Humana

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Stacie Weeks JD, MPH, Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Public Policy
1100 East William Street, Suite 101
Carson City, Nevada 89701

Submitted via email to ltss@dhcfp.nv.gov

RE: Nevada Medicaid Solicitation of Public Input Regarding Dual Special Needs Program Procurement

Dear Administrator Weeks,

This letter is in response to the Division of Health Care Financing and Public Policy's solicitation for public comment regarding dual eligible special needs program procurement in the State of Nevada.

Humana Inc., headquartered in Louisville, Kentucky, is a leading health care company that offers a wide range of insurance products and health and wellness services that incorporate an integrated approach to lifelong well-being. Humana currently serves nearly 1 million[1] dual eligible beneficiaries enrolled in our Dual Eligible Special Needs Plans (D-SNPs). Humana has offered D-SNPs since 2006, when special needs plans were first offered under Medicare Advantage[2]. In 2024, we offer D-SNPs across 34 states, including Nevada, since 2022. Humana's successful history in care delivery and health plan administration is helping to create a new kind of integrated care with the power to improve health and well-being and lower costs.

Humana appreciates the opportunity to provide input as the Division is developing its request for proposal (RFP) for Coordination Only (CO) D-SNP State Medicaid Agency Contracts (SMACs). We hope you find this feedback helpful and invite you to reach out with any questions.

Sincerely,

Catherine Field
Senior Vice President and West Division Leader, Medicare

[1] SNP Comprehensive Report – May 2024. https://www.cms.gov/files/zip/snp-comprehensive-report-may-2024.zip
[2] Special Needs Plans Statutory and Regulatory History. Special Needs Plans | CMS

1. **Addition of federal requirements such as health risk assessments with mandated screening tools, maintenance of an enrollee advisory committee, tracking of beneficiary cost sharing, and identification of providers that serve both Medicare and Medicaid beneficiaries in the network provider directory.** Nevada's CO D-SNP SMAC will incorporate all Centers for Medicare and Medicaid Services (CMS) federal requirements. To the extent applicable, the Division seeks input on information and data sharing needs to support CO D-SNP compliance with these requirements.

   Humana: Compliance with federal regulations governing D-SNPs is predicated on a relationship between Medicare Advantage Organizations (MAOs) and state Medicaid agencies that allows for open communication and secure data exchange. Variations in data formats, terminologies and coding practices between Medicare and Medicaid systems can create unintended barriers to data sharing. States have the opportunity to support secure and efficient data exchange by following CMS transmission and formatting standards. For example, utilizing the 837P format and X12 standards required by CMS when requesting encounter data.

   In addition to utilizing CMS standards for data exchange, Humana recommends the State account for federal D-SNP regulations in order to avoid conflict with any state-specific requirements. Specifically, we offer the following examples:

   - **Health Risk Assessment (HRA).** HRAs are a vital tool for engaging members in the development of an impactful care plan to improve health outcomes. The HRA is conducted initially within the 90 days before or after the date of enrollment and then annually thereafter. HRAs or targeted assessments may also be completed more frequently, as deemed appropriate by the member's Care Manager. Significant changes in a member's health status or condition and care transitions may trigger additional targeted assessments to determine necessary adjustments to the care plan. Separate of the CMS timing parameters for initial and annual HRAs, Humana recommends aligning reassessments to the member's needs versus a prescribed cadence (i.e., monthly, quarterly) as it improves member experience, engagement, and effective care plan development. Based on Humana's experience with the SNP population, members are more likely to engage and complete a HRA telephonically or through other modes, such as mail or the self-service option within online member portals. Humana's approach is to offer optionality to the member and utilize the member's preferred method. Providers also have access to the member's HRA and care plan through the provider portal. Humana's Model of Care allows Care Managers to utilize other clinical comprehensive assessments to supplement and/or substitute as the HRA, when appropriate and compliant with CMS requirements.

     To optimize completion rates, Humana successfully utilizes various clinical and non-clinical roles to complete the HRA. Narrowing HRA completions by a clinical role would negatively impact HRA completions. Non-clinical roles provide administrative support to the clinical care manager by completing the initial and annual HRA. However, the care manager is responsible for reviewing and analyzing the completed HRA with the member and develops the care plan.

