



2.10.13 Claims Management and Systems and Technical Requirements

2.10.13.1 Demonstrate understanding of the Louisiana Medicaid program in customizing a Louisiana-specific system for adjudicating claims.

**Claims Mission and Vision**

Humana’s state-of-the-art claims processing system meets all federal and LDH requirements for accuracy and timeliness and performs the required claims processing and payment functions outlined in the Model Contract. In 2018 we processed, on average, more than 425,000 medical and dental claims and encounters per day across our commercial, Medicare, and Medicaid business nationwide. Our claims processing mission is to “Pay It Right the First Time,” which means we aim to adjudicate and reimburse claims correctly at or near the point of service. We strive to achieve successful “first pass” claims processing and payment by educating and listening to providers and designing our systems to be flexible and responsive. In 2018, Humana paid or denied [REDACTED] of Medicaid medical claims (primary care, hospital, specialty care, and other) within 10 calendar days of receipt. That same year in our largest Medicaid market, non-pharmacy encounters were accepted at a [REDACTED] rate and pharmacy encounters at a [REDACTED] percent rate.



**Strategic Priorities**

We have designed our claims strategy with the ultimate goals of supporting providers and being an effective State partner in administering Medicaid covered services. Over the last several years, we have focused our claims management strategy in the following areas:

- **Provider Training and Education:** We employ multiple methods, including phone outreach, webinars, online training, mailings, in-person meetings, and workshops, to engage providers and their staff on coding, claims submission, and Humana’s claims payment policies and processes. We offer comprehensive provider trainings and accessible claims associates, such as Provider Claims Educators (PCE), to support providers. Information regarding claims processing is readily available on our website and in the Provider Handbook. For example, “Making It Easier for Physicians and Other Healthcare Providers” is a series of educational presentations about Humana’s claims payment policies and processes available on our website. Our Provider Services representatives are also available via our provider hotline to respond to claims inquiries.
- **Online Claims Editing:** To maximize our claims acceptance rate, our provider portal, Availity, has a unique suite of claims editing tools that allow users to receive status notifications in real time on claims submissions, edit claims submissions, file corrections, and add attachments, thereby avoiding common reasons for rejections. More than 80 percent of Humana’s providers use Availity for claims submissions and other functions.
- **Electronic Claims Submission:** Our multi-pronged strategy to increase electronic claims submission includes a direct data entry form on Availity, targeted outreach focused on providers who submit paper claims, promotional inserts mailed with paper checks and remits, and phone and email outreach. Humana’s eBusiness team, a dedicated group of provider-facing consultants, targets providers based on opportunities to drive efficiencies using self-service tools, including electronic funds transfer (EFT). As a result of these strategies, in the past year almost [REDACTED]. We will employ a similar strategy in Louisiana.
- **Gold Carding:** Humana is waiving prior authorization requirements for providers who consistently exceed prior authorization performance and quality criteria. We are currently implementing this provider-friendly innovation in our Florida Medicaid market, and will expand into Louisiana.
- **Fraud Detection and Auditing:** Based on decades of experience with claims processing, we have honed our automatic claims fraud detection, audit, and review processes (see Section 2.10.14 for more detail).

We have assembled a team of experts with deep experience in our claims processing operations. Under the leadership of the Claims Administrator, claims associates assigned exclusively to Medicaid will augment their strong understanding of Medicaid contracts with training on Louisiana’s specific requirements. We are prepared to hire additional claims associates as necessary (see Section 2.10.2.2 for more information).

**Customizing a Louisiana-Specific System**

Our flexible, proprietary systems allow us to easily configure code edits and processes to tailor our proven approach to Louisiana-specific requirements. We will fine-tune our claims process, as depicted in Attachment 2.10.13.1- A1 (Claims Adjudication Process), to meet the unique requirements of the Model Contract. Humana manages medical, behavioral health (BH), and pharmacy benefits in-house, ensuring consistent claims processing practices in these areas and granting us the ability to quickly prioritize and modify authorizations, fee schedules, and claims adjudication rules. For example, within a 24-hour period in our Florida Medicaid implementation, we edited our claims authorizations to allow payment to providers of Early Intervention Services (EIS) for children with special needs. Subsequently, we trained our claims adjusters on the EIS program and the edits required to enable this important service.



