# B. Company Background

## 1. Corporate Experience

a. Describe the Vendor's experience in the provision of managed care services to the populations specified in this Contract. Include the following information in the response:

UnitedHealth Group has 45 years of Medicaid/public sector experience. We provide managed care services to more than 5.96 million enrollees who are low income and/or medically fragile individuals in 31 states plus the District of Columbia. This includes:

- TANF: In 23 states representing 3,151,000 enrollees
- Children: In 23 states representing 2,735,000 enrollees aged from birth to 18 years
- Aged, blind and disabled (ABD): In 20 states representing 334,000 enrollees
- Dual Special Needs Plan (D-SNP): In 29 states plus the District of Columbia, representing 713,000 enrollees
- Foster care children: In 12 states, representing 55,000 enrollees
- Childless adults and programs for the uninsured: In 15 states representing 920,000 expansion enrollees

With a strong and enduring presence in the urban and rural communities we serve, UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) is committed to expanding access not only through network adequacy but also by leveraging innovation where there are gaps in available providers to better serve the Commonwealth's most vulnerable populations. Since 1986, we have provided local health care services throughout the Commonwealth, currently managing over 409,000 lives through our Medicare & Retirement and Employer & Individual business lines. Our strong relationships and in-depth knowledge of Kentucky uniquely positions us to support DMS' goals. These goals include improving health care quality, controlling health care cost trends and supporting providers in a population-based model of care, with integrated care delivery across behavioral and physical health. We are fully dedicated to collaborating with DMS, other MCOs, providers and community stakeholders to facilitate the successful implementation of the MCO program.


Our dedication to delivering high quality is anchored in our corporate values of **integrity, compassion, relationships, innovation and performance**. These values are at the center of all we do. Operating according to these values is fundamental to the work we currently perform serving Kentucky residents, to the experience we have with Medicaid managed care programs across the United States, and to how we support enrollees, providers and state partners to achieve program goals and improving outcomes. We know that health care must continue to evolve. With the strength of the UnitedHealth Group enterprise, we will continue collaborating with DMS in innovating toward the future, to 2025 and beyond. We will build upon a connected and simplified health care system, taking advantage of individual electronic health records and health information exchange, online banking, and insights into big data to make it easier for our enrollees to engage in their health management and to truly improve population health across Kentucky.

i. Experience in implementation of population health management programs and initiatives. Include information about how the Vendor has addressed social determinants of health.

Population health management is fundamental to identifying and addressing the social, behavioral, medical and functional needs of our enrollees to improve their health outcomes and reduce health disparities. Medicaid enrollees are at increased risk of developing chronic

illnesses. We are rooted in communities throughout the Commonwealth and work closely across the diverse geography from urban, to rural, to Appalachia. We have experience with the breadth of providers working on physical, behavioral and social health, and have depth of experience designing the right benefit mix to best support Kentuckians. This experience, along with understanding gained from our local partnerships, has given us insight into the unique needs of Kentuckians. We know our enrollees face unique challenges, such as food insecurity, unsafe/unstable housing, interpersonal violence and lack of transportation. Our population health approach takes into account these and other social determinants of health (SDOH).


We will lead and support innovative methods that promote better health outcomes across the Commonwealth's Medicaid population. Collaborating with our local community partners — including Shaping Our Appalachian Region (SOAR), Goodwill Industries of Kentucky, Volunteers of America, Kentucky Diabetes Network and Kentucky Youth Advocates — and our key provider partners in the University of Kentucky Health System, Kentucky Primary Care Association, CenterCare and others is central to our prevention and population health strategy. In-depth and ongoing analysis of regional and statewide population health data informed this strategy further.

We have **experience implementing population health-management programs and initiatives** for Medicaid and D-SNP enrollees in over 31 states. The following examples illustrate a few of our experiences that are relevant to the Kentucky MCO program populations we will serve.