     In addition to CMS required Part C HRA reporting, Humana currently provides HRA and social determinants of health (SDOH) reporting quarterly to several states. If the State chooses to request HRA and/or SDOH data, we recommend the use of a similar template, with quarterly or annual reporting periods, and the provision of technical specifications outlining the

specific data fields, timing, formatting, and modalities with the release of the SMAC to allow time for operational implementation. As part of the Quality Improvement program, Humana has developed specific measurable performance outcomes to demonstrate improvements with the Model of Care (e.g., access to care, beneficiary health status, staff structure, health risk assessment, implementation of care plans, etc.). The Model of Care is evaluated annually via the SNP Quality Improvement Evaluation (QIE). In addition to the QIE, metric performance is documented within the Model of Care metric tables as required by CMS.

- **Enrollee Advisory Committee (EAC).** In 2023, Humana established the first Nevada D-SNP EAC with a cohort representative of the population we serve. EAC meetings provide the opportunity to better understand and engage with members, and are intentionally structured to allow input from all participants, not just a dominant voice. While primary discussion topics include access to covered services, coordination of services, and health equity, we encourage participants to speak openly about their experiences as members of Humana's D-SNPs. Since establishing EACs, we have observed that:
    - Virtual, or a mix of in-person/virtual, sessions allow for the most representative advisory committee. The audio/video option allows for insights of those who cannot attend at a central location.
    - Inclusion of caregivers (family, friends) is important for members that depend on others for support in managing their health.
    - Sessions specifically targeted for non-English speaking members have proven to be valuable when supported based on membership.

  These learnings, along with member feedback we have received, will help Humana make decisions that best align with what our members value most, such as flexible supplemental benefits, caring and knowledgeable support services and easy access to providers.

In addition to the illustrative examples regarding HRAs and EACs, Humana has processes and systems in place to comply with all federal regulations governing D-SNPs, including tracking of beneficiary cost sharing and identification of providers that serve both Medicare and Medicaid beneficiaries in the network provider directory.

2. **Covered Populations.** Currently, health carriers offering CO D-SNPs must enroll the following dual eligible populations: Full Benefit Dual Eligible (FBDE), Qualified Medicare Beneficiary (QMBs), and Qualified Medicare Beneficiary Plus (QMB+). The Division seeks input on the scope of dual eligibles that may enroll in the CO D-SNP.

   Humana: According to CMS data[3], approximately 76 percent of Nevada's dual eligible beneficiaries fall within the three eligible populations covered under the current D-SNP contract. This leaves nearly one quarter of duals without a D-SNP option. We believe this warrants consideration by the State for inclusion of Specified Low-Income Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries Plus, Qualifying Individuals, and Qualified Disabled and Working Individuals. Our experience indicates that eligibility levels fluctuate over time because slight changes in income or assets can move members between dual-eligible categories. By including all dual-eligible categories in D-SNPs, we can provide better continuity of care and avoid disruption related to members losing

[3] Quarterly Enrollment Snapshot (06/2015-06/2023). MMCO Statistical & Analytic Reports | CMS

eligibility. In addition to providing D-SNP options for more beneficiaries, covering all dual eligible populations under the D-SNP would offer more enrollment stability over the long term.

3. **Expansion of Service Area.** Currently, all health carriers offering CO D-SNPs in Nevada must make such plans available to eligible Nevadans in Clark and Washoe Counties as authorized per CMS with rural counties as optional service areas. Nevada intends to expand the mandatory service areas for CO D-SNPs statewide over the term of the contract. Bearing in mind various network adequacy standards and CMS' approval of service areas, what factors or options should the Division consider with respect to a phased-in timeframe for achieving a statewide expansion of CO D-SNP operations?

   Humana: CMS requires an MAO to meet provider network adequacy criteria to ensure that the plan's members have adequate access to covered benefits through a network of providers that is consistent with community patterns of care.[4] Before approving an MAO to offer plans in a given service area, CMS evaluates its provider network using predetermined number, time, and distance standards specific to that service area.[5] These standards vary by county based on population size and density, with county designations divided into five categories: Large Metro, Metro, Micro, Rural and Counties with Extreme Access Considerations (CEAC). Based on CMS's 2024 Health Services Delivery Reference File[6], 11 of Nevada's 17 counties are designated CEAC, and of these, eight have no individual MA plan options in 2024.[7]

   Given the number of Nevada counties with extreme access considerations and CMS network adequacy requirements, establishing a statewide D-SNP will be challenging for plans. Prior to finalizing this approach, Humana encourages the State to discuss feasibility with CMS within the confines of MA network regulations.