Our subcontracted providers for transportation, dental, and vision benefits support claims submissions in paper, electronically, and through portals in order to produce HIPAA-compliant encounter files for submission to Humana. We attest to our ability to meet or exceed claims processing timeliness standards as defined in Section 2.18.2 of the Model Contract.

Humana associates are experienced at managing claims across varying services types including physical health, BH, pharmacy, and transportation. We understand the importance of differentiating the attending and billing provider to assess enrollee attribution and enabling providers to submit zero dollar claims to capture non-billable services, including social services and services by an at-risk, capitated provider. We will configure our proprietary, purpose-built encounter processing system, HERO, to meet Encounter Submission requirements as detailed in Section 2.18.15 of the Model Contract and displayed in Attachment 2.10.13.1-A4 (Non-Pharmacy Encounter Submission Process) and Attachment 2.10.13.1-A5 (Pharmacy Encounter Submission Process). We will also provide claims services for Louisiana Health Insurance Premium Payment (LaHIPP) program members in compliance with Section 2.18.19 of the Model Contract.

A trained and experienced team responsible for tracking performance of claims system edits manages each stage of the claims lifecycle (as depicted in Attachment 2.10.13.1-A2, Claim System Edits), ensuring we catch and correct errors immediately and adjudicate claims accurately and efficiently. The edits (inclusive of HIPAA level 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 can reduce the number of claims denials a provider receives.

*Humana has more than 100 code checks in place at the front end of Availity to ensure that the claim has all the necessary fields filled in and coded fields have valid values*

**Humana is one of only three organizations, and the only health plan, to have achieved Committee on Operating Rules for Information Exchange (CORE) Phase IV certification, ensuring that our electronic claims acknowledgement and adjudication are best in class.**

As shown in Attachment 2.10.13.1-A3 (Claim System Audits), Humana concurrently conducts five types of proactive pre-pay audits (performance guarantee, platform, focused, pre-disbursement, and performance management) to identify, prevent, and correct errors. In addition, Humana’s Enterprise Financial Recovery system conducts a post-pay review to assess over- and underpayments. As claims errors arise, our associates work with leaders and experts to resolve and correct them in a timely fashion. Periodic system upgrades and improvements that drive efficiency and effectiveness are core to our approach. Our claims management system complies with claims editing standards as defined in Section 2.18.8 of the Model Contract and we can adjust to meet any and all program requirements that may be added to the Contract. Humana’s Claims Administrator will oversee all functions of the claims adjudication process and work in tandem with the Provider Services Manager and PCEs.

*We issue payments every business day to e-claiming providers and at least twice weekly to all other providers. 88 percent of our Medicaid providers agree or strongly agree that our claims are paid in a timely manner.*

Humana provides specialized, State-specific support to our providers, recognizing that every provider network is unique. Our expert Provider Relations team will be on the ground in Louisiana conducting in-office trainings with

providers to ensure they understand the claims process (including claims submission requirements in Section 2.18.1.6 of the Model Contract), listening to issues they may be experiencing, adjusting our systems as appropriate, and offering additional targeted trainings as needed. We have multiple channels for hearing from and talking to providers, including in-person, the provider portal, and the toll-free line. We will take every opportunity to learn Louisiana-specific issues and respond with tailored solutions.

Humana also understands the importance of assessing claims to ensure our enrollees receive appropriate care. Humana’s Provider 360 Committee, composed of a broad cross-section of market and corporate personnel, reviews processes that contribute to improved provider experiences and continuously looks for improvement and innovation in claims processing.

2.10.13.2 Describe the Management Information System (MIS)

2.10.13.2.1 The length of time the Proposer has been utilizing the MIS proposed for the Contract

Humana maintains highly effective and efficient Management Information Systems (MIS) to support the complex demands of our health coverage and care coordination activities. Our technology fuels innovation and facilitates transaction processing, data collection, workflow, reporting, and analytics. We recognize that information technology (IT) is the backbone of our core business functions, supporting multiple lines of business and as such, have made strategic IT investments in excess of [REDACTED] across the enterprise between 2014 and 2018. Humana’s investment in an integrated IT platform differentiates us within the industry and enables us to offer enhanced service delivery to our [REDACTED] enrollees in medical and pharmacy benefits plans and [REDACTED] enrollees in specialty plans around the country.

