can manage these types of conditions. [and regular contact with a PCP and specialists]. Humana has robust and innovative strategies to manage high-need enrollees with chronic, comorbid conditions.

The top three (3) reasons for a potentially preventable readmission in Region 1 are: 1) Bipolar Disorders, 2) COPD, and 3) Pancreas Disorders. These diagnoses present an opportunity to more effectively manage BH conditions as well as better manage chronic conditions.

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Humana strategies to reduce potentially preventable hospital admissions and readmissions.
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Humana takes a proactive approach to reducing potentially preventable hospitals admissions and readmissions. We begin the process of reducing readmission rates at the time of the initial admission and continue throughout the enrollee's transition out of the hospital. We begin to assess and plan for discharge needs upon notification of an admission. Humana has the second lowest potentially preventable admission rate (PPA) among SMMC standard plans in admissions per one thousand (1,000) enrollees. [2] (Attachment MMA 1-1)

The narrative below describes how we use the following strategies, initiatives, and data to reduce PPAs and readmissions.

- Predictive Modeling and Case Management
- Proactive Healthcare
- Chronic obstructive pulmonary disease (COPD) and Congestive Heart Failure (CHF) Disease Management Program
- Early Indicator Report
- Utilization Management Prospective Review of Inpatient Admissions
- Telemedicine
- Utilization, Claims and Encounter data
- Transition Planning and Enhanced Transition Planning for High-Risk Enrollees
- Post-Discharge Follow-up
- In-Home Provider Visits Post-Discharge
- Frequently Admitted Member (FAM) Program
- Field Case Manager and Field Social Worker Pilots
- Innovations with Home Health Providers
- Neonatal Intensive Care Unit (NICU) CM Program.
- Enhanced Care Coordination for Enrollees Under Age Twenty-One (21)
- Mail-order Pharmacy
- Medication Reconciliation Pilot
- Medication Refill Concierge
- Discharge-to-Encounter Monitoring

PREDICTIVE MODELING AND CASE MANAGEMENT

Humana takes a proactive approach to reducing preventable admissions using innovative predictive models. Our proprietary predictive modeling tools and care management hierarchy

algorithms identify enrollees who would benefit from enrollment in our case management programs, with the goal of optimizing quality outcomes and preventing admissions. Using predictive modeling tools to guide case management activities, we can identify high-risk enrollees. We have included descriptions of one predictive model we use in our Florida Medicaid program below.

MEDICAID HIGH SEVERITY PREDICTIVE MODEL
Identifies the highest-risk, highest-cost, or highest-need Medicaid enrollees to prioritize outreach and care coordination efforts. We group the individuals based on characteristic profiles such as SSI, Temporary Assistance for Needy Families (TANF), and Long-Term Services and Supports (LTSS), and then develop a separate model for each of these groups tailored to the needs of that cohort.

Using our Medicaid Severity Score Predictive Model, we incorporate a severity score generated from medical, BH, and pharmacy claims into monthly reports identifying enrollees with high costs and clinically complex health conditions. The severity score is a predictor of future medical and pharmacy costs. This data allow Humana to identify enrollees with changing care needs, refer them to case management, move them between acuity levels, or alter their case management interventions.

We stratify the severity scores into complex, high, moderate, and low categories, which allows CMs to identify the enrollees at greatest risk for an admission. Prioritizing case management interventions ensures that enrollees identified as complex or high-risk receive interventions to avoid preventable events. Attachment MMA 1-2 includes case management protocols based on enrollee acuity level.

PROACTIVE HEALTHCARE

Humana has identified unique healthcare needs exist for two (2) specific cohorts of our Medicaid population:

- Enrollees in their twenties because of a lack of preventive healthcare during their teenage years

- Pregnant women, whose compliance with prenatal care is sometimes lacking, contributing to high risk pregnancies and NICU admissions

We can mitigate both circumstances with improved proactive healthcare centered on positive provider-enrollee relationships. By focusing on effective healthcare proactively in childhood, Humana believes we can address the health of these cohorts before our enrollees reach adulthood.

One way that Humana currently addresses this is using PCP visits conducted by our provider network team and Quality Improvement Nurses (QINs). We encourage PCPs to reach out to their enrollees without a documented child health checkup visit to schedule an appointment. We review detailed claims and encounter data reports to track and trend child visits to verify improvement by PCPs.

Below are some additional Humana initiatives to encourage proactive healthcare:

- Initiating a Healthy Kids outreach campaign to parents with school-aged children without a PCP visit

- Offering children a fifteen dollar ($15) store gift card (e.g., Apple Store and Amazon) when they visit their doctor for Well-Child Visits

- Identifying women's obstetrician/gynecologist (OB/GYN) during the welcome call, asking when their last visit was, and helping women connect with a CM to discuss OB/GYN care, as needed.

- Partnering with Pediatric Associates using its case management outreach program to contact enrollees who have not had a recent PCP visit.

EARLY INDICATOR REPORT (EIR)

Humana's sophisticated Early Indicator Report (EIR) includes key utilization indicators. The EIR incorporates claims data as well as data from the authorization system to enable early recognition of key clinical trends and schedule early interventions that reduce preventable events. We leverage authorization information from CGX to prevent any claims processing noise (e.g. inventory build-up and provider billing delays) from introducing excess restatements. Where authorizations exist, we have studied historical authorizations-versus-claims relationships to assess provider compliance in reporting authorizations. We base utilization projections for those incurred periods off the compliance-adjusted estimate of admission authorizations.

With the EIR, users can see overall performance at a glance, and can drill down to specific data elements to quickly analyze data and identify root causes. For example, if overall admits per one thousand (1,000) enrollees is unusually high, the drill down capability allows the user to view by market segments and by age of the population. This report informs clinical decision-making from analysis of month-to-month as well as year-over-year trended data

Attachment MMA 1-3 contains an example of drill-down capability for current Medicaid reporting on EIR report.

Existing utilization data help us establish metric targets. Tracking and trending to goals are also part of ongoing EIR analysis. If a metric appears to be unusually high or low, the actuarial team will drill down to root causes. We will then complete a gap analysis and return to the UM committee with strategic and tactical recommendations.

UTILIZATION MANAGEMENT (UM) PROSPECTIVE REVIEW OF INPATIENT ADMISSIONS

Humana UM performs real-time reviews of medical necessity criteria for inpatient admissions to divert potentially preventable admissions to a lower level of care when appropriate. When an enrollee presents at the emergency department, instead of immediately admitting them for an

inpatient stay, the UM team conducts a review of the medical necessity criteria prior to the inpatient admission either onsite at the facility or telephonically. We approve enrollees who do not meet medical necessity criteria for observation level of care, which is an outpatient service level, and place them in the appropriate level of care based on their presentation in the emergency department. If the enrollee's condition deteriorates while under observation, he or she is approved for an inpatient admission. After admitted, our UM Team performs discharge planning to ensure the enrollee connects with their PCP following discharge, as well as to ensure any supports the enrollee needs are in place.

TELEMEDICINE

HEALTH FIRST NETWORK PILOT

To increase access in Region 1, Humana is partnering with Health First Network (HFN) to initiate a pilot to serve HFN's high-risk and high-need enrollees. HFN has identified that eighty percent (80%) of its spend is attributed to eight hundred (800) out of thirty thousand (30,000) enrollees. HFN recognized an opportunity to support these enrollees with home-based and telemedicine services, and launched a pilot that began July 2017.

UTILIZATION, CLAIMS AND ENCOUNTER DATA

Humana monitors data from various sources to identify enrollees that are at high risk for hospital admissions or readmissions, and would benefit from case management or disease management. Our powerful CareHub platform, Humana's innovative enterprise solution for complete program integration for our provider community and enrollees, integrates all sources of identification and referral, from predictive modeling to claims data and lab results. We show this in Attachment MMA 1-4.

The CareHub CGX clinical workflow system supports an integrated approach to utilization and case management. As a fully integrated approach, this enterprise solution provides enhanced capabilities to identify candidates for programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention. The CareHub infrastructure uses technology solutions such as Atlas and Anvita clinical rules engines to drive timely and actionable data into an enterprise workflow. This includes automated processes to route enrollees to specific clinical programs and CMs and creation of Care Alerts that consist of evidence-based medicine Gaps-in-Care, HEDIS, and drug-to-drug disease interaction alerts.

Functionality includes:

- Management of automated referrals to clinical programs
- Assessments to evaluate an enrollee's condition and identify opportunities for improvement
- Plan of care (POC) to manage an enrollee's problems, goals, and clinician interventions
- Documentation of all contact with enrollees and providers and subsequent outcome of these contacts
- Management of medications, allergies, and immunizations for an enrollee

We use our data analytic capabilities to identify gaps in care and to identify those enrollees who would benefit from enhanced engagement either through case management or disease management. For enrollees not in case management, we can identify specific gaps in care that may lead to unnecessary admissions or readmissions, and work with providers to close those gaps. Once in case or disease management, Humana associates can help enrollees proactively address care needs in advance of an event that may lead to an unnecessary admission or readmission to the hospital.

DISEASE MANAGEMENT PROGRAMS

Empowering enrollees with chronic diseases to care for themselves on a daily basis is critical to minimizing the impacts of these illnesses. Routine and consistent self-care, monitoring change in condition, and enrollee-initiated rapid response when an impending exacerbation is detected will help control the condition, avert medical emergencies, and forestall disease progression. Thus, enrollee self-management in collaboration with the disease management (DM) and healthcare team ultimately reduces or prevents the need for unnecessary admissions and readmissions. In total, Humana offers thirteen (13) DM programs for our enrollees. Below is a brief description of two (2) of our DM programs directly related to the top three PPAs and PPRs in Region 1.

Chronic Obstructive Pulmonary Disease (COPD)

Through our COPD DM program, RN DM case managers help enrollees gain an understanding of the early warning signs of COPD exacerbation and the importance of following their medication regimen, routine blood work, proper diet, PCP follow-up, and influenza and pneumonia vaccines. Enrollees participate in goal setting around appropriate lifestyle modifications, often related to exercise and smoking cessation.

Congestive Heart Failure (CHF)

DM Case Managers help enrollees in our CHF program adhere to disease-specific, individualized treatment plans and medication regimens. The CHF DM program encourages enrollees to have active communication with doctors and specialists (e.g., cardiologist, pulmonologist) and are given ongoing education with helpful tips to manage their condition. Key components also include following appropriate nutritional and exercise plans and participating in a smoking cessation program.

TRANSITION PLANNING

Humana uses a Readmission Predictive Model (RPM) to assess the probability of an enrollee being readmitted into a facility within thirty (30) days. The RPM is a predictive modeling process with inputs from more than fifty (50) variables including demographics such as the enrollee's age and gender; previous medical and pharmacy claims including physician visits, admissions, days since last admission, Charlson Comorbidity Index, and number of medications; as well as information regarding their current admission (procedure, diagnosis, bed type, length of stay, and discharge disposition). The process generates a numerical RPM score, which we use for stratification and prioritization based on the risk of all-cause readmission within thirty (30) days.

UM nurses facilitate interaction and coordination with hospital staff to ensure continuity of care while enrollees are in the inpatient setting, and to coordinate post-discharge activities. We employ a mixed telephonic/onsite UM model based on each enrollee's needs. UM nurses collaborate by telephone with the facility for early identification of any gaps or barriers to

transition of care, and will go onsite for high-risk enrollees. They collaborate daily with hospital case managers and discharge planners on the discharge plan for hospitalized enrollees, promoting effective, safe, timely, and appropriate planning. UM nurses are responsible for identifying and collaborating with all community resources that will be involved at discharge and thereafter and for making post-discharge arrangements. Additionally, upon discharge the UM nurses coordinate services and the transition of care with the primary care physician.

The enrollee's CM and/or BH CM also serve as important components of the Transition Planning team for enrollees already engaged in a case management program. Case Management Assistants (CMAs), under the CM's guidance, support post-discharge planning to ensure the enrollee's necessary supports and services are in place. The CMA also ensures the enrollee receives the appropriate education to facilitate a smooth transition to home and prevent medically unnecessary emergency department visits or hospital readmission.

The effectiveness of our transition planning processes is evident in our outcomes. In both 2015 and 2016, we significantly surpassed our readmission rate goal for enrollees in case management:

- Readmit Rate Goal - 30% or less
- 2015 Readmit Rate - 23%
- 2016 Readmit Rate - 16%

ENHANCED TRANSITION PLANNING FOR HIGH-RISK ENROLLEES
We are focused on effective transitions for all our enrollees, but understand that certain populations require enhanced transition planning. CMs closely monitor high-risk enrollees post-discharge and on an ongoing basis to ensure safe transitions and to reduce readmissions. CMs coordinate care for high-risk enrollees by:

- Setting goals that promote coordinated care
- Scheduling appointments with providers
- Educating the enrollee regarding their disease or condition, their benefits, and Humana's clinical programs
- Coordinating care within and across treatment settings
- Giving enrollees and families one point of contact
- Creating a process through which healthcare providers can communicate with one another
- Making enrollee preferences known and accessible to all healthcare providers

POST-DISCHARGE FOLLOW-UP

Humana's post-discharge transition activities focus on identifying and addressing gaps in care post-discharge and preventing readmissions. We make post-discharge outreach to all enrollees discharged to home. The specific outreach is based on the enrollee's risk level, as determined by the enrollee's Readmission Predictive Model score.

- Complex and High-risk enrollees: Route directly to a CM for post-discharge outreach. The CM administers the Post-Discharge Screening Tool, which identifies gaps in care and documents

interventions to close those gaps, and identifies enrollees eligible for Humana case management or disease management programs.

- Medium-risk enrollees: Route to a CMA for an abbreviated post-discharge screening. If we identify potential gaps or the enrollee requests to speak with a nurse, a CM follows up within twenty-four (24) hours.

- Low-risk enrollees: Receive calls from a Humana nurse or social worker explaining Humana's Post-Discharge Management program, asking whether the enrollee is interested in further follow up. Enrollees who request follow up route to a CMA for the abbreviated post-discharge screening.

Humana's goal is to complete the post-discharge call to the enrollee within three (3) business days following discharge. We make at least three (3) attempts, on different days and at different times, to reach the enrollee. Upon reaching the enrollee, the CM or CMA requests permission to obtain a Protected Health Information (PHI) consent form, verifies the enrollee's name and date of birth, and notifies the enrollee that we are recording the call. The CM or CMA then asks a series of questions with the enrollee or caregiver to ensure the following items are in place:

- Enrollee received discharge instructions and fully understands their conditions and post-discharge care

- Enrollee is in a safe environment and their support system can adequately provide post-discharge support

- Enrollee obtained all post-discharge medications and understands how to take them, can identify side effects and complications, and knows when to report concerns. Additionally, if the enrollee cannot afford medications, then the case management team works with the enrollee on obtaining medications from community resources, pharmaceutical companies, or they contact the physician's office for assistance

- Home health services and durable medical equipment (DME) are in place, if needed

- Follow-up doctor's visits and outpatient care are arranged according to post-discharge instructions.

-- Enrollee has required transportation for follow-up visits, and understands their transportation benefit

-- No complications or new problems have occurred without being reported to the physician.

-- Enrollee understands when to report any complications to their physician and when to seek medical care.

At the end of the call, we remind the enrollee that there is a phone number on the back of their enrollee identification (ID) card to schedule transportation, and a phone number for the twenty-four seven (24/7) Nurse Advice Line.

The goal of post-discharge intervention is to identify and close any gaps in care that may lead to complications or readmissions. Internal studies, which suggest that the closer the post-discharge intervention follows the discharge, the more likely the intervention will have a positive impact on quality of care and reduce readmissions, inform our post-discharge activities.

Our goal for contact is at least thirty-five percent (35%) within a three (3)-day period for our Medicaid enrollees. We exceeded this goal in both 2015 (fifty-one percent (51%)) and 2016 (fifty-five percent (55%)), and realized a significant improvement over that period. Our ten (10)-day post-discharge contact rate also exceeded the goal of fifty-eight percent (58%) in both years and improved in 2016 over the prior year: seventy-three percent (73%) in 2015 and seventy-seven percent (77%) in 2016.

IN-HOME PROVIDER VISITS POST-DISCHARGE

To address provider access issues in Region 1, Humana offers in-home clinical visits for our most complex and vulnerable enrollees to bring care into enrollees' homes and help prevent readmissions. We typically use these services to address needs of enrollees with a "homebound" status. We contract with subcontractors and providers to provide high-quality in-home medical care while focusing on educating enrollees on their disease state, and about the importance of compliance with their treatment plan, medication adherence, understanding signs and symptoms that require immediate reporting to the PCP, and the importance of regular PCP visits.

FREQUENTLY ADMITTED MEMBER (FAM) PROGRAM

Humana recognizes that high-utilizing, medically complex enrollees drive a significant portion of utilization and spend in Medicaid populations. We developed the FAM Program to identify, engage, and manage high-utilizing enrollees in Region 1 to improve clinical and financial outcomes. On an ongoing basis, Humana analytics and clinical teams work together using real-time data to identify enrollees with the most acute facility inpatient admissions. We assign each FAM enrollee a designated UM nurse and supporting technician who follow these enrollees on all admissions. Having a consistent concurrent review nurse allows the UM team to build trust and a relationship with the enrollee, in addition to the relationship the enrollee has developed with their CM. Our transition team follows these enrollees for eight (8) weeks post-discharge. We have observed a fifty percent (50%) reduction in readmission rates for enrollees targeted by this program in a twelve (12)-month period.

FIELD CASE MANAGER AND FIELD SOCIAL WORKER PILOTS

Humana is currently conducting pilots involving Field Case Managers and Field Social Workers to reduce inappropriate utilization, reduce barriers to close gaps in care, and improve engagement of identified enrollees with complex needs. A Field Case Manager and a Field Social Worker conduct enrollee visits at the hospital, PCP, or the enrollee's home. We identify eligible enrollees through a variety of sources, including the following:

- Complex Acuity
- High-Utilizer Enrollee (as identified via Frequent Admitter Report)
- CM Referrals (Non-compliance with plan of care, complex needs, knowledge deficit with psychosocial barrier)
- UM Nurse Referral (high risk for readmission)
- Regional Medical Directors
- Physician Referral

We may expand this pilot to Region 1 to engage enrollees in more rural areas who do not regularly visit their PCP, as well as to engage those enrollees with more complex needs with the goal of preventing an out-of-area hospital admission.

INNOVATIONS WITH HOME HEALTH PROVIDERS

Opportunities exist to direct some traditionally high-cost, inpatient services to low-cost settings. For example, Humana currently partners with home health providers to move traditionally inpatient services, such as infusion therapy and wound care, into the home. We also partner with home health agencies that specialize in specific conditions. Their specialized expertise provides more effective in-home management of specific conditions to reduce emergency department visits and admissions.

MAIL-ORDER PHARMACY

We provide mail-order pharmacy delivery for enrollees who are actively engaged in case management or disease management, and who have physical or socioeconomic barriers to going to a pharmacy. Frail, elderly, or chronically ill enrollees may be homebound and have difficulty accessing a physical pharmacy location. Additionally, enrollees with socioeconomic barriers to accessing a pharmacy, such as lack of transportation or time off work, can benefit from having their medications delivered to their home. We provide up to a thirty-four (34)-day supply for most prescriptions, while filling a select few prescriptions for chronic conditions, such as diabetes and hypertension, for up to a one hundred (100)-day supply. Active engagement with a CM ensures that all enrollees participating in mail-order pharmacy are adherent with their medications, and that they have a resource for any questions regarding their regimen.

MEDICATION RECONCILIATION PILOT

We implemented a Medication Reconciliation Pilot in August 2017 for high-risk enrollees engaged with a Field Case Manager (FCM) in South Florida. During the post-discharge home visit, the FCM works with the Humana pharmacy team to conduct medication reconciliation. The pilot incorporates a pharmacist via telephone into the FCM's medication reconciliation process to ensure the enrollee gets the most out of his or her medications and to avoid medication-related problems that put enrollees at risk for adverse effects or readmission. We share information from these visits with the enrollee's PCP and upload it in the enrollee's electronic medical record (EMR).

If successful, we could expand this program to Region 1 to improve post-discharge care following an admission to ensure enrollees understand their medication regimen.

MEDICATION REFILL CONCIERGE

Humana's Medication Refill Concierge program is an enrollee outreach program that strives to improve adherence with specific medications. Interventions include live or voice activated technology (VAT) outbound calls to facilitate the next refill of a diabetes, hypertension, or hyperlipidemia medication. Increased adherence with medication, particularly for chronic conditions, helps reduce potential admissions and readmissions because of a lack of chronic care management.

NEONATAL INTENSIVE CARE UNIT (NICU) CASE MANAGEMENT PROGRAM

The NICU CM program provides utilization review and case management to reduce readmissions for infants with a NICU stay. Nurses with extensive NICU experience follow each case throughout the NICU stay and for thirty (30) days post-discharge. The nurses provide authorizations and medical necessity approvals, discharge planning, and support and education for families of the infants. For high-risk infants, the NICU nurses transfer the case to the Medicaid pediatric team for longer-term outreach for up to one (1) year to educate and support the caregiver to decrease unnecessary utilization.

ENHANCED CARE COORDINATION FOR ENROLLEES UNDER AGE TWENTY-ONE (21)

To reduce ED visits and hospital admissions, Humana offers enhanced care coordination for enrollees under age twenty-one (21) who are in nursing facilities and meet criteria for transition to their homes. A CM works collaboratively with the enrollee's MDT to transition the enrollee safely from the facility to the community, developing the transition plan within thirty (30) days prior to discharge. The transition plan includes all services and supports the enrollee needs to successfully reside in the community. During the first six (6) months following discharge from the nursing facility, the CM contacts the enrollee or enrollee's authorized representative at least twice per month, with at least one (1) of those meetings being face-to-face. For those enrollees who receive private duty nursing services (PDN), we conduct quarterly face-to-face visits. After the initial six (6)-month transition period, the CM continues to maintain monthly contact with the enrollee.

DISCHARGE-TO-ENCOUNTER MONITORING

Humana encourages timely PCP follow-up following discharge to improve enrollee outcomes and reduce readmissions. As a part of our monitoring of post-discharge follow-up, we:

- Provide timely appointments for post-discharge enrollees from all levels of care
- Monitor secure mailbox for discharge summaries to enhance coordination of care

- Provide follow-up appointments for all enrollees receiving Home Health to reduce readmission within thirty (30) days
- Ensure PCPs submit all claims and encounters on a timely basis
- Improve coordination with specialists following discharge

We have also developed a specific discharge-to-encounter report as part of our strategy to reduce readmissions and promote continuity of care. We use this reporting internally and deliver it to providers to monitor the following metrics by provider:

- Readmissions within thirty (30) days
- Readmissions within thirty (30) days with the same diagnosis
- Readmissions within thirty (30) days for the same diagnosis group
- Average number of days between discharge from the facility and when enrollee visits PCP office
- Rate of enrollee with an office visit within seven (7) days of discharge

Attachment MMA 1-5 includes an example of the discharge-to-encounter report from one of our MSO providers. We can modify and replicate this report for our Region 1 providers.

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A description of performance benchmarks for each area of focus;
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Humana relies upon MCG® utilization benchmarks for the Southeast Region as a guide from which to compare our performance. We use these benchmarks for the following indicators for admissions and readmissions:

- Acute care admissions per one thousand (1,000) enrollees per year
- Inpatient days per one thousand (1,000) enrollees per year
- Readmission rates within thirty (30) days

We use the benchmarks above as a guide to determine how Humana network providers perform relative to their peers. These indicators help identify areas where we can improve.

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Humana's Approach to Reducing the use of the Emergency Department for Non-Emergent/Urgent Visits

Assessment of hospital utilization rates and the potential for improvement;
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The top three (3) reasons for a potentially preventable emergency department visits in Region 1 are: 1) upper respiratory infections, 2) abdominal pain, and 3) gastrointestinal/vomiting. [3] These diagnoses indicate that enrollees in Region 1 access the emergency department for conditions treatable in primary care settings. The most effective means to reduce avoidable emergency department visits is to promote primary care and lower levels of care, such as urgent care centers.

Humana's internal utilization data show there is a substantial opportunity to improve emergency department visits per one thousand (1,000) enrollees. In 2016 there were one thousand fifty-one (1,051) ED visits per one thousand (1,000) enrollees, which indicates inappropriate use of the emergency department for urgent and non-emergent conditions.

In the narrative below, we discuss in detail our strategies for reducing potentially preventable emergency department visits, and how these strategies led to a three percent point (3%) reduction in emergency department use between 2016 and 2017 for Humana enrollees in Region 1.

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Humana strategies to reduce potentially preventable emergency department visits
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Reducing inappropriate use of the emergency department is an ongoing goal for Humana in Region 1, and a priority for our partnership with the Agency for Health Care Administration (AHCA). We understand that diverting care from emergency departments to more appropriate settings not only decreases costs, but also improves enrollee outcomes. Our current strategies to reduce the use of the emergency department for non-emergent/urgent visits include the following initiatives:

-Emergency department Predictive Model
- Humana's participation in the Event Notification System (ENS)
- Doctor on Demand (DoD)
- Transition Healthcare
- Expanded Urgent Care Network
- Enrollee education on appropriate care settings
- Nurse Care Line

EMERGENCY DEPARTMENT PREDICTIVE MODEL

The Humana Future Emergency Department Utilization Predictive Model quantifies the likelihood of future emergency department utilization for each enrollee. The model creates a comprehensive profile of each individual, which includes cost and utilization for different clinical, behavioral, and functional conditions as well as socioeconomic profiles. It enables Humana to identify and target high-risk enrollees for clinical interventions that reduce emergency department visits.

Past case management efforts related to emergency department use were solely retrospective; we intervened with enrollees after emergency department visits occurred. Humana's emergency department Predictive Model prospectively identifies enrollees likely to use emergency departments non-emergent reasons, 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 emergency department visits as a substitute for primary care, often detrimental to enrollees with chronic conditions, which also helps create a stronger patient-physician care partnership.

HUMANA'S PARTICIPATION IN AHCA'S EVENT NOTIFICATION SYSTEM (ENS)

Humana currently contracts with AHCA for the Florida Health Insurance Exchange's (HIE) ENS and receive daily emergency department visit information from facilities in Regions 9, 10, and 11.

Daily reports of emergency department encounters reduce the months-long notification lag to one (1) day. Timely outreach to enrollees to close gaps and notification to physicians has reduced unnecessary emergency department utilization. Humana leverages direct connect technology to send reports to physicians on a daily basis, which report the prior day's emergency department encounters for their patients.

Humana's UM system integrate HIE ENS notifications for timely tracking and reporting, which we use in conjunction with our emergency department Predictive Model to identify high-risk enrollees. emergency department CMs reach out to high-risk enrollees, complete an assessment to identify needs, close gaps, ensure there is timely physician follow-up scheduled, and educate enrollees on appropriate settings of care.

We are in the process of expanding our use of the ENS and are committed to using this system in regions upon contract award.

DOCTOR ON DEMAND (DoD)

Humana is launching a telemedicine partnership with DoD to encourage telemedicine as a means to limit out-of-network utilization and enhance non-emergency emergency department diversion. DoD is a platform that provides enrollees with access to physicians twenty-four (24) hours a day, seven (7) days a week from the enrollee's phone or computer. The platform allows enrollees to instantly see and talk to a physician from their homes using video chat technology. Additionally, the platform allows an enrollee to upload medical history, send images if necessary, and obtain prescriptions.

- As DoD directly employs its associates, they can exchange enrollees' medical records and easily transition between specialists.

- For medical care, DoD is available twenty-four (24) hours, seven (7) days a week, three hundred sixty-five (365) days a year. In less than five (5) minutes an enrollee and doctor can be face to face via video.

INNOVATIVE APPROACHES FOR HOMELESS ENROLLEES
Humana understands that frequent emergency department users are often homeless individuals who use the emergency department as primary care, as well as a safe place to spend the night.

We continually seek innovative and often unconventional solutions to prevent emergency department visits as well as readmissions for our homeless enrollees, who present unique challenges. We have taken our enrollees to doctor appointments post-discharge, and have even paid for hotel stays for homeless enrollees who required post-discharge wound care.

TRANSITION HEALTHCARE EMERGENCY MEDICAL SERVICES (EMS)

This community paramedic program provides in-home services such as prescription administration, echocardiograms (EKGs), blood and urine tests, respiratory treatment, intravenous (IV) therapy, and wound care to prevent non-urgent emergency department visits. The paramedics complete home safety assessments, medication reconciliation, care coordination, community resource navigation, and transport to a healthcare facility when necessary. We have found that bringing care into the enrollees' homes makes them much more likely to engage in preventive services, and less likely to use the emergency department unnecessarily.

We are currently piloting this program in Regions 10 and 11, and if successful, we will implement the program in Region 1.

EXPANDED URGENT CARE NETWORK

Humana recently expanded our urgent care network to include twenty-three (23) urgent care centers to expand access to appropriate care settings. Instead of visiting the emergency department for a non-emergent condition, we educate enrollees on using urgent care centers as a more appropriate care setting. We include information on urgent care centers in the new enrollee materials, the network provider list, provider and enrollee portals, and through the Nurse Care Line.

ENROLLEE EDUCATION ON APPROPRIATE CARE SETTINGS

Humana understands the importance of educating our enrollees to access care in the most appropriate setting; it is our job to help our enrollees access the right care, in the right place, at the right time. We educate enrollees on the importance of preventive care from the time of enrollment. New enrollee materials include a notification on how to access care in the most appropriate setting. Our CMs work with enrollees to guide them to the right care setting for their needs and to understand the available community resources. When an enrollee accesses care in an inappropriate setting, we follow up with education to change enrollee behavior in the future.

NURSE CARE LINE

Humana offers enrollees a twenty-four (24)-hour nurse care line. Enrollees may call in with any clinical question to receive advice from a registered nurse (RN). We encourage our enrollees to use the nurse care line as the first step in determining whether they need immediate care. The

nurse can assess symptoms over the phone and determine whether the enrollee may need to go to urgent care or wait for an appointment with their PCP instead of visiting the emergency departmenr. While the enrollee is on the phone, the nurse educates the enrollee on how to access care in the most appropriate setting, including the importance of preventive PCP visits and other clinically relevant information related to the enrollee.

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A description of performance benchmarks for each area of focus
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Humana relies upon MCG® utilization benchmarks for the Southeast Region as a guide to compare our performance. We use the Milliman benchmarks for the following indicators for emergency department visits:

- Emergency Department visits per one thousand (1,000) enrollees per year

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Humana's Approach to Reduce of the use of Unnecessary Ancillary Services during Hospitalization and Outpatient Visits

A description of the respondent's assessment (using available data sources) of hospital utilization rates and the potential for improvement
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Humana understands that unnecessary testing and delivery of ancillary services exists within the SMMC program in Florida. We assess how our providers prescribe ancillary services both during an inpatient stay and in the outpatient setting using our integrated clinical platform, CGX. We can see authorizations and claims for Managed Medical Assistance (MMA) and Long-term Care (LTC) services, providing us a full picture of the ancillary services of each enrollee. We use CGX as a common database through which we can investigate outliers in prescribing patterns, and we educate providers regarding the appropriate care guidelines for Florida Medicaid enrollees.

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Humana strategies to reduce the use of unnecessary ancillary services during hospitalizations and outpatient visits
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Humana uses the following strategies to reduce the use of unnecessary ancillary services during hospitalizations and outpatient visits:

- Care Decision Insights (CDI)
- Prior Authorization List
- Collaboration with Hospitalists
- In-home Nurse Visits

CARE DECISION INSIGHTS (CDI)

Independent research clearly supports the premise that certain specialists consistently have superior clinical outcomes, higher quality of care, and lower costs. [4] Humana is currently evaluating provider performance across its lines of business. We provide information to our physicians to help identify the top opportunities to improve their patients' care by utilizing specialists that demonstrate high efficiencies and effectiveness. Through our innovative CDI platform, we give PCPs information about the most efficient and effective specialists in Humana's network. We create efficiency ratings using three (3) steps:

1. Distilling data, Humana uses claims data to build episodes of care. We:

- Bundle all claims for a specific individual's case to create an episode of care
- Separate claims into conditions based on various clinical codes
- Categorize episodes by severity, geography, product, and age band
- Attribute each episode to appropriate providers who make up a subset of professional costs
- Adjust for outliers (e.g., heart transplants and other high-cost procedures)

2. Compare cost of the episodes with peers.

3. Assign a Performance Index.

Effectiveness ratings match known interventions with care received
- Measured by adherence to recommended, evidence-based care guidelines
- Determined with specialty-specific metrics measured over time

We also share information with PCPs and specialists about the sites of service to which they are referring Humana-covered patients for certain procedures. We help them identify the top opportunities to improve their patients' care by using sites of service that demonstrate high efficiency and effectiveness.

We also share new fee schedules with ambulatory surgery centers and outpatient hospitals for moving certain current inpatient procedures to outpatient settings.

Humana is currently modifying CDI to include Medicaid data and provider information. We will use CDI in Region 1 under the forthcoming contract period. Attachment MMA 1-6 contains examples of reports generated for PCPs using the CDI platform.

PRIOR AUTHORIZATION LIST (PAL)

Humana currently monitors procedures and services in Region 1 that may be inappropriately prescribed, or may be delivered in a lower-cost setting. Our prior authorization program promotes quality of care and optimal treatment options for enrollees while controlling costs to the healthcare delivery system. Ongoing review of utilization, financial, and quality data determines services that require prior authorization for payment. We implement a PAL in our current Florida operations.

Using the PAL for authorization of ancillary services allows us to manage utilization more effectively and efficiently, ensuring that enrollees do not receive and providers do not request unnecessary services.

COLLABORATION WITH HOSPITALISTS

Humana currently collaborates with hospitalists to develop best practices to help them avoid repetitive testing and to help them use specialists in the most appropriate manner. In Region 1, hospitalists work with the adult population PCPs to seamlessly coordinate care and ensure usage of only necessary services. Key responsibilities for the contracted hospitalist include:

- On behalf of the PCP, hospitalists accept, coordinate, and provide oversight for all inpatient healthcare services

- Ongoing communication throughout the hospitalization to reduce duplication and unnecessary ancillary services, and to prepare for a safe transition to a lower level of care

- Communication with the primary care physician upon admission to obtain a detailed medical history

- Conferring with discharge planners, utilization review nurses, Humana, Medical Service Organization (MSO)/Humana Medical Directors and others as necessary, and take all appropriate action to deliver reasonable and necessary medical care while avoiding medically unnecessary services or length of stay

- Returning the assigned enrollee's medical care to the assigned PCP for continuing care that the PCP determines is medically necessary after discharge from the facility.

- Providing a discharge notification to MSO/PCP to include:
-- Discharge instructions
-- Enrollee disposition
-- Discharge diagnoses
-- All pertinent diagnoses
-- Follow-up recommendations, referrals, and tests
-- Medications

We conduct outlier rounds, which include hospitalists and the Humana Medicaid Medical Directors examining cases where there is an abnormal amount or duration of services prescribed. We also conduct peer-to-peer conversations with hospitalists to discuss prescribing patterns and best practices. We are also working with hospitalists to help them better manage DME and home health providers to increase outpatient management of disease.

IN-HOME NURSE VISITS

We use in-home nurse visits to prevent unnecessary use of ancillary services both during an inpatient stay and in an outpatient setting. For the adult population, Humana authorizes in-home

nurses to help enrollees with medication administration (e.g. insulin, home IV antibiotics) and home health aides for services such as colostomy care.

In the pediatric population, Humana makes every effort to keep children in a community setting by providing skilled services in enrollees' homes. We use PDN and personal care services for medically fragile or medically complex children, children with a short-term acute need, and children with special needs. Our pediatric CMs routinely meet with families and other enrollees of the child's healthcare team to ensure that we meet the child's needs. Some children need help only with activities of daily living (ADLs), while others require private duty nurses capable of caring for technology-dependent children. We provide these services until they are no longer medically necessary.

In-home nurses educate families on enrollees' illnesses, and can work with ancillary providers to learn the necessary services and perform those services, including occupational therapy, physical therapy, and medication administration, in the home without an outpatient visit. These in-home nurses also help administer assessment tools for physicians in the home. The nurse can convey in real-time what is happening in the home, which prevents the child from undergoing unnecessary testing or seeking an inappropriately higher level of care.

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A description of performance benchmarks for each area of focus
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Humana takes a provider-based approach to benchmarks for ancillary services. We use claims and encounter data to examine prescribing patterns and to ensure enrollees receive medically necessary services. We compare providers to their peers to determine whether they prescribe the appropriate amount and duration of ancillary services. Humana's enrollee-centric approach to service delivery ensures we err on the side of the enrollee when reviewing authorized services, and that we work with providers to ensure they deliver the most appropriate care.

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A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings.
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Humana has developed provider incentive programs to encourage our network providers to direct their patients to the most appropriate, high-quality level of care for their needs. Separately, our enrollee incentive programs promote access to preventive services and encourage behavior change on the part of the enrollee.

PROVIDER INCENTIVES

VALUE-BASED PURCHASING (VBP)
To incentivize our providers to deliver the highest quality of care in the most appropriate setting, we have developed a custom-tailored continuum of VBP programs for Florida Medicaid providers that we currently implement in Region 1, and will maintain under the next contract. Best practices inform this continuum from Humana's nationwide experience and expertise, but it

is driven by the needs and capabilities of Florida providers and the enrollees they serve. Humana's value-based continuum for Florida Medicaid PCPs includes four (4) VBP programs. Two (2) of these programs – MPIP and Full-Value – extend to our specialists as well:

1. Quality-Cap Bonus: Our Quality-Cap Bonus program offers our Florida Medicaid providers a variation of our nationwide Star Rewards model. PCPs that exceed National Committee on Quality Assurance (NCQA) benchmarks across a series of HEDIS quality metrics related to access to primary care, immunizations, well-child visits, cancer screenings, and disease management can receive quarterly bonuses. The bonuses offered through this program incentivize providers to implement interventions that improve HEDIS measures related to reducing preventable events. Over $3 million was paid out in 2016 to Florida Medicaid providers.

For example, we offer bonuses to providers with strong performance on the Adults' Access to Preventive/Ambulatory Health Services (AAP) HEDIS measure to increase the percentage of our enrollees who visit their PCP for regular, preventive care. Among adults, regular PCP visits for preventive health services are essential for detecting and treating minor illnesses before they cause serious problems, for delivering preventive services, and for encouraging behavior change, such as smoking cessation and physical activity. By tying PCP visits to quality rewards, PCPs are motivated to ensure that their enrollees come in for regular visits. These regular interactions encourage enrollees to go to their PCP first for treatment of acute illnesses rather than the emergency department.

As another example, our Quality-Cap Bonus model incentivizes our PCPs to increase their rates of breast cancer and cervical cancer screening, leading to improved rates of early detection and greater access to specialist treatment for these conditions. The outcomes we expect to see from these incentives include reduced hospitalizations and overall lower morbidity related to these conditions as a result of early detection and treatment.

PCPs also play an important role in chronic condition management. For this reason, we include measures related to diabetes control in our Quality-Cap Bonus program, including HgbA1c Testing and HgbA1c Control. By incentivizing providers to help our enrollees manage these conditions, we expect to see a subsequent reduction in diabetes-related emergency department visits and inpatient admissions.

2. MMA Physician Incentive Program (MPIP): We operate an enhanced version of MPIP, the VBP program established by AHCA that rewards Medicaid providers who achieve quality targets with Medicare reimbursement rates. Higher Medicare reimbursement rates offer an incentive for MPIP providers to proactively drive quality improvement and achieve tangible gains related to their target measures, leading to better preventive care, improved health outcomes, and lower overall costs. Humana's program includes family practitioners, general practitioners, and pediatricians who see children aged zero (0) to twenty (20), as well as OB/GYNs and pediatric specialists. Each provider type has a tailored set of quality metrics related to positive health outcomes for their scope of services.

In collaboration with AHCA, Humana has added data-driven metrics that focus on reducing preventable events. Pediatric PCPs in our network can elect to use the Enrollee Encounter Rate and emergency department Utilization as a benchmark, or to use HEDIS measures, including

those related to well-child visits and access to primary care. OB/GYNs reimbursements tie to quality metrics related to prenatal care, Caesarean section (C-section) rates, and postpartum care. In recognition of the unique provider landscape in each region, we have established region-specific benchmarks for each metric.

By tying higher reimbursement rates to PCPs' performance in MPIP metrics related to well-child visits and children and adolescents' access to primary care, we expect to see a reduction in emergency department visits for preventable childhood illnesses. Parents and children who have developed a strong relationship with their PCP are more likely to visit the PCP for acute conditions rather than the emergency department. In addition, through early detection of childhood illnesses or developmental delays during well-child visits, we can ensure early access to care and treatment that will ultimately reduce admissions, reduce the incidence of acute conditions, including those that are vaccine-preventable, and lower costs.

Among board-certified family practitioners and general practitioners participating in MPIP, we incentivize preventive health services and PCP engagement through metrics related to well-child visits and the enrollee encounter rate. By emphasizing appropriate medical utilization, including preventive care, PCPs can better detect and treat acute conditions and manage chronic conditions, thus decreasing the need for inpatient admissions or emergency department visits.

3. Shared Savings: Humana rewards Florida Medicaid PCPs who reduce overall medical costs while maintaining performance standards across quality metrics, with a portion of the cost savings realized by Humana. The potential to receive shared savings while assuming no risk incentivizes PCPs to take steps that reduce preventable events, better manage chronic conditions, and lower costs, such as establishing care coordination and integration processes. Shared savings also help providers develop population health management capabilities that are essential to success in Full Value arrangements.

Therefore, we expect to see PCPs make referrals to specialists and assist enrollees with finding the most appropriate setting of care. For example, PCPs participating in this arrangement educate enrollees about seeking appropriate care, including when it is appropriate to call their PCP, visit an urgent care center, or go to the ED.

By tying payments to their performance on a broad swath of HEDIS quality metrics and overall cost savings, our Shared Savings program incentivizes PCPs to improve the health outcomes of our enrollees, such as the reduction of recurring, costly events like emergency department visits and hospital readmissions. Through improved rates of well-child visits and improved access to the PCP for adolescents and children that result from our program, we expect to see reductions in the number of children who require difficult and costly treatment for conditions that a PCP can prevent or detect. This includes the prevention of childhood diseases, including those that are vaccine-preventable, and the early detection and treatment of conditions with potentially serious effects, including elevated blood lead levels. Additionally, through a focus on nutrition and physical activity counseling for children, we expect to see lower levels of children who are treated for Type II diabetes.

Among adults, we include metrics related to breast and cervical cancer screening and adult well-visits. Through the inclusion of these metrics, tied with the potential to obtain a portion of

cost savings, we expect to see early detection and treatment of breast and cervical cancers through higher rates of screening. In addition, it reduces the risk of passing infection to an infant during delivery. Furthermore, by encouraging regular PCP visits for adults, we expect to see higher rates of screening and detection of common conditions, including diabetes, hypertension, and heart disease. Detection of these conditions and early entry into treatment can reduce future complications or disease.

4. Full Value (Global Risk): In our Florida Full Value model, we pay PCPs and specialists, including BH providers, on a per member per month (PMPM) basis to manage enrollee care. In this arrangement, providers accept full risk for the services enrollees use each month and their outcomes. When the cost of an enrollee's services is lower than a Full Value provider's monthly capitated rate to manage their care, the provider receives the cost savings surplus. The financial link with enrollee outcomes and service usage incentivizes providers to establish practices that ensure the best outcomes for enrollees, such as employment of care coordinators and social workers, integrated care teams, EHRs, and an emphasis on engaging enrollees in care.

By promoting shared accountability, the Full Value model incentivizes PCPs to address all aspects of the enrollee's care that might affect outcomes. With an emphasis on metrics that address potentially preventable events, Full Value VBP arrangements will improve outcomes that reflect more integrated care and attention to social determinants of health, including reduced emergency department visits, inpatient admissions and readmissions, and unnecessary ancillary services.

Providers operating under the Full Value model have both the incentive and resources to ensure that our enrollees receive preventive care, including engagement of unable-to-contact enrollees. Better attention to screening, immunizations, and well visits will help us see early detection of diseases, engagement in treatment, and fewer vaccine-preventable infections, such as influenza and varicella. Additionally, providers in our Full Value arrangements are often patient-centered medical homes (PCMHs), which promote comprehensive care through a team of providers, including PCPs, specialists, and support staff. By investing in integrated care and coordination with specialists, including BH providers, we expect to see fewer admissions and emergency department visits, better post-discharge follow-up care, and greater medication adherence through a more team-focused approach to the management of chronic conditions.

Additionally, through investments in the employment of CMs and social workers, our providers operating under the Full-Value model are better equipped to address the social determinants of health that can affect our enrollees' outcomes. By supporting our enrollees in all aspects of their lives, such as helping them navigate the healthcare system, adhere to their medications, use non-emergency transportation for provider visits, and access a safe living environment and healthy foods, we expect to see fewer preventable diseases, better management of chronic diseases, and fewer emergency department visits.

Humana's Florida Medicaid providers in Full Value risk arrangements outperform their non-risk counterparts in terms of quality, outcomes, and cost. In 2016 the risk providers had significantly higher quality scores on metrics related to preventive health, well-child visits, and diabetes management. As a result of their strong performance, these providers also have strong outcomes. Humana's Florida Medicaid risk providers average twenty-five point three percent (25.3%) fewer emergency department visits per one thousand (1,000) enrollees, and seventeen

point four percent (17.4%) fewer inpatient admissions per one thousand (1,000) enrollees. By reducing preventable events like these and helping enrollees access care in appropriate settings, Florida risk providers have fourteen point seven percent (14.7%) lower inpatient medical expenses and have reduced pharmacy expenses by eleven point four percent (11.4%).

ENROLLEE INCENTIVES

HEALTHY BEHAVIORS PROGRAM
Humana offers many incentives through our Healthy Behaviors program intended to encourage enrollees to participate in primary care rather than waiting for an urgent or emergent condition and seeking care in the emergency department.

- Smoking Cessation: Completion of our Smoking Cessation program entitles enrollees to a thirty dollar ($30) gift card, or a fifty ($50) gift card for those enrollees completing the program using medicine from their doctor.

- Substance Abuse: In our Substance Abuse program, we reward enrollees with a ten dollar ($10) gift card for joining the program, a twenty ($20) gift card for staying sober for ninety (90) days in the program, and another twenty dollar ($20) gift card for staying sober for one hundred eighty (180) days in the program.

- Baby/Well-Child Visits: Our Baby Well-Visit program is available to babies between zero (0) and eighteen (18) months of age who have been an enrollee of our Plan since birth. We educate parents or guardians about the importance of well visits at one (1), two (2), four (4), six (6), nine (9), twelve (12), fifteen (15), and eighteen (18) months of age, and provide a ten dollar ($10) gift card for each visit completed, up to three (3) visits.

- MomsFirst Prenatal Program: To encourage participation within the program, Humana offers an incentive card to encourage enrollees to receive appropriate prenatal and postpartum care. Enrollees who engage in the MomsFirst program and complete all of their prenatal and postpartum visits are eligible for a thirty dollar ($30) Babies“R”Us gift card.

- Humana Family Fit Program: Enrollees eighteen (18) years or older may join the Humana Family Fit program, which includes:

-- A personal health coach
-- Information on healthy eating
-- A weight scale
-- A walking kit: includes a steps counter, drawstring backpack, water bottle, and towel.

Once an enrollee joins the Health Family Fit Program, and then receives a check-up from their PCP, they receive a twenty-five dollar ($25) gift card.

Once the enrollee completes the Humana Family Fit program, and visits their primary care doctor, Humana rewards the enrollee with another twenty-five dollar ($25) gift card. (Maximum of two (2) gift cards per year, per enrollee).

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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A description of evidence-based interventions and strategies that will be used to target super-utilizers, particularly related to pain management and behavioral health conditions.

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STRATEGIES TARGETING BEHAVIORAL HEALTH CONDITIONS AND PAIN MANAGEMENT

Given that one of the leading causes of readmissions in Region 1 is bipolar disorders, there is an opportunity to bring innovative strategies around behavioral health management to the region. Humana, in conjunction with our BH subcontractor, Access Behavioral Health (ABH), prioritizes enrollees in need of care coordination and targeted interventions by risk and enrollees' healthcare needs. ABH currently operates as our BH subcontractor in Region 1, and is well-versed in the population as well as the provider landscape in the region. ABH has multiple initiatives helping enrollees identified as frequent users of high-end services to meet AHCA's goals of a) Reducing potentially preventable inpatient and outpatient hospital events and unnecessary ancillary services; and b) Rebalancing LTSS systems by increasing the percentage of enrollees receiving services in the community instead of an institution.

The ABH Diversion Projects combine intensive, unique, and specialized services designed to disrupt the cycle of high-cost utilization and divert into more traditional modalities of outpatient service provision.

A. COMMUNITY-BASED WRAP-AROUND TEAM is a multidisciplinary team designed to provide assertive mental health, substance abuse, and care coordination services to the population of enrollees that disproportionately use the most intensive and highest-cost services as their primary care. We collaborate with the local Federal Qualified Health Center (FQHC) to provide medical care, and it has agreed to embed physical healthcare providers into the team. The objectives are to:

- Increase ongoing compliance with medical and behavioral health treatment
- Reduce the number of emergency department visits, crisis stabilization, and hospital admissions
- Decrease incarcerations and law enforcement interactions
- Promote psychosocial rehabilitation skills development
- Provide crisis interventions as well as ongoing support

B. MEDICAL TEAM OF THE FQHC also provides home visit interventions to provide psychiatric intervention, medication checks, or therapeutic injections. The team provides overall care coordination to connect to outpatient medical, mental health, and substance abuse, as well as transportation to these services. It also connects these enrollees to other supports such as housing, food stamps, and other social services as needed by the individual.

C. OPIOID SERVICES EXPANSION: ABH participates in a region-wide task force that includes the BH community, law enforcement, the medical community, the faith community, and a range of BH and substance abuse providers to define collaborative ways to address the pain management and opioid concerns in Region 1.

D. WOMEN ONLY INTENSIVE OUTPATIENT PROGRAM (IOP): This program targets high-risk women in the population with moderate to severe substance use disorders by using The Matrix Model, an evidence-based intensive outpatient treatment model program. The aim of this program is to address early recovery and to develop and use relapse prevention skills. At a minimum, group enrollees attend nine (9) hours of group treatment per week. The IOP Therapist provides individual therapy sessions on an as-needed basis or at the client's request. The client is a parent referred through Dependency Court, FFN/WISE, Department of Children and Families. The program provides drug screens on a weekly basis.

E. WOMEN ONLY SUBSTANCE ABUSE GROUP: Designed specifically for women who are pregnant, postpartum, or involved with DCF/FFN, this group addresses the specific needs of women substance users with an emphasis on understanding the unique needs of women overcoming a substance use disorder. Emphasis includes increasing awareness and recognition of substance use patterns; exploring life patterns and relationships and how substance use has impacted relationships; understanding co-occurring disorders; and using effective coping strategies for pain management. This group meets once per week for three (3) hours for sixteen (16) weeks. It provides individual sessions on an as-needed basis or at the request of the client, and provides urinary analysis testing on a monthly basis.

F. ALTERNATIVE-TO-HOSPITALIZATION TREATMENT OPTIONS include assessment and observation areas within a centralized secure area, residential respite beds, short-term residential treatment, day programs, and intensive outpatient services.

G. STRENGTH-BASED DIVERSION NEEDS ASSESSMENT conducted collaboratively with the enrollee to determine which supports and services would benefit the enrollee.

H. ENROLLEE-CENTERED TREATMENT PLANNING and treatment planning review as a means of using the enrollee's strengths to divert from higher-end services.

I. INDIVIDUAL, FAMILY, AND GROUP THERAPY USING EVIDENCE-BASED MODALITIES in the home, school, or other community settings depending on enrollee need.

J. DIVERSION CASE MANAGEMENT SERVICE PROVISION to include referrals, linking and coordinating services, ongoing monitoring of the enrollee and services provided, follow-up with the enrollee to determine effectiveness of services and service plan, teaching the enrollee to advocate for needed services, and transition and discharge planning.

K. CHILD AND FAMILY TEAM STAFFING: When we consider a child or adolescent enrollee for residential treatment, a Child/Family Team meeting with the parents, the treatment team, and in some cases enrollees of the Department of Children and Families occurs to ensure that we have exhausted all outpatient services before placing them in a higher level of care.

L. CAFÉ PERC- ABH launched Café PERC (Peer Education Resource Community) at Lakeview Center in 2012 as a clubhouse-model, peer-support service organization (PSSO) where consumers of behavioral health services share information, socialization, and recreational activities with their peers. The café serves as a safe place where guests interact with one another in a comfortable, low-stress environment without fear of stigma or judgment. Lakeview's Behavioral Health Division assumed responsibility for Café PERC the following year, and ABH

continues active involvement. ABH associates facilitated training in Region 1 for Peer Recovery Certification, which is a designation for behavioral health consumers to become trained to act as support and advocates for other behavioral health consumers. Currently, these associates work at Café PERC.

TELEHEALTH

ABH currently offers telemedicine as well as individual, group, and family therapy via telehealth. This improves doctor/patient ratios as well as access to services for those who live in rural areas in Region 1, which subsequently reduces inpatient services for those enrollees. ABH credentials BH providers and practitioners who conduct telemedicine with the proper interactive electronic systems to protect the confidentiality of client information, and audio and visual data transferred during the provision of telemedicine services. Currently the ABH network has psychiatrists in three (3) provider organizations, or sixty percent (60%) of Organizational Provider Network, who conduct telemedicine services: Lakeview Center, Inc., Chautauqua Healthcare Services, and Children's Home Society of Florida. However, one hundred percent (100%) of psychiatrists and licensed mental health clinicians are eligible to provide telemedicine services as soon as they implement the required technology. There are no limitations on telemedicine services as long as providers and practitioners who conduct telemedicine have the proper interactive electronic systems that protect the confidentiality of client information, and the enrollee consents to telemedicine services.

REPORTING CAPABILITIES
ABH uses a variety of internal reports to assist Humana and ABH's sub-capitated network providers in managing high-cost cases:

1. Daily Inpatient Census Reports – Hospital inpatient census reports go to Humana and ABH sub-capitated providers daily. Humana CMs reference these reports for cases requiring medical case management where an enrollee may be hospitalized for behavioral health needs. ABH's sub-capitated providers use these reports to identify enrollees currently hospitalized to ensure that discharge and post-hospitalization follow up planning begins at admission.

2. Weekly Inpatient Discharge Reports –Weekly hospital discharge reports provide both Humana and ABH's sub-capitated providers a list of those enrollees discharged the previous week. In addition to discharge date and diagnosis, the report includes the provider, date, and time of the scheduled follow-up appointment. ABH providers use these reports as a guide for sending appointment reminders.

3. Weekly Readmission Reports - Inpatient hospital readmission reports sent weekly to ABH's sub-capitated network providers identify those enrollees with a hospital readmission occurring within thirty (30) days of a previous inpatient discharge. ABH sub-capitated network providers use these reports to assess the outpatient services provided to these enrollees requiring repeated hospitalizations. We initiate additional wrap-around services and address the enrollee's psychosocial situation for barriers to keeping outpatient appointments or medication compliance.

4. Weekly Customer Care Center Reports – ABH sends weekly reports to Customer Care Center associates; this report summarizes the total calls received for the week, abandonment rate, and the average speed of answer for enrollee and provider calls. In addition, a historical heat map, calculated in thirty (30)-minute increments, highlights the busiest times of the day to help us identify areas for improvement.

2015-2017 YTD STATISTICS FOR RECIDIVISM PROGRAMS

The percentage of readmissions within seven (7) days and thirty (30) days of hospitalization for ABH's enrollees has trended below the benchmark and maintained the goal since 2015. The rates remained steady in 2016, but in the current year they have decreased by two (2) percentage points for both the seven (7)-day and thirty (30)-day rate. This is a marked improvement from previous years, which we attribute to ABH Gap Reports and interventions, such as ensuring the correct contact information follows the enrollee from hospital to outpatient services. Attachment MMA 1-7 contains data on ABH's reduction in mental health readmission rates from 2015-2017.

CONTINUING EFFORTS TO REDUCE MENTAL HEALTH-RELATED ADMISSIONS

Integrating behavioral health and medical care is critical to the overall health and well-being of enrollees. In continuing efforts to improve integration, Humana will:

- Create a mental health provider scorecard showing mental health-related admissions, readmissions, and length of time from discharge to follow-up care visits (PCP or mental health provider).

- Analyze which providers offer effective care and where there is an opportunity for our nurses, QINs, and BH subcontractors to educate and offer support by looking at Early Indicator Report (EIR) data for behavioral health to understand utilization by provider. Pairing these data with our medical data, including claims and encounters, to create a comprehensive report card will help us see a full picture of the enrollee's health.

- Uncover areas of opportunity based upon analysis of our encounter data by tying in mental health utilization of the enrollee included within the encounter data submitted by our BH providers with all medical utilization to create a predictive model around potential preventable admissions and emergency department visits. We will include this information in our Joint Operating Committee (JOC) meetings to discuss providers with best practices, and suggest alternative models.

- Collaborate on BH discussions by holding regional bi-annual grand round meetings hosted by Humana Inc., inviting mental health providers and top MSOs (based on PCPs with the most mental health-utilizing enrollees) to discuss best practices and current challenging issues.

Footnotes

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[1] Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees, Quarterly Statewide Medicaid Managed Care Report, Business Intelligence Unit Medicaid Data Analytics, Spring 2017

[2] Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees, Quarterly Statewide Medicaid Managed Care Report, Business Intelligence Unit Medicaid Data Analytics, Spring 2017

[3] Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees, Quarterly Statewide Medicaid Managed Care Report, Business Intelligence Unit Medicaid Data Analytics, Spring 2017.

[4] "The Productivity of Physician Specialization; Evidence from the Medicare Program," Baicker & Chandra Brent James, MD, Intermountain Healthcare "Medicare Payments to Providers in 2012," Center for Medicare & Medicaid Services Humana Proprietary Internal Analysis, 2014

Evaluation Criteria:

1. The extent to which the respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health).

2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers.

3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples.

4. The extent to which the respondent plans to include the use of the Agency's Event Notification System as a means to extract relevant data from hospitals.

5. The adequacy of the respondent's description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.

6. The extent to which the respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid patients).

7. The extent to which the respondent proposed local performance benchmarks for:

- **(a)** Reducing potentially preventable hospital admissions and readmissions;
- **(b)** Reducing use of the emergency department for non-emergent/urgent visits; and
- **(c)** Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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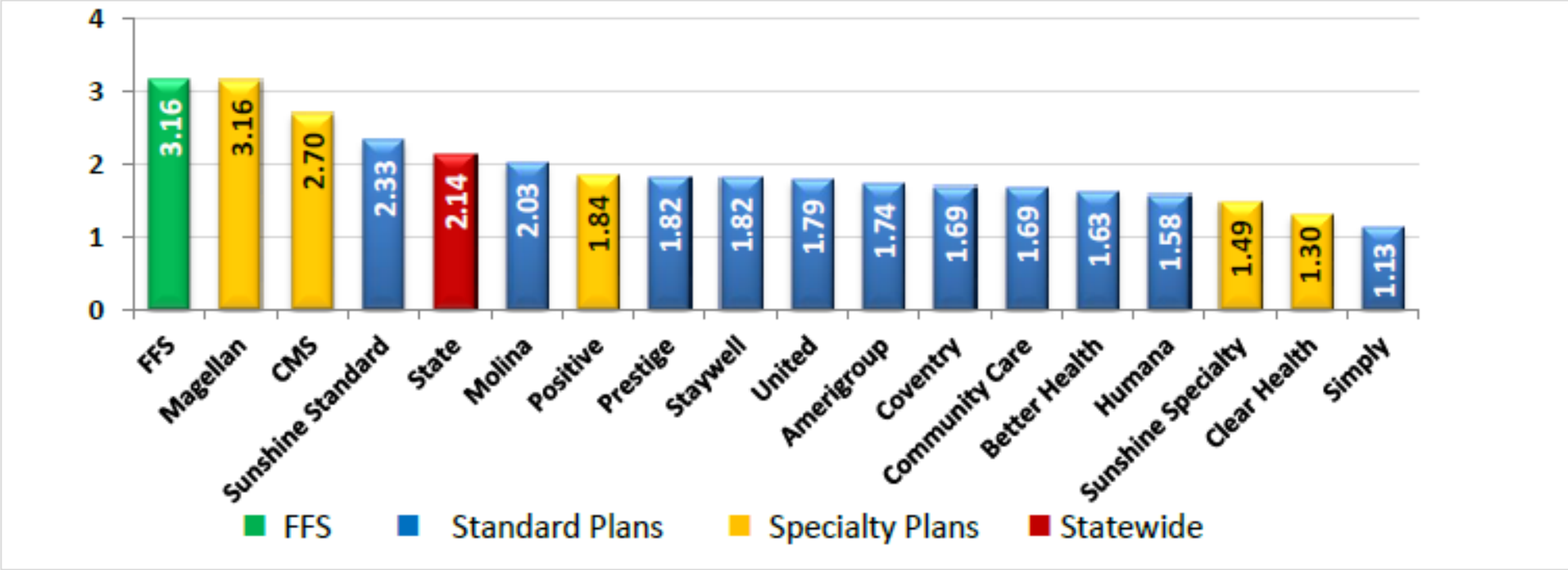
Attachment MMA 1-1: Risk Adjusted PPA Rates per 1,000 Enrollees Month by Plan, August 2014-July 2015

Humana has the second lowest potentially preventable admission rate (PPA) among SMMC standard plans in admissions per one thousand (1,000) enrollees.



Humana

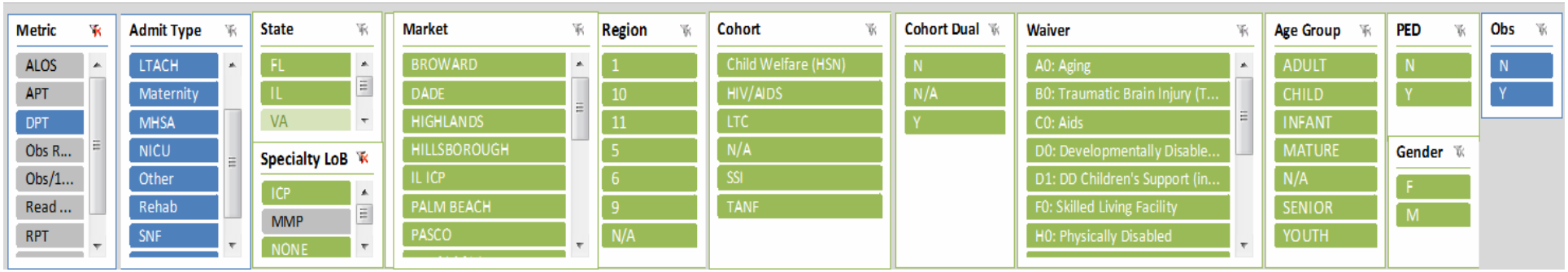
Attachment MMA 1-2: Humana Case Management Protocols based on Acuity Level

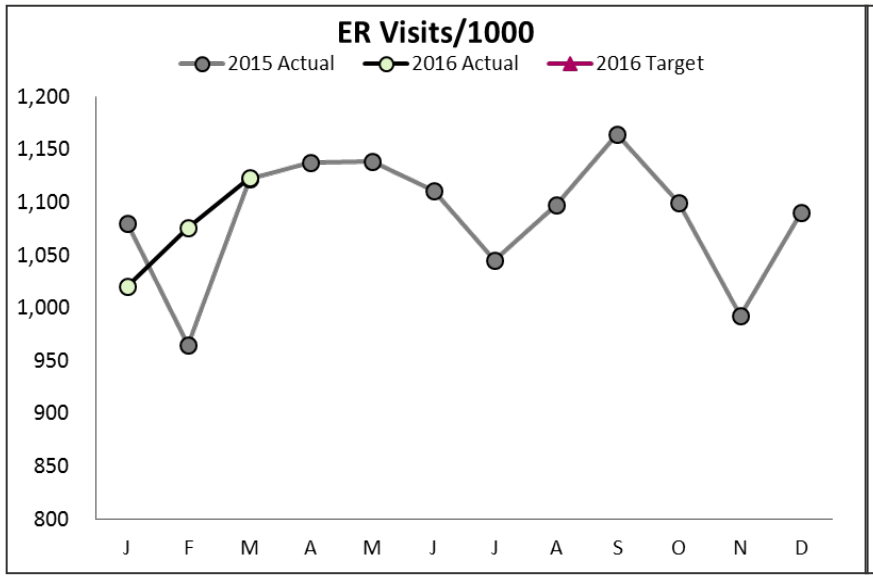
We stratify severity scores into complex, high, moderate, and low categories, which allows CMs to identify the enrollees at greatest risk for an admission. Prioritizing case management interventions ensures that enrollees identified as complex or high-risk receive interventions to avoid preventable events.

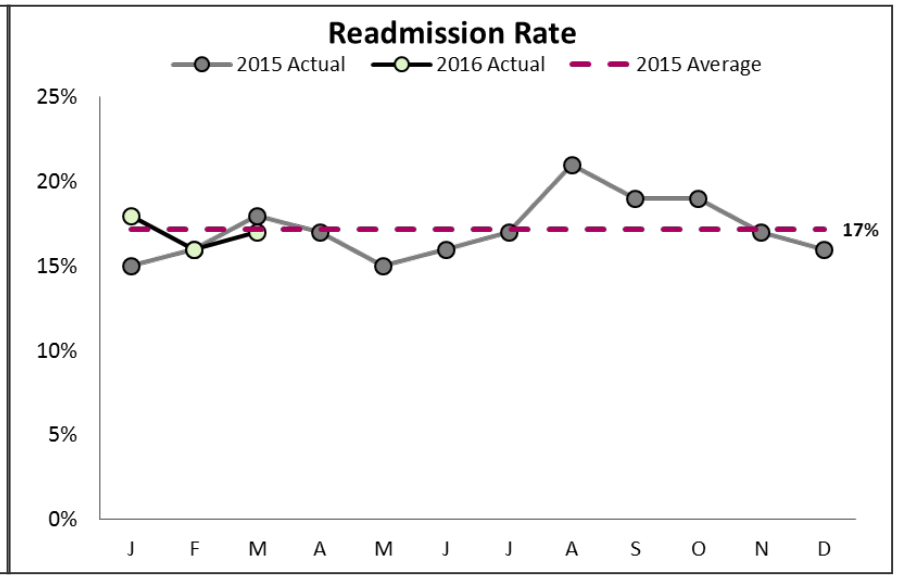
Risk Level	Definition	Outreach Frequency
Complex	• At least 2 hospitalizations w/in 30 days • Medical, educational and psychosocial barriers that lead to emergency department visits /readmissions • Collaboration w/interdisciplinary teams and Associate Medical Directors • Present during monthly MDT call • Complex needs for care coordination	Weekly
High	• At least 2 hospitalizations within the last 3 months • Medical, educational and psychosocial barriers that lead to emergency department visits /readmissions • Ongoing needs for care coordination	Monthly
Medium	• At least 2 previous hospitalizations within the last 6 months • Provide reinforcement about plan of care • Barriers to educational and self-healthcare management	Every other month
Low (short-term, episodic clinical management, and participation)	• No hospital admissions, but has emergency department utilization greater than 2 per 30 days • Knowledge deficit of the use of emergency department vs. urgent care and PCP visits for follow up care and sick visits	Every three months
Low (nonclinical monitored and pending High Utilizer Report monitoring status) Case Management Assistant	• No hospital admission within last 6 months • Stable with mild or no symptoms • Understands their disease and plan of care, but desires a case manager for follow up. Follow up every 6 months • Comply with their plan of care and do not require assistance with care coordination	Every six months

Attachment MMA 1-3: Example of Early Indicator Report (EIR)

Humana's sophisticated Early Indicator Report (EIR) incorporates claims data as well as data from the authorization system to enable early recognition of key clinical trends and schedule early interventions that reduce preventable events. With the EIR, users can 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 trends as well as year-over-year.





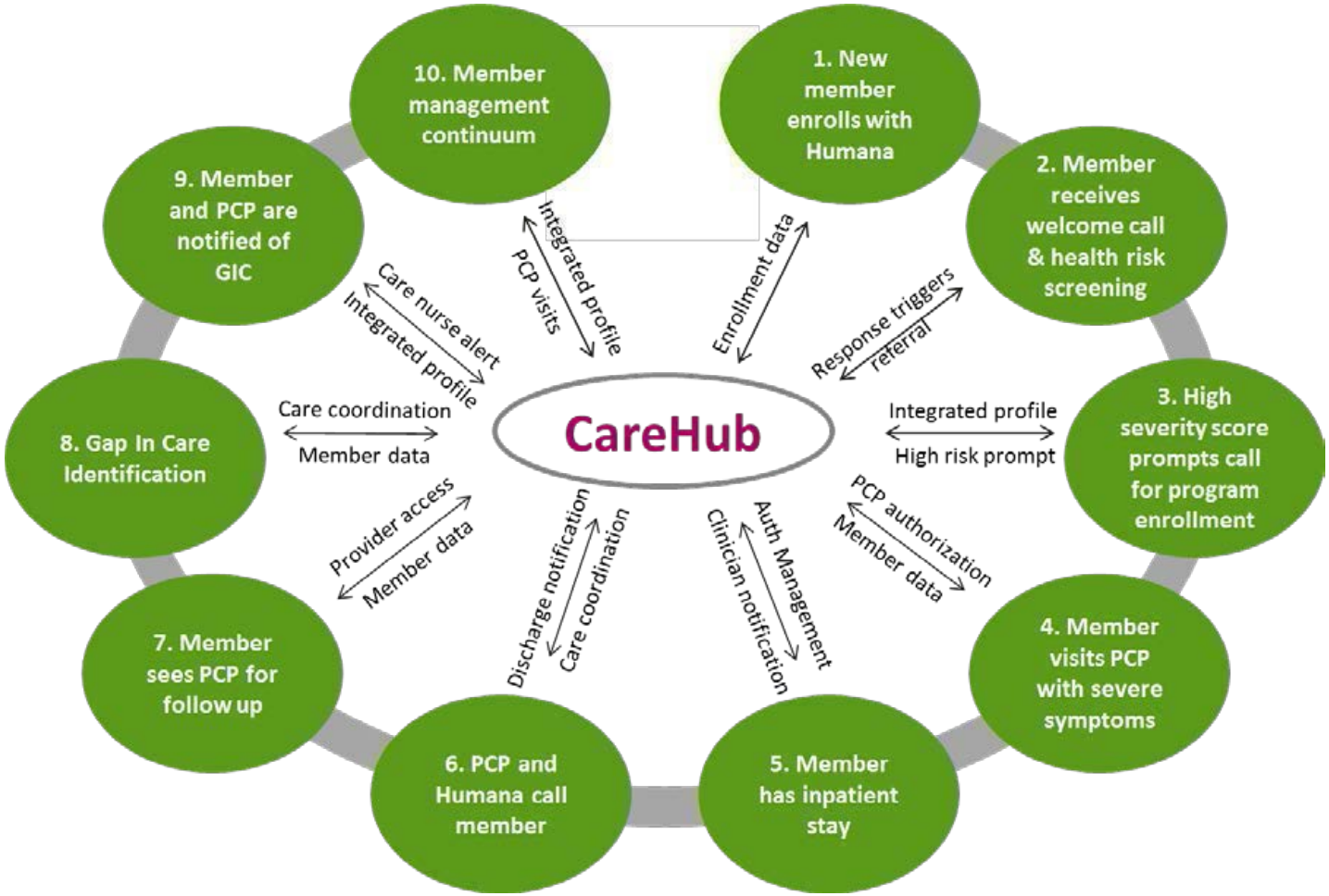


Humana

Attachment MMA 1-4: Humana's CareHub Platform

CareHub is Humana's enterprise solution for complete program integration for our provider community and enrollees. The CareHub Clinical Guidance eXchange (CGX) workflow system supports an integrated approach to utilization and care management. All of the various sources of identification and referral – from Predictive Modeling to claims data and lab results – are integrated into our powerful CareHub platform, as seen below.

Humana CareHub is the heart of our clinical analytics and engagement model



Humana

Attachment MMA 1-5: Discharge-to-Encounter Report

We have developed a specific discharge-to-encounter report as part of our strategy to reduce readmissions and promote continuity of care. We use this reporting internally and deliver it to providers to monitor metrics by provider.

MSO Sample
Discharge to Encounter

Column Labels	2015					2014				
Values	Inpatient	OBS	Skilled Nursing	IP_Rehab	2015 Total	Inpatient	OBS	Skilled Nursing	IP_Rehab	2014 Total
Total Admits	2,731	514	598	11	3,854	2,439	337	607	8	3,391
Readmit Within 30 Days	20.8%	0.0%	17.1%	27.3%	17.5%	20.8%	0.0%	17.5%	0.0%	18.1%
Readmit Within 30 Days Same DX	2.7%	0.0%	5.5%	27.3%	2.9%	2.6%	0.0%	5.1%	0.0%	2.8%
Readmit Within 30 Days Same DX Group	6.3%	0.0%	6.4%	27.3%	5.6%	6.0%	0.0%	6.3%	0.0%	5.4%
Average of Days_Between_Discharge_Office	91	89	89	40	90	209	226	174	190	203
Office Visit Within 7 Days	8.3%	11.5%	8.5%	18.2%	8.8%	5.6%	4.7%	8.2%	0.0%	6.0%
OBS Rate	0.0%	100.0%	0.0%	0.0%	15.8%	0.0%	100.0%	0.0%	0.0%	12.1%

HS_Patient_Type	ER
Values	
OP_Visits	2597
Average of Days_Between_Discharge_Office	94
Office Visit Within 7 Days	9.6%

Humana

Attachment MMA 1-6: Example CDI Reports Generated for Primary Care Physicians

We provide information to our physicians to help identify the top opportunities to improve their patients' care by utilizing specialists that demonstrate high efficiencies and effectiveness. Through our innovative CDI platform, we give PCPs information about the most efficient and effective specialists in Humana's network.

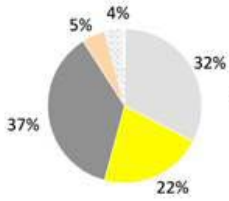
PCP Insights report

Care Decision Insights

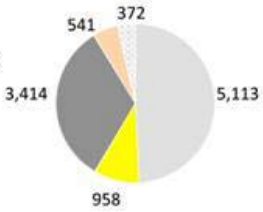
Below are your group's referrals by specialty. Consult the key to identify physician levels within the pie charts.

Efficiency baseline report

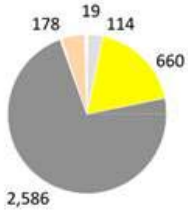
All (Weighted)



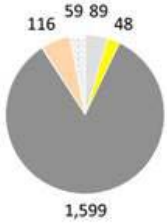
Cardiology



Orthopedic Surgery



Gastroenterology



Key:

Tier	Description
Platinum	Top quartile & statistically significantly efficient
Gold	Top half excluding Platinum
Silver	Bottom half excluding Bronze
Bronze	Bottom quartile & statistically significantly inefficient

For PCPs

Purpose:

Shows PCP referral patterns by specialty

Opportunities may include:

Assessment of current referral patterns and potential changes

Data time frame:

Most recent 16 months, updated monthly (only Medicare Advantage)

Cardiology – Market Insights report

Sample

Group	Efficiency	Effectiveness*
Specialist Group A		
Specialist Group B		
Specialist Group C		
Specialist Group D		
Specialist Group E		
Specialist Group F		
Specialist Group G		
Specialist Group H		
Specialist Group I		
Specialist Group J		
Specialist Group K		
Specialist Group L		
Specialist Group M		
Specialist Group N		
Specialist Group O		
Specialist Group P		
Specialist Group Q		
Specialist Group R		
Specialist Group S		
Specialist Group T		
Specialist Group U		

Efficiency key

Tier	Description
Platinum	Top quartile & statistically significantly efficient
Gold	Top half excluding Platinum
Silver	Bottom half excluding Bronze
Bronze	Bottom quartile & statistically significantly inefficient

Effectiveness* key

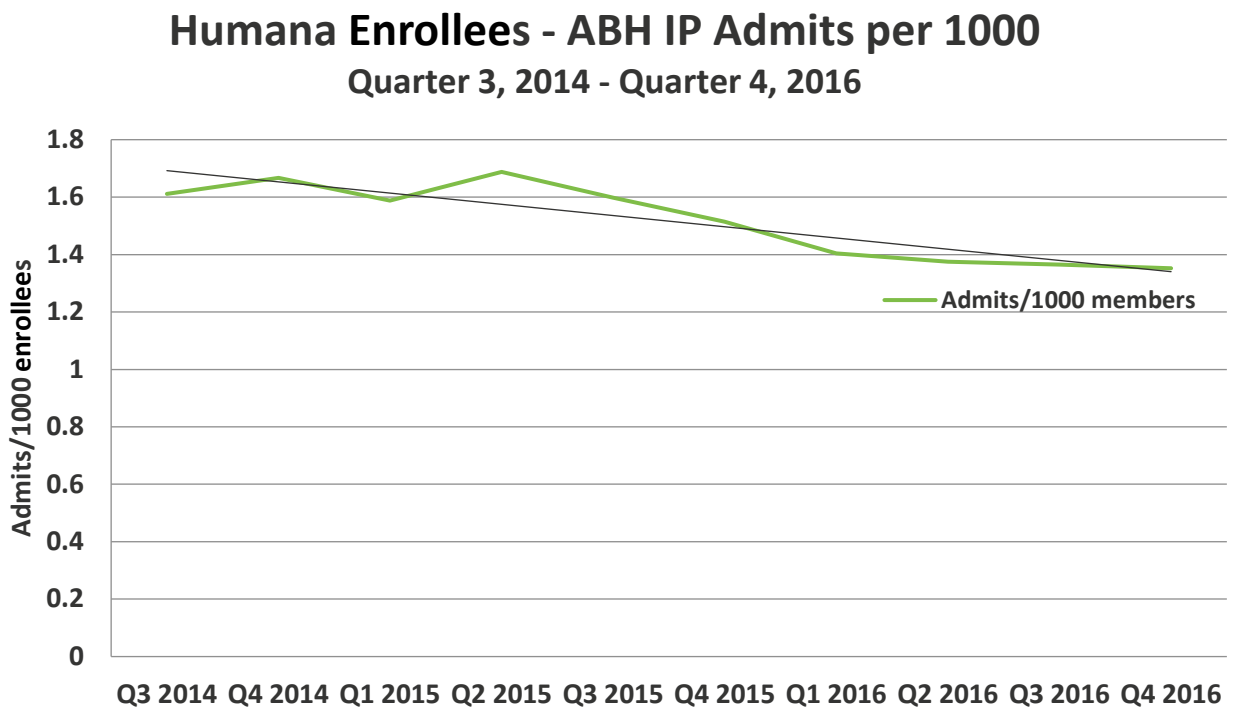
Effectiveness*	
Platinum	Top quartile & statistically significantly effective
Gold	Top half excluding Platinum
Silver	Bottom half excluding Bronze
Bronze	Bottom quartile & statistically significantly ineffective

Attachment MMA 1-7:
Access Behavioral Health's Reduction in Mental Health Readmissions 2015–2017

The percentage of readmissions has trended below the benchmark and maintained the goal since 2015. This is a marked improvement from previous years, which we attribute to ABH Gap Reports and interventions, such as ensuring the correct contact information follows the enrollee from hospital to outpatient services.

Agency Defined Hospital Readmission Rates:

Measure	Goal	2015	2016	2017 YTD
7-day Mental health readmission rate	Below 9%	6%	7%	4%
30-day Mental health readmission rate	Below 22%	18%	18%	16%



MMA SRC# 2 – Birth Outcomes (Statewide):

The respondent shall describe its organizational commitment to quality improvement as it relates to pregnancy and birth outcomes. More specifically, the respondent shall describe its overall approach, and specific strategies, that will be used to address prematurity prevention, improve perinatal outcomes, and reduce unintended pregnancies, including:

- A description of performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries;
- A description of incentives that will be implemented for providers and enrollees aimed at improving birth outcomes; and
- A description of strategies to decrease unintended pregnancies (e.g., increase in the use of long acting reversible contraceptives).

Response:

Quality improvement related to pregnancy and birth outcomes is among Humana's principal goals, due in large part to the significance of the proportion of Medicaid recipients it impacts. According to the Agency for Health Care Administration (AHCA) 2017 Comprehensive Quality Strategy, Florida Medicaid covered sixty-three percent (63%) of births in the State in calendar year 2015. In 2016, we identified nineteen thousand one hundred twenty-three (19,123) pregnancies among our enrollees and had twelve thousand eight hundred twenty-three (12,823) deliveries within our plan. The clear impact of birth outcomes on infants' health long after delivery and often well beyond their first year of life means that quality improvement in these areas will greatly benefit enrollees over their lifetime.

Because of the significant potential for quality improvement from current baselines, this issue is particularly important to Humana. Poor birth outcomes, unintended pregnancies, and non-medically indicated cesarean sections (C-sections) are prevalent throughout the State:

- The Florida Medicaid program covered fourteen thousand eight hundred thirty-seven (14,837) babies who started out in Neonatal Intensive Care Units (NICUs), many because they were born pre-term and/or with low birthweight.

- According to the Guttmacher Institute, in 2010, fifty-nine percent (59%) of all pregnancies in Florida, or two hundred seven thousand (207,000), were unintended. The unintended pregnancy rate in Florida is among the highest in the country: Fifty-eight (58) per one thousand (1,000) women aged fifteen to forty-four (15-44), versus a low of thirty-two (32) per one thousand (1,000) in New Hampshire and a high of sixty-two (62) per one thousand (1,000) in Delaware.

- Florida has some of the highest cesarean section (C-section) rates in the country, according to Consumer Reports rankings. Florida hospitals performed C-sections on thirty-two percent (32%) of low-risk pregnancies in 2014, second only to Washington, D.C. The national average was twenty-six percent (26%). Non-medically-indicated C-sections contribute to both unnecessary cost and unnecessary risk.

While these statistics are concerning, we are confident this is an area with significant potential for quality improvement, and committed to continuing to take a lead role in working with AHCA and other stakeholders to achieve that potential. We will continue to take steps to improve quality and outcomes through discussions and initiatives with providers, through prenatal and birth-related services to all pregnant enrollees to address the various factors associated with poor birth outcomes, through appropriate postpartum and postnatal care for the mother and the infant, and through a broad array of strategies to decrease unintended pregnancies.

In the remainder of this response, we discuss our overall approach and those specific strategies we use in each of the following areas:

- Improving birth outcomes
- Reducing non-medically indicated C-section and early elective deliveries
- Decreasing unintended pregnancies

==========

2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify high-risk pregnancies (including enrollees with co-occurring behavioral health conditions).

==========

IMPROVING BIRTH OUTCOMES

AHCA's August 2016 Quarterly Statewide Medicaid Managed Care (SMMC) Report focused on a cohort of pregnant women to establish a baseline for assessing the adequacy of women's access to prenatal care in the Managed Medical Assistance (MMA) program. Key findings included:

- 70% of women with a delivery had their first prenatal visit later than the recommended seven (7) months prior to delivery.

- 21% of women with a delivery had only late-occurring prenatal care in the third trimester or no prenatal care.

- The majority of women with a delivery, 85%, received prenatal visits for fewer than the recommended seven (7) consecutive months prior to delivery.

While most attention to pregnancy care focuses on the nine (9) months of pregnancy, postnatal care is important as well. The postnatal period lasts six (6) to eight (8) weeks, beginning immediately after birth. During this period, the mother goes through many physical and emotional changes while learning to care for her newborn. Postnatal care involves getting proper rest, nutrition, and vaginal care. Postnatal care for the newborn is, of course, equally critical.

Clearly, perinatal services are integral to positive birth outcomes. To this end, we have developed an array of clinical programs focusing on perinatal services that are crucial to keeping mothers and children healthy. The Humana Florida plan's Healthcare Effectiveness

Data and Information Set (HEDIS) rates for prenatal care and postpartum care have shown improvement between 2015 and 2016 measurement years. These 2016 rates are more favorable than the "Calendar Year 2015 Weighted Mean for Florida Medicaid Plans," as reported in AHCA's Comprehensive Quality Strategy, 2017 (see below). We continually seek additional opportunities for improvement in achieving benchmarks.

PRENATAL AND POSTPARTUM CARE

TIMELINESS OF PRENATAL CARE (percentage of deliveries with a prenatal care visit in the first trimester or within forty-two (42) days of enrollment)
- Humana 2016 86.37%
- Humana 2015 85.82%
- Weighted Means, FL Plans CY 2015 83%
- MPIP Year 2 Benchmark 69.54%

POSTPARTUM CARE (percentage of deliveries with a postpartum visit on or between twenty-one (21) and fifty-six (56) days after deliver)
- Humana 2016 70.07%
- Humana 2015 67.53%
- Weighted Means, FL Plans CY 2015 69%
- MPIP Year 2 Benchmark 60.93%

We discuss our strategies for facilitating and coordinating adequate prenatal and postnatal care for our enrollees in the remainder of this section.

MOMSFIRST OB CASE MANAGEMENT PROGRAM
Because we recognize the importance of continuous care within the perinatal period, we make every effort to identify pregnant enrollees as early as possible and to address the challenges they may face in obtaining adequate prenatal and postpartum care. To facilitate this, we invite all identified pregnant enrollees to participate in MomsFirst, Humana's OB Case Management Program, unless they have opted to enroll in the Healthy Start case management program. We coordinate our case management efforts with the local Healthy Start care coordinator/case manager to prevent duplication of services.

We use a number of sources to identify and refer pregnant women to MomsFirst, including:

- Daily Hospital Census
- Monthly Prenatal Pharmacy report
- Medicaid Education Satisfaction Unit/Welcome Calls
- Customer Care Calls
- Health Risk Assessment (HRA)
- Utilization Management (UM) and/or Nurse Liaisons
- Case Management
- Obstetrics (OB) Provider partnerships and incentives
- Self-Referrals

Our Performance Improvement Project, "Improving Timeliness of Prenatal Care & Well-Child Visits in the First 15 Months of Life – 6 or more visits," currently ongoing, also uses the Health

Information Exchange-Event Notification System (HIE-ENS) to alert us of pregnancies and allow us to reach out to enrollees sooner. Humana has also established a file sharing relationship with Healthy Start, which assists in early identification of pregnant enrollees.

We have established a phone queue for the OB team to facilitate warm transfers from various locations. Calls into the OB Phone Queue can come from the following sources:

- Medicaid Administration Education and Satisfaction Unit (ESU) when transferring new enrollees identified as pregnant
- OB Specialists with an enrollee who has expressed interest in the program on the phone
- Providers who are referring enrollees and/or have questions for OB Case Managers
- Enrollees who are pregnant and interested in the program
- Customer Care Specialists (CCSs) who have received specific calls from enrollees regarding OB services

Upon verification of a pregnant enrollee, the MomsFirst OB case manager (CM) conducts an initial welcome call to explain the MomsFirst program, begin enrollee engagement, and obtain the enrollee's consent for enrollment in OB Case Management. We prioritize outreach using our High Risk Pregnancy Model that uses claims and pharmacy data, survey information, and other data inputs to assign an initial acuity level. The case manager makes an initial outreach attempt within ten (10) business days for enrollees at highest risk, and all enrollees receive an initial outreach attempt within thirty (30) days. If the case manager is unable to contact a pregnant enrollee in two (2) attempts, he or she refers the case to an Unable to Contact (UTC) CCS within Humana's ESU, who will begin the process of locating her in the most effective and timely manner possible. Once located, we notify the case manager and update our clinical information system to include best time to call, alternative numbers, and other pertinent information.

When we have gained the enrollee's consent to participate in MomsFirst, the OB case manager completes a comprehensive case management assessment. The additional information gathered through the assessment, which involves direct communication with the enrollee, enables the case manager to make a final determination on acuity using the MomsFirst OB Case Management Program Acuity Levels grid (please see Attachment MMA 2-1) as guidelines. With all factors in mind, including predictive model scores and information gathered prior to and during the comprehensive assessment, the case manager assigns acuity based on clinical judgment. We then manage all enrollees based on their assigned acuity level (complex, high, or low), which may change throughout the duration of their pregnancy and we reassess monthly. Using our High Risk Pregnancy Model, we also alert the case manager of potential changes in condition that require reassessment. For example, we may initially assign an enrollee low acuity and later receive a pre-eclampsia diagnosis, which would trigger a task to the OB case manager alerting that the mother's risk may have increased and to investigate further.

Our MomsFirst program provides regular contact during the enrollee's pregnancy as well as follow-up contact during the six (6)-week postpartum period. We tailor contact to the enrollee's acuity level as well as their contact preferences. At minimum we call weekly for complex acuity enrollees, monthly for high acuity enrollees, or once per trimester for low acuity enrollees, with frequency based on enrollee need. The Multidisciplinary Team (MDT) includes enrollees deemed as complex in its case management rounds on a monthly basis. Humana contracts for in-home specialized services to those enrollees whom providers have identified as having a

medical need. Some of these in-home services include home management of nausea, hydration, coagulation disorders, diabetes, and hypertension by nurse administration of subcutaneous and continuous peripherally inserted central catheter (PICC) medication, peripheral intravenous (IV) hydration, and insulin injection. The contracted nurse may also administer Makena or 17P injections to the in-home enrollee to help prevent preterm labor. The nurse completes a comprehensive assessment and contacts the OB case manager to advise of enrollee issues and progress.

Using our Physician Finder Plus tool, the MomsFirst OB case manager also assists with identifying appropriate OB providers for the enrollee. If the enrollee has any difficulties scheduling an appointment, the case manager makes the appointment and calls the enrollee with appointment time and date. The case manager also helps to reduce transportation barriers, child care barriers, and other barriers that may exist by linking the enrollee to the non-emergency transportation broker and to appropriate community resources.

MomsFirst offers a wide array of prenatal and birth-related services to all pregnant enrollees to address the various factors associated with poor birth outcomes, including nutrition, breastfeeding, parenting, childbirth, and tobacco cessation support. A key aspect of our program is to evaluate the enrollee's support system and to encourage the involvement of the enrollee's identified partner in the process. The OB case manager provides education to the enrollee and identified partner on doctor visits, good dental health during pregnancy, Women, Infants and Children (WIC) programs, nutrition, family planning, delivery, postpartum care, and infant pediatrician selection. Case managers also make efforts to ensure that our pregnant enrollees and their chosen partners have access to childbirth education and parenting classes offered at convenient times; in locations that are accessible, convenient, and comfortable; and in languages spoken by the enrollees, with on-site oral interpretation services if necessary. Local health clinics and hospitals, community centers, and OB practices often have such resources available.

To drive participation within the program, Humana offers an incentive card that encourages enrollees to receive appropriate prenatal and postpartum care. Enrollees who engage in the MomsFirst program and complete all their prenatal and postpartum visits following engagement are eligible for a thirty dollar ($30) Babies"R"Us gift card.

POSTPARTUM OUTREACH

Whether a mother enrolls in MomsFirst or not, our case managers will make postpartum outreach calls to all enrollees who have delivered to ensure they complete a postpartum visit within twenty-one (21) to fifty-six (56) days. The case managers address any barriers that enrollees identify regarding lack of motivation, lack of transportation, childcare needs, and other issues that might prevent them from attending their postpartum appointment as scheduled. We have recently embedded postpartum case managers in seven (7) hospitals throughout Broward County. Nurses see enrollees in the hospital after delivery, conduct surveys at bedside, follow up once the enrollee is home to make sure mom and baby are settling in well, and follow up again within five (5) to six (6) weeks to ensure they have scheduled a postpartum visit. We are confident this program will increase engagement and compliance with postpartum visits and will yield positive health outcomes for mothers and babies. We plan to expand this program to Dade and Palm Beach counties.

We also place strong emphasis on recognizing and addressing postpartum depression and related conditions that may interfere with attaining the best possible health outcomes for mother and baby. Our OB case managers, knowledgeable about the signs of postpartum depression, connect our enrollees with needed behavioral health support when they identify enrollees at risk. (Please see Attachment MMA 2-2 for an example of Beacon Baby Blues and Postpartum Depression materials we share with new moms.)

NEONATAL INTENSIVE CARE UNIT (NICU) CASE MANAGEMENT

The NICU CM program provides utilization review and case management for infants who are inpatient in the NICU. Nurses with extensive NICU experience follow each case throughout the NICU stay and for thirty (30) days post-discharge. The nurses provide authorizations and medical necessity approvals, discharge planning, and support and education for families of the infants. For high-risk infants, the NICU nurses transfer the case to the Medicaid pediatric team for longer-term outreach to educate and support the caregiver in an effort to improve outcomes and decrease unnecessary utilization.

TRANSITION OF CARE PROCEDURES

Humana maintains and follows a Transition of Care (TOC) Policy and Procedure to provide a process for Clinical Advisors to review ongoing services to reduce the potential for an interruption in treatment or therapy. Our policy establishes the formal process by which the transition is directed for all new enrollees. This creates a bridge for the enrollee at the time of enrollment to promptly identify health status and necessary medical services, and facilitate early entry into appropriate Clinical Intervention Programs. Humana communicates with the enrollee, primary care physician (PCP), and provider(s) of service, both verbally and in writing, regarding the details of the TOC determination. Additionally, the TOC letter informs all parties of the need for care to transition to a participating provider.

A new pregnant enrollee seeing a non-participating OB/GYN is one example of a case appropriate for TOC. Humana encourages continuous care with the same physician throughout the pregnancy, even if the physician is not contracted. Pregnant women transitioning from fee-for-service (FFS) or another health plan, will have transition needs to ensure continuity of care and promote recommended prenatal care. Those who are actively receiving prenatal or postnatal care from a non-participating provider should continue seeking care from that provider for the entirety of the perinatal period, through six (6) weeks postpartum. Our priority is to facilitate the receipt of prenatal care, not disrupt it. This process includes our contacting the OB/GYN to provide the details and process for them to bill Humana and be paid. We also seek to enroll pregnant women into MomsFirst, as described above.

While we strongly seek to preserve continuity of care, it is also important to note that situations exist where a switch of provider may be in a new enrollee's best interests. Such situations may include ensuring cultural competency, geographic proximity to facilitate appropriate prenatal care, and provision of care by an OB/GYN specialist. In these situations, we assess the enrollee's interest in continuing with her existing provider and, if she desires, helping her identify alternatives. When provider switches occur, we work to ensure a complete transition of information to the new provider. Humana shall have adequate network capacity such that any new enrollee who is pregnant is able to have an initial visit with her provider within fourteen (14) calendar days of enrollment.

ADDRESSING CULTURAL DIVERSITY

Humana has a strong commitment to addressing cultural diversity and providing cultural competency training; to building a network and providing supports such as translation services that minimize barriers to care resulting from language and cultural barriers; and to disseminating culturally and linguistically appropriate materials to our enrollees. These efforts are particularly important to maximize the appropriate utilization of prenatal and postpartum services, as cultural values and beliefs related to pregnancy and linguistic isolation, often contribute to an individual's hesitancy to access services. Our materials are culturally and linguistically appropriate, and through our OB case management program described above, we ensure that our enrollees know about and can link to the translation services and community resources they need to facilitate their care throughout pregnancy.

EDUCATION AND OUTREACH

Humana includes information regarding how to obtain prenatal and postpartum care in new enrollee materials and articles on perinatal care in our newsletters. We conduct tailored education and outreach to our pregnant enrollees via postcards, our enrollee portal, and telephonic outreach, according to the enrollee's preferences and confidentiality requirements. We also participate in and sponsor community events such as urban and rural health fairs, and March of Dimes activities such as March for Babies community walks.

Humana partners with our OB providers and delivery facilities to provide enrollee access to educational classes available, including childbirth education classes and parenting education classes. Our MomsFirst case managers guide enrollees to community resources and transportation as necessary to help them attend classes.

We also develop and implement enrollee campaigns to address and promote timely health care. We have conducted a Women's Health Campaign that included education to pregnant enrollees about the critical importance of prenatal and postnatal care, and we are currently conducting a campaign targeting well-child visits.

Finally, and as noted above, education on a range of topics is a key component of our MomsFirst OB case management program. The following are just a few examples of the subjects included in case manager discussions with pregnant and post-partum enrollees:

- Sample discussion topics for pregnant enrollees:
-- Tobacco Usage
-- Smoke Cessation Counseling
-- Nutritional Assessment and Counseling
-- Referral to Women, Infant, and Children (WIC) for Potential Enrollment
-- Breast Feeding Benefits
-- Family Planning
-- HIV Status
-- Hepatitis B Surface Antigen (HBsAG) Status
-- Behavioral Health Issues
-- Immunization Programs
-- Home Preparation
-- Pediatrician Selection
-- Preterm Labor Signs and Symptoms

- Sample discussion topics for post-partum enrollees
-- Vaginal Discharge After Delivery
-- Need to Report Any Swelling or Redness
-- Suture Care
-- Monitoring for Mood Changes
-- Behavioral Health Issues
-- Episiotomy
-- Bathing
-- Nutrition
-- Physical Activity
-- Hormones
-- Breast Care
-- Nipple Care
-- Family Planning
-- Various Birth Control Methods
-- Routine Infant and Well-Child Visits

ADDITIONAL INITIATIVES TO IMPROVE BIRTH OUTCOMES
Humana offers other benefits and resources to pregnant and postpartum enrollees, including but not limited to the following:

- Humana's nutrition counseling benefit is available to all of our enrollees, and is of particular value to pregnant enrollees and new moms. The benefit gives enrollees needed guidance and support to make sound dietary choices and positive lifestyle changes aimed at reducing symptoms of disease or condition and improving their overall health. The benefit includes a detailed telephonic nutritional assessment with five (5) one-on-one telephonic sessions with a Registered Dietitian throughout the benefit year. Follow-up sessions include goal-setting and assessment of the nutritional care plan. We email or mail educational materials to the enrollee's home.

- Humana's expanded benefits also include post-discharge meal delivery of up to ten (10) frozen, precooked meals to the enrollee's home after discharge from inpatient hospital once per year and with the case manager's approval. This is a valuable nutritional benefit to many of our postpartum enrollees, who may otherwise neglect their own nutrition during their early weeks at home with their newborn. In addition, good nutrition for the mother is important to breastfeeding.

- As another aspect of Humana's commitment to quality improvement related to birth outcomes, our Enrollee and Community Engagement team is focused on improving Healthcare Effectiveness Data and Information Set (HEDIS) compliance through the Humana Storks program, which we developed to provide quality resources and support to new mothers at network hospitals resulting in better health outcomes through medical appointment adherence. For this pilot initiative, Enrollee Advocates visit enrollees who have given birth at two (2) hospitals within the Memorial Healthcare System to educate the new mother on how to access health services that will ensure the best outcomes for herself and her newborn. They share information on the importance of scheduling timely appointments for dental and medical services, lead screenings, and vaccination. Humana Storks also provides a care delivery

package with baby supplies including diapers, baby bottles, a bib, a tee-shirt, educational materials, and a list of urgent care centers.

"I was stopped at the nurse's station and was asked to explain the program. They wanted to view what was in the bag. I let them explore what I was bringing to the new moms and they were amazed…they said all insurance companies should do that. The moms and their families all seem to be happy to see me. I mentioned to the new mom I visited today that my purpose was to make sure she followed up with her physician and case manager and she said that she would." - Maria Kesti, Enrollee Advocate, Humana Storks Program

By pairing an in-person, high-touch visit with the new mother care package, the Humana Storks program increases engagement in MomsFirst, which improves the health of new mothers and babies.

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3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for pregnant enrollees that are determined to be high-risk.

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Effective data exchange and communication among providers is essential to providing seamless, coordinated care to all our enrollees and is one of the key objectives of our care coordination programs. Humana's strategies to improve data exchanges and communications between practitioners are a mixture of "high tech" and "high touch" solutions. We have summarized key examples below.

TECHNOLOGY STRATEGIES FOR IMPROVING DATA EXCHANGE AND COMMUNICATION

CAREHUB

At the center of our case management strategy is CareHub, Humana's enterprise solution for complete program integration of our provider community and enrollees. The CareHub Clinical Guidance eXchange (CGX) workflow system supports an integrated approach to utilization and case management. As a fully-integrated approach, this enterprise solution provides enhanced capabilities to identify candidates for programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention.

Through the use of various web portals (e.g., Availity Care Profile), messaging channels (e.g., e-mail, fax, postal mail, etc.), and the CareHub CGX clinical workflow system, we generate Care Alerts to distribute to MDT members involved in the care of high-risk pregnant enrollees. The CareHub infrastructure uses technology solutions such as Atlas and Anvita clinical rules engines to enable integration, collaboration, and data sharing throughout the healthcare delivery system. These Care Alerts consist of evidence-based Gaps-in-Care, HEDIS, and drug-to-drug/disease interaction alerts.

AVAILITY

Our network providers in Florida have access to the Availity web-based platform. Availity is one of the leading health information networks in the country, optimizing information exchange

between multiple healthcare stakeholders through a single, secure network. The Availity Health Information Network encompasses business and clinical services, and supports nationwide real-time and batch electronic data interchange via the Web and through business-to-business integration.

The Availity Care Profile includes claims information associated with office visits and hospitalizations, diagnoses and associated procedures, prescription history, lab event history, radiology event history, immunization history, and clinical messaging. This information is critically important when a first-time enrollee presents, or during an emergency department visit, post hospital discharge, or natural disaster. Use of the Availity Care Profile also improves enrollee safety, can eliminate duplicate or unnecessary procedures, and improves coordination and continuity of care. This allows us to more rapidly close gaps in care for enrollees, provide greater opportunity for preventative care services, and help manage chronic conditions.

HIGH-TOUCH STRATEGIES FOR IMPROVING DATA EXCHANGE AND COMMUNICATION

MOMSFIRST CASE MANAGER
For high-risk pregnant enrollees in our MomsFirst OB Case Management program, the OB case manager serves as the single point of contact between enrollees and Humana's various providers involved in the enrollee's care. The OB case manager is responsible for helping enrollees navigate the health care system, for ensuring they meet with the necessary providers, and for facilitating information-sharing among practitioners. Case managers may schedule visits to OB providers or facilities to ensure optimal management of OB enrollees and to facilitate provider relationships and communication.

COMPLEX CASE CONFERENCES
The MDT receives complex acuity cases on a monthly or more frequent basis, as needed, so the team can develop effective plans of care and treatment goals through shared responsibility and collective decision-making. The team may also evaluate non-complex cases deemed to have medically complex needs or challenging issues.

MEDICAL/BEHAVIORAL CLINICAL COLLABORATION
For our pregnant and post-partum enrollees with co-occurring behavioral health conditions, our behavioral health (BH) subcontractor's case managers engage in ongoing collaboration with the enrollee's medical providers and OB case manager. This collaboration includes:

- Attendance at Humana Case Management meetings, as requested, to review goals and interventions, and to re-evaluate and update the enrollee's comprehensive care plan across physical and behavioral health issues.

- Updates on enrollee adherence with treatment and aftercare plans for both behavioral and medical conditions.

- Updates between BH case management staff, MomsFirst case management staff, and enrollee's health care provider(s) on a regular basis. During the initial referral process, the referring party can indicate how often they would like updates on the enrollee's case.

- Regular clinical rounds between the BH leadership teams and the Humana Case Management team occur monthly, or as needed, to discuss complex cases, which may include complex OB cases.

IN-HOME SERVICES CONTRACTOR REPORTS TO PROVIDERS
As noted earlier in this response, Humana contracts for the provision of specialized in-home services, as needed. The contracted nurse submits reports on services provided and issues noted to the enrollee's PCP and OB.

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5. The extent to which the respondent describes financial and non-financial provider and enrollee incentives for evidence-based practices that will contribute to hitting the benchmarks.

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INCENTIVES FOR ENROLLEES AIMED AT IMPROVING BIRTH OUTCOMES

Above we described key incentives for enrollees aimed at improving birth outcomes, including the Babies"R"Us gift card associated with our MomsFirst program. We offer several other Healthy Behaviors programs that are targeted more broadly, but certainly include the improvement of birth outcomes as an important goal. In particular:

- Smoking cessation is particularly important to improving birth outcomes. Completing our Smoking Cessation program entitles enrollees to a thirty-dollar ($30) gift card, or a fifty-dollar ($50) gift card for those enrollees completing the program using medicine from their doctor

- In our Substance Abuse program, we reward enrollees with a ten-dollar ($10) gift card for joining the program, a twenty-dollar ($20) gift card for staying sober for ninety (90) days in the program, and another twenty-dollar ($20) gift card for staying sober for one hundred eighty days (180) days in the program

- Our Baby Well-Visit program is available to babies between zero (0) and eighteen (18) months of age who have been enrolled in our Plan since birth. We educate parents or guardians about the importance of well visits at one (1), two (2), four (4), six (6), nine (9), twelve (12), fifteen (15), and eighteen (18) months of age. Enrollees receive a ten-dollar ($10) gift card for each visit completed, up to three (3) visits.

INCENTIVES FOR PROVIDERS AIMED AT IMPROVING BIRTH OUTCOMES

Approved by AHCA, Humana's Managed Medical Assistance (MMA) Physician Incentive Program (MPIP) targets three (3) performance measures for OB providers aimed at improving birth outcomes:

FREQUENCY OF ONGOING PRENATAL CARE
Percentage of women with Medicaid deliveries who had eighty-one percent (81%) or more of expected prenatal visits (using HEDIS 2017 specifications)
November 6, 2015 - November 5, 2016

69.54%

POSTPARTUM CARE
Percentage of women who had a postpartum visit on or between twenty-one (21) and fifty-six (56) days after delivery (using HEDIS 2017 specifications)
November 6, 2015 - November 5, 2016
60.93%

FLORIDA MEDICAID CESAREAN SECTION RATE
Percentage of single live born Medicaid births in a practice that were delivered via cesarean section (using 2017 Agency Specifications)
January 1, 2016 - December 31, 2016
<35%

Physicians who are board-certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology (board-certified OB/GYNs), who are practicing within a group within the specified region and have had at least ten (10) Medicaid deliveries for the measurement period, and whose group has achieved all of the above standards for the Plan's Medicaid enrollees will be paid an equivalent to the appropriate Medicare Rate, as established by the Agency. For the first year of our OB MPIP, ninety-eight (98) of our OBs met all three (3) criteria. As of July 2017, we have one hundred fifteen (115) OBs qualified for and receiving the enhanced payment.

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1. The extent to which the respondent identified opportunities for improvement in achieving the benchmarks and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care.

6. The adequacy of the respondent's proposed performance benchmarks for reducing nonmedically indicated cesarean sections and early elective deliveries.

7. The extent to which the respondent describes its experience implementing successful strategies that resulted in a reduction in non-medically indicated cesarean sections and early elective deliveries. In order to receive all points for this component, the respondent must include outcome data on specific performance metrics.
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REDUCING NON-MEDICALLY INDICATED CESAREAN SECTIONS AND EARLY ELECTIVE DELIVERIES

As noted in the introduction, Florida has among the highest C-section rates in the country. While some C-sections are medically necessary, non-medically indicated C-sections carry risks and downsides, including the following [1]:

- Women with low-risk pregnancies undergoing their first C-section were three (3) times more likely to die or suffer serious complications compared with women delivering vaginally, according to a fourteen (14)-year analysis of more than two (2) million women in Canada

published in 2007 and cited by the American College of Obstetricians and Gynecologists (ACOG) guidelines.

- Having a C-section increases the likelihood that a woman will deliver via C-section for future births. Currently in the United States, the chance of having another C-section after the first is ninety percent (90%).

- With every additional C-section, the risk of a difficult delivery increases. Studies have found that the rate of difficult delivery can rise as much as five point one percent (5.1%), and that the risks increase most dramatically after a third C-section.

- The mother's recovery after a C-section is usually longer than recovery after a vaginal birth.

- Vaginal delivery for low-risk pregnancies may also be better for babies. Babies are less likely to suffer breathing problems such as transient tachypnea, and more likely to breastfeed, as it is easier to start breastfeeding when mothers are not recovering from major surgery.

- C-sections cost almost thirty percent (30%) more than vaginal births.

Obstetricians, health economists, and other experts cite many reasons for the high rate of C-sections in Florida and the nation, including unrealistic expectations that every birth should take place without complications, doctors practicing defensive medicine or chasing higher payment rates, and patient preference.

Early elective deliveries (EEDs) also compromise quality and positive birth outcomes. Tampa OB-GYN Robert Yelverton, state chair for the American Congress of Obstetricians and Gynecologists (ACOG), stated in a news release that "studies have shown that deliveries that are scheduled for non-medical reasons may increase harm to infants, increase health care costs, and worsen medical outcomes." Fortunately, this is an area where Florida has made much progress. A 2014 March of Dimes multi-state, hospital-based quality improvement program pilot was remarkably effective at reducing early elective deliveries of babies. The program, which included six (6) Florida hospitals, reduced the rate of early delivery from twenty-seven point eight percent (27.8%) to four point eight percent (4.8%).

Below we present our performance benchmarks for reducing nonmedically indicated C-sections and EEDs, and our strategies to achieve these benchmarks.

HUMANA'S BENCHMARKS

Humana's benchmark for EEDs is no early elective deliveries before thirty-nine (39) weeks. As noted above, strategies throughout the state to reduce the rate of EEDs have been quite successful. We include our C-section rate benchmark of thirty-five percent (35%) or less in our MMA Physician Incentive Program (MPIP). Qualified providers with at least ten (10) deliveries of single live born Medicaid births during the measurement period must meet the benchmark, as well as other birth outcomes measures discussed earlier in this response, in order to receive the quality incentive payment. For the first year of the MPIP, one hundred seventeen (117) OBs out of two hundred forty-two (242) qualified OBs achieved the C-section benchmark.

HUMANA'S STRATEGIES FOR REDUCING NON-MEDICALLY INDICATED C-SECTION RATES AND EARLY ELECTIVE DELIVERIES

Humana engages in a wide array of strategies to improve C-section and EED rates, which we summarize below. However, we recognize that this is a broad and difficult issue that requires the active involvement of all stakeholders if we are to truly move the needle in the State of Florida.

Humana is not only committed to being an active participant in tackling this issue, but we would also like to take the lead in partnering with AHCA and the Florida Association of Health Plans to reduce the rate of medically unnecessary C-sections throughout the State. A symposium involving multiple health plans, ACOG, hospitals, Federally Qualified Health Centers (FQHCs), and the news media is a potential first step to consider to embark on the necessary steps to change ingrained practice patterns and care-seeking behaviors that contribute to the problem we face in the State. Such joint efforts have proven effective elsewhere, including in South Carolina. They have also proven effective in reducing EEDs; health plan and hospital partnerships with the March of Dimes "It's Worth the Wait" program have had outstanding results. The broad partnership around C-sections we envision would focus both on educating enrollees on the risks presented by unnecessary C-sections, and on developing strategies directed toward hospitals. Such strategies might include creating hospital benchmarks and incentives, a single hospital payment rate regardless of type of delivery, and requiring authorizations for scheduling of operating rooms (ORs) for deliveries. We look forward to working with AHCA to put this idea in motion.

Below we summarize our current efforts related to C-section rates.

- IMPROVING EFFECTIVENESS OF BENCHMARKS. We are currently exploring mechanisms for enhancing the effectiveness of our C-section rate benchmarks. Given the wide variability of C-section rates across the State, using one (1) single benchmark (C-section rate of thirty-five percent (35%) or less) is less than optimal. For instance, in Regions 1, 6, and 9, our average rates are below the benchmark (thirty-one percent (31%), thirty-four percent (34%), and thirty-four percent (34%), respectively), while in Regions 10 and 11, average rates exceed the benchmark (forty-two percent (42%) and forty-three percent (43%), respectively). In areas where the rate is below the benchmark, we continue to engage and promote our provider network and work toward the national average of twenty-eight percent (28%). In areas where the rate exceeds the benchmark – and especially in areas where it far exceeds the benchmark – we do not rely solely on the incentive payment to achieve reduction. Rather, we understand that achieving the benchmark will happen only in a gradual approach. As described below, we engage in meetings and peer-to-peer counseling with provider groups whose rates exceed the benchmark, and we continually review their progress toward meeting the benchmark. We are also exploring the possibility of isolating and targeting the primary C-section rate, as reducing that rate is essential to reducing the overall rate. A recent analysis showed that of the C-sections performed in the first half of 2017, fifty-five point eight percent (55.8%) were primary C-sections, and forty-four point two percent (44.2%) were secondary.

- PARTNERING WITH QUALITY PROVIDERS. Related to the C-section benchmark, last year our Clinical Department team prepared performance report cards for our contracting OB/GYNs based on C-section rates. Based on the results, we terminated eighteen (18) providers in Region 11 who were not aligned with our quality strategy. Those terminations became effective

in February and March 2017. We also held meetings with twelve (12) additional groups of providers whose C-section rates and/or EEDs were of concern. Participants at these meetings included staff from our MomsFirst program, our Quality Department, and our Medical Director, who engaged in peer-to-peer counseling. We shared data with the groups on their C-section rates, as well as educational articles from ACOG. We have just embarked on an additional set of meetings with different groups of providers.

- MOMSFIRST OB CASE MANAGEMENT PROGRAM. A key component of our MomsFirst program, as described in detail under "Improving Birth Outcomes," is enrollee education on a range of topics, including the importance of bringing the pregnancy to term and the risks that may be associated with non-medically indicated C-sections and EEDs.

- PRIOR AUTHORIZATION FOR ELECTIVE C-SECTIONS. Elective C-sections require preauthorization for approval, allowing medical necessity review, which includes review of gestational age.

- PREGNANCY NOTIFICATION/C-SECTION WEBINAR. We sent letters to our participating OB/GYNs inviting them to participate in this webinar, hosted by the Manager of our MomsFirst program and other clinical team members. The webinar included education on C-section management, including use of the new Medicaid Prior Authorization for Elective C-section form, the need to make a clear case for surgery in "Clinical Findings," and avoiding basing requests for elective C-sections on convenience or relief of symptoms in the final stages of pregnancy. Since implementation of this required authorization, we have identified providers who require additional and ongoing education on the importance of medical necessity.

- PARTNERING WITH THE FLORIDA PERINATAL QUALITY COLLABORATIVE (FPQC). Humana is excited to help promote FPQC's initiative "Promoting Primary Vaginal Deliveries" (PROVIDE). We are emailing the FPQC alerts to the managed care departments of our participating hospitals and are promoting the initiative through our other communications with the hospitals. (Please see Attachment MMA 2-3 for FPQC Promotion.)

- PARTNERING WITH MARCH OF DIMES. Humana works with and supports the March of Dimes in tackling the C-section rate in Florida, with the aim of achieving the same success that March of Dimes has achieved with EEDs in Florida. Our Florida Medicare/Medicaid Chief Medical Officer serves on the South Florida March of Dimes Board of Directors, and Humana has held multiple meetings with March of Dimes leadership recently to discuss and work toward our shared objectives. In addition, Humana participates in March of Dimes activities, such as the March for Babies community walks, and March of Dimes is a selected Humana charity.

As a result of our strategies, we are seeing a decline in our C-section rate in each region in which we currently operate our MMA program, as shown below in the Florida MMA C-Section Rate by Region (2015- May 2017):

Region 1
2015 35.5%
2016 32.3%
May year-to-date (YTD) 2017 31.1%

Region 6
2015 35.9%
2016 33.8%
May YTD 2017 33.7%

Region 9
2015 36.4%
2016 35.4%
May YTD 2017 34.0%

Region 10
2015 43.0%
2016 43.4%
May YTD 2017 41.7%

Region 11
2015 48.0%
2016 46.2%
May YTD 2017 42.8%

Totals
2015 40.5%
2016 39.1%
May YTD 2017 37.0%

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4. The adequacy of the respondent's description of specific evidence-based programs and interventions that will be used to decrease the number of unintended pregnancies and the associated indicators or measures that will be used to determine their effectiveness.

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DECREASING UNINTENDED PREGNANCIES

Throughout Florida, unintended pregnancies comprise almost sixty percent (60%) of all pregnancies. An article recently published by the Guttmacher Institute described the very significant role Medicaid plays in funding family planning, outlined the strong protections the program has historically included for the coverage of family planning services, and specified some of the barriers that continue to exist – notwithstanding these protections – to obtaining these services, particularly within a managed care delivery system [2]. These barriers include, for example, inappropriate coverage limits, inadequate networks, and patient concerns about confidentiality. Humana is committed to reducing barriers to access, and engages in innovative solutions in a number of areas to do so, as described in this response.

ENROLLEE-FOCUSED INITIATIVES

OUTREACH TO WOMEN WHO HAVE RECENTLY GIVEN BIRTH

Nationally, the proportion of pregnancies that are unwanted increases with each subsequent child: sixteen percent (16%) for the first child, twenty-five percent (25%) for the second child, and thirty-five percent (35%) for the third child in the overall population, with these figures likely far higher within the poverty population [3]. Humana proactively seeks to educate and support women who have recently given birth in achieving their desired spacing between their recent birth and any subsequent desired pregnancy, and in avoiding a future unwanted pregnancy. Mothers addressing the challenges of taking care of a new infant can be particularly receptive to accessing family planning support. For enrollees participating in MomsFirst, the OB case manager discusses family planning with the pregnant enrollee, pre-and postpartum, and develops an enrollee-specific care plan approach to support the mother's family planning objectives. Areas of focus include appropriate methods of contraception including long-acting reversible contraceptives (LARC), counseling, and services available for family planning to all women and their partners, as well as resources for pregnancy prevention programs. The case manager encourages additional family planning and counseling for the enrollee and partner, and ensures that they both understand the behavioral and clinical drivers essential to their family planning objectives.

We also seek to engage all of our enrollees who have given birth as quickly as possible after delivery. This includes notifications directly to the mother via phone and email and, in those facilities where we have embedded postpartum case managers, a face-to-face visit prior to discharge from the hospital. We also send a congratulatory postcard and attempt to call all of our enrollees who have recently given birth, including those who have opted out of MomsFirst. This type of outreach includes information on family planning services and counseling at the most critical time: directly after delivery.

Because immediate postpartum LARC offers several benefits, including effective protection from unintended pregnancy immediately after birth and added convenience for patients, we are exploring developing a process for informed consent for postpartum LARC, which will address the timing, content, and ethical considerations associated with obtaining informed consent. We plan to implement a postpartum LARC informed consent process in the near future.

EDUCATING ENROLLEES ABOUT THE BENEFIT OF SEEKING FAMILY PLANNING SERVICES

Educating enrollees about the benefit of seeking family planning services is a core responsibility of the enrollee's PCP and OB/GYN. The Humana Provider Manual, which is an extension to the provider contract, instructs providers as follows:

- Any Medicaid provider can provide family planning services to a Medicaid enrollee without receiving preauthorization for such services.

- Medicaid providers should make available and encourage all pregnant women and mothers with infants to receive postpartum visits for the purpose of voluntary family planning, which may include a discussion of all appropriate methods of contraception, counseling, and services for family planning.

- Providers furnishing such family planning services to enrollees must document the offering and provision of family planning services in the enrollee's medical records.

We check for documentation of family planning counseling in our PCP chart audits.

Humana's enrollee education and outreach activities, including enrollee education materials, education provided as part of the MomsFirst program, health fairs, community events and campaigns, also include specific education on the importance of family planning and on birth spacing. We work with local and community resources, aligning initiatives to prevent duplication of services and to maximize educational opportunities. We collaborate with community agencies and our OB/GYN providers to develop positive family-planning education, practices among our enrollees. We meet with our contracted OB/GYN partners at a minimum quarterly to discuss the potential benefits of LARC, and working with the groups to alleviate any barriers.

INFORMING ENROLLEES OF THEIR RIGHT TO OBTAIN FAMILY PLANNING SERVICES FROM OUT-OF-NETWORK PROVIDERS
Irrespective of our provider network's depth regarding family planning services, our enrollees may obtain care from any Florida family planning provider, including out-of-network providers. Humana informs our enrollees of this right, both through the new enrollee materials and via recurring enrollee communications, emphasizing that they may self-refer to a qualified family planning provider not in our network. Our communications clearly inform enrollees that we cover the full scope of family planning methods, services, counseling, and follow-up care, when needed, whether delivered by in-network or out-of-network providers. We will also consider publishing in our provider directory a listing of qualified family planning service providers not in our network, as well as those in our network, to help enrollees select their preferred provider and as another means of reinforcing the enrollee's understanding of their right to obtain family planning services from out-of-network providers.

As we do in all markets, we also collaborate with associations such as ACOG and the American Academy of Family Physicians (AAFP). These relationships will help ensure that family planning service providers are aware of our payment policies and practices.

PROVIDER-FOCUSED INITIATIVES
Humana's provider initiatives aimed at decreasing unintended pregnancies focus on general education, revising and educating providers on relevant reimbursement policies and procedures, simplifying processes for providers to obtain contraceptive devices, and collaborating with statewide initiatives. Examples of our activities in each of these areas include:

- General Education. Our Lead Medical Director, MomsFirst case managers, Quality Improvement Nurses (QINs), and Provider Relations representatives all play an important role in keeping our providers abreast of AHCA and Humana initiatives to reduce the number of unintended pregnancies. (Please see Attachment MMA 2-4, a LARC Letter to our OB/GYNs.)

- Education on Relevant Reimbursement Policies and Procedures. Historically, there have been a number of barriers that have hindered the goal of increasing the use of LARC. First, LARC insertion was bundled into the global delivery payment, so there was little incentive for immediate postpartum LARC insertion in the hospital. Similarly, there were reimbursement and claims issues that acted as barriers to LARC insertion and removal in the physician's office. Recently, the Florida Medicaid program unbundled immediate postpartum LARC placement from delivery reimbursement, allowing hospitals to recover the cost of the device and associated services for immediate postpartum LARC placement. Humana also reimburses physicians for

insertion and removal of LARCs, including intrauterine devices (IUDs) and contraceptive implants. The letter in Attachment MMA 2-4 informed providers of the new payment policies, and encouraged them to discuss the option of choosing a LARC immediately postpartum. Attachment MMA 2-5 presents an "IUD Reimbursement Tip Sheet" we sent to providers last year. The Tip Sheet informed them that insertion and removal of an IUD is reimbursable in addition to a family planning new or established visit, and it provided the procedure codes to use when billing.

- Obtaining Contraceptive Devices. We have made it easy for our providers to obtain IUDs from Humana's Specialty Pharmacy. Providers may have the IUDs delivered to their offices or may have the enrollee bring it with them during their next visit with the provider.

- Collaborating with Statewide Initiatives. As we have done with FPQC's "Promoting Primary Vaginal Deliveries" initiative, we have also promoted FPQC's LARC initiative, sending out FPQC LARC alerts to our participating hospitals. Humana is committed to continuing to collaborate with statewide initiatives to achieve our shared goal of reducing the number of unintended pregnancies.

TRACKING FAMILY PLANNING METRICS
To monitor our overall effectiveness in facilitating and promoting access to family planning services, Humana tracks service utilization on an ongoing basis and measures changes in family planning utilization over time. We have isolated pharmacy and durable medical equipment codes associated with LARC, and are monitoring utilization trends by month and by region. Between 2015 and 2016, we saw an increase in LARC utilization of approximately twelve percent (12%), with the average number of enrollees per month receiving a LARC insertion by their OB/GYN increasing from one hundred twenty-two (122) to one hundred thirty-eight (138). We also monitor whether there are upticks in service utilization following implementation of specific initiatives such as a community event, a Humana-sponsored health fair, or an educational mailing. Such monitoring helps us to determine which types of strategies are most effective and which we should continue, as well as those that require revision or discontinuation.

Footnotes

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[1] Haelle, T. 2017, May 16. Your Biggest C-Section Risk May be Your Hospital. Consumer Reports. Retrieved from http://www.consumerreports.org/cro/index.htm
[2] Sonfield, A., Making Medicaid Managed Care Work for Family Planning Coverage and Services, Guttmacher Policy Review, Winter 2015, Volume 18, Number 1.
[3] Center for Disease Control, National Health Statistics Reports, #55, Intended and Unintended Births in the United States: 1982–2010, June 2012, William D. Mosher, Ph.D.; Jo Jones, Ph.D.; and Joyce C. Abma, Ph.D.

Evaluation Criteria:

1. The extent to which the respondent identified opportunities for improvement in achieving the benchmarks and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care.

2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify high-risk pregnancies (including enrollees with co-occurring behavioral health conditions).

3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for pregnant enrollees that are determined to be high-risk.

4. The adequacy of the respondent's description of specific evidenced-based programs and interventions that will be used to decrease the number of unintended pregnancies and the associated indicators or measures that will be used to determine their effectiveness.

5. The extent to which the respondent describes financial and non-financial provider and enrollee incentives for evidence-based practices that will contribute to hitting the benchmarks.

6. The adequacy of the respondent's proposed performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries.

7. The extent to which the respondent describes its experience implementing successful strategies that resulted in a reduction in non-medically indicated cesarean sections and early elective deliveries. In order to receive all points for this component, the respondent must include outcome data on specific performance metrics.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment MMA 2-1: MomsFirst OB Case Management Program Acuity Levels

Humana manages all enrollees based on their assigned acuity (complex, high, or low), which may change throughout the duration of their pregnancies. All OB Case Management cases start as HIGH acuity. Some of the qualifying conditions for complex or high case management include diabetes, high blood pressure, history of miscarriage, AIDS, epilepsy, co-occurring behavioral health conditions, substance abuse, and multiple pregnancies. Please see sample charts below.

Complex Acuity (Weekly Contact)	
Cardiac/Pulmonary	**Psych/Social**
• Preeclampsia • CHF • SVT (HR greater than 100) • Cardiac Surgery within 6 months pregnancy • Congenital Cardiac Anomaly (VSD, ASD)	• Substance Abuse (Current) • Suicidal Ideations • Anorexia • End of Life • Bedridden
Preterm Labor	**Medications**
• Complete Bed Rest	• Digoxin
Endocrine/Diet	**Anatomy/Urinary**
• Insulin Dependent Diabetic (Brittle/Uncontrolled- Grade determination) • Hyperthyroidism/Crisis • Severe Hyperemesis (IV Fluids, IV medications, PICC, TPN)	• Placenta Previa with complications • Placenta Percreta, Increta, Accreta with complications - PTL • Renal Failure
Immune Disorders/STI's	**Neuro**
• Cancer • AIDS (Noncompliant)	• Active Seizure activity within 6 months of pregnancy and during pregnancy
Fetal	**Blood Disorders/Liver**
• Intrauterine Fetal Surgery • Cardiac Arrhythmia	• End-Stage Liver Disease • DVT
Utilization	
• 2 unplanned admissions within 30 days • 3 pregnancy-related visits to ER/Triage in 30 days (Not routine Physician referral)	

Attachment MMA 2-1: MomsFirst OB Case Management Program Acuity Levels

High Acuity (Monthly Contact)	
Existing Health Conditions	**Other**
• Severe Asthma (uncontrolled) • Epilepsy • Hepatitis B/C • Sickle cell • Severe Anemia (symptomatic) • AIDS (compliant) • Anti-phospholipid syndrome • Clotting Disorders (ALL) • Mental Health Disorders (CM will evaluate stability and diagnosis)	• HX of Miscarriages X 3 or more prior to 16 weeks and currently less than 24 weeks gestation • Extreme BMI over 45 or greater Class III obesity/ BMI less than 18 based BMI • Pregnant with Multiples, Multiple large Fibroids (greater than 5cm) • Active Mental Health Diagnosis/Unstable/Medication • Cerclage, Incompetent Cervix • 2 or more Chronic diseases or co-morbidities • HTN • Current Fetal Demise >20 weeks • HX Preterm Spontaneous Labor/Delivery less than 35 weeks • Active STD/ Syphilis/Herpes Outbreak in Pregnancy • Hx of PTL or pregnancy related issues • Current Smoker in Pregnancy • Active Marijuana/Substance Use/Abuse • 2 or more pregnancy related ER visits after 24 weeks

Low Acuity	
• Uneventful pregnancy- No diseases/No co-morbidities • Pregnancy between ages 18- 42 with no complications • Social needs • Pregnancy over the age of 42 without complications • Stable Mental Health/ Counseling • Thyroid Disease • Anemia with Hgb>8 and on iron supplements • No Disease risk factors • Member Compliant with visits • Resolved UTI • Pregnancy before age 18	• HIV • Diabetes Diet Controlled • Previous Fetal Demise if due to Cord Accident only • One (1) ER visit for non-emergent diagnosis (CM to follow up for teaching) • Resolved Bleeding in 1st trimester • GBS positive • Migraines • Treated STD/BV resolved with current pregnancy • Controlled Asthma • Smoking Cessation with Pregnancy

Attachment MMA 2-2: Beacon Baby Blues and Postpartum Depression

We place emphasis on recognizing and addressing postpartum depression and related conditions that may interfere with the attainment of the best possible health outcomes for a mother and baby. Our OB case managers are knowledgeable about the signs of postpartum depression, and they connect our enrollees with needed behavioral health support when they identify enrollees at risk. Below is a sample of material we share with our new moms relative to postpartum depression.

beacon
health options

BABY BLUES AND POSTPARTUM DEPRESSION

What are the Baby Blues?

After the baby is born some women have mood swings. One minute they feel happy, and then they feel sad, or start to cry.

Some women have a hard time thinking, or trouble sleeping.

This could be the baby blues.

The baby blues usually go away within seven to ten days after having the baby.

What If I Feel Worse?

Some women have worse symptoms, or symptoms that last longer.

Some women begin feeling worse a few weeks after the baby is born, and may think about hurting their baby.

These may be signs of Postpartum Depression, which should not be ignored.

It can cause needless pain or death if you don't get help.

How Do I Get Help?

There are safe and effective treatments that may include taking medication, and talking to a therapist.

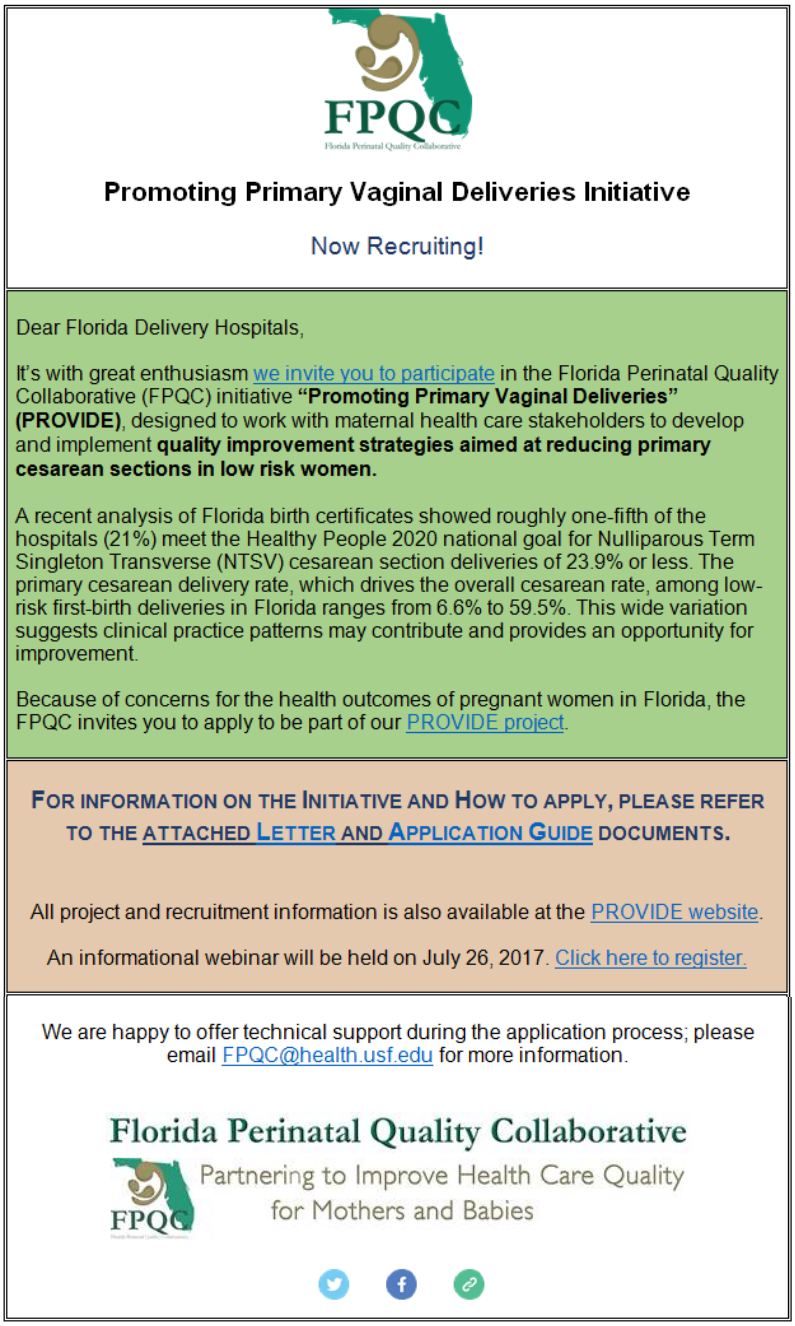
Don't ignore the symptoms. Talk to your doctor.

You owe it to yourself and your baby to get help.

If you don't have a doctor, please call Beacon at (800) 221-5487 to get an appointment.

Attachment MMA 2-3: Florida Perinatal Quality Collaborative Promotion

Humana helps promote Florida's Perinatal Quality Collaborative Promotion (FPQC) initiative "Promoting Primary Vaginal Deliveries" (PROVIDE). We email FPQC alerts, like the one below, to the managed care departments of our participating hospitals and promote the initiative through our other communications with the hospitals.



FPQC
Florida Perinatal Quality Collaborative

Promoting Primary Vaginal Deliveries Initiative

Now Recruiting!

Dear Florida Delivery Hospitals,

It's with great enthusiasm we invite you to participate in the Florida Perinatal Quality Collaborative (FPQC) initiative **"Promoting Primary Vaginal Deliveries" (PROVIDE)**, designed to work with maternal health care stakeholders to develop and implement **quality improvement strategies aimed at reducing primary cesarean sections in low risk women.**

A recent analysis of Florida birth certificates showed roughly one-fifth of the hospitals (21%) meet the Healthy People 2020 national goal for Nulliparous Term Singleton Transverse (NTSV) cesarean section deliveries of 23.9% or less. The primary cesarean delivery rate, which drives the overall cesarean rate, among low-risk first-birth deliveries in Florida ranges from 6.6% to 59.5%. This wide variation suggests clinical practice patterns may contribute and provides an opportunity for improvement.

Because of concerns for the health outcomes of pregnant women in Florida, the FPQC invites you to apply to be part of our PROVIDE project.

FOR INFORMATION ON THE INITIATIVE AND HOW TO APPLY, PLEASE REFER TO THE ATTACHED LETTER AND APPLICATION GUIDE DOCUMENTS.

All project and recruitment information is also available at the PROVIDE website.

An informational webinar will be held on July 26, 2017. Click here to register.

We are happy to offer technical support during the application process; please email FPQC@health.usf.edu for more information.

Florida Perinatal Quality Collaborative

FPQC

Partnering to Improve Health Care Quality for Mothers and Babies

Attachment MMA 2-4: LARC Letter to our OB/GYNs

Our Medical Director, MomsFirst Case Managers, Quality Improvement Nurses (QINs), and Provider Relations representatives all play an important role in keeping our providers abreast of Agency for Healthcare Administration (AHCA) and Humana initiatives to reduce the number of unintended pregnancies. Below is an example of our educational outreach.

Humana.

August 10, 2017

Dear Provider,

In Florida, as many as 59% of pregnancies are either unwanted or mistimed. Long Acting Reversible Contraceptives (LARCs), including Intrauterine devices (IUDs) and contraceptive implants are highly effective and can play a significant role in reducing unplanned pregnancies, and recent evidence has shown that providing LARC methods during the immediate postpartum period is safe and is supported by clinical evidence and guidelines (1).

Humana members can now receive LARC placement immediately following delivery in the hospital. In 2016 the Florida Medicaid program unbundled immediate postpartum LARC placement from delivery reimbursement, allowing hospitals to recover the cost of the device and associated services for immediate postpartum LARC placement. Humana reimburses physicians for insertion and removal of LARCs, including IUDs and contraceptive implants.

Humana understands that many women find it difficult to return to their physician's office for their postpartum visits and insertion of an IUD or contraceptive. Therefore, we are asking you to let your patients know that they have the option of choosing a LARC immediately postpartum. Additionally, please speak with the hospitals where you have privileges about LARC to ensure they have the devices available for your patients.

If you have additional questions please call your Humana Provider Contracting Representative.

Thank you for your continued care of our patients.

Sincerely,

Ian Nathanson, M.D.
Medical Director

1 Florida Perinatal Quality Collaborative (FPQC)

Attachment MMA 2-5: IUD Reimbursement Tip Sheet

Humana reimburses physicians for insertion and removal of long-acting reversible contraceptives (LARCs), including Intrauterine Devices (IUDs) and contraceptive implants. Below is an "IUD Reimbursement Tip Sheet" sent to providers last year informing them that insertion and removal of an IUD is reimbursable and providing the procedure codes to use when billing.

Humana.

Intrauterine Device (IUD) Reimbursement
Tip Sheet

June 2, 2016

Dear Provider,

Insertion and removal of an IUD is reimbursable in addition to a family planning new or established visit or an evaluation and management visit if all components of an evaluation and management visit are met and documented in addition to the IUD service.

Reimbursement for the IUD device is covered using the IUD specific HCPCS code. Additionally, you will need to submit a valid NDC number on the claim. The NDC number can be found on the product that is being administered to the recipient. Medicaid utilizes the 11 digit format, and this may require insertion of leading zeros if they do not appear on the package. Procedure code 99070 is not an appropriate code and cannot be reimbursed for an IUD.

You may also choose to order the IUD from Humana's Specialty Pharmacy and have the member bring it with them during their next visit with you.

There are many ways to get started with Humana Specialty Pharmacy:

Online:
https://www.humanapharmacy.com/Specialty

Phone:
Give us a call at 1-800-486-2668 (TTY: 711)
Monday through Friday from 8 a.m. to 8 p.m.
Saturday from 8 a.m. to 6 p.m. Eastern time

ePrescribe your prescription to us.

Fax:
Complete the prescription form and fax to 1-877-405-7940.

If you have additional questions please call your Humana Provider Contracting Representative.

Thank you

MMA SRC# 3 – Patient Centered Medical Homes (Regional):

The respondent shall describe its experience with patient centered medical homes (PCMHs) including the respondent's efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvement in quality measures. Specifically, the respondent shall describe programs and initiatives utilizing PCMHs to promote the Agency's goals.

Response:

Humana has long been involved and invested in the evolution of the patient-centered medical home (PCMH) model. In 2008, Humana began one of the earliest medical home pilots in the country, and continues to support provider efforts to secure PCMH recognition today. We have continued to expand our program and enhance and refine the ways we support our providers based on our lessons learned. In our Medicaid, Medicare, and Commercial markets in Florida, Humana contracts with one hundred ninety-four (194) PCMHs, serving more than one hundred thousand (100,000) Humana enrollees.

The PCMH model is built on a philosophy of delivering comprehensive, whole-person, and patient-centered care through primary care providers. PCMHs deliver accessible care with an emphasis on safety and quality and through a team-based approach that facilitates integrated and coordinated care for enrollees across the care spectrum. The model is designed to meet enrollee needs and deliver care in the appropriate setting, at the right time, and in a way that meets the enrollee's individualized goals and needs (see Attachment MMA 3-1).

PCMHs offer extended office hours, same day appointments, a twenty-four seven (24/7) clinician telephonic support line, effective care management programs and additional supports to enhance enrollee access to care. PCMHs in Humana's network use our robust data analytic tools, as well as their electronic medical records (EMRs) to identify enrollees with care gaps and needed services to manage the care of our enrollees. PCMHs provide our enrollees with education, including family planning services and information, refer our enrollees to the appropriate specialists, including behavioral health, OB/GYNs and early intervention providers, and manage enrollees' postpartum care. These features of PCMHs are designed to achieve quality outcomes, including prenatal and birth outcomes, by closing care gaps to reduce the rate of potentially preventable events.

We recognize and appreciate the role PCMHs play in improving access to care, facilitating care integration, and improving enrollee health outcomes. Moreover, Humana views PCMHs as well-positioned for Value Based Purchasing Arrangements. By transforming their practices to support the necessary infrastructure and capabilities needed to achieve PCMH accreditation, PCMHs are in a position to succeed in Humana's Shared Savings and Full Value VBP arrangements, creating financially aligned partnerships that make large strides towards our common goal of improving health and well-being outcomes for enrollees.

In our existing regions (1, 6, 9, 10, and 11), approximately seventy percent (70%) of PCMHs are in value-based purchasing arrangement.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:

(a) Enhanced access;
(b) Coordinated and/or integrated care; and
(c) Achievement of improved quality outcomes.

2. The extent to which the respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH for their PCP.

3. The extent to which the respondent's description of recognizing PCMHs addresses methodologies and processes to improve prenatal care and birth outcomes for enrollees assigned to a PCMH as their PCP.

==========

Humana's MMA network has five (5) PCMH groups with one hundred forty-seven (147) providers across twenty-one (21) locations in Region 1. See Attachment MMA 3-2 for map of PCMHs. Humana requires PCMHs to obtain certification from National Committee on Quality Assurance (NCQA), The Joint Commission, or Accreditation Association for Ambulatory Health Care (AAAHC) to be designated as a PCMH. These accreditations have rigorous requirements and guidelines to ensure that PCMHs have the resources and support in place to achieve overall improved health outcomes.

With a significant percent of Medicaid emergency department visits related to acute visits that could have been treated in a primary care setting, we recognize the importance of ensuring PCMHs are proactive in working with enrollees to receive care in the right setting. The primary goals of the PCMH model are to enhance access to care and to deliver integrated care in a manner which facilitates improved health outcomes and reduces potentially preventable events. Below we describe how PCMHs incorporate these goals in transforming their practices to deliver patient-centered care and deliver:
- Enhanced access to care
- Increased care integration
- Improved quality outcomes

ENHANCED ACCESS TO CARE

The PCMH model is structured to provide a variety of access points to PCPs, including a twenty-four (24) hours a day, seven (7) days a week clinician support line, extended office hours, telemedicine series and enhanced transportation services.

- All one hundred ninety-four (194) PCMHs in Humana's network have a twenty-four seven (24/7) clinician support line, providing our enrollees with timely clinical advice and guidance.

- One hundred seventeen (117) PCMHs offer expanded evening and weekend hours, which allows our enrollees to access care outside of work and school hours, increasing primary care

utilization and reducing potentially harmful, costly delays in seeking care. Humana has developed a strategy to further incentivize PCPs to offer increased after-hours coverage through enhanced reimbursement. PCMHs also keep appointment slots open for same-day availability for urgent visits.

- Some PCMHs offer telemedicine services. For example, Pediatric Associates, which is a PCMH serving fifty-six thousand (56,0000) Humana enrollees statewide under a value-based arrangement, has recently initiated a telemedicine program to increase access to care in the appropriate care setting. Humana and Pediatric Associates have agreed to partner together to expand their program for all Humana pediatric and adult enrollees statewide.

- Eighty-nine (89) PCMHs offer enrollees enhanced transportation services, in addition to the transportation offered through Humana's vendor, to mitigate barriers encountered in accessing timely care.

INCREASED CARE INTEGRATION
In order for a PCMH to achieve delivery of comprehensive care, a PCMH must invest in the resources and capabilities to support increased care integration, including:

- PCMHs have completed infrastructure changes, including the use of care coordinators, case management, and social workers, inside the practice to coordinate enrollee care.

- All PCMHs are required to implement an EMR system to seamlessly integrate enrollee care information. PCMHs leverage their EMR systems to identify enrollee clinical gaps, and send alerts to patients with these gaps. Using EMRs, providers are able to engage with enrollees to provide the care they need prior to a major health occurrence.

-- We require the EMR to be connected to the State's Health Information Exchange (HIE) to incorporate real-time and comprehensive health information into the data they are delivering.

-- Our enrollees are able to contact PCMH providers for clinical advice and guidance, using secure messaging available through the provider's EMR. Our providers are able to access and respond to these messages remotely, further encouraging our enrollees to seek care in the appropriate setting instead of unnecessarily accessing the emergency department or urgent care clinics.

-- Providers are able to make referrals to specialists and track clinical information, such as progress notes, clinical summaries, and lab and diagnostic results.

-- Many EMRs have patient portals which allow patients to communicate with their provider at any time. For example, a caregiver or parent may send a secure message through the portal conveying that their child has a fever as a result of a recent vaccination. The physician will be able to access the patient's health record remotely and provide advice accordingly.

- The PCMH model recognizes behavioral health as a primary factor impacting an enrollee's overall health outcomes and reducing potentially preventable events. Between August 2014 and July 2015, twenty percent (20%) of potentially preventable events in the Florida Medicaid program were related to a continuation of a mental health or substance abuse condition

following an initial hospitalization. During this same timeframe, forty-eight point eight percent (48.8%) of initial admissions were related to three behavioral health conditions: schizophrenia, bipolar depression, and major depression. PCMHs integrate and coordinate the delivery of behavioral health and primary care by identifying and screening patients for behavioral health conditions, as well as helping enrollees maintain and adhere to their behavioral medications and treatment.

-- PCMHs use standardized tools (i.e., PHQ-9, PHQ-2 and Edinburgh Postnatal Depression Scale) to identify patients with behavioral health conditions. This information is gathered during a comprehensive health assessment and is updated at least yearly. If a patient has a positive depression screening they are referred to behavioral health providers where a more comprehensive assessment is conducted. The PCMH's goal is to address and manage the condition at the practice level to avoid a psychiatric admission.

-- If an enrollee is hospitalized for a behavioral health condition, a case manager from our behavioral health vendor will reach out to the PCMH to coordinate care with information such as the enrollee's diagnosis, plan of care, and medication history.

-- Ninety-two (92) of the PCMHs in our network have co-located behavioral health case managers.

- PCMHs integrate behavioral health, dental, specialty and social services into the care delivered to enrollees. As the medical team leader, the PCMH is able to work with specialists, such as behavioral health providers and OB/GYNs, to ensure enrollees attend appointments and services are being rendered. Additionally, through this model, PCMHs are able to identify and mitigate barriers that may exist in accessing specialist services.

-- All PCMHs in our network have aligned with a dental clinic within a ten (10) mile radius of the practice to facilitate coordination of care and improve access to dental homes.

-- Our PCMHs have also established a robust referral department to conduct outreach and coordinate care with network specialists. PCMHs have enhanced relationships, communication, and experience working with their specialist partners.

- Our PCMHs offer education, prevention screenings, vaccinations, and family planning to improve compliance with preventive care.

-- We support PCMH providers in initiatives aimed at decreasing unintended pregnancies with a strong focus on prevention education for our enrollees. Our PCP contracts require PCMH providers to deliver voluntary family planning information and services, and HIV testing and counseling for enrollees of childbearing age. From January through August 2017, for example, approximately seventy (70) of our pediatric PCMH centers prescribed contraceptives.

-- Additionally, we require PCMHs to support care transitions and coordinate care through pregnancy and post-natal care, ensuring seamless care delivery for our enrollees.

-- We have made it easy for our PCMHs to obtain IUDs from Humana's Specialty Pharmacy. Providers may have the IUDs delivered to their office or may have the enrollee bring it with them during their next visit with the provider.

- Many PCMHs have affiliated OB/GYNs and midwives to better serve our enrollees and ensure continuity of care following an enrollee's pregnancy. These providers may be integrated into the same practice or located in the same building. For example, many of our federally-qualified health centers and rural health centers have attained PCMH recognition. Nearly all of these facilities have an affiliated OB/GYN, and approximately seventy (70) of these facilities have midwives available to our enrollees. The PCMH PCP can internally refer an enrollee to the OB/GYN, promoting a seamless transition of care and improving the quality of care for the enrollee through an early referral process. The PCMH is then easily able to follow up with the enrollee and OB/GYN to ensure the enrollee is attending prenatal appointments and receiving comprehensive prenatal care.

-- Following the delivery, our PCMHs continue to focus on postpartum care for assigned enrollees, as well as on pediatric services for the newborn. This includes screening for postpartum depression and any postpartum complications.

- Pediatric PCMHs play an important role in improving birth outcomes through Child Health Check-Ups (CHCUP). As the CHCUP periodicity schedule calls for ten (10) health check-ups within the first thirty (30) months of an infant's life, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit gives our pediatric PCMHs frequent checkpoints to both identify and facilitate treatment of any health problems that may have resulted from adverse birth outcomes. Additionally, these visits provide an opportunity for the pediatric PCMH to observe family interactions. If the provider notes any potential concerns in these interactions or if the family expresses any issues at home or in the community, the provider can then facilitate a direct referral to the in-house social workers for follow-up.

IMPROVED QUALITY OUTCOMES
Enhanced access to care and care integration are fundamental components driving PCMHs' ability to deliver quality outcomes and assist them in becoming successful population health managers. Below is a case study that represents improved quality outcomes that a PCMH can achieve by employing the fundamental PCMH components.

PCMH QUALITY ACHIEVEMENT CASE STUDY: POTENTIALLY PREVENTABLE EVENTS

Through the comprehensive approach PCMHs take for care coordination and integration, we have seen positive results in increasing preventive care and reducing potentially preventable events after we assist our providers with achieving PCMH certification. For example, we successfully worked with Doctor's Medical Center in Regions 9, 10, and 11 to assist them in achieving NCQA PCMH certification. This PCMH has ten thousand five hundred (10,500) Humana enrollees through a value-based agreement. Following this collaboration, we observed these results:

- Annual dental visit measure increased by 5%
- Cervical cancer screening measure increased by 12%

- Childhood immunizations combo 3 measure increased by 12%
- Emergency department weekday visits reduced by 8%

Additionally, we observed the below results for Pediatric Associates, a PCMH with over fifty-six thousand (56,000) Humana enrollees:

- 4% improvement in annual dental visit rate
- 39% improvement in child well visits in the first fifteen (15) months
- 7% emergency department visit reduction related to pharyngitis
- 10% emergency department visit reduction related to fevers

HUMANA'S PCMH PROVIDER SUPPORT

Humana has supported and will continue to support Florida providers in attaining PCMH recognition. Humana assists providers in achieving PCMH certification by providing appropriate education, tools, and individualized support to assist in provider transformation. Humana has a PCMH provider outreach program that helps our network PCPs identify gaps preventing their practices from achieving PCMH recognition. Please see Attachment MMA 3-3 for letters of support from PCMHs. Below are the descriptions of the two components of this program, the PCMH Provider Liaison and Humana communication tools.

PCMH Provider Liaison

Humana recognizes the PCMH Certification Process requires significant operational and philosophical changes. There is often resistance due to changes to the culture of the practice and the amount of work required to achieve and maintain PCMH certification. To assist with this transformation, we have a dedicated PCMH liaison who works with providers during their PCMH application process. By assisting with the drafting of policies and procedures, the compilation of data, and the assembling of the required documentation, we provide a valuable service to mitigate the burden these practices often encounter in performing these tasks on their own. Additionally, our provider liaison may support the provider during calls with EMR vendors and ensure PCMHs are connected to the HIE.

Communication Tools

Additional support is provided via communication tools such as webinars, educational workshops, and other initiatives to deliver technical assistance on PCMH topics for the practices in the program. One specific example of a communication tool is our Health Literacy program which is an important component of PCMH certification. This is an ongoing initiative to educate providers on how to integrate health literacy protocols within their practice. Humana conducted a series of webinars for both PCMH-certified providers and those who were in the process of becoming certified.

Beyond PCMH recognition, Humana empowers and supports PCMHs in areas such as care coordination support, front line assistance through Provider Relations Representatives, pharmacy services, technology support, data support, and Humana leadership support through Joint Operating Committees. We use our provider engagement model, along with our data analytics, to help support our PCMH providers in identifying and reaching out to enrollees. We utilize a variety of quantitative and qualitative measures to help providers identify potential high-utilizer and high-risk enrollees, which our Provider Relations Representatives review with our PCMHs monthly. Our Quality Improvement Nurses also meet with providers monthly to review

utilization data, including inpatient and outpatient hospitalizations, emergency room visits, pharmacy utilization, and HEDIS-related information. Our data sources allow us to create a full picture of enrollee utilization and potential emerging risk-factors. This data allows PCMHs to improve health outcomes and reduce potentially preventable events. These sources include, but are not limited to:

- Predictive modeling data
- Utilization and cost data
- HRA and survey tools
- Clinical assessments
- Multidisciplinary Team (MDT) members
- Specialist physicians
- Enrollee self-identification
- Caregiver identification
- Program referrals (Physician, Care Coordinators, Utilization Managers, Behavioral Health, Pharmacy or Medication Therapy Management, etc.)

We are also creating a mental health provider score card conveying mental health-related admissions, readmissions, and length of time from discharge to follow-up care visits for providers to review and use to identify opportunities for improvement.

PCMH CASE STUDIES

Below are illustrative examples of Humana's partnership with PCMHs serving the Florida Medicaid population.

PCMH CASE STUDY 1
Pediatric Associates is Florida's largest privately-owned primary care pediatric practice, with more than two hundred (200) providers and thirty-two (32) locations in Regions 4, 6, 9, 10 and 11. Pediatric Associates achieved NCQA PCMH recognition in 2015 and has approximately fifty-six thousand (56,000) assigned Humana Medicaid enrollees. They are open three hundred sixty-five (365) days a year with weekend hours, holiday hours, and evening hours available until 11:00 p.m. Additionally, they have recently launched telemedicine services for their enrollees and will insource their twenty-four seven (24/7) clinician line with registered nurses available for triage and clinical guidance.

Through their enhanced access and integrated care model, Pediatric Associates has become one of our top performing quality providers in Florida. They are ranked in the ninety-fourth (94th) percentile among similar Humana pediatric provider groups in Florida, and are ranked first out of twenty (20) Humana groups with a similar Medicaid pediatric population in Florida.

Humana works very closely with Pediatric Associates to ensure enrollees have improved access to care. Our leadership holds Joint Operating Committee meetings quarterly to discuss Medicaid initiatives and best practices that Humana and Pediatric Associates can implement together. For example, to ensure enrollees have immediate access to care for non-emergency services, Humana has assisted Pediatric Associates in determining the best location to open a pediatric urgent care center in Broward County to serve Humana Medicaid enrollees and all pediatric

patients in the community. We also partner with Pediatric Associates to contact enrollees who have not visited a PCP through their case management outreach program by providing them with the contact information for children in their service area. Additionally, Humana is partnering with Pediatric Associates on developing a strategy to expand their telemedicine program so it can be offered to all pediatric and adult enrollees across the state.

PCMH CASE STUDY 2
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 primary care providers to determine which offices were conducting outreach to their members post- discharge and what types of services were offered. Doctors Medical Center (DMC), a PCMH offering transportation, social work, and case management services, was identified as a partner for our collaborative, streamlined initiative. DMC was conducting outreach to their 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 durable medical equipment had been delivered, and offering short-term case management.

We worked with DMC to develop a process that would align with the efforts of both organizations, ending duplicative outreach by various departments, a frustration identified by our enrollees. Through this process, we jointly decided DMC would conduct outreach to their enrollees following inpatient or observation utilization, rather than Humana, and would refer to Humana if there was an additional need, such as for disease management.

The process was implemented in 2016 and has worked well for our enrollees, our providers, and Humana. DMC reported they rarely receive negative feedback from enrollees regarding follow-up calls from multiple sources after discharge since implementing this initiative. Additionally, DMC makes referrals to Humana case management and other services when needed. Through this collaboration, we saw a decrease in readmissions. In 2015 there were three hundred six (306) readmissions, while in 2016 there were two hundred seventy-six (276) readmissions.

PCMH CASE STUDY 3
Tampa Family Health Centers (TFHC) is the largest federally qualified health center in Region 6, with sixty-nine (69) providers across sixteen (16) locations that provide enrollee access to adult and pediatric primary care, as well as obstetrics and gynecology, dental, pharmacy, and social services. TFHC achieved PCMH recognition and has over four thousand three hundred (4,300) Humana Medicaid enrollees. Their evening, weekend, and holiday office hours ensure our enrollees have access to a wide range of services, at their convenience. They have a dedicated centralized operational team that manages all service operations for their providers across all locations, including monthly changes to membership panels, referrals, clinical and pharmacy prior authorization requests, and claims and encounter submissions. Humana's provider relations representative works directly with this centralized team to ensure any operational challenges are resolved and all team members are trained on Medicaid requirements and resources available to support their operation. Humana is partnering with TFHC to continue improving quality scores and outcomes by placing a case manager in some of their key locations to augment the care coordination they are currently providing.

SUMMARY

Because of the many benefits the PCMH model offers to our enrollees, including integrated care, enhanced access, and improved quality outcomes, Humana sees significant value for our enrollees to have the opportunity to establish relationships with PCMH providers. To encourage this relationship, Humana publishes providers with PCMH designation in our provider directories for enrollee choice. To help providers obtain PCMH certification, we offer provider support teams and value-based purchasing arrangements that align with PCMH certification. Through our commitment to PCMH provisions, we can reduce preventable events and improve birth outcomes.

Evaluation Criteria:

1. The extent to which the respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:

(a) Enhanced access;
(b) Coordinated and/or integrated care; and
(c) Achievement of improved quality outcomes.

2. The extent to which the respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH for their PCP.

3. The extent to which the respondent's description of recognizing PCMHs addresses methodologies and processes to improve prenatal care and birth outcomes for enrollees assigned to a PCMH as their PCP.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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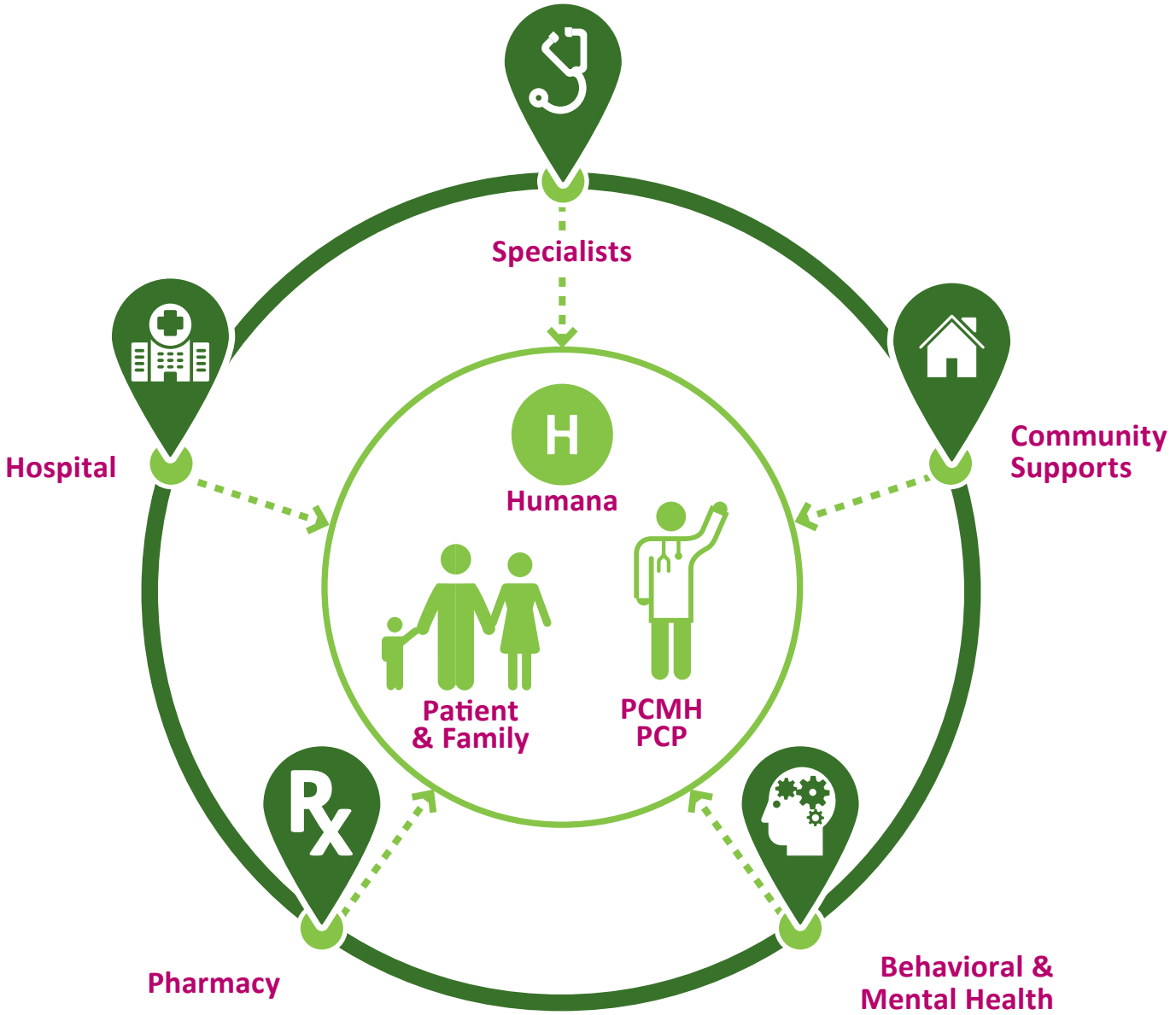
Attachment MMA 3-1: Patient Center Medical Home (PCMH) Infographic



Humana.

Attachment MMA 3-2: PCMH Map Region 1

Created by...
Humana

PCMH

5 groups at 21 locations

●Single locations (21)

×Multiple providers (0)

Service Areas

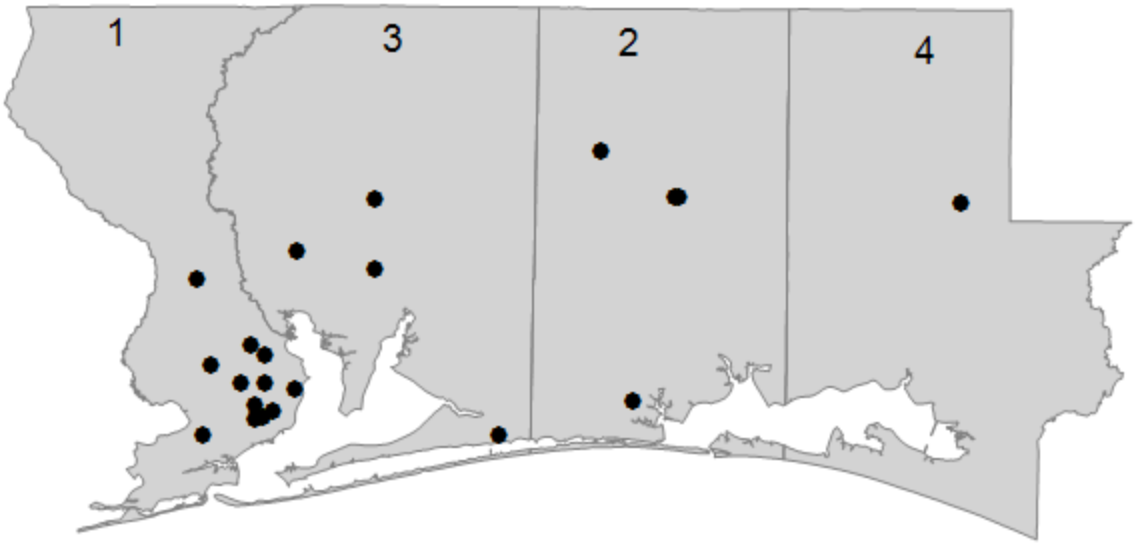
Region 1

18.19 miles

Region 1

Clinicians - 147

1. Escambia
2. Okaloosa
3. Santa Rosa
4. Walton



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(954) 782-0010

May 23, 2017

To Whom It May Concern:

It is with gratitude and deep appreciation that I send this letter for the support and education Humana and Latoya Powell provided in order for us to achieve PCMH Level II Recognition. The tools and systems used and implemented are invaluable in ensuring the delivery of quality medical care and follow up to our patients.

It enables us to reach goals set by our physicians and patients to optimize the delivery of timely appropriate care. Our patients, as a result, have become participants in ensuring their individual goals are met therefore, enriching their medical experiences and enhancing the quality of their lives.

In addition, we are now qualified to receive all benefits offered by governmental agencies that recognize the need and value these systems and education this status brings. Since the focus of health care is now cost effective quality medical care we are now prepared to meet all standards set by all agencies, insurers and patients.

We are proud to have had the opportunity to work in concert with Humana and Latoya toward achieving this valued goal.

Sincerely,

William V. Jensen, D.O.

WVJ/meg

LAKE WORTH PEDIATRICS
NAGARAKERE R. SHANKARAIAH, M.D., F.A.A.P.
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Diplomats American Board of Pediatrics

May 10, 2017

To Whom It May Concern:

Dear Sir/ Madam,

Please accept this correspondence as our formal written letter of support and reference on behalf of Latoya Powell, Medical Home Consultant/ SFL Senior Products with Humana.

Back in 2016 Lake Worth Pediatrics has started the process of transformation into a Patient Center Medical Home, a care delivery model where patients' treatment is coordinated through their primary care physician. It has been a journey performed with great care and completeness. Although the practice has been prepared and worked as a team, it became apparent that professional advice and assistance could be used.

Humana was responsive to our needs and recommended the services of Latoya Powell, Medical Home Consultant. As a professional, she has proved to be an excellent guide. Her expertise and knowledge has helped us to accomplish the completion in an efficient manner. She was very pleasant and always available. We would certainly not hesitate to use her advices and services again should the need arise.

Please call us should you need additional information concerning the services provided by Latoya Powell.

Sincerely yours,

Michelle Padurean-office manager

MMA SRC# 4 – Telemedicine (Regional):

The respondent shall describe its overall approach to utilizing telemedicine services to promote the Agency's goals, in particular as it relates to enhanced access to the following providers within the plan's network:

a. Primary Care;
b. Licensed mental health clinicians;
c. Psychiatrists;
d. Cardiologists;
e. Pulmonologists;
f. Endocrinologists; and
g. Internists.

The respondent shall describe any limitations placed on telemedicine services within its network and the percentage of providers with the network that are authorized to provide telemedicine services for the specialty types referenced above and those actually providing telemedicine.

Response:

Humana understands the value of and endorses the use of telehealth, including telemedicine technologies, as a component of effective and accessible care delivery. As the telehealth field continues to make advances, we believe telehealth concepts will continue to alter the way healthcare is delivered. As such, we're eager to play a role in this evolution. For instance, Humana is testing telemonitoring and its effectiveness in managing enrollees' complex conditions for our Medicare and Commercial lines of business across the nation. Specific to our Florida Medicaid business, Humana is actively educating providers on telemedicine requirements and reimbursement, as well as recruiting providers offering telemedicine services. We are currently engaged with several providers to support their telemedicine programs with the goal of extending access to care, closing care gaps, and encouraging care delivery in the appropriate setting. By taking a proactive and broad approach to telemedicine and related initiatives, we expect to reduce preventable events, increase the opportunity for detection and control of chronic diseases, and improve overall health outcomes.

Humana recognizes the many opportunities for effective, streamlined, and accessible health care that technology-enabled delivery models provide. We incorporate telemedicine throughout our company. In fact, onsite medical services for our employees at our headquarters in Louisville, Kentucky are available exclusively through telemedicine. Humana's employees and their families can easily schedule eVisits at our Health and Well-Being Center to receive preventive services, sick visits, urgent care, lab work, personal health coaching, and access to our well-being library. Additionally, Humana employees are able to access telemedicine services provided by Doctor on Demand. Humana's mission is to make care accessible, so we start by providing our employees with sophisticated health services where they work.

In response to this SRC, we have combined our response to evaluation criteria 1 and 3, which is provided below.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the Agency's goals.

3. The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:

a. The percentage of providers authorized to provide telemedicine services for the provider types referenced

b. The percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year.

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Humana understands the importance of telehealth and telemedicine services and how these services can increase access to care. According to the AHCA Telehealth report in December 2016, fifty-five percent (55%) of practitioners in nineteen percent (19%) of facilities in Florida indicated that they had been using telehealth for less than one (1) year, demonstrating that telehealth services are continuing to grow throughout the state. Our goal is to continue to increase telemedicine services through our network across Florida through continued development of our existing strong provider partnership models. With this work, we aim to increase access to primary care providers, mental health providers, and specialists such as cardiologists, pulmonologists, endocrinologists and internists for enrollees across all our lines of business. In accordance with Rules 59G-1.057 and 59G-4.001, F.A.C., the Agency allows for enrolled Medicaid providers to offer health services to enrollees through telemedicine technology. Telemedicine will allow us to enhance access to care (particularly in rural counties) and to ensure enrollees are accessing care in the right setting, leading to a decrease in potentially preventable events and improved health outcomes. We will continue to evaluate the effectiveness of these programs in enhancing access to care and identifying opportunities to expand telemedicine.

Region 1 has a unique set of challenges, including high levels of MMA membership, provider availability shortages in multiple specialties, and sparsely populated areas including one (1) designated rural county. Additionally, according to the quarterly Statewide Managed Medicaid Care Report in Winter 2016, Region 1 has the proportionately largest percentage of unhealthy Medicaid enrollees in the state and the lowest number of available providers. Given these challenges, Humana has partnered with Health First Network (HFN), a regionally dominant multi-disciplinary group providing access to approximately thirty thousand (30,000) Medicaid enrollees, who will target access to care issues for approximately five thousand (5,000) vulnerable Humana enrollees.

Humana authorizes one hundred percent (100%) of contracted practitioners licensed within their scope of practice to perform telemedicine services. In 2016, approximately seven percent (7%) of authorized Medicaid network providers provided telemedicine services statewide. Additionally through our partnerships with established telemedicine programs, approximately sixty-six percent (66%) of our enrollees have enhanced access to care to their PCPs through telemedicine services in Region 1.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

In an effort to reduce the occurrence of potentially preventable events and to encourage telemedicine utilization in Florida, we are using a multi-pronged approach to support and partner with our providers including Health First Network, Pediatric Associates, and our behavioral health partners. This approach also includes providing telemedicine directly to our enrollees through Doctor-on-Demand. We describe the components of our approach below.

HEALTH FIRST NETWORK (HFN): Health First Network, Inc. is an integrated and comprehensive network of more than seven hundred (700) physicians dedicated to improving the health care experience and quality of life for people in Northwest Florida. HFN primary care physicians and specialists provide care through a value-based arrangement to approximately thirty thousand (30,000) Humana enrollees in Escambia, Santa Rosa, Okaloosa, and Walton counties. Humana and HFN will collaborate in a regional demonstration to close care gaps and reduce potentially preventable events for approximately five thousand (5,000) vulnerable Humana enrollees through the effective use of telemedicine in three (3) specific care areas in which potentially preventable events frequently happen:
- Pediatrics
- Diabetes Mellitus and Cardiovascular preventive services
- Mental Health

Telemedicine can be particularly useful in targeting specific care areas where diagnosis and treatment plans are driven by lab results, such as endocrinology and cardiology. HFN will offer telemedicine services at a remote site utilizing a physician extender for patient positioning, interpretation, and technology operation of high-definition dermatology-grade cameras. The telemedicine interventions will be provided through a team approach with providers, which will include representation from:
- Pediatrics
- Cardiovascular preventive medicine
- Psychiatry, Psychology and other mental health providers
- Internists, Family Practitioners
- Nurse Practitioners and Physicians' Assistants
- Nurses and other ancillary providers (such as social workers in assisting patients in acquiring prescribed medications)

Expected outcomes of the pilot include:

BETTER ACCESS TO CARE – The pilot will help close gaps in annual wellness visits for infants and adolescents. By utilizing facilities more accessible to Medicaid enrollees, pediatricians can link to patients without the required travel time to remote sites.

IMPROVED MEDICATION ADHERENCE IN MENTAL HEALTH PATIENTS – With telemedicine access, providers are able to answer questions and explain directions and instructions regarding medications received from their mental health provide to help improve medication adherence.

DIABETES AND CARDIOVASCULAR SCREENING AND MANAGEMENT – Patients with existing diseases or who are at high risk for chronic disease should be seen at least quarterly. However, these frequent visits can become a barrier to care for enrollees, particularly those living in rural area. With telemedicine, HFN will be able to monitor patients with these conditions

and assist in closing care gaps. Additionally, through this pilot, specialists such as nutrition counselors, endocrinologists, and wound care specialists will be available via the telehealth portal.

Humana will explore replicating the HFN telemedicine pilot in additional geographies after assessing the demonstration's effectiveness in closing care gaps and enrollees receiving care in the appropriate setting.

PEDIATRIC ASSOCIATES: Pediatric Associates is Florida's largest privately owned primary care pediatric practice, with more than two hundred (200) providers at thirty-two (32) locations. Humana partners closely with Pediatric Associates, which has approximately fifty-six thousand (56,000) assigned enrollees at locations throughout Regions 6, 9, 10, and 11. Pediatric Associates is one of top performing providers in Humana's network. They are ranked in the ninety-fourth (94th) percentile among similar Humana pediatric provider groups in Florida and first (1st) out of twenty (20) Humana groups with similar populations. Our leadership meets quarterly to discuss Medicaid initiatives and best practices that Humana and Pediatric Associates can implement together. For example, both Humana and Pediatric Associates understand the importance for enrollees having access to care immediately for non-emergency services. Humana has assisted Pediatric Associates in determining the best location for them to open a pediatric urgent care center in Broward county to serve Humana Medicaid enrollees and all pediatric enrollees in that community.