## Delivering Home-based Primary Care (HBPC)

Home-based primary care is a person-centered, team-based model that includes physicians, nurse practitioners, RNs, behavioral therapists, social workers and care managers who provide HBPC to enrollees who are disabled or living with serious mental illness, and who are best served in a home setting. Developed by our team in Tennessee, this framework includes an integrated focus on all domains of care (medical, behavioral, social, functional and cognitive). We improve health outcomes by providing direct care in a manner that is culturally aligned, customizable and scalable. In Tennessee, the HBPC model serves about 3,000 of our Medicare and Medicaid enrollees with complex disabilities. On average, 98% of our enrollees are seen within 2 business days of discharge notification. When comparing 2017 to 2018, we saw reductions in both admissions (10% to 20%) and ED visits (23% to 33%). In addition to the utilization successes observed during implementation, this model closed over 18,300 gaps in care in 2018. Given this success, we are establishing HBPC in all Medicaid programs we serve, including our Kentucky MCO program.

## Addressing Oral Cancer Risk in Kentucky

In support of Oral Cancer Awareness Month held each April, the University of Kentucky College of Dentistry (UKCD) provided more than 300 oral health screenings during the annual 2019 *Hillbilly Days* event in Pikeville. These screenings were part of the *Eradicate Oral Cancer in Eastern Kentucky* project, made possible by a $1 million grant from the United Health Foundation, which is an ongoing 3-year grant to continue to support UKCD. We will apply the lessons learned from this partnership to the MCO population.


*"With the support of United Health Foundation and our local partner, the Pike County Health Department, the College of Dentistry was able to provide a tremendous community service by offering free oral cancer screenings,"* said Dr. Melvyn Yeoh, principal investigator for the project and assistant professor in UKCD's Division of Oral & Maxillofacial Surgery. *"Oral cancer can have a high rate of mortality,*

*often due to late discovery. By encouraging residents to be screened, the college is hoping to catch potential issues earlier while also educating participants on risk factors for oral cancer." Dr. Teichman, o*ur health plan medical director/chief medical officer, participates in the University of Kentucky College of Dentistry (UKCD) taskforce working to enhance the patient education and care provided to Kentuckians.

## Raising Awareness of Diabetes Risk

We have partnered with the Kentucky Diabetes Network (KDN) and with the University of Kentucky's Kentucky Regional Extension Center (UK KYREC) to engage populations at risk for diabetes. With KDN, we supported the design and distribution of an awareness program to support diabetes prevention through public service announcements in multiple counties; designed/printed and helped distribute 5,000 postcards on diabetes awareness; and funded 50 billboards in targeted areas to drive awareness of pre-diabetes and the Diabetes Prevention Program. With UK KYREC, we built and developed quality improvement capabilities through training and advisory services with focused implementation strategy around best practices in diabetes and pre-diabetes management for PCPs. The desired outcome is to train PCPs to engage their patients with diabetes to improve their health management, resulting in healthier individuals and improved outcomes.

## Applying Technology to Identify At-risk Individuals

We use our ***Hotspotting tool*** to identify individuals or targeted groups of enrollees by accessing data in real time. This powerful tool allows us to find enrollees who have the highest need (medical, behavioral, health-related resources) sooner, to better address their complex needs, improve care quality and reduce spend. We generate lists of these enrollees who are most likely to respond to care management interventions based upon dozens of evidence-based criteria. The tool works like this:

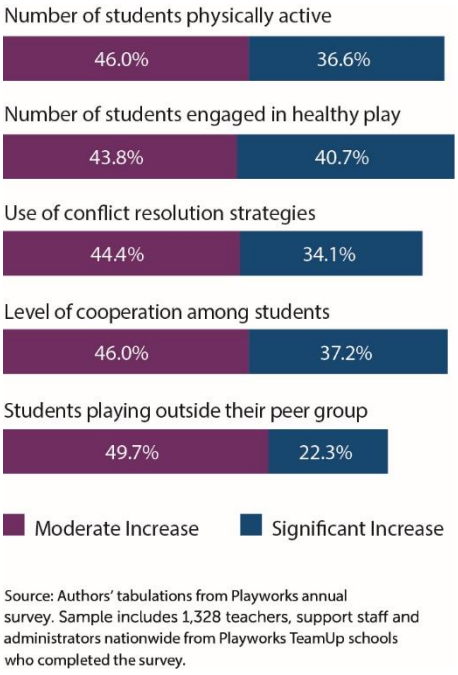
1. Data filters, such as resource needs, utilization, cost, product, location and demographics, are set within the tool to begin refining target populations.
2. That search generates an initial list of qualifying enrollees, which are sorted in multiple ways: by spend, top primary risk factors, product breakdown and geography.
3. We further refine the subgroup by applying additional data filters, ensuring we accurately identify enrollees most likely to benefit from care management interventions.


