9. Quality Management and Health Outcomes (Section 19.0 Quality Management and Health Outcomes)

a. Provide a detailed description of how the Vendor will support the Department in achieving its goals to transform the Medicaid program to empower individuals to improve their health and engage in their healthcare and to significantly improve quality of care and healthcare outcomes, and to reduce or eliminate health disparities. At a minimum, the Vendor's response should address:

i. How it will structure its organization to provide for a comprehensive and holistic approach to meet these goals, including coordination with Subcontractors and providers.

UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) is poised to improve the health and quality of care for Kentuckians and support the transformation of health care throughout the Commonwealth. Healthcare happens locally, and in collaboration with our Kentucky partners, we will apply our national experience and deploy the broad assets of our enterprise to empower individuals to improve their health and reduce disparities, one individual at a time.

Deploying collaborative, wide-ranging capabilities to improve health outcomes and reduce disparities: *We synthesize a wide variety of capabilities, including value-based payments (VBP) and behavioral health management efforts, to create distinctive pathways to* improve quality and health outcomes. We will collaborate with our partners to apply a combination of innovative payment strategies, strategic relationships with providers, evidence-based clinical strategies, care management models (e.g., care coordinators trained in motivational interviewing and trauma-informed care), and quality improvement and data measurement techniques to improve health care outcomes for Kentuckians with the Commonwealth's priority health conditions.

> "UnitedHealthcare incorporates a holistic approach to health care that is innovative and progressive and focuses on getting individuals back on their feet, off Medicaid, improving health conditions and overall reducing the per capita cost of health care in the state."
>
> — Marsha Berry, VP, Goodwill Industries of Kentucky

Leveraging national capabilities to support local Medicaid population: We have developed our proactive engagement strategy to empower Kentuckians, knowing they do not experience their lives in silos waiting for programs to help them improve their health; instead, UnitedHealthcare will engage each of its enrollees on their unique path. This engagement approach is based upon a learning system that tracks quality and health outcomes to verify progress and continual improvement.

Experience drives innovation: Lessons learned in our 31 other states serve as a foundation to create a customized approach for Kentuckians. Our approach adapts national best practices, transformative clinical and care management programs (e.g., our NICU care management team, supervised by our CMO, Dr. Jeb Teichman, and maternal health manager), and innovative VBP models to the needs of Kentucky's Medicaid population. It begins with identifying enrollee needs using personal conversations, sophisticated tools and data analytics, segmenting individuals into populations based upon their clinical and social needs, and connecting them with evidence-based care. Our quality strategy ensures we support the most vulnerable enrollees with our clinical, care management and prevention programs while tracking them over time to improve their health care outcomes.

Organizational Structure

Our organizational structure is locally driven, allowing us to assess needs determined from local challenges such as access, poverty and fear of trust in the health care system. This person first delivery care model puts the people and their communities first in our mission to help people live healthier lives. To build an organization unique to Kentucky, we have engaged the state's diverse communities, seeking input from individuals, health systems, community health centers, behavioral health providers, Community Action Agencies and many other stakeholders. These relationships have helped us understand that while communities like Hartford and Pikeville are both rural, the expansiveness of Ohio County requires a different approach to meeting enrollee needs than Pike County. Informed by these conversations and relationships, we designed an organization to meet the goals of DMS and Kentuckians to improve health care outcomes and reduce health disparities, empower individuals to engage in their health care to improve their health and enhance the quality of care, regardless of where they live and the resources within their communities. Additionally, with Optum behavioral health services and OptumRx as our affiliate vendor-partners within our UnitedHealth Group family of companies, DMS gains the strength of a single enterprise, along with the expertise from a diversified business, focused on bringing the most creative, innovative and fully integrated care to Kentuckians.

Improving Quality of Care: Our *Culture of Quality* is part of the fabric of our company and woven into everything we do. We integrate systematic approaches to evaluate and improve quality into every level of our organization. In Kentucky, our quality program will measure all of our care management and care improvement activities uniformly. Measuring our performance is fundamental to drive improved outcomes and to validate that we successfully support our enrollees' engagement in their health and health care. We monitor our success using multiple mechanisms that address each of our enrollees, regardless of their risk level. Examples include efforts to track preventive care through well-child visit rates to making certain early identification occurs through monitoring cancer screenings. For our chronic condition population, we will track relevant medication adherence, management and reconciliation measures in alignment with Kentucky's Health Collaborative's Core Measure set. The quality programs are also key to aligning our efforts with the health goals in Kentucky.

Our comprehensive and holistic quality program begins with our Quality Improvement Committee (QIC), which oversees the Quality Assessment and Performance Improvement (QAPI) program and is accountable for the implementation, coordination, performance and integration of all QAPI activities. The QIC, our chief medical officer (CMO) Dr. Jeb Teichman and our quality director, supported by the chief executive officer (CEO) Amy Johnston Little, will analyze and evaluate results of quality improvement (QI) activities, recommend policy decisions, verify that providers and enrollees are involved in the QAPI program, implement needed action and confirm that appropriate follow up occurs. The QIC is a multidisciplinary team consisting of medical and behavioral health clinical staff and operational leaders from the clinical team, utilization management (UM), risk management, member services, behavioral health, grievances and appeals, population health management, provider credentialing, ombudsman services, pharmacy services and provider services. This integrated team of local and national quality and operations experts work together to monitor emerging and ongoing quality issues and addresses them proactively. The QAPI program drives the day-to-day quality mission of Kentucky governance, committee activities and documents integrated performance objectives for all population groups to improve health outcomes.

Through the integration of our QIC, our QAPI program includes clinical services and operational functions, promoting effective coordination of continuous quality improvement (CQI) activities. The QIC designates subcommittees to enable more in-depth evaluation and discussion of

clinical and operational data and subcommittees that provide the mechanism by which we gather provider and enrollee feedback into our QAPI. The QIC reports to the UnitedHealthcare of Kentucky, Inc., Board of Directors, which holds final accountability for the quality of care and service rendered by UnitedHealthcare and our QAPI program.

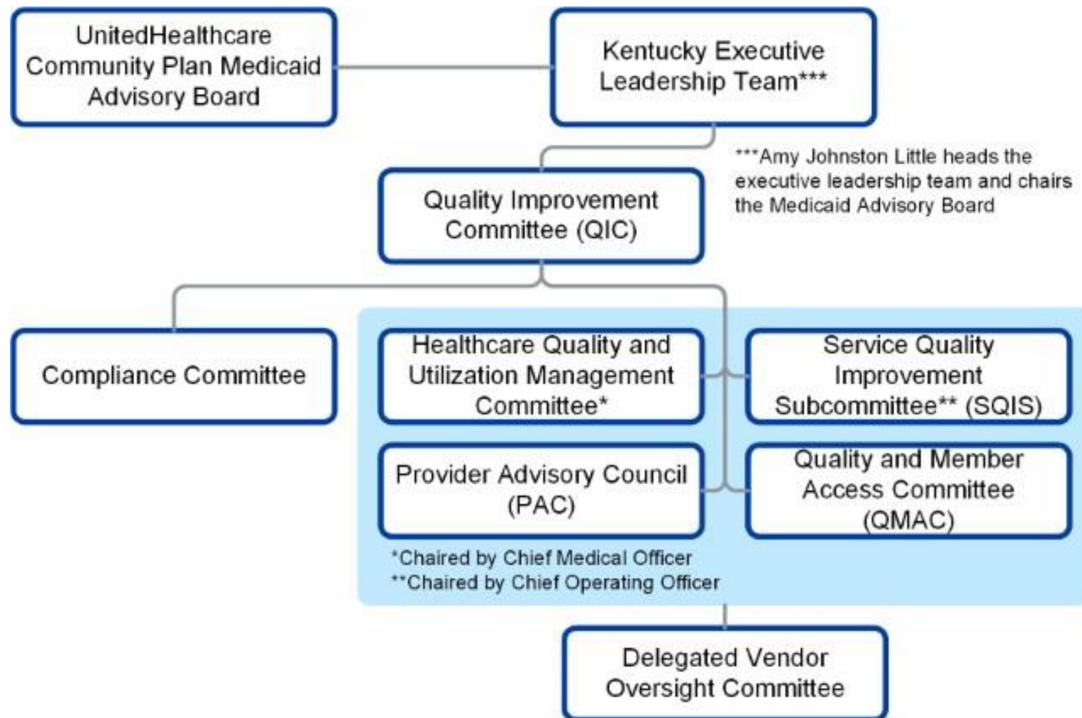


Figure 1. UnitedHealthcare Quality Improvement Committee.