Pediatric Associates recently launched a new telemedicine program through a partnership with American Well, a telehealth company, to develop their telemedicine system and use of a mobile application called Kids Now. Patients can schedule a telemedicine appointment through the Kids Now application, which is connected to Pediatric Associates' EMR and appointment scheduling system. They have four dedicated full-time physicians who provide telemedicine services via phone or video conferencing for their patients across the state. Pediatric Associates offers these services with full time coverage Monday through Friday 7:00 AM to 11:00 PM and Saturday/Sunday 3:00 PM to 11:00 PM. As of September 1, 2017, their Patient Contact Center is open twenty-four (24) hours, seven (7) days a week. In 2017, they are estimating fifty (50) telemedicine visits per day. We are working with Pediatric Associates to determine if this program is scalable statewide, and we can support them in achieving this goal. In a recent strategy meeting, Humana and Pediatric Associates agreed to partner together to expand their program for all Humana pediatric and adult enrollees statewide. Follow-up meetings have been scheduled to further develop the strategy for a possible 2018 implementation.

BEHAVIORAL HEALTH PROVIDER TELEMEDICINE: Behavioral health is a specific area of opportunity for telemedicine services. According to an AHCA report, twenty-seven percent (27%) of Medicaid potentially preventable events are tied to mental health or substance abuse with the top three conditions being schizophrenia, bipolar disorder, and major depression. Through telemedicine, enrollees with these conditions are able to access providers for prevention, medication adherence questions, and assessment. For example, behavioral health prevention can be addressed during a Bio-Psychosocial Evaluation and Psychological Testing which can be administered via telemedicine technology. The results of these testing and evaluation tools describe the biological, psychological, and social factors that may contribute to an enrollee's need for services. They also provide an assessment, evaluation, and diagnosis of

an enrollee's mental status or psychological condition. Delivering these via telemedicine allows providers to for early detection, reducing the number of potentially preventable events.

Our behavioral health vendor, Access Behavioral Health (ABH), credentials behavioral healthcare providers and practitioners who conduct telemedicine with the proper interactive electronic systems that protect the confidentiality of client information and audio and visual data transferred during the provision of telemedicine services. Providers certify that they offer these services and are meet the equipment requirements to be able to offer the services on the credentialing application. Currently the ABH network has psychiatrists in three provider organizations (sixty percent (60%) of organizational provider network) who conduct Telemedicine services (Lakeview Center, Inc., Chautauqua Healthcare Services, and Children's Home Society of Florida).

DOCTOR ON DEMAND: Humana is launching a telemedicine partnership with Doctor on Demand, effective October 2018, to encourage telemedicine as a means to improve enrollee access to care and prevent unnecessary emergency department visits. Doctor on Demand is an innovative platform that provides enrollees with access to a physician twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year from the enrollee's phone or computer. The platform allows enrollees to access care from a physician with an average wait time of fewer than five (5) minutes, or to schedule an appointment for a later time. Additionally, the platform allows an enrollee to upload medical history, send images if necessary, and designate a preferred participating pharmacy to obtain a prescription.

In partnership with Doctor on Demand, Humana intends to reduce potentially preventable events by providing enrollees an alternative way to access care in an appropriate care setting. Based on 2016 patient surveys, Doctor on Demand identified the following locations where patients would have sought care if they hadn't had access to their telemedicine services:
- 5% emergency room
- 41% urgent care center
- 12% stay at home
- 36% primary care provider office
- 6% other

More than half of potentially preventable emergency department visits were tied to conditions that could have been treated in a PCP's office. The most common non-emergent medical conditions that are seen by Doctor on Demand include but are not limited to cough, cold, flu, rash, urinary tract infection, sore throat, sprain or strain, vomiting, diarrhea, fever, and medication refills. These conditions are easily treatable in a telemedicine setting. We anticipate enrollees will respond positively to the convenience that Doctor on Demand provides and that enrollees utilize telemedicine services rather than visiting an emergency department or urgent care center. Humana will receive regular data intelligence from Doctor on Demand, including utilization reports to track and monitor items such as: number of visits, type of visits, percentage of utilization and visit, and service attributes.

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2.The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.

Humana is committed to AHCA's goals of enhancing access to care and delivering coordinated, integrated care, and we are committed to using telemedicine to help achieve these goals. The progress towards achieving our goal of increasing telemedicine utilization will be tracked in our Provider 360 Committee meetings, where cross-functional areas meet to discuss strategies, processes, and performance.

Humana aims to do whatever we can to enable providers who want to deliver telemedicine services, and we require providers follow all federal, state and Florida Medicaid requirements when providing telemedicine services. Humana may include a review of the practice by our legal designee to ensure all considerations for the practice of telemedicine have been met. Further, providers must also ensure that enrollee consent is captured and documented on the individual's medical or case record.

Despite advancements in telemedicine adoption, limitations and barriers to providing these services continue to exist. Identified barriers to adoption of telemedicine capabilities include, but are not limited to:

- Confusion over the differences between telehealth and telemedicine

- Financial barriers, including procurement of equipment and technology, ongoing maintenance costs, and achievement of Return on Investment

- Coverage and reimbursement varies across different programs, for instance there is no uniformity between Commercial, Medicare, and Medicaid products

- Difficulty accessing medical history and clinical information through Electronic Health Records and Health Information Exchange network due to interoperability between provider systems

Through our ongoing conversations, we have learned that the foremost concern for providers relates to reimbursement of telemedicine services. To overcome this, Humana has increased provider education and training around telemedicine services, including educational flyers and enhanced talking points for provider relations associates (see Attachment MMA 4-1). Our telemedicine educational flyer clearly communicates to providers that Humana reimburses for telemedicine services and references the provider manual for additional details on billing the correct modifying code.

Humana understands and supports AHCA's desire to identify providers delivering telemedicine services. Utilizing claims reports of providers who have submitted telemedicine encounters and provider relations knowledge of the emerging telemedicine landscape, we maintain a log of providers equipped with telemedicine capabilities. We share this information internally with the appropriate clinical and enrollment areas within Humana. Our goal is to relay this information to enrollees for whom telemedicine services may be particularly beneficial and to enhance access to care, while also supporting our providers in continuing to provide these services.

Evaluation Criteria:

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the Agency's goals.

2. The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.

3. The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:

(a) The percentage of providers authorized to provide telemedicine services for the provider types referenced; and

(b) The percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

What Physicians Need to Know about Telemedicine

Medicaid-covered patients can receive care from the comfort of their own home

What is telemedicine?

In an increasingly hectic world, some patients have trouble finding the time to visit their physicians for appointments, and urgent care and emergency room visits can be expensive. Many patients do not want to make an appointment for a minor ailment. For these patients, an alternative to consider is telemedicine.

Telemedicine is an evaluation, diagnosis or treatment delivered by a practitioner who is not located at the same site as the patient. Your Medicaid-covered patients may use telemedicine for covered services by conferencing with you over the phone or via an online call from the convenience of their home or care setting.

How is telemedicine reimbursed?

Telemedicine services provided to a patient with Florida Medicaid coverage must be performed by licensed practitioners within their scope of practice. The service is covered under Humana Florida Medicaid plans; however, to be reimbursed by Florida Medicaid for telemedicine services, physicians must use, at a minimum, audio and video equipment permitting two-way, real-time, interactive communication between the patient and the physician.

To be reimbursed, physicians need to include the modifier “GT” on their CMS 1500 claim form. Florida Medicaid will reimburse the practitioner who provides the evaluation, diagnosis or treatment recommendation.

Important exceptions:

Florida Medicaid does not reimburse for:

- Telephone conversations
- Chart review(s)
- Electronic mail messages
- Facsimile transmissions
- Equipment required to provide telemedicine services

These resources are available to help:

The following links provide additional details on payment and plan coverage:

- http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml
- https://www.humana.com/provider/support/clinical/medicaid-materials/florida

If you are currently providing telemedicine or considering telemedicine for your patients with Humana Medical Plan (Medicaid) coverage, please contact you Humana provider representative.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 5 – Provider Network Development (Statewide):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to primary and specialty care services, necessary to promote the Agency's goals, including:

a. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);
b. Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;
c. Strategies (including a description of data sources utilized) for measuring timely access to appointments with the following provider types:

(1) Cardiologists (pediatric and adult);
(2) Pulmonologists (pediatric and adult);
(3) Endocrinologists (adult);
(4) Internists (adult);
(5) Psychiatrists (pediatric and adult);
(6) Obstetricians/Gynecologists (adult); and
(7) Licensed mental health clinicians (pediatric and adult).

d. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider's success in making progress towards the Agency goals.

Response:

Humana creates and maintains an annual Network Development and Management Plan (NDMP) to serve as a guidepost for managing, measuring, and continually strengthening a broad and diverse network of high-quality providers. The NDMP contains background on our network design and provides descriptions of the processes to develop and maintain a comprehensive and effective network of providers. Our Statewide Medicaid Managed Care (SMMC) network enables appropriate and timely access to high-quality and cost-effective healthcare services to the managed medical assistance (MMA) enrollees while also providing long-term supports and services to the long-term care (LTC) Humana enrollees in the SMMC program. We have provided our statewide 2017 NDMP in Attachment MMA 5-1.

Humana has built and maintained strong partnerships with our contracted providers and subcontractors. We have created and are highly committed to a culture of collaboration and innovation in identifying and implementing approaches to improve healthcare delivery and enable positive health and social outcomes. The NDMP describes our approach to measuring and monitoring provider and subcontractor performance. We use that information to manage improvements with our network partners to ensure that enrollees have access to a wide choice of high-quality services, as well as to help our network partners increase effectiveness, quality, and cost efficiency. Our NDMP includes the following topics:
- Competitive landscape of provider network
- Prior year network analysis
- Description of basic network design and network access adequacy

- How enrollees access the system
- Analysis of timely access to services
- Provider satisfaction survey, methodology, and results
- Coordination of relationships among various levels of the system
- Assistance and communication tools provided to Primary Care Providers (PCPs)
- Network barriers and gaps
- Telemedicine as a mechanism to enhanced access to care
- Electronic health records (EHRs)
- Pharmacy services overview
- Subcontractor monitoring and oversight
- Internal department coordination
- Coordination with outside organizations

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1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.

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Humana continuously measures and evaluates enrollee access to ensure our network meets or exceeds the SMMC requirements. This includes measuring adequacy against contractual requirements, resolving network gaps, and addressing barriers to care, including transportation and linguistic needs. We also conduct strict oversight of our subcontractors to ensure they secure and monitor the same level of access. Our measurement and evaluation process crosses multiple plan functions, including customer care, quality assurance, and medical management for each region. Humana Provider Relations associates, under the direction of the Regional Vice President of Network Operations and Provider Experience, review various metrics to understand access to care levels across service categories.

Our approach to identifying gaps and ensuring network adequacy uses established Humana systems and infrastructure, proven techniques, strict oversight, and prompt follow-up to monitor and address any network issues. Humana uses data resources to monitor travel distance and times to ensure enrollees have access to the type of provider they need, and we include both our directly contracted and subcontracted providers in these analyses. Humana ensures access to all enrollees by analyzing multiple sources of information, as required by the Agency for Health Care Administration (AHCA). Below are descriptions of our network adequacy and access tools. The Provider Relations team reviews reports and results from these tools on an ongoing basis. We also review them during our quarterly Quality Management Committee (QMC) meetings to determine appropriate interventions and next steps.

ANALYTICAL REPORTING

ACCESS ANALYSIS — Using a proven geographical analysis tool, Quest Analytics, Humana utilizes geocoding technology to precisely measure enrollee to provider adequacy access. The Quest Analytics tool measures both distance and travel times against a baseline of two hundred percent (200%) of our enrollment for Regions 1 and 2, and one hundred twenty percent (120%) for Regions 3, 4, 5, 6, 7, 8, 9, 10, and 11. We analyze access for each provider specialty as

listed in the SMMC contract by enrollee age and gender group as specifically indicated for the provider type; for example, we map pediatricians to enrollees under the age of 21. This tool allows us to identify access issues at the county and ZIP code level. We also produce maps that display enrollee access and network deficiencies.

PROVIDER TO ENROLLEE RATIOS — We analyze provider to enrollee ratios monthly against network standards in accordance with AHCA requirements. We use this tool particularly often when we anticipate increased enrollment volume to ensure that our network has the capacity to accommodate additional enrollees.

Below are descriptions of the methods we use to identify enrollee barriers to accessing care. Our Provider Relations team and the Provider 360 Committee collect and review these data monthly. Our Provider 360 Committee is a cross-functional team, chaired by the Humana President of Florida Medicaid Operations, and meets on a monthly basis to review provider trends from our Claims department, as well as Availity usage, quality measures, provider system usage, and provider grievances and inquires. The Committee includes representatives from our Claims department, Grievance and Appeals department, Credentialing department, and Provider Relations.

CUSTOMER FEEDBACK

ENROLLEE SURVEYS—Humana annually reviews results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to identify any trends in barriers to care. We report the analysis of the results to our QMC to ensure we meet our goal benchmarks. We measure access to care results year over year in comparison to our established benchmark goals. In our 2016 CAHPS survey, Humana saw an increase in adult responses for “Got appointment with specialist as soon as needed” to seventy-five percent (75%) and “Got urgent care as soon as needed” to eighty-two percent (82%), a nine percent (9%) and two percent (2%) increase, respectively. We also saw an increase in “Ease of getting care, tests, or treatment needed” to eighty-six percent (86%) and “Got urgent care as soon as needed” responses for children to ninety percent (90%), two percent (2%) and two percent (2%) increase, respectively.

CLINICAL ACCESS TEAM (CAT) – Humana’s CAT facilitates resolution of identified clinical issues related to enrollee access. The CAT consists of three (3) non-clinical specialists who process inbound calls and ten (10) RNs who manage and resolve the cases. Issues may range from appointment availability to inability to locate a provider.

ASSOCIATES, ENROLLEE, PROVIDER, AND ADVISORY INPUT— On an ongoing basis, Humana examines anecdotal information from various internal and external sources as it pertains to network adequacy. This includes information contributed by individuals and committees, such as the Provider 360 Committee, as well as recommendations from providers to Humana to contract with specific providers and provider types.

MEANINGFUL DATA

COMPLAINTS AND GRIEVANCES— We receive complaints and grievances from enrollees and providers through multiple routes, which we record and track in our Customer Care Portal. For complaints that reflect network access issues or identify potentially noncompliant providers, we forward those to our Provider Relations team for review and action on a real-time basis. In addition, Humana will be designating a Provider Services Leader who will provide oversight on disputes.

OUT-OF-NETWORK REFERRALS—We examine out-of-network referrals quarterly to identify potential areas where we may need to expand specialty provider capacity.

CULTURAL AND LINGUISTIC NEEDS—Humana annually analyzes the cultural and linguistic needs of our enrollees and their geographic concentration to ensure appropriate access.

TIMELY ACCESS PCP WAIT TIMES REPORT—Humana's Provider Relations team annually conducts a survey of a statistically valid sample of PCPs to gauge appointment availability. We conduct the survey to assess wait times for scheduling appointments on an annual basis and will implement this process on a quarterly basis in 2019. During these calls, a Provider Relations representative contacts the primary care office with symptoms of a simulated condition/illness to discover the next available appointment. Through our 2016 audit, we found that the average wait times for providers was two (2) days for Sick Care Visits, one point two (1.2) days for Urgent Care Visits, and eight (8) days for Well Care Visits, which meet AHCA requirements.

AFTER-HOURS ACCESSIBILITY AUDIT—Humana calls PCP offices annually or on a more frequent basis to ensure enrollees have access to care during after-hours. The Provider Relations leadership team reviews these results and assigns them to the appropriate Provider Relations representative for immediate outreach to the provider, if necessary. Our attached NDMP conveys our results from our 2016 After-Hours Accessibility Audit, which exceeded AHCA requirements: Sixty percent (60%) of our PCPs offer after-hours care. Additionally, most of our patient-centered medical homes offer after-hours care. Humana also enhances access to after-hours care through our twenty-four (24) hours a day, seven (7) days a week nurse line. Enrollees can call this number and speak with a clinician for medical guidance. We can also warm-transfer enrollees to their PCP during office hours.

Additionally, Humana has developed a strategy to further incentivize PCPs to offer increased after-hours coverage. The initiative increases provider reimbursement for after-hour service codes 99050 and 99051. Given the current Medicaid-allowable reimbursement of seven dollars and twenty-eight cents ($7.28) and nine dollars and thirty-nine cents ($9.39), Humana offers a range of thirty-five dollars ($35) to fifty dollars ($50) for these services, which is a substantial increase.

OPEN/CLOSE PANELS—On a quarterly basis, we review the panel status of our PCPs by region and county. Additionally, we produce maps to visualize enrollee access to PCPs. We use these data to identify access barriers and implement additional targeted recruitment efforts.

ONGOING ACTIVITIES FOR NETWORK DEVELOPMENT TO MITIGATE IDENTIFIED GAPS AND BARRIERS

When our various network adequacy and access tools listed above identify network gaps or barriers, our Provider Relations team targets our provider recruitment strategy. The following recruitment strategies are ongoing, consistent practices built into Humana's network team management processes:

- If we identify providers that are not meeting contractual requirements (such as failing to meet after-hours requirement or appointment availability standards) we provide outreach and conduct provider education.

- To assist in identifying providers for recruitment to fill any recognized gaps, we use our collaborative provider partnerships with major health systems, ancillary providers, and large independent practice associations (IPAs).

- Humana enrollees can nominate a provider, in writing or telephonically, for recruitment. We forward nomination requests to the Provider Relations team for recruitment.

- We have an annual minority recruitment process to target providers to accommodate linguistic and cultural needs. We solicit feedback from minority associations, medical schools, and Native American tribes, as listed below:
-- Seminole Indian Tribe
-- Miccosukee Tribe
-- Florida Association of Minority Business Enterprise Officials
-- National Hispanic Medical Association (NHMA)
-- Minority Association of Pre-Med Students at Florida State University
-- Minorities in Medicine/Association of American Medical Colleges
-- Urban Promise
-- American Developing Smiles
-- Florida International University
-- Florida Atlantic University
-- University of Florida
-- University of Central Florida
-- Florida State University
-- University of South Florida

- We have provider recruitment mailboxes posted on our website where providers can electronically submit a request to join Humana's network.

- Because we have local Humana representatives, including our Provider Relations representatives and quality improvement nurses (QINs), we receive insight into new providers moving into areas. We are then able to target them for recruitment.

- We identify and target non-participating providers for recruitment through our review of single case letters of agreement and out-of-network utilization.

- We use a variety of available resources to identify specific providers to target, including the AHCA Master File (PML), AMA Website, Sunbiz, US News Health Report, Florida Department of Health, our competitor's directory, and web searches.

- We harvest data identifying providers who are already contracted for other Humana products in which their contracts have Health Maintenance Organization (HMO) provisions, and target these providers for recruitment.

- In areas where there are PCP shortages, we encourage our provider groups to recruit additional providers from outside the area, including physician extenders.

- We encourage our providers to offer telemedicine, reimbursing it in accordance with AHCA contractual requirements.

-- Additionally, we offer our enrollees access to Doctor-on-Demand, a telemedicine platform that provides enrollees with access to physicians twenty-four (24) hours a day, seven (7) days a week from the enrollee's phone or computer.

PROJECTION OF CHANGES IN FUTURE NETWORK CAPACITY NEEDS

Humana continuously considers projections of future capacity planning of our network measurement and management process. We base much of our network adequacy measurement process on updated enrollee counts and new maximum enrollment percentages. For instance, the Enrollee-to-Provider ratios and the Enrollee-Time-Distance measurements both require current enrollment files. As we add new enrollees, we take membership growth and geographic shifts in membership into account to ensure adequate access to care.

Significant provider contract re-negotiations can impact future network capacity planning. The Humana Network team maintains a strategic stratification of its major health system negotiations so that no more than one (1) health system in a market is under negotiation at a time. This strategy reduces the potential for multiple terminations at any given time.

Prior to any significant terminations, the Humana network team conducts a formal impact analysis of our network to proactively identify and address any enrollee access issues. To do this we use access analysis, open and close panels, and provider-enrollee ratios. This applies to hospitals, large provider groups, or subcontractors. In the event Humana initiates the termination, Humana conducts this analysis process well ahead of the ninety (90)-day notification to the provider and notifies AHCA within the contractual timeframe. In the event Humana receives a ninety (90)-day termination notice from a significant provider, our Provider Network team immediately begins the formal network termination impact analysis. We use this termination analysis as the basis to identify potential gaps and to identify priority targeted alternative providers that can act as a substitute for the impacted providers.

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2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and longterm interventions.

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We work collaboratively with enrollees and providers throughout the care planning and delivery process to ensure we meet standards and deliver care at an optimal level. We understand that

occasionally enrollees may need to rely on providers outside of our Medicaid network to meet their needs. Typically, enrollees engage with out-of-network providers when they are in the midst of treatment at the start of their enrollment period or when Humana's current network does not accommodate their specific situation. Our NDMP provides policies to ensure they can access services in a timely manner even if they require an out-of-network provider.

CONTINUITY FOR ENROLLEES

Continuity of care needs occur when an enrollee is newly eligible to Medicaid or switches from another Medicaid plan. It is critical that our policy and process coordinates services in a way that ensures there is no disruption or interruption of service delivery. Humana honors written documentation of a prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment or until the enrollee's PCP or behavioral health provider reviews the enrollee's treatment plan, whichever comes first.

Written documentation may include:
- Prior existing orders
- Provider appointments
- Prescriptions, including prescriptions at non-participating pharmacies

These guidelines include enrollees who:
- were recently hospitalized and now require follow up care
- are receiving behavioral health services and are within a plan of treatment
- are being treated for a condition that has a finite course of treatment
- have a life expectancy of less than six (6) months
- are in the end-stage of a disease
- have an unstable or life-threatening medical condition
- are pregnant
- are newborn (within the first ninety (90) days of life)

To support this objective, we will assess the treatment plan where available and determine whether the existing treatment plan is appropriate. For new enrollees in a course of treatment, Humana's Case Management team contacts the attending provider to discuss and review the current condition and course of treatment, as well as potential dates for end of service. If we believe the current treatment plan is ineffective, inappropriate, or misaligned to the medical needs of the enrollee, we will work with the provider to modify the treatment plan. We will reassess the enrollee's treatment plan within ninety (90) days.

Normally, Humana allows enrollees to continue their course of treatment with an out-of-network provider for a pre-determined transition period. In these instances, Humana will execute a Single Case Agreement (SCA) with the provider. The process and language of the SCA adheres to Humana's National Network Operations (NNO) policies and procedures and AHCA's contract requirements. This help us maintain a relationship, ensure payment, and confirm Humana can verify the provider's qualifications and credentials to conduct the care they are delivering.

IMMEDIATE, SHORT-TERM, AND LONG-TERM INTERVENTIONS TO ADDRESS NETWORK GAPS

In addition to continuity of care requests, we recognize out-of-network utilization reports may identify potential gaps in our network. Once we identify and confirm a gap or disruption in our provider network, we will notify AHCA and then design and implement an aggressive and prompt recruitment plan.

In situations where we have a shortfall or “hole” in our geographic access standards for a given provider type, we address it through the following mechanisms:

- Identify all providers of that type serving in the area through all available resources that include
-- AHCA Master File (PML)
-- AMA Website
-- Sunbiz
-- US News Health Report
-- Florida Department of Health
-- Competitor’s directories
-- Web searches (e.g., Google)

- We discuss availability shortages with our provider groups to encourage additional recruitment of providers from outside the area.

- Humana may engage the enrollee’s PCP to assist with identifying providers commonly used for referrals in his/her practice that are capable of providing and willing to provide care.

- Once identified, we will recruit providers into the network who will bring that component of the network into compliance with the accessibility standards, if available.

Humana’s recruitment efforts include a variety of means to maximize success. These include onsite, face-to-face meetings with providers, telephonic outreach, and use of existing provider relationships to reach other providers. If willing providers are available that can address the specific need, our Network team will contact these providers to arrange a face-to-face meeting to recruit the provider into our network. Conversely, if the required provider type is not available or unwilling to contract with Humana, we will offer the enrollee transportation to the nearest qualified provider, make arrangements with out-of-network providers, or coordinate care through available telemedicine conduits.

If Humana’s Network team is unable to quickly bring a provider into the network, we will execute a Letter of Agreement (LOA) with the provider. The process and language of the LOA adheres to Humana’s NNO policies and procedures. Humana tracks and trends single case agreements via a tracking grid. The Contracting teams perform analysis on a periodic basis to identify potential contracting opportunities. We encourage non-network providers to join Humana’s network, and following a satisfactory pre-assessment, a Humana Network or Clinical representative engages the provider to begin the network contract process.

In the event we identify a network gap and have made what we believe is a highly reasonable offer to applicable providers in a given area, identify there is a lack of available providers, or available providers are not actively enrolled with Florida Medicaid and are still unable to secure network participation, we will document our efforts to AHCA and request a waiver. In the absence of a contract, we will seek to work with needed providers through single-case agreements and will permit enrollees to seek care from these providers on an out-of-network basis.

CLINICAL ACCESS TEAM (CAT)

Humana's CAT facilitates access to care when we identify a clinical issue related to enrollee access. The CAT team consists of three (3) non-clinical specialists who process the inbound calls on a dedicated line and ten (10) registered nurses (RNs) who manage and resolve the cases. Issues may range from appointment availability to inability to locate a provider. Once we receive an inquiry, a CAT associate will review and telephonically contact the enrollee or appointed representative to acknowledge receipt and to clarify the issue. The CAT associate may contact providers involved in the access issue to determine any extenuating circumstances, to offer assistance to possible barriers in resolving the issue, or to work with internal departments such as Provider Contracting to facilitate a resolution.

The CAT team has seen very strong results over the past twelve (12) months as shown by the Key Performance Indicators for commercial, Medicare and Medicaid populations:
- Overall access cases: 99.2% compliant with inquiry resolution
- Overall access cases: case closure within fourteen (14) calendar days
- Overall service level (80% of calls answered within thirty (30) seconds): 82%
- Overall abandonment rate (less than 5% of calls abandoned): 5%

In addition to our CAT, we have a twenty-four (24) hours a day, seven (7) days a week nurse line available to enrollees. Our nurse line enhances after-hours care by providing an available clinician to our enrollees who can advise on the appropriate level care and the appropriate care setting.

CASE STUDIES

EXAMPLE #1: At Jackson Memorial in Miami-Dade County, a mother delivered a newborn baby with a rare, lethal congenital defect of the windpipe called a type four (4) laryngeal cleft. Humana's Clinical team called every facility in Florida and, despite a thorough search, could not find a surgeon in Florida able to repair the enrollee's defect. We identified that the best center to treat this defect was at Cincinnati Children's Hospital. Humana's Clinical team and the Provider Network team worked to arrange transfer of the newborn by air ambulance to the Cincinnati Children's Hospital intensive care unit. Prior to the transfer, Humana's Provider Network team successfully negotiated a letter of agreement with the facility to ensure the hospital would receive payment for their services. The surgery was successful, and after several weeks an air ambulance transferred the baby back to the intensive care unit (ICU) at Jackson Memorial to reunite with her family.

EXAMPLE #2: A thirty-seven (37)-year-old male enrollee admitted to a participating in-network hospital in Region 1 with a diagnosis of Hashimoto's encephalopathy, seizures, and an altered mental status. Because of his complex diagnosis and multiple comorbidities, the enrollee remained in this acute setting for three (3) months. Once the enrollee's team of providers agreed to consider an alternative care setting based on the progress of the enrollee's condition, Humana assisted the enrollee with arranging and receiving post-acute care tailored to his diagnosis. Humana identified several long-term acute rehabilitation facilities that specialized in complex neurological rehabilitation rather than using a standard rehabilitation facility, based on the Provider team's recommendations. Because there were no beds available at these neurological rehabilitation facilities available In Florida, we extended our search beyond state lines. A Texas neurology recovery center accepted the enrollee as a patient. Humana's Clinical team worked very closely with our Provider Network team to successfully transfer the enrollee, which required air transfer to the facility. Prior to the transfer, Humana's Provider Network team successfully negotiated a letter of agreement (LOA) with the facility to ensure we would accurately reimburse the services. The enrollee remained at this facility for two (2) months. Once the enrollee's condition showed improvement, we arranged for the enrollee to transfer back to a local non-participating neuro-restorative facility to allow the enrollee's family to actively participate in his care, and support him in his continued progress of rehabilitation.

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3. The adequacy of the respondent's approach for measuring timely access for the specified provider types and the extent to which the respondent's approach includes clear methodology for determining the following:

a. Average wait time for an urgent appointment

b. Average wait time for a routine appointment

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Humana currently conducts audits of appointment availability and office waiting times for PCPs, and will expand our current process to the specified provider types, which include pediatric and adult cardiologists, pediatric and adult pulmonologists, adult endocrinologists, adult internists, pediatric and adult psychiatrists, adult obstetricians/gynecologists, and pediatric and adult licensed mental health clinicians. In 2016 our PCPs averaged two (2) days for Sick Care Visits, one point two (1.2) days for an urgent care appointment, and eight (8) days for a well care appointment, which meets AHCA's requirements. We expect all participating providers to render care in full compliance with AHCA access guidelines. Humana will comply with the Agency's contractual requirements for Timely Access Standards, as listed below, and actively monitor adherence to these standards.

1. Appointments for urgent medical or behavioral health care services shall be provided:

a. Within forty-eight (48) hours of a request for medical or behavioral healthcare services that do not require prior authorization.

b. Within ninety-six (96) hours of a request for medical or behavioral healthcare services that do require prior authorization.

2. Appointments for non-urgent care services shall be provided:

a. Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.

b. Within fourteen (14) days for initial outpatient behavioral health treatment.

c. Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.

d. Within thirty (30) days of a request for a primary care appointment.

e. Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.

To facilitate timely access to appointments, routine care, urgent care services, we communicate the above standards to all network physicians using a variety of communications channels such as during site visits, the Provider Manual, and provider training materials posted on Humana.com and Availity.com. Humana will audit appointment availability and wait time for both urgent and routine visits using the process described below.

We choose a statistically valid sample of providers within a region for a variety of different access audits, including appointment availability and wait time for both urgent and routine visits. These audits monitor accessibility of appointments per Humana and AHCA's regulatory requirements and corroborate appointment wait time. Humana measures these appointment availability standards through initial credentialing site visits, complaint data, and provider self-reporting. We also conduct strict oversight of our subcontractors to ensure they secure and monitor the same level of access. The Provider Relations manager reviews results and assigns the appropriate Provider Relations representative for immediate outreach to the provider.

Humana also physically audits appointment schedules at least annually by visiting provider offices. On a random basis, a Humana associate will visit a provider's office to monitor the patient wait times, ensuring they meet accessibility standards. We also review enrollee surveys, provider surveys, complaints and grievances, and associates and provider input for insight into access issues. Our Provider 360 Committee reviews the results from these sources monthly.

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4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.

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Humana continually assesses network adequacy by reviewing and monitoring the following key components: (a) how enrollees access the care delivery system, (b) provider types by geographic area including providers who service medically complex enrollees, and (c) access to care for all levels of providers. These services include, but are not limited to:

- Acute Care Hospitals

- Primary Care

- Specialists including
-- Cardiologists (pediatric and adult);
-- Pulmonologists (pediatric and adult);
-- Endocrinologists (adult)
-- Internists (adult)
-- Obstetricians/Gynecologists (adult)
-- Psychiatrists (pediatric and adult)

- Behavioral health practitioners

- Ancillary services

- Physical therapy (pediatric)

- Speech-language pathology services (pediatric)

- Occupational therapy (pediatric)

We create time and distance reports biannually, at a minimum, using geographic access studies to ensure there are an adequate number of providers in Humana's network. Using a proven geographical analysis tool, Quest Analytics, Humana uses geocoding technology to precisely measure enrollee to provider adequacy access, including traffic density. The software produces mappings and summaries of enrollees with desired access and enrollees without desired access. We review the results of those reports and develop action plans to address any deficiencies.

Humana has consistently met the reporting criteria of the Provider Network Verification (PNV) file reporting requirements since MMA implementation. Humana performs weekly and monthly assessments based on the AHCA/PNV Adequacy Report. We assess the file against our network by provider type, and we apply our algorithm to proactively identify at-risk specialties for targeted recruitment opportunities. As a result, this process has allowed Humana to identify and rectify network gaps before they occur and before our enrollees experience access to care issues.

Our Provider Relations team and QMC monitor the reports for all provider types from our network adequacy tools, as well as from our subcontracted entities, on an ongoing basis to ensure that we proactively deploy network recruitment efforts and to quickly respond to network gaps as they arise.

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5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent.
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Keeping our providers engaged and in good standing is paramount to ensuring our enrollees receive quality care. As such, we have structured our provider engagement model to support the formation of true partnership and optimize the payer-provider relationship through

administrative simplicity, financial partnership, and strong provider satisfaction. We use the following approach to ensure our providers remain in good-standing and are satisfied:
- Interactive Provider Relations Model
- Value-Based Purchasing
- Provider Satisfaction Indicators
- Provider Performance Metrics

Humana's interactive provider relations model is a differentiator of Humana's provider network management strategy. A Provider Relations representative and QIN visit our PCPs monthly and our high-volume specialists on a quarterly basis to provide training, education, care gap data, and utilization data. This frequent interaction does not only support our providers, but it also informs us of any trends or issues our providers are facing. We have designed our model to support our providers wherever they need it to ensure they remain in good standing. We understand providers have the primary interaction with our enrollees and that it is critical to engage with them throughout their experience with Humana. Additionally, throughout our operational presence in Florida, Humana's local leadership team has established strong relationships with providers through extensive interactions. Humana's leadership regularly attends JOC meetings, provider association meetings, and strategy meetings with specific providers to discuss new initiatives, industry trends, and opportunities to reach our common goals. These interactions help support providers, identify provider needs, and maintain satisfaction from the provider community.

Humana has a sophisticated value-based model in Florida to establish financially- and quality-aligned incentive contracts with our providers. These agreements include full risk (global) capitation, shared savings model, quality-cap bonus, and MMA Physician Incentive Program payments to reward our providers for providing high-quality care. Humana designed its model to drive greater provider engagement and better clinical outcomes based on the idea that thoughtful reward incentives, packaged with consultative provider guidance and care gap alerts and integrated with comparative metrics and benchmarks, help providers raise the bar in quality. Our model helps providers more rapidly identify high-risk enrollees, improve chronic condition care delivery, reduce medical costs, and improve enrollee satisfaction. To ensure our providers remain in good standing, Humana supports our providers with several tools, including enrollee data and provider performance metrics, to keep them updated on a regular basis. This data includes a peer-to-peer performance indicator that keeps the provider aware of their performance within the network. Our provider engagement program allows Humana to truly partner with our network partners and optimize the payer-provider relationship, which keeps providers satisfied with their financial incentives and the care they deliver.

As a measure of provider satisfaction, Humana regularly monitors provider termination rate, which is less than one percent (1%) month over month. Humana also performs an annual provider satisfaction survey in all contracted regions in accordance with contractual obligations and in accordance with an AHCA-approved sample methodology and metrics. The purpose of this survey is to evaluate and measure provider satisfaction across service metric areas, including provider relations and communications, clinical management processes, authorization processes including denials and appeals, timeliness of claims payment and assistance with claims processing, complaint resolution process, and care coordination/case management support. Below are examples of our measures from our 2017 Provider Satisfaction Survey:

- My Provider Relations Representative is able to answer my questions: 99% agreement rate

- My Provider Relations Representative is professional and courteous: 99% agreement rate

- Educational and training materials are easy to understand: 98% agreement rate

- Denial notifications, including the denial reason(s), are provided in a timely manner: 100% agreement rate

- Case managers are knowledgeable, professional and courteous: 100% agreement rate

Additionally, Humana's cross-functional Provider 360 Committee, chaired by our Florida Medicaid Operations President, has a goal to continuously identify opportunities to improve the provider experience with Humana. Participants from various departments, including Provider Relations, Claims, Care Coordination, Grievance and Appeals, and Customer Care review various trends and data to understand concerns from providers, and to design initiatives to proactively address these concerns. The Committee meets monthly and produces reports for the QMC's review.

To ensure our providers remain in good standing, Humana provides several tools including enrollee data and provider performance metrics to keep them updated on regular basis, as described in more detail in the Criteria #6 below. These data include a peer-to-peer performance indicator that keeps the provider aware on their performance within the network.

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6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the Agency goals are transparent to providers, including the frequency with which providers will be able to access their progress.

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Humana offers a comprehensive set of tools and resources for our providers to achieve success in accomplishing the Agency's goals of enhanced access, integrated and coordinated care, and improving the quality of care to our enrollees. We provide these resouces and tools on a regular basis to ensure that provider performance and quality metrics are transparent to providers:

- Quality Improvement Nurses (QINs)
- Humana's Monthly Health Effectiveness Data and Information Set (HEDIS) Package
- PCP Reports
- CareHub Clinical Guidance eXchange (CGX)
- Service Fund Data Analytics

QUALITY IMPROVEMENT NURSES (QINS)

A provider liaison position, QINs assist providers in improving overall health outcomes and reducing potentially preventable events. We fill these positions with RNs who have a clinical background to facilitate and coordinate care between enrollees and providers. QINs, whom we assign geographically, meet monthly with PCPs, regardless of whether the provider is

alternative payment method, to analyze and close enrollee care gaps, facilitate education, manage medical costs, and document and improve coding accuracy. During the meeting with the PCP, QINs may develop a tailored plan of how to best support the provider in improving enrollee care.

HUMANA'S MONTHLY HEDIS PACKAGE

To help PCPs better manage the care of their enrollees, a QIN or Provider Relations representative delivers monthly HEDIS reports to every PCP. These reports capture preventable events among enrollees, gaps in care, and high utilizers of pharmaceuticals. In addition, practices can view their performance on HEDIS indicators to see how they compare with other providers in their region. We package this information in an actionable manner, providing call lists with the contact information for enrollees who have care gaps and a list of recommended actions for enrollees who are non-compliant with preventive care screening and/or disease management visits. Additionally, the QIN may work with the provider to develop initiatives around the care gaps, and work with providers to close them.

PCP REPORTS

A QIN or Provider Relations representative delivers to PCPs a monthly report indicating which of their Humana enrollees have care gaps. These reports will also identify enrollees on their patient panel with potentially preventable hospital admissions and/or avoidable use of the emergency department. Our providers and their staff use these reports to reach out to enrollees and address their care gaps and identify preventative services. They may also schedule any needed appointments and make referrals to specialists.

CAREHUB CLINICAL GUIDANCE EXCHANGE (CGX)

Our CGX system generates daily Emergency Department (ED) visit alerts and care alerts we distribute to our providers. These alerts consist of evidence-based medicine care gaps and drug-to-drug/disease interaction alerts. By promoting awareness and closure of these gaps, we help our providers improve the care they deliver.

SERVICE FUND DATA ANALYTICS

Humana developed the proprietary Service Fund risk-sharing management application for providers engaged in a risk or capitated arrangement. We use this innovative tool to calculate reimbursements to providers in these arrangements by tracking and aggregating information on capitation payments, claims expensing, claims payment, reconciliation, and settlement for all PCP contacts.

On a monthly basis, Service Fund makes data files available via Availity that contain information regarding provider membership, funding, claims activity, progress toward value-based payments, and capitation payments at both individual provider and group levels. Humana tailors the reports to providers in risk or value-based arrangements and makes them available for

provider access through an online portal as well as through our Provider Relations representatives. Additionally, Humana educates providers using Service Fund by walking through standard reports during initial trainings to show the data they have access to and to show how to use it to help manage their providers and financials. Provider Relations representatives meet with PCPs monthly to review the Service Fund reports and to discuss any issues or barriers they may face.

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.

2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.

3. The adequacy of the respondent's approach for measuring timely access for the specified provider types and the extent to which the respondent's approach includes clear methodology for determining the following:

(a) Average wait time for an urgent appointment; and
(b) Average wait time for a routine appointment.

4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.

5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent.

6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the Agency goals are transparent to providers, including the frequency with which providers will be able to access their progress.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

5 additional points will be awarded to respondents who demonstrate that providers shall have real-time access to their progress in achieving quality and/or performance metrics.

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2017
Network Development and Management Plan

Network Development & Management Plan
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1. HUMANA'S NATIONAL DEVELOPMENT & MANAGEMENT PLAN OVERVIEW

Humana's Commitment to Quality Care

As a company, Humana strives to offer its enrollees access to dependable, quality care. We've seen success in our partnership with AHCA by understanding and focusing on what's most important in comprehensive care today:

- Instituting a strong provider engagement model built on a partnership to work towards a common goal of delivering quality care to enrollees
- Being easy to do business with through simplification of administrative processes simplifying administrative burdens
- Offering value-based payments to providers to reward and retain them
- Removing barriers to care between providers and enrollees

Our Approach for Establishing & Retaining a Best-In-Class Provider Network

Humana has more than two decades of innovative network development and management experience in Florida. We understand the complexity of recruiting and contracting with the wide range of providers necessary to serve and care for the needs of our enrollees across the State. To continuously grow and maintain our best-in-class provider network across Florida, Humana has developed and consistently executes a rigorous provider recruiting and retention plan to:

- Evaluate the provider network and project needs
- Create and execute an acquisition and retention plan
- Engage with quality and efficient providers
- Simplify doing business with Humana
- Provide timely access to care for enrollees
- Drive continuous improvement through ongoing evaluation of the network

Annual Network Development & Management Plan Overview

Humana's network is built on the evidence-based belief that the following concepts are imperative in our healthcare delivery system and critical components of maximizing enrollee healthcare outcomes:

- Quality of care
- The patient-centered medical home concept
- Preventative and early intervention
- Extensive access to contracted network providers
- Versatile payment reimbursement methodologies to incentivize providers, including value-based payment models
- Communicative provider and subcontractor partnerships that are based on mutual clinical goals and administrative simplicity
- Widespread use of electronic health records

With these fundamental concepts in mind, we work collaboratively with our external network provider partners and subcontractors and internally with our Clinical, Member Services, Medicaid Operations, Quality, Provider Complaints, Provider Grievances, Pharmacy, Customer Service, and Finance Departments in developing our annual Network Development and Management Plan (NDMP). We obtain information from these sources to comprehensively draft our NDMP, analyze our network

progress from the previous year, and identify opportunities to improve our network and enhance access to care for our enrollees. Our provider network leadership team compiles the cross-functional information, which then goes through a compliance review to ensure we are adhering to all AHCA, State, and federal requirements.

2. QUALITY CARE & PROVIDER NETWORK IN FLORIDA

Humana has a long-standing presence in Florida serving Medicaid, Medicare, and Commercial populations. We have operated our Medicaid plan for 20 years and our Medicare plan for 30 years in Florida. Provider satisfaction and engagement are critical to our success in serving enrollees. Thus, throughout our presence in Florida, Humana's provider relations team has established strong relationships with our providers through extensive interactions. Humana leadership regularly attends Joint Operating Committee (JOC) meetings, provider association meetings, and strategy meetings with our providers to discuss new initiatives and opportunities to reach our common goals.

Our considerable experience assessing our existing provider network in Florida and engaging in recruitment strategies to ensure the composition of the network is sufficient to provide timely access to care for enrollees. These network assessments have given us invaluable insight into provider accessibility and availability. We understand that if our enrollees are unable to access our provider network in a timely fashion, we cannot develop or maintain a competent and responsive system of care to meet their needs.

Understanding the Competitive Landscape & Enrollee Enrollment

As of March 2017, Humana has the fifth largest or 10.8% of the membership market share in the 5 regions Humana serves the Florida Medicaid population.

Current MMA Market Share

Organization	March 2017 Enrollment	Market Share
Staywell Health Plan of Florida	675,980	22.0%
Sunshine State Health Plan, Inc.	431,391	15.6%
Molina Healthcare of Florida	345,289	11.2%
Amerigroup Florida, Inc.	342,253	11.1%
Humana Medical Plan	332,565	10.8%
Prestige Health Choice	325,548	10.6%
Other (Includes 6 plans)	575,143	18.7%
	3,078,169	

Source: AHCA Enrollment Report

Humana's MMA Membership and Growth Rate

Q1 2016	
January 1, 2016	332,148
March 31, 2016	344,668
Q1 2016 Growth %	3.63%
Q1 2017	
January 1, 2017	342,818
March 31, 2017	332,565

Q1 2017 Growth %	-3.08%

Source: AHCA Enrollment Report

Changes in Membership

Membership decreased by approximately 3.08% when comparing 1st quarter 2016 to 1st quarter 2017. Some of the reasons for the decrease are changes in eligibility, an enrollee's provider is no longer in the Humana network, an enrollee moved to specialty plan, or an enrollee moved out of area Our membership has trended with overall enrollment patterns of the number of Medicaid eligibles throughout the State.

New Enrollment

- 48% are by choice
- 52% auto-assigned
- 10% enrolled are identified as pregnant

Disenrollment

- 66% ineligible for plan
- 8% provider no longer with plan
- 8% moved to specialty plan
- 6% out of service area

Prior Year Network Analysis

The 2016 NDMP highlighted initiatives and goals for developing and sustaining an adequate network. It focused specifically on improving enrollee access to care and providing support and resources to our network providers. Our measures include a Medicaid network adequacy analysis that evaluates both provider to enrollee distance and provider to enrollee ratios by county and region. We take into consideration:

- cultural competency indicators such as enrollee access to physicians with diverse linguistic abilities
- handicap access
- after-hours access
- physician closed panel data

Additionally, we review results of the following data sources:

- enrollee satisfaction survey results (CAHPS)
- Critical Access Team (CAT) data
- timely access/PCP wait time survey data
- prevalence of providers with the varying levels of Electronic Health Record capabilities

Our 2016 network analysis demonstrates Humana's robust network of various providers, including but not limited to, Primary Care, Obstetrical Care, Specialty Care, Urgent/Emergent Care, Ancillary Services, Hospital Care, Oral Health, and Behavioral Health providers for our enrollees continuously, allowing for comprehensive access to care. Further, Humana meets the AHCA-required enrollee to provider and time and distance ratios for each specialty. There are a few areas of specialties that present some challenges, especially in rural counties, when compared to the AHCA-required enrollee to provider ratios even when considering the current published maximum enrollment ratios; however, the specialty services are available within the enrollees' geographic area.

An example of this is in Region 1. AHCA's published requirement for the specialty of Podiatry is twenty-two (22) providers, even though the PML only documents twelve (12) podiatrists available in the Region 1 area. The AHCA-published minimum provider-to-enrollee ratio for this specialty in this Region is one

specialty provider per 5,200 enrollees, which would provide access for 112,000 enrollees based on twenty-two (22) providers. Humana currently has five (5) providers under contract for Podiatry in Region 1, and has documented an extreme shortage of available providers to recruit and contract. Additionally, although ratios can only be calculated with contracted providers that participate within the Region, Humana has expanded its recruitment efforts into the neighboring counties in Region 2, as well as southern Alabama to attempt to improve enrollee access.

Our Focus on Continuous Improvement

Humana understands the importance of partnering with AHCA annually to review our network findings and measurements and to update our NDMP. Those discussions will help fuel new and innovative strategies to attract new providers, improve quality of care, and achieve cost savings for AHCA and our enrollees.

3. TODAY'S BASIC NETWORK DESIGN AND NETWORK ACCESS ADEQUACY

Humana designed its Florida network to provide all enrollees with adequate access to primary care and specialty providers, as well as convenient access to network pharmacies in the regions we serve. We are continuously monitoring and evaluating our network to identify opportunities for enhancement. We contract with high-quality providers within each region and maintain good relationships through active and ongoing provider engagement.

Existing Region 1

Humana's Region 1 provider network was initially established through our existing Medicare Advantage and Commercial networks. We have continued to develop our provider network since implementation, fortifying previously established relationships. Humana's Medicaid network includes the essential provider Sacred Heart Hospital, and also encompasses every single health system and hospital in the region, as well the majority of large IPA providers. Important Medicaid providers include Sacred Heart Health System, Nemours Children's Clinic, Escambia Community Clinics, West Florida Hospital, Health First Network, Fort Walton Beach Medical Center, Baptist Health System, North Okaloosa Medical Center, Santa Rosa Medical Center and Healthmark Regional Medical Center (a designated safety net hospital). Additionally, our Region 1 provider network includes three Federally Qualified Health Centers (FQHCs) (providing 11 locations) and nine Rural Health Clinics (RHCs) (providing nine locations) and one County Health Department. Our local mental and behavioral health provider, Access Behavioral Health (ABH), is contracted to manage and serve our enrollees' behavioral health needs. In addition, some of Humana's network providers are recognized as Patient-Centered Medical Homes (PCMH). In total, Humana's network has five PCMH groups with 147 providers across 21 locations in Region 1.

Since Region 1 presents unique challenges (e.g., significant MMA membership, a significant amount of rural areas and considerable provider availability shortages in multiple specialties), Humana continues to broaden our contracting activities' scope. Humana continues to grow our Region 1 provider network despite these challenges – see Table 1 below. We have accomplished this through tenacious recruitment activities, including stretching recruitment activities into Region 2. Specifically, we have reached out to all relevant needed providers in the contiguous counties of Bay, Holmes and Washington cities that are within a reasonable time and distance standard for enrollee access. In addition to recruiting in Region 2, we are recruiting providers in southern Alabama. We have worked to identify providers that not only support reasonable time and distance measurements, but also have active and enrolled Florida

Medicaid provider numbers. We are currently working on a contract with the University of South Alabama (USA) (hospital and physicians) to provide additional support for both pediatric and women's health services within the Escambia county catchment area.

Provider Type	Providers Added	Provider Service Locations Added
PCP	24	16
SPC	190	58

**measurement period from December 2015 through December 2016*

Despite our tenacious and ongoing recruitment activities and successful continued network growth, we continue to experience contractual ratio gaps in some specialties – see Table 2 below. We continually monitor these gaps through available resources like the Agency for Health Care Administration (AHCA) Master File (PML), American Medical Association (AMA) Website, Sunbiz, US News Health Report, Florida Department of Health, our competitors' directories and Google. In addition, we discuss availability shortages with our provider groups to encourage additional recruitment from outside the area. Prior to Amendment 11, Humana filed waivers for some of the specialties in which gaps remain. Humana will refile new waiver requests in January 2018.

Specialty	Status	Waiver Originally Filed
Dermatology	All contracting efforts have been exhausted	Yes
Endocrinology (Peds)	All contracting efforts have been exhausted	No
General Dentist	Working with vendor to recruit additional Dentists	Yes
Infectious Disease	All contracting efforts have been exhausted	Yes
Ophthalmology	Working with vendor to recruit additional Ophthalmologists	Yes
Optometry	Working with vendor to recruit additional Optometrists	Yes
Otolaryngology	All contracting efforts have been exhausted	Yes
Podiatry	All contracting efforts have been exhausted	Yes
Rheumatology	All contracting efforts have been exhausted	Yes

Notwithstanding these provider network challenges, Humana's Region 1 network continues to deliver steady performance with very few provider-initiated network terminations and steady enrollee growth. Since Medicaid Managed Care (MMA) implementation, our membership has grown from 51,733 enrollees and we are currently managing 53,278 enrollees (based on July 2017 834 enrollee files).

Expansion Region 2

As Humana began the process of building a new, wide-ranging and efficient Medicaid provider network for Region 2, we approached the process by leveraging our existing Medicare and commercial lines of business provider relationships who already provide services to approximately 9,000 enrollees today. These longstanding relationships gave Humana an initial base for a strong and competitive provider network.

Region 2 has a unique set of challenges, including provider availability shortages in multiple specialties and sparsely populated areas with multiple counties being designated as being Health Provider Shortage Areas with shortages of primary care, dental, and mental health providers. 12 of the 14 counties in the region are designated as rural. Additionally, according to the quarterly Statewide Managed Medicaid Care Report in Winter 2016, Region 2 has one of the highest proportion of unhealthy Medicaid enrollees in the State and one of the lowest number of available providers.

Humana's network is built on a combination of contracts and letters of intent (LOI). Feedback we often hear during network builds is that providers are unwilling to negotiate and execute full agreements until MCOs are awarded. Upon intent to negotiate notification, Humana will prioritize conversion of LOIs to contract agreements. Humana has successfully completed conversion of LOIs to contracts in many instances throughout the country during Medicaid network expansion activities, including in Florida, Kentucky, Illinois, and Virginia.

Similar to our previous successful provider network expansion efforts, Humana partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities. The concentration of providers in Region 2 are located in the anchor counties of Bay and Leon, where we have secured Tallahassee Memorial Health, Capitol Regional Medical Center, and Gulf Coast Medical Center. In addition, we have secured contracts or LOIs throughout the balance of Region 2 counties with Calhoun-Liberty Hospital, Campbellton Graceville Hospital, Gadsden Memorial Campus, Doctors Memorial Hospital, George E Weems Memorial Hospital, Doctors Memorial Hospital Bonifay, Madison County Memorial Hospital. Additionally to the facilities, we have secured contracts and LOIs with 151 adult PCPs, 29 pediatric PCPs, 16 OB/GYNs, 92 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 43 pediatric physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 204 medical specialists, 51 FQHC and RHC locations, 51 home health provider service locations, and 359 behavioral health providers. Humana will continue to improve upon building a full-functioning network that supports all enrollees in accessing and receiving the care they need. In addition, Humana's network has three PCMH groups with 39 providers across 18 locations in Region 2.

Expansion Region 3

As Humana began the process of building a new, wide-ranging and efficient Medicaid provider network for Region 3, we approached the process by leveraging our existing Medicare and commercial provider relationships who provide services to approximately 45,500 enrollees today. These longstanding relationships gave Humana an initial base for a strong and competitive provider network.
Region 3 has a unique set of challenges, including provider availability shortages in multiple specialties and sparsely populated areas with multiple counties being designated as Health Provider Shortage Areas of primary care, dental, and mental health providers. Region 3 has the largest total geography of all Florida Medicaid Regions with nine of the sixteen counties being designated as rural.

Similar to our previous successful provider network expansion efforts, Humana partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities. The concentration of providers in Region 3 are located in the anchor counties of Marion, Lake and Alachua where we have secured contracts with Bayfront Health Brooksville, Bayfront Health Spring Hill, Citrus Memorial Hospital, Lake City Medical Center, Munroe Regional Medical Center, North Florida Regional Medical Center, Oak Hill Hospital, Ocala Regional Medical

Center, Putnam Community Medical Center, Regional General Hospital Williston, Seven Rivers Regional Medical Center, Shands Lake Shore Regional Medical Center, Shands Live Oak Regional Medical Center, Shands Starke Regional Medical Center, South Lake Hospital, UF Health Shands Hospital, West Marion Community Hospital and LOIs with Leesburg Regional Medical Center, The Villages Regional Hospital, and Lake Butler Hospital.

In addition to the facilities, we have secured contracts with 309 adult PCPs, 152 pediatric PCPs, 67 OB/GYNs, 217 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 25 pediatric physical therapy, speech therapy, occupational therapy and respiratory therapy providers, 939 medical specialists, 97 FQHC and RHC locations, 17 home health providers, and 2,256 behavioral health providers. Humana will continue to develop a full-functioning network that supports all enrollees in accessing and receiving the care they need. In addition, Humana's network has eleven PCMH groups with 135 providers across 32 locations in Region 3.

Expansion Region 4

Humana brings significant experience in servicing a large membership base in the greater Jacksonville and surrounding counties across many products, including Medicare Advantage, Medicare PPO and Medicare Private Fee for Service and commercial lines of business. With our large portfolio of products, Humana currently provides medical coverage to approximately 71,000 enrollees. Humana's current Medicare and commercial footprint includes joint venture assets and an Access Center to provide guidance and support for our dual eligible population. Our joint venture opportunities have helped shape our local Medicare Advantage and commercial markets which gives Humana a proven track record to adeptly manage Medicaid enrollees. In addition, we have two Humana exclusive MSO partners who will be adding additional affiliated practices in 2018. These alliances in the Medicare Advantage and commercial network space allows us to leverage competitive market share through high quality, efficient providers who share an interest in value-based opportunities. Humana continues to lead the Jacksonville marketplace through our Bold Goal initiatives driving our communities to become 20% healthier by the year 2020. This initiative helps bring community partners, health organizations and hospitals together in support of health and well-being. Over 200 community organizations meet on a quarterly basis for a clinical town hall format to discuss barriers to health care and strategies to close health care gaps in the community. Our passion for population health makes Humana a strong partner to AHCA in expanding our Medicaid footprint.

In building our Medicaid provider networks, we partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities. The concentration of providers in Region 4 are located in the anchor counties of Duval, Volusia, and Clay where we have secured contracts with Flagler Hospital, Halifax Health Medical Center, Halifax Health Medical Center Port Orange, Memorial Hospital Jacksonville, Orange Park Medical Center, St Vincent's Medical Center Clay County, St Vincent's Medical Center Riverside, St Vincent's Medical Center Southside, and UF Health Jacksonville and LOIs with the Adventist facilities of Florida Hospital Deland, Florida Hospital Fish Memorial, Florida Hospital Flagler, Florida Hospital Memorial Medical Center, Florida Hospital New Smyrna and Florida Hospital Oceanside. Also, Humana secured a LOI with Southeast Georgia Health System Camden Campus and Brunswick Campus to further support Nassau county with enrollee access.

Additionally to the facilities, with 334 adult PCPs, 193 pediatric PCPs, 141 OB/GYNs, 113 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 175 pediatric physical

therapy, speech therapy, occupational therapy, and respiratory therapy providers, 763 medical specialists, 24 FQHC and RHC locations, 16 home health providers, and 2,832 behavioral health providers. In addition, Humana's network has seventeen PCMH groups with 263 providers across 76 locations in Region 4.

Expansion Region 5

Humana's Region 5 network was originally developed in 2012 in support of Humana's filing and being approved for both Pasco and Pinellas as expansion counties prior to MMA implementation. As expansion counties, we successfully managed approximately 2,000 Medicaid enrollees. Humana has extensive experience in servicing a large membership base of approximately 115,000 enrollees across many products, including Medicare Advantage, Medicare PPO, Medicare Private Fee For Service and commercial lines of business including exchange products which we leveraged to build and maintain a strong Medicaid network. Since 2012, we have continued to strengthen the network to provide support in our daily operations of Region 6 since both Pasco and Pinellas counties neighbor Hillsborough county and we experience a significant amount of MMA membership that seek specialty and ancillary services in Region 5 which is a typical pattern of care given the extremely close geographical proximity of the three counties. Our extensive Region 5 network has greatly improved enrollee access through having a greater availability of access to providers which has resulted in improved enrollee and provider experience and satisfaction.

The Humana Region 5 network consists of all of the hospitals and health systems with the exception of one, Adventist. Our provider network includes the following Region 5 designated statewide essential providers of Bayfront Health St. Petersburg and Johns Hopkins All Children's Hospital, as well Tampa General Hospital and their specialty physicians, Shriner's Hospital for Children and University of South Florida College of Medicine in neighboring Hillsborough County in Region 6. Additionally to the facilities, we have secured contracts a with 118 adult PCPs, 233 pediatric PCPs, 99 OB/GYNs, 158 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 54 pediatric physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 486 medical specialists, 16 FQHC and RHC locations, 8 home health providers, and 2662 behavioral health providers. In addition, Humana's network has five PCMH groups with 65 providers across 22 locations in Region 5.

Existing Region 6

Humana brings extensive experience in servicing a large enrollee base in the Tampa Bay area across many products, including Medicaid, Medicare Advantage, Medicare Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS), and a variety of Commercial lines of business, including exchange products. Through our large portfolio of products, Humana provides medical coverage for hundreds of thousands of enrollees, including large employer groups such as Hillsborough County Public Schools, Hillsborough County Sheriff's Office, and Pinellas County Public Schools, in which Humana provides a variety of medical coverage options to their employees and family members. Because of this rich history and experience, Humana has longstanding provider network relationships, which helped to initially foster a successful MMA network build, and continue to provide strength in our daily operations. The Humana Region 6 network consists of all of the hospitals and health systems in the region with the exception of one – Adventist. Additionally, our Region 6 provider network includes the following designated statewide essential providers: Tampa General Hospital (both the hospital and their specialty physicians), Shriner's Hospital for Children, University of South Florida College of Medicine, as well five FQHCs (providing 56 service locations), 13 RHCs, (providing 13 service locations) and one County Health

Department. Humana also secured a contract with Planned Parenthood with 11 locations across Regions 5, 6, and 8 to ensure enrollee access to additional alternative providers offering a wide variety of services such as family planning with extended hours including weekends. Additionally, All Children's Hospital, another state-designated essential provider, and Bayfront Medical Center in the neighboring Pinellas County (Region 5), support our enrollee pattern of care. In addition, some of Humana's network providers boast recognition as PCMHs. In total, Humana's network has twelve PCMH groups with 275 providers across 35 locations in Region 6.

Since MMA implementation, Humana has continued to experience steady enrollee growth in Region 6, beginning with 26,167 and we are currently managing 35,057 enrollees (based on July 2017 834 membership files). Our provider network also continues steady performance with very few provider initiated network terminations. We continue to grow our Region 6 provider network:

Provider Type	Providers Added	Provider Service Locations Added
PCP	50	49
SPC	424	71

**measurement period from December 2015 through December 2016*

Expansion Region 7

As Humana began the process of building new, wide-ranging and efficient Medicaid provider network for Region 7, we approached the process by leveraging many of our existing Medicare and commercial lines of business provider relationships who are providing services to approximately 70,000 enrollees today. These longstanding relationships gave Humana an initial base for a strong and competitive provider network.

Similar to our previous successful provider network expansion efforts, Humana partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities.

The concentration of providers in Region 7 are located in the anchor county of Orange. We have secured contracts with all the health systems with the exception of one, Adventist. These contracts are Arnold Palmer Medical Center, Central Florida Regional Hospital, Dr. P. Phillips Hospital, Health Central, Nemours Children's Hospital, Parrish Medical Center, Orlando Health, Osceola Regional Medical Center, Oviedo Medical Center, Poinciana Medical Center, South Seminole Hospital, St. Cloud Regional Medical Center, Winnie Palmer Hospital for Women and Babies, Wuesthoff Medical Center Melbourne, Wuesthoff Medical Center Rockledge. Additionally to the facilities, we have secured contracts with 402 adult PCPs, 252 pediatric PCPs, 202 OB/GYNs, 60 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 374 pediatric physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 1021 medical specialists, 31 FQHC and RHC locations, 16 home health providers, and 3845 behavioral health providers. In addition, Humana's network has fourteen PCMH groups with 184 providers across 64 locations in Region 7.

Expansion Region 8

As Humana began the process of building a new, wide-ranging and efficient Medicaid provider network for Region 8, we approached the process by leveraging many of our existing Medicare and commercial

lines of business provider relationships who are providing services to approximately 34,000 enrollees today. These longstanding relationships gave Humana an initial base for a strong and competitive provider network.

Region 8 has a unique set of challenges, including provider availability shortages in multiple specialties and sparsely populated areas with multiple counties being designated as Health Provider Shortage Areas of primary care, dental, and mental health providers.

Humana's networks are built on a combination of contracts and letters of intent (LOI). Feedback we often hear during network builds is that providers are unwilling to negotiate and execute full agreements until MCOs are awarded. Upon intent to negotiate notification, Humana will prioritize conversion of LOIs to contract agreements. Humana has successfully completed conversion of LOIs to contracts in many instances throughout the country during Medicaid network expansion activities, including in Florida, Kentucky, Illinois, and Virginia.

Similar to our previous successful provider network expansion efforts, Humana partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities. The concentration of providers in Region 8 are located in the anchor counties of Lee, Collier, and Sarasota, where we have secured contracts and LOIs with Bayfront Health Port Charlotte, Bayfront Health Punta Gorda, Cape Coral Hospital, DeSoto Memorial Hospital, Doctors Hospital of Sarasota, Englewood Community Hospital, Fawcett Memorial Hospital, Gulf Coast Medical Center, Health Park Medical Center, Hendry Regional Medical Center, Lee Memorial Hospital, Naples Community Hospital, North Collier Hospital, Physicians Regional Medical Center Collier, Physicians Regional Medical Center Pine Ridge, Sarasota Memorial Hospital, The Children's Hospital of Southwest Florida and Venice Regional Bayfront Health

Additionally to the facilities, we have secured contracts and LOIs with 190 adult PCPs, 112 pediatric PCPs, 69 OB/GYNs, 225 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 96 pediatric physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 454 medical specialists, 47 FQHC and RHC locations, 15 home health providers, and 1799 behavioral health providers. Humana will continue to improve upon building a full-functioning network that supports all enrollees in accessing and receiving the care they need. In addition, Humana's network has eight PCMH groups with 155 providers across 43 locations in Region 8.

Existing Region 9

Humana has serviced large Medicaid, Medicare Advantage, and Commercial enrollees for more than 20 years in Region 9, with stable, long-term network relationships that fostered a strong network of Medicaid providers. Humana's Medicaid network includes contracts with all of the major health systems, such as Martin Memorial Health System, HCA (including JFK Hospital) and Tenet. Our network also includes the essential provider, St. Mary's Hospital, and a large physician base that provides significant access to PCPs and specialists. In addition, Humana has unique Medicaid HMO and Medicare HMO partnerships with several Medical Service Organizations (MSOs) that provide primary care clinical management through recognized PCMHs. In total, Humana's network has thirteen PCMH groups with 132 providers across 24 locations in Region 9. We have approximately 39,000 enrollees assigned to providers in value-based arrangements. Additionally, we are contracted with 18 FQHC locations and 4 RHC locations. Some physicians in Region 9 provide walk-in primary care and specialty care telemedicine services for enrollees needing services after-hours or who are unable to get to a physician office

location. Since MMA implementation, Humana has continued to steadily grow membership in Region 9, beginning with 56,730 and we are currently managing 71,414 enrollees (based on August 2017 834 membership files). Our provider network continues steady performance with very few provider initiated network terminations. Humana continues to grow our Region 9 provider network:

Provider Type	Providers Added	Provider Service Locations Added
PCP	41	41
SPC	500	120

**measurement period from December 2015 through December 2016*

Existing Region 10

Humana has serviced large Medicaid, Medicare Advantage, and Commercial memberships for over 20 years in the Region 10, with stable long-term network relationships that fostered a strong Medicaid network. Humana's Medicaid network includes contracts with most major health systems' hospitals and physicians, including the South Broward Hospital District, Broward Health, HCA and Tenet. Humana's Medicaid network also includes essential providers Nova Southeastern University College of Osteopathic Medicine, Broward General Medical Center, and Memorial Regional Hospital. In addition, Humana has unique Medicaid HMO and Medicare HMO partnerships with several MSOs that provide primary care clinical management through recognized PCMHs. Many of those same providers are now part of Humana's Medicaid HMO network. In total, Humana's network has six PCMH groups with 309 providers across 15 locations in Region 10. We have approximately 88% of our enrollees assigned to providers in value-based arrangements. Additionally, we are contracted with 6 FQHC locations. Some physicians in Region 10 provide walk-in primary care and specialty care telemedicine services for enrollees needing services after-hours or who are unable to get to a physician office location.

Since MMA implementation, Humana has continued to experience steady growth of membership in Region 10, beginning with 44,129 and we are currently managing 71,951 enrollees (based on August 2017 834 membership files). Our provider network also continues steady performance with very few provider initiated network terminations. Humana continues to grow our Region 10 provider network:

Provider Type	Providers Added	Provider Service Locations Added
SPC	344	98

**measurement period from December 2015 through December 2016*

Existing Region 11

Humana has serviced large Medicaid, Medicare Advantage, and Commercial memberships for more than 20 years in Region 11, with stable, long-term network relationships that fostered a strong Medicaid network, even though 50% of the region is considered rural because of Monroe County. Humana's Medicaid network includes contracts with all of the essential providers and with the hospitals and physicians of most major health systems, such as Jackson Health System, University of Miami School of Medicine, Florida International University College of Medicine, Nicklaus Children's Hospital, HCA, and Tenet. In addition, Humana has unique Medicaid HMO and Medicare HMO partnerships with several MSOs that provide primary care clinical management through PCMHs. Many of those same providers

are now part of Humana's Medicaid HMO network. In total, Humana's network has thirteen PCMH groups with 623 providers across 57 locations in Region 11. We have approximately 73,000 enrollees assigned to providers in value-based arrangements. Additionally, we are contracted with 38 FQHC locations. Some physicians in Region 11 provide walk-in primary care and specialty care telemedicine services for enrollees needing services after-hours or who are unable to get to a physician office location.

Since MMA implementation, Humana has continued to experience steady enrollee growth in Region 11, beginning with 64,539 enrollees in 2014 to currently managing 81,763 enrollees (based on August 2017 83files), which is the highest current regional market share. Our specialist and ancillary provider network also continues steady performance with very few provider initiated network terminations. Humana continues to grow our Region 11 provider network:

Provider Type	Providers Added	Provider Service Locations Added
PCP	N/A	13
SPC	845	161

**measurement period from December 2015 through December 2016*

All provider types in Region 11, which includes Monroe County, are adequate to meet membership needs for access to care. Since we began building our MMA network in 2011, Humana has continued to recruit all required specialty types. Particular attention has been on Monroe County, which is considered rural, in an effort to maintain an adequate network for the approximately 317 enrollees Humana serves in that county. In doing so, Humana has continued to maintain strong partnerships with our contracted providers and subcontractors, and has created a culture of collaboration. Humana has maintained the same network in Monroe County throughout 2014 and to date. Additionally, considering our low membership in Monroe County, Humana continues to retain a strong network that includes two hospitals, seven pediatricians, seven adult PCPs, and over 50 various specialties such as Mental Health, Optometry/ Ophthalmology, Allergy, Cardiology, Hospice and Lab.

4. ONGOING NETWORK EVALUATION AND ENHANCEMENT

Humana measures and evaluates enrollee access to ensure our network meets or exceeds the Statewide Medicaid Managed Care requirements. We are continuously evaluating our Florida statewide provider network, as well as analyzing our capacity in each region, to ensure that enrollees have timely access to providers, including primary care physicians (PCPs), specialists and pharmacies. This includes measuring adequacy against contractual requirements, resolving network gaps and addressing barriers to care, including transportation and linguistic needs. We use network evaluation tools, including, but not limited to, timely access to care for enrollee's analyses; enrollee and provider feedback; and Geo Access reports to proactively target areas for network enhancement.

Our Provider Relations team and Quality Management Committee (QMC) monitor reports for all provider types from our network adequacy tools, on an ongoing basis, ensuring that we are proactively deploying network recruitment efforts, as well as quickly responding to network gaps as they arise. We also conduct strict oversight of our subcontractors to ensure the same level of access is monitored and maintained.

Provider Recruitment

Humana maintains a large network and actively assesses the overall network by provider type. We review and monitor the following key components in our network assessment: (a) the enrollee pattern of care, (b) provider types by geographic area including providers who service medically complex enrollees, and (c) access to care for all levels of providers. These services include, but are not limited to:

- Acute Care Hospitals
- Behavioral Health and Ancillary Services
- Compounding pharmacies
- Early intervention services
- Intermittent skilled nursing (pediatric andadult)
- Non-Emergent Transportation
- Occupational therapy (pediatric)
- Physical therapy (pediatric)
- Primary Care
- Private duty nursing services (pediatric)
- Skilled Nursing Facilities (SNF)
- Specialists including
  - Cardiologists (pediatric and adult)
  - Endocrinologists (adult)
  - Internists (adult)
  - Obstetricians/Gynecologists (adult)
  - Pulmonologists (pediatric and adult)
  - Psychiatrists (pediatric and adult)
- Specialized therapeutic foster care
- Speech-language pathology services P(pediatric)

We consider projections of future capacity planning in our network measurement and management process. Much of our network adequacy measurement process is based on updated enrollee counts and new maximum enrollment percentages. For instance, the enrollee to provider ratios and the time and distance measurements both require current enrollment files. As new enrollees are added, we take the enrollee growth and the geographic enrollment shifts into account to ensure adequate access to care, including linguistic and cultural needs and mitigation of barriers to care.

Significant provider contract re-negotiations can impact future network capacity planning. Humana's Provider Relations team maintains a strategic stratification of our major health system negotiations, so that no more than one health system in a market is under negotiation and has the potential for termination, as a result of the contract end date, at any given time.

Prior to any significant Humana or provider-initiated terminations, including hospitals, large provider groups, or subcontractors, Humana's provider relations team conducts a formal network termination impact analysis, using access analysis, open and closed panels, and provider-enrollee ratios, to verify that there will not be any enrollee access issues. When Humana initiates a termination, we conduct this analysis well ahead of the 90-day notification to the provider, and we notify AHCA within the contractual timeframe. In the event Humana receives a 90-day termination notice from a significant provider, our

provider relations team begins the formal network termination impact analysis. This termination analysis serves as the basis to identify gaps caused by potential terminations. Should we agree to accept the termination the provider, we use the analysis to prioritize targeted alternative providers or provider types that can serve as a substitute for the impacted providers.

How We Assess Network Barriers and Gaps

Humana has consistently met the reporting criteria of the PNV file reporting requirements since MMA implementation. We have identified several key barriers to reporting accuracy:

- Accuracy of provider Medicaid enrollment
- De-duping of provider NPI numbers and locations
- Single provider specialty assignment (i.e., providers that are contracted and credentialed with multiple specialties, but can only be "bucketed" to one primary specialty to support ratio counts)

While these barriers directly affect provider ratio counts, they do not reflect the true depth of the robust provider network and density of locations available to our enrollees based on time and distance measurements. Humana continues to work directly with AHCA and our provider network to resolve these barriers to network adequacy and ratio requirements.

Humana has consistently met the reporting criteria of the Provider Network Verification (PNV) file reporting requirements since MMA implementation. Humana performs a monthly assessment based on AHCA/PNV Adequacy Report. We assess the file against our network by provider type, and we apply our algorithm to proactively identify at-risk specialties for targeted recruitment opportunities. As a result, this process has allowed Humana to identify and rectify network gaps before they occur and our enrollees experience access to care issues.

Our Provider Relations team and Quality Management Committee monitor the reports for all provider types from our network adequacy tools, as well as from our subcontracted entities, on an ongoing basis ensuring that we are proactively deploying network recruitment efforts, as well as quickly responding to network gaps as they arise. Our comprehensive provider network monitoring efforts help us guarantee our enrollees have access to providers and services they need.

We also conduct systematic network adequacy measurement and management improvement in terms of appointment availability. Annually, Humana conducts "secret shopper telephone surveys" to assess wait times in scheduling appointments at provider offices. Providers in each region are chosen based on a statistically valid sample for the survey. The secret shopper survey monitors accessibility of appointments per Humana and AHCA regulatory requirements, and validates after-hours access to a healthcare professional.

The following are descriptions of our methods to identify enrollee barriers to accessing care. Our provider relations team and Provider 360 Committee collects and reviews this data monthly. Our Provider 360 Committee is a cross-functional team, which is chaired by Humana's Vice President of Florida Medicaid, and meets monthly to review provider trends from our Claims Department, as well as Availity (provider engagement) usage, quality measures, provider system usage, and provider grievances and inquires. The Committee includes representatives from our Claims Department, Grievance and Appeals Department, Credentialing Department, and Provider Relations.

Analytical Reporting

Access Analysis —Using a proven geographical analysis tool, the Quest Analytics Suite, Humana uses geocoding technology to precisely measure enrollee to provider adequacy access. This tool measures both distance and travel times against 200% of our enrollment for Regions 1 and 2and against 120% of our enrollment for Regions 3, 4, 5, 6, 7, 8, 9, 10 and 11. We analyze access for each provider specialty as listed in the Statewide Medicaid Managed Care contract by enrollee age/gender group as indicated by the provider type (e.g.,, pediatricians will be mapped to child members). Additionally, this tool enables us to identify access issues at the county and zip code level.

Provider to Enrollee Ratios—We analyze provider to enrollee ratios on a monthly basis against network standards established by Humana in accordance with AHCA requirements. We use these reports to assist us when we anticipate increased enrollment volume to ensure that our network has the capacity to accommodate additional enrollees.

Customer Feedback

- *Enrollee Surveys*—Humana will review CAHPS® and behavioral health enrollee satisfaction survey results annually to identify any access to care issues
- *Staff, Enrollee, Provider, and Advisory Input*—On an ongoing basis, Humana examines anecdotal information, including pattern of care, from various internal and external sources as it pertains to network adequacy, including information contributed by individuals and committees Some of these sources include the Provider 360 Committee, the Critical Access Team, and PCP feedback.

Meaningful Data

- *Complaints and Grievances*—Our Customer Service Department will forward enrollee and provider complaints and grievances reflecting access issues to the Provider Relations Department for review in real-time.
- *Out-of-Network Letters of Agreement*—We examine out-of-network referrals monthly to identify potential areas where provider specialty capacity needs to be expanded.
- *Cultural and Linguistic Needs*—Humana annually analyzes the cultural and linguistic needs of our enrollees and their geographic concentration to ensure appropriate access. For example, in Regions 9, 10, and 11, 36% of our enrollees report speaking Spanish at home. Thus, we strive to recruit providers who also speak Spanish to eliminate barriers to care. In our current network, 55% of our PCPs and 38% of our specialists speak Spanish.
- *Appointment Availability Audits*—We systematically conduct network adequacy measurement and management improvement in terms of appointment availability. Annually, Humana conducts “secret shopper telephone surveys” to assess wait times in scheduling appointments at provider offices. Providers in each region are chosen based on a statistically valid sample for the survey. The secret shopper survey monitors accessibility of appointments per Humana's and AHCA’s regulatory requirements, and validates after-hours access to a healthcare professional. Additionally, Provider Relations Representatives physically audit schedules during on-site visits.
- *After-hours Clinic Availability*—Humana annually conducts calls to PCP offices to ensure enrollees have after-hours access to care. Our Provider Relations Manager reviews results and assigns the appropriate Provider Relations Representative to immediately outreach to the provider if necessary. As noted in the provider manual and the provider contract, PCPs must provide 24-hour availability to enrollees by telephone. Through a direct connection with a clinician or an answering service, enrollees should be given the means to contact their PCP or a *back*-up physician to be triaged for care.

- *Open/Close Panels—On a quarterly basis, we review the panel status of our PCPs by region and county. If a PCP asks to freeze their panel, we review their capacity reports prior to closing the panels and require an updated attestation stating they are at capacity for all payors. We will require the PCP to have an action plan to hire additional physicians and/or physician extenders to be able to re-open their panels in 6 months. Additionally, we produce maps to visualize enrollee access to PCPs. We use this data to identify access barriers and implement additional targeted recruitment efforts.*

Humana will apply the same rigorous processes for identifying and resolving barriers and network gaps for any new regions awarded. For instance, we conduct statewide analyses weekly to guide our network expansion efforts for Regions 2, 3, 4, 5, 7, and 8, including time and distance reports and provider to enrollee ratio reporting. We also leverage our Medicare and Commercial provider networks to identify high performing providers to partner with, including providers participating in our STAR Rewards Program, Value Based Payment arrangements, or serving as Patient Centered Medical Homes, to serve our Medicaid enrollees.

Identifying Network Gaps

Humana creates time and distance reports using geographic access studies to ensure there are adequate numbers of providers, including but not limited to, primary care physicians, high-volume specialty providers, and hospitals in our network. Additionally, the ratio between a PCP and the PCP's assigned enrollees is calculated to ensure enrollees receive timely and appropriate services. Humana utilizes a software program called GEO Networks (Quest Analytics Suite Program), which factors for traffic density. Location comparisons are reported by county from the enrollee's home to the nearest source(s) of care. The software produces mappings and summaries of enrollees with desired access and enrollees without desired access. The provider relations team analyzes the results of those reports and develops action plans to mitigate gaps and address any deficiencies.

Ongoing Activities for Network Development Based on Identified Gaps and Future Needs Projections

Through our assessment tools, when network gaps or barriers are identified, our provider relations team initiates mitigation strategies. The following strategies are ongoing, consistent practices built into network management processes to mitigate identified gaps and barriers:

- Through our analyses, if we identify providers that are not meeting contractual requirements, such as failing to meet after-hours requirement or appointment availability standards, our Provider Relations Representatives will conduct provider education. If necessary, Humana will implement a Correct Action Plan to resolve any barriers to care within our Medicaid network, including subcontractors.
- We make every reasonable effort to contract with additional providers to resolve access issues. Should a provider refuse participation in Humana's network, we will secure a Single Case Agreement with the provider on a case-by-case basis.
- We use our collaborative provider partnerships with major health systems, ancillary providers and large IPAs, to identify providers for recruitment.
- Our provider nomination process enables enrollees to nominate a specific provider for recruitment.
- Our annual minority recruitment process targets providers to accommodate linguistic and cultural needs. We solicit feedback from minority associations, medical schools, and Native American tribes, as listed below.
    - Seminole Indian Tribe
    - Miccosukee Tribe

  - Florida Association of Minority Business Enterprise Officials
  - National Hispanic Medical Association (NHMA)
  - Minority Association of Pre-Med Students at Florida State University
  - Minorities in Medicine/Association of American Medical Colleges
  - Urban Promise
  - American Developing Smiles
  - American Developing Smiles
  - Florida International University
  - Florida Atlantic University
  - University of Florida
  - University of Central Florida
  - Florida State University
  - University of South Florida
- We maintain provider recruitment mailboxes where providers can electronically submit an application to become a Humana provider.
- Because we have several "on-the-street" Humana representatives, including our provider relations Representatives and quality improvement nurses, we receive insight about new providers moving into areas, enabling us to target them for recruitment.
- Through our review of single case letters of agreement and out-of-network utilization, we are able to identify and target non-participating providers for recruitment.
- We use a variety of resources to identify specific providers to target, including the AHCA Master File (PML), AMA Website, Sunbiz, US News Health Report, Florida Department of Health, our competitor's directory, and web searches.
- We harvest data identifying providers who are contracted for other Humana products with HMO provisions, and target these providers for recruitment.
- In areas where there are primary care provider shortages, we encourage our provider groups to recruit additional providers from outside the area, including physician extenders.
- We encourage our providers to offer telemedicine by reimbursing telemedicine in accordance with AHCA contractual requirements.

Identifying and Targeting the Right Providers Based on Gaps

Immediate, Short-term, and Long-term Interventions to Address Network Gaps

In situations other than continuity of care requests, we recognize that out-of-network utilization reports may identify potential gaps in our network. Once we identify and confirm a gap in our provider network, we design and implement an aggressive and prompt recruitment plan. We will notify and work with AHCA upon identification of major gaps or network disruptions. In situations where we have a shortfall or "hole" in our geographic access standards for a given provider type, we address it using the following mechanisms:

- Identify all providers that meet that provider type serving in the area through all available resources including the AHCA Master File (PML), AMA Website, Sunbiz, US News Health Report, Florida Department of Health, competitor's directories and Google. In addition, we discuss availability shortages with our provider groups to encourage additional recruitment of providers from outside the area.
- Recruit providers into the network who will bring that component of the network into compliance with the accessibility standards, if available.

- Provider PCP engagement: Humana may engage the enrollee's PCP to assist with identification of providers commonly used for referrals in his/her practice that are capable of providing and willing to provide care.
- In situations where we identify a network gap and have made what we believe is a highly reasonable offer to the provider(s) in a given area, identify there is a lack of available providers, and/or available providers are not actively enrolled with Florida Medicaid and are still unable to secure network participation, we will document our efforts to AHCA and request a waiver.
- Although maximum enrollment numbers were updated through Amendment 11, Humana continues to experience network gaps in specific regions. For instance, in Region 1 (which experienced an *increase* in the maximum enrollment number) we originally had 11 waivers on hold with the Agency for Health Care Administration. At the current time, we have additional waivers that are being prepared for filing utilizing the new Waiver template process. These waivers represent a significant lack of availability of providers in this region.

Specialty	**Status**	**Waiver Originally Filed**
Dermatology	All contracting efforts have been exhausted	Yes
Endocrinology (Peds)	All contracting efforts have been exhausted	No
General Dentist	Working with vendor to recruit additional Dentists	Yes
Infectious Disease	All contracting efforts have been exhausted	Yes
Ophthalmology	Working with vendor to recruit additional Ophthalmologists	Yes
Optometry	Working with vendor to recruit additional Optometrists	Yes
Otolaryngology	All contracting efforts have been exhausted	Yes
Podiatry	All contracting efforts have been exhausted	Yes
Rheumatology	All contracting efforts have been exhausted	Yes

In the absence of a contract, we will seek to work with needed providers through single-case agreements and will permit enrollees to seek care from these providers on an out-of-network basis.

When Humana determines that use of a non-par provider is appropriate, we employ the following steps:
- Determine if request is a plan benefit and if it meets medical necessity criteria
- Ensure no in-network providers within time and distance are capable of rendering service to enrollee
- If there is not an in-network option, then send the review to the Medical Director for approval
- Once approved, Humana works to negotiate rate, and the enrollee is seen for services.

In addition, Humana recognizes the potential need for enrollees to access critical services outside of their geographic area to ensure the enrollee receives the best care in a timely manner. Below are a few examples of complex cases that displays Humana's ongoing and proficient medical coordination between our clinical and network teams to ensure our enrollees receive the absolute best care in their time of need:

Region 1 example: A 37-year-old male patient was admitted to a participating in-network hospital in Region 1 with a diagnosis of Hashimoto's encephalopathy, seizures, and an altered mental status. Due to this enrollee's complex diagnosis and multiple comorbidities, the enrollee remained in this acute setting for three months. Once the enrollee's team of providers agreed to consider an alternative care setting based on the progress of the enrollee's condition, Humana assisted the enrollee with arranging and receiving post-acute care tailored to his diagnosis. Humana identified several long term acute rehabilitation facilities that specialized in complex neurological rehabilitation rather than utilizing a standard rehabilitation facility, based on the provider team's recommendations. Because there were no beds available at these neurological rehabilitation facilities available In Florida, we extended our search beyond state lines. The enrollee was accepted as a patient by a neurological recovery center in Texas. Humana's clinical team worked very closely with our provider network team to successfully transfer the enrollee, which required air transfer to the facility. Prior to the transfer, Humana's provider network team successfully negotiated a letter of agreement (LOA) with the facility to ensure the services would be accurately reimbursed. The enrollee remained at this facility for two months. Once the enrollee's condition showed improvement, we arranged for the enrollee to be transferred back to a local non-participating neuro-restorative facility to allow the enrollee's family to be active in the enrollee's care and support him in his continued progress of rehabilitation.

Region 11 example: A newborn born baby was delivered at Jackson Memorial in Miami-Dade County with a rare lethal, congenital defect of the windpipe called a type 4 laryngeal cleft. Humana's clinical team called every facility in Florida and, despite a thorough search, no surgeon in Florida was able to repair the enrollee's defect. We identified that the best center to treat this defect was located at Cincinnati Children's Hospital. Humana's clinical team and the provider network team worked to arrange to transfer of the newborn by air ambulance to the Cincinnati Children's Hospital intensive care unit. Prior to the transfer, Humana's provider network team successfully negotiated a letter of agreement with the facility to ensure the hospital would be paid for their services. The surgery was successful and after several weeks the baby was transferred by air ambulance back to the intensive care unit at Jackson Memorial to be reunified with her family.

Humana tracks and trends LOAs via a tracking grid for each. Our contracting teams perform analysis on a periodic basis to identify potential contracting opportunities. For example, common LOA types due to shortage of providers wiling to contract with Medicaid are the Home Health providers in Regions 1 and 6 because of a lack of availability (especially in rural areas) and extremely low home health skilled nursing and therapy rates.

Outcome Measures/Evaluation of Interventions to Fill Network Gaps

We base outcome measures and evaluation of Humana's intervention efforts to fill network gaps and resolve barriers on the following:

- Increase or reduction in the number of provider type gaps as measured using the AHCA required and other network measurement criteria described above (provider-to-enrollee ratio and time/distance standards, using the AHCA network measurement tool).
- Requests for specific services to be provided by non-par providers, or out of area providers. These requests are used as a measurement of the network adequacy status, and are collected and acted upon by the network team. The requests reach us through the portals that support provider services and customer services lines, as well as from the clinical management teams. The requests are generated from:

- PCPs seeking specialist referral services
- Enrollees
- Hospitals
- Specialists
- Humana Case Managers (CMs) who identify and report a need for either a specific provider or provider type

Humana's recruitment efforts include a variety of means to maximize success. These include on-site, face-to-face meetings with providers, telephonic outreach, and use of existing provider relationships to reach other providers. If willing providers are available that can address the specific need, our provider relations team will contact these providers to arrange a face-to-face meeting to recruit the provider into our network. Conversely, if the required provider type is not available or unwilling to contract with Humana, we will offer the enrollee transportation to the nearest qualified provider, make arrangements with out-of-network providers, or coordinate care through available telemedicine conduits.

Credentialing

Humana conducts rigorous credentialing and recredentialing of all providers in our network. Credentialing is one of the quality assurance components NCQA has regularly assessed in awarding Humana's Florida Medicaid plan accreditation. Humana has earned 100 percent of the available points on all NCQA surveys conducted between 2011 and March 2017. Our credentialing, recredentialing, and provider loading processes meet all state and federal requirements, as well as NCQA guidelines. Our process confirms that the provider has a current valid state license, holds current professional liability insurance, has completed the appropriate education and training for their specialty, and is free of sanctions by federal, state, and local authorities prior to the execution of a provider contract.

Providers are an essential part of Humana's mission to assist enrollees in achieving life-long well-being. Through our credentialing and recredentialing process, we ensure contracted providers are qualified to deliver the highest quality of care to our enrollees. Humana's proprietary workflow management tool, Accelerated Provider Exchange (APEX), quickens and automates the credentialing, provider load, and provider demographic update processes allowing us to achieve best in class turnaround times. To ensure providers are ready to provide services to Humana enrollees, we require all providers to complete a thorough credentialing process and ongoing recredentialing process.

5. ENGAGING BEST-IN-CLASS PROVIDERS

Humana believes the key to successfully engage best-in-class providers is to develop a partnership working towards a common goal of delivering quality care to our enrollees. To achieve this goal, we support our providers by providing the necessary tools and resources and by rewarding the providers that serve our enrollees best. Humana's orientation education, ongoing communication and support, and innovative ideas help us to engage and retain excellent providers.

a. Starting with a Common Goal

Our provider engagement model is built around attaining a mutual goal of improving quality outcomes by aligning on the common tenets of this goal, which include financial incentives, provider partnership, administrative simplicity, and provider satisfaction. The foundation of our model is to ensure providers are satisfied with the level of support and attentiveness as a result of our responsive and comprehensive

provider engagement model. Thus, we continually measure provider satisfaction to identify opportunities for improvement in how we interact and support our providers. A key measure of provider satisfaction is our provider network termination rate. Since 2014, our overall provider network termination rate for our MMA and LTC programs has been less than 1% month-to-month. Additionally, our hospital network has stayed stable since the implementation of the MMA program.

b. Initial and Orientation Training

Humana's comprehensive provider training program allows to us achieve more sophisticated, integrated, and engaged partnerships. Provider training activities – both initial and ongoing – are an important component of our relationship-building efforts. Humana offers a variety of training formats to ensure that information is accessible and convenient and accommodates providers' differing needs (organizationally and among individual staff) at all points in time.

Humana has been providing healthcare services for more than 50 years, and we understand that each provider's circumstances are different. We have structured our training programs to support a variety of people and in recognition of their different knowledge bases, needs, and learning styles. Our trainings are flexible and scalable; we provide web-based trainings for busy providers, conference-style trainings to a provider/staff, and one-on-one trainings. The training formats we use include face-to-face orientation and monthly meetings, Humana's Provider Handbook, materials available on our website, and our Availity portal, quarterly provider newsletters, and ongoing support available from our Provider Relations Representatives.

We believe our existing network and strong relationships with providers help strengthen the SMMC program operationally through enhanced access and improved quality outcomes for our enrollees. Thus, we use a cross-functional, integrated, and "high-touch" approach to support and train providers. This "high-touch" approach begins once a provider is credentialed and contracted. Humana's training begins during the negotiation of their provider agreement with Humana or during a single case agreement. Once the provider is considered an active and participating provider, our Credentialing Department will send a welcome packet with a copy of the monthly training calendar, as well as a list of all "on-demand" online trainings we offer, and a provider relations representative will schedule an orientation meeting within 30 days. All providers new to Humana's network receive orientation training from their assigned provider relations representative, who will also serve as their point of contact for all future trainings. This training is their opportunity to understand Humana operations and processes, provider roles and responsibilities, and the vast resources available to them. We conduct the initial orientation in the provider's office, which includes information on all necessary topics to help ensure a mutually successful partnership.

Below is a comprehensive list of all of the topics covered during the orientation training:

- Introduction to the Florida SMMC program
- Contracting and credentialing
- Access to care requirements
- Web resources
- Preauthorization and notification process
- Claims processing and claims resolution process
- Continuity of care
- Enrollee special needs consideration

- Enrollee screening for alcohol and substance abuse
- Clinical management programs
- Patient-center medical home
- Medicaid risk adjustment
- Medicaid Advisory Panel
- Service level agreements
- Agency for Health Care Administration (AHCA) provider based guidelines
- Annual compliance trainings
    - Humana Medicaid Orientation
    - Cultural Competency
    - Health, Safety and Welfare (HSW)
    - Fraud, Waste and Abuse (FWA) and Business Ethics
- Ob/GYN training (for Ob/GYNs only)
- Critical incident reporting
- Disenrollment/transfer of enrollee
- Helpful numbers and regionally specific Quick Reference Guides
- Florida Medicaid Provider Handbook
- Behavioral health tool kit for Primary Care Providers (for PCPs only)
- MMA provider incentive program (MPIP)
- EHR and HIE

The Provider Handbook includes detailed information on claims submission and payment processing, including by not limited to:

- Educational information regarding claims submission, payment processes, and explanation of a clean claim, including standards for submitting a clean/complete claim and following correct coding requirements.
- Information on how to submit a claim directly through Availity or to Availity through their existing clearinghouse to Humana.
- Information on how to submit a standard CMS 1500 and UB04 for paper submission and web claims submissions.
    - For those providers who elect to submit claims electronically, companion guides are made available for 837i and 837p transactions.
- Information on the correct use of ANSI X12 837 transactions, CMS 1500 or UB04 forms, and Availity electronic claims submission to ensure required data for a clean claim

Humana makes all information included in the Provider Handbook available to all providers via the provider website. Additionally, during the provider's orientation, we create an initial assessment as a baseline to identify if providers are correctly billing for services in accordance with State guidelines and the requirements of the provider contract. This baseline helps to determine frequency and content focus of future trainings needed.

Since 2013 we have conducted provider orientation training for more than 4,000 providers in Florida. We use provider feedback to continually modify and improve our provider training content, materials, and delivery sources.

c. Ongoing Training, Communication, and Support

Humana understands that for a number of reasons, including staff turnover, providers need refresher trainings. Providers are assigned a Provider Relations Representative, who is their point of contact for all trainings. We routinely review internal policy changes, and those of governing agencies, to ensure that our trainings capture up-to-date and relevant information. We seek to schedule these training sessions at the provider's convenience at a time when there is little/no patient care activity, and when as many provider staff as possible can attend. One-on-one trainings may be conducted in the provider's offices or at a Humana location. Conference-style, region-based trainings are held in a central location (e.g. hotel conference room, Chamber of Commerce facility, etc). We welcome and encourage AHCA representatives to attend any education seminars we conduct. Additionally, Humana conducts webinars twice per week with an opportunity for provider questions and answer sessions. All webinar schedules are posted in advance on our provider website with a description of training subject matter and time and date. If we identify that a provider needs additional training or if a provider requests it, we conduct follow-up provider service training through telephonic contact and/or face-to-face training, including on-site training for hard-to-reach providers, including those in rural regions.

Humana's Provider Relations Representatives visit providers regularly. During these visits, we deliver information to help the provider understand their overall performance metrics and ascertain whether their staff have any questions or training needs. During visits that occur subsequent to a recent training session, we ask whether there are any issues related to the prior training that they would like more information about or refresher information. We also use these visits as a mechanism to hand deliver important communications and publications that may previously have been mailed or posted to our provider website.

Furthermore, we recognize that provider education is not a static process, and that it may be necessary to reach providers in different ways, at different times, and through different delivery methods. Humana utilizes four simultaneous avenues of training to ensure we are supporting our providers in delivering the best care to our enrollees, which include:

1.) Face-to-face training
2.) Web-based individual training
3.) Webinars
4.) Available resources and "on-demand" training

Recognizing that PCPs serve as the medical home, our Provider Relations Representatives visit PCPs monthly. Below is a list of reports and data shared with PCP offices on a monthly basis:

- Performance profile/report card – snapshot used to review encounter rates, admits and days per thousand, average length of stay, ER visits per thousand and pharmacy opportunities
- New enrollment and disenrollment reports – reports listing all new and disenrolled enrollees from the PCPs panel
- Top 40 enrollees – report identifying the top 40 enrollees with highest incurred cost
- Top 40 drugs – report identifying the top 40 drugs prescribed and evaluation of any opportunities for generic equivalencies
- HEDIS reports including identification of gaps

- Encounter data – provides a 12-month trend and benchmark analysis for PCP encounters and fee for service claims by incurred and processed dates
- ER trends – report identifying enrollees who have had repetitive and excessive ER visits during a specific period of time
- Delivery system reports – provides a list of highly utilized, efficient specialists and mandatory networks available for enrollees
- Network changes – report that outlines changes to the network that may impact the PCP and enrollees
- Newsletters – quarterly publications that summarize topics vital to provider practices
- Mailings – various imperative communications that may have been mailed to their office that are reinforced during visits

Ongoing Claims and Payment Training

Humana's Provider Services Department supports providers and offers assistance with any claims-related issues they may be facing by phone, in-person, and through the web. Humana continuously monitors its providers' compliance with clean claim submission requirements via its claims data and analytics system. This system allows Humana to track claims-related performance measures such as timeliness of claims submission, percentage of clean claims, and percentage of denied claims for each individual provider. For example, we have improved our process since 2015, when on average 89 percent of electronic clean claims were paid within 10 days. In 2016, nearly 99 percent of our electronic clean claims were paid within 10 days. If a provider is identified as requiring assistance with claims submission, our Provider Relations staff offers two avenues for education: a provider relations representative may either contact the provider by phone or visit the provider's office for one-to-one training.

Web-based Individual Training:

Humana provides web-based training through the Availity portal, which is our health information network that optimizes information exchange between multiple health care stakeholders through a single, secure network. The Availity portal encompasses business and clinical services, and supports nationwide real-time and batch electronic data interchange via the web and through business-to-business integration. Recorded web-based trainings may be taken anywhere and are available 24 hours a day/seven days a week. In addition, instructor-led training is available at least one day per week. Through Availity, providers and their staff may access training related to:

- Claims management
- Authorizations management
- ERA/EFT management
- Clinical Solutions
- Electronic Data Interchange (EDI)
- Eligibility and Benefits Inquiry
- Patient Responsibility Estimator Tools
- Payment Collection and Processing
- 5010 Overview
- Annual Compliance training
    - Humana Orientation
    - Cultural Competency
    - Health, Safety and Welfare
    - Fraud, Waste and Abuse and Business Ethics

Providers are trained on compliance concepts and materials during orientations and are also required to complete them on an annual basis. Humana sends multiple reminders to providers, through email, fax blast, and phone calls, throughout the year using varying communication mechanisms to ensure these important compliance topics are met.

Educational Provider Materials

Humana distributes a provider handbook to all our providers, which includes a comprehensive review of educational topics, quick reference guides regarding prior authorizations, and enrollee-covered services materials. After a provider executes an agreement with us and during their orientation training, we review the handbook contents as well as any other information related to our health plan. Our handbook contains comprehensive information about a variety of topics and is a contractual extension to their provider agreement. Below is an overview of the topics covered in the handbook:

- MMA Program Description
- Covered Services
- Emergency Service Responsibility
- Child Health Checkup
- Provider Complaints
- Grievance System
- Chronic and Complex Conditions
- PCP and Other Provider and Subcontractor Responsibilities
- Telemedicine protocols and requirements
- Delegation or Subcontract Function
- Florida Health Information Exchange (HIE)
- Preauthorization and Referral Procedures
- Medical Records Requirement
- Claims and Encounter Submission Protocols and Standards
- Cultural Competency Plan
- Enrollee Rights and Responsibilities
- Fraud and Abuse Policy
- Health, Safety and Welfare
- Patient-Centered Medical Home (PCMH)
- Medicaid Advisory Panel
- Provider Rewards and Incentives
- Provider Resource Website
- Provider Training
- Availity
- Helpful Numbers

Humana also sends out provider newsletters on a quarterly basis and email blasts with important information pertaining to policy changes, quality, industry changes, and medical protocols. EAdditional examples of provider communications may include:

- Quality Reports
- Annual AHCA and CMS compliance training/communication on Fraud, Waste and Abuse and Cultural Competency
- Letters/emails/faxes

- Committee minutes or reports
- Provider bulletins, notices, and newsletters
- Online and hard copy reports
- Peer Review Committee communications related to potential quality of care issues
- Clinical newsletters
- Office visits

Provider Website Materials

Humana has a dedicated webpage where providers can easily access Medicaid provider materials. We also prominently display urgent updates and specific quality initiatives for our providers, such as annual checkups or breast cancer screenings. The following is a list of some of the information available on our provider website:

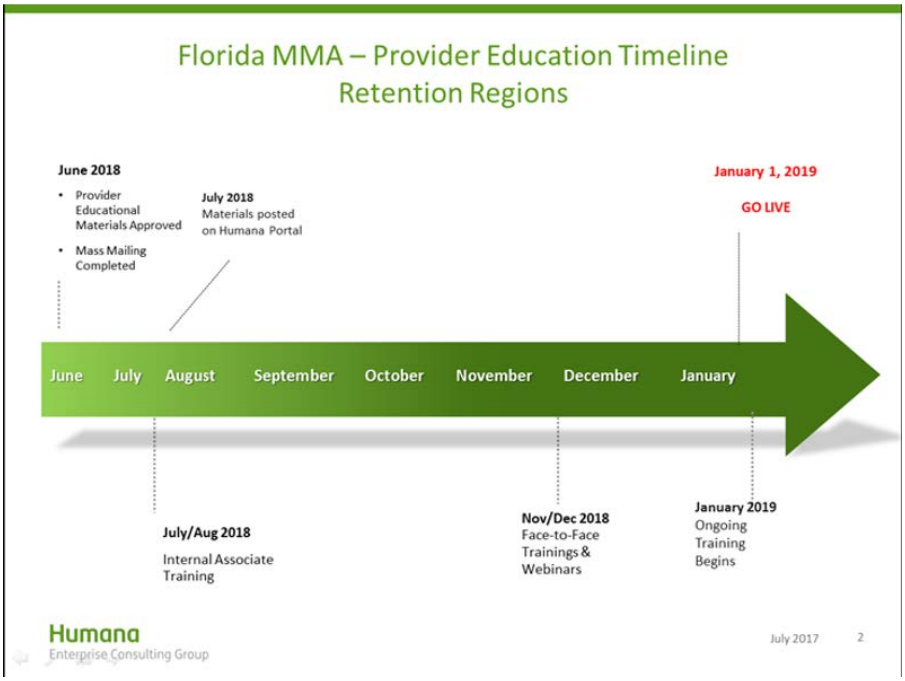
- Provider handbook
- Region-Specific Quick Reference Guides
- Assistive Care Quick Reference Guides
- Medicaid preauthorization and notification list
- Enrollee handbook
- Cultural competency plan
- Provider tools to address gaps in care
- Prescription Drug Guide
- Florida Medicaid preferred drug list
- Behavioral health tool kit
- Home health visit information
- Referral to Medicaid case management form
- Urgent updates
- Breast pump coverage
- Minority recruitment and retention information
- Provider nomination form
- Florida Medicaid Vaccines for Children (VFC) Program and child blood lead screening
- Crossover claims
- Child health check up
- Medicaid eligibility for newborn babies
- Healthy behavior programs
- Quality resources
- Program information
- Provider handbook
- Provider directory
- Helpful numbers
- Provider training calendar
- Electronic billing
- Provider ebilling companion guide

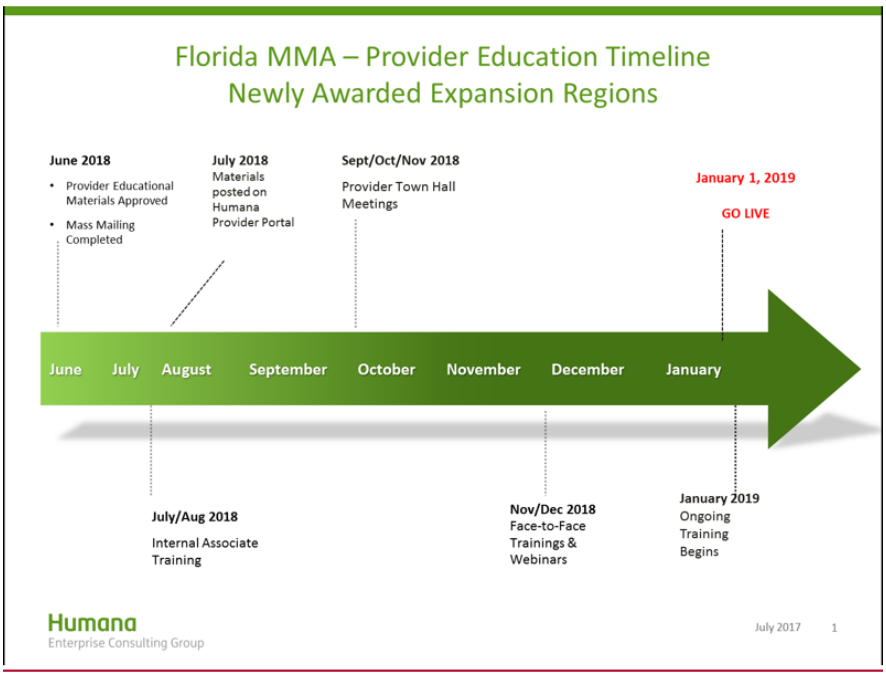
Review of Provider Claims for Training Opportunities

Our provider relations team has a comprehensive process to review claims reports. On a daily basis, our team reviews Availity rejection and denial reports for claims submitted electronically. On a monthly basis, our Provider 360 Committee reviews global provider claims, including electronic and paper claims, trends to widespread issues we need to address with our providers. On a quarterly basis, our provider outreach and provider contract representatives use these reports to provide feedback and identify training needs. Training methods include webinars, town halls, individual provider training, and newsletters. To assess the effectiveness of our trainings and educational materials we send out surveys to providers seeking feedback on the training.

The combination of our new provider orientation education training and ongoing training as well as our daily operational experience with our providers has laid the foundation for a strong training program that will be required for Humana's MMA expansion. We plan to approach provider education for the upcoming 2019 implementation through two strategies – one for existing/retention Regions and one for new, expansion Regions.

See Table 1 and 2 below





d. Rewarding Best-in-Class Providers

Humana's interactive and comprehensive provider engagement model is the basis of our provider retention efforts and a significant differentiator of Humana's provider network management strategy. Our PCPs and high-volume specialists have a relationship with an assigned Humana Quality Improvement Nurse and a Provider Relations Representative.

Provider Engagement in our Value-Based Payment Model

An effective provider engagement strategy enables the formation of true partnerships and optimizes the payer-provider relationship. Humana has extensive experience in creating modernized, value-based engaged provider partnerships that involve substantial financial risk/reward sharing and performance-based incentives for providers, which support our provider retention efforts. We designed our program to support the needs of providers, working constructively with providers from each organization regardless of their organizational size or level of technological sophistication. Humana provides a step-by-step opportunity to earn pay-for-performance financial rewards for achieving certain key clinical measures of success. As providers mature in their ability to achieve basic milestones, additional measures are added or increased outcome performance targets are established which allow providers to earn even greater pay-for-performance rewards.

Humana has a sophisticated value-based model in Florida to establish financially and quality aligned incentive contracts with our providers. These agreements include full risk (global) capitation, shared savings model, quality-cap bonus, and MMA Physician Incentive Program payments to reward our providers for providing high-quality care. Humana's model is designed to drive greater provider engagement and better clinical outcomes based on the idea that thoughtful reward incentives, packaged with consultative provider guidance and care gap alerts, integrated with comparative metrics and benchmarks helps providers to raise the bar in quality. Our model delivers an improved ability for providers to more rapidly identify high-risk enrollees, improve chronic condition care delivery, reduce medical costs, and improve enrollee satisfaction. To ensure our providers remain in good standing,

Humana supports our providers with several tools including enrollee data and provider performance metrics to keep our providers updated on a regular basis. This data includes a peer-to-peer performance indicator that keeps the provider aware of their performance within the network. Our provider engagement program allows Humana to truly partner with our network partners and optimize the payer-provider relationship, which keeps providers satisfied with their financial incentives and the care they are delivering.

Through our initial training and orientation, ongoing training programs, resources, and value-based payment model, Humana has built a best-in-class provider engagement model. However, we recognize that tools, resources and rewards aren't the only way to keep providers engaged. Providers need a corporate partner that is also easy to work with. That's why we strive to remove barriers and administrative burdens.

6. ACCESS TO CARE FOR ENROLLEES

At Humana, we strive to ensure enrollees can readily access appropriate care tailored to their needs from our extensive network of providers within the system, and we provide them multiple access points to find necessary information for timely access to services. Our access standards meet or exceed with AHCA as well as State and federal requirements.

We continuously monitor, analyze, and adjust access needs, types, and methods to ensure we provide a robust network of high-quality, contracted network providers, while striving to ensure we have the appropriate number of providers, provider-to-enrollee ratios, provider types, and availability to effectively service the diverse needs of Florida's enrollees. This helps us identify opportunities to improve our network and enhance access to care for our enrollees.

a. Analysis of Timely Access to Provider Services

Humana conducts various audits to ensure our providers are maintaining accessibility standards. We measure appointment availability standards through initial credentialing and recredentialing site visits, complaint data, capacity reports, and provider self-reporting. Humana also physically audits appointment schedules on a random basis and at least annually by visiting provider offices.

Humana currently conducts audits of appointment availability and office waiting times for PCPs and will expand our processes to the specified provider types, which include pediatric and adult cardiologists, pediatric and adult pulmonologists, adult endocrinologists, adult internists, pediatric and adult psychiatrists, adult obstetricians/gynecologists, and pediatric and adult-licensed mental health clinicians. In 2016, our PCPs averaged 1.2 days for a sick patient appointment, 2 days for an urgent care appointment, and 8 days for a well care appointment, exceeding AHCA's requirements. All participating providers are expected to render care in full compliance with AHCA access guidelines. Humana will comply with the Agency's contractual requirements for Timely Access Standards, as listed below, and actively monitor adherence to these standards.

1. Appointments for urgent medical or behavioral health care services shall be provided:
    (a) Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.
    (b) Within ninety-six (96) hours of a request for medical or behavioral health

care services that do require prior authorization.

2. Appointments for non-urgent care services shall be provided:
   (a) Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
   (b) Within fourteen (14) days for initial outpatient behavioral health treatment.
   (c) Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
   (d) Within thirty (30) days of a request for a primary care appointment.
   (e) Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.

To facilitate timely access to appointments, routine care, and urgent care services, we communicate the following standards to all network physicians through a variety of channels such as during site visits, the Provider Manual Appendix, and provider training materials posted on Humana.com and Availity.com.

APPOINTMENT TYPE	DEFINITION	STANDARD
Emergent	A sudden, unexpected situation which could become a threat to life or limb if not diagnosed and treated immediately (chest pain, excessive bleeding, constant/severe shortness of breath, severe abdominal pain, severe injury, etc.)	Immediately
Urgent	An unexpected illness/injury requiring treatment to prevent serious decline in health, but not life threatening (ear infection in child, fever lasting 1-2 days, persistent symptoms of illness lasting 3-4 days)	Within 24 hours
Routine or Primary Care	Non-urgent care for symptomatic issues (rash, arthritis, return visit to check blood pressure, etc.).	30 calendar days
After-hours access	Telephone information on how to access care after PCP's office has closed	Answering service capable of paging physician or answering service with instructions to call Humana First and/or instructions to go to nearest Emergency Room if emergent/urgent

Access Audit Process

Humana measures and evaluates enrollee access to appointments and wait times on an ongoing basis to ensure network providers meet the required standards. We also conduct strict oversight of our subcontractors to ensure they secure and monitor the same level of access.

We choose a statistically valid sample of providers within a region for a number of different access audits, including appointment availability and wait time for both urgent and routine visits. These audits monitor accessibility of appointments per Humana and AHCA's regulatory requirements and corroborate appointment wait time. Humana measures these appointment availability standards through initial credentialing site visits, complaint data, and provider self-reporting.

On a quarterly basis, Humana conducts a statistically valid sample of "secret shopper telephone surveys" to assess wait times in scheduling appointments at provider offices. The Provider Relations Manager reviews the results and assigns the appropriate provider relations representative for immediate outreach to the provider. Humana also physically audits appointment schedules by visiting provider offices annually. On a random basis, a Humana Provider Relations Representative will visit a provider's office to monitor enrollee wait times, ensuring the provider is meeting accessibility standards. We also review enrollee surveys, provider surveys, complaints and grievances, and staff and provider input for insight into access issues. Our Provider 360 Committee reviews the results from these sources on a monthly basis. While Humana currently conducts the above audits and measures for PCPs, we will expand these efforts to include the listed specialty types.

Telephonic and Visit "Secret Shopping"

We select the top 40% of PCPs in each region based on total enrollee count to survey via telephone or face to face. The secret shopper survey monitors accessibility of appointments per Humana and AHCA's regulatory requirements and corroborates after-hours access to a healthcare professional. (See Table)

The Provider Relations Representative contacts the Primary Care office with symptoms of a simulated condition/illness to assess the next available appointment.

Failure by the PCP center to meet standards will result in the following action steps:

- The center's panel will be immediately frozen to new enrollees
- A corrective action plan shall be implemented with the expectation that the center shall regain compliance with Humana's standards within a 30-day period
- The center shall be re-audited at the end of the 30-day corrective action period
- If the center is found to have regained compliance with Humana's accessibility standards, then the center's panel freeze shall be lifted
- In the event that the center does not improve accessibility standards and regain full compliance within the 30-day corrective action plan window, the center may be provided a notice of termination, with such termination to become effective immediately.

2016 Average PCP Wait Times by Number of Days

Average PCP Wait Times by Number of Days				
Region	**Total Number of PCP Locations Surveyed**	**Measure: Routine Sick Patient Care**	**Measure: Urgent Care**	**Measure: Well Care Visit**
Region 1	129	2	1.3	10.3

Region 6	335	1.8	1.2	18
Region 9	38	1.8	1.2	4.7
Region 10	33	2	1.3	3
Region 11	36	3	1.1	4
Average Wait Times (all regions)	**571**	**1.2**	**2**	**8**

Source: Timely Access/PCP Wait Times Report

Delegated entities (e.g., subcontractors, physician hospital organizations contracting with Humana on a capitated basis) shall collect data regarding appointment availability or other applicable functions utilizing Humana standards, and send written summary reports with supporting documentation to the Health Plan. Below is an example of Access Behavioral Health's survey results in Region 1 from 2016.

Access Behavioral Health Region 1: Appointment Time Access

Access Standard	Percentage of Network High-Volume Providers Who Meet Standard	Percentage of Network Practitioners Who Meet Standard
Emergent: within 6 hours	100%	100%
Urgent: within 48 hours	100%	100%
Routine (Initial): within 7 days	100%	74%
Follow up: Within 30 days	100%	100%

Additionally, in 2016, Beacon's Provider Relations team initiated a platform to ensure that Medicaid enrollees have timely access to care. Beacon's staff contacts 100 percent of the network providers (MDs, DOs, and ARNPs) each quarter and ask questions to determine the provider's ability to accommodate Humana/Beacon Medicaid enrollees. If a provider is unable to accommodate an enrollee according to Humana's access standards, Beacon ensures that the provider has an alternate plan in place to assure that these enrollees have access to care in urgent, emergent, and routine situations. Once the calls have been made to the providers, any changes that need to be made in the system are documented via Beacon's management information system. If additional documentation is needed prior to creating these events, Beacon's Provider Relations staff follows up to obtain it from the provider. Below is an example of Beacon's survey results in Regions 6, 9, 10 & 11.

Beacon: Appointment Time Access

Survey Question (reflects current Agency timely access standards)	Q1 Results
Can you accommodate a Humana/Beacon Florida Medicaid enrollee, who has an emergency, 24 hours per day, 7 days per week?	97.8% (176/180)
Can you accommodate a Humana/Beacon Florida Medicaid enrollee in need of urgent care within one (1) day of the request?	97.8% (176/180)
Can you accommodate a Humana/Beacon Florida Medicaid enrollee in need of a behavioral health routine initial evaluation ("sick care") with an appointment within one (1) week of the request?	92.8% (167/180)

Can you accommodate a Humana/Beacon Florida Medicaid enrollee in need of a behavioral health routine follow-up appointment ("well care") within one (1) month of the routine initial evaluation visit?	97.8% (176/180)

Future Enhancements

Humana will operationalize a plan in 2019 to increase the frequency of the timely access to service survey to a quarterly basis. We will also incorporate a statistically significant sample of designated high-volume specialty provider type, which include cardiologists, pulmonologists, endocrinologists, internists, psychiatrists, OB-GYN, and licensed mental health clinicians.

After-Hours Care Access

Humana also conducts calls to PCP offices to ensure enrollees have access to care during after-hours at least annually or as issues arise on a more frequent basis (See Table 1). Our Provider Relations Manager reviews the results and assigns the appropriate local provider relations representative for immediate outreach to the provider if necessary. As noted in the provider manual and the provider contract, PCPs must provide 24-hour availability to enrollees by telephone. Whether through an answering machine, or a taped message used after-hours, enrollees should be given the means to contact their PCP or a back-up physician so they can appropriately triage the enrollee for care.

Table 1

2016 After Hours Accessibility Audit

Region	Total PCP/FTE	Total PCP/FTEs After Hours	% of PCPs/FTEs w/After Hours	AHCA SLA Requirement
1	385.5	147.5	38%	30%
6	1348.5	855	63%	35%
9	575	363	63%	40%
10	420	300.5	72%	40%
11	621.5	409.5	66%	40%
Total	**3350.5**	**2075.5**	**60%**	

Humana values providers that offer after-hours to our enrollees and that realize the importance to our enrollees of having access to their PCP instead of going to an emergency room or an urgent care center. Humana is implementing an initiative to increase the reimbursement to encourage additional providers to offer after-hour services (99050 and 99051). Given the current Medicaid-allowable reimbursement of seven point two eight ($7.28) and nine point thirty-nine ($9.39), Humana is offering a range of thirty-five ($35) to fifty ($50) dollars, which is a substantial increase in reimbursement.

Enrollee Satisfaction Surveys

We also monitor enrollee wait times using enrollee satisfaction surveys (CAHPS), which we complete annually. Our Quality Management Committee (QMC) reports analysis of the to ensure we meet our goal benchmarks. Access to care results is measured year over year with established benchmark goals (see Table 2).

Table 2: Measurement and Results: CAHPS Analysis for Access to Care

Florida Medicaid Adult CAHPS Results				
CAHPS Question/Composite	**2016 Rate**	**2015 Rate**	**2015 Quality Compass National**	**2016 Market**
Getting Needed Care	77.5%	73.0%	80.8%	75.2%
Q14. Ease of getting care, tests, or treatment needed	79.3%	79.7%	82.9%	82.1%
Q25. Got appointment with specialist as soon as needed	75.8%	66.4%	78.7%	68.4%
Getting Care Quickly	78.8%	77.9%	80.7%	80.2%
Q4. Got urgent care as soon as needed	82.9%	80.6%	83.4%	83.0%
Q6. Got routine appointment as soon as needed	74.6%	75.3%	78.2%	77.6%

Florida Medicaid Child CAHPS Results				
CAHPS Question/Composite	**2016 Rate**	**2015 Rate**	**2015 Quality Compass National Average**	**2016 Market Goal**
Getting Needed Care	74.7%	82.4%	84.3%	84.9%
Q14. Ease of getting care, tests, or treatment needed	86.0%	83.9%	88.8%	86.4%
Q28. Got appointment with specialist as soon as needed	63.4%	81.0%	80.8%	83.4%
Getting Care Quickly	89.1%	87.8%	88.6%	90.4%
Q4. Got urgent care as soon as needed	90.1%	88.3%	90.2%	90.9%
Q6. Got routine care as soon as needed	88.1%	87.3%	87.1%	89.9%

Source: 2016 CAHPS Survey Results

Enrollee Turnover—Humana utilizes reporting of enrollees who have requested reassignment on a monthly basis. This report includes codes which may indicate dissatisfaction with appointment availability or office wait times.

Site Visits—Humana conducts provider site visits for PCPs during the credentialing and recredentialing process. As part of the site visits, we assess appointment scheduling policy, wait times, and after-hours accessibility. Humana also physically audits appointment schedules on a random basis during site visits.

Complaints and Grievances—Complaints and grievances from enrollees and providers are received through multiple routes and are recorded and tracked in our Customer Care Portal. Complaints that reflect network access issues or identify potentially noncompliant providers are forwarded to our Provider Relations team for review and action on a real-time basis. In addition, Humana will be designating a Provider Services Leader who will provide oversight on provider disputes.

Staff and Provider Input—Humana examines input from various internal and external sources pertaining to appointment availability and waiting times. Examples of these sources include our Provider 360 Committee, clinical access team, Provider Relations representatives, case managers, specialists' offices, and customer service specialists.

b. Telemedicine

Humana promotes telemedicine as a care delivery option to improve enrollee access to services, especially in remote geographical areas, provider shortage areas, and for enrollees with mobility issues. Humana's contracting policies and procedures define telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.

Provider relations representatives educate providers regarding telemedicine strategies and requirements. Humana strives to ensure that all providers seeking to deliver telemedicine strategies understand how specific rules for these services apply to any person or entity prescribing or reviewing a request for Florida Medicaid services, and to all providers of Florida Medicaid services that are enrolled in or registered with the Florida Medicaid program.
We also encourage our providers to offer telemedicine by reimbursing telemedicine in accordance with AHCA contractual requirements. We offer our enrollees access to Doctor-on-Demand to encourage telemedicine as a means ability to limit out-of-network utilization and enhance non-emergency ED diversion. Doctor on Demand is a platform that provides enrollees with access to physicians 24 hours a day, seven days a week from the enrollee's phone or computer. The platform allows enrollees to see and/or talk to a physician immediately using video or phone services or to make an appointment for a later time. Additionally, the platform allows an enrollee to upload medical history, send images if necessary, and obtain a prescription.

For providers licensed within their scope of practice to perform the service, Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between a recipient and a provider.

Florida Medicaid does not reimburse for:

- Telephone conversations, chart review(s), electronic mail messages, or facsimile transmissions.
- Equipment required to provide telemedicine services.

Furthermore, we ensure providers understand that Humana reimburses for telemedicine services in compliance with AHCA's guidelines:

- Florida Medicaid reimburses a provider who is providing the evaluation, diagnosis, or treatment recommendation located at a site other than where the recipient is located.
- Providers must include modifier GT on the CMS-1500 claim form, incorporated by reference in Rule 59G-4.001, F.A.C.

We have partnered with specific physicians throughout Regions 9, 10, and 11 to provide walk-in primary care and specialty care telemedicine services for their enrollees who need services after-hours or who are unable to get to an office location where the physician is located.

Humana continues to look for opportunities to partner with providers to deliver telemedicine services to improve enrollee access to services. In 2017, Humana developed an educational campaign to alert providers on appropriate requirements of telemedicine and Humana's reimbursement. In effort to educate providers, Humana created a one-page flyer promoting the benefits of telemedicine services, the state-mandated requirements, and Humana's reimbursement.

c. Pharmacy

Network Adequacy

We access pharmacy accessibility evaluations utilizing Quest Analytics for each region using the most current Medicaid membership file as a representation of the population.

Humana's pharmacy network team evaluates network access periodically on the following schedule:

- 4th quarter of each year for the upcoming year
- When requested by specific business areas when network service areas are being reviewed for the upcoming benefit year
- When a major pharmacy chain (> 5% of the network) leaves the network

Accessibility of pharmacy networks are evaluated to determine if networks meet adequacy based on the below standards:

- 1 pharmacy within 5 miles of an urban enrollee
- 1 pharmacy within 5 miles of a suburban enrollee
- 1 pharmacy within 15 miles of a rural enrollee

The following are the percentage of enrollees that must meet the above access standards:

- 90% of urban enrollees must meet access standards
- 90% of suburban enrollees must meet access standards
- 70% of rural enrollees must meet access standards

Compounding Pharmacies:

All pharmacies in the Humana network are able to provide enrollee's with compounded prescriptions. In addition, Humana's mail order pharmacy through PrescribeIT can also provide enrollees with compounded prescriptions. Humana continuously monitors enrollee concerns regarding access to pharmacies which includes compounded prescriptions to ensure there is adequate access.

Over-the-counter (OTC) Benefit

Humana offers an over-the-counter (OTC) program through PrescribeIT. Each enrollee has a monthly household benefit that allows up to a $17.50 coverage for each member of the household to be used toward any items that are offered on the order form. Orders ship to the enrollee's home by USPS or UPS at no charge for shipping.

Out of Network Requests

If new enrollees are utilizing a pharmacy that is not in our network, Humana will continue to allow the prescriptions to process for a period of 60 days during the enrollee's continuity-of-care period. Prior to

the end of the continuity of care 60-day time frame, Humana and the enrollee's provider(s) will educate them on how to access their drug benefit through Humana's participating pharmacy provider network.

d. How Enrollees Access the System

Humana understands that enrollees need convenient, easy-to-use system information so they can readily access appropriate care. Some of the ways enrollees access the system is through enrollee materials such as the enrollee handbook and online provider directory, as well as through access points including the Customer Service call center and Clinical Access Team (CAT). We educate enrollees on the available methods to access appropriate services on Humana's website, their enrollee ID card, and in their enrollee handbook. Enrollees and providers can contact Humana to translate these materials to their language of choice and send to them on demand. Our provider directory, both online and hard copy, gives enrollees ample means of finding a provider who is best qualified and best suits their healthcare needs.

Language Assistance and Alternative Formats **–** Effective communication with enrollees is paramount, and Humana strives to ensure "equality of opportunity" for meaningful access to health care services and activities. It promotes increased compliance and adherence to follow-up treatment, improved use of and access to preventive care, better understanding of covered services, navigation of the complex health care system, and improved enrollee satisfaction.

Humana provides, at no cost, appropriate access to oral interpretation services in 200 languages, video interpretation in 24 languages, including American Sign Language, and translated written materials of vital documents based on threshold languages and auxiliary aids required by disabled enrollees (current and future). Humana follows the Department of Health and Human Services' framework for Limited English Proficiency (LEP) and ADA enrollees for the development of the language assistance and alternative formats section of the Language Assistance and Alternative Formats Services. Below is a link to Humana Accessibility Resources: https://www.humana.com/accessibility-resources.

Humana ensures that all enrollee materials are reviewed using the Flesch-Kincaid Methodology to ensure they are written in a maximum fourth grade reading level and are easily understood (42 CFR 438.10 (5d)). Enrollee materials are printed in a type, style, and size that can easily be read by enrollees with varying degrees of visual impairment. Additionally, all enrollee materials are distributed in English and Spanish, but are also made available in varying alternative formats and foreign languages. We encourage enrollees in every mailing and on our website who need a specific format, such as braille or in a language other than English or Spanish, to request materials by calling Humana Customer Care.

e. New Enrollee Materials

New Enrollee ID Card and Welcome ***Kit*** - Enrollees that choose Humana Medical Plan as their preferred plan of choice receive two AHCA-approved mailings: one with their Humana Medical Plan Enrollee Identification Card and one with their New Enrollee Welcome Kit. The Welcome Kit includes a Welcome Letter, Important Phone Numbers List, a Health Risk Assessment Form with a self-addressed envelope, a Consent for Release of Medical Records Form, and a Continuity of Care Form with a self-addressed envelope.

The Welcome Letter introduces new enrollees to the unsecured enrollee website (https://www.humana.com/medicaid/florida/mma), where they can find materials including the Enrollee Handbook and Provider Directories and request free printed copies of any materials by calling Humana Customer Care. The letter also explains enrollment and disenrollment information and discusses each of the items included in the Welcome Kit. These materials direct enrollees to call Customer Care for any questions and concerns on how to access care and benefit information.

Enrollee Handbook - An easy-to-find and easy-to-read handbook is very important in supporting our Medicaid enrollees. Humana places great emphasis on making sure the enrollees can use the handbook at their convenience and in a manner they can easily understand. This includes the reading level, identifying easy-to-find phone numbers, and making the materials available in the language of their choice.

Provider Directories - Enrollees need detailed information on both providers and hospitals when making decisions regarding their healthcare services, so Humana strives to provide this information in an easy to use and accessible format, including the online provider directory. If enrollees are interested in learning more about Humana's physicians, such as their educational background or training, they may use the Physician Finder Plus tool on the Humana website (www.humana.com). We update this tool daily and make it accessible to all visitors to Humana.com, whether they are an enrollee or not, and without needing to log in.

Enrollees will find the "Find a Provider" feature at the top in the Quick Links section and specific links for doctors, dentists, and pharmacies on the middle of the page. This brings them to the search page, where the site prompts enrollees to enter criteria from the options below to find a provider that fulfills their needs:

- Enrollee ID number
- City, State
- ZIP code
- Network
- Provider type/Specialty
- Provider name
- "Sounds Like" provider name
- Group/Facility name
- Type of coverage
- Geographic location
- Geographic distance
- Gender
- Language
- Accreditation – NCQA, ABIM or Board Certification
- Accepting new patients status
- By symptom, condition, or procedure

Humana strives to ensure the information within Physician Finder Plus on humana.com is as accurate as possible. We make regular updates through demographic changes received from provider offices. Providers can report demographic changes in a variety of ways. They can submit changes electronically through Humana.com using the "Manage My Demographics" tool under the Resources tab. Providers

can also email, mail, or fax changes to the Provider Verification Unit. Additionally, providers can submit their changes to their Provider Relations Representative. Enrollees also have the option of alerting Humana to a demographic change by clicking on “Report updated information” on the provider’s details page in Physician Finder. Humana’s Data Collection and Verification team also contacts providers quarterly to give them an opportunity to submit any necessary demographic changes for the online directory.

Humana has built a feedback link within Physician Finder Plus whereby any logged-in enrollee can enter information submitted by a Medicaid enrollee about a specific provider. It collects and reports on two data elements: 1) enrollee’s experience; and 2) enrollee’s comfort with recommending that provider to others. We maintain the reported information for a limited amount of time and then purge it to make sure that the information is up-to-date. The information is only available via the secure portal to ensure only enrollees can submit feedback. Humana also reviews this information to help identify poor-performing providers. If a provider receives five submissions over a 12-month period that are below a score of 2 or below on a 5-point scale, we will refer it to provider relations for review.

Humana also provides a printed provider directory if an enrollee requests it. The directory contains both an English and Spanish section; however, the enrollee can request a directory in other languages by calling Customer Service. Additionally, enrollees can download the printed directory in a PDF format from Humana.com. We update the PDF format directory weekly.

f. Enrollee Access Points

Enrollees may need to access the network in a variety of ways, so Humana offers multiple access points including telephone accessibility, the Clinical Access Team (CAT), and oral interpretation services in 200 languages, to address their needs and preferences. We develop and adhere to stringent performance standards that help us monitor, maintain and report upon the various ways enrollees choose to access the network, while ensuring our providers maintain accessibility standards. We strive to ensure that all enrollees receive timely and appropriate access to care.

Telephone Accessibility - Humana Customer Services staff, available via our toll-free number, TTY/TDD, is in place to ensure enrollees have access from 8:00 a.m. to 8:00 p.m. each business day. We train our Customer Services Representatives (CSRs) to provide prompt, courteous, and accurate responses to a variety of inquiries that help the enrollee access the system, including but not limited to the following: (a) answers to questions regarding benefits and verification of eligibility; including communication of benefit changes; (b) providing assistance with selecting participating providers; (c) answers to prior authorization or claims questions; and (d) acceptance of complaints, grievances, and appeals.

After hours, on weekends, and holidays, the call center utilizes alternate technologies, such as an Integrated Voice Response (IVR) system. When an enrollee connects to the IVR, it asks in both English and Spanish if they would like to speak to a nurse about a care-related issue. If the enrollee says “yes,” it routes the call to Citra, our 24/7 nurse line vendor. If they say no, or simply hold on the line, it routes them back to the IVR. The IVR will allow them to self-serve or leave a message for callback on the next business day.

If Citra receives a non-care-related call and the enrollee would like to leave a message, Citra transfers them directly to the IVR. The automated answering system will permit any caller to leave a message that

includes a name and telephone number without requiring identifiable information such as enrollee ID or Social Security number. A representative will then call them back the next business day.

Monitoring and Reporting

Humana monitors and records all inbound calls, and logs each into our system to assist with any future calls an enrollee places to Humana. We train staff to respond to enrollee questions in all areas, including but not limited to covered services, provider network, and transportation. Calls from enrollees and providers alike are subject to the same call center performance requirements, which we monitor via the Medicaid Volume Report, produced daily.

Workforce Management provides real-time performance reporting on an ongoing basis, reported throughout the day to Operations Managers and Supervisors. This information includes call trending and real-time call and staffing adjustments made to address any identified needs/trends.

- Workforce Management adjusts associates' skill sets to provide adequate staffing at all times.
- We record 100% of all inbound calls received.
- Call and Call Center Representative performance information is housed within internal databases, Automated Call Distribution (ACD), and Workforce Management reporting systems.
- Workforce Management produces call reports, which it provides to the Customer Care Supervisor/ Team Lead. The format is similar to the Medicaid Volume Report, but includes pertinent individual measures.
- The report also addresses associates' use of time while on the phone including:
    - Talk time (time spent on each call with an enrollee/provider)
    - Not ready time (time not taking phone calls)
    - Hold time (time on hold by a caller while the CCS is researching)
- The Customer Care Supervisor/ Team Lead discuss call results with each CCS and provides coaching as needed.

The Call Center Supervisor/Team Lead, on a daily basis:

- Reviews and monitors the Medicaid Volume Report
- Analyzes the report information upon receipt
- Takes appropriate actions as needed based on the report data to adjust call center staff and to address trend impacts noted

The Call Center Supervisor/Associate's Team Lead assesses individual CCS performance on a weekly basis through:

- Side-by-side monitoring
- Monitoring of systems used
- Process followed based on call received
- Interaction documentation

Humana maintains results of the performance assessment in the associate's personnel file.

- Humana also tracks performance measures, as stipulated in the Florida Medicaid Contract, on the Medicaid Volume Report including:
- Call Answer Time: When a Medicaid enrollee calls the Call Center phone number he/she does not get a ring. The call rolls into the IVR system directly. The enrollee has the option to use IVR or opt-out. The call answer time (ASA) is measured in seconds as the time between x and y.

- Wait Time: We determine this from the time the call goes through to the IVR or the caller opts out to get a CCS. Refer to "Avg Wait" on the Medicaid Volume Report. This is the average time in seconds that a caller waited on the queue before a Customer Care Specialist answered the call.
- Abandonment rate: The abandonment rate is determined as follows: total calls disconnected/abandoned before a CCS receives it (ABA) divided by total number of calls offered (Offered). Refer to "ABA %" on the Medicaid Volume Report.
- Blocked Call Rate: The Medicaid Customer Care phone system does not block calls at any time.

Customer Care's minimum expectation for the overall quality performance score is 95%. The Medicaid Quality Summary Report is tracked at an individual level, which then rolls up into a Call Center Overall Monthly Summary Report. The Medicaid Quality Summary form is both the template and the report.

- On a daily basis, a Quality Associate (QA) pulls call recordings for a specified number of CCS's for a total of 5 observations per associate per month.
- A quality audit is completed at the individual level (by associate).
- All individual quality audits are rolled-up together to produce the Medicaid Monthly Quality Summary Report.
- Quality results are reported up to Senior Leadership (Service Operations Vice President and Senior VP & Chief Service & Information Officer) on a weekly basis for their review, comments, and feedback to the directors of the Customer Care operational area.

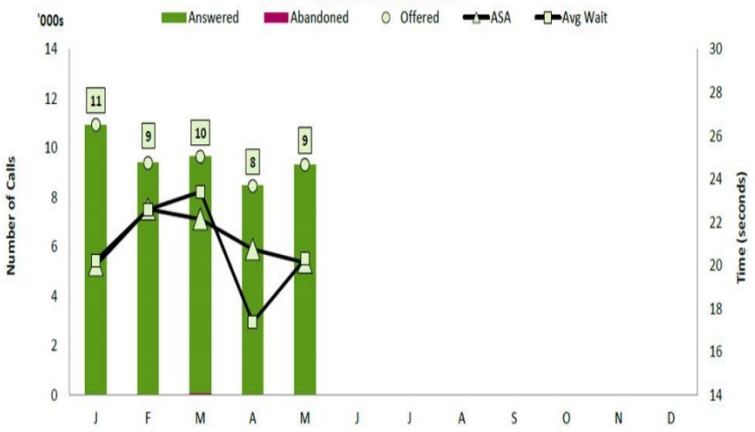
Clinical Access Team (CAT) - Humana has a Clinical Access Team (CAT) that facilitates access to care when we identify a clinical issue related to enrollee access. The CAT consists of three non-clinical specialists who process inbound calls and ten RNs who manage and resolve the cases. Issues may range from appointment availability to inability to locate a provider. Once an inquiry is received, a CAT associate will review and telephonically contact the enrollee or appointed representative to acknowledge receipt and to clarify the issue. The CAT associate may contact providers involved in the access issue to determine any extenuating circumstances, to offer assistance to possible barriers in resolving the issue, and to work with internal departments, such as Provider Relations, to facilitate a resolution. The CAT associate also provides guidance and education to promote better health outcomes for enrollees.

Performance Metrics

Here are the results of Humana's customer service performance metrics as of May 2017, including Service Level and Abandon Rate, Contractual SLA Performance, and Enrollee Calls; as well as Clinical Access Team (CAT) results:

Medicaid Customer Service: Service Level and Abandon Rate

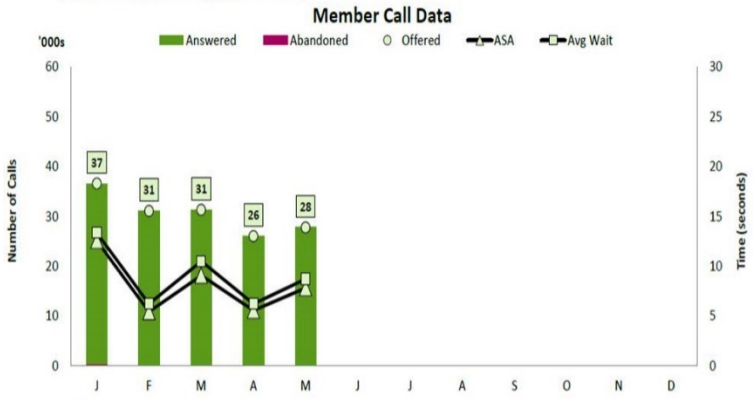
Florida - MMA - Regions 1 & 6:



Call Center - Contractual SLA Performance:

Metric/SLAs & Criteria (Member calls)	Dec	Jan	Feb	Mar	Apr	May
% Answered under 30 seconds	96.9%	90.5%	87.8%	89.1%	89.8%	90.3%
(ASA) is not to exceed 30 seconds	14	20	23	22	21	20
Average Call Blockage rate not to exceed .5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Call Abandonment rate not to exceed 3%	0.3%	0.6%	0.7%	0.9%	0.7%	0.6%

Florida - MMA - Regions 9 - 11:



Call Center - Contractual SLA Performance:

Metric/SLAs & Criteria (Member calls)	Dec	Jan	Feb	Mar	Apr	May
% Answered under 30 seconds	96.8%	90.8%	96.4%	95.2%	96.5%	95.2%
(ASA) is not to exceed 30 seconds	5	13	5	9	6	8
Average Call Blockage rate not to exceed .5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Call Abandonment rate not to exceed 3%	0.4%	0.9%	0.6%	0.8%	0.6%	0.7%

CAT Team Results

Over the past 12 months (7/2016 – 6/2017) with Key Performance Indicators (KPIs) for the commercial, Medicare and Medicaid population:

- Overall access cases: 99.2% compliant w/inquiry resolution & closure w/in 14 calendar days
- Overall service level (80% of calls answered within 30 seconds): 82%
- Overall abandonment rate (less than 5% of calls abandoned): 5%

At least monthly but as needed, the Plan reviews enrollee complaints from the CAT and other available sources to identify and trend complaints regarding access to care. We also monitor complaints received by our Critical Inquiry and Grievance and Appeals Departments on a monthly basis to identify and remedy access to care issues (see Table 4).

Table 4: Clinical Access Team and QI Access Complaints per 1000 Enrollees – 2016-2017

	Medicaid	
Time Period	**# of Complaints**	**Complaints/ 1000 enrollees**
2nd QTR 2016	3047	0.41
3rd QTR 2016	3049	0.41
4th QTR 2016	2390	0.32
1st QTR 2017	2588	0.35

Source: Clinical Access Team Reports and complaints received directly in market Network Administration and Quality Improvement

7. MAKING IT EASY TO DO BUSINESS WITH HUMANA

Humana strives to remove barriers and administrative burdens providers often face when working with Managed Care Organizations (MCOs). Humana's leadership team, including our local staff in Florida and our corporate staff in Kentucky, believe that in order to understand and adequately address the issues providers face, we must start with a strong provider engagement model, which is why we invest in efforts to partner with our providers and support them with the tools they need to succeed such as educational materials, face-to-face training, and claims resolution. We empower our providers to deliver a robust, high-quality, clinically integrated health care model to our Medicaid enrollees. Humana has a proven record of quality initiatives and successful enrollee outcomes since serving the Florida Medicaid population over the past 20 years. For example, Humana ranks second in NCQA Quality rankings amongst MMA Medicaid plans in Florida.

Our investment in staff and information systems technologies allows us to support our providers efficiently and cost- effectively. The support providers receive from Humana's provider relations team across our spectrum of products in Florida, which includes Medicaid, Medicare, and Commercial lines of business, enhances our connection to the provider community. Often when we bring on a provider for Medicaid services, they have already had exposure to Humana with other lines of business. This diversity gives Humana a larger volume of relationships with providers, more frequent interactions between our staff and provider staff, and fosters more sophisticated, aligned, performance-based financial arrangements aimed at improving quality outcomes while containing cost.

a. Gauging and Addressing Barriers to Providers

Humana's longstanding relationships with provider associations contribute to our ability to maintain engagement with providers. Our partnerships with physicians, hospital, long-term care, and ancillary provider associations allow for open and ongoing communication that allow us to gauge and address issues providers encounter while working with Humana. Provider associations are avenues for Humana to obtain feedback on opportunities for improvement from the provider community, as well as provide educational information and communications. Humana engages with provider associations through regularly scheduled conference calls and meetings, which Humana's senior leadership team frequently

attend. Association meetings are a particularly effective way to work with medical and long-term care providers on issues that are unique to these providers, such as Medicare crossover claim processes.

- A Humana leader was recently elected to the Florida Assisted Living Association (FALA) advisory board, as well as the advisory board to the Florida Area Agencies on Aging. This relationship has allowed Humana to play an instrumental role in improving coordination between various Councils on Aging.
- Humana's market director and national Medicaid director also meet monthly with Leading Age/ Florida Association of Homes for the Aging to work through open items, such as provider concerns, possible innovations to payment arrangements and stay updated with the Nursing Facility and Assisted Living Community.
- Humana leaders attend the annual Florida Hospice and Palliative Care Association (FHPCA) meeting, where we have developed an improved understanding and relationship of hospice providers. During the most recent meeting with FHPCA, we received positive feedback on our claims and referrals process. As a result of this meeting, we also recognized the need from hospice providers to better understand the coordination between medical and long-term care as it relates to claims, authorization, and enrollee responsibility. We are developing a quick reference guide for these providers.

b. Internal Engagement Support Model

Our provider relations staff meets on a bi-weekly basis to discuss trends, initiatives, and opportunities to train and educate front-line provider relations representatives. Educational opportunities include Medicaid-related topics such as AHCA alerts, fee schedule changes and agenda topics from AHCA monthly calls. This meeting is also used as a forum to discuss best practices and provider-specific challenges, such as OB/GYN, Ambulatory Surgery Center, Hospice, Home Health or Adult Day Care related. Additionally, provider relations staff meetings provide an opportunity for Humana's front-line Provider Relations Representatives to share the challenges our providers are experiencing with provider relations leadership. These meetings allow Humana provider relations leaders to obtain front-line information to inform the development of new educational materials or the presentation of an issue or concern to the Provider 360 Committee for consideration. See the visual representation of our provider engagement model below:

The diagram below conveys Humana's provider engagement model. Our model delivers cross-functional support to our providers to ensure we are aligned in achieving our mutual goal of improved quality outcomes for our enrollees through administrative simplicity, financial partnership, and provider satisfaction.

Beyond our established relationships with our providers, Humana is continually advancing our internal infrastructure to support provider engagement and satisfaction. Humana has established the Provider 360 Committee, a multifunctional team representing provider support areas which is chaired by Humana's Medicaid Market Vice President. The committee's objective is to review all functional areas to improve provider experience through review of provider metrics, identification of process improvement opportunities, and development of provider education initiatives and materials. The Committee has representation from:

- Market Executive Leadership
- Regulatory Compliance (MMA and LTC)
- Market Provider Relations/Contracting (MMA and LTC)
- Market Hospital Contracting
- Market Service Alignment Managers
- Provider Call center
- Provider Directory
- Claims Processing (MMA and LTC)
- Availity Liaison team
- eHUB team
- Physician Performance Management
- Market Quality Operations
- Market Clinical leaders
- Corporate Medicaid Implementation
- Critical Inquiry team
- Provider Communications

- QIC Committee

c. Simplify the Administrative Burdens

Humana's network is built on the evidence-based belief that quality of care, the patient centered medical home concept, preventative and early intervention, widespread access to contracted network providers, communicative provider and subcontractor partnerships that are based on mutual clinical goals and administrative simplicity, and widespread use of Electronic Health Records, are all now imperative in our healthcare delivery system, and a critical component of maximizing enrollee healthcare outcomes. With these fundamental concepts in mind, we work collaboratively with our external network provider partners and subcontractors and internally with our Medical Management, Medicaid Operations, Quality, Pharmacy, Customer Service, and Finance Departments. We make it easy for providers to find the materials they need by providing multiple sources for policies, training information, and Humana's internal systems. The following sections provide more details about our technology and informational resources.

d. Electronic Health Records (EHR)

Humana's ultimate goal of supporting our providers in delivering quality and appropriate care to our enrollees is supported by provider electronic health records (EHRs) and the Florida Health Information Exchange. Humana has a long history of investing in and promoting state of the art technology to facilitate timely and seamless transfer of information.

Humana has adopted various mechanisms to identify Florida providers who do and do not utilize EHRs, including:

- Conducting surveys of network providers
- Provider relations interaction with providers
- Assessing AHCA and CMS Eligible Professionals/Eligible Hospitals Info Links and the AHCA and CMS EMR List Links

Humana understands there are critical barriers to impacting EHR usage:

- High cost to implement EHR technology
- Strict maintenance/compliance requirements
- Administrative burden
- Understanding meaningful use

We educate our providers on the importance of using electronic health records and demonstrating meaningful use through the following mechanisms:

- Provider handbook
- Link to Florida Medicaid EHR Incentive Program website directly from Humana's provider Web portal
- Link to Florida's EHR and HIE newsletter, "Going Digital News Bytes" directly from
- Humana's provider Web portal

Since 2014 Humana has developed a strong data collection process in order to understand the network landscape relative to EHR usage. The table below shows year over year results from 2014 through 2015 and 2015 through 2016.

All Eligible EP & Hospitals 4th Qtr 2016-Full Dentist/Psych/all other spec-regions										
ALL SPEC/ALL LOCATIONS	DENOMINATOR	NUMERATOR	2016 4th Qtr	2016 3rd Qtr	*4q 2016 % of Improvement from 2015*	2015	2014	2015 % of Improvement from 2014	Goal	*4q diff from goal*
Region 1	2656	1456	54.82%	53.61%	*15.19%*	38.42%	34.10%	4.32%	55%	*0.18%*
Region 6	6229	2390	38.37%	34.27%	*9.79%*	24.49%	29.41%	-4.92%	60%	*21.63%*
Region 9	4153	1930	46.47%	46.14%	*11.65%*	34.49%	8.76%	25.73%	60%	*13.53%*
Region 10	3865	1488	38.50%	38.72%	*8.82%*	29.91%	10.10%	19.81%	50%	*11.50%*
Region 11	7928	2831	35.71%	35.73%	*11.97%*	23.75%	18.20%	5.55%	45%	*9.29%*
Total	24831	10095	40.65%	**39.42%**	***11.20%***	**28.23%**	-	-	-	-

Although Humana showed improvement of EHR usage throughout our provider network, in order to further bolster results Humana developed a one-page educational flyer to help providers better understand the importance of EHR and meaningful use. In addition, we developed a process improvement plan for 2017 through 2018 which includes the following steps:

- Provider Relations Representatives will deliver the EHR flyer to all PCP centers and OB/GYN offices during routine monthly visits
- Fax blast the EHR flyer to all other applicable provider types
- Ensure all subcontractors receive information from the flyer as an example of Humana's efforts and report back the results of their EHR outreach efforts for their downstream providers.

e. Assistance and Communication Tools Provided to the PCPs

Humana has developed an array of education and training materials for our providers. These tools allow providers to quickly find the answers they need so they can spend more time helping enrollees with their care.

Web-Based Tools

Humana offers providers a number of web-based business solutions to ensure they are able to interact with us on an optimum basis. Providers can access our portals, Humana.com and Availity.com, for services such as:

- Health and wellness programs
- Provider publications (including provider manuals)
- Provider Training
- Quality resources
- Clinical practice guidelines
- Pharmacy services
- Claim resources
- Verification of enrollee eligibility and benefits
- View enrollee ID cards
- Review care alerts and enrollee summaries
- Submit referrals and preauthorization requests
- Send attachments (i.e. medical records)
- Check claims status and remittance information
- Access to the Medicaid Long Term Care Program information

Providers can obtain support from Humana for web based training and assistance through a variety of channels. During orientations and ongoing provider visits they may request their Provider Relations Representative assist with training, contact us via a dedicated email box or by at enrolling in one of our web based training sessions published on Humana.com.

Florida Medicaid Provider Handbook

Humana's provider manual gives provider's information and guidance on a number of topics such as:

- Program Description
- Covered Services
- Emergency Service Responsibilities
- Child Health Checkups
- Provider Complaints
- Grievance System
- Chronic and Complex Conditions
- PCP and Other Provider/Subcontractor Responsibilities
- Telemedicine
- Delegation /Subcontractor Functions
- Florida Health Information Exchange
- Preauthorization and Referral Procedures
- Medical Record Requirements
- Claims and Encounter Submission Protocols and Standards
- Cultural Competency Plan
- Enrollee Rights and Responsibilities
- Fraud and Abuse Policy
- Health, Safety and Welfare
- Patient-Centered Medical Home (PCMH)
- Medicaid Advisory Panel
- Provider Rewards and Incentives (if applicable)
- Provider Resource Website
- Provider Training
- Availity
- Helpful Numbers

Quick Reference Guide

Providers and members of their office staff are provided a region specific Quick Reference Guide that is designed to assist them with information on daily topics like frequently called phone numbers, important addresses, vendor network contact information by specialty type, medically necessary services, expanded enrollee benefits, frequently used web addresses and a sample enrollee ID card.

We deliver Quick Reference Guides to providers during orientations and ongoing provider visits, and also make them available on our website.

Provider Newsletters

Humana publishes quarterly provider newsletters on its portal to assist providers with staying current with policy changes, quality initiatives, industry changes and medical protocols.

Additional Provider Reference Materials on the Web

Humana providers have access to a variety of tools on our website. The materials are current and up-to-date to allow providers to reference them on their schedule. Materials on the website include:

- Medicaid appendix to the provider manual
- Enrollee handbook
- Quick Reference Guide (including a version for assistive care services)
- Preauthorization and Notification List (PAL)
- Prescription Drug Guide
- Provider newsletters
- Compliance-based training modules and frequently asked questions and answers
- Obstetrician and gynecologists training
- Healthy Behaviors program including smoking cessation
- Quality resources such as information on child health check-ups, oral health for children and adolescents, prenatal and postpartum care for women and HEDIS measures overview
- Information on how to access our LTSS vendor portal
- Home Health Visit Information

Compliance-Based Training (All Provider Types – PCPs, Specialists, Subcontractors, Ancillaries and Hospitals)

Providers are expected to adhere to all training programs identified by our contract and Humana as compliance-based training. This includes agreement and assurance that all affiliated participating providers and staff members are trained on the identified compliance materials.

As part of the training requirements, providers must complete annual compliance training on the following topics:

- Medicaid Provider Orientation
- Compliance and Fraud, Waste and Abuse
- Cultural Competency
- Health, Safety and Welfare (Abuse, Neglect and Exploitation)

Providers and members of their office staff can access these online training modules seven days a week, 24 hours a day on both our website and Availity portal.

We strive to make it easy to do business with Humana. Through our meetings with providers and provider associations, we learn about and address the barriers providers face in their day-to-day activities. By hiring and promoting staff that dedicated to establishing a relationship with our providers, we ensure our providers are never without a support network. By pioneering simplicity, we allow our providers to spend more time focusing on our enrollees. Finally, Humana makes every effort to support and educate our providers so they can accomplish our common goal: providing quality care to our enrollees. That's also why we have established Quality Care Initiatives including efforts to better coordinate between departments and manage complex cases and diseases.

8. HUMANA'S QUALITY OF CARE INITIATIVES

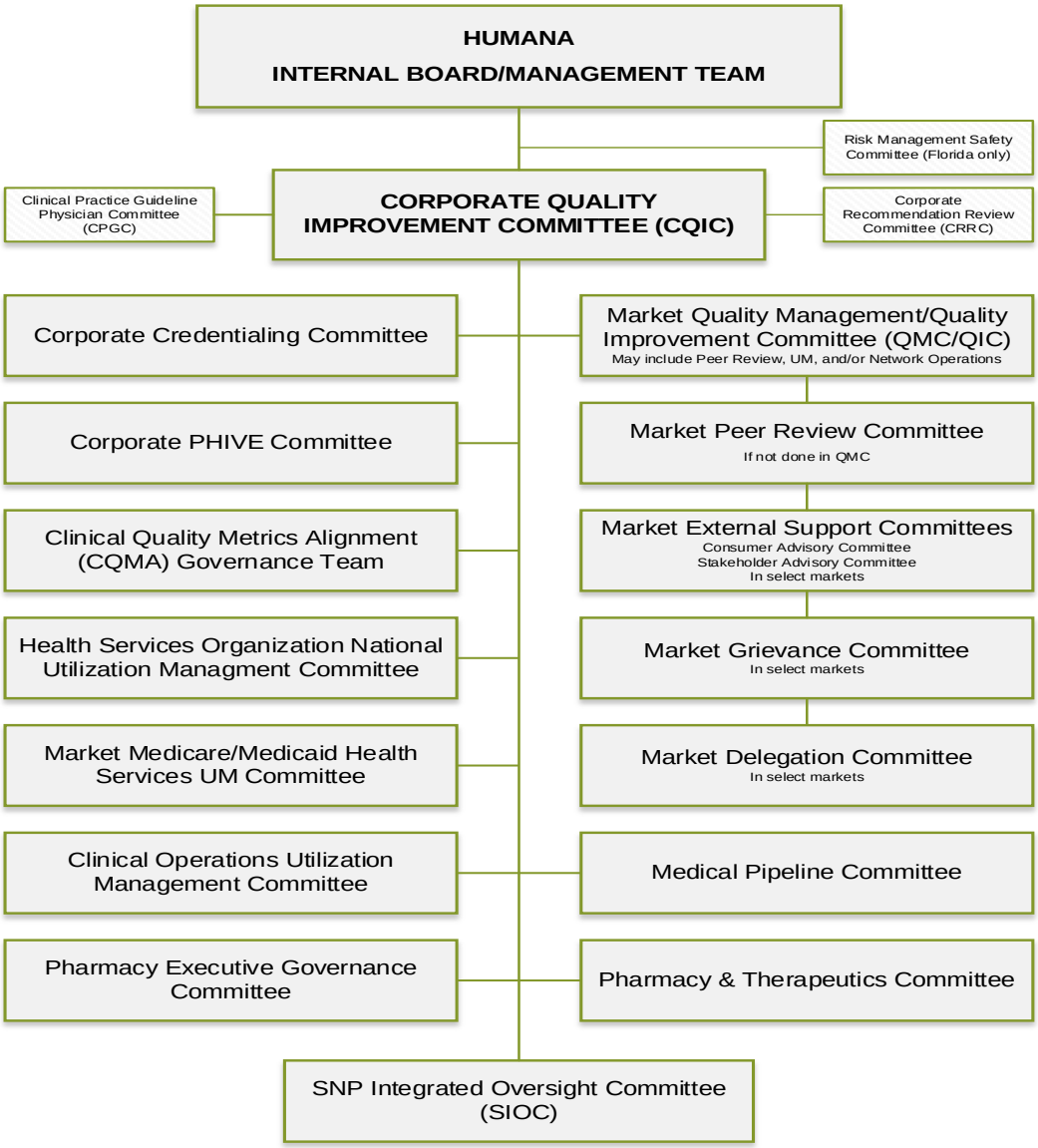
Humana serves its provider and enrollee population with a steadfast focus on improving outcomes, delivering exceptional access to care to enrollees, driving improvements in population health, all while reducing healthcare costs through well-being improvements. We do this through constant improvements to our internal processes, support mechanisms and ongoing initiatives including internal coordination across lines of business, and a strong focus on disease management and complex care.

a. Internal Department Coordination and Infrastructure

A solid infrastructure and dedicated leaders with quality improvement (QI) expertise ensure high quality comprehensive, coordinated healthcare to all enrollees. Humana's overall vision supports continuous quality improvement throughout the organization by a solid infrastructure and dedicated leaders with QIP expertise to ensure high quality, comprehensive and coordinated healthcare to all enrollees, across all plans. Corporate leadership on the Corporate Quality Improvement Committee, delegated by the Board of Directors, provides operational oversight for the QI program activities and recommends policy decisions by planning, analyzing and evaluating the activities. Quarterly and annually, the Quality Management Committee and the Florida Medicaid Quality Improvement Committee, report the Medicaid activity to include accomplishments, barriers and improvement initiatives.

The Internal Board/Executive Committee has ultimate responsibility for oversight of quality improvement activities. Members of the Internal Board/ Executive Committee include:

- President and Chief Executive Officer
- Executive Vice President and Chief Operating Officer
- Senior Vice President and Chief Medical Officer
- President, Employer Group Segment and Government
- President, Retail Segment
- President, Clinical Care Services
- President, Humana Pharmacy Solutions
- Senior Vice President and Chief Consumerism Officer
- Senior Vice President and Chief Strategy Officer
- Senior Vice President and Chief Human Resources Officer
- Senior Vice President and Chief Financial Officer
- Senior Vice President and Chief Innovation Officer
- Senior Vice President and Chief Information Officer
- Senior Vice President, Corporate Affairs
- Senior Vice President, Medicare Operations
- Senior Vice President and General Counsel



The Corporate Quality Improvement Committee (CQIC) oversees the quality improvement program, as delegated by the Internal Board/ Management Team. The Corporate Quality Improvement Committee's purpose is to use a centralized approach to the Quality Improvement program by forming one corporate committee that assumes the responsibility for the Quality Improvement Program of Humana. The CQIC is chaired by the Corporate Chief of Quality.

- The CQIC provides operational oversight for the Quality Improvement program activities and recommends policy decisions.
- The CQIC allocates a forum for members of the Committee to engage in review, coordination and direction of the Quality Improvement program.
- The Committee is charged with overseeing the establishment and integration of the Quality Improvement program and measurement of quality activities on a regular basis.
- The CQIC shall be comprised of voting members showcasing multi-specialty representation of the centralized and regionalized areas of operations. Voting members shall be stewards of

Humana's mission. Their recommendations are expected to be based on sound operational data, in support of member service, and the overall good of the markets serving Humana members.

The CQIC shall undertake the following functions and responsibilities:

- Oversee reporting of data from centralized/regionalized departments on a consistent basis, to include HEDIS improvement, CAHPS surveys, member satisfaction, disease management programs, appeals and grievances, credentialing, utilization management, member safety issues, customer service and many other quality and satisfaction metrics.
- Engage in discussion of such data with the representative and identify any opportunities for improvement.
- Improve communications between the markets and the centralized/regionalized operational areas and provide consistent reporting of data.
- Review, provide guidance and make recommendations concerning clinical guidelines, policies and procedures and Quality Improvement standards and related legal, regulatory and accreditation requirements.
- Provide guidance in defining the scope, objectives, activities and structure of Humana's Quality Improvement Program.
- Review ongoing reports from departmental quality improvement activities and determine the extent to which they meet standards and requirements, as defined in the Quality Improvement Program Description.
- Provide guidance to management teams and staff related to quality improvement priorities and projects to include Medicare Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs (CCIPs).
- Monitor organizational progress in meeting Quality Improvement Program goals and objectives as outlined in the Quality Improvement Work Plan and evaluate the overall effectiveness of QI Program on an annual basis.
- Review, approve and update, as indicated Quality Improvement Program Descriptions, Quality Improvement Annual Evaluations, and UM program documents on an annual basis.
- Review, prioritize and align the Quality Improvement Work Plan with the strategic objectives of the organization annually.
- Review and approval of Special Needs Plans (SNPs) Program Descriptions, Models of Care, and Models of Care Evaluations.

Members of the CQIC include, but are not limited to representatives from:

- Accreditation
- Appeals and Grievances
- Behavioral Health
- Claims
- Clinical Policy
- Clinical Programs
- Clinical Strategy
- Commercial Product UM
- Compliance
- Consumer Messaging
- Credentialing
- Customer Service

- Disease Management
- MHSO Product UM
- National Network Operations
- Pharmacy
- Provider Communications
- Provider Contracting
- Quality Operations, Compliance and Accreditation
- Risk Management
- Sales/National Accounts
- Specialty Benefits
- Stars, QRS and Medicaid Improvement

Behavioral Health Humana incorporates behavioral health aspects into the QI program. The Medical Director and Quality and Accreditation Director from the behavioral health provider are involved in the mental health aspects of the program which includes the management of substance abuse services. The Behavioral Health Medical Director, or designee, may participate and advise the Corporate Quality Improvement Committee on behavioral health issues. Monthly collaboration work groups are conducted between the delegated Managed Behavioral Health Organization (MBHO) and the Health Plan leadership.

Protected Health Information and Vendor Ethics (PHIVE) Committee is a corporate committee created to protect the privacy of Humana members and direct the ethical behavior of vendors. The PHIVE Committee reviews the handling of identifiable and de-identifiable member data and monitors interaction with vendors to promote the highest ethical standards. The PHIVE Committee meets monthly and reports to the CQIC. Members of the PHIVE Committee may include representatives from:

- Privacy Officer (chair)
- Pharmacy Solutions
- Physician Review
- Market Vice President
- Law Department
- Regulatory Implementation
- National Network Operations
- Technical Services Group
- Personal Nurse
- Insurance and Risk Management

Technology Assessment Forum (TAF) is chartered to create Humana Medical Coverage Policies for new and emerging technologies and to review existing policies on a regular basis. The committee's purpose is to verify that Medical Coverage Policies are evidence-based and facilitate consistency in clinical decision making, mitigate legal and financial risk, and support the goals of Humana to provide guidance to its consumers. Humana Medical Directors are the only voting members of this committee. The committee is chaired by the Medical Director for Clinical Policy Development or designee and meets at least quarterly. In addition to the voting Humana Medical Directors, members of TAF may include non-voting representation from:

- Claims Policy
- Clinical Claims Review
- Clinical Programs

- Customer Service
- Health Guidance Organization
- Humana Military Health Services
- Legal Department
- National Contracting
- Product Strategy
- Provider Contracting
- Additional representatives as appropriate

Following the TAF meetings, multiple departments are involved in implementation activities in an effort to ensure our prior authorization and claims systems and processes are congruent with our medical coverage policies. System and staffing impact decisions and timeframes are tracked through the Prior Authorization (PAL) Core team on SharePoint.

Medical Pipeline Committee is chartered to discover and research new and emerging medical technologies, with the purpose of developing a strategy, determining the expected financial impact around these new technologies, and distributing information to other departments throughout Humana. Medical technologies include, but are not limited to, medical devices, professional society recommendations, CMS coverage updates, and laboratory and genetic testing. The Medical Pipeline Committee currently refers information to the following departments: Technology Assessment Forum, Provider Contracting, Lab Pay Zero Initiative, Quality Operations Compliance and Accreditation, Pharmacy, Healthcare Economics, Claims, Provider Contracting, Product Development, and Medicare. The committee meets at least quarterly and publishes an update of activities that is distributed throughout the company. The Committee also issues alerts around technologies that may be of an urgent nature that may result in high utilization and/or high financial impact. Medical Pipeline Committee members may include representatives from:

- Clinical Policy Development
- Technology Assessment Forum
- Healthcare Economics
- Genetic Guidance Program
- Additional representatives as appropriate

Pharmacy and Therapeutics (P&T) Committee has a responsibility to review and make decisions about the appropriate use of drugs, biologicals, and select non-drug pharmacy-related products. The P&T Committee reviews policies that guide exceptions and other utilization management processes, including drug utilization review program, quality improvement program,, quantity limits, generic substitution, and therapeutic interchange. This charge may be relevant in many contexts including, but not limited to, clinical edits, drug utilization review, consumer programs, contracting, and networks. The Committee may render decisions through motions or may play an advisory role depending on the issue. Ultimately, the goal of the Committee is to confirm that proper decisions are made regarding drug access and the overall value of the benefit as it pertains to drugs, biologics, and select non-drug products.

- The co-chairs designate voting members of the P&T. Those persons utilized as consultants on various issues are considered non-voting. Other non-voting stakeholders for relevant agenda are invited at the discretion of P&T.
- Within the P&T Committee membership, there is at least one voting external physician member and at least one voting external pharmacist member who are experienced in geriatrics and/or

the care of disabled individuals. Neither may be employed by nor have any business interest in Humana.

- The P&T meets at least quarterly. Meetings are held via conference call.
- The voting members of the P&T Committee must be free of conflict of interest with any P&T agenda, and must state any new potential conflicts of interest prior to discussion. All voting members must also sign a statement of conflict of interest verifying either no conflict or disclosure of conflict, if it exists, at least annually. Any consideration of voting for members who have stated a conflict of interest will be made with consultation with the Humana Ethics and Compliance office prior to granting of such privilege.
- The P&T Committee reports up to the Vice President of Pharmacy through the governance structure.

Pharmacy Executive Governance Committee (EGC) The oversight authority of the Pharmacy QM Program is the Pharmacy Executive Governance Committee and consists of senior leaders within the company. The committee has the authority to make decisions and allocate resources for the Pharmacy QM Program. Additionally, the Pharmacy Executive Governance Committee defines the scope, objectives, activities, and structure of the QM Program. The Quality and Performance Improvement Program Description (QIPD) is reviewed by the Pharmacy Executive Governance Committee at least annually and updated as necessary. The QIPD is approved annually by the President, Humana Pharmacy Solutions; Director, Pharmacy Professional Practice and Clinical Operations; Director, Quality, Process, Learning, Accreditation and Policy; and Director, HPS Clinical Strategies.

Pharmacy Executive Governance Committee holds oversight of the quality-related programs and initiatives throughout Humana Pharmacy Solutions. It uses a centralized approach to monitoring and improving the process and outcomes for the varied areas that comprise Humana's Pharmacy Solutions program. The committee defines the scope, objectives, activities, and structure of the QM Program and provides operational oversight for the program activities and recommends policy decisions. The committee has the authority to make decisions and allocate resources for the QM Program.

The scope of the committee is to:

- Improve patient safety
- Impact value to customer, member, and health plan
- Enhance member, provider, and customer experience in relation to Pharmacy benefits
- Provide committee oversight of key Pharmacy processes and outcomes
- Discuss data, identifying barriers and opportunities for improvement
- Promote communication between operational areas and consistent trending and reporting of data
- Approve and update, annually, the Humana Pharmacy, Inc. Program and Evaluation
- Facilitate the integration of operational processes across the pharmacy
- Provide guidance to staff on quality management priorities and projects
- Monitor progress in meeting quality improvement goals and corrective actions
- Maintain approved minutes and other records of all committee meetings
- Monitor and enforce compliance with Accreditation Standards

Key functions of the EGC include:

- Allow committee representatives or their designees to report on quality performance of their respective areas
- Facilitate integration of operational processes across Humana Pharmacy Solutions by planning, analyzing, and evaluating quality improvement activities
- Promote objective and systematic monitoring and evaluation of consumer and client health services and facilitates compliance with regulatory requirements
- Provide status reports to the CQIC at least annually
- Meet at least once quarterly

Voting members are appointed by the Segment VP and President, Humana Pharmacy Solutions, and may include representatives from:

- Business Development
- Clinical Programs (Commercial and Medicare)
- Commercial Sales Segment Support
- Compliance
- Consumer Messaging
- Finance and Analytics
- Health Economics
- Human Resources
- Mail Order Pharmacy
- Specialty Pharmacy
- Pharmacy Professional Affairs
- Pharmacy & Therapeutics
- Pharmacy Contracting
- Pharmacy Networks
- Service Operations
- Environmental and Safety
- Quality, Process, Learning and Accreditation

Reporting Requirements for the PEGC include, but are not limited to:

- Accuracy
- Dispensing Accuracy
- Distribution Errors (External)
- Privacy Breach Metrics
- Call Quality
- Access to Service
- Prescription Turn Around Times
- Call Center Metrics
- Regulatory Compliance
- Satisfaction: Consumer and Client Pharmacy Networks
- Safety and Risk
- Risk Management

- Environmental and Associate Safety
- Quality Improvement Projects

The Member Safety Program is a component of Humana's Quality Improvement Program, which falls under the direction of the Corporate Quality Improvement Committee (CQIC), as delegated by Humana's Internal Board/Management team. The impact and effectiveness of the program is reviewed throughout the year by the CQIC according to the Quality Improvement Work Plan. The scope of the program includes all Humana members, providers, and associates unless noted otherwise.

The CQIC is in a unique position to not only review safety initiatives throughout Humana, but also to identify areas of priority focus for the company that aligns with national safety initiatives. Operational oversight of the Member Safety Program is within the scope of the Quality Operations, Compliance and Accreditation (QOCA) Department.
The Four Key Areas of Focus designated within the Humana Member Safety Program are as follows:

- 30-Day Readmissions
- Fall Prevention
- Medication Errors
- Inpatient and Surgical Complications
- Diagnostic/Therapy Radiological Services

Humana is actively involved in monitoring and improving safety by providing members with the tools and information necessary to decrease the likelihood of adverse events. Humana has developed a written Member Safety Program Description that is approved by the Corporate Quality Improvement Committee (CQIC). Member Safety reports quarterly to the CQIC to define and monitor safety initiatives which may vary with individual Markets.

Clinical Operations Utilization Management Committee provides oversight of clinical compliance activities impacting Clinical Operations. This committee supports more effective collaboration between leaders of all Clinical Services Programs performing utilization management and also includes representatives from Risk, Legal and Compliance.

The goal is to ensure a robust compliance committee via:

- Periodic meetings with key stakeholders to identify, discuss and mitigate risks related to utilization management;
- Creation of a forum to efficiently track key risk areas, providing an opportunity to brainstorm and discuss opportunities for improvement;
- Strengthening of the partnership/relationship between business operations and the Legal/Risk/Compliance;
- Monitor the performance of all delegated entities, including tracking and trending of data results over time
- Monitor deficiencies in the delegated entities' processes and to set priorities for corrective action plans in conjunction with the Delegation Compliance Department; and
- There will be standing agenda items as well as a running list of open issues and projects that will be developed to discuss updates/status.