Our team in Arizona recently used the Hotspotting tool to identify 1,302 enrollees experiencing homelessness in Phoenix. The team cross-referenced the list with disease conditions, resulting in a list of homeless enrollees likely to benefit from the combination of a care manager and housing navigator who then engaged with the enrollees. We will implement this tool for our MCO program to inform and guide our program design and enrollee engagement. We also will share the data with our Commonwealth partners, customized to their specific concerns.

## Playworks to Combat Childhood Obesity, Inactivity and Diabetes

**Playworks**
Children in Playworks schools spent significantly more time, a 43% difference, in vigorous physical activity at recess.

We have partnered with and launched Playworks in several of our markets across the U.S. and we are bringing this program to Kentucky. The Playworks program helps children stay active and build valuable life skills, like conflict resolution, through play. Recognizing Perry County ranks 119 out of Kentucky's 120 counties in health outcomes,




Source: Authors' tabulations from Playworks annual survey. Sample includes 1,328 teachers, support staff and administrators nationwide from Playworks TeamUp schools who completed the survey.

UnitedHealthcare is fueling a cross-sector collaboration to combat childhood obesity, physical inactivity and diabetes by partnering with Appalachian Regional Healthcare, Kids on the Move in Hazard, Perry County Promise Program, Perry County Schools System and Hazard Independent School System to fund Playworks recess implementation training in elementary schools located within the community. Playworks hosted on-site training in Hazard for elementary school staff, including follow-up consultations on location, during the 2019/2020 school year. We also introduced Playworks in Western Kentucky through collaboration with the Purchase District Health Department, Purchase Area Health Connections and the Childhood Obesity Prevention Action Team to provide training during the 2019 Healthy Kids Summit in August and training is continuing into February 2020 and beyond. In January 2017, the Centers for Disease Control and Prevention (CDC) and SHAPE America released new guidance documents for recess. Playworks contributed to the development of these guidance documents. The CDC and SHAPE America have taken the step to publicly recognize the importance of recess in the development of kids. Statistics are in the accompanying graphic from the Robert Wood Johnson Foundation, "Building a Culture of Health through Safe and Healthy Elementary School Recess."

## Decreasing Homelessness and Costs — Housing + Health

The **Housing + Health** program supports persistent health care utilizers who are struggling with homelessness, addiction and transitions from incarceration using an evidence-based biopsychosocial solution that integrates social services, nursing, medicine and behavioral health to transform human lives — *we will launch the Housing + Health program in Kentucky.*

Our localized Housing + Health teams work within community teams to bring together high quality housing with an evidence-based, Housing First approach. This approach offers dignified housing regardless of the enrollee's situation, alongside trauma-informed services that have demonstrated improved health outcomes and decreased inefficient health care utilization, particularly for the highest risk, most costly enrollees experiencing homelessness. We will implement our proven Housing + Health model alongside the MCT to address the high prevalence of homelessness in Louisville. The Housing + Health team has developed a transitional bridge housing model that allows complex, chronically homeless enrollees to stay for up to 1 year while they work toward permanent housing. Once safely housed, we focus on critical SDOH. This process aligns counseling and guidance, reliable transportation, nutrition and trauma-informed health care. Our teams develop deep community relationships and benefit from localized expertise to coordinate traditionally fragmented services to these most complex individuals as they transition off the streets. Moreover, our program lifts barriers that affect enrollees' health resulting from lack of safety and ability to meet their most basic social, behavioral and physical needs.