The ***Quality Improvement Committee (QIC)*** is the decision-making body comprised of local and national quality and operations experts, which is ultimately responsible for the implementation, coordination and integration of all QI activities. The QIC oversees the performance and effectiveness of subcommittees, recommends policy decisions, analyzes and evaluates results of improvement activities, institutes actions to address performance issues and validates follow up activities.

The ***Provider Advisory Council (PAC)*** performs peer review activities, including review of credentialing and recredentialing, and reviews disposition of concerns about the quality of care and service provided as requested by our Kentucky health plan CMO. In addition, the PAC is a forum where we hear firsthand from our network providers on what they need from us to assist in serving our enrollees. We benefit from leveraging the input of our local provider community and incorporating it into the programs we develop to support improved health outcomes. Our Behavioral Health Advisory Committee (BHAC) reports directly up to the PAC and provides recommendations, input and prioritization of initiatives or issues that affect the BH provider community.

The ***Healthcare Quality and Utilization Management Committee (HQUM)*** monitors clinical QI and UM activities and reports to the QIC. They review reports on inpatient mortality and other clinical quality issues and advise on improvement actions as indicated.

The ***Service Quality and Improvement Subcommittee (SQIS)*** monitors the quality of service delivered to our membership and reports to the QIC. While care coordinators are the primary identifiers of quality of care and service concerns, any department, enrollee or practitioner, can

also identify concerns. They collect, review and trend data related to quality of care, quality of service, enrollee experience and administrative issues to identify opportunities for improvement.

The ***Quality and Member Access Committee (QMAC)*** provides enrollee and family representatives the opportunity to discuss and direct feedback on our QAPI program and our support of the quality strategy by encouraging meaningful engagement with enrollees. Our goal is to drive improvements to our delivery model through enrollee feedback and engagement. Quality is a standing agenda item on the QMAC and enrollee initiatives are discussed at this committee where enrollee input is sought as a standing agenda item. The QMAC reflects the diversity of our enrolled membership on race, gender, special populations and geographic areas.

The ***Delegated Vendor Oversight Committee (DVOC)*** monitors the oversight of delegated entities. The DVOC will review all relevant metrics related to the care and service of Kentucky enrollees. The DVOC comprises subcontractor leadership and our staff makes certain we are meeting metrics, and if needed, develops and implements corrective action plans to close identified gaps. The DVOC meets on a regular schedule and may call expedited meetings to address critical issues timely as determined by our leadership and our subcontractors.

Clinical Team Structure

We have specifically designed our locally driven and regionally based clinical organization to deliver better health outcomes for every population throughout Kentucky. Under the direction of our CMO, our local clinical team will provide a holistic approach for our enrollees by addressing their social determinants of health (SDOH), physical and behavioral needs. Our multidisciplinary care teams (MCTs) deliver clinical care and care management, disease management programs, and quality measurement and improvement programs — all based upon proven, evidence-based solutions tailored to the needs of our Kentucky enrollees. Each region of Kentucky will have an MCT comprising a nurse practitioner (NP), behavioral health clinician, community health worker (CHW) and nurse care manager who complete assessments, provide intensive care management, and deliver integrated primary care and behavioral health for our most complex enrollees in their homes. Our CHWs will work within their communities to provide care coordination and connections to evidence-based interventions to enrollees with chronic disease, rising risk and special health care needs. Enrollees who become high-cost/high-need will seamlessly transition to MCTs to deliver whole person care. The whole person MCT works with the PCP to deliver positive health outcomes or can function as the PCP in cases where the person does not have access to a PCP.

Addressing Health Disparities: UnitedHealthcare has supported efforts to reduce and eliminate health disparities for over a decade through our continuous work to identify, address and monitor disparities associated with age, gender, geography, race and ethnicity, language and disability. Our enterprise wide Health Equity Services program brings together leaders from across all our lines of business and major functional areas (clinical, network, operations, data and informatics, member services and marketing) to foster a holistic approach to reduce disparities and enhance the end-to-end consumer experience.

This program was specifically designed to reduce health disparities to improve the quality of health of enrollees and their communities by embracing diversity and creating a continuum of culturally sensitive initiatives that promote health and prevent avoidable health care costs. Our current program key focus areas include:

- Incorporating multicultural data into population stratification
- Understanding gaps in health and health care to develop interventions

- Refining the enrollee-centered approach based upon demographics, including race, ethnicity and language preferences
- Developing multicultural capabilities and engagement strategies to enhance the enrollee experience

> "Solving the health challenges in Kentucky is paramount and we believe UnitedHealthcare's commitment to provide outstanding care to those who need it most will help the Commonwealth achieve its goal of increasing health outcomes and improving quality."
>
> — David Bolt, CEO, KPCA

We will apply the best practices of our Health Equity Services program to improve our ability to offer culturally competent care management programs and services that address health disparities throughout Kentucky. Given the importance of addressing health disparities, our Kentucky CMO will develop a Health Disparity Action Plan. As is the case with all of our health plans, this action plan will contain concrete action steps and metrics to track performance and improvement, paying particular attention to the varying needs and barriers of each geographic region in Kentucky.

Coordination with Providers and Subcontractors

Our locally led organization collaborates with providers and community-based organizations to deliver care in individuals' neighborhoods allowing us to develop and achieve shared QI and health-disparity reduction goals. We have worked with many local partners, including Kentucky Primary Care Association (KPCA), University of Kentucky (UK), Kentucky Health Care Association, Kentucky Youth Alliance, Kentucky Behavioral Health Coalition, NAMI Kentucky and Mental Health America Kentucky, to understand providers' perspectives on the need to bolster the primary care and behavioral health workforce and specialized programs that target the most complex individuals. Based upon the insights and advice from providers, we have developed tailored solutions that will bring new clinical resources to Kentucky.

Since entering the Commonwealth in 1986, we have maintained longstanding relationships with the provider community for our Medicare and commercial lines of business. These relationships have supported members across Kentucky and serve as the foundation for meeting the needs of our Medicaid enrollees. Our Kentucky provider network director, Margaret Enlow, is responsible for building relationships with providers and supporting their needs. A native of Harlan, Ms. Enlow continues to live in and has more than 30 years of experience working in Kentucky. She, along with her team, has credibility with and understands the needs of our provider partners. Ms. Enlow and her team have been meeting with providers since early 2018 to understand the specific challenges and opportunities with the Medicaid program. The team's goal is to go beyond a contractual relationship and create true collaborative partnerships. For instance, we have committed to work with KPCA to support their population health programs and align the VBP quality measures to reduce the administrative burden for their providers.

Our relationships with providers encourage open dialogue and feedback on opportunities for pilot programs, approaches to reduce administrative burden, and insight into existing successful programs that can be expanded. These relationships also provide a framework to build upon current successful associations to enhance the care coordination process. In addition to personal relationships with providers, we use our PAC as a focused forum to listen to our provider's input in the areas of quality management operations, clinical outcomes, improvement activities, data analyses, drivers of enrollee and provider satisfaction, overutilization and underutilization monitoring, provider profiling, credentialing, and quality of care and services monitoring. The PAC includes a multidisciplinary panel of providers, including PCPs, specialists, pharmacists, behavioral health specialists and allied health practitioners. The PAC is a forum where we hear firsthand from our network providers on what they need from us to assist in

serving our enrollees. We take the recommendations of our Kentucky-based network partners seriously in developing meaningful provider engagement programs.