4. **Change of Supplemental Benefits.** There are eight core Supplemental Benefits currently offered by CO D-SNPs as outlined here. Are there other supplemental benefits the Division should consider to best serve and enhance member experience as well as to improve access to services?

   Humana: Annually by the first Monday in June, all MAOs must submit to CMS for approval the plans and benefits they wish to offer in the next plan year.[8] This process, known as bid submission, is governed by federal regulations that dictate every aspect, including the types of benefits that are covered. While MA plans are required to cover all benefits covered under Traditional Medicare, supplemental benefits afford the opportunity to add value to plans. The eight core supplemental benefits outlined by Nevada are commonly available under D-SNPs to varying degrees. Humana supports the State's engagement in considering what supplemental benefits best serve and enhance

[4] Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance. Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance (cms.gov)
[5] 42 CFR 422.116
[6] https://www.cms.gov/files/document/2024-hsd-reference-file-updated-10182023.xlsx
[7] CMS Monthly Enrollment by Contract/Plan/State/County. May 2024. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-cpsc-2024-05
[8] 42 CFR 422.254

member experience. We also appreciate that the State affords plans the flexibility to adjust benefits, which may vary year-over-year based on the following factors:

- **Member preferences.** Humana continuously monitors feedback and utilization trends to ensure our plans meet the needs and preferences of beneficiaries and offer high quality and value.
- **Innovation.** Flexibility enables benefit innovation, and opens the door for the development of benefits that improve member welfare. One such example is Humana's Healthy Options Allowance, a monthly allowance on a Humana Spending Account which members can use for essentials like groceries, household and personal items, as well as
- **CMS approval.** CMS must approve all benefits and participation in programs such as the Value Based Insurance Design Model, which allows Humana to offer supplemental benefits beyond those that are primarily health related.
- **Plan variation.** Not all plans offer the same benefits, and benefits often vary based on service area. Beneficiaries living in rural areas may have different needs than those living in large metropolitan areas.

For these reasons, we recommend that the State continue affording D-SNPs the flexibility to determine which supplemental benefits to offer.

5. **Quality Measures and Reporting.** To enhance the quality of the CO D-SNP program for recipients, Nevada will begin utilizing the Medicare Advantage Star Ratings and Model of Care as a requirement under the SMAC to monitor and track performance of awardees. Throughout the contract period, anytime CMS requires a corrective action plan of a Medicare Advantage organization, a copy of that corrective action plan must be submitted to the Division for review. The Division is seeking input on consideration of these preferred measures. The Division is also seeking feedback on other measures or requirements it should consider as part of the upcoming RFP and SMAC to improve the quality of the CO D-SNP program and access to services.

   Humana: Humana is dedicated to driving quality health outcomes by serving members through a simple, cohesive, and meaningful experience to measurably improve member health through richer benefits, clinical programming, provider engagement, and analytics and reporting. As a result, Humana contracts have maintained a strong Star Rating for the last 5 years and our team is committed to the same strong performance into the future. For 2024, 94% of Humana's Medicare Advantage members are enrolled in plans rated 4-star or higher. In Nevada, Humana is an industry leader in quality, with 100% of D-SNP members on 4.0 and 4.5 Star plans.

   Humana's Star Ratings continue to reflect the company's strong focus on ensuring high quality of care, patient-centered clinical outcomes, and reliable customer service for its members. We are aligned with CMS's commitment to focusing on member experience as we believe this plays a vital role in the journey to quality health outcomes. The Stars organization collaborates with our internal Stars market team, clinical, pharmacy and risk adjustment teams among others, as well as external clinicians, pharmacists, and other key partners, to allow for cross-functional coordination and a richer member experience.

Health Equity Index (HEI):
Humana's commitment to the Stars quality is best demonstrated by the actions taken to remove health barriers for members. In accordance with CMS' framework for health equity, CMS developed the Health Equity Index (HEI) to incentivize plans to better identify and address members with health-related social needs (HRSN) to promote equitable care.

With the introduction of the new HEI, Humana is laser focused on our members with Social Risk Factors (SRF). At Humana, a significant portion of our 6.2M MA members have at least one Social Risk Factor, meaning they are qualified disabled, dual eligible, and/or receiving Low-Income subsidy. The Stars Health Equity team has conducted research specifically on our qualified disabled members to learn their specific and unique needs, to include focus groups and quantitative research which has yielded greater understanding of their mental, physical, and social challenges regarding engaging in their health care. This has informed work we have underway to directly impact these social needs to remove barriers to our members' achieving their best health possible. We are collaborating closely with partners throughout the US to ensure we meet the unique needs of our members with Social Risk Factors and are working to ensure we address where there are gaps in our members' health care. Additionally, implementation of the HEI in 2025 will allow Humana to project and track performance of our D-SNP populations in relation to addressing members with their health-related social needs.