*During Hurricane Irma, due to the integrated design of our MIS, we were able to automatically waive edits such as “refill too soon” for prescriptions and out-of-network provider authorizations for enrollees in specific areas*

The integrated system and business process platform we will bring to Louisiana Medicaid has been in place for more than two decades, continuously evolving as we invest to respond to the needs of the populations we serve and to keep current with modern technologies. We have successfully deployed this platform in Florida, Virginia, Kentucky, and Illinois for Medicaid Temporary Assistance for Needy Families (TANF) and Aged, Blind and Disabled (ABD) and Long-Term Services and Supports (LTSS), and 22 states for Dual Eligible Special Needs Program (D-SNP). Moreover, our MIS supports us in serving more than [REDACTED] members, including more than [REDACTED]. Our applications have proven able to successfully enable the workflows necessary to manage enrollee and provider interactions and improve every aspect of care, quality, and business processes. We have determined that our MIS has the technical capabilities to meet the requirements of the Louisiana Medicaid managed care program as specified in MCO Manual and Systems Companion guide.

2.10.13.2.2 Hardware and system architecture specifications for all systems

Humana deploys industry-leading hardware and software to ensure ongoing system performance at the highest level. We use Hewlett Packard's OpenView and SolarWinds Orion software for large-scale system and network management to measure end-to-end performance, diagnose any bottlenecks, pre-empt availability-threatening failures, and add capacity as utilization approaches thresholds. We supply multiple paths from different carriers to ensure safe and secure online connections with our internal operations. At a corporate level, our wide area network (WAN), campus local area network (LAN), telecommunications infrastructure, and secure dual data centers have the redundancy, scalability, and security to meet LDH requirements.

*Humana IT received the 2019 Enterprise Disruptor Award from Arista Networks, recognizing forward-thinking approaches to software design and infrastructure strategy*

Humana supplies secured access to business-critical applications and virtual desktops for our associates, business partners, and software developers. We employ an active-active model in our two data centers, which enables us to host capacity at a single data center in case of a disaster recovery situation. Citrix infrastructure securely hosts virtual applications, allowing authenticated users access to back-end data while keeping all data and interactions within the corporate walls. [REDACTED]



Humana’s primary hardened data center, [REDACTED] houses all production servers. Our secondary data center, located [REDACTED] offers redundancy and can be activated remotely. Application teams perform backups of critical servers and critical data at the file level nightly in the event some subset of the replicated data becomes corrupt. As a result of our 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 remotely by authorized associates via Humana’s secured virtual private network (VPN), allowing us to maintain operational functionality regardless of time or place. Both data centers are Tier III certified, which means they require no shutdowns for equipment replacement and maintenance, have exterior walls built to withstand 150 mile per hour winds, and are windowless in the area storing data.

Humana meets and often exceeds CMS Essential Functions Guidelines in limiting service interruption to 24 hours for Tier I applications in a disaster event. Through our Disaster Recovery (DR) Plan, we maintain processes for archiving and restoring data in the event of a system or subsystem failure. We retain three copies of our critical systems so we can mitigate issues if one of the copies becomes damaged or destroyed. The Disaster Recovery team has six full-time consultants and one Team Manager (Business Continuity and Emergency Coordinator) representing more than 100 years of experience in IT, including extensive background with Humana systems.

**Hardware and system architecture specifications for key systems**

Attachment 2.10.13.2.2-B1 (High Level System Architecture) provides an overview of the system architecture for the system as a whole. Attachments 2.10.13.2.2-B2 – 2.10.13.2.2-B9 include the system architecture for key systems including enrollment, claims processing, enrollee management, consumer communications, provider, utilization management (UM), care management, and financial management. Table A provides a high-level description of the system architecture found in these key subsystems.