This structure allows us to incorporate key clinical data and feedback from the field. In Louisiana, for example, our PAC identified an opportunity to improve birth outcomes through a specific engagement strategy with our OB providers, development of unique VBPs to align incentives, and improved access to educational tools to support improved outcomes. The result of the recommendation was an enhanced provider support model, including dedicated practice support resources to assist in enrollee identification, assist with care coordination and closing gaps in care. We also expanded provider education regarding VBPs and evidence-based care guidelines. In addition, we identified the need to expand the scope of care and community partners by focusing on relationships with community resources also in contact with our enrollees, facilitating longitudinal engagement of highest risk enrollees with all available resources, and using CHWs to remove social barriers to care.

We formally monitor the performance of our subcontractors to facilitate optimal performance and alignment with the goals of the program through the DVOC. Through strict service level agreements and key performance indicators in our contracts with subcontractors, we can track performance, penalize under -performance, and reward quality. Our control processes allow us to measure the performance of our subcontractors through reporting, regular communication and audits. The DVOC is responsible for making sure our subcontractors are meeting metrics, and if needed, develops and implements corrective action plans to close identified performance gaps. The DVOC meets on a regular schedule and may call expedited meetings to address critical issues timely, as determined by our leadership and our subcontractors. The DVOC develops compliance strategies and initiatives to support the subcontractor's performance, including an overall review of business performance, training, assessment of key compliance or regulatory issues and risks, audit planning and reporting, and issue escalation. The QIC has oversight of the DVOC and, therefore, our subcontractor's performance, and can intervene if needed. The vast majority of our subcontractors and vendors are part of the broad UnitedHealth Group enterprise. These internal capabilities allow us to provide an integrated approach to meeting the needs of our enrollees and providers without an over-reliance on external entities, which can create both fragmentation and increased pressure on vendor management. The relationship UnitedHealthcare has with vendors like Optum behavioral health services and OptumRx allows us to address any concerns identified by the DVOC quickly.

ii. Strategic solutions the Vendor will use in quality management, measurement, and improvement.

Managing, Measuring and Improving Quality

Quality and value are the shared responsibility of everyone on our team and our partners. We developed our QAPI program and solutions based upon our national infrastructure, resources and tools to manage, measure and improve quality of care for the Commonwealth and address local needs. With our comprehensive local partnerships, we have developed strategic solutions to address Kentucky's goals and needs. These solutions include high quality programs and solutions, enrollee health and wellness, chronic conditions, robust partnerships and pay-for-value solutions. To achieve this, we bring proven techniques for CQI to care management, member services, claim operations, UM, provider support and VBP.

Our integrated QAPI provides a sustainable foundation that puts our *Culture of Quality* in the forefront and makes sure we operate in accordance with all applicable state and federal regulatory requirements and accreditation standards. Our quality management plan will span all operational functions and endorse the Commonwealth's priorities. These organization-wide efforts and application of quality management tools across all operations (e.g., CQI, root cause

analysis, Six Sigma) will support and drive improvement in health outcomes and clinical quality (e.g., HEDIS), reduce preventable utilization (e.g., ED visits and readmissions), address health disparities, and increase enrollee and provider satisfaction. Our QAPI plan will establish measurable goals that correlate to the Commonwealth's priority health conditions. For each goal, we will measure a baseline for our eligible population, then create targets for the first, second and third contract year. If we do not reach a target for a given category, we will develop a performance improvement plan to verify that we understand the effective QI drivers and adjust accordingly. Using this data-driven approach and leveraging our deep relationships across the Commonwealth, we look forward to supporting a Healthier Kentucky.

For our QAPI program, we will use a comprehensive array of monitoring and improvement methods to identify and prioritize areas for improvement, set quantifiable goals, develop interventions and communicate outcomes.

Strategic Solutions to Advance Culture of Quality

The following are our strategic solutions for quality management, measurement and improvement that we will use to achieve the goals specified in this question.

UnitedHealthcare's *Culture of Quality*	
Objectives	**Strategic Solutions**
Central Aim #1: Improve Quality of Care	
Goal: **Support appropriate access to care, enrollee engagement, and reduce unnecessary ED utilization**	
▪ Timely access to primary and preventive care ▪ Maintain provider engagement ▪ Promote enrollee engagement ▪ Prevent inappropriate ED use	▪ Provider engagement teams will collaborate with Kentucky providers and community partners to provide data, identify trends and gaps, and develop action strategies improve health outcomes ▪ Measure and incentivize access to same-day appointments ▪ Provider-facing quality and clinical transformation personnel who provide in-person and web-based reports, trainings and education ▪ Benefit from our multi-faceted tools and educational resources to encourage enrollees to engage in their health care ▪ Identify urgent care centers to provide preventive care services ▪ Monitor inappropriate ED utilization in real-time using admission, discharge and transfer (ADT) feeds and develop targeted interventions for specific cohorts of high ED utilizers
Central AIM #2: Improve Health Outcomes	
Goal: **Manage complex populations**	
▪ Identify populations for care management ▪ Address behavioral and physical health comorbidities ▪ Address social determinants of health	▪ Hotspotting tool uses sophisticated data analytics to identify high-cost, high-need individuals and cohorts that can be influenced by specific interventions (such as homeless individuals) ▪ Multidisciplinary care teams deliver primary and behavioral health care in the home and provide intensive care management ▪ Housing + Health pilot will find and pay for stable housing with wraparound services to address trauma, complex behavioral health and social needs for targeted high-need enrollees

UnitedHealthcare's *Culture of Quality*	
Objectives	**Strategic Solutions**
***Goal:* Improve chronic conditions management**	
▪ Improve behavioral health care ▪ Improve substance use disorder (SUD)/opioid use disorder (OUD) care ▪ Improve diabetes management ▪ Improve asthma management ▪ Improve obesity management ▪ Empower individuals to self-manage their chronic diseases	▪ Partnerships with DMS, local community organizations and MCOs to develop aligned strategy to improve chronic conditions management across Kentucky ▪ VBP strategies that promote management of chronic medical and behavioral health conditions ▪ Partnerships with a variety of Kentucky's behavioral health providers, including independent practitioners, Community Mental Health Centers, Behavioral Health Services Organizations and Multi-Specialty Groups to provide care management to serious mental illness (SMI) population and VBP to support integrated primary care and behavioral health ▪ Partnership with the Kentucky Children's Alliance to validate quality care and appropriate treatment for children ▪ Partnership with Kentucky Regional Extension Center (REC) to provide practice transformation workshops to train providers in evidence-based practices for OUD and diabetes ▪ Gift card incentives for diabetic enrollees (>100% FPL) who complete HbA1c screenings and retinal eye exams ▪ Partnership with Kentucky Diabetes Network to support raise awareness of Diabetes Prevention Program (DPP) through postcard distribution with Walgreens and billboard placement throughout Kentucky communities ▪ Ability to connect overweight or obese individuals with weight loss opportunities and programing, such as through providing vouchers for Weight Watchers ▪ Partnership with American Heart Association as a "Healthy for Good" sponsor to create awareness and host community stakeholder meetings to discuss barriers and opportunities to incent individuals to complete annual health assessments ▪ Remote monitoring technologies and care management capabilities among enrollees with diabetes, congestive heart failure, COPD and others in rural areas (Regions 4, 7 and 8) that experience barriers to accessing providers
***Goal:* Promote wellness and prevention**	
▪ Promote child health, development and wellness ▪ Promote women's health ▪ Promote diabetes prevention and care ▪ Prevention Program	▪ Community partnerships to educate and provide care gaps (e.g., partnering with Perry County and Hazard Independent elementary schools to implement "Playworks" to help schools rethink recess, address safety, engagement and empowerment through structured physical activity and conflict resolution) ▪ School-based EPSDT and health education programs ▪ Health disparities action plans focused on maternal child health ▪ Provider partnerships and VBP to improve outcomes for pregnant women with OUD and decrease Neonatal Abstinence Syndrome (NAS) ▪ Partnership with Volunteers of America to support housing for pregnant women with OUD ▪ Partnership with UK to provide the Diabetes Prevention Program in underserved communities with high diabetes prevalence ▪ Support eligible enrollees to engage in Diabetes Prevention Program through covered sessions with Weight Watchers and UK pilot ▪ Provide gift card incentives to adult enrollees (>100% FPL) who