The Committee conducts review and analysis of clinical compliance related metrics, nurse inter-rater reliability assessment activities, Corrective Action Plans (CAPs), regulatory updates, compliance

related process/workflow changes, and quality monitoring and evaluation of effectiveness of the program. The committee is responsible for identification of improvement opportunities and development of appropriate corrective actions and compliance improvement interventions. The Committee is co-chaired by the Corporate Commercial Compliance Manager and the Clinical Operations Compliance Manager and meets monthly. The committee reports to the Corporate Quality Improvement Committee. Members of the Committee may include:

- Corporate Commercial Compliance Manager (co-chair) and Director
- Corporate Medicare and Medicaid Compliance Managers
- Clinical Operations Compliance Manager (co-chair), Compliance Consultants and Compliance Analyst
- Corporate Director of UM, CM and Specialty CM Programs
- Directors of Clinical Intake, Clinical Claims Review and Case Management
- Clinical Operations Process Managers, Relationship Managers and Performance Managers, including leaders from Humana Behavioral Health, Clinical Access Team, Delegation, Transplant, Genetic Guidance, and Neonatal Intensive Care Programs
- Legal and Risk Representatives
- Clinical Learning and Development
- Continuous Improvement and Quality
- Clinical Policy Representatives and Senior Regional Medical Director
- Other support staff and guests as deemed necessary

Corporate Credentialing Committee is responsible for review and assessment of practitioners utilizing appropriate standards for credentialing, re-credentialing, and de-credentialing. Credentialing for the company occurs as a regional function in Cincinnati and Louisville. There is a Credentialing Committee in Louisville (which combines Cincinnati and Louisville credentialing activities), one in Florida and one in Puerto Rico. Credentialing and re-credentialing data are presented to the Corporate QIC.

Physicians and other healthcare professionals participate on the Credentialing Committee, but only physician members have voting privileges. The Credentialing Committee is chaired by a Humana Medical Director, or designee, and meets monthly.

Members of the Credentialing committee include representatives from:

- Humana Medical Director or designee (chair)
- Credentialing
- Practicing network physicians

Corporate Recommendation Review Committee (CRRC) makes the final decision for Humana regarding recommendations for provider terminations for quality of care, received through the peer review process. The CRRC may affirm, modify or reverse the recommendation, or remand the matter back to the peer review committee for additional evidence. The CRRC is chaired by the Corporate Chief of Quality, with the majority of members being physicians. Members may include:

- Corporate Chief of Quality
- Humana Medical Directors
- Director of Quality Operations Compliance and Accreditation
- Director of National Network Operations or Vice President of Provider Center of Excellence
- The CRRC reports up through the CQIC

Quality Management Committee (QMC) is responsible for reviewing and evaluating aspects of preventive and clinical care at the market level. The QMC is responsible for review of market specific preventive health and clinical study initiatives, and/or focused studies. Peer review functions may be handled in QMC or by a separate Peer Review Committee. The QMC is empowered to develop appropriate corrective actions and quality improvement interventions. A Humana Medical Director or a physician designee chairs the QMC, which includes physician members who are actively practicing in the provider network. The QMC meets at least bi-annually or as often as needed. Members of the QMC may include representatives from:

- Medical Director or physician designee (chair)
- Practicing Network Physicians
- Quality Operations, Compliance and Accreditation
- Clinical Programs
- Risk Management
- Additional representatives, as appropriate

Florida Medicaid Quality Improvement Committee The Florida Medicaid Quality Improvement Committee (FL MMA QIC) provides oversight of Quality Improvement program activities and clinical recommendations for the Florida Medicaid plan. The FL MMA QIC meets quarterly and reports to the Corporate Quality Improvement Committee through the legal entity report.

The FL MMA QIC is comprised of voting members showcasing multi-department representation of the centralized and regionalized areas of operations. Voting members shall be stewards of Humana's mission. Their recommendations are expected to be based on sound operational data, in support of member service, and the overall good of the markets serving Humana members.

The Florida Medicaid Medical Director serves as Chairperson and presides at meetings of the FL MMA QIC. In the Chairperson's absence, the Divisional Director of Quality Operations, Compliance and Accreditation or the Associate Medical Director may act as Chairperson. Voting members of the FL MMA QIC includes representatives from the following areas, but is not limited to:

- Director, Health Services Organization, Case Management/Disease Management
- Director, Health Services Organization, Utilization Management
- Director, Medicaid Network Development and Operations (CFL & NFL)
- Director, Medicaid Provider Relations (SFL)
- Executive Director, FL Medicaid
- Florida Medicaid Medical Director (Chair)
- Manager, Medicaid Quality, Quality Operations, Compliance and Accreditation
- Market Vice President, Senior Products
- Operations Director

Ad hoc, non-voting membership varies based on reporting cycles to the Committee and may include representatives from various departments, including but not limited to:

- Customer Service Coordinator
- Divisional Director, Quality Operations, Compliance and Accreditation
- Manager, Medicaid Enrollee Program

- Market Director, Performance Improvement
- Market Director, Quality Improvement
- Market Manager, Finance
- Market Manager, Pharmacy
- Market Manager, Risk Management
- Market Risk Advisor, Compliance
- Process Consultant, Grievances & Appeals
- Representation from Medicaid partner, Health Choice

Peer Review Committee (PRC) is responsible for reviewing potential quality of care issues, determining the severity of the issue, and recommending quality improvements or corrective actions as appropriate. The PRC is responsible for development of individual provider quality improvement plans, where indicated, and review of progress toward resolution. Physicians and other healthcare professionals participate on the PRC, but only physician members have voting privileges. The PRC is chaired by a Humana Medical Director, or physician designee, and meets as needed to complete timely review of clinical quality concerns. The Peer Review Committee may function as a separate committee or within the Quality Management Committee at a market, regional or divisional level. The PRC reports to the local Market Quality Management Committee. Members of the Peer Review Committee may include representatives from:

- Humana Medical Director or designee
- Practicing network physicians: primary care and specialties
- Quality Operations, Compliance and Accreditation Divisional director and/or manager and support staff
- Additional representatives as appropriate

Delegation Committee is held at the market level with local delegation committees in Florida, Illinois, California, and the Southeast Region. In addition, the Health Services Organization reports to the CQIC on the delegated IPA/MSO utilization metrics for the following HSO Delegation Regions: California, Intermountain, Desert pacific, Central, Texas, Gulf States, North FL, Central FL, South FL, Southeast, and Great Lakes.

The Delegation Committee is responsible for coordination and review of Market delegated activities related to quality management or improvement, credentialing, claims payment, member rights and responsibilities, and/or utilization as appropriate. Responsibilities of the Delegation Committee include review and approval of reports from delegated entities and recommendations for corrective actions as necessary. The Delegation Committee meets at least quarterly and is chaired by a Market Senior Executive. The Delegation Committee may be combined with the Quality Management, Utilization Management, or Service Committee in the local market office. All Delegation activities are reported annually through the Corporate QIC.

Members of the Delegation Committee may include:

- Market Senior Executive (chair)
- Humana Medical Director
- Representative, Network or Provider Relations
- Representative, Quality Operations, Compliance and Accreditation

- Representative, Utilization Management
- Representative, Customer Service
- Representative, Compliance
- Representative, Delegation Oversight

Clinical Operations Utilization Management Committee provides oversight of clinical compliance activities impacting Clinical Operations. This committee supports more effective collaboration between leaders of all Clinical Services Programs performing utilization management and also includes representatives from Risk, Legal and Compliance. The goal is to ensure a robust compliance committee via:

- Periodic meetings with key stakeholders to identify, discuss, and mitigate risks related to utilization management
- Creates a forum to efficiently track key risk areas, providing an opportunity to brainstorm and discuss opportunities for improvement
- Strengthens the partnership/relationship between business operations and the Legal/Risk/Compliance
- Monitor the performance of all delegated entities, including tracking and trending of data results over time
- Monitor deficiencies in the delegated entities' processes and to set priorities for corrective action plans in conjunction with the Delegation Compliance Department
- There will be standing agenda items as well as a running list of open issues and projects that will be developed to discuss updates / status

The Committee conducts review and analysis of clinical compliance related metrics, nurse inter-rater reliability assessment activities, Corrective Action Plans (CAPs), regulatory updates, compliance related process/workflow changes, and quality monitoring and evaluation of effectiveness of the program. The committee is responsible for identification of improvement opportunities and development of appropriate corrective actions and compliance improvement interventions. The Committee is co-chaired by the Corporate Commercial Compliance Manager and the Clinical Operations Compliance Manager and meets regularly. The committee reports to the Corporate Quality Improvement Committee. Members of the Committee may include:

- Clinical Learning and Development
- Clinical Operations Compliance Manager (co-chair), Compliance Consultants and Compliance Analyst
- Clinical Operations Process Managers, Relationship Managers and Performance Managers, including leaders from Humana Behavioral Health, Clinical Access Team, Delegation, Transplant, Genetic Guidance, and Neonatal Intensive Care Programs
- Clinical Policy Representatives and Senior Regional Medical Director
- Continuous Improvement and Quality
- Corporate Commercial Compliance Manager (co-chair) and Director
- Corporate Director of UM, CM and Specialty CM Programs
- Corporate Medicare and Medicaid Compliance Managers
- Directors of Clinical Intake, Clinical Claims Review and Case Management

- Legal and Risk Representatives
- Other support staff and guests as deemed necessary

Health Services Organization National Utilization Management Committee is charged with facilitating process for monitoring the care given by hospitals, skilled nursing facilities, home health and other ancillary services. The committee is responsible for reviewing utilization data and related statistics, identifying trends, and recommending improvement strategies. The National HSO Committee also reviews and approves the HSO Policies and Procedures on at least an annual basis and when needed as changes occur. The committee meets four times a year.

Committee responsibilities include:

- Annual approval of the HSO UM Program Description, UM Work Plan and UM Evaluation
- Approval of HSO UM and Medical Management Policies and Procedures
- Evaluation of the effectiveness of, and identification of barriers to, HSO UM and CM activities
- Facilitation of a process for ongoing analysis of HSO utilization and trend data to identify outliers and create improvement plans to address appropriate utilization: This is accomplished through the monthly UM Metrics meeting, Medicare and Medicaid Trend meetings and the Model of Care operational reporting meetings where utilization trends and process compliance by division, region and product are reviewed and analyzed.
- Performance monitoring of all delegated entities, including tracking and trending of data results over time
- Monitoring deficiencies in the delegated entities' processes and setting priorities for corrective action plans in conjunction with the Delegation Compliance Department

Reporting Structure

- A National HSO UM Committee representative reports to the Corporate QIC annually. Recommendations and actions are communicated to appropriate committees and individuals, as well as to delegated entities, by means of memos and reports.

Membership and Voting

All committee members have voting privileges, with decisions made by a majority vote.

- HSO Chief Medical Officer, Chair Person
- Corporate HSO Staff
- Regional Medicare and Medicaid Health Services Medical Directors
- Regional Medicare and Medicaid Health Services Directors
- Regional Medicare and Medicaid Health Services Managers
- Behavioral Health Representatives

Risk Management/Safety Committee has oversight of the Risk Management Program and identifies corrective measures needed to eliminate or control recognized safety and health hazards and to recommend improvements. It acts on referrals for risk issues generated both internally and

externally. The Manager of Risk Management is the Chair of the Risk Management Committee, which meets a minimum of three times a year, or more frequently as needed. The committee reports quarterly to the Humana Internal Board/ Executive Committee. Members of the Risk Management/Safety Committee may include representatives from:

- Quality Operations, Compliance and Accreditation
- Health Services
- Workplace Solutions
- Humana Resources

Provider 360 Committee - Humana has a cross-functional Provider 360 Committee, chaired by the Medicaid Market President, with a goal to continuously identify opportunities to improve provider experience with Humana. Participants from various departments, including Provider Relations, Claims, Care Coordination, Grievance and Appeals, and Customer Service review various trends and data to understand concerns from providers and design initiatives to proactively address concerns. The Committee meets monthly and produces reports for the Quality Management Committee's review.

b. Disease/Complex Case Management

Disease Management

Humana's Disease Management Program is an enrollee-focused program where nurses help enrollees learn how to control their disease by providing education, support, community resources, and communication with their doctor and other specialists.

Humana's Disease Management (DM) Case Manager is a licensed nurse with skills, to classify, assess, monitor, evaluate, instruct, intervene and document goals and outcomes for each enrollee in the following programs:

- Diabetes
- Congestive Heart Failure
- Hypertension
- Asthma (adult and pediatric)
- HIV/AIDS
- Sickle Cell Disease
- Cancer

The Disease Management Program provides services that include but are not limited to:

- Evaluating enrollee needs that can affect control of their disease such as physical limitations, emotional stress, transportation difficulties, and environmental needs.
- Creating individualized self-management goals based on Health history, psychosocial assessment, doctors' recommendations, and enrollee needs.
- Providing education on diagnosis and treatment.
- Referrals to other healthcare providers as needed.
- Enrollee and provider support regarding diagnosis, plan of care, and other health related concerns.
- Educating enrollees on recommended health checks.
- Educating and assisting enrollees on reaching disease specific diet and exercise goals.

The goals of the Medicaid Disease Management program are to:

- Improve enrollees understanding and assist self-management of their disease with education and support while following their doctors plan of care.
- Help the enrollee to reach and maintain optimal control of their disease or diseases.
- Increase awareness of the health risks associated with certain personal behaviors and lifestyles.
- Improve enrollees' understanding of the importance of seeing their doctor or specialists for regular visits.
- Help enrollees know who to call if there is an urgent situation and in an emergency.
- Find and obtain community-based resources that meet the enrollee's medical, psychological, and social needs.
- Evaluate results of the program on the health of enrollees who participate in the program.

Complex Case Management

Humana's Complex Case Management is a service provided to Medicaid enrollees by Humana nurses specially trained to focus on enrollees with complex medical needs. Case Management is designed to meet the medical and psychosocial needs of the enrollee and varies depending on situation and severity. Our clinical team works to pair enrollees with network providers that can best manage the unique and specific special needs of each enrollee. A multidisciplinary team approach is utilized to ensure the enrollee's needs are met and all efforts are made to improve and optimize his/her overall health and well-being. A team of Physicians, Social Workers, and Community Services Partners are on hand to help make sure enrollees' needs are met and all efforts are made to improve and optimize their overall health and well-being. The case management program is optional.

9. CONTINOUS IMPROVEMENT THROUGH ONGOING EVALUATION

Built on partnership and toward a common goal of delivering quality care, Humana's provider engagement model is the basis of our provider retention efforts and a significant differentiator of our network management strategy. It is critical that we evaluate provider satisfaction and quality to monitor for opportunities to continuously improve. As a measure of provider satisfaction, Humana regularly monitors provider termination rate, which is less than 1% month over month. Humana also performs an annual provider satisfaction survey in all contracted Regions we operate in accordance with AHCA-contractual requirements.

Coordination and communication within and outside the system, with fellow providers as well as outside organizations are critical. Humana helps facilitate these opportunities for updates, education on changes, and ongoing enrollee quality of care. Given our operational presence in Florida, Humana's robust local leadership team has also established strong relationships with our providers, and regularly attends meetings to discuss new initiatives and opportunities to reach our common goals. These interactions help support providers, identify their needs, remove barriers, and maintain satisfaction within the provider community while making it easier to achieve our common goal.

a. Provider Satisfaction Survey, Methodology and Results

The Provider Relations team conducts an annual provider satisfaction survey in all of our contracted regions in accordance with contractual obligations and State approved sample methodology and

metrics. The survey enables Humana to evaluate and measure satisfaction across the following service metric areas: provider relations and communication, clinical management processes, authorization processes including denials and appeals, timeliness of claims payment and assistance with claims processing, complaint resolution process and care coordination/case management support. Since our provider satisfaction survey conveys valuable insight to the provider experience with Humana, we have taken steps to increase provider participation in responding to the survey. In 2015 we experienced a 15 percent response rate, which increased to 17 percent in 2016. Most recently in 2017, the rate increased to 30 percent.

Humana has received positive feedback in our provider satisfaction survey regarding our provider engagement model. For example in 2017, 99 percent of MMA respondents said their Provider Relations Representative was able to answer all of their questions and was professional and courteous. Additionally, 98 percent of respondents said the educational and training materials are easy to understand.

Humana uses a vendor, Talk2Rep, to make calls to designated provider offices with State-approved scripting. Surveys are conducted using a four-point Likert scale for the Primary care provider locations with the top 40 percent of total enrollees, and specialist locations with top 40 percent of highest claim volume. We then tabulate, analyze and evaluate survey results to identify opportunities for improvement and develop action plans based on identified service categories with highest overall "disagree/strongly disagree" responses.

Below is a snapshot of results of Humana's 2017 provider satisfaction survey, including survey sample size by provider type, number of successfully completed surveys and top five areas of strength:

Total Sample Size (all regions)	**224**
Total Primary Care Provider Locations	**77**
Total Specialist Provider Locations	**147**
Total Surveys Completed (all regions)	**68**
Primary Care Provider Locations	**19**
Specialist Provider Locations	**49**

Top 5 highest overall agree/strongly agree responses - areas of strength

Provider Relations and Communications	
Question(s):	
1b. My provider relations representative is: Able to answer my questions	99%
1d. My provider relations representative is: Professional and courteous	99%
3. Educational and training materials are easy to understand.	98%
Care Coordination and Authorizations	
Question:	
10. Denial notifications, including the denial reason(s), are provided in a timely manner.	100%
Clinical Management	
Question:	
20. Case managers are knowledgeable, professional and courteous.	100%

Top 5 highest overall disagree/strongly disagree responses - areas of potential opportunity	
Provider Relations and Communications	
Question:	
4b. In the last 12 months: I participated in an in-office visit from a Humana representative.	28%
Complaint and Appeals Resolution Process	
Question(s):	
15. I have filed a complaint/grievance or appeal and found the process easy to follow.	25%
16. The provider grievance process is effective.	24%
17. Overall, I am satisfied with the provider complaint, grievances and appeals process.	23%
19. My complaint was resolved without having to make multiple inquiries.	32%

Humana's 2017 provider satisfaction survey results were transmitted to The Agency for Health Care Administration on July 1, 2017.

b. Provider Quality

Humana strives to build strong partnerships between our PCPs and high-volume specialists and our Humana provider engagement team. Each has an assigned Humana Quality Improvement Nurse and a Provider Relations Representative, who visit PCPs on a monthly basis and high-volume specialists on a quarterly basis to provide training, education, gaps in care for enrollees, and utilization data. This frequent interaction not only supports our providers, but it also informs us of any trends or issues our providers are facing, as the model is designed to support them wherever they need it. We understand providers have the front-line interaction with our enrollees, and it is critical to engage with them throughout their experience with Humana.

Humana offers a comprehensive set of tools and resources for our providers to achieve success in accomplishing the Agency's goals of enhanced access, integrated and coordinated care, and improving the quality of care to our enrollees. We provide these tools on a regular basis to ensure that provider performance and quality metrics are transparent to providers:

- Quality Improvement Nurses
- Service Fund Data Analytics
- CareHub Clinical Guidance Exchange
- Humana's Monthly HEDIS Package
- PCP Reports (monthly, quarterly)

Quality Improvement Nurses

Humana has a provider liaison position called a Quality Improvement Nurse to assist providers in improving overall health outcomes and reducing potentially preventable events. We fill these positions with registered nurses who have a clinical background to facilitate and coordinate care between enrollees and providers. Quality Improvement Nurses are geographically assigned and meet with PCPs on a quarterly basis, regardless of whether the provider is alternative payment method, to analyze and close enrollee care gaps, facilitate education, manage medical costs, and document and improve coding accuracy. During the meeting with the PCP, Quality Improvement Nurses may develop a tailored plan of how to best support the provider in improving enrollee care.

Service Fund Data Analytics

Humana developed the proprietary Service Fund risk sharing management application for providers engaged in a risk or capitated arrangement. We use this innovative tool to calculate reimbursements to providers in these arrangements by tracking and aggregating information on capitation payments, claims expensing, claims payment, reconciliation, and settlement for all PCP contacts.

On a monthly basis, Service Fund makes data files available containing information regarding provider membership, funding, claims activity, progress toward value-based payments, and capitation payments at an individual provider level and at a group level. Humana tailors the reports to providers in risk or value-based arrangements. They are available for provider access through an online portal as well as through our Provider Relations representatives. Additionally, Humana educates providers using Service Fund by walking through standard reports during initial trainings to show the data to which they have access and how to use it to help manage their providers and financials. Provider Relations Representatives meet with PCPs monthly to review the Service Fund reports and to discuss any issues or barriers they may be facing.

CareHub Clinical Guidance Exchange

Our CareHub Clinical Guidance Exchange (CGX) system generates Care Alerts we distribute to our providers. These Care Alerts consist of evidence-based medicine care gaps and drug-to-drug/disease interaction alerts. By promoting awareness and closure of these gaps, we help our providers improve the care they deliver.

Humana's Monthly HEDIS Package

To help PCPs better manage the care of their enrollees, we provide a package of monthly HEDIS reports to every PCP. These reports capture preventable events among enrollees, gaps in care, and high utilizers of pharmaceuticals. In addition, practices can view their performance on HEDIS indicators to see how their performance compares with other providers in their region. We package this information in an actionable manner, providing call lists with the contact information for enrollees who have care gaps and a list of recommended actions for enrollees who are non-compliant with preventive care screening and/or disease management visits. Additionally, the QIN may work with the provider to develop initiatives around the care gaps and work with providers to close them

PCP Reports (Monthly, Quarterly)

Humana provides PCPs with a monthly report indicating which of their Humana enrollees have care gaps. These reports will also identify enrollees on their patient panel with potentially preventable hospital admissions and/or avoidable use of the emergency department. Our providers and their staff use these reports to reach out to enrollees and address the care gaps, as well as any identified preventative services. They may also schedule any needed appointments and make referrals to specialists.

c. Coordination of Relationships among Various Levels of the System

Joint Operations Committee Meetings

Humana utilizes Joint Operation Committee (JOC) meetings as a mechanism to meet face to face with providers to discuss and resolve issues or concerns. JOC meetings also allow Humana to use these forums as an opportunity to provide updates on contractual and program changes or offer technical

assistance. JOC meetings may be scheduled monthly, every other month, or quarterly depending on the needs of the provider network or Humana.

Medicaid Quality Work Group

The Medicaid Quality Work Group comprises representatives from various disciplines throughout the organization. Participants include representatives from Medicaid Administration, Provider Contracting, Health Services, Quality Improvement, and Quality Operations Compliance and Accreditation. Its goal is to evaluate plan performance related to services our Medicaid population receives. This group also focuses on developing appropriate enrollee and provider-focused interventions and evaluation of the implemented interventions. The work group is responsible for:

- Ongoing monitoring of HEDIS results and development, implementation, and monitoring of Florida Medicaid specific interventions.
- Organizing and collaborating on the development of an enrollee newsletter. The Work Group provides feedback on topics appropriate for the newsletter to encourage enrollees' healthy behaviors and active participation in health care.
- Provider target reports identifying enrollees with chronic conditions (e.g., diabetes, hypertension) as well as preventive and wellness visits shared with providers to assist providers in reaching out to enrollees needing care.
- Outreach, new enrollee welcome calls, and birthday wellness calls completed by the Medicaid Administration department. These calls encourage enrollees to visit their PCP routinely and participate in valuable screening activities.
- Ongoing collaboration with the Medicaid dental vendor, DentaQuest, as discussed at Work Group meetings. Recommendations from the Work Group are shared with the DentaQuest team.
- Enhanced follow-up process of postpartum women through the 8-week postpartum period.

Provider-to-Provider coordination

Humana emphasizes strong collaboration between the health plan, PCPs, and specialists for medical cost control, network development, data/information needs, and provider education. We encourage Florida PCPs to form their own "sub-network" of preferred facilities and specialists. This enables the PCP to develop critical relationships with the specialists, optimize communication and information sharing between the PCP and specialist, and ensure that enrollees receive quality, coordinated, and medically-necessary services.

Humana provides case management support to persons with one or more conditions that create a sufficient level of health status impairment or risk. For persons receiving case management support, we develop an individualized treatment plan that addresses all known health conditions, and coordination between co-occurring conditions. We share this individualized plan with the enrollee, the caregiver, the PCP, and with specialist providers who play a central role in treating one or more of the enrollee's key disorders. During the assessment process, the enrollee identifies those people essential to their health care. The case manager enlists and solicits the active participation of all appropriate stakeholders, including caregivers, providers, and community agencies to promote communication between the provider(s) and to facilitate coordination of services as necessary based upon the care plan and the needs of the enrollee. Methods to obtain input from these stakeholders regarding evaluation, problem identification and treatment recommendation may include telephone interaction, email, online communication through our Web portal, and potentially face-to-face meetings.

Humana's subcontractors such as Beacon, DentaQuest, One Homecare, and Logisticare attend Humana-sponsored Town Hall meetings with our network providers to answer questions and strengthen the partnership. Additionally, Humana facilitates in-service trainings between our contracted Hospitals, PCPs, MSOs, and our subcontractors to educate on their programs. In addition, the subcontractors attend monthly JOC meetings with Humana and the MSOs throughout the State, and hold webinar trainings for PCPs to educate them on their various programs.

Cross-Functional Provider Communications

- Provider Relations Representatives serve as the liaison between Humana and providers. The Provider Relations Representative works collaboratively with Humana departments and our network of primary care physicians, specialty care and ancillary providers, and facilities. Daily interactions between the Contracting Representatives, Medical Services, Claims, Customer Services and Finance Departments and the development of these interdepartmental relationships are critical to ensure effective coordination and communication when contracting with new vendors or transitioning services.
- Provider Call Center – Our provider Call Center is staffed with experienced provider representatives responsible for answering questions and participating in the sharing of information related to their practice and enrollee services.
- Provider Orientation – All contracted providers receive a Humana provider orientation within 30 days of their effective date into the network.
- Ongoing provider education visits – Contracted PCPs and SPCs will receive an educational visit from a Humana Representative no less than quarterly, or more often if needed. This includes face-to-face visits, telephonic, virtual webinars, or group sessions
- Joint Operating Committee (JOC) – As mentioned above, we schedule JOC meetings are scheduled monthly with large health systems to share medical information related to quality and protocols, training, and issue resolution.
- Newsletters – Newsletters are generated quarterly with information pertaining to policy changes, quality, industry changes, and medical protocols.
- Provider Manuals – These manuals contain information necessary for a provider to be successful. After a provider executes an agreement with us, we schedule an orientation session to review the manual contents as well as any other information related to our health plan.
- Provider Website – The Provider Website represents another means to obtain important, real time information about our operations. Newsletters, policies, medical protocols, claims, quality, and a multitude of other information are available to the provider through the portal.
- Webinars – The Provider Relations team hosts periodic webinars on various topics to ensure providers have access to updated Medicaid polices and requirements. Topics covered include but not limited to, claims processing, encounter submissions, Continuity of Care, Dual-eligible enrollees, Referrals and Authorizations, Contracting and Credentialing processes.
- Medicaid Advisory Panel – The Medicaid Advisory Panel identifies and reviews provider concerns and makes advisory recommendations to Humana. Humana may also make requests of the Medicaid Advisory Panel to provide feedback and recommendations on topics which will affect Medicaid enrollees. The Panel membership includes network providers, community leaders, and representatives from the various health plan disciplines.

d. Coordination with Outside Organizations

Humana recognizes the need for effective communication and coordination as a key to quality care and service excellence. We participate in and partners with national organizations, thereby keeping channels of communication open and furthering the delivery of high quality, comprehensive healthcare to all enrollees. Participation in national accrediting bodies affords input into policy-making and enhances the goal of increasing the quality of healthcare. Humana is certified by the Committee on Operating Rules for Information Exchange (CORE), which is an initiative by a non-profit alliance of health plans, networks, and trade associations to simplify healthcare administration. CORE certification ensures providers get consistent, uniform information thereby improving the quality of interaction with Humana.

Examples of national organizations Humana collaborates with include:

- National Quality Forum (NQF)
- American Health Insurance Plans (AHIP)
- National Council on Aging (NCOA) – falls pilot with the Centers for Disease Control
- National Committee for Quality Assurance (NCQA) – Health Plan Advisory Council participation
- Centers for Medicare and Medicaid Services (CMS)
- Utilization Review Accreditation Commission (URAC) – Board of Director membership
- Department of Health and Human Services (HHS) - Partnership for Patients Initiative and Million Hearts Campaign

Examples of Florida organizations Humana collaborates with include:

- Florida Assisted Living Association (FALA)
- Florida Health Care Association(FHCA)
- Florida Council on Aging (FCOA)
- Home Care Association of Florida (HCAF)
- Florida Gerontological Advanced Practice Nurses Association (FGAPNA) (Aging Life Care Association)
- The Florida Geriatric Care Managers Association (FGCMA)
- Leading Age Florida
- Florida Medical Directors Association (FMDA)
- Florida Association Directors of Nursing Administration/LTC (FADONA) Florida Health Care Social Workers Association (FHCSWA)
- Florida Association of Health Plans (FAHP)
- Alzheimer's Association
- Florida Alcohol and Drug Abuse Association (FADAA)
- Florida Council for Community Mental Health (FCCMH)
- Florida Medical Association
- Florida State Guardianship Association
- Florida Alliance of Home Care Services (FAHCS)
- Alliance for Aging
- Aging & Disability Resource Center (ADRC)
- Northwest Florida Area Agency on Aging, Inc.

Healthy Start

The Healthy Start program includes targeted support services that address identified risks. The range of free and voluntary Healthy Start services available to pregnant women, infants and children up to age three include:

- Childbirth, breastfeeding and car seat education classes
- Comprehensive assessment of service needs in light of family and community resources

- Home visits to provide education and support for breastfeeding, baby weight checks, parenting, immunization information and safe sleep
- Ongoing coordination to assure access to needed services and support to help families attain their goals
- Developmental screening, psychosocial assessments, nutritional education, smoking cessation counseling or referrals as needed

Humana will refer members to Healthy Start for these services when identified utilizing the Healthy Start Assessment Tool. The tool is used to determine eligibility for enrollment in Healthy Start's Care Coordination Program and is completed by their obstetrician at the initial visit. Eligibility is based on identified risk factors that may affect the health of the pregnancy. The goal of the program is to mitigate those risk factors. Members are automatically eligible when they exhibit one of the criteria that makes them automatically eligible, regardless of the Assessment Tool score (i.e.: homelessness, history of abuse, etc.).

In addition, Humana is working with Healthy Start on a contract that will include case finding services in which Healthy Start will attempt a home visit for members we are unable to locate.

Medicaid Advisory Panel

Community organizations and other agencies provide essential services, programs, and resources to qualified enrollees to support their quality of life and optimal well-being. To ensure that we address the needs of enrollees and identify any opportunities for improvement, Humana has developed a Medicaid Advisory Panel composed of providers including medical service organizations and hospital corporations, non-profit organizations and community agencies that serve the Medicaid population.

The Panel's purpose is to provide a forum for Humana management, leaders in community organizations, and senior hospital and medical service organization administrators to better understand the needs of our enrollees and our Plan requirements by identifying issues and concerns and providing feedback. The Panel obtains input from subject matter experts on our initiatives and strives to develop methods that we can use to better serve our enrollees. Creating new ways to approach universal challenges will lead to pilot projects, which the committee will track. This exchange of ideas allows the Plan to improve processes and develop methods to overcome challenges that we face in serving our enrollees.

There will be representatives on the Panel from various stakeholders (see below) who will be permanent enrollees. The panel will be driven topically per the consensus of the permanent enrollees. Each meeting will concentrate on one topic of interest to enrollees and/or providers. Guests may be invited as subject matter experts to speak to the topic being discussed at the meeting.

1. Network hospital corporations
2. Network medical service organizations
3. Non-profit organizations
4. Community agencies
5. Humana Medicaid administrative leadership

e. Subcontractor and Vendor Oversight Compliance

Humana partners with subcontractors to provide health care services to enrollees. To ensure that each subcontractor adheres and exceeds the requirements, Humana has implemented a rigorous oversight

program with corporate and market based teams responsible for the subcontractors' performance. We will continue to be compliant with AHCA's requirements around subcontractor monitoring and policies. Humana's Delegated Vendor Performance Oversight team (DVPO) is dedicated to monitoring and overseeing functions delegated to subcontractors. Delegation of Network Management responsibilities includes the following:

- All subcontracts that meet the Network Management Delegation definition shall have an executed and AHCA approved Network Delegation Amendment.
- Monitor compliance, network adequacy, and quality by monthly/quarterly reports and annual audits to include:
    - Policy and procedures
    - Provider Network Report of all provider groups, individual physician practices and sites in its network are not accepting new Medicaid enrollees
    - Availability of Providers providing Specialty Care services, including number and geographic distributions
    - Access to appointments
    - Opportunities to improve access for enrollees
    - Identified problems and corrective actions initiated and outcomes
- Implement Corrective Action Plans and monitor adherence to written subcontractors agreed upon process to correct noncompliance. As required, impose provider capitation payment penalties for outstanding corrective action plan issues, restriction, suspensions and/or terminations.

All subcontractors' performance and issues are presented to the DVOC for review and approval of necessary interventions and corrective actions plans in the event of subcontractors' non-compliance with the contractual provisions and service level agreements (SLAs). The oversight of subcontractors is performed by three entities, as described below.

- Market-based Delegate Relationship Managers (DRMs) – front line of Humana associates who work closely with the subcontractors. They are responsible for the due diligence of subcontractors and consistent oversight of operational performance according to the contract and SLAs. They hold joint operational meetings, which are designed to review past month's subcontractor performance with comparison to SLAs and contract provisions. The meetings are led by the DRM and attended by the Director of Oversight Vendor Performance. In addition, the Director of Oversight Vendor Performance holds monthly operational meetings with all DRMs to review subcontractors' performance, identify opportunities for improvement, develop corrective interventions and follow up on progress.
- Corporate Delegation Compliance – responsible for pre-delegation, annual and ad hoc audits of subcontractors. The audits are performed in accordance with the contractual provisions, NCQA Standards and SLAs. The audit results are presented to the DVOC for recommendations of interventions as appropriate.
- Delegated Vendor Performance Oversight unit – comprised of a director and coordinator. The role of this unit include but is not limited to:
    - In conjunction with DRMs, facilitate the coordination of oversight and monitoring activities
    - Review operational performance of subcontractors for adherence to contract provisions and SLAs
    - In conjunction with the DRMs, develop interventions, corrective action plans as necessary to improve performance and subcontractors compliance

- Participate in joint operational meetings with subcontractors; review performance and recommend improvements
- Review for under/overutilization trends and address with subcontractors
- Work with subcontractors to participate in the support of Humana's goals to improve health care outcomes (HEDIS campaigns, Plan initiatives, integration and specialty programs,)
- Establish vendor specific performance goals based on enrollees health outcomes
- Work closely with the Network Contracting Directors to monitor for financial solvency for subcontractors with financial risk

Summary of subcontractors performance are presented at the Delegated Vendor Oversight Committee (DVOC) which reports to Quality Improvement Committee.

SECTION II-HUMANA LONG-TERM CARE

1. Summary:

Humana Long Term Care (HLTC) has created and maintains this Network Development and Management Plan (NDMP) to ensure that all enrollees have appropriate access to cost effective medically necessary healthcare to avoid or delay nursing home placement when enrollees choose to remain in the community. In addition, it maintains a sufficient network to meet the needs of those that choose to reside in a nursing home.

We recognize that quality of care is imperative in our healthcare delivery system, and a critical component of maximizing enrollee healthcare outcomes. With this fundamental concept in mind, we work collaboratively with our Medical Management and Quality Departments to actively participate in ongoing network development activities that allow Humana HLTC to maintain a structure that fosters collaboration across all departments and increases effectiveness, efficiency and cost savings without compromising quality.

Throughout this document, HLTC illustrates and evaluates our goals, methodologies, and interventions. Methodologies used by HLTC allow us to assess geographically appropriate distribution of service providers, including, but not limited to: Home Health, Home Delivered Meals, Emergency Response, Adult day Health Care, Assisted Living and Nursing Homes for our membership.

Our commitment to excellence focuses on building and strengthening partnerships with our contracted providers and creating a culture of collaboration and innovation in identifying and implementing improved approaches to healthcare delivery. HLTC demonstrates within the Network Development and Management Plan that we monitor providers and other subcontractors to ensure that enrollees have a positive experience accessing their care.

The Network Development and Management Plan further outlines the current status of the Humana HLTC network and defines our future network needs. These needs are identified based on projected membership growth, including provider availability, membership medical needs and choice within the HLTC network. The Network Development and Management Plan estimates expected utilization based upon our mix of membership related to membership rate codes, geographic locations and specific individual needs. These are essential components of our Network Development Plan, allowing us to accurately anticipate and articulate future network needs and drive quality initiatives that promote our commitment to improved enrollee healthcare outcomes.

2. Introduction:

The Network Development and Management Plan (NDMP) for the Florida SMMC LTC is an annually updated tool to ensure that covered services are available and accessible in accordance with the access standards in the AHCA Contract with Plan and to meet the projected Plan enrollment levels for all 11 regions in the State of Florida.

When the Plan is establishing and maintaining the provider network, the Plan takes the following into consideration as required by 42 CFR 438.206:

a. The anticipated number of enrollees;

b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented;

c. The numbers and types (in terms of training, experience and specialization) of providers required to furnish the covered services;

d. The numbers of participating providers who are not accepting new enrollees;

e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees and whether the location provides physical access for Medicaid enrollees with disabilities
f. The quality rating of the provider.

3. Evaluation of the prior year's plan:

HLTC became a capitated plan in 2014and maintained the successful robust provider network it had in place during the fee-for-service program. Effective July 1, 2015, HLTC became one combined entity composed of both HLTC and Humana Comfort Choice operating under the new name of Humana HLTC. Humana HLTC successfully integrated both provider networks and maintained relationships with all providers in order to ensure continuity of care and access to care. During the period from July 1, 2015 through December 31, 2015, the former HLTC Provider Relations staff successfully contracted with over 250 providers that were servicing previous Humana Comfort Choice members. The addition of these additional providers resulted in an enhanced, robust network that successfully met the needs of our members through 2016 until the present.
All HLTC awarded regions had Nursing Home Diversion Waiver experience so the Providers, DOEA CARES, Community Based Organizations (CBO), and other stakeholders are familiar with the managed care concept of Home and Community Based Services (HCBS) as potential alternative to Skilled Nursing Facility (SNF) residency. We continue to strive to educate our providers while working in a partnership environment.
HLTC maintains a sufficient network and actively assesses the overall condition by provider type. The methodologies we utilize evaluate the condition of the network include review and analysis of the following: (a) how enrollees access the system, (b) all provider types by geographic area, (c) access to care for all various levels of providers and (d) quality rating of providers.
HLTC communicates to the provider network regarding changes in contractual and/or program policies and subcontractor requirements through on-site provider visits, meetings, phone, webinars and electronic communication and through informational faxes where we send out pertinent information to all providers as they are affected. HLTC is able to identify specific provider types and that enables us to communicate specific information to these specialties.
HLTC obtains data through a variety of mechanisms, including but not limited to Complaints, Grievance and Appeals, Operations Committee meetings and enrollee feedback. This information is used to evaluate the network and make necessary changes in order to meet AHCA guidelines and ensure access for our enrollees.
HLTC Care Managers and Provider Relations Specialists have in-person site visits to ensure outreach and communication to our provider network, review quality of care and enrollee satisfaction.

Our goals for the 2017-2018 plan year are:

1) Continue to work with AHCA and providers that need an enrolled or registered Medicaid number or specialty codes to obtain them and process their claims
2) Begin ranking providers on quality and efficiency ratings
3) Identify low performing providers in our network based on quality and efficiency ratings and move enrollees to high ranking providers where appropriate.
4) Consistently meet contractual network adequacy requirements and any additional access needs identified by our clinical and member support areas.
5) Expand the provider network to include specialty providers supporting members that are currently enrolled in the waiver programs that will be included in the LTC program (PAC, Brain and Spinal Cord Injury and Cystic Fibrosis).

4. 2017-2018 Humana Long Term Care Network Challenges

HLTC maintains a robust provider network throughout the state, meeting or exceeding contract requirements. The biggest challenge is satisfying home bases member needs in the rural areas of regions 1, 2 and 3. HLTC is taking an aggressive, innovative approach to meet these needs.

5. Availability and Accessibility for Covered Services:

HLTC ensures that they have the minimum of two providers for each type of service in each county in the state, except in some rural areas where providers do not exist. In areas where providers do not exist or refuse to be a participating provider, we have found alternative providers to serve enrollees in these areas. HLTC has obtained waivers from AHCA in these identified counties.
Most services provided under this plan are provided in the enrollee's home, and enrollees are not required to go to the location of the provider. Home and community based services are available on a seven (7) day a week basis, and for extended hours, as dictated by enrollee needs. Providers can provide services 24 hours/7 days a week when dictated by the members needs and authorized by the care manager. The largest percentage of the population resides in a nursing home or assisted living facility which provides all the services to the enrollee 24 hours a day. The exception is for enrollees attending Adult Day Health Care and Outpatient Therapy. HLTC provides transportation when needed to get to these locations. We ensure that these services are easily accessible and readily available to our members. Adult day cares do have a limited number of hours they are open for business. HLTC utilizes Assisted Living Facilities that are authorized to provide Adult Day Care Services in addition to free standing Adult Day Care Centers for this service to ensure that members have more options for geographic location as well as additional hours offered to them.
HLTC has determined that we currently have a robust network in non-rural counties, and have identified providers in neighboring counties to assist in the rural areas. This does result in an increased rate to provide incentives for providers to go to enrollees' homes in the rural areas. Thirty counties were identified as Rural on the Florida Rural Counties map at:
https://medicare.fcso.com/Rural_health/166451.pdf

6. Adult Companion Providers (See Homemaker & Companion Service Providers)

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
  - Licensed Provider Listing
  - Agencies that offer the same service
  - Providers that may make a longer ride than usual to service the area.
  - Health Care Services Pool for Temporary staff to existing network providers

- Longer-term interventions to fill network gaps and resolve barriers.
    - Engage existing Providers on capacity building
    - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

7. Adult Day Health Care Centers (ADCC)

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
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    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

8. Adult Family-Care Homes (AFCH)

- Enrollees access these services and providers through Plan Care Management authorization process.
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  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

9. Assistive Care Service Providers (see AFCH)

10. Assisted Living Facilities (ALF)

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
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    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

11. Attendant Care Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
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- Ongoing activities for network development include review of AHCA provider listing for new providers.
- Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

12. Behavior Management Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
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  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

13. Care Managers or Case Management Agency

- Enrollees access these services and providers through Plan Care Management authorization process.
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14. Home Adaptation Accessibility Providers

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15. Home Health Agencies (HHA)

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16. Homemaker and Companion Service Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
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17. Hospices

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    - Engage existing Providers on capacity building

    - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
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    - Ongoing activities for network development include review of AHCA provider listing for new providers.
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18. Medication Administration Providers

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- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

19. Medication Management Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
    - Licensed Provider Listing
    - Agencies that offer the same service
    - Providers that may make a longer ride than usual to service the area.
    - Health Care Services Pool for Temporary staff to existing network providers
- Longer-term interventions to fill network gaps and resolve barriers.
    - Engage existing Providers on capacity building
    - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

20. Medical Supplies Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.

- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
  - Licensed Provider Listing
  - Agencies that offer the same service
  - Providers that may make a longer ride than usual to service the area.
- Longer-term interventions to fill network gaps and resolve barriers.
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  - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
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- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

21. Nursing Facilities

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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  - Providers that may make a longer ride than usual to service the area.
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- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.

- Ongoing activities for network development include review of AHCA provider listing for new providers.
- Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

22. Nutritional Assessment and Risk Reduction Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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  - Licensed Provider Listing
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  - Providers that may make a longer ride than usual to service the area.
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  - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
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- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

23. Personal Care Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.

- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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    - Licensed Provider Listing
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    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

24. Personal Emergency Response System Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

25. Transportation Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
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    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

26. Therapy (Occupational) Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.

- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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    - Licensed Provider Listing
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    - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

27. Therapy (Speech) Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.

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  - Licensed Provider Listing
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  - Providers that may make a longer ride than usual to service the area.
  - Health Care Services Pool for Temporary staff to existing network providers
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- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

28. Therapy (Respiratory) Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
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  - Licensed Provider Listing
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  - Health Care Services Pool for Temporary staff to existing network providers
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  - Engage existing Providers on capacity building
  - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.

- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

29. Therapy (Physical) Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
    - Licensed Provider Listing
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- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

30. Coordination between Organizations

Coordination between internal departments

Departments	Department Leadership
Credentialing	Ange Sumner, Johanna Garcia
Quality Management	Sharon Mecoli
Claims	Elaine Jones
Utilization Management	Clinton Jules, MD
Grievances	Corporate G&A
Finance	Ron Weeden
IT Systems	Tom Payne
Operations	Natalia Aresu
Compliance	Shannon Childers
Care Management	Ela Alarcon-Cabrera
Network	Ed Miller

Coordination with outside organizations

Coordination with outside organizations is an ongoing process and one that will have more relevance for outside organizations under the integrated features of SMMC. HLTC through its 13+ years of network building for the Nursing Home Diversion Waiver and the professional experiences of its staff has a robust relationship with many associations, providers and the Aging Network. HLTC is continuing to develop effective relationships with the MMA plans. HLTC and the Humana MMA plan became a comprehensive plan in those regions where both plans exist on October 1, 2016. This change has improved the care management coordination of these members as they are now managed on the same clinical platform.

Network design by region and county for the SMMC LTC population

Enrollees access the Plan Network by use of the Provider Directory and Care Management Authorization. The Provider Directory can be found online at www.humana.com/humanalongtermcare. A hard copy is provided to the member upon request. Since the SMMC LTC enrollees require a Nursing Home Level of Care certification, the entire SMMC LTC population is considered “special”. However, within this group there are those that are transitioning to step down accommodations from either the hospital or nursing home. That group in transition and others deemed chronic and most at risk are Care Management hot spots.

The Network is designed to serve the SMMC LTC population with Long Term Services and Support (LTSS) provider types.

31. Provider Relations

Education and Training

The Plan offers training to all providers and their staff regarding the requirements of the Government Sponsored SMMC Contract and special needs of enrollees. The Plan will conduct initial training within thirty (30) calendar days of placing a newly contracted provider, or provider group, on active status for the SMMC program. The Plan also conducts ongoing training, as deemed necessary by the Plan or the Agency, in order to ensure compliance with program standards and the SMMC Contract.
The Plan’s training and education to providers includes Plan’s enrollment and credentialing requirements and processes.

HLTC provides weekly training webinars for new and established providers. The training calendar is posted on the HLTC home page.
The Plan shall ensure all participating providers required to report abuse, neglect, or exploitation of vulnerable adults under s. 415.1034, F.S., obtain training on these subjects. If the Plan provides such training to its providers, training materials will include the specified standards of the Government Sponsor and/or Contract.

Provider Credentialing
Medicaid Agency's Credentialing Criteria include:

- A copy of each provider's current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualifications
- No revocation, moratorium or suspension of the provider's state license by the Agency or the Department of Health, if applicable
- A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program
    - Plan shall ensure providers referenced above submit fingerprints electronically following the process described on the Agency's Background Screening website. The Plan shall verify Medicaid eligibility through the background screening system.
    - Plan shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.
    - Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening.
    - Individuals listed in s. 409.907(8) (a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.
- Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106)
- Evidence of the provider's professional liability claims history
- Any sanctions imposed on the provider by Medicare or Medicaid
- The provider's Medicaid ID number, Medicaid provider registration number or documentation of submission of the Medicaid provider registration form.
- Determination of whether the provider, or employee or volunteer of the provider, meets the definition of "direct service provider" and completion of a Level 2 criminal history background screening on each direct service provider to determine whether any have disqualifying offenses as provided for in s. 430.0402, F.S., and s. 435.04, F.S.
    - Any provider or employee or volunteer of the provider meeting the definition of "direct service provider" who has a disqualifying offense is prohibited from providing services to enrollees.
    - No additional Level 2 screening is required if the individual is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.)
        - The Plan must maintain a signed affidavit from each provider attesting to its compliance with this requirement, or with the requirements of its licensing

agency if the licensing agency requires Level 2 screening of direct services providers.
    - The Plan must include compliance with this requirement in its provider contracts and subcontracts and verify compliance as part of its subcontractor and provider monitoring activity.
- Ensure that Assisted Living Facilities meet the requirement of home-like environment characteristics as defined by the state.
- The Plan's credentialing and re-credentialing process must include ensuring that all long-term care providers are appropriately qualified, as specified in Table 1 - LTC Provider Qualifications & Minimum Network Adequacy Requirements as attached and updated.

Plan's credentialing and re-credentialing files must document the education, experience, prior training and ongoing service training for each staff member or provider rendering behavioral health services.

Credentialing and Re-credentialing (CR)
Provider agreements provide for monitoring and oversight by the Plan and the subcontractor to provide assurance that all licensed medical professionals and service provider types are credentialed in accordance with the Plan's and the Government Sponsor's credentialing requirements.
The Plan has clearly defined and documented procedures for assessing provider qualifications and service history including what provider types must be credentialed. The policies and procedures define a provider's right to review and correct credentialing information. The Credentialing Committee reviews provider credentials and makes recommendations.
During the initial credentialing verification the Plan verifies provider credentials, including a valid license to offer covered services and, when applicable, education, training, malpractice history and work history.

The provider applications include an attestation about limitations that would affect a provider's performance; a history of loss of provider license and felony convictions; a history of limitation of privileges or disciplinary actions; and current malpractice insurance coverage if applicable. The Plan reviews information (e.g., about disciplinary actions) from third parties as available and required.
The Provider on site quality review is based on provider type. The threshold for on-site review of services or treatment record-keeping practices is based on a complaint by a stakeholder such as the enrollee, Plan staff, other providers, agency, or government sponsor. The plan takes necessary steps when a provider does not meet its standards, and will evaluate those steps regularly until the provider improves or removed from participation with the Plan.
Before reevaluating a provider's qualifications for re-credentialing, the plan will receive information (e.g., about disciplinary actions) from third parties as applicable. The Re-credentialing Cycle Length for the plan to evaluate provider qualifications is at least every 36 months.
Ongoing Monitoring includes provider sanctions, complaints and quality issues between the re-credentialing cycles. The plan takes appropriate action when issues are identified.
The plan has a process for terminating the contracts of providers who demonstrate poor performance and a process for providers to appeal a terminated contract. The plan reports to appropriate authorities when it suspends or terminates a provider's contract according to the contract with the government sponsor.
The plan confirms that providers, such as hospitals, home health care agencies, skilled nursing facilities, nursing homes and behavioral health facilities, are in good standing with state and federal agencies and accrediting organizations and reviews the above standings at least every three years.

If the plan delegates CR activities, a delegation agreement will outline responsibilities of the delegate and the plan, the delegated activities and the evaluation process. The plan evaluates the delegate on a regular basis, usually annually.

Monitoring and Oversight
In addition to verification and monitoring noted above, on a monthly basis the Plan checks subcontractors and providers against the federal List of Excluded Individuals and Entities (LEIE) and the federal Excluded Parties List System (EPLS) or their equivalent, to identify excluded parties.
The Plan also checks the Agency's listing of suspended and terminated providers at the Agency website to ensure the Plan does not include any non-Medicaid eligible providers in its network.
The Plan also conducts these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and re-credentialing. The Plan will not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act.
The Provider Relations Department receives and maintains copies of all member complaints documents in the provider file to be reviewed at the time of credentialing and/or when an HLTC associates express concerns about the performance of a specific provider. Provider complaints identified via member satisfaction surveys are also shared with the provider relations department to be maintained in the members file. The Quality department reviews complaint and monitoring tools of providers and addresses concerns identified at the Quality Assurance Meetings. If at any time a provider is identified as performing below standards, it is brought under review by the QI committee to determine if the provider should be removed from the HLTC network. Due to the nature of the long term-care program the care managers are continually conducting informal monitoring of providers during monthly and quarterly interviews with members. All facility based members are seen face-to-face monthly which allows for the care manager to observe the care provided to the member.

32. Quality and Anti-Fraud Administration

Audits
The Plan will furnish specific data requested in order for the Government Sponsor to conduct the services/case record audit, including audit of enrollee plan of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under the Government Sponsor Contract.
Fraud
The Plan has specific controls in place for prevention and detection of potential or suspected fraud and abuse, including, but not limited to:
(a) An effective pre-payment and post-payment review process, including but not limited to data analysis, claims and other system edits, and auditing of participating providers (see s. 409.967(2)(f), F.S.);
(b) A description of the method(s), including detailed policies and procedures, for verifying enrollees' identity and if services billed by providers were actually received. Such methods must be either the use of electronic verification or biometric technology but may also include sending enrollee explanations of Medicaid benefits (EOMB), contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses;
(c) Provider profiling, credentialing, and re-credentialing, and ongoing provider monitoring including a review process for claims and encounters that shall include providers and non-participating providers who:
(i) Demonstrate a pattern of submitting falsified encounter data or service reports;

(ii) Demonstrate a pattern of overstated reports or up-coded levels of service;
(iii) Alter, falsify or destroy clinical record documentation;
(iv) Make false statements relating to credentials;
(v) Misrepresent medical information to justify enrollee referrals;
(vi) Fail to render medically necessary covered services they are obligated to provide according to their provider contracts;
(vii) Charge enrollees for covered services; and
(viii) Bill for services not rendered.

(d) Prior authorization;
(e) Utilization management;
(f) Subcontract and provider contract provisions;
(g) Provisions from the provider and the enrollee handbooks; and
(h) Standards for a code of conduct.

Care Management and Quality Related issues

Quality Related Issue	**Information to obtain from the Provider**	**Provider Type**
"Significant Change"	Does the Provider share "Significant Change" information with MCO	ALL
Free from any form of restraint	Is there evidence of any physical or chemical restraints	ALL
Advance Directives	Are Advance Directives documented and available	ALL
Staffing for services	Any regulatory ratios or License Survey's indicating lack of sufficient staff.	ALL
Services as contracted and authorized	License Surveys or reports indicating lack of compliance	ALL

Cultural considerations	Delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	ALL

Provider agreements include provisions for monitoring and inspections. Including:

- That the Agency and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;
- Provide for monitoring of services rendered to Managed Care Plan enrollees through the subcontractor.

Record Reviews

The Managed Care Plan has an approved strategy for conducting medical/case record reviews. The Provider agreement provides for inspections of any records pertinent to the Contract by the Agency and DHHS. The strategy includes the following:
(a) Designated staff to perform this duty;
(b) Process for establishing inter-rater reliability;
(c) Sampling methodology for case selection;
(d) The anticipated number of reviews by practice site (non-facility service providers such as home health agencies with multiple offices locations serving the region);
(e) Record confidentiality and security;
(f) The tool that the Managed Care Plan will use to review each site;
(g) Analysis and reporting, and
(h) How the Managed Care Plan shall link the information compiled during the review to other Managed Care Plan functions (e.g., QI, re-credentialing, peer review).

In addition to record retention requirements for provider or provider licensure, provider agreements require that records be maintained for a period not less than ten (10) years from the close of the AHCA Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the subcontract is continuous.)

HEDIS

HEDIS Measures Required as Part of the NCQA Accreditation Process for Medicaid Health Plans will be utilized as applicable to the SMMC program population served.

Changes in Plan

HLTC will provide the agency with the documentation of compliance with access requirements at any time there has been a significant change in the Plan's regional operations that would affect adequate capacity and services including but not limited to the following:

1. Changes in HLTC's services
2. Enrollment of a new population in HLTC

Provider Organizations and Resources
Florida Assisted Living Association (FALA)
Florida Conference on Aging (FCOA
Florida Health Care Social Workers Association (FHCSWA)
Florida State Guardianship Association (FSGA)
Home Care Association of Florida (HCAF)
LeadingAge Florida
National Association of Social Workers (NASW)

Centers for Independent Living (CIL)
Florida Health Finder link
See http://apps.ahca.myflorida.com/nhcguide/alternatives.shtml for additional information and listings on Alternatives to Nursing Homes.

Home Health Agency
Nursing Facilities

See http://apps.ahca.myflorida.com/nhcguide/RegionMap.aspx for Nursing Homes by Region including specific on the home such as languages spoken and ratings.

Support Sites

Able Trust	Florida Alliance for Assistive Services and Technology (FAAST)	National ADA and Disability Related Resources online
Able Trust - National Disability Mentoring Day	Florida Association for Retarded Citizens	National ADA Technical Assistance Program
Access Board	Florida Centers for Independent Living	National Association for the Deaf
Advocacy Center for Persons with Disabilities	Florida's Commuter Services.com	National Council on Disability
American Council for the Blind	Florida Council for Community Mental Health	Online Resource Guide to Medical Disability Rights
American Public Transportation Association	Florida Developmental Disabilities Council	Senior Care / Home Care Directory at Care.com
Brain Injury Association of Florida	Florida Department of Elder Affairs County Profiles	Safe and Mobile Seniors
Brain and Spinal Cord Injury Program	Florida Public Transportation Association	The Transportation Web
Center for Urban Transportation Research (CUTR)	Intelligent Transportation Systems (ITS)	Transportation Research Board
Community Transportation Association of America	ITS World	Welfare Information Network

Counties and Community Based Organizations (CBO)

AAA or ADRCs
http://elderaffairs.state.fl.us/doea/arc.php
Community Resource Directory Locator – Links for all Regions (PSA)

Counties
http://www.fl-counties.com/ Select individual county web site at bottom right of web page.

Housing Resources

General Information and HUD
The Department of Housing and Urban Development (HUD) has a number of resources to help seniors find affordable rentals. They offer a low-rent apartment search that shows low-rent apartments for senior citizens and people with disabilities, as well as for families and individuals. For low-rent apartments, the government gives funds directly to the apartment owners. There is an income limit to qualify. http://www.hud.gov/apps/section8/index.cfm

There is also the public housing program and public housing choice vouchers, commonly called Section 8. Public housing comes in all sizes and types and is managed by local housing agencies that are funded by the federal government. Public housing choice vouchers allow you to find a private rental and the government pays the landlord directly to subsidize the rent. Both programs are limited to low-income families and individuals. http://portal.hud.gov/hudportal/HUD?src=/topics/rental_assistance/phprog and
http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/abo

ut/fact_sheet
If you have questions or need help finding a rental, talk to a HUD-approved housing counselor.
http://www.hud.gov/offices/hsg/sfh/hcc/hcs.cfm
Homes and Communities www.hud.gov
National "multiple listing" service http://new.realtor.com
Senior Alternatives for Living www.alternativesforseniors.com
Remodeling www.improvenet.com

Housing - Universal Housing
Ageless Design www.agelessdesign.com/
Developer of Affordable / Modular Housing www.suitelivingcare.com

Housing - Retirement Housing
Retirement Communities www.seniorsites.com
Senior Alternatives for Living www.alternativesforseniors.com
The Retirement Net www.retirenet.com

Housing - Assisted Living
Assisted Living Federation of America www.alfa.org
National Center for Assisted Living www.ncal.org
AssistedLiving.com www.assistedliving.com

Housing - Advocacy / Ethics
Agency for Health Care Policy and Research www.ahcpr.gov
Office of Disability, Aging and Long-term Care Policy http://www.healthfinder.gov/orgs/HR3096.htm
Policy and practice updates www.medscape.com

Housing - Care Homes
Eden Online www.edenalt.com/home/index.htm
Detailed nursing home information from Medicare http://www.medicare.gov/NHCompare/home.asp
National Clearninghouse for Long-Term Care Information -
http://www.longtermcare.gov/LTC/Main_Site/index.aspx

Housing - Associations and Organizations
American Association of Homes and Services for Aging www.aahsa.org
American Health Care Association www.ahca.org
Office of Disability, Aging and Long-term Care Policy http://www.healthfinder.gov/orgs/HR3096.htm

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 6 – Provider Network Agreements/Contracts (Regional):

The Agency has identified some of the key network service provider types that will be critical in order for the respondent to promote the Agency's goals.

The respondent shall demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting **Exhibit A-4-b-1**, Provider Network Agreements/Contracts (Regional):

Response:

Please refer to the attached Exhibit A-4-b-1, which directly follows this document, for our response.

Evaluation Criteria:

For each service provider type the respondent may receive up to 20 points as described below. Points for each service provider type will be awarded as outlined in the table below:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	5
25.1%- 50%	10
50.1%- 75%	15
75.1% or greater	20

Score: This section is worth a maximum of 240 raw points based on the above point scale.

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EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Enter Respondent Name Below
Humana Medical Plan, Inc.

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

General Instructions:

Each Respondent shall complete the Managed Medical Assistance Agreements/Contracts scoring template worksheet. The respondent is required to submit the total number of individual providers with whom they have agreements/contracts per Provider Type by using column 'b' on the worksheet.

MMA Required Provider Types Workbook Explanation:

Service Provider Types to be Measured List
Endocrinology
Internal Medicine
Pediatrics, Cardiology
Pulmonary Diseases
Surgery, Cardiovascular
Pediatrics, Endocrinology
Cardiovascular Medicine
Psychiatry, Child
Psychiatry, Adult
OB-GYN

Statewide Essential Providers Scoring Template Fields		
Field	*Respondent Data Entry Required?*	*Description*
Service Provider Type	*No*	*See Service Provider Types to be Measured List above*
**Agreements/Contracts*	*Yes*	**Agreements/Contracts count to be entered by respondent*
Total Population	*No*	*Total Medicaid eligible in the region*
% of population	*No*	*% of total Medicaid eligible in the region AHCA utilizing for ratio Recipient Count*
Recipient Count	*No*	*Recipient count utilized for as part of calculation for Ratio Results*
Ratio	*No*	*Regional provider ratio*
Ratio Results	*No*	*Shows service provider type requirement count for region using Recipient Count as the dividend and Ratio as the divisor*
%	*No*	*The number of agreements/contracts Respondent entered in column 'b', divided by the total number of Statewide Essential providers and converted to a %*

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
240

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio	Ratio Results	%	Score
Board Certified or Board Eligible Adult Psychiatrist	36	117,974	0.3	35392	1500	23.00	100.0%	24
Board Certified or Board Eligible Child Psychiatrist	12	117,974	0.3	35392	7100	4.00	100.0%	24
Cardiology	43	117,974	0.3	35392	3700	9.00	100.0%	24
Cardiology (PEDS)	11	117,974	0.3	35392	16667	2.00	100.0%	24
Cardiovascular Surgery	23	117,974	0.3	35392	10000	4.00	100.0%	24
Endocrinology	10	117,974	0.3	35392	25000	1.00	100.0%	24
Endocrinology (PEDS)	6	117,974	0.3	35392	20000	2.00	100.0%	24
Internal Medicine	81	117,974	0.3	35392	3000	12.00	100.0%	24
Obstetrics/Gynecology	61	117,974	0.3	35392	1500	23.00	100.0%	24
Pulmonology	18	117,974	0.3	35392	7600	5.00	100.0%	24

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide):

The Agency has designed the MMA Physician Incentive Program with the expectation that Managed Care Plans should be able to increase compensation for physicians, using funds achieved through savings from effective care management, as specified by Section 409.967(2)(a), Florida Statutes. The respondent shall describe its plan for ensuring physician compensation rates are equal to or exceed Medicare rates for MMA covered services. Specifically, the response shall include detailed descriptions of quality initiatives the respondent intends to implement or maintain that produce savings by promoting the Agency's goals, as well as other areas where the respondent has evidence that a potential for savings and increased quality exists.

Response:

Humana is an industry leader in establishing value-based relationships, with decades of experience helping providers move into arrangements that reward high-quality care. In Florida, Humana now has more than eight hundred thousand (800,000) Medicaid and Medicare enrollees attributed to Primay Care Physicians (PCP) in our continuum of value-based provider (VBP) arrangements. Our approach to the Agency for Health Care Administration (AHCA) MMA Physician Incentive Program (MPIP) rewards providers that achieve improved enrollee results and demonstrate a commitment to quality care by paying higher Medicare reimbursement rates. We place a focus on engaging the enrollee in appropriate care; in fact, our MPIP model is the only one in the State that includes the enrollee encounter rate as an incentive metric. MPIP aligns with Humana's VBP strategy and is an integral part of our broader approach to improve the health and well-being of our enrollees in the communities we serve. We have used this experience to work with ACHA to develop an enhancement to the standard MPIP structure.

We are committed to implementing high-quality case management, disease management, utilization management, and enrollee outreach programs designed to reduce potentially preventable events, improve birth outcomes, and address other drivers of high costs in the Managed Medical Assistance (MMA) program. Humana has invested in staffing and programs that support the implementation of a range of initiatives to improve quality and reduce costs, allowing us to increase reimbursement rates through MPIP. We are committed to remaining a strong partner for AHCA and Florida providers by paying enhanced reimbursement rates, and we will implement and maintain further quality initiatives that will achieve the Agency's goals and better serve our enrollees.

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1. The extent to which the respondent's proposal to improve quality can be tied to redirecting costs to pay higher physician rates.

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Quality is one of Humana's core values. We take a comprehensive approach to quality improvement, monitoring, and analyzing the quality of care our MMA program services provide. Using techniques such as root cause analysis and the plan-do-study-act-adjust approach, we identify barriers to care for our enrollees and design initiatives accordingly. In addition to our internal efforts to impact quality improvement, we ensure PCPs receive comprehensive and actionable enrollee-level data specific to medical utilization and gaps in Healthcare

Effectiveness Data and Information Set (HEDIS). Combined with support from our quality improvement nurses and provider relations representatives, we enable providers to take actions that improve the quality of care they provide to our enrollees.

To date, we have focused many of our initiatives on the drivers of potentially preventable events (PPEs). PPEs indicate areas for improvement where enrollees may be struggling to manage their condition or may not be receiving the necessary preventive care, and thus are unnecessarily admitted to the hospital or Emergency Department (ED). PPEs are also major driver of costs in the health system:

- For Humana's Florida Medicaid enrollees, the average expense for each Emergency Department visit is three hundred and fifty dollars ($350), compared to just one hundred twenty-five dollars ($125) for an urgent care visit or fifty-five dollars ($55) for a PCP visit. Statewide, more than twenty-four percent (24%) of ED encounters are considered potentially preventable [1].

- Proactive, preventive care can help enrollees avoid costly hospital admissions. According to the Agency of Healthcare Research and Quality, in 2010, the average cost per inpatient hospital stay was nine thousand seven hundred dollars ($9,700) [2]. According to AHCA's 2017 report on PPEs among statewide Medicaid Managed Care enrollees, more than two (2) hospitalizations per one thousand (1,000) enrollee months are preventable [3].

- Potentially preventable hospital readmissions represent a substantial opportunity to reduce costs through improved care. The average cost of a readmission to Medicaid is twelve thousand three hundred dollars ($12,300), which is twenty-eight percent (28%) higher than the cost of an admission [4]. More than eighty-seven percent (87%) of hospital readmissions in Florida are considered potentially preventable [5].

Additionally, we have implemented quality initiatives that focus on mothers and babies. In addition to ensuring healthy outcomes for the mother and infant during the postpartum period and childhood, our investment in initiatives that improve birth outcomes through prenatal care and reduce unintended pregnancies have the potential to generate significant cost savings. The potential gross savings from preventing unintended pregnancies in Florida is an estimated nine hundred seventy-three point two million dollars ($973.2M) [6].

By developing quality initiatives that focus on better chronic condition management, promotion of preventive care and prenatal care, and reduction in unintended pregnancies, we can generate significant cost savings that can redirect into higher payments for our providers. Humana has experience improving quality and redirecting the cost savings to providers: Trade Secret as defined in Section 812.081, Florida Statutes Trade Secret as defined in Section 812.081, Florida Statutes Trade Secret as defin

We view MPIP and the rest of our VBP continuum as key pathways to engaging providers in quality improvement. Our clinical quality initiatives work in tandem with MPIP; allowing us to both invest more in MPIP, generating cost savings through our quality initiatives, and improve quality through MPIP itself. Therefore, we have taken care to design and implement a thoughtful, data-driven MPIP program. As mentioned previously, we have used our expertise and experience working with similar quality and value-based payment initiatives to collaborate

with AHCA in developing an enhancement to the standard MPIP structure. Our metrics related to preventive care and improving health outcomes go above and beyond those used by other plans. Namely, Humana is the only SMMC plan in Florida to include the enrollee encounter rate as a metric for its MPIP model.

For pediatric PCPs, we tie reimbursement rates to MPIP metrics related to HEDIS measures, including well-child visits and pediatric and adolescent access to primary care. By aligning payment rates to performance on these metrics, we incentivize providers to take actions that increase enrollee engagement. In the short term, through increased early detection of childhood illnesses or developmental delays during well-child visits, we can offer interventions and services that ultimately reduce avoidable admissions, decrease the incidence of acute conditions (including those that are vaccine-preventable), and reduce costs. In the long term, increased enrollee engagement by PCPs encourages enrollees to seek care in the most appropriate setting. Parents and children who have developed a strong relationship with their pediatric PCP are more likely to visit that PCP rather than the Emergency Department, for acute conditions. Through MPIP, we also hold providers accountable for the rate of Emergency Department visits for their patient panel, creating an additional incentive to reduce potentially preventable events.

For board-certified OB/GYNs, our MPIP program offers higher reimbursement rates for providers that meet performance targets on measures closely linked to birth outcomes. Our OB/GYN MPIP program includes HEDIS quality measures on the frequency of ongoing prenatal care as well as postpartum care. By encouraging appropriate care-seeking during the prenatal and postpartum periods, we can reduce the risk of pregnancy-related complications, including anemia, preterm birth, preeclampsia, and complications of diabetes. Greater coverage of postpartum care leads to greater uptake of postpartum family planning, improved breastfeeding rates, and improved detection and treatment of postpartum depression. Humana's OB/GYN MPIP program also includes AHCA's Florida Medicaid performance measure regarding cesarean section (C-section) rates. By linking payments to providers' C-section rates, we expect to see improvement in outcomes related to reduced utilization of C-sections. These outcomes include fewer neonatal intensive care unit (NICU) stays, reduced maternal hospital stays, reduced risk of respiratory problems in infants, and a reduced risk of complications in subsequent pregnancies.

We recently expanded our MPIP program to include pediatric specialists, including cardiologists, endocrinologists, nephrologists, neurologists, and psychiatrists. We incentivize pediatric specialists to pursue and maintain board certification to receive enhanced Medicare reimbursement rates through MPIP. Board certification reflects a commitment by the physician to continually expand their knowledge in their medical specialty, as it requires certified physicians to complete ongoing education to maintain their certificate. Through this arrangement, we expect to see improved outcomes for children with special conditions such as juvenile idiopathic arthritis, inflammatory bowel disease, and left heart syndrome.

Throughout this response, we will detail initiatives that we have implemented, assessed, and integrated into our daily operations to improve care for our enrollees. Additionally, we will discuss initiatives that respond to more recent trends that are still in their pilot phase, and which we intend to maintain under the next contract. Through these initiatives, we have generated cost savings that will directly support higher provider reimbursement rates under MPIP.

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2. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.

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As described above, PPEs are significant drivers of cost and inefficiency in the healthcare system, in addition to causing unnecessary stress and pain for enrollees and their caregivers. As part of our commitment to ensuring our enrollees receive quality care, we have introduced quality initiatives that improve participation in case management, enrollee awareness, and access to appropriate care settings, with the goal of reducing PPEs.

Humana has many quality initiatives designed to reduce the following events:
- Potentially Preventable Emergency Department Visits (PPVs)
- Potentially Preventable Hospital Admissions (PPAs)
- Potentially Preventable Hospital Readmissions (PPRs)

INITIATIVES TO REDUCE POTENTIALLY PREVENTABLE EMERGENCY DEPARTMENT VISITS

Through advanced PCP coordination, increased access to appropriate care settings, and enrollee education about proper care settings, our case management, disease management, and enrollee outreach programs reduce Emergency Department visits. This leads to lower costs and greater savings that can be redirected into our MPIP model. We have supported and enhanced our suite of clinical programs through past and current quality initiatives that target PPVs, detailed below.

LINKING ENROLLEES WITH POST-EMERGENCY DEPARTMENT CARE: THE SOUTH FLORIDA REAL-TIME ED INITIATIVE

Humana introduced the Real-Time ED Initiative in 2013, after identifying the need for up-to-date, real-time Emergency Department data to more effectively monitor and track Emergency Department utilization among our enrollees. Through this initiative, we introduced the following processes:

- Receive, assign, and process daily Emergency Department information from daily reports and an electronic encounter queue in the Humana clinical management system

- Notify PCPs of Emergency Department visits for their enrollees

- Contact enrollees to help them schedule follow-up appointments

- Provide discharge instructions to PCPs

- Contact, assess, and educate enrollees about condition management and when and where to seek treatment, if needed

- Refer enrollees to case management, disease management, and other services

To measure the effectiveness of this initiative, we tracked outcomes for those enrollees to whom we reached out. Across participating facilities in 2015, we saw an eighty-eight percent (88%) decrease in utilization in this population, from four thousand eight hundred twenty-nine (4,829) Emergency Department visits pre-outreach to eight hundred sixty-seven (867) post-outreach.

Based upon the success of this initiative, we expanded our efforts to engage PCPs and enrollees to reduce preventable Emergency Department visits. Today, we leverage the daily Emergency Department visit information that we obtain from more than sixty (60) facilities through Florida's Health Information Exchange and Event Notification System (HIE/ENS), reducing a months-long notification lag to one day. We have integrated these notifications into Humana's utilization management (UM) system for timely tracking and reporting of Emergency Department visits, and providers receive a daily report of their patients' Emergency Department encounters the prior day. We use this information in conjunction with our Emergency Department Utilization Predictive Model to determine high-risk enrollees who are most in need of immediate outreach. We also plan to add behavioral health-related visits to this model, helping us predict future visits for both medical and behavioral health conditions. Emergency Department case managers (CMs) reach out to high-risk enrollees and complete an assessment to identify needs, close gaps, educate on appropriate treatment settings, and ensure timely provider follow-up.

BRINGING MEDICAL SERVICES TO THE HOME: TRANSITION HEALTH CARE EMS PROGRAM

In addition to our quality initiatives that reduce repeat Emergency Department visits through stronger provider and enrollee outreach, we have recently introduced a pilot program to offer select medical services in enrollees' homes. As an alternative to visiting the Emergency Department, when members call Humana's twenty-four seven (24/7) nurse advice line, they can be triaged into our Transition Health Care Emergency Medical Services (EMS) program. This program provides in-home services, including prescription administration, echocardiograms, blood and urine tests, respiratory treatment, intravenous (IV) therapy, and wound care, with the goal of preventing non-urgent Emergency Department visits. The paramedics complete home safety assessments, medication reconciliation, care coordination, and community resource navigation. We anticipate that this initiative will reduce Emergency Department visits and produce cost savings that can redirect into provider reimbursements under MPIP. The program will also improve enrollees' experience and overall well-being, particularly those with complex needs, by offering services in the comfort of their home. We are currently implementing this pilot in Regions 10 and 11, and will expand to other regions following successful results.

REDUCING POTENTIALLY PREVENTABLE HOSPITAL ADMISSIONS

Our case management (CM) and utilization management (UM) approaches, combined with our emphasis on preventive care and provider engagement, drive down costs by preventing the acute events that drive PPAs and by identifying medically unnecessary inpatient admissions through front-end reviews, which reviews inpatient admissions to verify the admission meets approporiate inpatient stay criteria. We combine our standard processes with quality initiatives

that use advanced data analytics and innovative approaches to better manage the chronic conditions that are major drivers of PPAs.

IMPLEMENTING LOCAL SOLUTIONS TO REDUCE COSTS AND DELIVER BETTER CARE: OUR SICKLE CELL DISEASE MANAGEMENT (DM) PROGRAM

In June 2017 we launched our Sickle Cell Disease Management program. As sickle cell disease is a leading cause of PPAs statewide [7], we recognized the opportunity to improve enrollee outcomes and reduce costs through a disease management (DM) program specifically for this condition. We proactively identify enrollees with a diagnosis of sickle cell disease, beginning with a specific question on our welcome calls about any history of blood disease. Additionally, we educate our PCPs about our Sickle Cell DM program, and encourage them to refer any enrollees with a diagnosis of sickle cell disease to this program. Enrollees who elect to participate receive additional education and support from a disease management (DM) nurse. This education includes an emphasis on the importance of regular health check-ups with their PCP, appropriate steps to prevent infection, incorporation of healthy habits into their lifestyle, and information about support groups and community organizations that can provide additional information, assistance, and support.

In addition to our DM program, we will introduce a range of initiatives designed to support our enrollees with sickle cell disease and to reduce related events, spanning our case management, DM, and provider relations departments:

- Creation of a monthly dashboard provided to PCPs that lists enrollees diagnosed with sickle cell disease and their history of inpatient admissions, ED visits, and PCP visits

- Delivery of sickle cell disease-specific training for our case management, DM nurses and social workers

- Development and implementation of sickle cell disease-specific best practices and disease-specific education for DM case management staff

- Identification and recruitment of PCPs and pain management providers that have experience and success in treating enrollees with sickle cell disease

- Development of regional centers of excellence with providers who have a history of successful treatment of enrollees with sickle cell disease and other blood disorders

We will monitor several outcomes of our sickle cell program, including decreased inpatient utilization, decreased average length of stay for inpatient services, decreased Emergency Department utilization for a primary diagnosis of sickle cell disease, reduced associated costs, medication adherence, and improvement in acute pain.

COMMUNITY OUTREACH TO ENROLLEES: FIELD CASE MANAGER AND FIELD SOCIAL WORKER PILOTS

Through our case management program, Humana associates can help enrollees proactively address care needs before an event that may lead to an unnecessary admission or readmission to the hospital. We have introduced quality initiatives that leverage the data captured by Clinical Guidance eXchange (CGX), our case management system, to better tailor our case

management programs to enrollees who will benefit the most. Today, Humana is conducting pilots that assign field case managers (FCMs) and field social workers (FSWs) to conduct field visits at provider offices to engage high-risk enrollees in case management. We designed this program to reduce inappropriate utilization of care, to reduce barriers to closing gaps in care, and to improve the engagement of enrollees with complex needs through face-to-face support.

Our DM programs play a central role in helping our enrollees with chronic conditions more effectively manage their disease and avoid unnecessary hospital admissions. Therefore, we aim to actively engage all eligible enrollees in these programs. One recent quality initiative paired our FCM pilot with our disease management interventions to increase participation among enrollees living with HIV/AIDS. Through this initiative, we employ FCMs who are responsible for finding enrollees living with HIV/AIDS in the community. Once identified, an FCM visits the enrollee to introduce themselves in person and to educate the enrollee on the DM program and its benefits. With the permission of the enrollee, the FCM completes a survey and addresses any immediate medical, educational, social, and behavioral needs through linkage with Humana- or community-provided services. The FCM then facilitates contact with the DM nurse, who conducts ongoing telephonic outreach for the enrollee.

As a result of our FCM HIV/AIDS initiative, sixty-one percent (61%) of the eligible enrollees identified between June 2016 and May 2017 are now participating in our HIV/AIDS DM program. This is an increase from a fifty-four percent (54%) participation rate achieved in the first year of the initiative. By engaging our enrollees in DM, our enrollees have experienced better condition management and improved outcomes, resulting in an average cost reduction of forty-eight percent (48%).

REDUCING POTENTIALLY PREVENTABLE HOSPITAL READMISSIONS

Humana recognizes that effective transitions of care are critical to ensure enrollees are not readmitted, and we offer numerous, coordinated pre- and post-discharge initiatives to improve care for our enrollees throughout transitions between care settings. We identify enrollees at greatest risk of readmission and conduct discharge follow-up to identify trends in causes of readmissions. Through our sophisticated predictive models and data analytics tools, we reduce preventable hospital readmissions and reduce avoidable costs.

SERVING ENROLLEES WITH COMPLEX NEEDS DURING THE POST-DISCHARGE STAGE: ENHANCED TRANSITION PLANNING AND FREQUENTLY ADMITTED MEMBER PROGRAMS

We have introduced two (2) initiatives designed to reduce PPRs by reaching enrollees during the pre-discharge stage. Appropriate post-discharge planning is essential to reduce readmissions and yield greater cost savings that can redirect into MPIP. Humana's UM nurses facilitate interaction and coordination with hospital staff to ensure continuity of care and to coordinate post-discharge activities. They collaborate daily with hospital case managers and discharge planners for hospitalized enrollees to promote safe, timely, and appropriate planning.

The first of our quality initiatives in this area is Humana's Enhanced Transition Planning (ETP) program for our enrollees in complex case management. For those who have at least two (2) hospitalizations within the last three (3) months, a CM creates an individualized transition plan

that describes an assessment of needs, education, and assistance in scheduling follow-up appointments. In both 2015 and 2016, we significantly surpassed our readmission rate goal for those enrollees participating in this program. In 2016, we reached a sixteen percent (16%) readmission rate, which was a seven percentage point (7%) improvement over the previous year.

In addition to our ETP program, we operate a Frequently Admitted Member (FAM) program, which takes a prospective approach to the prevention of PPRs. In FAM, our clinical teams use real-time data and analytics to identify, stratify, and segment enrollees with the most acute facility inpatient admissions during the most recent three (3)-month period. We assign each FAM enrollee a designated UM nurse and supporting technician to monitor these enrollees throughout admissions and during the eight (8)-week post-discharge period. We have observed a fifty percent (50%) reduction in readmission rates for enrollees targeted by this program.

ADDRESSING A MAIN DRIVER OF PPRS: OUR MEDICATION RECONCILIATION PILOT
In addition to initiatives that reduce PPRs by targeting enrollees during the pre-discharge stage, we have introduced a quality initiative that addresses factors that contribute to PPRs during the post-discharge stage. Medication non-compliance is a leading cause of readmissions among Medicaid enrollees, particularly among those with behavioral health and chronic medical conditions [8,9]. We implemented a Medication Reconciliation pilot in August 2017 for high-risk enrollees engaged with a FCM. During the post-discharge home visit, the FCM works with the Humana pharmacy team to conduct medication reconciliation. The pilot incorporates a pharmacist via telephone into the FCM's medication reconciliation process to reduce medication-related problems that put enrollees at risk for adverse effects or readmission.

INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH IN ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM)
Major depression led to twelve percent (12%) of PPRs among Florida Medicaid enrollees between August 2014 and July 2015, making it the third leading contributor to PPRs statewide [10]. To better support enrollees with a diagnosis of major depression and to reduce associated admissions and readmissions, we have introduced a quality initiative that engages providers and enrollees to support antidepressant medication adherence. We identified two (2) key barriers to improve medication management among enrollees diagnosed with major depression: many providers lack an understanding of the AMM specification requirements, and many enrollees need education regarding the importance of medication adherence. To overcome these barriers, we have distributed AMM guidelines to all PCPs. Our quality improvement nurses reinforce the messages in these guidelines during their regular, face-to-face meetings with PCPs. To encourage higher engagement of enrollees, we distribute a monthly action list to our PCPs and behavioral health providers, listing those enrollees who are due for a follow-up visit for medication monitoring.

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3. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by improving prenatal care and birth outcomes.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana is committed to improving prenatal and birth-related outcomes for all pregnant enrollees and their infants. We divide quality programs dedicated to these efforts into initiatives that focus on:
- Improving prenatal care
- Reducing medically unnecessary C-sections
- Improving care for the newborn
- Reducing unintended pregnancies

IMPROVING THE TIMELINESS OF PRENATAL CARE THROUGH MOMSFIRST AND HIE/ENS

Because we are committed to facilitating early prenatal care for our enrollees, recognizing its importance to the health of both mother and baby, we have designed our specialized obstetric case management program, MomsFirst, to support women during the prenatal and postpartum periods. MomsFirst offers a wide array of prenatal and birth-related services to all pregnant Humana enrollees. Enrollees are assigned an obstetrics (OB) case manager who provides education to the enrollee and her identified partner on the frequency and importance of OB/GYN visits and good dental health during pregnancy, how to ensure proper nutrition for herself and her child, including how to access the Women, Infants, and Children (WIC) supplemental nutrition program, as well as education on family planning, delivery, postpartum care, and infant pediatrician selection. The case manager also helps with transportation, child care, and removing other structural barriers that may prevent the enrollee from visiting the OB/GYN or making other healthy lifestyle choices by linking the enrollee to our NET providers and other community resources.

Our MomsFirst program plays a powerful role in improving health outcomes for our pregnant enrollees and their babies, and in reducing the costs associated with labor and delivery. To expand participation in MomsFirst and to reach more of our pregnant enrollees with important prenatal education and support, we have introduced a quality initiative known as “Improving Timeliness of Prenatal Care & Well-child Visits in the First 15 Months of Life – 6 or more visits”. This initiative includes the following interventions:

- An OB educational webinar for provider office staff to reinforce the MomsFirst referral process, billing requirements, and our Healthy Behavior initiatives

- Enrollee education on our MomsFirst case management program and the Healthy Behaviors

- Prenatal and Postpartum Reward program

- Introduction of a pilot program for HIE/ENS to identify pregnant enrollees who have sought services at an Emergency Department, enabling earlier outreach to the enrollee

- Collaboration with Healthy Start to receive monthly files of participating enrollees, alerting us to enrollees for whom we hadn’t received notification of pregnancy from other sources

Through these interventions, we increased our timeliness of prenatal care measure to eighty-six point three seven percent (86.37%) in 2016, exceeding AHCA’s target of eighty-two point two five percent (82.25%). By engaging our enrollees in earlier and regular prenatal care, we anticipate better overall outcomes for both the mother and baby, leading to lower costs overall.

REDUCING C-SECTIONS
Research demonstrates that infants delivered via C-Section are more likely to experience short-term adverse health, such as respiratory complications, and resultant NICU stays. To reduce the C-sections that contribute to these costly conditions, we have instituted prior authorization requirements for elective C-sections and regular strategy meetings with OB/GYNs. Through these efforts, we have reduced our overall plan C-section rate by three percentage points (3%) since 2015. To further address medically unnecessary C-sections among our MMA enrollees, we will explore incentive contracting structures for hospitals to reduce costs associated with C-sections in short and long term.

IMPROVING BIRTH OUTCOMES THROUGH NEWBORN CARE: THE HUMANA STORKS PILOT
Our quality initiatives to improve birth outcomes extend to supporting our enrollees during the neonatal period. In addition to post-partum visits conducted by case managers in high-volume hospitals, we debuted the Humana Storks pilot program in January 2017. Through Humana Storks, our enrollee advocates visit enrollees who have given birth while they are still at the hospital. The advocate educates the new mother on how to access health services that will ensure the best outcomes for herself and her newborn, and offers support for scheduling upcoming appointments. In addition, the new mother receives a care package with baby supplies, including diapers, a diaper bag, baby bottles, a bib, tee-shirt, educational materials, and a list of urgent care centers. By engaging our newborn enrollees and their caregivers early in life and encouraging regular medical care, we will generate cost savings through screening, diagnosis, and treatment of early childhood illnesses that can then redirect into higher MPIP provider reimbursement rates.

REDUCING UNINTENDED PREGNANCIES EDUCATION ON LONG-ACTING, REVERSIBLE CONTRACEPTION (LARC)
Evidence demonstrates that the voluntary use of contraceptive devices to prevent unintended pregnancies can yield improved birth outcomes and cost savings. This is due to better timing and spacing of births. Humana is committed to introducing quality initiatives that proactively seek to educate and support women in achieving their desired timing and spacing of pregnancies and avoiding any future unintended pregnancies. Recently, the Florida Medicaid program unbundled immediate postpartum LARC placement from delivery reimbursement, allowing hospitals to recover the cost of the device and associated services for immediate postpartum LARC placement. To educate our providers on this change and encourage them to discuss postpartum family planning with their enrollees, we introduced an initiative to disseminate education materials to our providers on this change, including a “Tip Sheet” that assists with billing.

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4. The extent to which the respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.
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We have implemented additional initiatives with our provider partners to drive quality improvement, including value-based purchasing arrangements and tools that equip providers with the information they need to deliver high-quality, cost-effective care for enrollees. We have

designed these initiatives to deliver greater value at reduced cost, enabling us to redirect cost savings through the MPIP program.

VALUE-BASED PURCHASING (VBP) MODELS

Humana has extensive experience implementing value-based purchasing (VBP) models in Florida and across the U.S. With a focus on supporting our providers to move from pay-for-service to pay-for-value, our VBP continuum of models meets providers "wherever they are" on this transformational path. While “full value” risk arrangements offer the greatest opportunity to improve quality and reduce costs, not all providers have the scale and capabilities to be successful in this type of arrangement and not all are interested in it. Therefore, we may initially bring providers into rewards-type programs and then into upside-only shared savings arrangements. Along this pathway, we incentivize our providers to become patient-centered medical homes, developing capabilities to provide coordinated care for enrollees and reduce costs. When our providers have the capabilities and readiness to accept full risk, we help them move into a full-value VBP arrangement if and when they want. This pay-for-value model focuses on promoting evidenced-based, high-quality care through improved care coordination, leading to lower health care costs and better outcomes.

Our VBP program has contributed to significant cost savings through a reduction in PPEs. Humana’s Florida Medicaid providers in “full value” risk arrangements outperform their non-risk counterparts in terms of quality, outcomes, and cost. In 2016 the risk providers had significantly higher quality scores on metrics related to preventive health, well-child visits, and diabetes management. As a result of their strong performance, these providers also have strong outcomes: Humana’s Florida Medicaid risk providers are averaging twenty-five point three percent (25.3%) fewer emergency department visits per thousand (1,000) enrollees and seventeen point four percent (17.4%) fewer hospital admissions per thousand (1,000) enrollees. By reducing preventable events like these and helping enrollees to access care in appropriate settings, Florida risk providers have fourteen point seven percent (14.7%) lower inpatient medical expenses and have reduced pharmacy expenses by eleven point four percent (11.4%).

TOOLS FOR PROVIDERS TO BETTER MANAGE ENROLLEES

We offer a range of tools through which our providers can view their HEDIS performance in real-time, identify enrollees with care gaps for follow-up, and view other data that can help them more effectively manage our enrollees’ care. Our providers use these data to introduce their own quality initiatives and take actions that will improve outcomes, such as employing care coordinators and social workers to promote integration of care and access to community resources. Together with the Humana-led quality initiatives, these provider-led initiatives can lead to better enrollee health and lower costs.

CAREHUB CLINICAL GUIDANCE EXCHANGE (CGX)
Our CGX system displays Care Alerts for our case managers. Care Alerts consist of evidence-based clinical care gaps and drug-to-drug/disease interaction alerts. Our providers incorporate findings from these alerts into their medical records and clinical decision-making processes. Additionally, our system sends information to providers via an electronic medical record (EMR).

ANVITA INSIGHTS ENGINE

The Anvita Insights Engine delivers personalized analyses that identify enrollees who (1) are at risk for dangerous medical events (including hospitalizations), (2) are taking contraindicated therapies that should be discontinued, (3) are missing preventive services, and (4) have cost-savings interchange opportunities to lower costs. When deployed at the point of care, Anvita can identify, rank, and score competing treatments by safety, efficacy, and cost in real-time, using virtually all known clinical data. Anvita's tools empower our providers to reduce preventable events and provide high-quality, effective treatments at a lower cost for our enrollees.

AVAILITY CARE PROFILE

The Availity Care Profile, a platform that provides a consolidated view of enrollees and their health care services across providers, is a powerful tool for improving enrollee safety, reducing unnecessary services, eliminating duplication of procedures, and driving coordination and continuity of care. Available to all of our network providers in Florida, the Availity Care Profile includes claims information associated with office visits and hospitalizations, diagnoses and associated procedures, prescription history, lab event history, radiology event history, immunization history, and clinical messaging. This information allows providers to improve outcomes by more rapidly closing clinical care gaps, delivering preventive care, and managing chronic conditions more effectively.

HUMANA'S MONTHLY HEDIS PACKAGE

To help PCPs more effectively manage the care of our enrollees, we provide a package of monthly HEDIS reports to every PCP. These reports capture preventable events among enrollees, gaps in care, and high utilizers of pharmaceuticals. In addition, practices can view their performance on HEDIS indicators and see how their performance compares with other providers in their region. We package this information to be actionable, with call lists that include contact information for enrollees who have care gaps and a list of recommended actions for enrollees who are noncompliant with preventive care screening or disease management visits.

SUPPORT OFFERED TO PROVIDERS TO IMPROVE QUALITY

FACE-TO-FACE SUPPORT

We use a dedicated approach to supporting providers to increase provider performance, effectiveness, and the quality of care delivery to our enrollees. We have developed a series of programs, processes, metrics, and resources, including the HEDIS package described above. This is complemented by a robust process to identify and leverage best practices among our provider network. The series of reports documented above, combining medical and behavioral health utilization data, allows us to target outreach to those providers with high numbers of PPEs.

Our approach to face-to-face support includes the following departments and activities:

- Provider Relations: Our provider relations representatives (PRRs) are our direct liaisons and field representatives to our providers. They are responsible for meeting with innetwork PCPs monthly and high-volume specialists quarterly. In this front-line position, they are also

responsible for educating providers, clarifying provider inquiries, and relaying provider concerns to the broader Provider Relations team. We currently have more than fifty (50) provider relations representatives assigned to providers throughout the State.

- Quality: Our quality improvement nurses (QINs), who we geographically assign to PCPs and meet with PCPs quarterly, deliver provider-specific metrics, coach providers on gap closing opportunities, and provide resources and educational opportunities for providers and staff. There are nearly twenty (20) QINs assigned to PCPs in our Florida Medicaid network.

- Claims and Documentation: Our Claims Department provides education for providers to ensure accuracy of documentation and coding

- Case Management: Our Case Management and Disease Management teams assist our providers in developing strategies for engagement of enrollees qualified for care programs, provide feedback on program activity, and identify strategies to respond to actionable care opportunities (ED utilization, readmissions, etc.)

JOINT OPERATING COMMITTEE

We have established a Joint Operating Committee (JOC) with a wide range of providers, including our high-volume, fee-for-service networks, capitated specialty networks, hospital-based physician groups, and global risk providers. The JOC is a critical element of a successful risk relationship with our providers, creating an open line of communication between our providers and Humana.

The goal of this committee is to identify the best way to provide the highest quality of care to our enrollees in the most affordable manner and to discuss ongoing operations. To guide the meetings, we provide our risk partners with a package of reports including:
- Financial Performance Summary
- Medical Metric Report with comparison to regional averages and benchmarks
- Inpatient Stay Reports summarized by primary diagnosis and compared to PCP office visits
- Behavioral Health Utilization Reports
- Emergency Department and Outpatient Reports by diagnosis
- Emergency Department Visit Report
- OB-GYN Report
- Top 40 Report to identify members with high admissions and Emergency Department visits

Through these reports, Humana reviews provider performance on metrics related to hospital admission and readmission rates, HEDIS quality, medications taken for pharmacy, settlement data for finance, and medical risk adjustment. By discussing these metrics, we work collaboratively to identify ways to improve performance, drive better enrollee outcomes, and ensure a successful risk relationship.

Footnotes

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[1] Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees, Quarterly Statewide Medicaid Managed Care Report, Business Intelligence Unit Medicaid Data Analytics, Spring 2017
[2] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb146.pdf
[3] Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees, Quarterly Statewide Medicaid Managed Care Report, Business Intelligence Unit Medicaid Data Analytics, Spring 2017
[4] https//www.hcup-us.ahrq.gov/reports/statbriefs/sb199-Readmissions-Payer-Age.pdf
[5] Analyzing Potentially Preventable Healthcare Events of Florida Medicaid Enrollees, Quarterly Statewide Medicaid Managed Care Report, Business Intelligence Unit Medicaid Data Analytics, Spring 2017
[6]https//www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy
[7] http://ahca.myflorida.com/Medicaid/Finance/data_analytics/BI/docs/Quarterly_SMMC_Report Spring_2017.pdf
[8]https://www.openminds.com/market-intelligence/executive-briefings/drives-medicaid-behavioral-health-readmission-rates/
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3845797/
[10]http://ahca.myflorida.com/Medicaid/Finance/data_analytics/BI/docs/Quarterly_SMMC_ Report_Spring_2017.pdf

Evaluation Criteria:

1. The extent to which the respondent's proposal to improve quality can be tied to redirecting costs to pay higher physician rates.

2. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.

3. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by improving prenatal care and birth outcomes.

4. The extent to which the respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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C. RECIPIENT EXPERIENCE

MMA SRC# 8 – Primary Care Providers (PCP) Assignment (Statewide):

The respondent shall describe its overall process of assigning enrollees to primary care providers (PCPs), including its assignment algorithm. The response shall include the quality and/or performance metrics used to determine high quality PCPs, and the timeframes associated with processing an enrollee's request to change PCPs.

Response:

An enrollee's relationship with his or her primary care provider (PCP) forms the foundation of a successful enrollee experience. PCPs guide enrollees as they interact with the healthcare system and help enrollees take responsibility for their health. Enrollees who access care through their PCP tend to have better health outcomes and greater satisfaction with the services that they receive. Additionally, appropriate care-seeking at the PCP (as opposed to the emergency department (ED) or an urgent care center) contributes to cost savings. Humana is committed to assisting enrollees in choosing a PCP who meets their needs, including their unique health conditions, cultural and language preferences, and proximity to their residence. When enrollees do not make an affirmative choice in PCP selection, our intelligent, automated PCP assignment process is designed to match enrollees with a PCP who fits their needs and preferences at a location near their home, allowing enrollees to access services immediately upon enrollment.

OVERVIEW OF HUMANA'S PCP ASSIGNMENT PROCESS

Humana recognizes the importance of facilitating strong connections between enrollees and PCPs. To support this, we make significant efforts to ensure that, whenever possible, enrollees affirmatively choose a PCP. However, when an enrollee does not choose a PCP, Humana assigns a PCP within the following timelines:

- Two (2) days of enrollment for new enrollees
- Twenty-four (24) hours for enrollees with express enrollment
- Three (3) days for PCP change requests received on maintenance files from the state

Our PCP assignment algorithm is designed to assign a PCP that is most suited for the enrollee. It takes into account important considerations such as continuity of care and ease of access to the PCP's office.

- To ensure continuity of care, our algorithm will assign enrollees to the in-network PCP identified in the enrollment supplemental file

- For enrollees who were previously enrolled with Humana in the past six (6) months, the algorithm re-assigns the enrollee to the most recent PCP on record

- If the enrollee has family members who are Humana enrollees, then the algorithm assigns enrollees to the same in-network PCP as their family members

If this information is not available at the time of initial PCP assignment, then Humana uses the accessibility standards defined in the current contract (a maximum of twenty (20) miles and thirty (30) minutes from the enrollee's address) to assign enrollees to the closest PCP with an open panel.

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1. The extent to which the respondent's description includes how quality and/or performance metrics are defined and utilized in the assignment process.

2. The extent to which the respondent's algorithm includes assignment of enrollees to high quality PCPs.

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Our PCP assignment process is rooted in our unwavering commitment to maintain a high-quality network, as demonstrated by independent, objective measurement sources including HEDIS quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Humana serves more than two point two five (2.25) million medical plan enrollees across Florida, and through this experience, we have extensive quality performance data for PCPs throughout the state. In 2015, our enrollees reported an eighty point nine percent (80.9%) satisfaction rate with their personal doctor, above the national average as reported by National Committee for Quality Assurance's (NCQA) Quality Compass. Defined quality metrics guide our provider improvement processes and assignment procedures, with enrollee assignment limits placed on providers with low performance. Additionally, we are developing a new initiative to stratify provider performance into levels to meet AHCA's goal of incorporating quality metrics into the PCP assignment process.

DEVELOPING A HIGH-QUALITY PCP NETWORK

Our approach to PCP assignment is premised upon maintaining a high-quality network. We consider provider quality in every step of our network development process, from contracting to credentialing to re-credentialing. These processes ensure that only the highest performing providers are included in our provider network and are available for enrollee assignment.
During the contracting phase, we administer a provider assessment form that helps our associates determine if the provider is a good addition to our network and can meet the needs of our enrollees. This assessment contains questions such as:

- Is the provider familiar with HEDIS measures?
- How often does the PCP see his or her Medicaid patients?
- Does the office have Electronic Medical Records?
- Does the PCP offer after-hours and weekend appointments?
- Is the practice Patient Centered Medical Home (PCMH) certified? If yes, at what level?

Our credentialing process includes a comprehensive provider site visit utilizing an evaluation tool that reviews federal, state, and ADA compliance measures. Our associates catalog and

verify the following information to ensure the safety and appropriateness of these providers for our enrollees:

- Current valid state license(s)
- Current valid Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substance (CDS) certificate (as applicable)
- Education, training, and current board certification
- Work history
- History of professional liability claims that resulted in settlements and/or judgments
- State sanctions, restrictions on licensure and/or limitations on scope of practice
- Medicare and Medicaid sanctions

DEFINING AND UTILIZING QUALITY AND PERFORMANCE METRICS

Once a provider is included in our network, we strive to ensure consistent, high-quality performance. For nearly thirty (30) years, Humana has been actively measuring providers and facilities including the effectiveness and efficiency of providers. We measure provider quality through our annual provider audits which measure providers' performance on HEDIS quality measures.

Humana has launched the Physician Performance Measurement initiative, developed in consultation with current Humana providers. The initiative will evaluate providers on evidence-based clinical measures developed by credible organizations such as the NCQA and the AQA Alliance (formerly known as the Ambulatory Care Quality Alliance), and endorsed by the National Quality Forum (NQF). To support this initiative, Humana has invested in Optum Symmetry EBM Connect software to secure NCQA certification for our physician measurement program and to ensure the quality and objectivity of our provider data. This information will serve as an empirically-based, data-driven approach to identify PCP performance indicators that align with AHCA's quality improvement plan. As an example, measures we are considering for inclusion within the Children and Adolescents' Access to Primary Care Practitioners measure set are:

- Patient(s) 12-24 months of age that had a PCP visit during the 12 months prior to the end of the report period

- Patient(s) 25 months to 6 years of age that had a PCP visit during the 12 months prior to the end of the report period

- Patient(s) 7-11 years of age that had a PCP visit during the 24 month report period

- Patient(s) 12-19 years of age that had a PCP visit during the 24 month report

Providers will be evaluated by effectiveness measures related to their specialty and will be compared to colleagues within similar geographic locations. Providers will be placed into performance levels based on Humana's effectiveness performance index. We plan to calculate this performance index by dividing the actual compliance rate by the expected compliance rate.

The expected compliance rate is the composite value derived by multiplying the peer compliance rate by the provider's prevalence rate for each given measure.

INCLUSION OF QUALITY IN THE PCP ASSIGNMENT PROCESS

Humana will evaluate the PCP tier designations at least annually using a rolling measurement period. Physicians with performance significantly below their peer average will be referred to Humana's quality department for provider outreach and a potential Corrective Action Plan (CAP). While the provider is on the CAP, we close their panel to any new enrollee assignments. If the provider improves their performance in line with the CAP's goals and timeline, the panel will be re-opened to enrollee assignment.

In accordance with the previously mentioned NCQA PHQ certification, Humana will display an indication of the providers' quality performance in the online Provider Directory for enrollees to view and for our Customer Care Specialists (CCS) to use as they assist enrollees in making changes to their PCP assignment.

In addition to the stratification of our providers into performance levels, we are examining additional options to include quality in the PCP assignment process. We will work with providers and AHCA to determine the best approach to support incorporation of quality and performance metrics into the PCP assignment process. Our physician advisory committee will support and inform our physician performance measurement initiative. Our providers will consult with Humana to inform, among other things, our data selection, evaluation methods, and quality improvement programs. Moving forward, we will also use this committee to inform the application of this initiative to our PCP assignment algorithm. In addition, associates from our market quality department will work with our Provider Advisory Group, which includes representation from our Provider Network and Provider Relations teams, to steer and inform the identification of metrics to support our PCP stratification process. The Provider 360 Committee (a cross-functional team that meets monthly and includes representation from executive leadership and our quality, provider relations, and claims department) will also be used as a forum to discuss and review the quality metrics identified for the upcoming year. This committee will ensure our measures align with the quality improvement goals set by AHCA as well as internally developed quality improvement goals.

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3. The extent to which the respondent can process requests for PCP changes within three (3) business days.

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Humana's systems reflect a PCP change within twenty-four (24) hours from the time of request. Enrollees are able to request PCP changes at any time by contacting our Customer Care department; visiting our MyHumana online enrollee portal; and through their Case Manager, as applicable. If the request for a PCP change is made telephonically, our CCSs use Humana's Customer Relationship Management System (CRM) and the Physician Finder Plus (PFP) tool to guide the enrollee through the PCP selection process. Case Managers can also contact the Customer Care department on the enrollee's behalf to request a PCP re-assignment. Humana's

CRM provides our CCSs with information about the enrollee to guide the PCP selection process, including:

- Enrollee's current address (which is verified by the CCS)
- Enrollee's preferred language
- Preferred contact timeframe
- Current family member PCP assignments, if applicable
- PCP's NCQA PCMH accreditation status
- Provider type and board certification credentials (e.g.. family practitioner, pediatrician)
- Provider quality performance (in early 2019)

When enrollees request a PCP change, our CCSs have access to a complete, 360-degree view of the enrollee via CRM. Our specialists can see the enrollee's calling time preferences, current and previously filed complaints or grievances, care gaps, and more. The specialists can use this information to better understand the enrollee's needs and document the reason for the change. Our CCSs are also trained to ensure the PCP change is the best decision for the enrollee given the enrollee's location and needs, including any existing conditions or language requirements. During this call or via our website, CCSs enter PCP changes in real time, instantaneously updating the enrollee's profile in CRM in compliance with the contractual requirements. The platforms viewed by our associates and providers are updated with the new PCP assignment that night. This change may be viewed by our associates and providers as soon as it is entered into the system. Our automated system also sends enrollee ID cards once a PCP change is entered.

When a CCS identifies an enrollee who has more than two PCP changes in the past six (6) months, the CCS works to identify the enrollee's rationale for the PCP change and to determine if the enrollee would benefit from a referral to case management or if the enrollee has a lack of understanding of their benefits. In the latter case, the CCS educates the enrollee on how to access care and the benefits they receive through MMA. Any overall trends noted in enrollee requests for PCP reassignments, including potential quality of care concerns for specific provider(s), are used to inform our provider outreach and quality improvement efforts.

Evaluation Criteria:

1. The extent to which the respondent's description includes how quality and/or performance metrics are defined and utilized in the assignment process.

2. The extent to which the respondent's algorithm includes assignment of enrollees to high quality PCPs.

3. The extent to which the respondent can process requests for PCP changes within three (3) business days.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

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MMA SRC# 9 – PCP Timely Access Standards (Statewide):

The respondent shall describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards. The respondent shall also describe the process and methodology it uses for determining whether a PCP has the capacity to accept new patients.

Response:

Humana brings broad and lengthy experience assessing provider networks in Florida into our provider recruitment strategies. These strategies ensure that network composition sufficiently provides enrollees with timely access to care for urgent and non-urgent services, and give us invaluable insight into provider accessibility and availability. We understand that to achieve effective and responsive care delivery, our enrollees must be able to access our provider network in a timely fashion.

We comply with the Agency for Health Care Administration's (AHCA) contractual requirements for timely access standards, as listed below, and actively monitor provider adherence to these standards:

1. Appointments for urgent medical health care services shall be provided:
a. Within forty-eight (48) hours of a request for medical health care or behavioral health services that do not require authorization
b. Within ninety-six (96) hours of a request for medical health care or behavioral health services that do require authorization

2. Appointments for non-urgent care services shall be provided:
a. Within thirty (30) days of a request for primary care appointment

3. The primary care provider (PCP) provides or arranges for coverage of services, consultation, or approval for referrals twenty-four hours per day, seven days per week (24/7) by a Medicaid-enrolled PCP(s)

There are several methods we use to ensure enrollees have access to an adequate selection of PCPs, including family practice, general practice, internal medicine, and pediatric providers. The first method to ensure timely access to care begins with the broad scale of our provider network. We routinely monitor our network composition against AHCA's Geographic Access and Provider per Enrollee ratio requirements defined in the Managed Medical Assistance (MMA) Provider Network Standards Table, Section VIII. This guarantees that we have a sufficient number of providers to meet our enrollees' needs within each geographic area, and within the required time and distance access standards.

Humana also ensures providers maintain accessibility, appointment availability and after-hours coverage through an array of processes and tools to monitor these standards. Lastly, Humana has several processes in place to assess PCP panel capacity to ensure enrollees are assigned to a suitable provider.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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1. The extent to which the respondent's process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VIII., Provider Services, Item A., Network Adequancy Standards, Sub-Item 8., Timeline Access Standards.

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Our Humana provider agreement and Florida Medicaid Provider Manual contractually require participating PCPs to ensure enrollees have timely access to care for PCP services and referrals to specialists for medical and behavioral health, as follows:
- Urgent care: Enrollee must be seen within one (1) day of the request
- Sick care: Enrollee must be seen within one (1) week of requesting an appointment
- Well-care visit: Enrollee must be seen within one (1) month of requesting an appointment

We require all participating providers to render care in full compliance with AHCA and Humana's access guidelines. Additionally, as noted in the provider manual and the provider contract, PCPs must provide twenty-four (24)-hour availability to enrollees by telephone. Whether through an answering service, call forwarding, provider call coverage, or other AHCA-approved means, enrollees must be able to connect with clinicians who can render a clinical decision twenty-four (24) hours a day, seven (7) days a week. Humana audits appointment availability and wait time for urgent visits, non-urgent visits, and after-hours coverage using the monitoring methods described below.

TIMELY ACCESS PCP WAIT TIMES REPORT - Humana's Provider Relations team conducts an annual survey of a statistically valid sample of PCPs to gauge appointment availability. During these calls, a Provider Relations representative contacts the primary care office with symptoms of a simulated condition/illness to discover the next available appointment. Through our 2016 audit, we found that the average wait times for providers was two (2) days for sick care visits, just over one (1) day for urgent care visits, and eight (8) days for well-care visits, which exceeded AHCA requirements. See Attachment MMA 9-1 for Humana's 2016 PCP audit results. Starting in 2019 we will implement this process on a quarterly basis.

AFTER-HOURS ACCESSIBILITY AUDIT - Humana calls PCP offices annually or on a more frequent basis to ensure enrollees have after-hours access to care. The Provider Relations leadership team reviews results and then assigns the appropriate Provider Relations representative for immediate outreach to the provider, if necessary. Attachment MMA 9-2 includes results from our 2016 After-Hours Accessibility Audit, which exceeded AHCA requirements, as sixty percent (60%) of our PCPs offer after-hours care. Additionally, most of our patient-centered medical homes offer after-hours care. Humana also enhances access to after-hours care through our twenty-four seven (24/7) nurse line, which allows enrollees to call and speak with a clinician for medical guidance. Enrollees can also be warm transferred to their PCP during office hours.

Humana has developed a strategy to further incentivize PCPs to offer increased after-hours coverage. The initiative increases provider reimbursement for after-hours service codes 99050 and 99051. Given the current Medicaid-allowable reimbursement of seven dollars and twenty-eight cents ($7.28) and nine dollars and thirty-nine cents ($9.39), Humana is offering a range of thirty-five ($35) to fifty ($50) dollars, which is a substantial increase in reimbursement.

ENROLLEE SURVEYS - Humana annually reviews results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to identify any appointment and wait time issues. We report the results to our Quality Management Committee (QMC) to ensure we meet goal benchmarks. We measure access to care results year over year in comparison to our established benchmark goals (see Attachment 9-3). In our 2016 CAHPS survey, Humana saw an increase in adult responses for "Got appointment with specialist as soon as needed" to seventy-five percent (75%) and "Got urgent care as soon as needed" to eighty-two percent (82%) (a nine percent (9%) and two percent (2%) increase, respectively). We also saw an increase in "Ease of getting care, tests, or treatment needed" to eighty-six percent (86%) and "Got urgent care as soon as needed" responses for children to ninety percent (90%) (two percent (2%) and two percent (2%) increases, respectively).

ENROLLEE TURNOVER - On a monthly basis Humana reviews reporting of enrollees who have requested reassignment. This report includes codes that may indicate dissatisfaction with appointment availability or office wait times.

SITE VISITS - Humana conducts provider site visits for PCPs during the credentialing and recredentialing process. As part of these visits, we assess appointment scheduling policy, wait times, and after-hours accessibility. Humana also physically audits appointment schedules on a random basis during site visits.

COMPLAINTS AND GRIEVANCES - We receive complaints and grievances from enrollees and providers through multiple routes, which we record and track in our Customer Care Portal. Our Provider Relations team receives complaints that reflect network access issues or identify potentially non-compliant providers for review and action on a real-time basis. In addition, Humana will be designating a Provider Services Leader for oversight on provider disputes.

STAFF AND PROVIDER INPUT - Humana examines input from various internal and external sources pertaining to appointment availability and wait times. Examples of these sources include our Provider 360 Committee, the Clinical Access Team (CAT), Provider Relations representatives, case managers (CMs), specialists' offices, and customer care specialists (CCSs).

Our Provider Relations leadership team and Provider 360 Committee review the reports, based on data collection frequency, and identify issues related to potentially non-compliant PCPs. Provider Relations representatives follow up with non-compliant providers to ascertain problems, educate the provider, and if necessary, put the provider on a corrective action plan to remedy root cause issues.

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2. The extent to which the respondent's monitoring plan includes specific mitigation steps it will take if there is a potential access accessibility issue identified.

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If a provider fails to meet contract standards for appointment availability, wait times, or after-hours coverage, Humana's Provider Relations team will promptly reach out to educate the provider. Our Provider Relations team will then re-audit the provider after thirty (30) days. If the

provider is still not meeting our access standards, Humana develops and implements a corrective action plan (CAP), which we communicate to the provider in writing and during a meeting between the provider and Provider Relations representative. Humana's actions in addressing contractual non-compliance, such as not meeting appointment availability and access standards, may include, but are not limited to, the following:

- Immediately freezing the PCP's panel to new enrollees.

- Implementing a CAP with the expectation that the PCP shall regain compliance with Humana's standards within a thirty (30)-day period.

- Re-auditing the PCP at the end of the thirty (30)-day CAP.

- Lifting the PCP's panel freeze if we find the PCP has regained compliance with Humana's accessibility standards.

- Providing a notice of termination or extending the CAP window if the PCP does not improve accessibility standards and regain full compliance within the thirty (30)-day CAP window. Since the implementation of our MMA program, we have not terminated any providers related to accessibility and availability reasons.

Humana's Quality Management Committee (QMC) reviews all instances where providers are not meeting appointment availability and access standards. Humana continues to monitor an identified case to ensure that the provider office has implemented remedies for the indicated issues.

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3. The extent to which the respondent's process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.
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Humana monitors PCPs' capacity to accept new enrollees using a variety of mechanisms described below. We have designed all methods to cap PCP enrollment at levels that guarantee enrollees' access to care is within all AHCA access standards.

CREDENTIALING ATTESTATION - During our credentialing and recredentialing processes, we require PCPs to complete an attestation, which includes reporting how many active enrollees they have in their panel. Their panel must not exceed three thousand (3,000) active enrollees for all healthcare plans and lines of business. We have included an example of this attestation in Attachment 9-4.

PCP CLOSE PANEL PROCESS - Because many of our providers also serve our Medicare and commercial population in Florida, we implemented a process that extends a requested panel freeze for Medicaid enrollees to enrollees of all lines of business. If a PCP asks to freeze their panel, we review their capacity reports prior to closing it, and require an updated attestation stating they are at capacity for all payors. We require the PCP to have an action plan to hire

additional physicians and/or physician extenders to be able to re-open their panels in six (6) months.

FAILURE TO MEET ACCESS OR QUALITY STANDARDS - Humana may require a PCP to close their panel for reasons such as failure to meet availability and access standards, or for failure to meet Humana quality standards, such as unsafe office conditions, office uncleanliness, discrimination, or ADA noncompliance issues. In these situations, we ensure there are an adequate number of participating providers accepting new enrollees, or we recruit additional providers that have capacity to accept new patients. We will re-open the panel upon evidence that the provider is meeting availability and access standards or has improved quality standards.

MONTHLY RATIO REPORTING – Humana analyzes our network monthly against AHCA's regional ratio requirements, as listed below.

- Regions 1 and 2 must have an adequate number of PCPs against two hundred percent (200%) of the Managed Care Plan's actual monthly enrollment

- Regions 3 - 11 must have an adequate number of PCPs against one hundred twenty percent (120%) of the Managed Care Plan's actual monthly enrollment

- The ratio requirement is one (1) PCP per one thousand five hundred (1,500) HMO Medicaid enrollees. The ratio requirement may be increased by 750 enrollees for every full-time physician extender (ARNP or PA) affiliated with the PCP's office.

Monthly measurement reporting allows Humana to ensure there are an adequate number of PCPs available to accept new patients if a change in network participation or unexpected PCP panel status were to occur. PCP panels must not exceed three thousand (3,000) active enrollees for all health plans across all lines of business. We have designed our PCP assignment algorithm to take these factors into account to understand a PCP's capacity to accept new patients. Our auto-assignment system does not assign enrollees to PCPs with closed panels.

Our Provider 360 Committee meets monthly to discuss specific provider performance issues and identify any providers that we should close off from enrollee assignment. The committee reviews PCPs "closed" in the previous month to identify progress and steps needed to achieve an "open" status. As of October 2017, over eighty-nine percent (89%) of PCP panels were open. Attachment MMA 9-5 demonstrates that we exceed PCP-to-enrollee ratios statewide.

Evaluation Criteria:

1. The extent to which the respondent's process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.,** Provider Services, **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards.

2. The extent to which the respondent's monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.

3. The extent to which the respondent's process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment MMA 9-1: 2016 PCP Audit Results

Humana's Provider Relations team annually conducts a survey of a statistically valid sample of PCPs to gauge appointment availability. Please see below for Humana's 2016 PCP audit results.

Table 1: AHCA Contractual Requirements

1. APPOINTMENT TYPE	2. STANDARD
Emergent	Immediately
Urgent	Within 24 hours
Routine or Primary Care	30 calendar days
After-hours access	Answering service capable of paging physician or answering service with instructions to call Humana First and/or instructions to go to nearest Emergency Room if emergent/urgent

Table 2: Humana Average PCP Wait Times by Number of Days

Average PCP Wait Times by Number of Days				
Region	Total Number of PCP Locations Surveyed	Measure: Routine Sick Patient Care	Measure: Urgent Care	Measure: Well Care Visit
Region 1	129	2	1.3	10.3
Region 6	335	1.8	1.2	18
Region 9	38	1.8	1.2	4.7
Region 10	33	2	1.3	3
Region 11	36	3	1.1	4
Average Wait Times (all regions)	571	2	1.2	8

**In Regions 1 and 6, we conducted a full analysis of our network, rather than just a statistically significant sample to ensure there were no access issues. **

Attachment MMA 9-2: 2016 After-Hours Accessibility Report

Humana calls PCP offices annually or on a more frequent basis to ensure enrollees have access to care during after-hours. Results are reviewed by the Provider Relations leadership team and assigned to the appropriate Provider Relations representative for immediate outreach to the provider, if necessary. The table below conveys our results from our 2016 After-Hours Accessibility Audit, which exceeded Agency for Health Care Administration (AHCA) requirements in the following regions.

Region	Total PCP/FTE	Total PCP/FTEs After-Hours	% of PCPs/FTEs w/After-Hours	AHCA Contractual SLA Requirement	Humana Results
1	385.5	147.5	38%	30%	Exceeds
6	1348.5	855	63%	35%	Exceeds
9	575	363	63%	40%	Exceeds
10	420	300.5	72%	40%	Exceeds
11	621.5	409.5	66%	40%	Exceeds
Total	3350.5	2075.5	60%		

**In Regions 1 and 6, we conducted a full analysis of our network, rather than just a statistically significant sample to ensure there were no access issues. **

Attachment MMA 9-3: Measurement and Results: CAHPS

Humana annually reviews results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to identify any appointment and wait time issues. We report the analysis of the results to our Quality Management Committee (QMC). We measure access to care results year-over-year in comparison to our established benchmark goals.

Florida Medicaid Adult CAHPS Results			
CAHPS Question/Composite	2015 Rate	2016 Rate	2016 Market Goal
Getting Needed Care			
Ease of getting care, tests, or treatment needed	79.70%	79.30%	82.10%
Got appointment with specialist as soon as needed	66.40%	75.80%	68.40%
Getting Care Quickly			
Got urgent care as soon as needed	80.60%	82.90%	83.00%

Florida Medicaid Child CAHPS Results			
CAHPS Question/Composite	2015 Rate	2016 Rate	2016 Market Goal
Getting Needed Care			
Ease of getting care, tests, or treatment needed	83.90%	86.00%	86.40%
Getting Care Quickly			
Got urgent care as soon as needed	88.30%	90.10%	90.90%
Got routine care as soon as needed	87.30%	88.10%	89.90%

Attachment MMA 9-4: Humana Credentialing Attestation

Humana Medical Plan – Florida Medicaid
Attestation for Primary Care Physicians

In accordance with Section 1932(b)(7) of the Social Security Act (as enabled by Section 4704(a) of the 1997 Balanced Budget Act), the plan shall provide adequate assurances that it has the capacity to serve the expected Medicaid enrollment in that service area.

The minimum standards for primary care physicians must be met to ensure adequate accessibility to all primary care services for all enrolled recipients at all ages.

One FTE primary care physician is required per 1,500 HMO Medicaid members. The ratio may be increased by 750 HMO Medicaid members for every one physician extender (ARNP or PA).

A full-time primary care physician in the Humana Medical Plan may not have more than 2,400 Commercial and Medicare Member Equivalent (CMME) members enrolled in his/her panel. A Medicare enrollee is equivalent to three non-Medicare enrollees (ratio@1:3). A physician extender may increase the panel enrollment by an additional 1,200 CMME members.

I attest that my total patient load is no greater than 3,000 active patients for all health care entities and lines of business.

I attest that I understand the above guidelines for Medicaid and Humana Medical Plan and am in compliance with these established standards for my panel. The plan may audit my enrolled membership for Medicaid, commercial and Medicare.

PCP name (Printed)	PCP signature
Center number	Date
Group name	Tax ID

Medicaid attestation procedures

- The Medicaid Attestation is required for all PCPs contracted for Medicaid at time of initial credentialing and recredentialing.
- The “Printed name” and “Center number” fields are not required; however, the “PCP signature” and “Date” must be present.
- Attestation must be signed within 180 days of credentialing approval date.

Attachment MMA 9-5: PCP to Enrollee Ratios

The tables below demonstrate that as of October 2017, we exceed PCP to enrollee ratios statewide.

Table 1: PCP to Enrollee Ratios in Existing Regions

Region	Actual Enrollment	Number of Required PCPs	Contracted PCPs	Met Requirement
01	55,489	37	245	Exceeded
06	37,895	26	473	Exceeded
09	70,605	48	448	Exceeded
10	71,603	48	499	Exceeded
11	79,937	54	784	Exceeded
Grand Total	315,529	213	2,449	Exceeded

Table 2: PCP to Enrollee Ratios in Expansion Regions

Region	Projected Enrollment	Number of Required PCPs	Contracted PCPs	Met Requirement
02	26,923	18	180	Exceeded
03	42,972	9	461	Exceeded
04	18,942	13	527	Exceeded
05	11,072	8	351	Exceeded
07	11,164	8	654	Exceeded
08	13,194	9	302	Exceeded
Grand Total	124,267	65	2, 475	Exceeded

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 10 – Transitions of Care (Statewide):

The respondent shall describe how it will address the transition of care between service settings, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home. Identify specific methodologies for ensuring that transition planning ensures appropriate primary care and behavioral health follow up, where appropriate. Provide an example of an effective transition plan.

Response:

Individuals within the healthcare system are most vulnerable when transitioning between care settings and levels of care. Humana has worked to identify communication challenges through the transition process and develop practices aimed at resolving them. Together, our utilization management and case management teams serve as the link that connects the various care settings and levels of care through which an enrollee moves. They coordinate care and share information through discharge plans, plans of care, medication lists, and other clinical reports to ensure a safe and effective transition. Processes are integrated within our Clinical Guidance eXchange (CGX) clinical platform to ensure continuous information sharing among all involved parties. Our CGX clinical workflow system supports an integrated approach to care coordination. As a fully-integrated approach, this enterprise solution provides enhanced capabilities to identify enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention.

We have created transition processes that meet the needs of our enrollees and their families during these critical times when they are most likely to seek education and help with care coordination. Our transition planning actions start as soon as we are made aware that our enrollee is hospitalized, and they continue throughout the admission as well as post-discharge. Humana's post-discharge transition activities focus on identifying and addressing gaps in care and services post-discharge and preventing readmissions.

OVERVIEW OF HUMANA'S TRANSITION PROCESSES

For transitions from inpatient acute and long-term care facilities to the community, we follow the Dr. Eric Coleman Care Transitions Model, which is grounded in improving quality and safety during transitions. At the foundation of our transition processes are the following five (5) pillars of care:

- Coordinated and proactive discharge planning, including communication among all stakeholders, referral to needed post-discharge services and collaboration with community based agencies

- Timely and appropriate primary and specialty care follow-up post-discharge

- Medication management and medication reconciliation during transitions

- Establishing a medical home with a focus on prevention and proactive health management in the outpatient setting

- Empowering Enrollees and caregivers through education on their health conditions

Throughout an enrollee's transition from one level of care or setting to another, Humana Utilization Management and Case Management Nurses review all relevant clinical information including assessments, care plans, discharge plans, and medications to address barriers to care and to ensure services are in place to facilitate a seamless transition between care settings. They facilitate the transfer of information across care setting and levels of care, coordinating with facilities and providers to ensure medication reconciliation occurs and all other necessary communication among providers takes place.

We begin to assess and plan for discharge needs upon notification of an admission. Along with reviewing the enrollee's current clinical and functional status, we identify potential readmission risk using Humana's proprietary Readmission Predictive Model (RPM) (please see Attachment MMA 10-1). Available on admission, the RPM augments clinical review and helps identify enrollees who may benefit from more intensive support across transitions of care.

Humana associates involved in transition of care between service settings (sometimes referred to collectively as "transition associates" throughout this response) include Utilization Management Nurses, Case Managers (CMs), Behavioral CMs, Social Workers, and Case Management Assistants who together guide enrollees and their caretakers from admission to discharge to recovery. These individuals operate within a multidisciplinary team (MDT) in order to ensure that enrollees' holistic needs are identified and addressed during this transition. The MDT may include the enrollee, their caregivers, the enrollee's Primary Care Physician (PCP), and other providers involved in their care. Humana's Medical Directors work with the team to ensure approvals between levels of care and to communicate with physicians in community and inpatient settings.

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1. The extent to which the respondent's process and example address the following transition of care requirements:

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In the following response, we describe our process and provide a real case example that addresses each of the transition of care requirements. Our case example is a twenty (20) year old male enrollee, "Alex," who suffered a traumatic brain injury in September 2016 when he was hit by a vehicle while riding a motorcycle without a helmet. His diagnoses upon admission to the hospital included Respiratory Failure, Altered Mental Status, and Subdural Hematoma; he underwent a Ventriculoperitoneal (VP) shunt, a Decompressive Craniotomy, and a Tracheostomy, and had a gastrostomy tube (G-tube) inserted. Due to Alex's severe injuries, he transitioned first to a Skilled Nursing Facility and then to an inpatient acute rehabilitation hospital before being discharged to home on February 16, 2017.

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a. Assessment criteria for making sure the enrollee can be served safely in the community;

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Humana strives to provide efficient, enrollee-centered, and safe care planning for all enrollees transitioning between service settings. Throughout an enrollee's transition from one level of care or setting to another, Humana transition associates review all relevant clinical information including assessments, existing plans of care, discharge plans, and medications to address barriers to care and to ensure services are in place to facilitate a seamless transition between care settings. They also conduct home assessments to obtain authorizations for necessary modifications and equipment needed prior to transitions home.

Discharge planning, an integral part of the inpatient Utilization Management (UM) process, begins on admission to an inpatient stay. UM Nurses have direct access to our hospitals' Electronic Health Records (EHRs), which facilitates information gathering and reduces burden on hospital staff. Telephone UM Nurses facilitate interaction and coordination with hospital staff to ensure continuity of care while enrollees are in the inpatient setting, to identify any gaps or barriers in transition of care, and to coordinate post-discharge activities. The UM Nurse completes a comprehensive assessment of the enrollee and caregiver needs through completion of the Discharge Planning Assessment Tool in Humana's clinical platform, (CGX). The assessment gathers information on key factors that determine whether the enrollee can be served safely in the community, including but not limited to the following:

- Medical needs at time of discharge;
-- Availability of support from family and friends;
-- Access to a PCP and specialists;

- Potential barriers to discharge such as:
-- Confusion, cognitive Impairment, and memory loss
-- Cultural or language barriers
-- Currently active behavioral health diagnosis
-- Diagnosis resulting in significant life style change or educational needs
-- Drug abuse
-- Environmental risk (pediatric or dependent enrollee in risk environment)
-- Financial barriers
-- History of falls

- Healthcare behaviors and challenges such as:
-- Access issues, resides in rural area
-- History of non-compliance with plan of care or medications

In our case example, Alex was initially admitted to the hospital following his accident. Alex was determined to be eligible for Humana's Complex Case Management program and was assigned a CM shortly after his admission. Humana's transition team, consisting of the UM Nurse, CM, and Social Worker, engaged in assessment and discharge planning coordination with Alex's mother and his attending physician, medical team, and discharge planning staff at the hospital, where Alex remained until November 1, 2016. During his hospitalization, the CM referred Alex to Florida's Brain and Spinal Cord Injury Program and began assisting and guiding his mother regarding an application to the Traumatic Brain Injury and Spinal Cord Injury Waiver program.

Because of Alex's severe injuries, he could not be safely transitioned home at that time; he suffered from cognitive impairment, and his injuries were going to require significant lifestyle

changes and educational services. The discharge planning team agreed that a skilled nursing facility (SNF) was the most appropriate level of care at that point. In this setting, Alex could gain strength and stamina necessary in order to eventually fully participate in rehabilitation at an acute inpatient rehabilitation facility. During his time at the SNF, Alex received physical, occupational, and speech therapy (PT, OT, and ST). He was also fitted for and received custom splints for his upper and lower extremities. He made progress with his therapy, gaining enhanced mobility and the ability to follow simple commands on a consistent basis. He also regained his desire to eat.

Alex was transferred to an inpatient acute rehabilitation facility on January 24, 2017. During Alex's three (3) weeks at the rehabilitation facility, his tracheostomy was removed and he continued intensive rehabilitation. Alex's CM visited Alex and his mother in the facility and called his mother weekly. A swallow study was performed during his stay, which he did not pass, and the timeframe for a second swallow study was discussed. Since he did not pass the swallow study, Alex's G-tube had to remain in place and thus skilled nursing services would continue to be required. Humana's post-acute UM Nurse met with Alex's mother and collaborated with the facility discharge planner, facility therapy staff, primary care physician, Humana Medical Director, and Alex's Humana CM to discuss goals and discharge planning. It remained his mother's desire to have Alex go home. The Humana Social Worker on our transition team contacted Alex's mother and discussed available community resources. After a meeting with Alex's (MDT) and family, it was decided Alex could be safely transitioned home. Before discharge, Alex's CM completed a home visit and arranged needed services and supplies. Alex was safely discharged home on February 16, 2017.

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b. Collaboration with providers' (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;

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Humana's transition associates have extensive training and experience in collaborating with facility discharge planning staff to ensure smooth transitions for our Managed Medical Assistance (MMA) enrollees in Florida. Transition associates review initial discharge planning information from the facility and work closely with facility discharge planning staff to identify and review potential barriers to discharge through communications with the enrollee, their caregivers, the providers, and hospital nurses and social workers. Humana's transition associates also share relevant information with the facility discharge planning staff (e.g., known barriers to discharge that may be available in our integrated (CGX) documentation platform). The Discharge Planning assessment referenced above is a working document that is updated throughout the inpatient stay as additional information becomes available, up to and including the final facility discharge plan.

Humana's transition associates ensure the appropriate exchange of information to facilitate transitions to new settings or levels of care, including changes in medications and the discharge plan. Pre-discharge activities related to collaboration with facility discharge planning staff and other relevant stakeholders include the following:

- Involvement, cooperation, communication, and coordination during the planning process with the physician, hospital and facility representatives, the enrollee or authorized representative, the

enrollee's family or caregivers, pre-established community resources, Humana CMs; and appropriate clinical programs

- Provision of authorizations for needed post-discharge services as ordered by the treating physicians, such as home health and durable medical equipment (DME)

- Referral and scheduling assistance with our home care partners

- Referral and scheduling assistance to ensure necessary post-discharge appointments are arranged with the PCP, behavioral health providers, and other specialists

- Consideration for and referral to Humana care management programs such as disease management, case management, and other clinical programs

- Notification and coordination of discharge orders with providers, social supports, and community resources (e.g., home health, DME), the enrollee or authorized representative, the enrollee's family or caregivers, Humana CMs, and clinical programs as appropriate

The UM Nurse communicates the discharge plan with the enrollee, facility, caregivers, and PCP to effectively transition the enrollee home or to another facility and to ensure understanding of the plan by all parties.

Humana maintains detailed procedures for facility transfers, including hospital to hospital, Long-Term Acute Care Hospital (LTACH), Inpatient Rehabilitation Facilities (IRF), SNF, and Psychiatric Facilities. Our procedures address and ensure effective collaboration and define transition associate responsibilities. This includes PCP notification and facilitating communication between the transferring facility and the accepting facility. CMs with behavioral health experience and training are assigned to work with behavioral health facilities. We have also established regular calls between our transition team and hospitals to support discharges to assisted living facilities, group homes, and other services; this partnership serves our common goal of helping enrollees achieve health and well-being.

SPECIAL COLLABORATION PROCESSES FOR HIGH-RISK ENROLLEES

In addition to our standard pre-discharge transition processes, our transition team also engages in the following collaboration calls for high-risk enrollees during their inpatient stay:

- CASE CONFERENCES are scheduled on an "as needed" basis for enrollees with complex discharge planning needs or referrals. The UM nurse or social worker identifies enrollees based on the current clinical status during the inpatient stay or through identified historical utilization patterns (e.g., multiple readmissions). The case conference may include the post-acute team of nurses and medical directors, social workers, CM, PCP, and long-term care team. The teams work collaboratively to ensure the enrollee's discharge plan is safe, effective, and addresses all of the enrollee's needs. Following the call, the UM nurse contacts the enrollee and hospital case management team and updates them with the plan of care. Our social workers or CMs may also contact the enrollee and give information and referral assistance for community resources.

- OUTLIER CALLS are held weekly for enrollees with an extended inpatient stay. The call includes the UM nurse, UM leader, Medical Director(s), CM, and Social Worker. The purpose of the call is to discuss the enrollee's inpatient medical admission, discharge needs, and any anticipated barriers to discharge. If barriers to discharge are identified, the Associate Medical Director reaches out to the admitting physician for a peer-to-peer discussion. During the call, the teams discuss the enrollee's plan of care and schedule case conferences as needed.

- When an enrollee under twenty-one (21) years of age has a serious or complex medical condition that may require long-term care services (nursing facility, medical foster care, or model waiver services), Humana's transition team will refer to and work with the Medicaid interagency Children's Multidiciplinary Assessment Team (CMAT). The CMAT will determine eligibility for services to meet the enrollee's medical needs. In such cases, Humana's transition team works with the parent or legal guardian to initiate a referral for a CMAT level of care recommendation; coordinate with the local CMAT staff; attend the CMAT staffing; and coordinate services for the enrollee, ensuring that all medically necessary care is authorized and delivered in a timely fashion.

In our case example, Humana's transition team collaborated with discharge planning staff at all three (3) facilities in which Alex received care prior to his discharge home. In addition to working with hospital discharge staff prior to Alex's transfer to the SNF as noted above, the CM convened two (2) MDT conferences while Alex was at the SNF, one on November 29, 2016, and the second on January 19, 2017, at which time it was decided that Alex was ready to transition to an inpatient acute rehabilitation hospital and then to his home. Following the calls, the UM nurse updated Alex's family and the SNF discharge planning team about his plan of care. Alex was evaluated and accepted for admission by the rehabilitation center. A transition of care conference call was held that included Alex's CM and the Post-Acute UM Nurse who would be working with Alex at the rehabilitation center to discuss care needs and family discharge goals.

Alex was transferred to the rehabilitation center on January 24, 2017. Humana's post-acute UM Nurse met with Alex's mother and collaborated with the facility discharge planner, facility therapy staff, primary care physician, Humana Medical Director, and Alex's Humana CM to discuss goals and discharge planning. The MDT met again to determine whether Alex could safely be transitioned home. After the CM conducted a home assessment, made all post-discharge arrangements, and ordered needed services, Alex was discharged to his home on February 16, 2017.

The transition team notified Alex's PCP of all facility transfer plans and facilitated communication between the transferring facility and the accepting facility to ensure smooth transfers.

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c. Referral and scheduling assistance;

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Humana's transition associates provide referral and scheduling assistance both prior to and post-discharge. As noted above, prior to discharge they give authorizations for needed post-discharge services as ordered by the treating physicians, as well as referral and scheduling

assistance with our home care partners. They ensure a timely post-discharge appointment with the PCP or specialist is arranged. They also refer the enrollee to Humana care management programs such as disease management or case management. Humana's provider network is highly engaged. Communication between our transition team and the enrollee's PCP and specialists often occurs during the hospitalization. This helps ensure that the enrollee's outpatient providers are aware of what is occurring during the hospitalization and can ensure appropriate follow-up.

Post-discharge, transition associates continue to provide referral and scheduling assistance to ensure follow-up doctors' visits and outpatient care are arranged according to post-discharge instructions. They also assist with removing barriers to keeping appointments (e.g., by ensuring the enrollee has transportation for follow-up visits). When high-risk enrollees are discharged home, a Field CM visits the enrollee in the home and provides scheduling and referral assistance, a home assessment, and other support as needed.

In our case example, a Humana social worker contacted Alex's mother and discussed available community resources. The social worker also helped Alex's mom connect with Legal Aide for assistance related to Power of Attorney, as well as the local Aging and Disabilities Resource Center. The CM completed a home visit and arranged the following services and supplies: skilled nursing 24 hours/day, 7 days/week by assigned Home Health Agency. DME equipment including hospital bed, wheelchair, shower chair, Hoyer lift, enteral formula, and all G-tube supplies. The CM also ordered soft supplies such as briefs and underpads.

After his February discharge home, Alex's CM continued to provide referral and scheduling assistance. The CM made a home visit after Alex was transferred home, and followed up with Alex's PCP and specialty physicians in the community who are treating Alex. Alex continues to receive physical, occupational, and speech therapy in an outpatient setting. When Alex began communicating by typing on his computer and texting on his phone, his mother called the CM to share her excitement. The CM visited Alex in his home again on June 16, 2017, and arranged for Alex to be evaluated for a custom wheelchair to enhance his mobility, which he received in July 2017. The CM referred Alex to the Humana social worker in case for any additional assistance or resources were needed and has also arranged for a second swallow study to be performed in September 2017.

Alex's CM has continued to follow up with Alex's mom over the past year about application for the Traumatic Brain Injury and Spinal Cord Injury Waiver, but his mother has decied not to take any action. The CM has also worked to establish Alex's eligibility for the Long-term Care (LTC) program. Alex signed a consent form for the LTC program and had an appointment scheduled with his PCP in September 2017 for the 3008 form to be completed. The CM just received the 3008 form back from the PCP office and sent the application packet to the CARES unit. She will continue to follow up and assist Alex's mom with the LTC eligibility process.

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d. Coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred

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Post-discharge transition activities include a call to the enrollee within three (3) business days following discharge. Transition associates ensure that follow-up doctor's visits and outpatient care are arranged according to post-discharge instructions. They continue to communicate with the enrollee and their caregivers, PCP, behavioral health provider, and other relevant stakeholders to continually assess and intervene proactively, ensuring that enrollees are receiving necessary care and services. For enrollees in case management, the CM regularly facilitates case conferences to coordinate care and promote communication with the care team caring for the enrollee. PCPs and behavioral health providers are responsible for notifying our transition team of missed appointments, and CMs also follow up to make sure the appointment occurred.

Humana's approach to provider engagement includes proactively working with the PCP to serve as a central care coordinator following a discharge. Nearly half of Humana's MMA enrollees are attributed to PCPs in full value, global risk arrangements, which create incentives for providers to keep enrollees stable post-discharge and prevent readmissions.

Humana's HEDIS results for "Follow-up after Hospitalization for Mental Illness within seven (7) Days Post-Discharge" exceeded the national mean in measurement year 2016 and saw improvement between 2015 and 2016. Our performance on this measure also exceeded the Florida mean for measurement years 2015 and 2016.

In our case example, Alex's CM provides assistance to the family in scheduling and keeping physician appointments, communicates with Humana's transportation vendor to obtain appropriate transport, and communicates regularly with his PCP and community specialists to ensure appointments are kept. The CM also collaborates directly with Alex's PCP and specialists to ensure he is in compliance with his post-discharge plan, as well as to communicate any concerns Alex or his family may have, such as those surrounding his progress with mobility.

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e. Processes to prevent unnecessary hospital or nursing facility readmissions.

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Humana's post-discharge transition activities focus on identifying and addressing gaps in care and preventing readmissions. Post-discharge outreach is made to all enrollees discharged home. The specific outreach is based on the enrollee's risk level, as determined by the enrollee's Readmission Predictive Model score.

- High-risk enrollees are routed directly to a CM for post-discharge outreach. The CM administers the Post-Discharge Screening Tool, in its entirety, identifies gaps in care and documents appropriate interventions, and identifies enrollees eligible for Humana case management or disease management programs.

- Medium-risk enrollees are routed to a case management assistant for an abbreviated post-discharge screening. If gaps in care are identified, or if the enrollee requests to speak with a nurse, a CM follows up within twenty-four (24) hours.

- Low-risk enrollees are routed to a Voice Activated Technology (VAT) system and receive a VAT call that explains Humana's Post-Discharge Management program and invites enrollees to request a call back. Enrollees who request a call back are routed to a case management assistant for the abbreviated post-discharge screening.

Humana's goal is to complete the post-discharge call to the enrollee with three (3) business days following discharge. At least three (3) attempts, on different days and at different times, are made to reach the enrollee. Upon reaching the enrollee, the CM or case management assistant requests permission to obtain a Protected Health Information (PHI) consent form if not already obtained during the enrollee's hospitalization, verifies name and date of birth, and notifies the enrollee that the call is recorded. The CM or case management assistant then walks through a series of questions with the enrollee or caregiver to ensure the following items are in place:

- Enrollee received discharge instructions and fully understands their condition(s) and post-discharge care.

- Enrollee is in a safe environment with a support system to adequately provide post-discharge support.

- Enrollee was able to obtain all post-discharge medications and understands how to take them, can identify side effects and complications, and knows when to report concerns. Additionally, if the enrollee cannot afford medications, the case management team works with the enrollee on obtaining medications from community resources, pharmaceutical companies, or contacts the physician's office for assistance.

- Home health services and durable medical equipment are in place, if needed.

- Follow-up doctor's visits and outpatient care are arranged according to post-discharge instructions.

- Enrollee has required transportation for follow-up visits, and understands the transportation benefit.

- No complications or new problems have occurred without being reported to the physician.

- Enrollee understands when to report any complications to their physician and when to seek medical care.

At the conclusion of the call, we remind enrollees that there is a phone number on the back of their ID cards to schedule transportation and a phone number for the twenty-four (24) hours a day, seven (7) days a week Nurse Advice Line.

The goal of all post-discharge intervention is to identify and close any gaps in care that may lead to complications or readmissions. Humana's program is based on best practices identified in the clinical literature and on our own internal studies, which suggest that the closer the post-discharge intervention follows the discharge, the more likely the intervention will have a positive impact on outcomes and decrease inappropriate and costly readmissions. Our goal is to contact

at least thirty-five percent (35%) of enrollees within three (3) days after discharge. We exceeded this goal in both 2015 at fifty-one percent (51%) and 2016 at fifty-five percent (55%), and saw a significant improvement over that period. Our ten (10) day post-discharge contact rate also exceeded our goal (of at least fifty-eight percent (58%)) in both years and improved in 2016 as compared to the prior year (seventy-three percent (73%) in 2015 to seventy-seven percent (77%) in 2016).

We are focused on effective transitions for all our enrollees, but understand that certain populations require enhanced transition planning. As appropriate, enrollees are engaged in a case management program. If behavioral health needs are identified during or after the inpatient stay, then enrollees are referred to our behavioral health programs for support.

CMs closely monitor enrollees, especially those at high-risk, to ensure a safe transition from inpatient settings to the community and to reduce avoidable readmissions. CMs are responsible for creating an individualized transition plan for the enrollee, which includes:

- Setting goals that promote positive health outcomes

- Scheduling appointments

- Educating enrollees on their conditions to reduce preventable emergency department visits, hospital admissions, and readmissions

- Educating enrollees on benefits available through Humana and community resources

- Addressing enrollee post-discharge needs prior to hospital discharge (such as home health services, securing discharge medications prior to discharge, transportation)

- Coordinating care within and across treatment settings

- Giving enrollees and families a single point of contact

- Creating a process through which healthcare providers can communicate with one another about the enrollee's care

- Making enrollee preferences known and accessible to all providers

Humana has many tailored transition processes and programs to reduce readmissions for high-need populations, including:

- FIELD CASE MANAGEMENT. Humana has Field CM and Field Social Worker Pilots for the purpose of reducing barriers in order to close gaps in care, reducing readmissions, and improving engagement for enrollees with complex needs. Field CMs and Social Workers meet with the enrollee wherever they need to, including in the hospital.

We have also instituted a field visit component for all of our telephone CMS throughout our MMA program. While the majority of enrollee contacts will continue to be telephone, each CM will conduct at least one (1) field visit per month per caseload at the hospital or PCP office to

engage enrollees who have been identified for case management but whom we have been unable to contact.

- MEDICATION RECONCILIATION PILOT. We implemented a Medicaid Reconciliation Pilot in August 2017 for high-risk enrollees engaged with a Field CM (FCM). During the post-discharge home visit, the FCM works with the Humana pharmacy team to conduct medication reconciliation. The pilot incorporates a pharmacist into the FCM's medication reconciliation process to ensure the enrollee is getting the most out of his or her medications and to avoid medication-related problems that put enrollees at risk for adverse effects or readmission. Information from these visits is shared with the enrollee's PCP and uploaded in the enrollee's electronic medical record (EMR).

- FREQUENTLY ADMITTED MEMBER (FAM) PROGRAM. Humana has a FAM Program to identify, engage, and manage high-utilizing enrollees and improve their clinical outcomes. On an ongoing basis, clinical analytics teams use real-time data (e.g., authorizations) to identify enrollees with multiple facility inpatient admissions. Each FAM enrollee is assigned a designated UM nurse and supporting technician who follow these enrollees on all admissions. Having a consistent, concurrent review nurse allows the UM team to build trust with the enrollee, in addition to the relationship the enrollee has developed with their CM. It also facilitates the UM team's ability to coordinate medical record sharing between the PCP and hospitals. Our transition team follows these enrollees for eight (8) weeks post-discharge. We have observed a fifty percent (50%) reduction in readmission rates for enrollees targeted by this program.

- DIRECTING ENROLLEES TO "CHOICE SNFS." For some enrollees who are ready to be discharged from the hospital, immediate discharge to the home would present a risk of readmission due to short-term complex medical needs. To address this, we have identified high-acuity SNFs in our network where such enrollees can be transferred for additional therapy and in-facility doctor visits prior to being discharged home. To ensure enrollees are able to identify and access the highest quality, most appropriate SNFs, we created a SNF scorecard. The SNF scorecard is a tool used to identify services available, acuity levels, compliance with regulations, patient satisfaction and additional programs available at a SNF. Scorecard measures include:

- Services available

- Availability to admit new residents

- Wound care management capabilities

- Availability of intravenous (IV) medication and nutrition

- CMS Nursing Home Compare ratings

- Engagement with Humana CMs

- IN-HOME PHYSICIAN OR NURSE PRACTITIONER VISITS POST-DISCHARGE. Humana offers a variety of approaches to in-home clinical visits for our most complex and vulnerable enrollees that help prevent readmissions. First, many of our providers send nurse practitioners

or physician assistants to high-risk enrollees' homes post-discharge. Additionally, we contract with an in-home provider of medical services, typically used to address needs of enrollees with a "home bound" status. The provider is an in-home physician-based healthcare delivery company dedicated to improving access to high-quality in-home medical care. They also offer education on enrollees' disease state, and about the importance of compliance with their treatment plan, medication adherence, understanding signs and symptoms that require immediate reporting to the PCP, and the importance of regular PCP visits.

- POST-DISCHARGE MEALS. Good nutrition is essential for recovery following a hospitalization or skilled nursing stay. Humana offers post-discharge meal delivery as an expanded benefit to our enrollees, which covers up to ten (10) home-delivered meals per year after discharge from an inpatient hospital, long-term acute care hospital, or rehabilitation facility. This benefit is particularly helpful for enrollees who have limited social supports.

- NEONATAL INTENSIVE CARE UNIT (NICU) CM PROGRAM. The NICU CM program provides utilization review and case management of infants that are inpatient in the NICU in order to reduce readmissions. Nurses with extensive NICU experience follow each case throughout the NICU stay and for thirty (30) days post-discharge. The nurses provide authorizations and medical necessity approvals and discharge planning. They also offer support and education for families of the infants to address any concerns the family has about what to expect at home. For high-risk infants, the NICU nurses transfer the case to the Medicaid pediatric team for longer term outreach for up to one year to educate and support the caregiver.

- ENHANCED CARE COORDINATION FOR ENROLLEES UNDER AGE TWENTY-ONE (21). For enrollees under age twenty-one (21) who are in nursing facilities and meet criteria for transition from the nursing facility to home, a CM works collaboratively with each enrollee's MDT to transition the enrollee safely from the facility to the community. A transition plan is developed thirty (30) days prior to discharge, including the services and supports the enrollee needs to successfully reside in the community. During the first six (6) months following discharge from the nursing facility, the CM contacts the enrollee at least twice per month, including at least one face-to-face meeting. After the initial six (6) month transition period, the CM continues to maintain monthly contact with the enrollee or their authorized representative.

In our case example, Alex receives Enhanced Care Coordination for Enrollees under Age twenty-one (21) and complex case management from a Field CM who visits Alex and his mother both in the home and over the phone. Alex's progression through inpatient acute, SNF, and finally inpatient rehabilitation facilities maximized his potential for recovery. He initially transferred from the hospital to a SNF because he could not participate with the rigorous therapy regimen that is provided in an acute rehabilitation setting. However, after he received three (3) months of therapy (PT, OT, ST) at a lower level of intensity in the SNF he progressed in strength and endurance so that he was ready for the transition of care to the rehabilitation center where he received intensive therapy. Alex has been home since February 16, 2017 with no readmissions.

The effectiveness of our transition planning processes is evident in our outcomes. In both 2015 and 2016, we significantly surpassed our readmission rate goal for enrollees in Complex Case Management:
Readmission Rate Goal: 30% or less

2015 Readmit Rate: 23%
2016 Readmit Rate: 16%

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2. The extent to which the respondent's process and example ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

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Humana places the utmost importance on enrollee privacy and confidentiality. Ethics and the protection of enrollee privacy are integral to the case management process that occurs on a daily basis, and all of our associates receive thorough training that includes protection of the enrollee's privacy consistent with confidentiality requirements. All Humana associates and contractors must complete Humana's Ethics and Compliance training within thirty (30) days of hire and annually thereafter. This mandatory training is tracked for every associate. Topics include, but are not limited to: Privacy and Information Protection Policies including the Acceptable Use Policy, role of Enterprise Information Protection (EIP) and the Privacy Office, key definitions and responsibilities, social engineering tactics such as phishing, physical safeguards, and security incident and privacy breach reporting. Humana holds an annual Cyber Security Awareness event each October for the enterprise. This event is a weeklong focus on all things information protection. Renowned information security experts share their knowledge throughout the week with presentations, expo halls, and interactive activities.

We also offer our contracted healthcare providers and business partners an important part of our Enterprise Compliance Program: Ethics Every Day for Contracted Healthcare Providers and Business Partners. This training outlines our program's standards of conduct requirements, including reporting of improper disclosure of, or access to, enrollee information. It also addresses the safeguarding of information used to perform functions for or related to Humana, including following the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the more recent Health Information Technology for Economics and Clinical Health Act (HITECH). Healthcare providers and business partners are expected to have policies and procedures in place to affirm the integrity of their organizations' information. Examples include:

- Privacy and security training program for employees and business partners

- Confidentiality agreements, where applicable

- A procedure for the required return and destruction of Protected Health Information (PHI) if an agreement involving the support of Humana is terminated

- A procedure for restricting the marketing of PHI

Several safeguards are in place to ensure that enrollee privacy rights are guaranteed at all times. We have both inbound and outbound call authentication processes to ensure we are speaking with the enrollee, as follows:

- Inbound Call Authentication (three (3) required):
-- Enrollee ID

-- Medicaid ID number
-- Enrollee date of birth (DOB)
-- Enrollee zip code
-- Enrollee group name, group number, or product type (only if needed)

- Outbound Call Authentication:
-- Dial the enrollee's number on file
-- Ask to speak with the enrollee, addressing by full name
-- Ask for other appropriate identification such as zip code or DOB
-- If unable to provide zip code or DOB, ask for enrollee ID, group name, group number or product type, Medicaid ID, or SSI#

If we do not have a complete Power of Attorney consent form or a signed PHI consent form in our documentation system, the CM and other members of the Humana team obtain verbal consent from the enrollee at each contact to speak to anyone other than the enrollee. Authentication of the consent is documented in the CGX system at each contact.

The CM may request that the enrollee complete a PHI consent form if the enrollee requests that the CM speak to another person on an ongoing basis about their health status and concerns. A PHI consent form is then mailed to the enrollee with a self-addressed, stamped envelope. The PHI consent form allows Humana to obtain an enrollee's permission to discuss personal health information with a specific person named on the PHI form.

Humana employees are prohibited from disclosing any medical information to anyone inside or outside the health plan, except when required by law. Humana employees are educated on ensuring appropriate PHI and sign a confidentiality statement upon hire and on an annual basis. Enrollee- and Provider-specific information is used solely for the purposes of utilization management, quality management, disease management, discharge planning, care management and coordination, and claims payment. It is shared only with those individuals who need access to such information in order to conduct utilization management and related processes. Agreements with providers functioning in a peer review capacity specifically address and uphold the confidential nature of all enrollees' medical information.

Humana operates a framework of internal IT controls and information security policies and procedures to maintain the health information system's compliance with HIPAA and other privacy laws, as well as commonly accepted professional standards of health information management. We rely on secure software systems to protect and maintain our enrollees' sensitive medical information. The CGX system contains our enrollees' care plans, which can only be accessed by the enrollee's case manager, the UM Nurse and the enrollee's PCP. Following a defense-in-depth methodology, Humana utilizes numerous controls that are used to prevent data loss and breach of confidentiality. These include, but are not limited to: firewalls, De-Militarized Zones (DMZs), intrusion prevention, intrusion detection, group policies within active directory (least privilege), role-based access control (RBAC), data segmentation, anti-virus, anti-malware, full disk encryption, data loss prevention (DLP) tools, active data-in-use monitoring, monitoring of dark web activity, and web content filtering to protect endpoints from malicious websites. Humana undergoes many internal and third party audits including the National Institute of Standards and Technology (NIST), the Health Information Trust Alliance (HITRUST), the Payment Card Industry Data Security Standard (PCI DSS), and various state

department of insurance audits. Humana is currently certified as being compliant with NIST, HITRUST, and PCI DSS standards.

In our case example, Humana's UM Nurse provided and reviewed the Discharge Management Tools with the Alex's mother and obtained consent for the release of PHI during his stay at the inpatient hospital to which he was initially admitted.

Evaluation Criteria:

1. The extent to which the respondent's process and example address the following transition of care requirements:

- **(a)** Assessment criteria for making sure the enrollee can be served safely in the community;
- **(b)** Collaboration with providers' (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;
- **(c)** Referral and scheduling assistance;
- **(d)** Coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred; and
- **(e)** Processes to prevent unnecessary hospital or nursing facility readmissions.

2. The extent to which the respondent's process and example ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment MMA 10-01: Humana's Readmission Predictive Model

Humana uses the Readmission Predictive Model (RPM) to assess the probability of an enrollee being readmitted into a facility within 30 days. A score is generated on the day of admission. Generating scores at the time of admission gives more time to intervene and prevent the next potential admission, and helps improve the "reach rate," since the enrollee will still be in the hospital when the score is generated.

Trade Secret as defined in Section 812.081, Florida Statutes

[redacted]

Trade Secret as defined in Section 812.081, Florida Statutes

Readiness Model – *Complexity*

This is an example of how a predictive model works:

Traditional, diagnosis-only approaches treat enrollees A and B equally.

[redacted]

The take away

Humana's readmission predictive modeling approach, built on a database of a half million admissions, allows stratification and prioritization to those enrollee in the most need.

Humana.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 11 – Provider Network – Network Development Plan (Regional):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to the following services:

- Physical therapy (pediatric);
- Speech-language pathology services (pediatric);
- Occupational therapy (pediatric);
- Private duty nursing services (pediatric);
- Intermittent skilled nursing (pediatric and adult);
- Early intervention services;
- Compounding pharmacies; and
- Specialized therapeutic foster care.

The respondent's approach shall include at a minimum:

a. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);

b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;

c. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received; and

d. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services.

Response:

Humana's annual Network Development and Management Plan (NDMP) describes our ability to manage, measure, and continually strengthen our network of high quality providers. It serves as a guide to our Provider Relations associates and Agency for Health Care Administration (AHCA) for our network development and maintenance efforts. We submit an updated version to the Florida AHCA annually with regional updates. The Humana Medicaid network enables appropriate and timely access to high quality and cost-effective healthcare services for our enrollees. Our NDMP conveys how we ensure timely access to all provider types and services, including access to pediatric physical therapy, pediatric speech-language pathology services, pediatric occupational therapy, pediatric private duty nursing services, pediatric and adult intermittent skilled nursing, early intervention services, compounding pharmacies, and specialized therapeutic foster care. The NDMP also serves as a description and confirmation of our compliance with the standards and recommendations that have been outlined in the contract with AHCA and with its objectives for access, range and diversity of providers. We have provided our 2017 Network Development and Management Plan in Attachment MMA-11-1.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

With a commitment to excellence, Humana has built and maintains strong partnerships with our contracted providers and subcontractors. We have created and maintain a culture of collaboration and innovation in identifying and implementing improved approaches to healthcare delivery. The NDMP describes our approach to measuring and monitoring provider and subcontractor performance. We use that information to manage improvements with our network partners to ensure that enrollees have a wide choice of high quality access to services and to help our network partners increase effectiveness, quality, and cost efficiency. Our NDMP includes the following topics:

- Competitive landscape of provider network
- Prior year network analysis
- Description of basic network design and network access adequacy
- How enrollees access the system
- Analysis of timely access to services
- Provider satisfaction survey, methodology, and results
- Coordination of relationships among various levels of the system
- Assistance and communication tools provided to the Primary Care Providers (PCPs)
- Network barriers and gaps
- Telemedicine as a mechanism to enhanced access to care
- Electronic health records
- Pharmacy services overview
- Subcontractor monitoring and oversight
- Internal department coordination
- Coordination with outside organizations

REGION 1 NETWORK DEVELOPMENT STATUS

Humana initially established and built our Region 1 provider network through our existing Medicare Advantage and commercial networks. Since we began building our network in this region in 2011, Humana has continued to develop our provider network (specifically targeting providers with Medicaid experience) and to strengthen previously established relationships. The Humana Medicaid network of providers includes the essential provider Sacred Heart Hospital, as well as all health systems and hospitals in the region and most of large Independent Practice Association (IPA) providers in the region. Important Medicaid providers include Sacred Heart Health System, Nemours Children's Clinic, Escambia Community Clinics, West Florida Hospital, Health First Network, Fort Walton Beach Medical Center, Baptist Health System, North Okaloosa Medical Center, Santa Rosa Medical Center, and Healthmark Regional Medical Center (a designated safety net hospital). Additionally, our Region 1 provider network includes three (3) Federally Qualified Health Centers (providing eleven (11) locations), nine (9) Rural Health Clinics (providing nine (9) locations) and one (1) County Health Department. Our local mental and behavioral health provider, Access Behavioral Health (ABH), is contracted to manage and serve the behavioral health needs of our Medicaid enrollees. Humana's network has five (5) Patient-Centered Medical Home (PCMH) groups with one hundred and forty-seven (147) providers across twenty-one (21) locations in Region 1.

Region 1 has a unique set of challenges, including high levels of Managed Medical Assistance (MMA) enrollment, provider availability shortages in multiple specialties, and sparsely populated

areas including one (1) designated rural county. Additionally, according to the quarterly Statewide Managed Medicaid Care Report in Winter 2016, Region 1 has the proportionately largest percentage of unhealthy Medicaid enrollees in the state and the lowest number of available providers. Despite these challenges, Humana continues to broaden the scope of its contracting activities and enhance our Region 1 provider network. These efforts are conveyed in Table 1 of the attached NDMP. We have accomplished this growth through aggressive recruitment activities, which included extending our recruitment activities into Region 2 based on patterns of care. Specifically, we have reached out to needed provider types in the contiguous counties of Bay, Holmes, and Washington, which are within a reasonable time and distance standard for enrollee access. We have also attempted to recruit providers in southern Alabama who are within reasonable time and distance measurements, and are actively enrolled as a Florida Medicaid provider. We are currently working to contract with the University of South Alabama (hospital and physicians) to supplement pediatric and women's health services within the Escambia county catchment area.

Humana's Region 1 network continues to perform well with very few provider-initiated network terminations and steady enrollee growth. Since MMA implementation, our enrollment has grown from fifty-one thousand, seven hundred and thirty-three (51,733) to fifty-three thousand, two hundred and seventy-eight (53,278) enrollees (based on July 2017 834 enrollee files). From December 2015 to December 2016, we added twenty-four (24) PCPs in sixteen (16) locations and one hundred and ninety (190) specialists in fifty-eight (58) locations.

Despite our tenacious and ongoing recruitment activities and successful continued growth of the network, we continue to experience contractual ratio gaps in some specialties – see Table 2 in our attached NDMP. We continually monitor these gaps and use available resources to identify providers to fill the gaps, such as the AHCA Master File (PML), AMA Website, Sunbiz, US News Health Report, Florida Department of Health, our competitor's directory, and web searches. In addition, we discuss availability shortages with our provider groups to encourage additional recruitment of providers from outside the area. Prior to Amendment 11, Humana filed waivers for some of the specialties in which gaps remain. Humana will refile new waiver requests in January 2018.

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(a) Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region-specific identified gaps and future needs projection.

b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;
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Humana continuously measures and evaluates enrollee access to ensure our network meets or exceeds the Statewide Medicaid Managed Care requirements. This includes measuring adequacy against contractual requirements, resolving network gaps and addressing barriers to care, including transportation and linguistic needs. We also conduct strict oversight of our

subcontractors to ensure the same level of access is secured and monitored. Our measurement and evaluation process crosses multiple plan functions. This includes customer service, quality assurance and medical management for each region. The Humana Provider Relations associates, under the direction of the Regional Vice President of Network Operations and Provider Experience, reviews various metrics to understand access to care levels across service categories.

Our approach to identifying gaps and ensuring network adequacy uses established Humana systems and infrastructure, proven techniques, strict oversight, and prompt follow-up to monitor and address any network issues. Humana uses data resources to monitor travel distance and times to ensure enrollees have access to the type of provider they need. Humana includes both our directly contracted and subcontracted providers in our analyses. Humana ensures access to all enrollees through analysis of multiple sources of information, as required by AHCA. Below are descriptions of our network adequacy and access tools. The reports and results from these tools are reviewed on an ongoing basis by our Provider Relations team. They are also reviewed during our quarterly Quality Management Committee meetings to determine appropriate interventions and next steps.

ANALYTICAL REPORTING

ACCESS ANALYSIS

Using a proven geographical analysis tool, Quest Analytics, Humana utilizes geocoding technology to precisely measure enrollee to provider adequacy access. The Quest Analytics tool measures both distance and travel times against a baseline of two hundred percent (200%) of our enrollment for Regions 1 and 2 and one hundred and twenty percent (120%) for regions 3, 4, 5, 6, 7, 8, 9, 10 and 11. We analyze access for each provider specialty as listed in the SMMC contract by enrollee age and gender group as specifically indicated for the provider type (for example, pediatricians will be mapped to enrollees under the age of twenty-one (21)). This tool allows us to identify access issues at the county and zip code level. Additionally, we produce maps that display enrollee access and network deficiencies.

PROVIDER TO ENROLLEE RATIOS

Provider to enrollee ratios are analyzed monthly against network standards in accordance with the AHCA requirements. We use this tool particularly often when we anticipate increased enrollment volume to ensure that our network has the capacity to accommodate those additional enrollees.

Below are descriptions of the methods we use to identify enrollee barriers to accessing care. This data is collected and reviewed monthly by our Provider Relations team and the Provider 360 Committee. Our Provider 360 Committee is a cross-functional team, chaired by the Humana President of Florida Medicaid Operations, and meets on a monthly basis to review provider trends from our claims department, as well as Availity usage, quality measures, provider system usage, and provider grievances and inquires. The Committee includes representatives from our Claims department, Grievance and Appeals department, Credentialing department, and Provider Relations.

CUSTOMER FEEDBACK

ENROLLEE SURVEYS

Humana annually reviews results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to identify any trends in barriers to care. We report the analysis of the results to our Quality Management Committee (QMC) to ensure our goal benchmarks are met. We measure access to care results year-over-year in comparison to our established benchmark goals. In our 2016 CAHPS survey, Humana saw an increase in adult responses for "Got appointment with specialist as soon as needed" to seventy-five-point eight percent (75.8%) and "Got urgent care as soon as needed" to eighty-two-point nine percent (82.9%) (a nine-point four percent (9.4%) and two-point three percent (2.3%) increase, respectively). We also saw an increase in "Ease of getting care, tests, or treatment needed" to eighty-six percent (86.0%) and "Got urgent care as soon as needed" responses for children to ninety-point one percent (90.1%) (two-point one percent (2.1%) and one-point eight percent (1.8%), respectively).

Clinical Access team (CAT) – Humana has a Clinical Access team (CAT) that facilitates resolution of identified clinical issues related to enrollee access. The CAT consists of three (3) non-clinical specialists who process inbound calls and ten (10) RNs who manage and resolve the cases. Issues may range from appointment availability to inability to locate a provider.

Associate, Enrollee, Provider, and Advisory Input— On an ongoing basis, Humana examines anecdotal information from various internal and external sources as it pertains to network adequacy. This includes information contributed by individuals and committees, such as the Provider 360 Committee. This includes recommendations from providers to Humana to contract with specific providers and provider types.

MEANINGFUL DATA

Complaints and Grievances— Complaints and grievances from enrollees and providers are received through multiple routes and are recorded and tracked in our Customer Care Portal. Complaints that reflect network access issues or identify potentially noncompliant providers are forwarded to our Provider Relations team for review and action on a real-time basis. In addition, Humana will be designating a Provider Services Leader who will offer oversight on disputes.

Out-of-Network Referrals—We examine out-of-network referrals quarterly to identify potential areas where specialty provider capacity may need to be expanded.

Cultural and Linguistic Needs—Humana annually analyzes the cultural and linguistic needs of our enrollees and their geographic concentration to ensure appropriate access.

Timely Access PCP Wait Times Report—Humana's Provider Relations team annually conducts a survey of a statistically valid sample of PCPs to gauge appointment availability. We conduct the survey to assess wait times for scheduling appointments on an annual basis and will implement this process on a quarterly basis in 2019. During these calls, a Provider Relations representative contacts the primary care office with symptoms of a simulated condition/illness to discover the next available appointment. Through our 2016 audit, we found that the average wait times for providers was one-point two (1.2) days for Urgent Care Visits, two (2) days for Sick Care Visits, and eight (8) days for Well Care Visits, which meet AHCA requirements.

After-Hours Accessibility Audit—Humana calls PCP offices annually or on a more frequent basis to ensure enrollees have access to care during after-hours. Results are reviewed by the Provider Relations leadership team and assigned to the appropriate Provider Relations representative for immediate outreach to the provider, if necessary. Our attached NDMP conveys our results from our 2016 After-Hours Accessibility Audit, which exceeded AHCA requirements as sixty percent (60%) of our PCPs are offering after-hours care. Additionally, our patient-centered medical homes all offer after-hours care. Humana also enhances access to after-hours care through our nurse line available twenty-four (24) hours a day, seven (7) days a week. Enrollees can call this number and speak with a clinician for medical guidance. Enrollees can also be warm transferred to their PCP during office hours. Additionally, Humana has developed a strategy to further incentivize PCPs to offer increased after-hours coverage. The initiative increases provider reimbursement for after-hour service codes 99050 and 99051. Given the current Medicaid-allowable reimbursement of seven dollars and twenty-eight cents ($7.28) and nine dollars and thirty-nine cents ($9.39), Humana is offering a range of thirty-five dollars ($35) to fifty dollars ($50) for these services which is a substantial increase.

Open/Close Panels—On a quarterly basis, we review the panel status of our PCPs by region and county. Additionally, we produce maps to visualize enrollee access to PCPs. We use this data to identify access barriers and implement additional targeted recruitment efforts.

ONGOING ACTIVITIES FOR NETWORK DEVELOPMENT TO MITIGATE IDENTIFIED GAPS AND BARRIERS

When network gaps or barriers are identified through our various network adequacy and access tools listed above, our Provider Relations team targets our provider recruitment strategy. The following recruitment strategies are ongoing, consistent practices and are built into Humana's network team management processes to mitigate identified gaps and barriers.

- If, through our aforementioned analyses and processes, we identify providers that are not meeting contractual requirements (such as failing to meet after-hours requirement or appointment availability standards) we outreach and conduct provider education.

- To assist in identifying providers for recruitment to fill any recognized gaps, we use our collaborative provider partnerships with major health systems, ancillary providers and large IPAs.

- Humana enrollees have the capability to nominate a provider, in writing or telephonically, for recruitment. Nomination requests are forwarded to the Provider Relations team for recruitment.

- We have an annual minority recruitment process to target providers to accommodate linguistic and cultural needs. We solicit feedback from minority associations, medical schools, and Native American tribes, as listed below:
-- Seminole Indian Tribe
-- Miccosukee Tribe
-- Florida Association of Minority Business Enterprise Officials
-- National Hispanic Medical Association (NHMA)

-- Minority Association of Pre-Med Students at Florida State University
-- Minorities in Medicine/Association of American Medical Colleges
-- Urban Promise
-- American Developing Smiles
-- American Developing Smiles
-- Florida International University
-- Florida Atlantic University
-- University of Florida
-- University of Central Florida
-- Florida State University
-- University of South Florida

- We have provider recruitment mailboxes posted on our website where providers can electronically submit a request to join Humana's network.

- Because we have local Humana representatives, including our Provider Relations Representatives and quality improvement nurses, we receive insight to new providers moving into areas. We are then able to target them for recruitment.

- We can identify and target non-participating providers for recruitment through our review of single case letters of agreement and out-of-network utilization.

- We use a variety of available resources to identify specific providers to target, including the AHCA Master File (PML), AMA Website, Sunbiz, US News Health Report, Florida Department of Health, our competitor's directory, and web searches.

- We harvest data identifying providers who are already contracted for other Humana products in which their contracts have Health Maintenance Organization provisions, and target these providers for recruitment.

- In areas where there are primary care provider shortages, we encourage our provider groups to recruit additional providers from outside the area, including physician extenders.

- We encourage our providers to offer telemedicine by reimbursing telemedicine in accordance with AHCA contractual requirements.

-- Additionally, we offer our enrollees access to Doctor-on-Demand, a telemedicine platform that gives enrollees with access to physicians twenty-four (24) hours a day, seven (7) days a week from the enrollee's phone or computer.

PROJECTION OF CHANGES IN FUTURE NETWORK CAPACITY NEEDS

Humana continuously considers projections of future capacity planning of our network measurement and management process. Much of our network adequacy measurement process is based on updated enrollee counts and new maximum enrollment percentages. For instance, the Enrollee-to-Provider ratios and the Enrollee-Time-Distance measurements both require

current enrollment files. As new enrollees are added, we take the enrollee growth and the geographic shifts in enrollment into account to ensure adequate access to care.

Significant provider contract re-negotiations can impact future network capacity planning. The Humana network team maintains a strategic stratification of its major health system negotiations such that no more than one health system in a market is under negotiation at a time. This strategy reduces the potential for multiple terminations at any given time.

Prior to any significant terminations the Humana network team conducts a formal impact analysis of our network to proactively identify and address any enrollee access issues. This is accomplished using access analysis, open and close panels, and provider-enrollee ratios. This applies to hospitals, large provider groups, or subcontractors. In the event Humana initiates the termination, Humana conducts this analysis process well ahead of the ninety (90) day notification to the provider and notifies AHCA within the contractual timeframe. In the event Humana receives a ninety (90) day termination notice from a significant provider, our provider network team begins the formal network termination impact analysis immediately. This termination analysis is used as the basis to identify potential gaps and to identify priority targeted alternative providers that can act as a substitute for the impacted providers.

==========
2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.
==========

We work collaboratively with enrollees and providers throughout the care planning and delivery process to ensure standards are met and care is delivered at an optimal level. We understand that occasionally enrollees may need to rely on providers outside of our Medicaid network to meet their needs. Typically, enrollees engage with out-of-network providers when they are amidst treatment at the start of their enrollment period or Humana's current network does not accommodate their specific situation. Our NDMP has policies to ensure services can be accessed in a timely manner even if they require an out-of-network provider.