Table A – Hardware and System Architecture for Key Systems		
Function	System	System Function and Architecture
Enrollment	HERO	Validates eligibility files (834) for HIPAA compliance
	Customer Interface (CI)	Receives validated enrollment data into mainframe-based platform system; houses plan and member-level data; serves as source system of data for downstream systems
Claims Processing	eHub	Receives claims from more than 200,000 providers through more than 100 clearinghouses; performs eligibility verification; routes electronic and paper claims (formatted for HIPAA 837) to CAS
	Claims Adjudication System (CAS)	Automatically assesses each claim to verify identity of the enrollee and provider as well as the accuracy and appropriateness of the claim; performs an average [REDACTED] in approximately one second of processing time on each submission
Customer Service Systems	CI	Processes and loads membership information for Medicaid enrollees from HIPAA 834 files; sends enrollment information to data warehouse and other downstream systems; tags enrollment with the required Meta data needed to support data isolation
	Customer Resource Management (CRM)	Offers Member Services representatives (MSRs) a 360-degree enrollee view, encompassing administrative and clinical matters of specific importance to the enrollee, and Provider Service representatives a complete view of claims, prior authorizations, referral history, and enrollees’ providers
	Avaya	Has co-functionality with our new Interactive Voice Response (IVR) (Nuance) and CRM platforms; supports three-way calling; houses four main Avaya Call Managers (Release 7.1) within our data centers

Table A – Hardware and System Architecture for Key Systems		
Function	System	System Function and Architecture
	Nuance	Processes enrollee and provider calls to MSRs using latest language and accent recognition software; IVR routes enrollees quickly to appropriate service, recognizing more than 600 verbal commands
	Accelerated Provider Exchange (APEX)	Intakes provider data system to enable provider onboarding and data updates through robust workflows; supports downstream systems such as CAS, PIMS, PMDM
	Provider Information Management System (PIMS)	Holds demographic data, providers’ servicing locations, credentialing information, and providers’ affiliations
	Provider Master Data Management (PMDM)	Connects all provider records, linking disparate provider data sources and enabling enterprise-wide provider identity
Utilization Management / Service Authorization	CareHub	Uses internal and proprietary integrated set of tools to monitor and track health outcomes and utilization for enrollee populations; incorporates CGX and other tools
	Clinical Guidance eXchange (CGX)	Integrates enrollee data from a variety of sources (claims, Health Needs Assessments (HNAs), biometrics, personal health profiles, lab tests, and results) to support the Clinical Insights Engine (such as Transcend and Atlas) and Clinical Analytics
Care Management / Care Coordination	CareHub and CGX	Supplies enhanced capabilities to identify candidates for programs, document gaps in care, automate care planning, monitor plan compliance, identify outcomes for further intervention, and give providers a 360-degree view of enrollee
Financial Management	Oracle EBS Financial platform	Supports all financial operations and processing; Incorporates Total Reconciliation Solution (TREC) to perform all reconciliations monthly, as well as chain of trust compliance for interfaces coming into the GL; uses PayPilot, for processing provider and some enrollee payments

2.10.13.2.3 All proposed functions and data interfaces

**Functions of MIS**

1. Manage enrollee information to optimize delivery of benefits:
  - a. Maintain a fully automated enrollment process to add or modify membership information, including coverage effective and end dates, based on incoming enrollment data
  - b. Able to identify a distinct enrollee across populations and systems and maintain and cross-reference all enrollee-related information with the most current Medicaid provider number
  - c. Track covered services enrollees receive through the information system, and accurately and fully maintain those covered services as HIPAA-compliant Encounter transactions
  - d. Enable flow of information on enrollees required to ensure well-coordinated, timely, and high-quality care
2. Pay providers promptly and accurately:
  - a. Employ industry standard medical billing taxonomies (e.g., procedure and diagnosis codes) to describe services delivered and encounter transactions produced
  - b. Generate standard Explanation of Benefits (EOB), paper remits, and checks
  - c. Pay financial transactions to providers in compliance with federal and State laws and regulations
  - d. Maintain a robust coordination of benefits process designed to pre-emptively avoid making payments for services that are the responsibility of another payer
  - e. Deploy state-of-the-art electronic payment systems and encourage provider uptake of electronic payment to promote efficiency