EMPOWER

The Housing + Health socio-clinical care model involves partnerships between social workers and nurses who meet with the enrollees and tailor programs based upon the enrollee's strengths and desires. We help them gain access to

social entitlements like long-term housing vouchers, waivers, Social Security Income and food benefits (SNAP) to create long-term self-sufficiency.

This program has demonstrated compelling results nationally. Since October 2017, UnitedHealthcare has housed 248 high risk/high cost Medicaid enrollees in Arizona, Nevada and Wisconsin. We began analyzing our models in 2017 using pre- and post-intervention utilization and cost medical claims data. Overall, we have seen a total cost of care reduction of 10% to 20%. Clinically, we found that claims costs per patient per month decreased by 44% to 51%. This reduction was based upon eliminating unnecessary use of ED (33% to 43% decrease in ED visits); preventing inpatient admissions (55% decrease in admissions) and decreasing length of stay (67% decrease in length of stay).

Our health plan staff includes a housing coordinator who will support our clinical teams to address one of the most critical issues facing those in poverty, homelessness. We recognize the impact of housing insecurity on helping members focus on health and wellness, such as the reduction of ED utilization and increasing primary care visits. We offer enrollees who are homeless and are experiencing housing insecurity the necessary supports by using our local housing navigator, who connects enrollees with local housing resources. Those resources can include assistance with obtaining housing vouchers, verifying a home is safe from environmental dangers and negotiating short-term rental relief.

## Addressing Social Determinants of Health

Widespread recognition and evidence demonstrate that SDOH are primary drivers for health outcomes, health care costs and quality. Our population health management approach identifies social and economic barriers that stand in the way of enrollees meeting their health care goals and underpins our model. We incorporate addressing SDOH into our population health management approach as follows:

- Using data from enrollee screenings to identify barriers that may negatively affect our enrollees' ability to meet their goals, and to identify frequent SDOH barriers in specific populations and geographies
- Analyzing community capacity and quality to confirm population needs are being met
- Developing internal processes to connect individuals within populations to community-based organizations identified for these frequent barriers
- Investing in innovative best practices that build capacity, improve quality and reduce health care costs

Using a data-driven approach to understand health risks, needs and circumstances: Addressing SDOH barriers is a vital component of improving population health. Research shows that social and economic factors influence almost 40% of all health outcomes as compared to the physical environment we live in (10%), our overall health behaviors (30%) and access to quality clinical care (20%). Based upon this knowledge, we have spent extensive time and effort to understand how to address these issues better, and we have deep experience identifying enrollees' social barriers and identifying community-based partners to support enrollees' needs. Using this information, we are better able to support our local partners and communities through investments that increase community capacity intending to improve overall populations and community health.


Understanding the social barriers and needs of our enrollees is critical in our overall effort to improve their health and well-being. We have a multi-pronged approach to collecting SDOH data using SDOH screening tools, ICD-10 codes and available external data sources, including in-person observation. Funded

by a Center for Medicare & Medicaid Innovation (CMMI) Accountable Communities of Health grant, we are working with our Hawaii state partners to screen and risk stratify 75,000 individuals annually at clinics and FQHCs for social barriers to housing, food, transportation and interpersonal violence. We use the data on social needs and barriers collected from these tools to confirm that our care coordinators address the SDOH that have a profound effect on health outcomes.

ii. Three (3) examples of initiatives the Vendor has implemented for Medicaid managed care programs that have supported improved outcomes. Describe whether such initiatives were cost effective and resulted in sustained change.

We are constantly exploring ways to fulfill our mission of helping people lead healthier lives and our goal of delivering improved health outcomes to our enrollees. Quality improvement and population health management initiatives are significant elements of our approach to achieving our mission and goal. While we have many examples of initiatives we implemented for Medicaid managed care programs in the over 31 states we serve, we offer the following cost-effective and results-proven examples of programs we are tailoring for use in Kentucky.

## Example 1: Reducing Tobacco Use

Reducing and eliminating tobacco use has immediate and long-term health benefits. It is a public health priority in the Commonwealth and across the country — and something we have considerable experience supporting. In addition to promoting evidence-based covered benefits such as counseling and pharmacotherapy in all of the states we serve, the following examples highlight additional efforts we have taken to reduce tobacco use in other states.