CONTINUITY FOR ENROLLEES
Continuity of care needs occur when an enrollee is newly eligible to Medicaid or switches from another Medicaid plan. It is critical that our policy and process coordinates services in a way that ensures service delivery is not disrupted or interrupted. Humana honors written documentation of a prior authorization of ongoing covered services for a period of sixty (60) days after the effective date of enrollment or until the enrollee's PCP or behavioral health provider reviews the enrollee's treatment plan (whichever comes first).

Written documentation may include:
- Prior existing orders
- Provider appointments
- Prescriptions, including prescriptions at non-participating pharmacies

These guidelines include enrollees who:
- were recently hospitalized and now require follow up care

- are receiving behavioral health services and are within a plan of treatment
- are being treated for a condition that has a finite course of treatment
- have a life expectancy of less than six (6) months
- are in the end stage of a disease
- have an unstable or life-threatening medical condition
- are pregnant
- are newborn (within the first ninety (90) days of life)

To support this objective, we will assess the treatment plan (where available) and determine whether the existing treatment plan is appropriate. For new enrollees in a course of treatment, Humana's care management team contacts the attending provider to discuss and review the current condition and course of treatment as well as potential dates for end of service. If we believe the current treatment plan is ineffective, inappropriate, or misaligned to the medical needs of the enrollee, we will work with the provider to modify the treatment plan. The enrollee's treatment plan will be reassessed within ninety (90) days.

Normally, Humana allows enrollees to continue their course of treatment with an out-of-network provider for a predetermined transition period. In these instances, Humana will execute a Single Case Agreement (SCA) with the provider. The process and language of the SCA adheres to Humana's National Network Organization policies and procedures and AHCA's contract requirements. This maintains a relationship, ensures payment and confirms Humana can verify the provider's qualifications and credentials to conduct the care being delivered.

IMMEDIATE, SHORT-TERM, AND LONG-TERM INTERVENTIONS TO ADDRESS NETWORK GAPS

In addition to continuity of care requests, we recognize out-of-network utilization reports may identify potential gaps in our network. Once we identify and confirm a gap or disruption in our provider network, we will notify AHCA and then design and implement an aggressive and prompt recruitment plan.

In situations where we have a shortfall or "hole" in our geographic access standards for a given provider type, we address it through the following mechanisms:

- Identify all providers of that type serving in the area through all available resources that include:
-- AHCA Master File (PML)
-- AMA Website
-- Sunbiz
-- US News Health Report
-- Florida Department of Health
-- Competitor's directories
-- Web searches (i.e. Google)

- We discuss availability shortages with our provider groups to encourage additional recruitment of providers from outside the area.

- Humana may engage the enrollee's PCP to assist with identification of providers commonly used for referrals in his/her practice that are capable of providing and willing to provide care.

- Once identified, we will recruit providers into the network who will bring that component of the network into compliance with the accessibility standards, if available.

Humana's recruitment efforts include a variety of means to maximize success. These include on-site, face-to-face meetings with providers, telephonic outreach, and use of existing provider relationships to reach other providers. If willing providers are available that can address the specific need, our network team will contact these providers to arrange a face-to-face meeting to recruit the provider into our network. Conversely, if the required provider type is not available, or unwilling to contract with Humana, we will offer the enrollee transportation to the nearest qualified provider, make arrangements with out-of-network providers or coordinate care through available telemedicine conduits.

If Humana's network team is unable to quickly bring a provider into the network, we will execute a Letter of Agreement (LOA) with the provider. The process and language of the LOA adheres to Humana's National Network Organization policies and procedures. Humana tracks and trends single case agreements via a tracking grid. The contracting teams preform analysis on a periodic basis to identify potential contracting opportunities. Non-network providers are encouraged to join Humana's network, and following a satisfactory pre-assessment, a Humana Network or Clinical representative engages the provider may begin the network contract process.

If we identify a network gap and have made what we believe is a highly reasonable offer to any applicable providers in a defined area, identify there is a lack of available providers, or available providers are not actively enrolled with Florida Medicaid and are still unable to secure network participation, we will document our efforts to AHCA and request a waiver. In the absence of a contract, we will seek to work with needed providers through single-case agreements and will permit enrollees to seek care from these providers on an out-of-network basis.

CLINICAL ACCESS TEAM

Humana has a Clinical Access team (CAT) that facilitates access to care when a clinical issue related to enrollee access is identified. The CAT team consists of three (3) non-clinical specialists who process the inbound calls on a dedicated line and ten (10) registered nurses who manage and resolve the cases. Issues may range from appointment availability to inability to locate a provider. Once an inquiry is received, a CAT associate will review and telephonically contact the enrollee (or appointed representative) to acknowledge receipt and to clarify the issue. The CAT associate may contact providers involved in the access issue to determine any extenuating circumstances, to offer solutions to possible barriers in resolving the issue, or work with internal departments (such as Provider Contracting) to facilitate a resolution.

The CAT team has seen very strong results over the past twelve (12) months as shown by the Key Performance Indicators for commercial, Medicare and Medicaid populations:

- Overall access cases: 99.2% compliant with inquiry resolution

- Overall access cases: case closure within 14 calendar days
- Overall service level (80% of calls answered within 30 seconds): 82%
- Overall abandonment rate (less than 5% of calls abandoned): 5%

In addition to our CAT, we have a nurse line available to enrollees twenty-four (24) hours a day, seven (7) days a week. Our nurse line enhances after hours care by always have a clinician available to our enrollees to advise on the appropriate level care and the appropriate care setting.

==========

c. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received; and

3. The extent to which the respondent's plan includes strategies for measuring the time in-between when services are authorized and when they are received.

==========

Humana has implemented strategies to measure the time in-between when services are authorized and when they are received to improve health outcomes and reduce potentially preventable events. Year over year since the implementation of the MMA program, we have seen an increase in utilization of pediatric physical therapy, pediatric speech-language pathology services, pediatric occupational therapy, pediatric private duty nursing services, pediatric and adult intermittent skilled nursing, early intervention services, compounding pharmacies, and specialized therapeutic foster care. We measure this utilization metric to ensure our enrollees have access to these services. Since 2014, the overall volume of claims from these services has increased from one hundred seventeen thousand, six hundred eighty-two (117,682) to two hundred ninety-six thousand, six hundred ninety-two (296,692) in 2017. Additionally, we monitor the calls received by our Customer Service line and CAT team, as well as reports from our other network access tools, to identify access issues related to these provider types. We have received minimal complaints on not being able to access these provider types. These measures indicate our network is providing sufficient access to these services for our enrollees. Humana also will use our quarterly meetings with specialists and delegated entities to determine if specialists are meeting contract times.

Humana will also utilize electronic visit verification (EVV) to ensure that our enrollees are receiving the correct and timely home-based services, such as therapies, private duty nursing and intermittent skilled nursing. Humana has partnered with Sandata to utilize EVV with innovative technology, including things such as geo-mapping combined with mobile technology, across several states, including Florida, for its Medicare Advantage line of business. Prior to implementation of this contract, Humana plans to develop additional EVV processes which will provide real-time data and can be used to identify when authorized services have not been received.

However, Humana recognizes the need to continue to improve the process to monitor access to these services. We are exploring ways to utilize EVV, referral and authorization, and claims data to produce a quarterly report by region for the following specialties and/or service types:

- Physical therapy (pediatric);
- Speech-language pathology services (pediatric);

- Occupational therapy (pediatric);
- Private duty nursing services (pediatric);
- Intermittent skilled nursing (pediatric and adult);
- Early intervention services;
- Compounding pharmacies; and
- Specialized therapeutic foster care.
- Cardiologist
- Pulmonologist
- Endocrinologist

These reports will help us to identify trends that may indicate barriers to care. We will also distribute these reports to provider relations and clinical areas for investigation, outreach, and potential contracting and education needs.

Our Provider 360 Committee reviews all reports related to access to care and determine strategies to overcome access issues.

REVIEW WITH ENROLLEES

Each month, the Care Management program takes verification of services to a higher level by contacting enrollees at random to ensure that authorized services were received. Enrollees are contacted by the Care Manager by phone and a listing of their authorized and billed services is reviewed. If a discrepancy exists between the claimed services and what the enrollee reports as having happened, then the case is referred to the Special Investigations Unit for investigation.

CASE STUDY
A Humana provider, One Homecare Solutions (OHC), has implemented an EVV solution to measure the time when an enrollee receives a service. When Home health services are being rendered to the enrollee, the OHC nurse will utilize a mobile EVV app to both check in and check out once services are completed. The information is reported and provided to Humana.
In addition, ONE's One Finalization Group makes follow-up calls to our enrollees receiving private duty nursing services to confirm services have been rendered, which is also captured and reported.

==========
d. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services.

4. The extent to which the respondent's update of its network development and management data that will be used to inform improvements to increase access to services.
==========

Humana creates and maintains our annual Network Development and Management Plan (NDMP) to serve as a description of our commitment and a guidepost for fostering our ability to manage, measure, and continually strengthen a robust network of high quality providers. We update our NDMP annually for submission to AHCA with guidance and leadership from our Provider Network Directors.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana's network is built on the evidence-based belief that the following concepts are imperative in our healthcare delivery system and critical components of maximizing enrollee healthcare outcomes:

- Quality of care
- The patient centered medical home concept
- Preventative and early intervention
- Extensive access to contracted network providers
- Communicative provider and subcontractor partnerships that are based on mutual clinical goals and administrative simplicity
- Widespread use of electronic health records

With these fundamental concepts in mind, we work collaboratively with our external network provider partners and subcontractors and internally with our Medical Management, Enrollee Services, Medicaid Operations, Quality, Provider Complaints, Provider Grievances Departments, Pharmacy, Customer Service, and Finance Departments in developing our annual NDMP. We obtain information from these sources to thoroughly draft our NDMP, analyze our network progress from the previous year, and identify opportunities to improve our network and enhance access to care for our enrollees. Our NDMP includes descriptions and analyses of the competitive landscape of provider network, the prior year network, the description of basic network design and network access adequacy, how enrollees access the system, the analysis of timely access to services, the provider satisfaction survey (including methodology and results), coordination of relationships among various levels of the system, assistance and communication tools provided to the PCPs, network barriers and gaps, telemedicine, electronic health records, pharmacy, subcontractor monitoring and oversight, internal department coordination, and coordination with outside organizations.

Once the NDMP is drafted by our Provider Network Directors, our leadership team reviews the NDMP and gives input. Additionally, the NDMP goes through a compliance review to ensure we are adhering to all AHCA, state, and federal requirements.

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5. The extent to which the respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations

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Humana partners with subcontractors to provide healthcare services to enrollees. To ensure that each subcontractor adheres to and exceeds the requirements, Humana has implemented a rigorous oversight program with corporate and market-based teams responsible for the subcontractors' performance. We will continue to be compliant with AHCA's requirements for subcontractor monitoring and policies. Humana's Delegated Vendor Performance Oversight team (DVPO) is dedicated to monitoring and overseeing functions delegated to subcontractors.

Delegation of Network Management responsibilities includes the following:

- All subcontracts that meet the Network Management Delegation definition shall have an executed and AHCA approved Network Delegation Amendment.

- Monitor compliance, network adequacy, and quality by monthly/quarterly reports and annual audits to include:

-- Policy and procedures

-- Provider Network Report of all provider groups, individual physician practices and sites in its network are not accepting new Medicaid enrollees

-- Availability of Providers providing Specialty Care services, including number and geographic distributions

-- Access to appointments

-- Opportunities to improve access for enrollees

-- Identified problems and corrective actions initiated and outcomes

- Implement Corrective Action Plans and monitor adherence to written subcontractors agreed upon process to correct noncompliance. As required, impose provider capitation payment penalties for outstanding corrective action plan issues, restriction, suspensions, and/or terminations.

All subcontractors' performance and issues are presented to the Delegated Vendor Oversight Committee (DVOC) for review and approval of necessary interventions and corrective actions plans in the event of subcontractors' non-compliance with the contractual provisions and service level agreements (SLAs). The oversight of subcontractors is performed by three entities, as described below.

- Market-based Delegate Relationship Managers (DRMs) – front line of Humana associates who work closely with the subcontractors. They are responsible for the due diligence of subcontractors and consistent oversight of operational performance according to the contract and SLAs. They hold joint operational meetings, which are designed to review past month's subcontractor performance with comparison to SLAs and contract provisions. The meetings are led by the DRM and attended by the Director of Oversight Vendor Performance. In addition, the Director of Oversight Vendor Performance holds monthly operational meetings with all DRMs to review subcontractors' performance, identify opportunities for improvement, develop corrective interventions, and follow up on progress.

- Corporate Delegation Compliance – responsible for pre-delegation, annual, and ad hoc audits of subcontractors. The audits are performed in accordance with the contractual provisions, NCQA Standards, and SLAs. The audit results are presented to the DVOC for recommendations of interventions as appropriate.

- Delegated Vendor Performance Oversight unit – comprised of a director and coordinator. The role of this unit includes but is not limited to:

-- In conjunction with DRMs, facilitate the coordination of oversight and monitoring activities

-- Review operational performance of subcontractors for adherence to contract provisions and SLAs

-- In conjunction with the DRMs, develop interventions, corrective action plans as necessary to improve performance and subcontractor compliance

-- Participate in joint operational meetings with subcontractors; review performance and recommend improvements

-- Review for under/overutilization trends and address with subcontractors

-- Work with subcontractors to participate in the support of Humana's goals to improve healthcare outcomes (HEDIS campaigns, Plan initiatives, integration and specialty programs,)

-- Establish vendor specific performance goals based on enrollees health outcomes

-- Work closely with the Network Contracting Directors to monitor for financial solvency for subcontractors with financial risk

Summary of subcontractor performance is presented at the DVOC which reports to Quality Improvement Committee.

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region-specific identified gaps and future needs projection.

2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.

3. The extent to which the respondent's plan includes strategies for measuring the time in-between when services are authorized and when they are received.

4. The extent to which the respondent's update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.).

5. The extent to which the respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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2017
Network Development and Management Plan

Network Development & Management Plan
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1. HUMANA'S NATIONAL DEVELOPMENT & MANAGEMENT PLAN OVERVIEW

Humana's Commitment to Quality Care

As a company, Humana strives to offer its enrollees access to dependable, quality care. We've seen success in our partnership with AHCA by understanding and focusing on what's most important in comprehensive care today:

- Instituting a strong provider engagement model built on a partnership to work towards a common goal of delivering quality care to enrollees
- Being easy to do business with through simplification of administrative processes simplifying administrative burdens
- Offering value-based payments to providers to reward and retain them
- Removing barriers to care between providers and enrollees

Our Approach for Establishing & Retaining a Best-In-Class Provider Network

Humana has more than two decades of innovative network development and management experience in Florida. We understand the complexity of recruiting and contracting with the wide range of providers necessary to serve and care for the needs of our enrollees across the State. To continuously grow and maintain our best-in-class provider network across Florida, Humana has developed and consistently executes a rigorous provider recruiting and retention plan to:

- Evaluate the provider network and project needs
- Create and execute an acquisition and retention plan
- Engage with quality and efficient providers
- Simplify doing business with Humana
- Provide timely access to care for enrollees
- Drive continuous improvement through ongoing evaluation of the network

Annual Network Development & Management Plan Overview

Humana's network is built on the evidence-based belief that the following concepts are imperative in our healthcare delivery system and critical components of maximizing enrollee healthcare outcomes:

- Quality of care
- The patient-centered medical home concept
- Preventative and early intervention
- Extensive access to contracted network providers
- Versatile payment reimbursement methodologies to incentivize providers, including value-based payment models
- Communicative provider and subcontractor partnerships that are based on mutual clinical goals and administrative simplicity
- Widespread use of electronic health records

With these fundamental concepts in mind, we work collaboratively with our external network provider partners and subcontractors and internally with our Clinical, Member Services, Medicaid Operations, Quality, Provider Complaints, Provider Grievances, Pharmacy, Customer Service, and Finance Departments in developing our annual Network Development and Management Plan (NDMP). We obtain information from these sources to comprehensively draft our NDMP, analyze our network

progress from the previous year, and identify opportunities to improve our network and enhance access to care for our enrollees. Our provider network leadership team compiles the cross-functional information, which then goes through a compliance review to ensure we are adhering to all AHCA, State, and federal requirements.

2. QUALITY CARE & PROVIDER NETWORK IN FLORIDA

Humana has a long-standing presence in Florida serving Medicaid, Medicare, and Commercial populations. We have operated our Medicaid plan for 20 years and our Medicare plan for 30 years in Florida. Provider satisfaction and engagement are critical to our success in serving enrollees. Thus, throughout our presence in Florida, Humana's provider relations team has established strong relationships with our providers through extensive interactions. Humana leadership regularly attends Joint Operating Committee (JOC) meetings, provider association meetings, and strategy meetings with our providers to discuss new initiatives and opportunities to reach our common goals.

Our considerable experience assessing our existing provider network in Florida and engaging in recruitment strategies to ensure the composition of the network is sufficient to provide timely access to care for enrollees. These network assessments have given us invaluable insight into provider accessibility and availability. We understand that if our enrollees are unable to access our provider network in a timely fashion, we cannot develop or maintain a competent and responsive system of care to meet their needs.

Understanding the Competitive Landscape & Enrollee Enrollment

As of March 2017, Humana has the fifth largest or 10.8% of the membership market share in the 5 regions Humana serves the Florida Medicaid population.

Current MMA Market Share

Organization	March 2017 Enrollment	Market Share
Staywell Health Plan of Florida	675,980	22.0%
Sunshine State Health Plan, Inc.	431,391	15.6%
Molina Healthcare of Florida	345,289	11.2%
Amerigroup Florida, Inc.	342,253	11.1%
Humana Medical Plan	332,565	10.8%
Prestige Health Choice	325,548	10.6%
Other (Includes 6 plans)	575,143	18.7%
	3,078,169	

Source: AHCA Enrollment Report

Humana's MMA Membership and Growth Rate

Q1 2016	
January 1, 2016	332,148
March 31, 2016	344,668
Q1 2016 Growth %	3.63%
Q1 2017	
January 1, 2017	342,818
March 31, 2017	332,565

Q1 2017 Growth %	-3.08%

Source: AHCA Enrollment Report

Changes in Membership

Membership decreased by approximately 3.08% when comparing 1st quarter 2016 to 1st quarter 2017. Some of the reasons for the decrease are changes in eligibility, an enrollee's provider is no longer in the Humana network, an enrollee moved to specialty plan, or an enrollee moved out of area Our membership has trended with overall enrollment patterns of the number of Medicaid eligibles throughout the State.

New Enrollment

- 48% are by choice
- 52% auto-assigned
- 10% enrolled are identified as pregnant

Disenrollment

- 66% ineligible for plan
- 8% provider no longer with plan
- 8% moved to specialty plan
- 6% out of service area

Prior Year Network Analysis

The 2016 NDMP highlighted initiatives and goals for developing and sustaining an adequate network. It focused specifically on improving enrollee access to care and providing support and resources to our network providers. Our measures include a Medicaid network adequacy analysis that evaluates both provider to enrollee distance and provider to enrollee ratios by county and region. We take into consideration:

- cultural competency indicators such as enrollee access to physicians with diverse linguistic abilities
- handicap access
- after-hours access
- physician closed panel data

Additionally, we review results of the following data sources:

- enrollee satisfaction survey results (CAHPS)
- Critical Access Team (CAT) data
- timely access/PCP wait time survey data
- prevalence of providers with the varying levels of Electronic Health Record capabilities

Our 2016 network analysis demonstrates Humana's robust network of various providers, including but not limited to, Primary Care, Obstetrical Care, Specialty Care, Urgent/Emergent Care, Ancillary Services, Hospital Care, Oral Health, and Behavioral Health providers for our enrollees continuously, allowing for comprehensive access to care. Further, Humana meets the AHCA-required enrollee to provider and time and distance ratios for each specialty. There are a few areas of specialties that present some challenges, especially in rural counties, when compared to the AHCA-required enrollee to provider ratios even when considering the current published maximum enrollment ratios; however, the specialty services are available within the enrollees' geographic area.

An example of this is in Region 1. AHCA's published requirement for the specialty of Podiatry is twenty-two (22) providers, even though the PML only documents twelve (12) podiatrists available in the Region 1 area. The AHCA-published minimum provider-to-enrollee ratio for this specialty in this Region is one

specialty provider per 5,200 enrollees, which would provide access for 112,000 enrollees based on twenty-two (22) providers. Humana currently has five (5) providers under contract for Podiatry in Region 1, and has documented an extreme shortage of available providers to recruit and contract. Additionally, although ratios can only be calculated with contracted providers that participate within the Region, Humana has expanded its recruitment efforts into the neighboring counties in Region 2, as well as southern Alabama to attempt to improve enrollee access.

Our Focus on Continuous Improvement

Humana understands the importance of partnering with AHCA annually to review our network findings and measurements and to update our NDMP. Those discussions will help fuel new and innovative strategies to attract new providers, improve quality of care, and achieve cost savings for AHCA and our enrollees.

3. TODAY'S BASIC NETWORK DESIGN AND NETWORK ACCESS ADEQUACY

Humana designed its Florida network to provide all enrollees with adequate access to primary care and specialty providers, as well as convenient access to network pharmacies in the regions we serve. We are continuously monitoring and evaluating our network to identify opportunities for enhancement. We contract with high-quality providers within each region and maintain good relationships through active and ongoing provider engagement.

Existing Region 1

Humana's Region 1 provider network was initially established through our existing Medicare Advantage and Commercial networks. We have continued to develop our provider network since implementation, fortifying previously established relationships. Humana's Medicaid network includes the essential provider Sacred Heart Hospital, and also encompasses every single health system and hospital in the region, as well the majority of large IPA providers. Important Medicaid providers include Sacred Heart Health System, Nemours Children's Clinic, Escambia Community Clinics, West Florida Hospital, Health First Network, Fort Walton Beach Medical Center, Baptist Health System, North Okaloosa Medical Center, Santa Rosa Medical Center and Healthmark Regional Medical Center (a designated safety net hospital). Additionally, our Region 1 provider network includes three Federally Qualified Health Centers (FQHCs) (providing 11 locations) and nine Rural Health Clinics (RHCs) (providing nine locations) and one County Health Department. Our local mental and behavioral health provider, Access Behavioral Health (ABH), is contracted to manage and serve our enrollees' behavioral health needs. In addition, some of Humana's network providers are recognized as Patient-Centered Medical Homes (PCMH). In total, Humana's network has five PCMH groups with 147 providers across 21 locations in Region 1.

Since Region 1 presents unique challenges (e.g., significant MMA membership, a significant amount of rural areas and considerable provider availability shortages in multiple specialties), Humana continues to broaden our contracting activities' scope. Humana continues to grow our Region 1 provider network despite these challenges – see Table 1 below. We have accomplished this through tenacious recruitment activities, including stretching recruitment activities into Region 2. Specifically, we have reached out to all relevant needed providers in the contiguous counties of Bay, Holmes and Washington cities that are within a reasonable time and distance standard for enrollee access. In addition to recruiting in Region 2, we are recruiting providers in southern Alabama. We have worked to identify providers that not only support reasonable time and distance measurements, but also have active and enrolled Florida

Medicaid provider numbers. We are currently working on a contract with the University of South Alabama (USA) (hospital and physicians) to provide additional support for both pediatric and women's health services within the Escambia county catchment area.

Provider Type	Providers Added	Provider Service Locations Added
PCP	24	16
SPC	190	58

**measurement period from December 2015 through December 2016*

Despite our tenacious and ongoing recruitment activities and successful continued network growth, we continue to experience contractual ratio gaps in some specialties – see Table 2 below. We continually monitor these gaps through available resources like the Agency for Health Care Administration (AHCA) Master File (PML), American Medical Association (AMA) Website, Sunbiz, US News Health Report, Florida Department of Health, our competitors' directories and Google. In addition, we discuss availability shortages with our provider groups to encourage additional recruitment from outside the area. Prior to Amendment 11, Humana filed waivers for some of the specialties in which gaps remain. Humana will refile new waiver requests in January 2018.

Specialty	Status	Waiver Originally Filed
Dermatology	All contracting efforts have been exhausted	Yes
Endocrinology (Peds)	All contracting efforts have been exhausted	No
General Dentist	Working with vendor to recruit additional Dentists	Yes
Infectious Disease	All contracting efforts have been exhausted	Yes
Ophthalmology	Working with vendor to recruit additional Ophthalmologists	Yes
Optometry	Working with vendor to recruit additional Optometrists	Yes
Otolaryngology	All contracting efforts have been exhausted	Yes
Podiatry	All contracting efforts have been exhausted	Yes
Rheumatology	All contracting efforts have been exhausted	Yes

Notwithstanding these provider network challenges, Humana's Region 1 network continues to deliver steady performance with very few provider-initiated network terminations and steady enrollee growth. Since Medicaid Managed Care (MMA) implementation, our membership has grown from 51,733 enrollees and we are currently managing 53,278 enrollees (based on July 2017 834 enrollee files).

Expansion Region 2

As Humana began the process of building a new, wide-ranging and efficient Medicaid provider network for Region 2, we approached the process by leveraging our existing Medicare and commercial lines of business provider relationships who already provide services to approximately 9,000 enrollees today. These longstanding relationships gave Humana an initial base for a strong and competitive provider network.

Region 2 has a unique set of challenges, including provider availability shortages in multiple specialties and sparsely populated areas with multiple counties being designated as being Health Provider Shortage Areas with shortages of primary care, dental, and mental health providers. 12 of the 14 counties in the region are designated as rural. Additionally, according to the quarterly Statewide Managed Medicaid Care Report in Winter 2016, Region 2 has one of the highest proportion of unhealthy Medicaid enrollees in the State and one of the lowest number of available providers.

Humana's network is built on a combination of contracts and letters of intent (LOI). Feedback we often hear during network builds is that providers are unwilling to negotiate and execute full agreements until MCOs are awarded. Upon intent to negotiate notification, Humana will prioritize conversion of LOIs to contract agreements. Humana has successfully completed conversion of LOIs to contracts in many instances throughout the country during Medicaid network expansion activities, including in Florida, Kentucky, Illinois, and Virginia.

Similar to our previous successful provider network expansion efforts, Humana partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities. The concentration of providers in Region 2 are located in the anchor counties of Bay and Leon, where we have secured Tallahassee Memorial Health, Capitol Regional Medical Center, and Gulf Coast Medical Center. In addition, we have secured contracts or LOIs throughout the balance of Region 2 counties with Calhoun-Liberty Hospital, Campbellton Graceville Hospital, Gadsden Memorial Campus, Doctors Memorial Hospital, George E Weems Memorial Hospital, Doctors Memorial Hospital Bonifay, Madison County Memorial Hospital. Additionally to the facilities, we have secured contracts and LOIs with 151 adult PCPs, 29 pediatric PCPs, 16 OB/GYNs, 92 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 43 pediatric physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 204 medical specialists, 51 FQHC and RHC locations, 51 home health provider service locations, and 359 behavioral health providers. Humana will continue to improve upon building a full-functioning network that supports all enrollees in accessing and receiving the care they need. In addition, Humana's network has three PCMH groups with 39 providers across 18 locations in Region 2.

Expansion Region 3

As Humana began the process of building a new, wide-ranging and efficient Medicaid provider network for Region 3, we approached the process by leveraging our existing Medicare and commercial provider relationships who provide services to approximately 45,500 enrollees today. These longstanding relationships gave Humana an initial base for a strong and competitive provider network.
Region 3 has a unique set of challenges, including provider availability shortages in multiple specialties and sparsely populated areas with multiple counties being designated as Health Provider Shortage Areas of primary care, dental, and mental health providers. Region 3 has the largest total geography of all Florida Medicaid Regions with nine of the sixteen counties being designated as rural.

Similar to our previous successful provider network expansion efforts, Humana partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities. The concentration of providers in Region 3 are located in the anchor counties of Marion, Lake and Alachua where we have secured contracts with Bayfront Health Brooksville, Bayfront Health Spring Hill, Citrus Memorial Hospital, Lake City Medical Center, Munroe Regional Medical Center, North Florida Regional Medical Center, Oak Hill Hospital, Ocala Regional Medical

Center, Putnam Community Medical Center, Regional General Hospital Williston, Seven Rivers Regional Medical Center, Shands Lake Shore Regional Medical Center, Shands Live Oak Regional Medical Center, Shands Starke Regional Medical Center, South Lake Hospital, UF Health Shands Hospital, West Marion Community Hospital and LOIs with Leesburg Regional Medical Center, The Villages Regional Hospital, and Lake Butler Hospital.

In addition to the facilities, we have secured contracts with 309 adult PCPs, 152 pediatric PCPs, 67 OB/GYNs, 217 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 25 pediatric physical therapy, speech therapy, occupational therapy and respiratory therapy providers, 939 medical specialists, 97 FQHC and RHC locations, 17 home health providers, and 2,256 behavioral health providers. Humana will continue to develop a full-functioning network that supports all enrollees in accessing and receiving the care they need. In addition, Humana's network has eleven PCMH groups with 135 providers across 32 locations in Region 3.

Expansion Region 4

Humana brings significant experience in servicing a large membership base in the greater Jacksonville and surrounding counties across many products, including Medicare Advantage, Medicare PPO and Medicare Private Fee for Service and commercial lines of business. With our large portfolio of products, Humana currently provides medical coverage to approximately 71,000 enrollees. Humana's current Medicare and commercial footprint includes joint venture assets and an Access Center to provide guidance and support for our dual eligible population. Our joint venture opportunities have helped shape our local Medicare Advantage and commercial markets which gives Humana a proven track record to adeptly manage Medicaid enrollees. In addition, we have two Humana exclusive MSO partners who will be adding additional affiliated practices in 2018. These alliances in the Medicare Advantage and commercial network space allows us to leverage competitive market share through high quality, efficient providers who share an interest in value-based opportunities. Humana continues to lead the Jacksonville marketplace through our Bold Goal initiatives driving our communities to become 20% healthier by the year 2020. This initiative helps bring community partners, health organizations and hospitals together in support of health and well-being. Over 200 community organizations meet on a quarterly basis for a clinical town hall format to discuss barriers to health care and strategies to close health care gaps in the community. Our passion for population health makes Humana a strong partner to AHCA in expanding our Medicaid footprint.

In building our Medicaid provider networks, we partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities. The concentration of providers in Region 4 are located in the anchor counties of Duval, Volusia, and Clay where we have secured contracts with Flagler Hospital, Halifax Health Medical Center, Halifax Health Medical Center Port Orange, Memorial Hospital Jacksonville, Orange Park Medical Center, St Vincent's Medical Center Clay County, St Vincent's Medical Center Riverside, St Vincent's Medical Center Southside, and UF Health Jacksonville and LOIs with the Adventist facilities of Florida Hospital Deland, Florida Hospital Fish Memorial, Florida Hospital Flagler, Florida Hospital Memorial Medical Center, Florida Hospital New Smyrna and Florida Hospital Oceanside. Also, Humana secured a LOI with Southeast Georgia Health System Camden Campus and Brunswick Campus to further support Nassau county with enrollee access.

Additionally to the facilities, with 334 adult PCPs, 193 pediatric PCPs, 141 OB/GYNs, 113 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 175 pediatric physical

therapy, speech therapy, occupational therapy, and respiratory therapy providers, 763 medical specialists, 24 FQHC and RHC locations, 16 home health providers, and 2,832 behavioral health providers. In addition, Humana's network has seventeen PCMH groups with 263 providers across 76 locations in Region 4.

Expansion Region 5

Humana's Region 5 network was originally developed in 2012 in support of Humana's filing and being approved for both Pasco and Pinellas as expansion counties prior to MMA implementation. As expansion counties, we successfully managed approximately 2,000 Medicaid enrollees. Humana has extensive experience in servicing a large membership base of approximately 115,000 enrollees across many products, including Medicare Advantage, Medicare PPO, Medicare Private Fee For Service and commercial lines of business including exchange products which we leveraged to build and maintain a strong Medicaid network. Since 2012, we have continued to strengthen the network to provide support in our daily operations of Region 6 since both Pasco and Pinellas counties neighbor Hillsborough county and we experience a significant amount of MMA membership that seek specialty and ancillary services in Region 5 which is a typical pattern of care given the extremely close geographical proximity of the three counties. Our extensive Region 5 network has greatly improved enrollee access through having a greater availability of access to providers which has resulted in improved enrollee and provider experience and satisfaction.

The Humana Region 5 network consists of all of the hospitals and health systems with the exception of one, Adventist. Our provider network includes the following Region 5 designated statewide essential providers of Bayfront Health St. Petersburg and Johns Hopkins All Children's Hospital, as well Tampa General Hospital and their specialty physicians, Shriner's Hospital for Children and University of South Florida College of Medicine in neighboring Hillsborough County in Region 6. Additionally to the facilities, we have secured contracts a with 118 adult PCPs, 233 pediatric PCPs, 99 OB/GYNs, 158 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 54 pediatric physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 486 medical specialists, 16 FQHC and RHC locations, 8 home health providers, and 2662 behavioral health providers. In addition, Humana's network has five PCMH groups with 65 providers across 22 locations in Region 5.

Existing Region 6

Humana brings extensive experience in servicing a large enrollee base in the Tampa Bay area across many products, including Medicaid, Medicare Advantage, Medicare Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS), and a variety of Commercial lines of business, including exchange products. Through our large portfolio of products, Humana provides medical coverage for hundreds of thousands of enrollees, including large employer groups such as Hillsborough County Public Schools, Hillsborough County Sheriff's Office, and Pinellas County Public Schools, in which Humana provides a variety of medical coverage options to their employees and family members. Because of this rich history and experience, Humana has longstanding provider network relationships, which helped to initially foster a successful MMA network build, and continue to provide strength in our daily operations. The Humana Region 6 network consists of all of the hospitals and health systems in the region with the exception of one – Adventist. Additionally, our Region 6 provider network includes the following designated statewide essential providers: Tampa General Hospital (both the hospital and their specialty physicians), Shriner's Hospital for Children, University of South Florida College of Medicine, as well five FQHCs (providing 56 service locations), 13 RHCs, (providing 13 service locations) and one County Health

Department. Humana also secured a contract with Planned Parenthood with 11 locations across Regions 5, 6, and 8 to ensure enrollee access to additional alternative providers offering a wide variety of services such as family planning with extended hours including weekends. Additionally, All Children's Hospital, another state-designated essential provider, and Bayfront Medical Center in the neighboring Pinellas County (Region 5), support our enrollee pattern of care. In addition, some of Humana's network providers boast recognition as PCMHs. In total, Humana's network has twelve PCMH groups with 275 providers across 35 locations in Region 6.

Since MMA implementation, Humana has continued to experience steady enrollee growth in Region 6, beginning with 26,167 and we are currently managing 35,057 enrollees (based on July 2017 834 membership files). Our provider network also continues steady performance with very few provider initiated network terminations. We continue to grow our Region 6 provider network:

Provider Type	Providers Added	Provider Service Locations Added
PCP	50	49
SPC	424	71

**measurement period from December 2015 through December 2016*

Expansion Region 7

As Humana began the process of building new, wide-ranging and efficient Medicaid provider network for Region 7, we approached the process by leveraging many of our existing Medicare and commercial lines of business provider relationships who are providing services to approximately 70,000 enrollees today. These longstanding relationships gave Humana an initial base for a strong and competitive provider network.

Similar to our previous successful provider network expansion efforts, Humana partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities.

The concentration of providers in Region 7 are located in the anchor county of Orange. We have secured contracts with all the health systems with the exception of one, Adventist. These contracts are Arnold Palmer Medical Center, Central Florida Regional Hospital, Dr. P. Phillips Hospital, Health Central, Nemours Children's Hospital, Parrish Medical Center, Orlando Health, Osceola Regional Medical Center, Oviedo Medical Center, Poinciana Medical Center, South Seminole Hospital, St. Cloud Regional Medical Center, Winnie Palmer Hospital for Women and Babies, Wuesthoff Medical Center Melbourne, Wuesthoff Medical Center Rockledge. Additionally to the facilities, we have secured contracts with 402 adult PCPs, 252 pediatric PCPs, 202 OB/GYNs, 60 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 374 pediatric physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 1021 medical specialists, 31 FQHC and RHC locations, 16 home health providers, and 3845 behavioral health providers. In addition, Humana's network has fourteen PCMH groups with 184 providers across 64 locations in Region 7.

Expansion Region 8

As Humana began the process of building a new, wide-ranging and efficient Medicaid provider network for Region 8, we approached the process by leveraging many of our existing Medicare and commercial

lines of business provider relationships who are providing services to approximately 34,000 enrollees today. These longstanding relationships gave Humana an initial base for a strong and competitive provider network.

Region 8 has a unique set of challenges, including provider availability shortages in multiple specialties and sparsely populated areas with multiple counties being designated as Health Provider Shortage Areas of primary care, dental, and mental health providers.

Humana's networks are built on a combination of contracts and letters of intent (LOI). Feedback we often hear during network builds is that providers are unwilling to negotiate and execute full agreements until MCOs are awarded. Upon intent to negotiate notification, Humana will prioritize conversion of LOIs to contract agreements. Humana has successfully completed conversion of LOIs to contracts in many instances throughout the country during Medicaid network expansion activities, including in Florida, Kentucky, Illinois, and Virginia.

Similar to our previous successful provider network expansion efforts, Humana partnered with regionally dominant health systems and large multi-disciplinary groups that have solid foundations in each of the communities. The concentration of providers in Region 8 are located in the anchor counties of Lee, Collier, and Sarasota, where we have secured contracts and LOIs with Bayfront Health Port Charlotte, Bayfront Health Punta Gorda, Cape Coral Hospital, DeSoto Memorial Hospital, Doctors Hospital of Sarasota, Englewood Community Hospital, Fawcett Memorial Hospital, Gulf Coast Medical Center, Health Park Medical Center, Hendry Regional Medical Center, Lee Memorial Hospital, Naples Community Hospital, North Collier Hospital, Physicians Regional Medical Center Collier, Physicians Regional Medical Center Pine Ridge, Sarasota Memorial Hospital, The Children's Hospital of Southwest Florida and Venice Regional Bayfront Health

Additionally to the facilities, we have secured contracts and LOIs with 190 adult PCPs, 112 pediatric PCPs, 69 OB/GYNs, 225 adult physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 96 pediatric physical therapy, speech therapy, occupational therapy, and respiratory therapy providers, 454 medical specialists, 47 FQHC and RHC locations, 15 home health providers, and 1799 behavioral health providers. Humana will continue to improve upon building a full-functioning network that supports all enrollees in accessing and receiving the care they need. In addition, Humana's network has eight PCMH groups with 155 providers across 43 locations in Region 8.

Existing Region 9

Humana has serviced large Medicaid, Medicare Advantage, and Commercial enrollees for more than 20 years in Region 9, with stable, long-term network relationships that fostered a strong network of Medicaid providers. Humana's Medicaid network includes contracts with all of the major health systems, such as Martin Memorial Health System, HCA (including JFK Hospital) and Tenet. Our network also includes the essential provider, St. Mary's Hospital, and a large physician base that provides significant access to PCPs and specialists. In addition, Humana has unique Medicaid HMO and Medicare HMO partnerships with several Medical Service Organizations (MSOs) that provide primary care clinical management through recognized PCMHs. In total, Humana's network has thirteen PCMH groups with 132 providers across 24 locations in Region 9. We have approximately 39,000 enrollees assigned to providers in value-based arrangements. Additionally, we are contracted with 18 FQHC locations and 4 RHC locations. Some physicians in Region 9 provide walk-in primary care and specialty care telemedicine services for enrollees needing services after-hours or who are unable to get to a physician office

location. Since MMA implementation, Humana has continued to steadily grow membership in Region 9, beginning with 56,730 and we are currently managing 71,414 enrollees (based on August 2017 834 membership files). Our provider network continues steady performance with very few provider initiated network terminations. Humana continues to grow our Region 9 provider network:

Provider Type	Providers Added	Provider Service Locations Added
PCP	41	41
SPC	500	120

**measurement period from December 2015 through December 2016*

Existing Region 10

Humana has serviced large Medicaid, Medicare Advantage, and Commercial memberships for over 20 years in the Region 10, with stable long-term network relationships that fostered a strong Medicaid network. Humana's Medicaid network includes contracts with most major health systems' hospitals and physicians, including the South Broward Hospital District, Broward Health, HCA and Tenet. Humana's Medicaid network also includes essential providers Nova Southeastern University College of Osteopathic Medicine, Broward General Medical Center, and Memorial Regional Hospital. In addition, Humana has unique Medicaid HMO and Medicare HMO partnerships with several MSOs that provide primary care clinical management through recognized PCMHs. Many of those same providers are now part of Humana's Medicaid HMO network. In total, Humana's network has six PCMH groups with 309 providers across 15 locations in Region 10. We have approximately 88% of our enrollees assigned to providers in value-based arrangements. Additionally, we are contracted with 6 FQHC locations. Some physicians in Region 10 provide walk-in primary care and specialty care telemedicine services for enrollees needing services after-hours or who are unable to get to a physician office location.

Since MMA implementation, Humana has continued to experience steady growth of membership in Region 10, beginning with 44,129 and we are currently managing 71,951 enrollees (based on August 2017 834 membership files). Our provider network also continues steady performance with very few provider initiated network terminations. Humana continues to grow our Region 10 provider network:

Provider Type	Providers Added	Provider Service Locations Added
SPC	344	98

**measurement period from December 2015 through December 2016*

Existing Region 11

Humana has serviced large Medicaid, Medicare Advantage, and Commercial memberships for more than 20 years in Region 11, with stable, long-term network relationships that fostered a strong Medicaid network, even though 50% of the region is considered rural because of Monroe County. Humana's Medicaid network includes contracts with all of the essential providers and with the hospitals and physicians of most major health systems, such as Jackson Health System, University of Miami School of Medicine, Florida International University College of Medicine, Nicklaus Children's Hospital, HCA, and Tenet. In addition, Humana has unique Medicaid HMO and Medicare HMO partnerships with several MSOs that provide primary care clinical management through PCMHs. Many of those same providers

are now part of Humana's Medicaid HMO network. In total, Humana's network has thirteen PCMH groups with 623 providers across 57 locations in Region 11. We have approximately 73,000 enrollees assigned to providers in value-based arrangements. Additionally, we are contracted with 38 FQHC locations. Some physicians in Region 11 provide walk-in primary care and specialty care telemedicine services for enrollees needing services after-hours or who are unable to get to a physician office location.

Since MMA implementation, Humana has continued to experience steady enrollee growth in Region 11, beginning with 64,539 enrollees in 2014 to currently managing 81,763 enrollees (based on August 2017 83files), which is the highest current regional market share. Our specialist and ancillary provider network also continues steady performance with very few provider initiated network terminations. Humana continues to grow our Region 11 provider network:

Provider Type	Providers Added	Provider Service Locations Added
PCP	N/A	13
SPC	845	161

**measurement period from December 2015 through December 2016*

All provider types in Region 11, which includes Monroe County, are adequate to meet membership needs for access to care. Since we began building our MMA network in 2011, Humana has continued to recruit all required specialty types. Particular attention has been on Monroe County, which is considered rural, in an effort to maintain an adequate network for the approximately 317 enrollees Humana serves in that county. In doing so, Humana has continued to maintain strong partnerships with our contracted providers and subcontractors, and has created a culture of collaboration. Humana has maintained the same network in Monroe County throughout 2014 and to date. Additionally, considering our low membership in Monroe County, Humana continues to retain a strong network that includes two hospitals, seven pediatricians, seven adult PCPs, and over 50 various specialties such as Mental Health, Optometry/ Ophthalmology, Allergy, Cardiology, Hospice and Lab.

4. ONGOING NETWORK EVALUATION AND ENHANCEMENT

Humana measures and evaluates enrollee access to ensure our network meets or exceeds the Statewide Medicaid Managed Care requirements. We are continuously evaluating our Florida statewide provider network, as well as analyzing our capacity in each region, to ensure that enrollees have timely access to providers, including primary care physicians (PCPs), specialists and pharmacies. This includes measuring adequacy against contractual requirements, resolving network gaps and addressing barriers to care, including transportation and linguistic needs. We use network evaluation tools, including, but not limited to, timely access to care for enrollee's analyses; enrollee and provider feedback; and Geo Access reports to proactively target areas for network enhancement.

Our Provider Relations team and Quality Management Committee (QMC) monitor reports for all provider types from our network adequacy tools, on an ongoing basis, ensuring that we are proactively deploying network recruitment efforts, as well as quickly responding to network gaps as they arise. We also conduct strict oversight of our subcontractors to ensure the same level of access is monitored and maintained.

Provider Recruitment

Humana maintains a large network and actively assesses the overall network by provider type. We review and monitor the following key components in our network assessment: (a) the enrollee pattern of care, (b) provider types by geographic area including providers who service medically complex enrollees, and (c) access to care for all levels of providers. These services include, but are not limited to:

- Acute Care Hospitals
- Behavioral Health and Ancillary Services
- Compounding pharmacies
- Early intervention services
- Intermittent skilled nursing (pediatric andadult)
- Non-Emergent Transportation
- Occupational therapy (pediatric)
- Physical therapy (pediatric)
- Primary Care
- Private duty nursing services (pediatric)
- Skilled Nursing Facilities (SNF)
- Specialists including
  - Cardiologists (pediatric and adult)
  - Endocrinologists (adult)
  - Internists (adult)
  - Obstetricians/Gynecologists (adult)
  - Pulmonologists (pediatric and adult)
  - Psychiatrists (pediatric and adult)
- Specialized therapeutic foster care
- Speech-language pathology services P(pediatric)

We consider projections of future capacity planning in our network measurement and management process. Much of our network adequacy measurement process is based on updated enrollee counts and new maximum enrollment percentages. For instance, the enrollee to provider ratios and the time and distance measurements both require current enrollment files. As new enrollees are added, we take the enrollee growth and the geographic enrollment shifts into account to ensure adequate access to care, including linguistic and cultural needs and mitigation of barriers to care.

Significant provider contract re-negotiations can impact future network capacity planning. Humana's Provider Relations team maintains a strategic stratification of our major health system negotiations, so that no more than one health system in a market is under negotiation and has the potential for termination, as a result of the contract end date, at any given time.

Prior to any significant Humana or provider-initiated terminations, including hospitals, large provider groups, or subcontractors, Humana's provider relations team conducts a formal network termination impact analysis, using access analysis, open and closed panels, and provider-enrollee ratios, to verify that there will not be any enrollee access issues. When Humana initiates a termination, we conduct this analysis well ahead of the 90-day notification to the provider, and we notify AHCA within the contractual timeframe. In the event Humana receives a 90-day termination notice from a significant provider, our

provider relations team begins the formal network termination impact analysis. This termination analysis serves as the basis to identify gaps caused by potential terminations. Should we agree to accept the termination the provider, we use the analysis to prioritize targeted alternative providers or provider types that can serve as a substitute for the impacted providers.

How We Assess Network Barriers and Gaps

Humana has consistently met the reporting criteria of the PNV file reporting requirements since MMA implementation. We have identified several key barriers to reporting accuracy:

- Accuracy of provider Medicaid enrollment
- De-duping of provider NPI numbers and locations
- Single provider specialty assignment (i.e., providers that are contracted and credentialed with multiple specialties, but can only be "bucketed" to one primary specialty to support ratio counts)

While these barriers directly affect provider ratio counts, they do not reflect the true depth of the robust provider network and density of locations available to our enrollees based on time and distance measurements. Humana continues to work directly with AHCA and our provider network to resolve these barriers to network adequacy and ratio requirements.

Humana has consistently met the reporting criteria of the Provider Network Verification (PNV) file reporting requirements since MMA implementation. Humana performs a monthly assessment based on AHCA/PNV Adequacy Report. We assess the file against our network by provider type, and we apply our algorithm to proactively identify at-risk specialties for targeted recruitment opportunities. As a result, this process has allowed Humana to identify and rectify network gaps before they occur and our enrollees experience access to care issues.

Our Provider Relations team and Quality Management Committee monitor the reports for all provider types from our network adequacy tools, as well as from our subcontracted entities, on an ongoing basis ensuring that we are proactively deploying network recruitment efforts, as well as quickly responding to network gaps as they arise. Our comprehensive provider network monitoring efforts help us guarantee our enrollees have access to providers and services they need.

We also conduct systematic network adequacy measurement and management improvement in terms of appointment availability. Annually, Humana conducts "secret shopper telephone surveys" to assess wait times in scheduling appointments at provider offices. Providers in each region are chosen based on a statistically valid sample for the survey. The secret shopper survey monitors accessibility of appointments per Humana and AHCA regulatory requirements, and validates after-hours access to a healthcare professional.

The following are descriptions of our methods to identify enrollee barriers to accessing care. Our provider relations team and Provider 360 Committee collects and reviews this data monthly. Our Provider 360 Committee is a cross-functional team, which is chaired by Humana's Vice President of Florida Medicaid, and meets monthly to review provider trends from our Claims Department, as well as Availity (provider engagement) usage, quality measures, provider system usage, and provider grievances and inquires. The Committee includes representatives from our Claims Department, Grievance and Appeals Department, Credentialing Department, and Provider Relations.

Analytical Reporting

Access Analysis —Using a proven geographical analysis tool, the Quest Analytics Suite, Humana uses geocoding technology to precisely measure enrollee to provider adequacy access. This tool measures both distance and travel times against 200% of our enrollment for Regions 1 and 2and against 120% of our enrollment for Regions 3, 4, 5, 6, 7, 8, 9, 10 and 11. We analyze access for each provider specialty as listed in the Statewide Medicaid Managed Care contract by enrollee age/gender group as indicated by the provider type (e.g.,, pediatricians will be mapped to child members). Additionally, this tool enables us to identify access issues at the county and zip code level.

Provider to Enrollee Ratios—We analyze provider to enrollee ratios on a monthly basis against network standards established by Humana in accordance with AHCA requirements. We use these reports to assist us when we anticipate increased enrollment volume to ensure that our network has the capacity to accommodate additional enrollees.

Customer Feedback

- *Enrollee Surveys*—Humana will review CAHPS® and behavioral health enrollee satisfaction survey results annually to identify any access to care issues
- *Staff, Enrollee, Provider, and Advisory Input*—On an ongoing basis, Humana examines anecdotal information, including pattern of care, from various internal and external sources as it pertains to network adequacy, including information contributed by individuals and committees Some of these sources include the Provider 360 Committee, the Critical Access Team, and PCP feedback.

Meaningful Data

- *Complaints and Grievances*—Our Customer Service Department will forward enrollee and provider complaints and grievances reflecting access issues to the Provider Relations Department for review in real-time.
- *Out-of-Network Letters of Agreement*—We examine out-of-network referrals monthly to identify potential areas where provider specialty capacity needs to be expanded.
- *Cultural and Linguistic Needs*—Humana annually analyzes the cultural and linguistic needs of our enrollees and their geographic concentration to ensure appropriate access. For example, in Regions 9, 10, and 11, 36% of our enrollees report speaking Spanish at home. Thus, we strive to recruit providers who also speak Spanish to eliminate barriers to care. In our current network, 55% of our PCPs and 38% of our specialists speak Spanish.
- *Appointment Availability Audits*—We systematically conduct network adequacy measurement and management improvement in terms of appointment availability. Annually, Humana conducts “secret shopper telephone surveys” to assess wait times in scheduling appointments at provider offices. Providers in each region are chosen based on a statistically valid sample for the survey. The secret shopper survey monitors accessibility of appointments per Humana's and AHCA’s regulatory requirements, and validates after-hours access to a healthcare professional. Additionally, Provider Relations Representatives physically audit schedules during on-site visits.
- *After-hours Clinic Availability*—Humana annually conducts calls to PCP offices to ensure enrollees have after-hours access to care. Our Provider Relations Manager reviews results and assigns the appropriate Provider Relations Representative to immediately outreach to the provider if necessary. As noted in the provider manual and the provider contract, PCPs must provide 24-hour availability to enrollees by telephone. Through a direct connection with a clinician or an answering service, enrollees should be given the means to contact their PCP or a *back*-up physician to be triaged for care.

- *Open/Close Panels—On a quarterly basis, we review the panel status of our PCPs by region and county. If a PCP asks to freeze their panel, we review their capacity reports prior to closing the panels and require an updated attestation stating they are at capacity for all payors. We will require the PCP to have an action plan to hire additional physicians and/or physician extenders to be able to re-open their panels in 6 months. Additionally, we produce maps to visualize enrollee access to PCPs. We use this data to identify access barriers and implement additional targeted recruitment efforts.*

Humana will apply the same rigorous processes for identifying and resolving barriers and network gaps for any new regions awarded. For instance, we conduct statewide analyses weekly to guide our network expansion efforts for Regions 2, 3, 4, 5, 7, and 8, including time and distance reports and provider to enrollee ratio reporting. We also leverage our Medicare and Commercial provider networks to identify high performing providers to partner with, including providers participating in our STAR Rewards Program, Value Based Payment arrangements, or serving as Patient Centered Medical Homes, to serve our Medicaid enrollees.

Identifying Network Gaps

Humana creates time and distance reports using geographic access studies to ensure there are adequate numbers of providers, including but not limited to, primary care physicians, high-volume specialty providers, and hospitals in our network. Additionally, the ratio between a PCP and the PCP's assigned enrollees is calculated to ensure enrollees receive timely and appropriate services. Humana utilizes a software program called GEO Networks (Quest Analytics Suite Program), which factors for traffic density. Location comparisons are reported by county from the enrollee's home to the nearest source(s) of care. The software produces mappings and summaries of enrollees with desired access and enrollees without desired access. The provider relations team analyzes the results of those reports and develops action plans to mitigate gaps and address any deficiencies.

Ongoing Activities for Network Development Based on Identified Gaps and Future Needs Projections

Through our assessment tools, when network gaps or barriers are identified, our provider relations team initiates mitigation strategies. The following strategies are ongoing, consistent practices built into network management processes to mitigate identified gaps and barriers:

- Through our analyses, if we identify providers that are not meeting contractual requirements, such as failing to meet after-hours requirement or appointment availability standards, our Provider Relations Representatives will conduct provider education. If necessary, Humana will implement a Correct Action Plan to resolve any barriers to care within our Medicaid network, including subcontractors.
- We make every reasonable effort to contract with additional providers to resolve access issues. Should a provider refuse participation in Humana's network, we will secure a Single Case Agreement with the provider on a case-by-case basis.
- We use our collaborative provider partnerships with major health systems, ancillary providers and large IPAs, to identify providers for recruitment.
- Our provider nomination process enables enrollees to nominate a specific provider for recruitment.
- Our annual minority recruitment process targets providers to accommodate linguistic and cultural needs. We solicit feedback from minority associations, medical schools, and Native American tribes, as listed below.
    - Seminole Indian Tribe
    - Miccosukee Tribe

  - Florida Association of Minority Business Enterprise Officials
  - National Hispanic Medical Association (NHMA)
  - Minority Association of Pre-Med Students at Florida State University
  - Minorities in Medicine/Association of American Medical Colleges
  - Urban Promise
  - American Developing Smiles
  - American Developing Smiles
  - Florida International University
  - Florida Atlantic University
  - University of Florida
  - University of Central Florida
  - Florida State University
  - University of South Florida
- We maintain provider recruitment mailboxes where providers can electronically submit an application to become a Humana provider.
- Because we have several "on-the-street" Humana representatives, including our provider relations Representatives and quality improvement nurses, we receive insight about new providers moving into areas, enabling us to target them for recruitment.
- Through our review of single case letters of agreement and out-of-network utilization, we are able to identify and target non-participating providers for recruitment.
- We use a variety of resources to identify specific providers to target, including the AHCA Master File (PML), AMA Website, Sunbiz, US News Health Report, Florida Department of Health, our competitor's directory, and web searches.
- We harvest data identifying providers who are contracted for other Humana products with HMO provisions, and target these providers for recruitment.
- In areas where there are primary care provider shortages, we encourage our provider groups to recruit additional providers from outside the area, including physician extenders.
- We encourage our providers to offer telemedicine by reimbursing telemedicine in accordance with AHCA contractual requirements.

Identifying and Targeting the Right Providers Based on Gaps

Immediate, Short-term, and Long-term Interventions to Address Network Gaps

In situations other than continuity of care requests, we recognize that out-of-network utilization reports may identify potential gaps in our network. Once we identify and confirm a gap in our provider network, we design and implement an aggressive and prompt recruitment plan. We will notify and work with AHCA upon identification of major gaps or network disruptions. In situations where we have a shortfall or "hole" in our geographic access standards for a given provider type, we address it using the following mechanisms:

- Identify all providers that meet that provider type serving in the area through all available resources including the AHCA Master File (PML), AMA Website, Sunbiz, US News Health Report, Florida Department of Health, competitor's directories and Google. In addition, we discuss availability shortages with our provider groups to encourage additional recruitment of providers from outside the area.
- Recruit providers into the network who will bring that component of the network into compliance with the accessibility standards, if available.

- Provider PCP engagement: Humana may engage the enrollee's PCP to assist with identification of providers commonly used for referrals in his/her practice that are capable of providing and willing to provide care.
- In situations where we identify a network gap and have made what we believe is a highly reasonable offer to the provider(s) in a given area, identify there is a lack of available providers, and/or available providers are not actively enrolled with Florida Medicaid and are still unable to secure network participation, we will document our efforts to AHCA and request a waiver.
- Although maximum enrollment numbers were updated through Amendment 11, Humana continues to experience network gaps in specific regions. For instance, in Region 1 (which experienced an *increase* in the maximum enrollment number) we originally had 11 waivers on hold with the Agency for Health Care Administration. At the current time, we have additional waivers that are being prepared for filing utilizing the new Waiver template process. These waivers represent a significant lack of availability of providers in this region.

Specialty	**Status**	**Waiver Originally Filed**
Dermatology	All contracting efforts have been exhausted	Yes
Endocrinology (Peds)	All contracting efforts have been exhausted	No
General Dentist	Working with vendor to recruit additional Dentists	Yes
Infectious Disease	All contracting efforts have been exhausted	Yes
Ophthalmology	Working with vendor to recruit additional Ophthalmologists	Yes
Optometry	Working with vendor to recruit additional Optometrists	Yes
Otolaryngology	All contracting efforts have been exhausted	Yes
Podiatry	All contracting efforts have been exhausted	Yes
Rheumatology	All contracting efforts have been exhausted	Yes

In the absence of a contract, we will seek to work with needed providers through single-case agreements and will permit enrollees to seek care from these providers on an out-of-network basis.

When Humana determines that use of a non-par provider is appropriate, we employ the following steps:
- Determine if request is a plan benefit and if it meets medical necessity criteria
- Ensure no in-network providers within time and distance are capable of rendering service to enrollee
- If there is not an in-network option, then send the review to the Medical Director for approval
- Once approved, Humana works to negotiate rate, and the enrollee is seen for services.

In addition, Humana recognizes the potential need for enrollees to access critical services outside of their geographic area to ensure the enrollee receives the best care in a timely manner. Below are a few examples of complex cases that displays Humana's ongoing and proficient medical coordination between our clinical and network teams to ensure our enrollees receive the absolute best care in their time of need:

Region 1 example: A 37-year-old male patient was admitted to a participating in-network hospital in Region 1 with a diagnosis of Hashimoto's encephalopathy, seizures, and an altered mental status. Due to this enrollee's complex diagnosis and multiple comorbidities, the enrollee remained in this acute setting for three months. Once the enrollee's team of providers agreed to consider an alternative care setting based on the progress of the enrollee's condition, Humana assisted the enrollee with arranging and receiving post-acute care tailored to his diagnosis. Humana identified several long term acute rehabilitation facilities that specialized in complex neurological rehabilitation rather than utilizing a standard rehabilitation facility, based on the provider team's recommendations. Because there were no beds available at these neurological rehabilitation facilities available In Florida, we extended our search beyond state lines. The enrollee was accepted as a patient by a neurological recovery center in Texas. Humana's clinical team worked very closely with our provider network team to successfully transfer the enrollee, which required air transfer to the facility. Prior to the transfer, Humana's provider network team successfully negotiated a letter of agreement (LOA) with the facility to ensure the services would be accurately reimbursed. The enrollee remained at this facility for two months. Once the enrollee's condition showed improvement, we arranged for the enrollee to be transferred back to a local non-participating neuro-restorative facility to allow the enrollee's family to be active in the enrollee's care and support him in his continued progress of rehabilitation.

Region 11 example: A newborn born baby was delivered at Jackson Memorial in Miami-Dade County with a rare lethal, congenital defect of the windpipe called a type 4 laryngeal cleft. Humana's clinical team called every facility in Florida and, despite a thorough search, no surgeon in Florida was able to repair the enrollee's defect. We identified that the best center to treat this defect was located at Cincinnati Children's Hospital. Humana's clinical team and the provider network team worked to arrange to transfer of the newborn by air ambulance to the Cincinnati Children's Hospital intensive care unit. Prior to the transfer, Humana's provider network team successfully negotiated a letter of agreement with the facility to ensure the hospital would be paid for their services. The surgery was successful and after several weeks the baby was transferred by air ambulance back to the intensive care unit at Jackson Memorial to be reunified with her family.

Humana tracks and trends LOAs via a tracking grid for each. Our contracting teams perform analysis on a periodic basis to identify potential contracting opportunities. For example, common LOA types due to shortage of providers wiling to contract with Medicaid are the Home Health providers in Regions 1 and 6 because of a lack of availability (especially in rural areas) and extremely low home health skilled nursing and therapy rates.

Outcome Measures/Evaluation of Interventions to Fill Network Gaps

We base outcome measures and evaluation of Humana's intervention efforts to fill network gaps and resolve barriers on the following:

- Increase or reduction in the number of provider type gaps as measured using the AHCA required and other network measurement criteria described above (provider-to-enrollee ratio and time/distance standards, using the AHCA network measurement tool).
- Requests for specific services to be provided by non-par providers, or out of area providers. These requests are used as a measurement of the network adequacy status, and are collected and acted upon by the network team. The requests reach us through the portals that support provider services and customer services lines, as well as from the clinical management teams. The requests are generated from:

- PCPs seeking specialist referral services
- Enrollees
- Hospitals
- Specialists
- Humana Case Managers (CMs) who identify and report a need for either a specific provider or provider type

Humana's recruitment efforts include a variety of means to maximize success. These include on-site, face-to-face meetings with providers, telephonic outreach, and use of existing provider relationships to reach other providers. If willing providers are available that can address the specific need, our provider relations team will contact these providers to arrange a face-to-face meeting to recruit the provider into our network. Conversely, if the required provider type is not available or unwilling to contract with Humana, we will offer the enrollee transportation to the nearest qualified provider, make arrangements with out-of-network providers, or coordinate care through available telemedicine conduits.

Credentialing

Humana conducts rigorous credentialing and recredentialing of all providers in our network. Credentialing is one of the quality assurance components NCQA has regularly assessed in awarding Humana's Florida Medicaid plan accreditation. Humana has earned 100 percent of the available points on all NCQA surveys conducted between 2011 and March 2017. Our credentialing, recredentialing, and provider loading processes meet all state and federal requirements, as well as NCQA guidelines. Our process confirms that the provider has a current valid state license, holds current professional liability insurance, has completed the appropriate education and training for their specialty, and is free of sanctions by federal, state, and local authorities prior to the execution of a provider contract.

Providers are an essential part of Humana's mission to assist enrollees in achieving life-long well-being. Through our credentialing and recredentialing process, we ensure contracted providers are qualified to deliver the highest quality of care to our enrollees. Humana's proprietary workflow management tool, Accelerated Provider Exchange (APEX), quickens and automates the credentialing, provider load, and provider demographic update processes allowing us to achieve best in class turnaround times. To ensure providers are ready to provide services to Humana enrollees, we require all providers to complete a thorough credentialing process and ongoing recredentialing process.

5. ENGAGING BEST-IN-CLASS PROVIDERS

Humana believes the key to successfully engage best-in-class providers is to develop a partnership working towards a common goal of delivering quality care to our enrollees. To achieve this goal, we support our providers by providing the necessary tools and resources and by rewarding the providers that serve our enrollees best. Humana's orientation education, ongoing communication and support, and innovative ideas help us to engage and retain excellent providers.

a. Starting with a Common Goal

Our provider engagement model is built around attaining a mutual goal of improving quality outcomes by aligning on the common tenets of this goal, which include financial incentives, provider partnership, administrative simplicity, and provider satisfaction. The foundation of our model is to ensure providers are satisfied with the level of support and attentiveness as a result of our responsive and comprehensive

provider engagement model. Thus, we continually measure provider satisfaction to identify opportunities for improvement in how we interact and support our providers. A key measure of provider satisfaction is our provider network termination rate. Since 2014, our overall provider network termination rate for our MMA and LTC programs has been less than 1% month-to-month. Additionally, our hospital network has stayed stable since the implementation of the MMA program.

b. Initial and Orientation Training

Humana's comprehensive provider training program allows to us achieve more sophisticated, integrated, and engaged partnerships. Provider training activities – both initial and ongoing – are an important component of our relationship-building efforts. Humana offers a variety of training formats to ensure that information is accessible and convenient and accommodates providers' differing needs (organizationally and among individual staff) at all points in time.

Humana has been providing healthcare services for more than 50 years, and we understand that each provider's circumstances are different. We have structured our training programs to support a variety of people and in recognition of their different knowledge bases, needs, and learning styles. Our trainings are flexible and scalable; we provide web-based trainings for busy providers, conference-style trainings to a provider/staff, and one-on-one trainings. The training formats we use include face-to-face orientation and monthly meetings, Humana's Provider Handbook, materials available on our website, and our Availity portal, quarterly provider newsletters, and ongoing support available from our Provider Relations Representatives.

We believe our existing network and strong relationships with providers help strengthen the SMMC program operationally through enhanced access and improved quality outcomes for our enrollees. Thus, we use a cross-functional, integrated, and "high-touch" approach to support and train providers. This "high-touch" approach begins once a provider is credentialed and contracted. Humana's training begins during the negotiation of their provider agreement with Humana or during a single case agreement. Once the provider is considered an active and participating provider, our Credentialing Department will send a welcome packet with a copy of the monthly training calendar, as well as a list of all "on-demand" online trainings we offer, and a provider relations representative will schedule an orientation meeting within 30 days. All providers new to Humana's network receive orientation training from their assigned provider relations representative, who will also serve as their point of contact for all future trainings. This training is their opportunity to understand Humana operations and processes, provider roles and responsibilities, and the vast resources available to them. We conduct the initial orientation in the provider's office, which includes information on all necessary topics to help ensure a mutually successful partnership.

Below is a comprehensive list of all of the topics covered during the orientation training:

- Introduction to the Florida SMMC program
- Contracting and credentialing
- Access to care requirements
- Web resources
- Preauthorization and notification process
- Claims processing and claims resolution process
- Continuity of care
- Enrollee special needs consideration

- Enrollee screening for alcohol and substance abuse
- Clinical management programs
- Patient-center medical home
- Medicaid risk adjustment
- Medicaid Advisory Panel
- Service level agreements
- Agency for Health Care Administration (AHCA) provider based guidelines
- Annual compliance trainings
    - Humana Medicaid Orientation
    - Cultural Competency
    - Health, Safety and Welfare (HSW)
    - Fraud, Waste and Abuse (FWA) and Business Ethics
- Ob/GYN training (for Ob/GYNs only)
- Critical incident reporting
- Disenrollment/transfer of enrollee
- Helpful numbers and regionally specific Quick Reference Guides
- Florida Medicaid Provider Handbook
- Behavioral health tool kit for Primary Care Providers (for PCPs only)
- MMA provider incentive program (MPIP)
- EHR and HIE

The Provider Handbook includes detailed information on claims submission and payment processing, including by not limited to:

- Educational information regarding claims submission, payment processes, and explanation of a clean claim, including standards for submitting a clean/complete claim and following correct coding requirements.
- Information on how to submit a claim directly through Availity or to Availity through their existing clearinghouse to Humana.
- Information on how to submit a standard CMS 1500 and UB04 for paper submission and web claims submissions.
    - For those providers who elect to submit claims electronically, companion guides are made available for 837i and 837p transactions.
- Information on the correct use of ANSI X12 837 transactions, CMS 1500 or UB04 forms, and Availity electronic claims submission to ensure required data for a clean claim

Humana makes all information included in the Provider Handbook available to all providers via the provider website. Additionally, during the provider's orientation, we create an initial assessment as a baseline to identify if providers are correctly billing for services in accordance with State guidelines and the requirements of the provider contract. This baseline helps to determine frequency and content focus of future trainings needed.

Since 2013 we have conducted provider orientation training for more than 4,000 providers in Florida. We use provider feedback to continually modify and improve our provider training content, materials, and delivery sources.

c. Ongoing Training, Communication, and Support

Humana understands that for a number of reasons, including staff turnover, providers need refresher trainings. Providers are assigned a Provider Relations Representative, who is their point of contact for all trainings. We routinely review internal policy changes, and those of governing agencies, to ensure that our trainings capture up-to-date and relevant information. We seek to schedule these training sessions at the provider's convenience at a time when there is little/no patient care activity, and when as many provider staff as possible can attend. One-on-one trainings may be conducted in the provider's offices or at a Humana location. Conference-style, region-based trainings are held in a central location (e.g. hotel conference room, Chamber of Commerce facility, etc). We welcome and encourage AHCA representatives to attend any education seminars we conduct. Additionally, Humana conducts webinars twice per week with an opportunity for provider questions and answer sessions. All webinar schedules are posted in advance on our provider website with a description of training subject matter and time and date. If we identify that a provider needs additional training or if a provider requests it, we conduct follow-up provider service training through telephonic contact and/or face-to-face training, including on-site training for hard-to-reach providers, including those in rural regions.

Humana's Provider Relations Representatives visit providers regularly. During these visits, we deliver information to help the provider understand their overall performance metrics and ascertain whether their staff have any questions or training needs. During visits that occur subsequent to a recent training session, we ask whether there are any issues related to the prior training that they would like more information about or refresher information. We also use these visits as a mechanism to hand deliver important communications and publications that may previously have been mailed or posted to our provider website.

Furthermore, we recognize that provider education is not a static process, and that it may be necessary to reach providers in different ways, at different times, and through different delivery methods. Humana utilizes four simultaneous avenues of training to ensure we are supporting our providers in delivering the best care to our enrollees, which include:

1.) Face-to-face training
2.) Web-based individual training
3.) Webinars
4.) Available resources and "on-demand" training

Recognizing that PCPs serve as the medical home, our Provider Relations Representatives visit PCPs monthly. Below is a list of reports and data shared with PCP offices on a monthly basis:

- Performance profile/report card – snapshot used to review encounter rates, admits and days per thousand, average length of stay, ER visits per thousand and pharmacy opportunities
- New enrollment and disenrollment reports – reports listing all new and disenrolled enrollees from the PCPs panel
- Top 40 enrollees – report identifying the top 40 enrollees with highest incurred cost
- Top 40 drugs – report identifying the top 40 drugs prescribed and evaluation of any opportunities for generic equivalencies
- HEDIS reports including identification of gaps

- Encounter data – provides a 12-month trend and benchmark analysis for PCP encounters and fee for service claims by incurred and processed dates
- ER trends – report identifying enrollees who have had repetitive and excessive ER visits during a specific period of time
- Delivery system reports – provides a list of highly utilized, efficient specialists and mandatory networks available for enrollees
- Network changes – report that outlines changes to the network that may impact the PCP and enrollees
- Newsletters – quarterly publications that summarize topics vital to provider practices
- Mailings – various imperative communications that may have been mailed to their office that are reinforced during visits

Ongoing Claims and Payment Training

Humana's Provider Services Department supports providers and offers assistance with any claims-related issues they may be facing by phone, in-person, and through the web. Humana continuously monitors its providers' compliance with clean claim submission requirements via its claims data and analytics system. This system allows Humana to track claims-related performance measures such as timeliness of claims submission, percentage of clean claims, and percentage of denied claims for each individual provider. For example, we have improved our process since 2015, when on average 89 percent of electronic clean claims were paid within 10 days. In 2016, nearly 99 percent of our electronic clean claims were paid within 10 days. If a provider is identified as requiring assistance with claims submission, our Provider Relations staff offers two avenues for education: a provider relations representative may either contact the provider by phone or visit the provider's office for one-to-one training.

Web-based Individual Training:

Humana provides web-based training through the Availity portal, which is our health information network that optimizes information exchange between multiple health care stakeholders through a single, secure network. The Availity portal encompasses business and clinical services, and supports nationwide real-time and batch electronic data interchange via the web and through business-to-business integration. Recorded web-based trainings may be taken anywhere and are available 24 hours a day/seven days a week. In addition, instructor-led training is available at least one day per week. Through Availity, providers and their staff may access training related to:

- Claims management
- Authorizations management
- ERA/EFT management
- Clinical Solutions
- Electronic Data Interchange (EDI)
- Eligibility and Benefits Inquiry
- Patient Responsibility Estimator Tools
- Payment Collection and Processing
- 5010 Overview
- Annual Compliance training
    - Humana Orientation
    - Cultural Competency
    - Health, Safety and Welfare
    - Fraud, Waste and Abuse and Business Ethics

Providers are trained on compliance concepts and materials during orientations and are also required to complete them on an annual basis. Humana sends multiple reminders to providers, through email, fax blast, and phone calls, throughout the year using varying communication mechanisms to ensure these important compliance topics are met.

Educational Provider Materials

Humana distributes a provider handbook to all our providers, which includes a comprehensive review of educational topics, quick reference guides regarding prior authorizations, and enrollee-covered services materials. After a provider executes an agreement with us and during their orientation training, we review the handbook contents as well as any other information related to our health plan. Our handbook contains comprehensive information about a variety of topics and is a contractual extension to their provider agreement. Below is an overview of the topics covered in the handbook:

- MMA Program Description
- Covered Services
- Emergency Service Responsibility
- Child Health Checkup
- Provider Complaints
- Grievance System
- Chronic and Complex Conditions
- PCP and Other Provider and Subcontractor Responsibilities
- Telemedicine protocols and requirements
- Delegation or Subcontract Function
- Florida Health Information Exchange (HIE)
- Preauthorization and Referral Procedures
- Medical Records Requirement
- Claims and Encounter Submission Protocols and Standards
- Cultural Competency Plan
- Enrollee Rights and Responsibilities
- Fraud and Abuse Policy
- Health, Safety and Welfare
- Patient-Centered Medical Home (PCMH)
- Medicaid Advisory Panel
- Provider Rewards and Incentives
- Provider Resource Website
- Provider Training
- Availity
- Helpful Numbers

Humana also sends out provider newsletters on a quarterly basis and email blasts with important information pertaining to policy changes, quality, industry changes, and medical protocols. EAdditional examples of provider communications may include:

- Quality Reports
- Annual AHCA and CMS compliance training/communication on Fraud, Waste and Abuse and Cultural Competency
- Letters/emails/faxes

- Committee minutes or reports
- Provider bulletins, notices, and newsletters
- Online and hard copy reports
- Peer Review Committee communications related to potential quality of care issues
- Clinical newsletters
- Office visits

Provider Website Materials

Humana has a dedicated webpage where providers can easily access Medicaid provider materials. We also prominently display urgent updates and specific quality initiatives for our providers, such as annual checkups or breast cancer screenings. The following is a list of some of the information available on our provider website:

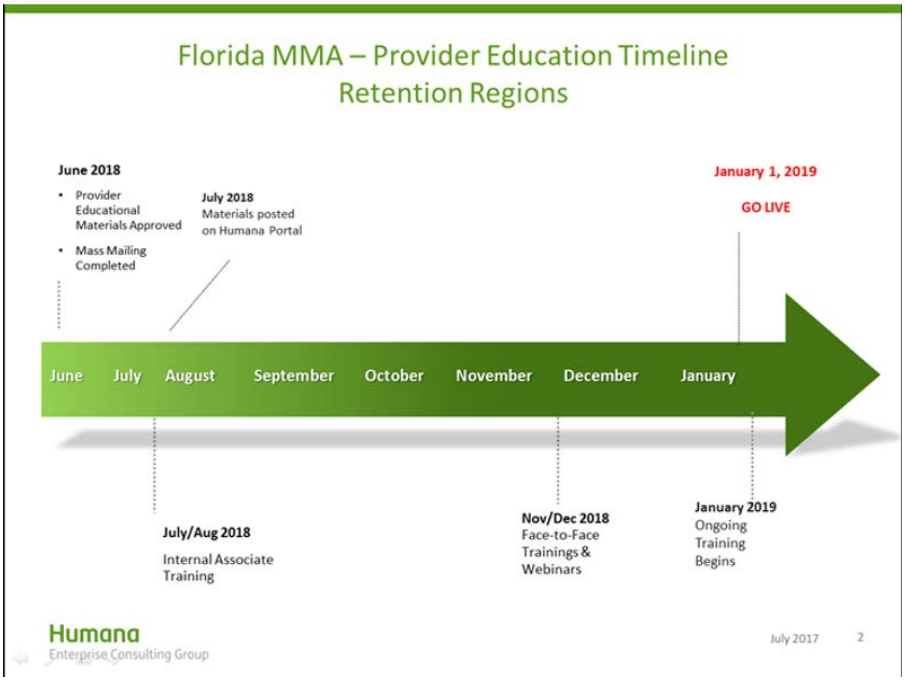
- Provider handbook
- Region-Specific Quick Reference Guides
- Assistive Care Quick Reference Guides
- Medicaid preauthorization and notification list
- Enrollee handbook
- Cultural competency plan
- Provider tools to address gaps in care
- Prescription Drug Guide
- Florida Medicaid preferred drug list
- Behavioral health tool kit
- Home health visit information
- Referral to Medicaid case management form
- Urgent updates
- Breast pump coverage
- Minority recruitment and retention information
- Provider nomination form
- Florida Medicaid Vaccines for Children (VFC) Program and child blood lead screening
- Crossover claims
- Child health check up
- Medicaid eligibility for newborn babies
- Healthy behavior programs
- Quality resources
- Program information
- Provider handbook
- Provider directory
- Helpful numbers
- Provider training calendar
- Electronic billing
- Provider ebilling companion guide

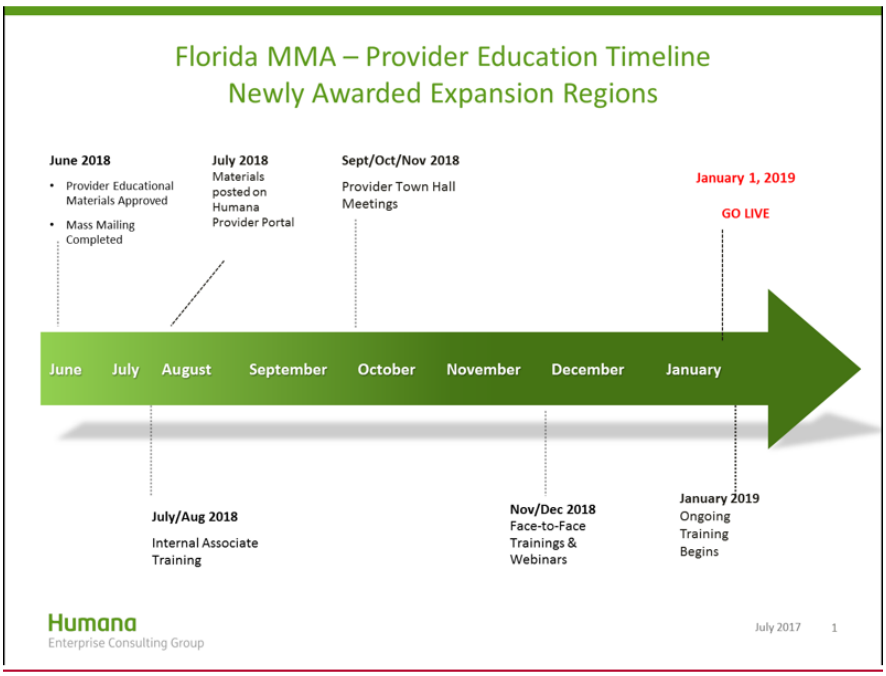
Review of Provider Claims for Training Opportunities

Our provider relations team has a comprehensive process to review claims reports. On a daily basis, our team reviews Availity rejection and denial reports for claims submitted electronically. On a monthly basis, our Provider 360 Committee reviews global provider claims, including electronic and paper claims, trends to widespread issues we need to address with our providers. On a quarterly basis, our provider outreach and provider contract representatives use these reports to provide feedback and identify training needs. Training methods include webinars, town halls, individual provider training, and newsletters. To assess the effectiveness of our trainings and educational materials we send out surveys to providers seeking feedback on the training.

The combination of our new provider orientation education training and ongoing training as well as our daily operational experience with our providers has laid the foundation for a strong training program that will be required for Humana's MMA expansion. We plan to approach provider education for the upcoming 2019 implementation through two strategies – one for existing/retention Regions and one for new, expansion Regions.

See Provider Education Time Lines below





d. Rewarding Best-in-Class Providers

Humana's interactive and comprehensive provider engagement model is the basis of our provider retention efforts and a significant differentiator of Humana's provider network management strategy. Our PCPs and high-volume specialists have a relationship with an assigned Humana Quality Improvement Nurse and a Provider Relations Representative.

Provider Engagement in our Value-Based Payment Model

An effective provider engagement strategy enables the formation of true partnerships and optimizes the payer-provider relationship. Humana has extensive experience in creating modernized, value-based engaged provider partnerships that involve substantial financial risk/reward sharing and performance-based incentives for providers, which support our provider retention efforts. We designed our program to support the needs of providers, working constructively with providers from each organization regardless of their organizational size or level of technological sophistication. Humana provides a step-by-step opportunity to earn pay-for-performance financial rewards for achieving certain key clinical measures of success. As providers mature in their ability to achieve basic milestones, additional measures are added or increased outcome performance targets are established which allow providers to earn even greater pay-for-performance rewards.

Humana has a sophisticated value-based model in Florida to establish financially and quality aligned incentive contracts with our providers. These agreements include full risk (global) capitation, shared savings model, quality-cap bonus, and MMA Physician Incentive Program payments to reward our providers for providing high-quality care. Humana's model is designed to drive greater provider engagement and better clinical outcomes based on the idea that thoughtful reward incentives, packaged with consultative provider guidance and care gap alerts, integrated with comparative metrics and benchmarks helps providers to raise the bar in quality. Our model delivers an improved ability for providers to more rapidly identify high-risk enrollees, improve chronic condition care delivery, reduce medical costs, and improve enrollee satisfaction. To ensure our providers remain in good standing,

Humana supports our providers with several tools including enrollee data and provider performance metrics to keep our providers updated on a regular basis. This data includes a peer-to-peer performance indicator that keeps the provider aware of their performance within the network. Our provider engagement program allows Humana to truly partner with our network partners and optimize the payer-provider relationship, which keeps providers satisfied with their financial incentives and the care they are delivering.

Through our initial training and orientation, ongoing training programs, resources, and value-based payment model, Humana has built a best-in-class provider engagement model. However, we recognize that tools, resources and rewards aren't the only way to keep providers engaged. Providers need a corporate partner that is also easy to work with. That's why we strive to remove barriers and administrative burdens.

6. ACCESS TO CARE FOR ENROLLEES

At Humana, we strive to ensure enrollees can readily access appropriate care tailored to their needs from our extensive network of providers within the system, and we provide them multiple access points to find necessary information for timely access to services. Our access standards meet or exceed with AHCA as well as State and federal requirements.

We continuously monitor, analyze, and adjust access needs, types, and methods to ensure we provide a robust network of high-quality, contracted network providers, while striving to ensure we have the appropriate number of providers, provider-to-enrollee ratios, provider types, and availability to effectively service the diverse needs of Florida's enrollees. This helps us identify opportunities to improve our network and enhance access to care for our enrollees.

a. Analysis of Timely Access to Provider Services

Humana conducts various audits to ensure our providers are maintaining accessibility standards. We measure appointment availability standards through initial credentialing and recredentialing site visits, complaint data, capacity reports, and provider self-reporting. Humana also physically audits appointment schedules on a random basis and at least annually by visiting provider offices.

Humana currently conducts audits of appointment availability and office waiting times for PCPs and will expand our processes to the specified provider types, which include pediatric and adult cardiologists, pediatric and adult pulmonologists, adult endocrinologists, adult internists, pediatric and adult psychiatrists, adult obstetricians/gynecologists, and pediatric and adult-licensed mental health clinicians. In 2016, our PCPs averaged 1.2 days for a sick patient appointment, 2 days for an urgent care appointment, and 8 days for a well care appointment, exceeding AHCA's requirements. All participating providers are expected to render care in full compliance with AHCA access guidelines. Humana will comply with the Agency's contractual requirements for Timely Access Standards, as listed below, and actively monitor adherence to these standards.

1. Appointments for urgent medical or behavioral health care services shall be provided:
    (a) Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.
    (b) Within ninety-six (96) hours of a request for medical or behavioral health

care services that do require prior authorization.

2. Appointments for non-urgent care services shall be provided:
   (a) Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
   (b) Within fourteen (14) days for initial outpatient behavioral health treatment.
   (c) Within fourteen (14) days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
   (d) Within thirty (30) days of a request for a primary care appointment.
   (e) Within sixty (60) days of a request for a specialist appointment after the appropriate referral is received by the specialist.

To facilitate timely access to appointments, routine care, and urgent care services, we communicate the following standards to all network physicians through a variety of channels such as during site visits, the Provider Manual Appendix, and provider training materials posted on Humana.com and Availity.com.

APPOINTMENT TYPE	DEFINITION	STANDARD
Emergent	A sudden, unexpected situation which could become a threat to life or limb if not diagnosed and treated immediately (chest pain, excessive bleeding, constant/severe shortness of breath, severe abdominal pain, severe injury, etc.)	Immediately
Urgent	An unexpected illness/injury requiring treatment to prevent serious decline in health, but not life threatening (ear infection in child, fever lasting 1-2 days, persistent symptoms of illness lasting 3-4 days)	Within 24 hours
Routine or Primary Care	Non-urgent care for symptomatic issues (rash, arthritis, return visit to check blood pressure, etc.).	30 calendar days
After-hours access	Telephone information on how to access care after PCP's office has closed	Answering service capable of paging physician or answering service with instructions to call Humana First and/or instructions to go to nearest Emergency Room if emergent/urgent

Access Audit Process

Humana measures and evaluates enrollee access to appointments and wait times on an ongoing basis to ensure network providers meet the required standards. We also conduct strict oversight of our subcontractors to ensure they secure and monitor the same level of access.

We choose a statistically valid sample of providers within a region for a number of different access audits, including appointment availability and wait time for both urgent and routine visits. These audits monitor accessibility of appointments per Humana and AHCA's regulatory requirements and corroborate appointment wait time. Humana measures these appointment availability standards through initial credentialing site visits, complaint data, and provider self-reporting.

On a quarterly basis, Humana conducts a statistically valid sample of "secret shopper telephone surveys" to assess wait times in scheduling appointments at provider offices. The Provider Relations Manager reviews the results and assigns the appropriate provider relations representative for immediate outreach to the provider. Humana also physically audits appointment schedules by visiting provider offices annually. On a random basis, a Humana Provider Relations Representative will visit a provider's office to monitor enrollee wait times, ensuring the provider is meeting accessibility standards. We also review enrollee surveys, provider surveys, complaints and grievances, and staff and provider input for insight into access issues. Our Provider 360 Committee reviews the results from these sources on a monthly basis. While Humana currently conducts the above audits and measures for PCPs, we will expand these efforts to include the listed specialty types.

Telephonic and Visit "Secret Shopping"

We select the top 40% of PCPs in each region based on total enrollee count to survey via telephone or face to face. The secret shopper survey monitors accessibility of appointments per Humana and AHCA's regulatory requirements and corroborates after-hours access to a healthcare professional. (See Table)

The Provider Relations Representative contacts the Primary Care office with symptoms of a simulated condition/illness to assess the next available appointment.

Failure by the PCP center to meet standards will result in the following action steps:

- The center's panel will be immediately frozen to new enrollees
- A corrective action plan shall be implemented with the expectation that the center shall regain compliance with Humana's standards within a 30-day period
- The center shall be re-audited at the end of the 30-day corrective action period
- If the center is found to have regained compliance with Humana's accessibility standards, then the center's panel freeze shall be lifted
- In the event that the center does not improve accessibility standards and regain full compliance within the 30-day corrective action plan window, the center may be provided a notice of termination, with such termination to become effective immediately.

2016 Average PCP Wait Times by Number of Days

Average PCP Wait Times by Number of Days				
Region	**Total Number of PCP Locations Surveyed**	**Measure: Routine Sick Patient Care**	**Measure: Urgent Care**	**Measure: Well Care Visit**
Region 1	129	2	1.3	10.3

Region 6	335	1.8	1.2	18
Region 9	38	1.8	1.2	4.7
Region 10	33	2	1.3	3
Region 11	36	3	1.1	4
Average Wait Times (all regions)	**571**	**2**	**1.2**	**8**

Source: Timely Access/PCP Wait Times Report

Delegated entities (e.g., subcontractors, physician hospital organizations contracting with Humana on a capitated basis) shall collect data regarding appointment availability or other applicable functions utilizing Humana standards, and send written summary reports with supporting documentation to the Health Plan. Below is an example of Access Behavioral Health's survey results in Region 1 from 2016.

Access Behavioral Health Region 1: Appointment Time Access

Access Standard	Percentage of Network High-Volume Providers Who Meet Standard	Percentage of Network Practitioners Who Meet Standard
Emergent: within 6 hours	100%	100%
Urgent: within 48 hours	100%	100%
Routine (Initial): within 7 days	100%	74%
Follow up: Within 30 days	100%	100%

Additionally, in 2016, Beacon's Provider Relations team initiated a platform to ensure that Medicaid enrollees have timely access to care. Beacon's staff contacts 100 percent of the network providers (MDs, DOs, and ARNPs) each quarter and ask questions to determine the provider's ability to accommodate Humana/Beacon Medicaid enrollees. If a provider is unable to accommodate an enrollee according to Humana's access standards, Beacon ensures that the provider has an alternate plan in place to assure that these enrollees have access to care in urgent, emergent, and routine situations. Once the calls have been made to the providers, any changes that need to be made in the system are documented via Beacon's management information system. If additional documentation is needed prior to creating these events, Beacon's Provider Relations staff follows up to obtain it from the provider. Below is an example of Beacon's survey results in Regions 6, 9, 10 & 11.

Beacon: Appointment Time Access

Survey Question (reflects current Agency timely access standards)	Q1 Results
Can you accommodate a Humana/Beacon Florida Medicaid enrollee, who has an emergency, 24 hours per day, 7 days per week?	97.8% (176/180)
Can you accommodate a Humana/Beacon Florida Medicaid enrollee in need of urgent care within one (1) day of the request?	97.8% (176/180)
Can you accommodate a Humana/Beacon Florida Medicaid enrollee in need of a behavioral health routine initial evaluation ("sick care") with an appointment within one (1) week of the request?	92.8% (167/180)

Can you accommodate a Humana/Beacon Florida Medicaid enrollee in need of a behavioral health routine follow-up appointment ("well care") within one (1) month of the routine initial evaluation visit?	97.8% (176/180)

Future Enhancements

Humana will operationalize a plan in 2019 to increase the frequency of the timely access to service survey to a quarterly basis. We will also incorporate a statistically significant sample of designated high-volume specialty provider type, which include cardiologists, pulmonologists, endocrinologists, internists, psychiatrists, OB-GYN, and licensed mental health clinicians.

After-Hours Care Access

Humana also conducts calls to PCP offices to ensure enrollees have access to care during after-hours at least annually or as issues arise on a more frequent basis (See Table 1). Our Provider Relations Manager reviews the results and assigns the appropriate local provider relations representative for immediate outreach to the provider if necessary. As noted in the provider manual and the provider contract, PCPs must provide 24-hour availability to enrollees by telephone. Whether through an answering machine, or a taped message used after-hours, enrollees should be given the means to contact their PCP or a back-up physician so they can appropriately triage the enrollee for care.

Table 1

2016 After Hours Accessibility Audit

Region	Total PCP/FTE	Total PCP/FTEs After Hours	% of PCPs/FTEs w/After Hours	AHCA SLA Requirement
1	385.5	147.5	38%	30%
6	1348.5	855	63%	35%
9	575	363	63%	40%
10	420	300.5	72%	40%
11	621.5	409.5	66%	40%
Total	**3350.5**	**2075.5**	**60%**	

Humana values providers that offer after-hours to our enrollees and that realize the importance to our enrollees of having access to their PCP instead of going to an emergency room or an urgent care center. Humana is implementing an initiative to increase the reimbursement to encourage additional providers to offer after-hour services (99050 and 99051). Given the current Medicaid-allowable reimbursement of seven point two eight ($7.28) and nine point thirty-nine ($9.39), Humana is offering a range of thirty-five ($35) to fifty ($50) dollars, which is a substantial increase in reimbursement.

Enrollee Satisfaction Surveys

We also monitor enrollee wait times using enrollee satisfaction surveys (CAHPS), which we complete annually. Our Quality Management Committee (QMC) reports analysis of the to ensure we meet our goal benchmarks. Access to care results is measured year over year with established benchmark goals (see Table 2).

Table 2: Measurement and Results: CAHPS Analysis for Access to Care

Florida Medicaid Adult CAHPS Results				
CAHPS Question/Composite	**2016 Rate**	**2015 Rate**	**2015 Quality Compass National**	**2016 Market**
Getting Needed Care	77.5%	73.0%	80.8%	75.2%
Q14. Ease of getting care, tests, or treatment needed	79.3%	79.7%	82.9%	82.1%
Q25. Got appointment with specialist as soon as needed	75.8%	66.4%	78.7%	68.4%
Getting Care Quickly	78.8%	77.9%	80.7%	80.2%
Q4. Got urgent care as soon as needed	82.9%	80.6%	83.4%	83.0%
Q6. Got routine appointment as soon as needed	74.6%	75.3%	78.2%	77.6%

Florida Medicaid Child CAHPS Results				
CAHPS Question/Composite	**2016 Rate**	**2015 Rate**	**2015 Quality Compass National Average**	**2016 Market Goal**
Getting Needed Care	74.7%	82.4%	84.3%	84.9%
Q14. Ease of getting care, tests, or treatment needed	86.0%	83.9%	88.8%	86.4%
Q28. Got appointment with specialist as soon as needed	63.4%	81.0%	80.8%	83.4%
Getting Care Quickly	89.1%	87.8%	88.6%	90.4%
Q4. Got urgent care as soon as needed	90.1%	88.3%	90.2%	90.9%
Q6. Got routine care as soon as needed	88.1%	87.3%	87.1%	89.9%

Source: 2016 CAHPS Survey Results

Enrollee Turnover—Humana utilizes reporting of enrollees who have requested reassignment on a monthly basis. This report includes codes which may indicate dissatisfaction with appointment availability or office wait times.

Site Visits—Humana conducts provider site visits for PCPs during the credentialing and recredentialing process. As part of the site visits, we assess appointment scheduling policy, wait times, and after-hours accessibility. Humana also physically audits appointment schedules on a random basis during site visits.

Complaints and Grievances—Complaints and grievances from enrollees and providers are received through multiple routes and are recorded and tracked in our Customer Care Portal. Complaints that reflect network access issues or identify potentially noncompliant providers are forwarded to our Provider Relations team for review and action on a real-time basis. In addition, Humana will be designating a Provider Services Leader who will provide oversight on provider disputes.

Staff and Provider Input—Humana examines input from various internal and external sources pertaining to appointment availability and waiting times. Examples of these sources include our Provider 360 Committee, clinical access team, Provider Relations representatives, case managers, specialists' offices, and customer service specialists.

b. Telemedicine

Humana promotes telemedicine as a care delivery option to improve enrollee access to services, especially in remote geographical areas, provider shortage areas, and for enrollees with mobility issues. Humana's contracting policies and procedures define telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.

Provider relations representatives educate providers regarding telemedicine strategies and requirements. Humana strives to ensure that all providers seeking to deliver telemedicine strategies understand how specific rules for these services apply to any person or entity prescribing or reviewing a request for Florida Medicaid services, and to all providers of Florida Medicaid services that are enrolled in or registered with the Florida Medicaid program.
We also encourage our providers to offer telemedicine by reimbursing telemedicine in accordance with AHCA contractual requirements. We offer our enrollees access to Doctor-on-Demand to encourage telemedicine as a means ability to limit out-of-network utilization and enhance non-emergency ED diversion. Doctor on Demand is a platform that provides enrollees with access to physicians 24 hours a day, seven days a week from the enrollee's phone or computer. The platform allows enrollees to see and/or talk to a physician immediately using video or phone services or to make an appointment for a later time. Additionally, the platform allows an enrollee to upload medical history, send images if necessary, and obtain a prescription.

For providers licensed within their scope of practice to perform the service, Florida Medicaid reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between a recipient and a provider.

Florida Medicaid does not reimburse for:

- Telephone conversations, chart review(s), electronic mail messages, or facsimile transmissions.
- Equipment required to provide telemedicine services.

Furthermore, we ensure providers understand that Humana reimburses for telemedicine services in compliance with AHCA's guidelines:

- Florida Medicaid reimburses a provider who is providing the evaluation, diagnosis, or treatment recommendation located at a site other than where the recipient is located.
- Providers must include modifier GT on the CMS-1500 claim form, incorporated by reference in Rule 59G-4.001, F.A.C.

We have partnered with specific physicians throughout Regions 9, 10, and 11 to provide walk-in primary care and specialty care telemedicine services for their enrollees who need services after-hours or who are unable to get to an office location where the physician is located.

Humana continues to look for opportunities to partner with providers to deliver telemedicine services to improve enrollee access to services. In 2017, Humana developed an educational campaign to alert providers on appropriate requirements of telemedicine and Humana's reimbursement. In effort to educate providers, Humana created a one-page flyer promoting the benefits of telemedicine services, the state-mandated requirements, and Humana's reimbursement.

c. Pharmacy

Network Adequacy

We access pharmacy accessibility evaluations utilizing Quest Analytics for each region using the most current Medicaid membership file as a representation of the population.

Humana's pharmacy network team evaluates network access periodically on the following schedule:

- 4th quarter of each year for the upcoming year
- When requested by specific business areas when network service areas are being reviewed for the upcoming benefit year
- When a major pharmacy chain (> 5% of the network) leaves the network

Accessibility of pharmacy networks are evaluated to determine if networks meet adequacy based on the below standards:

- 1 pharmacy within 5 miles of an urban enrollee
- 1 pharmacy within 5 miles of a suburban enrollee
- 1 pharmacy within 15 miles of a rural enrollee

The following are the percentage of enrollees that must meet the above access standards:

- 90% of urban enrollees must meet access standards
- 90% of suburban enrollees must meet access standards
- 70% of rural enrollees must meet access standards

Compounding Pharmacies:

All pharmacies in the Humana network are able to provide enrollee's with compounded prescriptions. In addition, Humana's mail order pharmacy through PrescribeIT can also provide enrollees with compounded prescriptions. Humana continuously monitors enrollee concerns regarding access to pharmacies which includes compounded prescriptions to ensure there is adequate access.

Over-the-counter (OTC) Benefit

Humana offers an over-the-counter (OTC) program through PrescribeIT. Each enrollee has a monthly household benefit that allows up to a $17.50 coverage for each member of the household to be used toward any items that are offered on the order form. Orders ship to the enrollee's home by USPS or UPS at no charge for shipping.

Out of Network Requests

If new enrollees are utilizing a pharmacy that is not in our network, Humana will continue to allow the prescriptions to process for a period of 60 days during the enrollee's continuity-of-care period. Prior to

the end of the continuity of care 60-day time frame, Humana and the enrollee's provider(s) will educate them on how to access their drug benefit through Humana's participating pharmacy provider network.

d. How Enrollees Access the System

Humana understands that enrollees need convenient, easy-to-use system information so they can readily access appropriate care. Some of the ways enrollees access the system is through enrollee materials such as the enrollee handbook and online provider directory, as well as through access points including the Customer Service call center and Clinical Access Team (CAT). We educate enrollees on the available methods to access appropriate services on Humana's website, their enrollee ID card, and in their enrollee handbook. Enrollees and providers can contact Humana to translate these materials to their language of choice and send to them on demand. Our provider directory, both online and hard copy, gives enrollees ample means of finding a provider who is best qualified and best suits their healthcare needs.

Language Assistance and Alternative Formats **–** Effective communication with enrollees is paramount, and Humana strives to ensure "equality of opportunity" for meaningful access to health care services and activities. It promotes increased compliance and adherence to follow-up treatment, improved use of and access to preventive care, better understanding of covered services, navigation of the complex health care system, and improved enrollee satisfaction.

Humana provides, at no cost, appropriate access to oral interpretation services in 200 languages, video interpretation in 24 languages, including American Sign Language, and translated written materials of vital documents based on threshold languages and auxiliary aids required by disabled enrollees (current and future). Humana follows the Department of Health and Human Services' framework for Limited English Proficiency (LEP) and ADA enrollees for the development of the language assistance and alternative formats section of the Language Assistance and Alternative Formats Services. Below is a link to Humana Accessibility Resources: https://www.humana.com/accessibility-resources.

Humana ensures that all enrollee materials are reviewed using the Flesch-Kincaid Methodology to ensure they are written in a maximum fourth grade reading level and are easily understood (42 CFR 438.10 (5d)). Enrollee materials are printed in a type, style, and size that can easily be read by enrollees with varying degrees of visual impairment. Additionally, all enrollee materials are distributed in English and Spanish, but are also made available in varying alternative formats and foreign languages. We encourage enrollees in every mailing and on our website who need a specific format, such as braille or in a language other than English or Spanish, to request materials by calling Humana Customer Care.

e. New Enrollee Materials

New Enrollee ID Card and Welcome Kit - Enrollees that choose Humana Medical Plan as their preferred plan of choice receive two AHCA-approved mailings: one with their Humana Medical Plan Enrollee Identification Card and one with their New Enrollee Welcome Kit. The Welcome Kit includes a Welcome Letter, Important Phone Numbers List, a Health Risk Assessment Form with a self-addressed envelope, a Consent for Release of Medical Records Form, and a Continuity of Care Form with a self-addressed envelope.

The Welcome Letter introduces new enrollees to the unsecured enrollee website (https://www.humana.com/medicaid/florida/mma), where they can find materials including the Enrollee Handbook and Provider Directories and request free printed copies of any materials by calling Humana Customer Care. The letter also explains enrollment and disenrollment information and discusses each of the items included in the Welcome Kit. These materials direct enrollees to call Customer Care for any questions and concerns on how to access care and benefit information.

Enrollee Handbook - An easy-to-find and easy-to-read handbook is very important in supporting our Medicaid enrollees. Humana places great emphasis on making sure the enrollees can use the handbook at their convenience and in a manner they can easily understand. This includes the reading level, identifying easy-to-find phone numbers, and making the materials available in the language of their choice.

Provider Directories - Enrollees need detailed information on both providers and hospitals when making decisions regarding their healthcare services, so Humana strives to provide this information in an easy to use and accessible format, including the online provider directory. If enrollees are interested in learning more about Humana's physicians, such as their educational background or training, they may use the Physician Finder Plus tool on the Humana website (www.humana.com). We update this tool daily and make it accessible to all visitors to Humana.com, whether they are an enrollee or not, and without needing to log in.

Enrollees will find the "Find a Provider" feature at the top in the Quick Links section and specific links for doctors, dentists, and pharmacies on the middle of the page. This brings them to the search page, where the site prompts enrollees to enter criteria from the options below to find a provider that fulfills their needs:

- Enrollee ID number
- City, State
- ZIP code
- Network
- Provider type/Specialty
- Provider name
- "Sounds Like" provider name
- Group/Facility name
- Type of coverage
- Geographic location
- Geographic distance
- Gender
- Language
- Accreditation – NCQA, ABIM or Board Certification
- Accepting new patients status
- By symptom, condition, or procedure

Humana strives to ensure the information within Physician Finder Plus on humana.com is as accurate as possible. We make regular updates through demographic changes received from provider offices. Providers can report demographic changes in a variety of ways. They can submit changes electronically through Humana.com using the "Manage My Demographics" tool under the Resources tab. Providers

can also email, mail, or fax changes to the Provider Verification Unit. Additionally, providers can submit their changes to their Provider Relations Representative. Enrollees also have the option of alerting Humana to a demographic change by clicking on “Report updated information” on the provider’s details page in Physician Finder. Humana’s Data Collection and Verification team also contacts providers quarterly to give them an opportunity to submit any necessary demographic changes for the online directory.

Humana has built a feedback link within Physician Finder Plus whereby any logged-in enrollee can enter information submitted by a Medicaid enrollee about a specific provider. It collects and reports on two data elements: 1) enrollee’s experience; and 2) enrollee’s comfort with recommending that provider to others. We maintain the reported information for a limited amount of time and then purge it to make sure that the information is up-to-date. The information is only available via the secure portal to ensure only enrollees can submit feedback. Humana also reviews this information to help identify poor-performing providers. If a provider receives five submissions over a 12-month period that are below a score of 2 or below on a 5-point scale, we will refer it to provider relations for review.

Humana also provides a printed provider directory if an enrollee requests it. The directory contains both an English and Spanish section; however, the enrollee can request a directory in other languages by calling Customer Service. Additionally, enrollees can download the printed directory in a PDF format from Humana.com. We update the PDF format directory weekly.

f. Enrollee Access Points

Enrollees may need to access the network in a variety of ways, so Humana offers multiple access points including telephone accessibility, the Clinical Access Team (CAT), and oral interpretation services in 200 languages, to address their needs and preferences. We develop and adhere to stringent performance standards that help us monitor, maintain and report upon the various ways enrollees choose to access the network, while ensuring our providers maintain accessibility standards. We strive to ensure that all enrollees receive timely and appropriate access to care.

Telephone Accessibility - Humana Customer Services staff, available via our toll-free number, TTY/TDD, is in place to ensure enrollees have access from 8:00 a.m. to 8:00 p.m. each business day. We train our Customer Services Representatives (CSRs) to provide prompt, courteous, and accurate responses to a variety of inquiries that help the enrollee access the system, including but not limited to the following: (a) answers to questions regarding benefits and verification of eligibility; including communication of benefit changes; (b) providing assistance with selecting participating providers; (c) answers to prior authorization or claims questions; and (d) acceptance of complaints, grievances, and appeals.

After hours, on weekends, and holidays, the call center utilizes alternate technologies, such as an Integrated Voice Response (IVR) system. When an enrollee connects to the IVR, it asks in both English and Spanish if they would like to speak to a nurse about a care-related issue. If the enrollee says “yes,” it routes the call to Citra, our 24/7 nurse line vendor. If they say no, or simply hold on the line, it routes them back to the IVR. The IVR will allow them to self-serve or leave a message for callback on the next business day.

If Citra receives a non-care-related call and the enrollee would like to leave a message, Citra transfers them directly to the IVR. The automated answering system will permit any caller to leave a message that

includes a name and telephone number without requiring identifiable information such as enrollee ID or Social Security number. A representative will then call them back the next business day.

Monitoring and Reporting

Humana monitors and records all inbound calls, and logs each into our system to assist with any future calls an enrollee places to Humana. We train staff to respond to enrollee questions in all areas, including but not limited to covered services, provider network, and transportation. Calls from enrollees and providers alike are subject to the same call center performance requirements, which we monitor via the Medicaid Volume Report, produced daily.

Workforce Management provides real-time performance reporting on an ongoing basis, reported throughout the day to Operations Managers and Supervisors. This information includes call trending and real-time call and staffing adjustments made to address any identified needs/trends.

- Workforce Management adjusts associates' skill sets to provide adequate staffing at all times.
- We record 100% of all inbound calls received.
- Call and Call Center Representative performance information is housed within internal databases, Automated Call Distribution (ACD), and Workforce Management reporting systems.
- Workforce Management produces call reports, which it provides to the Customer Care Supervisor/ Team Lead. The format is similar to the Medicaid Volume Report, but includes pertinent individual measures.
- The report also addresses associates' use of time while on the phone including:
    - Talk time (time spent on each call with an enrollee/provider)
    - Not ready time (time not taking phone calls)
    - Hold time (time on hold by a caller while the CCS is researching)
- The Customer Care Supervisor/ Team Lead discuss call results with each CCS and provides coaching as needed.

The Call Center Supervisor/Team Lead, on a daily basis:

- Reviews and monitors the Medicaid Volume Report
- Analyzes the report information upon receipt
- Takes appropriate actions as needed based on the report data to adjust call center staff and to address trend impacts noted

The Call Center Supervisor/Associate's Team Lead assesses individual CCS performance on a weekly basis through:

- Side-by-side monitoring
- Monitoring of systems used
- Process followed based on call received
- Interaction documentation

Humana maintains results of the performance assessment in the associate's personnel file.

- Humana also tracks performance measures, as stipulated in the Florida Medicaid Contract, on the Medicaid Volume Report including:
- Call Answer Time: When a Medicaid enrollee calls the Call Center phone number he/she does not get a ring. The call rolls into the IVR system directly. The enrollee has the option to use IVR or opt-out. The call answer time (ASA) is measured in seconds as the time between x and y.

- Wait Time: We determine this from the time the call goes through to the IVR or the caller opts out to get a CCS. Refer to “Avg Wait” on the Medicaid Volume Report. This is the average time in seconds that a caller waited on the queue before a Customer Care Specialist answered the call.
- Abandonment rate: The abandonment rate is determined as follows: total calls disconnected/abandoned before a CCS receives it (ABA) divided by total number of calls offered (Offered). Refer to “ABA %” on the Medicaid Volume Report.
- Blocked Call Rate: The Medicaid Customer Care phone system does not block calls at any time.

Customer Care’s minimum expectation for the overall quality performance score is 95%. The Medicaid Quality Summary Report is tracked at an individual level, which then rolls up into a Call Center Overall Monthly Summary Report. The Medicaid Quality Summary form is both the template and the report.

- On a daily basis, a Quality Associate (QA) pulls call recordings for a specified number of CCS’s for a total of 5 observations per associate per month.
- A quality audit is completed at the individual level (by associate).
- All individual quality audits are rolled-up together to produce the Medicaid Monthly Quality Summary Report.
- Quality results are reported up to Senior Leadership (Service Operations Vice President and Senior VP & Chief Service & Information Officer) on a weekly basis for their review, comments, and feedback to the directors of the Customer Care operational area.

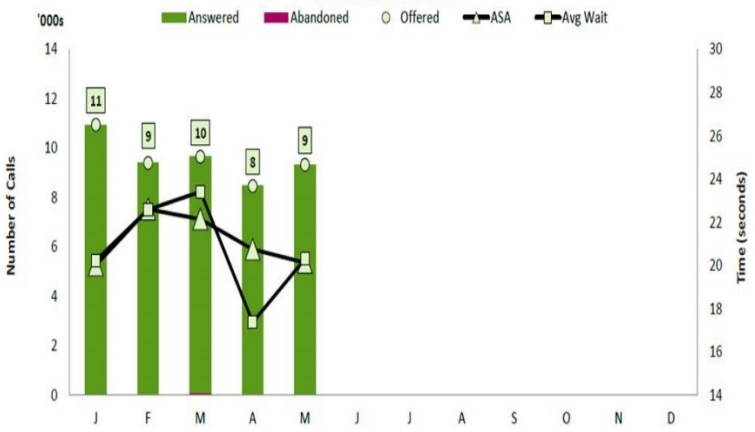
Clinical Access Team (CAT) - Humana has a Clinical Access Team (CAT) that facilitates access to care when we identify a clinical issue related to enrollee access. The CAT consists of three non-clinical specialists who process inbound calls and ten RNs who manage and resolve the cases. Issues may range from appointment availability to inability to locate a provider. Once an inquiry is received, a CAT associate will review and telephonically contact the enrollee or appointed representative to acknowledge receipt and to clarify the issue. The CAT associate may contact providers involved in the access issue to determine any extenuating circumstances, to offer assistance to possible barriers in resolving the issue, and to work with internal departments, such as Provider Relations, to facilitate a resolution. The CAT associate also provides guidance and education to promote better health outcomes for enrollees.

Performance Metrics

Here are the results of Humana’s customer service performance metrics as of May 2017, including Service Level and Abandon Rate, Contractual SLA Performance, and Enrollee Calls; as well as Clinical Access Team (CAT) results:

Medicaid Customer Service: Service Level and Abandon Rate

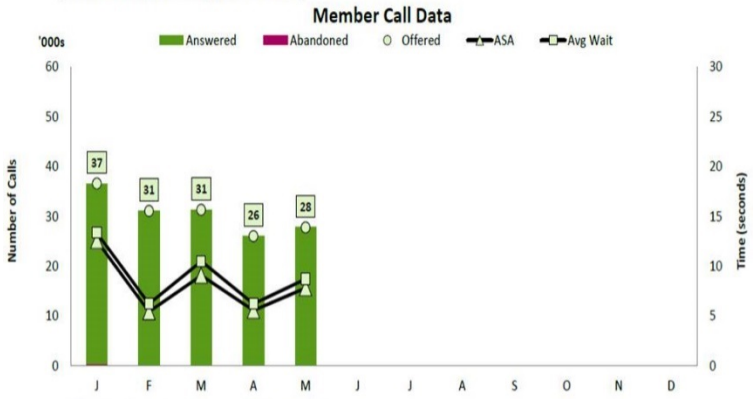
Florida - MMA - Regions 1 & 6:



Call Center - Contractual SLA Performance:

Metric/SLAs & Criteria (Member calls)	Dec	Jan	Feb	Mar	Apr	May
% Answered under 30 seconds	96.9%	90.5%	87.8%	89.1%	89.8%	90.3%
(ASA) is not to exceed 30 seconds	14	20	23	22	21	20
Average Call Blockage rate not to exceed .5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Call Abandonment rate not to exceed 3%	0.3%	0.6%	0.7%	0.9%	0.7%	0.6%

Florida - MMA - Regions 9 - 11:



Call Center - Contractual SLA Performance:

Metric/SLAs & Criteria (Member calls)	Dec	Jan	Feb	Mar	Apr	May
% Answered under 30 seconds	96.8%	90.8%	96.4%	95.2%	96.5%	95.2%
(ASA) is not to exceed 30 seconds	5	13	5	9	6	8
Average Call Blockage rate not to exceed .5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Call Abandonment rate not to exceed 3%	0.4%	0.9%	0.6%	0.8%	0.6%	0.7%

CAT Team Results

Over the past 12 months (7/2016 – 6/2017) with Key Performance Indicators (KPIs) for the commercial, Medicare and Medicaid population:

- Overall access cases: 99.2% compliant w/inquiry resolution & closure w/in 14 calendar days
- Overall service level (80% of calls answered within 30 seconds): 82%
- Overall abandonment rate (less than 5% of calls abandoned): 5%

At least monthly but as needed, the Plan reviews enrollee complaints from the CAT and other available sources to identify and trend complaints regarding access to care. We also monitor complaints received by our Critical Inquiry and Grievance and Appeals Departments on a monthly basis to identify and remedy access to care issues (see Table 4).

Table 4: Clinical Access Team and QI Access Complaints per 1000 Enrollees – 2016-2017

	Medicaid	
Time Period	**# of Complaints**	**Complaints/ 1000 enrollees**
2nd QTR 2016	3047	0.41
3rd QTR 2016	3049	0.41
4th QTR 2016	2390	0.32
1st QTR 2017	2588	0.35

Source: Clinical Access Team Reports and complaints received directly in market Network Administration and Quality Improvement

7. MAKING IT EASY TO DO BUSINESS WITH HUMANA

Humana strives to remove barriers and administrative burdens providers often face when working with Managed Care Organizations (MCOs). Humana's leadership team, including our local staff in Florida and our corporate staff in Kentucky, believe that in order to understand and adequately address the issues providers face, we must start with a strong provider engagement model, which is why we invest in efforts to partner with our providers and support them with the tools they need to succeed such as educational materials, face-to-face training, and claims resolution. We empower our providers to deliver a robust, high-quality, clinically integrated health care model to our Medicaid enrollees. Humana has a proven record of quality initiatives and successful enrollee outcomes since serving the Florida Medicaid population over the past 20 years. For example, Humana ranks second in NCQA Quality rankings amongst MMA Medicaid plans in Florida.

Our investment in staff and information systems technologies allows us to support our providers efficiently and cost- effectively. The support providers receive from Humana's provider relations team across our spectrum of products in Florida, which includes Medicaid, Medicare, and Commercial lines of business, enhances our connection to the provider community. Often when we bring on a provider for Medicaid services, they have already had exposure to Humana with other lines of business. This diversity gives Humana a larger volume of relationships with providers, more frequent interactions between our staff and provider staff, and fosters more sophisticated, aligned, performance-based financial arrangements aimed at improving quality outcomes while containing cost.

a. Gauging and Addressing Barriers to Providers

Humana's longstanding relationships with provider associations contribute to our ability to maintain engagement with providers. Our partnerships with physicians, hospital, long-term care, and ancillary provider associations allow for open and ongoing communication that allow us to gauge and address issues providers encounter while working with Humana. Provider associations are avenues for Humana to obtain feedback on opportunities for improvement from the provider community, as well as provide educational information and communications. Humana engages with provider associations through regularly scheduled conference calls and meetings, which Humana's senior leadership team frequently

attend. Association meetings are a particularly effective way to work with medical and long-term care providers on issues that are unique to these providers, such as Medicare crossover claim processes.

- A Humana leader was recently elected to the Florida Assisted Living Association (FALA) advisory board, as well as the advisory board to the Florida Area Agencies on Aging. This relationship has allowed Humana to play an instrumental role in improving coordination between various Councils on Aging.
- Humana's market director and national Medicaid director also meet monthly with Leading Age/ Florida Association of Homes for the Aging to work through open items, such as provider concerns, possible innovations to payment arrangements and stay updated with the Nursing Facility and Assisted Living Community.
- Humana leaders attend the annual Florida Hospice and Palliative Care Association (FHPCA) meeting, where we have developed an improved understanding and relationship of hospice providers. During the most recent meeting with FHPCA, we received positive feedback on our claims and referrals process. As a result of this meeting, we also recognized the need from hospice providers to better understand the coordination between medical and long-term care as it relates to claims, authorization, and enrollee responsibility. We are developing a quick reference guide for these providers.

b. Internal Engagement Support Model

Our provider relations staff meets on a bi-weekly basis to discuss trends, initiatives, and opportunities to train and educate front-line provider relations representatives. Educational opportunities include Medicaid-related topics such as AHCA alerts, fee schedule changes and agenda topics from AHCA monthly calls. This meeting is also used as a forum to discuss best practices and provider-specific challenges, such as OB/GYN, Ambulatory Surgery Center, Hospice, Home Health or Adult Day Care related. Additionally, provider relations staff meetings provide an opportunity for Humana's front-line Provider Relations Representatives to share the challenges our providers are experiencing with provider relations leadership. These meetings allow Humana provider relations leaders to obtain front-line information to inform the development of new educational materials or the presentation of an issue or concern to the Provider 360 Committee for consideration. See the visual representation of our provider engagement model below:

The diagram below conveys Humana's provider engagement model. Our model delivers cross-functional support to our providers to ensure we are aligned in achieving our mutual goal of improved quality outcomes for our enrollees through administrative simplicity, financial partnership, and provider satisfaction.

Beyond our established relationships with our providers, Humana is continually advancing our internal infrastructure to support provider engagement and satisfaction. Humana has established the Provider 360 Committee, a multifunctional team representing provider support areas which is chaired by Humana's Medicaid Market Vice President. The committee's objective is to review all functional areas to improve provider experience through review of provider metrics, identification of process improvement opportunities, and development of provider education initiatives and materials. The Committee has representation from:

- Market Executive Leadership
- Regulatory Compliance (MMA and LTC)
- Market Provider Relations/Contracting (MMA and LTC)
- Market Hospital Contracting
- Market Service Alignment Managers
- Provider Call center
- Provider Directory
- Claims Processing (MMA and LTC)
- Availity Liaison team
- eHUB team
- Physician Performance Management
- Market Quality Operations
- Market Clinical leaders
- Corporate Medicaid Implementation
- Critical Inquiry team
- Provider Communications

- QIC Committee

c. Simplify the Administrative Burdens

Humana's network is built on the evidence-based belief that quality of care, the patient centered medical home concept, preventative and early intervention, widespread access to contracted network providers, communicative provider and subcontractor partnerships that are based on mutual clinical goals and administrative simplicity, and widespread use of Electronic Health Records, are all now imperative in our healthcare delivery system, and a critical component of maximizing enrollee healthcare outcomes. With these fundamental concepts in mind, we work collaboratively with our external network provider partners and subcontractors and internally with our Medical Management, Medicaid Operations, Quality, Pharmacy, Customer Service, and Finance Departments. We make it easy for providers to find the materials they need by providing multiple sources for policies, training information, and Humana's internal systems. The following sections provide more details about our technology and informational resources.

d. Electronic Health Records (EHR)

Humana's ultimate goal of supporting our providers in delivering quality and appropriate care to our enrollees is supported by provider electronic health records (EHRs) and the Florida Health Information Exchange. Humana has a long history of investing in and promoting state of the art technology to facilitate timely and seamless transfer of information.

Humana has adopted various mechanisms to identify Florida providers who do and do not utilize EHRs, including:

- Conducting surveys of network providers
- Provider relations interaction with providers
- Assessing AHCA and CMS Eligible Professionals/Eligible Hospitals Info Links and the AHCA and CMS EMR List Links

Humana understands there are critical barriers to impacting EHR usage:

- High cost to implement EHR technology
- Strict maintenance/compliance requirements
- Administrative burden
- Understanding meaningful use

We educate our providers on the importance of using electronic health records and demonstrating meaningful use through the following mechanisms:

- Provider handbook
- Link to Florida Medicaid EHR Incentive Program website directly from Humana's provider Web portal
- Link to Florida's EHR and HIE newsletter, "Going Digital News Bytes" directly from
- Humana's provider Web portal

Since 2014 Humana has developed a strong data collection process in order to understand the network landscape relative to EHR usage. The table below shows year over year results from 2014 through 2015 and 2015 through 2016.

All Eligible EP & Hospitals 4th Qtr 2016-Full Dentist/Psych/all other spec-regions										
ALL SPEC/ALL LOCATIONS	DENOMINATOR	NUMERATOR	2016 4th Qtr	2016 3rd Qtr	*4q 2016 % of Improvement from 2015*	2015	2014	2015 % of Improvement from 2014	Goal	*4q diff from goal*
Region 1	2656	1456	54.82%	53.61%	*15.19%*	38.42%	34.10%	4.32%	55%	*0.18%*
Region 6	6229	2390	38.37%	34.27%	*9.79%*	24.49%	29.41%	-4.92%	60%	*21.63%*
Region 9	4153	1930	46.47%	46.14%	*11.65%*	34.49%	8.76%	25.73%	60%	*13.53%*
Region 10	3865	1488	38.50%	38.72%	*8.82%*	29.91%	10.10%	19.81%	50%	*11.50%*
Region 11	7928	2831	35.71%	35.73%	*11.97%*	23.75%	18.20%	5.55%	45%	*9.29%*
Total	24831	10095	40.65%	**39.42%**	***11.20%***	**28.23%**	-	-	-	-

Although Humana showed improvement of EHR usage throughout our provider network, in order to further bolster results Humana developed a one-page educational flyer to help providers better understand the importance of EHR and meaningful use. In addition, we developed a process improvement plan for 2017 through 2018 which includes the following steps:

- Provider Relations Representatives will deliver the EHR flyer to all PCP centers and OB/GYN offices during routine monthly visits
- Fax blast the EHR flyer to all other applicable provider types
- Ensure all subcontractors receive information from the flyer as an example of Humana's efforts and report back the results of their EHR outreach efforts for their downstream providers.

e. Assistance and Communication Tools Provided to the PCPs

Humana has developed an array of education and training materials for our providers. These tools allow providers to quickly find the answers they need so they can spend more time helping enrollees with their care.

Web-Based Tools

Humana offers providers a number of web-based business solutions to ensure they are able to interact with us on an optimum basis. Providers can access our portals, Humana.com and Availity.com, for services such as:

- Health and wellness programs
- Provider publications (including provider manuals)
- Provider training
- Quality resources
- Clinical practice guidelines
- Pharmacy services
- Claim resources
- Verification of enrollee eligibility and benefits
- View enrollee ID cards
- Review care alerts and enrollee summaries
- Submit referrals and preauthorization requests
- Send attachments (i.e. medical records)
- Check claims status and remittance information
- Access to the Medicaid Long Term Care Program information

Providers can obtain support from Humana for web based training and assistance through a variety of channels. During orientations and ongoing provider visits they may request their Provider Relations Representative assist with training, contact us via a dedicated email box or by at enrolling in one of our web based training sessions published on Humana.com.

Florida Medicaid Provider Manual

Humana's provider manual gives provider's information and guidance on a number of topics such as:

- Program Description
- Covered Services
- Emergency Service Responsibilities
- Child Health Checkups
- Provider Complaints
- Grievance System
- Chronic and Complex Conditions
- PCP and Other Provider/Subcontractor Responsibilities
- Telemedicine
- Delegation /Subcontractor Functions
- Florida Health Information Exchange
- Preauthorization and Referral Procedures
- Medical Record Requirements
- Claims and Encounter Submission Protocols and Standards
- Cultural Competency Plan
- Enrollee Rights and Responsibilities
- Fraud and Abuse Policy
- Health, Safety and Welfare
- Patient-Centered Medical Home (PCMH)
- Medicaid Advisory Panel
- Provider Rewards and Incentives (if applicable)
- Provider Resource Website
- Provider Training
- Availity
- Helpful Numbers

Quick Reference Guide

Providers and members of their office staff are provided a region specific Quick Reference Guide that is designed to assist them with information on daily topics like frequently called phone numbers, important addresses, vendor network contact information by specialty type, medically necessary services, expanded enrollee benefits, frequently used web addresses and a sample enrollee ID card.

We deliver Quick Reference Guides to providers during orientations and ongoing provider visits, and also make them available on our website.

Provider Newsletters

Humana publishes quarterly provider newsletters on its portal to assist providers with staying current with policy changes, quality initiatives, industry changes and medical protocols.

Additional Provider Reference Materials on the Web

Humana providers have access to a variety of tools on our website. The materials are current and up-to-date to allow providers to reference them on their schedule. Materials on the website include:

- Medicaid appendix to the provider manual
- Enrollee handbook
- Quick Reference Guide (including a version for assistive care services)
- Preauthorization and Notification List (PAL)
- Prescription Drug Guide
- Provider newsletters
- Compliance-based training modules and frequently asked questions and answers
- Obstetrician and gynecologists training
- Healthy Behaviors program including smoking cessation
- Quality resources such as information on child health check-ups, oral health for children and adolescents, prenatal and postpartum care for women and HEDIS measures overview
- Information on how to access our LTSS vendor portal
- Home Health Visit Information

Compliance-Based Training (All Provider Types – PCPs, Specialists, Subcontractors, Ancillaries and Hospitals)

Providers are expected to adhere to all training programs identified by our contract and Humana as compliance-based training. This includes agreement and assurance that all affiliated participating providers and staff members are trained on the identified compliance materials.

As part of the training requirements, providers must complete annual compliance training on the following topics:

- Medicaid Provider Orientation
- Compliance and Fraud, Waste and Abuse
- Cultural Competency
- Health, Safety and Welfare (Abuse, Neglect and Exploitation)

Providers and members of their office staff can access these online training modules seven days a week, 24 hours a day on both our website and Availity portal.

We strive to make it easy to do business with Humana. Through our meetings with providers and provider associations, we learn about and address the barriers providers face in their day-to-day activities. By hiring and promoting staff that dedicated to establishing a relationship with our providers, we ensure our providers are never without a support network. By pioneering simplicity, we allow our providers to spend more time focusing on our enrollees. Finally, Humana makes every effort to support and educate our providers so they can accomplish our common goal: providing quality care to our enrollees. That's also why we have established Quality Care Initiatives including efforts to better coordinate between departments and manage complex cases and diseases.

8. HUMANA'S QUALITY OF CARE INITIATIVES

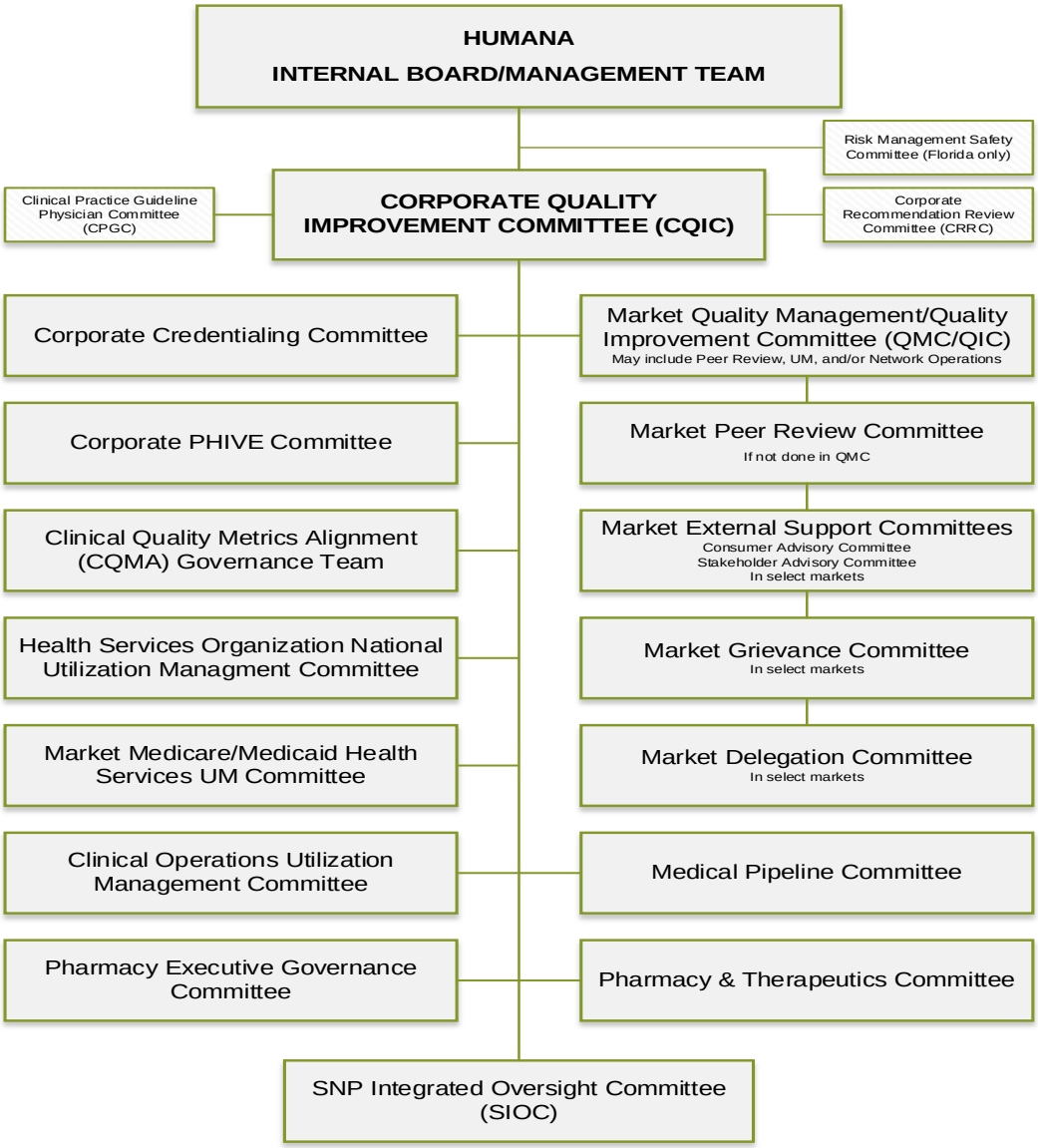
Humana serves its provider and enrollee population with a steadfast focus on improving outcomes, delivering exceptional access to care to enrollees, driving improvements in population health, all while reducing healthcare costs through well-being improvements. We do this through constant improvements to our internal processes, support mechanisms and ongoing initiatives including internal coordination across lines of business, and a strong focus on disease management and complex care.

a. Internal Department Coordination and Infrastructure

A solid infrastructure and dedicated leaders with quality improvement (QI) expertise ensure high quality comprehensive, coordinated healthcare to all enrollees. Humana's overall vision supports continuous quality improvement throughout the organization by a solid infrastructure and dedicated leaders with QIP expertise to ensure high quality, comprehensive and coordinated healthcare to all enrollees, across all plans. Corporate leadership on the Corporate Quality Improvement Committee, delegated by the Board of Directors, provides operational oversight for the QI program activities and recommends policy decisions by planning, analyzing and evaluating the activities. Quarterly and annually, the Quality Management Committee and the Florida Medicaid Quality Improvement Committee, report the Medicaid activity to include accomplishments, barriers and improvement initiatives.

The Internal Board/Executive Committee has ultimate responsibility for oversight of quality improvement activities. Members of the Internal Board/ Executive Committee include:

- President and Chief Executive Officer
- Executive Vice President and Chief Operating Officer
- Senior Vice President and Chief Medical Officer
- President, Employer Group Segment and Government
- President, Retail Segment
- President, Clinical Care Services
- President, Humana Pharmacy Solutions
- Senior Vice President and Chief Consumerism Officer
- Senior Vice President and Chief Strategy Officer
- Senior Vice President and Chief Human Resources Officer
- Senior Vice President and Chief Financial Officer
- Senior Vice President and Chief Innovation Officer
- Senior Vice President and Chief Information Officer
- Senior Vice President, Corporate Affairs
- Senior Vice President, Medicare Operations
- Senior Vice President and General Counsel



The Corporate Quality Improvement Committee (CQIC) oversees the quality improvement program, as delegated by the Internal Board/ Management Team. The Corporate Quality Improvement Committee's purpose is to use a centralized approach to the Quality Improvement program by forming one corporate committee that assumes the responsibility for the Quality Improvement Program of Humana. The CQIC is chaired by the Corporate Chief of Quality.

- The CQIC provides operational oversight for the Quality Improvement program activities and recommends policy decisions.
- The CQIC allocates a forum for members of the Committee to engage in review, coordination and direction of the Quality Improvement program.
- The Committee is charged with overseeing the establishment and integration of the Quality Improvement program and measurement of quality activities on a regular basis.
- The CQIC shall be comprised of voting members showcasing multi-specialty representation of the centralized and regionalized areas of operations. Voting members shall be stewards of

Humana's mission. Their recommendations are expected to be based on sound operational data, in support of member service, and the overall good of the markets serving Humana members.

The CQIC shall undertake the following functions and responsibilities:

- Oversee reporting of data from centralized/regionalized departments on a consistent basis, to include HEDIS improvement, CAHPS surveys, member satisfaction, disease management programs, appeals and grievances, credentialing, utilization management, member safety issues, customer service and many other quality and satisfaction metrics.
- Engage in discussion of such data with the representative and identify any opportunities for improvement.
- Improve communications between the markets and the centralized/regionalized operational areas and provide consistent reporting of data.
- Review, provide guidance and make recommendations concerning clinical guidelines, policies and procedures and Quality Improvement standards and related legal, regulatory and accreditation requirements.
- Provide guidance in defining the scope, objectives, activities and structure of Humana's Quality Improvement Program.
- Review ongoing reports from departmental quality improvement activities and determine the extent to which they meet standards and requirements, as defined in the Quality Improvement Program Description.
- Provide guidance to management teams and staff related to quality improvement priorities and projects to include Medicare Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs (CCIPs).
- Monitor organizational progress in meeting Quality Improvement Program goals and objectives as outlined in the Quality Improvement Work Plan and evaluate the overall effectiveness of QI Program on an annual basis.
- Review, approve and update, as indicated Quality Improvement Program Descriptions, Quality Improvement Annual Evaluations, and UM program documents on an annual basis.
- Review, prioritize and align the Quality Improvement Work Plan with the strategic objectives of the organization annually.
- Review and approval of Special Needs Plans (SNPs) Program Descriptions, Models of Care, and Models of Care Evaluations.

Members of the CQIC include, but are not limited to representatives from:

- Accreditation
- Appeals and Grievances
- Behavioral Health
- Claims
- Clinical Policy
- Clinical Programs
- Clinical Strategy
- Commercial Product UM
- Compliance
- Consumer Messaging
- Credentialing
- Customer Service

- Disease Management
- MHSO Product UM
- National Network Operations
- Pharmacy
- Provider Communications
- Provider Contracting
- Quality Operations, Compliance and Accreditation
- Risk Management
- Sales/National Accounts
- Specialty Benefits
- Stars, QRS and Medicaid Improvement

Behavioral Health Humana incorporates behavioral health aspects into the QI program. The Medical Director and Quality and Accreditation Director from the behavioral health provider are involved in the mental health aspects of the program which includes the management of substance abuse services. The Behavioral Health Medical Director, or designee, may participate and advise the Corporate Quality Improvement Committee on behavioral health issues. Monthly collaboration work groups are conducted between the delegated Managed Behavioral Health Organization (MBHO) and the Health Plan leadership.

Protected Health Information and Vendor Ethics (PHIVE) Committee is a corporate committee created to protect the privacy of Humana members and direct the ethical behavior of vendors. The PHIVE Committee reviews the handling of identifiable and de-identifiable member data and monitors interaction with vendors to promote the highest ethical standards. The PHIVE Committee meets monthly and reports to the CQIC. Members of the PHIVE Committee may include representatives from:

- Privacy Officer (chair)
- Pharmacy Solutions
- Physician Review
- Market Vice President
- Law Department
- Regulatory Implementation
- National Network Operations
- Technical Services Group
- Personal Nurse
- Insurance and Risk Management

Technology Assessment Forum (TAF) is chartered to create Humana Medical Coverage Policies for new and emerging technologies and to review existing policies on a regular basis. The committee's purpose is to verify that Medical Coverage Policies are evidence-based and facilitate consistency in clinical decision making, mitigate legal and financial risk, and support the goals of Humana to provide guidance to its consumers. Humana Medical Directors are the only voting members of this committee. The committee is chaired by the Medical Director for Clinical Policy Development or designee and meets at least quarterly. In addition to the voting Humana Medical Directors, members of TAF may include non-voting representation from:

- Claims Policy
- Clinical Claims Review
- Clinical Programs

- Customer Service
- Health Guidance Organization
- Humana Military Health Services
- Legal Department
- National Contracting
- Product Strategy
- Provider Contracting
- Additional representatives as appropriate

Following the TAF meetings, multiple departments are involved in implementation activities in an effort to ensure our prior authorization and claims systems and processes are congruent with our medical coverage policies. System and staffing impact decisions and timeframes are tracked through the Prior Authorization (PAL) Core team on SharePoint.

Medical Pipeline Committee is chartered to discover and research new and emerging medical technologies, with the purpose of developing a strategy, determining the expected financial impact around these new technologies, and distributing information to other departments throughout Humana. Medical technologies include, but are not limited to, medical devices, professional society recommendations, CMS coverage updates, and laboratory and genetic testing. The Medical Pipeline Committee currently refers information to the following departments: Technology Assessment Forum, Provider Contracting, Lab Pay Zero Initiative, Quality Operations Compliance and Accreditation, Pharmacy, Healthcare Economics, Claims, Provider Contracting, Product Development, and Medicare. The committee meets at least quarterly and publishes an update of activities that is distributed throughout the company. The Committee also issues alerts around technologies that may be of an urgent nature that may result in high utilization and/or high financial impact. Medical Pipeline Committee members may include representatives from:

- Clinical Policy Development
- Technology Assessment Forum
- Healthcare Economics
- Genetic Guidance Program
- Additional representatives as appropriate

Pharmacy and Therapeutics (P&T) Committee has a responsibility to review and make decisions about the appropriate use of drugs, biologicals, and select non-drug pharmacy-related products. The P&T Committee reviews policies that guide exceptions and other utilization management processes, including drug utilization review program, quality improvement program,, quantity limits, generic substitution, and therapeutic interchange. This charge may be relevant in many contexts including, but not limited to, clinical edits, drug utilization review, consumer programs, contracting, and networks. The Committee may render decisions through motions or may play an advisory role depending on the issue. Ultimately, the goal of the Committee is to confirm that proper decisions are made regarding drug access and the overall value of the benefit as it pertains to drugs, biologics, and select non-drug products.

- The co-chairs designate voting members of the P&T. Those persons utilized as consultants on various issues are considered non-voting. Other non-voting stakeholders for relevant agenda are invited at the discretion of P&T.
- Within the P&T Committee membership, there is at least one voting external physician member and at least one voting external pharmacist member who are experienced in geriatrics and/or

the care of disabled individuals. Neither may be employed by nor have any business interest in Humana.

- The P&T meets at least quarterly. Meetings are held via conference call.
- The voting members of the P&T Committee must be free of conflict of interest with any P&T agenda, and must state any new potential conflicts of interest prior to discussion. All voting members must also sign a statement of conflict of interest verifying either no conflict or disclosure of conflict, if it exists, at least annually. Any consideration of voting for members who have stated a conflict of interest will be made with consultation with the Humana Ethics and Compliance office prior to granting of such privilege.
- The P&T Committee reports up to the Vice President of Pharmacy through the governance structure.

Pharmacy Executive Governance Committee (EGC) The oversight authority of the Pharmacy QM Program is the Pharmacy Executive Governance Committee and consists of senior leaders within the company. The committee has the authority to make decisions and allocate resources for the Pharmacy QM Program. Additionally, the Pharmacy Executive Governance Committee defines the scope, objectives, activities, and structure of the QM Program. The Quality and Performance Improvement Program Description (QIPD) is reviewed by the Pharmacy Executive Governance Committee at least annually and updated as necessary. The QIPD is approved annually by the President, Humana Pharmacy Solutions; Director, Pharmacy Professional Practice and Clinical Operations; Director, Quality, Process, Learning, Accreditation and Policy; and Director, HPS Clinical Strategies.

Pharmacy Executive Governance Committee holds oversight of the quality-related programs and initiatives throughout Humana Pharmacy Solutions. It uses a centralized approach to monitoring and improving the process and outcomes for the varied areas that comprise Humana's Pharmacy Solutions program. The committee defines the scope, objectives, activities, and structure of the QM Program and provides operational oversight for the program activities and recommends policy decisions. The committee has the authority to make decisions and allocate resources for the QM Program.

The scope of the committee is to:

- Improve patient safety
- Impact value to customer, member, and health plan
- Enhance member, provider, and customer experience in relation to Pharmacy benefits
- Provide committee oversight of key Pharmacy processes and outcomes
- Discuss data, identifying barriers and opportunities for improvement
- Promote communication between operational areas and consistent trending and reporting of data
- Approve and update, annually, the Humana Pharmacy, Inc. Program and Evaluation
- Facilitate the integration of operational processes across the pharmacy
- Provide guidance to staff on quality management priorities and projects
- Monitor progress in meeting quality improvement goals and corrective actions
- Maintain approved minutes and other records of all committee meetings
- Monitor and enforce compliance with Accreditation Standards

Key functions of the EGC include:

- Allow committee representatives or their designees to report on quality performance of their respective areas
- Facilitate integration of operational processes across Humana Pharmacy Solutions by planning, analyzing, and evaluating quality improvement activities
- Promote objective and systematic monitoring and evaluation of consumer and client health services and facilitates compliance with regulatory requirements
- Provide status reports to the CQIC at least annually
- Meet at least once quarterly

Voting members are appointed by the Segment VP and President, Humana Pharmacy Solutions, and may include representatives from:

- Business Development
- Clinical Programs (Commercial and Medicare)
- Commercial Sales Segment Support
- Compliance
- Consumer Messaging
- Finance and Analytics
- Health Economics
- Human Resources
- Mail Order Pharmacy
- Specialty Pharmacy
- Pharmacy Professional Affairs
- Pharmacy & Therapeutics
- Pharmacy Contracting
- Pharmacy Networks
- Service Operations
- Environmental and Safety
- Quality, Process, Learning and Accreditation

Reporting Requirements for the PEGC include, but are not limited to:

- Accuracy
- Dispensing Accuracy
- Distribution Errors (External)
- Privacy Breach Metrics
- Call Quality
- Access to Service
- Prescription Turn Around Times
- Call Center Metrics
- Regulatory Compliance
- Satisfaction: Consumer and Client Pharmacy Networks
- Safety and Risk
- Risk Management

- Environmental and Associate Safety
- Quality Improvement Projects

The Member Safety Program is a component of Humana's Quality Improvement Program, which falls under the direction of the Corporate Quality Improvement Committee (CQIC), as delegated by Humana's Internal Board/Management team. The impact and effectiveness of the program is reviewed throughout the year by the CQIC according to the Quality Improvement Work Plan. The scope of the program includes all Humana members, providers, and associates unless noted otherwise.

The CQIC is in a unique position to not only review safety initiatives throughout Humana, but also to identify areas of priority focus for the company that aligns with national safety initiatives. Operational oversight of the Member Safety Program is within the scope of the Quality Operations, Compliance and Accreditation (QOCA) Department.
The Four Key Areas of Focus designated within the Humana Member Safety Program are as follows:

- 30-Day Readmissions
- Fall Prevention
- Medication Errors
- Inpatient and Surgical Complications
- Diagnostic/Therapy Radiological Services

Humana is actively involved in monitoring and improving safety by providing members with the tools and information necessary to decrease the likelihood of adverse events. Humana has developed a written Member Safety Program Description that is approved by the Corporate Quality Improvement Committee (CQIC). Member Safety reports quarterly to the CQIC to define and monitor safety initiatives which may vary with individual Markets.

Clinical Operations Utilization Management Committee provides oversight of clinical compliance activities impacting Clinical Operations. This committee supports more effective collaboration between leaders of all Clinical Services Programs performing utilization management and also includes representatives from Risk, Legal and Compliance.

The goal is to ensure a robust compliance committee via:

- Periodic meetings with key stakeholders to identify, discuss and mitigate risks related to utilization management;
- Creation of a forum to efficiently track key risk areas, providing an opportunity to brainstorm and discuss opportunities for improvement;
- Strengthening of the partnership/relationship between business operations and the Legal/Risk/Compliance;
- Monitor the performance of all delegated entities, including tracking and trending of data results over time
- Monitor deficiencies in the delegated entities' processes and to set priorities for corrective action plans in conjunction with the Delegation Compliance Department; and
- There will be standing agenda items as well as a running list of open issues and projects that will be developed to discuss updates/status.

The Committee conducts review and analysis of clinical compliance related metrics, nurse inter-rater reliability assessment activities, Corrective Action Plans (CAPs), regulatory updates, compliance

related process/workflow changes, and quality monitoring and evaluation of effectiveness of the program. The committee is responsible for identification of improvement opportunities and development of appropriate corrective actions and compliance improvement interventions. The Committee is co-chaired by the Corporate Commercial Compliance Manager and the Clinical Operations Compliance Manager and meets monthly. The committee reports to the Corporate Quality Improvement Committee. Members of the Committee may include:

- Corporate Commercial Compliance Manager (co-chair) and Director
- Corporate Medicare and Medicaid Compliance Managers
- Clinical Operations Compliance Manager (co-chair), Compliance Consultants and Compliance Analyst
- Corporate Director of UM, CM and Specialty CM Programs
- Directors of Clinical Intake, Clinical Claims Review and Case Management
- Clinical Operations Process Managers, Relationship Managers and Performance Managers, including leaders from Humana Behavioral Health, Clinical Access Team, Delegation, Transplant, Genetic Guidance, and Neonatal Intensive Care Programs
- Legal and Risk Representatives
- Clinical Learning and Development
- Continuous Improvement and Quality
- Clinical Policy Representatives and Senior Regional Medical Director
- Other support staff and guests as deemed necessary

Corporate Credentialing Committee is responsible for review and assessment of practitioners utilizing appropriate standards for credentialing, re-credentialing, and de-credentialing. Credentialing for the company occurs as a regional function in Cincinnati and Louisville. There is a Credentialing Committee in Louisville (which combines Cincinnati and Louisville credentialing activities), one in Florida and one in Puerto Rico. Credentialing and re-credentialing data are presented to the Corporate QIC.

Physicians and other healthcare professionals participate on the Credentialing Committee, but only physician members have voting privileges. The Credentialing Committee is chaired by a Humana Medical Director, or designee, and meets monthly.

Members of the Credentialing committee include representatives from:

- Humana Medical Director or designee (chair)
- Credentialing
- Practicing network physicians

Corporate Recommendation Review Committee (CRRC) makes the final decision for Humana regarding recommendations for provider terminations for quality of care, received through the peer review process. The CRRC may affirm, modify or reverse the recommendation, or remand the matter back to the peer review committee for additional evidence. The CRRC is chaired by the Corporate Chief of Quality, with the majority of members being physicians. Members may include:

- Corporate Chief of Quality
- Humana Medical Directors
- Director of Quality Operations Compliance and Accreditation
- Director of National Network Operations or Vice President of Provider Center of Excellence
- The CRRC reports up through the CQIC

Quality Management Committee (QMC) is responsible for reviewing and evaluating aspects of preventive and clinical care at the market level. The QMC is responsible for review of market specific preventive health and clinical study initiatives, and/or focused studies. Peer review functions may be handled in QMC or by a separate Peer Review Committee. The QMC is empowered to develop appropriate corrective actions and quality improvement interventions. A Humana Medical Director or a physician designee chairs the QMC, which includes physician members who are actively practicing in the provider network. The QMC meets at least bi-annually or as often as needed. Members of the QMC may include representatives from:

- Medical Director or physician designee (chair)
- Practicing Network Physicians
- Quality Operations, Compliance and Accreditation
- Clinical Programs
- Risk Management
- Additional representatives, as appropriate

Florida Medicaid Quality Improvement Committee The Florida Medicaid Quality Improvement Committee (FL MMA QIC) provides oversight of Quality Improvement program activities and clinical recommendations for the Florida Medicaid plan. The FL MMA QIC meets quarterly and reports to the Corporate Quality Improvement Committee through the legal entity report.

The FL MMA QIC is comprised of voting members showcasing multi-department representation of the centralized and regionalized areas of operations. Voting members shall be stewards of Humana's mission. Their recommendations are expected to be based on sound operational data, in support of member service, and the overall good of the markets serving Humana members.

The Florida Medicaid Medical Director serves as Chairperson and presides at meetings of the FL MMA QIC. In the Chairperson's absence, the Divisional Director of Quality Operations, Compliance and Accreditation or the Associate Medical Director may act as Chairperson. Voting members of the FL MMA QIC includes representatives from the following areas, but is not limited to:

- Director, Health Services Organization, Case Management/Disease Management
- Director, Health Services Organization, Utilization Management
- Director, Medicaid Network Development and Operations (CFL & NFL)
- Director, Medicaid Provider Relations (SFL)
- Executive Director, FL Medicaid
- Florida Medicaid Medical Director (Chair)
- Manager, Medicaid Quality, Quality Operations, Compliance and Accreditation
- Market Vice President, Senior Products
- Operations Director

Ad hoc, non-voting membership varies based on reporting cycles to the Committee and may include representatives from various departments, including but not limited to:

- Customer Service Coordinator
- Divisional Director, Quality Operations, Compliance and Accreditation
- Manager, Medicaid Enrollee Program

- Market Director, Performance Improvement
- Market Director, Quality Improvement
- Market Manager, Finance
- Market Manager, Pharmacy
- Market Manager, Risk Management
- Market Risk Advisor, Compliance
- Process Consultant, Grievances & Appeals
- Representation from Medicaid partner, Health Choice

Peer Review Committee (PRC) is responsible for reviewing potential quality of care issues, determining the severity of the issue, and recommending quality improvements or corrective actions as appropriate. The PRC is responsible for development of individual provider quality improvement plans, where indicated, and review of progress toward resolution. Physicians and other healthcare professionals participate on the PRC, but only physician members have voting privileges. The PRC is chaired by a Humana Medical Director, or physician designee, and meets as needed to complete timely review of clinical quality concerns. The Peer Review Committee may function as a separate committee or within the Quality Management Committee at a market, regional or divisional level. The PRC reports to the local Market Quality Management Committee. Members of the Peer Review Committee may include representatives from:

- Humana Medical Director or designee
- Practicing network physicians: primary care and specialties
- Quality Operations, Compliance and Accreditation Divisional director and/or manager and support staff
- Additional representatives as appropriate

Delegation Committee is held at the market level with local delegation committees in Florida, Illinois, California, and the Southeast Region. In addition, the Health Services Organization reports to the CQIC on the delegated IPA/MSO utilization metrics for the following HSO Delegation Regions: California, Intermountain, Desert pacific, Central, Texas, Gulf States, North FL, Central FL, South FL, Southeast, and Great Lakes.

The Delegation Committee is responsible for coordination and review of Market delegated activities related to quality management or improvement, credentialing, claims payment, member rights and responsibilities, and/or utilization as appropriate. Responsibilities of the Delegation Committee include review and approval of reports from delegated entities and recommendations for corrective actions as necessary. The Delegation Committee meets at least quarterly and is chaired by a Market Senior Executive. The Delegation Committee may be combined with the Quality Management, Utilization Management, or Service Committee in the local market office. All Delegation activities are reported annually through the Corporate QIC.

Members of the Delegation Committee may include:

- Market Senior Executive (chair)
- Humana Medical Director
- Representative, Network or Provider Relations
- Representative, Quality Operations, Compliance and Accreditation

- Representative, Utilization Management
- Representative, Customer Service
- Representative, Compliance
- Representative, Delegation Oversight

Clinical Operations Utilization Management Committee provides oversight of clinical compliance activities impacting Clinical Operations. This committee supports more effective collaboration between leaders of all Clinical Services Programs performing utilization management and also includes representatives from Risk, Legal and Compliance. The goal is to ensure a robust compliance committee via:

- Periodic meetings with key stakeholders to identify, discuss, and mitigate risks related to utilization management
- Creates a forum to efficiently track key risk areas, providing an opportunity to brainstorm and discuss opportunities for improvement
- Strengthens the partnership/relationship between business operations and the Legal/Risk/Compliance
- Monitor the performance of all delegated entities, including tracking and trending of data results over time
- Monitor deficiencies in the delegated entities' processes and to set priorities for corrective action plans in conjunction with the Delegation Compliance Department
- There will be standing agenda items as well as a running list of open issues and projects that will be developed to discuss updates / status

The Committee conducts review and analysis of clinical compliance related metrics, nurse inter-rater reliability assessment activities, Corrective Action Plans (CAPs), regulatory updates, compliance related process/workflow changes, and quality monitoring and evaluation of effectiveness of the program. The committee is responsible for identification of improvement opportunities and development of appropriate corrective actions and compliance improvement interventions. The Committee is co-chaired by the Corporate Commercial Compliance Manager and the Clinical Operations Compliance Manager and meets regularly. The committee reports to the Corporate Quality Improvement Committee. Members of the Committee may include:

- Clinical Learning and Development
- Clinical Operations Compliance Manager (co-chair), Compliance Consultants and Compliance Analyst
- Clinical Operations Process Managers, Relationship Managers and Performance Managers, including leaders from Humana Behavioral Health, Clinical Access Team, Delegation, Transplant, Genetic Guidance, and Neonatal Intensive Care Programs
- Clinical Policy Representatives and Senior Regional Medical Director
- Continuous Improvement and Quality
- Corporate Commercial Compliance Manager (co-chair) and Director
- Corporate Director of UM, CM and Specialty CM Programs
- Corporate Medicare and Medicaid Compliance Managers
- Directors of Clinical Intake, Clinical Claims Review and Case Management

- Legal and Risk Representatives
- Other support staff and guests as deemed necessary

Health Services Organization National Utilization Management Committee is charged with facilitating process for monitoring the care given by hospitals, skilled nursing facilities, home health and other ancillary services. The committee is responsible for reviewing utilization data and related statistics, identifying trends, and recommending improvement strategies. The National HSO Committee also reviews and approves the HSO Policies and Procedures on at least an annual basis and when needed as changes occur. The committee meets four times a year.

Committee responsibilities include:

- Annual approval of the HSO UM Program Description, UM Work Plan and UM Evaluation
- Approval of HSO UM and Medical Management Policies and Procedures
- Evaluation of the effectiveness of, and identification of barriers to, HSO UM and CM activities
- Facilitation of a process for ongoing analysis of HSO utilization and trend data to identify outliers and create improvement plans to address appropriate utilization: This is accomplished through the monthly UM Metrics meeting, Medicare and Medicaid Trend meetings and the Model of Care operational reporting meetings where utilization trends and process compliance by division, region and product are reviewed and analyzed.
- Performance monitoring of all delegated entities, including tracking and trending of data results over time
- Monitoring deficiencies in the delegated entities' processes and setting priorities for corrective action plans in conjunction with the Delegation Compliance Department

Reporting Structure

- A National HSO UM Committee representative reports to the Corporate QIC annually. Recommendations and actions are communicated to appropriate committees and individuals, as well as to delegated entities, by means of memos and reports.

Membership and Voting

All committee members have voting privileges, with decisions made by a majority vote.

- HSO Chief Medical Officer, Chair Person
- Corporate HSO Staff
- Regional Medicare and Medicaid Health Services Medical Directors
- Regional Medicare and Medicaid Health Services Directors
- Regional Medicare and Medicaid Health Services Managers
- Behavioral Health Representatives

Risk Management/Safety Committee has oversight of the Risk Management Program and identifies corrective measures needed to eliminate or control recognized safety and health hazards and to recommend improvements. It acts on referrals for risk issues generated both internally and

externally. The Manager of Risk Management is the Chair of the Risk Management Committee, which meets a minimum of three times a year, or more frequently as needed. The committee reports quarterly to the Humana Internal Board/ Executive Committee. Members of the Risk Management/Safety Committee may include representatives from:

- Quality Operations, Compliance and Accreditation
- Health Services
- Workplace Solutions
- Humana Resources

Provider 360 Committee - Humana has a cross-functional Provider 360 Committee, chaired by the Medicaid Market President, with a goal to continuously identify opportunities to improve provider experience with Humana. Participants from various departments, including Provider Relations, Claims, Care Coordination, Grievance and Appeals, and Customer Service review various trends and data to understand concerns from providers and design initiatives to proactively address concerns. The Committee meets monthly and produces reports for the Quality Management Committee's review.

b. Disease/Complex Case Management

Disease Management

Humana's Disease Management Program is an enrollee-focused program where nurses help enrollees learn how to control their disease by providing education, support, community resources, and communication with their doctor and other specialists.

Humana's Disease Management (DM) Case Manager is a licensed nurse with skills, to classify, assess, monitor, evaluate, instruct, intervene and document goals and outcomes for each enrollee in the following programs:

- Diabetes
- Congestive Heart Failure
- Hypertension
- Asthma (adult and pediatric)
- HIV/AIDS
- Sickle Cell Disease
- Cancer

The Disease Management Program provides services that include but are not limited to:

- Evaluating enrollee needs that can affect control of their disease such as physical limitations, emotional stress, transportation difficulties, and environmental needs.
- Creating individualized self-management goals based on Health history, psychosocial assessment, doctors' recommendations, and enrollee needs.
- Providing education on diagnosis and treatment.
- Referrals to other healthcare providers as needed.
- Enrollee and provider support regarding diagnosis, plan of care, and other health related concerns.
- Educating enrollees on recommended health checks.
- Educating and assisting enrollees on reaching disease specific diet and exercise goals.

The goals of the Medicaid Disease Management program are to:

- Improve enrollees understanding and assist self-management of their disease with education and support while following their doctors plan of care.
- Help the enrollee to reach and maintain optimal control of their disease or diseases.
- Increase awareness of the health risks associated with certain personal behaviors and lifestyles.
- Improve enrollees' understanding of the importance of seeing their doctor or specialists for regular visits.
- Help enrollees know who to call if there is an urgent situation and in an emergency.
- Find and obtain community-based resources that meet the enrollee's medical, psychological, and social needs.
- Evaluate results of the program on the health of enrollees who participate in the program.

Complex Case Management

Humana's Complex Case Management is a service provided to Medicaid enrollees by Humana nurses specially trained to focus on enrollees with complex medical needs. Case Management is designed to meet the medical and psychosocial needs of the enrollee and varies depending on situation and severity. Our clinical team works to pair enrollees with network providers that can best manage the unique and specific special needs of each enrollee. A multidisciplinary team approach is utilized to ensure the enrollee's needs are met and all efforts are made to improve and optimize his/her overall health and well-being. A team of Physicians, Social Workers, and Community Services Partners are on hand to help make sure enrollees' needs are met and all efforts are made to improve and optimize their overall health and well-being. The case management program is optional.

9. CONTINOUS IMPROVEMENT THROUGH ONGOING EVALUATION

Built on partnership and toward a common goal of delivering quality care, Humana's provider engagement model is the basis of our provider retention efforts and a significant differentiator of our network management strategy. It is critical that we evaluate provider satisfaction and quality to monitor for opportunities to continuously improve. As a measure of provider satisfaction, Humana regularly monitors provider termination rate, which is less than 1% month over month. Humana also performs an annual provider satisfaction survey in all contracted Regions we operate in accordance with AHCA-contractual requirements.

Coordination and communication within and outside the system, with fellow providers as well as outside organizations are critical. Humana helps facilitate these opportunities for updates, education on changes, and ongoing enrollee quality of care. Given our operational presence in Florida, Humana's robust local leadership team has also established strong relationships with our providers, and regularly attends meetings to discuss new initiatives and opportunities to reach our common goals. These interactions help support providers, identify their needs, remove barriers, and maintain satisfaction within the provider community while making it easier to achieve our common goal.

a. Provider Satisfaction Survey, Methodology and Results

The Provider Relations team conducts an annual provider satisfaction survey in all of our contracted regions in accordance with contractual obligations and State approved sample methodology and

metrics. The survey enables Humana to evaluate and measure satisfaction across the following service metric areas: provider relations and communication, clinical management processes, authorization processes including denials and appeals, timeliness of claims payment and assistance with claims processing, complaint resolution process and care coordination/case management support. Since our provider satisfaction survey conveys valuable insight to the provider experience with Humana, we have taken steps to increase provider participation in responding to the survey. In 2015 we experienced a 15 percent response rate, which increased to 17 percent in 2016. Most recently in 2017, the rate increased to 30 percent.

Humana has received positive feedback in our provider satisfaction survey regarding our provider engagement model. For example in 2017, 99 percent of MMA respondents said their Provider Relations Representative was able to answer all of their questions and was professional and courteous. Additionally, 98 percent of respondents said the educational and training materials are easy to understand.

Humana uses a vendor, Talk2Rep, to make calls to designated provider offices with State-approved scripting. Surveys are conducted using a four-point Likert scale for the Primary care provider locations with the top 40 percent of total enrollees, and specialist locations with top 40 percent of highest claim volume. We then tabulate, analyze and evaluate survey results to identify opportunities for improvement and develop action plans based on identified service categories with highest overall "disagree/strongly disagree" responses.

Below is a snapshot of results of Humana's 2017 provider satisfaction survey, including survey sample size by provider type, number of successfully completed surveys and top five areas of strength:

Total Sample Size (all regions)	**224**
Total Primary Care Provider Locations	**77**
Total Specialist Provider Locations	**147**
Total Surveys Completed (all regions)	**68**
Primary Care Provider Locations	**19**
Specialist Provider Locations	**49**

Top 5 highest overall agree/strongly agree responses - areas of strength

Provider Relations and Communications	
Question(s):	
1b. My provider relations representative is: Able to answer my questions	99%
1d. My provider relations representative is: Professional and courteous	99%
3. Educational and training materials are easy to understand.	98%
Care Coordination and Authorizations	
Question:	
10. Denial notifications, including the denial reason(s), are provided in a timely manner.	100%
Clinical Management	
Question:	
20. Case managers are knowledgeable, professional and courteous.	100%

Top 5 highest overall disagree/strongly disagree responses - areas of potential opportunity	
Provider Relations and Communications	
Question:	
4b. In the last 12 months: I participated in an in-office visit from a Humana representative.	28%
Complaint and Appeals Resolution Process	
Question(s):	
15. I have filed a complaint/grievance or appeal and found the process easy to follow.	25%
16. The provider grievance process is effective.	24%
17. Overall, I am satisfied with the provider complaint, grievances and appeals process.	23%
19. My complaint was resolved without having to make multiple inquiries.	32%

Humana's 2017 provider satisfaction survey results were transmitted to The Agency for Health Care Administration on July 1, 2017.

b. Provider Quality

Humana strives to build strong partnerships between our PCPs and high-volume specialists and our Humana provider engagement team. Each has an assigned Humana Quality Improvement Nurse and a Provider Relations Representative, who visit PCPs on a monthly basis and high-volume specialists on a quarterly basis to provide training, education, gaps in care for enrollees, and utilization data. This frequent interaction not only supports our providers, but it also informs us of any trends or issues our providers are facing, as the model is designed to support them wherever they need it. We understand providers have the front-line interaction with our enrollees, and it is critical to engage with them throughout their experience with Humana.

Humana offers a comprehensive set of tools and resources for our providers to achieve success in accomplishing the Agency's goals of enhanced access, integrated and coordinated care, and improving the quality of care to our enrollees. We provide these tools on a regular basis to ensure that provider performance and quality metrics are transparent to providers:

- Quality Improvement Nurses
- Service Fund Data Analytics
- CareHub Clinical Guidance Exchange
- Humana's Monthly HEDIS Package
- PCP Reports (monthly, quarterly)

Quality Improvement Nurses

Humana has a provider liaison position called a Quality Improvement Nurse to assist providers in improving overall health outcomes and reducing potentially preventable events. We fill these positions with registered nurses who have a clinical background to facilitate and coordinate care between enrollees and providers. Quality Improvement Nurses are geographically assigned and meet with PCPs on a quarterly basis, regardless of whether the provider is alternative payment method, to analyze and close enrollee care gaps, facilitate education, manage medical costs, and document and improve coding accuracy. During the meeting with the PCP, Quality Improvement Nurses may develop a tailored plan of how to best support the provider in improving enrollee care.

Service Fund Data Analytics

Humana developed the proprietary Service Fund risk sharing management application for providers engaged in a risk or capitated arrangement. We use this innovative tool to calculate reimbursements to providers in these arrangements by tracking and aggregating information on capitation payments, claims expensing, claims payment, reconciliation, and settlement for all PCP contacts.

On a monthly basis, Service Fund makes data files available containing information regarding provider membership, funding, claims activity, progress toward value-based payments, and capitation payments at an individual provider level and at a group level. Humana tailors the reports to providers in risk or value-based arrangements. They are available for provider access through an online portal as well as through our Provider Relations representatives. Additionally, Humana educates providers using Service Fund by walking through standard reports during initial trainings to show the data to which they have access and how to use it to help manage their providers and financials. Provider Relations Representatives meet with PCPs monthly to review the Service Fund reports and to discuss any issues or barriers they may be facing.

CareHub Clinical Guidance Exchange

Our CareHub Clinical Guidance Exchange (CGX) system generates Care Alerts we distribute to our providers. These Care Alerts consist of evidence-based medicine care gaps and drug-to-drug/disease interaction alerts. By promoting awareness and closure of these gaps, we help our providers improve the care they deliver.

Humana's Monthly HEDIS Package

To help PCPs better manage the care of their enrollees, we provide a package of monthly HEDIS reports to every PCP. These reports capture preventable events among enrollees, gaps in care, and high utilizers of pharmaceuticals. In addition, practices can view their performance on HEDIS indicators to see how their performance compares with other providers in their region. We package this information in an actionable manner, providing call lists with the contact information for enrollees who have care gaps and a list of recommended actions for enrollees who are non-compliant with preventive care screening and/or disease management visits. Additionally, the QIN may work with the provider to develop initiatives around the care gaps and work with providers to close them

PCP Reports (Monthly, Quarterly)

Humana provides PCPs with a monthly report indicating which of their Humana enrollees have care gaps. These reports will also identify enrollees on their patient panel with potentially preventable hospital admissions and/or avoidable use of the emergency department. Our providers and their staff use these reports to reach out to enrollees and address the care gaps, as well as any identified preventative services. They may also schedule any needed appointments and make referrals to specialists.

c. Coordination of Relationships among Various Levels of the System

Joint Operations Committee Meetings

Humana utilizes Joint Operation Committee (JOC) meetings as a mechanism to meet face to face with providers to discuss and resolve issues or concerns. JOC meetings also allow Humana to use these forums as an opportunity to provide updates on contractual and program changes or offer technical

assistance. JOC meetings may be scheduled monthly, every other month, or quarterly depending on the needs of the provider network or Humana.

Medicaid Quality Work Group

The Medicaid Quality Work Group comprises representatives from various disciplines throughout the organization. Participants include representatives from Medicaid Administration, Provider Contracting, Health Services, Quality Improvement, and Quality Operations Compliance and Accreditation. Its goal is to evaluate plan performance related to services our Medicaid population receives. This group also focuses on developing appropriate enrollee and provider-focused interventions and evaluation of the implemented interventions. The work group is responsible for:

- Ongoing monitoring of HEDIS results and development, implementation, and monitoring of Florida Medicaid specific interventions.
- Organizing and collaborating on the development of an enrollee newsletter. The Work Group provides feedback on topics appropriate for the newsletter to encourage enrollees' healthy behaviors and active participation in health care.
- Provider target reports identifying enrollees with chronic conditions (e.g., diabetes, hypertension) as well as preventive and wellness visits shared with providers to assist providers in reaching out to enrollees needing care.
- Outreach, new enrollee welcome calls, and birthday wellness calls completed by the Medicaid Administration department. These calls encourage enrollees to visit their PCP routinely and participate in valuable screening activities.
- Ongoing collaboration with the Medicaid dental vendor, DentaQuest, as discussed at Work Group meetings. Recommendations from the Work Group are shared with the DentaQuest team.
- Enhanced follow-up process of postpartum women through the 8-week postpartum period.

Provider-to-Provider coordination

Humana emphasizes strong collaboration between the health plan, PCPs, and specialists for medical cost control, network development, data/information needs, and provider education. We encourage Florida PCPs to form their own "sub-network" of preferred facilities and specialists. This enables the PCP to develop critical relationships with the specialists, optimize communication and information sharing between the PCP and specialist, and ensure that enrollees receive quality, coordinated, and medically-necessary services.

Humana provides case management support to persons with one or more conditions that create a sufficient level of health status impairment or risk. For persons receiving case management support, we develop an individualized treatment plan that addresses all known health conditions, and coordination between co-occurring conditions. We share this individualized plan with the enrollee, the caregiver, the PCP, and with specialist providers who play a central role in treating one or more of the enrollee's key disorders. During the assessment process, the enrollee identifies those people essential to their health care. The case manager enlists and solicits the active participation of all appropriate stakeholders, including caregivers, providers, and community agencies to promote communication between the provider(s) and to facilitate coordination of services as necessary based upon the care plan and the needs of the enrollee. Methods to obtain input from these stakeholders regarding evaluation, problem identification and treatment recommendation may include telephone interaction, email, online communication through our Web portal, and potentially face-to-face meetings.

Humana's subcontractors such as Beacon, DentaQuest, One Homecare, and Logisticare attend Humana-sponsored Town Hall meetings with our network providers to answer questions and strengthen the partnership. Additionally, Humana facilitates in-service trainings between our contracted Hospitals, PCPs, MSOs, and our subcontractors to educate on their programs. In addition, the subcontractors attend monthly JOC meetings with Humana and the MSOs throughout the State, and hold webinar trainings for PCPs to educate them on their various programs.

Cross-Functional Provider Communications

- Provider Relations Representatives serve as the liaison between Humana and providers. The Provider Relations Representative works collaboratively with Humana departments and our network of primary care physicians, specialty care and ancillary providers, and facilities. Daily interactions between the Contracting Representatives, Medical Services, Claims, Customer Services and Finance Departments and the development of these interdepartmental relationships are critical to ensure effective coordination and communication when contracting with new vendors or transitioning services.
- Provider Call Center – Our provider Call Center is staffed with experienced provider representatives responsible for answering questions and participating in the sharing of information related to their practice and enrollee services.
- Provider Orientation – All contracted providers receive a Humana provider orientation within 30 days of their effective date into the network.
- Ongoing provider education visits – Contracted PCPs and SPCs will receive an educational visit from a Humana Representative no less than quarterly, or more often if needed. This includes face-to-face visits, telephonic, virtual webinars, or group sessions
- Joint Operating Committee (JOC) – As mentioned above, we schedule JOC meetings are scheduled monthly with large health systems to share medical information related to quality and protocols, training, and issue resolution.
- Newsletters – Newsletters are generated quarterly with information pertaining to policy changes, quality, industry changes, and medical protocols.
- Provider Manuals – These manuals contain information necessary for a provider to be successful. After a provider executes an agreement with us, we schedule an orientation session to review the manual contents as well as any other information related to our health plan.
- Provider Website – The Provider Website represents another means to obtain important, real time information about our operations. Newsletters, policies, medical protocols, claims, quality, and a multitude of other information are available to the provider through the portal.
- Webinars – The Provider Relations team hosts periodic webinars on various topics to ensure providers have access to updated Medicaid polices and requirements. Topics covered include but not limited to, claims processing, encounter submissions, Continuity of Care, Dual-eligible enrollees, Referrals and Authorizations, Contracting and Credentialing processes.
- Medicaid Advisory Panel – The Medicaid Advisory Panel identifies and reviews provider concerns and makes advisory recommendations to Humana. Humana may also make requests of the Medicaid Advisory Panel to provide feedback and recommendations on topics which will affect Medicaid enrollees. The Panel membership includes network providers, community leaders, and representatives from the various health plan disciplines.

d. Coordination with Outside Organizations

Humana recognizes the need for effective communication and coordination as a key to quality care and service excellence. We participate in and partners with national organizations, thereby keeping channels of communication open and furthering the delivery of high quality, comprehensive healthcare to all enrollees. Participation in national accrediting bodies affords input into policy-making and enhances the goal of increasing the quality of healthcare. Humana is certified by the Committee on Operating Rules for Information Exchange (CORE), which is an initiative by a non-profit alliance of health plans, networks, and trade associations to simplify healthcare administration. CORE certification ensures providers get consistent, uniform information thereby improving the quality of interaction with Humana.