3. Facilitate communication with and among enrollees and providers:
  - a. Operate a Member Portal that complies with Sections 2.14.9 and 2.14.10 of the Model Contract, providing enrollees with an enhanced ability to find providers, learn about benefits, offer health information, manage their care, and reach the Managed Care Organization (MCO) and its providers
  - b. Maintain a provider portal, offering providers the ability to upload claims, view claim status, receive prior authorizations, verify client eligibility, submit clinical data, and facilitate credentialing
  - c. Offer digital capabilities that enhance enrollee-provider communications and self-care opportunities. In Louisiana, we will expand our digital capabilities to enhance prenatal care, diabetes care management, and BH
4. Track and account for finances:
  - a. Ensure that all financial transactions are auditable according to generally accepted accounting principles (GAAP) guidelines
  - b. Incorporate audit trails throughout our applications and maintain a history of changes and adjustments and audit trails for current and retroactive data
5. Provide reports to LDH, providers, and others in accordance with requirements to ensure optimal care delivery:
  - a. Extract data elements to produce reports specified in the System Companion Guide, MCO Manual, or the Contract (Section 2.19.1.9 of the Model Contract) using our Medicaid Data Mart, built to facilitate such reporting
  - b. Transmit HIPAA-compliant encounter data transactions on electronic media to the contractor LDH designates to receive it
  - c. Track quality of care enrollees receive and report to participating providers to improve performance and enrollee health and well-being

*Newsweek recognized Humana as Best in Customer Service among health insurance companies in its "America's Best Customer Service 2019" rankings*

**MIS Data Interfaces**

Humana’s Electronic Transmissions department, whose sole function is to fulfill inbound and outbound data feeds from our systems, ensures that we take all appropriate security measures to protect the data and monitor the data feeds in the operational steady state. New data feeds will be subject to all applicable System Development Life Cycle (SDLC) disciplines. In addition, Humana will work with LDH to establish necessary connectivity with the appropriate testing environments that it uses to test connectivity and functionality. Through systematic data exchange tests, Humana will submit test transactions that meet LDH processing specifications consistent with the rules outlined in the System Companion Guide and other applicable standards as specified or referenced in Section 2.19 of the Model Contract, review detailed information on errors for correcting files, re-submit test transactions, and track testing activity with online utilities. In addition, Humana will provide data in XML format for analytics purposes as specified in Section 2.19.1.9 of the Model Contract.

Table B below shows many of the electronic interfaces we have established to stand up Medicaid programs in Virginia, Kentucky, Florida, and Illinois, as well as existing (Y) and planned (P) connections in Louisiana. Where we refer to “State,” this includes State subcontractors undertaking file transfers.

File Type	From –To	KY	IL	FL	LA-MA	LA
Enrollment 834 (Daily/Monthly)	State – Humana	Y	Y	Y	NA	P
Capitation Payment 820 (Monthly)	State – Humana	Y	Y	Y	NA	P
Provider File (Daily/Weekly)	State – Humana	Y	Y	Y	NA	P
Humana Provider Network (Weekly)	Humana – State	Y	Y	Y	NA	P
Humana Provider File (Weekly)	Humana – State	Y	Y	Y	NA	P
Encounter 837 (Weekly, Monthly)	Humana – State	Y	Y	Y	NA	P
Enc. Resp. 999, 277 (Weekly, Monthly)	State – Humana	Y	Y	Y	NA	P
NCPDP Rx Enc. (Weekly, Monthly)	Humana – State	Y	Y	Y	NA	P
NCPDP Rx Enc. Resp. (Weekly, Monthly)	State – Humana	Y	Y	Y	NA	P
Historical Claims/Auth (Monthly)	State – Humana	NA	Y	NA	NA	NA
Eligibility File (Monthly)	Humana – State	NA	NA	NA	Y	NA
Eligibility Response File (Monthly)	State – Humana	NA	NA	NA	Y	NA
Eligibility Inquiry 270, 271 (Daily)	State – Humana	NA	NA	NA	NA	P

2.10.13.2.4 Data and process flows for all key business processes

Attachment 2.10.13.2.4-C1 (Systems Flow Diagram) provides an overview of the process and data flows for the overall system. Attachments 2.10.13.2.4-C2 – 2.10.13.2.4-C12 include data and process flows for key subsystems, including enrollment, claims processing, customer service systems, provider management, UM, care management, HEDIS, and reporting. Table C describes the data and process flows for key processes.