UnitedHealthcare's *Culture of Quality*	
Objectives	**Strategic Solutions**
	complete an annual dental exam ▪ Provide a gift card incentive to enrollees (>100% FPL) who complete their adolescent well-child visit ▪ Healthy First Steps Rewards and additional incentives via gift card to pregnant women for completing all prenatal examinations
***Goal*: Work with communities to improve population health**	
▪ Address unmet resource needs ▪ Address the opioid crisis ▪ Address tobacco use ▪ Address obesity	▪ Provider incentive programs targeting priority measures and unmet needs ▪ Opioid dashboard with key performance indicators to identify needs, direct resources and monitor progress ▪ Promotion and maintenance of a high quality medication-assisted therapy (MAT) network ▪ Partnership with providers to implement innovative OUD VBP models that increase access to and the quality of MAT services ▪ Personalized coaching through care coordinators to support tobacco cessation (e.g., Smokefree Teen, Quit Start, DipfreeTXT) ▪ Develop community-specific health disparity action plans incorporating information on key elements such as of race, ethnicity, language data and eligibility category. ▪ Foster cross-sector relationships to address unmet community needs, (e.g., UnitedHealthcare has introduced a Medicaid Innovation Zone in Hazard to accelerate rapid cycle delivery of innovative solutions and services to individuals using Medicaid)
Central Aim #3: Reduce Disparities	
***Goal:* Improve health equity**	
Reduce health disparities	▪ Develop community-specific health disparity action plans incorporating information on key elements such as of race, ethnicity, language data and eligibility category ▪ Partnership with UK Center on Excellence in Rural Health to build provider capacity with community health workers in areas where gaps exist ▪ Partnership with Community Action Kentucky (and directly to Community Action Agencies) to address enrollee gaps across the continuum of clinical and social ▪ Partnership with the UK to support the availability of the evidence-based national Diabetes Prevention Program across underserved regions in Kentucky, specifically those with diagnosed diabetes prevalence rates higher than the state and national averages
Central Aim #4: Empowering high quality providers	
***Goal:* Pay for value**	
Promote high value appropriate care	▪ Three-tiered medical economics reporting and analytics, population-based trends, clinical and quality program efficacy studies, and enrollee-level case reviews and clinical rounds ▪ Comprehensive and innovative VBP strategy for outpatient and facility-based care delivery ▪ Provider recommendation engine to direct enrollees to the highest quality providers

UnitedHealthcare's *Culture of Quality*	
Objectives	**Strategic Solutions**
Central Aim #5: Empowering Individuals	
***Goal:* Enrollees engaged in health and wellness**	
▪ Enable enrollees to self-manage ▪ Foster community engagement	Provide the information and tools necessary to develop health promotion and self-management skills and to learn the basics of health insurance. This includes supporting individuals seeking primary care and in treating mild to moderate behavioral health conditions; encouraging health promotion and self-management of chronic conditions; and making simple, health literacy tools and resources easily available in a variety of modalities.

iii. Innovative strategies and enhanced services, if any, that the Vendor proposes to implement to enhance the health and well-being of Enrollees and to improve health outcomes, including examples of successes with similar Medicaid populations.

INNOVATE

UnitedHealthcare has evolved beyond a care management approach that is "one size fits all" to bring a transformative new model of Managed Care delivery to Kentucky. We are implementing integrated and innovative, tailored tools and interventions that address the behavioral, physical and social needs of our complex population; deploying targeted, evidence-based clinical programs that improve outcomes for specific chronic conditions; and introducing resources to support engagement of enrollees in improving their own health and wellness.

Complex Care Innovations

High-cost/high-need enrollees too often experience fragmented care that is costly and ineffective. Medical care, behavioral health care, substance use treatment and social needs are all too often delivered in an uncoordinated, difficult to navigate system of multiple providers and care coordinators. Some enrollees simply need better assistance navigating the range of resources available to them. For our highest cost and highest need individuals, we will provide a truly transformative approach.

Whole Person Care Multidisciplinary Care Teams (MCTs): We will deploy our proven, clinician-driven MCTs to address the comprehensive needs of high-risk enrollees in a coordinated and effective manner. Combining direct clinical care, behavioral health, care management and SDOH expertise in a single team is a distinctive approach that UnitedHealthcare deploys in multiple states such as Tennessee, Arizona and Missouri. We learned that this approach to provide direct care that is integrated and holistic has immense value for individuals after an inpatient hospitalization and among complex individuals unable to receive care in their community due to unresolvable access issues, functional impairments or other barriers. In Tennessee, this model served approximately 3,000 Medicare and Medicaid dual eligible enrollees with disabilities. To date, 98% of enrollees in this program received a follow-up care visit in their home by the MCT within 2 days of hospital discharge. When comparing 2018 to 2017, there was an average decrease of 10% to 20% in inpatient admissions and 23% to 33% in ED visits for individuals enrolled in the program and, in 2018, this model closed 18,300 gaps in care.

In Kentucky, each cross-functional MCT will be anchored in communities across the Commonwealth. Each MCT comprises a NP, licensed behavioral health clinician, licensed child psychiatrist, community health worker and nurse care manager to meet complex enrollees' physical, behavioral and social needs holistically. With our unique capability to provide integrated primary and behavioral health care directly to our enrollees through this approach, the MCTs will deliver comprehensive physical, behavioral and functional assessments and care

management, and then directly meet identified care needs. The MCT partners with PCPs to deliver positive health outcomes, but can also function as the PCP in cases where the enrollee does not have access to a PCP.

The breadth of services we offer in our integrated MCTs will meet the complex needs of high cost/high needs allowing us to deliver personalized care management, social resources and direct care delivery for targeted high-cost and high-need individuals, even during their most vulnerable periods. For example, when an individual with complex needs (physical or mental health) is discharged from an inpatient setting, our care management team will contact the person and immediately schedule an in-home follow-up appointment with the MCT. In the home, the nurse care manager will provide a comprehensive assessment; the NP will provide evidence-based interventions such as medication reconciliation and enrollee and family education that help prevent readmissions; and the licensed clinical social worker will provide any necessary counseling and help address any social needs such as food insecurity.

In Kentucky, PCPs often struggle to meet the behavioral health and social needs of these very vulnerable and complex individuals, leading to preventable hospital admissions and readmissions. Our distinctive approach will remove the burden from PCPs while providing comprehensive care that will meet these complex individuals' holistic physical, behavioral and social needs so they can transition back to community-based primary care after their needs are addressed and their condition is stabilized.

Addressing the needs of high-cost/high-need individuals encompasses more than clinical services. Without resources like stable housing, healthy food, reliable transportation or social connection, an individual's health can be adversely affected. Left unaddressed, these SDOH can lead to a decline in a person's health. By focusing on delivering health care one person at a time where they live, our integrated teams can meaningfully change people's lives.

Aligning Health and Housing Systems: At the national level, we are partnering with the Corporation for Supportive Housing (CSH) and the Council of Large Public Housing Authorities (CLPHA) to implement the Aligning Health and Housing Initiative (AHHI). The AHHI reflects a multisector effort to improve the health outcomes of Medicaid enrollees who are served through managed health care and live in publicly assisted housing. Through data matching and analytics, AHHI identifies individual and population health needs and then designs and implements systems of care and interventions at the person, program and population level.

Through our AHHI, we have developed data sharing agreements with six local public housing agencies (PHAs) to identify our members living in PHA assisted housing. We analyze their health care needs, utilization and outcomes to identify both population and individual needs, and develop targeted interventions. If awarded in Kentucky, we would engage with public housing agencies to tailor and replicate these efforts to improve health outcomes.