Examples of national organizations Humana collaborates with include:

- National Quality Forum (NQF)
- American Health Insurance Plans (AHIP)
- National Council on Aging (NCOA) – falls pilot with the Centers for Disease Control
- National Committee for Quality Assurance (NCQA) – Health Plan Advisory Council participation
- Centers for Medicare and Medicaid Services (CMS)
- Utilization Review Accreditation Commission (URAC) – Board of Director membership
- Department of Health and Human Services (HHS) - Partnership for Patients Initiative and Million Hearts Campaign

Examples of Florida organizations Humana collaborates with include:

- Florida Assisted Living Association (FALA)
- Florida Health Care Association(FHCA)
- Florida Council on Aging (FCOA)
- Home Care Association of Florida (HCAF)
- Florida Gerontological Advanced Practice Nurses Association (FGAPNA) (Aging Life Care Association)
- The Florida Geriatric Care Managers Association (FGCMA)
- Leading Age Florida
- Florida Medical Directors Association (FMDA)
- Florida Association Directors of Nursing Administration/LTC (FADONA) Florida Health Care Social Workers Association (FHCSWA)
- Florida Association of Health Plans (FAHP)
- Alzheimer's Association
- Florida Alcohol and Drug Abuse Association (FADAA)
- Florida Council for Community Mental Health (FCCMH)
- Florida Medical Association
- Florida State Guardianship Association
- Florida Alliance of Home Care Services (FAHCS)
- Alliance for Aging
- Aging & Disability Resource Center (ADRC)
- Northwest Florida Area Agency on Aging, Inc.

Healthy Start

The Healthy Start program includes targeted support services that address identified risks. The range of free and voluntary Healthy Start services available to pregnant women, infants and children up to age three include:

- Childbirth, breastfeeding and car seat education classes
- Comprehensive assessment of service needs in light of family and community resources

- Home visits to provide education and support for breastfeeding, baby weight checks, parenting, immunization information and safe sleep
- Ongoing coordination to assure access to needed services and support to help families attain their goals
- Developmental screening, psychosocial assessments, nutritional education, smoking cessation counseling or referrals as needed

Humana will refer members to Healthy Start for these services when identified utilizing the Healthy Start Assessment Tool. The tool is used to determine eligibility for enrollment in Healthy Start's Care Coordination Program and is completed by their obstetrician at the initial visit. Eligibility is based on identified risk factors that may affect the health of the pregnancy. The goal of the program is to mitigate those risk factors. Members are automatically eligible when they exhibit one of the criteria that makes them automatically eligible, regardless of the Assessment Tool score (i.e.: homelessness, history of abuse, etc.).

In addition, Humana is working with Healthy Start on a contract that will include case finding services in which Healthy Start will attempt a home visit for members we are unable to locate.

Medicaid Advisory Panel

Community organizations and other agencies provide essential services, programs, and resources to qualified enrollees to support their quality of life and optimal well-being. To ensure that we address the needs of enrollees and identify any opportunities for improvement, Humana has developed a Medicaid Advisory Panel composed of providers including medical service organizations and hospital corporations, non-profit organizations and community agencies that serve the Medicaid population.

The Panel's purpose is to provide a forum for Humana management, leaders in community organizations, and senior hospital and medical service organization administrators to better understand the needs of our enrollees and our Plan requirements by identifying issues and concerns and providing feedback. The Panel obtains input from subject matter experts on our initiatives and strives to develop methods that we can use to better serve our enrollees. Creating new ways to approach universal challenges will lead to pilot projects, which the committee will track. This exchange of ideas allows the Plan to improve processes and develop methods to overcome challenges that we face in serving our enrollees.

There will be representatives on the Panel from various stakeholders (see below) who will be permanent enrollees. The panel will be driven topically per the consensus of the permanent enrollees. Each meeting will concentrate on one topic of interest to enrollees and/or providers. Guests may be invited as subject matter experts to speak to the topic being discussed at the meeting.

1. Network hospital corporations
2. Network medical service organizations
3. Non-profit organizations
4. Community agencies
5. Humana Medicaid administrative leadership

e. Subcontractor and Vendor Oversight Compliance

Humana partners with subcontractors to provide health care services to enrollees. To ensure that each subcontractor adheres and exceeds the requirements, Humana has implemented a rigorous oversight

program with corporate and market based teams responsible for the subcontractors' performance. We will continue to be compliant with AHCA's requirements around subcontractor monitoring and policies. Humana's Delegated Vendor Performance Oversight team (DVPO) is dedicated to monitoring and overseeing functions delegated to subcontractors. Delegation of Network Management responsibilities includes the following:

- All subcontracts that meet the Network Management Delegation definition shall have an executed and AHCA approved Network Delegation Amendment.
- Monitor compliance, network adequacy, and quality by monthly/quarterly reports and annual audits to include:
    - Policy and procedures
    - Provider Network Report of all provider groups, individual physician practices and sites in its network are not accepting new Medicaid enrollees
    - Availability of Providers providing Specialty Care services, including number and geographic distributions
    - Access to appointments
    - Opportunities to improve access for enrollees
    - Identified problems and corrective actions initiated and outcomes
- Implement Corrective Action Plans and monitor adherence to written subcontractors agreed upon process to correct noncompliance. As required, impose provider capitation payment penalties for outstanding corrective action plan issues, restriction, suspensions and/or terminations.

All subcontractors' performance and issues are presented to the Delegated Vendor Oversight Committee DVOC for review and approval of necessary interventions and corrective actions plans in the event of subcontractors' non-compliance with the contractual provisions and service level agreements (SLAs). The oversight of subcontractors is performed by three entities, as described below.

- Market-based Delegate Relationship Managers (DRMs) – front line of Humana associates who work closely with the subcontractors. They are responsible for the due diligence of subcontractors and consistent oversight of operational performance according to the contract and SLAs. They hold joint operational meetings, which are designed to review past month's subcontractor performance with comparison to SLAs and contract provisions. The meetings are led by the DRM and attended by the Director of Oversight Vendor Performance. In addition, the Director of Oversight Vendor Performance holds monthly operational meetings with all DRMs to review subcontractors' performance, identify opportunities for improvement, develop corrective interventions and follow up on progress.
- Corporate Delegation Compliance – responsible for pre-delegation, annual and ad hoc audits of subcontractors. The audits are performed in accordance with the contractual provisions, NCQA Standards and SLAs. The audit results are presented to the DVOC for recommendations of interventions as appropriate.
- Delegated Vendor Performance Oversight unit – comprised of a director and coordinator. The role of this unit include but is not limited to:
    - In conjunction with DRMs, facilitate the coordination of oversight and monitoring activities
    - Review operational performance of subcontractors for adherence to contract provisions and SLAs
    - In conjunction with the DRMs, develop interventions, corrective action plans as necessary to improve performance and subcontractors compliance

- Participate in joint operational meetings with subcontractors; review performance and recommend improvements
- Review for under/overutilization trends and address with subcontractors
- Work with subcontractors to participate in the support of Humana's goals to improve health care outcomes (HEDIS campaigns, Plan initiatives, integration and specialty programs,)
- Establish vendor specific performance goals based on enrollees health outcomes
- Work closely with the Network Contracting Directors to monitor for financial solvency for subcontractors with financial risk

Summary of subcontractors performance are presented at the DVOC which reports to Quality Improvement Committee.

SECTION II-HUMANA LONG-TERM CARE

1. Summary:

Humana Long Term Care (HLTC) has created and maintains this Network Development and Management Plan (NDMP) to ensure that all enrollees have appropriate access to cost effective medically necessary healthcare to avoid or delay nursing home placement when enrollees choose to remain in the community. In addition, it maintains a sufficient network to meet the needs of those that choose to reside in a nursing home.

We recognize that quality of care is imperative in our healthcare delivery system, and a critical component of maximizing enrollee healthcare outcomes. With this fundamental concept in mind, we work collaboratively with our Medical Management and Quality Departments to actively participate in ongoing network development activities that allow Humana HLTC to maintain a structure that fosters collaboration across all departments and increases effectiveness, efficiency and cost savings without compromising quality.

Throughout this document, HLTC illustrates and evaluates our goals, methodologies, and interventions. Methodologies used by HLTC allow us to assess geographically appropriate distribution of service providers, including, but not limited to: Home Health, Home Delivered Meals, Emergency Response, Adult day Health Care, Assisted Living and Nursing Homes for our membership.

Our commitment to excellence focuses on building and strengthening partnerships with our contracted providers and creating a culture of collaboration and innovation in identifying and implementing improved approaches to healthcare delivery. HLTC demonstrates within the Network Development and Management Plan that we monitor providers and other subcontractors to ensure that enrollees have a positive experience accessing their care.

The Network Development and Management Plan further outlines the current status of the Humana HLTC network and defines our future network needs. These needs are identified based on projected membership growth, including provider availability, membership medical needs and choice within the HLTC network. The Network Development and Management Plan estimates expected utilization based upon our mix of membership related to membership rate codes, geographic locations and specific individual needs. These are essential components of our Network Development Plan, allowing us to accurately anticipate and articulate future network needs and drive quality initiatives that promote our commitment to improved enrollee healthcare outcomes.

2. Introduction:

The Network Development and Management Plan (NDMP) for the Florida SMMC LTC is an annually updated tool to ensure that covered services are available and accessible in accordance with the access standards in the AHCA Contract with Plan and to meet the projected Plan enrollment levels for all 11 regions in the State of Florida.

When the Plan is establishing and maintaining the provider network, the Plan takes the following into consideration as required by 42 CFR 438.206:

a. The anticipated number of enrollees;

b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented;

c. The numbers and types (in terms of training, experience and specialization) of providers required to furnish the covered services;

d. The numbers of participating providers who are not accepting new enrollees;

e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees and whether the location provides physical access for Medicaid enrollees with disabilities
f. The quality rating of the provider.

3. Evaluation of the prior year's plan:

HLTC became a capitated plan in 2014and maintained the successful robust provider network it had in place during the fee-for-service program. Effective July 1, 2015, HLTC became one combined entity composed of both HLTC and Humana Comfort Choice operating under the new name of Humana HLTC. Humana HLTC successfully integrated both provider networks and maintained relationships with all providers in order to ensure continuity of care and access to care. During the period from July 1, 2015 through December 31, 2015, the former HLTC Provider Relations staff successfully contracted with over 250 providers that were servicing previous Humana Comfort Choice members. The addition of these additional providers resulted in an enhanced, robust network that successfully met the needs of our members through 2016 until the present.
All HLTC awarded regions had Nursing Home Diversion Waiver experience so the Providers, DOEA CARES, Community Based Organizations (CBO), and other stakeholders are familiar with the managed care concept of Home and Community Based Services (HCBS) as potential alternative to Skilled Nursing Facility (SNF) residency. We continue to strive to educate our providers while working in a partnership environment.
HLTC maintains a sufficient network and actively assesses the overall condition by provider type. The methodologies we utilize evaluate the condition of the network include review and analysis of the following: (a) how enrollees access the system, (b) all provider types by geographic area, (c) access to care for all various levels of providers and (d) quality rating of providers.
HLTC communicates to the provider network regarding changes in contractual and/or program policies and subcontractor requirements through on-site provider visits, meetings, phone, webinars and electronic communication and through informational faxes where we send out pertinent information to all providers as they are affected. HLTC is able to identify specific provider types and that enables us to communicate specific information to these specialties.
HLTC obtains data through a variety of mechanisms, including but not limited to Complaints, Grievance and Appeals, Operations Committee meetings and enrollee feedback. This information is used to evaluate the network and make necessary changes in order to meet AHCA guidelines and ensure access for our enrollees.
HLTC Care Managers and Provider Relations Specialists have in-person site visits to ensure outreach and communication to our provider network, review quality of care and enrollee satisfaction.

Our goals for the 2017-2018 plan year are:

1) Continue to work with AHCA and providers that need an enrolled or registered Medicaid number or specialty codes to obtain them and process their claims
2) Begin ranking providers on quality and efficiency ratings
3) Identify low performing providers in our network based on quality and efficiency ratings and move enrollees to high ranking providers where appropriate.
4) Consistently meet contractual network adequacy requirements and any additional access needs identified by our clinical and member support areas.
5) Expand the provider network to include specialty providers supporting members that are currently enrolled in the waiver programs that will be included in the LTC program (PAC, Brain and Spinal Cord Injury and Cystic Fibrosis).

4. 2017-2018 Humana Long Term Care Network Challenges

HLTC maintains a robust provider network throughout the state, meeting or exceeding contract requirements. The biggest challenge is satisfying home bases member needs in the rural areas of regions 1, 2 and 3. HLTC is taking an aggressive, innovative approach to meet these needs.

5. Availability and Accessibility for Covered Services:

HLTC ensures that they have the minimum of two providers for each type of service in each county in the state, except in some rural areas where providers do not exist. In areas where providers do not exist or refuse to be a participating provider, we have found alternative providers to serve enrollees in these areas. HLTC has obtained waivers from AHCA in these identified counties.
Most services provided under this plan are provided in the enrollee's home, and enrollees are not required to go to the location of the provider. Home and community based services are available on a seven (7) day a week basis, and for extended hours, as dictated by enrollee needs. Providers can provide services 24 hours/7 days a week when dictated by the members needs and authorized by the care manager. The largest percentage of the population resides in a nursing home or assisted living facility which provides all the services to the enrollee 24 hours a day. The exception is for enrollees attending Adult Day Health Care and Outpatient Therapy. HLTC provides transportation when needed to get to these locations. We ensure that these services are easily accessible and readily available to our members. Adult day cares do have a limited number of hours they are open for business. HLTC utilizes Assisted Living Facilities that are authorized to provide Adult Day Care Services in addition to free standing Adult Day Care Centers for this service to ensure that members have more options for geographic location as well as additional hours offered to them.
HLTC has determined that we currently have a robust network in non-rural counties, and have identified providers in neighboring counties to assist in the rural areas. This does result in an increased rate to provide incentives for providers to go to enrollees' homes in the rural areas. Thirty counties were identified as Rural on the Florida Rural Counties map at:
https://medicare.fcso.com/Rural_health/166451.pdf

6. Adult Companion Providers (See Homemaker & Companion Service Providers)

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
  - Licensed Provider Listing
  - Agencies that offer the same service
  - Providers that may make a longer ride than usual to service the area.
  - Health Care Services Pool for Temporary staff to existing network providers

- Longer-term interventions to fill network gaps and resolve barriers.
    - Engage existing Providers on capacity building
    - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

7. Adult Day Health Care Centers (ADCC)

- Enrollees access these services and providers through Plan Care Management authorization process.
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8. Adult Family-Care Homes (AFCH)

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  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

9. Assistive Care Service Providers (see AFCH)

10. Assisted Living Facilities (ALF)

- Enrollees access these services and providers through Plan Care Management authorization process.
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11. Attendant Care Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
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- Ongoing activities for network development include review of AHCA provider listing for new providers.
- Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

12. Behavior Management Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
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- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
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  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

13. Care Managers or Case Management Agency

- Enrollees access these services and providers through Plan Care Management authorization process.
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14. Home Adaptation Accessibility Providers

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15. Home Health Agencies (HHA)

- Enrollees access these services and providers through Plan Care Management authorization process.
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16. Homemaker and Companion Service Providers

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17. Hospices

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18. Medication Administration Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
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19. Medication Management Providers

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20. Medical Supplies Providers

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- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
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- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

21. Nursing Facilities

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
  - Licensed Provider Listing
  - Agencies that offer the same service
  - Providers that may make a longer ride than usual to service the area.
- Longer-term interventions to fill network gaps and resolve barriers.
  - Engage existing Providers on capacity building
  - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.

- Ongoing activities for network development include review of AHCA provider listing for new providers.
- Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

22. Nutritional Assessment and Risk Reduction Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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  - Licensed Provider Listing
  - Agencies that offer the same service
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- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

23. Personal Care Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.

- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
    - Licensed Provider Listing
    - Agencies that offer the same service
    - Providers that may make a longer ride than usual to service the area.
    - Health Care Services Pool for Temporary staff to existing network providers
- Longer-term interventions to fill network gaps and resolve barriers.
    - Engage existing Providers on capacity building
    - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

24. Personal Emergency Response System Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

25. Transportation Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
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    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

26. Therapy (Occupational) Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.

- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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    - Licensed Provider Listing
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    - Providers that may make a longer ride than usual to service the area.
    - Health Care Services Pool for Temporary staff to existing network providers
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- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

27. Therapy (Speech) Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.

- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
  - Licensed Provider Listing
  - Agencies that offer the same service
  - Providers that may make a longer ride than usual to service the area.
  - Health Care Services Pool for Temporary staff to existing network providers
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  - Ongoing activities for network development include review of AHCA provider listing for new providers.
  - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

28. Therapy (Respiratory) Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
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  - Licensed Provider Listing
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  - Health Care Services Pool for Temporary staff to existing network providers
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  - Engage existing Providers on capacity building
  - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.

- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

29. Therapy (Physical) Providers

- Enrollees access these services and providers through Plan Care Management authorization process.
- Timely access to services is ensured by having a sufficient number of providers to meet the needs of the membership. Care Managers follow up to ensure that providers are timely in the delivery of services.
- Relationship of this service provider to other provider contacts is facilitated by the use of Plan Care Management process which engages these providers through other agencies and requires observational feedback to the Care Manager when no other agency, such as Home Health, is involved.
- Barriers and Network Gaps would be identified through Care Management authorization process and the Network Scorecard which highlights to the Plan the number of such providers in the Service Area.
- Immediate / short-term interventions to address network gaps includes use of LOA (Letter of Agreement) and targeting new providers through:
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    - Engage existing Providers on capacity building
    - Engage Regional Community Based Organizations (CBO) from a jobs perspective.
- Outcome measures/evaluation of interventions to fill network gaps and resolve barriers will generally be based on reported efforts by Care Manager/Provider/Enrollee and specific measures such as number of Plan Network providers relative to the total number of providers licensed.
- Future capacity during the coming year for this covered service is projected to be met by current network and current network development efforts.
    - Ongoing activities for network development include review of AHCA provider listing for new providers.
    - Continued engaged with CBO and Provider Agencies related to identified gaps and future needs projection.

30. Coordination between Organizations

Coordination between internal departments

Departments	Department Leadership
Credentialing	Ange Sumner, Johanna Garcia
Quality Management	Sharon Mecoli
Claims	Elaine Jones
Utilization Management	Clinton Jules, MD
Grievances	Corporate G&A
Finance	Ron Weeden
IT Systems	Tom Payne
Operations	Natalia Aresu
Compliance	Shannon Childers
Care Management	Ela Alarcon-Cabrera
Network	Ed Miller

Coordination with outside organizations

Coordination with outside organizations is an ongoing process and one that will have more relevance for outside organizations under the integrated features of SMMC. HLTC through its 13+ years of network building for the Nursing Home Diversion Waiver and the professional experiences of its staff has a robust relationship with many associations, providers and the Aging Network. HLTC is continuing to develop effective relationships with the MMA plans. HLTC and the Humana MMA plan became a comprehensive plan in those regions where both plans exist on October 1, 2016. This change has improved the care management coordination of these members as they are now managed on the same clinical platform.

Network design by region and county for the SMMC LTC population

Enrollees access the Plan Network by use of the Provider Directory and Care Management Authorization. The Provider Directory can be found online at www.humana.com/humanalongtermcare. A hard copy is provided to the member upon request. Since the SMMC LTC enrollees require a Nursing Home Level of Care certification, the entire SMMC LTC population is considered “special”. However, within this group there are those that are transitioning to step down accommodations from either the hospital or nursing home. That group in transition and others deemed chronic and most at risk are Care Management hot spots.

The Network is designed to serve the SMMC LTC population with Long Term Services and Support (LTSS) provider types.

31. Provider Relations

Education and Training

The Plan offers training to all providers and their staff regarding the requirements of the Government Sponsored SMMC Contract and special needs of enrollees. The Plan will conduct initial training within thirty (30) calendar days of placing a newly contracted provider, or provider group, on active status for the SMMC program. The Plan also conducts ongoing training, as deemed necessary by the Plan or the Agency, in order to ensure compliance with program standards and the SMMC Contract.
The Plan’s training and education to providers includes Plan’s enrollment and credentialing requirements and processes.

HLTC provides weekly training webinars for new and established providers. The training calendar is posted on the HLTC home page.
The Plan shall ensure all participating providers required to report abuse, neglect, or exploitation of vulnerable adults under s. 415.1034, F.S., obtain training on these subjects. If the Plan provides such training to its providers, training materials will include the specified standards of the Government Sponsor and/or Contract.

Provider Credentialing
Medicaid Agency's Credentialing Criteria include:

- A copy of each provider's current medical license for medical providers, or occupational or facility license as applicable to provider type, or authority to do business, including documentation of provider qualifications
- No revocation, moratorium or suspension of the provider's state license by the Agency or the Department of Health, if applicable
- A satisfactory level II background check pursuant to s. 409.907, F.S., for all treating providers not currently enrolled in Medicaid's fee-for-service program
    - Plan shall ensure providers referenced above submit fingerprints electronically following the process described on the Agency's Background Screening website. The Plan shall verify Medicaid eligibility through the background screening system.
    - Plan shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.
    - Individuals already screened as Medicaid providers or screened within the past twelve (12) months by another Florida agency or department using the same criteria as the Agency are not required to submit fingerprints electronically but shall document the results of the previous screening.
    - Individuals listed in s. 409.907(8) (a), F.S., for whom criminal history background screening cannot be documented must provide fingerprints electronically following the process described on the Agency's background screening website.
- Disclosure related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106)
- Evidence of the provider's professional liability claims history
- Any sanctions imposed on the provider by Medicare or Medicaid
- The provider's Medicaid ID number, Medicaid provider registration number or documentation of submission of the Medicaid provider registration form.
- Determination of whether the provider, or employee or volunteer of the provider, meets the definition of "direct service provider" and completion of a Level 2 criminal history background screening on each direct service provider to determine whether any have disqualifying offenses as provided for in s. 430.0402, F.S., and s. 435.04, F.S.
    - Any provider or employee or volunteer of the provider meeting the definition of "direct service provider" who has a disqualifying offense is prohibited from providing services to enrollees.
    - No additional Level 2 screening is required if the individual is qualified for licensure or employment by the Agency pursuant to its background screening standards under s. 408.809, F.S., and the individual is providing a service that is within the scope of his or her licensed practice or employment. (See s. 430.0402(3), F.S.)
        - The Plan must maintain a signed affidavit from each provider attesting to its compliance with this requirement, or with the requirements of its licensing

agency if the licensing agency requires Level 2 screening of direct services providers.
    - The Plan must include compliance with this requirement in its provider contracts and subcontracts and verify compliance as part of its subcontractor and provider monitoring activity.
- Ensure that Assisted Living Facilities meet the requirement of home-like environment characteristics as defined by the state.
- The Plan's credentialing and re-credentialing process must include ensuring that all long-term care providers are appropriately qualified, as specified in Table 1 - LTC Provider Qualifications & Minimum Network Adequacy Requirements as attached and updated.

Plan's credentialing and re-credentialing files must document the education, experience, prior training and ongoing service training for each staff member or provider rendering behavioral health services.

Credentialing and Re-credentialing (CR)
Provider agreements provide for monitoring and oversight by the Plan and the subcontractor to provide assurance that all licensed medical professionals and service provider types are credentialed in accordance with the Plan's and the Government Sponsor's credentialing requirements.
The Plan has clearly defined and documented procedures for assessing provider qualifications and service history including what provider types must be credentialed. The policies and procedures define a provider's right to review and correct credentialing information. The Credentialing Committee reviews provider credentials and makes recommendations.
During the initial credentialing verification the Plan verifies provider credentials, including a valid license to offer covered services and, when applicable, education, training, malpractice history and work history.

The provider applications include an attestation about limitations that would affect a provider's performance; a history of loss of provider license and felony convictions; a history of limitation of privileges or disciplinary actions; and current malpractice insurance coverage if applicable. The Plan reviews information (e.g., about disciplinary actions) from third parties as available and required.
The Provider on site quality review is based on provider type. The threshold for on-site review of services or treatment record-keeping practices is based on a complaint by a stakeholder such as the enrollee, Plan staff, other providers, agency, or government sponsor. The plan takes necessary steps when a provider does not meet its standards, and will evaluate those steps regularly until the provider improves or removed from participation with the Plan.
Before reevaluating a provider's qualifications for re-credentialing, the plan will receive information (e.g., about disciplinary actions) from third parties as applicable. The Re-credentialing Cycle Length for the plan to evaluate provider qualifications is at least every 36 months.
Ongoing Monitoring includes provider sanctions, complaints and quality issues between the re-credentialing cycles. The plan takes appropriate action when issues are identified.
The plan has a process for terminating the contracts of providers who demonstrate poor performance and a process for providers to appeal a terminated contract. The plan reports to appropriate authorities when it suspends or terminates a provider's contract according to the contract with the government sponsor.
The plan confirms that providers, such as hospitals, home health care agencies, skilled nursing facilities, nursing homes and behavioral health facilities, are in good standing with state and federal agencies and accrediting organizations and reviews the above standings at least every three years.

If the plan delegates CR activities, a delegation agreement will outline responsibilities of the delegate and the plan, the delegated activities and the evaluation process. The plan evaluates the delegate on a regular basis, usually annually.

Monitoring and Oversight
In addition to verification and monitoring noted above, on a monthly basis the Plan checks subcontractors and providers against the federal List of Excluded Individuals and Entities (LEIE) and the federal Excluded Parties List System (EPLS) or their equivalent, to identify excluded parties.
The Plan also checks the Agency's listing of suspended and terminated providers at the Agency website to ensure the Plan does not include any non-Medicaid eligible providers in its network.
The Plan also conducts these checks during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and re-credentialing. The Plan will not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act.
The Provider Relations Department receives and maintains copies of all member complaints documents in the provider file to be reviewed at the time of credentialing and/or when an HLTC associates express concerns about the performance of a specific provider. Provider complaints identified via member satisfaction surveys are also shared with the provider relations department to be maintained in the members file. The Quality department reviews complaint and monitoring tools of providers and addresses concerns identified at the Quality Assurance Meetings. If at any time a provider is identified as performing below standards, it is brought under review by the QI committee to determine if the provider should be removed from the HLTC network. Due to the nature of the long term-care program the care managers are continually conducting informal monitoring of providers during monthly and quarterly interviews with members. All facility based members are seen face-to-face monthly which allows for the care manager to observe the care provided to the member.

32. Quality and Anti-Fraud Administration

Audits
The Plan will furnish specific data requested in order for the Government Sponsor to conduct the services/case record audit, including audit of enrollee plan of care, provider credentialing records, service provider reimbursement records, contractor personnel records, and other documents and files as required under the Government Sponsor Contract.
Fraud
The Plan has specific controls in place for prevention and detection of potential or suspected fraud and abuse, including, but not limited to:
(a) An effective pre-payment and post-payment review process, including but not limited to data analysis, claims and other system edits, and auditing of participating providers (see s. 409.967(2)(f), F.S.);
(b) A description of the method(s), including detailed policies and procedures, for verifying enrollees' identity and if services billed by providers were actually received. Such methods must be either the use of electronic verification or biometric technology but may also include sending enrollee explanations of Medicaid benefits (EOMB), contacting enrollees by telephone, mailing enrollees a questionnaire, contacting a representative sample of enrollees, or sampling enrollees based on business analyses;
(c) Provider profiling, credentialing, and re-credentialing, and ongoing provider monitoring including a review process for claims and encounters that shall include providers and non-participating providers who:
(i) Demonstrate a pattern of submitting falsified encounter data or service reports;

(ii) Demonstrate a pattern of overstated reports or up-coded levels of service;
(iii) Alter, falsify or destroy clinical record documentation;
(iv) Make false statements relating to credentials;
(v) Misrepresent medical information to justify enrollee referrals;
(vi) Fail to render medically necessary covered services they are obligated to provide according to their provider contracts;
(vii) Charge enrollees for covered services; and
(viii) Bill for services not rendered.

(d) Prior authorization;
(e) Utilization management;
(f) Subcontract and provider contract provisions;
(g) Provisions from the provider and the enrollee handbooks; and
(h) Standards for a code of conduct.

Care Management and Quality Related issues

Quality Related Issue	**Information to obtain from the Provider**	**Provider Type**
"Significant Change"	Does the Provider share "Significant Change" information with MCO	ALL
Free from any form of restraint	Is there evidence of any physical or chemical restraints	ALL
Advance Directives	Are Advance Directives documented and available	ALL
Staffing for services	Any regulatory ratios or License Survey's indicating lack of sufficient staff.	ALL
Services as contracted and authorized	License Surveys or reports indicating lack of compliance	ALL

Cultural considerations	Delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.	ALL

Provider agreements include provisions for monitoring and inspections. Including:

- That the Agency and DHHS may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed;
- Provide for monitoring of services rendered to Managed Care Plan enrollees through the subcontractor.

Record Reviews

The Managed Care Plan has an approved strategy for conducting medical/case record reviews. The Provider agreement provides for inspections of any records pertinent to the Contract by the Agency and DHHS. The strategy includes the following:
(a) Designated staff to perform this duty;
(b) Process for establishing inter-rater reliability;
(c) Sampling methodology for case selection;
(d) The anticipated number of reviews by practice site (non-facility service providers such as home health agencies with multiple offices locations serving the region);
(e) Record confidentiality and security;
(f) The tool that the Managed Care Plan will use to review each site;
(g) Analysis and reporting, and
(h) How the Managed Care Plan shall link the information compiled during the review to other Managed Care Plan functions (e.g., QI, re-credentialing, peer review).

In addition to record retention requirements for provider or provider licensure, provider agreements require that records be maintained for a period not less than ten (10) years from the close of the AHCA Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Managed Care Plan if the subcontract is continuous.)

HEDIS

HEDIS Measures Required as Part of the NCQA Accreditation Process for Medicaid Health Plans will be utilized as applicable to the SMMC program population served.

Changes in Plan

HLTC will provide the agency with the documentation of compliance with access requirements at any time there has been a significant change in the Plan's regional operations that would affect adequate capacity and services including but not limited to the following:

1. Changes in HLTC's services
2. Enrollment of a new population in HLTC

Provider Organizations and Resources
Florida Assisted Living Association (FALA)
Florida Conference on Aging (FCOA
Florida Health Care Social Workers Association (FHCSWA)
Florida State Guardianship Association (FSGA)
Home Care Association of Florida (HCAF)
LeadingAge Florida
National Association of Social Workers (NASW)

Centers for Independent Living (CIL)
Florida Health Finder link
See http://apps.ahca.myflorida.com/nhcguide/alternatives.shtml for additional information and listings on Alternatives to Nursing Homes.

Home Health Agency
Nursing Facilities

See http://apps.ahca.myflorida.com/nhcguide/RegionMap.aspx for Nursing Homes by Region including specific on the home such as languages spoken and ratings.

Support Sites

Able Trust	Florida Alliance for Assistive Services and Technology (FAAST)	National ADA and Disability Related Resources online
Able Trust - National Disability Mentoring Day	Florida Association for Retarded Citizens	National ADA Technical Assistance Program
Access Board	Florida Centers for Independent Living	National Association for the Deaf
Advocacy Center for Persons with Disabilities	Florida's Commuter Services.com	National Council on Disability
American Council for the Blind	Florida Council for Community Mental Health	Online Resource Guide to Medical Disability Rights
American Public Transportation Association	Florida Developmental Disabilities Council	Senior Care / Home Care Directory at Care.com
Brain Injury Association of Florida	Florida Department of Elder Affairs County Profiles	Safe and Mobile Seniors
Brain and Spinal Cord Injury Program	Florida Public Transportation Association	The Transportation Web
Center for Urban Transportation Research (CUTR)	Intelligent Transportation Systems (ITS)	Transportation Research Board
Community Transportation Association of America	ITS World	Welfare Information Network

Counties and Community Based Organizations (CBO)

AAA or ADRCs
http://elderaffairs.state.fl.us/doea/arc.php
Community Resource Directory Locator – Links for all Regions (PSA)

Counties
http://www.fl-counties.com/ Select individual county web site at bottom right of web page.

Housing Resources

General Information and HUD
The Department of Housing and Urban Development (HUD) has a number of resources to help seniors find affordable rentals. They offer a low-rent apartment search that shows low-rent apartments for senior citizens and people with disabilities, as well as for families and individuals. For low-rent apartments, the government gives funds directly to the apartment owners. There is an income limit to qualify. http://www.hud.gov/apps/section8/index.cfm

There is also the public housing program and public housing choice vouchers, commonly called Section 8. Public housing comes in all sizes and types and is managed by local housing agencies that are funded by the federal government. Public housing choice vouchers allow you to find a private rental and the government pays the landlord directly to subsidize the rent. Both programs are limited to low-income families and individuals. http://portal.hud.gov/hudportal/HUD?src=/topics/rental_assistance/phprog and
http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/abo

ut/fact_sheet
If you have questions or need help finding a rental, talk to a HUD-approved housing counselor.
http://www.hud.gov/offices/hsg/sfh/hcc/hcs.cfm
Homes and Communities www.hud.gov
National "multiple listing" service http://new.realtor.com
Senior Alternatives for Living www.alternativesforseniors.com
Remodeling www.improvenet.com

Housing - Universal Housing
Ageless Design www.agelessdesign.com/
Developer of Affordable / Modular Housing www.suitelivingcare.com

Housing - Retirement Housing
Retirement Communities www.seniorsites.com
Senior Alternatives for Living www.alternativesforseniors.com
The Retirement Net www.retirenet.com

Housing - Assisted Living
Assisted Living Federation of America www.alfa.org
National Center for Assisted Living www.ncal.org
AssistedLiving.com www.assistedliving.com

Housing - Advocacy / Ethics
Agency for Health Care Policy and Research www.ahcpr.gov
Office of Disability, Aging and Long-term Care Policy http://www.healthfinder.gov/orgs/HR3096.htm
Policy and practice updates www.medscape.com

Housing - Care Homes
Eden Online www.edenalt.com/home/index.htm
Detailed nursing home information from Medicare http://www.medicare.gov/NHCompare/home.asp
National Clearninghouse for Long-Term Care Information -
http://www.longtermcare.gov/LTC/Main_Site/index.aspx

Housing - Associations and Organizations
American Association of Homes and Services for Aging www.aahsa.org
American Health Care Association www.ahca.org
Office of Disability, Aging and Long-term Care Policy http://www.healthfinder.gov/orgs/HR3096.htm

D. PROVIDER EXPERIENCE

MMA SRC# 12 – Provider Credentialing (Statewide):

The respondent shall describe its proposed process to credential and recredential providers (including subcontractors' processes, if applicable), including credentialing timeframes, internal continuous quality improvement initiatives for recredentialing, transparency for providers on their application status and the steps the respondent or its subcontractors will take to ensure the respondent and the Agency have accurate provider demographic information in-between credentialing cycles.

Response:

Humana has designed our credentialing and recredentialing processes to ensure our network of contracted providers are qualified to deliver the highest possible quality of care to enrollees. All Humana-contracted providers complete a thorough initial credentialing and ongoing recredentialing process. As of August 2017, Humana has initiated credentialing, credentialed, and recredentialed more than four hundred sixty-six thousand (466,000) providers nationwide. Our success in provider credentialing and load process is a combination of both our dedicated and knowledgeable credentialing staff and our proprietary workflow management tool.

Accelerated Provider Exchange (APEX), Humana's proprietary workflow management tool, automates and accelerates the credentialing, provider load, and provider demographic update processes. It has enabled best-in-class turnaround times while allowing Humana associates throughout the company to communicate with providers regarding their credentialing and network participation status in real time and with full transparency throughout the process. Since January 2017, Humana has fully credentialed and loaded providers as participating in claims and directory systems in an average of forty-two (42) days. Following the implementation of system efficiencies six (6) months ago, we have reduced the average credential and load time to thirty-two (32) days. Humana is also implementing an improved provider information verification process to ensure we have updated provider demographic and participation status information available to our enrollees, enhancing their access to care. We recognize that process efficiency and communication of provider participation status are both critical to ensure provider engagement and satisfaction.

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1. The adequacy of the respondent's description of its credentialing and recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor.

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Humana has strict, documented credentialing and recredentialing policy and procedure processes in place, written to reflect and capture the highest level of credentialing requirements amongst all governing agencies, including the requirements of the Florida Statewide Medicaid Managed Care (SMMC) contract. Humana currently conducts all

credentialing and recredentialing processes internally without the use of an external entity. However, Humana will comply with any new credentialing requirements, including but not limited to streamlined credentialing processes and working with credentialing verification organizations. Our Credentials Committee exists to ensure that we adhere to the processes and procedures outlined and that we credential and recredential providers within the set requirements. The Committee, which Humana's Medical Director (MD) chairs, includes representation from a range of participating providers in both primary care and specialty disciplines.

Our credentialing, recredentialing, and provider loading processes meet all state and federal requirements as well as NCQA guidelines. The process confirms that the provider has a current valid state license, holds current professional liability insurance, has completed the appropriate education and training for the given specialty, and is free of sanctions by federal, state, and local authorities prior to the execution of a provider contract.

Credentialing is one of the quality assurance components the National Committee on Quality Assurance (NCQA) regularly assesses in awarding Humana's Florida Medicaid plan accreditation. Humana has earned one hundred percent (100%) of the available points on all NCQA surveys conducted between 2011 and March 2017. If awarded additional regions, Humana is prepared to perform our timely credentialing processes to ensure we have an adequate network ahead of go-live. Additionally, because many providers in regions throughout the State participate in our Medicare and commercial networks, we will only need to collect Medicaid-specific credentialing elements to fully credential the providers ahead of delivering services to the Managed Medical Assistance (MMA) population.

CREDENTIALING AND RECREDENTIALING CRITERIA

Humana will continue to use existing processes for contracting, credentialing, recredentialing, and loading providers. This process requires each healthcare provider to include the following information when applying to contract with us:

- COMPLETED APPLICATION - Provider must supply a completed application and attest to the correctness/completeness of the application. Attestation signature date must not be greater than one hundred eighty (180) days.

- EDUCATION AND TRAINING - Provider has completed appropriate education and training for applied specialty.

- BOARD CERTIFICATION - As applicable, evidence provider is board certified. Board certification is not a requirement of network participation.

- STATE LICENSE - Provider holds a current state professional license, certificate, or registration in the state(s) in which they will treat Humana enrollees.

- ACTIVE, VALID FLORIDA MEDICAID IDENTIFICATION (ID) NUMBER - Provider demonstrates current eligibility for participation in Medicaid, as applicable, and is enrolled with a Florida Medicaid ID number.

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MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

- DRUG ENFORCEMENT ADMINISTRATION (DEA) AND/OR CONTROLLED DANGEROUS SUBSTANCE (CDS) CERTIFICATE - Provider holds a current federal DEA certificate and/or a CDS certificate, if applicable to profession.

- PROFESSIONAL LIABILITY INSURANCE (PLI) - Provider holds current PLI in contracted amounts, has completed the PLI exception procedure, or has documentation of coverage under the Federal Tort Claims Act for professional liability coverage.

- CLAIMS HISTORY - Provider has acceptable liability claims history. Any history of repeated catastrophic claims which, after examination by the Credentials Committee and/or the medical/dental director, indicates a propensity for or trend in malpractice claims, and/or are unusual for a provider in that specialty, is grounds for denial, unless the provider satisfies the Credentials Committee that such actions do not indicate a continuing quality of care concern.

- WORK HISTORY - Provider demonstrates appropriate history of employment and clinical practice. Provider should explain any gaps in work history greater than six (6) months and should satisfy the Credentials Committee that such gaps do not indicate a continuing quality of care concern.

- HOSPITAL PRIVILEGES - Provider holds current clinical privileges in good standing at a participating facility, if applicable to care provider delivers. Clinical privileges should not contain any Material Limitations.

- FEDERAL, STATE, AND LOCAL SANCTION-FREE STATUS - Provider holds current sanction-free status by federal, state, and local authorities to provide healthcare services, unless provider satisfies the Credentials Committee that such sanction does not present a continuing quality of care concern. This includes the Office of Inspector General, the General Services Administration, and Medicaid sanctions.

- PRIOR ACTIONS OR RELINQUISHMENTS - Provider should not have a history of any action in effect within the last five (5) years taken by a federal, state, or local government, including but not limited to the applicable state licensing body; by a hospital, health plan, or other health care entity; or by a professional society to discipline, exclude, suspend, revoke, deny; or any suspensions or other restrictions that include Material Limitations. Additionally, providers within the last five (5) years should not have voluntarily relinquished any membership, license, privileges, or participation status or other ability to render healthcare services, including, but not limited to, a state license or clinical privileges; while under investigation by the entity providing such membership, privileges, participation status, or other ability to render health care services; or in return for such entity not conducting an investigation. Such prior actions or relinquishments may not be grounds for denial if the provider satisfies the Credentials Committee that such action or relinquishment does not indicate a continuing quality of care concern.

- CONVICTIONS - Provider has not been convicted of, nor, has pleaded guilty or no contest to, (a) any felony, or (b) any misdemeanor involving moral turpitude or related to the practice of a healthcare profession, the Federal Health Program fraud and abuse, third-party

reimbursement, or controlled substances, unless the provider satisfies the Credentials Committee that the conviction or plea does not present a continuing quality of care concern.

- LACK OF PHYSICAL OR MENTAL IMPAIRMENT - Provider should not demonstrate a lack of physical or mental impairment, including impairments from chemical dependency, that may impair their ability to practice or may pose a risk of harm to patients.

- QUALITY - For recredentialing purposes only, provider should demonstrate an acceptable performance record related to Humana enrollees. This record includes activities/findings collected through Humana's quality improvement (QI) programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities. "Quality" refers to the measure of competence, professional conduct, care, and safety that a provider affords an enrollee. Denials based on this criterion that constitute an Adverse Action, which are actions or recommendations that limit, reduce, restrict, suspend, revoke, terminate, deny, or fail to renew a provider's participation in Humana, require further action under the Humana Provider Quality Review Process.

- CONFIRM LANGUAGES - National Network Operations and Credentialing Operations will confirm languages that the providers use, including American Sign Language (ASL).

- NATIONAL PROVIDER IDENTIFIER (NPI) AND TAXONOMY - Provider has an NPI and taxonomy that is assigned and verifiable through the National Plan and Provider Enumerator System (NPPES).

- BACKGROUND SCREENING - Provider is subject to a level II background check pursuant to s. 409.907, F.S., for all providers not currently enrolled in Medicaid.

- PCP PATIENT LOAD ATTESTATION - Attestation that the total active patient loads is no more than three thousand (3,000) patients per PCP. An active patient is one that the provider sees a minimum of three (3) times per year.

- DISCLOSURE OF OWNERSHIP – We collect disclosure of ownership forms related to ownership and management (42 CFR 455.104), business transactions (42 CFR 455.105), and conviction of crimes (42 CFR 455.106) as part of the credentialing and recredentialing process.

PROVIDERS SUBJECT TO CREDENTIALING PROCESS

Humana requires credentialing for all providers in our provider directory. Because Humana operates a long-term care (LTC) plan in every region of the State, the credentialing process for our Managed Medical Assistance (MMA) and LTC plans frequently intersect, creating a comprehensive approach to our credentialing process and enhancing access to services for all of our enrollees. Providers subject to credentialing and recredentialing include, but are not limited to:

MEDICAL PROVIDERS:

- Medical Doctors

- Oral Surgeons

- Chiropractors

- Osteopaths

- Podiatrists

- Nurse Practitioners, who are licensed, certified, or registered by the state to practice independently or as required by state regulations

- Dentists

- Optometrists

BEHAVIORAL HEALTH PROVIDERS:

- Psychiatrists and other physicians

- Addiction medicine specialists

- Doctoral or Master's level psychologists who are state-certified or licensed

- Master's level clinical social workers who are state-certified or licensed

- Master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state-certified or licensed

- Other behavioral health specialists who are licensed, certified, or registered by the state to practice independently

ORGANIZATIONAL PROVIDERS WE ASSESS INCLUDE ANY FACILITY PRINTED IN THE DIRECTORY, AND ARE NOT LIMITED TO:

- Hospitals
- Home health agencies
- Skilled nursing facilities (SNFs)
- Free-standing surgical centers
- Hospices
- Clinical laboratories
- Comprehensive outpatient rehabilitation facilities
- Outpatient physical therapy and speech pathology providers
- Pharmacies
- Providers of end-stage renal disease services

- Providers of outpatient diabetes self-management training
- Portable x-ray suppliers
- Rural health clinics and federally-qualified health centers
- Transportation

WE ALSO ASSESS BEHAVIORAL HEALTHCARE FACILITIES PROVIDING MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES IN THE FOLLOWING SETTINGS:

- Inpatient
- Residential
- Ambulatory

CREDENTIALING AND RECREDENTIALING APPLICATION PROCESS

Information about and assistance with the credentialing and recredentialing process is available from Provider Relations representatives, the provider handbook, the provider website, the provider call center, provider orientation, and quick reference guides. Humana requires participation in the Council for Affordable Quality Healthcare Inc.'s (CAQH) Universal Credentialing ProView, an online service that helps physicians and other healthcare providers with the credentialing process, including state-specific credentialing applications as required by state regulations. Humana acts only upon complete credentialing and recredentialing applications, defined as a submitted application form completed with responsive and accurate information, dated and signed, and accompanied by all required and requested documents. Upon receipt of a complete credentialing or recredentialing application, a credentialing specialist loads the provider application into APEX. Humana plans to enhance this process in the future by implementing an automatic feed from CAQH to APEX. Currently, APEX includes a credentialing module that organizes supporting documentation, automates the process, and facilitates the credentialing specialist's review of the credentialing application for mandatory criteria.

PROVIDER OFFICE SITE EVALUATIONS

As part of the pre-credentializing process, Humana surveys all primary care provider and obstetricians/gynecologists' office locations as applicable to confirm they meet our office site standards. During credentialing and recredentialing, representatives conduct a site visit for applying providers to verify data, as listed below, that we collect on the application. Humana's comprehensive provider site visit evaluation tool meets all federal, state, and Americans with Disabilities Act (ADA) compliance measures, included in Attachment MMA 12-1. We save the completed evaluation tool in the provider's and it is credentialing file.

During this site visit, Humana verifies information including, but not limited to:

- ADA compliance

- Waiting and exam room cleanliness and accessibility

- Risk management (e.g., emergency procedures and safe disposal of identified chemicals)

- Ancillary services (e.g., Clinical Laboratory Improvement Amendments (CLIA) certificates)

- Safety (e.g., signage)

- Access and availability (e.g., answering services, appointment scheduling)

- Medical record keeping and filing (e.g., security measures)

- Thresholds for acceptable performance against criteria

Humana verifies all items listed above during credentialing, and then re-verifies every three (3) years during recredentialing. Regardless of site visit score, any significant deficiency in any critical element will result in a site visit failure. We allow all site visit failures time to correct deficiencies and require a repeat site visit prior to submitting a provider's application for credentialing. Significant deficiency examples include:
- Non-compliance with ADA
- Inadequacy of medical/treatment record keeping
- Uncleanliness of waiting and exam room space

VERIFICATION PROCESS

Humana's APEX system contains links to various verification sources, which helps streamline and expedite the credentialing and recredentialing verification process. For example, APEX receives a feed from the American Medical Association (AMA) that allows verification of credentialing information in real time. We also have links to the Office of the Inspector General verification source and the General Administration Sources verification source to review any sanctions against the provider. Additionally, we have built in an "attach a screenshot" feature in APEX as part of the credentialing and recredentialing process. A credentialing specialist can capture a screenshot of a verification site, such as licensure verification, which becomes evidence of verification as part of the credentialing file. This advancement eliminates the need to print and upload the verification to our system, further expediting our credentialing process.

APEX records date of verification, verification source, and the report date as part of the credentialing and recredentialing process. Humana also assigns each member of its credentialing staff a unique electronic identifier as part of the credentialing quality assurance process, which we record in APEX.

Verification of credentialing information comes from one of the following sources:
- The primary source
- A contracted agent of the primary source
- Another National Committee for Quality Assurance (NCQA)-accepted source for the credential

Appropriate documentation of verifications includes:
- Credentialing documents signed and dated by verifier
- A detailed checklist, including the name of the source used, the date of verification, the signature or initials of the credentialing specialist who verified the information, and the report date, if applicable.

CREDENTIALING AND RECREDENTIALING DECISION-MAKING PROCESS

Humana uses a tiered process for credentialing and recredentialing approval, with categorization determining the path for approval. This process allows the Credentials Committee to expedite credentialing approval or more thoughtfully consider an approval.

For Category I credentialing applications, those files meeting all credentialing criteria, Humana's medical or dental director approves these daily and presents them to the Credentials Committee during monthly meetings. The Credentials Committee has final approval or denial authority for credentialing and recredentialing applications.

Humana's medical or dental director presents Category II applicants, whose applications do not meet all credentialing criteria for expedited approval, on a monthly basis to the Credentials Committee. The committee comprises participating providers in both primary care and specialty disciplines who employ a peer review process to determine whether to approve or deny Category II applicants. Meeting minutes document evidence of the Credentials Committee's discussion and decisions, certified by chairperson or designee signature. Once credentialed, recredentials are due every three (3) years from initial approval date.

Humana processes the credentialing or recredentialing decision of the Credentials Committee as follows:

- APPROVALS: The Credentials Committee notifies providers of the decision within sixty (60) days.

- DENIALS: Humana notifies the provider of the reasons for the denial and provides notice of an opportunity to request reconsideration of the decision in writing within fourteen (14) days of the notice. Upon reconsideration, the Credentials Committee affirms, modifies, or reverses its initial decision. Humana notifies the provider in writing of the Credentials Committee's reconsideration decision within sixty (60) days.

- ADVERSE ACTIONS: Adverse Actions are actions or recommendations that limit, reduce, restrict, suspend, revoke, terminate, deny, or fail to renew a provider's participation in Humana's Network for reasons related to quality and that adversely affect, or could adversely affect, an enrollee's health or welfare. Adverse Actions lasting longer than thirty (30) days entitle the applicant to prompt notice of his or her right to request a hearing under the Humana Provider Quality Review Process.

ONGOING MONITORING AND INTERVENTIONS

Humana monitors provider sanctions, complaints, and quality issues between recredentialing cycles, and ensures corrective actions are taken to address occurrences of poor quality. We implement ongoing monitoring and appropriate interventions, up to and including removal from the network, by collecting and reviewing the following information within thirty (30) calendar days of its release:

- Medicare and Medicaid sanctions and exclusions
- Sanctions or limitations on licensure
- Complaints
- Identified Adverse Events

GATHERING DATA FOR RECREDENTIALING PROCESS

Humana recredentials its providers at least every thirty-six (36) months. Humana employs effective and structured mechanisms to collect provider performance information for the recredentialing process. APEX automatically populates the provider performance score into the provider's file prior to the recredentialing decision. Provider performance indicators include:

- Provider complaints
- Outlier prescriber/procedure history
- Grievance and appeals
- Healthcare Effectiveness Data and Information Set (HEDIS) scores
- Utilization

Humana's Quality Management System (QMS) electronically tracks providers with confirmed quality of care issues by NPI and interfaces with the APEX for a quality performance score.

DELEGATED AND SUBCONTRACTOR CREDENTIALING

Delegated and subcontractor credentialing is the process by which Humana has agreed to allow qualified entities to perform a portion of our credentialing review process and oversees the delegate to ensure ongoing adherence to program requirements. Humana delegates credentialing and recredentialing activities to organizations or entities that demonstrate compliance with federal, state, and accreditation requirements, such as NCQA. These activities include:

- Collection of application and attestation
- Primary source verification
- Site visits and medical record keeping review
- Ongoing monitoring of information
- Credentialing and recredentialing decision making

Before Humana delegates the credentialing function to any entity, we perform a pre-authorization performance capacity audit to evaluate compliance with Humana's standards, which includes compliance with federal, state, and NCQA accreditation. We review the following criteria during the audit:

- Credentialing policies and procedures

- Program descriptions and work plans
- Forms, tools, and reports
- Credentialing Committee minutes
- Sub-delegation agreements
- Letters of accreditation
- Credentialing file review

Humana measures results on a standard audit form that determines if we approve the entity for delegated credentialing.

- Entities with a score of ninety-five percent (95%) or above are approved.

- Entities with a score between seventy percent (70%) and ninety-five percent (95%) (by section and total) may be approved with a corrective action plan (CAP) in place, which will include the identified issues and deficiencies, the corrective actions required, and the timeframes for performance of the corrective actions and achieved results.

- If an entity scores below seventy percent (70%) during a pre-delegation review, Humana does not approve them for delegation.

The delegated entity is subject to annual reviews to ensure they meet state, federal, and NCQA Accreditation oversight requirements. Please refer to Attachment MMA 12-2 for our delegated credentialing audit process and Attachment MMA 12-3 for our delegation policy. If during the annual audit, a delegate falls below seventy percent (70%), we will either place the entity on a CAP or terminate them, depending on the issues that led to the non-compliance. In 2016 we placed three (3) entities on CAPs for credentialing, which were all subsequently resolved. The Credentials Committee determines the corrective action to take against a delegated entity failing to comply with federal, state, NCQA Accreditation, and Humana credentialing requirements. Humana has a delegation agreement in place with all delegated or subcontracted entities. It outlines the responsibilities of both the plan and the delegated entity as well as the assessment and evaluation of the credentialing standards. Ongoing oversight ensures that the delegated entity continues to operate in a compliant manner.

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2. The extent to which the respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days.

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Humana continues to exceed industry standard and state requirements for credentialing as a result of our provider credentialing experience, processes, and proprietary workflow management tool, APEX. On average, Humana completed the credentialing verification process with an average of ten (10) days in 2016 and within an average of seven (7) days to date in 2017. Since January 2017, Humana has fully verified credentials and loaded providers as participating in claims and directory systems in an average of forty-two (42) days. In Florida, Humana credentialed eight thousand one hundred twenty-five (8,125) providers and recredentialed three thousand eight hundred six (3,806) providers in 2016.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana recognizes that our ability to move providers rapidly through the credentialing and loading process directly impacts enrollees' access to care. We have designed our process to expeditiously credential and load providers to ensure we can proactively fill any identified network deficiencies as quickly as possible, as described in our case examples below. Humana has established processes and technology, including APEX, to monitor compliance with AHCA's required timeframe of one hundred twenty (120) days to process credentialing applications. Furthermore, Humana's processes support not only the credentialing verification processes to occur within thirty (30) days, but also for the end-to-end provider participation process to occur within sixty (60) days. Humana's policy requires that providers be credentialed and loaded as participating in Humana's directory and claims systems within sixty (60) days of receipt of a complete credentialing application.

Humana has advanced our credentialing and recredentialing processes through a variety of system and process improvements and investments. For example, we have introduced data feeds with the AMA to verify board certification and education records, as well as with various verification sources, including the National Practitioner Data Bank, licensure boards, Office of Inspector General sanctions, and General Service Administration sanctions, to allow for real-time verification.

CASE EXAMPLES

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1. There are occasional circumstances in which our network team requires urgent credentialing of a provider, and our credentialing team can move a provider through the credentialing process in a single day. We have experienced several situations in which a provider has retired without advance notice, requiring us to locate another provider to serve our enrollees and fill unexpected network gaps. After our provider network team identified and contracted with new providers, the credentialing team quickly completed all credentialing verification for a Category I application, ensuring our enrollees had timely access to care.

2. After an unexpected termination of a subcontractor agreement that affected multiple regions, Humana quickly contracted with more than thirty-five (35) providers including sixteen (16) home health agencies, fourteen (14) durable medical equipment and medical supplies providers, five (5) intravenous (IV) home infusion providers. Using the Category I application process, our credentialing team completed the credentialing process within a few days, allowing us to rapidly load these providers into our system and minimize provider network and enrollee disruption.

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3. The adequacy of the respondent's approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process.

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Humana understands that communication with providers through the contracting process, credentialing, and recredentialing is critical to maintaining an engaged provider network. We developed APEX not only as a workflow management tool, but also as a business monitoring tool. This tool initiates communication with providers when we need credentialing

or recredentialing information, and it also provides Humana associates insight to a provider's credentialing status. Attachment MMA 12-4 conveys the APEX data flow.

CREDENTIALING AND RECREDENTIALING PROVIDER EDUCATION AND ASSISTANCE

Humana provides transparency around credentialing and recredentialing processes by educating providers and assisting in the application process using the following methods:

- PROVIDER RELATIONS REPRESENTATIVES DURING PROVIDER RECRUITMENT - During the provider recruitment period, Humana initiates a discussion around the credentialing process with providers to ensure they understand the process and to help answer questions about the process. Additionally, provider relations representatives will offer guidance to providers on how to enroll as a Florida Medicaid provider and a high-level overview on AHCA's streamlined credentialing process if necessary. We also prompt providers to enroll in and update their CAQH application prior to initiating the credentialing process to ensure their information is up-to-date. Provider relations representatives also play a critical role during the recredentialing process by communicating with providers regarding any required action on their part to complete recredentialing.

- PROVIDER RELATIONS REPRESENTATIVE DURING PRE-CREDENTIALING - If there is any information missing from the credentialing or recredentialing application, a provider relations representative will reach out to the provider by phone or email to obtain the additional information or answer any questions about the application.

- PROVIDER MANUAL - Humana provides detailed information and answers to frequently asked questions about the credentialing process in the provider manual, which we make available to providers both online and in hard copy.

- PROVIDER WEBSITE - Humana's provider website has information available twenty-four (24) hours a day, seven (7) days a week on the credentialing process and recredentialing process.

- PROVIDER CALL CENTER – We train our customer service specialists (CSSs) to understand and explain the credentialing and recredentialing processes.

- INITIAL PROVIDER ORIENTATION – We provide training on the re-credentialing process during initial provider orientation.

CREDENTIALING AND RECREDENTIALING REAL-TIME STATUS UPDATES

Our provider relations representatives and CSSs use APEX when we receive a provider inquiry regarding credentialing/recredentialing and participation status. If providers need assistance during the credentialing or recredentialing process, they can contact their provider relations representative, submit a question through email, or call our provider call center. We thoroughly train our provider relations representatives in the credentialing processes and

criteria to ensure they can fully assist our providers. Once the application is approved, APEX generates a letter to send to the provider with the approval status.

CREDENTIALING AND RECREDENTIALING CREDENTIALS COMMITTEE DECISION

All providers presented to the Credentials Committee will receive written communication regarding Humana's decision to approve or deny credentialing within sixty (60) days. We send any providers denied credentialing a communication that includes instruction on where they can find information on how to have the Committee reconsider the decision. Please see Attachment MMA 12-5 for a sample of a Credentialing Committee denial letter.

TRANSPARENCY DURING RECREDENTIALING PERIOD

Humana understands that the recredentialing process is critical to both access to care as well as continuity of care for our enrollees. To ensure that our providers remain in network and do not experience a lapse in credentialing status, Humana has invested in processes and technology that has resulted in a recredentialing rate of ninety-nine percent (99%) within the three (3)-year window.

Humana's recredentialing process depends on effective and frequent communication with our providers. APEX initiates the recredentialing process systemically seven (7) months before a provider's credentialing expires, initiating communication with providers and documenting Humana's efforts to contact providers regarding the recredentialing period.

- Seven (7) months prior to recredentialing due date, APEX creates a list of providers requiring credentialing. APEX automatically searches CAQH for updated provider information, comparing it to Humana's stored demographic information. APEX produces reports for provider relations representatives to monitor.

- Six (6) months prior to a recredentialing due date, APEX automatically initiates an outbound communication via fax to the provider. This communication notifies the provider of their recredentialing timeline and details what action is required on their part.

- Four (4) months prior to a recredentialing due date, a credentialing associate places an outbound phone call to discuss any outstanding information required for recredentialing. APEX logs and tracks all outbound calls.

- Three (3) months prior to a recredentialing due date, APEX produces a report of providers with outstanding information. The credentialing team mails a letter to the provider notifying them of the recredentialing due date and required action on the provider's part.

- Two (2) months prior to the recredentialing due date, Humana market contractors reach out to providers to request assistance in obtaining outstanding information.

- One (1) month prior to the recredentialing due date, we send a letter via certified mail with receipt of confirmation to notify the provider that we will terminate their credentialing status

at the end of the month and that we request they contact their market contractor immediately.

- At the recredentialing due date, a Humana credentialing specialist initiates the decredentialing process within APEX.

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4. The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its recredentialing process.

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Humana conducts ongoing monitoring of credentialed providers between credentialing and recredentialing cycles. We continuously monitor provider complaints, sanctions, limitations on licensure, identified adverse events, enrollee complaints about providers, and quality issues. We receive an updated list of sanctions and licensure issues from CAQH on a weekly basis and compare the list to all platforms with participating and non-participating providers. If there is an issue with a participating provider, our credentialing specialists review the issue and determine if there is a need to de-credential the provider. If there is an issue with a non-participating provider, our specialists forward an APEX task with the information to prevent claims payment to providers who do not meet licensure or sanction requirements. If Humana receives a complaint about the provider's office, Humana will conduct a site visit, regardless of the provider's credentialing status.

One of Humana's advantages in operating multiple lines of business is that we closely monitor providers in all regions and have greater opportunities to identify problem areas. We provide a large overall enrollee volume to many of our providers, which broadens the degree in which we can and will become directly aware of a problem. If a Medicare Advantage (MA) enrollee raises a complaint with a provider, we will typically assess and address it within the context of all Humana lines of business.

QUALITY REVIEW OF REQUIRED CREDENTIALING/RECREDENTIALING PROCESSES

Humana's provider credentialing and recredentialing process is consistent with CMS, NCQA, and American Accreditation Health Care Commission/Utilization Review Accreditation Commission standards. Humana's provider credentialing and recredentialing process meets AHCA credentialing requirements.

GATHERING DATA FOR RECREDENTIALING PROCESS

Humana has effective and structured mechanisms for the collection of provider performance indicators during the recredentialing process, which include provider complaints, outlier prescriber/procedure history, grievance and appeals, HEDIS scores, utilization, and providing excessive ancillary or preventative services. Humana's Quality Management System (QMS) electronically tracks providers with confirmed quality of care issues by NPI and interfaces with APEX. When a provider is queried, it generates a quality performance

score that considers the provider performance indicators. If the provider receives a quality performance score of nine (9) or less within the three (3)-year period, we classify the provider's file as a Category I file, which the medical director then reviews and approves. If the provider receives a quality performance score of greater than nine (9), we classify the provider as a Category II provider, which we refer to our Credentials Committee for further review.

During credentialing, Humana also reviews any enrollee complaints against a provider since the last credentialing or recredentialing cycle. When the Quality Improvement Committee (QIC) reviews quarterly and annual reports, it may recommend denying certain providers from inclusion. Humana's QIC also reviews any provider complaints about the credentialing and recredentialing process on a routine basis. If any issues are raised that can help refine our credentialing process or highlight gaps, we will address them.

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5. The extent to which the respondent and its subcontractors incorporate the Agency's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes.

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Through Humana's Florida-based provider knowledge, our provider relations and credentialing experience, and our partnership with AHCA, we ensure providers experience a streamlined process when applying for participation in our network. If included in our contract with AHCA, Humana will incorporate AHCA's streamlined credentialing capability and limited enrollment process into our current credentialing processes.

CREDENTIAL VERIFICATION ORGANIZATION (CVO) PROCESSES AND THIRD-PARTY CREDENTIALING VENDORS

Selecting a CVO and streamlining credentialing will simplify the credentialing and recredentialing process for Florida providers and health plans. If AHCA pursues using a CVO, we will credential our providers using the CVO processes, and we will provide education and assistance through multiple avenues to complete credentialing.

CVO EDUCATION AND ASSISTANCE UPON IMPLEMENTATION

If at any point our providers need assistance in completing the credentialing application, providers can contact their provider relations representative, submit a question through email, or call the provider call center. We will thoroughly train our provider relations representatives in the CVO credentialing processes to ensure they are fully able to assist our providers.

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6. The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan in-between credentialing cycles.

==========

Humana has created multiple avenues for providers to update demographic and participation changes, which we integrate into our work streams and databases to ensure the highest accuracy of provider information for our stakeholders. We require providers and subcontractors to inform us of any changes in demographic information and accepting new patient status per their contracts with Humana. Providers can submit changes electronically through the Availity portal using the Provider Data Management Tool or Manage My Demographics tool within Humana Payer Spaces under the Resources Tab. Providers can also email, mail, or fax changes to the Provider Verification Unit at Humana.

During regular visits with PCPs and high-volume specialists, Humana provider relations representatives gather necessary provider information updates at each visit. They send these updates to our data load team, making it easy for providers to share changes with Humana. Our provider relations representatives may also review rosters from large provider groups to review any changes to participation status. Providers may also self-report any changes in demographic or participation status to their provider relations representative or through our provider relations call center.

Additionally, Humana investigates and corrects complaints and reports from enrollees that indicate provider data is inaccurate. Enrollees also have the option of alerting Humana to a demographic change by clicking on “Report updated information” on the provider’s details page in Physician Finder on Humana.com.

Quarterly, Humana’s Data Collection and Verification (DCAV) department performs outreach to all participating professional offices in Humana’s network. During the outreach process, Humana sends a request to provider offices to review the information Humana has on file and has posted within its provider directory. The DCAV team asks providers to identify errors, corrections, and updates. The focus of the review is to ensure accuracy of directory demographics like address and appointment phone number, as well as to verify the providers that work in that office.

Recently, we implemented a Provider Data Management feature on our Availity web portal. In this workflow, the provider can update their service locations, any new providers joining the organization, contact information, and panel status. Once the provider attests to the information, Humana will have access to the updated information. Availity also sends providers a quarterly notification to remind providers to review, change, and attest their demographic information.

We require our subcontractors to provide us with any participation or panel changes for providers and to send us updated rosters at least monthly, which we include in our directory.

SUMMARY

Humana’s credentialing process is exceptionally adept at enrolling and loading qualified providers in our network to serve our enrollees. Through this process, which is industry-leading in both speed and quality, Humana provides our enrollees quality care through a

carefully and efficiently credentialed and recredentialed provider network. We have made significant investments and improvements to our technology and processes to ensure providers experience a streamlined process with Humana, and we review this process annually to identify new opportunities for improvement. Our ability to quickly contract and credential providers allows us to fill network gaps efficiently, improving enrollee access to care. Humana is implementing an improved provider data verification system, which will result in an enhanced process to collect provider demographic information and participation status during credentialing cycles. Finally, by incorporating the quality of care a provider delivers into our recredentialing process, we improve both the enrollee experience and their health outcomes, creating a higher standard of care.

Evaluation Criteria:

1. The adequacy of the respondent's description of its credentialing and recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor.

2. The extent to which the respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days.

3. The adequacy of the respondent's approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process.

4. The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its recredentialing process.

5. The extent to which the respondent and its subcontractors incorporate the Agency's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes.

6. The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan in-between credentialing cycles.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Attachment MMA 12-1: Provider Office Site Evaluation Tool

Humana®

Practitioner Office Site Evaluation Tool (POSET)

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Provider information

Please enter your provider information	
Group or provider name (1)	
PCP or specialist (2)	
Specialty type (3)	
Practitioner name (4)	
Manager/Contact (5)	
Office address (6)	
Office city (7)	
Office state (8)	
Office ZIP code (9)	
Phone number (10)	
Fax number (11)	
Manager/Contact email (12)	
Practice tax ID (13)	
Practitioner individual NPI (14)	
Organization/Entity NPI (15)	
Website address (16)	
Designated contact for disability-related issues (17)	
Name of individual from provider's office completing site survey (18)	
Date of site survey completion (19)	

Provider auditor conducting site survey

Company conducting audit (1)	
Name of auditor (2)	
Email of auditor (3)	

Survey purpose

- ○ Initial credentialing
- ○ Recredentialing
- ○ Audit, based on cause

Provider type

- ○ PCP
- ○ OB/GYN
- ○ Pediatrician
- ○ Specialist

Translation services – Limited English proficiency requirements

1. Are translation services available in a minimum of 150 languages (oral interpretation vendor)?
   - ○ Yes (1)
   - ○ No (2)

General information

2. Do/can you provide alternative appointment scheduling for those who need extra time?
   - ○ Yes (1)
   - ○ No (2)

3. Are members' rights to file a grievance visually posted?
   - ○ Yes (1)
   - ○ No (2)

4. On inspection, is the office functionally safe and sanitary?
   - ○ Yes (1)
   - ○ No (2)

5. Is there a policy and procedure document that states what to do in case of emergency?
   - ○ Yes (1)
   - ○ No (2)

Parking for disabled people

6. Is the parking adequate and close by?
   - Yes (1)
   - No (2)

7. Does your facility provide one accessible parking space per 25 total parking spaces?
   - Yes (1)
   - No (2)

8. Is at least one van-accessible parking space available per every one to 25 total spaces?
   - Yes (1)
   - No (2)

9. Is the parking space clearly marked by the International Symbol of Access?
   - Yes (1)
   - No (2)

10. If only on-street parking is available, is there an unobstructed curb cut/ramp?
    - Yes (1)
    - No (2)

Exterior travel route

11. If the accessible route crosses a curb, is a curb ramp provided?
    - Yes (1)
    - No (2)
    - N/A (3)

12. Is the ramp at least 36 inches wide?
    - Yes (1)
    - No (2)
    - N/A (3)

Building entrance

13. Is the exterior entry door at least 32 inches wide and does it open at least 90 degrees?
    - Yes (1)
    - No (2)

14. Does the entrance door have handles that can be opened without grasping, pinching or twisting of the wrist?
    - Yes (1)
    - No (2)

Interior route

15. Are all interior travel route paths at least 36 inches wide?
    - Yes (1)
    - No (2)
    - N/A (3)

16. Is the route stable, firm and slip-resistant?
    - Yes (1)
    - No (2)
    - N/A (3)

17. Is the route clear of any free object that may stick out?
    - Yes (1)
    - No (2)
    - N/A (3)

18. Is the interior door leading from waiting room to other interior rooms at least 32 inches wide and does it open at least 90 degrees?
    - Yes (1)
    - No (2)
    - N/A (3)

19. Does the facility have an elevator?
    - Yes (1)
    - No (2)
    - N/A (3)

20. Do the sliding doors reopen automatically when obstructed by an object? (Note: If constructed before March 15, 2012, and manually operated, the door is not required to reopen automatically.)
    - Yes (1)
    - No (2)
    - N/A (3)

21. Are the call buttons no higher than 54 inches from the floor?
    - Yes (1)
    - No (2)
    - N/A (3)

22. Are the in-car buttons no higher than 48 inches from the floor?
    - Yes (1)
    - No (2)
    - N/A (3)

23. Do the elevators provide audible signal indicators and or Braille signage?
    - Yes (1)
    - No (2)
    - N/A (3)

24. Are there audible signals when the elevator car passes or stops at a floor?
    - Yes (1)
    - No (2)
    - N/A (3)

Waiting room/area

25. Is there an open space at least 36 inches wide by 48 inches long in the waiting area to accommodate a wheelchair?
    - Yes (1)
    - No (2)

26. Does the reception area accommodate at least 1.5 seats per number of patients scheduled each hour?
    - Yes (1)
    - No (2)

Restrooms

27. Does the restroom entry configuration provide adequate maneuvering space for a person using a wheelchair? (A person in a wheelchair needs 36 inches of clear width for forward movement and a five-foot diameter or T-shaped clear space to make turns. If a restroom's entry vestibule has two doors, a person in a wheelchair needs a minimum distance of 48 inches clear of the door swing between the two doors.)
    - Yes (1)
    - No (2)
    - N/A (3)

28. In restrooms without stalls, is there a 30-inch-by-48-inch area of open floor space (or larger) clear of the door swing?
    - Yes (1)
    - No (2)
    - N/A (3)

29. Is the side-wall grab bar at least 42 inches long?
    - Yes (1)
    - No (2)
    - N/A (3)

30. Is the rear-wall grab bar at least 36 inches long?
    - Yes (1)
    - No (2)
    - N/A (3)

31. Is the toilet paper dispenser no greater than 48 inches above the floor below the side-wall grab bar?
    - Yes (1)
    - No (2)
    - N/A (3)

32. Is there a least one accessible sink that provides enough space for wheelchair users to park in front of the sink (30 inches wide by 48 inches long)?
    - Yes (1)
    - No (2)
    - N/A (3)

33. Is the faucet handle operable without needing to grasp, twist or pinch?
    - Yes (1)
    - No (2)
    - N/A (3)

34. Are the soap and towel dispensers (or hand-driers) within reach (i.e., no higher than 48 inches from floor) and not over an obstruction?
    - Yes (1)
    - No (2)
    - N/A (3)

Exam rooms

35. Is the entry door to the exam room at least 32 inches wide?
    - Yes (1)
    - No (2)

36. Is there adequate space for a mobility device to make a 180-degree turn (i.e., at least 30 inches by 48 inches) on one side of the exam table?
    - Yes (1)
    - No (2)

37. Are there private changing areas that are accessible?
    - Yes (1)
    - No (2)

38. Are gowns and drapes provided?
    - Yes (1)
    - No (2)

Compliance for the physically disabled: Equipment/Scales

39. Is there a weight scale that can accommodate people in wheelchairs or who are unable to stand without assistance, which is either integrated into a patient lift, integrated into an exam table or has a wheelchair-accessible platform?
    - Yes (1)
    - No (2)

40. Does your office have or can your office adapt an exam table for accessible transfers of people who use a wheelchair or are unable to transfer without assistance? (This may include the use of an adjustable-height table, transfer board, portable lift or a stretcher/gurney.)
    - Yes (1)
    - No (2)

Accommodations for hearing, speech and sight disabilities

41. Does the office have the ability to accommodate members with hearing, speech and sight disabilities? (The following materials are examples of accommodations: paper/writing utensil, visual aids, written materials, assistive-listening devices or systems and access to qualified sign language interpreters.)
    - o Yes (1)
    - o No (2)

Americans with Disabilities Act (ADA) and cultural competency training

42. Do your staff members receive ADA training once a year?
    - o Yes (1)
    - o No (2)

43. If yes, how does the staff receive ADA training?
    - o Internally (1)
    - o Managed-care-provided (e.g., Humana) (2)
    - o ADA.gov (3)

Plans, policies and licensure

44. Is there a hazardous materials/waste policy that describes the storage of sterile needles and proper disposal of used needles?
    - o Yes (1)
    - o No (2)

45. Is there an exposure-control process that includes infections control and universal precautions policies, procedures or protocols?
    - o Yes (1)
    - o No (2)

46. Does the office have a Clinical Laboratory Improvement Amendments (CLIA) certificate?
    - o Yes (1)
    - o No (2)

CLIA certificate number (1)	
Certificate date (2)	
Certificate expiration date (3)	
Waiver number (4)	
Waiver expiration date (5)	

47. Does the office have a standard list of abbreviations, acronyms, symbols and dose designations that **are not** to be used? The list must include:
    - – U, u
    - – IU
    - – Q.D., QD, q.d., qd, Q.O.D., QOD, q.o.d. qod
    - – Trailing zero (x.o mg)
    - – Lack of leading zero (.xmg)
    - – MS
    - – MSO4
    - – MgSO4
    - o Yes (1)
    - o No (2)

48. Does the office confirm that its preprinted forms do not include any of the previously mentioned abbreviations?
    - o Yes (1)
    - o No (2)

49. Does the office label all medications and medication containers (e.g., syringes, basins) to identify the contents?
    - o Yes (1)
    - o No (2)

50. Are all medications stored and maintained in an area away from public access **and** in an area, cabinet or room that can be securely locked?
    - Yes (1)
    - No (2)

51. Is there a 24-hour answering service or machine instructing members about how to obtain care?
    - Yes (1)
    - No (2)

52. Are your office hours and after-hours phone number posted internally and externally? (Note: May be "N/A" only if the office is located in large building and outside posting is prohibited by building management.)
    - Yes (1)
    - No (2)
    - N/A (3)

Medical records

NOTE: For initial credentialing and recredentialing, the reviewer must evaluate one blinded medical record to assess the adequacy of medical-record-keeping practices.

53. Are medical records maintained in an area away from public access?
    - Yes (1)
    - No (2)

54. Is a Health Insurance Portability and Accountability Act (HIPAA)-compliant written authorization obtained from the member or the member's authorized representative for maintaining the release of medical records? (Ask to see policy and procedure and the release form.)
    - Yes (1)
    - No (2)

55. Is there a mechanism for tracking referrals and reports to and from other practitioners and providers (e.g., between a primary care physician and a specialist)?
    - Yes (1)
    - No (2)

56. Is there evidence that medical record documentation standards have been implemented (e.g., legible, clear, concise, consistent, complete)?
    - Yes (1)
    - No (2)

57. Is there prominent documentation in an individual's record regarding the execution of an advance directive?
    - Yes (1)
    - No (2)

58. Is there a policy/procedure that outlines anti-discrimination in health care delivery? (Ask to see policy.)
    - Yes (1)
    - No (2)

59. Is there an appointment available for:
    a. Complete physical exam, routine preventive health, or well-child visits within 21 to 30 calendar days?
    - Yes (1)
    - No (2)

    b. Symptomatic visit within seven calendar days?
    - Yes (1)
    - No (2)

    c. Specialty care within 21 working days?
    - Yes (1)
    - No (2)

d. Urgent visit within 24 hours?
- Yes (1)
- No (2)

e. Emergent visit as soon as possible (i.e., immediately)?
- Yes (1)
- No (2)

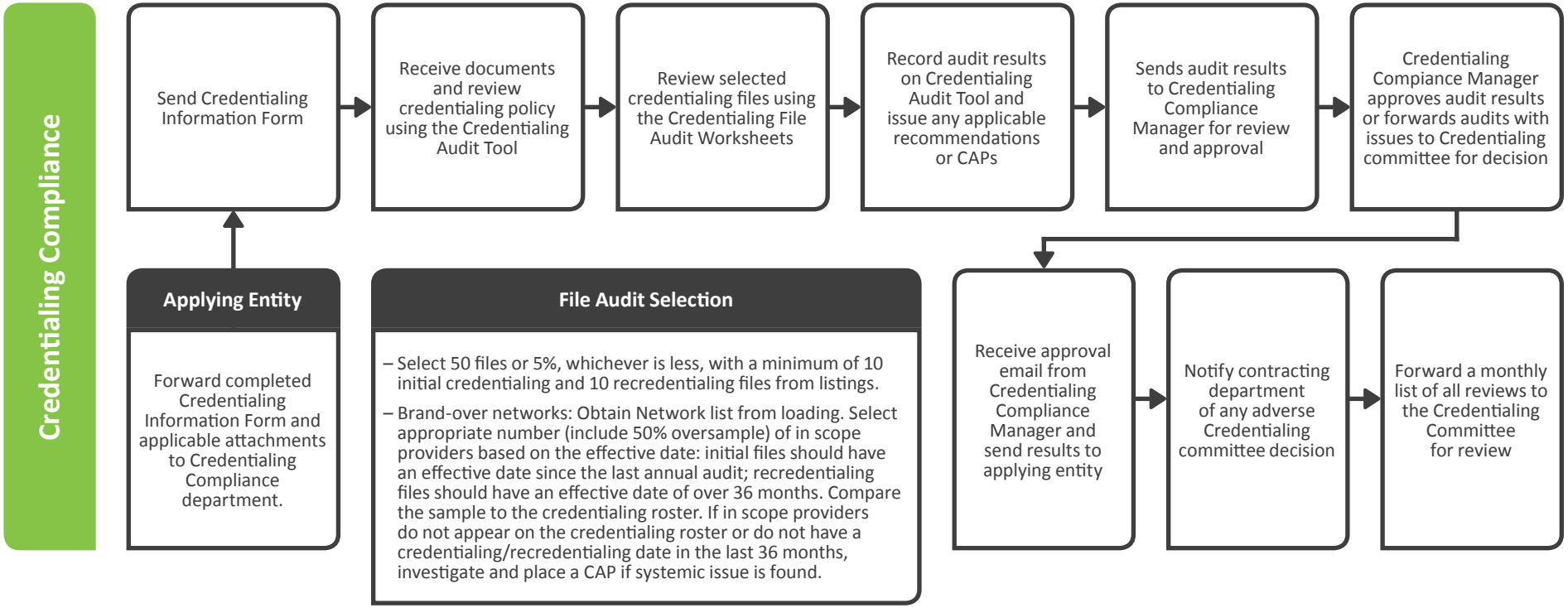
f. Do physicians see patients within 15 to 30 minutes of scheduled appointments?
- Yes (1)
- No (2)

Summary
Office address:
Practitioner(s) at this site:
1. The undersigned health plan representative has identified the following areas needing improvement and has discussed these areas with the practitioner or designee:
Follow-up to the site review will be evaluated by the health plan. Health plan representative signature: _____ Title:_____ Date:
Comments to the health plan:
I, the undersigned practitioner or designee, have reviewed the results of the office site evaluation. I agree to correct any area needing improvement as indicated by Humana. Practitioner/designee signature: _____Title: _____ Date:

	Scoring range
Excellent	**90 – 100%**
Acceptable	**80 – 89%**
Unacceptable	**79% and below**
Any "N/A" answer will receive the assigned score for a "yes" answer automatically when entered into the system.	

Attachment MMA 12-2: Annual Delegated Credentialing Audit Process

Humana measures results on a standard audit form that determines if the entity will be approved for delegated credentialing. The delegated entity is also subject to annual reviews to ensure it is meeting State, Federal and Accreditation oversight requirements. Please see below for our delegated credentialing audit process.



Delegation Policy

Humana

Humana Policy and Standards

Creation Date:	September, 1996	**Accountable Dept:**	10906- Licensure and Business Partner Compliance
Publication Date:	July 18, 2016	**Business Domain:**	02 Governance and Compliance
Last Review ed:	July 18, 2016	**Business Area:**	13.05 Delegation

Scope:

This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Statement:

This policy describes the oversight process for any activity or function for the Medicare, Medicaid, Marketplace Exchanges (FFM, SBM, SHOP, SPM), commercial and specialty lines of business that have been delegated by Humana to another entity. Humana remains responsible for the performance and compliance of any function that is delegated. Functions that may be delegated include, but are not limited to:

- Claims Processing
- Claims Repricing
- Credentialing
- Clinical Health Services for medical and behavioral health
  - Utilization Management (UM)
  - Complex Case Management (CCM)
  - Disease Management (DM)
  - Quality Improvement (QI)
- Special Needs Plan (SNP)

The following standards are part of this Delegation Policy:

- Pre-Delegation Audit
- Annual Delegation Audit
- Corrective Action Plan
- Delegation Services Addendum and Delegation Attachments
- Provisions for Protected Health Information (PHI)
- Sub-Delegation
- Termination of Delegation
- Additional Delegated Functions

Definitions:

Additional Delegated Functions- Any additional activity or function that has been delegated by Humana.

Annual Delegation Audit- Method to evaluate an entity's contractual, regulatory and accreditation organization compliance and performance capacity annually.

Claims Processing- The process to receive, investigate and an act on a claim filed by a provider or an insured. It involves multiple administration and customer service layers that include review, investigation, adjustment, and remittance of payment or denial of a claim. Delegation of claims processing is whereby Humana delegates all of these processes to another entity.

Complex Case Management- Coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

Concurrent- A review for an extension of a previously approved, ongoing course of treatment or number of treatments.

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Corrective Action Plan- Issued to a delegated entity when they fail to meet established thresholds of compliance.

Credentialing- The process of obtaining and reviewing the documentation provided by the applicant and/or obtained during the process for the purpose of determining participation privilege status in the health plan.

Delegated Entity- An entity contracted to perform a function on behalf of Humana.

Delegation- A formal process whereby a health plan gives a qualified contracted provider group the authority to perform certain business functions on its behalf.

Delegation Attachment- A legal document that covers the specific performance requirements based on the function being delegated.

Delegation Council- A cross-functional group to review and vet proposals that involve clinical or claim delegation

Delegation Services Addendum- An additional document not included in the main part of the contract. It contains additional terms, obligations and information regarding the delegation of specific functions to an entity.

Disease Management- A multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions.

Pre-Delegation Audit- Method to evaluate an entity's compliance and performance capacity prior to the execution of a delegation contract.

Pre-service Review- A service that an organization must approve, in whole or in part, in advance of a member obtaining medical care or services.

Post Service- Assessing appropriateness of medical services on a case-by-case or aggregate basis after services was provided.

Sub-Delegation- An entity contracted with a delegated entity to perform a function on behalf of the delegate.

Utilization Management- A formal evaluation (pre-service, concurrent, or post service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment plans.

Acronyms:

BAA- Business Associate Agreement

CAC- Contract Approval Committee

CAP- Corrective Action Plan

FFM- Federally-Facilitated Marketplace

HIPAA- Health Insurance Portability and Accountability Act

HITECH- Health Information Technology for Economic and Clinical Health Act

SBM- State-Based Marketplace

SHOP- Small Business Health Options Program

SNP- Special Needs Plan

SPM- State Partnership Marketplace (partnership of state and federal agencies)

Related Documents: N/A

Standard: Pre-Delegation Audit

Purpose: To evaluate the entity's capability to perform the requested delegated functions on behalf of Humana in a contractually compliant manner.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been recommended for delegation by a Humana contractor to perform an activity or function on Humana's behalf.

Requirement: The Delegation Compliance department will perform a pre-delegation audit prior to any function being delegated to a prospective entity upon receipt of the Request for Delegation form and the Predelegation Questionnaire (claims delegation only). The pre-delegation audit will include evaluation of a prospective delegate's compliance and performance capacity which will include a review and approval of the following applicable items of the prospective delegate:

- Delegation Council review of proposed clinical health services and claims delegation
- Contract Approval Committee (CAC) approval for claims delegation
- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Audit of contracted sub-delegate's program including policies, procedures and program documents
- Letters of accreditation
- Financial solvency
- File audit
- Federal/state exclusion screenings
- Offshore contracting

If a delegate requests a change of a subcontractor at any point, Humana's Delegation Compliance department will review and approve the subcontractor's policies, procedures and program documents, either directly or by review and approval of the delegate's audit of the proposed sub-delegate. These reviews will be conducted prior to contracting and require the subcontractor to comply with all Humana, federal, state and accreditation requirements.

Results of the pre-delegation audit are recorded on a standardized audit tool and then scored to determine the prospective delegate's ability to meet compliance requirements. Approval or rejection of the prospective delegate's pre-delegation audit will be based on the following compliance thresholds:

- Prospective delegates with a pre-delegation audit score of less than 70% must be referred to the appropriate committee, market leadership, compliance leadership, or business owner for additional evaluation and final determination on the entity's ability to meet Humana requirements to assume a delegated function.

- Prospective delegates with a pre-delegation audit score of 70%- 94% or those missing critical elements may only be approved if a Corrective Action Plan (CAP) is implemented. Refer to the Corrective Action Plan standard.

- Prospective delegates with pre-delegation audit score of 95% or higher may be approved without requiring a CAP, although potential opportunities for improvement should be documented and communicated to the delegate

Definitions: N/A

Related Documents: N/A

Standard: Annual Delegation Audit

Purpose: To review annually the functions of a delegated entity against contractual, state, federal and accreditation organization standards and requirements to ensure compliance.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to

perform an activity or function on its behalf.

Requirement: The Delegation Compliance department will perform an annual delegation audit to evaluate a delegate's continued ability to meet delegation compliance requirements, which will include a review and approval of the following applicable items of the delegate:

- Policies and procedures
- Program descriptions and work plans
- Forms, tools and reports
- Sub-delegation agreements
- Audit of contracted sub-delegate's program including policies, procedures and program documents
- Letters of accreditation
- Financial solvency
- File audit
- Confirming no offshore contracting

If a delegate requests a change of a subcontractor at any point, Humana's Delegation Compliance department will review and approve the subcontractor's policies, procedures and program documents, either directly or by review and approval of the delegate's audit of the proposed sub-delegate. These reviews will be conducted prior to contracting and require the subcontractor to comply with all Humana, federal, state and accreditation requirements.

Results of the annual audit are recorded on a standardized audit tool and then scored to determine the delegate's ability to meet compliance requirements. Approval or rejection of the delegates annual delegation audit scores will be based on the following compliance thresholds:

- Delegates with annual delegation audit scores of 70% or less must be referred to the appropriate committee, market leadership, compliance leadership or business owner for additional evaluation and final determination on appropriate and necessary next steps which may include; additional corrective measures, cancellation of a particular delegated function by termination of a delegation attachment, or termination of the delegation services addendum.

- Delegates with annual delegation audit scores of 70%-94% may only be approved if a Corrective Action Plan (CAP) is implemented. Refer to Corrective Action Plan standard.

- Delegates with annual delegation audit scores of 95% or higher may be approved without requiring a CAP, although potential opportunities for improvement should be documented and communicated to the delegate.

Definitions: N/A

Related Documents: N/A

Standard: Corrective Action Plan

Purpose: To formally identify and document any contractual, regulatory or accreditation organization performance requirements or other issues, provide an explanation of how the delegate is determined to be non-compliant and provide a plan of action to bring the delegate into compliance.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: The Delegation Compliance department will issue a Corrective Action Plan (CAP) when the delegate fails to meet established compliance thresholds, contractual requirements, or other requirements. Specific deficiencies resulting in a CAP include, but are not limited to:

- Failure to achieve an overall audit score of 95%, or
- Failure to achieve a single-item score of equal to or greater than 70%, or
- Failure to meet compliance thresholds for critical elements as specified on standardized audit tool, during a pre-delegation, annual delegation audit, or contractual review.

A CAP should contain:

1. The identified issues and deficiencies
2. The corrective actions required, and
3. The timeframes for performance of the corrective actions and achieved results.

The delegate's performance under the CAP will be monitored by Delegation Compliance. Monitoring frequency is dependent upon the potential risks identified, and will occur until the delegate has achieved the required results.

If a delegate fails to achieve the required results within the timeframe provided, the delegate's results will be referred to the appropriate committee, market leadership, compliance leadership or business owner for additional evaluation and a final determination on appropriate and necessary next steps, which may include; additional corrective measures, cancellation of a particular delegated function by termination of a delegation attachment, or termination of the delegation services addendum.

Definitions: N/A

Related Documents: N/A

Standard: Delegation Services Addendum and Delegation Attachments

Purpose: To establish a legally enforceable contractual arrangement between Humana and an entity that outlines the legal obligations mutually agreed upon between the parties to the agreement.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: Upon approval of delegation pursuant to the pre-delegation audit standard, Humana and delegate must execute Humana's Delegation Services Addendum and Delegation Attachment for each delegated function. The written Delegation Services Addendum and Delegation Attachment(s) must:

- Be mutually agreed upon.
- Describe the activities and the responsibilities of Humana and the delegated entity.
- Requires at least semiannual reporting by the delegated entity to Humana.
- Describe the process by which Humana evaluates the delegated entity's performance.
- Describe the remedies available to Humana if the delegated entity does not fulfill its obligations, including revocation of the Delegation Attachments.
- Retain for Humana the right to approve, suspend and terminate any delegated or sub-delegated function, including but not limited to the termination of individual practitioners, providers and provider sites where credentialing decision making is delegated.
- Retain for Humana pre-approval rights for any proposed sub-delegation.
- Contractually require that delegate shall provide sufficient oversight of the subcontractor to ensure that the subcontractor shall comply with all of the terms and conditions of the Delegation Services Addendum and attachments, or allow Humana to perform direct oversight of sub-delegate..
- Require delegate to comply with Humana, state and federal law and accreditation organization requirements.
- For Qualified Health Plans (QHP): Delegate must comply with 45 CFR 156.340 and permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of 45 CFR 156.340 until 10 years from the final date of the agreement period.

The Delegation Compliance department will maintain the Delegation Services Addendum with applicable Delegation Attachment(s).

Definitions: N/A

Related Documents: 45 CFR 156.340

Standard: Provisions for Protected Health Information (PHI)

Purpose: To protect the confidentiality, integrity, and availability of electronic PHI when it is stored, maintained, or transmitted.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: If a delegation arrangement involves the use of protected health information (PHI), Humana and delegate must execute Humana's Business Associate Agreement (BAA). The BAA should be mutually agreed upon and describe the following information:

- A list of allowed uses of PHI.
- A description of delegate safeguards to protect the information from inappropriate use or further disclosure.
- A stipulation that the delegate will ensure that sub-delegates have similar safeguards.
- A stipulation that the delegate will provide individuals with access to their PHI.
- A stipulation that the delegate will inform the organization if inappropriate uses of the information occur.
- A stipulation that the delegate will ensure that PHI is returned destroyed or protected if the delegation agreement ends.
- All other requirements under HIPAA/HITECH Act statutes and regulations.

The Business Associate Agreement (BAA) should be maintained by the Humana's Privacy Office and a copy of the BAA to the Delegation Compliance department.

Definitions: N/A

Related Documents: N/A

Standard: Sub-Delegation

Purpose: To establish requirements if a delegate choses to sub-delegate any activities that are currently delegated to them by Humana.

Scope: This standard governs the sub-delegation by any delegate of a delegated function

Requirement: The delegate will request Humana's approval to sub-delegate any portion of the delegated functions or activities. The delegate will demonstrate to Humana a plan for adequate oversight of the sub-delegate or request oversight by the Delegation Compliance department prior to approval of the sub-delegate.

If Humana approves the sub-delegation, the delegate will provide Humana documentation of a written sub-delegation agreement (and, as applicable, a Business Associate Agreement) that:

- Is mutually agreed upon.
- Describes the activities and the responsibilities of the delegate and the sub-delegated entity.
- Requires at least semiannual reporting of the sub-delegated entity to the delegate.
- Describes the process by which the delegate evaluates the sub-delegated entity's performance.
- Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement.
- Allows Delegation Compliance access to all records and documentation pertaining to monitoring and oversight of the sub-delegates delegated activities.

If it retains oversight responsibilities, the delegate will provide:

- Evidence of annual oversight of sub-delegated entity.

Definitions: N/A

Related Documents: N/A

Standard: Termination of Delegation

Purpose: To mitigate any risks the delegate may impose on Humana due to failure to comply with regulatory, contractual and other compliance requirements.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: A delegate's failure to perform or comply with the terms of the Delegation Services Addendum and attachments will result in Delegation Compliance referring the delegate's noncompliance or unacceptable performance status to the appropriate committee, market leadership, compliance leadership, or business owner recommending termination of delegation. Specific deficiencies that may lead to termination include:

- Failure to comply with state and federal laws, rules and regulations.
- Failure to comply with Humana or accreditation organization standards.
- Failure to cooperate with Humana's delegation audit process.
- Failure to comply with any term of the Delegation Services Addendum or delegation attachment(s).
- Failure to comply with the terms of any implemented Corrective Action Plan.
- Failure to submit accurate and timely delegation reports, as specified in the Delegation Services Addendum and attachments.
- Placement on any federal/state government programs exclusion lists.

Either the termination of the Delegation Services Addendum and/or a rescission of the delegated function/service should be initiated.

Definitions: N/A

Related Documents: N/A

Standard: Additional Delegated Functions

Purpose: To identify functions that could be delegated to an entity that would be out of scope for the Delegation Compliance department to oversee and/or monitor.

Scope: This Delegation Policy governs Humana's relationships with any entity that has been delegated by Humana to perform an activity or function on its behalf.

Requirement: The following additional activities or functions may be delegated by operational areas within Humana when the operational area assumes responsibility for oversight of that function or activity:

- Network Management
  - Provider access and availability
  - Provider contracting

Oversight of these additional activities or functions should meet the requirements of Humana's Delegation Policy and all standards therein.

Definitions: N/A

Related Documents: N/A

Owner:	Devin Prather	**Executive Team Member:**	Greg Catron
Accountable VP / Director:	Marla Sanders		

Disclaimer:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by a particular issue, to allow for consistency, Humana will follow the most stringent requirement.
This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/standard) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/standard) supersedes all other policies, standards, guidelines, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained in Policy Source to ensure no modifications have been made.

Non-Compliance:

Failure to comply with any part of Humana's policies, standards, guidelines, and procedures may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over any and all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to noncompliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Policy Source site of Humana's secure intranet (Humana Self-Service).

Humana Internal
UNCONTROLLED WHEN PRINTED. Check controlled location to verify that this is the current version before use.

Attachment MMA 12-4: Credentialing Life Cycle of an APEX Work Case

Work Case Created

- Provider Relations team initiates task for completion of credentialing once all credentialing related documents including completed office site visit evaluation an ownership addendum are received

Automation:
- Systematic evaluation to determine where the Work Case needs to go next
- Full Terminations of Practitioners & Practitioner Groups executed without Contract Load involvement, when possible

Contract Payment-related Work Performed

- Contract Information System Modeling (Assess pre-implementation impact of payment terms)
- Contract Information System Load

Demographic and Contract Participation Work Performed

- Contract Load Team
- Data Collection and Verification Team (DCAV)

Automation:
- Provider records updated
- Systematic evaluation to determine need for Credentialing, Enrollment, & /or Service Fund involvement

Credentialing Work Performed

- Credentialing team performs all validation steps in compliance with process and policy (i.e. verification of provider's licensure, education, certification)

Automation:
- Provider record updated
- Cred Approval or Cred Denial Letter sent
- Notice of Cred Denial sent to Work Case Originator, when applicable

Service Fund Work Performed

- Service Fund Team (Member Assignment/Reassignment, modifications to Capitated payment mechanisms, etc…)
- Not all Work Cases/Providers encounter this step

Automation:
- Comments entered on Work Case and Attachments linked to Providers are archived to the Providers'' records
- Notice of Completion email sent to Work Case Originator, if requested

Provider Orientation

- Provider Relations Representative communicates effective date to provider and schedules Humana orientation training

Humana.

Attachment MMA 12-5: Credentialing Committee Denial Letter

Humana

January 1, 2015

John Doe, MD
500 West Main St
Suite 100
Louisville, KY 40202

Sent via Certified Mail, Return Receipt Requested
123456789

Dear Dr. John Doe,

This letter serves as notification that your credentialing application has been denied by the Humana Credentials Committee for the following reason:

<Insert reason from attached list>

This determination was based on Humana's established credentialing criteria. You may be eligible to reapply for participation two years from this decision date.

If you feel this determination was made in error, you may submit a request for reconsideration by the Credentials Committee within 14 days of receipt of this letter. Please forward the request to my attention at the email address furnished below and include a detailed explanation regarding the issue you wish to be reconsidered to sbarczak@humana.com.

If you have additional questions, please contact Denise Carnes at dcarnes@humana.com.

Sincerely,

Sylvester Barczak, M.D.

Sylvester Barczak, M.D.

Cc: Network Contracting
Credentialing File
Credentialing Committee

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 13 – Value Based Purchasing (Regional):

a. The respondent shall describe the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated by primary care, specialty care and hospital-based care.

b. The respondent shall describe the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five (5) Contract years, delineated by primary care, specialty care and hospital-based care.

c. The respondent shall include specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by primary care, specialty care and hospital-based care.

d. The respondent shall describe specific VBP arrangements it intends to implement and/or maintain in an effort to promote the Agency's goals, delineated by primary care, specialty care and hospital-based care.

Response:

Value-based purchasing (VBP) plays a powerful role in improving the quality of care that enrollees receive by rewarding providers who deliver better care at lower costs. Humana is an industry leader in establishing value-based relationships. With thirty (30) years of experience building VBP partnerships with our providers, Humana was one of the first health plans nationwide to partner with providers to develop these models. Over these decades of partnership and with a continuous focus on improvement, we have developed a VBP strategy that produces positive results through stronger clinical models, an enhanced focus on health, an enrollee-centric approach, and industry-leading provider relationships. Today, more than two million (2,000,000) Humana enrollees nationwide are attributed to more than forty-nine thousand (49,000) primary care providers (PCPs) engaged in VBP arrangements.

In Florida, Humana has been deeply committed to improving health outcomes and reducing costs through VBP programs in our Medicaid, Medicare, and commercial plans. We now have more than eight hundred thousand (800,000) Florida Medicaid and Medicare enrollees attributed to local VBP-engaged PCPs. A map displaying the locations of these providers throughout the State can be found in Attachment MMA 13-1. We have developed a custom set of locally-responsive models tailored to fit the needs of our Florida Medicaid providers. Through data analytics and in-person assistance from our Provider Relations representatives and others, we support our providers to move along a continuum of VBP programs towards whatever end-point on the risk-bearing spectrum with which they feel most comfortable. Humana will continue harnessing VBP arrangements to drive improved results among our Florida Medicaid enrollees, including the reduction of potentially preventable events and better birth outcomes.

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a. The respondent shall describe the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated by primary care, specialty care and hospital-based care.

d. The respondent shall describe specific VBP arrangements it intends to implement and/or maintain in an effort to promote the Agency's goals, delineated by primary care, specialty care and hospital based care.

1. The extent to which the respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.

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Our experience developing our continuum of value-based programs has demonstrated that the health care system delivers better outcomes when providers are offered thoughtful incentives, consultative guidance, and care gap alerts that are integrated with and measured by thoughtful comparative metrics and benchmarks. Among those providers engaged in VBP arrangements, we have repeatedly observed more rapid identification of high-risk enrollees, stronger delivery of care for chronic conditions, reduction of medical costs, and greater enrollee satisfaction.

An effective provider engagement strategy enables the formation of true partnerships and optimizes the payer-provider relationship. For some providers, the shift from a fee-for-service delivery model to value-based payments can be challenging. It requires the effective use of enrollee data, a focus on care coordination, and attention to enrollee engagement, with the enrollee and PCP serving as the hub of the care model (Attachment MMA 13-2). For many providers, these are lofty goals; for others, they are attainable with only minor adjustments to their current models. Humana's continuum of value-based programs allows each provider to enter into a VBP arrangement that suits its current capabilities, experience, and readiness. For example, while Full Value arrangements offer the greatest opportunity to improve quality and reduce costs, many providers have not yet developed the scale and capabilities to be successful in a risk-bearing environment. After working with the provider to determine the appropriate starting point, Humana offers the guidance and resources necessary to support the provider in moving as far along the continuum as desired.

Our continuum encompasses four models, each progressively moving further away from a volume-based payment model and closer to a value-based design. Each step provides a gradual evolution towards true value-based care delivery. Humana's nationwide Value-based Continuum is described below and illustrated in Attachment MMA 13-3.

PCPs are enrollees' most frequent point of entry into the health care system, and are best-suited for the efficient delivery of preventive care services. In addition, with their frequent touchpoints with enrollees and an increasingly whole-person focus, PCPs serve as a central point of coordination among specialists and hospitals. For these reasons, we have emphasized PCP-centric models in our value-based continuum.

STAR REWARDS: This program is our quality-only reward available to PCPs in our network. The goal for each practice in this program is to meet quality targets for at least four of five HEDIS quality measures. These measures include: comprehensive diabetes care – neuropathy screening; comprehensive diabetes care – HbA1c control; breast cancer screening; colorectal cancer screening; and medication adherence - hypertension. Rewards

are calculated annually as the aggregate of all physicians' performance within each practice. The bonuses offered through this program incentivize providers to learn about how they can drive improvement on HEDIS measures related to reducing preventable events.

MODEL PRACTICE: Physicians can earn incentives for achieving quality targets for the additional clinical and strategic initiative measures that are added for this program, such as emergency department (ED) utilization and readmission rates. This design helps providers take accountability for a broader set of measures that are related to positive health outcomes. While providers receive bonus payments for achievements in the model practice program, they are also eligible for shared-savings opportunities. When providers are eligible for shared savings, they are incentivized to deliver preventive care that reduces avoidable costs, such as vaccines, cancer screenings, and regular check-ups.

MEDICAL HOME: The third level of Humana's continuum is offered to groups that are either recognized as a patient-centered medical home (PCMH) or are in the process toward recognition from any accrediting agency, such as NCQA or The Joint Commission. The Medical Home program is suited for providers that have made progress in addressing some of the necessary requirements to become successful population health managers. For example, participants in the Medical Home program have implemented an electronic medical records system and likely use electronic prescribing systems. Additionally, they may have made other infrastructure changes, including the employment of care coordinators inside the practice. Under the Medical Home design, rewards measures and shared savings arrangements are the same as in the Model Practice program. However, with the Medical Home program, a care coordination payment is made to address the cost of building capabilities to achieve PCMH certification. This shared savings feature incentivizes larger, more sophisticated PCPs to coordinate enrollees' care through effective referrals, the sharing of data with other providers, and helping enrollees receive care in the most appropriate settings.

FULL VALUE: The final level of Humana's value-based continuum is the Full Value model. In this model, we pay a per-enrollee, per-month global capitation rate to providers to fully manage the cost and quality of care for our enrollees. This model ensures clinical cost savings are reinvested back to PCPs. Before providers advance to Full Value, Humana assesses their capabilities and infrastructure to ensure participating providers are in a position to be successful in the arrangement. Infrastructure that supports success in Full Value arrangements includes social workers or case management staff, referral teams, outreach to enrollees that are designated unable-to-contact, electronic health records, and a HEDIS team that manages gaps and develops action plans for the provider. As providers assume full risk for enrollee outcomes through this model, they are incentivized to manage and improve all aspects of enrollees' care, including care delivered by specialists or by hospitals, as well as social determinants of health. In addition to ensuring enrollees receive the appropriate preventive care, the Full Value model drives improved enrollee outcomes by motivating providers to coordinate care at all levels, from primary care to specialty care to inpatient stays, and to ensure that enrollees are adhering to their course of treatment.

FLORIDA MEDICAID VALUE-BASED PURCHASING MODELS

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Based on our successful national value-based continuum, we have developed a custom-tailored continuum of VBP programs specifically for Florida Medicaid providers that we will maintain under the next contract. This continuum is informed by best practices from Humana's nationwide experience and expertise, but it is driven by the needs and capabilities of Florida providers and the enrollees they serve. Humana's Florida Medicaid PCPs participate in this full continuum of VBP programs, while specialists are currently participating in our MPIP and Full Value models.

PCPS AND SPECIALISTS

Humana's value-based continuum for Florida Medicaid PCPs includes four VBP programs. Two of these programs – MPIP and Full Value – extend to specialists:

QUALITY-CAP BONUS: Our Quality-Cap Bonus program offers our Florida Medicaid providers a variation of our nationwide Star Rewards model. PCPs that exceed NCQA benchmarks across a series of HEDIS quality metrics related to access to primary care, immunizations, well-child visits, cancer screenings, and disease management can receive quarterly bonuses. Humana has rewarded high-performing Florida Medicaid providers with [redacted] in bonuses through this program since 2014. The bonuses offered through this program incentivize providers to implement interventions that improve HEDIS measures related to reducing preventable events. As providers assume no risk in this model, it serves as an introduction to VBP and prepares providers to move along the continuum towards higher-risk arrangements.

MMA PHYSICIAN INCENTIVE PROGRAM (MPIP): We operate an enhanced version of MPIP, the VBP program established by AHCA that rewards Medicaid providers who achieve quality targets with Medicare reimbursement rates. Higher reimbursement rates offer an incentive for MPIP providers to proactively drive quality improvement and achieve tangible gains related to their target measures, leading to better preventive care, improved health outcomes, and lower overall costs. Humana's program includes family practitioners, general practitioners, and pediatricians who see children ages zero (0) to twenty (20), as well as OB/GYNs and pediatric specialists. Each provider type has a tailored set of quality metrics related to specific health outcomes for their scope of services. In collaboration with AHCA, Humana enhanced the standard program by adding data-driven metrics that focus on reducing preventable events and improving birth outcomes. Pediatric PCPs in our network can elect to use the Enrollee Encounter Rate and Emergency Department Utilization as a benchmark or to use HEDIS measures, including those related to well-child visits and access to primary care. OB/GYNs' reimbursements are tied to quality metrics related to Prenatal Care, Caesarean Section Rates, and Postpartum Care. In recognition of the unique provider landscape in each region, we have also established region-specific benchmarks for each metric. Humana is continuously vetting additional quality metrics for all providers in the MPIP program in order to support the shift from pay-for-volume to pay-for-value.

SHARED SAVINGS: In a design similar to the Model Practice and Medical Home arrangements featured in Humana's nationwide Value-Based continuum, Humana rewards Florida Medicaid PCPs who reduce overall medical costs, while maintaining performance standards across quality metrics, with a portion of the cost savings realized by Humana. The potential to receive shared savings, while assuming no risk, incentivizes PCPs to take steps (such as establishing care coordination and integration processes) that reduce preventable events,

better manage chronic conditions, and lower costs. Shared savings also helps providers develop population health management capabilities that are essential to success in Full Value arrangements.

FULL VALUE (GLOBAL RISK): In our Florida Full Value model – exactly as with our nationwide Full Value model, described above - we pay PCPs and specialists, including behavioral health (BH) providers, on a PMPM basis to manage the care of our enrollees. In this arrangement, providers accept financial risk for the outcomes resulting from the services used by enrollees each month. When the cost of an enrollee's services is lower than a Full Value provider's monthly capitated rate to manage their care, the provider receives the cost savings surplus. Conversely, when the cost of the enrollee's care exceeds the provider's Full Value rate, the provider is accountable for the deficit incurred. The financial link with enrollee outcomes and service usage incentivizes providers to establish practices that enable the best outcomes for enrollees, such as employment of care coordinators and social workers, integrated care teams, electronic health records, and an emphasis on engaging enrollees in care.

HOSPITALS

While this continuum of VBP arrangements has a direct impact on hospital-based care, Humana does not currently directly enter into VBP arrangements with hospitals. This was a deliberate choice, informed by our success working through PCPs to reduce avoidable hospitalizations and readmissions. We have found value based models that incentivize PCPs to take a proactive approach to preventive care and take a lead role in coordinating care between providers are most successful in ultimately reducing preventable events and improving the appropriate utilization of hospital-based care. However, Humana remains committed to improving quality through value-based care, and we will continue to explore innovative payment models with all provider types, including hospitals.

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b. The respondent shall describe the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five (5) Contract years, delineated by primary care, specialty care and hospital-based care.

2. The extent to which the respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five (5) Contract years, including a rationale for the intending percentages.

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The number of Florida providers in Humana's VBP arrangements has increased dramatically over the past decade. Today, Humana has more than eight hundred thousand (800,000) Florida Medicaid and Medicare enrollees attributed to PCPs engaged in VBP arrangements. We anticipate that our volume of VBP contracts will continue to grow over the course of AHCA's new SMMC contract. For Region 1, we have developed the following projections for the specific percentage of providers expected to participate in VBP arrangements, delineated by primary, specialty, and hospital-based care for each of the five (5) Contract years.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

REGION 1 VBP PROJECTIONS BY CONTRACT YEAR AND PROVIDER TYPE

Trade Secret as defined in Section 812.081, Florida Statutes

[redacted]

Trade Secret as defined in Section 812.081, Florida Statutes [redacted]

HOSPITALS

In Region 1, Humana has chosen not to contract with Hospitals through VBP arrangements throughout the contract.

While Humana's continuum of VBP arrangements has a direct impact on hospital-based care, we do not directly enter into VBP arrangements with hospitals. This was a deliberate choice, informed by our success working through PCPs and specialists to reduce avoidable hospitalizations and readmissions. We have found that we are most successful in improving hospital-based care through VBP by incentivizing PCPs and specialists to take a proactive approach to preventive care and a lead role in coordinating care between providers at all levels of the health system.

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c. The respondent shall include specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by primary care, specialty care and hospital-based care.

3. The extent to which the respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage of the continuum.

==========

Each stage of our value-based continuum has quality measures and incentives that are designed to achieve specific outcomes related to reducing potentially preventable events, improving birth outcomes, and improving the overall quality of care for our enrollees. To achieve these outcomes, each model emphasizes the importance of care coordination, preventive services, and the management of chronic conditions with measures that are reflective of our providers' capabilities and preparedness to address these areas.

PRIMARY CARE

QUALITY-CAP BONUS

Humana's Quality-Cap Bonus program rewards PCPs who perform above national NCQA benchmarks on a series of metrics tied to quality improvement. These metrics are tied to the reduction of potentially preventable events and the early detection and treatment of disease.

For example, we offer bonuses to providers with strong performance on the Adults' Access to Preventive/Ambulatory Health Services (AAP) HEDIS measure in order to increase the percentage of our enrollees who visit their provider for regular preventive care. Among

adults, regular PCP visits for preventive health services are essential for detecting and treating minor illnesses before they cause serious problems, for delivering preventive services, and for encouraging behavior change such smoking cessation and physical activity. By linking PCP visits to quality rewards, PCPs are further incentivized to ensure that their enrollees come in for regular visits. These regular interactions encourage enrollees to go to their PCP first for treatment of acute illnesses, rather than the ED.

Another example is our Quality-Cap Bonus model, which incentivizes our PCPs to increase their rates of breast cancer and cervical cancer screening. This leads to improved rates of early detection and greater access to specialist treatment for these conditions. The outcomes we expect to see from these incentives include reduced hospitalizations and overall lower morbidity related to these conditions as a result of early detection and treatment.

PCPs also play an important role in chronic condition management. For this reason, we include measures related to diabetes control in our Quality-Cap Bonus program, including HgbA1c Testing and HgbA1c Control. By incentivizing providers to help our enrollees manage these conditions, we expect to see a related reduction in diabetes-related ED visits and inpatient admissions.

MPIP

By linking higher reimbursement rates to PCPs' performance in MPIP metrics related to well-child visits and children's and adolescents' access to primary care, we expect to see a reduction in ED visits for preventable childhood illnesses. Parents and children who have developed a strong relationship with their pediatric PCP are more likely to visit the PCP for acute conditions rather than the ED. In addition, through early detection of childhood illnesses or developmental delays during well-child visits, we can enable early access to care and treatment that will ultimately reduce admissions, reduce the incidence of acute conditions (including those that are vaccine-preventable), and lower costs.

For family practitioners and board-certified general practitioners participating in MPIP, we incentivize preventive health services and PCP engagement through metrics related to well-child visits and the enrollee encounter rate. As a result of this emphasis on appropriate medical utilization (including preventive care), PCPs can better detect and treat acute conditions and manage chronic conditions, thus decreasing the need for inpatient admissions or ED visits.

SHARED SAVINGS

After providers have demonstrated success in the Quality-Cap Bonus or MPIP programs, Humana helps them grow into more sophisticated arrangements, such as our Shared Savings model. Providers participating in this model are incentivized to lower the cost of care for enrollees while achieving high-quality outcomes. Therefore, we expect to see PCPs make referrals to specialists and assist enrollees with finding the most appropriate setting of care. For example, PCPs participating in this arrangement educate enrollees about appropriate care-seeking such as when it is appropriate to call their PCP, visit an urgent care center, or go to the ED.

By tying payments to performance on a broad set of HEDIS quality metrics and achievement of overall cost savings, our Shared Savings program incentivizes PCPs to improve the health

outcomes of our enrollees. Examples include reduction of recurring and costly events like ED visits and hospital readmissions. Through improved rates of well-child visits and improved access to the PCP for adolescents and children that result from our Shared Savings program, we expect to see reductions in the number of children who require difficult and costly treatment for conditions that can be prevented or detected by a PCP. This includes the prevention of childhood diseases, including those that are vaccine-preventable, and the early detection and treatment of conditions with potentially serious effects, including elevated blood lead levels. Additionally, through a focus on nutrition and physical activity counseling for children, we expect to see fewer children who are require treatment for Type II diabetes.

For adults, we include metrics related to breast and cervical cancer screening and adult well-visits. The inclusion of these metrics combined with aligned incentives created by a shared savings structure, creates a situation in which we expect to see high rates of screening for, and thus earlier detection and treatment of, breast and cervical cancers. According to the National Cancer Institute, screening with mammography can lead to a fifteen (15) percent to twenty (20) percent relative reduction in mortality from breast cancer. Regular pap screenings decrease cervical cancer incidence and mortality by at least eighty (80) percent. Screening for chlamydia reduces the complications of chlamydial infection, including pelvic inflammatory disease. In addition, it reduces the risk of passing the infection to an infant during delivery. Furthermore, by encouraging regular PCP visits for adults, we expect to see higher rates of screening and detection of common conditions, including diabetes, hypertension, and heart disease. Detection of these conditions and early entry into treatment can reduce future complications or disease.

Given the important role of the PCP in chronic disease management, we include HEDIS metrics related to asthma and diabetes control in our Shared Savings program. This will result in fewer ED and inpatient visits related to asthma and fewer complications from diabetes, including neuropathy and eye problems, as well as fewer ED and inpatient visits.

FULL VALUE

By promoting shared accountability, the Full Value model incentivizes PCPs to address all aspects of the enrollee's care that might affect outcomes. With an emphasis on metrics that address potentially preventable events, Full Value VBP arrangements will improve outcomes that reflect more integrated care and attention to social determinants of health, including reduced ED visits, inpatient admissions and readmissions, and unnecessary ancillary services.

Humana's Florida Medicaid providers in Full Value risk arrangements outperform their non-risk counterparts in terms of quality, outcomes, and cost. In 2016, the risk providers had significantly higher quality scores on metrics related to preventive health, well child visits, and diabetes management. As a result of their strong performance, these providers also have strong outcomes – Humana's Florida Medicaid risk providers average twenty-five point three percent (25.3%) fewer ED visits per one thousand (1,000) enrollees and seventeen point four percent (17.4%) fewer inpatient admissions per one thousand (1,000) enrollees. By reducing preventable events like these and helping enrollees access care in appropriate settings, Florida risk providers have fourteen point seven percent (14.7%) lower inpatient

medical expenses and have reduced pharmacy expenses by eleven point four percent (11.4%).

Providers operating under the Full Value model have both the incentive and resources to ensure that our enrollees are receiving preventive care, including engagement of unreachable enrollees. Through better attention to screening, immunizations, and well visits, we expect to see early detection of diseases, engagement in treatment, and fewer vaccine-preventable infections such as influenza and varicella. Additionally, providers in our Full Value arrangements are commonly patient-centered medical homes (PCMHs), which promote comprehensive care through a team of providers, including PCPs, specialists, and support staff. By investing in integrated care and coordination with specialists (including behavioral health providers) we expect to see fewer admissions and ED visits, better post-discharge follow-up care, and greater medication adherence through a more team-focused approach to the management of chronic conditions.

Additionally, through investments in the employment of case managers and social workers, our providers operating under the Full Value model are better equipped to address the social determinants of health that can affect our enrollees' outcomes. By better supporting our enrollees in all aspects of their lives we expect to see fewer preventable diseases, better management of chronic diseases, and fewer ED visits. This support includes things such as help navigating the health care system, programs to enable adherence to their medication schedules, availability of non-emergency transportation for provider visits, and access to a safe living environment and healthy foods.

The Full Value arrangement also supports providers as they introduce cost-saving innovations such as telemedicine. Telemedicine can help PCPs, particularly those in rural areas, better connect with the specialists that can help them manage the chronic conditions of their enrollees.

SPECIALTY CARE

MPIP

For board-certified OB/GYNs, our MPIP program is designed to drive improvements in measures closely linked to birth outcomes. As providers are incentivized to improve the frequency of ongoing prenatal care among enrollees, we expect to see a reduced risk of pregnancy-related complications, including anemia, preterm birth, preeclampsia, and complications of diabetes. Additionally, we expect to see a lower proportion of babies born at a low birthweight, as babies born to mothers who receive no prenatal care are three times more likely to be born at a low birthweight. Babies who are born to mothers who receive no prenatal care are also five times more likely to die, according to the U.S. Department of Health and Human Services' Office on Women's Health.

According to the American College of Obstetricians and Gynecologists, by connecting provider payments to C-section rates, we also expect to see reduced maternal hospital stays, reduced risk of respiratory problems in infants, and a reduced risk of complications in subsequent pregnancies.

Our MPIP program will also measure the percentage of enrollees with a postpartum care visit, which leads to improvements in outcomes. Greater coverage of postpartum care can lead to greater uptake of post-partum family planning, improved breastfeeding rates, and improved detection and treatment of post-partum depression. In addition, for those women with pre-existing conditions, such as diabetes, we can expect to see improved outcomes related to their condition as the OB/GYN can help them get back on track in managing their condition during the post-partum period.

Pediatric specialists (including cardiologists, endocrinologists, nephrologists, neurologists, and psychiatrists) are incentivized to pursue and maintain board certification in order to receive a Medicare rate payment through MPIP. Board certification is a process that exceeds state licensing requirements for practicing medicine. Certification reflects an ongoing commitment by the physician to continually expand their knowledge in their medical specialty. Once a physician is certified by the board, they are required to formally maintain their certificate through ongoing education. Through this arrangement, we expect to see improved outcomes for children with special conditions such as Juvenile Idiopathic Arthritis, Inflammatory Bowel Disease, and Left Heart Syndrome.

FULL VALUE

Our Full Value arrangements use a range of metrics to assess our medical specialists' performance and determine payments, including HEDIS, enrollee encounter rate, surplus/deficit calculations, and medical metrics, including admissions, readmissions, and ED visit rates. With attention to a broad swath of indicators and an emphasis on better outcomes at lower costs, our specialists in this arrangement are incentivized to take actions that support integrated care with PCPs and other specialists, promote medication adherence, and help our enrollees seek care at their PCP's office or urgent care, rather than the ED. In addition, specialists are encouraged to avoid costly and unnecessary ancillary services such as those radiology or laboratory services that do not have a bearing on enrollee outcomes. By taking these steps, we expect our enrollees who see specialists in VBP arrangements to have fewer inpatient admissions and readmissions, fewer ED visits, and use fewer unnecessary ancillary services.

For BH specialists in our network, the outcomes measured through the Full Value arrangement are also directly linked to the reduction of preventable events. Incentives are determined based upon 7-day and 30-day follow-up rates after hospitalization; initiation and engagement of alcohol and other drug dependence treatment; and hospital psychiatric re-admissions at thirty (30), sixty (60), ninety (90), and one hundred eighty (180) days. By encouraging our BH providers to focus on proper follow-up care following hospital admissions and initiation of substance use treatment, we expect to see higher engagement in treatment for our enrollees and improved management of their BH conditions, resulting in fewer ED visits and inpatient admissions associated with BH.

HOSPITAL-BASED CARE

As discussed above, Humana has chosen not to enter into VBP arrangements with hospitals. We have determined through our experience operating VBP arrangements for PCPs and specialists that we are able to successfully improve hospital outcomes through these

models. We educate our PCPs on actions they can take in ambulatory settings to reduce potentially preventable hospitalizations. An example of this communication can be found in Attachment MMA 13-4. By incentivizing providers to focus on all aspects of an enrollee's care, including the care they receive in the hospital, and by rewarding them for reducing inpatient admissions among our enrollees, we see fewer inpatient admissions and readmissions, and better coordination of post-discharge care.

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4. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.

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At the most fundamental level, our VBP programs are designed to reduce potentially preventable events by tying payments to overall enrollee outcomes. We build VBP arrangements around three (3) key strategies to reduce preventable events:

- Incorporation of preventive care measures
- Incorporation of clinical initiative measures and
- Implementation of Shared Savings and Full Value models

Preventive care plays an important role in all of our VBP programs. Payments are tied directly to preventive care measures, including access to primary care for children, adolescents, and adults, well-child visits, and the enrollee encounter rate. In addition to controlling preventable events through the administration of screenings, immunizations, and other prevention activities, regular engagement with the PCP contributes to reduced ED visits. When enrollees have established a strong relationship with their PCP, they are more likely and feel more comfortable going to their PCP for acute incidents than to the ED. Additionally, VBP may incentivize providers to stay open later and have more flexible hours to better accommodate enrollees' needs.

Clinical initiative measures – incorporated into our MPIP, Shared Savings and Full Value models – directly link VBP with reducing potentially preventable events. These measures include acute care admissions per one thousand (1,000) enrollees per year, inpatient days per one thousand (1,000) enrollees per year, readmission rates within thirty (30) days; and ED visits per one thousand (1,000).

Through our Shared Savings and Full Value arrangements, providers are incentivized to deliver services and coordination that reduce costly ED visits, hospital admissions, and readmissions, as reducing these events allows providers to experience greater savings. Namely, these arrangements incentivize management of chronic conditions, which are the top two (2) contributors to inpatient admissions and readmissions in Region 1 (COPD and congestive heart failure). Providers in these arrangements are more likely to coordinate with specialists to help enrollees manage their conditions, and provide the support and resources that enrollees need to adopt healthy habits, including smoking cessation, exercise, and healthy eating. In addition, providers engaged in these arrangements have frequently established procedures for following up with unable-to-contact enrollees and ensuring that enrollees do not miss appointments. Through social workers or case managers, they can

connect enrollees with community resources, such as smoking cessation support, that contribute to improved outcomes and respond to the social determinants of health.

Additionally, by incentivizing our providers to reduce readmissions, our VBP program promotes integrated care. Behavioral health-related conditions are a leading cause of readmissions in Region 1, with bipolar disorder as the leading contributor, and pancreas disorders (most commonly caused by chronic alcohol consumption) as the 3rd leading cause. To control readmissions related to these conditions, PCPs need to coordinate with BH providers, and BH providers need to make sure that follow-up appointments are completed. In addition, PCPs are incentivized to link enrollees with substance use programs to help them control their condition.

Within our Shared Savings and Full Value programs – through which providers can share in a portion of Humana's savings – PCPs and specialists are further incentivized to reduce the use of unnecessary ancillary services as a cost-reduction measure. By reducing the number of unnecessary radiology services, diagnostic tests, laboratory tests, therapy services, and pharmaceuticals, our VBP program is successful in not only lowering costs, but also ensuring a better quality of care for our enrollees by cutting down the amount of time they spend in outpatient facilities receiving tests and avoiding any pain associated with these procedures.

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5. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for improvement of birth outcomes

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Humana shares AHCA's goals of reducing unintended pregnancies and promoting positive birth outcomes. Our VBP programs incentivize providers to focus on the main contributors to good birth outcomes, including frequent prenatal care, postpartum care, and reduction of medically unnecessary C-sections.

Our MPIP program is open to any physician who is board-certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology and who had at least ten (10) Medicaid deliveries during the measurement period. As of July 2017, we have one hundred fifteen (115) OB/GYNs who are qualified for and are receiving the enhanced payment through MPIP. These physicians are responsible for hundreds of pregnant Medicaid enrollees, providing the prenatal and postpartum care and deliveries.

The indicators by which our MPIP providers are measured are directly linked to AHCA's goals for improving birth outcomes, including increasing the frequency of prenatal care, increasing the number of women who complete a postpartum care visit, and a reduction in medically unnecessary C-sections. By linking reimbursement rates to these indicators, we incentivize our providers to take actions that improve birth outcomes among our enrollees.

Family planning education and support is critical to the reduction in unintended pregnancies and is thus an important contributor to better birth outcome rates across the population. To that end, PCPs can counsel and administer family planning methods to our enrollees to prevent

future unintended pregnancies or can refer our enrollees to a location where they can receive the family planning method of their choice. OB/GYNs can also administer family planning methods to women who are not pregnant and counsel pregnant women on family planning methods that can be used post-partum. This includes administering these methods during the immediate or intermediate post-partum period.

This collection of approaches, as enabled by our Shared Savings and Full Value programs, encourages both PCPs and specialists to invest in initiatives that drive improved birth outcomes and reduce overall avoidable medical costs.

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6. The extent to which the respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.

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As described throughout this response, Humana currently implements a continuum of VBP strategies for Florida Medicaid PCPs. Our VBP arrangements have been informed by over twenty (20) years of experience serving Floridians and the strong relationships we have built with providers throughout the state over that time. This continuum reflects our commitment to meeting providers at their level of readiness and supporting them to move as far as they like along the spectrum to full accountability.

In the first level of our continuum, the Quality-Cap Bonus program serves as an introduction to VBP for our PCPs. Through this program, PCPs can receive incentive payments for their performance on key HEDIS measures. We currently have more than one thousand (1,000) Florida Medicaid PCPs participating in this program in Florida.

In the next level, PCPs and specialists can participate in the MMA Provider Incentive Program (MPIP). Humana's MPIP model rewards providers who both achieve certain standards in the HEDIS measures and who achieve progress in medical metrics, including the enrollee encounter rate and ED visits per one thousand (1,000) enrollees. MPIP encourages providers to take a whole-person view of health, with an emphasis on prevention and bringing enrollees into care. Today, more than sixty-five thousand (65,000) Humana MMA enrollees are attributed to PCPs that qualify for Medicare reimbursement rates through the MPIP program.

Providers' engagement in MPIP sets them up for the next level of our continuum, our Shared Savings model. In this model, PCPs are eligible to receive a portion of Humana's own savings based upon their performance on a range of HEDIS metrics and their overall medical savings. By encouraging providers to focus on quality of care in addition to lowering costs, we prepare them to take on greater risk. Humana has more than one hundred twenty-eight thousand (128,000) MMA enrollees attributed to providers under a Shared Savings arrangement in Florida.

The final level of our continuum is our Full Value model. In this model, PCPs and specialists receive a per-enrollee, per-month sub-capitation payment. As this arrangement gives our providers full responsibility for the care of our enrollees and allows them to keep any surplus, providers are incentivized to take steps that will prevent costly events, such as ED

visits and admissions. Providers are also incentivized to invest in integrated models of care and to ensure enrollees are receiving the appropriate preventive care. Today, more than one hundred sixty-one thousand (161,000) Humana MMA enrollees are attributed to Florida Medicaid providers in a Full Value arrangement.

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7. The extent to which the respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

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SHARING SPECIFIC DATA ELEMENTS WITH PROVIDERS

We use a range of tools to share specific data elements with providers under a VBP arrangement. In addition to sharing VBP-specific information, including capitation payments, providers can view their HEDIS performance in real-time, identify enrollees with care gaps for follow-up, and view other data that can help them to better manage our enrollees' care, achieve savings, and prepare to progress along the VBP continuum.

CAREHUB CLINICAL GUIDANCE EXCHANGE

Our CareHub Clinical Guidance Exchange (CGX) system generates Care Alerts that are distributed to our providers. These Care Alerts consist of evidence-based medicine care gaps and drug-to-drug/disease interaction alerts. By promoting awareness and closure of these gaps, we help our providers improve their results and progress along the continuum of VBP arrangements.

ANVITA INSIGHTS ENGINE

The Anvita Insights Engine delivers personalized patient analyses that identify enrollees who (1) are at risk for dangerous medical events, including hospitalizations; (2) are taking contraindicated therapies that should be discontinued; (3) are missing preventive services; and (4) have cost-savings interchange opportunities to lower costs. Furthermore, when deployed at the Point of Care, Anvita can identify, rank, and score competing treatments by safety, efficacy, and cost in real-time by using virtually all known clinical data. When combined, Anvita's tools empower our providers to reduce preventable events and provide high-quality, efficacious treatments at a lower cost for our enrollees, increasing their opportunities to benefit from our VBP risk arrangements.

AVAILITY CARE PROFILE

The Availity Care Profile, a platform that provides a consolidated view of enrollees and their health care services across providers, is a powerful tool for improving enrollee safety, reducing unnecessary services, eliminating duplication of procedures, and driving coordination and continuity of care. Available to all of our network providers in Florida, the Availity Care Profile includes claims information associated with office visits and hospitalizations, diagnoses and associated procedures, prescription history, lab event history, radiology event history, immunization history, and clinical messaging. By allowing more rapid closure of gaps in care for enrollees, greater opportunity for preventive care

services, and better chronic condition management, providers are enabled to improve enrollee outcomes, ultimately contributing to better payments through VBP.

SERVICE FUND DATA ANALYTICS

Humana developed the proprietary Service Fund risk sharing management application for providers engaged in a risk or capitated arrangement. This innovative tool is used to control reimbursements to providers in these arrangements by tracking and aggregating information on capitation payments, claims expensing, claims payment, reconciliation, and settlement for all PCP contacts.

On a monthly basis, Service Fund makes data files available containing information regarding provider membership, funding, claims activity, progress toward value-based payments, and capitation payments at an individual provider level and at a group level. Humana tailors the reports to providers in risk or value-based arrangements. They are available for provider access through an online portal, as well as through our Provider Relations representatives. Additionally, Humana educates providers using Service Fund by walking through standard reports during initial trainings to show the data to which they have access and how to use it to help manage their providers and financials. On a monthly basis, our Provider Relations Representatives meet with PCPs to review the Service Fund reports and to discuss any issues or barriers they may be facing.

HUMANA'S MONTHLY HEDIS PACKAGE

To help PCPs better manage the care of their enrollees through VBP arrangements, we provide a package of monthly HEDIS reports to every PCP. These reports capture preventable events among enrollees, gaps in care, and high utilizers of pharmaceuticals. In addition, practices can view their performance on HEDIS indicators, and see how their performance compares with other providers in their region. An example of this report is included in Attachment MMA 13-5. We package this information in an actionable manner, providing call lists with the contact information for enrollees who have care gaps and a list of recommended actions for enrollees who are non-compliant with preventive care screening and/or disease management visits. These reports can serve as a catalyst for providers to make changes to their organization to better meet the needs of Humana enrollees. For example, several providers have created outreach teams that use the reports to contact enrollees with care gaps and schedule appointments to address them.

LEVEL OF RESPONDENT SUPPORT OFFERED TO PROVIDERS TO ENSURE PROGRESSION ALONG THE CONTINUUM OF VBP ARRANGEMENTS

In addition to encouraging progression along the continuum of VBP arrangements through strong data capabilities, Humana's departments provide in-person support to help our providers close care gaps, identify ways to improve their performance, and act on the data that we provide.

FACE-TO-FACE SUPPORT

We use a dedicated approach to supporting providers to increase provider performance and effectiveness and move along the continuum of VBP arrangements. The departments that engage in face-to-face support for our providers work together in tandem to help providers

to succeed in their current VBP arrangements and to move along the continuum towards pay-for-value models. We have developed a series of programs, processes, metrics, and resources – including the HEDIS package described above – complemented by a robust process to identify and leverage best practices among our provider network.

Our approach to face-to-face support includes the following departments and activities:

- Provider Relations: Our Provider Relations representatives are our direct liaisons and field representatives to our providers. They are responsible for meeting with PCPs and high-volume specialists in our network monthly. In this front-line position, they are also responsible for educating providers, clarifying provider inquiries, and relaying provider concerns to the broader Provider Relations team. We currently have more than fifty (50) Provider Relations representatives assigned to providers throughout the state.

- Quality: Our Quality Improvement Nurses (QINs), who are geographically assigned to PCPs and meet with PCPs quarterly, deliver provider-specific metrics, coach providers on gap closing opportunities, and provide resources and educational opportunities for providers and staff. There are nearly twenty (20) QINs assigned to PCPs in our Florida Medicaid network.

- Claims and Documentation: Our Claims Department provides education for providers to ensure accuracy of documentation and coding.

- Care Management: Our Care Management and Disease Management teams assist our providers in developing strategies for engagement of enrollees qualified for care programs, provide feedback on program activity, and identify strategies to respond to actionable care opportunities (ED utilization, readmissions, etc.).

JOINT OPERATING COMMITTEE

In addition to monthly meetings between our Provider Relations representatives and our providers in risk arrangements, we have established a Joint Operating Committee (JOC) with a wide range of providers, including our high-volume fee-for-service networks, capitated specialty networks, hospital-based physician groups, and global risk providers. The JOC is a critical element of a successful risk relationship with our providers, allowing an open line of communication between our providers and Humana.

The goal of this committee is to identify the best way to provide the highest quality of care to our enrollees in the most affordable manner and discuss ongoing operations. To guide the meetings, we provide our risk partners with a package of reports including:

- Financial Performance Summary
- Medical Metric Report with comparison to regional averages and benchmarks
- Inpatient Stay Reports summarized by primary diagnosis and compared to PCP office visits
- ED and Outpatient Reports by diagnosis
- ED Visit Report
- OB-GYN Report
- Top Forty (40) Report to identify enrollees with high admissions and ED visits

Through these reports, Humana reviews provider performance on metrics related to hospital admission and readmission rates, HEDIS quality, medications taken for pharmacy, settlement data for finance, and medical risk adjustment. Through discussion of this data, along with the provider's experience in VBP, we work collaboratively to identify ways to improve performance, drive better enrollee outcomes, and ensure a successful risk relationship.

Evaluation Criteria:

1. The extent to which the respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.

2. The extent to which the respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five (5) Contract years, including a rationale for the intended percentages.

3. The extent to which the respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum.

4. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.

5. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for improvement of birth outcomes.

6. The extent to which the respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.

7. The extent to which the respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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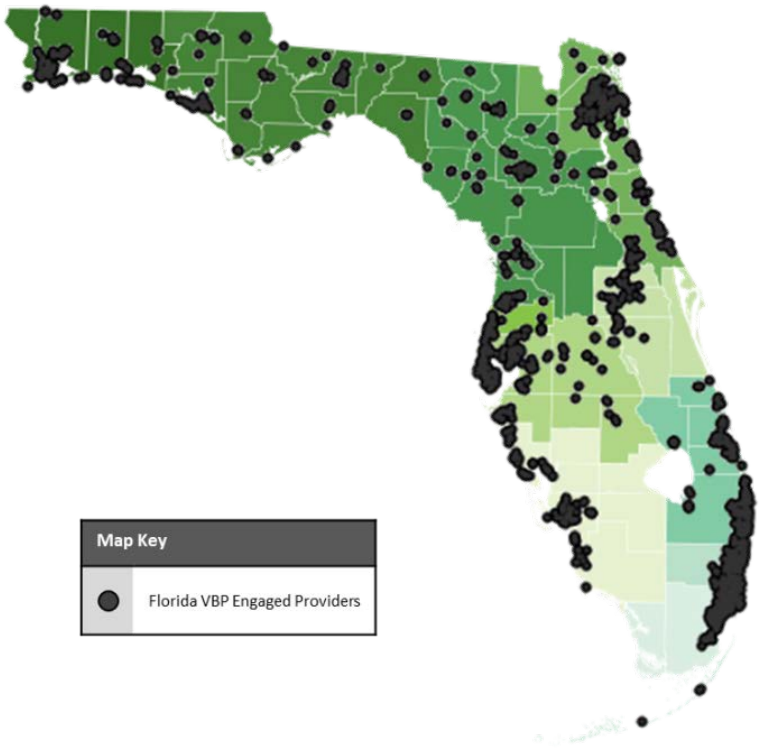
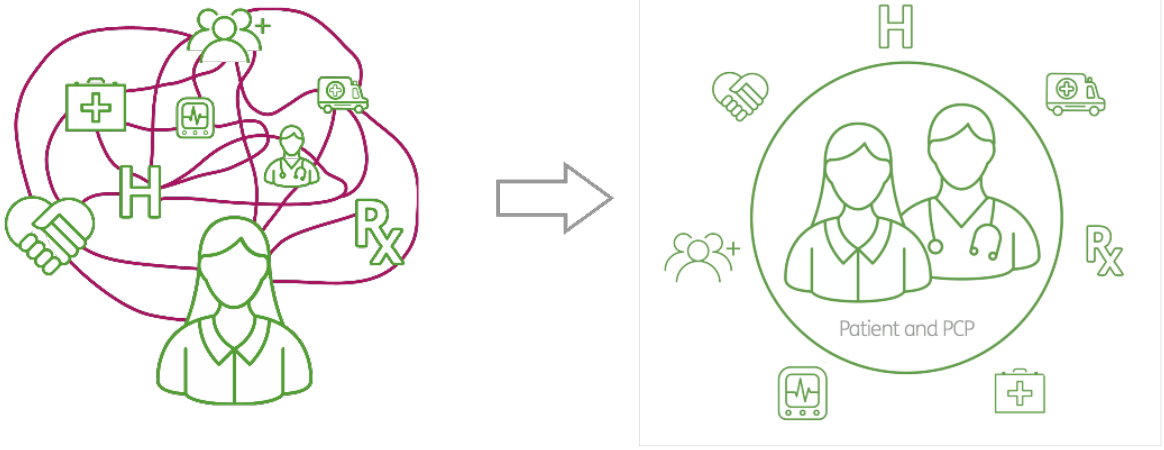
Attachment MMA 13-1: Map of Humana Network Providers Engaged in VBP in Florida



Attachment MMA 13-2: Value-Based Care Model

The shift from a fee-for-service delivery model to value-based payments can be challenging. It requires the effective use of enrollee data, a focus on care coordination, and attention to enrollee engagement, with the enrollee and PCP serving as the hub of the care model, as seen below.

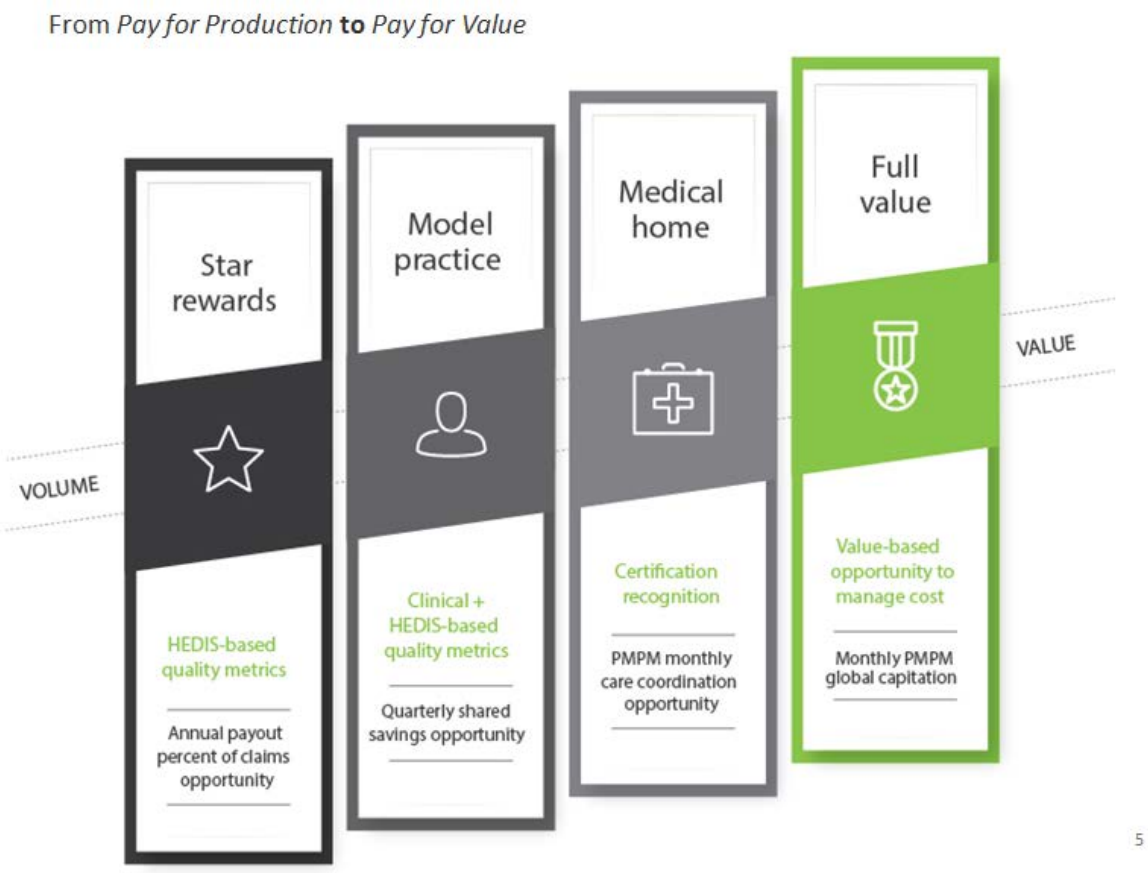


Fee-For-Service Model

Value-based Care Model

Attachment MMA 13-3: Humana's Value-Based Continuum

Humana's Value-Based Continuum encompasses four models, each progressively moving further away from a volume-based payment model and closer to a value-based design. Each step provides a gradual evolution towards true value-based care delivery. Humana's nationwide Value-Based Continuum is illustrated below.



HEDIS® Measure Overview: Hospitalization for Potentially Preventable Complications (HPC)

For 2016, the National Committee for Quality Assurance (NCQA) added Hospitalization for Potentially Preventable Complications, or HPC, to its Healthcare Effectiveness Data and Information Set (HEDIS). This measure, which tracks the number of admissions for complications of chronic and acute ambulatory care sensitive conditions (ACSC), is an important indicator of care coordination. The Centers for Medicare & Medicaid Services (CMS) will include this measure on the Star display page in 2017 and in the 2018 Star ratings, unless there are issues with the initial data collection. Data collected in 2016 will be used by CMS to calculate the measure for the Star display page in 2017.

Please note: The information offered in this flier is based on HEDIS technical specifications. It is not meant to preclude clinical judgment. Treatment decisions should *always* be based on clinical judgment.

Who is included in HPC?

Patients 67 and older as of Dec. 31 of the measurement year are included in HPC. The measure looks at the rate of acute inpatient discharges with a diagnosis considered an ACSC per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC. Patients enrolled in an institutional special needs plan (I-SNP) any time during the measurement year are excluded. The rate is risk-adjusted based on comorbidity, age and gender.

How do you do well on HPC?

To do well, organizations must limit admissions for complications of chronic and acute ambulatory care sensitive conditions. The conditions are listed below. Detailed code descriptions are available in the NCQA HEDIS 2016 Technical Specifications guide.

ACSC List

An ambulatory care sensitive condition is defined as an acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions included in the HPC measure are:

Chronic ACSC

- Diabetes short-term complications
- Uncontrolled diabetes
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Diabetes long-term complications
- Lower-extremity amputation among patients with diabetes
- Asthma
- Heart failure

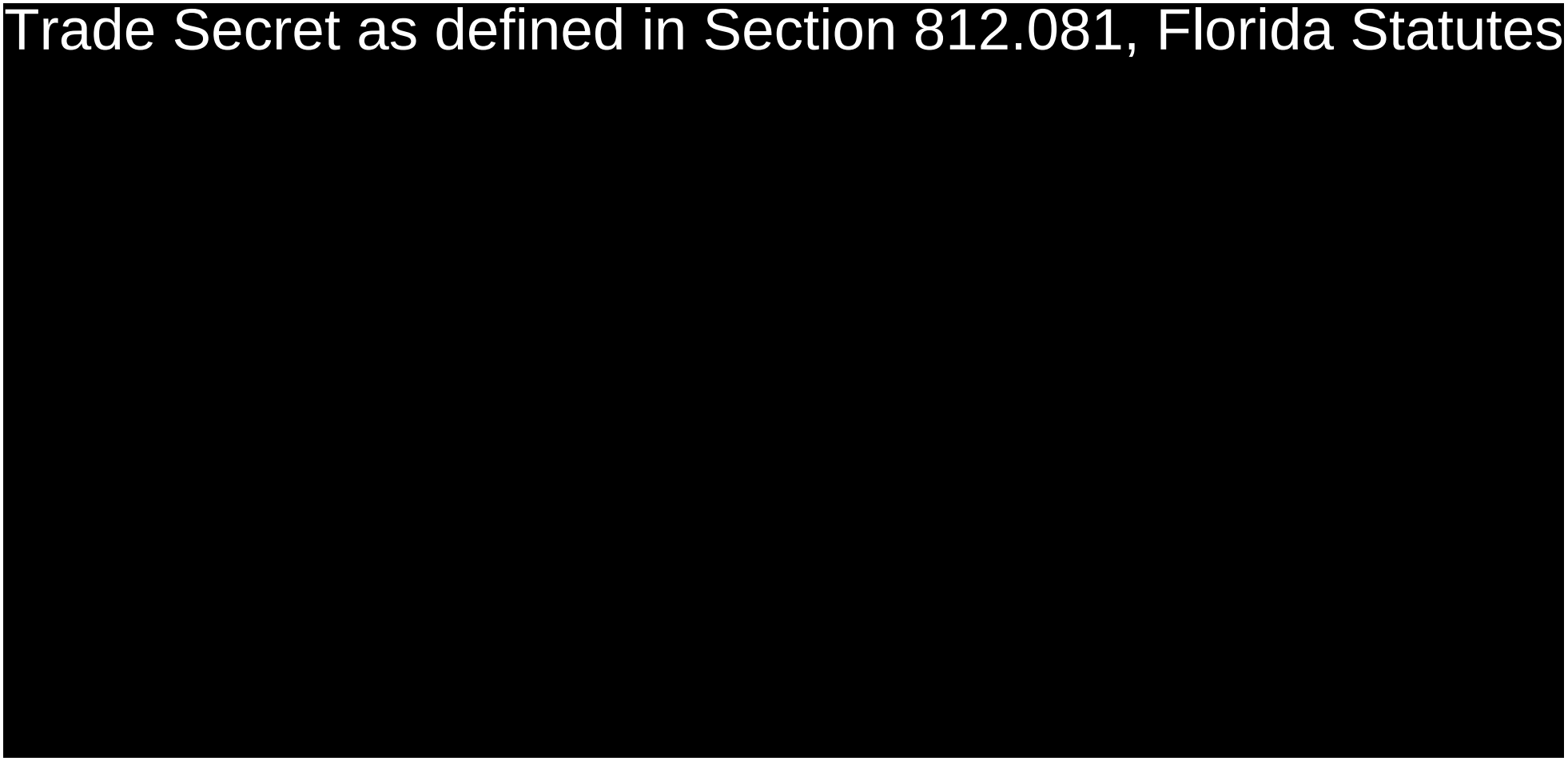
Acute ACSC

- Bacterial pneumonia
- Cellulitis
- Urinary tract infection
- Pressure ulcer

How primary care physicians can help

- Ensure appropriate outpatient management of the above conditions
- Coordinate efforts with specialists and other health care providers to prevent complications and subsequent admissions
- Provide prompt follow-up care postdischarge to prevent complications and subsequent readmissions

Source: HEDIS 2016 Healthcare Effectiveness Data and Information Set (HEDIS®) Technical Specifications. HEDIS is a set of standardized performance measures designed to help purchasers and consumers compare the performance of health plans on an apples-to-apples basis. HEDIS is a registered trademark of the National Committee for Quality Assurance.


Trade Secret as defined in Section 812.081, Florida Statutes

E. DELIVERY SYSTEM COORDINATION

MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. Include in table format, the target population (TANF, ABD, dual eligibles), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-b-2**, MMA Performance Measurement Tool (10-2-2017) to provide results for the following HEDIS measures:

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

Humana is committed to providing high-quality care for our enrollees. Our performance and experience meeting quality standards in Florida, and nationally, demonstrate our commitment to quality:

- Humana is ranked 2nd in quality among Florida's Medicaid plans according to the National Committee for Quality Assurance (NCQA)[1], serving more than three hundred thirty thousand (330,000) enrollees in Florida

- Humana's Florida Medicaid plan has been NCQA accredited since 1997. We are in the process of seeking an additional NCQA certification for Long-term Care Case Management.

- We are also one of the top quality Medicare Advantage plans in the State of Florida, according to the Centers for Medicare and Medicaid Services' (CMS) Star rating, having achieved four point five 4.5 (of five (5)) Stars. On our respondent plan, Humana Medical Plan, Inc., we serve more than three hundred sixty-five thousand (365,000) Medicare beneficiaries across the state. Across all of our plans in the State of Florida, we serve over six hundred twenty thousand (620,000) Medicare beneficiaries, including more than one hundred five thousand (105,000) who are eligible for both Medicare and Medicaid.

- Nationally, two point four (2.4) million of Humana Medicare Advantage members are in 4-plus Stars contracts. Humana has received a four point five (4.5)-Star rating for five (5) of our Medicare Advantage contracts offered in eight (8) states.

Healthcare Effectiveness Data and Information Set (HEDIS) data plays a major role in how we measure, monitor, and improve the quality of care being provided to enrollees. Humana's robust quality improvement program promotes quality of care and patient outcomes performance for all of our Medicaid membership. We regularly measure, monitor, and evaluate our performance against AHCA and NCQA benchmarks in order to conduct oversight and improvement of medical and behavioral health care and support services.

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1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.

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OVERVIEW

Humana has extensive experience achieving quality standards with similar target populations for HEDIS measures listed in this SRC. We have been monitoring and tracking HEDIS measures in our Florida SMMC plan for over twenty (20) years, in our Group Commercial plan for over twenty (20) years, and in our Florida Commercial Marketplace (Exchange) plan since go-live in 2014. Below we have included a brief overview of the top three (3) largest Medicaid and Commercial contracts for our respondent plan in Florida, Humana Medical Plan, Inc. These correlate to the three (3) contracts shown in Exhibit A-4-b-2.

1. Florida Medicaid Managed Care
-- 325,909 enrollees
-- Program Summary and Populations Served: Medicaid, TANF and ABD

2. Florida Group Commercial
-- 167,336 enrollees
-- Program Summary and Populations Served: Commercial group benefits for ages 0 to 64

3. Florida Commercial Marketplace (Exchange)
-- 19,998 enrollees
-- Program Summary and Populations Served: Exchange benefits for commercial population ages zero (0) to sixty-four (64)

FLORIDA SMMC

Humana has operated as a Medicaid plan in Florida since 1997. We currently operate as an MMA plan across five regions, serving nearly three hundred thirty thousand (330,000) Florida enrollees. We provide the full range of Medicaid preventive services for Medicaid TANF-eligible

individuals, as well as those enrollees who are aged, blind and disabled. We currently serve two hundred sixty-four thousand nine hundred thirty-three (264,933) TANF Medicaid enrollees, of which two hundred nine thousand three hundred two (209,302) are under the age of twenty-one (21). We currently monitor the following forty-two (42) measures in our Florida SMMC operations, including those measures listed in this SRC:

- Adolescent Well Care Visits – (AWC)
- Adults' Access to Preventive/Ambulatory Health Service – (AAP)
- Annual Dental Visits (ADV)
- Antidepressant Medication Management - (AMM)
- Adult BMI Assessment – (ABA)
- Breast Cancer Screening – (BCS)
- Cervical Cancer Screening - (CCS)
- Childhood Immunization Status – (CIS) – Combo 2 and 3
- Comprehensive Diabetes Care – (CDC)
-- Hemoglobin A1c (HbA1c) testing
-- HbA1c poor control
-- HbA1c control (<8%)
-- Eye exam (retinal) performed
-- Medical attention for nephropathy
- Controlling High Blood Pressure – (CBP)
- Follow-up Care for Children Prescribed ADHD Medication – (ADD)
- Immunization for Adolescents – (IMA)
- Chlamydia Screening in Women – (CHL)
- Prenatal and Postpartum Care – (PPC)
- Medication Management for People with Asthma – (MMA)
- Well-Child Visits in the First 15 Mos. of Life – (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life – (W34)
- Children and Adolescents' Access to Primary Care Practitioners – (CAP)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – (IET)
- Ambulatory Care – (AMB)
- Lead Screening in Children – (LSC)
- Annual Monitoring for Patients on Persistent Medications – (MPM)
- Frequency of Ongoing Prenatal Care – (FPC)
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia – (SAA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics – (APM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents – (APC)

HEDIS & Agency-Defined
- Follow-Up after Hospitalization for Mental Illness – (FHM)

AHCA-DEFINED
- Mental Health Readmission Rate – (RER)
- Transportation Timeliness – (TRT)
- Transportation Availability – (TRA)
- Highly Active Anti-Retroviral Treatment – (HAART)
- HIV-Related Outpatient Medical Visits – (HIVV)

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

CHILD HEALTH CHECK UP REPORT (CMS-416)
- Dental Treatment Services – (TDENT)
- Sealants – (SEA)

CHILD CORE SET
- Preventive Dental Services – (PDENT)
- Dental Sealants for 6-9 yr. Old Children at Elevated Carries Risk – (SEAL)
- Human Papillomavirus (HPV) Vaccine for Female Adolescents – (HPV)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents – (WCC)

ADULT CORE SET
- Antenatal Steroids (ANT)
- Plan All-Cause Readmissions – (PCR)
- HIV Viral Load Suppression – (VLS)
- Medical Assistance with Smoking and Tobacco Use Cessation – (MSC)

FLORIDA COMMERCIAL

Humana currently operates as a Group Commercial plan state-wide in Florida, serving over one hundred sixty-seven thousand (167,000) Florida enrollees. We provide the full range of commercial benefits for enrollees ages zero (0) to sixty-four (64). We currently monitor the following measures in our Florida Group Commercial operations.

- Adult Body Mass Index (BMI) Assessment
- Child and Adolescent BMI, Nutrition, Physical Activity
-- BMI Percentile Total
-- Nutrition Counseling Total
-- Physical Activity Counseling Total
- Childhood Immunization
-- DTaP
-- IPV
-- MMR
-- HIB
-- Hepatitis B
-- Varicella
-- Pneumococcal Conjugate
-- Combination 2
-- Combination 3
- Adolescent Immunization
-- Combo 1
-- Meningococcal
-- Tdap/Td
- HPV vaccine for Female Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

- Chlamydia Screening in Women: Ages 16-20 yrs., 21-24 yrs., and total
- Appropriate Testing for Pharyngitis
- Urinary Tract Infection (URI) Treatment
- Acute Bronchitis Treatment
- Spirometry Testing
- Pharmacotherapy for Chronic Obstructive Pulmonary Disease (COPD)
-- Bronchodilator
-- Corticosteroid
- Appropriate Medication for Asthma: Ages 5-11 yrs., 12-18 yrs., 19-50 yrs., 51-64 yrs. and total
- Medication Management for People With Asthma
-- Medication Compliance 75%
- Controlling High Blood Pressure
- Persistence Beta-Blocker Treatment
- Comprehensive Diabetes Care
-- Blood Pressure Control < 140/90
-- Eye Exam
-- Good HbA1C Control < 8.0
-- HbA1c <7.0% Special Population
-- HbA1c Testing
-- Monitoring Diabetic Nephropathy
-- Poor HbA1c Control
- Imaging Studies for Low Back Pain
- Antidepressant Treatment
-- Acute Phase Treatment
-- Continuation Phase Treatment
- Follow-up Care for Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
-- Continuation &Maintenance
-- Initiation
- Follow-up Mental Illness Discharges
-- 7 Days
-- 30 Days
- Monitoring for Long Term Med ACE or ARBs
-- Digoxin
-- Diuretics
-- Total
- Adult Access to Preventive Care: Ages 20-44 yrs., 45-64 yrs., 65 yrs. and older, and total
- Children's Access to Primary Care: Ages 12-24 mos., 25 mos.-6 yrs., 7-11 yrs., and 12-19 yrs.,
- Alcohol and Other Drugs (AOD) Treatment
-- Initiation
-- Engagement
- Prenatal and Postpartum Care
-- Postpartum Care
-- Prenatal Care
- Well-Child Visit, first 15 mos.
-- Six or More Visits
- Well-Child Visit, 3-6 yrs.
- Well-Care Visit – Adolescent
- Plan All-Cause Readmissions

-- Total Observed-to-Expected Ratio

FLORIDA COMMERCIAL MARKETPLACE (EXCHANGE)

Humana currently operates as a Florida Commercial Marketplace (Exchange) plan state-wide in Florida, serving over nineteen thousand (19,000) Florida enrollees. We provide the full range of commercial benefits for enrollees, ages zero (0) – sixty-four (64). We currently monitor the following measures in our Florida Commercial Marketplace (Exchange) operations.

- Child and Adolescent BMI, Nutrition, Phys Activity
-- BMI Percentile Total
-- Nutrition Counseling Total
-- Physical Activity Counseling Total
- Cervical Cancer Screening
- Chlamydia Screening in Women: Ages 16-24 yrs., 21-24 yrs., and total
- Appropriate Testing for Pharyngitis
- URI Treatment
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
-- Eye Exam
-- Good HbA1C Control < 8.0
-- HbA1c Testing
-- Monitoring Diabetic Nephropathy
- Imaging Studies for Low Back Pain
-- Total
- Follow-up Mental Illness Discharges
-- 7 Days
- Monitoring for Long Term Med
-- ACE or ARBs
-- Digoxin
-- Diuretics
-- Total
- AOD Treatment
-- Initiation
-- Engagement
- Prenatal and Postpartum Care
-- Postpartum Care
-- Prenatal Care
- Well-Child Visit, 3-6 yrs.
-- 6 or More Visits

EXPERIENCE MEASURING HEDIS IN OTHER MEDICAID PLANS

In addition to our experience as Humana Medical Plan in Florida, Humana has broader experience measuring HEDIS performance for measures included in this SRC in our shared

parent affiliate Medicaid plans in other states. We describe our experience in Kentucky and Illinois below.

KENTUCKY MEDICAID
Humana has served as a Medicaid health plan in Kentucky since 2013, and currently covers the physical and behavioral health services for over one hundred forty thousand (140,000) Medicaid TANF and ABD enrollees state-wide. We currently monitor the follow measures in our Kentucky program:

HEDIS Measures
- Well-Child Visits in the 1st 15 mos. of Life
- Well-Child Visits, 3-6 yrs.
- Well-Child Visits, 12-21 yrs.
- Lead Screening in Children
- Annual Dental Visit, 2-21 yrs.
- Height and Weight Measurement, 3-17 yrs.
- BMI Measurement, 3-17 yrs.
- Counseling for Nutrition, 3-17 yrs.
- Counseling for Physical Activity, 3-17 yrs.
- Timeliness of Prenatal Care
- Frequency of Prenatal Care Visits, >=81%
- Timeliness of Postpartum Care
- Screening for Tobacco Use
- Counseling/Education for Tobacco Use
- Antidepressant Medication Management, Acute and Continuation Phase
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder who are Using Antipsychotics
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
- Follow-Up Care for Children Prescribed ADHD Medication, Initiation and Continuation Phase
- Follow-Up After Hospitalization for Mental Illness within 7 days and within 30 days of Discharge
- Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment
- Use of Appropriate Meds for People with Asthma, Total
- Med Management for People with Asthma, Compliance 75%
- Asthma Medication Ratio, Total
- Hemoglobin A1c (HbA1c) Testing
- HbA1c Poor Control (>9.0%)
- Eye Exam (Retinal) Performed
- Medical Attention for Nephropathy
- Blood Pressure Control (<140/90 mm Hg)
- Adult BMI Assessment
- Breast Cancer Screening
- Cervical Cancer Screening
- Persistence of ß-Blocker Treatment After a Heart Attack
- Cholesterol Management for Patients With Cardiovascular Conditions
- Controlling High Blood Pressure Appropriate Testing for children with Pharyngitis

- Appropriate Treatment for Children with Upper Respiratory Infections (URI)
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
-- Systemic Corticosteroid
-- Bronchodilator
- Adults' Access to Preventive/Ambulatory Health Services: Ages 20-44 yrs., 45-64 yrs., and 65 yrs. and older
- Children and Adolescents' Access to PCP: Ages 12-24 mos., 25 mos.-6 yrs., 7-11 yrs., and 12-19 yrs.

KY HEALTH OUTCOME PERFORMANCE MEASURES
- Screening and/or Counseling for Tobacco
- Screening and/or Counseling for Alcohol/Substance Use
- Screening and/or Counseling for Sexual Activity
- Screening for Depression
- Annual Dental Visit in Children with Special Health Care Needs (CSHCN), 2-21 yrs.
- Well-Child Visits in CSHCN, in the 1st 15 mos., 3-6 yrs., 12-21 yrs.
- Access to PCP in CSHCN, 12-24 mos, 25 mos.-6 yrs., 7-11 yrs., 12-19 yrs.
- Screening for Tobacco Use
- Positive Screening for Tobacco Use
- Received Intervention for Tobacco Use
- Screening for Alcohol Use
- Positive Screening for Alcohol Use
- Received Intervention for Alcohol Use
- Screening for Substance/Drug Use
- Positive Screening for Substance/Drug Use
- Received Intervention for Substance/Drug Use
- Assessment/Education/Counselling for Nutrition
- Assessment/Education/Counselling for Over the Counter (OTC)/Prescription Med
- Screening for Domestic Violence
- Postpartum Depression
- Healthy Weight for Height
- Counselling for Nutrition
- Counselling for Physical Activity
- LDL-C/Cholesterol Screening

ILLINOIS INTEGRATED CARE PROGRAM
Humana has served as a Medicaid health plan in the Illinois Integrated Care Program (ICP), and currently covers the medical and Long-term Care services for over five thousand one hundred (5,100) enrollees in the state. We currently monitor the follow measures in our ICP program:

- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Adult BMI Assessment
- Annual Dental Visit
- Antidepressant Medication Management
-- Acute
-- Continuation

- Asthma Medication Ratio
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Adolescent Well-Care Visits
- Breast Cancer Screening
- Controlling Blood Pressure
- Cervical Cancer Screening
- Comprehensive Diabetes Care (CDC)
-- CDC-<100LDL-C
-- CDC-BP<140/80
-- CDC-BP<140/90
-- CDC-CDC HBA <8
-- CDC-CDC Neph
-- CDC-CDC-HbA1c
-- CDC-Eye Exams
-- CDC-HbA1c<7
-- CDC-HbA1c>9
-- CDC-LDL-C
- Chlamydia Screening in Women
- Frequency of Prenatal Care (FPC)
-- FPC-21-40%
-- FPC-41-60%
-- FPC-61-80%
-- FPC-< 21%
-- FPC->= 81%
- Follow up after Hospitalization (FUH)
-- FUH-30-Day
-- FUH-7-Day
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
-- Engagement
-- Initiation
- Use of Imaging Studies for Low Back Pain
- Medication Management for People With Asthma
-- 50% compliance
-- 75% compliance
- Annual Monitoring for Patients on Persistent Medications
-- ARBs
-- Digoxin
-- Diuretics
- Non-Recommended Cervical Cancer Screening in Adolescent Females
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation
-- Bronchodil
-- SCsteroid
- Prenatal and Postpartum Care
-- Postpartum
-- Prenatal
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia
- Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Statin Use in Patients with Cardiovascular Disease
- Statin therapy for patients with diabetes
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

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2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

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Exhibit A-4-b-2 contains our HEDIS 2016 and HEDIS 2017 performance for the measures listed in this SRC.

Footnotes

[1] http://healthinsuranceratings.ncqa.org/2017/search/Medicaid/FL

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.

2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 70 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 60 points as described below:

Exhibit A-4-b-2, MMA Performance Measurement Tool (10-2-2017), provides for forty-two (42) opportunities for a respondent to report prior experience in meeting quality standards (seven (7) measure rates, three (3) states each, two (2) years each).

For each of the seven (7) measure rates, a total of 5 points is available per state reported (for a total of 105 points available). The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean and 1 point if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 1 point for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 60 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 105 points, the final score will be

60 points (100%). If a respondent receives 95 (90%) of the available 105 points, the final score will be 54 points (90%). If a respondent receives 10 (10%) of the available 105 points, the final score will be 6 points (10%).

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EXHIBIT A-4-b-2
MMA SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL (10-2-2017)

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/ HEDIS 2017 performance measure data for the selected HEDIS measures for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The performance measures that respondents are required to report on can be found on the Performance Measure Group B tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year.

EXHIBIT A-4-b-2
MMA SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL (10-2-2017)

RESPONDENT NAME:	Humana Medical Plan, Inc.

Group B						
	State #1:	Florida	State #2:	Florida	State #3:	Florida
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Adolescent Well-Care Visits	55.19	51.58	48.65	50.40		
Childhood Immunization Status - Combination 3	73.72	72.51	75.43	75.91	72.79	64.85
Frequency of Ongoing Prenatal Care - ≥ 81% of expected visits	69.59	71.53				
Immunizations for Adolescents - Combination 1	72.99	78.59	72.02	72.02	51.60	
Timeliness of Prenatal Care	85.82	86.37	85.63	85.38	78.05	80.00
Well-Child Visits in the First 15 Months of Life - 6 or more visits	62.56	66.91	83.35	84.66	62.82	74.38
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	74.89	75.43	83.90	82.21	71.11	77.46

Total Points	66

MMA SRC# 15 – Failure to Meet HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

Humana employs continuous quality improvement (CQI) strategies to ensure we are constantly improving care and outcomes for our enrollees. Through our CQI approach, we execute a planned sequence of systematic and documented activities aimed at both resolving identified variances and improving processes. To address areas where we have performed below the state or national target, we employ the following processes:

- Analysis of plan demographics (including clinical, geographic, and cultural) to identify high-risk populations, areas of network need, enrollee education opportunities, and performance improvement opportunities

- Analysis of access and availability issues including after hours availability of Primary Care Physicians (PCPs)

- Analysis of continuity and coordination of care

- Review of other non-clinical areas of performance (such as Service Center call statistics and other enrollee services functions, marketing and outreach, claims processing timeliness and accuracy, and provider satisfaction.)

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1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.

2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

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FLORIDA SMMC

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Per the Statewide Medicaid Managed Care (SMMC) Contract, plans are required to meet the National Committee for Quality Assurance (NCQA) 50th percentile in order to be in compliance with contract quality standards.

In calendar year (CY) 2015, Humana performed below Healthcare Effectiveness Data and Information Set (HEDIS) or Contract-required quality standards for only one measure listed in this SRC in our Florida SMMC program: Immunizations for Adolescents – Combination 1

In CY 2016, Humana performed above HEDIS and/or contract required quality standards for ALL measures listed in this SRC in our FL SMMC program, and improved our rates in all measures. Please refer to Attachment MMA 15-1 to see how our HEDIS 2016 and 2017 scores compared to the NCQA 50th percentile standard.

COMPARISON TO FLORIDA ALL-PLAN AVERAGE
Each year, AHCA releases the SMMC HEDIS averages, for all SMMC plans in the state, by measure. In CY 2015, we performed above the all-plan average for the following measures listed in this SRC:
- Childhood Immunization Status (Combo 3) - Performed above all-plan average
- Well-Child Visits in the First 15 Months (6 or more) - Performed above all-plan average
- Immunizations for Adolescents (Combo 1) - Performed above all-plan average
- Adolescent Well Care Visits - Performed above all-plan average
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits) - Performed above all-plan average
- Timeliness of Prenatal Care - Performed above all-plan average

In CY 2016, we performed above the all plan average for the following measures listed in this SRC:
- Well-Child Visits in the First 15 Months (6 or more) - Performed above all-plan average
- Immunizations for Adolescents (Combo 1) - Performed above all-plan average
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits) - Performed above all-plan average
- Timeliness of Prenatal Care - Performed above all-plan average

STRATEGIC ACTIONS TAKEN TO IMPROVE PERFORMANCE MEASURES
Humana actively monitors and takes actions to improve performance measures. We hold a monthly Medicaid Strategy meeting, which includes the Medicaid Medical Director, to review HEDIS measures and discuss successes and areas for improvement. Our Florida HEDIS team holds monthly meetings on specific HEDIS measures to drill down on root causes of any performance issues. We continuously monitor our performance through our HEDIS dashboards, showing real time performance on measures and our compliance with NCQA and Agency for Health Care Administration (AHCA) standards. Finally, HEDIS performance is a discussion topic at the quarterly comprehensive Quality Improvement Committee (QIC) meetings. We discuss how improvements on the medical and long-term care (LTC) components of care can improve outcomes for both populations.

SPECIFIC ACTIONS TAKEN IN FLORIDA SMMC PROGRAM TO IMPROVE HEDIS PERFORMANCE

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Following our analysis of why we performed below the target on Immunizations for Adolescents – Combination 1, we identified opportunities for improvement and barriers that might impede improvement. We conducted quarterly Florida QIC meetings to initiate and evaluate various action plans specific to performance metrics and quality benchmarks.

We identified the following opportunities and barriers between Calendar Year 2015 and Calendar Year 2016.

Enrollee-Based Opportunities and Barriers
- Failure to schedule or keep appointments for chronic conditions or preventive care.

- Failure to establish initial appointment; enrollee has no established relationship with a PCP.

- Lack of health education regarding the importance of preventive screenings, immunizations, or warning signs for chronic conditions.

- Enrollee transportation issues vary, but some examples of barriers include the enrollee being allowed only one escort, or enrollee and children may have different providers and health plans, making it difficult to coordinate transportation.

Provider-Based Initiatives
- No available office staff to contact enrollees for preventive screenings, immunizations, or follow up on chronic conditions

- Incorrect demographic data received from the plan or State and unable to locate enrollee

- Lack of knowledge of enrollee incentives offered by plan

IMPROVEMENTS, INTERVENTIONS, AND ACTIONS
To improve our rate for Immunizations for Adolescents – Combination 1, we implemented the following initiatives in 2016:

Enrollee-Based Initiatives
- Conducted welcome calls to new Medicaid enrollees and caregivers to encourage them to schedule their recommended routine and disease-specific screenings and immunizations. The enrollee and caregiver were also offered assistance with scheduling visits and transportation.

-Conducted Birthday Wellness and Postpartum calls, to remind enrollees to make an appointment for their checkups and screenings.

- Initiated distribution of Wellness wallet and immunization cards to Adolescents for convenient enrollee access to health information.