Functional Area	Data and Process Flow
Enrollment	Fully automated to add or modify membership information (including coverage effective and end dates) based on incoming enrollment data from LDH and the enrollment broker; enables unique member identification (ID) (displayed on the member ID card and on the enrollee mailings and handbooks) to follow the enrollee throughout Humana systems and processes (including feeds to subcontractors, providers, and partners)
Claims Processing	<p>On a nightly basis, Humana’s CAS:</p> <ul style="list-style-type: none"> <li>Generates standard EOB, paper remits, and checks</li> <li>Interfaces with eHub where the HIPAA 835 electronic remit transaction is created and routed to the various clearinghouses</li> <li>Routes EFT payment transactions to PayPilot, which creates and routes the EFT transactions to the various provider bank accounts</li> <li>Routes finalized and pended claim information to the Operational Data Store and Electronic Data Warehouse, which can then be accessed via Humana’s robust Web portals</li> <li>Interfaces with Humana’s finance and general ledger systems</li> </ul>
Customer Service Systems	<ul style="list-style-type: none"> <li><b>Enrollee Management:</b> Integrates enrollee information using isolated enrollee file (Member Golden Record); maintains the integrity of the Member Golden Record to the operational data stores through composite view handlers; flows to enterprise systems such as CRM, enrollee and provider portals, and MyHumana smartphone application via real-time service</li> <li><b>Telephone Management:</b> Partner with Mattersight to supply artificial intelligence (AI)-based technology to seamlessly route calls to the appropriate associate in the most efficient manner using natural language response</li> <li><b>Provider Management:</b> Enables access to provider information through an integrated, enterprise-wide provider service used in real time to enable referrals, authorizations, IVR, primary care provider (PCP) identification, and provider lookup; enables providers access to real-time information available in Humana’s MIS (e.g., enrollee eligibility) through Availity</li> </ul>



Table C – Data and Process Flows for Key Processes	
Functional Area	Data and Process Flow
Utilization Management/ Service Authorization	Intake prior authorization requests through a variety of channels, including online submissions, phone calls, or fax; match the approved authorization to the claim and pay automatically and promptly; pend for review claims that do not match automatically; give providers and enrollees a clearly communicated path to appeal an adverse decision based on medical necessity
Care Management/ Care Coordination	Facilitate communication to and among: <ul style="list-style-type: none"> <li>• <b>Providers:</b> By automatically e-faxing authorizations to the servicing providers, sending care plans to the PCP, and enabling provider access to care management information through our provider portal, Availity</li> <li>• <b>Hotline:</b> By supplying eligibility files daily to our after-hours hotline which, in turn, sends daily call log information to the care management system</li> <li>• <b>Enrollees:</b> By enabling access via the Member Portal to their care plan results, HNA, and ability to note risk factors for social determinants of health (SDOH)</li> <li>• <b>Case managers (CM):</b> By supplying CMs and the UM team a 360-degree clinical view of the enrollee (authorizations, referrals, service plans (SPs), HNAs) via the business partner portal</li> </ul>
Financial Management	Use the integrated Enterprise Resource Planning (ERP) platform, Oracle EBS Financial, as the single source of general ledger (GL) external and Department of Investigations (DOI) reporting; classify operational transactions such as claims, premiums, and commission payments that feed the GL to ensure our monthly, quarterly, and year-end are complete for the company’s external and SEC reporting

2.10.13.2.5 Resources dedicated to Medicaid Management Information System (MMIS) exchanges

The following is an overview of the Humana MIS organizational structure and staffing to support enterprise-wide operations, including Medicaid line of business in Louisiana:

- **IT Infrastructure:** Oversees Humana’s data centers, network, storage, disaster recovery, and end-user support
- **Solution Engineering:** Designs, develops, integrates, maintains, and supports robust and cost-effective end-to-end business technology solutions
- **Business Technology Leadership (BTL):** Acting as the single point of contact with Humana’s business leadership, BTL builds strategic partnerships and manages relationships between IT and aligned business groups by providing thought leadership on IT solutions and services
- **Technology Advancement:** Identifies and integrates new business-facing technology, processes, products, and services; includes enterprise architecture and acquisitions responsibilities
- **Enterprise Information Protection:** Defines Enterprise Security strategy and architecture, defines and monitors implementation of Information Security policies and procedures, maintains cybersecurity operations center 24 hours a day, seven days a week, and is responsible for Enterprise Identity/Access management
- **IT Strategy, Operations and Service Assurance:** Develops strategic roadmaps while managing the Program and Project Competency Center, IT service assurance, and IT operations
- **IT Chief of Staff:** Responsible for diversity, inclusion, culture, and IT communications

*IDG named Humana IT one of its 2019 Digital Edge Award winners, highlighting companies at the forefront of digital transformation, fostering business innovation in a culture of collaboration*

Humana currently maintains resources in Louisiana to help our associates address any local hardware, software, and network issues.

2.10.13.3 Attest to the availability of the data elements required to produce management reports

We attest that we can relate and extract data elements to produce management reports in formats required by LDH using our Medicaid Data Mart, which we built specifically to facilitate Medicaid reporting. Humana has a mature IT reporting infrastructure that incorporates best practices into its data acquisition, reporting, and analytics environment. By leveraging many industry-leading reporting tools including Qlikview, Tableau, Oracle's BI Publisher,

Oracle Business Intelligence Enterprise Edition (OBIEE), and SQL Server Reporting Services (SSRS), we interrogate core databases such as enrollment, claims, premium, clinical, provider, pharmacy, and financial to enable a robust array of reports that includes drill-down dashboards, schedules, and ad-hoc reports.

2.10.13.4 Describe in detail any system changes or enhancements contemplated during the term of the Contract, including a description of how the Proposer will ensure the continuity of all operations

Humana’s integrated, proprietary MIS enables our architects and engineers to update system capabilities in response to the needs of the business without disruptions or downtime incurred when dependent on subcontractors. Table D shows the enhancements we plan to undertake to improve overall capabilities and respond to specific needs of the Louisiana Medicaid program.

**Table D – System Enhancements or Upgrades**

System	Description of Upgrade/Enhancement	Status	Completion Date
Enrollment	Minor configuration changes to meet Louisiana specifications, e.g., PCP assignment/reassignment	Planning	October 2019
Claims Processing and Encounters	Replacement of encounter processing system (Edifecs) with Humana-developed system (HERO) to enhance data integration and reporting	Ongoing	Early 2020
Utilization Management/ Service Authorization	None	N/A	N/A
Case Management / Disease Management	None	N/A	N/A
Provider	Modernization of Health Service Delivery (HSD) and Provider Master Data Management (PMDM)	Ongoing	HSD (2020) PMDM (2021)
Member Management	Add co-browsing capability (Glance) to facilitate communication with enrollees using hotlines	Pilot	Early 2020

The Enterprise Change Management team is responsible for evaluating risk and preparedness for all technology changes across Humana and our subcontractors. This team facilitates Change Approval Board meetings multiple times each week to ensure that high- and medium-risk infrastructure and security changes, as well as changes affecting critical systems, are operationally ready for deployment. Humana incorporates audit trails throughout our applications and maintains a history of change and audit trails for current and retroactive data.

2.10.13.5 Describe the capacity to interface with LDH’s system and that of its network providers and material subcontractors

Humana has demonstrated its capacity to exchange data with Medicaid programs in several states and can confirm our capability to interface with LDH and its intermediaries concerning key functions, as described in Section 2.19.1.19 of the Model Contract. These include enrollment and eligibility, encounters, provider information, electronic visit verification (EVV), and reporting. In addition, Humana promotes interoperability amongst its providers and enrollees. We have configured technology to align with the Fast Health Interoperable Resources (FHIR) HL7 Standards and have built application program interfaces (APIs) to support real-time data exchange with our providers. We have bi-directional data sharing with providers via connections with electronic health record (EHR) systems, State health information exchanges (HIEs), and material subcontractors who submit data on dental, vision, BH, and nurse hotlines. These transactions include but are not limited to ADT, CCD (C32, C62, CCDA), and images. We also support providers through Health Effectiveness Data and Information Set (HEDIS) and quality of care transmissions via Humana’s proprietary population health management platform.