Affect Investing to Improve Health: UnitedHealthcare has been an active member of the Appalachian Funders Network (AFN) Health Working Group since 2018. The Health Working Group has focused recently on responses to the opioid epidemic and improving oral health. The AFN brings together local and regional funders to support healthy, equitable and vibrant communities in Appalachia. Last year, UnitedHealthcare supported an AFN member initiative to create stronger alignment and collaborative action among organizations and leaders in Central Appalachia. The goal of the program is to attract and absorb capital that advances social and economic opportunities and positively influences SDOH.

UnitedHealthcare is also engaged with Invest Appalachia, an integrated capital strategy that aims to address the deep challenges of the region by filling capital gaps and supporting efforts

to build a new economy in the region. The initiative will integrate and align social capital, philanthropic dollars, and patient debt and subordinated loans to support clean energy, community health and food or agriculture development.

Socio-Clinical Model of Care: We embed the culture of trauma-informed care in the training and development of all frontline staff within the MCT. Subject matter experts from our national team provide training on evidence-based clinical care concepts, such as trauma-informed care and adverse childhood experiences (ACEs), while incorporating other principles like motivational interviewing, harm reduction, positive psychology and person-centered care. These training sessions broaden our knowledge base and help us create a trauma-informed environment to better understand, engage and support enrollees with complex socio-clinical needs.

As the enrollee's advocate in the community, CHWs are trained to identify needs and gaps then link enrollees to resources that promote, maintain and/or improve health outcomes and reduce health disparities. Our CHWs are trained to locate and encourage engagement with social supports to tackle poverty by working directly with the enrollee in their immediate community. The CHWs also receive condition-specific training for a solid understanding of specific conditions supported through our models of care (e.g., heart failure, chronic kidney disease, sickle cell). Understanding common health problems, along with issues related to poverty allows us to align meaningful interventions and builds the foundation for meeting the tailored needs of our enrollees. Our goal is to provide culturally competent socially coordinated care with compassion and empathy to build trust and support enrollees on their journey toward short-term and long-term goals.

Housing + Health Model: Stable and dignified housing is an essential need for whole-person health and wellbeing. 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. We use our Hotspotting tool to identify groups of the most complex enrollees who are experiencing homelessness. The Housing + Health team identifies local housing vendors who can deliver high fidelity housing first services — a harm reduction model that targets individuals with significant mental health and addiction issues. If the vendor is new to the Housing First Model, the Housing + Health team provides training and ongoing technical assistance. The MCT clinicians will work with these individuals to navigate toward housing, which we will provide for up to 12 months. During this period, we work with the enrollee to identify permanent housing solutions and make certain that they are prepared to benefit from programs for which they are eligible, including housing vouchers and subsidies. We support their transition to permanent housing by assisting them with necessary documentation (e.g., state-issued ID), gathering household items, aligning resources for utilities and preparing enrollees to live on their own successfully with behavioral and social supports. We will initially pilot housing for 10 homeless individuals in Louisville and potentially other areas across the state such as working in London, Kentucky. In partnership with the Fletcher Group, we will closely track the results, share results with DMS and use the results to inform future pilots and any decisions to expand the program.

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 person per month involved decreased by 44% to 51%. This reduction was based upon eliminating unnecessary use of EDs (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).

Since complex enrollees often have unmet behavioral health needs, we are leveraging a unique partnership to make certain that our enrollees with SMI can obtain medications for their behavioral and physical conditions at on-site pharmacies.

Baby Box Program: We will support access to programs like Baby Box, which is available to pediatricians who want to provide a means to support the American Academy of Pediatrics Safe Sleep initiative and Kentucky's focus on reducing sudden unexplained infant death (SUID). Baby Box provides a family with an alternative sleeping place for their newborn as opposed to co-sleeping with caregivers.

Partnership with Community Action Kentucky: Our collaboration with Community Action Kentucky (CAK) and their network of 23 member agencies with outreach offices in every Kentucky county has the potential to make an impact on moving the needle of Kentuckians' health outcomes. Community action agencies (CAAs) are trusted service providers in local communities that we will partner with to connect enrollees via direct referral linkage between our care coordinators and CAA case managers to help identify unmet health and social needs. Community action agencies are a lifeline to meeting needs of their communities, with over 300,000 individuals participating in CAA programs and services over the past year. This innovative partnership will help improve the health of enrollees in a cost-effective manner. Initially, we will partner with three CAAs (LKLP Community Action Council in Hazard, Audubon Area Community Services in Owensboro and Northern Kentucky Community Action Commission in Covington) to refer and deliver highly targeted services based upon the enrollee's needs. Our collaboration will include a bidirectional referral tracking and management systems to allow service level data and closed-loop referral tracking. As we gain experience, we will scale, as appropriate, to other CAAs across the Commonwealth.

The Fletcher Group: Recognizing the important role that recovery housing serves in addressing the needs of individuals experiencing SUD, homelessness or other social stressors, we are in initial conversations with Fletcher Group to discuss the feasibility of innovative alternative payment models to support individuals in Recovery Kentucky centers. An advanced collaboration to explore billable service gaps, peer support reimbursements, telehealth visits and targeted case management has the potential to develop value-based programs and innovative IT solutions. This partnership has the potential to be a unique, first-in-class approach to improve the mental and physical well-being of Kentuckians in recovery.

Partnership with Genoa: Genoa Healthcare is the largest provider of behavioral health care pharmacy and outpatient telepsychiatry services in the United States. Genoa has more than 450 pharmacies nationwide, with nine pharmacies located on-site at Kentucky behavioral health providers including LifeSkills, Inc. in Bowling Green, New Vista in Lexington (two locations), Centerstone in Louisville (three locations), and Four Rivers Behavioral Health in Mayfield and Paducah. Its on-site pharmacies specialize in serving the needs of individuals with serious and persistent mental illness (SPMI) and SUD. Genoa Healthcare partners very closely with the care coordinators, by either working directly with them or working with the enrollee and looping in the care coordinator when needed. Genoa Healthcare pharmacies achieve more than 90% medication adherence rates, 40% fewer hospitalizations and 18% fewer ED visits. This results in lower total cost of care for individuals.

InTrust Healthcare: InTrust Healthcare provides behavioral health services across 33 counties in the Commonwealth. While this includes the urban counties of Franklin, Fayette and Jefferson, they also provide services in the rural counties of southern Kentucky. Based in Somerset, they

have done a great deal of work to reduce recidivism within many of the communities they serve and partnered with the hospital in Somerset to strengthen population health outcomes. We share their commitment to facilitate quality services in community settings and are excited to enhance our partnership to improve health outcomes.

Promoting Chronic Disease Management

Individuals with chronic physical and behavioral health conditions often struggle to access high quality primary care and to identify and enroll in evidence-based programs that help them manage their chronic disease and achieve better outcomes. Our model segments individuals into populations based upon their clinical conditions and uses CHWs to connect these enrollees with evidence-based interventions that we know are effective in improving outcomes for their specific condition. Examples of our robust array of evidence-based interventions include:

Vivify Health Remote Monitoring: We equip enrollees with diabetes, heart failure or COPD with evidence-based end-to-end remote care management to support active self-management of chronic conditions. The Bluetooth-enabled devices facilitate the collection of biometric data, qualitative feedback to questions about enrollee health and needs. Participation in the program provides enrollees access to video educational tools to support further engagement in health. Vivify Health's results include readmission reductions over 65% and adherence and satisfaction levels exceeding 95%.

Diabetes Prevention Program (DPP): We link enrollees with prediabetes with the most effective, evidence-based intervention to prevent diabetes. Through partnerships with Kroger and Weight Watchers, our enrollees will be able to access DPP at no or reduced cost. We also have a pilot with the UK to offer DPP in underserved regions with the highest prevalence of diabetes.

Specialized Disease Self-management Tools: We empower enrollees to manage their own conditions with evidence-based tools for diseases including heart disease, diabetes, obesity, behavioral health conditions and SUDs.