- Ongoing Childhood Check-up Call Campaign for education and appointment initiatives.

- Continued the Targeted Women and Children Outreach Campaign to reach women of child-bearing age with or without children who had not undergone screenings to encourage them to receive cervical cancer screening, breast cancer screening, and chlamydia screening.

- Healthy Behavior Programs are provider-based programs, including: Baby Well Visits Program, Pediatric Well Visit Program, Mom's First Prenatal and Post-Partum Program, Smoking Cessation Program, Substance Abuse Program, and the Humana Family Fit Program. These programs are aimed at improving our enrollees' healthy behaviors. Once enrollees meet the requirements of the program, they receive a gift card.

- Clinical Alert (enrollees): The clinical alert is a reminder banner with different messages each month. The banner is placed on the enrollee portal. (Attachment MMA 15-2)

Provider-Based Initiatives
- Throughout 2016, Quality Improvement nurses (QIN) visited pediatric offices, distributing and discussing action lists in the form of Tool Kits and gap reports to educate Medicaid providers about performance measures required by AHCA. Providers were encouraged to fax in documents and lab results as supplemental data to close the gaps in immunization records.

- Offered PCP quality bonus encouraging providers to meet quality standards.

-Continued use of enhanced Medicaid specific performance report card to show comparison of each provider's performance to peers.

- Continued distribution of a childhood checkup up provider tool.

- Distribution of Provider Medicaid HEDIS checklist, a one-page document that enables providers to track the services that have been completed. (Attachment MMA 15-3)

- Clinical Alert (providers): The clinical alert is a reminder banner with a different well-being message each month. The banner is placed on the provider portal. (Attachment MMA 15-4)

We have included our 2015 and 2016 roadmap for this measure in Attachment MMA 15-5.

MEANINGFUL IMPROVEMENTS
Through our HEDIS improvement initiatives during 2016, we improved our rate for Immunizations for Adolescents – Combination 1 from 72.99% (HEDIS 2016) to 78.59% (HEDIS 2017).

ONGOING IMPROVEMENT INITIATIVES FOR MEASURES THAT MET BENCHMARKS

Humana continuously strives to improve quality outcomes, including areas where we have met contract-required benchmarks, but improvement is still desirable. We are always seeking ways to improve the quality of care provided to our enrollees. Each year, we develop our HEDIS roadmap, containing strategies and initiatives to improve all of our HEDIS measures. Our roadmaps include ongoing improvement initiatives for those measures where we have fallen below contract standards, as well as those where we have met contract standards, but are still seeking to improve. Following are examples of initiatives from our 2018 roadmap, based on HEDIS 2017 results where we met the benchmark for each measure, illustrating how we are constantly working to improve quality outcomes.

CHILDHOOD IMMUNIZATION STATUS - COMBO 3

	HEDIS 2016	HEDIS 2017
Humana:	73.72	72.51
NCQA 50th Percentile:	71.53	71.06

For this measure, we met the benchmark for HEDIS 2016 and HEDIS 2017; however, our rate declined between those reporting years. Going into HEDIS 2018 reporting year, we have the following initiatives in place to improve our performance on this measure:

- Healthy Behavior Reward Program: Baby Well Visit Program

- 2017 Medicaid PCP Bonus

- Monthly Child Health Checkup (CHCUP) and Dental Reminder Call Campaign

- Monthly Welcome Calls to New Enrollees

- 2017 Medicaid HEDIS CAHPS Guide & Checklist delivered to providers

- Quality Improvement Nurse Educational Visits to Pediatrician Offices

- Children/Adolescent Wellness Wallet Card

- Clinical Alert (enrollees and providers)

- Florida SHOTS data - monthly

- Voice Activated Technology (VAT) call targeted to parents/caregivers of non-compliant children for a Well Care Visit, immunization and lead screening

- Targeted Adult & Child Wellness Letter Campaign

WELL-CHILD VISITS IN THE 3RD, 4TH, 5TH, AND 6TH YEARS OF LIFE

	HEDIS 2016	HEDIS 2017
Humana:	74.89	75.43
NCQA 50th Percentile:	72.05	71.42

For this measure, we met the benchmark for HEDIS 2016 and HEDIS 2017 and even improved from one year to the next; however, our rate did not improve as much as we would like between those reporting years. Going into HEDIS 2018 reporting year, we identified the following initiatives to increase our performance on this measure:

- Healthy Behavior Reward Program: Pediatric Well Visit Program

- 2017 Medicaid PCP Bonus - CAP Measure

- Monthly Welcome Calls to New Enrollees

- Monthly Child Health Checkup (CHCUP) and Dental Reminder Call Campaign

- Monthly Quality Improvement Nurse Educational Visits to Pediatrician Offices

- 2017 Medicaid HEDIS CAHPS Guide & Checklist delivered to providers

- Provider Educational Pamphlet: FL Medicaid Child Check-Up Information

- Children/Adolescent Wellness Wallet Card

- Clinical Alert (enrollees and providers)

- Voice Activated Technology (VAT) call targeted to parents/caregivers of non-compliant children for a Well Care Visit, immunization and lead screening

- Targeted Adult & Child Wellness Letter Campaign

FLORIDA GROUP COMMERCIAL

While there are no contractually required benchmarks for our Florida Group Commercial plan, we monitor our performance against the NCQA HMO/POS 50th percentile to identify areas for improvement. In 2015 and 2016 we monitored and measured all HEDIS measures listed in this SRC, except for one: Frequency of ongoing prenatal care ≥81% of expected visits.

In CY 2015 (HEDIS 2016), Humana performed below the NCQA 50th percentile standard for the following measures listed in this SRC in our Florida Group Commercial plan:

- Childhood Immunization Status – Combination 3
- Immunizations for Adolescents – Combination 1
- Timeliness of Prenatal Care

In CY 2016 (HEDIS 2017), Humana performed below the NCQA 50th percentile standard for the following measures listed in this SRC in our Florida Group Commercial plan:

- Childhood Immunization Status – Combination 3
- Immunizations for Adolescents – Combination 1
- Timeliness of Prenatal Care

SPECIFIC ACTIONS TAKEN IN FLORIDA GROUP COMMERCIAL PLAN TO IMPROVE HEDIS PERFORMANCE
We conducted an analysis of our performance, identifying the following opportunities and barriers, improvements and changes, and conclusions and recommendations:

Opportunities and Barriers

- Enrollees lacking knowledge of plan coverage, particularly for preventive services

- Limited scope and effectiveness of provider-directed initiatives

- Provider reward program remains in early stages, leading to a lack of incentive to engage providers in quality improvement

Improvements and Changes
- Dedicated chart chase team resulted in closure of nearly four thousand four hundreed (4,400) open gaps.

- Continue cross-departmental coordination with other areas, such as ProActive and Marketing, to multi-message enrollees on topics of importance such as plan coverage and preventive services.

- Increase provider relationships by engaging with existing Provider Organized Delivery System (PODS) groups or Virtual PODS. PODS groups engage and build trusting relationships with providers to help them provide the right care at the right time for our enrollees; partner with Provider Development Center of Excellence (PDCoE) to expand rewards coverage.

-Educate and inform enrollees on materials available on Humana's website for wellness related educational opportunities, such as Humana Beginnings, Smoking Cessation, and Personal Nurse.

-Expand blood pressure and maternity care email campaigns.

Conclusions and Recommendations
- Focus on enrollee awareness of preventive services, maternity, and diabetes-related initiatives

- Leverage PODS model and other market resources to engage in communication and relationship-building with Commercial providers to broaden range of message

FLORIDA COMMERCIAL MARKETPLACE (EXCHANGE)

While there are no contractually required benchmarks for our Florida Commercial Marketplace plan, we monitor our performance against the NCQA HMO/POS 50th percentile to identify areas for improvement. In 2015 and 2016 we monitored and measured all HEDIS measures listed in this SRC, except for the following:

- Adolescent Well Care Visits
- Immunization for Adolescents – Combination 1 (not reported in HEDIS 2017)

In CY 2015 (HEDIS 2016), Humana performed below the NCQA 50th percentile standard for the following measures listed in this SRC in our Florida Marketplace plan:

- Childhood Immunization Status – Combination 3
- Timeliness of Prenatal Care

- Immunizations for Adolescents – Combination 1
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Well-Child Visits in the first 15 Months of Life (6 or more visits)

In CY 2016 (HEDIS 2017), Humana performed below the NCQA 50th percentile standard for the following measures listed in this SRC in our Florida Marketplace plan:

- Childhood Immunization Status – Combination 3
- Timeliness of Prenatal Care
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Well-Child Visits in the first 15 Months of Life (6 or more visits)

SPECIFIC ACTIONS TAKEN IN FLORIDA MARKETPLACE PROGRAM TO IMPROVE HEDIS PERFORMANCE
We conducted an analysis of our performance, identifying the following opportunities and barriers, improvements and changes, and conclusions and recommendations:

Opportunities and Barriers
- High turnover rate among marketplace enrollment decreases effectiveness of quality initiatives, especially enrollee experience-focused initiatives.

- Data indicates high out-of-network utilization, emergent care services, and a low number of PCP visits.

- Out-of-network emergent access to care leads to a higher financial burden for enrollees and does not link to positive changes in health outcomes.

- Many enrollees lack education concerning how and where to utilize health insurance. Coverage levels and clarity on out-of-pocket costs related specifically to preventive screenings.

- Provider attribution issues, specifically auto-assignment to a PCP when an enrollee is unfamiliar with their assigned physician, or physician hours, costs, and geography are primary driving factors. Strong PCP relationships are critical to gap closure.

- Providers are unfamiliar with measure specifications.

Improvements and Changes
- A Quality Improvement Strategy (QIS) focused on enrollee-PCP engagement has been submitted to the Centers for Medicare and Medicaid Services (CMS). Enrollee-PCP relationships are key to enrollee retention and gap closure.

- Preliminary data indicates improved enrollee experience scores versus 2014 beta test results. Increased focus on enrollee perception-related initiatives throughout the year was a contributing factor.

- Increased scope of provider outreach initiatives aimed at improving HEDIS scores.

- Commercial team dedicated to chart chase activity resulted in increased gap closure for reporting year 2015 versus reporting year 2014.

Conclusions and Recommendations
- Focus on improving enrollee experience scores related to Enrollee Survey, which is heavily weighted in the calculation in overall quality star scores

- QIS to enhance enrollee-PCP engagement to improve the opportunity to coordinate care

- Focus on tactics to drive up results in specific HEDIS preventive areas and Qualified Health Plan Enrollee Scores

- Better understand emergency department utilization to effectively encourage enrollees to engage in PCP relationships

- Continued focus on maturity of Commercial rewards program

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.

2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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Attachment MMA 15-1: Humana HEDIS 2016 and 2017 Results Compared to NCQA 50th Percentile

In calendar year 2016, Humana performed above HEDIS and/or contract required quality standards for ALL measures listed in this SRC in our FL SMMC program, and improved our rates in all measures. Please refer to the table below to see how our HEDIS 2016 and 2017 scores compared to the NCQA 50th percentile standard.

Measure	HEDIS Year	
	2016 (CY 2015)	2017 (CY 2016)
Adolescent Well-Care Visits		
Humana Medical Plan, Inc. - Florida	**55.19**	**51.58**
NCQA 50th Percentile	49.07%	48.41
Childhood Immunization Status - Combo 3		
Humana Medical Plan, Inc. - Florida	**73.72**	**72.51**
NCQA 50th Percentile	71.53%	71.06
Frequency of Ongoing Prenatal Care (>= 81%)		
Humana Medical Plan, Inc. - Florida	**69.59**	**71.53**
NCQA 50th Percentile	59.49%	59.26
Prenatal and Postpartum Care - Timeliness of Prenatal Care		
Humana Medical Plan, Inc. - Florida	**85.82**	**86.37**
NCQA 50th Percentile	85.07%	82.25
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life		
Humana Medical Plan, Inc. - Florida	**74.89**	**75.43**
NCQA 50th Percentile	72.05%	71.42
Well-Child Visits in the first 15 Months of Life (6 or more visits)		
Humana Medical Plan, Inc. - Florida	**62.56**	**66.91**
NCQA 50th Percentile	59.69%	59.57
Immunizations for Adolescents - Combination 1		
Humana Medical Plan, Inc. - Florida	72.99	**78.59**
NCQA 50th Percentile	73.09%	74.52

Attachment MMA 15-2: Member Portal Clinical Alerts

The clinical alert is a reminder banner with a different message each month. The banner is placed on the member portal.

Clinical Timeline 2016 – Clinical Alerts Member Portal

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Cervical Health Awareness	Healthy Heart Month	Colorectal Cancer Awareness	Alcohol Awareness Month	High Blood Pressure Education	Mid-Year Wellness Reminder	Promote Eye Exam	Immunization Awareness Month	Healthy Eating & Lifestyle	Breast Cancer Awareness	Diabetes Awareness Month	National Influenza Vaccination

All Year Round (Except June): *Don't forget to schedule yours and/or your child's free yearly well-visit and dental checkup. Call your doctors or call Customer Service at 1-800-477-6931 (TYY: 711) to schedule appointments today, and remember these visits are at no cost to you!*
Jan: If you are a female, consult your doctor or an OB/GYN for an annual Pap smear testing
Feb: This is Healthy Heart Month. Time to think about eating healthy and exercising to keep your heart strong. Consult your doctor on lifestyle changes.
Mar: If you are age 50 and older, it is important to talk to your doctor about a colon screening.
Apr: If you or someone you love struggles with drugs and/or alcohol, speak with your physician. You may also call our Customer Services at 1-800-477-6931 and ask about the Healthy Behavior Reward Program.
May: Is your blood pressure below 120/80? If not or you are not sure, consult your doctor to discuss treatment options.
Jun: We are half way through the year. Have you schedule yours and/or your child's free yearly well0visit and dental check-up. *Call your doctors or call Customer Service at 1-800-477-6931 (TYY: 711) to schedule appointments today, and remember these visits are at no cost to you!*
Jul: Have you or your child had an eye exam this year? If not, we encourage you to schedule with an in-network eye doctor. Yearly eye exam is important to maintain good vision.
Aug: Are you or your child up to date on all immunization? Consult your doctor about the importance of getting immunized.
Sept: It is important to maintain a healthy diet and weight. Humana offers nutritional counseling for free. Call Customer Services at 1-800-477-6931 and ask about the benefit.
Oct: Are you a female age 50-74? Have you had a mammogram done this year or last year? If not, consult your doctor about a mammogram.
Nov: If you or someone you love are living with diabetes, education and support are important to help you stay in control and healthy. Humana offers a Diabetes Disease Management Program for free. To learn more about our program, call at 1-800-322-2758
Dec: It's not too late! A yearly flu vaccine is recommended for everyone 6 months and older. Consult your doctor and get your flu vaccine today.

1.0.9.5 12/2015 Katie Wetherington – SMCC Contract Manager

2017 ADULT MEDICAID SCREENINGS, SERVICES AND EDUCATION CHECKLIST

MEMBER NAME: _____ DOB: _____ HUMANA ID:_____

PREVENTION AND SCREENINGS	DESCRIPTION OF REQUIREMENT	DATE COMPLETED
❑ Adult body mass index (BMI)	BMI assessment for adults ages 18 to 74 between Jan. 1, 2016, and Dec. 31, 2017	___/___/___ **Result:**
❑ Breast cancer screening	Mammography for women ages 50 to 74 between Oct. 1, 2015, and Dec. 31, 2017, or exclusion due to bilateral mastectomy	___/___/___
❑ Cervical cancer screening	Pap smear evident for women ages 21 to 64 between Jan. 1, 2015, and Dec. 31, 2017, or pap/human papillomavirus co-testing for women ages 30 to 64 between Jan. 1, 2013, and Dec. 31, 2017, or exclusion due to complete/total/radical hysterectomy	___/___/___
❑ Chlamydia screening	At least one test for chlamydia in women ages 16 to 24, who are sexually active, before Dec. 31, 2017	___/___/___
❑ Ambulatory or preventive care visit	An ambulatory or preventive care visit as defined for adults ages 20 and older before Dec. 31, 2017	___/___/___
RESPIRATORY CONDITIONS	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Medication management for people with asthma	Monitor adherence to asthma controller medication regimen for members ages 5 to 64 diagnosed with persistent asthma **Asthma controller medications:** **Antibody inhibitor:** omalizumab; **Inhaled steroid combinations:** Symbicort®, Advair®, Dulera®; **Inhaled corticosteroid:** beclomethasone, Pulmicort®, fluticasone CFC-free, mometasone; **Leukotriene modifiers:** montelukast, zafirlukast; **Mast cell stabilizers:** cromolyn; **Methylxanthines:** theophylline	___/___/___ **Rx:**
CARDIOVASCULAR CONDITIONS	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Controlling high blood pressure	Blood pressure controlled in adults ages 18 to 85 (target depends on age and diabetes diagnosis) prior to Dec. 31, 2017, with a diagnosis of hypertension prior to June 30, 2017	___/___/___ **Result:**
DIABETES CARE (ADULTS 18 AND OLDER)	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Annual diabetic retinal eye exam	Diabetic retinal eye exam before Dec. 31, 2017	__/__/__ **Result:**
❑ Annual HbA1c testing	Testing and control of HbA1c lower than 8 percent before Dec. 31, 2017	__/__/__ **Result:**
❑ Medical attention for nephropathy	Nephropathy screening test or evidence of nephropathy as per claim/ encounter, nephrologist visit, urine protein test or ACE inhibitor/ARB therapy before Dec. 31, 2017	__/__/__ **Result:**
BEHAVIORAL HEALTH MANAGEMENT	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Antidepressant medication management	Encourage and monitor compliance with antidepressant medications for members ages 18 and older, newly diagnosed with major depression	__/__/__
❑ Initiation and engagement of alcohol and drug dependence treatment	Initiate treatment through an inpatient alcohol or other drug dependence (AOD) admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis and have two or more additional services with a diagnosis of AOD within 30 days of the initial visit	Initial: __/__/__ Follow-ups: __/__/__ __/__/__
❑ Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	One blood glucose or HbA1c test for members ages 18 to 64 years old with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication before Dec. 31, 2017	Glucose/HbA1c: __/__/__

Please note: This is for office use only and should not be submitted to Humana to close Healthcare Effectiveness Data and Information Set (HEDIS®) gaps in care for your patients.

2017 MEDICAID PEDIATRIC SCREENINGS, SERVICES AND EDUCATION CHECKLIST

MEMBER NAME: _____ DOB:_____ HUMANA ID: _____

PREVENTION AND SCREENINGS	DESCRIPTION OF REQUIREMENT	DATE COMPLETED
❑ Chlamydia screening	At least one test for chlamydia in women ages 16 to 24, who are sexually active, before Dec. 31, 2017	____/____/____
❑ Immunizations (childhood and adolescent)	• Childhood immunizations are up to date by the child's second birthday • Adolescent immunizations are up to date by the child's 13th birthday	____/____/____
❑ Lead screening	At least one blood lead screening before the child's second birthday	____/____/____ **Result:**
❑ Well-care visit (childhood and adolescent)	• At least six well-child visits prior to **15 months** of age • At least one well-child visit for children/adolescents 1 to 21 years of age before Dec. 31, 2017 *(Note: Documentation should include complete history, including physical and mental health, physical exam, BMI/BMI percentile, nutrition counseling and anticipatory guidance.)*	____/____/____
❑ Annual dental visit	An annual dental visit with a dental practitioner for all members ages 2 to 20 before Dec. 31, 2017	____/____/____
RESPIRATORY CONDITIONS	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Medication management for people with asthma	Monitor adherence with asthma controller medication regimen for members ages 5 to 64 diagnosed with persistent asthma **Asthma controller medications:** **Antibody inhibitor:** omalizumab **Inhaled steroid combinations:** Symbicort®, Advair®, Dulera® **Inhaled corticosteroid:** beclomethasone, Pulmicort®, fluticasone CFC-free, mometasone **Leukotriene modifiers:** montelukast, zafirlukast **Mast cell stabilizers:** cromolyn **Methylxanthines:** theophylline	____/____/____ **Rx:**
BEHAVIORAL HEALTH MANAGEMENT	**DESCRIPTION OF REQUIREMENT**	**DATE COMPLETED**
❑ Follow-up management for children with newly prescribed attention deficit disorder/ attention deficit hyperactivity disorder (ADD/ADHD)	• An in-person outpatient visit within 30 days of prescription fill • Two additional in-person outpatient follow-up visits between days 31 and 300 of prescription fill	____/____/____ ____/____/____ ____/____/____
❑ Initiation and engagement of alcohol and drug dependence treatment	• Initiate treatment through an inpatient alcohol or other drug dependence (AOD) admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis and • Have two or more additional services with a diagnosis of AOD within 30 days of the initial visit	Initial: ___ /____ / ____ Follow-ups: ___ /____ /____ ___ /____ /____
❑ Metabolic monitoring for children and adolescents on antipsychotics	One blood glucose or HbA1c test and one LDL-C or cholesterol test for children/adolescents 1 to 17 years old who had two or more antipsychotic prescriptions before Dec. 31, 2017	Glucose/HbA1c: ___/___/___ LDL-C/cholesterol: ___/___/___

Please note: This document is for office use only and should not be submitted to Humana to close Healthcare Effectiveness Data and Information Set (HEDIS®) gaps in care for your patients.

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Attachment 15-4: Provider Portal Clinical Alerts

2017 Florida Medicaid Provider Web Banners

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Cervical Health Awareness	Healthy Heart Month	Colorectal Cancer Awareness	Alcohol Awareness Month	High Blood Pressure Education	Mid-Year Wellness Reminder	Promote Eye Exam	Immunization Awareness Month	Healthy Eating & Lifestyle	Breast Cancer Awareness	Diabetes Awareness Month	National Influenza Vaccination

Jan: Jan is Cervical Health Awareness Month. Please help us raise awareness on the importance of getting an annual well-woman check.

Feb: February is Healthy Heart Month. Please educate your patients to make heart-healthy choices to prevent the nation's leading killers.

Mar: March is Colorectal Cancer Awareness Month. Please help us raise awareness on the importance of getting colorectal cancer screening regularly.

Apr: April is Alcohol Awareness Month. Humana offers a Healthy Behavior Substance Abuse Program. To refer a member, please call 1-800-221-5487.

May: May is High Blood Pressure Education Month. Please educate your patients about contributing lifestyle factors and healthy choices.

Jun: We are halfway through the year. Please be sure to reach out to those patients who have not had a yearly check-up.

Jul: Encourage your patients to schedule an annual eye exam with an in-network optometrist or ophthalmologist to maintain good vision.

Aug: August is Immunization Awareness Month. Please educate patients and caregivers about the value of immunization throughout their lifespans to prevent dangerous and deadly diseases.

Sept: It is important to maintain a healthy diet and weight. Patients can learn more about Humana's free nutritional counseling by calling Customer Service at 1-800-477-6931.

Oct: October is Breast Cancer Awareness Month. Please help us raise awareness on the importance of getting a mammogram.

Nov: November is Diabetes Awareness Month. Refer patients to our free Diabetes Disease Management Program by calling 1-800-322-2758.

Dec: It's not too late! A yearly flu vaccine is recommended for everyone 6 months old and older. Please encourage your patients to get vaccinated today.

Attachment MMA 15-5: Humana CY 2015 and CY 2016 HEDIS Improvement Roadmap for Immunizations for Adolescents – Combo 1.

HEDIS Measure	2015 Initiatives	Start Date	End Date
Immunization for Adolescent	Healthy Behavior Reward Program: First Baby Well Visit	1/1/2015	12/31/2015
	2015 Medicaid PCP Bonus	1/1/2015	12/31/2015
	Monthly CHCUP Call Campaign	1/1/2015	12/31/2015
	Monthly Action List	1/1/2015	12/31/2015
	Monthly Welcome Call to New Enrollee	1/1/2015	12/31/2015
	2015 Medicaid HEDIS CAHPS Guide & Checklist	3/1/2015	12/31/2015
	QIN Educational Visits to Pediatrician Offices	4/1/2015	6/30/2015
	Children/Adolescent Wellness Wallet Card	6/1/2015	12/31/2015
	Florida SHOTS data – Changed from Quarterly to Monthly	6/1/2015	12/31/2015
	One Time Targeted Women and Children Outreach Campaign	7/28/2015	9/30/2015

HEDIS Measure	2016 Initiatives	Start Date	End Date
Immunization for Adolescent (Specs updated to include HPV)	Healthy Behavior Reward Program: Pediatric Well Visit Program	2/1/2016	12/31/2016
	2016 Medicaid PCP Bonus	1/1/2016	12/31/2016
	Monthly CHCUP and Dental Reminder Call Campaign	1/1/2016	12/31/2016
	Monthly Action List	4/1/2016	12/31/2016
	Monthly Welcome Call to New Enrollee	1/1/2016	12/31/2016
	2016 Medicaid HEDIS CAHPS Guide & Checklist	1/25/2016	12/31/2016
	QIN Educational Visits to Pediatrician Offices	1/1/2016	12/31/2016
	Children/Adolescent Wellness Wallet Card	1/1/2016	12/31/2016
	Clinical Alert ***New** (Members and Providers)*	8/1/2016	8/31/2016
	Florida SHOTS data – Monthly	5/1/2016	12/31/2016
	Targeted Women and Children Outreach Campaign	9/15/2016	10/31/2016

MMA SRC# 16 – HEDIS (Data Sources) (Statewide):

The respondent shall describe:

a. The extent to which it has used the following standard supplemental data sources for its HEDIS and other performance measures:

- Laboratory result files;
- Immunization data in State or county registries;
- Transactional data from behavioral healthcare vendors; and
- Current or historic State transactional files in a standard electronic format.

b. The extent to which it has used supplemental data from electronic health record vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.

c. The extent to which it has experience reporting HEDIS measures collected using Electronic Clinical Data Systems.

Response:

Incorporating data from numerous and varied sources is crucial in order to have a well-rounded evaluation and an effective reporting of Healthcare Effectiveness Data and Information Set (HEDIS) measures. Humana has decades of specifically applicable experience collecting data in association with HEDIS reporting. This includes using laboratory result files, immunization data in state or county registries, transactional data from behavioral healthcare vendors, and current or historic state transactional files in a standard electronic format. We have been monitoring and tracking HEDIS data, including supplemental data, since we began Medicaid operations in Florida in 1997. As a Florida SMMC Medicaid plan for the last four (4) years, Humana has been using supplemental data sources under the current contract for HEDIS and other performance measures. These capabilities and experience are enabled by our advanced technological capabilities to facilitate electronic clinical data transfer in Florida.

Our response to this SRC outlines our experience in our current operations as a comprehensive SMMC plan as well as the advantages and opportunities we bring to Florida as a national health care company, providing the experience and resources to innovate, adopt, and scale new technologies.

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1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare vendors; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures.
==========

Capturing accurate results data on a regular basis is crucial to the success of Humana's Integrated Care Delivery Model. Nationally, across all lines of business, Humana is currently capturing data from two hundred (200) active lab connections and received more than five

hundred ninety-seven million (597,000,000) lab records in 2016. Humana is also capturing supplemental data from two hundred eighty-eight (288) active provider connections and received more than eighty-two million (82,000,000) records in 2016. This trend is continuing in 2017 as we have already received two hundred seventy-eight million (278,000,000) lab records and two hundred five million (205,000,000) supplemental records as of June 28, 2017.

The Humana Clinical Innovations Quality Systems Integration Lab/Supplemental team works cross-departmentally to maximize the capture of clinical data for analytic, disease management, business intelligence, and HEDIS reporting. Humana pulls from our sizeable national experience using supplemental data for our Medicaid line of business.

The supplemental data we use for HEDIS measures in the Florida SMMC program include:

- Lead Screening
- Chlamydia
- Cervical Cancer
- Childhood Immunization Status (CIS)
- Immunizations for Adolescents
- Diabetes Screening for People with Schizophrenia
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Annual Monitoring for Patients on Persistent Medications
- Adult BMI monitoring
- Cervical Cancer Screening (CCS)
- Comprehensive Diabetes Care (CDC)

To increase the pass rate for several HEDIS measures including CDC and CCS, we require our Florida providers to submit laboratory results on our enrollees. Immunization data is solicited directly from eleven (11) states by QSI Data Intake and the results are used to determine pass rates for the Immunizations for Adolescents (IMA) and CIS measures. As a partner with the State of Florida, we work directly with the Florida State Health Online Tracking System (SHOTS) program to supply child immunization status data to the State, including Humana wholly owned provider centers that are contracted with Florida SHOTS to enter immunization data into the registry. We have also signed a data exchange agreement with Florida SHOTS to receive immunization data based on eligibility information we receive from AHCA. As part of the data exchange agreement, Humana submits the immunization data for our Florida membership to Florida SHOTS in the required electronic format.

Humana evaluates all collected lab and supplemental data for completeness and relevancy at several points along the intake process. Annually, an external certified auditor must review Humana's supplemental data systems, processes, and content for National Committee for Quality Assurance (NCQA) compliance. The auditor performs the review onsight and in-depth with the appropriate Humana teams.

We take corrective measures to address quality and ensure that the records received will fulfill the NCQA, Centers Medicare & Medicaid (CMS), and Agency-defined Adult and Child Core Set measure requirements. Corrective measures are identified and implemented through:

- Contacting the data vendor for missing, incomplete, or incorrectly formatted records

- Reviewing internal processes for end-to-end data integrity

- Reviewing record quality flags and addressing the internal or external process that led to the flag

- Reviewing the data type against the NCQA technical specifications to ensure measure eligibility, compliance and exclusion criteria are properly documented in an enrollee's data

- Externally validating enrollee data and measure eligibility, compliance, and exclusion documentation

We identify enrollees with missing data for a particular measure and determine the reason for the data gap. We use the reason for missing data as a guide to implement corrective measures for retrieving that data.

Humana utilizes transactional data files from AHCA and our two behavioral health partners in Florida to supply our HEDIS file with eligibility and enrollment information. We receive the 834 enrollment files and 837 enrollment files from AHCA; our information technology (IT) team then extracts the enrollee enrollment information into the HEDIS vendor file layout. Humana also receives weekly transactional electronic claims data feeds from our behavioral health partners. We mine the data into the engine of our HEDIS subcontractor, VERSCEND. That data is then used to support our behavioral health HEDIS or AHCA's Agency-Defined measures.

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2. The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.

==========

At Humana, we use our electronic health record (EHR) data exchange to support clinical and quality initiatives. In our Florida Medicaid program, EHRs provide the opportunity for providers to identify and close care gaps, to ensure the care enrollees receive is appropriate, and to aid in the concurrent review process. For example, there are currently virtual rounds in facilities that allow providers to see the status of their enrollees. EHRs ensure providers have access to files to understand enrollee labs and diagnoses, among other things. Our providers and clinical staff have access to hospital medical records, giving them real time access to our enrollees' information. This ability affords us better understanding of the ongoing health issues of our enrollees and enhances our ability to manage those health issues.

We use the clinical information collected through the EHR data exchange in the monitoring, analysis and reporting of our HEDIS and other performance measures. Attachment MMA 16-1 illustrates Humana's connectivity solution at a high level.

We consider EHR data extractions and exchange an important component of the Humana-provider-enrollee partnership aimed at creating better outcomes for Floridians. We evaluate all EHR data extracts for completeness and relevancy at several points along the intake process. Corrective measures to address quality ensure that the records received will fulfill the NCQA

measure requirements. Enrollees with missing data for a measure are identified and the reason for the missing data is determined as a guide to enable the retrieval of that data. We follow up with providers to address missing enrollee data. For example, if a pediatric enrollee missed a scheduled immunization, we follow up with the provider to address any quality of care issues and help them develop a plan to address care gaps.

In April, our Florida comprehensive program connected with the AHCA Event Notification System (ENS) to allow Humana to receive real-time data feeds on hospital utilization data. Our current connection to the ENS automatically generates reports for providers on emergenct department usage and emergency department medications prescribed. We also supplement our inpatient authorization data with discharge information received on the admission, discharge, and transfer files via the ENS. This information enables us to follow our enrollees post discharge to ensure they receive a follow up appointment, medications, and the necessary community and social supports, and ultimately to reduce re-admissions.

In Florida, Humana is contracted with a certified HEDIS vendor, VERSCEND. All of our data is evaluated using the VERSCEND engine to ensure accuracy. We have been working with certified HEDIS eVendors for a total of nine (9) years in Florida and have worked with VERSCEND specifically for four (4) years. We have a strong working relationship with VERSCEND and there has not been a need for bringing additional eVendors into our processes.

Nationally, we also have hundreds of established connections directly with provider EHR systems and receive data from providers. These processes load the received data into Humana's supplemental and lab data-marts. This is part of our broader strategy to enable providers to best use their data to support quality improvements.

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3. The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS).
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Electronic Clinical Data Systems (ECDS) reporting represents an innovation in the realm of quality data capturing and monitoring. With our broader electronic clinical data transfer capabilities, demonstrated willingness and ability to innovate, and long standing relationship with AHCA and providers across the state, Humana is an ideal partner to support AHCA in expanding and implementing ECDS.

HUMANA'S ELECTRONIC CLINICAL DATA TRANSFER CAPABILITIES

Humana began expanding its health information technology (HIT) more than three (3) years ago to eliminate chart chase and to provide a more seamless exchange of clinical data. Our HIT approaches aim to reduce provider disruption and reduce the cost of onsite record retrieval. Our goal has been real time integration of structured, usable data. Attachment MMA 16-2 illustrates the high-level capabilities of our HIT architecture.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana's corporate resources provide the ability for successful scalability of initiatives and new technologies. Humana has developed its new Internal Health Information Exchange (iHIE) system that provides one stop shopping for clinical information inside Humana regardless of the back-end system hosting the data. Internal users can access records of many types such as images, medical record extracts, assessments, and care plans, all from a single location.

COMPONENTS OF THE IHIE INCLUDE:

- Registry: This is the catalog and record-locator service that maintains the location and pointers of clinical documents and how to get that information if requested

- Repository: The systems that store the actual records and maintain the pointers to those records that can notify or push the information to users additionally, users can retrieve the records on-demand

SERVICES IN THE IHIE INCLUDE:

- Document Registration: Allows systems which have clinical information to register a document and provide its locator ID so that the iHIE can make it available to other systems

- Document Query: Allows system to ask the iHIE if any information is available for an enrollee. The iHIE will return a list of available documents

- Document Get: Retrieves a record and makes it available to the requesting system

- Document Notification/Push: Allows systems to subscribe to messages that whenever the iHIE receives a registration, it can automatically push the data to the system which needs it

HUMANA AS A DEMONSTRATED PARTNER TO AHCA

We have demonstrated our commitment to partnering with AHCA in advancing electronic information exchange through the Florida HIE ENS. In 2013, Humana identified a need for enhanced, real-time emergency department data in order to identify those enrollees who accessed the emergency department appropriately so we could ensure their transitional care from one setting to another was as seamless as possible, as well as to better target those enrollees who were using the emergency department inappropriately to educate them on a better way to access the care they needed. We led the initiative to develop electronic data exchanges with the goal of reducing avoidable emergency department visits and driving out unnecessary spending.

Building upon our success with the real-time emergency department pilot, Humana is currently contracted with AHCA as part of Florida HIE's ENS for Regions 9, 10, and 11. Physicians receive a daily report of the prior day's emergency department encounters for their patients. Humana continues to reach out to high-utilizing enrollees to make sure their needs are taken care of and to engage them in case management. Our Case Managers also partner with the providers to encourage them to reach out to other low-utilizing patients to address care needs.

(Please see Attachment MMA 16-3 for Humana's emergency department Messages Distribution Model.)

Enhancing care and improving enrollee experience is truly a partnership between Humana and providers. We use direct trust technology to send reports to physicians. We have achieved savings through emergency department visit reduction, in part due to timely collaboration with management services organizations (MSOs) and PCPs to identify and close gaps. We identify utilization metrics targeted at increasing the quality of care and work with our providers to use that utilization data in a meaningful way to improve health outcomes.

HIE ENS notifications have been integrated into Humana's utilization management system allowing for timely tracking and reporting. HIE ENS allows us to understand the lag between emergency department\ encounters and PCP follow-up office visits in a similar way as the current Admit-to-Encounter report for inpatient admissions. Humana receives an automated daily report with the admission, discharge, and transfer data, which includes emergency department visit information. We deliver a file to providers each day that includes both ENS notifications and the emergency departments Medicaid Predictive Model. Including the Predictive Model score better equips our providers to identify their enrollees with the highest risk of a potential emergency department visit or admission.

HUMANA'S BROADER CLINICAL DATA TRANSFER CAPABILITIES

Nationally, Humana has nearly one thousand (1,000) provider location connections, of which more than eight hundred sixty (860) are connected via Transcend Insights, utilizing the IHE (Integrating Health Experience) standard protocols. The provider groups include (but are not limited to) hospitals, physician groups and labs. The volume of documents and results that we have received year to date is in the tens of millions. Humana is currently in talks with multiple state and regional HIEs to connect and exchange documents similar to what we are exchanging with individual provider groups. Attachment MMA 16-4 illustrates Humana's capabilities with inbound and outbound data exchange.

In partnership with our wholly-owned organization, Transcend Insights, we have established bi-directional data exchange with several industry leading EHR systems to accept electronic medical records using industry IHE standards. This exchange is Humana's main connectivity channel to transmit clinical data transactions bi-directionally with providers. While we prefer to connect in this method, we are also able to exchange data via non-IHE-standard methods such as secured file exchange (Secured FTP, FHIR API's and messaging under the Direct Trust standard or the Direct Protocol). Internally, Humana has a clinical case management system, Clinical Guidance eXchange (CGX), for the creation and management of care plans and assessments, and a record registry and repository to broker the transmission and receipt of care plans and assessments with external entities. Humana uses industry standard technologies such as the IHE profiles and HL7 CCDs to achieve interoperability with external providers and other clinical entities.

Our experience partnering with AHCA on the HIE ENS demonstrates our capability to explore new and innovative ways to measure the quality of care we deliver to our enrollees. Through our interoperable clinical system, CGX, we can capture clinical, quality, and utilization management

data to inform our HEDIS performance measuring activities. As a national health care company with multiple lines of business, we also have the ability to bring a very broad and diverse set of capabilities to Florida in a meaningful and scalable way, making us an ideal partner for exploring ECDS and other technologies in Florida.

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare vendors; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures.

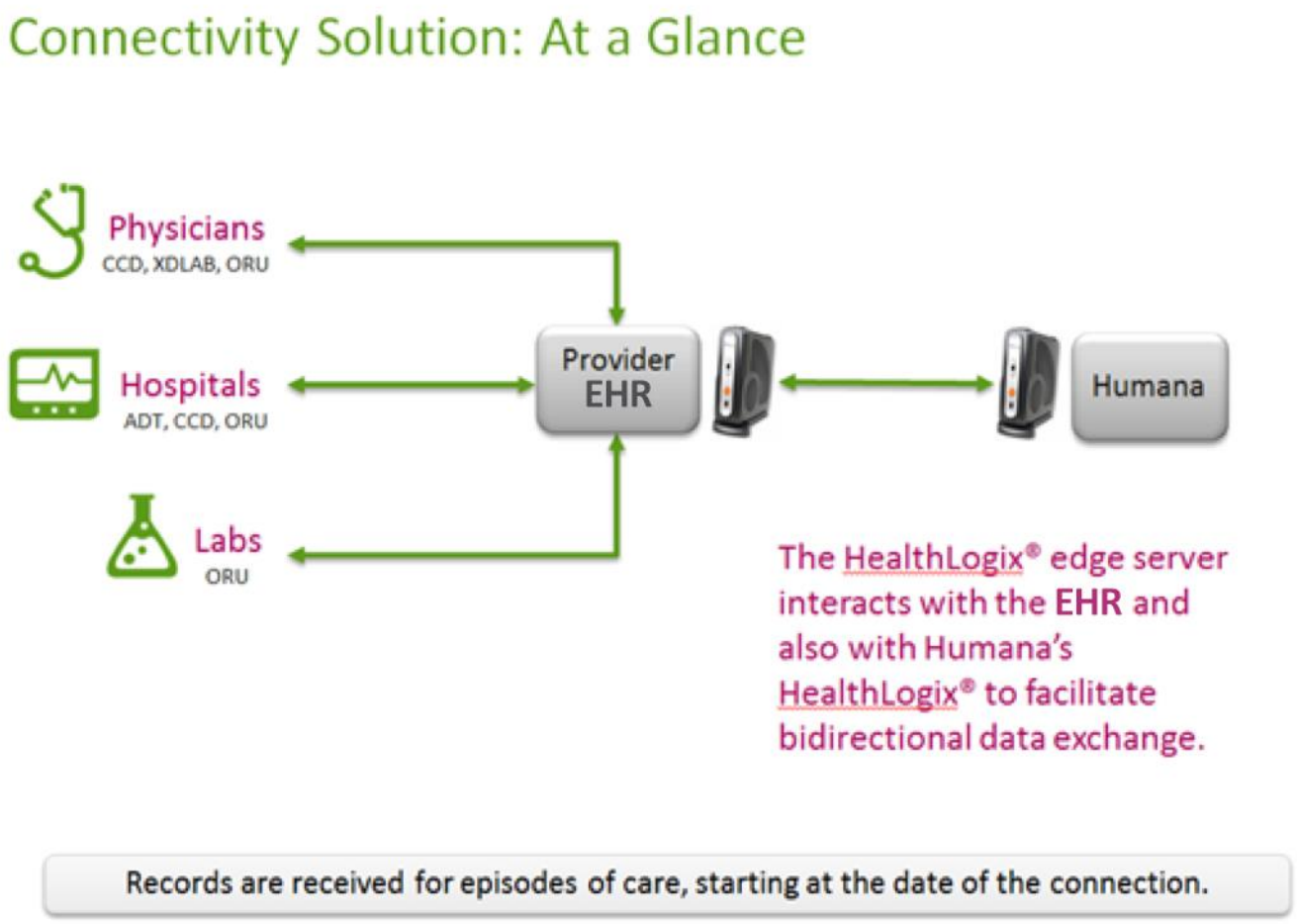
2. The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.

3. The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS).

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

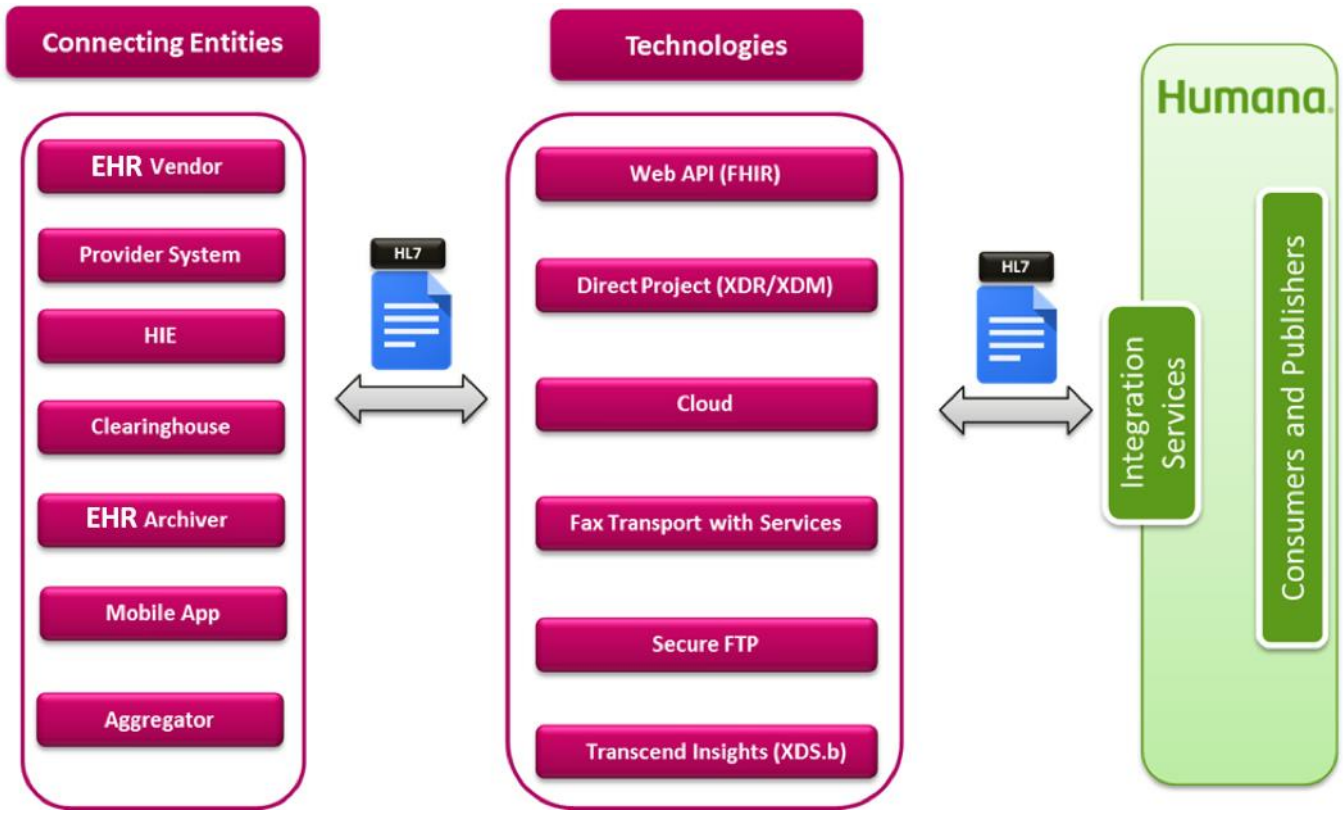
Attachment MMA 16-1: Humana's EHR/EMR Connectivity Solution

At Humana, we use our EHR data exchange to support our clinical and quality initiatives. In our Florida Medicaid program, EHRs/EMRs provide the opportunity for providers to identify and close care gaps, to ensure the care enrollees receive is appropriate, and to aid in the concurrent review process. We utilize the clinical information collected through the EHR data exchange in the monitoring, analysis and reporting of our HEDIS and other performance measures. The chart below illustrates our connectivity solution at a high level.



Attachment MMA 16-2: Humana HIT Architecture

Humana began expanding its health information technology (HIT) over three years ago to eliminate "chart chase" and to provide a more seamless exchange of clinical data. Our HIT approaches aim to reduce provider disruption, as well as reduce the cost of onsite record retrieval. Our goal has been real time integration of structured, usable data. The chart below illustrates the high-level capabilities of our HIT architecture.



Attachment MMA 16-3: Humana's Emergency Department Messages Distribution

Humana is leveraging direct trust technology to send reports to physicians. We have achieved savings and emergency department visit reduction, in part, due to timely collaboration with management services organizations (MSOs) and primary care providers (PCPs) to identify and close gaps. Below is an overview of our emergency department Messages Distribution Model.

ADT messages flow into Humana's HIT area from external clinical organizations. Some of these ADTs will come from emergency departments.

ADT

ADT

ADT

Humana

At Humana, these ADT messages are interrogated to determine if this is an ER event. If so, an ER event message is created for distribution to the PCP.

ADT

ED Message

Filter

Event Factory

PCP's want and need this information for treatment and risk mitigation reasons.

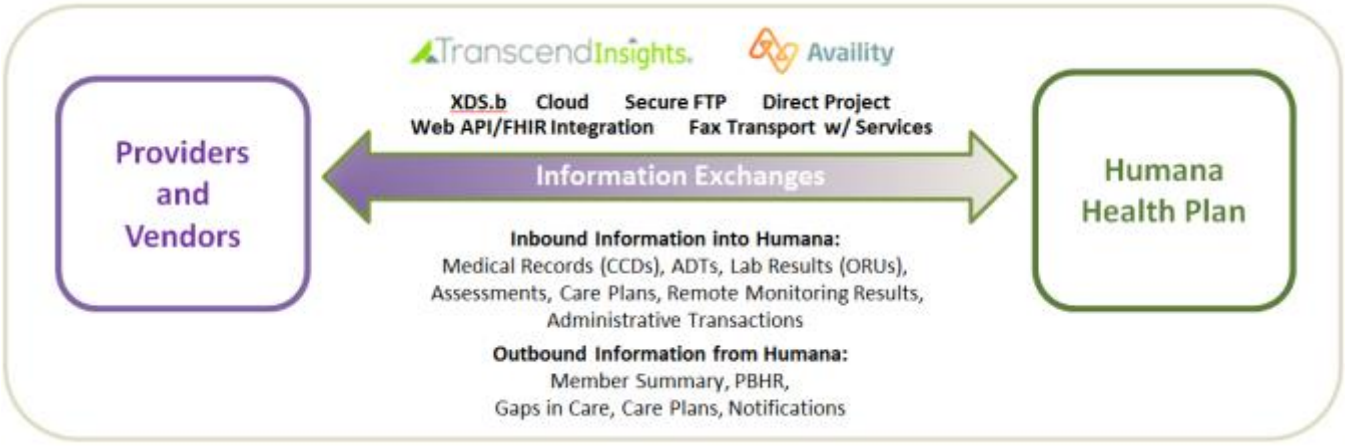
Direct Message

Emergency Department Message using Direct SMTP

Direct is a national encryption standard for securely exchanging clinical healthcare data via the Internet. It allows the provider to receive the message in a variety of ways including EMR integration and email.

Attachment MMA 16-4: Humana's Bi-Directional Informational Exchange

Humana is currently talking with multiple state and regional Health Insurance Exchanges (HIEs) to connect and exchange documents similar to what we are exchanging with individual provider groups. The graphic below illustrates Humana's capabilities with inbound and outbound data exchange.



MMA SRC# 17 – Coordination of Carved Out Services (Statewide):

The respondent shall describe its approach to coordinating services that are not covered by the respondent, but are covered by Florida Medicaid either through the FFS delivery system (e.g., behavior analysis services, prescribed pediatric extended care) or through a prepaid dental plan.

Response:

Humana's approach to coordinating services focuses on ensuring that enrollees receive all medically necessary services in a timely manner in the most appropriate setting. Our goal for our referral processes, whether Humana services, fee-for-service (FFS) delivery system or prepaid dental plan, is supporting the best possible quality outcomes for enrollees throughout the health care system. To achieve this goal, we use proactive identification of enrollees who require referrals, close coordination with Florida state agencies and the prepaid dental plan, collaboration with other plans through which our enrollees have coverage (including Medicare, Tricare, and commercial plans), and a multi-faceted communications program that involves and engages all stakeholders. Effective and efficient care coordination places the enrollee at the center of a cohesive process to meet their care and support needs through the Florida MMA Program.

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1. The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services
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Humana's reciprocal referral for needed services process ensures enrollees are receiving care from a coordinated delivery system in which transfers from Humana to FFS state agencies or a prepaid dental plan are as seamless as possible. Our Clinical Guidance eXchange (CGX) and Customer Relations Management (CRM) systems - used by our clinical and Customer Care associates, respectively – provide a unified view of enrollee needs and services across our organization, enabling seamless coordination and continuity of care for enrollees receiving carved out services. Our care coordination processes involve all stakeholders in one coordinated effort to ensure they are effective, efficient, and improve outcomes. Those stakeholders include:

- Enrollees and authorized representatives
- Florida state agencies providing Medicaid FFS benefits
- Prepaid dental plan
- Providers
- Case managers
- Humana social workers
- Humana provider relations team
- Humana Customer Care specialists
- Subcontractors, including our behavioral health and non-emergency transportation (NET) partners

STRONG WORKING RELATIONSHIP WITH STATE AGENCIES

As a partner in Florida Medicaid for more than twenty (20) years in Florida, Humana has established meaningful relationships and open communications with Florida state agencies, including the Department of Health and Agency for Persons with Disabilities. The quality of these relationships is fundamental to the success of our coordination processes. We work closely with all Florida state agencies that provide Medicaid FFS benefits to facilitate timely referrals and provide seamless coordination for enrollees. We engage with these agencies to offer information about Humana's covered benefits and to share contact information for reciprocal referrals to Humana for MMA services. Our close working relationships enable us to follow up on referrals for our enrollees (with the enrollee's permission) and provide timely resolution of any potential issues. Our case managers work with state agency case managers, as appropriate, to ensure that enrollees are receiving the care they need.

PROACTIVE IDENTIFICATION AND REFERRAL

Humana takes a proactive approach to facilitating referrals for services provided through the FFS delivery system and prepaid dental plan. We identify enrollees who may qualify for these services through a variety of sources, including the following:

- 834 enrollment data
- Inbound calls from enrollees
- Case management program, supports, and assessments
- Disease management
- Clinical Guidance eXchange
- Customer Relations Management
- Provider inquiries/referrals
- Outbound Welcome Calls
- Subcontractor inquiries

Our social workers and case managers review 834 enrollment data to identify enrollees who may qualify for waiver services, including Familial Dysautonomia and iBudget. Enrollees who call or are otherwise identified as requesting assistance with obtaining waiver services are referred to our social workers for outreach and assistance.

When a social worker or case manager identifies an enrollee who may meet these criteria through this data review, assessment, or a referral, they reach out to the enrollee to provide education about the benefits of the FFS services the enrollee may be eligible to receive. If the enrollee agrees to a referral for these benefits, the social worker warm transfers the enrollee to the appropriate agency. If a warm transfer is not possible, the social worker or case manager contacts the agency on behalf of the enrollee and assists the enrollee with the application process. The social worker then follows up to determine if the enrollee is receiving the benefit and provides information or assistance if needed.

ENROLLEE STORY: IMPROVING ENROLLEE OUTCOMES THROUGH COORDINATION
Manuel is a twenty-eight (28)-year-old enrollee who had been diagnosed with diabetes and cognitive impairments. Melissa, a Humana social worker, received a referral from Manuel's case

manager to coordinate the support and services Manuel required to manage his condition. When Manuel was referred, he was homeless and had poor health literacy. Together with Manuel's medical and behavioral case managers, Melissa assisted Manuel to relocate to a safe boarding home where he could receive appropriate support for diabetes management and cognitive limitations. Recognizing that Manuel might qualify and benefit from services provided through the iBudget waiver, Melissa worked with the case managers to obtain the information needed to help Manuel obtain the waiver. After Melissa overcame initial challenges in obtaining the IQ test to qualify for the waiver, Manuel received the iBudget waiver and was able to move into a long-term placement better suited to his care needs.

CARE COORDINATION OF MEDICAID FFS SERVICES

Humana's case managers coordinate with state agencies that provide Medicaid FFS services to facilitate referrals for enrollees in the case management program. In addition to facilitating referrals originating from providers, our case managers draw upon their extensive clinical knowledge, training, and familiarity with Medicaid FFS benefits to identify enrollees who require these benefits. For example, our pediatric case managers assist caregivers for children who may qualify for prescribed pediatric extended care (PPEC) by offering information about the benefit, identifying providers in their area who provide the services, assisting the enrollee/caregiver to coordinate any necessary referrals from the provider, and submitting necessary paperwork or applications to the state. Our case manager sends the enrollee's care plan and notes to the PPEC case manager for review and coordination (with enrollee/caregiver permission) and invites the PPEC provider to participate in the enrollee's multi disciplinary team (MDT).

For those enrollees who may qualify for and benefit from behavior analysis (BA) services, our Behavioral Health (BH) case managers can provide specialized support and guidance to coordinate service provisions. After a provider submits a written order for BA services, the BH case manager assists the enrollee in finding a BA provider and submitting the request for coverage to Beacon Health Options (Beacon), as the administrative services organization responsible for AHCA's BA Utilization Management program. Our case managers continue to provide follow-up and care coordination upon initiation of BA services, including ensuring enrollee satisfaction with their chosen BA providers and facilitating any needed re-authorizations. Information about BA services is integrated into our enrollee's case record in CGX to further facilitate HIPAA-compliant communication among the enrollee's case managers and providers.

Our close working relationship with Beacon – as one of our own BH vendor and as the administrative services organization responsible for BA Utilization Management - also facilitates reciprocal referrals to Humana for Medicaid managed care. Beacon's associates enable referrals to managed care plans for those recipients of Beacon's UM services, including BA authorizations, and will help recipients to contact AHCA's Medicaid hotline to access services and resources available through the MMA program.

COLLABORATING WITH PROVIDERS

Humana's highly engaged provider network is a key source of referrals for appropriate Medicaid FFS benefits and prepaid dental plan services. Our providers work closely with enrollees, case managers, and state agencies to make timely referrals. Our Provider Relations team educates providers about benefits and the appropriate referral processes through a variety of communication channels. In addition to including information about these carved out services and the appropriate referral processes in our provider manual, we will disseminate a short and easy-to-use benefit guide via mail, fax, and face-to-face meetings that will allow our providers to quickly and easily access more information about referrals for these benefits, including information from AHCA's website. In addition, our quarterly provider newsletter and provider website will be used to share information about these services, including contact information for any questions about referrals.

Additionally, as the MMA program transitions from carved-in to carved-out dental services, we will similarly engage with our providers to offer guidance and education regarding the changes in the benefit structure, ensuring they have updated information about the prepaid dental plan to share with their patients.

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2. The adequacy of the respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems.

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ENGAGING AND EDUCATING ENROLLEES

It is crucial that enrollees understand how to appropriately access all of their benefits. We use a variety of methods to engage and educate our enrollees, helping them to understand the difference in benefits covered by Humana and those covered by other Medicaid delivery systems, including Medicaid FFS and the prepaid dental plan. We begin this education during initial enrollment and continue to assist enrollees in understanding their full range of benefits throughout their membership with Humana. Communications include:

- Welcome Call
- Customer Care inbound calls
- Enrollee handbook
- Enrollee website portal

In addition to educating enrollees about the differences in benefits, we offer information about how to obtain assistance with needed referrals and provide phone numbers enrollees can call to receive assistance with the referral process. We also highlight how care coordination assists enrollees whether they are receiving services from Humana, Medicaid FFS, the prepaid dental plan, and/or another insurer, such as Medicare or a commercial plan.

WELCOME CALL

Humana places a Welcome Call to all new enrollees. This call is an opportunity for us to establish a direct and personal connection with each enrollee, to provide important information about benefits, and to gather key enrollee information. During the call, we answer questions about covered benefits through Humana, discuss benefits available through Medicaid FFS, and refer to the prepaid dental plan for information about covered dental services. We encourage enrollees to review the enrollee handbook and enrollee portal, or call the Customer Care center, if they have any questions at a later date. We also arrange to send additional information about Medicaid FFS benefits to any enrollees who request it.

CUSTOMER CARE INBOUND CALLS

Humana's Customer Care Specialists provide information and assistance to enrollees on an ongoing basis. We encourage enrollees to call our Customer Care line if they have questions, would like to discuss their benefits, or ask for assistance. When an enrollee calls with a question about covered benefits, a Customer Care specialist explains the benefits covered by Humana, Medicaid FFS, and/or the prepaid dental plan. Through CRM, our specialists can view the enrollee's record and provide tailored information and guidance for their case. If the benefit the enrollee is seeking is covered elsewhere, our specialist transfers the enrollee to the appropriate organization for more information about the referral process.

ENROLLEE HANDBOOK

Our enrollee handbook, easily accessible through our website or via mail if requested, contains information about Medicaid covered services. With AHCA's approval, we will enhance our handbook to include a list of Medicaid FFS benefits alongside the list of Humana's covered benefits. We will clearly delineate which benefits are covered, explain where or by whom they are covered, and provide more information about how to contact Humana or a state agency for questions/referrals for these services. Our handbook will also include AHCA-approved language on the prepaid dental plan, including contact information for referrals and the list of dental services covered through this plan.

ENROLLEE PORTAL

With AHCA's approval, our online enrollee portal will also be enhanced to provide a clear description of the services covered through Medicaid FFS and the prepaid dental plan, including information on how enrollees can obtain any necessary referrals through their provider and instructions for how to complete applications for waiver. We will also provide Humana contact phone numbers that enrollees can call to ask questions or request assistance with referrals.

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3. The extent to which the respondent's description includes a process for ensuring respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems.

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Educating all associates and subcontractors about services available through other Medicaid delivery systems is key to ensuring that enrollees receive accurate information about benefits and timely referrals. Humana begins this educational process long before an associate or subcontractor interacts with enrollees and conducts refresher courses and updates to information throughout the year.

EMPLOYEE ON-BOARDING

All Humana employees complete an on-boarding program and annual online refresher training sessions, which include information about services and associated referral procedures for Medicaid managed care benefits, Humana's expanded benefits and Medicaid FFS benefits. Enrollee-facing employees, including our case managers, social workers, and Customer Care specialists, receive additional education on how to recognize enrollees who may qualify for FFS benefits and how to coordinate and complete referrals for these services. As MMA shifts from a carved-in to carved-out model for dental services, we will ensure that all associates and subcontractors understand this and other changes to the contract through our training program.

ONGOING COMMUNICATION

In addition to our established, initial training programs, Humana continually looks for other opportunities to ensure that our associates and subcontractors know and effectively communicate appropriate information on services available through other Medicaid delivery systems. Regular associate meetings provide a forum for associate education, and we use these sessions to reiterate and reinforce information about referral processes for FFS services. Any updates or changes to these services – including updates to benefits covered through Medicaid FFS and the prepaid dental plan – are communicated to all associates and subcontractors through email updates and alerts, work instructions, and policy and procedure updates. These updates are reiterated during our regular associate meetings.

SUBCONTRACTOR TRAINING

Our subcontractors are required to complete the same on-boarding and annual online training as Humana associates, including information about Medicaid FFS services. In addition to this training, our subcontractor relationship managers serve as a main point of contact to field any questions subcontractors may have about Humana policies and procedures related to these benefits. These managers share any updates through email and regularly recurring meetings. For example, we ensure that our behavioral health subcontractors are familiar with AHCA's policies on behavioral analysis services and that their providers are aware of all authorization processes. We also ensure our non-emergency transportation vendors understand that our enrollees' transportation to Medicaid FFS and prepaid dental plan services is a covered benefit.

Evaluation Criteria:

1. The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services.

2. The adequacy of the respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems.

3. The extent to which the respondent's description includes a process for ensuring respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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MMA SRC# 18 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Jose is a 15-year old male. He is diagnosed with bipolar disorder and is currently hospitalized under the Baker Act; this is his third psychiatric admission under the Baker Act in the past year. Up until six (6) months ago, Jose lived with his mother and two younger siblings, but he moved in with his father after his behavior declined and his mother was unable to protect herself and his siblings from Jose's angry outbursts and verbal and physical aggression. His father is physically disabled from a work injury, and he is concerned about managing Jose upon release, as Jose's behavior at home and school has significantly declined. At school, Jose is currently failing and has a notable number of absences and office referrals for altercations. Jose was diagnosed two months ago, during his second psychiatric admission, with bipolar disorder. Jose has been prescribed a low dose of Seroquel daily, but he does not take it consistently because of the side effects. He experiences drowsiness, dry mouth, and nausea. In his current admission, his laboratory testing results showed evidence of thyroid dysfunction. The hospital social worker assisted the family in completing and submitting a referral for Statewide Inpatient Psychiatric Program (SIPP) services, but the SIPP provider informed the social worker that authorization was denied. Jose's father has called the plan's enrollee help line for assistance with completing an expedited appeal. Jose was involved in outpatient therapy for the past six weeks. There have not been any adjustments to his medications to date. Jose has been enrolled in Medicaid since he was 5-years old. He has been enrolled in his health plan since July 2014.*

The respondent shall describe its approach to coordinating care for an enrollee with Jose's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

JOSE

LOOKING BACK: HUMANA IS INTRODUCED TO JOSE

In July 2014, Jose was a newly eligible ten (10) year old enrolled into Humana's Managed Medical Assistance (MMA) plan. Jose received a Welcome Call from the Florida-based Humana Medicaid Administration Education and Satisfaction Unit (ESU). This call was initiated by Jose's telephone number being loaded into auto dialer software upon enrollment. Jose's mother was successfully contacted and the ESU Customer Care Specialist, Alicia, welcomed Jose's mother (as his guardian) to the plan. Alicia completed a health risk screening, provided an overview on well-child visits, and educated her about well-check incentives available for meeting Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines and annual check-ups for Jose. Alicia also confirmed receipt of the new enrollee welcome materials, identified any immediate health concerns, and verified the name and contact information of Jose's current pediatrician. Jose's mother agreed to receive reminders about Child Health Check-Ups through the Child Wellness Campaign. Through this discussion with Jose's mother, Alicia determined there was no need for medical or behavioral referral for case management at that time.

LOOKING BACK: JOSE'S INITIAL STRATIFICATION, SYSTEM SUPPORTS AND MONITORING

Humana's integrated care approach includes ongoing review of Jose's health information to identify and target care needs. The identification process includes: daily and systematic reviews for inpatient authorizations and emergency visits; Healthcare Effectiveness Data and Information Set (HEDIS) gap in care alerts (to ensure EPSDT requirements are up to date according to the periodicity schedule); as well as monthly Medicaid Severity Scores predicting high cost or utilization. This model includes medical, pharmacy, and behavioral health claims to identify enrollees who might benefit from case or disease management. During Jose's first two (2) years with the Humana plan, he was not identified for potential case or disease management. He was also up to date on all EPSDT requirements and had not had any hospital admissions until this last year.

LOOKING BACK: JOSE'S BEHAVIORS AND BAKER ACT ADMISSIONS

Towards the end of 2018, Jose began displaying escalating behaviors that negatively impacted his interactions with his family and his performance at school. This resulted in two (2) inpatient admissions under the Baker Act. He was also diagnosed with bipolar disorder and was prescribed a low dose of Seroquel. After each of these admissions, our behavioral health (BH) utilization review clinician, Lisa, (who is a licensed clinical social worker) partnered with the facility in the discharge planning process. Throughout both of these Baker Act admissions, Lisa maintained ongoing contact with the facility, reviewed Jose's progress during multidisciplinary team (MDT) meetings, and assisted with identifying barriers that might have prevented successful discharge or readmission.

She also spoke with Jose's parents to give them information on the Complex Case Management (CCM) program. Lisa explained that the CCM program would connect a licensed BH case manager to Jose and the family. The case manager would assist by identifying care needs and coordinating appropriate covered and non-covered services. These could include covered services like outpatient individual and family therapy, as well as non-covered services like engagement with the Boys and Girls Club and Boy Scouts of America. This could also include additional support services through organizations such as the National Alliance for Mental Health. Unfortunately, Jose's parents declined her offer for CCM at the time.

Through her training and experience, Lisa understood that timely access and availability of providers was essential in establishing and engaging ongoing treatment for Jose. Lisa educated the family and coordinated providers and community resources for Jose and his parents (including individual and family support groups). While Jose's case was not in active case management while he was outpatient, it was flagged for additional monitoring and opportunities for future case management engagement.

DAY 1: JOSE'S THIRD BAKER ACT ADMISSION

In February of 2019, Lisa receives a request for an inpatient authorization under the Baker Act for now fifteen (15) year old Jose. Lisa accesses his enrollee record through Humana's clinical system, CareHub Clinical Guidance Exchange (CGX) [1], to review the previous admission details, authorization history, and demographic information. She is familiar with Jose and his family from working with them on his two (2) previous admissions. To gain a full picture of Jose, Lisa views the Integrated Member Profile (IMP) tab of CGX which contains a comprehensive snapshot of case management activity, diagnosis, medications, authorizations, and alerts. Jose's file in CGX contains details on his:

- First admission in September, 2018

- Historical MDT meeting documentation; participants include Jose's Primary Care Physician (PCP)

- Demographic information and details of his family (he has two (2) siblings, his parents, Frank and Marie, are separated, and Frank had a work injury leading to disability)

- Documented cultural and language preferences

- Release of Information for Behavioral Health on file, in order to share information on Jose's BH admissions with his PCP

- Residence change in September, 2018 when Jose moved in with his father

- Second admission in December, 2018 with a diagnosis of bipolar disorder

- Current medication, Seroquel (low dose)

- New indication of thyroid dysfunction on this February, 2019 admission

- Increasing episodes of behavioral issues including truancy, verbal, and physical aggression at home and school

- Eligibility for CCM, documentation of multiple discussions since the first admission, and the family choosing not to participate

- Lack of psychiatric claims information supporting completion of outpatient follow-up, meaning it appears Jose has not been seeing his treating provider on a regular basis

Lisa understands it is important to engage Jose and his family as soon as possible with swift and comprehensive interventions to promote successful outcomes. She feels the CCM program is the best solution to accomplish this goal. Within twenty-four (24) hours of receipt of the inpatient authorization request, Lisa completes her review of Jose's information in the system. She learns the reason for his admission and contacts the facility discharge planner to communicate the receipt and approval of the authorization. Lisa also obtains additional details about Jose's admission from the facility discharge planner and they discuss his status and the timing for engaging in necessary after-care services.

Together, they review Jose's inpatient treatment plan and initiate the discharge planning process. Lisa learns the facility and Jose's family are planning to submit a referral for a Statewide Inpatient Psychiatric Program (SIPP) placement for Jose. A SIPP is available for children and youth requiring treatment in a psychiatric residential setting when a less restrictive setting is not viable and where services are expected to be beneficial and relatively short-term. Jose's family feels this is the best option for him at this point.

DAY 2: SIPP REFERRAL FOR JOSE AND CLINICAL PEER TO PEER

Jose's facility discharge planner gathers the required information and sends a referral for a SIPP placement for Jose. The SIPP provider submits the request for authorization through the provider portal to Humana as a result of this referral. A SIPP assigned utilization management (UM) clinician reviews the submitted assessment and clinical data given by the facility discharge planner, however, the clinician finds that the information provided within the request does not support the authorization of a SIPP placement. Per our process, the UM clinician notifies a Humana board-certified and Florida licensed psychiatrist for further review. Upon receipt, the Humana reviewing psychiatrist contacts the SIPP provider to gain insight on treatment strategies and historical interventions.

Together, the reviewing psychiatrist and the SIPP provider conduct an analysis of Jose's clinical and behavioral picture, noting the recent addition of a thyroid dysfunction, which had not been noted during previous admissions. They discuss the fact that a potential medical cause for Jose's escalating behaviors has not yet been explored. The reviewing psychiatrist discusses Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and potential medical causes, which must be addressed and controlled prior to exploring a SIPP psychiatric placement. Jose's current medication compliance and reported side effects are also reviewed. They note that he is inconsistent in taking his Seroquel and that he needs a follow-up for medication review and adjustment.

Multiple community-based options are identified as alternatives to SIPP placement. After discussion, the SIPP provider and reviewing psychiatrist decide the Therapeutic Behavioral On-site Services (TBOS) is a better fit for Jose's situation and note that it is a covered alternative behavioral health treatment option. TBOS provides in-home services including individual and family therapy, behavior management, and therapeutic support. The conversation concludes with the facility provider and the reviewing psychiatrist agreeing on the value of Jose residing in his father's home if possible. This plan allows exploration of the various potential causes contributing to his recent decline in behavior prior to seeking a SIPP placement. The facility and

Jose's father, Frank, will receive written notification of the adverse benefit determination, including grievance and appeal information, along with the right to a Medicaid Fair Hearing.

EXPEDITED APPEAL
Upon receipt of the notice of adverse benefit determination, Frank calls the Humana Enrollee Help Line and explains that he would like to file an expedited appeal of his son's denied SIPP request. He is transferred to Humana's Grievance and Appeals (G&A) department and the representative accepts Frank's request for an expedited appeal and documents accordingly in the system. His expedited appeal is submitted to the SIPP-assigned utilization manager. This initiates a second-level review by the medical director, who is a board-certified psychiatrist and was not involved in Jose's initial determination. This review is completed and the decision upholding the adverse benefit determination of SIPP denial is communicated to Jose's Dad less than seventy-two (72) hours of receipt of his expedited appeal request.

DAY 2 – 3: ONGOING CASE MANAGEMENT FOR JOSE

In conjunction with the appeal process, Lisa obtains a copy of Jose's inpatient individualized treatment plan for review to ensure that the care he is receiving is appropriate and aligns to his presenting condition. Through her comprehensive training and experience, Lisa knows there are less restrictive alternatives available so she initiates an MDT meeting including herself, Jose, his parents, his treating psychiatrist, and the facility discharge planner to review Jose's current inpatient treatment plan. She makes sure the following items are discussed:

-Information obtained during the initial assessment

- Up to date release of information forms for release of Behavioral Health information are on file

- Current diagnosis of thyroid dysfunction and the need for follow up with Jose's PCP

- The peer-to-peer outcomes and the treating provider's plan to explore alternatives to SIPP placement, specifically TBOS

- The family's prioritization and preference around Jose's care

- Medication side effects, evaluation of medical therapies and alternatives, compliance, monitoring and education

- Jose's planned inpatient therapies:

-- Individual and group therapy to include anger and behavior management strategies

-- Family therapy

- Barriers to Jose's access-to-care, such as transportation and provider hours that have prevented Jose from previous engagement in psychiatric sessions

- Resources and support to remove the identified barriers, specifically covering transportation and provider options

- Efficacy of the outpatient therapy sessions he has been attending for the past six (6) weeks

- Jose's eligibility for CCM, as he has had multiple admissions, has the presence of psychosocial barriers, and has complex needs for care coordination

Jose's parents share that they are overwhelmed with the number of individuals involved in Jose's care and are feeling frustrated as Jose's behavior continues to worsen. Lisa uses this opportunity to highlight the benefit of having a CCM case manager to help Frank and Marie. She explains that the CCM facilitates communications between Jose's entire treatment team and Jose's PCP, and that this coordination will ensure effective and timely delivery of care for Jose. Frank accepts the recommendation and Lisa generates a referral for CCM outreach. Frank also agrees to TBOS for Jose and is open to any local provider. Lisa enlists the assistance of a BH after-care coordinator to identify contracted TBOS providers specializing in adolescent treatment, with appointment availability, located near Jose's father. The after-care coordinator uses a systematically maintained provider directory in order to locate an appropriate provider with capacity to meet Jose's need for timely and appropriate care. Lisa facilitates the scheduling of an initial appointment to occur within seven (7) days of Jose's discharge. She also helps Frank schedule transportation to ensure he makes it to the appointment. Had an in-network provider not been accessible for Jose, a single case agreement with the provider would have been established to meet Jose's after care needs.

DAY 4: JOSE'S DISCHARGE PLAN

Lisa and Jose's family create a discharge plan. Lisa documents the following in CGX and provides a copy to Jose's family, his BH outpatient therapist, and his PCP:

- Crisis plan in case Jose experiences difficulties
- Follow-up BH appointment scheduled for 7 days and 30 days
- Follow-up PCP appointment for medical work-up
- Medication reconciliation and prescriptions
- Pertinent condition-specific education
- Transportation arrangements confirmed
- Lisa's contact information
- Confirmed Individual Education Plan review appointment with parents and advised support can be provided upon request

Alex, Jose's newly assigned CCM, reviews Jose's file in CGX, and contacts Lisa to discuss his current status and discharge plan. Alex becomes a part of the MDT, as they work towards the scheduled discharge date, and completes the comprehensive needs assessment while Jose is inpatient. The comprehensive needs assessment drives the development of the plan of care by identifying and prioritizing Jose's cognitive, psychosocial, behavioral history, medical history, cultural, linguistic, and functional needs.

DAY 5: JOSE'S POST DISCHARGE AND AFTER CARE

Once Jose is home, Alex works closely with him and his family, ensuring the after-care plan is initiated. Jose's plan of care (POC) is developed and finalized five days after Alex's initial assessment. Services on the POC are authorized and initiated within fourteen (14) days. Alex utilizes a holistic person-centered approach (including Jose and his family) in the POC development and ensures that Jose remains at the center of all strategies and identified interventions. Alex performs ongoing coordination and communication with Jose's PCP and outpatient care team and provides copies of the POC. Based on Jose's identified issues and needs, the self-management strategies to meet his goals include:

- Engaging in bi-weekly anger management and coping skill development sessions with his TBOS therapist
- Participating with family (including siblings) in bi-weekly therapy sessions with TBOS therapist
- Following all PCP recommendations, including re-establishing psychiatric visits
- Adhering to medication recommendations as identified and communicating all side effects to the prescribing provider
- Actively participating in Individual Education Planning sessions with Jose's school counselor
- Joining an after school club, sports team, or community program
- Engaging in monthly support group sessions with his family

Lisa completes her utilization management process by calling Jose and his father to remind them of both his seven (7) day and thirty (30) day scheduled follow up appointments. She also confirms that there are no transportation needs. She documents her call in CGX to ensure Alex can see that she has completed this follow up.

DAY 30 AND BEYOND: JOSE'S ONGOING COMPLEX CASE MANAGEMENT

Alex ensures that Jose completes his full medical evaluation and has received his PCP's final results and recommendations. He also makes sure that Jose has begun taking his newly prescribed thyroid medication. In addition, his newly assigned TBOS behavioral health therapist has met with Jose and Frank at their home and completed a psychosocial assessment to determine the appropriate therapeutic approach to Jose's care. Alex continues to engage and support Jose and his family through monthly contacts and quarterly face to face visits, and will reconvene the MDT every six (6) months or more frequently if needed. Less than a month after returning home, Jose is consistently taking his prescribed thyroid medication. He has been working with his TBOS therapist on managing his behavior and is currently focused on identifying triggers to his anger and managing associated symptoms appropriately. Alex is seeing results from the coordination of covered services, the education provided to Jose and his family, and the community resources to which they were connected. He also sees Jose is beginning to achieve his desired goal of managing his behaviors to hold positive interactions with his entire family, including his mother, Marie.

Humana's approach to Jose's situation ensures that care and supports are being provided in the right place, at the right time, involving the appropriate providers as well as natural and community supports. The goal of case management is to empower Jose to self-manage his needs in the least restrictive environment, as well as to be a source of support and guidance on

his personal health and well-being journey. Jose is a great example of how a caring and coordinated group of people can improve the health and well-being of a person in need.

Footnote

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[1] CareHub is Humana's enterprise solution for complete program integration for our provider community and enrollees. CGX supports an integrated, comprehensive approach to medical, behavioral health, pharmacy, utilization, and care management. Full system integration allows our care team the capability to identify potential enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify opportunities for intervention.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

- **a.** Identification processes for enrollees with complex health conditions or who are in need of care coordination;
- **b.** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **c.** Application of the respondent's case management risk stratification protocol;
- **d.** Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
- **e.** Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
- **f.** Application of discharge and aftercare planning protocols that facilitate a successful transition;
- **g.** Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
- **h.** Description of the assessment of provider capacity to meet the specific needs of enrollees;
- **i.** Identification of strategies that promote enrollee self-management and treatment adherence;
- **j.** Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
- **k.** Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment MMA 18-1: Jose's Visual Story Guide

We have provided this document as a visual guide to our response. The key timelines from our core response are duplicated here in a format intended to supplement and enable a comprehensive review of Humana's approach to Jose.

About Jose:

Jose is a 15-year old male, enrolled in Medicaid since age 5 and has been with Humana's plan since July 2014. He is diagnosed with bipolar disorder and is currently hospitalized under the Baker Act; this is his third psychiatric admission under the Baker Act in the past year. Up until six (6) months ago, Jose lived with his mother and two younger siblings. However, he moved in with his father after his behavior at home and in school declined and his mother was unable to protect herself and his siblings from Jose's angry outbursts and verbal and physical aggression. Jose is prescribed a low dose of Seroquel daily, but he is noncompliant and is now showing evidence of a Thyroid dysfunction. Jose's SIPP authorization was denied and his father called Humana for help filing an expedited appeal.

Key Components of Care

- **Highly engaged BH Utilization Review Clinician and BH CCM** for ongoing contact, identification of care needs, coordination of appropriate services, among other supports for Jose and his family
- **Integrated Plan of Care (POC) Approach** for ongoing review of Jose's health information to identify and target care needs
- **Ongoing Education, Engagement, and Relationship** with Jose and his family to ensure they are equipped with resources and tools to promote successful outcomes
- **TBOS, an Alternative BH Treatment option** for Jose, instead of a SIPP psychiatric placement
- **Multidisciplinary Team (MDT)** composed of Jose, Jose's parents, the BH utilization review clinician, CCM, his treating psychiatrist, and the facility discharge planner
- **Focus on Jose's Path Forward** by evaluating medical therapies, medication side effects, compliance and monitoring, and making necessary adjustments as needed

Jose's Support System

- **Lisa** — BH Utilization Review Clinician
- **Alex** — Complex Case Manager
- **Frank** — Father
- **Marie** — Mother
- **Psychiatrist**
- **Facility Discharge Planner**

Jose's Timeline:

1 — Looking Back July 1st 2014:
Initial enrollment into Humana's MMA plan when Jose was 10 years old

2 — Looking Back 3rd week of July 2014:
Welcome call from ESU CCS, Alicia

3 — Admission Day 1: Jose's 3rd Baker Act Admission
Lisa reviews Jose's CGX record and contacts facility discharge planner to initiate coordination

4 — Admission Day 2:
SIPP referral requested, Peer to Peer completed; TBOS identified as better fit; receives adverse determination on SIPP, Frank receives notice

5 — Admission Day 2-3: Ongoing Case Management
Lisa schedules and holds MDT meeting, CCM referral is accepted by Jose's parents; Frank agrees to TBOS for Jose

6 — Admission Day 4: Jose's Discharge Plan
Lisa & Jose's family create discharge plan, include Alex in MDT

7 — Day 5: Post Discharge & After Care
Alex works with Jose and family to ensure after-care plan is initiated

8 — 7 Days Post Discharge:
Lisa conducts follow up for seven day appointment confirmation

9 — 30 Days Post Discharge:
Lisa conducts final follow up for 30 day appointment confirmation, concluding her UM activity

10 — Day 30 & Beyond:
TBOS BH Therapist meets with Jose and determines POC; from Date of Discharge to current, Jose is engaged with Alex, CCM

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 19 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Jane is a 57-year old female with Type II diabetes mellitus and hypertension. Jane is compliant with her treatment plan, which consists of the following prescribed drugs: Insulin and Lisinopril. She is also compliant with her follow-up appointments with her specialists. She lives alone, but receives support from her eldest daughter who lives nearby. Jane thought she timed her follow-up visit with her endocrinologist adequately to allow sufficient time to receive a new prescription for all drugs; however, Jane realizes she only has enough insulin to last through the doses for tomorrow. Her appointment with Dr. Seem, her endocrinologist, is in two weeks. Jane calls her doctor's office who informs her that they have no availability to see her today or tomorrow and Dr. Seem will not write a new prescription without examining Jane since it has been four months since her last appointment. Jane decides to call her health plan's member hotline for assistance.*

The respondent shall describe the approach for handling Jane's call and how the respondent would help Jane obtain her medication.

Response:

SERVING JANE'S IMMEDIATE NEEDS WHILE DEVELOPING LONG-TERM SOLUTIONS

FEBRUARY 15, 2019: JANE'S CUSTOMER CARE CALL
Jane, a Humana enrollee with an urgent need to obtain an insulin refill from her doctor, calls the Humana toll-free number on the back of her ID card. This connects Jane to Marvin, a Customer Care Specialist (CCS), at Humana's Tampa-based Customer Care Call Center, which operates between 8:00 am and 8:00 pm. If Jane had Limited English Proficiency (LEP) and required language assistance, Humana would offer bilingual CCSs to assist in Spanish or would provide a full-service, over-the-phone interpretation and translation service for up to 170 additional languages, as well as services for hearing impaired enrollees.

CCS Marvin answers Jane's call, authenticates her identity, informs her that the call may be recorded, and accesses her enrollee information on his screen. Marvin finds no alerts for gaps in care for Jane and sees that Jane has historically not been triggered for disease management, is not currently assigned to a case manager, and is not engaged in a clinical program. Jane explains to Marvin that she regularly sees her doctors and faithfully takes her medications. She further explains that she needs a refill, but that her next appointment is in two weeks and her doctor has refused to provide a refill before then. Marvin recognizes from his training that Jane's situation is not a benefit inquiry, but rather a lack of access to urgently needed medical care. He further recognizes that this is a serious issue and requires immediate action.

Through his training and experience, Marvin knows Jane's type of access to care issue is often resolved with a conference call to the provider's office, as there is often simply a misunderstanding between the provider and the enrollee. Marvin obtains Jane's permission to

perform a three-way call with Jane's endocrinologist, Dr. Seem. On this call, the office staff confirms that it will not provide the prescription until Jane is seen at her appointment in two weeks. Marvin realizes that if this barrier is left unattended, it could lead to dangerous blood sugar levels. This would likely lead to Jane needing to visit an urgent care center or, worse yet, an emergency department. This triggers Marvin to initiate the escalation process. With Jane still on the line, Marvin disconnects with Dr. Seem's office and explains to Jane that the next step is to transfer her call to our Clinical Access Team (CAT). He obtains Jane's agreement to directly connect her to a registered nurse (RN) on that team. To ensure this connection is successful, Marvin initiates a warm transfer, keeping Jane on the line so that he can directly introduce Jane and fully explain her situation to Ruby, the Florida licensed RN receiving her call.

The CAT is comprised of RNs like Ruby who are knowledgeable of enrollee benefits and clinical needs. They are also equipped to identify appropriate solutions for Jane and advocate on her behalf to access care. The CAT's mission is to provide personalized guidance toward issue resolution and to enable enrollees like Jane to access preventive care which will promote healthy behaviors, positive health outcomes and well-being. Ruby has been trained to facilitate timely clinical access to care, initiate referrals to appropriate clinical programs, provide guidance to in-network providers, and promote Humana's compliance with regulatory and accreditation requirements. She was also trained to serve as a liaison for enrollees or their representative, providers, and other appropriate stakeholders. Ruby benefits from Humana's significant presence managing more than two million (2,000,000) members across multiple lines of business in Florida, as the CAT has fostered strong and effective provider relationships which facilitate timely resolutions.

JANE'S ESCALATION AND RESOLUTION

Ruby speaks with Jane and after she determines that her current clinical condition is stable, she verifies her correct understanding of Jane's access to care issue. Ruby secures Jane's permission and makes a second three-way call to Dr. Seem's office. Ruby requests to speak with his nurse. It is determined there are no earlier appointments available, but through her discussion with Ruby, Dr. Seem's nurse recognizes the urgency of Jane's situation and states that since Jane is scheduled, they will provide a one-time insulin refill. She further explains that this refill will be phoned to Jane's preferred pharmacy. Dr. Seem's nurse advises that if Jane's upcoming appointment is missed or rescheduled, Jane will not be able to obtain further refills. Jane confirms her understanding of this and Ruby ends the call with Dr. Seem's office, keeping Jane on the line. Ruby confirms with Jane that she has the appointment date and time noted and transportation to the appointment has been scheduled. Jane states that she will ask her daughter to pick up the insulin refill today. Ruby ensures that Jane has the Customer Care number and reminds her that it is available for her to call 24 hours per day. She also reminds Jane about the Nurse Advice Line number which will allow her to access the after-hours nurse line, in case she has any additional issues or health concerns.

MARCH 1, 2019: RUBY FOLLOWS UP WITH JANE
Ruby schedules a reminder to contact Jane for a discussion about her appointment with Dr. Seem. When Ruby calls Jane, she confirms that Jane obtained her new prescription and picked up her insulin. She also confirms that there are no continued access-to-care issues and that no new needs are identified. Ruby also suggests that Jane may wish to provide a Release of

Information to Humana so Jane's daughter is able to call on her behalf. She explains one of the benefits of this is that Humana would be able to engage with Jane's daughter to increase family support to help her manage her medical issues. Jane agrees to complete the form. Ruby confirms her address and sends the form to Jane in the mail. Ruby and Jane discuss a tracking and reminder system to make sure she is keeping up with all of her appointments and to ensure timely refills are available. They discuss the goal of avoiding a potential exacerbation of her symptoms that would require a visit to urgent care or the emergency department. Ruby then provides Jane additional information on Humana's Diabetes Disease Management (DM) program, which could help her more effectively manage her diabetes. Jane would like to learn more about her condition and agrees to enroll in the DM program. Ruby advises Jane that she will receive a call from the Humana DM RN to enroll her in the program within 7 to 10 days. Ruby makes a note to follow up with Jane in two weeks to ensure the DM RN contacts her for enrollment.

MARCH 1, 2019: RUBY ADDRESSES ISSUE WITH DR. SEEM
After the conversation with Jane, Ruby contacts our Provider Relations Team, notifying them of the issue Jane experienced with Dr. Seem and requests that they contact him and his staff to provide additional education and training concerning the requirement to provide timely medically necessary services to enrollees. The Provider Relations team will coordinate with Dr. Seem and his staff, reviewing contract obligations, the Provider Manual, and information related to serving enrollees with empathy and understanding, as well as conforming to contractual requirements around timing of visits and enrollees' access to care.

Ruby educates Jane about her grievance and appeals rights and options, but Jane does not feel this is necessary as the issue was resolved. Had Jane wished to file a grievance, Ruby would offer a warm transfer to Customer Care and, if declined, she would provide Jane with the Customer Care number so she could call on her own. When contacted, the CCS would log the grievance in Humana's Customer Relationship Management (CRM) system [1] and it would be promptly reviewed by our Grievance and Appeals team to determine the most appropriate way to assist Jane in resolving her issue. We would provide her with help filling out forms and assist her in reaching necessary agencies and obtaining information about the provider's actions leading to the filing of the grievance.

REFLECTING ON HUMANA'S FOCUS ON REPEATABLE LONG-TERM RESULTS

After Ruby was able to help Jane resolve her immediate issue, our integrated team took the opportunity to explore the underlying issue that led to Jane's situation. The team was able to work with her to develop long-term solutions to empower her in the self-management of her chronic conditions.

Jane's situation was resolved through our standard process steps and protocols. However, we recognize that this is not the case in all situations. Our representatives are trained to seamlessly handle all situations that may arise. Below we detail this by providing additional information on the training CCS Marvin received to enable him to properly work through Jane's issue as well as the alternate escalation options Ruby would have worked through had Dr. Seem's nurse not agreed to provide the one time refill.

MARVIN'S TRAINING TO SUPPORT ENROLLEES LIKE JANE

Marvin's CCS training included eight weeks of classroom study, call shadowing, live-call demonstrations, and call monitoring and review. CCSs such as Marvin are equipped to properly identify and triage cases like Jane's, locating appropriate resources to resolve enrollee issues in a timely manner. More specifically, Marvin has learned strategies to identify indicators of access-to-care barriers, prioritize immediate needs, identify enrollee health literacy levels, display empathy and emotional support on calls, and advocate for the enrollee utilizing resource tools to remove or work around the barriers creating the needs. Marvin also completed training on cultural competency, disaster recovery, risk management, and how to provide clear and understandable guidance to enrollees in the event of complex situations.

Marvin utilizes multiple tools, including the Customer Care operational manual and policies and procedures to reference appropriate call scripts, actions, referrals, escalation protocols, and to document the actions leading to the enrollee's inquiry or issue resolution in the CRM system. Marvin is able to update information when applicable and capture the enrollee's preferences in the system for future reference.

Our CCS staff also complete specific prescription-related training that addresses procedures for ensuring enrollees have access to medications. The CCS is prepared for situations where there is an access-to-care need to accurately determine when medication overrides should be granted to enrollees, how to locate resources corresponding to immediate medication needs identified, and resolve authorization related claim denials according to procedural guidelines. Examples of resource documents covered in this training module include:

- Florida Medicaid Plan Lost, Stolen or Damaged Prescriptions
- Pharmacy Disaster Exception Process
- Natural Disaster Guidance
- Replacement Medications for Declared and Non-Declared Disaster
- Florida Medicaid Non-Certified Pharmacies

RUBY'S ALTERNATE ESCALATION OPTIONS

If Ruby had not been successful in obtaining the appointment and refill from Dr. Seem's office for Jane, there are several other escalation protocols and strategies that would have been utilized to prevent an urgent care or emergency room visit, or a preventable hospital admission:

- Involving a Humana Medical Director to engage in a peer-to-peer conversation with Dr. Seem to request the necessary medication on an urgent need basis

- Contacting Jane's PCP, requesting that the PCP issue the prescription for Jane's insulin to cover her until her scheduled appointment with Dr. Seem

- Providing guidance to schedule an appointment with a new in-network endocrinologist, who might be available to see her on the same day, using the Humana online provider directory

- Utilizing our new telemedicine partnership with Doctor on Demand, where Jane can talk with a physician via live video feed within 5 minutes of her request

- Accessing an appointment at one of Humana's wholly owned/joint venture provider groups in Florida

- Contacting Jane's pharmacy to request a one-time emergency fill on her insulin

If a medical emergency had been identified or if this had occurred during a time of disaster, Ruby would have directed Jane to seek appropriate medical services and resources.

Footnotes:

[1] CRM is Humana's documentation system for enrollee support activities, providing message optimization, enrollee-centric prioritization, data mining and reporting, and enhanced processes for quality management to streamline the flow of data to other internal systems.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

(a) Training for call center staff that illustrates the ability to triage cases of this nature, including the internal escalation process available to call center staff.

(b) Description of the interventions and strategies that would assist Jane in avoiding a visit to urgent care or the emergency department to receive a new prescription.

(c) Evidence of the integration between and among all relevant departments, including subcontractors if applicable, to facilitate a seamless resolution.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment MMA 19-1: Jane's Visual Story Guide

We have provided this document as a visual guide to our response. The key timelines from our core response are duplicated here in a format intended to supplement and enable a comprehensive review of Humana's approach to Jane.

About Jane:

Jane is a 57-year-old female with Type II diabetes mellitus and hypertension, and is an existing Humana MMA Medicaid enrollee. She is compliant with her treatment plan (Insulin and Lisinopril) and follow up appointments with her endocrinologist, Dr. Seem. Realizing that she only has enough insulin to last until the following day, Jane calls Dr. Seem's office, but they have no availability and will not write a new prescription until she is seen. Jane calls Humana on February 15, 2019 and speaks to Marvin, a Customer Care Specialist (CCS), for assistance.

Key Components of Care

- **Highly Experienced Customer Care** team of specialists trained to identify situations, assess risks, escalate, and facilitate resolution to mitigate disruptions in care
- **Clinical Access Team (CAT) Escalation** when barriers can't be resolved conventionally, with a licensed RN trained to facilitate timely access, referrals, guidance, and compliance while acting as a liaison for enrollees, representatives, and providers
- **Follow-Up Education and Engagement** to help inform Jane on our DM program, discuss goals, and engage other supports, such as Jane's daughter and a DM RN
- **Focus on Repeatable Long-Term Results** to help resolve immediate issues while providing information and solutions that empower Jane to self-manage her care
- **Provider Education and Training** with Dr. Seem and his staff, via Humana's Provider Relations team

Jane's Support System

- **Jane's Daughter**
- **Marvin** CCS
- **Ruby** CAT RN
- **Dr. Seem's Office** Endocrinologist

Jane's Timeline:

1. **Trigger for Action**
   Jane needs an insulin refill, but her next appointment is in two weeks and Dr. Seem has refused to provide a refill before then. Marvin, Humana's CCS, recognizes this is a serious issue that requires immediate action.
2. **Day 1: Customer Care Call**
   Marvin receives Jane's call, authenticates her identify, and accesses her enrollee information. He notes no prior gaps in care, and she has not been triggered for DM.
3. **Day 1: 3-Way Facilitated Call**
   Marvin gets Jane's permission to make a 3-way call with Dr. Seem's office, confirming her next prescription will not be filled prior to her appointment.
4. **Day 1: Escalation to CAT**
   Marvin triggers an escalation to the CAT and transfers her to Ruby, a RN on the team.
5. **Day 1: CAT Assessment**
   Ruby speaks with Jane, verifies situation and with Jane's permission, makes second three-way facilitated call to Dr. Seem.
6. **Day 1: CAT Facilitated 3-Way Call**
   Ruby facilitates 3-way call with Dr. Seem's office, requesting to speak to a nurse, who recognizes the urgency and agrees to a one-time refill.
7. **Day 1: One-Time Refill Request Approved**
   Post-call, Ruby confirms Jane's appointment time and educates her on the Customer Care number and Nurse Advice Line.
8. **Day 15: CAT Follow-Up and DM Enrollment**
   Ruby follows up with Jane to remind her about her upcoming appointment and also educates her on Humana's Diabetes DM program. A Humana DM RN will call Jane within 7-10 days to enroll her in the program.
9. **Day 15: Provider Relations Follow-Up**
   Ruby contacts Humana's Provider Relations team to notify them of Dr. Seem and his staff, and to recommend additional education and training, and to re-review contractual obligations with the office.
10. **Day 15: Grievance Option**
    Ruby lets Jane know about her option to file a grievance with the customer care team, but Jane declines since her issue has been resolved.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 20 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Emma is four-years old. She currently lives in a pediatric nursing facility. At the age of two she was admitted to PICU following a respiratory arrest during an acute illness. A further complication of her condition led to her requiring a tracheostomy to support her breathing. Following an acute exacerbation of her condition, she is now unable to breathe without the support of her ventilator when she is tired, asleep, or unwell. She is fully ventilated overnight. Her difficulties are compounded by complex seizures. Emma's doctor says Emma needs to have nurses or health care assistants with her at all times to monitor her ventilation. Emma's most recent developmental screening indicates the presence of an intellectual disability. Emma's condition has stabilized, but her mother is concerned about agreeing to bring her home permanently. Her mother is the sole income for their home, which includes three older siblings and Emma's maternal grandmother. Emma's grandmother is retired, and her ability to help the family is limited by severe rheumatoid arthritis.*
>
> *To be discharged to her home, Emma's physician has ordered a custom wheelchair that must be individually fabricated and assembled. Her physician also ordered an electronic tablet to provide cognition exercises for Emma. The tablet has a cognition exercise application that reduces the likelihood for any seizure activity that may occur with other similar tablets. Florida Medicaid does not cover the tablet nor the wheelchair, which includes a part that will make it easier for Emma to hold the tablet. Her mother is unable to bear the costs for these special service items. Further orders for Emma's transition to home care are:*
>
> - *Continuous pulse oximetry monitoring.*
> - *Apnea monitor when she is not on the ventilator.*
> - *A backup generator for the ventilator if the power goes out in the home.*
>
> *Emma is a new enrollee. Prior to her enrollment, all services were provided through the Medicaid FFS delivery system.*

The respondent shall describe its approach to coordinating care for an enrollee with Emma's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

EMMA

Emma had an acute illness with respiratory arrest when she was two (2) years old, and has been living in a nursing facility for the last two years. She has a tracheostomy and is supported by the ventilator when she is sick, tired, or asleep. Emma's condition is compounded by complex seizures and her most recent diagnosis of an intellectual disability. Emma has three sisters at home with her mother and grandmother. While Emma is medically fragile, she is stable and can be discharged home with specific equipment and services. Emma is a new enrollee to the Humana plan.

DAY 1: HUMANA IS INTRODUCED TO EMMA

Notification of Emma's eligibility comes to Humana via the 834 enrollment file. Humana loads Emma's eligibility information and auto-creates a case in Humana's proprietary clinical workflow system, CareHub Clinical Guidance eXchange (CGX) [1]. CGX has business rules in place to initially stratify Emma's case as high-risk, due to her complex needs, so it is prioritized for assignment. Concurrently, this electronic transmission triggers Humana's welcome materials to be mailed within five days of notification.

Following the auto-case creation, Humana assigns Emma to "Amy," a Humana Registered Nurse (RN) with not only pediatric experience, but also intensive care experience. Amy manages Humana enrollees at Emma's skilled nursing facility (SNF). Amy, as with all Humana pediatric case managers, exceeds the minimal experience requirements and works within the identified case load ratio of no more than fifteen (15) enrollees to one (1) case manager for enrollees under age twenty-one (21) residing in a SNF.

In addition to Amy's specific pediatric experience, she was provided with Humana's eight (8) week orientation. This included training on Medicaid, Humana's systems, ethics, cultural competency, motivational interviewing, and other computer-based training. After initial orientation, Amy was mentored by senior case managers who advised her on topics like providing education on community resources and resolving enrollee issues in a timely manner. Amy learned strategies for identifying barriers to care, prioritizing immediate needs, and displaying empathy and emotional support. Amy has also been provided with ongoing training to keep her up to date and continuously learning. This has been offered to her through monthly half-day education, training, and oversight sessions to ensure she has access to the most up-to-date information and to her case manager mentors.

DAY 2: INITIAL OUTREACH AND VISIT TO EMMA

When Amy receives an electronic alert of Emma's assignment, she reviews Emma's demographic information and location and plans to visit the facility the following day. Since Amy manages Humana enrollees in this SNF, she has an established relationship with staff that work there. During her visit, Amy collaborates with admissions to verify enrollment, eligibility, and location. After reviewing Emma's facility medical record, Amy notes Emma's length in the facility, the illness that led to her requiring a tracheostomy, her ventilator support, her complex seizures, and her recent diagnosis with an intellectual disability. Since Emma was a resident of the facility prior to her Humana enrollment, Amy understands the requirement to note the physician's orders for what Emma will need to be discharged home when she initiates transition planning. Amy has a relationship with the facility's Social Worker (SW) who assists Amy in obtaining a copy of Emma's facility Plan Of Care (POC) and her pre-admission screening and resident review (PASRR) I and II. Amy also obtains the schedule for Emma's multidisciplinary team (MDT) meeting at the facility so she can participate.

Amy is fortunate to catch Emma's mother visiting this morning. Amy introduces herself and Humana's program to Emma's mother. She also confirms that Emma's mother, "Susan," received Humana's welcome materials and Emma's ID card. Amy explains program options to Susan and obtains a completed Freedom of Choice form. Susan shares with Amy that she would love to have Emma home with their family, but also knows Emma must have a customized wheelchair and an electronic tablet to be discharged home, and given that she provides the sole income for the household, she cannot afford them. Susan also knows these were previously not included in Emma's fee-for-service (FFS) Medicaid coverage and is hopeful that Humana will enable Emma's transition home.

Amy knows the importance of having educational materials, information, and resources to ensure Susan is prepared, not only to make informed decisions, but to be appropriately comfortable with Emma's care. Susan shares how she has become familiar with the ventilator and alarms, including Emma's suction equipment, and is appreciative of how much education and training the facility has provided. While Amy is mindful of the time it takes to review new material, complete a comprehensive assessment, and finalize a plan of care (POC), she lets Susan know they need to finalize it within five days. Susan agrees to continue and is appreciative of any help Humana can provide Emma.

Amy completes Emma's pediatric health risk assessment, including assessing for appropriate cognitive function, and reviews facility records and other released records to identify child health screenings in accordance with the Agency-approved periodicity schedule. Through collaboration with the SNF and Emma's identified MDT, Humana's finalized POC includes Emma's and Susan's goals for desired wellness, health, functional, and quality of life outcomes. Emma's MDT consists of Emma and Susan, Emma's facility physician and nurse, SW, therapists, and now Amy. Amy obtains and documents Emma's community primary care provider (PCP), and provides a copy of Emma's POC, to notify of Emma's upcoming transition plan and Susan's desire to have Emma re-established as a patient.

Amy assesses for community and other supportive services, and refers Emma for needed assistance. Amy collaborates with the facility SW to ensure Emma has been referred to the local Women, Infants, and Children (WIC) program, and educates Susan on the importance of getting the referral information after Emma's well-child visits. Emma's POC encourages well-child visits to help prevent further illness or exacerbations of chronic illness. As part of understanding what

Emma and Susan need without overwhelming them, Amy continues to build trust while completing required assessments, finalizing Emma's POC, and obtaining state-required documents. Emma requires a high level of family and mental health support in addition to twenty-four (24) hours a day, seven (7) days a week medical supervision, ongoing care from medical specialists, and customized equipment.

Emma needs an individualized, age-appropriate educational plan, taking into account her physical and intellectual disabilities. Amy wants to make sure Susan is aware of and has the opportunity to participate in available programs, like Florida's Voluntary Prekindergarten (VPK), to help build the foundation for educational success. Amy also wants to make sure Susan is aware of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to ensure Emma's screenings are up to date.

Amy provides Susan her contact information and encourages Susan to contact her with any questions or concerns.

DAY 8: AMY REVIEWS EMMA'S CASE WITH HUMANA'S MEDICAL DIRECTOR

Due to Emma's condition and the amount of support and durable medical equipment (DME) needed to safely transition her home, Amy reaches out to Humana's Medical Director after the initial meeting to review and discuss Emma's case. The Medical Director reviews what Amy has done with Emma so far and agrees with the need for specialized equipment to make Emma's transition home a success. The Medical Director shares that it is highly likely both the customized wheelchair and the electronic tablet with cognition exercises will be approved, meeting medical necessity, consistent with EPSDT, and appropriate in light of Emma's intellectual disability.

DAY 28 – 68: ONGOING CONTACT WITH EMMA WHILE IN THE SNF

Amy's clinical judgment and adherence to principles of patient-centered care dictate the frequency of contacts to help prepare Emma and Susan for discharge. Amy maintains monthly contact and continues to build on their relationship and work with the family towards Emma's transition home. Amy shares with Susan that she has discussed Emma with Humana's Medical Director and that he is optimistic about the approval of Emma's DME. Amy educates Susan on Humana's authorization process and how our Medical Director may request a peer-to-peer discussion to get a better understanding of the ordering physician's thoughts over other options. Amy also educates Susan on the grievance and appeals processes and her rights to a Medicaid Fair Hearing should she ever disagree with a decision made regarding Emma.

Amy continues her monthly visits with Emma and Susan while Emma is in the facility. Amy participates in the facility's MDT to provide input, gain insight, and to review the services and supports Emma needs as she prepares for transition. Amy updates Emma's individualized POC with input from the MDT. Amy also collaborates with Humana's transition team to update Emma's transition plan. Amy informs Susan of other Humana associates who will help with Emma's transition and tells her about other resources available to her, including home visits.

Social Workers and Field Case Managers (FCMs) specializing in community resources and supports are periodically introduced into the MDT meetings as they prepare for transition.

Amy works with the SNF to facilitate orders for Emma's DME. The orders for Emma's discharge include a customized wheelchair, an electronic tablet to provide cognition exercises, a continuous pulse oximeter, an apnea monitor, a backup generator (for the ventilator), and nurses or health care assistants twenty-four (24) hours a day, seven (7) days a week. After review of Emma's case, Humana's Medical Director does in fact request a peer-to-peer review with the ordering physician to discuss the appropriateness of the apnea monitor and a backup generator. Susan was prepared for this due to Amy's advanced education about its likelihood. With twenty-four (24) hours a day, seven (7) days a week private duty nursing (PDN) and a ventilator with alarms and pulse oximetry, Humana's Medical Director cites evidence and clinical practice guidelines that an apnea monitor is not medically necessary. The Medical Director also recommends a heart monitor and two portable ventilators (for safety and convenience), which could also be used in transport instead of a backup generator.

Following the peer review, Humana's Medical Director and Emma's ordering physician agree upon the equipment appropriate for Emma. This includes the customized wheelchair, the tablet with cognition exercises, a pulse oximeter, a heart monitor, two portable ventilators (each with a backup battery), a suction machine and disposable medical supplies for respiratory support. Private Duty Nursing was approved twenty-four (24) hours a day, seven (7) days a week to assure proper ongoing care, and emergency care, if needed.

DAY 58: MAKING SURE EMMA WILL BE SAFE IN A DISASTER OR EMERGENCY

Amy assists Susan with notifying the power company of Emma's disability status and dependency on a ventilator. This allows for Emma to be prioritized for evacuation and for power restoration after an outage. Amy registers Emma with Florida's special needs shelter to ensure there is a disaster plan for the family to follow in the event of an emergency. In addition to widespread disaster and emergency planning, Amy assists Susan in completing a personal emergency plan for individual or local outages. Susan now knows which hospital to request transportation to by ambulance, if Emma has an emergency and she needs to dial 9-1-1.

DAY 88 – 117: ONGOING CONTACT AND TRANSITION PLANNING WITH EMMA

Amy collaborates with the facility SW and ensures Susan's home has been evaluated and that recommended home modifications are addressed. Since Emma's wheelchair is customized to size, it is not necessary to widen the doors. However, Susan does need a wheelchair ramp. Humana's SW, who is also involved with Emma's MDT, works with Susan to identify resources and community supports, to include coordination with a contractor for ramp installation to accommodate Emma's wheelchair. In addition to the DME company providing a respiratory therapist for Emma, Humana sources in-home physical therapy (PT) and occupational therapy (OT) as recommended by Emma's PCP. Amy identifies providers and establishes a schedule for all ordered services prior to the transition.

In preparation for Emma's transition, Amy assists Susan in identifying in-network providers to be included on Emma's MDT. The team will include a pediatrician, pulmonologist, neurologist, ENT, cardiologist, gastroenterologist, and any other specialists she might need. Additionally Amy, Susan, and Emma's grandmother are included in these meetings. For pediatric specialists not listed on the Managed Medical Assistance Provider Network Standards Table, Amy reaches out to Humana's network team to ensure access to services for Emma by completing letters of agreement with a local specialist and neurologist within a reasonable distance from home, approximately fifteen (15) minutes travel time.

Amy informs Susan of Humana's mail order pharmacy for Emma's maintenance medications and assists in transferring her prescriptions, explaining the procedure for reorder and prescription changes. Amy encourages Susan to use Humana's One Medication Experience (OME), which is accessible on the computer or a mobile application. OME allows visibility to prescription or other (including over-the-counter) medications through claims data or as entered by anyone on Emma's care team (including Susan). Capturing Emma's medications in OME allows Emma's case managers, pharmacists, and Susan the ability to see one comprehensive list of medications. This group of individuals can also be alerted for any contraindications, duplication, or interactions. Emma's medication list can be accessed through CGX. This single point of record effectively establishes a highly valuable, single source of truth which can be utilized by Humana's clinical care team for reference in planning or coordination activities.

Amy also understands the need for counseling and support for Emma's family. Amy refers Susan to local education and support resources and groups for Susan, Emma's siblings, and Emma's grandmother. Counseling is also available to help Emma adjust to her home environment. Transition counseling is provided to teach Emma's siblings how to help Emma, what normal and appropriate interactions with her look like, what they should do to make sure she is safe, and how to help ensure Emma feels like a part of the family. Amy recommends and provides information on Red Cross CPR and first aid classes for Emma's whole family.

Amy informs Susan about Emma being a good candidate to attend a Florida Medicaid Prescribed Pediatric Extended Care (PPEC) center. A PPEC is designed to provide medical and therapeutic care to medically complex Medicaid enrollees younger than twenty-one (21) years in a non-residential setting. Florida's PPEC program is a fee-for-service program that is managed by a Medicaid Quality Improvement Organization (QIO). Humana collaborates with the QIO to ensure that the care rendered at the PPEC meets Emma's physiological, developmental, nutritional, and social needs while aligning with the care rendered at home. Susan agrees to allow Humana to apply for Emma to attend, with the understanding that Humana will pay for Emma's services and therapies at the PPEC. Amy collaborates with Susan, the PPEC, and the QIO to arrange safe transportation between home and PPEC, recognizing the need for a skilled nurse to manage her ventilator during transport.

DAY 118 – EMMA MEETS HER FIELD CASE MANAGER AND SOCIAL WORKER

Amy continues to meet with Emma and Susan at the facility until they are ready for transition. Amy is comfortable with Emma's transition plan and happy with the progress that has been made. Amy introduces Susan to Emma's field case manager (FCM) and social worker (SW), during a MDT meeting. The FCM visit is scheduled for post-transition in order to assess that

services are meeting their needs, how they are adjusting to being at home, and to answer any questions they may have.

Amy ensures Emma's community PCP is aware of Emma's transition and has a follow-up appointment scheduled, and assists Susan in arranging for non-emergent transportation, by ambulance, to her PCP appointment.

DAY 122: EMMA RECEIVES HER NEW WHEELCHAIR AND TABLET

Private duty nursing is scheduled to begin the day of transition. Emma receives her new customized wheelchair at the facility to allow her to practice and get comfortable with it. Emma adapts quickly to her wheelchair and her tablet. Emma is excited to be going home with her mother, her sisters, and her grandmother. Non-emergent ambulance transport is scheduled due to Emma's respiratory condition and Emma's private duty nurse will be waiting upon arrival. Several of Emma's follow-up appointments are scheduled and Amy also assists with scheduling non-emergent transportation for them by ambulance. Amy provides Susan with information and guidance, and reassures her that she can call her any time to help with appointments, transportation, or other needs that arise for Emma.

DAY 124: EMMA'S TRANSITION HOME

After four months and anxiously awaiting this big day, Emma comes home to be with her family. Emma does not remember living at home, having been at the SNF for more than two years. Emma immediately sees the balloons that her sisters and grandmother are holding as they are waiting out front. Emma's private duty nurse (PDN) and the respiratory therapist from the DME company are both there, ready to meet Emma and verify everything is working properly. While Susan was very familiar with all Emma's equipment at the SNF, the respiratory therapist educates Susan and Emma's grandmother on her new equipment. Emma's PDN listens and reinforces key points from their education and training as well. Amy calls to check on Emma and Susan and make sure everything is okay and she confirms the previously scheduled upcoming visit from Emma's FCM. Within ten days of discharge, Amy ensures the 2506 form is submitted to alert the State that Emma has been discharged from the nursing facility.

DAY 127: EMMA'S FCM VISIT

Emma's FCM visits her, completing Emma's assessment in her new environment and ensuring services are in place with no gaps in care. The FCM also updates her POC, and makes sure Emma and Susan are comfortable in their new environment with no issues or concerns.

DAY 150: FOSTERING AN ONGOING RELATIONSHIP WITH EMMA AND SUSAN

Amy maintains monthly contact with Susan, while Emma's FCM visits them to review Emma's POC quarterly, or more frequently if Emma has a change in condition or Susan requests a change in Emma's services. In addition to monthly contacts and quarterly visits, Emma's MDT

meets every six (6) months to provide a comprehensive review of the services and supports Emma needs, to authorize reimbursable services that are ordered, and to update the POC. Emma's MDT will meet more often, if needed, and is updated to include not only core members such as Emma, Susan and the Case Managers, but also other health care professionals involved in Emma's care, like her Private Duty Nurses, interagency or school staff, and any others Susan requests to participate. It is within these MDT meetings that Amy keeps Emma's Individualized Service Plan up to date and accurately reflecting Emma's services, supports and goals. Amy participates with interagency or school representatives, when Susan requests it, in order to update Emma's educational support plan or Individualized Educational Plan.

On a monthly basis, Amy reviews Emma's case with the Humana Medical Director. It is particularly exciting for Amy to review and share Emma's progress, since the Medical Director is familiar with Emma from when she was in the SNF. Our Medical Directors also participate in AHCA's monthly Enhanced Care Coordination meetings and can address aspects of Emma's care if needed during these gatherings.

Amy, with support from Emma's MDT, continues to educate Susan on Emma's illness, reportable signs and symptoms, and medication administration (to include side effects and interactions), appropriate use and functioning of DME, EPSDT, the importance of screenings and vaccinations at the appropriate time, and the importance of updating Emma's PCP and specialists when things change. Susan and Emma's grandmother are trained to know what to do should Emma have a seizure, how to perform safe suctioning techniques and how to care for Emma's tracheostomy. Amy and Emma's care team work with Emma's family to assist in Emma's care, if needed. Amy provides resources for covering EPSDT and ensures robust communication is open and ongoing between Emma's PDNs and her community PCP by including them in the MDT meetings and providing updated POCs.

Amy and Emma's MDT also continues to reinforce that it is important to encourage independence in Emma and that, despite their best intentions, the support of family members and medical professionals alone may not be sufficient to enable her to develop her capabilities. Counseling and education for the family members to gain and maintain a healthy and helpful perspective on this is recommended, and is communicated to be an integral part of Emma's care.

Humana's ongoing approach to case management helps Susan to make decisions about service options, identify personal goals, achieve or maintain Emma's highest level of self-sufficiency, and identify and invite others to participate in MDT meetings at times and locations of convenience. It also provides a method for Susan to request updates to the POC, as needed. If at any time Susan declines case management for Emma, Humana complies with all requirements, but continues monthly contact and continues to offer case management on an annual basis. All communications are documented in Emma's record in CGX.

Amy continues to make appropriate referrals and assists with scheduling for health care and non-emergent transportation services, by ambulance, including those identified through well-child visits and care coordination follow-up services. Amy also informs Susan how to access specialists without the need for a referral, as appropriate for Emma's condition and identified needs. Throughout the entire process, all assessments, forms, communications, and other interactions are documented and maintained within Emma's record in CGX.

LOOKING AHEAD: EMMA'S PATH FORWARD

In thinking towards the future, Emma's ability to attend school or receive home education needs to be considered. Emma may be eligible to attend full- or half-day kindergarten. Emma needs her nurse with her at all times and needs non-emergent transport on a daily basis. It is Susan's goal to have Emma attend their neighborhood school with her other children. Emma's MDT, with direction from Amy, will investigate options, including transport to the school of Susan's choice, as well as schools outside her district that may accept her into their program.

Emma has now been home for six months, and is attending a PPEC center. Emma has experienced very few days of not feeling well. She loves being home with her family, and while Susan was the most apprehensive about bringing Emma home, she is the first one to say how much she enjoys having all her girls under the same roof. Susan is now an advocate in one of her support groups for other families wanting to bring their child home. She often laughs and says the biggest problem they have is her girls taking Emma's tablet, wanting a turn to play those games. Emma is adjusting very well and with PDN in the home twenty-four (24) hours a day, seven (7) days a week, Susan says she worries much less than when Emma was in the facility. Amy continues to monitor Emma closely for any changes in condition, as she knows Emma is a medically fragile child who is dependent on timely services and regular medical care in order to maintain her health and happiness.

Footnotes

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[1] CGX supports an integrated, comprehensive approach to medical, behavioral health, pharmacy, utilization, and care management. Full system integration allows our care team the capability to identify potential enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify opportunities for intervention. CGX is part of CareHub, Humana's enterprise solution for complete program integration for our provider community and enrollees.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

- **a.** Identification processes for enrollees with complex health conditions or who are in need of care coordination;
- **b.** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **c.** Application of the respondent's case management risk stratification protocol;
- **d.** Identification of service needs (covered and non-covered) and a description for service referral processes that the respondent has in place;
- **e.** Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
- **f.** Application of discharge and aftercare planning protocols that facilitate a successful transition;

g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;

h. Description of the assessment of provider capacity to meet the specific needs of enrollees;

i. Identification of strategies that promote enrollee self-management and treatment adherence;

j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and

k. Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondents' workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoid unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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F. OVERSIGHT AND ACCOUNTABILITY

No SRCs in this Category for MMA.

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Attachment MMA-20-1: Emma's Visual Story Guide

We have provided this document as a visual guide to our response. The key timelines from our core response are duplicated here in a format intended to supplement and enable a comprehensive review of Humana's approach to Emma.

About Emma:

Emma is four (4) years old, a new MMA Medicaid enrollee to Humana's plan, with recent coverage through Medicaid FFS. She had an acute illness with respiratory arrest when she was two (2) years old and is currently living in a skilled nursing facility (SNF). She has a tracheostomy and is supported by the ventilator when she is sick, tired, or asleep. Emma's condition is compounded by complex seizures and her most recent diagnosis of an intellectual disability. Emma has three (3) sisters at home, with her mother and grandmother. While she is medically fragile, her condition has stabilized and she can be discharged home with specific equipment and services. Her mother is concerned about agreeing to bring her home permanently because of Emma's complex needs.

Key Components of Care

- **Stratification** prioritizes Emma for immediate assignment due to complex needs
- **Focus on transitioning Emma home** to live with her family, while including appropriate services and supports to effectively manage her needs there
- **Knowledgeable Case Manager (CM), Field Case Manager (FCM), respiratory therapist, Medical Director, and Private Duty Nurse (PDN)** to fully assess Emma's needs, help prepare her for discharge, and provide post-transition support, services, and ongoing education for Emma and her family
- **Multidisciplinary Team (MDT)** composed of in-network providers and specialists, as well as Emma's mother and grandmother, to help with transition and ongoing care
- **Focus on Emma's path forward** including education options (e.g. VPK), follow-up services (e.g. EPSDT), PPEC, and recreation to keep family's desires at the forefront of her plan of care (POC)
- **Customized Durable Medical Equipment (DME) authorized for Emma; transition home** – each with backup battery, suction machine and disposable medical supplies for respiratory support

Emma's Support System	**Susan** Mother	**Emma's Grandmother**	**Emma's siblings**	**Amy** Humana Pediatric CM	**SNF**	**Humana Medical Director**	**Humana FCM**	**Humana FSW**	**PDN**	**Community PCP and Specialists**

Emma's Timeline:

Pre-Humana: Health Status
Emma has been in a SNF for two (2) years after respiratory arrest. She also has complex seizures and has recently been diagnosed with an intellectual disability. She can be discharged home with specific supports, but her mother is reluctant.

Day 1: Case Management Assignment
Emma's case is automatically created and prioritized based on complex needs. She is assigned to Amy, a pediatric CM.

Day 2-3: Outreach
Amy visits the SNF. Once verified, she meets family, discusses POC, completes the health risk assessment (HRA), and begins discharge planning.

Day 8: Medical Director Case Review
Amy reviews Emma's case with Humana's Medical Director to approve specialized equipment for her transition.

Day 28-68: Ongoing Contact & DME Review
Amy maintains monthly contact and updates POC post-MDT meetings. Medical Director has peer-to-peer review with Emma's physician to agree upon appropriate DME.

Day 58: Emergency & Disaster Planning
Amy assists Susan in creating a personalized emergency and disaster plan for the family.

Day 88 – 117: Transition Planning
Amy meets with Field Social Worker (FSW) to evaluate home for transition; finds in-network providers for MDT and includes family; collaborates with Quality Improvement Organization for PPEC candidacy.

Day 118: Field CM & Social Worker
FCM & Social Worker (SW) attend MDT meeting; schedule PCP appointment and FCM visit for post-transition period.

Day 122 – 124: Emma's Transition Home
Emma's DME arrives and her transport is scheduled home. Appropriate medical professionals verify everything is working and educate Emma's family on equipment.

Day 127: FCM Visit
Humana's FCM visits Emma's home to assess new environment; ensures services are in place with no gaps in care.

Ongoing: Monitoring
Monthly contact, quarterly reviews of POC, and MDT meetings every 6 months, or sooner if needed. Emma attends PPEC.

1 2 3 4 5 6 7 8 9 8 11

G. STATUTORY REQUIREMENTS

MMA SRC #21 – Provider Network Agreements/Contracts Statewide Essential Providers (Statewide)

The respondent shall submit **Exhibit A-4-b-3**, Provider Network Agreements/Contracts Statewide Essential Providers, to demonstrate its progress with executing agreements or contracts with Statewide Essential Providers by submitting **Exhibit A-4-b-3**:

Response:

Humana has recruited Statewide Essential Providers into our network and maintains strong relationships with these providers to ensure access to care for our enrollees. These include:

- Tampa General Hospital
- Shands Teaching Hospital
- Shands-Jacksonville
- Florida State University College of Medicine
- Jacksonville Memorial Hospital—Jackson Health System
- Sacred Heart Hospital
- Winnie Palmer Hospital at Arnold Palmer Medical Center—Orlando Health
- All Children's Hospital
- NEO: All Children's Hospital
- OB: Bayfront Medical Center
- St. Mary's Medical Center
- Broward General Medical Center
- Lee Memorial Health System
- University of Florida College of Medicine
- University of Miami School of Medicine
- University of South Florida College of Medicine

In preparing our submission file, Humana reviewed our strategy to contract with additional faculty Statewide Essential Providers, including the University of Central Florida College of Medicine, Nova Southeastern University of Osteopathic Medicine, and Florida International University College of Medicine.

Through our experience and our conversations with these providers, they have not expressed interest in becoming contracted providers and instead, prefer to sign single case letters of agreements if services are required. These providers receive payment as per the Agency for Health Care Administration's (AHCA) mandatory fee schedule. Please refer to attached Exhibit A-4-b-3.

EXAMPLE OF ESSENTIAL PROVIDER PARTNERSHIP
Humana has maintained a contract agreement with the University of South Florida (USF) for our Medicare and commercial populations for more than a decade. In 2012, in support of Humana's Medicaid network development, we amended the contract to include services to Medicaid enrollees and now have approximately one thousand (1,000) Medicaid enrollees attributed to

USF. We share a mutually rewarding relationship in which our teams work closely together on all aspects of the contract and business operations, including Medicaid contract compliance, clinical programs and authorizations, claims reconciliation, and financial recovery. USF also serves on Humana's Bold Goal Health Advisory Board. Humana's Bold Goal is to make the Tampa Bay community 20% healthier by 2020 through community engagement and stakeholder partnerships.

Evaluation Criteria:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	10
25.1%- 50%	20
50.1%- 75%	30
75.1% or greater	40

Score: This section is worth a maximum of 40 raw points based on the above point scale.

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EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

General Instructions:

Each Respondent shall complete the Managed Medical Assistance Agreements/Contracts scoring template worksheet. The respondent is required to submit the total number of agreements/contracts with Statewide Essential Providers by using column 'b' on the worksheet.

MMA Statewide Essential Providers Scoring Workbook Explanation:

Statewide Essential Providers List
Tampa General Hospital
Shands Teaching Hospital
Shands-Jacksonville
Jackson Memorial Hospital, Jackson Health System
Sacred Heart Hospital
Winnie Palmer Hospital at Arnold Palmer Medical Center, Orlando Health
NEO: All Children's Hospital
OB: Bayfront Medical Center
St. Mary's Medical Center
Broward General Medical Center
Memorial Regional Medical Center-
Lee Memorial Health System
University of Florida College of Medicine
University of Miami School of Medicine
University of South Florida College of Medicine
University of Central Florida College of Medicine
Nova Southeastern University College of Osteopathic Medicine
Florida State University College of Medicine
Florida International University College of Medicine
All Children's Hospital
Miami Children's Hospital
Nemours
Shriners Hospitals for Children

Statewide Essential Providers Scoring Template Fields		
Field	*Respondent Data Entry Required?*	*Description*
Service Provider Type	*No*	*Statewide Essential Provider*
**Agreements/Contracts*	*Yes*	*Agreements/Contracts count shall be entered by Respondent*
Statewide Essential Count	*No*	*Total number of available statewide essential providers (see Statewide Essential Providers list above)*
%	*No*	*The number of agreements/contracts Respondent entered in column 'b', divided by the total number of Statewide Essential Providers and converted to a %*
Score	*No*	*Specific statewide essential provider type score*

**entry is only field to be completed by the respondent*

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

Enter Respondent Name Below
Humana Medical Plan, Inc.

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

SRC Score
40

Service Provider Type	Agreements/Contracts	Statewide Essential Count	%	Score
Statewide Essential	20	23	87.0%	40

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

Percentage of Agreements/Contracts	Points
0.0%	0
1.0%	10
25.1%	20
50.1%	30
75.1%	40

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

RESPONDENT NAME: Humana Medical Plan, Inc.

A. RESPONDENT BACKGROUND / EXPERIENCE

LTC SRC# 1 – Participant Direction of Services (Statewide):

The respondent shall describe its experience with participant direction of services (also referred to as self-directed or consumer-directed) by specifying the model(s) of participant direction used in the states in which the respondent currently operates and previously operated (e.g., agency with choice or fiscal employer agent). The respondent shall include a flowchart depicting how services are authorized and delivered through the participant direction programs referenced in the response. The description shall include:

- Whether the model(s) includes the use of employer authority, budget authority, or both;
- The target population (ABD, DD, general aging population, etc.);
- The number of participants in each participant direction program;
- The services provided through its participant direction programs;
- The monitoring approach used to prevent and detect waste and abuse, specifically over-utilization of services;
- The lessons learned from implementing participant direction programs; and
- The innovations it has deployed to enhance the delivery of services through the participant direction program.

Response:

Participant direction of services provides Long-term Care (LTC) enrollees with autonomy, independence, and greater oversight of their care. By allowing a trusted individual to be present in the home to provide these services, our enrollees experience a level of comfort and support that may not be otherwise attainable. Our enrollee-centric approach to the participant-directed option (PDO) uses streamlined processes to care planning, service authorization, and claims and encounter submissions. We incorporate our lessons learned and innovations from our PDO program in Florida as well as from our affiliate health plan experience in Illinois and Virginia in order to continually improve our approach to PDO service delivery. For example, we have embraced the use of electronic visit verification (EVV), which operates in conjunction with our case managers dedicated approach to PDO monitoring to prevent and address any potential fraud, waste, and abuse. In addition, we have introduced a PDO specialist position to serve as a designated liaison between our case managers, fiscal/employer agents (F/EAs), and enrollees and to provide expert management of PDO enrollment and oversight.

Today, approximately five percent (5%) of Humana's LTC enrollees in Florida – accounting for more than one thousand (1,000) enrollees – participate in our F/EA PDO model. This experience, combined with our broader organization's more than thirty (30) years of experience working with physically disabled and elderly individuals in Florida and nationwide, makes us an ideal partner to continue providing LTC enrollees in Florida with the support and direction they need to direct their own care.

==========

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent's description includes experience with managing a participant direction of service delivery model.
==========

Humana has implemented a participant direction of service model in Florida since SMMC LTC implementation in 2014. Additionally, our affiliate health plans in Illinois and Virginia have operated PDO models for Medicaid enrollees since 2013 and 2014, respectively. Across these plans, we serve more than one thousand seven hundred (1,700) individuals who have selected PDO for all or a portion of their service delivery. This breadth of experience has informed the continued growth and evolution of our PDO model, as described below.

==========
Whether the model(s) includes the use of employer authority, budget authority, etc.
==========

We employ a F/EA PDO model in Florida, with the enrollee maintaining employer authority. The F/EA is responsible for:

- Managing the budgetary aspects of PDO, including payroll and taxes
- Completing background checks
- Training enrollees who select the PDO model on employer responsibilities, including interviewing, hiring, and supervising

Our contracts with two F/EAs in Florida, GT Independence and Public Partnerships, LLC (PPL), provide our enrollees with their choice of F/EA, including the ability to transfer to another F/EA, if desired.

In addition to our local experience with the employer authority model in Florida, due to our shared services and national leadership model we are able to draw upon our affiliates' experience with the employer authority model in Illinois and Virginia. In both of these states, the enrollee is empowered to select, hire, and monitor their direct service worker (DSW). In Illinois, the state serves as the F/EA, rather than an outside vendor, and oversees the payment of DSWs.

==========
The target population (ABD, DD, general aging population), etc.
==========

Our Florida LTC enrollees who receive or are eligible for home- and community-based services (HCBS) are the target population for PDO. Among those enrollees who are eligible, we recognize that PDO is especially suited to enrollees who:

- May benefit from directing their own care and have the ability to select who provides their care
- Want to train and direct their workers about their individual needs and preferences
- Have trusted individuals in their lives who currently provide or can provide care

Our Case Managers (CMs) educate all enrollees with eligible PDO services on their care plan about PDO upon enrollment, and annually thereafter. Additionally, we educate those enrollees who are transitioning from institutional settings to the community about PDO. All of our CMs

have been extensively trained to provide specialized support and guidance for our enrollees electing PDO.

We are committed to ensuring that our enrollees who do choose PDO are prepared to hold employer authority, either by themselves or with the support of a representative. Using the PDO pre-screening tool and LTC self-assessment, the CM assesses the enrollee's preparedness for PDO. If the enrollee chooses to appoint a representative to manage their PDO responsibilities, or if the CM determines through the LTC self-assessment that a representative is needed to assist the enrollee in carrying out some or all of the PDO duties, the CM asks the enrollee to select a representative. This representative must pass a Level 2 Background Screening clearance and complete the PDO pre-screening tool and LTC self-assessment.

==========
The number of participants in each participant direction program.
==========

As of July 2017, we have one thousand fifty-two (1,052) PDO participants in Florida. Our affiliated health plans serve four hundred fifty-one (451) PDO participants in Virginia and two hundred four (204) PDO participants in Illinois.

==========
The services provided through participant direction programs.
==========

The following services are provided through Humana's PDO program in Florida:
- Adult companion care
- Attendant care
- Homemaker
- Personal care services
- Intermittent skilled nursing

ENROLLEE STORY

Dolores, a 78-year-old LTC enrollee in Florida, was residing in an assisted living facility after the death of her husband. While Dolores wanted to live at home, home health services were not adequate for her needs, and she did not have any immediate family in Florida to care for her. Her CM, Vicky, spoke with Dolores and her daughter about these challenges. Dolores and her daughter did not feel comfortable choosing someone they did not know to care for Dolores in the home. Vicky reviewed the PDO program with Dolores and her daughter, and explained that since the daughter was not the legal representative of her mother, she could be employed via PDO to provide services for her mother. While her daughter was initially hesitant (as she did not have any medical background) Vicky assured her that the PDO program would provide the proper training and support to enable her to effectively carry out these services. Dolores's daughter then agreed to move home from Ohio with her spouse and children to care for her mother through PDO. In the words of Vicky, "The PDO program was a blessing for them. Dolores' daughter was still employed, and, most important, Dolores was able to come back from the nursing home."

==========

2. The extent to which the respondent's flowchart provides a description that addresses the following components:
a) Care planning
b) Service authorization
c) Involvement of the Fiscal Employer Agent
d) Electronic Visit Verification
e) Claims processing
f) Claims payment
g) Encounter data submission

==========

A flowchart describing our PDO processes in Florida, from care planning through encounter data submission, can be found in Attachment LTC 1-1. Our PDO processes are informed by our experience operating a PDO program in Florida, and our affiliates' experience with PDO in Illinois and Virginia. The processes used by our affiliates in Illinois and Virginia are depicted in Attachment LTC 1-2 and LTC 1-3, respectively. Our processes are designed to ensure that enrollees receive PDO services in a timely, safe, and healthy manner. They have evolved over time to incorporate our lessons learned and innovations, including our introduction of the PDO specialist role and Electronic Visit Verification (EVV).

During the care planning process, we educate all of our enrollees with eligible services on their care plan about the participant directed option. After confirming the enrollee's preparedness for PDO (including the assignment of a representative if needed) we leverage the capabilities of our PDO specialist and F/EA to ensure timely service authorization and reduce gaps in care. Once PDO services begin and agency services are terminated, our F/EA, CMs, and PDO Specialists monitor for potential fraud, waste and abuse (FWA), supported by the capabilities of EVV. Our claims processing and payment procedures are optimized to provide the prompt and accurate resolution of claims and submission of encounter data.

==========

3. The extent to which lessons learned have been utilized to improve the respondent's participant direction of services delivery model.

==========

We evolve and adapt our PDO policies and procedures as we learn what is best for our enrollees. During the past four years of supporting LTC enrollees to use PDO in Florida, we have continually adapted our program to incorporate lessons learned. These include:

- A team approach to management of enrollees using PDO is crucial to improving care coordination and oversight. From our experience providing PDO, we have learned that strong communication between the CM, F/EA, and PDO Specialist enables us to quickly identify and resolve any issues. This lesson learned has led to the introduction of more regular meetings and communications between all those involved in the enrollee's PDO experience. From the initial face-to-face meeting between the CM, enrollee, and F/EA, to PDO Specialists' monthly Joint Operating Committee meetings with the F/EA, we rely on our working relationships between all parties to ensure that our enrollees use PDO in a safe, effective manner that meets their needs.

- Enrollees should be aware of when they need to contact the F/EA or CM. For example, if an enrollee is having difficulty with management of the DSW, the F/EA can help to resolve and diffuse the situation, including resolving any miscommunications, clarifying responsibilities, and terminating the DSW, if needed. We have incorporated this lesson learned into our PDO approach through a concerted effort to remind our enrollees how and when to contact us. Throughout their initial meeting and all subsequent communications, the F/EA and CM remind the enrollee of how they can reach the F/EA and CM with any questions or concerns. Additionally, we emphasize the situations in which doing so is imperative, including failure to provide services or any safety concerns. Our CM's monthly contact with the enrollee provides a recurring opportunity to check in on the enrollee's satisfaction with PDO and to resolve any issues.

- Enrollees with cognitive needs who are approved for PDO require more hands-on assistance and follow-up from the CM and F/EA. We have used this lesson learned to adjust the approach used by the F/EA and CM to support enrollees with cognitive needs and to ensure they understand their responsibilities as the employer. In addition to the face-to-face training on employer responsibilities provided by the F/EA upon the enrollee's initiation of PDO, the F/EA and CM continue to provide regular and ad hoc support to anticipate, prevent, and respond to communication difficulties or other issues these enrollees may encounter in PDO. Our screening tools are also designed to identify those enrollees with cognitive needs who may benefit from a representative to manage PDO on their behalf. A representative may also be assigned if the CM and/or F/EA feel that it is necessary, based on their observations of the enrollee's ability to manage employer responsibilities.

- The prevention and detection of fraud, waste, and abuse in PDO requires a specialized approach. We have learned that the nature of PDO services, including their provision in the enrollee's home by non-traditional workers, requires special monitoring to prevent and detect FWA. To strengthen our approach to FWA monitoring, we will introduce EVV to our PDO program in Florida. EVV is a powerful tool that reduces FWA through real-time confirmation of service delivery while improving the PDO experience for both the enrollee and DSW. For the enrollee, it ensures that they are receiving services in conjunction with their care plan, and provides an extra layer of accountability on which they can rely. For the DSW, it helps them to easily and conveniently track their hours and services provided.

- Enrollees may refuse provision of services by DSWs, as outlined in their care plan. For a number of reasons, enrollees may refuse the provision of services that are outlined in the care plan. This can create a frustrating experience for both the enrollee and DSW, in addition to having negative effects on the enrollee's health and well-being. We have incorporated this lesson learned into our DSW onboarding, during which we train the DSW on how to respond to this situation, including immediately informing the F/EA of any issues. When this problem is encountered, the CM and F/EA will work together with the enrollee and DSW to ensure that the enrollee receives services in accordance with their care plan.

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4. The extent to which the described experience demonstrates past innovations or planned innovations in the participant direction of services (e.g., mobile telephone applications, implementation of electronic access/training to complete required forms, and electronic visit verification).

==========

Our PDO experience across diverse markets has helped us to identify innovations that have improved quality and outcomes for our LTC enrollees in Florida and across our markets. As we continue to grow our experience with PDO, we will continue to identify innovations that can improve outcomes for our enrollees. Our past and planned innovations include:

- PDO Specialist: Because of the success that Humana has had with this role in both our Illinois and Florida programs, the PDO Specialist role will continue to play an essential part in our LTC program. PDO specialists are dedicated to working solely with PDO services, and serve as the key point of contact between the Humana CM, the F/EA, and the enrollee to resolve any PDO-related issues. Their expertise in PDO allows us to efficiently refer our enrollees who are interested in and suited for PDO to the F/EA, expediting the delivery of PDO services to our enrollees.

- Integrated PDO service back up plan: Humana has developed an innovative approach in which the back-up plan is fully integrated within the enrollee's plan of care within our Clinical Guidance eXchange (CGX) case management system. This integration allows any Humana staff member who has access to our CGX platform the ability to access an enrollee's plan of care and back-up plan. In the event that a PDO enrollee needs to call upon their back-up plan, the enrollee can receive real-time answers as to how to implement the back-up plan from their CM or Customer Care.

- Electronic transmission of service authorization: After learning that our vendors in Florida relied on fax to receive service authorizations, and having successfully usinusedg electronic transmission in our Virginia PDO program, Humana initiated the introduction of electronic transmission of service authorizations with both GT Independence and PPL as vendors in Florida. The electronic transmission of service authorizations has several benefits for our PDO program, including the elimination of data entry on the part of PPL and GT Independence for service authorizations, accompanied by a reduction in errors. In addition, this method of transmission delivers quicker and more efficient processing of service authorizations, allowing our enrollees to receive PDO services rapidly.

- Electronic visit verification: We have partnered with F/EAs who have experience in EVV administration, and will introduce this innovation to our LTC enrollees. EVV delivers improved accountability and oversight to our PDO program. By requiring the DSW to check-in and check-out with each visit via a mobile application, we increase accountability and responsibility for that individual. In addition, the use of EVV allows our CMs, PDO Specialists, and F/EAs to verify when hands-on services are being provided by a DSW who resides with the enrollee. We can confirm that services are being provided in the time slot preferred by the enrollee (e.g., in the morning or afternoon), that the DSW is staying with the enrollee for the appropriate amount of time, and that there is no overutilization or underutilization of services.

==========

5. The extent to which the respondent's monitoring approach ensures that fraud, waste, and abuse is monitored and prevented, including over utilization of services.

==========

We continually monitor utilization of PDO services with an eye towards detecting and preventing any FWA. Our associates receive specialized training on prevention and detection of FWA in

PDO services and our CMs, PDO Specialists, and F/EAs work collaboratively to monitor for FWA. This includes the prevention of overutilization through face-to-face visits, check-ins with the enrollee, and standard reviews of timesheets and EVV data.

Our process to prevent FWA begins with the development of the plan of care and the authorization of PDO services. Our PDO Specialist and CM authorize only services that are in line with the plan of care and are consistent with the services the enrollee had previously received through an agency. This reduces the likelihood of any unnecessary increase in the hours of service provided by the DSW. Through the CM's regular check-ins, the enrollee confirms that services are being completed in accordance with the care plan. Further, the CM monitors duplication of PDO and non-PDO services, missed services, and the enrollee's satisfaction with services.

Once the enrollee begins receiving PDO services, the CM seeks to schedule the ninety (90)-day face-to-face visits during the time in which the DSW should be present at the enrollee's residence. The CM looks for any indications that the enrollee may not be receiving adequate services, such as a messy home. Additionally, if there is a suspicion that the DSW may not be providing the authorized services, the CM may drop in visitat a time outside of the ninety (90)-day face-to-face visit (after obtaining permission from the enrollee to enter the home) to confirm that the DSW is present during scheduled hours.

The F/EA monitors the utilization of services based on the DSW's timesheets, data collected through EVV, and the enrollee's care plan to guard against overutilization or underutilization of services. Any issues detected by the F/EA are immediately relayed to the CM and PDO Specialist. Additionally, the PDO specialist holds a monthly Joint Operating Committee meeting with each F/EA to review their activities and reports, and to discuss any emerging issues that need to be resolved.

Any potential FWA is escalated to Adult Protective Services and Humana's Florida-dedicated Special Investigations Unit (SIU), which will undertake a comprehensive investigation of the allegations. The SIU is part of Humana's Claims Cost Management department. The SIU conducts pre- and post-payment reviews of claims paid to the F/EA, and uses data analytics through our Claims Adjudication system to identify potentially fraudulent activity that may warrant further investigation. SIU is responsible for investigating, resolving, and elevating any suspected fraudulent activities, including recovery or denial of payment for claims deemed to be fraudulent or inappropriately billed.

Evaluation Criteria:

1. The extent to which the respondent's description includes experience with managing a participant direction of service delivery model.

2. The extent to which the respondent's flowchart provides a description that addresses the following components:

(a) Care planning;
(b) Service authorization;
(c) Involvement of the Fiscal Employer Agent;

(d) Electronic Visit Verification;
(e) Claims processing;
(f) Claims payment; and
(g) Encounter data submission.

3. The extent to which lessons learned have been utilized to improve the respondent's participant direction of service delivery model.

4. The extent to which the described experience demonstrates past innovations or planned innovations in participant direction of services (e.g., mobile telephone applications, implementation of electronic access/training to complete required forms, and electronic visit verification).

5. The extent to which the respondent's monitoring approach ensures that fraud, waste and abuse is monitored and prevented, including over utilization of services.

Score: This section is worth a maximum of 55 raw points with each of the above components being worth a maximum of 5 points each.

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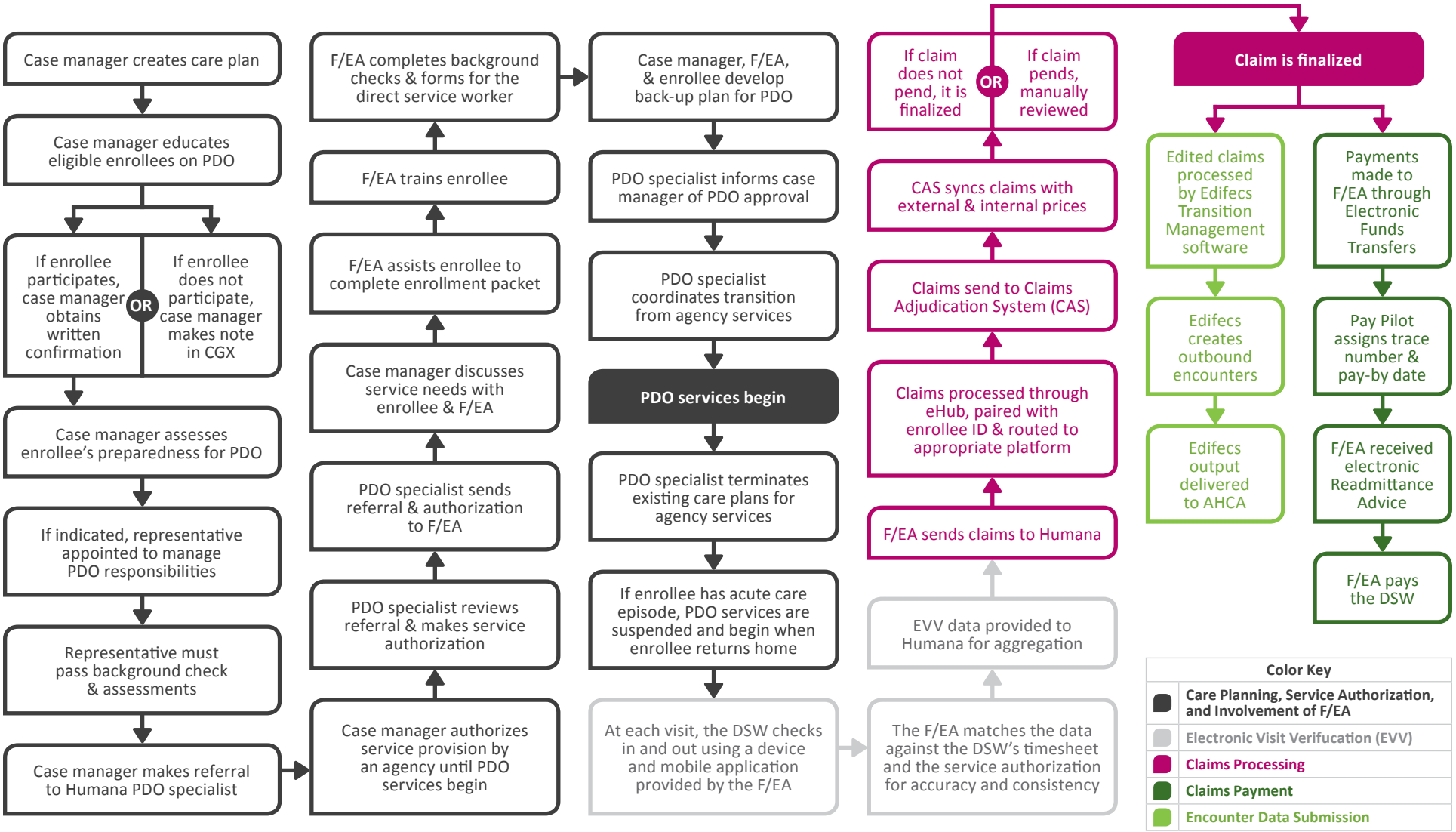
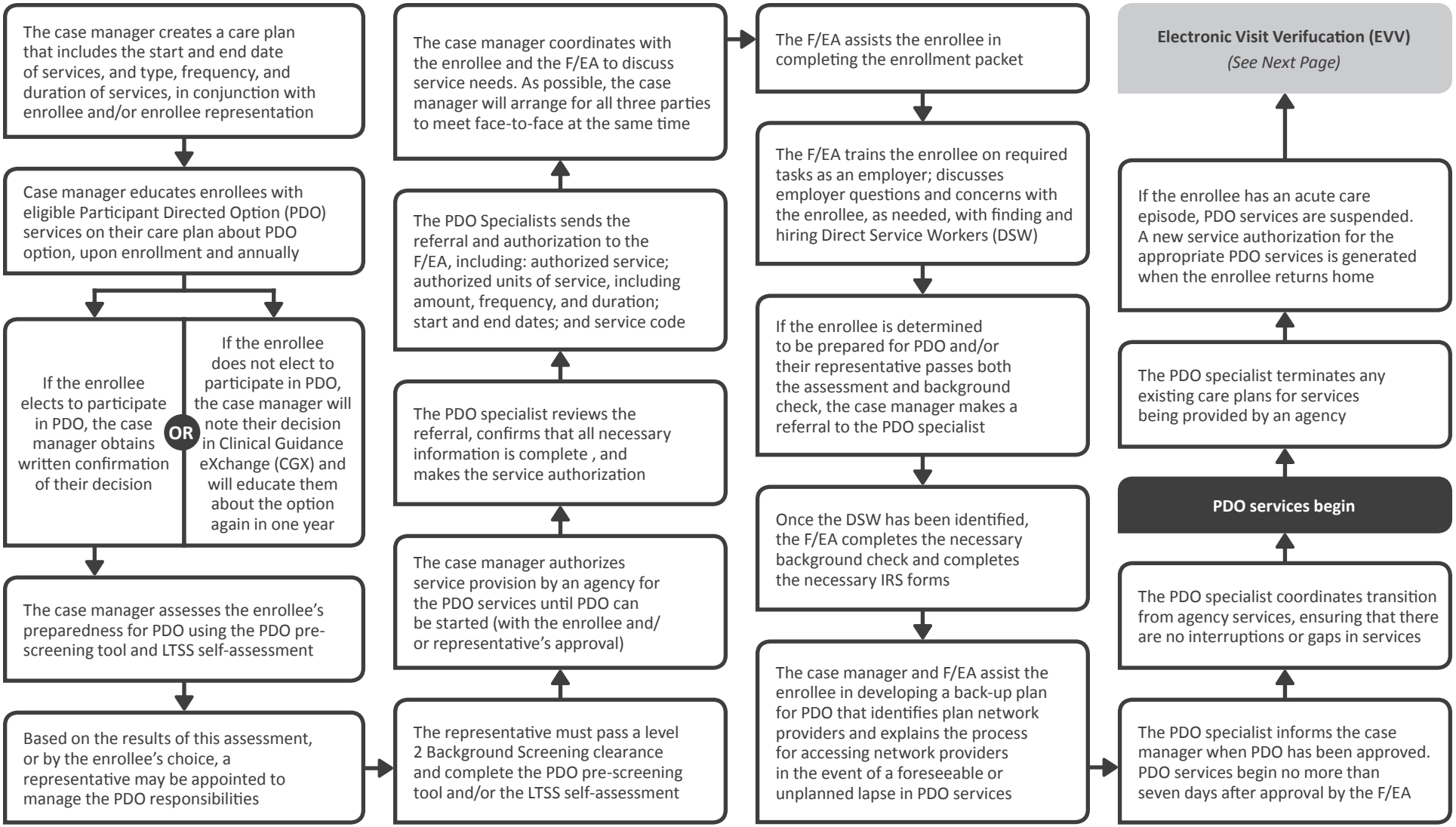
Attachment LTC-1-1: Participant Directed Option (PDO) in Florida

Participant Directed Option: Process *(See following pages for detailed process)*



Attachment LTC-1-1: Participant Directed Option (PDO) in Florida

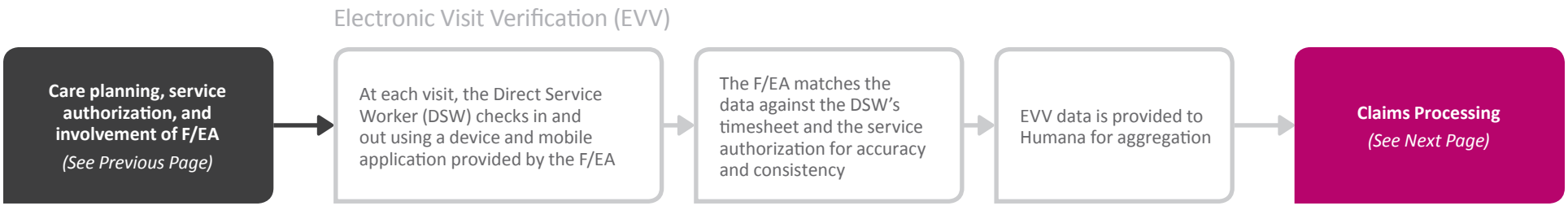
Care Planning, Service Authorization, and Involvement of Fiscal/Employer Agent (F/EA)



Humana.

Attachment LTC-1-1: Participant Directed Option (PDO) in Florida

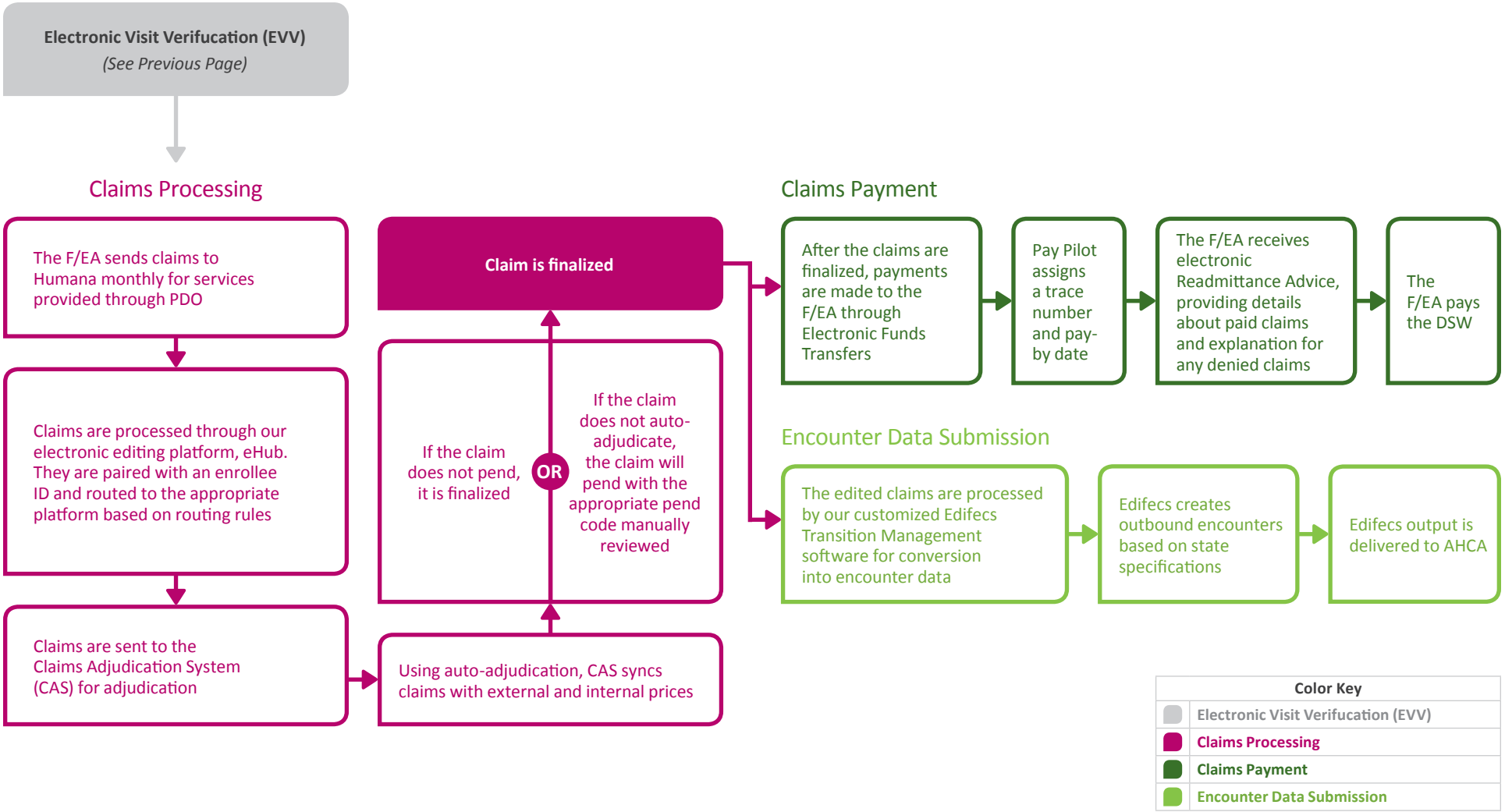
Electronic Visit Verification (EVV)



Color Key	
	Care Planning, Service Authorization, and Involvement of F/EA
	Electronic Visit Verifucation (EVV)
	Claims Processing

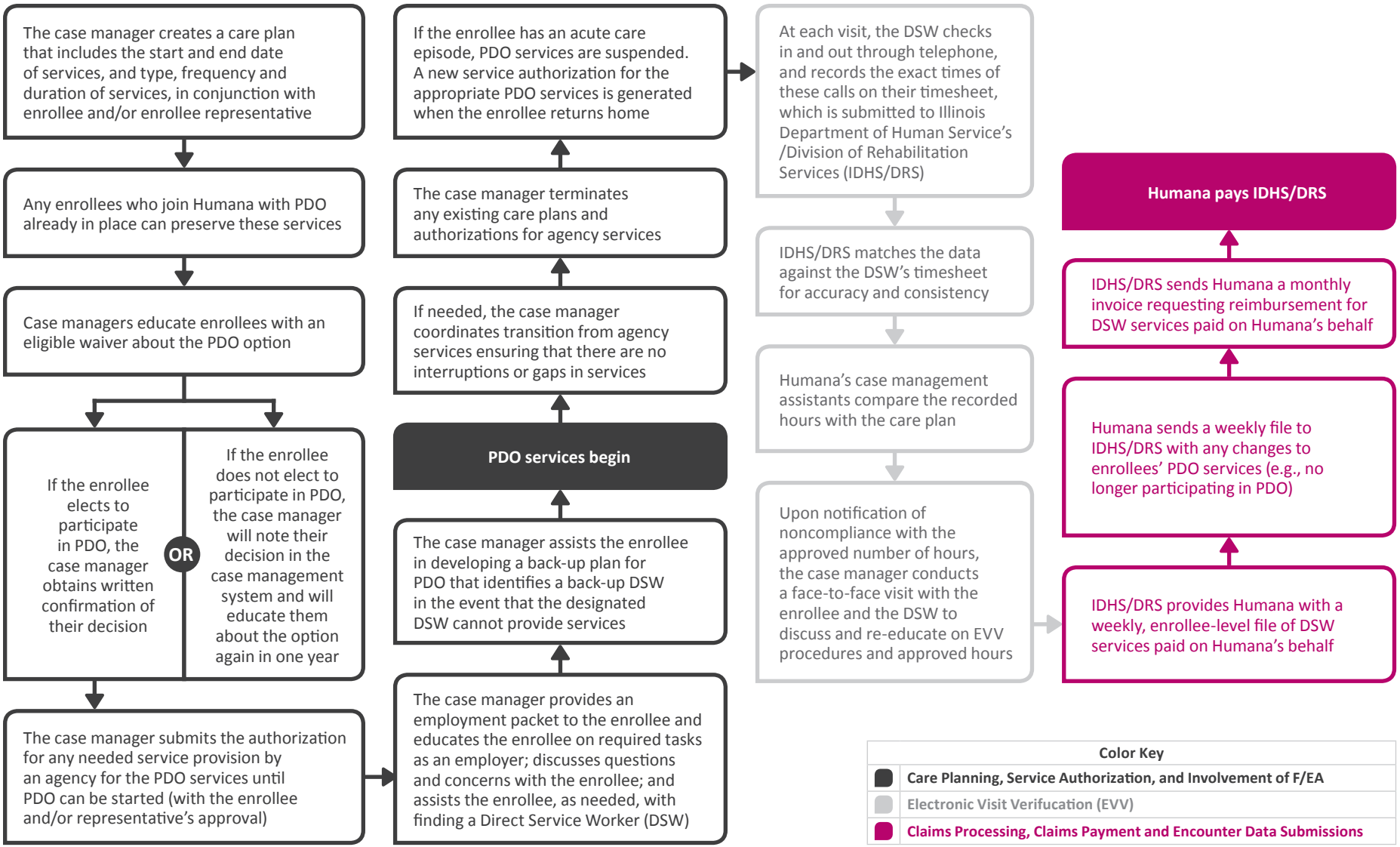
Attachment LTC-1-1: Participant Directed Option (PDO) in Florida

Claims Processing, Claims Payment and Encounter Data Submissions



Attachment LTC-1-2: Participant Directed Option (PDO) in Illinois

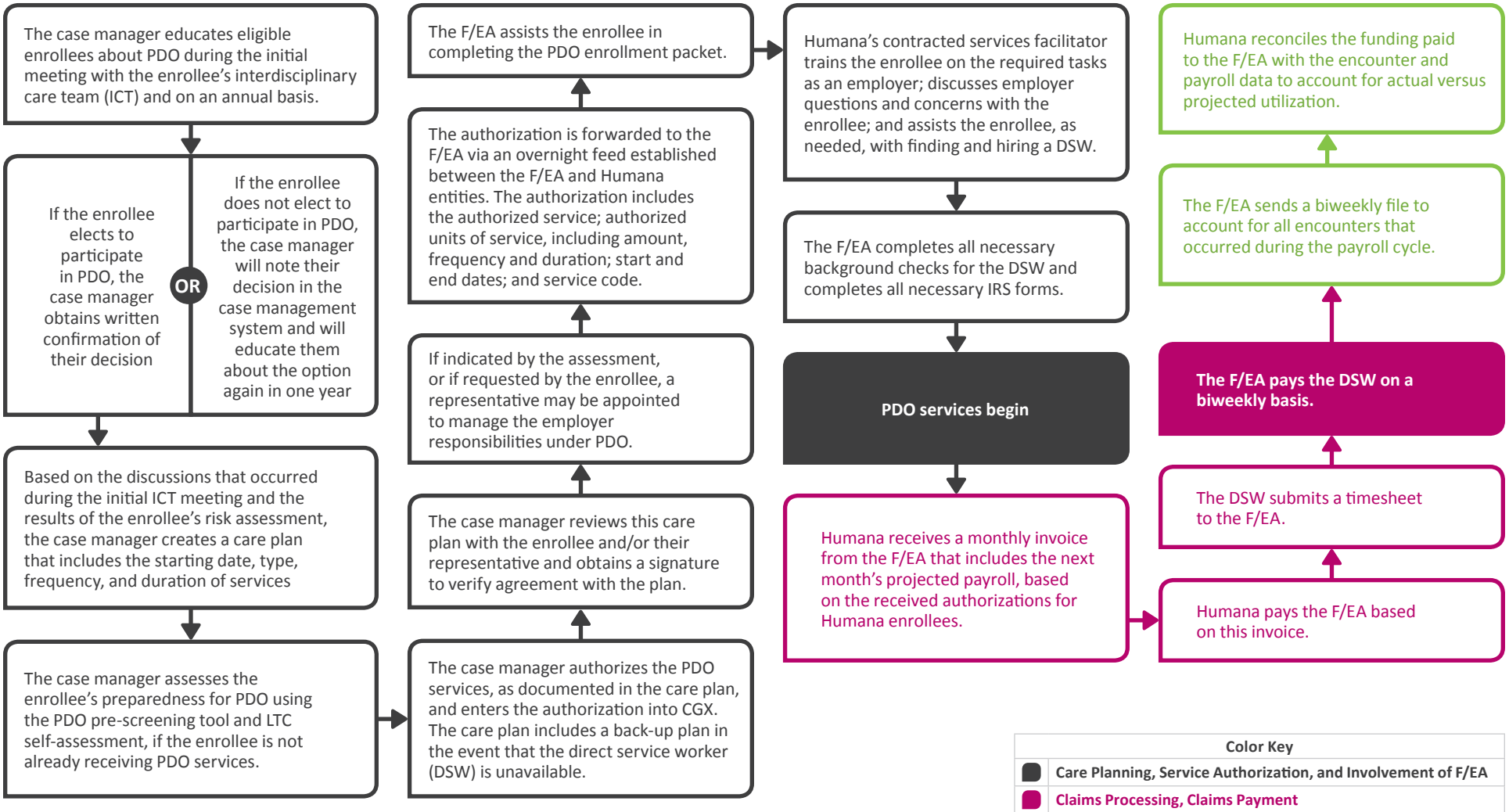
Participant Directed Option: Process



Humana.

Attachment LTC-1-3: Participant Directed Option (PDO) in Virginia

Participant Directed Option: Process



Color Key	
	Care Planning, Service Authorization, and Involvement of F/EA
	Claims Processing, Claims Payment
	Encounter Data Submissions

Humana.

Electronic Visit Verification is not currently in use in Humana Inc.'s Virginia long-term services and supports plan.

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

LTC SRC# 2 – Performance Measures (Statewide):

a. The respondent shall describe its experience in measuring performance and achieving quality standards with populations similar to the target population for the long-term care (LTC) component of the SMMC program. Describe experience with and performance on measures of the following elements of LTC:

(1) Comprehensive LTC assessment and update (the percentage of LTC plan enrollees who have documentation of a comprehensive assessment within the appropriate time frame);

(2) Comprehensive LTC Care Plan (the percentage of LTC enrollees who have documentation of a Comprehensive LTC Care Plan within the appropriate time frame);

(3) Shared Care Plan (the percentage of LTC plan enrollees with a care plan for whom all or part of the care plan was transmitted to key LTC providers and the primary care provider within the appropriate time frame);

(4) Re-Assessment and Care Plan Update after Discharge (the percentage of discharges from inpatient facilities in the measurement year for LTC plan enrollees resulting in a re-assessment and care plan update within 30 days of discharge);

(5) Admission to an Institution from the Community among LTC enrollees (the percentage of LTC enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID)) from the community that result in a short-term or long-term stay during the measurement year);

(6) Successful Transition after Short-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollee institutional admissions that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission); and

(7) Successful Transition after Long-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollees who are long-term residents (101 days or more) of institutions who are successfully discharged to the community (community residence for 30 or more days)).

b. The respondent shall describe any instances of failure to meet Contract-required quality standards for these types of measures, actions taken to improve performance, and how improvement was measured. (See Section 409.966(3)(a)2., Florida Statutes)

c. The respondent shall describe its experience with and performance on other LTC performance measures, any instances of failure to meet Contract-required quality standards for these measures, actions taken to improve performance, and how improvement was measured.

d. The respondent shall describe the data sources used for collecting and reporting LTC performance measures.

e. The respondent shall describe how the respondent has obtained data needed to track measures related to care plan updates after hospital admissions and discharges, and emergency department visits.

Response:

Humana has developed our Long-term Care (LTC) Quality Improvement Plan (QI Plan) utilizing our experience of more than fifteen (15) years managing LTC services in Florida. Our mission is to provide comprehensive, effective, cost-efficient healthcare and support services through a community-based program tailored to the individual.

The purpose of Humana's Long-term Care's Quality Improvement Program is to monitor, evaluate, and facilitate improvement in the quality of healthcare services provided to Humana enrollees receiving LTC services enrolled in our Comprehensive Plan. Our program is based on the development and implementation of person-centered care plans that promote enrollees' ability to remain in a community setting as long as their needs can be safely met. We evaluate the success of our program through continuous monitoring of performance measures. We track and analyze Healthcare Effectiveness Data and Information Set (HEDIS), Agency-defined, and other LTC-related performance measures to ensure we are caring for our enrollees in the most appropriate setting, and while delivering most appropriate services. We utilize a team approach across departments (such as, Quality, Utilization Management and Case Management) to ensure high quality, appropriate services are geared to maintaining and improving the enrollees' independence. Our integrated case management platform, Care Guidance eXchange, (CGX), allows our case managers to have an integrated view of medical, behavioral, and LTC for our enrollees. Our ability to assess our enrollees' entire spectrum of care allows us to better manage and monitor the type and quantity of services we should provide. Our approach to quality leads to improved outcomes. In 2017, seventy-six percent (76%) of our enrollees indicated that their quality of life has improved as a result.

==========

a. The respondent shall describe its experience in measuring performance and achieving quality standards with populations similar to the target population for the long-term care (LTC) component of the SMMC program. Describe experience with and performance on measures of the following elements of LTC:

(1) Comprehensive LTC assessment and update (the percentage of LTC plan enrollees who have documentation of a comprehensive assessment within the appropriate time frame);

(2) Comprehensive LTC Care Plan (the percentage of LTC enrollees who have documentation of a Comprehensive LTC Care Plan within the appropriate time frame);

(3) Shared Care Plan (the percentage of LTC plan enrollees with a care plan for whom all or part of the care plan was transmitted to key LTC providers and the primary care provider within the appropriate time frame);

(4) Re-Assessment and Care Plan Update after Discharge (the percentage of discharges from inpatient facilities in the measurement year for LTC plan enrollees resulting in a re-assessment and care plan update within 30 days of discharge);

(5) Admission to an Institution from the Community among LTC enrollees (the percentage of LTC enrollee admissions to an institution (nursing facility or intermediate care facility for

individuals with intellectual disabilities (ICF/IID)) from the community that result in a short-term or long-term stay during the measurement year);

(6) Successful Transition after Short-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollee institutional admissions that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission); and

(7) Successful Transition after Long-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollees who are long-term residents (101 days or more) of institutions who are successfully discharged to the community (community residence for 30 or more days)).
==========

EXPERIENCE ACHIEVING QUALITY STANDARDS WITH SIMILAR TARGET POPULATIONS

Humana has a long history of serving elderly and high needs populations, and performance monitoring is integral to measuring the effectiveness of our programs. As a previous Nursing Home Diversion Program health plan from 2007 to 2014, and now a statewide LTC plan, Humana has more than a decade of experience in creating opportunities to achieve positive healthcare outcomes and monitoring enrollees' progress in achieving those outcomes. Humana currently serves more than twenty thousand (20,000) of Florida's most vulnerable individuals through the LTC program. We serve similar populations in Virginia and Illinois Duals Demonstration programs, where we provide dual eligible enrollees with medical, behavioral, and LTC benefits. Through our Illinois Integrated Care Program (ICP), we provide medical, behavioral, and LTC benefits to non-dual Medicaid enrollees.

Additionally, Humana has long-standing experience serving Florida enrollees in Medicare Advantage (MA) and Special Needs Plans (SNP). Both populations have many similarities with Florida LTC enrollees. Nationally, as of April 2017, Humana's MA membership was approximately three point two million (3.2M) enrollees throughout all fifty (50) states and Puerto Rico. Of those, more than one hundred thousand (100,000) enrollees were enrolled in SNPs that serve dual eligible populations. The information below illustrates our LTC programs, along with the number of enrollees and years active for each program, and the program summary. For each area that follows, we have laid out our response with our Florida experience followed by our similar experience managed through our affiliate organizations under our mutuual parent organization, Humana Inc. Our shared services and national leadership model enables us to apply models, learnings, and best practices from these programs directly to the benefit of our Florida SMMC enrollees.

- Florida Long Term Care
-- 21,239 enrollees
-- 2014 – present
-- Medicaid LTC

- Virginia Duals Demonstration
-- 8,621 enrollees
-- 2014 – present
-- Duals – CMS Financial Alignment Demo (medical, behavioral, and LTC benefits)

- Illinois Duals Demonstration
-- 6,355 enrollees
-- 2014 – present
-- Duals – CMS Financial Alignment Demo (medical, behavioral, and LTC benefits)

- Illinois Integrated Care Program (ICP)
-- 5,626 enrollees
-- 2014 – present
-- Medicaid LTC (non-duals only)

In accordance with the Centers for Medicare and Medicaid Services' (CMS) and the National Committee for Quality Assurance's (NCQA) proposed strategy for performance measurements focusing on vulnerable populations, Humana has focused on monitoring, evaluating, and improving quality performance in several areas. Many of these requirements are highly relevant to the proposed ITN, and include:

- Ongoing evaluation of Quality Improvement (QI) Program structure and processes to meet contract requirements

- Annual assessment of HEDIS measures, tied to national benchmarks

- Annual Enrollee Satisfaction Survey

FLORIDA EXPERIENCE MONITORING AND MEASURING MEASURES IN THIS SRC
Humana currently monitors all seven (7) specific measures listed in this SRC. Below is our experience with each of these measures, as well as our outcomes.

==========
(1) Comprehensive LTC assessment and update (the percentage of LTC plan enrollees who have documentation of a comprehensive assessment within the appropriate time frame)
==========

We currently monitor this measure in our Florida Medicaid program through the HEDIS measure – Required Record Documentation (RRD)-701B Assessment. Below is our rate for measurement year (MY) 2016.
-- RRD – 701B Assessment 2016 rate = 90.24% (Benchmark = 90.0%)

==========
(2) Comprehensive LTC Care Plan (the percentage of LTC enrollees who have documentation of a Comprehensive LTC Care Plan within the appropriate time frame)
==========

We monitor a similar, stricter measure in our Florida Medicaid program through the HEDIS measure – RRD-Care Plan-Enrollee Participation. Below is our rate for MY 2016.
-- RRD – Care Plan-Enrollee Participation = 95.00% (Benchmark = 90.0%)

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(3) Shared Care Plan (the percentage of LTC plan enrollees with a care plan for whom all or part of the care plan was transmitted to key LTC providers and the primary care provider within the appropriate time frame)
==========

We monitor the HEDIS measure – RRD-Care Plan-PCP Notification. Below is our rate for MY 2016.
-- RRD – Care Plan-PCP Notification = 63.57% (Benchmark = 90.0%)

==========
(4) Re-Assessment and Care Plan Update after Discharge (the percentage of discharges from inpatient facilities in the measurement year for LTC plan enrollees resulting in a re-assessment and care plan update within 30 days of discharge);
==========

We monitor and track this measure in our Florida LTC operations. For measurement year 2016, fifty-seven-point seven three percent (57.73%) of Humana enrollees discharged from inpatient facilities resulted in a re-assessment and care plan update within thirty (30) days of discharge.