This high level of connectivity has increased the number of notifications to providers on enrollee admissions and service utilization, led to gap in care closures, and improved our ability to report on services our enrollees received. Most importantly, it enhanced the quality and timeliness of care they received. We aim to achieve similar results for Medicaid enrollees in Louisiana through our relationships with the four HIEs in the State. We have agreed to connect with the Louisiana Health Information Network (LHIN) for the exchange of ADT data, which will enable the flow of Medicaid data on January 1, 2020, if awarded the Contract.

*In 2018, Humana experienced more than [REDACTED] transactions with EHR vendors and health information exchanges on behalf of providers located in Louisiana and 24 other states*

Through the exchange of data with LHIN, which receives ADT data from almost all Louisiana hospitals, we will fulfill the contractual requirement in Section 2.19.3.5 of the Model Contract to ensure that emergency departments (EDs) provide data on high drug utilizers, persons exhibiting drug-seeking behavior, and those in need of chronic disease management. Additionally, in fulfillment of contractual requirement in Section 2.17.12.3 of the Model Contract, we will enable providers of value-added benefits (VAB) access to data to assist in service delivery, which will prove especially beneficial to providers offering respite care to the homeless.

We also have a commitment to connect with the Greater New Orleans Health Information Exchange, to increase connectivity to Federally Qualified Health Centers (FQHC) and leverage the Corrections-Community Care Continuum (GC4). We have engaged with Louisiana Health Information Exchange (LAHIE) and have been impressed by their knowledge of patient-centered medical home (PCMH) certification criteria and their connections with PCPs. We want to build upon our relationship with LAHIE to strengthen the capacity of our contracted providers to achieve PCMH certification. Based on discussions with Health Sync, which is establishing health information exchange capabilities in Louisiana, we plan to build data exchange partnerships with provider practices throughout the State. Our connectivity with our subsidiaries and major subcontractors meets standards for speed, accuracy, and security:

- DST Pharmacy Solutions, the claims adjudicator for Humana Pharmacy Solutions (our in-house Pharmacy Benefit Manager (PBM)), is a 24-hour, real-time point-of-sale (POS) processing engine running on a DB2 database. Humana connects with DST Pharmacy Solutions via a secure VPN tunnel used by all data transmissions, systems interfaces, and transactions between the two organizations.
- DentaQuest, our dental subcontractor, has an MIS system known as Windward, built on a .NET/SQL platform and designed specifically to support Medicaid and Children’s Health Insurance Program (CHIP) dental programs. DentaQuest uses Level IV HIPAA editing to create 837D encounter files for submission to Humana’s eHub.
- Superior Vision uses Health Solutions Plus (HSP), an integrated IT system modified for our use. HSP is a multi-tiered client/server system that runs on the Microsoft Windows 2012 Server Enterprise platform, which supports both internal network access and access through Internet portals and IVR systems. The HSP system tracks services upon receipt of an eligibility verification request and submission of a claim and retains data as HIPAA-compliant encounter transaction extracts in multiple formats, including the ASC X12 5010 HIPAA compliant 837 transaction set for submission to Humana.

Using our deep technical expertise and considerable experience in exchanging data with and among providers, subcontractors, and HIEs, we are committed to advancing the Louisiana Health IT Roadmap, 2018-2021. In reviewing the Roadmap, we note that EHR adoption rates lag behind neighboring States and the country as a whole; event notification is limited outside of hospital systems; a large amount of vital health data remains in disparate, unconnected health systems; and there is a need for leadership in promoting and coordinating health information exchange. We will assist in addressing these issues through our relationships with contracted providers, health systems, and major subcontractors. In addition, recognizing the value of health information exchange as a public utility and our role as a national leader in health information technology, Humana will collaborate with LDH and other MCOs in building a robust information infrastructure and implementing the 18 initiatives recommended to LDH in the IT Roadmap, particularly Initiative 7, “Louisiana Medicaid-HIE Connection.”