UnitedHealthcare Doctor Chat Virtual Visits: UnitedHealthcare Doctor Chat is a chat-first workflow with barrier-free access to care in 90 seconds or less. Any visit that cannot be resolved through secure chat can be escalated to telephone or video. Ultimately, UnitedHealthcare Doctor Chat can resolve 90% of Medicaid enrollee issues without having to refer the individual to in-person care. In addition to using this capability to improve access to care for enrollees in rural areas, we will promote this program to enrollees who have visited an ED two or more times in 1 year as a way of reducing medical costs driven by unnecessary ED visits.

Empowering Individuals to Improve Their Health and Wellness

We will have resources integrated throughout the organization to help individuals engage more actively in their health, including a specialized outreach team devoted to enrollee self-management. Our Kentucky membership will be able to connect with *Avocate4Me*, which will assist enrollees in fully understanding their benefits and health and wellness opportunities.

> "UnitedHealthcare is committed to its patients through not only providing health care, but also collaborating to address the many challenges facing the entire spectrum of health of its members."
>
> — Jared Arnett, Executive Director, SOAR

Community Health Workers: Community Health Workers (CHWs) are uniquely positioned as trusted resources in their

communities to educate Kentuckians on identifying risk factors and accessing preventive care and social resources to help enrollees live healthier lives. In December 2019, UnitedHealthcare and University of Kentucky Center of Excellence in Rural Health (UK CERH) announced a partnership to support the first-ever Students Striving Toward Better Health in Self and Community initiative, which will be available to Perry County High School and Hazard Independent High School students. The program presents a unique, first-in-class partnership that demonstrates how private business, higher education and communities are addressing rural health and opportunity in Kentucky together. The grant will provide free college tuition to 23 students at Hazard Independent and Perry County High School for CHW accreditation through Hazard Community and Technical College. Initiative objectives are to prepare high school students for potential secondary study and professional roles in health care, increase student awareness and recognition of chronic disease, and improve the health and well-being of those in their communities and families. Core components include:

- ***Health and CHW focused curriculum:*** Students completing this certificate will obtain skills in communication, outreach, advocacy, health coaching, organization and legal or ethical issues related to community health. Students will be awarded six credit hours.
- ***Community health worker apprenticeship:*** Students who successfully complete the coursework and are 18 years of age or older will be eligible to apply for a paid apprenticeship (funded by UK CERH) during the last semester of their senior year. Internships will occur at Appalachian Regional Healthcare or Primary Care Center of Eastern Kentucky in Hazard.
- ***Community health improvement project:*** Each student will identify a community issue related to chronic disease and work with local stakeholders to determine how to best address the prevention and management of the disease using local assets in an innovative manner.
- ***UnitedHealthcare internship:*** Each student will be paired with a UnitedHealthcare virtual mentor for a 3-month internship to explore the inner workings of a health plan and possible professional opportunities within the industry.

Curriculum advisors from the Kentucky Community and Technical College System have worked through accreditation standards for this initiative to be replicable in other areas throughout the state. This innovative partnership between health care leaders, higher education institutions and communities will help move the needle on health and health care access while providing promising opportunities for our Kentucky youth.

Individual Health Record (IHR): Through our new, patented IHR, we can simultaneously collect and translate different data sources from the last 3 years of enrollees' medical history into a single consolidated view. Our IHR is at the forefront of health care technology and revolutionizes how enrollees, providers and care coordinators access and take action on an individual's health and health care. By revealing clinical intelligence from data feeds into a single, complete, secure, and easily readable record, the information becomes meaningful and easier to act on. By empowering our enrollees with the IHR, providers can enhance their preparation for a visit, care coordinators have an additional resource to understand those they serve and enrollees have a consolidated record of their medical history. While this system is still new and we do not yet have outcomes, feedback in other states has been favorable.

Health Disparities

We will offer culturally competent care management programs and services that address health disparities in Kentucky. To identify meaningful goals, we use internal and external sources of data to identify major health disparities that are affecting outcomes for our population in

Kentucky. We start by examining HEDIS performance measures and NCQA Quality Compass Benchmarks for the Commonwealth's priority health conditions to determine specific gaps in care by urban and rural locations, race, ethnicity, gender and age, and we track these measures after we go live instead of waiting until the end of the HEDIS measure period. We enrich our understanding of disparities by adding external data from the CDC Diabetes Interactive Atlas, the Behavioral Risk Factor Surveillance System, CDC WONDER Mortality Data and data from the National Center for Health Statistics to analyze adult obesity, tobacco use, diabetes prevalence, infant mortality and overdose mortality rates in Kentucky.

After we use these data sources to identify sub-populations within our overall population with specific gaps in care, we identify targets for health improvement, develop programs to address them and evaluate their effectiveness.

Figure 2. Our health disparities approach starts with aggregation of data. We use internal and external data to prioritize the disparities faced by key sub-populations, which informs our implementation of programs in our communities.

Our health plan CMO, Dr. Teichman, champions the development of a **Kentucky Health Disparities Action Plan** with the support of our diversity health plan lead who is responsible for ensuring we have disparity initiatives and education ongoing throughout the health plan teams. Our Health Disparities Action Plan will describe improvement goals for each measure, target locations, target ethnicity, gender or age brackets, and specific action items that we will accomplish each year to implement evidence-based strategies and programs that will close the gaps.

We bring an array of successful strategies to Kentucky for addressing racial, ethnic, language and geographic barriers because of our lessons learned from prioritizing health disparity initiatives across all our health plans. For example, our plans deploy a powerful tool — ***Healthify*** — as a comprehensive bridge to connect individuals to local resources and address health disparities. *Healthify* is a web-based community resource tool used to identify and connect individuals to available community resources that provide assistance with food, housing, employment, utility bills, support groups, transportation, childcare and clothing. In Kentucky, our MSAs, CHWs, nurse care managers and other staff will use *Healthify* to help bridge the gap between unmet health care and social needs for individuals at risk for poor outcomes or inappropriate use of health care services. *Healthify* users can also target cultural, linguistic and educational support for prevalent demographics, including rural areas of Kentucky where individuals face numerous social barriers to improving health outcomes.

Our Kentucky Health Disparities Action Plan will draw upon the proven strategies and enhanced services that have demonstrated results in other states. Each of our health plans maintains a specifically tailored Health Disparities Action Plan with strategies targeted to meet the needs of their Medicaid populations based upon our analysis of state and health plan data. We are in the process of working incrementally toward having all of our health plans apply for NCQA's distinction program, and we are proud of **our Ohio, Mississippi, Michigan and Maryland health plans that received NCQA's Multicultural Health Care (NCQA MCH) Distinction in 2017.** Obtaining NCQA MCH distinction requires us to analyze our HEDIS data based upon race, ethnicity and language and document improvement in those areas — an initiative that all

our health plans currently perform and we will bring to Kentucky. Following are examples of Health Disparity Action Plans from our Michigan and Maryland plans that demonstrate how we identified priorities based upon public health data and data on unmet enrollee needs and then implemented innovative strategies to improve targeted health outcomes.