==========
(5) Admission to an Institution from the Community among LTC enrollees (the percentage of LTC enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID)) from the community that result in a short-term or long-term stay during the measurement year);
==========

We monitor and track this measure in our Florida LTC operations. For measurement year 2016, seventeen-point four five percent (17.45%) of LTC enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID)) from the community resulted from a short-term stay, and eighty-two point five five percent (82.55%) resulted from a long-term stay.

Overall in 2016, there were twelve thousand and fifteen (12,015) enrollees who were receiving home and community-based services (HCBS). There were two hundred and twelve (212) transitions from the community to an institution meaning, more than ninety-eight percent (98%) of our enrollees receiving HCBS services remained in the community.

==========
(6) Successful Transition after Short-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollee institutional admissions that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission)
==========

We monitor this measure in our Florida LTC operations. For measurement year 2016, Humana successfully transitioned sixty-two-point four eight percent (62.48%) of our enrollees who had a short-term institutional stay (one hundred (100) days or less) back into the community for thirty (30) days or longer.

==========

(7) Successful Transition after Long-Term Institutional Stay among LTC enrollees (the percentage of LTC enrollees who are long-term residents (101 days or more) of institutions who are successfully discharged to the community (community residence for 30 or more days)).
==========

We monitor and track this measure in our Florida LTC operations. For measurement year 2016, Humana successfully transitioned thirty-seven-point five two percent (37.52%) of our enrollees who had a long-term (one hundred (100) days or more) institutional stay back into the community for thirty (30) days or longer.

EXPERIENCE MONITORING SIMILAR MEASURES TO THOSE IN THIS SRC

In addition to our Florida experience, Humana has broader experience with LTC measures through our plans in other states. Since 2014, Humana has been providing medical, behavioral health, and long-term care services to Illinois dual eligible enrollees through our Illinois Duals Demonstration. Since 2014, we have also operated a Duals Demonstration program covering the same services in Virginia. Since 2014, Humana has been providing LTC, behavioral, and medical benefits to Medicaid eligible enrollees in our Illinois Integrated Care Program (ICP). In these programs, we monitor and track transitions from facilities into the community, as well as enrollee success in the community.

In these programs, we monitor and assess the following LTC measures:

- Enrollee movement to or maintenance in the community
- Enrollees moving from nursing facility to community
- Enrollees moving from community to nursing facility

We also track measures related to plan of care completion, case manager engagement, transitions between levels of care, and between service settings, to ensure our enrollees are receiving the right care, in the right place, at the right time. While we are not contractually required to report on measures that specifically align with the measures listed in a. 1-7 above, we do monitor and analyze outcomes related to overall coordination of care for these enrollees. The components of this coordination of care are similar to the measures a. 1-7 in this SRC: completion of a care plan, ensuring primary care physicians (PCPs) and facilities have access to the care plan, and striving to successfully transition enrollees back into the community from facilities.

==========
b. The respondent shall describe any instances of failure to meet Contract-required quality standards for these types of measures, actions taken to improve performance, and how improvement was measured. (See Section 409.966(3)(a)2., Florida Statutes)
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HUMANA'S APPROACH TO IMPROVING QUALITY

Humana utilizes a total quality management ("TQM") approach to QM. All employees are encouraged to identify areas and strategies for improvement and submit their suggestions to the

QIC. We employ the nationally recognized, standardized four-step management method of plan-do-study-act (PDSA) as the guiding philosophy for Quality Management.

Detailed steps include, but are not limited to:
- Monitor for system-wide issues
- Identify opportunities for improvement
- Determine the root cause
- Explore alternatives and develop a plan of action
- Activate the plan, measure the results, evaluate effectiveness of actions, and modify the approach as needed

The Humana QI Program is a framework for the organized, ongoing and systematic measurement, assessment and performance improvement activities. Humana utilizes the following as part of its TQM process:
- A quick fix process is used for problems that do not need a comprehensive approach to problem solving and solution implementation

- Quality assessment activities, such as enrollee and associate satisfaction surveys, utilization management, and enrollee record review, help ensure that standards are met and maintained, and identify areas for review by quality improvement committee

- Performance measure data reports specific to the measures chosen to be evaluated

- Review of utilization management data

- Review of the Florida Agency for Healthcare Administration reports

The QIC reviews suggestions, as well as its own data, to determine areas for potential improvement. Upon selection of an area for potential improvement, a top-level strategy is determined and implementation is directed to the Director of Quality Management, or appropriate Department manager as determined by the QIC in conjunction with the Medicaid LTC Market Clinical Director and the Medicaid LTC Market Operations Director.

The Quality Manager oversees the quality management team to ensure that all quality initiatives are monitored and corrective action plans are implemented and followed up on in a timely manner. Upon direction from the QIC, the Quality Manager develops an implementation strategy utilizing the PDSA method, in conjunction with the appropriate departmental associates. At a minimum, at each quarterly QIC meeting, the Manager reports on the status of the improvement project. The QIC reviews and makes modifications based on these reports.

Findings that have a significant negative effect on enrollees' quality of care are reported to the Florida Medicaid LTC Clinical Director and the Florida Medicaid LTC Operations Director by the Quality Management team and the QIC members immediately following the discovery.

SPECIFIC MEASURES FAILING TO MEET THE BENCHMARK
In 2016, Humana only failed to meet quality standards for one of the measures similar to those listed in a. 1-7 of this SRC, Plan of Care – PCP Notification. As mentioned above, our CY 2016 rate for this measure was sixty-three-point five seven percent (63.57%), falling below the ninety percent (90%) benchmark set by AHCA. Following the PDSA cycle, we identified this measure

as an area for improvement, and determined increased support and education for our case managers would improve our performance. Humana has undertaken the following initiatives in 2017 to improve our rate on this measure:

- Clinical and Authorization Data Analyst (ADA) teams track Plan of Care (POC) completion daily, so the POC can be sent to the PCP timely

- System enhancement to CGX to add POC to PCP automation implemented in September 2017

- Daily team meetings and weekly one-on-one meetings by all direct reports to review compliance and identify any gaps

- Mandatory adherence to using available reports and tools in our care management software, CGX

- Continuous education and reinforcement for the clinical associates on end to end process of the FL LTC program and the contract requirements;

- Increasing administrative support to Case Managers

In calendar year 2017, we have tracked compliance monthly as a part of our improvement plan. As of October 2017, our rate for Plan of Care – PCP Notification is twenty-two percent (22%) higher than the rate at this time last year, indicating that our interventions over the course of 2017 have increased performance in this measure.

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c. The respondent shall describe its experience with and performance on other LTC performance measures, any instances of failure to meet Contract-required quality standards for these measures, actions taken to improve performance, and how improvement was measured.

==========

EXPERIENCE ACHIEVING QUALITY STANDARDS FOR OTHER LTC MEASURES

Humana has strong experience measuring, monitoring and analyzing other LTC performance measures, as well as medical HEDIS measures associated with MMA-eligible enrollees. We have experience in producing thorough, audited results that exceed State and federal requirements.

FLORIDA LONG-TERM CARE PROGRAM

In our current Florida LTC program, Humana tracks the following additional measures for all our LTC enrollees on a monthly basis and compares them to national benchmarks. Our 2016 results for these measures (compared to the benchmarks) are included below.

- Advanced Care Planning – Total = 69.52% (Benchmark = 31.6%)
- Medication Review – Total = 98.84% (Benchmark = 80.9%)
- Functional Status Assessment – Total = 93.89% (Benchmark = 61.8%)
- Call Answer Timeliness = 97.75% (Benchmark = 81.50%)

- Required Record Documentation – Freedom of Choice Form = 90.71% (Benchmark = 90.0%)
- Face-to-Face Encounters (F2F) = 93.95% (Benchmark = 90.0%)
- Case Manager Training (CMT) = 83.50% (Benchmark = 90.0%)
- Timeliness of Service (TOS) = 93.27% (Benchmark = 90.0%)

For 2016, Humana only performed below the benchmark for one measure: Case Manager Training. To improve our performance on this measure, we have undertaken the following initiative in 2017:

- A Case Manager trainer will ensure all Case Managers complete the required training modules at Regional trainings held throughout the year.

As of October 2017, we have conducted Case Manager Trainings in ten (10) out of the eleven (11) Regions in Florida; one hundred and twenty-two (122) Case Managers have been trained year-to-date. As a part of our year-end HEDIS analysis, we will analyze our performance on this measure to determine if our interventions yielded improved results.

EXPERIENCE IN OTHER PROGRAMS ACHIEVING QUALITY STANDARDS FOR OTHER LTC MEASURES

Dual Demonstration Programs
The Humana Virginia and Illinois duals populations are very similar to those of the Florida Comprehensive Plan enrollee population we currently manage. We provide medical, behavioral health, and LTC services, and we all monitor a broad range of performance measures. We currently monitor and track fifty (50) performance measures in our Virginia and Illinois dual demonstration programs, four (4) of which are LTC measures. These measures are:

VA Dual Demonstration
- Care of Older Adults (COA) – Advance Care Planning = 19.74%
- Care of Older Adults (COA) – Functional Status = 73.89%
- Care of Older Adults (COA) – Medication Error = 38.94%
- Care of Older Adults (COA) – Pain Assessment = 76.87%

IL Dual Demonstration
- Care of Older Adults (COA) – Advance Care Planning = 50.12%
- Care of Older Adults (COA) – Functional Status = 82.97%
- Care of Older Adults (COA) – Medication Error = 80.29%
- Care of Older Adults (COA) – Pain Assessment = 90.02%

We track and monitor these measures, and report performance through the Corporate Quality Improvement Committee (CQIC). We also conduct an annual Quality Improvement Evaluation (QIE) where we:

- Analyze our performance against benchmarks
- Identify barriers to performance improvement
- Identify interventions that will overcome barriers and improve outcomes

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d. The respondent shall describe the data sources used for collecting and reporting LTC performance measures.

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DATA SOURCES USED TO COLLECT AND REPORT LTC PERFORMANCE MEASURES

To monitor progress towards achieving the healthcare outcomes listed above, Humana collects both qualitative and quantitative data through a variety of methods. Examples of data collection methods include:

- Data collected on health service utilization, including frequency of selected services, from the Florida Event Notification System (ENS). Utilization data includes, but is not limited to: admissions, readmissions, emergency department admissions.

- Integrated care delivery platform, CGX
-- Allows for case manager to case manager communication and data sharingacross medical and LTC services, providing a comprehensive view of our enrollees
-- Seamless communication and data sharing between Care Managers
-- Case managers can access acute and LTC service information via CGX, including care plans and service history

- Submitted 701B captures – Assessment and Care Plan

- Data collected from plans of care and chart review on continuity and coordination between settings of care, and in transitions of care from one provider to another.

- A quarterly review on the long-term care records of enrollees who have received services during the previous quarter. These audits include appropriateness and timeliness of enrollee assessments and contacts, comprehensiveness of and compliance with the plan of care, and appropriate and timely provision of services.

- A quarterly QI Work Plan Status Report submitted to the Humana Internal Board of Directors through the CQIC. The QI Program Status Report highlights accomplishments, including achievements on healthcare outcomes, revisions to the Work Plan, and regulatory updates to further improve performance.

- Data collected on the case management program to ensure that the program provides effective education, support, and coordination of care to enrollees.

- Provider “process” and “rate-based” measures, tracked through a Reporting Portal that creates quarterly reports for review and analysis. If a provider’s trends appear outside of the average or fail to meet measure targets, further analysis and action may be taken to help the provider achieve measure targets.

- Data collected from enrollee grievances and appeals, complaint logs from provider representatives, clinical complaints, and mandatory incident reports, which help deliver a more holistic summary of healthcare outcomes.

We also monitor our progress by conducting peer audits, supervisory audits, quality assurance audits, utilization management audits, and implementing and evaluating performance improvement plans. Many of these audits are conducted by individuals reviewing and assessing individual enrollee records utilizing auditing tools developed by our quality improvement department. Other audits are conducted utilizing quantitative data, and we utilize claims and encounter data or other data elements in our system such as diagnosis, activities of daily living (ADL) function, medications, and others. Enrollee satisfaction is also used to measure progress towards positive outcomes.

ENROLLEE SATISFACTION SURVEYS
We use enrollee satisfaction surveys to inform how we are performing against certain LTC measures. Humana partners with DSS Research, an NCQA-certified survey vendor, to develop Consumer Assessment of Healthcare Providers and Systems (CAHPS) custom questions, provide results for our Florida Comprehensive Plan, and conduct extensive analysis of the results.

Humana collects and analyzes data on these CAHPS scores and produces a report that includes the goal, time-period, previous and current results by plan type, barrier analysis, specific plans that are market outliers, and a plan of action to help each plan reach the goal by a set timeframe. Based on these analyses, a list of opportunities and barriers, improvements and changes, and conclusions and recommendations are made to improve CAHPS performance. Analysis of our 2017 CAHPS results follows.

The majority of enrollees rated the plan highly and have seen improvements in their health and quality of life.

- 77% rated the plan an 8, 9, or 10 (on a scale of 0 to 10, in which 0 is the worst).

- Since enrolling:
-- 59% indicated that their overall health has improved.
-- 76% indicated that their quality of life has improved.

Ratings of the Long-term Care services and case managers are driving the overall plan rating.
- Scores on 2 of the 3 most important measures increased significantly:
-- The overall rating of the case manager – 80% in 2017 versus 72% in 2016 (8, 9, or 10 on a 0 to 10 scale).
-- The overall rating of long-term care services – 80% in 2017 versus 71% in 2016 (8, 9, or 10 on a 0 to 10 scale).

- Performance on other measures is stable:
-- The timeliness of long-term care services is the most important measure and received a score of 89%.
-- The ease of contacting the case manager and the helpfulness of customer service (both at 78%).
-- More than 9 of 10 indicated that the customer service associates were courteous and respectful.

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e. The respondent shall describe how the respondent has obtained data needed to track measures related to care plan updates after hospital admissions and discharges, and emergency department visits.
==========

As a Comprehensive Plan, we have an integrated view of our enrollees, allowing us to easily obtain data needed to track measures related to care plan updates after hospital admissions and discharges and emergency department visits. As mentioned above, our integrated care delivery platform, CGX, allows for case manager to case manager communication across medical and LTC services, providing a comprehensive view of our enrollees. There is seamless communication between case managers, providing a repository for up-to-date data on admissions and discharges. Case managers access acute and LTC service information via CGX, including care plans, care plan updates and service history. We can document all care plan updates following an admission and discharge via CGX.

Data collected on health service utilization from the Florida ENS helps us track and monitor care plan updates following an emergency department visit. We receive real time notification on emergency department visits through the ENS. Once notified, our case managers follow up with the enrollee, assess any changes in services necessary and update the care plan accordingly.

For those enrollees who are particularly complex, we convene MDTs to discuss care plans and transitions after an admission. The MDTs review complex discharges for comprehensive enrollees to ensure the enrollees obtain necessary services. Care plan updates are discussed during MDT meetings. We can extract data from the MDT meeting minutes, as well as the associated care plan updates to monitor and track our performance related to post-discharge and post-emergency department visit care planning.

We also obtain data through chart reviews on continuity and coordination between settings of care, and in transitions of care from one provider to another.

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for measures related to the elements of LTC identified as number a.(1) through a.(7).

2. The extent of experience (e.g., number of Contracts, enrollees, or years) in achieving quality standards with similar target populations for other LTC performance measures.

3. The extent to which the described experience demonstrates the ability to effectively measure quality improvement.

4. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way.

5. The extent to which the respondent met all quality measures or successfully remediated all failures.

6. The extent to which the respondent has used multiple data sources and has obtained data needed to collect and report on LTC performance measures, including those that require information related to care plan updates after hospital admissions and discharges, and emergency department visits.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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B. AGENCY GOALS

LTC SRC# 3 – Transitions of Care (Statewide):

The respondent shall describe how it will address transition and discharge planning for an enrollee going from a hospital or nursing facility rehabilitation setting and returning to a community setting. The respondent should identify specific strategies for ensuring that transition and discharge planning incorporates assessment of appropriate supports in the home, provision of supplies and home care/nursing services. The respondent shall include an example of an effective transition plan with appropriate timeframes for each step of the process.

Response:

Individuals are most vulnerable when transitioning between care settings and levels of care. A For individuals receiving Home and Community Based Services (HCBS) who are hospitalized, the transition back to the community can be complicated. For these enrollees, the reinstatement of HCBS (in addition to traditional transition needs) must be addressed in order for the transition back to the community to be safe and sustainable. We have worked to identify communication challenges that can occur during the transition process and to develop practices aimed at addressing them.

Together, our utilization management and care management teams serve as the link that connects the various care settings and levels of care through which an enrollee moves. They facilitate the coordination of information and transfer of knowledge necessary to ensure a safe and effective transition by sharing discharge plans, plans of care, medication lists, and other clinical reports. Processes are integrated within our Clinical Guidance eXchange (CGX) documentation platform [1] to ensure continuous information sharing among all involved parties.

For transitions from inpatient acute and long-term care facilities to the community, our transitions are based on the Dr. Eric Coleman Care Transitions Model, which is grounded on improving quality and safety during transitions. At the foundation of our transition processes are the following five (5) pillars of care:

- Coordinated and proactive discharge planning, including communication among all stakeholders, referral to needed post-discharge services and collaboration with community based agencies

- Timely and appropriate primary and specialty care follow-up post discharge

- Medication management and medication reconciliation between and during transitions

- Establishment of the medical home with a focus on prevention and proactive health management in the outpatient setting

- Enrollee and caregiver empowerment through heightened awareness and knowledge of their health condition, including exacerbation triggers

We have created transition processes that meet the needs of our enrollees and their families during these critical times when they are most likely to seek education and help with care coordination. Our transition planning actions start as soon as we are made aware that an enrollee is hospitalized and continue throughout the admission as well as post-discharge. Our transition planning activities promote high quality, cost-effective outcomes as evidenced by care occurring in the most appropriate setting, at the most appropriate time, with timely follow-up with treating physicians, and with prevention of emergency services or readmission.

Associates involved in transition of care between service settings include the following, who together guide enrollees and their caregivers from admission to discharge to recovery:

- Long-term Care (LTC) Case Manager (CM), who serves as the enrollee's primary CM and leads the transition team

- Utilization Management (UM) Nurses, who lead UM functions during all stages of the transition planning, from inpatient to permanent residence

- RN Specialists, who act in a consultative role for the medical components of the enrollee's care as needed

- Behavioral or other Disease Management CMs, as applicable

- Transition Coordinator (TC), who serves as our housing specialist and facilitates community placements as needed for enrollees at risk of custodial placement

In the remainder of this response, these associates are sometimes referred to collectively as the "transition team." Humana's Medical Directors work with the team to ensure approvals between levels of care and to communicate with physicians in the community and inpatient settings.

Each transition team (as well as the enrollee's ongoing care team) is regionally based as each member of the team is assigned to a specific region or small regional grouping. This regional configuration facilitates team familiarity with the localities they serve, effective and long-standing working relationships among team members, and optimal communication across the team.

The remainder of our response is organized as follows.

- Initially, we will walk through Humana's *process* for addressing transition and discharge planning for an enrollee going from a hospital or nursing facility rehabilitation setting and returning to a community setting

- Following the discussion of our process, we will present an *example* showing how our process was used to successfully transition one of our enrollees this past year

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1. The extent to which the respondent's *process* addresses the following components of transition and discharge planning:
(a) Assessment criteria for making sure the enrollee can be served safely in the community;

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EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Humana strives to provide efficient, enrollee-centered, and safe care planning for all individuals transitioning between service settings. Throughout an enrollee's transition from one level of care or setting to another, Humana Utilization Management and Case Management Nurses review all relevant clinical information including assessments, care plans, discharge plans, and medications to address barriers to care and to ensure services are in place to facilitate a seamless transition between care settings. They facilitate the transfer of information and knowledge across care settings and levels of care, coordinating with facilities and providers to ensure medication reconciliation occurs and all other necessary appropriate communication among providers takes place.

The transition team may be notified of an enrollee admission through a variety of means, including the following:

- For comprehensive enrollees and dual eligible enrollees in a Humana Medicare plan, UM Nurses receive notification through the daily hospital census and alert the LTC CM.

- The LTC CM, through regular contact with the enrollee or caregiver, will be aware of most scheduled admissions

- The enrollee, enrollee's family or caregiver, or LTC providers may also notify the primary CM of an unscheduled admission

Discharge planning begins on admission to an inpatient stay. The enrollee's CM, in coordination with the Humana UM Nurse and hospital associates, begins to develop a discharge plan as soon as the enrollee is admitted into the hospital. As part of that plan, we assess barriers that may impact the enrollee's ability to stay in the community. The CM addresses identified barriers and assists the enrollee to maintain an optimal level of health and wellness, addressing all post-discharge needs.

Transition associates complete a comprehensive assessment of the enrollee and family or caregiver needs through completion of the Discharge Planning Assessment Tool in CGX. The assessment gathers information on criteria that determine whether the enrollee can be served safely in the community. This includes but is not limited to the following:

- Availability of support from family and friends

- Access to Primary Care Physician (PCP) and specialists

- Potential barriers to discharge such as:
-- Confusion, cognitive impairment, or memory loss
-- Exacerbation of behavioral health condition
-- Diagnosis resulting in significant lifestyle change or educational needs
-- Substance abuse
-- Environmental risk (pediatric or dependent member in risk environment)
-- Financial barriers
-- History of falls
-- Lack of relationship with PCP
-- Inconsistent and unreliable caregiver support

- Healthcare behaviors and challenges such as:
-- Limited access to healthcare, resides in rural area
-- History of non-compliance with plan of care or medications

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1. The extent to which the respondent's *process* addresses the following components of transition and discharge planning:
(b) Collaboration with providers' discharge planning staff (e.g., hospitals, institutional settings, assisted living facilities, ancillary providers)

==========

Humana's transition team members have extensive experience collaborating with facility discharge planning associates to ensure smooth transitions for our LTC enrollees in Florida. The transition team reviews initial discharge planning information from the facility and works closely with facility discharge planning associates to identify and review potential barriers to discharge through communications with the enrollee, their family or caregivers, providers and hospital nurses and social workers. Humana's transition team also shares relevant information regarding enrollees with the facility discharge planning associates (e.g., information on known barriers to discharge that may be available in our integrated CGX documentation platform). The Discharge Planning assessment referenced above is a working document that is updated throughout the inpatient stay as additional information becomes available, up to and including the final facility discharge plan.

Humana's transition team ensures the appropriate exchange of information to facilitate transitions to new settings or levels of care, including changes in medications and the discharge plan. In anticipation of discharge, the assigned CM communicates with a variety of individuals about the enrollee's health status and any potential coordination needs following discharge, who may include the attending provider, the PCP or treating specialist, behavioral health providers, hospital social workers and discharge planners, and the enrollee and applicable caregivers. The CM will schedule a Multidisciplinary Team (MDT) conference to solicit the expertise of the various MDT members in discussing the discharge plan of enrollees with complex cases. Before the meeting, the CM documents the identified issues prompting the meeting and the guidance being sought.

As a result of this ongoing collaboration while the enrollee is hospitalized, the assigned CM determines whether to maintain or update the enrollee's plan of care. If the enrollee's plan of care changes, the CM tasks the UM department to review and document the action in CGX. The CM communicates the discharge plan and any plan of care changes with the enrollee, facility, caregivers, and PCP in order to effectively transition the enrollee home or to another facility and to ensure understanding of the plan by all parties.

Humana maintains detailed procedures for facility transfers, including hospital to hospital, Long-Term Acute Care Hospital (LTACH), Inpatient Rehabilitation Facilities (IRF), Skilled Nursing Facilities (SNF), and Psychiatric Facilities. Our procedures ensure effective collaboration and outline transition associates' responsibilities. This includes but is not limited to PCP notification as well as facilitation of communication between the transferring facility and the accepting facility to ensure a smooth transfer.

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EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent's *process* addresses the following components of transition and discharge planning:
(c) Referral and scheduling assistance;
(d) Coordination with home and community-based providers, including DME and home health providers as appropriate to meet the enrollee's needs;
==========

Upon notification of an admission, the CM is responsible for suspending HCBS services during the period the enrollee is hospitalized. The CM is also responsible for determining the enrollee's discharge needs. These may include, but are not limited to, the following:

- Scheduled follow-up appointment with the enrollee's PCP or specialist

- Access to prescribed medications

- Comparison with current prescriptions to identify duplication of therapy, drug interactions, and contra-indications (Medication Review)

- Home care, Durable Medical Equipment (DME) or other services post-discharge

- Access to transportation

- Appropriate community resources to address non-covered or exhausted benefits post discharge

- Need of additional HCBS services due to functional decline

- Need of medically necessary "in lieu of" services

Humana's transition team provides referral and scheduling assistance both prior to and post discharge. Prior to discharge, the CM ensures the timely reinstatement of the services the enrollee had been receiving, and ensures authorizations for additional post-discharge services as ordered by the treating physician (such as home health and durable medical equipment (DME)). The CM also provides referral and scheduling assistance as follows:

- Referral and scheduling assistance with our home care partners

- Referral and scheduling assistance to ensure necessary post discharge appointments are arranged with the PCP, behavioral health providers, and other specialists

- Consideration for and referral to Humana Medicaid and Medicare care management programs such as disease management and other clinical programs if enrollees meet eligibility and program criteria

- Notification and coordination of discharge orders with providers, social supports and community resources (e.g., home health, DME), the enrollee and/or authorized representative, the enrollee's family or caregivers, and Humana Clinical Programs

Post-discharge, the CM continues to provide referral and scheduling assistance to ensure follow-up doctors' visits and outpatient care are arranged according to post-discharge instructions. The CM also assists with removing barriers to keeping appointments (e.g., by ensuring the enrollee has required transportation for follow-up visits and understands their transportation benefit).

As discussed in section (e) below, post-discharge transition activities include a post-discharge visit to the enrollee within five (5) business days following discharge. The CM ensures that follow-up doctors' visits and outpatient care are arranged according to post-discharge instructions. The CM continues to communicate, as needed, with the enrollee, their caregiver, PCP, behavioral health provider, and other relevant stakeholders to continually assess, maintain, and intervene proactively, ensuring that enrollees are receiving necessary care and services.

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1. The extent to which the respondent's *process* addresses the following components of transition and discharge planning:
(e) Processes to prevent unnecessary hospital or nursing facility readmissions.

==========

We begin to assess and plan for discharge needs upon notification of an admission. Along with reviewing the enrollee's current clinical status, we identify potential readmission risk using Humana's proprietary Readmission Predictive Model (RPM). For more detail on our RPM, please see Attachment LTC 3-1. Available on admission, the RPM augments clinical review and helps identify enrollees who may benefit from more intensive support.

The goal of all post-discharge intervention is to identify and close any gaps in care that may lead to a poor quality outcome such as complications or readmissions and to ensure the enrollee has a full support system in place for successful community re-entry. Humana's program is based on best practices identified in the clinical literature and on our own internal studies, which suggest that the more closely the post-discharge intervention follows the discharge, the more likely it os that the intervention will have a positive impact on quality of care and will reduce avoidable and costly readmissions.

Face-to-face post-discharge outreach is made to all enrollees discharged home. Our goal is for the CM to complete a change in condition (CIC) visit within forty-eight (48) hours after discharge whenever possible, and always within five (5) business days following discharge. During the CIC visit, the CM:

- Completes a new 701b assessment, which includes assessment for any changes in ADLs and IADLs, a medication review and an assessment of the enrollee's caregiver supports and natural supports

- Updates the Plan of Care, authorizing additional services that may be needed

- Identifies any symptoms or issues that need to be documented and notifies the enrollee's PCP

- Assesses for barriers to access and treatment and schedules appointments with the PCP, specialists, therapy providers, and with transportation to appointments

The CM also ensures that the following items are in place:

- Enrollee received discharge instructions and fully understands their condition(s) and post-discharge care

- Enrollee is in a safe environment and a caregiver or support system is able to adequately provide post-discharge support

- Enrollee was able to obtain all post-discharge medications and understands how to take them, can identify side effects and complications, and knows when to report concerns. Additionally, if the enrollee cannot afford medications, the case management team works with the enrollee on obtaining medications from community resources, pharmaceutical companies, or contacts the physician's office for assistance.

- Home health services and DME are in place

- Follow-up doctor's visits, outpatient care and all HCBS, supports, and supplies are arranged according to post-discharge instructions

- Enrollee has needed transportation for follow-up visits, and understands his or her transportation benefit

- No complications or new problems have occurred without being reported to the physician

- Enrollee understands when to report any complications to their physician and when to seek medical care

We have recently added a new component to the face-to-face post-discharge visit which we believe will further enhance our strong transition process by promoting PCP engagement. While we encourage our enrollees to schedule a follow-up appointment, some enrollees may face barriers that prevent them from doing so. For these enrollees, the CM attempts to call the PCP during the post-discharge visit to schedule the follow-up appointment, to confirm changes in the enrollee's medications, and to share and receive other pertinent information.

We are focused on effective transitions for all of our enrollees, but we understand that certain populations require enhanced transition planning. As appropriate, enrollees are engaged in disease management programs. If behavioral health needs, such as depression or anxiety, are identified after the inpatient stay, then the enrollee is referred to our Behavioral Health program for support. As noted above, the CM may decide to schedule a formal MDT conference to solicit the expertise of the various MDT members in discussing the discharge plan of enrollees with complex cases and transition of care concerns, to prevent readmissions and unplanned nursing home placement. The MDT panel participants for these enrollees may include the enrollee, the enrollee's caregiver (if applicable), Medical Director, all care team members, Front Line Leader, HCBS providers and any other participants involved in the enrollee's care (e.g., PCP, specialists, behavioral health provider, Medicare Advantage health plan).

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2. The extent to which the respondent's *process* ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

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Humana places the utmost importance on enrollee privacy and confidentiality. Ethics and the protection of enrollee privacy are integral to case management, and all of our associates receive comprehensive training that includes protection of the enrollee's privacy consistent with confidentiality requirements. All Humana associates and contractors must complete Humana's Ethics and Compliance training within thirty (30) days of hire and annually thereafter. This mandatory training is tracked for every associate. Topics include, but are not limited to: Privacy and Information Protection Policies including the Acceptable Use Policy, role of Enterprise Information Protection (EIP) and the Privacy Office, key definitions and responsibilities, social engineering tactics such as phishing, physical safeguards, and security incident and privacy breach reporting. Humana also holds an annual Cyber Security Awareness event each October for the enterprise. This event is a weeklong focus on all key topics related to information protection. Renowned information security experts share their knowledge throughout the week with presentations, expo halls, and interactive activities.

We also offer our contracted healthcare providers and business partners an important part of our Enterprise Compliance Program: Ethics Every Day for Contracted Healthcare Providers and Business Partners. This document outlines our program's standards of conduct requirements, including reporting of improper disclosure of or access to enrollee information. It also addresses the safeguarding of information used to perform functions for or related to Humana, including following the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the more recent Health Information Technology for Economics and Clinical Health Act (HITECH). Healthcare providers and business partners are expected to have policies and procedures in place to affirm the integrity of their organizations' information.

Examples include:

- Privacy and security training program for employees and business partners

- Confidentiality agreements, where applicable

- A procedure for the required return or destruction of protected health information (PHI) if an agreement involving the support of Humana is terminated

- A procedure for restricting the marketing of PHI

Several safeguards are in place to ensure that enrollees' privacy rights are guaranteed at all times. We have both inbound call and outbound call authentication processes to ensure we are speaking with the enrollee, as follows:

Inbound Call Authentication (require at least 3):
- Enrollee identification number
- Medicaid identification number
- Enrollee date of birth
- Enrollee zip code

- Enrollee group name, group number, or product type (only if needed)

Outbound Call Authentication:
- Dial the enrollee's number on file
- Ask to speak with the enrollee, addressing by full name
- Ask for other appropriate identification such as zip code or DOB
- If unable to provide zip code or date of birth, ask for enrollee identification number, group name, group number or product type, Medicaid identification number, or social security number

If we do not have a complete Power of Attorney consent form or a signed PHI consent form in our documentation system, the CM and other members of the Humana team obtain verbal consent from the enrollee at each contact to speak to anyone other than the enrollee. Authentication of the consent is documented in CGX at each contact.

The CM may request that the enrollee complete a PHI consent form if the enrollee requests that the CM speak to another person on an ongoing basis regarding their health status and concerns. A PHI consent form is then mailed to the enrollee with a self-addressed, stamped envelope. The PHI consent form allows Humana to obtain an enrollee's permission to discuss personal health information with a specific person named on the PHI form.

Humana employees are prohibited from disclosing any medical information to anyone inside or outside the health plan, except when required by law. Humana employees are educated on ensuring appropriate PHI and sign a confidentiality statement upon hire and on an annual basis. Enrollee and provider specific information is used solely for the purposes of utilization management, quality management, disease management, discharge planning, care management and coordination, and claims payment. It is shared only with those individuals who need access to such information in order to conduct utilization management and related processes. Agreements with providers functioning in a peer review capacity specifically address and uphold the confidential nature of all enrollees' medical information.

Humana operates a framework of internal IT controls and information security policies and procedures to maintain the health information system's compliance with HIPAA and other privacy laws, as well as commonly accepted professional standards of health information management. We rely on secure software systems to protect and maintain our enrollees' sensitive medical information. The CGX system contains our enrollees' care plans, which can only be accessed by the enrollee's care manager, the UM Nurse, and the enrollee's PCP. Following a defense-in-depth methodology, Humana utilizes numerous controls that are used to prevent data loss and breach of confidentiality. These include, but are not limited to: firewalls, De-Militarized Zones (DMZs), intrusion prevention, intrusion detection, group policies within active directory (least privilege), role-based access control (RBAC), data segmentation, anti-virus, anti-malware, full disk encryption, data loss prevention (DLP) tools, active data-in-use monitoring, monitoring of dark web activity, and Web content filtering to protect endpoints from malicious websites. Humana undergoes many internal and third party audits including the National Institute of Standards and Technology (NIST), the Health Information Trust Alliance (HITRUST), the Payment Card Industry Data Security Standard (PCI DSS), and various state department of insurance audits. Humana is currently certified as being compliant with NIST, HITRUST, and PCI DSS standards.

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EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The respondent shall include an example of an effective transition plan with appropriate timeframes for each step of the process.

1. The extent to which the respondent's *example* addresses the following components of transition and discharge planning:

3. The extent to which the respondent's *example* provides appropriate timeframes for each step of the transition and discharge planning process.
==========

We present our case example, including appropriate timeframes for each step of the transition and discharge planning process, below.

"Edward" is a fifty-seven (57) year old male with a history of anoxic encephalopathy due to a cardiac arrest in July of 2016, chronic respiratory failure which required a tracheostomy, and was status post aspiration with a feeding tube. Edward also has a history of subarachnoid hemorrhage, seizure disorder, Stage III sacral ulcer and Stage II pressure ulcer to bilateral buttocks, hypertension, atrial fibrillation, and congestive heart failure.

Edward had been in case management in Humana's MMA program since 2016, and the MMA CM had assisted Edward and his daughter in applying for the LTC program. Edward was hospitalized in February 2017 due to wound infections and remained hospitalized until July 2017. It was during this hospitalization that he was approved for the LTC program. The MMA CM contacted Humana's LTC team to inform them of Edward's imminent eligibility and to review his case with the team. Humana's LTC team received Edward's eligibility record in mid-June 2017 for a July 1, 2017 start date and assigned an LTC CM within twenty-four (24) hours of receipt of his information.

The LTC CM reviewed Edward's case record in Humana's CGX clinical platform (where she could review what had been done with Edward while in the MMA program) and reached out to his daughter with a welcome call the day after she received Edward's eligibility record (two (2) weeks prior to his start date with the LTC program). She explained the program to Edward's daughter, discussed how she would work with her and Edward to support his transition back to home, and would continue as Edward's primary CM throughout his LTC enrollment. Edward's daughter provided updates on his status and indicated she was still unsure of Edward's discharge date. The CM also provided his daughter with her contact information and advised her that she would be reaching out to the hospital social worker and would follow Edward during his hospital stay to monitor for discharge orders. She also encouraged Edward's daughter to call her with any questions and informed her that she would complete a new enrollee orientation once Edward was discharged to home.

The CM immediately scheduled an MDT Conference (which included the MMA and LTC UM Nurses, the MMA and LTC CMs, the MMA and LTC Front Line Leaders, and the Medical Director) to review Edward's current condition and discharge plans. A second MDT Conference was held prior to Edward's discharge, which also included Edward's daughter and attending physician to develop an appropriate tentative Service Plan and Plan of Care to meet Edward's and his daughter's needs.

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EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent's *example* addresses the following components of transition and discharge planning:
(a) Assessment criteria for making sure the enrollee can be served safely in the community;
==========

In the week following the LTC team's receipt of Edward's eligibility record, and two (2) weeks prior to his start date in the LTC program, Humana's transition team, led by the LTC CM, reviewed all relevant clinical information. The LTC CM completed the 701B Comprehensive Assessment, the Discharge Planning Assessment Tool, and the Caregiver Assessment tool to determine what Edward and his daughter would require in order for Edward to be safely discharged to his home. During the hospitalization, Edward's wounds were debrided, and then treated conservatively, his nutritional status was optimized, and Edward and his daughter were educated on the prevention and management of pressure injuries. Edward was in need of a Clinitron (or Air-Fluidized Bed) prior to discharge for the management of his pressure injuries and prevention of further infection. Edward's LTC CM arranged for the DME company to evaluate his home to ensure it could structurally and electrically accommodate the Air-Fluidized Bed. She also arranged for the reinstatement of skilled nursing services, which Edward would require because of his ventilator.

==========
1. The extent to which the respondent's *example* addresses the following components of transition and discharge planning:

(b) Collaboration with providers' discharge planning staff (e.g., hospitals, institutional settings, assisted living facilities, ancillary providers)
==========

Both the MMA UM Nurse and the LTC CM collaborated with hospital discharge associates, including the hospital social worker, monitoring discharge orders and identifying, reviewing, and addressing potential barriers to discharge. During the three (3) weeks prior to Edward's discharge (the point at which the LTC CM had become involved), they had daily communication with hospital discharge planning associates and were made aware of the date and time of Edward's planned discharge.

==========
1. The extent to which the respondent's *example* addresses the following components of transition and discharge planning:
(c) Referral and scheduling assistance;
(d) Coordination with home and community-based providers, including DME and home health providers as appropriate to meet the enrollee's needs;
==========

Edward's CM coordinated all prescriptions for DME, wound care orders, and skilled service requests prior to his discharge from the hospital. These were reviewed for medical necessity, approved, and delivered to Edward's home prior to his discharge and scheduled to commence on day of discharge. The CM arrived at Edward's home one (1) day after he was discharged from the hospital to complete the new enrollee orientation and finalize Edward's plan of care to include his personal goals. The CM also provided Edward's daughter information on resources including caregiver support groups, hospice, and palliative care. Edward's daughter was

hesitant to discuss these issues at that time so the CM provided emotional support and reviewed the Member Handbook with her to ensure she had all the information she needed. The CM also showed Edward's daughter how to access Humana's Caregiver Support Portal for helpful information and caregiver resources. The CM confirmed that all services were in place, registered Edward with the local special needs shelter, and created a backup plan to ensure Edward would remain safe in the home setting. She also made sure that Edward had a scheduled PCP follow-up appointment and set up an appointment for Edward with a wound care specialist.

==========

1. The extent to which the respondent's *example* addresses the following components of transition and discharge planning:
(e) Processes to prevent unnecessary hospital or nursing facility readmissions.

==========

Edward's transition team engaged in a number of processes and activities aimed at maintaining Edward safely in his home and preventing hospital readmission or nursing facility placement:

- Two (2) MDT conferences were held in the three (3) weeks prior to Edward's discharge. The first included the MMA and LTC UM Nurses, the MMA and LTC CMs, the MMA and LTC Front Line Leaders, and the Medical Director to review Edward's current condition and discharge plans. A second MDT Conference was held prior to Edward's discharge, which also included Edward's daughter and attending physician to develop an appropriate tentative Service Plan/Plan of Care to meet Edward's and his daughter's needs.

- The CM conducted a visit to Edward's home one (1) day after his return home to ensure all necessary services were in place, to provide support and information to Edward's daughter, to create a back-up plan, and to schedule follow-up appointments with Edward's PCP and wound care specialists.

- As a high acuity enrollee, Edward and his daughter receive weekly telephonic contact from his CM during the first month following his discharge, with a face-to-face visit at the end of his first month back home.

- Because of Edward's complex needs, we also extended and formalized the role of his MDT to ensure that his care is regularly reviewed through a team approach, ensuring that any gaps in his care are addressed and resolved. Edward's MDT panel participants included Edward and his daughter, our Medical Director, Edward's CM and Front Line Leader (CM Supervisor), and Edward's PCP as needed. The MDT met monthly for the first two (2) months following Edward's discharge. Because no issues of concern were identified, the next MDT conference was scheduled to occur three (3) months after the last conference, unless Edward's CM identifies any urgent or emergent situations in the interim.

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2. The extent to which the respondent's *example* ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

==========

During Edward's stay at the hospital, Humana's UM Nurse provided and reviewed the Discharge Management Tools with Edward and his daughter and obtained consent for the release of PHI to Edward's daughter. Once Edward was discharged home, the CM followed Humana's outbound and inbound call authentication processes and all other privacy procedures, including sharing information with Edward's PCP via secure email.

Footnotes

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[1] CareHub is Humana's enterprise solution for complete program integration for our provider community and enrollees. CGX supports an integrated, comprehensive approach to medical, behavioral health, pharmacy, utilization, and care management. Full system integration allows our care team the capability to identify potential enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify opportunities for intervention.

Evaluation Criteria:

1. The extent to which the respondent's process and example address the following components of transition and discharge planning:

- **(a)** Assessment criteria for ensuring the enrollee can be served safely in the community;
- **(b)** Collaboration with providers' discharge planning staff (e.g., hospitals, institutional settings, assisted living facilities, ancillary providers);
- **(c)** Referral and scheduling assistance;
- **(d)** Coordination with home and community-based providers, including DME and home health providers as appropriate to meet the enrollee's needs; and
- **(e)** Processes to prevent unnecessary hospital or nursing facility readmissions.

2. The extent to which the respondent's process and example ensure the protection of the enrollee's privacy consistent with confidentiality requirements.

3. The extent to which the respondent's example provides appropriate timeframes for each step of the transition and discharge planning process.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment LTC 3-1: Humana's Readmission Predictive Model

Humana calculates the Readmission Predictive Model (RPM) to assess the probability of an enrollee being readmitted into a facility within 30 days. A score is generated on the day of admission. Generating scores at the time of admission gives more time to intervene and prevent the next potential admission, and helps improve the "reach rate," since the enrollee will still be in the hospital when the score is generated.

Trade Secret as defined in Section 812.081, Florida Statutes

[redacted]

Trade Secret as defined in Section 812.081, Florida Statutes

Readiness Model – *Complexity*

This is an example of how a predictive model works:

Memb

Memb

[redacted]

Traditional, diagnosis-only approaches treat enrollees A and B equally.

The take away

Humana's readmission predictive modeling approach, built on a database of a half million admissions, allows stratification and prioritization to those enrollees in the most need.

Humana.

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

LTC SRC# 4 – Provider Network Agreements/Contracts (Regional):

The Agency has identified some the key network provider types that will be critical in order for the respondent to promote the Agency's goals.

The respondent shall demonstrate its progress with executing agreements or contracts it had with providers in the region by submitting **Exhibit A-4-c-1**, Provider Network Agreements/Contracts (Regional) (10-2-2017):

Response:

Please refer to the attached Exhibit A-4-c-1, which directly follows this document for our response.

Evaluation Criteria:

For each service type the respondent may receive up to 60 points as described below. There are four (4) service types available in a region.

Percentage of agreements/contracts for each service type	Points
0.0%	0
1.0% - 25%	15
25.1% - 50%	30
50.1% - 75%	45
75.1% or greater	60

Score: This section is worth a maximum of 240 raw points based on the above point scale.

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General Instructions:

Each Respondent shall complete the Long-term Care Agreements/Contracts scoring template worksheet. The respondent is required to submit the total number of individual Service Provider Type with whom they have agreements/contracts by using column 'b' on the worksheet

LTC Service Providers Scoring Workbook Explanation:

Service Provider Types
Assisted Living Facility
Adult Day Care Center
Home Health Agency
Nurse Registry

Statewide Essential Providers Scoring Template Fields		
Field	*Respondent Data Entry Required?*	*Description*
Service Provider Type	*No*	*Provider types providing the specific service in the LTC program.*
Agreements/Contracts	*Yes*	*Agreements/Contracts count shall be entered by Respondent (Individual Service Provider Type)*
Available Service Provider Types	*No*	*The number of each Service Provider Type available for Agreements/Contracts*
%	*No*	*The number of agreements/contracts Respondent entered in column 'c', divided by the total number of Available Service Provider Types and converted to a %*
Score	*No*	*Specific Service Type score*

**notates only field to be completed by the respondent*

EXHIBIT A-4-c-1
LTC SRC# 4 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL)
(10-2-2017)

SRC Score	225

Service Provider Type	Agreements/Contracts	Available Service Provider Types	%	Score
Assisted Living Facility	31	48	65%	**45**
Adult Day Care Center	3	3	100%	**60**
Home Health Agency	14	14	100%	**60**
Nurse Registry	4	4	100%	**60**

C. RECIPIENT EXPERIENCE

LTC SRC# 5 – Transition from Nursing Facility to Community (Statewide):

The respondent shall describe its experience with transitioning individuals from institutional to community settings and strategies to ensure individuals maintain successful community placement including:

a. Experience and strategies pertaining to deploying transitional care teams and using evidence-based practices with support from other clinical resources and community-based organizations.

b. Experience and strategies pertaining to individuals who reside in an institutional setting for rehabilitation, or have otherwise resided in a facility for less than one year.

c. Experience and strategies pertaining to individuals who have resided in an institutional setting for more than one year.

Response:

Long-term Care (LTC) plans have a responsibility to help enrollees age reside or age in their most appropriate setting of choice. Through our statewide LTC plan, Humana has helped more than one thousand seven hundred (1,700) Florida Medicaid enrollees transition out of institutions into community settings. Providing a systematic referral, coordination, and continuity of care system is essential to ensure that enrollees transitioning from institutional to community settings will continue to receive timely and appropriate care. When an enrollee desires to move back to his or her home and can live safely in that environment, services to coordinate a smooth transition are important in order to prevent hospitalizations or deterioration of conditions that may prevent him or her from maintaining stability in a home or community-based setting. Following a transition, services to ensure the enrollee has the support structure needed to remain and thrive in the community become critical to prevent readmission.

==========
a. Experience and strategies pertaining to deploying transitional care teams and using evidence-based practices with support from other clinical resources and community-based organizations.
==========

Humana has extensive experience with transitioning individuals from institutional to community settings across various states and programs. Through a partnership with the Florida Department of Elder Affairs, Humana participated in the Nursing Home Diversion (NHD) program for Florida's frail and elderly population from 2007 to 2013. The coordination of LTC services in the NHD program helped enrollees maintain their residence in the community and prevented unnecessary transitions into nursing facilities. The state transitioned the NHD program to the LTC program in 2013 and today Humana provides managed LTC services to approximately twenty-one thousand (21,000) enrollees across all eleven (11) Florida Medicaid regions, serving

as the only statewide LTC health plan. We cover LTC benefits for Aged, Blind, and Disabled (ABD) as well as dual eligible enrollees in the LTC program. Humana manages LTC benefits for another twenty thousand (20,000) Medicaid enrollees in Virginia and Illinois through our affiliate health plans under Humana, Inc..

In the remainder of this response, we provide detail on the strategies we use to provide effective and safe transitions for enrollees.

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1. The extent to which the respondent identifies how it will coordinate care with all individuals and/or entities necessary.
==========

Transitioning enrollees from institutions into community settings carries risks of acute incidents and hospitalizations if not appropriately planned. To mitigate those risks, we assign a specialized, experienced team to manage all aspects of each transition. Through our multidisciplinary team (MDT) structure (which incorporates all medical, behavioral, and LTC aspects of an enrollee's care) we ensure that the transition takes into account all of an enrollee's needs. The MDT includes the enrollee and their caregivers, case manager (CM), transition coordinator (TC), Frontline Leader, Utilization Management representative, primary care provider (PCP), Medical Director, and other service providers as needed.

Humana's Transitions Program is for transitions from long-term facilities to the community. Based on the evidence-based Dr. Eric Coleman Care Transitions Model®, which is grounded in improving quality and safety during transition periods, our program identifies enrollees residing in a nursing facility who express the desire to and can safely transition into a community setting. We then support each enrollee's transition into an independent home, an apartment, an assisted living facility (ALF), or a group home. Our Transitions Program incorporates the following evidence-based practices [1] (which we describe throughout our response):

- Assignment of a Transition Coordinator (TC) who provides one-on-one assistance with the enrollee's transition process

- Coordinated and proactive discharge planning, including communication among all stakeholders, referral to needed post-discharge services, and collaboration with community-based agencies

- Timely and appropriate primary and specialty care follow up after the transition

- Medication management and medication reconciliation during transitions

- Enrollee and caregiver empowerment by educating them on their health conditions, including exacerbation triggers

- Enhanced oversight through increased face-to-face and telephonic contacts as outlined in the transition risk stratification and as needed

The goal of the Transitions Program is to ensure our enrollees receive services in their preferred and most appropriate setting. TCs join the enrollee's MDT when we identify that the enrollee is a

transition candidate. As our housing specialists, TCs are familiar with the housing options and community resources available to enrollees and the steps necessary to ensure a smooth transition. They work exclusively on providing person-centered, one-on-one assistance with the transition process.

We initiated our Transitions Program in Florida immediately upon LTC program implementation in 2013. Prior to implementation, the Humana transition team and plan leadership identified many barriers to successfully transitioning enrollees. Nursing facility staff were often either unaware of or resistant to the program. CM associates required additional training and education. Enrollees and family members were unsure about their options and also benefited greatedly from additioinal education. We also needed to identify community resources to maintain successful placement. To address these barriers, we devoted significant time and resources to accomplishing the following:

- Conducted outreach, led by our provider relations department, to develop strong and effective relationships with nursing facility staff and provide education on our program

- Trained CMs on identifying enrollees who may be eligible to transition and on providing information to address concerns of enrollees who may be apprehensive about (or unaware of) their eligibility to transfer to a less intensive environment

- Developed a formal and rigorous Transition Program training module

- Involved the enrollee and family members from the beginning of the process, providing individualized education

- Identified and developed relationships with community-based organizations and engaged in reciprocal education and information-sharing about our programs and services

Humana TCs collaborate with CMs when an enrollee is transitioning from a custodial nursing facility or other institutional care setting back to a community setting. Both the CM and TC record all information within Humana's clinical workflow system, Clinical Guidance eXchange (CGX). CGX supports an integrated, comprehensive approach to utilization and case management, providing the TC, CM, and other Humana associates secure access to pertinent information at any time. As a Comprehensive Medicaid plan that also serves many dual-eligible enrollees in Medicare plans, we use CGX to effectively coordinate acute, primary, behavioral, and social services with long-term services and supports necessary for a successful transition. Our CMs and TCs also identify and coordinate with any non-Humana health plans serving our enrollees, including non-Humana Dual Eligible Special Needs Plans (D-SNPs), Medicare Advantage (MA) plans, and Fee-For-Service (FFS) Medicare. Below we summarize key steps in the transition process.

IDENTIFICATION OF ENROLLEES FOR TRANSITION

We identify enrollees for transition through the Case Management process:

- CMs identify enrollees' interest in and ability to transition through our contact processes that include initial, monthly, quarterly, annual, and as-needed assessments. During the in-facility

visit, the CM educates the enrollee and family members regarding Home and Community-Based Services (HCBS), the Participant Directed Option (PDO), and Freedom of Choice, using talking points Humana's transition team has developed for this purpose.

- CMs and TCs receive direct referrals from nursing facility staff during their regular visits to nursing facilities.

- Our TCs also play a key role in the identification process. They review the 701T assessment administered to all nursing facility residents, review the facility's minimum data set (MDS), which is updated quarterly with information about enrollees' expectations for facility discharge, and perform monthly nursing facility "sweeps" (facility visits alongside CMs) to provide additional insight as to which enrollees may be candidates for transition.

- We may also identify enrollees for potential transitions through CM grand rounds with nursing facility staff and through referrals from treating physicians, other providers, family members, and enrollee self-referrals.

If an enrollee expresses a desire to transition out of a nursing facility, his or her CM completes the first section of our Transition Screening Tool (Attachment LTC 5-1) to ensure the enrollee can safely reside in a new setting. Our CMs complete the Transition Screening Tool for enrollees residing in nursing facilities during the initial and annual health assessments, and as needed. The CM documents the results of this assessment in the enrollee record contained in CGX. This section of the tool includes an assessment of the enrollee's desire to enter the new setting, the enrollee's health status and functional limitations, and identification of supports necessary and available to aid the transition. For enrollees who are transitioning to live with a caregiver who works during the day or for enrollees who will be left alone at any time, our CMs administer the LTSS Risk Ranking Tool (Attachment LTC 5-2), which assesses the enrollee's needs for assistance with a variety of tasks to determine their risk level and corresponding level of CM contact. We are now completing the Transition Screening Tool for one hundred percent (100%) of our enrollees residing in nursing facilities. This is done so that we may track and report on candidates for safe transition. Additionally, we track transition candidates who choose to remain in the nursing facility. As applicable, the CM also administers Humana's Caregiver Support Survey (as discussed in more detail below) to assess caregiver willingness and availability to support the transition. If the enrollee has the desire to transition and meets the criteria, the CM refers the enrollee to the TC and informs the enrollee of what to expect.

PROCESSES FOR IMPLEMENTING THE TRANSITION

Upon receipt of a referral, the TC completes the full Repatriation Survey within seven (7) days, to determine whether enrollees can safely transition into the community. We use:

- An evaluation of whether the enrollee will have sufficient support systems in their new service setting

- A thorough safety check at the enrollee's new home, with authorizations for necessary modifications prior to the transition

- A projection of necessary services needed to accomplish the transition

- A financial screening to ensure the enrollee is capable of accessing all necessary services in their new service setting

- A risk assessment to identify potential health risks during the transition, and a determination of steps to mitigate each risk

After the TC collaborates with the CM to determine that the enrollee can safely transition, they meet face-to-face with the enrollee and authorized representative, their family, nursing facility staff, and social services staff to coordinate the transition. The TC completes the following:

- Risk Agreement – Instructs the enrollee on the risks involved in transitioning. The TC obtains the enrollee's signature on the Risk Agreement.

- Home Monitoring Assessment – If the enrollee is transitioning to a private home, then the TC assesses the physical environment and completes the checklist.

- Home-like Environment Assessment – If the enrollee is transitioning to an ALF or Adult Family Care Home (AFCH), the TC assesses the setting for home-like environment and completes the checklist.

The TC coordinates with the PCP, nursing facility staff, community resources, and providers throughout the transition process, which takes an average of four (4) weeks. During this time, the TC develops a draft plan of care to identify services, supports, and other needs of the enrollee. This plan of care helps the TC:

- Ensure that all required durable medical equipment (DME) and any home modifications needed are complete prior to the transition

- Arrange physician appointments in the home if needed

- Conduct medication review and education to ensure compliance with the medication regimen

- Update the enrollee's new address

- Refer the enrollee to Disease Management (DM) as appropriate to decrease readmission risk

- Terminate nursing facility authorizations that are in place

- Arrange for any needed service authorizations to avoid a delay in care

- Upon transition, the TC finalizes the plan of care in collaboration with the CM and the MDT

To further support a move into the community, Humana offers an enhanced benefit to offset the costs associated with transitions. Humana's Nursing Facility Transition enhanced benefit helps pay for things like security and utility deposits, household supplies, and moving costs. As applicable, the TC arranges for the family to visit ALFs, senior apartments, or an independent home to choose which they prefer.

PROVISION OF OTHER CLINICAL RESOURCES TO SUPPORT TRANSITION

Humana is committed to doing what is necessary to help our enrollees live in the least-restrictive, while still fully supportive environment possible. For example, some enrollees may be considered “borderline” candidates for transition. This means they have a desire to move to a community setting, but are not yet medically prepared to do so. In this instance, we will support our enrollees to transition through the provision of tailored therapy (such as physical and occupational therapy) to prepare them to successfully reside in a community setting.

ENROLEE EXAMPLE
Paolo is an insulin-dependent, diabetic LTC enrollee who had a recent below-the-knee amputation. Since November 2016 he resided in a Miami nursing facility. Paolo had a strong desire to transition back into the community. After careful assessment and collaboration with his TC and other stakeholders, Paolo determined transition to an ALF was his best option.

Finding an ALF to accept Paolo was not easy. He needed to manage his insulin and blood sugar regimens for ALFs to accept him. Paolo also required a wheelchair until a prosthetic leg could be ordered and fitted. Humana Medicare had agreed to cover the prosthetic leg as an outpatient. To make this transition work, the Humana LTC plan paid for Paolo’s skilled nursing where he learned insulin self-management skills and purchased a wheelchair. After Paolo transitioned to the community and received his prosthesis, the Humana LTC plan covered physical therapy (PT) services so he could learn to walk with his new prosthesis.

MAINTAINING ENROLLEES IN THE COMMUNITY

TCs remain actively involved during the first ninety (90) days post-transition. The first ninety (90) days following transition is a crucial time, as enrollees are at the highest risk of re-institutionalization. During this period, CMs and TCs frequently monitor enrollees' statuses. Based on needs identified through enrollee assessment and using a risk ranking tool we developed specifically for nursing facility transitions, TCs and CMs determine the contact schedule with the enrollee for the first ninety (90) days:

- All enrollees receive a change in condition visit within five (5) days following their transition. For those transitioning to a home setting, we aim to conduct this visit within twenty-four (24) to forty-eight (48) hours following the transition. During this joint visit by a TC and CM, we complete all post-transition assessments and use them to update the plan of care, including a new 701B, fall risk screening, risk ranking, signed new Freedom of Choice certification, caregiver assessment tool, and medication review and reconciliation. The TC and CM complete a new care plan, obtain signatures from the enrollee or their representative, and provide copies of this plan to the enrollee, their providers, and the facility (if the enrollee has moved to an ALF). We also prepare an emergency preparation plan.

- Enrollees at Low Risk (generally ALF placements with no skilled care): We contact monthly at a minimum, with a face-to-face visit by day thirty (30) as needed.

- Enrollees at Moderate Risk (generally discharges to home with family or natural supports): Receive, at minimum, weekly calls with a face-to-face visit by day thirty (30).

- Enrollees at High Risk (generally discharges to home, with minimal natural supports): Receive, at a minimum, weekly calls, with face-to-face visits by day fourteen (14) and day thirty (30).

- If there is a safety concern regarding an enrollee transitioning from a nursing facility to home, we hold an MDT meeting to work through safety issues. We may also visit these enrollees weekly to ensure a safe transition.

CUSTODIAL PREVENTION PROGRAM

For all enrollees living in the community, Humana's Custodial Prevention Program helps prevent or delay custodial placement. When an enrollee's CM is concerned with the potential for institutionalization, they engage the TC. The TC visits the enrollee and caregivers in their community residence to review the enrollee's current needs and always addresses the enrollee's choice. The TC may recommend an increase in services to provide additional support to the member and discusses alternative placement such as an ALF, if appropriate. The CM also notifies the TC of any hospital or rehabilitation facility admissions. The CM and TC monitor the enrollee's stay in the acute care setting to ensure that the enrollee is able to return to his or her preferred place of residence. The TC may visit the enrollee in the facility, coordinate with facility discharge planners, and recommend increases in HCBS services to address the enrollee and caregiver's additional needs. Our Custodial Prevention Program has been successful. For enrollees identified as being at risk for placement in an institutional setting and referred to a TC, the program has resulted in the prevention or delay of up to fifteen (15) custodial placements per month.

COLLABORATING WITH COMMUNITY-BASED ORGANIZATIONS

A key aspect of ensuring a safe transition and maintaining enrollees in the community setting is identifying and connecting the enrollees with community organizations and resources that provide the support they need and help them connect to their community. Community supports are wide-ranging and include organizations and programs such as food banks, adult day health, caregiver respite, faith-based organizations, and community centers. Community supports are crucial, especially for enrollees who have resided in a custodial setting for a long period of time and no longer have natural supports in place in the community.

Our TCs and CMs focus on collaboration with community-based organizations as a primary aspect of the transition process. We hire our HCBS CMs from within the communities they serve so they are familiar with the organizations and services available to our enrollees. Our CMs also have multiple tools available to them to identify community supports, including the online United Way 211 Community Resource Directory and auntbertha.com (a comprehensive database of community programs covering every ZIP code in the United States). In addition to these national social service search and referral software platforms, Humana also has a home-grown and easily searchable Community Resource Directory that our CMs can directly edit and update based on their most up-to-date knowledge of local community resources and the services they provide. These resource guides provide information on the community-based organizations and state and local agencies and their services. These include food, clothing, furniture, medical equipment, housing/shelter, home repairs, cell phones, counseling services, social contact and

adult day care. Our CMs do more than refer our enrollees to these organizations they connect them to these services and coordinate with the organizations on an ongoing basis.

"I've used the United Way 211 Directory for additional resources for enrollees. There's a live chat option that I've utilized during a visit and was able to get a few contacts for assistance with utilities before I left the enrollee's home that day. It was a quick process. Enrollees can also dial 2-1-1 to receive the same assistance." - Humana Case Manager

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2. The extent to which the respondent assesses potential caregiver willingness and availability in supporting the transition.

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Humana recognizes that families and caregivers play a critical role in supporting enrollees in the community. In addition to administering the enrollee assessment for potential transitions, the CM also administers a caregiver support tool completed for all natural supports involved in the enrollee's care. The tool collects information on each enrollee's caregiver, including their health, work schedule, emotional support system, available assistance hours, and the functions the caregiver needs help with such as bathing, dressing, and grooming. Attachment LTC 5-3 is a copy of Humana's Caregiver Support Tool.

In addition to assessing the caregiver's potential and willingness to support the transition, we offer extensive education and support for caregivers. An often-overlooked aspect of LTC is the caregiver's well-being, as enrollees and caregivers are often part of the same family unit with shared needs and concerns. Thus, we engage in caregiver support interventions, including the following:

- Caregiver education to ensure caregiver is knowledgeable about the enrollee's needs and risk factors.

- Referral to Humana's Caregiver Support Portal (Attachment LTC 5-4 includes screenshots of the Portal).

- Information on enrollees' Consent for Release of Protected Health Information form. Once Humana files the form, designated caregivers will receive:

-- Permission to view the enrollee's plan information
-- Information on free support services
-- A free subscription to Humana's quarterly caregiver newsletter

- Assistance and intervention if enrollee is at risk for placement because of caregiver burnout. In this event, the CM requests an MDT conference to discuss the current plan of care, review gaps, and discuss interventions. If the enrollee is at risk for placement, the CM may escalate to the TC to review the enrollee's current plan of care, address need for additional support, arrange respite care, or assist with alternate placement as needed.

- Using the online resource directories described above to assist caregivers in accessing free or reduced cost community services, and educating and empowering caregivers to use the online resources available.

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3. The extent to which the respondent's description addresses transitioning enrollees with special circumstances or medical conditions (e.g., complex needs); enrollees with ongoing needs; and enrollees who at the time of their transition have existing prior authorization or approval for ancillary services.

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Transitioning enrollees with special circumstances or medical conditions requires unique considerations. For instance, for enrollees with the following issues, ALFs are typically not an appropriate setting:

- Diagnosed with communicable disease (excluding HIV)

- Unable to perform Activities of Daily Living (ADLs) with assistance or supervision

- Bedridden

- Unable to transfer with assistance

- Have Stage three (3) or four (4) pressure ulcers, including surgical incisions or wounds that have not been stabilized

- Danger to themselves or others (real or potential)

- Feeding tubes

- Tracheotomy, oral, nasopharyngeal suctioning

- Flight risk (real or potential) – a lockdown-type ALF may be a consideration

- Impaired cognitive ability that limits understanding or communication

- More than minimal staff assistance required to take medications

If such enrollees want to go home with a caregiver who is willing and able to learn how to provide care safely, they may be able to transition home after discussions with the Plan Medical Director and an MDT discussion. We provide more frequent monitoring for enrollees with co-morbidities and complex medical conditions, high-utilizing enrollees, enrollees with special health care needs, and enrollees with hospitalizations to maintain the enrollee's health during the transition period. We will assess enrollees with emergency department visits to determine contributing reasons for these visits, and take actions to prevent avoidable emergency department visits and inpatient admissions post-transition.

Humana is aware that the Agency for Health Care Administration (AHCA) will consolidate individuals in three (3) HCBS waivers into the LTC program by January 1, 2018: The Project AIDS Care (PAC) waiver, Adult Cystic Fibrosis (ACF) waiver, and Traumatic Brain Injury and Spinal Cord Injury waiver. In preparation for managing the care for such enrollees, we have staffed our Utilization Management (UM) team with nurses who have experience with these

waiver programs and will do a review of all high-end DME. We will also hire nurse-trained CMs with experience with these waiver populations. We will place each specially-trained CM in the region with the highest volume of the applicable special needs enrollees. These specialized CMs will provide their expertise and support to CMs in all regions.

As detailed above, the TC's role ensures effective transitions for enrollees with ongoing needs and for enrollees who, at the time of their transition, have existing prior authorization or approval for ancillary services. TCs review existing authorizations and services the enrollee receives and discusses them with the enrollee's PCP. TCs' responsibilities include ensuring that all required DME is ordered prior to the transition, scheduling and confirming physician appointments, arranging transportation services, terminating nursing facility authorizations in place, conducting medication review and education to ensure a pharmacy is secured, prescriptions are obtained and enrollee is compliant with the medication regimen, and referring the enrollee to DM as appropriate to decrease readmission risk. The CM who works with the enrollee post-transition continues to ensure we meet the enrollee's ongoing needs, and consults with the TC to support the enrollee in their new home and prevent readmission to a nursing facility.

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4. The extent to which the respondent demonstrates through data its success rate at transitioning individuals from institutional to community settings.

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Since 2014 we have helped more than one thousand seven hundred (1,700) Florida Medicaid enrollees successfully transition from institutions to community settings. Humana collects, tracks, and reports on relevant data throughout all our operational areas to evaluate the effectiveness of our programs and interventions. To improve transition data, we now use the Transition Screening Tool for one hundred percent (100%) of our enrollees residing in nursing facilities. This allows us to track and report the number who are candidates for safe transition.

Attachment LTC 5-5 displays total transitions from institutional to community settings per year from 2014 through 2016. As these data points demonstrate, we have continually increased the number of enrollees who have transitioned via the various strategies for improvement we have employed. Our success rate is continuing in 2017, with three hundred seventy-five (375) transitions as of August 31, 2017.

Number of transitions, 2014:	204
Number of transitions, 2015:	486
Number of transitions, 2016:	665

Over the past two (2) rate years, we have achieved an average annual transition rate (reflecting the percentage of enrollees residing in a nursing facility who have transitioned to a community setting) of eight percent (8%). Additionally, we have decreased the percentage of our enrollees residing in a nursing home by four percent (4%) over the past year and a half, from forty-one percent (41%) in January 2016 to thirty-seven percent (37%) in July 2017. We are on track to achieve AHCA's goal of maintaining sixty-five percent (65%) of our enrollees in a community setting and thirty-five percent (35%) of our enrollees in a nursing facility.

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5. The extent to which the respondent demonstrates through data its success rate at maintaining individuals who have transitioned from an institutional placement to community placements.

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For measurement year 2016, the rate of maintaining enrollees in the community after transitioning from a short-term placement, one hundred (100) days or less, in an institutional setting was sixty-two percent (62%). For the same year, the rate of maintaining enrollees in the community after transitioning from a long-term institutional placement, more than one hundred (100) days, was thirty-eight percent (38%).

We continually enhance data capabilities to capture a full picture of our enrollees' experience. Using the data captured in CGX, we can identify the reasons why some enrollees have been re-admitted to an institution, and can develop targeted population- and individual-level strategies to better support their transitions. Additionally, we will institute post-transition reviews of individual enrollees who have reverted to the institutional setting, enabling TCs and CMs to identify necessary actions to prevent future institutional placements.

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b. Experience and strategies pertaining to individuals who reside in an institutional setting for rehabilitation, or have otherwise resided in a facility for less than one year.

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Enrollees who have resided in an institutional setting for rehabilitation or have otherwise resided in a facility for less than one (1) year are more likely to have active social supports in the community and have maintained a residence outside of the community. We have developed strategies for these enrollees to overcome barriers to bring the enrollee back to their prior environment in the community, whether that is an independent home, an apartment in a senior living facility, an adult family care home, or an ALF.

Humana's experience transitioning so many enrollees to community settings has shown us that a safe living environment is essential for a successful transition back into the community. Prior to transitions, we arrange for a home environment assessment by an occupational therapist. Additionally, we assess if the enrollee may be more successful in a senior apartment, with fewer maintenance duties, than in an independent home. To ensure that our enrollees and their support system are ready for and comfortable with this transition, our CMs arrange for a day trip to the new environment. This helps enrollees test their new environment and gives their CM an opportunity to identify any modifications or supports necessary for a successful transition.

When available, natural support systems are also critical to transitioning back to the community after a short institutional stay. While enrollees who have resided in an institutional setting for less than one (1) year may have a tighter connection to their support system in the community than enrollees who have been in an institutional setting for a greater period, they may still re-enter the community with new needs. Therefore, our TCs take steps to prepare the support system for the transition, including the arrangement of services, such as adult day care, that serve the enrollee as well as the caregiver.

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c. Experience and strategies pertaining to individuals who have resided in an institutional setting for more than a year.
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Our TCs and CMs commit themselves to helping our enrollees transition to a community environment at an appropriate time, whether the enrollee has been in an institutional setting for months or years. Through regular assessments and facility visits by our TCs, we evaluate all enrollees residing in an institutional setting for their interest in and preparedness to transition.

We apply the same core strategies used to support enrollees who have been in an institutional setting for less than one (1) year to enrollees who have resided in that setting for more than one (1) year. However, we also recognize the unique circumstances of these enrollees and have implemented strategies that provide the additional support they may require post-transition. Enrollees who have resided in a facility for more than one (1) year may not have maintained as strong support system or a home outside of the institution.

Therefore, our TCs (working in collaboration with the CM and the MDT) are generally involved in these transitions for a longer period. The enrollee's risk score, adjustment to community living, and stability in their environment determine the frequency of touchpoints and monitoring by the TC, beyond the minimum contacts described above. This flexible model allows us to tailor our approach to suit each enrollee's unique needs after transitioning to a community setting.

SUMMARY

Helping enrollees who have the desire and ability to transition safely from an institutional setting to the community achieve their goals is rewarding and critically important. We are proud of our success helping enrollees transition out of institutions reside or age. Humana continually strives to improve our processes and help more enrollees make the transition.

Footnote:

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[1] See, for example, Exploring Transitional Care: Evidence-Based Strategies for Improving Provider Communication and Reducing Readmissions. Rupal Patel Mansukhani, Mary Barna Bridgeman, Danielle Candelario, Laurie J. Eckert. P T. 2015 Oct; 40(10): 690–694.

Evaluation Criteria:

1. The extent to which the respondent identifies how it will coordinate care with all individuals and/or entities necessary.

2. The extent to which the respondent assesses potential caregiver willingness and availability in supporting the transition.

3. The extent to which the respondent's description addresses transitioning enrollees with special circumstances or medical conditions (e.g., complex needs); enrollees with ongoing needs; and enrollees who at the time of their transition have existing prior authorization or approval for ancillary services.

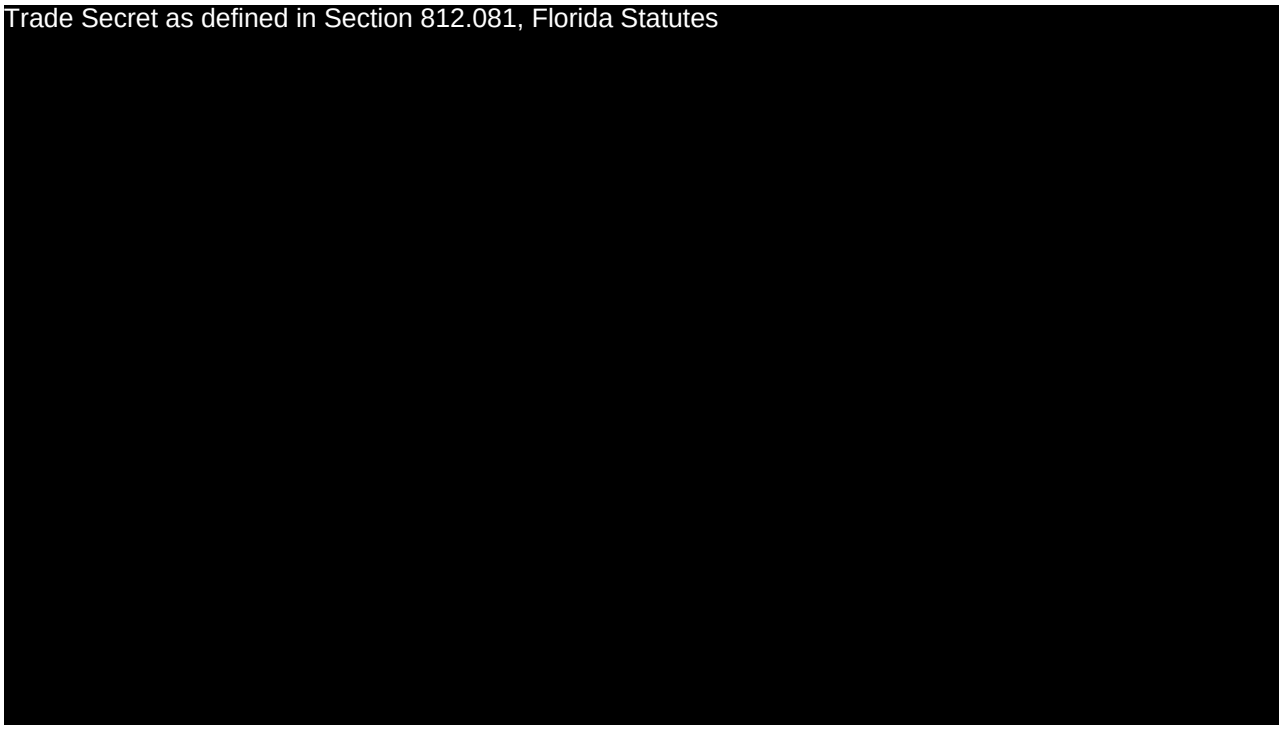
4. The extent to which the respondent demonstrates through data its success rate at transitioning individuals from institutional to community settings.

5. The extent to which the respondent demonstrates through data its success rate at maintaining individuals who have transitioned from an institutional placement to community placements.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

Attachment LTC 5-1: Transition Screening Tool

Trade Secret as defined in Section 812.081, Florida Statutes



Definitions of transition risk rankings:

Low: Enrollee transitioning to an ALF without services

Moderate: Enrollee transitioning to home setting with a low risk ranking

High: Enrollee transitioning to a home setting with a moderate or high risk ranking

Attachment LTC 5-2: LTSS Risk Ranking Tool

Enrollee Name:

Trade Secret as defined in Section 812.081, Florida Statutes

[redacted]

Total A:

Trade Secret as defined in Section 812.081, Florida Statutes
[redacted]

Total B:

Trade Secret as defined in Section [redacted]	

Score	Risk Ranking
Trade Secret as defined in Section 812.081, Florida Statutes [redacted]	

Risk Ranking:	(High/Medium/Low)
Case Manager Name	
Date Completed	

Humana

LTC Supplemental Assessment

Care Manager Name: _____

Member's Name: _____	Natural Support's Name: _____
Medicaid ID Number: _____	Relationship to Member: _____
	Natural Support's Address: _____
	Address (cont.): _____
Today's Date: _____	Natural Support's Telephone Number: _____

Care Manager:

[redacted]

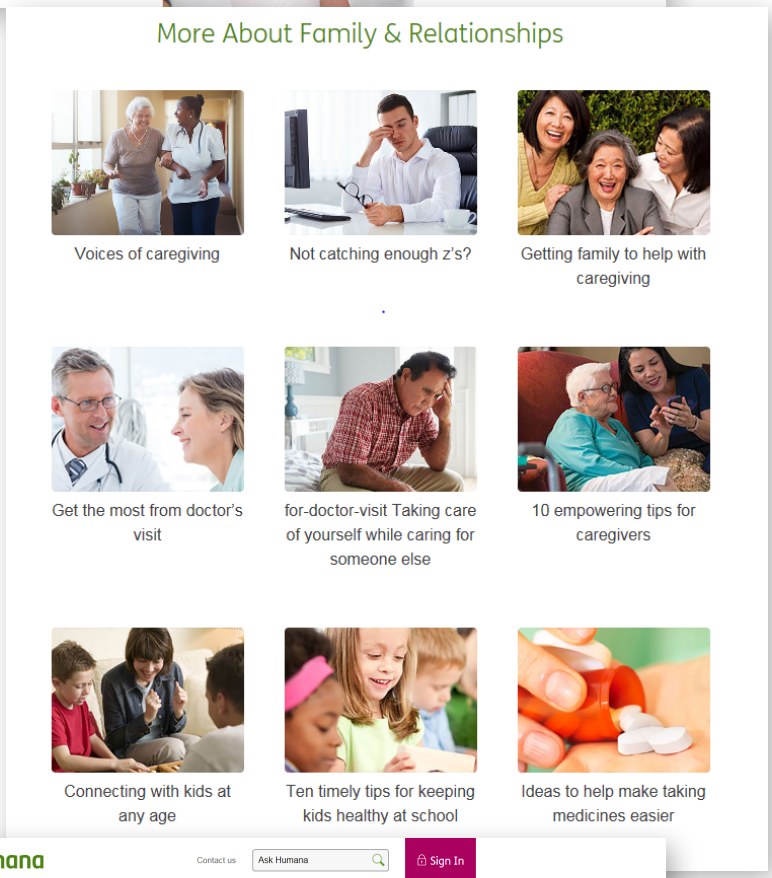
Care Manager to review with Member's Natural Support:

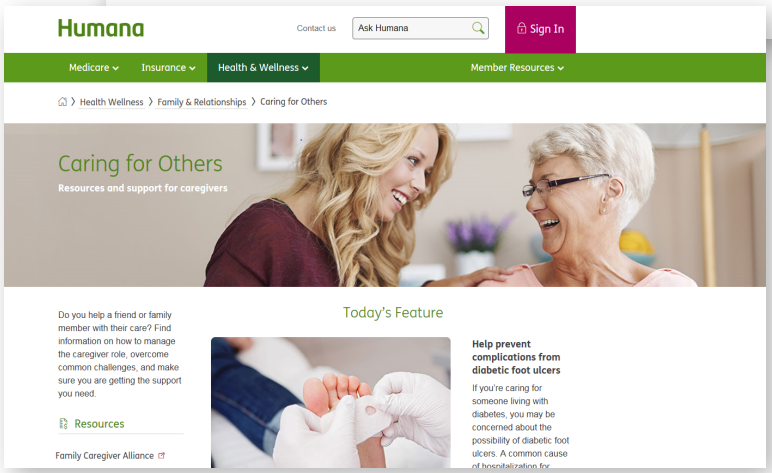
Trade Secret as defined in Section 812.081, Florida Statutes

[redacted]

Disclaimer: If in any event the natural support(s) are unable to continue to provide care for member, Care Manager provided resource and additional support in addition to our help line (1-888-998-7732). Natural supports were educated that the assessment is confidential and personal to the recipient and shall be protected in member's medical record.

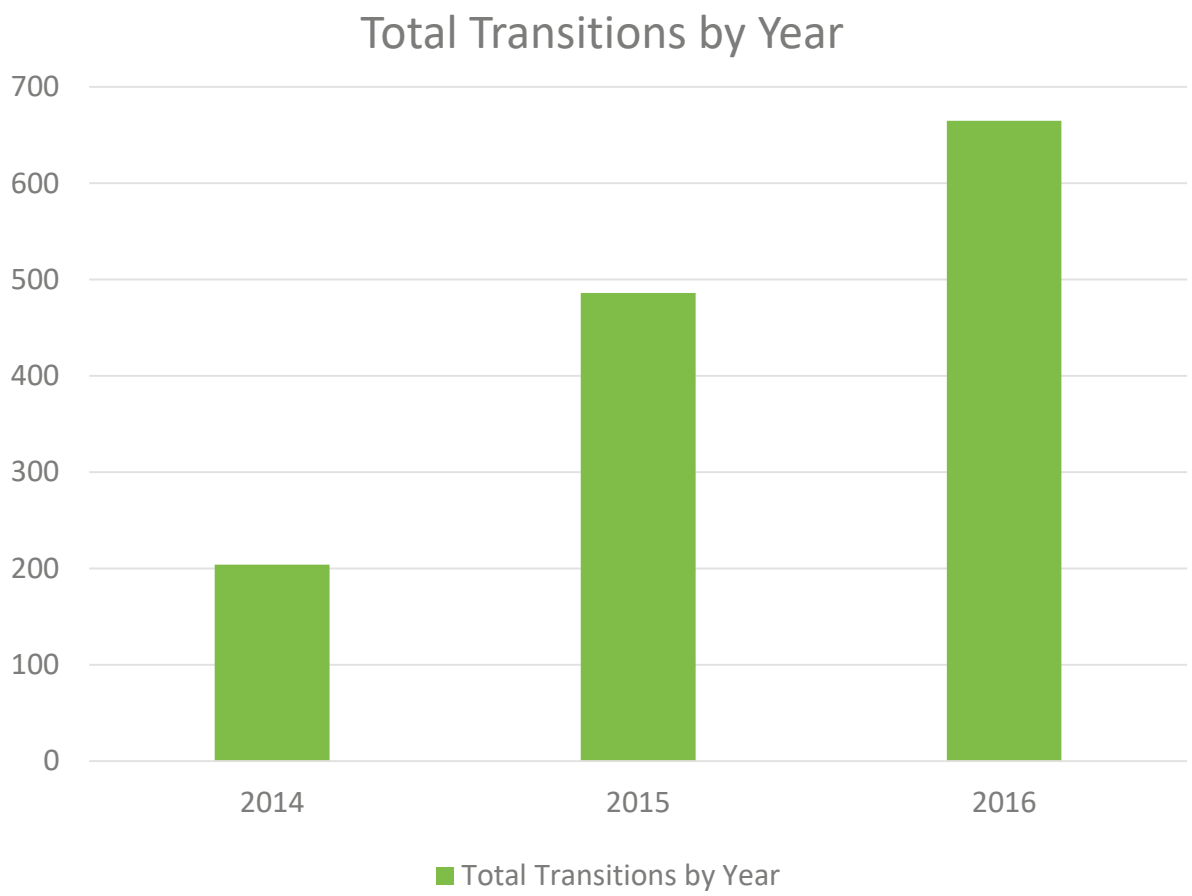
Attachment LTC 5-4: Caregiver Support Portal Screenshots





Attachment LTC 5-5: Annual Institutional to Community Setting Transitions from 2014-2016

Humana has continually increased the number of enrollees who have transitioned via the various strategies for improvement. Humana's success rate is continuing on pace in 2017.



Strategies for Improvement:

- Nursing home sweeps conducted monthly by regional TC (Transitional Coordinator)
- TC visit all newly enrolled NF enrollees to introduce self and explain Transition option
- Weekly TC attendance on regional CM meetings to engage staff in referral process
- TC builds relationship with NF providers
- Education of CM staff on importance of explaining Freedom of Choice to enrollee/ POA in NF
- Build relationship with ALFs in region for ease of transitioning enrollees

TC = Transition Coordinator
CM = Case Manager
ALF = Assisted Living Facility

Humana

LTC SRC# 6 – Care Planning (Statewide):

The respondent shall provide a flowchart depicting how it will use the information contained in the State of Florida approved assessment (Florida Department of Elder Affairs 701B Comprehensive Assessment), the respondent's supplemental assessment (if applicable), and any additional information collected in its utilization and case management processes for LTC services, in order to properly complete the initial care planning process for a recipient in a facility-based setting and in a community-based setting.

Response:

Understanding each enrollee's unique needs, personal goals, care goals, and resources when developing the plan of care (POC) is critical to addressing the enrollee's health and well-being. In addition to using the State of Florida's approved assessment, 701B or 701T, Humana also includes our supplemental assessments, when applicable, and information collected in the case management processes to assess the enrollee's risk level, preferences, and cultural needs. We use these sources of information in order to develop a POC tailored to each individual living in both community and facility-based settings.

Humana's Case Manager (CM) determines the appropriate assessment to conduct based on the enrollee's location, whether that be community (701B) or facility (701T). The assessment helps the CM understand an enrollee's individual demographics, living situation, and supports as well as the enrollee's care needs in areas such as memory, general health, activities of daily living/instrumental activities of daily living (ADL/IADLs), health conditions, mental health, nutrition, and medications.

Additional mini-assessments appropriate to the enrollee's situation are used to uncover additional personal and health-related information. Data components captured in supplemental assessments such as the Falls, Domestic Violence, Readmission Risk, Homelike Environment, Disaster, and Participant Directed Option (PDO) assessment are crucial for creating a full picture of an enrollee's needs and preferences.

One of the most critical components of the POC is the enrollee's personal health and well-being goals. This element of the POC becomes the roadmap to improve enrollees' clinical outcomes and quality of life. Humana understands that enrollee-centered, tailored care is not only desirable, but critical to driving positive health and well-being outcomes. Humana CMs leads this process and encourage enrollees' participation from start to finish.

Appropriately incorporating natural supports can also make a significant difference in an enrollee's health and overall well-being. We use the Caregiver Support Tool to understand the caregiver's schedule, type of assistance provided, health status, and other relevant information. This enrollee-centered process of gathering information from the assessments, building a thorough POC, and including natural supports in an informed way contributes to a holistic approach to the enrollee's care and, ultimately, drives positive outcomes.

Please see Attachment LTC 6-1 for a flowchart that illustrates the data components collected using the 701B and 701T in addition to supplemental assessments, participants, and specific actions resulting from the process.

Evaluation Criteria:

1. The extent to which the flowchart outlines specific data components it will use from the State of Florida approved assessment in the development of the plan of care for enrollees.

2. The extent to which the flowchart outlines specific data components it will use from the respondent's supplemental assessment, and/or any additional informational sources, in the development of the plan of care for enrollees.

3. The extent to which the flowchart incorporates specific data components it will use to ensure a person-centered approach is achieved in the care planning process, including documenting personal goals.

4. The extent to which the respondent uses the caregiver assessment to determine the availability of family/informal support systems, and the amount of assistance the existing support systems are able to provide the enrollee, in making authorization decisions.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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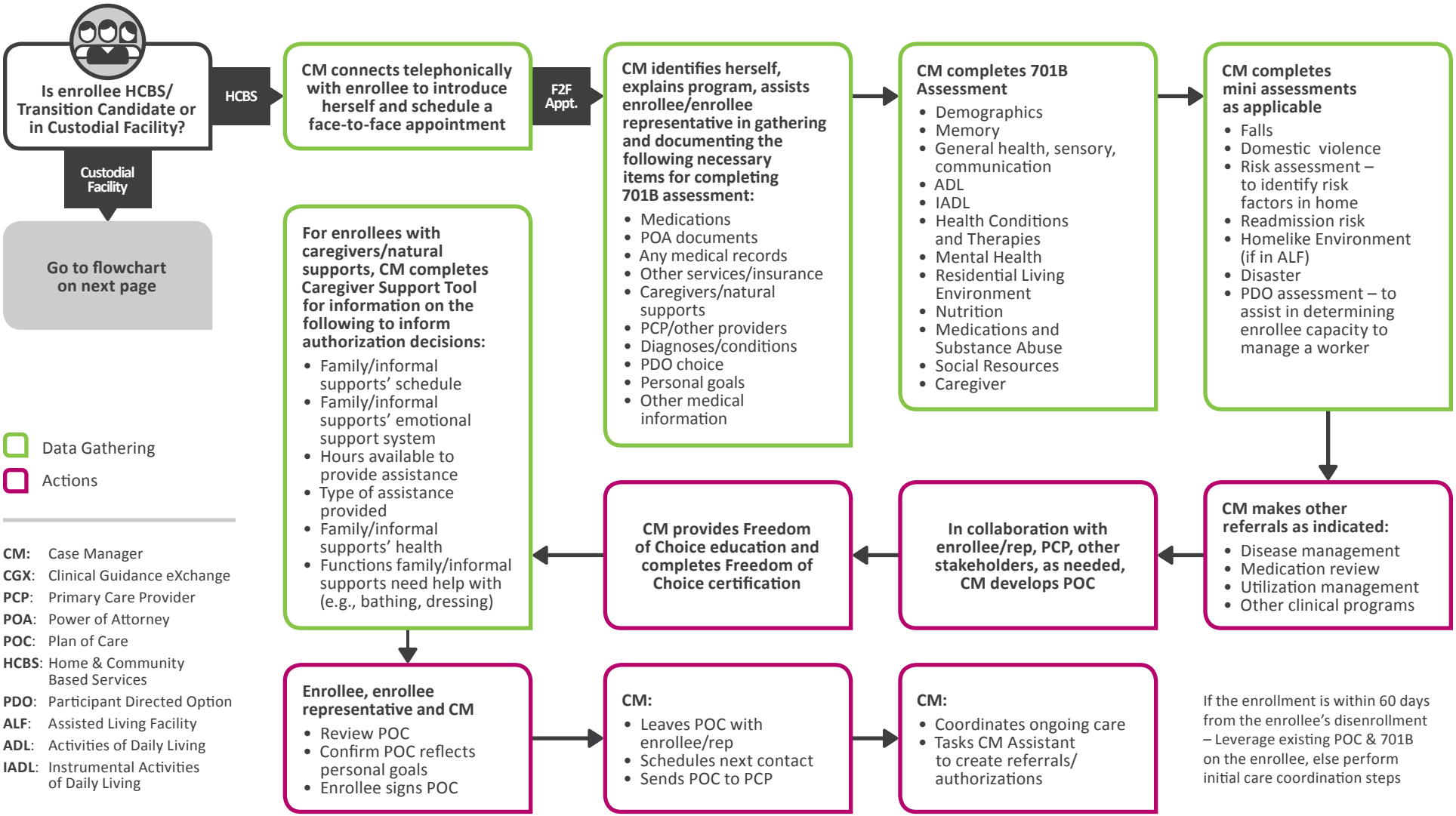
Attachment LTC-6-1: Initial Care Planning Process – HCBS or Custodial Facility Setting

To identify enrollees' care needs and available family and informal support systems, Humana uses the State of Florida approved assessments (701B and 701T), as well as our internal supplemental assessment tools and information sources. These assessment tools and other information sources are depicted in the flowchart below.



Data Gathering

Actions

CM: Case Manager
CGX: Clinical Guidance eXchange
PCP: Primary Care Provider
POA: Power of Attorney
POC: Plan of Care
HCBS: Home & Community Based Services
PDO: Participant Directed Option
ALF: Assisted Living Facility
ADL: Activities of Daily Living
IADL: Instrumental Activities of Daily Living

Humana.

Attachment LTC-6-1: Initial Care Planning Process – HCBS or Custodial Facility Setting

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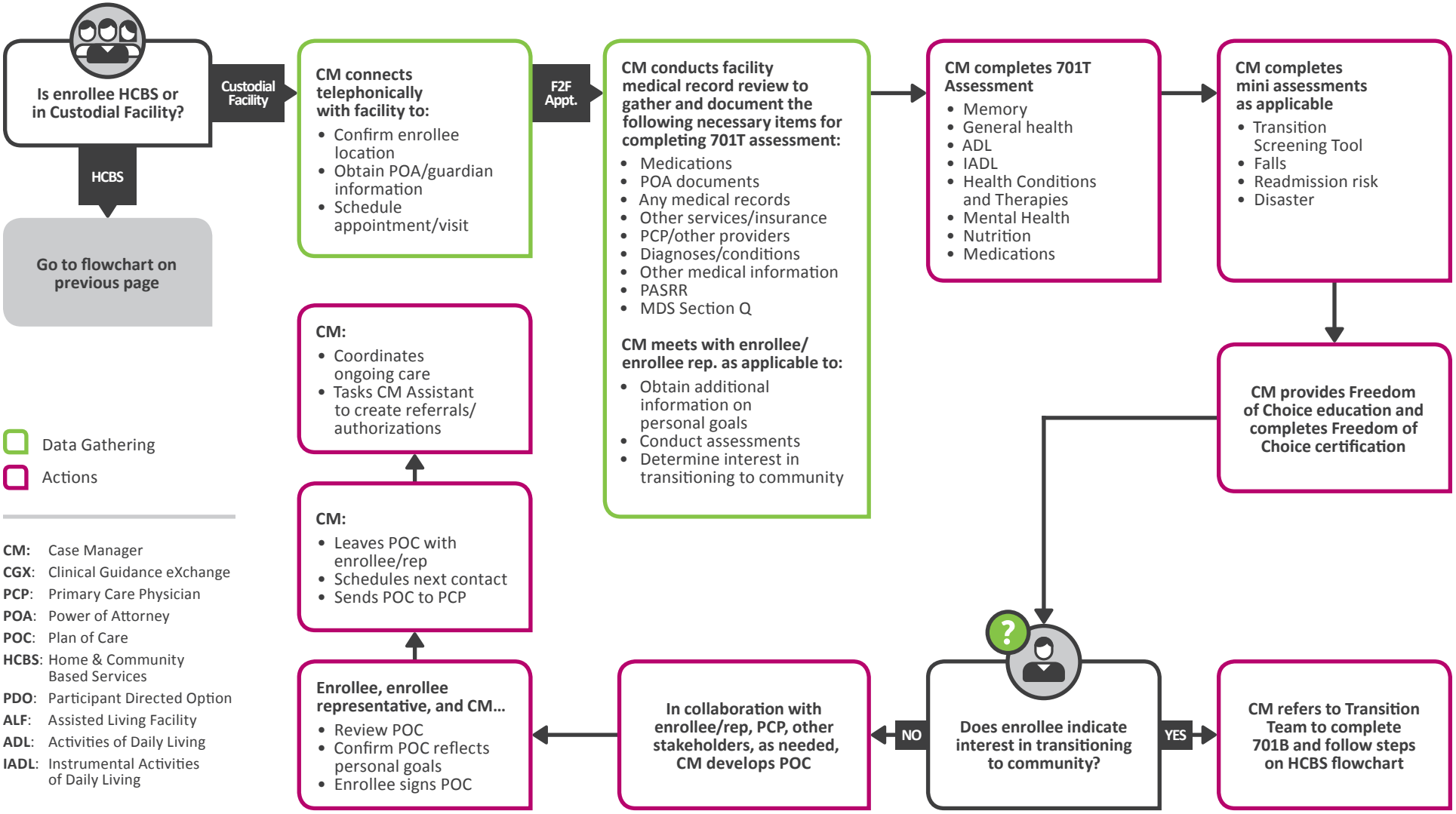

Data Gathering

Actions

CM: Case Manager
CGX: Clinical Guidance eXchange
PCP: Primary Care Physician
POA: Power of Attorney
POC: Plan of Care
HCBS: Home & Community Based Services
PDO: Participant Directed Option
ALF: Assisted Living Facility
ADL: Activities of Daily Living
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Humana.

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

LTC SRC# 7 – Freedom of Choice & Residential Settings (Statewide):

The respondent shall describe how it will address the enrollee's preference in residential settings (i.e., home, adult family care home, assisted living, or nursing facility). The respondent shall describe the safeguards it will have in place during the implementation of the re-procurement of the SMMC program to ensure enrollees do not have to move out of their current residence, by residential setting.

Response:

Individuals face a deeply personal choice when deciding where to live. An enrollee's freedom to choose is not just limited to residential setting. It also extends to the specific facility or provider that delivers the enrollee's Long-term Care (LTC) services, whether that provider is a specific nursing home, a specific assisted living facility (ALF), a community-based agency provider, or a provider under a participant directed option (PDO). Empowering enrollees with freedom of choice in residential and provider settings has a positive impact on their emotional state and perspective while supporting favorable outcomes. Humana's processes and system of care work to support enrollees in their chosen place to live.

Humana understands that during the implementation of the SMMC (Statewide Medicaid Managed Care) re-procurement, there may be switching among health plans by the State's eligible LTC recipients. By putting appropriate safeguards in place, it is our intent to honor the enrollee's preferred living arrangements and to ensure enrollees do not have to move out of their current residences.

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1. The extent to which the respondent's description addresses the process it will use to ensure enrollees are educated about their choice in residential setting, including freedom of choice.
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Humana understands that our enrollees have the right to choose where they live, and we ensure that enrollees understand that and other rights. We train all of our associates on that right and our new enrollee materials include information on enrollees' freedom of choice rights.

Our Florida Medicaid new enrollee materials include the following statement:

"Your Case Manager ensures that you or your caregiver are the only ones who can choose where you live. It is your choice to live in the community or a long-term care facility. The Case Manager can provide you with information on where to live. They can also provide you with Humana participating providers and/or cost compares of where to live."

Humana's Case Managers (CMs) identify and support each enrollee's individual goals by incorporating them throughout the care coordination process. CMs provide enrollees with assistance and guidance in selecting a living situation that best meets their goals, taking into consideration each enrollee's medical needs, desired location (e.g., near relatives or friends), and other preferences. Our goal is to support and educate enrollees to achieve self-advocacy wherever possible.

CMs review the Freedom of Choice certification with enrollees and their authorized representatives during initial enrollee orientation. This often occurs prior to enrollment start date but is always completed within five (5) business days of enrollment for enrollees in the community and within seven (7) business days of enrollment for those in a nursing facility. Thereafter, the CM reviews the Freedom of Choice certification annually and when there is a change in the enrollee's living arrangement. During the review, the CM determines whether enrollee and their authorized representatives have received information about Medicaid services available in the community. If an enrollee or authorized representative responds that they have not received information about Medicaid services available in the community, then the CM reviews home and community-based services (HCBS) and options for receiving Medicaid services in the community, as applicable, with the enrollee before completing the Freedom of Choice Certification. If the enrollee or authorized representative has received information, then the CM reviews and reinforces the information and answers any questions they have. Following this review, the CM requests that the enrollee or authorized representative read and review the Freedom of Choice Certification, indicate enrollee choice for receiving Medicaid services, and sign the form. We provide a copy of the completed and signed certification to the enrollee or authorized representative via hand delivery or mail within five (5) business days from the date of certification.

In our current Florida LTC program, Humana tracks the Required Record Documentation (RRD) measure for the Freedom of Choice form and compares our performance to national benchmarks. Our 2016 performance on this measure was ninety-point seven one percent (90.71%), above the ninety percent (90%) Agency for Health Care Administration (AHCA) benchmark.

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2. The extent to which the respondent describes initial or ongoing case manager training to confirm enrollee preference in residential setting.

==========

Freedom of Choice is a key topic in the new CM training curriculum. We require all CMs to complete this training, which educates them on the importance of residential choice for enrollees. During the training, we give CMs instructions on how to complete the Freedom of Choice form and how to educate enrollees about their choice in residential setting. Additionally, the resource tools we make available to all CMs in our integrated clinical platform, Clinical Guidance eXchange (CGX), contain mandatory fields with prompts to review and certify Freedom of Choice forms to ensure they do not miss this important review.

We reinforce this education on enrollee choice in residential settings during annual refresher trainings mandated for all Humana CMs. The following training sessions also reinforce various topics, including enrollee preference of residential setting and freedom of choice:

- Monthly clinical team meetings to discuss key LTC processes, during which every department presents

- Weekly Front Line Leader (FLL) training meetings for associates who supervise CMs

- Ongoing training from FLLs for CMs, including regular monthly meetings and weekly touch-base meetings

==========

3. The extent to which the respondent's description addresses how all residential settings are considered for enrollee placement.

==========

Humana is committed to ensuring that enrollees not only have the right to choose their care setting, but also the right to choose their specific residence. When CMs work with enrollees and their authorized representatives to develop a plan of care, they consider all options available. We assign CMs by region and they generally live in the regions they serve. This enables them to have intimate knowledge of what is available to each enrollee. CMs also understand the service options, interventions, and programs available that may help make it possible for each enrollee to succeed in a particular setting. For instance, our CMs are aware of adult day health services and of the enrollee's natural supports.

CMs also consult with our Transition Coordinators (TCs), who are also Humana's housing specialists, to find the best housing options for enrollees. CMs and TCs review all residential options with enrollees, calling attention to safety factors that may inform their decision. The team of CMs and TCs help enrollees understand the services and supports available at each residential setting, such as PDO for enrollees transitioning into the community. Through this collaboration, we help enrollees find the most appropriate option to meet their needs and goals.

Sometimes the expense of moving into a new community setting is the biggest barrier. Humana offers up to two thousand five hundred dollars ($2,500) to help an enrollee move out of a nursing facility and into their own home. This benefit helps pay for items like security and utility deposits, household furnishings and supplies, and moving expenses.

Humana currently serves LTC members through the SMMC program in all eleven (11) regions throughout the State. Through this experience, we have developed strong capabilities to accommodate each enrollee's choice, regardless of current location or preferences to relocate. The following examples demonstrate how Humana CMs consider all residential settings for enrollee placement:

- One of our enrollees shared a home with her husband for decades, but he recently passed away. Afterward, the enrollee wanted to consider finding a new home. Following several discussions with her CM, the enrollee decided an ALF would be her best option. Unfortunately, many ALFs do not allow pets and she did not want to give up her dog, who was her faithful companion and brought her much joy. Her CM found an ALF that accepted dogs and met the enrollee's other needs and preferences.

- Another enrollee had been doing well at home, but his mobility had recently declined and he was unable to get upstairs to his bedroom. Further, his friend who had been mowing his lawn had recently moved away, and the enrollee felt that lawn upkeep had become more of a problem than it was worth. He did not wish to move into an institutional setting or even an ALF, so his CM and TC transitioned this enrollee to a senior living apartment, where he is happy and doing well.

- An 83-year-old enrollee with an end-stage cancer diagnosis resided in a nursing facility (NF). Her only son lived in New York, and she had no other support system. While at the NF, the CM

worked with the enrollee to ensure access to clinical services and appointments for services outside of the NF. At one point, the enrollee expressed her desire to transfer to a facility she preferred over the one she currently lived in. Although she had no complaints about the current facility, she preferred to spend her last weeks in a different one. The CM maintained regular communication with the son, who agreed with the transfer. The CM facilitated the transfer for the enrollee to get her into the location of her choice. The enrollee passed away several weeks afterwards at her facility of preference.

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4. The extent to which the respondent's description includes safeguards the respondent has in place to ensure enrollees will not have to move out of their current residence, by residential setting.

==========

Humana has a number of safeguards in place to ensure our enrollees will not have to move out of their current residence. We categorize the safeguards we implement into two groups: those for enrollees residing at their own home or an adult family care home and those for enrollees residing at ALFs or NFs. For enrollees in both groups, we conduct an initial assessment, during which we discuss the enrollee's personal goals, where the enrollee would like to live, and the enrollee's freedom of choice to remain in their current residence. We confirm the enrollee's preference and obtain a signed Freedom of Choice certification from the enrollee.

HOME AND ADULT FAMILY CARE HOME

For our enrollees who reside in their own home or an adult family care home, we have designed safeguards that address the financial, safety, and support issues that may otherwise result in relocation to an ALF or a nursing home. These safeguards include the following:

- We engage natural supports in the enrollee's care, including family members and friends. We maintain the HCBS services the enrollee is currently receiving, and add services that may be necessary to maintain the enrollee safely in their home, apartment, or adult family care home. As needed, we arrange for home modifications, such as ramps, that reduce falls and increase enrollee mobility.

- As needed, we arrange for the provision of a companion care benefit. To reduce strain on any home-based caregivers and provide a social outlet for our enrollees, we also arrange for respite care and contract with adult day care centers throughout the State.

- We offer expanded benefits to assist the enrollee in staying healthy and safe. Some examples include:

-- Non-medical transportation to provide enrollees with access to community events or other social and emotional supports to avoid social isolation

-- Pill organizer to assist enrollees in administering and maintaining their medication regimens.

ASSISTED LIVING FACILITIES AND NURSING FACILITIES

If an enrollee is residing in an out-of-network facility when they enroll in our plan, or if an existing enrollee requests a specific provider not in our network, we engage our provider contracting team and make every effort to contract with that facility unless there are quality of care concerns (e.g., facility is unlicensed or we have previously terminated the facility due to quality issues). If this is the case, we educate the enrollee or their representative, but understand that it is ultimately the enrollee's decision whether to remain in the facility. We strive to guarantee transparency in all our contracting processes, and will update the enrollee on progress in contracting with the facility.

Evaluation Criteria:

1. The extent to which the respondent's description addresses the process it will use to ensure enrollees are educated about their choice in residential setting, including freedom of choice.

2. The extent to which the respondent describes initial or ongoing case manager training to confirm enrollee preference in residential setting.

3. The extent to which the respondent's description addresses how all residential settings are considered for enrollee placement.

4. The extent to which the respondent's description includes safeguards the respondent has in place to ensure enrollees will not have to move out of their current residence, by residential setting.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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D. PROVIDER EXPERIENCE

LTC SRC# 8 Home and Community-Based Services (HCBS) Performance and Credentialing (Statewide):

The respondent shall describe how its staff will create, collect, report and use internal provider performance measures and/or criteria for home and community-based, residential, and participant direction provider types. The respondent shall include how the performance measures will improve network quality and be utilized in recredentialing activities, and if/how the respondent will use the internally-developed performance measures to limit its provider networks pursuant to Section 409.982(1)(c), Florida Statutes.

Response:

To achieve our goal of providing quality care that meets the needs of our enrollees, Humana has invested in systems and processes to ensure a high-performing network of providers. We apply a continous approach to monitoring the quality of services delivered by Long-Term Care (LTC) providers, using tools that draw data from a number of sources to provide a comprehensive picture of our providers' performance. This data is captured in actionable tools, that enable our associates to identify high-performing providers, support low-performing providers to improve their performance, and ultimately create a network comprised of quality, experienced providers to meet our enrollees' needs.

In 2015, after one year of SMMC LTC operations, Humana conducted an extensive analysis of our LTC network's performance. As a result of this analysis, we developed a plan that identified performance indicators and providers in need of intervention, with the goal of increasing our enrollees' quality of care. These interventions led to a marked reduction in quality of care incidents reported to our Quality Operations department each quarter, from two hundred fourteen (214) in fourth quarter of 2015 to forty-six (46) in fourth quarter of 2016. During 2016, we issued three Corrective Action Plans (CAP); as of October first, 2017, we have not issued any CAPs.

==========
1. The extent to which the respondent's description includes a plan to create, collect, report and use provider performance measures.
==========

Data on provider performance is captured through our Provider Performance Engagement (PPE) tool. Our PPE tool collects provider performance data from several sources and generates a score between zero (0) and one hundred (100). This data gives our Provider Relations department a complete view of our LTC providers' performance, enabling the continuous monitoring of provider performance and identification of areas for improvement.

The PPE tool is designed to capture a range of metrics to evaluate all aspects of our providers' performance. These metrics have been developed through years of experience serving Florida's elderly and LTC populations who receive care from home health providers, assisted living facilities (ALFs), nursing facilities (NFs), and adult day care providers. Recognizing the unique role of each of these provider types, we include specific metrics for each. These metrics, broken

down by provider type, are described further below. Attachment LTC 08-1 provides a description of the scoring methodology and indicates where the data is stored.

HOME HEALTH PROVIDERS, ASSISTED LIVING FACILITIES, NURSING FACILITIES, AND ADULT DAY CARE PROVIDERS:

Trade Secret as defined in Section 812.081, Florida Statutes

HOME HEALTH PROVIDERS AND NURSING FACILITIES ONLY:

Trade Secret as defined in Section 812.081, Florida Statutes

HOME HEALTH PROVIDERS ONLY:

Trade Secret as defined in Section 812.081, Florida Statutes

ASSISTED LIVING FACILITIES ONLY:

Trade Secret as defined in Section 812.081, Florida Statutes

NURSING FACILITIES ONLY:

Trade Secret as defined in Section 812.081, Florida Statutes

ADULT DAY CARE ONLY:

Trade Secret as defined in Section 812.081, Florida Statutes

USING PPE DATA

Our Provider Relations department meets quarterly to review individual and global provider results and provide a quarterly reporting summarizing PPE results for discussion with the Quality Improvement Committee (QIC). The QIC can recommend actions for poor performing providers, and can assess systemic issues for further action by our Provider Relations department, such as revisions to our provider education tools. Individual provider PPE scores will also be made available to our Credentialing department to be used in the LTC provider recredentialing process.

Additionally, the Provider Relations leader will report findings related to the PPE tool to the Provider 360 Committee. Our Provider 360 Committee is a cross-functional team that meets monthly and includes representation from executive leadership and our Quality, Provider Relations, and Claims departments. This Committee uses data and results from the PPE to gauge provider performance and collaborate with our Provider Relations department to develop performance improvement interventions.

Humana takes quality of care and provider performance seriously. Therefore, any provider who has achieved a PPE score of seventy (70) or below or who has an identified quality of care issue (which results in an automatic PPE failure) will automatically be placed on a Corrective Action Plan (CAP) to ensure improvement on the measured metrics. Case Managers receive a list of PPE scores to share with enrollees to assist with choosing quality providers.

FUTURE PPE ENHANCEMENTS

USING ELECTRONIC VISIT VERIFICATION TO COLLECT DATA
Electronic Visit Verification (EVV), used by our home health and participant-directed providers, will be integrated into our PPE tool as a source of missed visit data. With EVV, our providers use a mobile application to check in and check out when delivering services to an enrollee. This provides an extra level of accountability for our providers delivering home-based services, and will enable us to easily verify that the authorized services have been provided to enrollees.

ADDITION OF SPECIFIC METRICS FOR PARTICIPANT-DIRECTED PROVIDERS
Humana is examining innovative financing mechanisms for participant-directed providers. As we explore implementing these programs, we will update the PPE tool to add data points that will

support the calculation of incentive payments for participant-directed providers. These data points may include:

Trade Secret as defined in Section 812.081, Florida Statutes

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2. The extent to which the respondent describes how performance measures are reported and trended for each participating provider type and incorporates utilization data, quality of care concerns, performance measure scoring, and provider and enrollee satisfaction in recredentialing activities.

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QUALITY MEASURES IN RECREDENTIALING ACTIVITIES

While maintenance of required certifications forms the core of Humana's recredentialing criteria, we also incorporate quality-related information for each specific provider into recredentialing decisions. Our PPE tool, which covers the HCBS and institutional provider types listed above, will be used to measure each provider's performance in conjunction with other quality-related information (i.e., grievances and complaints, medical record audits, historical CAPs, enrollee satisfaction measures) to offer provider-specific information for recredentialing functions. At the time of recredentialing, the Provider Relations department and Quality Managament Committee meet to review trend reports on individual provider performance and quality-related information. Jointly, this team uses the PPE score to provide a recommendation to the Credentialing Committee for approval or denial of recredentialing status.

RECREDENTIALING METRICS SPECIFIC TO NURSING FACILITIES

In accordance with AHCA guidelines, we incorporate additional metrics into the recredentialing process for NFs. For any NF that does not meet the CMS stars rating standard defined by AHCA, or internal quality measures, we refer the provider to our QIC for a CAP. The guidelines used for NF recredentialing are described below:

1. If the NF has an overall rating of two (2) or more stars, the NF has met this measure. If the NF has less than two (2) overall stars, proceed with the review.

2. If the NF has a rating of less than two (2) stars in the Quality Measures category within the Long-Stay Residents section, the NF has not met this measure. If the NF has a rating of two (2) or more stars in the Quality Measures category within the Long-Stay Residents section, proceed with the review.

3. Determine under the Quality Measures category within the Long-Stay Residents section, if the percentage of long-stay residents who receive an antipsychotic medication at the NF is the same as the statewide average or less. If the percentage is more than the statewide average percentage, the NF has not met this measure. If the percentage is the same or less than the statewide average percentage, the facility has met this measure.

Nursing facilities that do not pass the AHCA requirements under recredentialing are placed on a CAP. If the facility is not compliant with the CAP, the facility will be brought before the QIC, which will make a determination regarding decredentialing and possible exclusion from our network.

==========
3. The extent to which the respondent's description includes a plan to communicate the performance measure results to providers, including any provider incentives or alternative payment methodology opportunities available.
==========

COMMUNICATION OF PERFORMANCE MEASURE RESULTS TO PROVIDERS
Individualized scorecards will be delivered to each home health, ALF, NF, and adult day care provider on a quarterly basis by their Provider Relations Representative. These scorescards summarize the provider's performance on each metric captured in the PPE tool, as well as:
- Comparison to the provider's scores from the last measurement period
- Comparison to the top ten (10) percent of their peers on each indicator
- Areas of strong and poor performance

An example of this scorecard is in Attachment LTC 08-2.

In addition to the individualized scorecard, aggregated findings by provider type regarding quality outcomes and measurements will be communicated with providers in a variety of ways, including:
- Provider bulletins, notices, and newsletters
- Online and hard copy reports
- Provider educational sessions
- Written instructive communications
- Clinical and provider association newsletters

PROVIDER INCENTIVES
Humana is exploring how we can use the PPE tool as the foundation for value-based purchasing (VBP) opportunities for our LTC providers. These models are described below.

VBP FOR HOME AND COMMUNITY BASED SERVICES (HCBS): HCBS providers play a pivotal role by in reducing unecessary residential nursing facility and hospital utilization. Given that enrollees receiving HCBS typically spend more time with their direct service workers (DSWs) than with their PCPs, Humana is considering using VBPs for DSWs employed through participant-direction or through an agency. HCBS VBP arrangements may be structured to encourage DSWs to take a more vocal, proactive role in enrollees' care. DSWs who visit enrollees on a daily or weekly basis can identify subtle changes that are indicative of health concerns that need urgent treatment. We hope to incentivize DSWs to report this information to Case Managers to determine the appropriate course of action.

VBP FOR NURSING FACILITIES (NF): Humana has also developed VBP models that incentivize nursing facilities to help enrollees avoid hospitalization and, when appropriate, return to a community setting. We are exploring ways to extend a program that has been successful in our Medicare plans to our Medicaid providers. Humana is currently operating an incentive

program in North Florida for our Medicare Advantage plan that offers rewards for Skilled Nursing Facilities (SNFs) based on achieving performance targets on measures such as discharge rates, re-hospitalization rates after discharge, post-discharge follow-up within seven (7) days, as well as appropriate documentation. Awards are paid on a quarterly basis. Currently, Humana has seventy-nine (79) SNFs included in the North Florida-based program. On average, we award a bonus payout to seventy (70) to seventy-five (75) facilities each quarter. Our Provider Relations Representatives provide education and training to help NFs achieve their goals.

==========

4. The extent to which the respondent's description includes the establishment of data-based targets to determine the completion of provider corrective action plans and utilization of these targets pursuant to Section 409.982(1), Florida Statutes, including the ability for providers to be notified of performance issues prior to termination.

==========

Through the PPE tool, Humana can identify providers who are not meeting performance targets or that are underperforming relative to their peers. Underperforming providers presenting quality concerns receive written notification from the Provider Relations department. The Provider Relations department works with the provider to develop a CAP that identifies specific non-compliance issues; the staffing responsibilities, resources, and timeline to correct the situation; and data-based targets tailored to the provider's specific situation. Examples of these targets include:

- Greater than ninety (90) percent of services delivered, per authorization
- Less than one (1) percent rate of enrollee substantiated grievances within one quarter
- One hundred (100) percent of provider staff completion of required training

Each performance target has a specific timeline for completion, with most targets scheduled for completion in thirty (30) days or less. Provider Relations Representatives reach out to providers to explain the CAP and provide ongoing support to help providers achieve their targets.

The provider is monitored for a period of ninety (90) days following the development of a CAP in order to document the improvement in performance. Achievement of CAP performance targets is also monitored through subsequent PPE reports. Once all deficiencies are corrected, the provider is sent written notification and the CAP is closed. Providers who do not address deficiencies within the ninety (90) days receive a letter of non-compliance from the Provider Relations department and are presented to the Quality Improvement Committee for extension of the CAP or termination. Our goal is always to assist providers in reaching performance targets in a constructive manner. We only resort to contract termination after all other options have been exhausted.

Evaluation Criteria:

1. The extent to which the respondent's description includes a plan to create, collect, report and use provider performance measures.

2. The extent to which the respondent describes how performance measures are reported and trended for each participating provider type and incorporates utilization data, quality

of care concerns, performance measure scoring, and provider and enrollee satisfaction in recredentialing activities.

3. The extent to which the respondent's description includes a plan to communicate the performance measure results to providers, including any provider incentives or alternative payment methodology opportunities available.

4. The extent to which the respondent's description includes the establishment of data-based targets to determine the completion of provider corrective action plans and utilization of these targets pursuant to Section 409.982(1), Florida Statutes, including the ability for providers to be notified of performance issues prior to termination.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment LTC 8-1: Provider Performance Engagement (PPE) Metrics

Provider Performance Engagement (PPE) Metrics					
Performance Metric	Home Health Agency	Assisted Living Facility	Nursing Facility	Adult Day Care	Data Source
Trade Secret as defined in Section 812.081, Florida Statutes					
Totals	100	100	100	100	

Humana.

Nursing facility scorecard

Parent company:		Date:	
Facility:		Region:	
Address:		County:	
City:	State:	ZIP:	
Facility contact(s):		Phone:	
Tax ID	SMG ID		

Services available

☐ Rehab (Therapies PT, OT, ST) ☐ Memory Care ☐ Ventilator, IV, PEG

Trade Secret as defined in Section 812.081, Florida Statutes

Facility score

Level

General comment (Scores from last period, rankings on each metric as compared to top 10% of providers, comments on areas of strong and weak performance)

Humana.

Adult Day Care Scorecard

Parent company:		Date:	
Facility:		Region:	
Address:		County:	
City:	State:	ZIP:	
Facility contact(s):		Phone:	
Tax ID	SMG ID		

Services available

☐ Transportation ☐ Baths ☐ Specialized Alzheimer's Services

☐ Licensed Nurse on staff

Trade Secret as defined in Section 812.081, Florida Statutes

Facility score

Level

General comment (Scores from last period, rankings on each metric as compared to top 10% of providers, comments on areas of strong and weak performance)

Humana. **HCBS scorecard (Home Health, Homemaker, nurse registries, CCE and OAA)**

Parent company:		Date:	
Facility:		Region:	
Address:		County:	
City:	State:	ZIP:	
Facility contact(s):		Phone:	
Tax ID	SMG ID		

Services available

☐ Non-skilled Services ☐ Therapies - PT, OT, ST ☐ Skilled Nursing

Trade Secret as defined in Section 812.081, Florida Statutes

Facility score

Level

General comments (Scores from last period, rankings on each metric as compared to top 10% of providers, comments on areas of strong and weak performance)

Humana.

Assisted living facility scorecard

Parent company: Date:

Facility: Region:

Address: County:

City: State: ZIP:

Facility contact(s): Phone:

Tax ID SMG ID

Services available

☐ Transportation ☐ Assistive Care Services ☐ Memory Care

☐ Medication Management ☐ Therapeutic Meals

Trade Secret as defined in Section 812.081, Florida Statutes

Facility score

Level

General comments (Scores from last period, rankings on each metric as compared to top 10% of providers, comments on areas of strong and weak performance)

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

LTC SRC# 9 – Claims Submission and Payment (Statewide):

The respondent shall describe how it will educate and train LTC providers about claims submission and payment processes.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

==========
The respondent shall describe how it will educate and train LTC providers about claims submission and payment processes.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.
==========

Humana believes that when we partner with our providers and support them with the tools and education they need to succeed, we empower them to deliver sophisticated, high quality, clinically integrated care and supports models to our enrollees while also creating administrative simplicity. As such, Humana has developed a multifaceted and comprehensive claims training and education program specifically for our Long-term Care (LTC) providers. Our statewide LTC presence and experience working with LTC providers, both in Florida and through our health plans nationally, has provided us with insight on the challenges and barriers providers may experience when billing for services for Medicaid enrollees. The lessons we've learned from these programs have informed the design and evolution of our training model.

Our training program begins at the point of initial contracting, with ongoing trainings that provide frequent opportunities for our providers to refresh their knowledge on claims submission and payment processes. Our Provider Relations Representatives are fully trained on all applicable claims and payment processes, including rate changes, patient responsibility, Medicare coordination and crossover, AHCA's third-party claims dispute resolution contract, and medical necessity criteria, enabling them to provide individual support and training for our network. Humana continuously monitors the effectiveness of our provider education and training activities through provider satisfaction surveys and trend reports on claims submissions, as well as by gathering input from Provider Relations Representatives, Humana's leadership team, and provider associations. We adjust our trainings based on these inputs to ensure we are meeting the needs of all our providers and guarantee our updated materials are available to providers in both print and online formats. Finally, Humana uses several communication outlets to ensure that providers are continuously aware of any identified system changes or outages that may impact billing or payment, including those from our subcontractors.

We are proud of our relationships with LTC providers across the State of Florida and will continue to work diligently to ensure their long-term viability and value. This commitment is evidenced in our provider network's results. In December 2016, our average electronic clean claim processing and payment for our long-term care providers averaged ninety-nine point six eight percent (99.68%) of all electronic claims submitted. We will continue to evolve our training

approach to meet and exceed the needs of these providers, and are eager to maintain and improve upon these results.

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1. The extent to which the respondent describes the initial and ongoing training targeted to LTC providers, including the type, location, and frequency of training.

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INITIAL TRAINING

Humana has an established and comprehensive process to train and educate all new LTC providers (including sub-capitated providers, subcontractors, atypical providers and out-of-network providers) on claims processes. The goal of this approach is to ensure accuracy, timeliness, and completeness of claim submission and payment processes in both rural and non-rural areas.

Upon negotiation of the provider agreement or during a single case agreement, Humana initiates the training process. Once the provider is considered active and participating, our credentialing department will send a welcome packet with a copy of the monthly training calendar and a list of all “on-demand” online trainings offered. At that point, a Provider Relations Representative will schedule an orientation meeting within thirty (30) days.

During the orientation, the Provider Relations Representative reviews training materials, such as the Provider Handbook, and familiarizes the provider with links to educational materials on our provider-facing website.

Our Provider Handbook is available to all providers via the provider website and contains detailed information on claims submission and payment processing. This includes but is not limited to:

- Information regarding claims submission and payment processes, as well as an explanation of a clean claim and standards for submitting a clean and complete claim and following correct coding requirements

- Information on how to submit a claim directly through Availity or through their existing clearinghouse to Availity
--Information on how to submit a standard CMS 1500 and UB04 for web and paper claims submissions (for those providers who elect to submit claims electronically, companion guides are made available for 837i and 837p transactions)

- Information on the correct use of ANSI X12 837 transactions, CMS 1500 or UB04 forms, and Availity electronic claims submission to ensure required data for a clean claim

ONGOING TRAINING

Our ongoing trainings are designed to refresh providers’ knowledge on claims submission and payment processes, explain updates to these processes, and ensure that any new provider staff

are aware of our processes. We provide these trainings at various frequencies in three main forms: webinars, online modules, and telephonic and face-to-face sessions.

Humana conducts webinars for our LTC provider network twice a week. All webinars have an opportunity for provider questions and answers. Webinar schedules are posted in advance on our provider website, as shown in Attachment LTC 9-1. This posting includes a description of the subject matter, date, and time of the training. Among the topics reviewed during these sessions are:
- Common submission errors
- Techniques for avoiding errors
- Claims and payment processes
- Prohibited marketing and outreach activities
- Mandatory reporting under the contract
- Other provider responsibilities

Additionally, we conduct Availity training webinars twice a week. The Availity subject matter of these webinars is determined by requests from providers, trends observed by our Provider Relations department, and system or programmatic changes.

If after any webinar we identify that a provider still needs or desires additional training, we offer follow-up telephonic and face-to-face sessions.

In addition to our standing webinars, we offer online modules, available through our computer-based training system, which offer twenty-four (24) hours a day seven (7) days a week access to trainings on topics such as abuse and neglect, Medicaid orientation, LTC managed care overview, Availity, and fraud, waste, and abuse training.

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2. The extent to which the respondent's initial and ongoing training addresses characteristics unique to facility-based vs. community-based providers' claims submission and payment (e.g., rate changes, patient responsibility, Medicare coordination and crossover).

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ADDRESSING THE UNIQUE CHARACTERISTICS OF FACILITY-BASED PROVIDERS

Humana ensures that facility-based providers are educated on the appropriate use of UB-04 claims form, electronical funds transfers (EFT), and electronic claims submission methods to ensure timeliness and accuracy of payment. Additionally, our training includes specific information and requirements on facilities regarding patient responsibility, crossover payments, and AHCA annual and retroactive rate changes. Our Provider Relations Representatives work with the owners of these facilities to assess their familiarity with managed care. When a provider has less experience in managed care, we work with them closely on the payment rates and billing processes to ensure they receive timely reimbursement. We also reach out for follow-ups to ensure these providers are accurately submitting claims. For facilities that have more experience with managed care, the Provider Relations Representative continues to focus on supporting the use of existing electronic claim submission. Should AHCA implement changes to the existing nursing facility payment structure, our Provider Relations Representatives will adjust

our training and provide in-person, telephonic, and web-based trainings to educate our providers accordingly.

ADDRESSING THE UNIQUE CHARACTERISTICS OF HCBS PROVIDERS

Historically, many Home and Community Based Services (HCBS) providers were small, cash-only businesses, and some remain that way today. Due to many of them being largely unfamiliar with Managed Care, Humana has made educating HCBS providers on Healthcare Common Procedure Coding System (HCPCS) and AHCA fee schedules, and electronic claims submission a priority. Our HCBS trainings cover requirements specific to certain HCBS provider types, for instance our Assisted Living facilitiy (ALF) training and educational materials specify that ALFs are required to collect patient responsibility. Additionally, our trainings provide procedural information on how to bill utlizing authorizations that match an enrollee's plan of care.

We provide additional training and education to ensure that HCBS providers have the appropriate tools and knowledge needed to complete electronic claims submission rather than submitting CMS 1500 paper forms. During our initial training, we provide an overview presentation on the Availity portal and its functionality, that includes screen shots of shortcuts on how to submit corrected claims, how to void claims, how to set up EFT and electronic remittance advice (ERA), how to check claims status, remittance advises, and companion guides for providers who want to submit claims as 837 batches. We also provide claims guidelines for submission data requirements and guidelines on how to add units and date spans.

MEDICARE COORDINATION AND CROSSOVER

For both HCBS and facility-based providers, our claims submission and payment trainings include information on Medicare coordination and crossover. The Florida Mediciad Provider Handbook includes a description of Medicare coordination of benefits procedures. This is a regular topic of discussion during telephonic and face-to-face communications from our Provider Relations Representatives. We assist our providers with understanding plan payment and their responsibility for patient payment, as well as Medicaid versus Medicare payments. Further, because we offer Medicare Advantage and cover all eleven (11) regions for managed LTC, our Provider Relations Representatives are able to assist providers in understanding the coordination and crossover between payments.

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3. The extent to which the respondent will provide ongoing education and training, including problem resolution, responding to provider requests for training and how the respondent will evaluate the effectiveness of its education and training activities, including provider satisfaction.

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RESPONDING TO PROVIDER REQUESTS FOR TRAINING

Providers can request additional training at any time through their assigned Provider Relations Representative or through our Provider Call Center staff. These requests are then communicated to our Provider Relations team (which oversees our webinars and online training module) to create or adjust a training addressing that topic. If the provider has requested tailored support, the request is shared with the responsible Provider Relations Representative for individual telephonic or in-person support. They are specifically trained to answer questions and provide support on LTC claims, rate changes, patient responsibility, and Medicare coordination and crossover.

During the initial provider orientation, we administer an assessment to determine if providers are correctly billing for services in accordance with State guidelines and the requirements of the provider contract. We then offer trainings and support tailored to the identified areas of improvement for that provider.

Throughout the provider's contract, Humana continuously monitors each provider's compliance with clean claim submission requirements via our claims data and analytics system. This system allows Humana to track claims-related performance measures such as timeliness of claims submission, percentage of clean claims, and percentage of denied claims for each individual provider. Our claims department sends the Provider Relations team a daily LTC claim denial report which includes the denial reason, the codes billed, and the amount billed and denied. We use the report to track trends and identify needs for additional provider education on an individual or group level. If a provider is identified as requiring assistance with claims submission, our Provider Relations staff offers education either by phone or through a visit to the provider's office.

Ensuring our providers receive adequate and timely problem resolution to billing submission, answering payment questions and training requests is critical to maintaining provider engagement. Providers have access to an Avality technical support line (1-800-Availity) which is available twenty-four (24) hours a day seven (7) days a week. Upon calling, the provider will receive real-time support from an Availity representative. For non-technical issues, our Providers Relations Representatives and Provider Call Center staff are available to answer questions and resolve concerns.

EVALUATION OF EFFECTIVENESS OF EDUCATION AND TRAINING ACTIVITIES

Humana uses two primary methods to evaluate the quality and effectiveness of its claims and payment training.

First, we administer a satisfaction survey following each webinar, workshop, and group training session. This survey offers an opportunity for our providers to evaluate the quality of the training session that they attended, including the handouts and information received. The information obtained through these surveys enables our team to evaluate the quality of the training from the provider's standpoint, identify opportunities for additional education, and develop action plans to remediate any gaps identified. Additionally, this input helps our Provider Relations team to modify our training types to meet our providers' needs. For example, based on the feedback we have received from past trainings, we have added additional time to our training sessions for provider questions and one-on-one support from a Humana representative.

Second, our Provider 360 Committee reviews statewide provider trends to identify any global issues providers are encountering with submitting claims. Our Provider 360 Committee is a cross-functional team, chaired by the President of our Florida Medicaid Operations, and meets on a monthly basis. The purpose of these meetings is to review provider trends from our claims department, as well as Availity usage, quality measures, provider system usage, and provider grievances and inquiries. The committee includes representatives from our executive leadership and our Quality, Provider Relations, and Claims departments. Based on our review of claims submissions, the committee informs our Provider Relations department of any concerns or needs to implement additional claims submission training sessions for providers.

CASE STUDY: ONE-ON-ONE TRAINING TO IMPROVE PROVIDER PERFORMANCE

An ALF provider was submitting paper claims with incorrect date ranges and procedure codes. Because their claims were consistently being denied, they contacted their Provider Relations Representative and requested support. The representative visited the provider in-person and helped them register for our online claim submission portal, Availity. We walked the provider through the steps to submit original claims electronically and the provider corrected the procedure codes and date ranges for the denied claims. The provider has successfully used Availity to submit electronic claims since the training without any problems. This case study demonstrates the effectiveness of our hands-on claims submission support in improving provider satisfaction and the resulting improvement to the quality of care and supports delivered to our enrollees.

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4. The extent to which the respondent ensures training materials and tools are transparent and easily accessible.

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To ensure the transparency of our training materials and tools, we have instituted processes to collect and apply feedback from our providers. We collect feedback on our training materials through Provider Relations Representatives, provider satisfaction surveys, our Provider Services department, provider association meetings, and through interaction with Humana leadership. This input is used to inform changes in our training materials, including clarifying language, adding updated information, and providing clearer descriptions of Humana processes. As part of our commitment to transparency, all updated materials are shared with our providers online and through our Provider Relations Representatives. If we are unable to make a change requested by a provider for any reason, we communicate this to the requesting provider. Additionally, to assist our providers we offer provider training and educational materials in Spanish.

Along with ensuring transparency in our materials, we are committed to making our training materials and tools accessible to our entire network of LTC providers. During our initial orientation, we educate our providers on the tools that we have available (such as our Provider Handbook and reference guides), how they can access them twenty-four (24) hours a day seven (7) days a week online, or how to contact their Provider Relations Representative for a printed copy. Additionally, our online modules are available through our computer-based training system at all times, allowing our providers to access them at a time that is convenient for them.

These modules cover topics such as abuse and neglect, Medicaid orientation, LTC managed care overview, Availity, and fraud, waste, and abuse.

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5. The extent to which the training materials provided to LTC providers include information on how to access the Agency's third party claims dispute resolution contract (Maximus).

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The following LTC provider training materials are used to convey information on how to access the Agency's third-party claims dispute resolution contract, Maximus:

- Provider Handbook: The Florida Medicaid Provider Handbook is distributed in our provider orientation packet and is always available on Humana's website.

- Face-to-face and telephonic support: Our Provider Relations Representatives and provider call center staff will also direct providers to the State's training on Maximus, available on AHCA's website upon request. Our provider relations staff is trained annually on third party claims disputes and can assist in providing additional education to our long-term care providers.

- Provider Services Leader: Humana's Provider Services Leader is charged with oversight of all provider dispute resolution teams to ensure compliance with AHCA requirements as well as implementation of best practices across our provider organization.

To date, Humana has never received a complaint through Maximus. This speaks to the success of our process in training our providers on claims processing, as well as communication of the reason for any denied claims to our providers and our resolution process.

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6. The extent to which the respondent will provide training to providers on medical necessity criteria, as defined in the Contract pursuant to 42 Code of Federal Regulations 447.45 and in 59G-1.010(166), Florida Administrative Code.

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Provider understanding of medical necessity criteria is key to ensuring appropriate and timely service provision for our enrollees. Therefore, we use a variety of training methods to educate our providers on AHCA's definition of medical necessity, including our provider handbook and our provider orientation.

In addition to covering the definition of medical necessity, our provider orientation and ongoing trainings explain Humana's own medical necessity review process, how medical necessity reviews intersect with claims processing and payment, and how providers can provide the information needed for medical necessity reviews.

As with all of the content we include in our provider trainings, we constantly look for opportunities to refresh our providers' knowledge on this content. If our Provider 360 Committee or Utilization Management department recognize trends related to the medical necessity criteria that indicate a need for further education, we may conduct tailored training for individual providers. Following these trainings, the responsible Provider Relations Representative tracks

the provider's progress and trends monthly, offering additional training and support to respond to further needs.

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7. The adequacy of the respondent's notification process when system issues are identified/resolved by the respondent and/or its subcontractor(s), including notification to all impacted parties of estimated time for resolution, and updates and notification to providers prior to launching system changes that may impact billing and payment.

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We recognize that system issues may cause frustration or inconvenience for our provider network. Therefore, in addition to taking measures to reduce the number of Humana and subcontractor system issues, we take measures to notify all impacted parties of the estimated time for resolution as quickly as possible. When a system issue is identified that impacts our providers, this information is relayed to our providers through fax blasts, e-mails, our website, and our Availity portal. We update this information with the estimated downtime as soon as it is available. We have found that these are reliable ways to disseminate this information to our providers; thus far in 2017, the uptime of our Availity portal has been ninety-nine point seventy-eight percent (99.78%).

If we expect that an issue will last for an extended period of time and have a notable impact on claims submission, our Provider Relations Representatives reach out to our high-volume providers on a one-on-one basis to explain the situation and discuss how we can work with the them to ensure timely claims processing and payment upon resolution of the systems issue. Additionally, our Provider Call Center staff are made aware of all systems issues so they can provide accurate, up-to-date information upon receipt of a call from a provider. For example, during Hurricane Irma, we posted information on the front page of our Humana Health Care Provider webpage (www.humana.com/provider) about Humana's policy for continuity and payment of services for LTC enrollees during and outside of the disaster grace period for Hurricane Irma.

In addition to unexpected systems issues, we are committed to providing advance notification to our providers of planned systems changes that may impact billing and payment. To the extent possible, these systems changes take place at night and during the weekend, when claims submission is more infrequent. As with unplanned outages, we inform our providers of upcoming systems changes through fax blasts, e-mails, our website, and the Availity portal. Our Provider Relations Representatives also conduct one-on-one outreach to high-volume providers as warranted.

Evaluation Criteria:

1. The extent to which the respondent describes the initial and ongoing training targeted to LTC providers, including the type, location, and frequency of training.

2. The extent to which the respondent's initial and ongoing training addresses characteristics unique to facility-based vs. community-based providers' claims submission and payment (e.g., rate changes, patient responsibility, Medicare coordination and crossover).

3. The extent to which the respondent will provide ongoing education and training, including problem resolution, responding to provider requests for training and how the respondent will evaluate the effectiveness of its education and training activities, including provider satisfaction.

4. The extent to which the respondent ensures training materials and tools are transparent and easily accessible.

5. The extent to which the training materials provided to LTC providers include information on how to access the Agency's third party claims dispute resolution contract (Maximus).

6. The extent to which the respondent will provide training to providers on medical necessity criteria, as defined in the Contract pursuant to 42 Code of Federal Regulations 447.45 and in 59G-1.010(166), Florida Administrative Code.

7. The adequacy of the respondent's notification process when system issues are identified/resolved by the respondent and/or its subcontractor(s), including notification to all impacted parties of estimated time for resolution, and updates and notification to providers prior to launching system changes that may impact billing and payment.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

Attachment LTC 9-1: LTC Provider Training Dates

Humana Long-Term Care Plan offers training for providers regarding managed long-term-care (MLTC) plan requirements, processes and procedures. You can contact the provider contracting specialist in your region to set a time and date for training. You also can attend one of our scheduled webinars by clicking its registration link below.

For questions related to registration, please contact provider relations at 1-561-665-4435 or email LTCProviderrelations@humana.com.

Date and time	Topic	Register
11 a.m., Sept. 6, 2017	Availity	Click here to register. Register
2:00 p.m., Sept.6, 2017	LTCMC Overview-CMS 1500	Click here to register. Register
11:00 a.m., Sept. 7, 2017	Fraud, Waste, and Abuse Training	Click here to register. Register
2:00 p.m., Sept. 7, 2017	Humana Medicaid Provider Orientation Training	Click here to register. Register
11:00 a.m., Sept. 12, 2017	Availity Refresher	This is an open forum webinar where you can ask questions and get a refresher on ways you can use Availity. To register for this webinar click here: Register
3:00 p.m., Sept.12, 2017	LTCMC Overview UB04	Click here to register. Register

Attachment LTC 9-1: LTC Provider Training Dates

11:00 a.m., Sept. 15, 2017	Fraud, Waste, and Abuse Training	Click here to register. Register
1:00 p.m., Sept. 15, 2017	Humana Medicaid Provider Orientation Training	Click here to register. Register
9:30 a.m., Sept. 19, 2017	Availity Claims Submission Training	Click here to register. Register
3:00 p.m., Sept. 19, 2017	LTCMC Overview-CMS 1500	Click here to register. Register
10:00 a.m., Sept. 21, 2017	Fraud, Waste, and Abuse Training	Click here to register. Register
2:30 p.m., Sept. 21, 2017	Humana Medicaid Provider Orientation Training	Click here to register. Register

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

LTC SRC# 10 – Claims Submission and Payment (Statewide):

The respondent shall describe how it will ensure that electronically-submitted nursing facility and hospice claims processes will enable claims payment within ten (10) business days after receipt of clean claims. (See Section 409.982 (5), Florida Statutes) The respondent shall provide the specific data metrics it will use to ensure compliance with this provision.

Response:

Timely payment is critical to reducing our provider's time spent on administrative issuesand enabling their focus on delivering high-quality care to our enrollees. Timely payment is also key for Humana as we work to maintain a strong relationship with providers who care for some of our highest need enrollees. Our broad and deep experience in serving multiple lines of businesses has allowed us to design, refine, and deliver sophisticated claims processing systems and internal reports to continually monitor our claims payment timeliness (among other metrics) with particular attention provided to nursing home and hospice claims. Through our systems, we can monitor our claims through all phases in their lifecycle and review them at any point as they are being processed through real-time and drill-down reports. We have also designed reports and additional monitoring tools to ensure that our claims system is properly functioning and accurately processing and paying claims.

We strive to ensure one hundred percent (100%) of all nursing home and hospice electronic claims are processed within ten (10) business days. In 2016, nearly ninety-nine percent (99%) of our electronic clean claims were paid within ten (10) business days. We have continued this trend thus far in 2017.

In the past three (3) years, we have enhanced our claims process and have supported Long-term Care Providers in electronic claim submission by implementing an online provider engagement portal, Availity. We are continuing to support nursing home and hospice providers with the latest and most advanced tools, while supporting our smaller providers who may not have sophisticated billing capabilities. We have built easy-to-use direct data entry capabilities enabling our providers to key in fields to submit a claim for processing, eliminating the need for use costly tools to create an 837 file. We also accept claims via batch submission from a number of clearinghouses and billing agencies. We also accept business-to-business claims submissions directly to our electronic Hub (eHub) which is the gateway to our claims processing system. Our efforts to support our provider's accurate and complete submissions has helped increase the rate of clean claims.

In addition, during administration of the current contract, we have invested heavily in order to streamline our claims processing and payment process. LTC claims have been mitigated to our internal Claims Adjudication System (CAS), enabling our claims teams to utilize tools for inventory tracking, workflow, adjudication logic, internal controls, and financial recoveries. As a result of this increased integration, we do not foresee additional system changes to support operation as a Florida comprehensive plan.

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EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent describes the systems that will be used to measure timeliness of claims payment.

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Humana diligently tracks key claims payment metrics to ensure providers are paid in a timely fashion. Humana has the systems and processes in place to ensure that we pay clean nursing facility and hospice claims within the deadline in Florida Statutes §409.982(5) of ten (10) business days. We closely track all nursing facility and hospice claims on a real-time basis, from the time we receive them until they are paid. Humana's monitoring systems are designed to track claims through all phases in the lifecycle of each claim and review them at any point during processing. Our systems offer automated and ad-hoc reporting that can be drilled down to a claim level, claims processing system level, or aggregated in other ways. On a routine basis, responsible departments monitor key metrics to validate all claims are being processed accurately and are on track for timely payment. These metrics roll-up into daily, weekly, and monthly dashboards that are reviewed and assessed by multiple departments across the company via cross functional forums, including Claims, Encounters, Provider Relations, and Regulatory Compliance.

Humana has a dedicated corporate LTC Claims Operations Performance Manager responsible for monitoring only LTC claims. The LTC Operations Performance Manager works with operational stakeholders and our local market to share reports and engage in root cause identification and process improvement discussions on a routine basis. Our Performance Manager is an active participant on Florida Medicaid Local Market Operating Committee meetings, reporting out on Florida LTC claims performance metrics and informing leadership of process improvement opportunities.

DESCRIPTION OF REPORTS THROUGHOUT CLAIMS LIFECYCLE

Humana uses multiple systems throughout the lifecycle of claims payment to measure timeliness, including claims clearinghouses, processing system, and workflow system.

Claims are received and undergo an initial review by a range of clearinghouses. We have designed proactive reporting mechanisms, whereby Humana receives reports from our trading partners every four (4) hours with the number of claims processed and the number of claims that are still in queue. Through these reports we can monitor for the volume of claims to anticipate for and identify system issues when lower than expected volumes are reported; allowing us to monitor for systemic issues and anticipate volume to ensure timeliness of processing of all claims.

To support providers' ability to submit clean electronic claims, we have designed a claims feedback tool for our providers to receive real-time feedback by submitting key elements of their 837 file. Availity, Humana's preferred clearinghouse and provider engagement portal, allows our providers to test whether a claim will reject for any reason through the Claims Code Editor. This tool offers providers guidance on how to improve coding and helps reduce instances in which claims are denied or marked as dirty.

eHub, our front end system that receives all claims from our Availity and other trading partners, performs HIPAA edit validation and member eligibility verification and routes successful claims to the Claims Adjudication System (CAS). Throughout our claims processing system, we have metrics to ensure all claims submitted through eHub are received and (for the claims that have passed all edits within eHub) are submitted to CAS in a timely fashion. We monitor eHub exception reports, as well as daily and weekly performance reports, to assess for processing issues in real-time, alerting our Claims Processing Organization of systematic issues that need further attention.

Claims may require pending if they do not have all the required information, including authorizations for services delivered. These claims are pended in CAS to ensure they are processed with all the correct information. We have also identified common pend codes for claims to ensure the maximum number of nursing facility and hospice claims that are submitted electronically can be paid within ten (10) days when clean. Humana closely monitors this process and maintain a status record for all open claims for the purpose of real-time monitoring to offer status updates to providers on their claims in an easy-to-find fashion. MACESS is our primary operational workflow system that queues all pended claims to the appropriate and qualified team, where one or more associates work the claims on a first-in, first-out basis. We also maintain a historical record of all processed claims for ten (10) years, offering detailed explanation of the life of a particular claim and notes passed between our departments to resolve any issue associated with adjudicating the claim.

An additional key monitoring and strategy tool our claims team utilizes are the real-time reports we can generate from MACESS. MACESS is a workflow processing system that delivers pended claims into queues based on a predetermined hierarchy. Electronic, clean nursing facility and hospice claims that have not been paid by day seven (7) are escalated for review and root cause analysis. Our Team Leads review each pend code queue for these outstanding claims and ensure we have adequate staff to work these claims and ensure payment by the tenth day of the claim submission date.

REGULAR MONITORING AND OVERSIGHT OF NURSING FACILITY AND HOSPICE CLAIMS

We have equipped our Front Line Associates and Team Leads with smart analytics to continuously monitor claims performance. We have QlikView business intelligence dashboards which include nursing home and hospice claims metrics on auto-adjudication rates and claims processing cycle times.

These reports can be filtered by facility (nursing home and hospice) and by reason for pending to assess the volume impact of that pend code and the age of claims that have pended. These dashboards pull from our source of truth, the Enterprise Data Warehouse (EDW), and offer the ability to support any root cause analysis through additional drill-down analytics.

On a daily basis, these reports are reviewed by our Front Line Associates and Team Leads to ensure our claims process is functioning optimally. On a weekly basis, Team Leads of each department review dashboards and performance reports to ensure

appropriate assignment of resources and to identify issues to initiate root-cause analysis. Any issues that require the attention of our Information Technology Team or our Florida Leaders are brought up with the respective teams immediately to identify root causes of any issues and resolve matters in a rapid fashion.

On a monthly basis, summary reports showing open and recently resolved issues are developed and shared with the respective teams. Our Local Market Operating committee brings together each of our operational departments to discuss performance against contract Service Level Agreements (SLA) and national benchmarks. Additional drill-down capabilities and root-cause analyses are conducted using the previously mentioned business intelligence dashboards. Information gathered and actions identified from these meetings are reported to our Medicaid Compliance Committee, Quality Improvement Committee, and Corporate Operational Governance Committee. These cross-functional forums include our Florida leadership team and provide an avenue to discuss claims and encounter processing metrics, identify opportunities for improvements, and assess process improvements. Identified issues are immediately addressed during these meetings, with follow-up meetings to rapidly address low-performing metrics. Associates from our Corporate Claims Processing Teams also participate in these meetings.

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2. The extent to which the respondent's data metrics demonstrate an ability to comply with Section 409.982(5), Florida Statutes.

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Humana closely tracks all claims submitted by nursing facility and hospice providers to determine if we have paid them within ten (10) business days as required by section 409.982 (5), Florida Statutes. In 2016, we achieved ninety-nine point eight nine percent (99.89%) compliance with this requirement attesting to the success of systems and process enhancements implemented. 2017 year-to-date performance is in excess of ninety-nine percent (99%), and moving forward, we will continue to strive for payment of one hundred percent (100%) of clean nursing facility and hospice claims within ten (10) business days.

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3. The extent to which the respondent describes how it will work with providers when the timeliness standards are not met.

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Humana understands the importance of paying claims in a timely manner. We have designed reports to inform and pre-empt any clean, electronic nursing facility and hospice claims that may pay outside the timeframes of the contract so that we can communicate and inform the provider about the late payment and anticipated payment date. When Humana is unable to meet a state claims payment deadline such as the one for nursing home and hospice claims, our claims processing department will provide a daily Retail Services Operations Compliance (RSOC) report of clean electronic nursing facility and hospice claims by age. The claims are benchmarked to seven (7) business day and ten (10) business day thresholds.

To offer a proactive communication strategy, our Provider Relations Department will communicate the status of claims that are at day eight (8) in the lifecycle. Claims that are lagged at these timeframes are identified for outbound telephonic outreach by our Provider Relations Team and will be tracked in our provider engagement tracking tool, Customer Relationship Managers. The Provider Relations Representative will offer transparency to the provider as to the status of the claim and will affirm that we will work the claim through our process with the goal of paying it within the ten (10) business day timeframe. A follow-up phone call will be made to providers for claims that have not been paid within ten (10) business days, with an anticipated date for payment. These phone calls will be logged in our system to track and monitor completeness of communication.

Humana has worked hand-in-hand with our nursing facility and hospice providers to ensure timely payment of claims. Our working relationship is exemplified by Dana McHugh, Executive Director of FAHA Health and Service, “Our experience working with the Humana provider relations team has been consistently professional and positive. The FAHA H&S providers greatly appreciate Humana’s common sense provider and member centric approach.”

ROOT-CAUSE ANALYSES OF CLAIMS PAYMENT LAGS

Humana also has a structured mechanism to review trends in our claims metrics and report claims issues to our cross-functional Provider 360 Committee. The Provider 360 Committee is also an avenue for our Florida market team and our corporate resources to discuss processes and performance to achieve our overarching claims goals. The sole objective of the Provider 360 Committee is to review performance measures that contribute to our provider’s experience with Humana. Claim Timeliness reports are reviewed during Provider 360 Committee meetings to assess the need for internal process improvements, additional provider education, and to support our efforts to ensure provider satisfaction. During these meetings, information reported from our claims performance are discussed cross-functionally, with perspective shared by our Provider Relations Team and local market staff who then offer additional strategies and avenues to improving performance. As a result, our Claims Team and Provider Relations Team work closely together to identify providers who have difficulty submitting claims and providers who have submitted claims with higher than expected levels of denials. Our Claims and Provider Relations Team also review trended denial reports on a weekly basis, which can be drilled down to the provider level. During these discussions, the Provider Relations Team also identifies change of ownership of existing providers to assess how well their claims submissions are being processed and to identify if they have applied for a new provider number. Based on findings from this analysis, the Provider Relations Team offers targeted education.

CONTINUAL PARTNERSHIP TO IMPROVE PAYMENT TIMELINESS

Additionally, our Provider Relations Team has created workgroups with our providers. Upon request staff from the provider’s office as well as our Claims and Provider Relations Team work one-on-one to conduct root-cause analysis and offer provider education to resolve claims processing issues in an effective and manner.

Humana participates in the Florida Association of Health Plan's forums and meetings to discuss operational claims payment opportunities. Information from the meetings is shared with our Provider Relations Team. Humana's LTC Operations Director and Provider Relations Team attend the Florida Association of Hospice and Palliative Care meetings where claims issues are discussed. During these meetings, we have an opportunity to engage with our key providers to discuss claims payment issues or provider issue trends in an effort to improve claims payment timeliness.

Humana has a strong working relationship with our major clearinghouses to address quality of claims submission. Most recently, we have worked with our major clearinghouses to educate them about the complete submission of the service dates required as part of nursing facility and hospice claims.

To address the administrative burden of submitting, waiting, and receiving approvals on cross-over claims from both the Centers for Medicare and Medicaid Services and from Humana separately, we have implemented an initiative to streamline the process for our providers so that claims are submitted only once. Humana is coordinating the transmission of the provider claim along with Coordination of Benefits data to Emdeon using Medicaid COBA ID, which is shared with our systems for processing. This process creates efficiencies within the systems between payers and reduces the administrative and monitoring burden on our nursing facility providers.

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4. The extent to which the respondent ensures that billing systems platform changes will be limited.

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Humana offers a unified billing system platform for all medical and Long-term Care claims. Humana has no plans to make any significant changes to our preferred clearinghouse and provider engagement portal, Availity, or our claims processing platform, Claims Adjudication System (CAS), in the foreseeable future. Humana understands the disruption that can occur when a payer transitions to a new billing system platform and the impact on providers. While we continually update the logic and codes we have designed with Availity and built into CAS, we are very cautious to test these changes thoroughly before they are implemented.

Evaluation Criteria:

1. The extent to which the respondent describes the systems that will be used to measure timeliness of claims payment.

2. The extent to which the respondent's data metrics demonstrate an ability to comply with Section 409.982(5), Florida Statutes.

3. The extent to which the respondent describes how it will work with providers when the timeliness standards are not met.

4. The extent to which the respondent ensures that billing systems platform changes will be limited.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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E. DELIVERY SYSTEM COORDINATION

LTC SRC# 11 – Case Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Alisha is a 35-year old single mother who suffered from a major car accident when she was 27 years old, which resulted in incomplete paraplegia. Until she received Medicaid coverage, Alisha was unable to afford the recommended level of physical and occupational therapy treatments that would have assisted her in maintaining maximum mobility in her upper extremities. As such, Alisha requires assistance with almost all self-care tasks. Alisha has suffered from clinical depression since her accident. She is cognitively intact and since starting individual therapy sessions with a licensed mental health clinician, she has started to express a desire to be more engaged in her community. Alisha has a primary care physician (who specializes in internal medicine) and is also seen by a neurologist. Alisha's physician has ordered ongoing maintenance physical therapy; she also receives personal care services and durable medical equipment. Alisha gave birth to a son, Noah, one year before the accident. Alisha's mother assists with Noah's care as often as she can, but her mother recently accepted a job in a different city, which will mean Alisha will have less supports (both for herself and Noah). Alisha and Noah currently live with her mother. Because her mother is moving, Alisha has been looking for a new place to live, but she is having trouble finding a home that is functional for her needs. Since Alisha is experiencing changes in her support system and living situation, she requests assistance from her case manager.*

The respondent shall describe its approach to coordinating care for an enrollee with Alisha's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. Comprehensive Assessment;
b. Caregiver Assessment;
c. Person Centered Care Planning;
d. Transition Planning;
e. Disease Management;
f. Utilization Management/Service Authorization; and
g. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

ALISHA

Alisha is a 35 year old, disabled, single mom who has been living with her mother after having an accident, sustained at 27. This accident left Alisha with a T-10 incomplete paraplegia. Alisha

has control of her hands and arms, and good control of her abdominal muscles and trunk. While things are clearly very different than before her accident, she still leads a very fulfilling life. She has an active nine year old son, Noah, who her mother has been helping with since the accident.

Alisha enrolled in Humana's comprehensive plan eight months ago and is established with the Long Term Care (LTC) program. Alisha has a strong relationship with her case manager, "Nina", which is evident in her case record in Humana's proprietary clinical workflow system, CareHub Clinical Guidance Exchange (CGX) [1]. CGX supports an integrated and comprehensive approach, which gives Nina the ability to see all applicable elements of Alisha's record. This includes medical, behavioral health, long term services and supports, pharmacy, and utilization and care management in one system. Nina maintains monthly contact, keeps Alisha's assessments and individualized plan of care (POC) updated, and knows Alisha and her current status very well.

Nina is part of a case management team that includes a Transition Coordinator, Manuel. Manuel is an expert on community based services, advocacy, nursing, social work, and housing. He has attended additional training in transition services that include home modifications and housing options available in his area. Manuel will be able to support Alisha in applying for subsidized or low income housing, moving assistance, and utility assistance (including her deposits and ongoing subsidies), all while keeping her preferences at the forefront.

DAY 1: ALISHA'S MOTHER IS MOVING; ALISHA CALLS NINA

Alisha calls Nina and tells her that her mother is moving within the next two months. Alisha says she has been looking for a place to live, but she is having difficulty finding a place that will accommodate her functional limitations. She would like to stay in her current neighborhood or at least in the same school district so Noah does not need to change schools. Nina knows that one of Alisha's primary goals is to be more involved in the community and, more specifically, at Noah's school. Nina also knows how much support Alisha's mother provides for her and Noah and that Alisha wants her mom to be able to speak with Nina. Nina reviews Alisha's case record to ensure there is a current release of information (ROI) for her mother and schedules a face-to-face visit due to Alisha's significant change in social circumstances.

DAY 5: NINA VISITS ALISHA

Nina visits Alisha within five days to review and update the comprehensive assessment. Nina completes the caregiver assessment on Alisha's mother. With this information, Nina and Alisha work together to start on Alisha's transition plan and create a "draft" POC to be implemented when Alisha's mother moves. Nina learns Alisha's mother will help support her by letting them stay in the house through the end of the school year (in four months).

In order to update her "draft" POC, Nina addresses upcoming changes and updates Alisha's current medical, functional and behavioral health status, as well as her strengths and needs. After her mother leaves, Alisha will need more personal care hours, more help with Noah, and a new place to live that will accommodate her and Noah's needs. Nina educates Alisha on Noah's

Medicaid benefits, as he may be eligible for additional services (like meal preparation) due to Alisha's disability. Nina discusses the importance of Noah's health care and provides resources for Alisha to access an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule. Nina informs Alicia that Humana will support her continuity of service with her current providers after she transitions to her new location and makes sure that all service providers are informed of Alisha's new address and date of transition.

Nina knows Alisha is in individual therapy sessions for clinical depression and has been doing very well. She encourages Alisha to discuss her mother's move with her licensed mental health clinician and also encourages her to keep these sessions as a priority, even with all the activity around the move.

Nina updates Alisha's current POC with her newly identified goals to include increasing her independence, finding a new house or apartment, accessing transportation, and finding after school care for Noah. Based on Alisha's upcoming changes, Nina and Alisha identify participants of her Multidisciplinary Team (MDT). Participants include Alisha, Nina, the Transition Coordinator Manuel, as well as her primary care physician (PCP), neurologist, physical and behavioral health therapist, Humana's Medical Director, a utilization care coach, and Alisha's mother. The MDT provides input and feedback as Alisha's POC is reviewed and updated. The POC updates are documented in CGX and provided to Alisha and her PCP. They can also be accessed through our member and provider portal.

DAY 6 – 49: MONTHLY CONTACT WITH ALISHA

In anticipation of Alisha's change in residence, frequent outreach will be necessary. Through Humana's integrated system, Nina and Manuel easily see all contacts, visits, and updated documents and have the ability to message each other. All visits and contacts are scheduled with Alisha at the end of each interaction and documented in CGX. Each month Nina discusses timely service delivery, satisfaction of services, anticipated service disruptions, and any changes in condition or upcoming appointments. With Alisha's mother's support, she is able to stay in their home until school ends.

DAY 50: HOME MODIFICATIONS

With Manuel's assistance, Alisha secures a new home that allows for home modifications. Nina coordinates with Alisha's PCP to obtain a prescription for a Physical Therapy (PT) evaluation to assess Alisha's new residence for home accessibility needs. Alisha already has many assistive devices that allow her to independently care for herself, including a motorized wheelchair. After completion of the PT evaluation, the recommendations for home modifications include installation of a portable wheelchair ramp, two shower grab bars, a hand held shower, and widening of the bathroom door. Nina collaborates with Alisha's landlord to obtain written consent to allow for the recommended home modifications. Nina explains to Alisha that home modification requests are routinely processed through utilization management for medical necessity determination and are approved within seven calendar days; and that if the request is denied, she will have the right to file an appeal. Alisha's home modifications are approved and three contractors are selected for estimates. A contractor is selected based on its reputation, past work, quality of reviews, cost, and timeliness of completion. Alisha is notified of the

selected contractor and is informed that the modifications are expected to take two to three weeks. Once the date is confirmed, all providers are notified of the transition date to ensure there are no gaps in services, including Alisha's PT maintenance therapy. Long Term Care homemaker/chore benefits will be utilized to assist Alisha in packing and cleaning of her home. Manuel assists in locating movers for Alisha. Alisha and Nina also discuss how great it is that the new home is within the same school district and the bus runs a route following after-school care for Noah.

DAY 70: POC FINALIZATION AND SERVICE AUTHORIZATION

Nina updates and finalizes Alisha's POC based on her assessment and utilization tools. The need for additional services is determined based on standard of care criteria and medical necessity. Humana utilizes a risk ranking tool to determine service hours based on individual needs such as bathing, dressing, grooming, meal preparation, and the amount of time needed to perform these tasks. The fact that Alisha's mother is no longer able to provide caregiving support is factored into her service hour determination. Upon completion of this needs assessment, Alisha is assigned a risk ranking of moderate, with a range of potential service hours using a standardized tool as a guide. Nina triggers CGX to automatically send the updated POC to Alisha's PCP.

Nina enters authorization requests in CGX with the identified service hours and sends them for utilization review. Should the requested hours be greater than the recommended range of service hours, an assigned Utilization Care Coach will complete an additional review and base the approval on medical necessity. If the Utilization Care Coach determines the requested number of hours require additional review, a medical director will be asked to make the final determination. Only a medical director has the authority to deny these requests.

Upon approval of the requested service hours, CGX automates a faxed authorization to the existing service provider. Nina explains to Alisha, that in the event the request for service hours is denied, Alisha would receive a notice of adverse benefit determination letter, providing information on grievance and appeals and her rights to a Medicaid Fair Hearing. Nina would provide assistance with this process if Alisha chose to file an appeal. If Alisha decided to appeal the decision, she would receive a written acknowledgement from Humana within five business days from the receipt of her appeal. She would be advised that her request would be reviewed and a decision would be communicated to her within 30 calendar days. Alisha's appeal would be submitted through the clinical appeal review process and would be reviewed by a medical director not previously involved in the original decision. Alisha would be notified of the decision of her request for appeal, both verbally and in writing. Should the adverse decision be upheld, she would be advised of her right to a Medicaid Fair Hearing. In this instance the requested hours were determined to be medically necessary and all Alisha's hours were approved.

Nina also explains to Alisha that if at any time she would like (or requires) a change in service providers, Nina will make the necessary referrals to ensure there is no disruption in care. Nina also informs her that she would address any service provider complaints within 24 hours and, if she is unable to resolve them, would facilitate the process for filing any grievances identified by Alisha. She tells Alisha that this includes assisting with the coordination of new Home and Community Based Service (HCBS) providers, a new PCP, or new behavioral health services. She will also guide Alisha in updating her address with relevant sources like her pharmacy,

service providers, specialists, physical and occupational therapists, and durable medical equipment companies. Along with these updates, Nina assists her in modifying transportation arrangements and identifying supportive community resources within her new community. Humana case managers have access to a number of resource directories to help locate services and resources that may not be covered by the comprehensive plan. These include the Humana Community Resource Directory, Local 2-1-1 resources and online local community resources. Nina tells Alisha about her transportation benefit and her enhanced transportation benefits for additional transportation needs. Nina assists Alisha in scheduling her next appointments.

DAY 90: ALISHA'S NEW HOME

Within five days of Alisha's move into her new home, Nina conducts a face-to-face visit. In addition to finalizing her POC, Nina assists Alisha with her disaster preparedness and emergency plan by helping her notify emergency management services of Alisha's circumstances and registering her for a special needs shelter and transportation in case of emergency evacuation. Nina obtains Alisha's electronic signature on the updated POC and provides a copy to her. Additionally, the POC is automatically sent to Alisha's PCP from CGX. Nina lets Alisha know that she and her physician can also access the POC on Humana's member and provider portal. Nina calls within fourteen (14) days to confirm Alisha's providers are delivering services as authorized and Alisha is satisfied with the services being provided.

DAY 91 – 110: ALISHA'S NEW SURROUNDINGS & SUPPORT SYSTEM

Nina continues to monitor and reassess Alisha's needs as she continues to adapt to the many changes in her life and with her support system. Nina is able to identify and address Alisha's needs through the following activities:

- Annual and change in condition medication reviews

- Reviewing and coordinating application completion for Medicaid renewal

- Ongoing education of plan benefits

- Resources simplifying self-health management such as telemedicine

- Medical transportation and mail order pharmacy services

- Assessing and educating Alisha on medical risks specific to her paraplegia, like urological and digestive complications, skin care, and feeding issues

- Education and information on breathing and coughing techniques to maintain good airway clearance

- Offering information on preventive measures for herself like mammogram and cervical cancer screenings

- Providing relevant health education to promote ongoing health literacy and access to care emergency department and urgent care diversion and self-management planning

At this time, Alisha does not qualify for any disease management programs, but if she were identified as needing referrals through re-assessment, self-referral, or the Humana Medicaid Risk scoring algorithm, Nina would encourage participation and submit the referral. Nina assists Alisha in identifying other possible avenues of coverage and benefits, such as Supplemental Security Income to support benefit and income maximization. Nina will quickly find out if Alisha has had to visit the emergency room through the Health Information Exchange – Electronic Notification System (HIE-ENS) daily report. Nina also receives alerts through CGX of a hospital admission or discharge. Upon finding out about a hospital admission Nina will suspend services and generate a notice of adverse benefit determination letter (NOABD), which is sent to Alisha and the provider.

Nina tells Alisha about Humana's One Medication Experience which provides her access to create and update all prescribed medications and supplements within a feature called One Medication List (OML) by accessing her profile via computer or mobile application. This application not only gives Alisha the ability to manage her own medical information, but reconciles her medication list within CGX, establishing a single source of truth that can be utilized by Alisha and her Humana clinical care team.

As Alisha's needs and priorities change Nina will provide resources and supports as needed to support these changes. Nina will also be on the look out for any changes in health care status as well as with behavioral health issues that may require coordination with clinical and behavioral health specialists. CGX allows Nina to complete real time updates to assessments, POC and service needs while meeting Alisha in her home. The system also permits electronic signature capture and in home printing for providing POC copies to Alisha at the time of visit rather than depending upon delivery via post mail. The system also allows Nina to send a copy of the updated POC to Alisha's PCP. Recent enhancements now allow for the generation of authorization notices to Home and Community Base Service (HCBS) providers. Therefore, service need changes and progress notes can be captured, updated, and shared electronically for faster implementation.

DAY 115 – 159: CONTINUING MONTHLY CONTACT

Nina maintains monthly contacts and has open discussions with Alisha to find out how she feels her POC is working. Together, they review any barriers to the achievement of her goals and expectations and make POC changes as needed. These contacts may occur more frequently if Alisha experiences a significant change in her health, care needs, or circumstances. Nina always likes to be updated on Noah's activities and school progress and encourages Alisha to contact her if she has any problems, questions, or concerns.

DAY 160: NINA'S QUARTERLY FACE-TO-FACE VISIT WITH ALISHA

After three months in her new home, Nina visits Alisha and finds her adapting quite well to her new environment. Alisha expresses an interest in becoming more engaged in her community and involved with Noah's school and activities. Nina assesses Alisha's progress with her

existing behavioral health provider and explores additional community supports closer to her new home to empower Alisha in self-managing her care. Maintaining this added support and connecting her with others will be important for Alisha as she manages her symptoms of depression. This includes supporting Alisha's interest of being more involved with Noah, and his school. Alisha identified increased independence as one of her goals, which includes the ability to care for her son as essential to her goal. Nina reminds Alisha about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for Noah and links Alisha to community resources, support groups, and volunteer opportunities.

In addition to Alisha's goal to be more involved with Noah, she desires to be more productive and Noah's school would like her to volunteer. Nina provides community resources to help Alisha access these services, including an opportunity for vocational rehabilitation. Noah's school welcomes Alisha as a volunteer.

Alisha contacts Nina after this recent visit and expresses her gratitude for her help and support during her transition, which at times felt overwhelming to her. Alisha said she is now more optimistic and less apprehensive about her and Noah's future. Alisha is more involved in making decisions about her life and her care. She volunteers weekly at Noah's school and participates in all therapy sessions and treatments, and is compliant with her medications and doctors' appointments. Alisha is the happiest she has been since her accident and visits with her mom monthly.

Footnote

[1] CareHub is Humana's enterprise solution for complete program integration for our provider community and enrollees. CGX supports an integrated, comprehensive approach to medical, behavioral health, pharmacy, utilization, and care management. Full system integration allows our care team the capability to identify potential enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify opportunities for intervention.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

- **(a)** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **(b)** Application of the respondent's case management risk stratification protocol, including a rationale for the decision;
- **(c)** Application of a person centered care planning approach;
- **(d)** Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
- **(e)** Description of the interventions and strategies that would be used to facilitate community integration and transition planning;
- **(f)** Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services;

(g) Description of the assessment of provider capacity to meet the specific needs of enrollees;

(h) Identification of strategies that promote self-management and compliance with the plan of care;

(i) Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and

(j) Application of strategies to integrate information across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent demonstrates experience providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

5. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

6. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows.

Score: This section is worth a maximum of 75 raw points with each of the above components being worth a maximum of 5 points each.

Attachment LTC-11-1: Alisha's Visual Story Guide

We have provided this document as a visual guide to our response. The key timelines from our core response are duplicated here in a format intended to supplement and enable a comprehensive review of Humana's approach to Alisha.

About Alisha:

Alisha is a 35-year-old, disabled single mom who has lived with her mother since an accident she had at 27, which left her with a T-10 incomplete paraplegia. She has suffered from clinical depression since her accident and sees a licensed mental health clinician. She has an active nine-year-old son, Noah, who her mother has helped with since the accident. However, Alisha's mother recently accepted a job in another city, meaning she'll have less support for herself and Noah and must secure new housing that is functional for her needs. Established with the Long-term Care (LTC) program, Alisha enrolled in Humana's comprehensive plan eight months ago and is requesting assistance from her CM, "Nina."

Key Components of Care

- **Ongoing, Highly Engaged CM-Enrollee relationship** for open, frequent contact, and timely access to support, especially as Alisha's situations change
- **Dedicated Transition Coordinator (TC)** with expertise in community-based services, advocacy, nursing, social work, and housing, including home modifications
- **Plan of Care (POC)** continuously updated to include Alisha's needs, accessible by her Multidisciplinary Team (MDT)
- **Keeping Alisha's newly identified goals at forefront,** helping connect her to community organizations, and opportunities to get more involved with her son

Alisha's Support System

- **Nina** CM
- **Manuel** TC
- **Alisha's Mother**
- **Alisha's MDT**
- **Noah** (Alisha's son)

Alisha's Timeline:

1 — Long-term Care (LTC) Status
Established with Humana's LTC program, Alisha enrolled in Humana's comprehensive plan 8 months ago.

2 — Day 1: Housing Needs Change
Alisha notifies Nina that she needs a new place to live; Nina schedules a face-to-face visit to discuss and determine necessary changes, as well as any updated goals.

3 — Day 5: Review & Update Comprehensive Assessment
Nina completes caregiver assessment with Alisha's mother and creates a draft POC, including resources for Alisha's son to access an EPSDT periodicity schedule.

4 — Days 6-49: Monthly Contact
Nina and TC Manuel use Humana's proprietary workflow system, CGX, to stay in contact; Nina discusses timely service delivery, satisfaction of services, anticipated disruptions, and any changes of condition with Alisha.

5 — Day 50: Secures Home That Allows For Modifications
Manuel assists in securing a new home for Alisha; Nina helps her obtain a prescription for a PT evaluation of the home's accessibility. Home modifications are approved, a contractor is selected, and providers are notified of transition date.

6 — Day 70: POC Finalization and Service Authorization
Nina determines needs for additional service hours using risk ranking tool and needs assessment; Alisha is assigned a risk ranking of moderate. Nina informs Alisha on next steps to include updating providers with her new address, modifying transportation requests, identifying community support, and scheduling her next appointments.

7 — Day 90: New Home
Nina visits Alisha within 5 days of moving into her new home and assists her with disaster preparedness and emergency planning. Alisha electronically signs her finalized POC. Nina follows up in 14 days to ensure providers are delivering services as authorized.

8 — Day 91-110: New Support System
Nina monitors and reassesses Alisha's needs as she adapts to her new surroundings through multiple processes: annual and change in condition medication reviews, ongoing education of plan benefits, medical transportation, and mail-order pharmacy, among others.

9 — Day 115-160: Continuing Monthly & Quarterly Contact
Nina maintains monthly contact around the effectiveness of her POC, and has quarterly face-to-face visits to check in while also providing community resources for Alisha.

LTC SRC# 12 – Case Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Mr. and Mrs. Smith are a husband and wife, both in their early 70s. They have an adult daughter who lives in State. The Smiths are both enrolled in Medicaid managed care and are dual-eligible for Medicaid and Medicare. The Smiths are enrolled in Medicare FFS. Mr. Smith is enrolled in a Managed Medical Assistance plan, while Mrs. Smith is newly enrolled in your LTC Plus Plan or Comprehensive Plan. Mrs. Smith has moderate to severe dementia that is progressing. She is able to walk with the aid of a walker and she can feed herself. However, she needs assistance with bathing and dressing, and she needs supervision due to wandering. Mrs. Smith was admitted to the hospital three months ago for pneumonia but was discharged to a nursing facility, as her husband was unable to care for her on his own anymore. Mrs. Smith would like to move home. Mr. Smith would like for her to move home, but he is concerned that he cannot meet all of her needs on his own. Mr. Smith has a single, below-the-knee amputation, but is otherwise healthy. Their small home is cluttered, and they have many pets. Mr. Smith says he is overwhelmed because she needs more care than he can provide by himself.*

The respondent shall describe its approach to coordinating care for an enrollee with Mrs. Smith's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. Comprehensive Assessment;
b. Caregiver Assessment;
c. Person Centered Care Planning;
d. Transition Planning;
e. Disease Management;
f. Utilization Management/Service Authorization; and
g. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

MR. AND MRS. SMITH

Mrs. Smith is a new enrollee to Humana and brand new to the Long-term Care (LTC) program after experiencing an acute episode of pneumonia requiring hospitalization, inpatient rehabilitation, and subsequent placement into a nursing facility (NF). She has a history of moderate to severe dementia, and has been known to wander. She uses a walker for assistance and can feed herself. Enrollees like Mrs. Smith benefit from Humana's proven success with transitioning enrollees back to the community. Since 2014,has helped more than one-thousand seven hundred (1,700) LTC enrollees transition from institutional settings back into the community. (See Attachment LTC 12-2 – Transitions Graph).