***Intensive Individual and Group Counseling in Nevada:*** UnitedHealthcare Community Plan of Nevada runs a tobacco cessation program led by two licensed alcohol and drug counselors (LADC). The program includes intensive individual and group counseling, aligning with U.S. Public Health Services Clinical Practice Guideline on Tobacco Dependence Treatment. Enrollees are invited to participate in an initial enrollee orientation and one-on-one assessment. From there, our LADCs develop individualized treatment plans with education, support and medication therapy, as appropriate. More than 2,100 UnitedHealthcare enrollees attend the group classes annually, and more than 1,200 attended a one-on-one consult. In a survey of enrollees who completed at least 10 sessions, ***70% stated that they had quit smoking at the end of the 10 weeks, and 67% of enrollees who completed the program remained tobacco-free 12 months later.***


***A "Prescriptive" Approach in Tennessee:*** In Tennessee, leaders from our health plan are Steering Committee members on the Tobacco Free Tennessee Coalition, collaborating with other health plans, universities, hospitals, political activists, policy writers and mental health organizations. We also support the Tennessee Department of Health's *Baby and Me Tobacco Free* program, which provides diaper reward vouchers to women who remain tobacco free. Understanding that enrollees tend to follow physician instructions if they are provided with a prescription, we collaborate with hundreds of local providers to offer "prescription pads" that contain the steps for facilitating tobacco cessation for our TennCare enrollees. The prescription pads contain information for making referrals to a smoking cessation program, what smoking cessation aids are covered under the TennCare benefit and contact information for the state Quitline. Provider feedback from the prescription pads has been positive, with many providers requesting additional pads for their offices. Since this program has been in place, we have seen an **increase of over 59% in claims for nicotine replacement and tobacco cessation medications** between 2015 and 2017.

***Educating Providers in Wisconsin on Treating Tobacco Use:*** In partnership with the Center for Tobacco Research and Intervention at the University of Wisconsin – School of Medicine and Public Health, the UnitedHealthcare Community Plan of Wisconsin recently engaged with local providers to provide training, technical assistance and evidence-based research on treating tobacco dependence. Topics include system changes to integrate Clinical Practice Guideline recommendations, information on the seven FDA-approved tobacco cessation medications and education about Quitline, including enrollee referral tools. To encourage participation, UnitedHealthcare offered CME credits to providers. Although a new partnership, early feedback is promising. In the initial months since the training launched, provider participation and response has exceeded expectations, with providers reporting the training offered valuable information to help them better care for their patients.

## Example 2: Genoa Pharmacy Services for Community Mental Health Centers

UnitedHealth Group owns **Genoa**, which serves 650,000 individuals annually and is the largest provider of pharmacy, outpatient telepsychiatry and medication management services across the United States. With Genoa, we currently have 300 Suboxone certified providers and 35 board-certified addictions providers (plus board-eligible addictions providers) in their national telepsychiatry network. Our Genoa pharmacies are located within community mental health centers (CMHCs) to improve access to and promote medication adherence for enrollees with behavioral health needs. As a team, we are leveraging our experience to create new opportunities for integration of Genoa's CMHC-based model into our care management and enrollee programs, and, most importantly, ***we are already working with CMHCs in Kentucky and bringing Genoa into the Commonwealth.***

Based upon a study in the American Journal of Psychiatry, only 41% of Medicaid beneficiaries with schizophrenia using antipsychotic medication adhered to treatment recommendations. The rates of medical hospitalization and hospital costs were lower for those who were adherent versus those who were non-adherent. Our goal in integrating Genoa pharmacies into CMHCs is to increase medication adherence rates, lower rates of hospitalization and lower ED utilization.

Genoa has delivered a **reduced total cost of care, highlighted by 40% fewer hospitalizations and an 18% reduction in ED visits**. These innovations have improved quality metrics, achieving a 4+ Star Rating for several Medicare Part C and Part D measures (5 Stars in medication therapy management). We engaged enrollees and providers with a 98% satisfaction rate and a 75% action-plan acceptance rate.