Recommended Measures
Humana has taken several approaches to continue performance improvement on specifics Star quality measures as it relates to Special Needs Plan (SNP) care management. These include:

- Reducing the risk of falling:
  Continuing digital balance training program for members who reported having a fall risk identified during an in-home wellness assessment or through Patient Experience survey. This cognitive behavioral training program includes education around fall prevention, annual wellness visits, urinary urgency, etc. Other educational campaigns are aimed at getting members with self-reported or predicted risk of falls to discuss treatment options with PCP (Primary Care Physicians).
- Provider materials to practices:
  Humana has developed a suite of materials available to physician offices for ordering. This includes posters, buttons, one-pagers, member materials, and other collateral to support CAHPS/HOS goals by driving conversations and actions aligned to performance improvement, such as fall prevention activities.
- Special Needs Plans (SNP) Care Management:
  We partner with our care management team as part of their SNP outreach program to reach out to members to complete the HRA (Health Risk Assessments) and provide the support needed. In addition to care managers, our sales representatives that have developed relationships with members complete HRAs (Health Risk Assessments) and NPs visiting members' homes as part of the IHWA program.
- Care for Older Adults (COA):
  We connect with care management, IHWA, and pharmacy to reach out to members to complete assessments for COA (Care for Older Adults). In addition to our partnerships, we also collaborate with a vendor to call members who are not reached in those programs and attempt to connect with those members to complete assessments.

Quality Improvement (QI) Program

Humana's SNP QI program focuses on the performance of the entire plan utilizing a multi-disciplinary approach that includes monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from high risk to lower risk on the care continuum. Specific legislative and regulatory provisions allow Humana SNP products to focus on specific subsets of the Medicare population with the intent to improve care and control costs for these beneficiaries. Consistent, comparable measures that reflect the service delivery and outcomes important to these populations and that promote quality improvement and maturation of SNP products are necessary. Humana's Quality Improvement program and the associated Model of Care measures are aligned with CMS requirements as described within the MOC Quality Improvement Program Plan Requirements Attestation.

Humana SNP QI program outlines the structure, processes, and methods used to determine activities and influence outcomes related to the improvement of care, service, and treatment of beneficiaries. All Humana SNP beneficiaries are included in the scope of the QIP. This inclusion serves to improve prioritization of effort and resource allocation to better meet the expectations and needs of our members.

As part of the QI program, Humana has developed specific measurable performance outcomes to demonstrate improvements with the model of care (e.g., access to care, beneficiary health status, staff structure, health risk assessments, implementation of care plans, etc.). The Model of Care (MOC) is evaluated annually via the SNP Quality Improvement Evaluation (QIE). Improvement initiatives are based upon performance evaluation of MOC effectiveness such as improvement in:

- Access and affordability to healthcare needs.
- Appropriate utilization of services for preventative health and chronic conditions.
- Coordination of care and appropriate delivery of services.
- Transition of care across settings and providers.

Humana SNP uses data collection, measurement, and analysis to track issues that are relevant to the SNP population. Health outcome measures are analyzed on a monthly, quarterly, or on an annual basis using a suite of dashboard reports to meet the Centers for Medicare and Medicaid (CMS) MOC quality measurement and performance improvement requirements including performance and enrollee health outcome measures to continuously analyze, evaluate, and report MOC quality performance. Metric performance is also documented within the MOC metric tables as required by CMS. Additionally, entities who deliver care management to Humana beneficiaries work directly to improve star ratings directly associated with care management including the Star SNP Care Management measure. Humana recommends the state leverage Part C and other HEDIS measures to monitor plan performance and member health outcomes (i.e., Part C-HRA, Medication adherence, Care of Older Adult).

CMS Corrective Action Plans (CAPs)

Humana recommends the State review CAPs that are applicable to Nevada D-SNP members and only after they have been reviewed and approved by CMS. We further suggest the State provide D-SNPs at least 15 days from the date of receipt of approval from CMS to provide the finalized CAP to our state agency contact. This provides sufficient time for the D-SNP to review applicability to Humana's Nevada D-SNP member population.