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

DAY 1: MRS. SMITH'S NEW ENROLLEE IDENTIFICATION

After electronic notification of the 834 enrollment file, Humana loads Mrs. Smith's eligibility information and auto-creates a case in Humana's proprietary clinical workflow system, Carehub's Clinical Guidance eXchange (CGX) [1]. CGX supports an integrated and comprehensive approach that allows our case managers (CMs) to more effectively serve enrollees. Being fully integrated helps Humana identify enrollees for case and disease management and monitor enrollees for compliance. Concurrently, this electronic transmission triggers Humana to mail our new enrollee materials within five (5) days of notification.

Following the auto-case creation, we assign the file to "Sally," one of Humana's LTC CMs. We consider Sally's education, experience, and geographic location, as well as Mrs. Smith's language preference in making this assignment. Sally manages Humana enrollees at this LTC facility and has available caseload capacity, as defined by the contractually defined caseload ratios. Through our experience in the Florida Managed LTC program, we recognize the need to assign local CMs like Sally that are familiar with unique circumstances of the nearby facilities, their region, and the enrollees they serve.

To add to the experience Sally brought to Humana when hired, she also underwent Humana's comprehensive onboarding program, which includes twelve (12) weeks of LTC-focused training. Senior CMs mentored Sally, counseling her on strategies to identify and resolve barriers to access to care and health literacy, guidance on ways to prioritize immediate needs, and advice on ways to display empathy and emotional support. We have also provided Sally with ongoing training to keep her up to date and continuously learning through monthly half-day education, training, and oversight sessions to ensure she has access to the most up-to-date information and her mentors.

DAY 2: INITIAL OUTREACH

Sally receives an electronic alert to notify her of Mrs. Smith's assignment. Because Sally is managing other Humana enrollees in this facility, she has established relationships with many workers at the facility and can effectively collaborate with admissions to verify Mrs. Smith's enrollment, eligibility, and location. In reviewing Mrs. Smith's information with the facility Social Worker, she learns that there is a diagnosis of progressing moderate to severe dementia, and that she needs to involve Mr. Smith, Mrs. Smith's husband, in the assessment process. Sally also notes Mrs. Smith's recent hospitalization and inpatient rehabilitation for pneumonia. Mr. Smith has power of attorney (POA), so Sally obtains his contact information to call, introduce herself and her role with Humana, and welcome Mrs. Smith to Humana's plan while discussing plan specifics with Mr. Smith.

During Sally's welcome call with Mr. Smith, she outlines the need for an in-person visit with him and Mrs. Smith. Sally works around Mr. Smith's schedule and sets up an appointment for later

in the week. She asks Mr. Smith if he would like others present to participate in Mrs. Smith's initial evaluation. Mr. Smith mentions they have a daughter, who works full time and helps, but also that she lives an hour away and will not be able to attend at this time. Sally makes sure that Mr. Smith received Humana's new enrollee materials and identification (ID) card for Mrs. Smith, confirms the appointment date and time at the facility, and provides her contact information in case Mr. Smith has any questions or needs to reschedule.

DAY 6: INITIAL ASSESSMENT

Sally arrives early at the facility on the day of the appointment to speak with the facility staff and review Mrs. Smith's medical records, medication list, and minimum data set (MDS) assessment. She also obtains copies of Mrs. Smith's POA, Advance Directive, and pre-admission screening resident review (PASRR) I and II for Humana's case record. This gives Sally a comprehensive picture of Mrs. Smith's medical, behavioral, and social needs, as well as the current facility care plan.

Sally meets with Mr. and Mrs. Smith privately in her room, while her roommate is at physical therapy (PT). She completes the comprehensive assessment, reviews and completes Mrs. Smith's Freedom of Choice form, and reviews the new enrollee materials. These materials include the enrollee handbook, which provides detailed information about benefits, enrollee rights and responsibilities, grievance and appeals, and rights to a Medicaid Fair Hearing. This assessment and discussion gives Sally a picture of Mrs. Smith's current medical condition, functional limitations, behavioral health, and social circumstances, as well as strengths, needs, goals and informal supports available.

With these determinations in mind, Sally ensures the following actions are completed:

- Mrs. Smith's dementia is worsening

- Mrs. Smith has completed her PT and Occupational Therapy (OT), and continues to use a walker

- Mrs. Smith's respiratory condition has shown improvement post-pneumonia

- Mr. Smith would like to bring his wife back home with him, but is afraid he cannot take care of her because of his own functional limitations

- The Smiths own their home, which is walker- and wheelchair-accessible

- Mrs. Smith has a history of wandering and gets lost in the neighborhood

- Mr. Smith completes a release of information (ROI) to allow Sally to discuss Mrs. Smith with their daughter

- Sally obtains a list of participants Mr. Smith would like to include in the Multidisciplinary Team (MDT) for Mrs. Smith. This includes Mr. and Mrs. Smith, their daughter, Community Primary Care Physician (PCP), LTC CM, Humana's Medical Director, Humana's utilization management care coach, and the NF's medical director

- Sally completes the Caregiver Support Tool with Mr. Smith

- Sally completes and submits the initial 2506A state form

Sally documents all information she gathers during the visit into CGX and creates an initial plan of care, indicating that the goal is for Mrs. Smith to return home. Additionally, the system allows her to capture any identified cultural or ethnic preferences. Sally collects electronic signatures on the plan of care and provides one (1) copy each to Mr. Smith, the facility, and Mrs. Smith's Community PCP. The CGX system allows Sally to send a fax of the plan of care (POC) to the PCP. Sally explains that at Humana, there are also Transition Coordinators (TCs) that assist with transition planning. Mr. Smith expresses interest in this, so Sally gains Mr. Smith's approval and makes a referral so they can begin the transition process.

DAY 18: MRS. SMITH'S INITIAL TRANSITION PLANNING

Amy, one of Humana's TCs, receives Sally's referral for Mrs. Smith. Amy and Sally collaborate to review Mrs. Smith's assessment, caregiver and informal support, and healthcare needs for her to safely transition back home. Amy contacts Mr. Smith to introduce herself and set a date for their initial meeting. Amy notifies Sally of the meeting date and time so she can participate and help facilitate Mrs. Smith's transition.

Amy will be of unique value to the Smiths, as she has received additional training in transition services such as home modifications and prevention of readmissions. She can also help enrollees like Mrs. Smith appropriately access the two thousand five hundred dollars ($2,500) in transition funds available to her as an expanded benefit. Amy, as would be the case with all Humana TCs, is part of Mrs. Smith's MDT, because of her broad experience and deep knowledge of community resources that may be helpful to provide support in transitioning, while taking Mrs. Smith's individual preferences into consideration.

DAY 25: MDT MEETING

Amy and Sally coordinate an MDT meeting that includes the participants identified during the first assessment. During the meeting, the MDT reviews her current status and identifies transition needs, including barriers to care and concerns with her transition home. Amy completes a repatriation screening tool within CGX, which captures key information like how long Mrs. Smith has been in the NF, her desire and ability to transition, her available caregiver support, and her functional limitations.

DAY 34: POST-MDT DISCUSSION

After the MDT meeting, Amy, Sally, Mr. and Mrs. Smith, and their daughter review and address the needs of both Mr. and Mrs. Smith to ensure that they have addressed all potential barriers.

The discussion focuses on educating Mr. Smith on the importance of taking care of himself. Amy explains that he needs to be at his optimal health to properly support and maintain Mrs. Smith at home. She explains to Mr. Smith the importance of taking care of his own health and health care needs including attending medical appointments, adhering to his medication, and maintaining his activity level. To this end, Sally adds respite care as a service to provide Mr. Smith a break from time to time so that he can attend to his own health and well-being needs.

Mrs. Smith needs daily assistance for bathing, ambulation, and meal preparation. The group discusses options for personal care services and adult day health centers (ADHC). The Smiths' daughter is an occasional caregiver on weekends, but her role is limited by her job and family needs. Amy educates Mr. Smith on the Participant Directed Option (PDO) for personal care services, but Mr. Smith requests agency support. They also need homemaker services for meal preparation and housekeeping. Mr. Smith developed a back-up plan for the provided services in case the authorized provider is unable to provide service. Amy uses the Humana services guide and her assessment to take into account Mrs. Smith's current functional abilities and gaps. She uses these to develop appropriate hours for her personal care services. Amy provides several nearby personal care agency names for the family to select from so they can choose a provider that has experience in managing enrollees with dementia. Mr. Smith and his daughter say they want to discuss care options for Mrs. Smith before making a decision.

Amy offers a referral to Humana's Alzheimer's/Dementia Disease Management (DM) program that can assist him in managing Mrs. Smith's increasing dementia and confusion, as well as educate him on sundown syndrome, which is common with Alzheimer's. Mr. Smith accepts the referral for DM. Sally makes a referral for DM and provides the website for Alzheimers.org for Mr. Smith and their daughter, as the site includes community resource information for support services.

DAY 45: ADULT DAY HEALTH CENTER (ADHC) DISCUSSION

Sally meets with Mr. Smith and his daughter to discuss the ADHC option for Mrs. Smith, as it would provide her with socialization, and enable Mr Smith to be successful with his caregiving role. Mr. Smith and their daughter agree that would be beneficial. Sally explains the transportation benefit to and from the ADHC, with the addition of personal care services before and after ADHC. Sally provides names of several in-network ADHC providers, with experience in dementia for the family to visit so they can select one that meets their needs to help plan for Mrs. Smith's transition home.

Sally asks about Mrs. Smith's life before the onset of dementia and what activities she enjoyed. Mr. Smith shares that she always enjoyed being outdoors and fresh air. Together, Sally works with Mr. Smith to identify a personal goal for Mrs. Smith to take a fifteen- (15) minute outdoor walk twice a week with the supervision of her personal care aide.

DAY 50: AMY FOLLOWS UP – ADDITIONAL TRANSITION SUPPORT NEEDS

Amy follows up on additional needs to support Mrs. Smith's transition back home. Through Amy's evaluation of the Smith's home, she learns Mrs. Smith currently has a walker, a raised toilet seat, shower chair, grab bars, and a handheld shower, and the home is equipped with a wheelchair ramp. She then works with the NF's physical therapists to evaluate Mrs. Smith for additional durable medical equipment (DME). They find the only additional item needed was adjustable bed rails. Amy will follow up with the NF Social Worker and Medical Director to obtain a prescription for bed rails and ensure delivery occurs prior to Mrs. Smith's return home.

Mrs. Smith requires adult pull-ons for incontinence, so Amy makes the necessary arrangements to have them delivered to her home. Amy secures a PCP appointment within seven (7) days of Mrs. Smith's discharge date to get her re-established with her PCP, to review and reconcile medications, and to ultimately decrease her risk for readmission. Amy assists in scheduling transportation to and from the PCP visit to remove any barriers to access to care. Amy obtains a prescription for a registered nurse (RN) to evaluate for medication review and reconciliation.

Discussions about safety in the home prompt Amy to review safety concerns with Mr. Smith and their daughter in regards to the potential for Mrs. Smith to fall or wander. She also makes suggestions for how to keep her safe including installing door chimes, purchased using Humana's transition expanded benefit. Since a personal emergency response system is not appropriate for Mrs. Smith because of her dementia, Amy explores the idea of a wandering GPS watch, which can also be purchased using this benefit. Mr. Smith agrees this would be a helpful item. Mr. Smith also shares they have had four (4) dogs for years, and consider them his family too; he agrees to keep them outside as much as he can.

DAY 51-64: MRS. SMITH'S TRANSITION PLAN

Together, Amy and Sally collaborate on Mrs. Smith's transition plan. Sally continues seeing Mrs. Smith monthly in the facility, and updates Mr. Smith while waiting for her transition plan and services to be in place prior to discharge. She maintains regular contact with Amy so each stays updated on Mrs. Smith's care through Humana's integrated system.

In preparation of Mrs. Smith's return home, Amy also reviews the disaster plan and emergency evacuation. Amy also assists in registering the Smiths with a special needs shelter, through the Special Needs Registry.

DAY 65- 77: MRS. SMITH'S PLAN OF CARE

Sally updates the POC based on Mrs. Smith's assessment and utilization tools. She determines the need for additional services based on standard of care criteria and medical necessity. Humana uses a risk ranking tool to determine service hours based on individual needs such as bathing, dressing, grooming, meal preparation, and the amount of time needed to perform these tasks. Upon completing this comprehensive assessment, Mrs. Smith is stratified as moderate, with a range of potential service hours using a standardized tool as a guide.

Sally enters authorization requests in CGX with the identified service hours and sends them for utilization review. She knows that if the requested hours end up being greater than the recommended range of service hours, an assigned Utilization Care Coach will complete an additional review and base the approval on medical necessity. If that Utilization Care Coach determines the requested number of hours requires additional review, we will ask a Medical Director to make the final determination within seven (7) days, as only a Medical Director has the authority to deny these requests.

When Sally's requested number of service hours is approved, CGX automates a faxed authorization to the current service provider. Sally knows that if the request for service hours is denied, Mr. Smith will receive a notice of adverse benefit determination letter, providing information on grievance and appeals and rights to a Medicaid Fair Hearing. Sally explains this to Mr. Smith and informs him that she can provide assistance with this process if Mr. Smith chooses to file an appeal, and that if he does so, he will receive a written acknowledgement from Humana within five (5) business days from the receipt of the appeal. We would advise him that we will review his request and communicate a decision within thirty (30) calendar days. In that case, we would submit Mr. Smith's appeal through the clinical appeal review process, and a Medical Director not previously involved in the original decision would review it. Once there is a decision, we would notify Mr. Smith of Humana's decision of her request for appeal, both verbally and in writing. Should we uphold an adverse decision, we would advise him of his right to a Medicaid Fair Hearing.

In Mrs. Smith's case, we determined that Sally's requested hours were medically necessary and that we approved all of Mrs. Smith's hours. We approved the ADHC for three (3) days each week to allow for socialization. Sally reviews this completed POC with Mr. Smith to ensure he agrees with the services, which he finalizes with his electronic signature. This prompts CGX to update the authorizations with the determined start date of services. Applicable providers then received authorizations via fax.

Sally informs Mr. Smith that if at any time he requests or requires a change in service providers, she will make the necessary referrals to ensure there is no disruption in care. Sally will also collaborate with Humana Provider Relations to address any service provider complaints within twenty-four (24) hours. If she is unable to resolve, Sally will facilitate the process for filing any

grievances identified by Mr. Smith, including assisting with the coordination of new Home and Community Based Service (HCBS) providers, her PCP, and any behavioral health services. Sally will also assist him with modifying transportation arrangements and identifying supportive community resources within her new community. Humana CMs have access to resource directories to help locate services and resources that the comprehensive plan may not cover. These include the Humana Community Resource Directory, Local 2-1-1 resources, and online local community resources. Sally provides information on Mrs. Smith's transportation benefit and on how to use her enhanced transportation benefits for additional transportation needs.

Sally tells Mr. Smith about Humana's One Medication Experience, which gives enrollees access to create and update all prescribed medications and supplements within a feature called One Medication List (OML). Enrollees access their enrollee profile via computer or mobile phone application. Mr. Smith informs Sally he is not very good with computers, but he will have their daughter update her medication list. Sally reaches out to the daughter and educates her on using this application so she can review and keep up to date on her mother's medicine, and reconcile her medication list within Humana's system, establishing a single source of truth that the Smiths and the Humana Clinical Care team can all use. Sally also coordinates with the Smith's Medicare plans to secure a mail order pharmacy delivery.

DAY 78 THROUGH DAY 168: MRS. SMITH'S TRANSITION HOME (FIRST 90 DAYS)

Day 78: After much coordination, Mrs. Smith is ready to go home. Amy ensures approval and scheduling or delivery of the following items and services prior to Mrs. Smith's transition:

- Personal Care Agency identified and authorization on file with start date to align with date of Mrs. Smith's return home

- Adult Day Care scheduled to begin one (1) week after transition per Mr. Smith's request. Transportation to and from adult daycare was scheduled

- Nurse visit for medication reconciliation scheduled within the first week

- Consumable medical supply order placed for the adult pull-ons and that the first shipment has arrived

- Mrs. Smith is wearing her ID band and wandering GPS watch

- Door chimes installed throughout the house

- Mr. Smith has been working with the Disease Management RN as part of the Alzheimer's/Dementia program and has taken steps to make the home safer for Mrs. Smith

DAY 82: Upon successful transition home, Sally remains Mrs. Smith's CM because she manages a mixed caseload and the Smith's home is within close proximity of the NF. Amy has

already been in contact with Sally and they coordinate a face-to-face review to take place on Mrs. Smith's fourth day home. During this visit, they review and sign the finalized POC. Sally leaves a copy with Mr. Smith and faxes a copy to Mrs. Smith's community PCP.

DAY 89: The next week, Sally calls the Smiths to ensure that she is receiving all authorized services and that Mr. Smith is satisfied with the services provided.

DAY 92: Mr. Smith receives a call from the disease management CM checking to see if everything is going well after Mrs. Smith's transition. Mr. Smith says both the wind chimes on the doors and Mrs. Smith's GPS watch have been helpful and provide him peace of mind. Mr. Smith appreciates having the time now to reconnect with his friends at the senior center and has begun realizing how many other families are dealing with similar concerns.

Amy ensures completion of the CF-ES 2506A Form within ten (10) days of discharge from the NF and the CF-ES 2515 Form (Certification of Enrollment Status HCBS) within ten (10) business days of receipt of the applicable enrollment file from the agency.

DAY 100: Amy, the Transition Coordinator, maintains contact with the Smiths and closes out the Smith's transition plan during their thirty (30)-day face-to-face POC review. Because there are no new or urgent issues related to the transition, Amy is no longer involved. Sally continues to work with the Smiths.

Sally continues monthly contacts and has open discussions with Mr. Smith to gain his perspective on how Mrs. Smith's POC is working. They review any barriers to the achievement of their goals and expectations, and make POC changes as needed. Sally informs Mr. Smith that these contacts may occur more frequently if Mrs. Smith experiences a change in condition in her health, care needs, or circumstances. Sally encourages and reminds Mr. Smith to notify her as soon as possible if service delivery isn't timely, services are missed, if there is a change in circumstances, or if they are not happy with the current providers or service plan.

Sally can track and monitor any activity Mrs. Smith may have in an emergency department or hospital, should they occur. She would receive notification of each emergency department visit via a daily report called the Health Information Exchange – Electronic Notification System (HIE-ENS) and receive info from CGX alerting her of any admission or discharge from the hospital or a skilled nursing facility (SNF). Sally would suspend services and generate a notice of adverse benefit determination letter (NOABD), which would go to Mr. Smith and the provider should Mrs. Smith have any interruption in services.

Additionally, Sally reviews utilization and missed visit reports to identify patterns of services so we can correct any deviations from optimal usage of healthcare services. Sally monitors Mrs. Smith's condition and continues to ensure services meet her needs. For example, she will check whether the current consumable medical supply order is sufficient, and whether the ADHC or personal care aides are appropriately scheduled for her changing needs. She will also determine if there is caregiver stress or burnout for Mr. Smith.

Sally continues her quarterly face-to-face visits with Mr. and Mrs. Smith, which include the following:

- Reviewing Mrs. Smith's current medical/functional/behavioral health status, including strengths and needs

- Identifying any changes or updates of family/natural support system or community resources and their availability to assist Mrs. Smith and her family, including barriers to such assistance

- Re-assessing Mrs. Smith's environment, including fall risk screening

- Reviewing any needed provider appointments or medical needs and assisting with scheduling or transportation as needed

- Discussing medication reconciliation

- Reviewing current service delivery and satisfaction of those services

- Updating/revising Mrs. Smith's POC

DAY 108 AND BEYOND: ONGOING ENGAGEMENT AND RELATIONSHIP

At Sally's quarterly face-to-face visit with Mr. and Mrs. Smith, Mr. Smith shares that Mrs. Smith has been attending ADHCs on Mondays, Wednesdays, and Fridays, where she is engaged with activities at the center. While the ADHCs care for Mrs. Smith, Mr. Smith socializes with his friends at the local senior center. He is grateful and feels fortunate to have his wife at home while enjoying quality time with his family and friends. Their daughter is thankful that her mom is socializing and visits her parents on the weekend with the grandchildren. Mrs. Smith's move back to her home has been fantastic for her and her family.

Footnote

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[1] CareHub is Humana's enterprise solution for complete program integration for our provider community and enrollees. CGX supports an integrated, comprehensive approach to medical, behavioral health, pharmacy, utilization, and care management. Full system integration allows our care team the capability to identify potential enrollees for programs, document gaps in care, automate care planning, monitor plan compliance, and identify opportunities for intervention.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

(a) Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
(b) Application of the respondent's case management risk stratification protocol, including a rationale for the decision;
(c) Application of a person centered care planning approach;
(d) Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
(e) Description of the interventions and strategies that would be used to facilitate community integration and transition planning;
(f) Application of coordination protocols utilized with other insurers, (when applicable) primary care providers, specialists, other service providers, and community partners particularly when referrals are needed for non-covered services;
(g) Description of the assessment of provider capacity to meet the specific needs of enrollees;
(h) Identification of strategies that promote self-management and compliance with the plan of care;
(i) Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
(j) Application of strategies to integrate information across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondents workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent demonstrates experience providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

5. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

6. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes into its workflows.

Score: This section is worth a maximum of 75 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment LTC 12-1: Mr. and Mrs. Smith's Visual Story Guide

We have provided this document as a visual guide to our response. The key timelines from our core response are duplicated here in a format intended to supplement and enable a comprehensive review of Humana's approach to Mr. and Mrs. Smith.

About Mr. and Mrs. Smith:

Mrs. Smith is in her early 70s, dually eligible for Medicaid and Medicare, enrolled in Medicare FFS, and newly enrolled in Humana's comprehensive plan. After experiencing an acute episode of pneumonia, Mrs. Smith required hospitalization, inpatient rehabilitation, and subsequent placement into a nursing facility (NF). She has a history of moderate to severe dementia and has been known to wander. She uses a walker for assistance and can feed herself. Mrs. Smith's husband, Mr. Smith, is also in his early 70s, dually eligible for Medicaid and Medicare, enrolled in a non-Humana MMA plan, and has power of attorney (POA) for Mrs. Smith. Mr. Smith wants to move his wife home, but is concerned he cannot meet her needs. Their home is cluttered, they have many pets, and have an adult daughter who lives in state.

Key Components of Care

- **All Necessary Services and Supports in Place** while helping transition Mrs. Smith from the NF back to her home
- **Enrollee and Caregiver's Needs and Goals** at heart of her plan of care (POC)
- **Disease Management (DM) Referral and DM CM** pulled in to help educate Mr. Smith on how to manage Mrs. Smith's worsening Alzheimer's/dementia conditions
- **Ongoing Engagement and Relationship** with the Smiths to ensure we meet care goals, while keeping enrollee and caregiver abilities and preferences in mind

The Smith's Support System

- **Mr. Smith** — Husband with POA
- **Sally** — LTC Case Manager (CM)
- **Amy** — Transition Coordinator (TC)
- **Disease Management CM** (CM)
- **The Smiths' Daughter**

Mr. and Mrs. Smith's Timeline:

1 — Pre-Humana: Health Status
Mrs. Smith has a history of moderate to severe dementia. She needs daily assistance for bathing, ambulation, and meal preparation. Hospitalized with an acute episode of pneumonia, she needed inpatient rehabilitation and was placed in a NF.

2 — Day 1: Enrollment
New enrollee materials triggered within 5 days of enrollment; CGX assigns case to an LTC CM, Sally.

3 — Day 2: Initial Outreach
Sally contacts the facility and notes hospitalization reason; she has welcome call with Mr. Smith, who has POA. She sets up an in-person meeting, confirms materials receipt, and learns about the Smith's daughter.

4 — Day 6: Initial Assessment
At the NF, Sally obtains copies of all documents for Humana's records, and meets with the Smiths to assess and make initial determinations.

5 — Day 18: Transition Plan
Sally brings in a Transition Coordinator (TC), Amy, and adds her to the multidisciplinary team (MDT). Amy sets up time with the Smiths to plan her transition home.

6 — Day 25-34: MDT & Post-MDT
MDT reviews status, needs and barriers. Amy fills out repatriation screening tool; team educates Mr. Smith and sharing options including PDO; DM referral.

7 — Day 45: ADHC
Sally meets with Mr. Smith & daughter to discuss Adult Day Health Center options and suggest activities for Mrs. Smith following discharge.

8 — Day 50-64: Additional Transition Planning
Amy assesses the Smith's home and DME, arranges delivery, secures PCP appt in 7 days post-discharge, reviews safety concerns with Mr. Smith. Amy and Sally collaborate on plans.

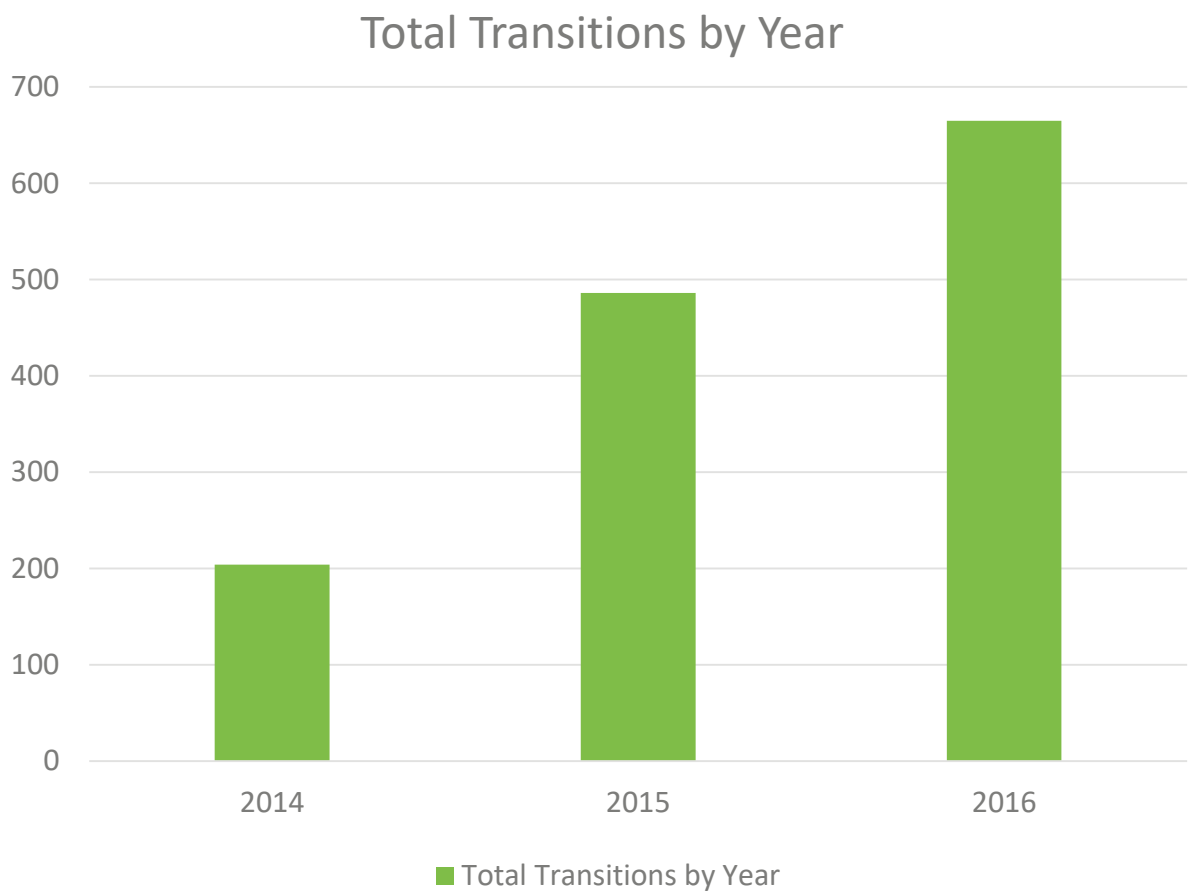
9 — Day 65-77: POC Updates
Sally updates the POC based on transition plan. She adjusts approved service hours and educates Mr. Smith on One Medication List.

10 — Day 78-168: Transition Home (First 90 Days)
Amy ensures approval, scheduling and deliveries of services. Sally coordinates meeting for 4 days post-transition. MDT has 30-day face-to-face POC follow-up. Disease Management (DM) follows up with Mr. Smith.

11 — Ongoing:
Sally continues quarterly face-to-face visits with the Smiths to check in on POC status and additional needs.

Attachment LTC 12-2: Annual Institutional to Community Setting Transitions from 2014-2016

Humana has continually increased the number of enrollees that have transitioned through the various strategies for improvement. Humana's success rate is continuing apace in 2017.



Methods for Improvement:

- Nursing home sweeps conducted monthly by regional TC (Transitional Coordinator)
- TC visit all newly enrolled NF enrollees to introduce self and explain Transition option
- Weekly TC attendance on regional CM meetings to engage staff in referral process
- TC builds relationship with NF providers
- Education of CM staff on importance of explaining Freedom of Choice to enrollee/ POA in NF
- Build Relationship with ALFs in region for ease of transitioning enrollees

F. OVERSIGHT AND ACCOUNTABILITY

LTC SRC# 13 – Management Experience and Retention (Statewide):

The respondent shall describe its approach to the hiring and promoting retention, throughout the Contract term, of executive managers (e.g., CEO, COO, CFO, CMO, vice presidents, senior managers) who have expertise and experience in serving elders and adults with disabilities who require LTC, and document such expertise and experience. The respondent shall describe the relevant experience of their current management team. [See Section 409.981(3)(a), Florida Statutes]

Response:

APPROACH TO HIRING EXECUTIVES WITH LONG-TERM CARE (LTC) EXPERIENCE

Humana's approach to hiring executives requires a thorough examination of each candidate's qualifications including education, experience, and a proven track record of success. We seek healthcare executives who have demonstrated LTC experience, a deep understanding of the unique challenges in the Florida Medicaid market, and a capacity to innovate and grow as part of a team dedicated to our goal of the perfect provider, stakeholder, enrollee, and associate experience.

Humana's recruiting model focuses on placing the right applicants into the right positions to enhance our Perfect Experience: a commitment to helping our enrollees achieve their best health and lifelong well-being. During the executive search process, we use an internal executive search team, external executive search firms, and various research and hiring vendors to deploy a comprehensive recruitment strategy. Our internal Enterprise Talent Development (ETD) team specifically focuses on talent development and internal mobility of executive managers. We have aligned our external Talent Acquisition team to recruit and hire executive managers. Whenever specialized training or licensure is required, we identify and recruit individuals with the appropriate certifications and background.

PROMOTING FROM WITHIN
Humana has more than fifty thousand (50,000) diverse associates serving enrollees nationwide; ten thousand (10,000) of these associates are in Florida. We dedicate significant time and resources to internal leadership development, maintaining internal talent pools from which to source qualified candidates for key executive vacancies as top positions in the organization shift. We maintain our internal talent pools by tracking and monitoring Talent Profiles, experiential moves, and the Humana Way Executive Leader Assessment. Talent Profiles, our self-led talent and performance management system, provide a platform for our leaders and associates to regularly highlight accomplishments, showcase their skills, and create a development plan. Experiential moves, which are internal job changes that allow our leadership to gain experience across all departments, are part of our foundational executive development methodology. Our Human Resources team manages the internal executive candidate slating process. This process includes gathering requirements, building candidate slates, and ensuring cross-organizational vetting of potential candidates. They integrate candidate slating activities

with the succession planning process, preparing the CEO to highlight the top leadership pipeline to the Board of Directors. We then select and extend an offer to the final candidate.

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3. The degree to which the respondent provides evidence, data, or metrics to demonstrate the effectiveness of its approaches to staff retention, including staff tenure, by contract, for the respondent's two (2) most recent contracts.

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PROMOTING RETENTION THROUGHOUT THE CONTRACT TERM

The retention of key executives is vital for our enrollees' continuity of care. Humana promotes retention through career development, recognition programs, financial incentives, and an exceptional organizational culture. These retention strategies ensure that we have a deep pool of candidates capable of sustaining our care delivery systems. Humana begins promoting retention during the onboarding process, and continues to assist our associates in increasing their value, experience, and expertise throughout their careers at Humana. According to the most recent Bureau of Labor Statistics from January 2016, the average employee with a job in management occupations stays with an employer six point three (6.3) years. Our current Medicaid executives, profiled in this narrative, have an average tenure of more than ten (10) years, and a total of three hundred fifteen (315) years with Humana. In addition to their long tenure with Humana, our executives boast more than seven hundred fifty (750) years of industry experience. We sustain our strong retention and experience data and metrics through our dedication to maintaining exceptional retention strategies, culture and versity

Humana is a place where people can grow, develop, and take on broader responsibilities. Overall, the Florida Medicaid team members have averaged three (3) advancements in roles over their tenures. These changes represent developmental opportunities and accomplishments, many of which you can read about in each executives' biography. John Barger, who leads our national Medicaid program, has developed his career working in and leading different businesses across the enterprise. He has spent the last seventeen (17) years based in Florida. Ten (10) other Florida Medicaid executive managers have also made experiential moves during their tenure with Humana. This speaks to the quality of our Leader Training and Development programs.

CAREER DEVELOPMENT

Humana has maintained strong associate retention, as described in Attachment 4, during our two (2) most recent contracts:
- Florida Medicaid LTC contract implemented on August 1, 2013
- Florida Medicaid Managed Medical Assistance (MMA) contract implemented on January 1, 2014

Humana is dedicated to growth-based careers, prioritizing experiences to increase career satisfaction, loyalty, and a flexible, higher quality workforce. We regularly offer required and optional programs, workshops, and webinars focused on career cultivation. During their first year in an executive management position, we require our executive managers and associates

to complete our Required First-Year Curriculum. Comprised of three (3) programs, Humana Leadership Orientation, Fundamentals of Employment Law, and Leadership Essentials, this curriculum provides the foundation our associates need to thrive in their new roles.

HUMANA LEADERSHIP ORIENTATION
The Humana Leadership Orientation (HELLO) program is a dynamic virtual orientation experience for new Humana leaders. Whether newly promoted or newly hired into a leadership role, this program helps guide their leadership journey. Areas HELLO addresses include the Humana culture and leadership expectations of growth and development, along with a focus on behaviors that drive associate engagement and well-being.

LEADERSHIP ESSENTIALS
Leadership Essentials is a virtual learning experience for our executive managers and associates who are interested in developing the fundamentals of leadership. The program focuses on the essential leadership practices of interpersonal effectiveness, leading positively, business acumen, and talent development.

After executive managers and associates complete our Required First-Year Curriculum, they can access our second tier of career development programs. These programs build upon the skills and knowledge acquired during the executive manager's first year, and focus on transitional innovation for developing the next generation of Humana leaders. We update new opportunities regularly on our leadership development website, The Leader Connection, which focuses on growth and development, leadership connection, and leading and retaining talent with tools, resources, and opportunities. The diversity and abundance of our programs allow executive managers to hone their skills in specific areas. See Attachment 2 for a description of selected second-tier development programs. See Attachment 3 for a selection of Medicaid and LTC-specific courses.

Our executive managers and associates identified in this response have taken advantage of the abundance of career development available. Since January 1, 2013, these leaders have completed a cumulative total of one thousand one hundred eighteen (1,118) courses specific to job and career growth, with an average of thirty-six (36) courses completed per leader. Many courses are specific to their current positions, Medicaid, and LTC, as shown below.
- 382 completed Medicaid courses, averaging 12 per leader
- 152 completed LTC and Elder Care courses, averaging 5 per leader
- 287 completed executive development courses, averaging 9 per leader
- 297 completed other relevant courses, averaging 7 per leader

Humana employs a variety of programs and strategies to encourage retention among all associates, including executives. These include recognition programs for tenure, financial incentives, diversity opportunities, and an exceptional culture that enables associates to thrive in an environment of support and recognition. Many groups have recognized our strong associate retention, culture, and mission, including 2016 Military Times, Temkin Group Customer Experience Excellence Awards, RobecoSam Sustainability Award (Gold Class 2017), and others.

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1. The extent to which executive managers have expertise and experience in implementing innovative care delivery systems serving elders and adults with disabilities who require LTC

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXPERIENCE IMPLEMENTING INNOVATIVE LTC CARE DELIVERY SYSTEMS

Humana's leadership has experience implementing innovative care delivery systems serving adults with disabilities and elders who require LTC in Florida. Humana managed the Nursing Home Diversion (NHD) program for Florida's frail and elderly population from 2007 to 2013 before the state transitioned to an expanded and fully-capitated Long-term Care (LTC) model in 2013. Today we contract to provide managed LTC across all eleven (11) regions in Florida. Among numerous national and local managed care organizations (MCOs), Humana had the highest-rated plan in Florida Medicaid from 2011 to 2015, according to the National Committee on Quality Assurance (NCQA).

In both Illinois and Virginia, our national Medicaid leaders led the partnership with local Community Service Boards to coordinate behavioral health needs of the long-term services and supports (LTSS) enrollees, as well as able-bodied elderly and disabled in both state's demonstration programs. We describe the implementation of our Illinois and Virginia programs below.

ILLINOIS IMPLEMENTATION
Humana provides managed LTSS (MLTSS) under Illinois' Integrated Care Program (ICP) for more than five thousand one hundred (5,100) older adults and adults with disabilities who are not dual eligibles. This program integrates medical services and LTSS for enrollees using a coordinated care model, which we implemented alongside the Illinois (CMS) Dual Eligible Financial Alignment Demonstration.

VIRGINIA IMPLEMENTATION
Through Humana's leadership team, the organization maintains a similar experience implementing innovative care delivery systems serving elders and adults with disabilities who require LTSS services in Virginia through our Commonwealth Coordinated Care (CCC) Program, a CMS Financial Alignment Demonstration program. We implemented an LTSS program with clinical social workers and nurses to provide monitoring and comprehensive reviews for nursing facility residents that incorporated medical, behavioral, and social needs. Humana offers coverage in all current CCC regions, providing fully-integrated care management and service coordination to nearly ten thousand (10,000) enrollees.

Examples of our executive managers' experience implementing innovative care delivery systems serving elders and adults with disabilities who require LTC include:

- Developing and implementing an LTC case manager (CM) assignment algorithm and management tool accounting for geolocation, enrollee exceptions, associate status, language preferences, and regional panel targets. This resulted in a reduction in average distance to enrollees and increased CM satisfaction.

- Developed MLTSS physician-based "aligned incentive" models for clinical management of comprehensive non-dual and dual demonstration enrollees improving physician engagement, improved clinical documentation, and care quality.

- CareHub – Humana's integrated technology solution is available to associates using our cutting-edge CareHub infrastructure. As Humana's clinical management platform, CareHub includes all the clinical and care management documentation. All designated care management associates, including acute CMs, utilization management (UM) associates, Humana CMs, Community Health Educators, and Field Case Managers, can create and update enrollee records using this platform. We can track enrollee health status using the Clinical Tools function, which collects important information such as measurements and generates trend reports for associates and enrollees. This function is part of a menu of applications that ties all enrollee experiences, including pharmacy encounters and communications, eligibility status, claims and utilization, and power of attorney documentation, into a centralized electronic enrollee record repository.

The objective of the CareHub "ecosystem" is to improve enrollee outcomes and achieve quality objectives by addressing gaps in care through integration at the point of care. Our CareHub infrastructure leverages technology to enhance clinical delivery. It uses technology solutions to enable integration, collaboration, and data-sharing throughout the healthcare delivery lifecycle.

- Clinical Guidance eXchange (CGX) – The CareHub CGX clinical workflow system supports an integrated, comprehensive approach to utilization and care management. As a fully integrated approach, this enterprise solution provides enhanced capabilities to monitor over- and underutilization, identify candidates for programs, document gaps in care, automate care planning, monitor plan compliance, and identify undesirable outcomes for further intervention. Our CGX system documents both medical and LTC information, allowing us a full view of our comprehensive enrollees.

- Atlas – The Atlas Clinical Rules Engine allows us to identify, stratify, and route enrollees for:
-- Chronic Condition Management:
--- Diabetes – both disease management and education
--- Coronary Artery Disease – both disease management and education
--- Cancer – both disease management and education
--- End-stage Renal/Chronic Kidney Disease
-- Asthma
-- Transplant Management
-- Rare Disease
-- Emergency Department (ED) Case Management (Complex Case Management)

- Anvita – Humana has established a first-of-its-kind clinical infrastructure that optimizes technology to enhance enrollee engagement and clinical delivery. Anvita converts diverse enrollee data into real-time, actionable insights that drive change and arm world-class clinicians to deliver industry-leading programs and services.

The Anvita engine and CareHub deliver personalized analyses that identify enrollees who (1) are at risk for adverse medical events, including hospitalizations; (2) are taking contraindicated therapies; (3) are missing preventative services; (4) have cost-saving interchange opportunities to lower costs; (5) need electronic, automated prior authorization of expensive services; and (6) have resolvable data gaps in their electronic record.

When deployed at the point of care, Anvita can identify, rank, and score competing treatments by safety, efficacy, and cost in real-time, using virtually all known clinical data. Anvita also

translates confusing industry terminology into consumer-friendly language, in real-time, to help physicians and enrollees have symmetrical views while enabling shared decision-making.

- Availity – Network providers in Florida have access to the Availity web-based platform. Availity is one of the leading health information networks in the country, optimizing information exchange between multiple healthcare stakeholders through a single, secure network. The Availity Health Information Network encompasses business and clinical services, and supports nationwide real-time and batch electronic data interchange via the web and through business-to-business integration.

The Availity Care Profile includes claims information associated with office visits and hospitalizations, diagnoses and associated procedures, prescription history, lab event history, radiology event history, immunization history, and clinical messaging. This information is critically important when a first-time enrollee presents, or during an emergency department visit, post-hospital discharge, or natural disasters. Use of the Availity Care Profile also improves enrollee safety by eliminating duplicate or unnecessary procedures to improve coordination and continuity of care. This allows more rapid closure of gaps in care for enrollees, greater opportunity for preventive care services, and chronic condition management.

- Humana's Medicaid Severity Predictive Model – We run new eligible enrollee information, such as claims, pharmacy, demographic, and diagnosis, within the first thirty (30) days of enrollment and monthly thereafter, through our proprietary Medicaid Risk Score algorithm. This score provides guidance for enrollees with high-risk factors and triggers them for case management and/or disease management outreach and participation efforts. By stratifying enrollees based upon future risk and high cost for case management, Humana can reduce cost and effort and improve care quality and health outcomes using appropriate intervention strategies for enrollees predicted to have high healthcare costs. If an enrollee is not eligible for case management and/or disease management at initial enrollment, our Medicaid Severity Predictive Model will continue to run in the background to assess changes in condition that may make the enrollee eligible for referral into case management and/or disease management.

- Area Agency on Aging (AAA) Partnerships – A barrier we faced in implementing the Virginia CCC program was the availability of qualified care management associates to meet contractual care coordinator eligibility requirements. As we enrolled tens of thousands of enrollees in the program, there was a significant need to hire additional care coordinators to meet initial care planning requirements and provide ongoing care management services afterward. To alleviate this issue, Humana partnered with local area agencies on aging (AAAs) for many care management functions, including facility-to-community transitions. In effect, Humana and the AAAs co-located care management associates and responsibilities. In addition to alleviating a workforce shortage, the AAAs also provided historical expertise on the population, which further aided in effectively serving our enrollees. This partnership also allowed us to maintain and further develop existing enrollee relationships while allowing us to enhance, rather than supplant, local healthcare resources.

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1. The extent to which executive managers have expertise and experience in implementing innovative care delivery systems serving elders and adults with disabilities who require LTC.

2. The extent to which executive managers have expertise and experience for their respective positions.

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CURRENT MANAGEMENT TEAM RELEVANT EXPERIENCE

Our Florida executive management team has a combined one hundred thirty-three (133) years of expertise and experience serving elders and adults with disabilities who require LTC services. See Attachment 1 for leader biographies with photos.

FLORIDA MEDICAID LEADERS

Our Florida Medicaid leaders provide executive oversight and management for the current Humana Florida Medicaid contracts. Our national Medicaid leadership supports them, which we briefly profile below.

JAIMIE WHITE, PRESIDENT, FLORIDA MEDICAID OPERATIONS
As a lifelong Florida resident, Ms. White is a highly engaged professional with more than seventeen (17) years of experience in leadership, program development, and business analytics within the Florida Medicaid and Medicare environments. She has LTC expertise serving the dual-eligible and senior populations, leading strategies to reduce financial barriers to care and to leverage community-based resources to meet social needs, allowing enrollees to focus on their health. Ms. White is skilled in analyzing problems, developing and simplifying procedures, and finding innovative solutions that guide overall business strategy.

Ms. White started her career in health care with Physicians Healthcare Plans, Inc. (PHP), a Florida-based health maintenance organization (HMO), which administered Medicaid and Florida Healthy Kids benefits to more than two hundred thousand (200,000) recipients. PHP promoted her to positions with increasing management responsibility through Amerigroup's purchase of PHP's Medicaid business in 2002, in which the company became CarePlus. When Humana acquired CarePlus in 2005, Ms. White was already in a leadership role, where she continued to progress to her current role. She has accumulated expertise and experience in serving the dual-eligible and senior populations in Florida, including:

SERVICE OPERATIONS
- Customer Care center leader, driving development of programs focused on enriching quality within the Dual Eligible Special Needs Plan (D-SNP) enrollees' service experience.

DUAL ELIGIBLE SERVICE AND SUPPORT STRATEGY
- Contract owner for CarePlus' D-SNP contract with the State of Florida. Responsible for D-SNP plan design, implementation, and execution of D-SNP contractual requirements and administration of D-SNP benefits.

- Implemented Social Services Outreach program to educate enrollees on State and Federal resources available to address financial insecurity.

- Developed process to proactively identify recertification dates for dual-eligible enrollees and assist enrollees with recertification

- Supported implementation of an Access Community partnership with Department of Children and Families in Miami-Dade County

PROCESS IMPROVEMENT AND TECHNOLOGY IMPLEMENTATIONS
- Led strategic technology initiatives across operations to create process efficiencies, enabling the successful absorption of forty percent (40%) growth in enrollment over a thirteen (13)-month period

- Led implementation of the CMS 837 Encounter Data reporting

- Managed conversion of paper-based claims to an electronic 837 record, supported improved accuracy in encounter data reporting to CMS, and generated administrative cost savings of more than five hundred thousand dollars ($500,000) per year

DR. IAN NATHANSON, LEAD MEDICAL DIRECTOR, FLORIDA MEDICAID MARKET
Dr. Nathanson is dedicated to and passionate about improving the health of children through direct clinical care, education and rsearch. He has forty-five (45) years of experience in healthcare and has written forty-nine (49) publications (including one book chapter and 36 abstracts). He has an extensive education and background in medicine, with specializations in pediatrics, pediatric pulmonology and pediatric sleep, and leadership positions in more than four (4) professional medical societies. Dr. Nathanson has received three (3) prestigious research grants from the National Institutes of Health (NIH), the Cystic Fibrosis (CF) Foundation, and the Agency for Healthcare Research and Quality. As well as two (2) Clinical/Research fellowships from the CF Foundation, Cardiovascular Research Institute at the University of California at San Francisco, and the Visiting Scientist Department of Physiology University of London, England.

DR. LOUIS FERNANDEZ, CHIEF MEDICAL OFFICER, FLORIDA MEDICARE/MEDICAID
Dr. Fernandez has more than twenty (20) years of experience driving clinical results and leading diverse cross-functional teams in outcome-based clinical management. During this time, he has maximized profitability through cost containment and performance optimization. He has also led institutional decision-making by effectively influencing committees on enrollee care and quality assurance. Dr. Fernandez also has a passion for leading stakeholders to integrate healthcare into a model that provides value and service to all. He is board-certified in obstetrics and gynecology (OB/GYN).

DR. CLINTON JULES, MEDICAL DIRECTOR, FLORIDA MEDICAID MARKET
Dr. Jules has more than fourteen (14) years of experience in the Florida Medicaid, Medicare, and LTC markets. He is skilled in providing medical services for enrollees, with a deep understanding of LTC services, home care services, nursing facilities, and assisted living facilities (ALFs). He has demonstrated experience leading teams to implement plans, policies, and procedures regarding LTC and transitions between facilities. He is board certified in internal medicine.

NATALIA ARESU, DIRECTOR, FLORIDA MEDICAID OPERATIONS
Ms. Aresu is an innovative leader with more than ten (10) years of experience in LTC and healthcare operations. She joined Humana in 2013 through the America Eldercare acquisition

and has experience in the implementation of operations for LTC and Statewide Medicaid Managed Care (SMMC) programs, as well as nursing facility diversion. A subject matter expert in the development and implementation of LTC clinical and operational software, Ms. Aresu has extensive knowledge of Agency for Health Care Administration (AHCA) requirements and Medicaid Benefits and Policy, and more than sixteen (16) years of experience in the healthcare industry. She has developed and implemented all case management and operational training programs for new associates. She also designed, developed, and implemented customized case management software to manage the LTC population. She serves on the Advisory Board of Impact Broward, a non-profit organization that provides respite services for elderly adults and veterans, and mentorship programs to children. As an Advisory Board member Ms. Aresu is heavily involved with numerous community and outreach events.

ELA ALARCON-CABRERA, CLINICAL DIRECTOR, FLORIDA MEDICAID OPERATIONS
Ms. Alarcon-Cabrera has more than thirteen (13) years of experience in LTC, healthcare and medical management. In her various roles leading clinical management and operations of large health plans, she identified Medicaid overpayment resulting in an estimated ninety-two million dollars ($92M) in savings of medical and prescription claims; developed Florida's first Institutional Equivalent SNP coordinating with LTC programs; established a national clinical management program to manage high cost claims; and supported the Mergers & Acquisitions team with the clinical integration of a newly acquired international health organization.

AMARILIS FERNANDEZ, MANAGER, FLORIDA MEDICAID CARE MANAGEMENT
Ms. Fernandez has extensive knowledge of Managed Care, Medicaid, Medicare, commercial insurance, and LTC programs, with more than thirty (30) years of experience in the healthcare industry. She holds a registered nurse (RN) certification in Florida, and is skilled in Complex Case Management, Nursing Facility Diversion, SNPs, and Disease Management including oncology, diabetes, congestive heart failure (CHF)/coronary artery disease (CAD), Alzheimer's/dementia, asthma/chronic obstructive pulmonary disease (COPD), and end of life care.

ANNIE SINANAN, CONTRACT MANAGER, FLORIDA MEDICAID OPERATIONS
Ms. Sinanan has more than twenty-five (25) years of experience overseeing and reporting audit activities and compliance issues with Humana healthcare plans in Florida. She has extensive knowledge of AHCA reporting and contract requirements, and a proven history of promoting positive relationships between AHCA and Humana. She is skilled in coordinating compliance with ad-hoc requests, special projects, and conflict resolution and communication.

LINDA LAWRENCE, COMPLIANCE OFFICER, FLORIDA MEDICAID MARKET
Ms. Lawrence has been with Humana since 1985. She was a Medical Center Administrator prior to joining the Compliance team, where she has served for the past twenty-five (25) years. She has worked in both the Commercial and Medicare areas in addition to Medicaid, and has been dedicated to Medicaid and LTC for the last eight (8) years.

SHANNON CHILDERS, RISK ADVISOR, FLORIDA MEDICAID MARKET
Ms. Childers has extensive knowledge of compliance risks and contractual requirements for LTC Medicaid programs, with seventeen (17) years of experience reviewing and preparing legal documents. She is skilled in reimbursement issues, fraud allegations, and Medicaid program integrity audits, and has experience implementing Corrective Action Plans (CAPs) to address noncompliance.

JASON FENNEMORE, STRATEGIC CONSULTANT, FLORIDA MEDICAID OPERATIONS
Mr. Fennemore has more than ten (10) years of experience leading healthcare management teams. He has demonstrated ability to develop efficient strategies and execute marketing plans. Mr. Fennemore is knowledgeable about the clinical, case management, and financial aspects of LTC programs. His background and education are in healthcare management and operations.

JULIE LOSEE, CLINICAL DIRECTOR, FLORIDA MEDICAID OPERATIONS
Ms. Losee has more than thirty-five (35) years of experience in the healthcare industry, with a background and education in nursing. She has experience leading multiple teams responsible for one hundred thousand (100,000) Florida Medicaid enrollees.

DANIELLE ANTALOCY, CLINICAL MANAGER, FLORIDA MEDICAID OPERATIONS
Ms. Antalocy has close to ten (10) years of experience in the healthcare industry. She is a skilled RN with a proven track record of positive, engaging leadership and exceeding goals. Ms. Antalocy has a strong commitment to providing education and ongoing training to associates, as demonstrated by her ability to implement new processes per State requirements, as well as her background and education in healthcare.

SHARON MECOLI, MANAGER, FLORIDA MEDICAID QUALITY OPERATIONS
Ms. Mecoli has thirty-five (35) years of experience as a certified RN. She is knowledgeable about Case Management and Quality of Care improvement, and skilled in Regulatory Compliance, Medicaid LTC, Operations Management, Grievance and Appeals, Process Improvement, and Policy Development.

SHARON COOK-MCEWEN, DIRECTOR, FLORIDA MEDICAID OPERATIONS
Ms. Cook-McEwen is a highly motivated executive leader who has demonstrated ability to analyze trends, develop new processes, and collaborate with large teams to improve outcomes for enrollees and healthcare providers alike. She has more than twenty (20) years of experience in healthcare management, with a background and education in nursing and business administration. She assumes direct responsibility for quality and operational metrics, and successfully leads teams to increase efficiency and prevent losses.

MICHAEL PRATT, VICE PRESIDENT, FLORIDA MEDICAID OPERATIONS
Mr. Pratt has more than twenty (20) years of experience providing detailed analyses of financial statements and reports for healthcare companies. His quality leadership and management of large teams provide healthcare services to Medicaid enrollees. He is highly skilled in financial analysis, cost savings, compliance, and project management, and has been working with the Humana Medicaid program since 2014.

JOE PIEMONTE, VICE PRESIDENT, FLORIDA MEDICAID OPERATIONS
Mr. Piemonte has more than twenty-five (25) years of experience in the healthcare industry and more than ten (10) years of experience in contracting, contract administration, and provider relations for more than one hundred fifty (150) hospitals and more than nine hundred million dollars ($900M) in annual spend in various lines of business. He has expertise in cross-functional team management, strategic planning and execution, and process and design improvement. He has demonstrated ability to negotiate large contracts and achieve positive outcomes while reducing budgets.

SHARON COLEMAN, DIRECTOR, FLORIDA MEDICAID PROVIDER RELATIONS AND CONTRACTING
Ms. Coleman has twenty-two (22) years of experience negotiating physician, ancillary, and hospital agreements and leading physician engagement strategies, including complex process resolution. She led the development of Humana's Medicaid and Duals expansion states, which allowed for involvement in all aspects of network build. Currently, she leads the Central Florida contracting team responsible for commercial, Medicare and Medicaid, as well as overseeing Medicaid operations and compliance for North Florida.

KATRINA KNIGHT-VERA, DIRECTOR, FLORIDA MEDICAID PROVIDER RELATIONS AND CONTRACTING
Ms. Knight-Vera has more than seventeen (17) years of experience in the managed care industry. During that time, she has led provider network contracting, re-contracting, compliance, and operational activities with physician, ancillary, and hospital providers. In her current role, she is responsible for all Medicaid network service level agreement requirements, which include provider education, network adequacy and state reporting, as well as contracting and re-contracting initiatives. Additionally, she collaborates with Health Services, Finance, and Medicaid leadership on developing clinical and network strategies to improve quality outcomes for our enrollees.

EDWARD MILLER, MANAGER, FLORIDA MEDICAID PROVIDER RELATIONS AND CONTRACTING
Mr. Miller has extensive experience managing home health, home infusion, and durable medical equipment (DME) companies, with six (6) years of experience in LTC and an additional five (5) years of experience in the healthcare industry. Since 2015 he has overseen Humana's Florida Medicaid LTC Provider Relations and Contracting teams to ensure network adequacy and provider engagement program improvements, among other responsibilities.

MEDICAID NATIONAL LEADERS

Our national Medicaid leaders support all Humana Medicaid contracts, partnering with our Florida management team to provide an integrated approach to care for our Florida enrollees.

ALAN WHEATLEY, PRESIDENT, RETAIL SEGMENT
Mr. Wheatley has more than twenty (20) years of experience at Humana. He created Humana's new Dual Eligible, Medicaid, and LTC business, and has deep knowledge of Medicaid programs. Mr. Wheatley has developed strategy for Humana's Medicare Prescription Drug Plan program encompassing three point two million (3.2M) enrollees. As Humana's leading President encompassing Medicare/Medicaid, he led all aspects of the business including developing the growth strategy that led to a fifteen percent (15%) compound annual growth rate (CAGR) since 2008, enabled by focus on enrollee and provider experiences.

DR. ROY BEVERIDGE, CHIEF MEDICAL OFFICER, NATIONAL MEDICARE/MEDICAID/DUALS
Dr. Beveridge has an extensive medical research background, with more than forty (40) years of experience in medicine and healthcare, and extensive publications in the fields of medical oncology, stem cell transplantation, quality design, and population health. He is known for creating collaborative environments among physician communities and providing thought

leadership around population health. He is board certified in medical oncology and internal medicine.

JOHN BARGER, VICE PRESIDENT, DUAL ELIGIBLE AND MEDICAID PROGRAMS
Based in Tampa, Florida, Mr. Barger has more than twenty (20) years of executive leadership in healthcare and significant experience working with traditional Medicaid, LTC, Medicare, Dual Demonstrations, commercial insurance programs, and care delivery organizations. He is knowledgeable in clinical operations management, quality programs, network contracting, provider relations, and finance. Mr. Barger is committed to serving vulnerable populations both personally and professionally, taking an active role in inner-city mentoring and faith-based initiatives in Tampa Bay for more than ten (10) years. His leadership development has focused on impacting the corporate culture by valuing associates and empowering them to make a meaningful difference in society through their work.

MARISSA CHILDERS, DIRECTOR NATIONAL MEDICAID/DUALS CLINICAL DELIVERY & QUALITY IMPROVEMENT
Ms. Childers is an accomplished healthcare professional with twenty (20) years of healthcare experience. She demonstrates success in employer-based workplace health and wellness management, clinical program management, case management, ambulatory and clinical nursing, and academia. She has extensive experience in LTC and worker's compensation case management, including program development, implementation and evaluation, quality improvement processes, and risk assessment.

ANDY NICHOLS, DIRECTOR, NATIONAL MEDICAID/DUALS STRATEGY AND COMMUNITY DEVELOPMENT
Mr. Nichols has six (6) years of experience in Medicaid, LTC, and duals strategy and development, and nearly a decade with Humana in total. He has been highly engaged in the growth of Humana's Medicaid and Duals program, participating in or leading business development efforts in all new and prospective markets, including the development of community-based stakeholder relationships, local care and support model partnerships, and proposal submissions. With a background in engineering and community development, Mr. Nichols is an entrepreneurial-minded strategic leader with a demonstrated skillset in relationship building, growth planning, delivery systems analysis, portfolio management, cost optimization, and civic planning.

RON WEEDEN, DIRECTOR, NATIONAL MEDICAID/DUALS FINANCE
Based in Tampa, Florida, Mr. Weeden has an extensive background in strategic planning, financial analysis, project management, forecasting, and budgeting specifically within Florida Medicaid, with twenty (20) years of healthcare experience. He is an extremely motivated, results-driven financial professional with exceptional leadership skills. Mr. Weeden demonstrates ability to proactively produce and lead exceptional performance within a team environment, and creatively resolve problems while capitalizing on opportunities.

JEB DUKE, DIRECTOR, NATIONAL MEDICAID/DUALS PROGRAM MANAGEMENT
Mr. Duke has ten (10) years of experience in Medicaid, Duals, and LTC, and is knowledgeable about contracts, developing segment structures, and facilitating process change. He is an experienced leader with an education in accounting and background in leading large teams as a United States Marine Corps (USMC) Commanding Officer. He has demonstrated ability to coordinate and improve processes that facilitate administrative savings.

DEBORAH BEAVIN, DIRECTOR, NATIONAL MEDICAID/DUALS STRATEGIC PARTNERSHIPS AND IMPLEMENTATION

Ms. Beavin has more than thirty (30) years of experience in business operations, with expertise in cross-functional team management, strategic planning and execution, and process and design improvement. She joined Humana as our Chief Procurement Officer in 2004. Ms. Beavin is a proven operational Leader, procurement expert, and Six Sigma Master Black Belt with extensive experience delivering productivity, driving process improvement and design initiatives, and collaboratively contributing notable business benefit in various roles. She led the organization's Corporate Procurement team in the introduction of a best-in-class Procurement process, which resulted in eight percent (8%) year-over-year supplier-related savings, a transition of ninety-two percent (92%) of spending to e-enabled methods, and a supply base reduction of sixty percent (60%). Since 2015 she has been serving as Medicaid's Culture leader, leading a group of Culture Champions across Medicaid to bolster associate engagement, belonging, and health.

JEFF LAYMAN, VICE PRESIDENT, NATIONAL OPERATIONS PROCESS TRANSFORMATION

Mr. Layman has nearly twenty (20) years of experience with Humana. He has led a variety of successful efforts creating a culture that both anticipated and responded to Humana's customers' needs. Mr. Layman has designed flexible business processes to meet an ever-changing business environment; established strategic development of service and process innovations; and led teams of associates dedicated to implementing innovation.

CHERYL D. GALLON, VICE PRESIDENT, VIRGINIA MEDICAID/DUALS MARKET & NATIONAL MEDICAID STRATEGIC PROJECTS

Ms. Gallon has a background and education in healthcare and business management, with more than twenty-two (22) years of experience in managed care, strategic planning, and operations. She has extensive knowledge of government programs such as Medicaid Fee-For-Service (FFS), Medicaid managed care, and Medicare, and is highly skilled in federal and state Medicaid regulations, compliance, project management, problem identification, and solutions.

ROSS WESTREICH, VICE PRESIDENT, ILLINOIS MEDICAID/DUALS MARKET & NATIONAL MEDICAID STRATEGIC PROJECTS

Throughout his twenty (20)-year tenure with Humana in Illinois, Ross Westreich is a seasoned executive and leader in the healthcare industry. Since joining Humana, Ross has gained experience working across the board in the senior products space, including market operations, product development, financial analysis, and strategic planning. Throughout his career, Mr. Westreich has built strong relationships with Illinois providers, enrollees, and the community.

HUMANA'S EXECUTIVE TEAM OFFERS EXPERIENCE AND EXPERTISE

Our dedication to rigorous recruiting, associate development, and retention has ensured that we have talented people, world-class associate engagement and commitment to service. Our Florida executive management team offers a wealth of knowledge and experience specific to Medicaid, Florida, elders, and adults with disabilities who require LTC. Our team is poised to deliver the highest level of service to Florida Medicaid enrollees.

EXHIBIT A-4-c
LTC SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which executive managers have expertise and experience in implementing innovative care delivery systems serving elders and adults with disabilities who require LTC.

2. The extent to which executive managers have expertise and experience for their respective positions.

3. The degree to which the respondent provides evidence, data, or metrics to demonstrate the effectiveness of its approaches to staff retention, including staff tenure, by contract, for the respondent's two (2) most recent contracts.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Jaimie White

Upon Award: President, Florida Medicaid Operations

Qualifications

- Highly engaged professional with 17+ years of progressively responsible experience in leadership, health plan operations, operations audit/cost containment, member services, program development, and business analytics within the Medicare, Medicaid, and Commercial environments
- Skilled in analyzing problems, developing and simplifying procedures, and finding innovative solutions that guide overall business strategy
- Demonstrated experience driving consistent improvement in plan operations and risk mitigation

Professional Experience

2017–Present Humana's President, Florida Medicaid Operations

- Market Leader of Humana's Florida Medicaid portfolio of products, including MMA and Long-Term Care with a total membership of 340k.
- Leads cross-functional strategy to support the Medicaid, Long Term Care and Dual eligible member experience
- Develops strategies to apply consumer feedback to improve the member experience and improve Quality and Compliance performance

2013–2017 CarePlus Health Plans, Inc. (Subsidiary of Humana)'s Service Vice President

- Senior Leader of a Florida-based Medicare Advantage plan covering 108k lives, specializing in the dual eligible population
- Successfully managed the absorption of a 40% membership increase within a 13-month period
- Aligned operations and service focus to support a 5 STAR strategy, ultimately contributing to a nationally recognized 5 STAR overall rating for the 2015 plan year

2010–2013 CarePlus Health Plans, Inc.'s Director, Claim Operations

- Responsible for direct oversight of Medicare Advantage Plan medical claims payment processes/policies, including oversight of MRA Data Submissions, inbound/outbound HIPAA transaction sets for claim processing, CMS Encounter Data Reporting, and ad hoc data analysis

CarePlus Health Plans, Inc.'s Director, Operations Audit & Support

- Responsible for the oversight of the Verification Department, Coordination of Benefits Unit, Financial Recovery, Provider Financial Configuration, and Product Development

Education and Certifications

- Bachelor of Science in Finance from University of Tampa
- Associate of Arts in Business Administration from Hillsborough Community College

Dr. Ian Nathanson

Upon Award: Lead Medical Director, Florida Medicaid Market

Qualifications

- Dedication and passion to improve the health of children through direct clinical care, education, and research
- 45+ years' experience and 49 publications, including 1 book chapter and 36 abstracts
- Extensive education and background in medicine with leadership positions in 4+ professional medical societies
- Recipient of 4 prestigious research grants and 2 Clinical/Research fellowships

Professional Experience

2014–Present	Humana's Lead Medical Director, Florida Medicaid Market
2011–2014	eQ Health Solutions', Associate Medical Director
2009–2010	Keystone Peer Review Organization's Medical Director
1989–2009	Nemours Children's Clinic's Chief Executive
1979–1989	Children's Hospital of Buffalo's Pulmonary Division Director

Education and Certifications

- Doctor of Medicine from State University of New York at Buffalo
- Bachelor's Degree in French Studies from State University of New York at Buffalo
- Certified in Pediatrics, American Board of Pediatrics
- Certified in Pediatric Pulmonology, American Board of Pediatrics
- Certified in Sleep Medicine, American Board of Pediatrics
- License: Florida ME0055343

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Dr. Louis Fernandez

Upon Award: Chief Medical Officer, Florida Medicare/Medicaid

Qualifications

- 20+ years of experience driving business results, leading diverse, cross functional teams in outcome based clinical management
- Maximized profitability through cost containment and performance optimization
- Led institutional decision making by effectively influencing committees on patient care and quality assurance
- Passion for driving stakeholders to integrate healthcare into a model that provides value and service to all

Professional Experience

2015–Present Humana's Chief Medical Officer, Florida Medicare/Medicaid

- Acts as primary relationship with regional provider community to optimize clinical integration
- Provides oversight and direction for implementation/operation of clinical programs and strategies

2012–2015 Humana's Regional Medical Director, Medicare Gulf States Region

- Provided clinical leadership and strategy across regional clinical organization with fiscal and trend management
- Interfaced with the regional provider community with focus on improvement of services/cost performance

2010–2012 Wellpoint's Medical Director, Integrated Health Model

2006–2010 Wellpoint's Physician Reviewer, Commercial and Medicare

- Responsible for administration of health plan medical services and ensured clinical integrity of clinical programs, including overall medical policies of the business unit

Education and Certifications

- Master of Science in Healthcare and Informatics from Northwestern University
- Doctor of Medicine from University of Illinois School of Medicine
- State of Illinois Physician and Surgeon License
- Accredited by American Board of Obstetrics and Gynecology
- Accredited by National Board of Medical Examiners
- Languages: English and Spanish

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Dr. Clinton Jules

Upon Award: Medical Director, Florida Medicaid Market

Qualifications

- Background and education in medicine with over 14 years of experience in the Florida Medicaid, Medicare and LTC markets
- Skilled in providing medical services for patients, with a deep understanding of long term care services, home care services, nursing facilities and assisted living facilities
- Demonstrated experience leading teams to implement plans, policies and procedures regarding LTC and transitions between facilities

Professional Experience

2017–Present Humana's Medical Director, Florida Medicaid Market

- Reviews medical necessity of member requests for long term care services including DME, home care services, supplies, home modifications, and other services not covered by members medical plan
- Works with utilization management team to implement and streamline processes and procedures integral to LTC
- Provides leadership for the development and implementation of policies and procedures in LTC
- Reviews medical necessity for inpatient vs observation (FER), hospital to hospital transfers, peer to peer reviews, re-consideration and appeals, LTACH and SNF case reviews

2011–2017 Humana's Program Group Leader, IPC/Team Health Post-acute care

- Provided initial plan of care for patients admitted to assisted living, skilled nursing and nursing facilities and provided subsequent care to patients at assisted living, skilled nursing and nursing facilities
- Implemented discharge planning and home transition to patients at skilled nursing and nursing facilities
- Reviewed complex cases within group and provide assessment of standards of care and quality review and processes analysis

2004–2011 Medical Director, St Johns Rehabilitation and Nursing Center

Education and Certifications

- Doctor of Medicine from University of Pittsburgh School of Medicine
- Bachelor of Arts from Cornell University
- Certification: American Board of Internal Medicine 2001 – 2024
- Licensure: Florida; Medicare/Medicaid contracted

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Natalia Aresu

Upon Award: Director, Florida Medicaid Operations

Qualifications

- Forward-thinking innovative leader with extensive health care operations experience
- Subject Matter Expert in design, development and implementation of long term care clinical and operational software
- Extensive knowledge of AHCA requirements and Medicaid Benefits and Policy with over 10 years' experience in the health care industry

Professional Experience

2015–Present Humana's Director, Florida Medicaid Operations

- Develops, manages and implements Florida's LTC program including Long Term Care and Home and Community Based Services with a revenue of $776M and the staff associated with those programs
- Collaborates with government agencies, Executive team, Humana Directors and managers and supervisors to coordinate, develop and evaluate programs and initiatives affecting the LTC population
- Collaborates with internal stakeholders to facilitate the intake, development, implementation, and measurement of Enterprise initiatives undertaken to optimize LTC functions
- Responsible for oversight and accountability of Florida's LTC program consisting organizational policies, objectives and initiatives

2014–2015 Humana/American Eldercare's Operations Manager

- Managed Authorization Data Analysis Departments, Member and Provider Call Center, Operations Analyst and Enrollment Specialists
- Identified areas to improve operations and coordinates with Quality Department to implement quality initiatives

2006–2014 Humana/American Eldercare's Quality Management and Staff Development

- Responsible for planning, developing, and facilitating new staff and on-going training including presentations and development of training materials as well as tracking compliance of training requirements for new and existing case management staff

2005–2006 American Eldercare's Senior Care Manager

Education and Certifications

- Master of Business Administration from Florida Atlantic University
- Bachelor of Arts in Forensic Psychology from John Jay College, City University of NewYork
- Bilingual in Spanish/English

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Ela Alarcon Cabrera

Upon Award: Clinical Director, Florida Medicaid Operations

Qualifications

- Over 13 years of experience in healthcare, medical management, and LTC
- Identified Medicaid overpayment resulting in an estimated $92M savings of Medical & Rx claims
- Developed Florida's first Institutional Equivalent SNP coordinating with LTC programs
- Increased LTC program profits over 25% by streamlining operational processes
- Established national clinical management program to manage high cost claims
- Supported M&A team with the clinical integration of a newly acquired international health organization

Professional Experience

2016–Present Humana's Clinical Director, Florida Medicaid Operations

2014–2016 CareNational Health Systems, Inc.'s Vice President, Strategy and Business Development

- Developed and implements home based chronic care management program contracting with HMOs, ACOs and risk medical groups
- Outlined the strategy, capital requirements and timeline for a Medicare Plan
- Identified key provider partnership opportunities, capital requirements, and licensing & growth strategies in the market

2013–2014 Sunshine Health Plan, Inc./Centene Corporation's Vice President, Operations and Business Strategy

- Successfully developed and introduced Statewide Medicare SNP and Healthcare Exchange products
- Identified and corrected medical claims process inefficiency resulting in an estimated savings of $88M
- Identified and corrected pharmacy claims process inefficiency resulting in $4.3 million per year savings
- Responsible for product development, operations/clinical operations, and ROI

2010–2012 Simply Health Plans, Inc.'s Vice President, Long Term Care & Clinical Operations

- Responsible for Medicare/Medicaid LTC applications and product start up
- Managed program compliance, provider network, medical management, marketing and outreach

2007–2010 United Health Care/Evercare's Director, Health Services

- Strategized, developed, and directed operations of the health services department to ensure provision of high quality, cost-effective medical services
- Responsible for the development and management to budget related to medical care, directs actions to control targeted costs for inpatient and outpatient services

Education and Certifications

- Doctor of Medicine from Universidad Central Del Este

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Amarilis Fernandez

Upon Award: Manager, Florida Medicaid Care Management

Qualifications

- Extensive knowledge of Managed Care, Medicaid, Medicare, LTC programs in Florida
- 30+ years of experience in the healthcare industry in Florida
- Skilled in Complex Case Management, Nursing Home Diversion, Special Needs Programs, Long Term Care, and Disease Management (Oncology, Diabetes, CHF/CAD, Alzheimer's/Dementia, Asthma/COPD)

Professional Experience

2016–Present Humana's Manager, Florida Medicaid Care Management

- Responsible for the management of the Utilization Management, Transitions of Care, Complex Care, PDO and Disease Management Departments for Humana's LTC program statewide

2013–2016 Centene/Sunshine Health's Director, Long Term Care and Support Services

- Director of LTC and Support Services department, which included over 10,000 LTC members (80% being dual members - Medicaid /Medicare) in Regions 9, 10 and 11
- Responsible for the recruiting, staffing and building a team for the LTC and Support Services Department from ground level for South Florida, Regions 9, 10, and 11
- Service area transitioned over 250 members from the Nursing Home setting to a least restrictive environment, exceeding program goals with a savings of over 15M for the fiscal year

2011–2013 Centene/Sunshine Health's Director, Case Management, Medicaid

- Responsible for the oversight of the day-to-day operations for Complex Case Management, Chronic-Complex Case Management, and Disease Management

2010–2011 Centene/Sunshine Health's Manager, Case Management, Medicaid

Education and Certifications

- Bachelor's Degree in Nursing from University of Miami
- Registered Nurse (1986 – Present)
- Certified Case Manager (2000 – Present)
- Languages: English and Spanish

Annie Sinanan

Upon Award: Contract Manager, Florida Medicaid Operations

Qualifications

- 25+ years' experience overseeing and reporting audit activities and compliance issues with Humana healthcare plans in Florida
- Extensive knowledge of AHCA reporting and contract requirements and proven history of promoting positive relationships between AHCA and Humana
- Skilled in coordinating compliance with ad hoc requests, special projects and conflict resolution

Professional Experience

2001–Present Humana's Contract Manager, Florida Medicaid Operations

- Oversees contract compliance in all aspects of the Medicaid program
- Submits all informational materials or changes to AHCA for review and approval prior to use with and distributed to members
- Coordinates with AHCA on program audits, responds to requests for materials for desk/administrative review and provides support during audit prep and during on-site audits.
- Channels request for clarification of contracts, benefits or other issues and shares AHCA responses with all departments
- Provides support, guidance, direction and assistance throughout Humana and AHCA

1996–2001 Humana Medical Plan, Inc.'s Compliance Manager

- Oversaw of all compliance and audit activities within the South Florida market.
- Reported to HCFA on a monthly basis, institutionalized corrections, section A allegation investigations, corrective action plans, logging and trending for HCFA review for Medicare Sales offices in South Florida
- Responsible for HCFA approval of all marketing materials through Corporate, as well as completing hospital bill audits for overage/shortage charges

1991–1996 Humana Medical Plan, Inc.'s Service Assurance

1985–1991 Humana Medical Plan's Contract Manager

Education and Certifications

- Associate Degree in Business from Gandhi Targore College
- Licensed Practical Nurse

Linda Lawrence

Upon Award: Compliance Officer, Florida Medicaid Market

Qualifications

- Expertise in managing compliance and regulatory requirements for the managed care industry with 30+ years' experience working in the healthcare industry
- Experience working in the Florida Medicaid market, specifically coordinating compliance and training and mitigating risks
- Managed suite of on-site specialty providers, and an urgent walk-in clinic servicing approximately 15,000 Medicare and Commercial members

Professional Experience

1985–Present Humana's Compliance Officer, Florida Medicaid Market

- Manages Humana's relationship with regulatory agencies and provides guidance for complying with regulatory requirements for the statewide Medicaid Managed Care Program including both Managed Medical Assistance (MMA) and Long-Term Care (LTC) as administered by the Florida Agency for Health Care Administration (AHCA)
- Conducts audits on operational activities/reports results/implements and monitors corrective actions
- Interacts with regulatory agencies
- Participates in company and external work groups/committees
- Directs regulatory exams
- Provides consultation and direction for government products.

Past Positions

- Regulatory Compliance Director, Medicare & Medicaid
- Compliance Coordinator
- Training Coordinator
- Medical Center Administrator
- Systems Technician
- Senior Field Service Coordinator
- Field Service Coordinator

Education and Certifications

- Bachelor of Science in Professional Studies from Barry University

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Shannon Childers

Upon Award: Compliance Risk Advisor, Florida Medicaid

Market Qualifications

- Extensive knowledge of compliance risks and contractual requirements for LTC Medicaid programs with 17 years of experience reviewing and preparing legal documents
- Skilled in reimbursement issues, fraud allegations and Medicaid program integrity audits
- Experience implementing Corrective Action Plans to address noncompliance

Professional Experience

2013–Present Humana Compliance Risk Advisor, Florida Medicaid Market

- Serves as a dedicated compliance resource for corporate and market associates
- Reports existing and potential compliance risks to executive leadership, including the Medicaid Compliance Officer, Medicaid Chief Operating Officer, and Market Vice President
- Conducts oversight and monitoring at a contractual requirement level for a Medicaid long-term care contract with the state of Florida
- Implements Corrective Action Plans with business areas to address metrics, reports, and general noncompliance
- Coordinates on-site audits, including preparation and post-audit remediation

2012–2013 Associate, Jeyaram & Associates

- Handled Medicaid and Medicare reimbursement issues, appeals, and litigation
- Represented clients for utilization review appeals, Medicaid program integrity audits, and Medicare audits
- Advised healthcare clients regarding compliance with state and federal regulations, including Anti-Kickback, the False Claims Act, HIPAA, and Stark

2010–2012 Contract Attorney

- Prepared legal documents, applied state/federal law to facilitate post-judgment debt collection, negotiated to settle cases, and attended hearings/trials when necessary

2006–2008 Law Clerk, Sexton and Wykoff, PLLC

- Drafted court pleadings, orders, and legal memoranda, communicated with clients/ attorneys/court staff, prepared case timelines, and produced detailed case analysis

2004–2005 AIM Healthcare's Financial Analyst

2000–2004 CIGNA Healthcare's Financial/Data Analyst

Education and Certifications

- Juris Doctor from University of Tennessee College of Law
- Bachelor of Arts in Economics from Vanderbilt University
- Member of State Bar of Georgia

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Jason Fennemore

Upon Award: Strategic Consultant, Florida Medicaid Operations

Qualifications

- Background and education in healthcare management and operations with over 10 years' experience leading healthcare management teams
- Demonstrated ability to develop efficient strategies and execute marketing plans
- Knowledge of clinical, case management and financial aspects of LTC programs

Professional Experience

2015–Present Humana's Strategic Consultant, Florida Medicaid Operations

- Serves internal market and corporate operational leadership teams
- Recognizes and identifies opportunities for market to contribute to plan development
- Develops and executes internal operational strategies and execution of initiatives
- Assist teams to evaluate and develop future state planning

2014–2015 Humana American Eldercare Inc.'s Regional Director, Operations

- Responsible for the efficient operation of the care management systems
- Ensured all contract requirements were met
- Lead cost savings planning relevant to issues for LTC enrollees and the organization

2010–2014 American Eldercare Inc.'s Executive Director, Southwest Florida Region

- Responsible for Provider Service Network for LTC Program in Florida
- Directed daily operations of the branch including clinical, care management, and financial operations

Education and Certifications

- Master of Business Administration in Health Care Management from Saint Leo University
- Bachelor Degree in Business Management from McColl School of Business, College of Arts and Science, Queens University of Charlotte

Julie Losee

Upon Award: Clinical Director, Florida Medicaid Operations

Qualifications

- 35+ years' experience in the healthcare industry with a background and education in nursing
- Familiarity with Florida Medicaid market with experience leading multiple teams responsible for 100,000 Medicaid enrollees

Professional Experience

2017–Present Humana's Clinical Director, Florida Medicaid Operations

- Full scope director for Utilization, Prior Authorization, Case Management, Disease Management and Quality for Humana's 100,000-member North Florida Medicaid

2013–2017 IASIS Integrated Care Solutions' Senior Director of Clinical Services

- Full scope director for Utilization Management, Prior Authorization, Case Management, Disease Management and Quality for 100,000-member Medicaid contract for Humana

2006–2015 St. Anthony's Hospital, BayCare Health System's Manager of Clinical Services

- Utilization Management director in 350 bed acute care facility including case management, social service, discharge planning, complex case management, denials management, and grant administration

2000–2001 Summit Medical Litigation Consulting's Consultant

- Legal nurse consultant expert witness in medical litigation specializing in skilled nursing, hospital, and assisted living facility cases

Education and Certifications

- Bachelor of Science in Business from North Adams State College
- Bachelor Candidate in Nursing at the University of Massachusetts
- Associate of Science from Berkshire Community College
- Registered Nurse in the State of Florida
- Six Sigma Black Belt Certification
- Diplomat for the American Board of Quality Assurance & Utilization Review Physicians
- Additional coursework in InterQual Certification, Management Certification in Healthcare and Case Management
- Member of the American Case Management Association
- Awarded the Best Outcome Project Collaborative at BayCare Health System and Pinellas Point Nursing and Rehabilitation Center

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Danielle Antalocy

Upon Award: Clinical Manager, Florida Medicaid Operations

Qualifications

- Experienced RN with proven track record of positive, engaging leadership and exceeding goals
- 8+ years of experience and education in healthcare with a strong commitment to providing education and ongoing training to staff
- Demonstrated ability to implement new processes per state requirements

Professional Experience

2014–Present Humana's Clinical Manager, Florida Medicaid Operations

- Develops and updates policy and procedures for case management, transitions, and disease management
- Hires and trains all Transition and Disease Management staff on guardrails, risk ranking, and utilization tools
- Developed Utilization Management process implemented with Care Management staff
- Provides accurate and immediate data/reporting needs to AHCA

2013–2014 Humana LTC's Frontline Leader

- Interviewed, hired and trained all Case Managers for rollout of new LTC program
- Responsible for monitoring adherence to quality and performance measures.
- Developed spreadsheets, trainings, policy and procedures, general supervising of all Care Management staff

2011–2013 Humana HSO's Utilization Management Frontline Leader

2011–2011 Humana HSO's Utilization Management Clinical Advisor

2009–2011 Arlington Home Health's Intake Manager/Utilization Review Nurse Manager

- Responsible for managing all aspects of the patient intake process
- Collaborated with physicians in determining patients' home care needs
- Ensured compliance with all state and federal referral / intake regulatory requirements

Education and Certifications

- Bachelor of Science in Nursing from The Ohio State University: College of Nursing

Sharon Mecoli

Upon Award: Manager, Florida Medicaid Quality Operations

Qualifications

- Background and education in healthcare with 35 years of experience as a certified registered nurse
- Knowledgeable about Case Management and Quality of Care improvement
- Skilled in Regulatory Compliance, Medicaid Long Term Care, Operations Management, Grievance and Appeals, Process Improvement and Policy Development

Professional Experience

2013–Present Humana's Manager, Florida Medicaid Quality Operations

- Quality of Care issues analysis; reporting and Corrective Action Plan implementation
- Responsible for HEDIS Performance Measures data collection reporting and Care Management Quality metrics and reporting
- Case File Audits and Remediation reports to the State Agency
- State Agency required Performance Improvement Projects
- Provider Medical Record Audits
- Implementation/facilitation of Corrective Action Plans to drive quality improvement

2009–2013 American Eldercare Home Health Inc./Heritage Home Health's Director, Quality Improvement

- Provided quality and operational oversight for 14 Home Health Branches in Florida Maintained Joint Commission Accreditation

2007–2009 Heritage Home Health's Administrator

2005–2007 Heritage Home Health's Director of Nursing

2003–2005 Heritage Home Health's Clinical Supervisor

1991–2003 Boca Raton Community of Home Health's Medicare Home Health RN

1981–1986 Boca Raton Community Hospital's Medical/Surgical Nurse

Education and Certifications

- Mercy Hospital School of Nursing
- Registered Nurse (RN) Since 1982
- CPHQ – Aug 2017

Sharon Cook-McEwen

Upon Award: Director, Florida Medicaid Operations

Qualifications

- Highly motivated executive leader with demonstrated ability to analyze trends, develop new processes, and collaborate with large teams in order to improve outcomes for enrollees and healthcare providers alike
- 20+ years' experience in healthcare management with a background and education in nursing and business administration
- Assumes direct responsibility for financial and operational metrics and successfully leads teams to increase efficiency and prevent losses

Professional Experience

2016–Present Humana's Director, Florida Medicaid Operations

- Collaborates with corporate and market operations teams to manage performance outcomes, while ensuring contractual requirements are delivered
- Identifies and supports opportunities for process and service improvements to increase efficiency and simplify provider and member experience
- Builds and sustains productive long-term relationships with government and community partners and agencies, to ensure successful business outcomes and develop community relationships

2015–2016 Aetna Better Health of Ohio's Vice President, Clinical

- Implemented elements of Aetna's 3-way contract for the management of dually eligible enrollees with the Centers for Medicare & Medicaid Services (CMS) and the Ohio Department of Medicaid (ODM)
- Provided executive oversight of Aetna's clinical management department that provided care management activities to dually eligible Medicare and Medicaid enrollees (LTC/LTSS)
- Developed departmental policies and procedures and created a training program for Aetna's contracted vendor's care management teams

2014–2015 Advicare Corporation's Director, Medical Management and Quality

- Implemented UM, QM, and CM departments for a start-up managed care organization that provided services to managed Medicaid and Medicare/Medicaid Dual eligible beneficiaries (LTC/LTSS)
- Designed and analyzed QM, UM, and CM reports to measure the Medical Management and Quality Departments' productivity and compliance with performance standards

Education and Certifications

- Bachelor's in Business Administration from Upper Iowa University
- Associate's in Sciences from Hinds Community College
- Registered Nurse with the SC Board of Nursing
- Certified Case Manager (CCM) with the Commission for Case Management

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Michael Pratt

Upon Award: Vice President, Florida Medicaid Operations

Qualifications

- 20+ years' experience providing detailed analyses of financial statements and reports for healthcare companies
- Quality leadership and management of large teams that provide healthcare services to Medicaid enrollees
- Skilled in financial analysis, cost savings, compliance and project management

Professional Experience

2017–Present Humana's Vice President, Florida Medicaid Operations

- Leads a team to provide clinical and operational services to 100K Florida Medicaid enrollees
- Manages a successful transition of operations from the third-party vendor who had been providing clinical and operational services to Humana for three years

2014–2017 Health Choice Florida, Inc.'s Chief Executive Officer

- Created and led a company providing third party administrative services to a $54 billion health plan from startup in 2014 to acquisition by the health plan in 2017. Company revenues ranged between $21 million to $23 million per annum, with EBITDA ranging from 26% to 36%
- Managed a team of 200 employees across two states to provide clinical and operational services to 100K Florida Medicaid members.
- Oversaw all aspects of the P&L for the company, and with executive team of seven senior leaders developed and executed on the strategic plan for the company

2010–2014 Deloitte Consulting's Government Programs Specialist, Health Plans

- Leader in the Government Programs Solutions area of the Health Plan practice focusing on resolving Medicaid and Medicare issues affecting our major for-profit and not-for-profit health plan clients, focused on Medicaid implementations, Medicare stars ratings, policy processes, proposal development, marketing reviews, compliance program effectiveness, and CMS sanctions assistance

2008–2010 WellCare, Inc.'s Director, Corporate Compliance

- Created and led a new Compliance investigation unit to investigate sales agent instances of potential non-compliance based on secret shopping and predictive analytics of the new sales agent metrics

Education and Certifications

- Master of Business Administration in International Business, Accounting, Finance from New York University
- Bachelor of Arts in Economics from Columbia University

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Joseph Piemonte

Upon Award: Vice President, Florida Medicaid Operations

Qualifications

- 25+ years' experience in the healthcare industry and 10+ years' experience in contracting, contract administration and provider relations for over 150 hospitals and over $900 million in annual spend in various lines of business in business
- Expertise in cross-functional team management, strategic planning and execution, and process and design improvement
- Demonstrated ability to negotiate large contracts and achieve positive outcomes while reducing budgets

Professional Experience

2005–Present Humana's Vice President, Florida Medicaid Operations

- Proactively converted all inpatient fixed rate Medicare contracts to CMS DRG methodology to capitalize on DSH elimination, sequestration and base rate reductions
- Negotiated $94M statewide commercial contract in 2011, achieved best outcome in over a decade, $1.5M below budget; renegotiated the same contract and reduced trend to 2.4% and $1.3M below budget
- Converted all inpatient fixed rate Medicare contracts to CMS DRG methodology to capitalize on DSH elimination, sequestration and base rate reductions

2004–2005 Cigna Healthcare's Director/Senior Contract Negotiator

- Successfully negotiated the movement of CIGNA's lead product from POS to HMO rate (an 18% reduction) for the third largest Dallas-Fort Worth hospital system; resulted in a 2% premium reduction for the product
- Re-contracted Dallas' largest pediatric facility; saved $900,000 annually and reduced claims errors
- Resolved long-standing hospital and physician claims problems by addressing rate methodologies and loading errors, facilitating more accurate claims administration and greatly improved provider relations

2001–2003 Aetna's Provider Network Manager

- Transitioned a rental network to a directly contracted market, negotiated various new contracts, and developed the medical cost budget

2000–2001 Aetna's Corporate Consultant for Strategy Development & Contract Negotiations

- Built a nationwide network to support the roll-out of a new managed indemnity product. Contracted 5,600 hospitals, 5,000 ancillaries, and 200,000 physicians.

Education and Certifications

- Master's degree in Health Administration from the University of Scranton
- Bachelor's Degree in Biology from the University of Pittsburgh
- Some education in Medical Ethics from the University of Pittsburgh
- Fellowship with the American College of Healthcare Executives

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Sharon Coleman

Upon Award: Director, Florida Medicaid Provider Relations and Contracting

Qualifications

- 22 years of experience negotiating physician, ancillary and hospital agreements and leading physician engagement strategies including complex process resolution
- Led the development of Humana's Medicaid and Duals expansion states, which allowed for involvement in all aspects of network builds
- Currently leads the Central Florida contracting and provider relations team responsible for Medicare, Medicaid and commercial, as well as overseeing Medicaid operations and compliance for Regions 1 and 6

Professional Experience

2014–Present Humana's Director of Contracting Negotiations for Central Florida

- Leads provider network contracting, re-contracting and network compliance operations for central Florida for Medicare, Medicaid and commercial lines of business
- Responsible for financial trend solutions and creation of innovative payment arrangements including value-based purchasing agreements
- Leads Medicaid provider network compliance operations including policy development, process support, vendor oversight, and provider education strategies and material development

2012–2014 Humana's Director, Duals and Medicaid Expansion

- Lead network development operational activities for all Duals and Medicaid expansion states. Responsible for dynamic solutions and operational support of local market contracting teams
- Responsible for provider network RFP/ITN responses including network evaluation and identification of process and policy compliance gaps
- Lead network support and infrastructure build for expansion readiness with focus on operational improvement, vendor integration, and both internal and external partner training

2012–2015 Humana's Manager, Network Relations

- Lead integration of national initiatives and projects for all Florida markets. Market lead for network expansion, network filings, provider education, delegation/subcontractor compliance, financial recovery and claims resolution.

Education and Certifications

- Bachelor's in Health Science from the University of South Florida
- People First Practitioner Certification / Disney Perfect Experience

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Katrina Knight-Vera

Upon Award: Director, Florida Medicaid Provider Relations and Contracting

Qualifications

- Highly motivated and dedicated professional offering over seventeen years of experience negotiating physician, ancillary and hospital agreements.
- Leads Medicaid provider network compliance operations including policy development, process support, vendor oversight, and provider education strategies and material development
- Outstanding leadership and interpersonal skills which consistently result in successful business relationships with internal and external partners.

Professional Experience

2014–Present Humana's Director, Medicaid Provider Relations and Network

- Lead provider network contracting, re-contracting, compliance and operational activities for Medicaid in Florida Regions 9, 10 and 11
- Responsible for financial trend bending activities, network optimization, value-based purchasing agreements and targeted contracting and compliance
- Leads and collaborates with network partners to develop dynamic solutions in a heavily matrixed service partner environment

2011–2014 Humana's Provider Administration Manager

- Managed six direct reports and oversee large practice and ancillary provider contracts for Medicare, Medicaid and Commercial products in South Florida and Statewide
- Implemented local strategic plans in order to effectively influence providers, provider affairs, and service centers
- Contributed to the training and development of associates in the Provider Contracting area

2010–2011 Humana's Contracting Executive

- Contracted with Large Physician and Ancillary groups in South Florida for Medicare and Medicaid lines of business
- Supported Humana's competitive market position by engaging in strategic negotiation and relationship-building with providers

2008–2010 Tenet Healthcare's Director of Managed Care

- Negotiated with Health Plans on new and existing Hospital and Physician agreements for Commercial, Medicare and Medicaid lines of business, using strategic development, planning, organizing, and contract rate and language negotiations

Education and Certifications

- Bachelor's in Public Administration from Florida International University

Attachment LTC 13-1: Resumes – Florida Medicaid Leaders

Edward Miller

Upon Award: Manager, Florida Medicaid Provider Relations and Contracting

Qualifications

- Extensive experience managing home health, long term managed care, provider relations and networks, home infusion, and durable medical companies
- 6 Years of experience with LTC with an additional 5 years of experience in the health care industry

Professional Experience

2015– Present Humana, Manager, Florida Medicaid Provider Relations and Contracting

- Oversees statewide LTC provider relations and contracting teams to ensure network adequacy and improve provider engagement in the program
- Provides a consistent provider experience across Humana's Organization

2011–2015 American Eldercare's Regional Director, Operations

2009–2010 InfuScience's Regional General Manager, Florida Home Infusion Business

2005–2009 Pediatric Services of America's General Manager, South Florida Operations OptionCare's

2004–2005 General Manager

Education and Certifications

- Bachelor of Science in Engineering from United States Coast Guard Academy

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Alan Wheatley

Upon Award: President, Retail Segment

Qualifications

- Leads all aspects of Humana's Retail (Medicare, Medicaid/Duals, Commercial) business, including developing the growth strategy that led to a 15% CAGR since 2008
- Developed strategy for Humana's Medicare Prescription Drug Plan program encompassing 3.2M members
- Created Humana's new Dual Eligible, Medicaid, and Long-term care business

Professional Experience

2014–Present Humana's President, Retail Segment

- Leads operations and strategic direction with full bottom-line responsibility for Humana's $40 billion consumer product businesses covering more than 7 million individuals
- Responsible for Retail Segment business include Medicare, Individual Medical (HumanaOne), Medicaid, Long-term Care and Individual Specialty
- Creates and drives strategy, drives execution of organizational goals, develops a high-performing team focused culture, oversight of business compliance and leads and directs sales strategy and activities

2010–2014 Humana's President, Medicare, Medicaid, and Long-Term Care

- Leveraged business acumen and visionary drive to lead and guide all aspects of Humana's Medicare organization
- Oversaw Humana's 2.8 million-member Medicare Advantage business that drives over $30 billion in annual revenue
- Managed strategy and pricing, developed products, designed and contracted networks, and coordinated and oversaw CMS relationship

2008–2010 Humana's Vice President & COO/CFO, Senior Products

- Worked with sales and marketing partners to develop and implement member acquisition strategy including management of more than $200 million in marketing spend

2006–2008 Humana's Vice President, Medicare Service Operations

Education and Certifications

- Master's Degree in Business Administration from University of Louisville
- Bachelor of Arts in Finance from University of Kentucky

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Dr. Roy Beveridge

Upon Award: Chief Medical Officer, National Medicare/Medicaid/Duals

Qualifications

- Extensive medical research background with 40+ years' experience in medicine and health care and extensive publications in the fields of medical oncology, stem cell transplantation, quality design and population health
- Known for creating collaborative environments among physician communities and providing thought leadership around population health
- Board certified in medical oncology and internal medicine

Professional Experience

2013–Present Humana's Chief Medical Officer, National Medicare/Medicaid/Duals

- Develops and implements Humana's clinical strategy, with an emphasis on advancing the company's integrated care delivery model

2010–2013 McKesson Specialty Health/The US Oncology Network's Chief Medical Officer

2009–2010 US Oncology, Inc.'s Executive Vice President & Medical Director

2004–2009 US Oncology, Inc.'s Chairman

1988–2009 Fairfax Northern Virginia Hematology-Oncology, PC's Partner

1988–2009 Inova Fairfax Hospital's Co-Director of Bone Marrow Transplant Program

Education and Certifications

- Internal Medicine Residency at University of Chicago Hospital
- Internal Medicine Internship at University of Chicago Hospital
- Doctor of Medicine from Cornell University
- Bachelor's Degree in Cell Biology from Johns Hopkins University

Attachment LTC 13-1: Resumes – National Medicaid Leaders

John Barger

Upon Award: Vice President, Dual Eligible and Medicaid Programs

Qualifications

- Over 18 years of executive leadership in health care
- Knowledgeable in clinical operations management, quality programs, network contracting, provider relations, P&L leadership, sales, and finance
- Significant experience working with Medicaid, Medicare, and commercial insurance programs

Professional Experience

2015–Present **Humana's Vice President, Dual Eligible and Medicaid Programs**

- Responsible for the national management and operations of Humana's Medicaid and state-based contract programs including Dual Demonstration, TANF and long-term care programs
- Lead operations and market teams in Florida, Virginia, Illinois and Kentucky
- Accountable for finances in all of Humana's Medicaid programs

2013–2015 & 2006–2008 **Humana's Market President Central, Florida Market**

- Responsible for the overall management of Humana's Central Florida Medicare Operations
- Managed clinical operations, quality programs, network contracting, provider relations, and finance

2011–2013 **Humana's Market President and COO, Humana Puerto Rico**

- Responsible for the management and direction of a 500,000-member statewide HMO subsidiary generating over $1.5 billion in annual revenue
- Focused on government sponsored health care programs including Medicare Risk, Medicare Advantage, and Medicaid Risk, and Primary Care Delivery

2009–2011 **WellCare Inc.'s Chief Operating Officer, West Florida Region**

- Responsible for sales, network management, finance, and community outreach for a region with $800 million in annual revenue

2008–2009 **WellCare Inc.'s Vice President, Finance and COO, Prescription Drug Plan and Private Fee for Service Plans**

- Responsible for the overall financial and operational management of WellCare's PDP and PFFS business units

Education and Certifications

- Bachelor's Degree in Business Administration and Finance from the University of Wisconsin
- Virginia CPA (Inactive)

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Marissa Childers

Upon Award: Director, National Medicaid/Duals Clinical Delivery & Quality Improvement Leader

Qualifications

- Accomplished healthcare professional with 20 years of health care experience
- Demonstrated success in employer based workplace health & wellness management, clinical program management, case management, health clinic operations (occupational health, health & wellness, and acute episodic care), ambulatory and clinical nursing, and academia
- Extensive experience in LTSS and worker's compensation case management, including program development, implementation and evaluation, quality improvement processes, and risk assessment

Professional Experience

2013–Present Humana's Director, National Medicaid/Duals Clinical Delivery & Quality Improvement Leader

- Responsible for Medicaid clinical program development, implementation, performance and compliance
- Provide Commonwealth and state guidance for program development and clinical operations development

2013 Humana's LTSS Strategic Consultant and Senior Products Medicaid

- Responsible for Dual Demonstration LTSS clinical program development and implementation as well as oversight of LTSS Clinical performance and compliance across multiple markets

2011–2013 UnitedHealthcare's Health Services Director, CHOICES Program

- Subject Matter Expert for LTSS Coordination for peers and direct reports
- Developed strategies to implement and fulfill contractual obligations and compliance metrics for LTSS
- Applied resources to deliver high quality care management to Plan members and Customers

2011 UnitedHealthcare's Manager, Case Management

Education and Certifications

- Master's Degree in Sociology from Ohio University
- Bachelor's Degree from Kent State University
- Associate's Degree in Nursing from Shawnee State University Registered Nurse
- Tennessee Board of Nursing, License # RN 175337
- Registered Nurse, Ohio State Board of Nursing, License # RN-267004
- Certified Case Manager, License # 00090539

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Andy Nichols

Upon Award: Director, National Medicaid/Duals Strategy & Community Development

Qualifications

- Has 6 years of experience in Medicaid, LTSS, and Duals strategy and business development experience and nearly a decade of experience working with Humana.
- Entrepreneurial-minded, quick-learning, strategic leader with a diverse background in engineering and community development,
- Demonstrated skill set in relationship building, growth planning, delivery systems analysis, cost optimization, and civic planning

Professional Experience

2015–Present Humana's Director, National Medicaid/Duals Strategy & Community Development

- He has been highly engaged in the growth of Humana's Medicaid and Duals program, participating in or leading business development efforts in all new and prospective markets, including the development of community based stakeholder relationships, local care and support model partnerships, and proposal submissions

2012–2015 Humana's Strategic Consultant, Medicaid/Duals Strategy & Business Development

2008–2012 Humana's Manager, Real Estate Portfolio Strategy & Capital Planning

- Led the planning and optimization of Workplace Solutions' capital spend, ranging from $20M-$50M per year
- Developed capital guidance statements for CFO's quarterly reports through fixed assets group

2007–2007 St. Louis Rams' Sales and Marketing Graduate Intern

- Ran due diligence and reported on prospective sponsorship opportunities and new brand alignments
- Conducted & submitted to the NFL league office a complete internal audit of team sponsorship activity

Education and Certifications

- Master's Degree in Business Administration in Strategy, Finance, Entrepreneurship, Real Estate, and Management from Washington University in St. Louis – Olin Business School
- Bachelor's Degree in Civil Engineering and Structural Design (with a dual major in Entrepreneurial Business) from Washington University in St. Louis
- Master of Corporate Real Estate (MCR) Certification

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Ron Weeden

Upon Award: Director, National Medicaid/Duals Finance

Qualifications

- 20 years of experience in healthcare with an extensive background in strategic planning, financial analysis, project management, forecasting, and budgeting specifically within Florida Medicaid
- Extremely motivated and results driven financial professional with exceptional leadership skills
- Demonstrates ability to proactively produce and lead exceptional performance within a team environment and creatively resolve problems and capitalize on opportunities

Professional Experience

2016–Present Humana's Director, National Medicaid/Duals Finance

- Manage $2.6B in revenue across 5 lines of business: FL MMA, FL LTC, VA Duals, IL Duals, KY
- Chair Corporate Trend Committee
- Improved pre-tax results by $100M over a 2-year time period
- Oversight of state P&L's, trend initiatives, MSO risk arrangements, admin and capitated contracting

2014–2016 Humana's Medicare Finance Director, Central Florida

- CFL Finance: Reorganized, staffed and retained, associate development
- Effectively developed bid and budget strategy plans
- Evaluated specialty capitations: PMPM and Leakage, and identified contracting opportunities
- Identified utilization opportunities or shifts in care (i.e. outpatient to office, ER to urgent care, etc.)
- Identified and measured market specific PIP's (i.e. HBO, Humana at Home, etc)

2013–2014 Avmed Health Plan's Director, Healthcare Economics

2011–2013 Fallon Community Health Plan's Director, Medical Expense, Financial Modeling and Cost Analysis

2000–2011 CVS Caremark's Manager, Capital & Treasury

1998–2000 Fallon Community Health Plan's Manager, Provider Network Financial Planning & Operations

1995–1997 Reliant Medical Group's Senior Financial Utilization Analyst

Education and Certifications

- Master's Degree in Business Administration from Nichols College
- Bachelor of Science in Business Administration in Finance from University of Florida

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Jeb Duke II

Upon Award: Director, National Medicaid/Duals Program Management

Qualifications

- 5 years of experience in Medicaid/Duals/LTC – knowledgeable about contracts, developing segment structures, and facilitating process flows
- Experienced leader with an education in management and background in leading large teams as a United States Marine Corps Platoon Commander and later, a Commanding Officer
- Demonstrated ability to coordinate and improve processes that facilitate administrative savings

Professional Experience

2017–Present Humana's Director, National Medicaid/Duals Program Management

- Responsible for Kentucky Medicaid contract execution, oversight and administration
- Owner of Humana Medicaid Innovation strategy to include mobile, analytics and information technology
- Responsible for Medicaid Long Term Services and Supports and Duals integration strategy development

2013–2017 Humana's Program Manager

- Acted as Chief of Staff of the Medicaid/Duals/LTC Segment responsible for segment staff planning, administration and coordination
- Responsible for the development, planning and execution market performance reviews
- Developed segment oversight structure and facilitated Medicaid Governance during plan expansion periods
- Developed Medicaid trend initiatives facilitating segment claim and administrative savings

2012–2013 Humana's Process Engineer

- Acted as a Program Manager within the Medicaid and Dual Eligible department
- Coordinated CareSource Alliance program structure implementation and managed committee oversight

2011–2012 Humana's Project Manager

- Coordinated project work across Provider Communications, Product, CMS CMU, Reporting, Service Operations and State Contracting
- Coordinated Quality and Health Outcomes compliance teams resulting in the closing of identified gaps within Humana's Model of Care

Education and Certifications

- Post Baccalaureate in Accounting from University of Louisville
- Master's Degree of Business Administration from University of Kentucky
- Bachelor's Degree in Business Administration and Management from University of Kentucky

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Deborah Beavin

Upon Award: Director, Medicaid/Duals Strategic Partnerships and Implementation

Qualifications

- 30+ years' experience in business with expertise in cross-functional team management, strategic planning and execution, and process and design improvement
- Proven operational Leader, procurement expert, and Six Sigma Master Black Belt with extensive experience delivering productivity, driving process improvement and design initiatives, and collaboratively contributing notable business benefit in various roles
- A creative, results-oriented leader with a proven track record for quickly assessing situations and promptly delivering result through collaborative, positive leadership, and cross-enterprise coordination

Professional Experience

2014–Present Humana's Director, Medicaid/Duals Strategic Partnerships and Implementation

- Leads the corporate Medicaid Operations team
- Responsible for Medicaid and Duals strategic third-party relationships, implementation of new and expanding programs, process improvement initiatives, and cross-market Medicaid governance

2004–2014 Humana's Chief Procurement Officer

- Led the organization's Corporate Procurement team in the introduction of a best-in-class Procurement process, comprehensive category management methodology and application
- Created bottom-line driven goals and objectives tied to strategic intents, spend visibility and supporting analytical tools
- Created a standard, comprehensive purchasing and contracting process in support of commercial and government-related purchases

2001–2003 General Electric's Sourcing Leadership, Appliances, Lighting and Motors Businesses

- Led a team responsible for managing a $1.2 billion finished goods buy across the business' affiliates located in US, Canada, Brazil, and Mexico

2000–2001 General Electric's Six Sigma Master Black Belt and Commercial Quality Leader, Appliance Business

- Led a team of Six Sigma Black Belts identifying and implementing process improvement opportunities within the sales organization and with key customers

Education and Certifications

- Master of Business Administration from University of Louisville
- Bachelor of Arts in Computer Science and Mathematics from Bellarmine University

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Jeff Layman

Upon Award: Vice President, National Operations Process Transformation

Qualifications

- 36 years of health care experience with Humana in Medicaid/Commercial service operations, account installation, provider affairs, accounting, and internal audit
- Led a variety of successful efforts that created a culture that both anticipated and responded to Humana's customer's needs
- Designed flexible business processes to meet an ever-changing business environment
- Established strategic development of service and process innovations
- Led teams of associates dedicated to the implementation of innovation

Professional Experience

2015–Present Humana's Vice President, National Operations Process Transformation

- Leads Humana's governance, program implementation, vendor management, reporting and technology integration teams.
- Serves as the primary Medicaid operational leader for each functional area engaged in Medicaid/LTSS/Duals program implementation, financial analysis, and regulatory compliance/oversight

2008–2015 Humana's Vice President, Account Installation and Spending Account Operations

- Led a team of approximately 1,400 dedicated associates that developed and implemented an industry leading strategy & model for gathering customer requirements and managing the end-to-end implementation process

2005–2008 Humana's Vice President, Market Relationship Management

- Established teams aligned with market areas and national account segment
- Managed account installations and providing expert assistance for issue research and resolution
- Cultivated & maintained relationships with market leaders, brokers and customers

1998–2005 Humana's Director, Provider Affairs

1997–1998 Humana's Director, Accounting

1993–1997 Humana's Director, Financial Analysis

1990–1993 Humana's Director, Internal Audit

Education and Certifications

- Bachelor of Science in Commerce – Accounting from University of Louisville
- Certified Public Accountant in State of Kentucky

Cheryl D. Gallon

Upon Award: Vice President, Virginia Medicaid/Duals Market & National Medicaid Strategic Projects

Qualifications

- Background and education in health care and business management, with over 22+ years of experience in managed care, strategic planning and operations
- Extensive knowledge of government programs such as Medicaid Fee-For-Service, Medicaid managed care, Medicaid Duals, Medicare, and Long-Term Services & Supports
- Skilled in federal and state Medicaid regulations, compliance, project management, problem identification and solutions

Professional Experience

2016–Present **Humana's Vice President, Virginia Medicaid/Duals Market & National Medicaid Strategic Projects**

- Responsible for the program financial profitability, oversight of health plan administration and operations for Humana's Virginia managed Medicaid programs that include the Medicare-Medicaid Financial Alignment/Dual Demonstration program
- Developed positive collaborative relationships with regulatory staff, key stakeholders and community agencies, e.g. Virginia Health Care Association (nursing facilities), Virginia Center for Assisted Living, Virginia Association for Home Care and Hospice, Virginia Association for Personal Care Providers, Area Agencies on Aging, and the Centers for Independent Living among many others
- Provide leadership and oversight for Financial Analytics, Clinical Model of Care, Member Outreach, Quality Assurance, Network Development, Provider Relations, and State Contract Compliance for all members including those on waiver programs receiving Long Term Services and Supports

2014–2016 **Humana's Executive Director, Virginia Commonwealth Coordinated Care**

- Responsible for performance of the company's Virginia Dual Eligible product
- Achieved successful compliance audits and receipt of quality performance withhold payments
- Led teams in the development of market strategies and operational improvements
- Developed successful supplemental benefit options for members enrolled in Humana's Commonwealth Coordinated Care program

2002–2014 **HealthPlus of Michigan, Inc.'s Director, Medicaid Services**

- Responsible for oversight of all Medicaid Services operations at HealthPlus for both Medicaid, MIChild (CHIP), County Health Plans (Adult Benefit Waiver), and Healthy Michigan Plan (Medicaid Expansion) programs

2000–2002 **Physicians Health Plan of Mid-Michigan's Director, Medicaid Services**

Education and Certifications

- Master's Degree in Business Administration from Eastern Michigan University
- Bachelor's Degree in Health Care Administration from Eastern Michigan University
- Certified Healthcare Insurance Executive, America's Health and Insurance Plans, June 2007

Attachment LTC 13-1: Resumes – National Medicaid Leaders

Ross Westreich

Upon Award: Vice President, Illinois Medicaid/Duals Market & National Medicaid Strategic Projects

Qualifications

- Analytical, financially skilled business leader with expertise in margin improvement, budgeting, project management, product development and pricing, training and team building, risk adjustment, strategic planning, modeling and analytics, and provider relations
- 20+ years' experience in the health care industry, leads the market operations and spearheaded the 2014 roll out of Humana's Medicare-Medicaid Alignment Initiative (MMAI) and Integrated Care Program (ICP). He is responsible for the program's success as well as overseeing every facet of Medicaid.
- Throughout his career he has built strong relationships with Illinois providers, members, and the community as a whole

Professional Experience

2013–Present Humana's Vice President, Illinois Medicaid/Duals Market & National Medicaid Strategic Projects

- Responsible for strategic planning and oversight of health plan administration and operations for Humana's Illinois managed Medicaid programs; Medicare-Medicaid Alignment Initiative (MMAI) and Integrated Care Program (ICP)
- Responsible for programs financial profitability and quality outcomes, establishing annual operating plans, program growth and ensuring contract compliance
- Provide leadership and oversight for Financial Analytics, Member Outreach, Quality Assurance, Network Development, Provider Relations, and State Contract Compliance for all members including those receiving Long Term Services and Supports

2011-2013 Humana's Vice President of Medicare Operations

- Produced additional revenues of over $35 million per year via the leadership of a 60 associate department dedicated to Medicare Risk Adjustment
- Designed the organizational structure and processes which allow for the review of over 300,000 medical records annually
- Increased STAR ratings on 80% of CMS contracts, which resulted in greater reimbursement from CMS and increase the marketability of our products

2008-2011 Humana's Vice President of the Central Illinois Market

- Successfully grew the Medicare business an average of 20% per year by expanding the service area, provider base, and product offerings
- Increased profitability of the acquired business by strategically migrating members from networked PPO products to more tightly managed HMO plans resulting in a 5% increase in margin
- Through strategic planning and emphasis on local market intelligence, successfully retained 96% of the acquired lives at a higher margin

Education and Certifications

- Bachelor's of Science in Business and Public Administration from Drake University
- Oracle 8i: SQL and PL/SQL from Oracle University

Attachment LTC 13-2: Second-Tier Development Programs

Once executive managers and associates have completed our Required First-Year Curriculum, they can access our second-tier of career development programs. The second-tier development programs build upon the skills and knowledge acquired during the executive manager's first year and focus on transitional innovation to developing the next generation of Humana leaders. New opportunities are regularly updated on our leadership development website, The Leader Connection. The site is dedicated to growth and development, leadership connection, and leading and retaining talent with tools, resources, and opportunities. The goal of the program is to create leaders dedicated to Enrollee well-being and qualified to solve difficult health care system problems.

The descriptions below provide insight into selection of our second-tier development programs.

Experiential Moves

The Experiential Moves program gives high-potential executive managers opportunities to move to other areas of the company to build their overall understanding of the business and facilitate their ability to take over greater scope in the organization.

Leading Virtually

This 6-week program designed leaders or aspiring leaders with direct reports working remotely or virtually. During the course of this program, we will cover the main components of leading virtually-results, process, relationships, and communication. This course will equip you with techniques and strategies to help you become a better virtual leader.

Coaching

This program focuses on the practical application of coaching skills. During the session, participants will work in small teams to navigate a variety of leadership coaching scenarios, and take away tools and tactics to implement in their approach to coaching.

Change

We offer a comprehensive curriculum to help associates and leaders navigate the personal aspects of change to help others, help others develop capabilities to thrive through change, apply a process to link behaviors to business results and drive a successful change.

The Change Curriculum includes:

- Leading Change: Setting the Foundation (Self-Paced and In-Person)
- FIT for Change (Self-Paced , Virtual and In-Person)

Healthcare Leaders 2020

The genesis for Health Care Leaders 2020 (HCL 2020) occurred during Humana Executive Committee Succession Management Reviews. In the reviews, Humana Senior Executives identified the need to evolve high potential executive managers – leaders – who were out-of-industry hires, and functional experts to fully understand the health insurance industry and be grounded in solid business acumen.

Humana began partnering with Harvard Business School (HBP) and other leading institutions to develop and deliver a best in class, health care leader curriculum that would transform Humana and influence change in the health care system. HBP and Humana mounted a needs assessment among internal and external executives, and business partners of Humana.

HCL 2020 develops and mobilizes leaders to deal with the challenges that lie ahead and leverage opportunities to redefine health care. Some goals for HCL 2020 include:

- Provide a transformational experience for leaders, in their perspective, skills, and careers
- Develop leaders who will influence not just Humana but the entire industry, through a future focus with a broad vision that incorporates systems thinking
- Create visible change that demonstrates Humana's commitment to real business impact for Humana and its stakeholders and healthier communities that we serve

Thrive Here

This innovative workshop, facilitated by a distinguished industry expert, prepares executives for the twenty-first century. In an intimate cohort of 20 key leaders, participants deepen their understanding of Humana's changing member needs, cultivate Gender Balance initiatives (to make communities we serve healthier), and experience mindful sponsorship of Humana's executive talent.

Participants will be equipped with the skills to sponsor and be sponsored and experience custom opportunities for growth through a 6-month sponsorship pairing. Our business leaders will better enable collaboration, empowerment, and candor; reflect and represent Humana's Medicaid and LTC member base; and sponsor the next generation of talent by leveraging the skills of gender balance and gender bilingualism.

Development Acceleration Program (DAP)

The Development Acceleration Program (DAP) is a talent development experience for high potential executive managers wherein participants are placed in matrix teams and complete project work for a business sponsor. The DAP experience is 12 weeks and the business sponsor creates a context for accelerating development. Through the DAP journey DAP participants build enterprise acumen, increase their leadership networks, and get to showcase their talents while solving real world challenges.

Physician Executive Development Program (PEDP)

The Physician Executive Development Program (PEDP) is a two-phased experience for physician leaders of leaders, addressing the leadership challenges faced by our physician leaders, and increasing the Humana and business acumen of participants.

Physician Leadership Development Program (PLDP)

The Physician Leadership Development Program is a blended learning experience designed to develop fundamental leadership capabilities of participants. Participants also complete AAPL online courses aligned to course focus areas to receive CME credit

Attachment LTC 13-3: Select Courses on Medicaid and LTC

Selection of Courses Specific to Medicaid, Long-Term Care, and Florida

The sample listing of training courses (below) speak to our dedication to the training and development of our Medicaid and LTC leaders (and associates). These and other courses provide continual learning opportunities that align to each person's level of experience or tenure with Humana.

Medicaid Basics

- Online Class
- Medicaid Basics information including eligibility and benefits.

Florida Medicaid Contract

- Senior Products Learning & Development
- SPLD-Florida-Medicaid Basic

Medicaid 110: Medicaid Plan Product Training

- Senior Products Learning & Development
- This course covers an Industry overview of Medicaid Plans including the program overview, population information, program principles, benefits, and the Humana landscape.

Medicaid 112: Medicare-Medicaid Plan Product Training

- Senior Products Learning & Development
- This course covers an Industry overview of Dual Eligible Plans including the program overview, population information, program principles, benefits, and the Humana landscape.

Medicaid Product Training: Florida Medicaid Plan

- Senior Products Learning & Development
- This course reviews the Florida Medicaid Plan. This course covers a plan summary, landscape, and benefit details for the plan.

Medicaid 111: Long Term Services and Supports Product Training

- Senior Products Learning & Development
- This course covers an Industry overview of Long Term Services and Supports including the program overview, population information, program principles, benefits, and the Humana landscape.

Medicaid: Florida Contract Training

- Senior Products Learning & Development
- Description: ELearning course. Definitions and abbreviations; Florida Medicaid; General Responsibilities of the Managed Care Plan; enrollment/disenrollment specifications; unborn/newborn enrollment; marketing and outreach; enrollee materials; required Medicaid benefits; Humana expanded benefits; Humana Healthy Behavior Program; Incentive programs; and more.

Medicaid 101: Basics

- Senior Products Learning & Development
- Description: Description: ELearning course. Explores basic framework of Medicaid; eligibility; benefits; Humana's involvement in the Medicaid program; Dual Demonstration; Long Term Care Services and Support; Non-Long Term Care Services and Support; additional resources.

Medicaid Duals Member Communications

- Senior Products Learning & Development
- Preparation in creating a document to send to Medicaid Duals members. This eLearning course describes the steps to requesting an Intake of a communications; the steps a document goes through from the Intake to Business and Corporate Reviews, and Regulatory Filing and Approval; also demonstrates the steps to checking the status of a document, and more.

Understanding Medicaid in Florida

- Online Class
- This course will provide an overview of Medicaid in Florida.

Medicaid 104: Closing The Gaps

- Senior Products Learning & Development
- Description: ELearning course. Medicaid is an important program that can offer those who do not have access to health insurance the chance to receive the healthcare they desperately need. The factors that make a person eligible for Medicaid is one set of struggles in their life.

Medicaid 103: Long Term Services and Supports

- Senior Products Learning & Development
- Description: ELearning course. Focus on Long Term Services and Supports; eligibility; Long Term Care; Home and Community Based Services; Participant Directed Option or Consumer Direction; printable infographics of listed topics.

Medicaid Product Training: Florida Long-Term Care Plan

- Senior Products Learning & Development
- This course reviews the Florida Long Term Care Plan. This course covers a plan summary, landscape, and benefit details for the plan.

2017 IRR - Intake Medicare/Medicaid Performance Test

- Clinical Learning & Development
- This is the Annual 2017 IRR Performance Test for Intake - Medicare/Medicaid associates only.

Medicaid: Cultural Competency

- Senior Products Learning & Development
- ELearning course. Overview of culture and cultural competence, the benefits of clear communication, addresses health care for various subcultures and populations in the United States, reflects on strategies when working with seniors and people with disabilities, accessing interpretation services and written materials in alternative languages and more.

Audit Acumen

- Senior Products Learning & Development
- The Audit Acumen course introduces the types of audits, sheds light on what to anticipate as you prepare for an audit, enlightens you about the guiding principles for participating in the audit, and clarifies the expectations for what happens after the audit is complete.

Audit Acumen: After an Audit

- Senior Products Learning & Development
- Focuses on the major elements of what occurs once the results of a Centers for Medicare and Medicaid Services is received. Topics include: if non-compliance occurs; describes different audit conditions; steps to a remediation plan; expectations of an Independent Validation Audit.

Legislation, Regulation and Requirements (LRR) Solution (Medicare and Medicaid)

- Senior Products Learning & Development
- Covers the Legislative, Regulatory, and Requirements (LRR) process; completing the IAQ; submitting evidence; and responding to a request for change. Segment that work with the Legislative, Regulatory, and Requirements (LRR) Solution.

Attachment LTC 13-4: Tenure and Retention Rates

Item	Tenure Metrics	Total Years	Years of Experience per FL Leader
1	Humana Years of Service	315.3	10.2
2	Years in Health Care outside of Humana	434.6	14.0
3	Total Years of Experience in Health Care	749.9	24.2
4	Years of Long Term Care Experience	238.6	7.7

Item	Retention and Mobilizing Talent Metrics	Total Career/ Role Changes	Avg. Career Moves per FL Leader
5	Career 'moves' since joining Humana	95	3.1
6	Humana Leadership Retention Rate for 2016 was 92%		

Source for items 1-5: Humana Capital Analytics Population Tool (as of 9/27/17)

Source for item 6 - Humana Investor Day, 2016 Report on HR Retention and Engagement

Exhibit A-4-d, Specialty Submission Requirements and Evaluation Criteria

Humana did not complete **Exhibit A-4-d, Specialty Submission Requirements and Evaluation Criteria and Applicable Attachments/Exhibits** as we are submitting our response as a Comprehensive Plan.

Introduction to Exhibit A-5: Summary of Respondent Commitments

Introduction to Exhibit A-5: Summary of Respondent Commitments

Due to formatting restrictions within the Exhibit A-5: Summary of Respondent Commitments Excel document for Region 2 and Regions 4 through 11, we were unable to fully display our commitments within Exhibit A-5 for the Hard Copy response. However, our commitments will be viewable in the Electronic response by clicking on each cell.

In addition, the Exhibit A-5 Excel document would not allow us to add additional lines to the document. Therefore, we added any remaining commitments to additional Exhibit A-5 Excel documents. For each of our regional responses, you will find multiple, signed Exhibit A-5 documents.

EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

PURPOSE: The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to capture commitments made by the respondent in response to this solicitation.

INSTRUCTIONS: The respondent shall identify each commitment made/proposed in the solicitation. Commitments include, but are not limited to: innovations that assist in achieving the Agency goals, improvements in service delivery coordination and quality outcomes for enrollees, improving the enrollee experience, commitments made in the respondent's provider engagement approach which result in an improved provider experience, and commitments reducing overall costs to the Medicaid program. The respondent shall identify the solicitation section/sub-section (Attachment X, Exhibit Y, Subsection Z), as applicable where the commitment can be found.

Category	Commitment (Brief Summary/Description)	Solicitation Section Reference
Example: Agency Goals	(Respondent to complete)	Exhibit A-4-a, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Recipient Experience	Humana will offer sixteen (16) Additional Expanded Benefits as detailed in Exhibit A-4-a-3.	Exhibit A-4-a, Section C., Recipient Experience, SRC #10 - Additional Expanded Benefits (Regional)
Recipient Experience	In 2018, to support the smart phone technology-dependent Medicaid population, Humana will expand MyHumana mobile application to our Medicaid plans.	Exhibit A-4-a, Section C., Recipient Experience, SRC #11 - Online Provider Directory (Statewide)
Recipient Experience	Additional improvements to the Humana Florida Medicaid website will be prioritized for implementation by October 1, 2018.	Exhibit A-4-a, Section C., Recipient Experience, SRC #11 - Online Provider Directory (Statewide)
Recipient Experience	Humana, upon receipt of NCQA certification for its physician measurement program, will display performance ratings within Physician Finder Plus.	Exhibit A-4-a, Section C., Recipient Experience, SRC #11 - Online Provider Directory (Statewide)
Recipient Experience	Humana will offer its MyHumana mobile application allowing enrollees to: view benefit information; access enrollee identification (ID) cards; find a provider; access health information; view clinical alerts; and send secure messages to a team of Humana associates	Exhibit A-4-a, Section C., Recipient Experience, SRC #11 - Online Provider Directory (Statewide)
Recipient Experience	Humana will offer RXMentor a new mobile application enabling enrollees to manage their prescription medication list, vitamins or supplements list, and over-the-counter medication list. RxMentor includes details about medications (strength, dosage, allergic reactions); images of the pills to make them easier to distinguish; and options to discussion medications with a pharmacist.	Exhibit A-4-a, Section C., Recipient Experience, SRC # 13 - Social Media (Statewide)
Recipient Experience	Humana will launch a Medicaid Facebook Page as well as a Medicaid YouTube Playlist within our corporate YouTube channel	Exhibit A-4-a, Section C., Recipient Experience, SRC # 13 - Social Media (Statewide)
Recipient Experience	Humana's CRM will serve as the central point for the planning, implementation, fulfillment, and tracking of member communication across all of our channels. CRM will allow Humana to compliantly deliver targeted and personalized messaging based on member preferences and needs.	Exhibit A-4-a, Section C., Recipient Experience, SRC # 13 - Social Media (Statewide)
Provider Experience	Humana will develop a reference guide to help hospice works understand the coordination betweem medical and long-term care as it related to claims, authorization, and enrollee responsibility.	Exhibit A-4-a, Section D., Provider Experience, SRC # 15 - Provider Engagement Model (Statewide)

EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

Provider Experience	To support adherence to processing requirements, CRM will offer summary and detailed status reporting of all provider complaints	Exhibit A-4-a, Section D., Provider Experience, SRC # 16 - Dispute Resolution (Statewide)
Provider Experience	Humana will offer AHCA access to an on-line, secure portal and business intelligence tools to make available on demand Humana's claims process and payment data and metrics.	Exhibit A-4-a, Section D., Provider Experience, SRC # 17 - Claims Processing and Payment Process (Statewide)
Delivery System Coordination	Humana will pilot the mPulse HIPAA-compliant platform in Florida to extend our EPSDT outreach.	Exhibit A-4-a, Section E, Delivery System Coordination, SRC #22 - EPSDT (Statewide)
Delivery System Coordination	We will design a detailed EPSDT module that will cover the federal and state EPSDT requirements and EPSDT operations throughout the plan.	Exhibit A-4-a, Section E., Delivery System Coordination, SRC #22 - EPSDT (Statewide)
Delivery System Coordination	Humana will adopt the Project ECHO model.	Exhibit A-4-A, Section E., Delivery System Coordination, SRC #23 - Behavioral Health/Primary Care Integration (Statewide)
Delivery System Coordination	We plan to pursue the credentialing of at least one BH therapist in all Federally Qualified Health Centers (FQHCs) in accordance with guidelines issued by the Centers for Medicare and Medicaid Services.	Exhibit A-4-A, Section E., Delivery System Coordination, SRC #23 - Behavioral Health/Primary Care Integration (Statewide)
Oversight and Accountability	Humana will comply with AHCA's desire to implement EVV capability for both personal care and home health services.	Exhibit A-4-a, Section F., Oversight and Accountability, SRC # 32 - SIU (Statewide)
Agency Goals	To increase access in Region 1, Humana is partnering with Health First Network (HFN) to initiate a pilot to serve HFN's high-risk and high-need enrollees.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC #1 - Potentially Preventable Events (Regional)
Agency Goals	In continuing efforts to improve integration, Humana will: • Create a mental health provider scorecard showing mental health-related admissions, readmissions, and length of time from discharge to follow-up care visits (PCP or mental health provider). • Analyze which providers offer effective care and where there is an opportunity for our nurses, QINs, and BH subcontractors to educate and offer support by looking at Early Indicator Report (EIR) data for behavioral health to understand utilization by provider. Pairing these data with our medical data, including claims and encounters, to create a comprehensive report card will help us see a full picture of the enrollee's health. • Collaborate on BH discussions by holding regional bi-annual grand round meetings hosted by Humana, inviting mental health providers and top MSOs (based on PCPs with the most mental health-utilizing enrollees) to discuss best practices and current challenging issues.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC #1 - Potentially Preventable Events (Regional)
Agency Goals	Humana currently contracts with AHCA for the Florida Health Insurance Exchange's (HIE) ENS for Regions 9, 10, and 11 and is receiving daily ED visit information from more than sixty (60) facilities. We will expand our use of the ENS to Region 1.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC #1 - Potentially Preventable Events (Regional)
Agency Goals	Humana will monitor procedures and services in Region 1 that may be inappropriately prescribed, or may be delivered in a lower-cost setting.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC #1 - Potentially Preventable Events (Regional)

Humana Medical Plan, Inc.

Respondent Name

E Barger, III

Authorized Official Signature

10/21/17

Date

EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

John E. Barger III

Authorized Official Printed Name

Vice President of
Dual Eligible and
Medicaid Programs

Authorized Official Title

EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

PURPOSE: The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to capture commitments made by the respondent in response to this solicitation.

INSTRUCTIONS: The respondent shall identify each commitment made/proposed in the solicitation. Commitments include, but are not limited to: innovations that assist in achieving the Agency goals, improvements in service delivery coordination and quality outcomes for enrollees, improving the enrollee experience, commitments made in the respondent's provider engagement approach which result in an improved provider experience, and commitments reducing overall costs to the Medicaid program. The respondent shall identify the solicitation section/sub-section (Attachment X, Exhibit Y, Subsection Z), as applicable where the commitment can be found.

Category	Commitment (Brief Summary/Description)	Solicitation Section Reference
Example: Agency Goals	(Respondent to complete)	Exhibit A-4-a, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Agency Goals	Humana and HFN will collaborate in a regional demonstration to close care gaps and reduce potentially preventable events.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC # 4 - Telemedicine (Regional)
Agency Goals	We will create a mental health provider score card conveying mental health-related admissions, readmissions, and length of time from discharge to follow-up care visits for providers to review and use to identify opportunities for improvement.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC # 3 - Patient Centered Medical Homes (Regional)
Agency Goals	DOCTOR ON DEMAND: Humana is launching a telemedicine partnership with Doctor on Demand, effective October 2018,	Exhibit A-4-b, Section B., Agency Goals, MMA SRC # 4 - Telemedicine (Regional)
Agency Goals	Humana will be designating a Provider Services Leader who will provide oversight on disputes.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC # 5 - Provider Network Development (Statewide)
Provider Experience	Humana is implementing an improved provider information verification process to ensure we have updated provider demographic and participation status information available to our enrollees, enhancing their access to care.	Exhibit A-4-b, Section D. Provider Experience, MMA SRC #12 - Provider Credentialing (Statewide)
Delivery System Coordination	With AHCA's approval, we will enhance our handbook to include a list of Medicaid FFS benefits alongside the list of Humana's covered benefits.	Exhibit A4b, Section E., Delivery System Coordination, MMA SRC #17 - Coordination of Carved Out Services (Statewide)
Delivery System Coordination	With AHCA's approval, our online enrollee portal will be enhanced to provide a clear description of the services covered through Medicaid FFS and the prepaid dental plan, including information on how enrollees can obtain any necessary referrals through their provider and instructions for how to complete applications for the waiver process. We will also provide Humana contact phone numbers that enrollees can call to ask questions about or request assistance with referrals.	Exhibit A4b, Section E., Delivery System Coordination, MMA SRC #17 - Coordination of Carved Out Services (Statewide)
Delivery System Coordination	As MMA shifts from a carved-in to carved-out model of dental services, we will ensure that all associates and subcontractors understand this and other changes to the contract through our training program.	Exhibit A4b, Section E., Delivery System Coordination, MMA SRC #17 - Coordination of Carved Out Services (Statewide)

EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

Recipient Experience	We will hire nurse-trained CMs with experience with these three (3) waiver populations (The Project AIDS Care (PAC) waiver, Adult Cystic Fibrosis (ACF) waiver, and Traumatic Brain Injury and Spinal Cord Injury waiver). We will place each specially-trained CM in the region with the highest volume of the applicable special needs enrollees.	Exhibit A-4-c, Section C., Recipient Experience, LTC SRC #5 - Transition from Nursing Facility to Community (Statewide)
Recipient Experience	Additionally, we will institute post-transition reviews of individual enrollees who have reverted to the institutional setting, enabling transition coordinators and case managers to identify necessary actions to prevent future institutional placements.	Exhibit A-4-c, Section C., Recipient Experience, LTC SRC #5 - Transition from Nursing Facility to Community (Statewide)

Humana Medical
Plan, Inc.

Respondent Name

J E Barger, III — 10/21/17

Authorized Official Signature — **Date**

John E. Barger III

Authorized Official Printed Name

Vice President of
Dual Eligible and
Medicaid Programs

Authorized Official Title

EXHIBIT A-6
SUMMARY OF MANAGED CARE SAVINGS

PURPOSE: The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to identify managed care savings included by the respondent in response to this solicitation.

THE AGENCY RESERVES THE RIGHT TO INCLUDE ANY OR ALL MANAGED CARE SAVINGS LISTED HEREIN, OR AS NEGOTIATED, AS PART OF THE RESULTING CONTRACT.

INSTRUCTIONS: THE RESPONDENT SHALL IDENTIFY EACH MANAGED CARE SAVINGS PROPOSED IN ITS RESPONSE TO THIS SOLICITATION AND IDENTIFY BOTH THE SOLICITATION SECTION(S)/SUBSECTION(S)/ITEM(S), AND THE SECTION/COLUMN OF THE COST PROPOSAL TEMPLATE (ATTACHMENT C) IN WHICH THE MANAGED CARE SAVINGS IS PROPOSED. (SEE EXAMPLE BELOW) ADDITIONAL PAGES MAY BE INCLUDED AS NEEDED.

Managed Care Savings Activity (Brief Summary/Description)	Solicitation Section Reference	Cost Proposal Template (Attachment C) Reference
Hospital Readmissions	**Example:** *Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 1 Potentially Preventable Events (Regional)*	**Example:** *Cost Proposal Template (Attachment C)., Managed Care Savings Adjustments, #1*
Comprehensive Disease and Case Management: Reduces preventable admissions, readmissions, ER visits, and other avoidable costs. Also improves birth outcomes. Case management and care plan review for LTC members ensures appropriate setting of care and effective use of home health and transportation services for home based membership. Although incremental administrative expenses are necessary to support such programs, there is a favorable return on investment relative to medical expenses in addition to providing higher quality and better outcomes.	Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 1 Potentially Preventable Events (Regional), Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 2, Birth Outcomes (Statewide), Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 7 MMA Physician Incentive Program (MPIP) (Statewide), Exhibit A 4-c., LTC Submission Requirements and Evaluation Criteria - SRC# 3 Transitions of Care (Statewide), Exhibit A 4-c., LTC Submission Requirements and Evaluation Criteria - SRC# 5 Transition from Nursing Facility to Community (Statewide)	Cost Proposal Template (Attachment C)., Managed Care Savings Adjustments, #1
Comprehensive Utilization Management and Social Work: Reduces preventable admissions, readmissions, and emergency department visits, and also ensures appropriate treatment setting (e.g. office visit, outpatient, inpatient, and SNF). Although incremental administrative expenses are necessary to support such programs, there is a favorable return on investment relative to medical expenses in addition to providing higher quality and better outcomes.	Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 1 Potentially Preventable Events (Regional)	Cost Proposal Template (Attachment C)., Managed Care Savings Adjustments, #1
Increase PCP reimbursement for after-hours visits and real-time notification of emergency department visits for PCPs.	Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 1 Potentially Preventable Events (Regional)	Cost Proposal Template (Attachment C)., Managed Care Savings Adjustments, #3
Network Contracting: reducing costs and preventable events through significant value-based provider relationships and other strategic contracting initiatives.	Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 1 Potentially Preventable Events (Regional), Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 7 MMA Physician Incentive Program (MPIP) (Statewide), Exhibit A 4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 13 Value Based Purchasing (Regional)	Cost Proposal Template (Attachment C)., Managed Care Savings Adjustments, #3
Front End Review (FER) and Prior Authorization List (PAL): Review facility, physician, and ancillary authorizations as well as pharmacy dispensing for appropriateness of treatment and place of treatment. Although incremental administrative expenses are necessary to support such programs, there is a favorable return on investment relative to medical expenses.	Exhibit A-4-b., MMA Submission Requirements and Evaluation Criteria - SRC# 1 Potentially Preventable Events (Regional)	Cost Proposal Template (Attachment C)., Managed Care Savings Adjustments, #1

Humana Medical Plan, Inc.

Respondent Name

John E Barger, III 10/21/17

Authorized Official Signature **Date**

John E. Barger III

Authorized Official Printed Name

Vice President of Dual Eligible and Medicaid Programs

Authorized Official Title

EXHIBIT A-7
CERTIFICATION OF DRUG-FREE WORKPLACE PROGRAM

In the event of Identical or Tie Bids/Proposals: Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free work place program shall be given preference in the award process. Established procedures for processing tied awards will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).

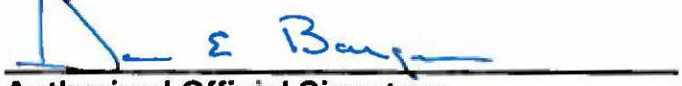
4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by, any employee who is so convicted.

6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

Humana Medical Plan, Inc.
Respondent Name



Authorized Official Signature

10/8/17
Date

John E. Barger III
Authorized Official Printed Name

VP of Dual Eligible and Medicaid Programs
Authorized Official Title

EXHIBIT A-9
REGIONAL PREFERENCE HIERARCHY

RESPONDENT NAME: Humana Medical Plan, Inc.

The Agency shall award one (1) additional Contract in a region to each successful respondent who receives a Region 1 or 2 Contract award. The Agency shall award the additional Contract in the respondent's highest desired region of preference in which the respondent submitted a responsive reply and negotiates a rate acceptable to the Agency.

Respondents shall complete the Regional Preference Hierarchy Table below, to indicate its preference for receipt of additional Contract awards.

If the Regional Preference Hierarchy Table is left blank, the respondent indicates that it does not desire any additional region awards.

Respondents shall indicate the region(s) in hierarchy order (highest desire being 1 and lowest desire being 10).

REGIONAL PREFERENCE HIEARCHY	
Order Requested for Additional Award	**By Region**
1.	Trade Secret as defined in Section 812.081, Florida Statutes [redacted]
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Humana Medical Plan, Inc.
Respondent Name

J E Barger — 10/6/2017

Authorized Official Signature **Date**

John E. Barger, III
Authorized Official Printed Name

Vice President, Dual Eligible & Medicaid Programs
Authorized Official Title

Humana Medical Plan, Inc.
October 2018 – September 2019 Cost Proposal Development
For
State of Florida
Agency for Health Care Administration
Statewide Medicaid Managed Care Program
Managed Medical Assistance Program

Prepared for:
State of Florida

Prepared by:
Humana Medical Plan, INC.

C. Jo Erwin, FSA, MAAA
Actuarial Director, Medicaid Pricing and Public Policy Analysis

Rodger Yan, FSA, MAAA
Actuarial Director, Medicaid Pricing

Kirsten Stryker, ASA MAAA
Associate Actuary, Medicaid Pricing

Liwei Song, FSA, MAAA
Actuary, Medicaid Pricing

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Exhibit 1: Summary of MMA RY18/19 Capitation Rates by Region and Rate Group

Trade secret as defined in Section 812.081, Florida Statutes

Exhibit 2: Summary of MMA RY 18/19 Maternity Kick Payment

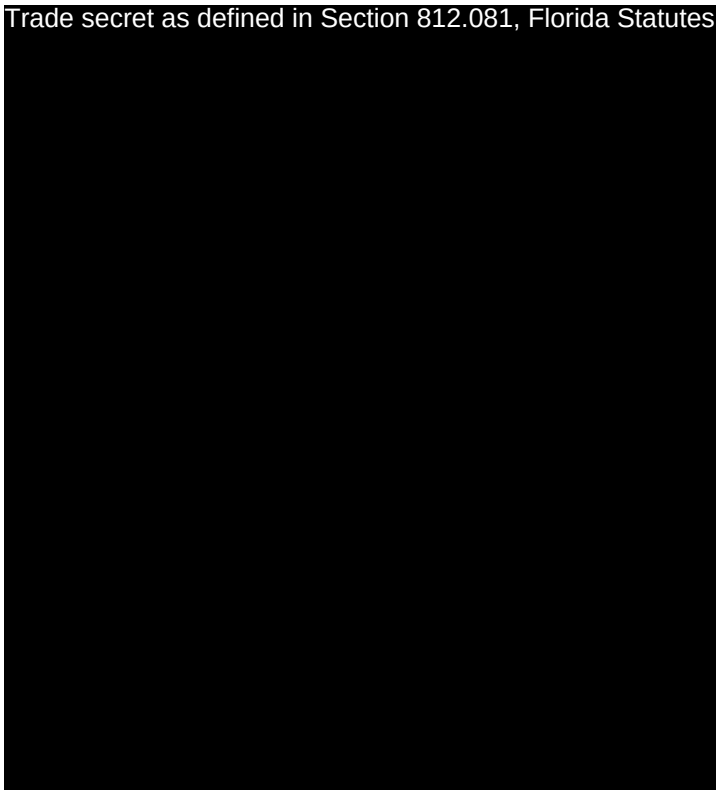
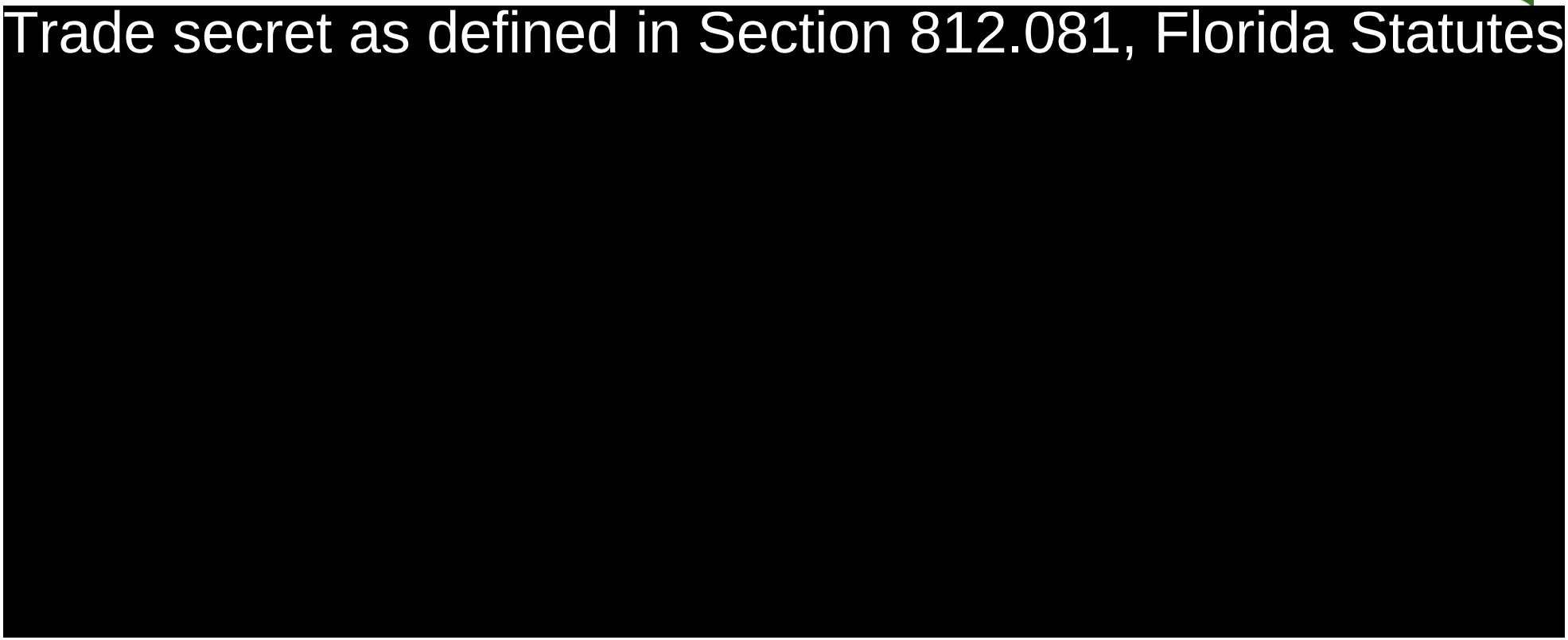


Exhibit 3: Summary of MMA RY18/19 Results of Sensitivity Testing



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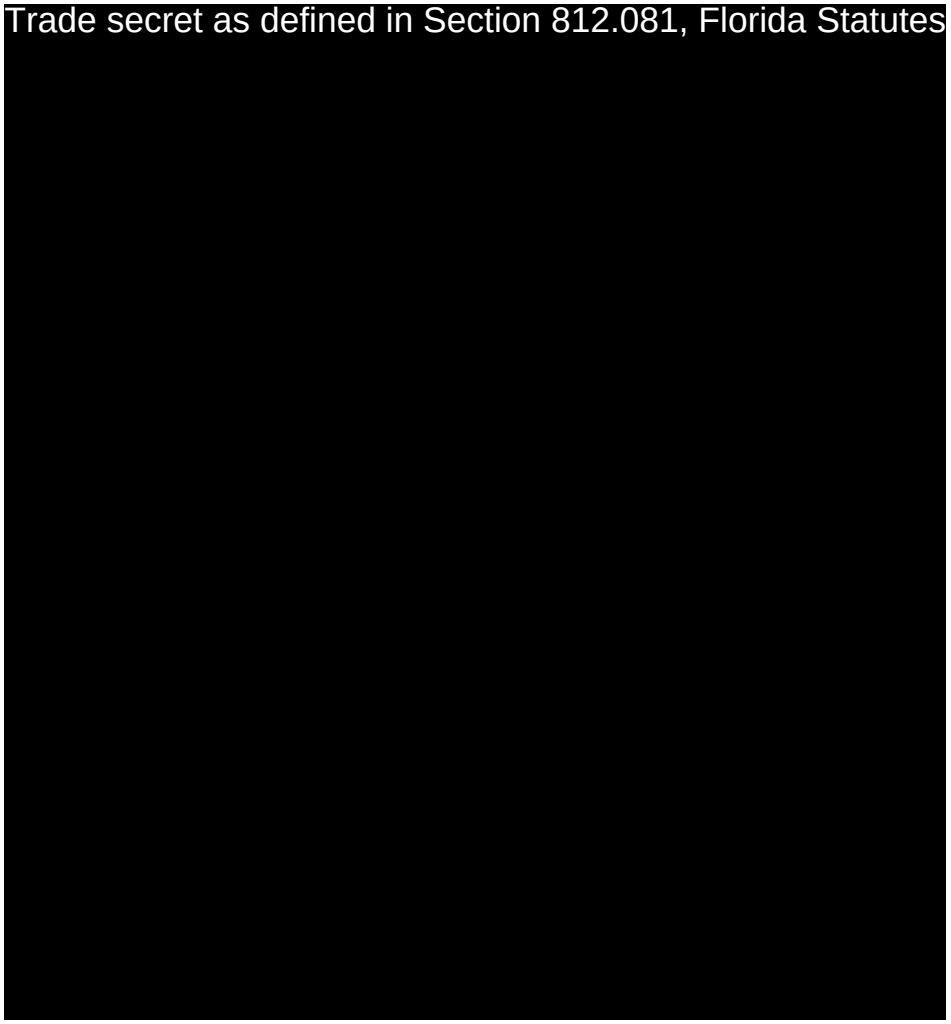


Humana Medical Plan, Inc.
October 1, 2018 to September 30, 2019 (RY 18/19) MMA Program Cost Proposal
For
Florida Agency for Health Care Administration
Statewide Medicaid Managed Care (SMMC)
Managed Medical Assistance (MMA) Program
Actuarial Certification
Regions 1-11

I, C. Jo Erwin, am an Actuarial Director with Humana, Inc. I am a member of the American Academy of Actuaries and a Fellow in the Society of Actuaries. I meet the Qualification Standards for Statement of Actuarial Opinion established by the American Academy of Actuaries. I reviewed the calculated capitation rates and am familiar with the relevant requirements of 42 CFR 438; the CMS Checklist - "Documentation Requirements for Actuarially Sound Capitation Rates, Edit Date: November 10, 2014", the 2017-2018 Medicaid Managed Care Rate Development Guide and Actuarial Standard of Practice (ASOP) 49.

This actuarial certification is provided in response to the Agency for Health Care Administration's (AHCA's) Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program Invitation to Negotiate (ITN) for Regions 1-11 for the effective period October 1, 2018 through September 30, 2019. This certification may not be appropriate for other purposes.

To the best of my information, knowledge and belief, the RY 18/19 cost proposals developed by Humana are in compliance with the relevant requirements of 42 §CFR 438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(3), (b)(4) and (b)(9)), 438.5, 438.6 and 438.7 (excluding paragraph (c)(3)).

I have examined the information in the data book and the adjustments made to develop the proposed rates as applied in the included cost proposals. I have also reviewed the ITN instructions and current experience for current managed care companies.

For purposes of this certification, actuarially sound capitation rates are defined as rates that:

- have been developed in accordance with generally accepted actuarial principles and practices; and
- are appropriate for the Medicaid populations to be covered, and the services to be furnished under the contract;

In developing the actuarially sound capitation rates, I relied upon the accuracy of data and information from AHCA and associates of Humana, Inc. I evaluated that data for reasonableness and consistency. I did not audit the data.

In my opinion, the capitation rates are actuarially sound, as defined in ASOP 49. They have been developed in accordance with generally accepted actuarial principles and practices, and are

appropriate for the populations to be covered and the services to be furnished under the contract. The assumptions used in the development of the capitation rates have been documented in the Actuarial Memorandum.

The certification includes rates for the following populations: TANF non-SMI, TANF SMI, SSI Medicaid Only non-SMI, SSI Medicaid Only SMI, SSI Dual Eligible, Child Welfare, HIV/AIDS Medicaid Only, HIV/AIDS Dual Eligible, LTC Medicaid Only, and LTC Dual Eligible.

Humana's cost proposal development excludes adjustments for the following items based on Section II.F (MMA) of the cost proposal instructions and rate methodology narrative.

- Seasonality adjustments needed for the differences in timing between the RY 18/19 period assumed for the cost proposal and the actual program implementation schedule.
- Adding nursing facility services for adults that are excluded from the SMMC LTC program as a covered benefit under MMA. This applies to MMA nursing facility and hospice services.
- Subject to CMS approval, transition of the Medicaid recipients receiving home and community-based waiver services through Project AIDS Care, Traumatic Brain Injury, and Adult Cystic Fibrosis waivers into the LTC Program, which will move these members into the LTC Medicaid Only or LTC Dual Eligible rate groups.
- Implementation of LTC program Express Enrollment, which will transition more members into the LTC Medicaid Only and LTC Dual Eligible rate groups faster.
- The enrollment of certain CMSN members into MMA capitated plans resulting from the Florida Department of Health's rescreening process that identified CMSN members that did not meet current CMSN enrollment criteria. This program change transitioned more members into MMA capitated plans during the second half of 2015.
- Restructuring of the existing MMA rate group structure, risk adjustment process, or other changes, if necessary, to develop actuarially sound rate mechanisms for any new specialty populations covered by one or more Specialty Plans.
- Application of final rate cell factors to final negotiated rates by rate group and region.
- Florida Medicaid FFS hospital, physician, and other provider reimbursement rates in effect for RY 18/19.
- Costs related to the inclusion of the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) wraparound payments which make up the difference between capitated plan payments and the Agency's encounter reimbursement rates.
- Costs related to the MMA Physician Incentive Program (MPIP). The MMA data book data reflects a time period prior to the October 2016 implementation of the MPIP and therefore fully excludes all costs associated with the MPIP.
- Compliance with the Medicaid managed care regulation published by the Centers for Medicare and Medicaid Services that disallows capitation payments eligible for the federal match for members aged 21 to 64 with a stay of more than 15 days in a given calendar month in an Institute for Mental Disease (IMD).
- The July 1, 2016 program change that provided Medicaid eligibility to lawfully residing children if they meet all other eligibility requirements (previously, most children had to be lawfully residing in the United States at least five years before they qualified for Medicaid services).

- Development of the medical school faculty physician group value based purchasing arrangement (if necessary).
- Development of the revised organ transplant kick payment amount.
- Development of the Behavioral Health Reform Waiver Services enhanced payment amount for temporary housing assistance and other supportive behavioral health services.
- Other program changes excluded from the cost proposal instructions and rate methodology narrative.
- Costs related to the federal health insurance provider fee (HIPF).

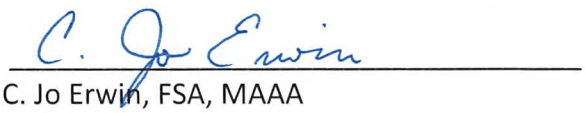
We understand that the Agency will adjust the final negotiated capitation rates to reflect the impact of these items and they therefore have been excluded from Humana's cost proposal development.

Per ITN instructions the submitted rates reflect a standard 1.0 risk based on information provided in the datebook.

Actuarial methods, considerations, and analyses used in forming my certification conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this Certification.

The actuarially sound capitation rates are based on a projection of future costs based on a set of assumptions. The rates are reasonable based on historical results for the managed Medicaid industry. Actual experience will vary from the assumptions in the rate development. I am not certifying that Humana Medical Plan, Inc. will achieve the target assumptions documented in our Actuarial Memorandum.

This Opinion assumes the reader is familiar with the Florida Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. The Opinion is intended for the State of Florida Agency for Health Care Administration and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.



C. Jo Erwin, FSA, MAAA
Member, American Academy of Actuaries
October 13, 2017

Humana, Inc.
Actuarial Director
Medicaid Pricing and Public Policy Analysis
500 West Main Street, NCT - 21
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Humana Medical Plan, Inc.
October 2018 – September 2019 Cost Proposal Development
For
State of Florida
Agency for Health Care Administration
Statewide Medicaid Managed Care Program
Long Term Care Program

Prepared for:
State of Florida

Prepared by:
Humana Medical Plan, INC.

C. Jo Erwin, FSA, MAAA
Actuarial Director, Medicaid Pricing and Public Policy Analysis

Rodger Yan, FSA, MAAA
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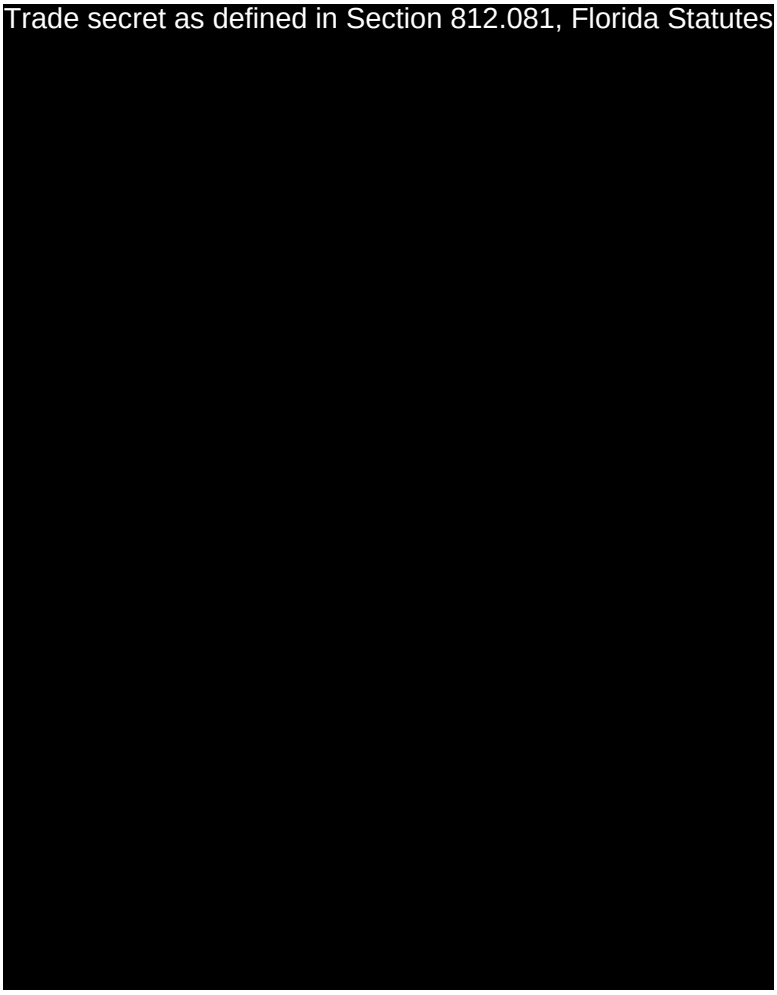
Exhibit 1: Summary of LTC RY 18/19 Capitation Rates by Region

Exhibit 2: Summary of LTC RY18/19 Results of Sensitivity



Humana Medical Plan, Inc.
October 1, 2018 to September 30, 2019 (RY 18/19) LTC Program Cost Proposal
for
Florida Agency for Health Care Administration
Statewide Medicaid Managed Care (SMMC) Long Term Care (LTC) Program
Actuarial Certification - Regions 1-11

I, C. Jo Erwin, am an Actuarial Director with Humana Medical Plan, Inc. I am a member of the American Academy of Actuaries and a Fellow in the Society of Actuaries. I meet the Qualification Standards for Statement of Actuarial Opinion established by the American Academy of Actuaries. I reviewed the calculated capitation rates and am familiar with the relevant requirements of 42 CFR 438; the CMS Checklist - "Documentation Requirements for Actuarially Sound Capitation Rates, Edit Date: November 10, 2014", the 2017-2018 Medicaid Managed Care Rate Development Guide and Actuarial Standard of Practice (ASOP) 49.

This actuarial certification is provided in response to the Agency for Health Care Administration's (AHCA's) Statewide Medicaid Managed Care (SMMC) Long Term Care (LTC) Program Invitation to Negotiate (ITN) for Regions 1-11 for the effective period October 1, 2018 through September 30, 2019. This certification may not be appropriate for other purposes.

To the best of my information, knowledge and belief, the RY 18/19 cost proposals developed by Humana are in compliance with the relevant requirements of 42 §CFR 438.3(c), 438.3(e), 438.4 (excluding paragraphs (b)(3), (b)(4) and (b)(9)), 438.5, 438.6 and 438.7 (excluding paragraph (c)(3)).

I have examined the information in the data book and the adjustments made to develop the proposed rates as applied in the included cost proposals. I have also reviewed the ITN instructions and current experience for current managed care companies.

For purposes of this certification, actuarially sound capitation rates are defined as rates that:

- have been developed in accordance with generally accepted actuarial principles and practices; and
- are appropriate for the Medicaid populations to be covered, and the services to be furnished under the contract;

In developing the actuarially sound capitation rates, I relied upon the accuracy of data and information from AHCA and associates of Humana Medical Plan, Inc. I evaluated that data for reasonableness and consistency. I did not audit the data.

In my opinion, the capitation rates are actuarially sound, as defined in ASOP 49. They have been developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract. The

assumptions used in the development of the capitation rates have been documented in the Actuarial Memorandum.

The certification includes rates for the following two mutually exclusive rate groups:

- Home and community based services (HCBS)
- Non-HCBS

These rate groups cover individuals 18 years or older and eligible for placement in a nursing facility based on the Comprehensive Assessment and Review for Long-Term Care Services tool. In addition, initial LTC enrollment included transition of members from the following Medicaid Waivers:

- Assisted Living
- Aged and Disabled Adult Waiver or the Consumer-Directed Care Plus part of this waiver
- Adult Day Health Care Waiver
- Nursing Home Diversion Waiver
- Channeling Services for Frail Elders Waiver

The cost proposal does not include rates for the following waiver populations that are being added subject to CMS Approval:

- Project AIDS Care
- Traumatic Brain and Spinal Cord Injury
- Adult Cystic Fibrosis

Humana's cost proposal development excludes adjustments for the following items based on Section III.F (LTC) of the cost proposal instructions and rate methodology narrative. The Agency will adjust the final negotiated capitation rates to reflect the impact of these items.

- Nursing Facility/Hospice Rate changes
- Community High Risk Pool (CHRP) – no adjustment was made to reflect projected withholds or recoveries from the CHRP.
- Transition Percentages – no adjustments were applied for the blending of the HCBS and non-HCBS rates.
- Patient Responsibility Changes
- Seasonality adjustments needed for the differences in timing between the RY 18/19 period assumed for the cost proposal and the actual program implementation schedule.
- The following program changes are expected to have a material impact on the LTC program.
    1. New waiver populations that pending CMS approval will transition into the LTC program January 1, 2018 for receipt of their home and community-based services.
        a. Project AIDS Care
        b. Traumatic Brain and Spinal Cord Injury
        c. Adult Cystic Fibrosis
    2. Implementation of LTC program Express Enrollment, which will enroll members into the LTC program more quickly.
    3. Other program changes excluded from the cost proposal instructions and rate methodology narrative.

Exhibit 3: LTC Actuarial Certification

We understand that AHCA will adjust final negotiated rates to reflect the impact of these items and they therefore have been excluded from Humana's cost proposal development. In addition, the submitted rates do not reflect any expanded benefit costs.

Actuarial methods, considerations, and analyses used in forming my certification conform to the appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this Certification.

The actuarially sound capitation rates are based on a projection of future costs based on a set of assumptions. The rates are reasonable based on historical results for Humana and the managed Medicaid industry. Actual experience will vary from the assumptions in the rate development. I am not certifying that Humana Medical Plan, Inc. will achieve the target assumptions documented in our Actuarial Memorandum.

This Opinion assumes the reader is familiar with the Florida Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. The Opinion is intended for the State of Florida Agency for Health Care Administration and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.

C. Jo Erwin, FSA, MAAA
Member, American Academy of Actuaries
October 13, 2017

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Exhibit C-1: Capitated Plan Cost Proposal Template
Statewide Medicaid Managed Care (SMMC) Invitation to Negotiate (ITN)
Cost Proposal Template Basic Instructions & General Inputs
Region 1 Cost Proposal

General Inputs:

Respondent Organization Name: Humana Medical Plan, Inc.
Region: 1

Basic Instructions:

1. The purpose of this capitated plan cost proposal template, as part of the SMMC ITN, is to provide Respondents with a means for completing the SMMC Cost Proposal ("cost proposal") required in Attachment A of the SMMC ITN. This template is intended only for Respondents proposing to become a capitated plan in the SMMC program. Respondents proposing to become a Fee-for-Service (FFS) Provider Service Network (PSN) should fill out a different template.

2. **Respondents must follow the instructions presented in the SMMC ITN document " Attachment C: Cost Proposal Instructions and Rate Methodology Narrative."** That document includes both strict instructions for completing the cost proposal, as well as other information about the cost proposal and rate negotiation process that Respondents may find useful when completing their cost proposals. Please refer to that document for comprehensive instructions for completing the capitated plan cost proposal template.

3. **Under the "General Inputs" section above, Respondents should enter their organization name, as well as the region to which this cost proposal template applies.** Respondents must submit a separate capitated plan cost proposal template (with each of the necessary components completed) for each individual rate region in which they are proposing to participate in the SMMC program. The Respondent organization name and region entered on this tab will cause values in other tabs of the capitated plan cost proposal template to populate accordingly.

4. This single capitated plan cost proposal template Excel file includes tabs for three distinct components (the MMA cost proposal template, the LTC cost proposal template, and the non-benefit expense cost proposal template) that are required for different SMMC plan types. Please see the "Tab Structure" section below for details on the tabs included in this file, as well as a listing of which tabs should be completed by Respondents depending on their chosen SMMC plan type. Complete definitions for the SMMC plan types and additional instructions can be found in the SMMC ITN document "Attachment C: Cost Proposal Instructions and Rate Methodology Narrative."

5. In tabs that are not required for the Respondent's chosen SMMC plan type, Respondents should leave all inputs blank.
6. The capitated plan cost proposal template is password protected to allow Respondents to enter information only in cells shaded peach. Respondents must not change any formulas in the capitated plan cost proposal template and must submit the capitated plan cost proposal template with the original sheet and workbook protection intact. A formatting key is shown below and is also shown on each tab throughout the template for reference.
7. Respondents must enter a numeric value into each and every peach cell on all required tabs for their chosen SMMC plan type (except for the Respondent Organization Name input, the Proposed Specialty Population input in Worksheet M.11, and the adjustment factor name inputs on the various tabs, which can be input as text). If numeric values are not entered into each and every required peach cell, the cost proposal template will not appropriately calculate a proposed capitation rate from the Respondent's input base data and adjustments. If a particular adjustment factor, per member per month (PMPM) amount, or per delivery amount does not apply for a given region, rate group, or service category, Respondents should enter a 1.000 multiplicative adjustment factor or a $0.00 additive cost in the required input cells to allow the cost proposal template to appropriately calculate a proposed capitation rate.

8. Do not insert rows or columns in the template, or use the "cut" command on any cells within the template. If the Respondent requires more columns for adjustments than provided, please combine adjustments so that they can be entered into the number of columns in the template and include a description of each adjustment and its value in the Actuarial Memorandum that accompanies the cost proposal template (along with Excel numerical support as needed).

9. Respondents should complete the applicable MMA cost proposal template and LTC cost proposal template worksheets before completing the non-benefit expense cost proposal template worksheet. The non-benefit expense cost proposal template for capitated plans uses conditional formatting to apply dark shading to the rows for the rate groups that do not include a calculated projected service cost in the MMA or LTC worksheets. As a result, after a Respondent completes the appropriate MMA and LTC worksheets (depending on the Respondent's chosen SMMC plan type), Respondents only need to complete the rows for the rate groups that are not shaded. Respondents should enter 0 member months, 0 deliveries, $0.00 PMPM, or $0.00 per delivery in the peach cells in the rows that are shaded.

10. The final proposed capitation rates are shown in cells X23 through X42 of the 'N.1 Admin, Gain, Loss' tab.

11. Respondents should use the following file naming convention when submitting their cost proposal templates:
   a. Respondents should replace the "Region XX" portion of the cost proposal template Excel file name with the region to which the particular cost proposal template applies (e.g., "Region 1").
   b. Respondents should replace the "Respondent Name" portion of the cost proposal template Excel file name with their own organization's name.
   c. Aside from the file name changes described in items 11.a and 11.b, Respondents should not change the name of the cost proposal template Excel file.

Formatting key:

Peach shading indicates information to be input by Respondents.
White and other shading indicates information that Respondents are not permitted to change.
Yellow highlighting indicates formula-driven total projected cost or final capitation rate.

Blue font indicates values input by Respondents, or hard-coded inputs in the starting template.
Black font indicates formula-driven results automatically populated in the cost proposal template.

Tab Structure:

The capitated plan cost proposal template is set up to include the following tabs:
MMA Cost Proposal Template tabs
- M.1 through M.10, Section A: One tab for each existing MMA rate group (excluding the Maternity Kick Payment) where Respondents should enter their proposed base data and various adjustments as part of their cost proposals.
- M.1 through M.10, Section B: One tab for each existing MMA rate group (excluding the Maternity Kick Payment) which includes a condensed summary of the information in Section A for each rate group. No input by Respondents is needed on the Section B tabs.
- M.11, Section A: One tab where Respondents proposing to become a Specialty plan covering a new customized specialty population should, to the best of their ability, enter their proposed base data and various adjustments as part of their cost proposals.
- M.11, Section B: One tab for a proposed new customized specialty population that includes a condensed summary of the information in Worksheet M.11, Section A. No input by Respondents is needed on this tab.
- M.12: One tab for the Maternity Kick Payment where Respondents should enter their proposed base data and various adjustments as part of their cost proposals.

LTC Cost Proposal Template tab - L.1: One tab where Respondents should enter their proposed base data and various adjustments as part of their cost proposals for both the HCBS and Non-HCBS rate groups.
Non-Benefit Expense Cost Proposal Template tab - N.1: One tab where Respondents should enter their proposed administrative allowance and gain/loss margin for the relevant rate groups.

The following table illustrates which tabs in the capitated plan cost proposal template should be completed by Respondents for each SMMC plan type (please refer to the SMMC ITN document " Attachment C: Cost Proposal Instructions and Rate Methodology Narrative" for complete details):

SMMC Cost Proposal Submission Requirements for Each SMMC Plan Type ("Yes" = Required, "No" = Not Required, "N/A" = No Respondent Inputs)

Tab Name	Comprehensive Plan	LTC Plus Plan	MMA Plan	HIV/AIDS Specialty Plan	Child Welfare Specialty Plan	SMI Specialty Plan	Other Customized Specialty Plan[1]
M.1 Sec A - TANF NonSMI	Yes	No	Yes	No	No	No	No
M.1 Sec B - TANF NonSMI	N/A	No	N/A	No	No	No	No
M.2 Sec A - TANF SMI	Yes	No	Yes	No	No	Yes	No
M.2 Sec B - TANF SMI	N/A	No	N/A	No	No	N/A	No
M.3 Sec A - SSI Med Only NonSMI	Yes	No	Yes	No	No	No	No
M.3 Sec B - SSI Med Only NonSMI	N/A	No	N/A	No	No	No	No
M.4 Sec A - SSI Med Only SMI	Yes	No	Yes	No	No	Yes	No
M.4 Sec B - SSI Med Only SMI	N/A	No	N/A	No	No	N/A	No
M.5 Sec A - SSI Dual Elig	Yes	No	Yes	No	No	Yes	No
M.5 Sec B - SSI Dual Elig	N/A	No	N/A	No	No	N/A	No
M.6 Sec A - Child Welfare	Yes	No	Yes	No	Yes	Yes	No
M.6 Sec B - Child Welfare	N/A	No	N/A	No	N/A	N/A	No
M.7 Sec A - HIVAIDS Med Only	Yes	No	Yes	Yes	No	Yes	No
M.7 Sec B - HIVAIDS Med Only	N/A	No	N/A	N/A	No	N/A	No
M.8 Sec A - HIVAIDS Dual Elig	Yes	No	Yes	Yes	No	Yes	No
M.8 Sec B - HIVAIDS Dual Elig	N/A	No	N/A	N/A	No	N/A	No
M.9 Sec A - LTC Med Only	Yes	Yes	No	No	No	No	No
M.9 Sec B - LTC Med Only	N/A	N/A	No	No	No	No	No
M.10 Sec A - LTC Dual Elig	Yes	Yes	No	No	No	No	No
M.10 Sec B - LTC Dual Elig	N/A	N/A	No	No	No	No	No
M.11 Sec A - New Specialty	No	No	No	No	No	No	Yes
M.11 Sec B - New Specialty	No	No	No	No	No	No	N/A
M.12 - Maternity Kick Payment	Yes	Yes	Yes	Yes	Yes	Yes	Yes
L.1 - LTC	Yes	Yes	No	No	No	No	No
N.1 Admin, Gain, Loss	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Work Area[2]	Optional	Optional	Optional	Optional	Optional	Optional	Optional

[1] Respondents proposing to become a new customized type of Specialty plan should submit a full MMA cost proposal to the best of their ability.
[2] The 'Work Area' tab is an unprotected work space that is optional for Respondents to use when completing the cost proposal template.

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