## Example 3: Improving Maternal and Infant Health, including Neonatal Abstinence Syndrome Outcomes, In Tennessee

Like Kentucky, Tennessee has been hit hard by the opioid epidemic, contributing to increasing rates of Neonatal Abstinence Syndrome (NAS) and foster care placement. Working in close partnership with the state and other Medicaid health plans, our UnitedHealthcare Community Plan of Tennessee engaged in numerous initiatives to prevent and address the issue among women of childbearing age, improve the medication-assisted treatment (MAT) ecosystem, and provide comprehensive care to pregnant women with opioid use disorder and their infants. For example, we partnered with 180 health partners to implement an innovative program that focuses on finding and engaging opioid-dependent mothers in trusting relationships, immediately filling gaps in care, stabilizing health-related resource needs, and supporting mom and baby postpartum. The care team includes licensed nurses, behavioral health professionals and peer specialists who engage with enrollees in their communities. We identify and refer enrollees to the program through partnerships with OB/GYNs, MAT providers and behavioral

health providers, and use our data analytic tools to identify pregnant women with an elevated risk of an NAS birth.

Since June 2017, **346** UnitedHealthcare Community Plan of Tennessee enrollees have been actively engaged in the program. Of the **181** who have delivered so far, **63% were negative for NAS (defined by infant need for pharmacological intervention); 93% of moms are stabilized in MAT; 100% are receiving behavioral health services; and 96% of babies were able to go home with their families.** We also found **70%** of moms opted for birth control; **38**% reported a reduction in smoking, and **76%** reported a reduction in alcohol use. In addition to improved health outcomes for mom and baby, we have found this initiative to result in cost savings. A financial analysis of mothers engaged in the program between June 2017 and January 2019 saw an approximate **$6,700 savings per enrolled case**. These financial outcomes are driven mostly by improvements in length of stay and overall costs for mothers and newborns enrolled in the program.

iii. A summary of lessons learned from the Vendor's experience providing similar services to similar populations.

Beyond the previously described specific lessons in Tennessee, Nevada, Wisconsin and other states, if we were to summarize our experiences in a key lesson, it is that we know that achieving health takes more than doctors, hospitals and prescription drugs. **It takes an understanding of local nuances and a model to address the full set of factors that affect health. We are excited to bring a model that highlights collaborative partnerships with community-based organizations, stakeholders and providers in Kentucky with a shared vision to drive innovation.**

We have learned that ***strong, collaborative partnerships*** between health care providers, local public agencies and community-based organizations lead to improved quality of care, lower costs, increased engagement with local providers and community-based organizations, and better health for our enrollees and families. Our approach in building partnerships starts with the goals of the Commonwealth and needs of the local communities, is refined and improved through feedback and input from enrollees and the community, and is influenced by our clinical care model. Once we screen enrollees, we support our clinical partners in providing technology and in connecting them to local public agencies and community-based service providers, so the needs of our enrollees can be addressed. Through our relationships with local public agencies, we connect enrollees who are SNAP and Low Income Home Energy Assistance Program eligible to programs and resources to assist with food insecurity and utility concerns. Our partnerships with local public housing authorities, emergency shelters and homeless outreach agencies connect enrollees to rent and tenancy supports. We have learned that innovative and collaborative partnerships to address integration, SDOH screening and risk stratification, and enrollee engagement are critical to delivering high quality whole-person care management, and to achieve improved health and wellness outcomes.