Example #1: State of Michigan	
Unmet Resource Need	For our Michigan health plan, an initiative to address disparities in postpartum rates incorporates literacy rates, food insecurity, housing stability, family, employment and social exclusion in key geographic areas. For example, 10 counties show a disparity in access to services for African-American enrollees, two counties for Hispanic enrollees and one county has Asian enrollees.
Data Used, Data, Metrics Collected	Timeliness of postpartum care rates.
Health Disparity Identified	HEDIS 2018 final rates indicate the disparity index is 8.25% for enrollees and varies by race/ethnicity and county.
Health Disparity Reduction Goals	The disparity reduction goal is to decrease the disparity between African-American and Caucasian women to less than 5% without reducing the rate for all other races in the health plan. The goal is to reduce the disparity index by 3.26 percentage points in HEDIS 2019.
Data Source to Identify Health Disparity	We use race data provided by the Michigan Department of Health and Human Services and claims data to determine an enrollee's eligibility for the HEDIS 2018 denominator. We validate data using NCQA-certified software.
Population Assessment	Because data indicated disparities varied by race/ethnicity and geography, we studied specific cities and reviewed rates of functional literacy in those areas via data from the National Institute for Literacy and reports from the Detroit Regional Workforce. Up to 47% of the City of Detroit adults are functionally illiterate, with Wayne County up to 36%, Macomb and Oakland at 13% to 15%. Many suburbs — including Pontiac (34%), Inkster (34%), Southfield (24%) — have high rates. Across Michigan, one in three adults reads below a sixth grade level. Furthermore, the Robert Wood Johnson Foundation County Health Rankings database indicates that individuals in these areas, and particularly Wayne County, are more likely to experience food insecurity (21%), residential segregation (71%) and lower social association rates (7.1).
Collaboration Strategies with State and Local Agencies	***Partnerships:*** Our Michigan health plan actively participates with Region 8 and 10 Perinatal Councils. They collaborate with Great Start Collaborative Oakland/Macomb to educate individuals on the preventive and access needs of Medicaid enrollees and families. They partner with SisterFriends and MakeYourDate with the Detroit health department to develop matrix of resources to support Medicaid mom and family on unmet health-related needs. We also collaborate with Nurse Family Partnership to introduce new moms to extended supports and services where available. ***SisterFriends:*** SisterFriends is a health disparity intervention designed to address unmet health-related needs. Volunteer mentors called SisterFriends provide support and care for pregnant moms and help moms ("Little Sisters") overcome obstacles to accessing existing perinatal care services. SisterFriends also provides a comprehensive assessment for unmet health-related needs and whether a woman needs referral for mental health or substance use services.
Innovative Quality Improvement Interventions	***Enrollee outreach:*** The health plan offers individuals in-home visits as an alternative to office visits for enrollees residing in the Wayne, Oakland and Macomb counties. Additionally, **they provide** added educational phone calls to African-American women in Region 10 during the postpartum period. ***Complex care management*** of pregnant enrollees to outreach and educate on the importance of postpartum care and focused care coordination for newborns in low

Example #1: State of Michigan	
	performing geographical areas. ***Taxi rides*** so new mothers do not need to take bus transportation. ***Provider outreach:*** We schedule in-office visits with large volume OB/GYN providers to educate on incremental billing, adherence to ACOG guidelines for timing of postpartum visit and solicit support for enrollee outreach and education. We collaborate with the Michigan Maternal Infant Health Program — Michigan's largest, evidence-based home visitation program for Medicaid eligible pregnant women and infants — to follow up with enrollees in the home with education on timely postpartum care. ***Community Boards:*** We are currently participating on the Macomb County Nurse Family Partnership Community Board, an evidence-based home visiting program, to increase referrals and thus introduce new moms to the extended support available.
Overall Impact of the QI/ Performance Improvement Plan (PIP)	Due to interventions such as those described previously that take into consideration unmet resources needs, UnitedHealthcare of Michigan has improved their rates of postpartum care 2016-2018 by 15 percentage points.

Example #2: State of Maryland	
Unmet Resource Need	For our Maryland health plan, patterns in postpartum care were tied to infant mortality rates. Postpartum care was selected based upon the results of an analysis of individuals who delivered in 2016. The data points used for analysis were race/ethnicity and county.
Data Used, Data, Metrics Collected	The Maryland plan conducted an analysis of enrollees who delivered in 2016 by race/ethnicity, county and ZIP code. The Index of Disparity was evaluated by sub-populations against the performance goal of 74%. Though no sub-population met the interim performance goal, the recommended postpartum care and care for infant enrollees in the first several months of life may help reduce the likelihood of adverse outcomes.
Health Disparity Identified	Partnering with CHWs can gain the trust of pregnant women at high-risk of delivering premature or underweight babies, a risk factor for infant mortality. Those who care for the high-risk women will be incented if the women reach predetermined goals, such as delivering a healthy weight baby, having stable housing or enrolling their children in enrichment programs, known to reduce their risk of bad health outcomes. The index of disparity was evaluated by sub-populations against the performance goal of 74%. The index of disparity was less than 5 percentage points. The populations experiencing the highest disparity in postpartum care are African-American women.
Health Disparity Reduction Goals	To collaborate with community-based organizations on developing processes to increase the number of African-American mothers completing their postpartum visit in Prince George's (PG) County from baseline percentage of 51% to the performance goal of 74%.
Data Source to Identify Health Disparity	We use HEDIS claims and gap data; claims data to identify deliveries; race/ethnicity data and county of residency data provided from state enrollment files; infant mortality data from the Maryland Governor's Office for Children.
Population Assessment	We found that African-American enrollees living in PG County had some of the lowest postpartum. Infant mortality rates in PG County are among the highest in the country. In Maryland, the statewide infant mortality rate is 6.7:1,000. In PG County, the infant mortality rate is 8.9:1,000, but for African-American enrollees in PG County it is 13:1,000. In 2016, there were 93 fetal deaths and 47 infant deaths in PG County. These statistics highlight disparities, which affect African-American women and infants in higher proportions.

Example #2: State of Maryland	
Collaboration Strategies with State and Local Agencies	This project developed collaboration between the PG's health department and our Healthy First Steps maternal health coordinator to expand outreach and referrals between our organizations. The targeted population is African-American mothers who reside in PG County's hot spot ZIP codes.
Innovative Quality Improvement Interventions	***Healthy First Steps:*** African-American enrollees identified as having a high-risk pregnancy are risk stratified as intensive and placed in high-risk care management. Once engaged, the care coordinator contacts these individuals twice monthly, with a goal of quarterly in-person visits, to build trust and verify that we are meeting the enrollee's needs. After delivery, the care coordinator does a "warm handoff" to the CHW to engage the enrollee through the first year of the infant's life to confirm access to needed services that improve health outcomes. ***Baby Showers:*** The Maryland health plan successfully hosted two Baby Showers at farmer's markets in the border areas between counties known for their multicultural demographic demonstrated through market analysis. This outreach activity will continue. ***Partnering with Providers:*** We are collaborating with Optum Home Care to identify early those individuals who need high-risk intervention along with the Maryland maternal child-health program manager and nurse representatives from this program to work with high-volume provider practices. Our goal is to improve linkages to the medical home for our high-risk individuals and increase referrals to our care coordinator program. We are targeting select high-volume practices in PG County as priority practices.
Overall Impact of the QI/PIP	In calendar year 2017, our Healthy First Steps program helped to decreased NICU admissions and premature birth rates from 2016 rates for African American infants. However, our HEDIS 2018 results reached 66.42%, falling slightly short of the goal. We will continue to analyze opportunities for targeted interventions based upon identified disparities.

We are using our national experience in health disparities to develop and implement a focused plan for Kentucky tailored to the people we serve based upon Kentucky public health data and data on our enrollees' unmet physical, behavioral health and social needs and gaps in care.

iv. Internal tools and technology infrastructure the Vendor will use to support improvements in health outcomes and to identify, analyze, track, and improve quality and performance metrics as well as the quality of services provided by Network Providers at the regional and statewide levels.

To drive clinical and operational performance improvement, our QAPI will incorporate ongoing monitoring of critical quality indicators, formal performance improvement plans (PIPs), and CQI initiatives and improvement action plans in compliance with federal and state regulations and NCQA health-plan accreditation standards.