***Lasting relationships*** are based upon lessons learned with our state partners. We understand the importance of maintaining relationships and we invest heavily in open and ongoing dialogue. Using processes like one-on-one meetings with DMS, we learn about any issues with performance and receive feedback that enables us to adjust to changing environments or expectations. This interaction supports opportunities to provide feedback to our partners on areas of mutual interest, such as provider relationships or operational challenges. The importance of a trusted relationship is vital to program success, and should be based upon **open communication, transparency and shared commitment to achieving state goals**. We are committed to supporting the Commonwealth's Medicaid program with a local focus on excellence, and the national resources and experience to support implementation and the

ongoing evolution of the MCO program. We place a high value on building relationships to support collaboration with DMS, other agencies and other MCOs during monthly and other scheduled meetings to explore issues, ideas and innovations for the efficient and economical delivery of quality services to enrollees. An example of how our relationship approach has delivered innovation/improvement comes from our longstanding relationship with the Arizona Medicaid Department, wherein conversations over a series of years, we were able to show the value of a fully integrated physical and behavioral health program. We worked closely with our state partner on a timeline and strategy to bring the previously separate program together to provide fully integrated health care to Arizona Medicaid enrollees.

iv. How the Vendor will apply such lessons learned to the Kentucky Medicaid managed care program.


From the lessons described throughout this section, there are two primary ***lessons we will apply in Kentucky***: First, we will be ***a collaborative partner*** to DMS, our providers, community organizations and, most importantly, our enrollees, as we are only successful if they are successful. Second, we will ***drive innovation*** — to improve our enrollees' health through creative work to get upstream from health problems. We do this through investing in SDOH with our community partners, innovating to better support our providers by eliminating administrative burden and rewarding them for quality and value, and innovating with DMS, our state partner, to help weave together the variety of state and public programs into a holistic solution to improve health across the Commonwealth. It is only with these collaborative partnerships that we will help meet DMS' goals. With that approach in mind, here are a few of the specifics on how we will apply these lessons learned to the MCO program:

As we have done in other many other states such as Tennessee, Michigan, and Arizona, we will build **lasting, transparent relationships with DMS, state agencies and other MCOs** through regular meetings and shared initiatives to deliver innovation and transformation of the Medicaid program. We will continue to listen.

> "We are eager for the department to leverage UnitedHealthcare's many years of working with states' Medicaid programs and members to bring a wealth of knowledge, ideas and innovative programs to Kentucky."
>
> David Bolt, Chief Executive Officer, Kentucky Primary Care Association

We have developed, and we will continue to evolve ***collaborative partnerships with our providers***, as they are on the front line. We will continue to be their advocate and supporter, not regulator and barrier. We have a deep relationship with the University of Kentucky, working on specific diabetes and opioid programs. We have built a truly unique partnership with the Kentucky Primary Care Association that will provide funds to support frontline, local case management staff. We will continue moving more of our providers into value-based payment arrangements throughout this contract period, always pushing for better ways to support our providers.

We have built and we will continue building ***partnerships with local agencies and community organizations***. With UK KYREC, we are partnering to support practice transformation programs with rural health centers to improve outcomes in diabetes and opioid abuse. With Volunteers of America (VOA) and Scholar House, we are partnering to increase capacity for supportive housing to give Kentuckians access to safe housing and a path to independence from government programs. Jennifer Hancock, CEO of VOA, even stated, *"UnitedHealthcare has done a fantastic job and should be afforded the opportunity to serve the constituents of the great state of Kentucky."* With Goodwill Industries of Kentucky, we are partnering to increase capacity in job training programs to break the cycle of recidivism and help Kentuckians get up and off of

Medicaid. As the Commonwealth's program and market forces evolve, we also will continue evolving and finding new creative ways to support Kentuckians.

Most importantly, for our enrollees, we will ***apply the strength of UnitedHealth Group to bring experience and tools*** to provide the best care with high quality programs:

- We will implement our HBPC model for enrollees who are disabled or living with serious mental illness, and who are best served in a home setting
- We will apply our experience to create new opportunities to integrate Genoa's CMHC-based model into our MCO program care management and enrollee programs
- We will implement our Hotspotting tool to identify individuals or targeted groups of enrollees by using data in real time to find individuals who have the highest need (medical, behavioral, health-related resource needs) sooner, to better address their complex needs, improve care quality and reduce spend
- We will apply our data-driven approach to understand our enrollees' health risk, needs and circumstances, and use the data to implement a ***successful SDOH strategy in Kentucky***

We will implement innovative initiatives to address population health issues, such as reducing tobacco use or improving maternal and infant health by applying the lessons we have learned from successful initiatives in other states.