Kentucky Quality Program Tools	Description
Quality Assessment and Performance Improvement Plan (QAPI)	The QAPI will delineate planned PIPs and other ways we intend to improve quality over the coming year. In addition to the prior year's evaluation findings, throughout the year we use multiple inputs into our QAPI, including benchmarking done by our QIC, stakeholder feedback from our PAC and QMAC, survey results and regional public health data. Scorecards capturing this data over time and comparing our performance against internal, state and national benchmarks and Kentucky performance goals are key tools in helping us drive CQI. We use established, evidence-based, standardized approaches for quality evaluation and improvement as tools in our program (e.g., Plan-Do-Study-Act [PDSA], Rapid Cycle Improvement, Lean and Six Sigma).
Quality Management Program Description (QMPD)	Kentucky leaders will set short- and long-term performance goals aligned with the DMS's quality strategy aims, goals and objectives and our UnitedHealthcare strategic plan. We document this structure in our annual QMPD, which we use to create our Quality Improvement Work Plan (QIWP).
Quality Improvement Work Plan (QIWP)	The QIWP is an important tool that establishes expectations for interdepartmental participation and coordination and the key quality measures for monitoring and improvement.
Quality Management Program Evaluation (QMPE)	Each year, we conduct an annual evaluation (QMPE) of the prior year's QAPI. This allows us to understand our successes and our ongoing opportunities for improvement. Opportunities identified during the evaluation are then documented on the following year's QIWP, enabling continuous improvement for our quality program and strategy overall.
Performance Improvement Plans (PIPs)	We deploy PIPs that address the entire plan population or a targeted populations or individuals with special health care needs. We will maintain a minimum of three PIPs (two clinical) annually targeted at the Commonwealth's objectives, upon approval by DMS. Based upon our understanding of the needs of Medicaid beneficiaries in Kentucky, we will initially focus on diabetes prevention and obesity, behavioral health integration and Care Needs Assessment completion. These are areas affected by race, ethnicity, language disparities and regional variations and as such, we will monitor disparity data and develop targeted interventions for subgroups as needed.

> In 2019, we will complete 45 Medicaid/CHIP health plan HEDIS submissions, 71 commercial submissions, four Marketplace submissions and 163 Medicare submissions.

Our innovative national data management systems and local customized data management processes identify, analyze and track data to improve quality, performance metrics and the quality of services delivered by providers. These systems and processes increase our capture of claims, medical records and other types of supplemental data (e.g., Kentucky Health Information Exchange [KHIE] immunization registry, *americashealthrankings.org*), which improves our analytical capability in support of our quality performance improvement process and incentives program. By matching data from our data warehouse with gaps in care identified by our NCQA-certified software, have the ability to analyze quality data by a multitude of variables (e.g., age, gender, race, religion, geography, diagnosis, comorbid diagnoses).

We generate HEDIS, EPSDT, CMS Core Measures and state custom measures using NCQA-certified software, which provides us with **bimonthly and ad hoc reports to support CQI programs**, and our annual, certified results, validated by the external HEDIS compliance

auditor. Monthly analysis of our performance provides us with the opportunity to participate in clinical studies, implement changes and to assess the quality and appropriateness of care provided to enrollees regularly. In addition, we use the following tools and technology to capture, process and ultimately incorporate supplemental data sources into our quality measure rates and create meaningful tools to inform or identify opportunities in clinical quality performance and management:

Internal Technology	Description
ICD-10 Codes for Social Determinants of Health (SDOH)	UnitedHealthcare partnered with NCQA and the National Association of Community Health Centers to implement diagnostic codes for services that target the SDOH. One of the key barriers to expanding access to nonmedical care for social needs is a lack of coding standardization. In response, we have started to roll out new ICD-10 codes that providers can use to document these needs. Our newly announced collaboration with the American Medical Association (AMA) continues to build on these efforts. We are working with AMA to standardize how data is collected, processed and integrated for social and environmental factors contributing to an enrollee's well-being. We are also working with CMS and CDC to facilitate the nationwide adoption of ICD-10 codes. Capturing this rich data on SDOH in claims will allow us to incorporate enrollees' social needs into our QI initiatives.
Admission, Discharge or Transfer (ADT) Feeds	We use ADT feeds to understand an enrollee's history of admissions that indicate their risk level and to identify opportunities for individualized support. In Colorado and Virginia, we use real-time ADT to alert a care coordinator supporting a previously identified high-risk individual about a pattern of ED visits. This allows the care coordinator to reach out as soon as possible to understand if the enrollee's needs could be better addressed through urgent care or their PCP. In some cases, the care coordinator has physically met with the enrollee while they are still in the ED to talk in person, and identify appropriate treatment and care for their situation.
UnitedHealthcare Pre/Post Report	This provides clinical and financial leadership insight into the performance of our clinical programs and the expense and utilization profiles of individuals who enroll in these programs. It summarizes enrollees' expenses and utilization before and after enrolling in clinical programs and assesses program effectiveness by comparing the observed changes to control groups. Data is provided at the month and category of service level enabling detailed insight into the claims patterns that result in eligibility for various programs and how patterns evolve with and without intervention.
ClaimSphere	Our NCQA-certified HEDIS reporting engine enables us to capture data from multiple sources to improve enrollee care by enabling receipt of real-time clinical data and feeding clinical workflows expansion of electronic medical record (EMR) integration. ClaimSphere directly integrates with our claims administration system enabling the use of pre-adjudicated claims and helping to more quickly identify and incorporate data into reporting and outreach activities.
Verato	Verato provides referential matching, which improves our ability to match lab, supplemental and historical data to our enrollee populations, improving the accuracy of our HEDIS reporting and individual targeted outreach strategies. Implementation of this technology in similar states has led to HEDIS rate improvement by more holistically capturing clinical events.
Provider Registry and Portal	Our Provider Registry and portal supports providers by sharing population-based and individualized clinical and quality information. Users will be able to monitor gaps, receive admission and discharge notifications, and extract relevant supplemental data from the practice's EMR and upload that data to the registry to reflect gap closure.
Kentucky Health Information Exchange (KHIE)	We are currently engaged to support both KHIE and our providers (e.g., KPCA and their system CHARLI) by investigating ways to exchange data to support better enrollee outcomes. These discussions have explored the availability of ADT and CCD

Internal Technology	Description
	summaries to engage care coordination, immunization history and explore the future collection of SDOH.
Electronic Health Record	The electronic health record (EHR) helps providers move along the continuum from basic transactional/look-up capabilities on our provider portal, to becoming an active participant in HIE and VBP initiatives. Implementing an integrated EHR with easy-to-use, effective tools automates administrative tasks such as eligibility, financial assessment and billing, while enhancing enrollee care. The EHR also allows providers to upload records with data, decreasing the need for on-site record review, ongoing data capture for identifying open and recently closed gaps in care, and identifying providers that may need more support to improve enrollees' outcomes.
Lab Gateway	We support Lab Gateway through our ongoing work with provider groups and national, regional and local lab vendors to collect and house laboratory data and results not captured through claims. We receive data from contracted provider groups and labs at least monthly, consisting of lab data matched to individual demographics provided in the data record. We validate the data and enrollee eligibility confirmation, standardized code submission and data record legibility before it is stored in the enterprise data warehouse.
Clinical Services Quality of Care Monitoring	Our clinical services quality of care department monitors quality of care complaints and referrals. Participating physicians, other health care professionals and facilities are continuously monitored for complaints and adverse events. Additionally, physicians and other health care professionals are monitored at least semi-annually for national and local trends in complaints and/or adverse events.

v. Methods to ensure a data-driven, outcomes-based continuous quality improvement process, including an overview of data that is shared with providers to support their understanding of progress in achieving improved outcomes.

To validate a data-driven, outcomes-based CQI process, we begin by first developing quality goals based upon state and national benchmarks, Commonwealth requirements and meaningful improvement and then using our partnerships with local providers to share data to achieve better health care outcomes for enrollees. We identify opportunities for improvement through ongoing monitoring of key quality of care or service indicators that include access to and availability of care, enrollee safety issues and outcomes, utilization data, clinical quality performance measures, enrollee and provider surveys, enrollee complaints and appeals, enrollee input from our QMAC, and provider input from our PAC.

Data is at the core of our QAPI, and we use it to monitor and improve quality of care and health care outcomes, and to reduce or eliminate health disparities. By routinely analyzing key indicators that measure the processes and outcomes of care rendered to our enrollees, we identify where we should focus improvement efforts. If a key quality indicator does not meet our performance expectations, we employ a variety of rigorous methods to drive improvement. Following is an overview of data we track and trend to improve people's lives:

Data Collection Method	Description
Retrospective Reporting	We use our NCQA-certified HEDIS engine to generate our retrospective results annually. We partner with our certified HEDIS auditor to ensure our success in the generation of HEDIS rates that pass auditor review. We assess the final rates to determine where performance has improved, declined or plateaued. That information is reported to the QIC and informs the QI Work Plan and Evaluation.
Performance Monitoring	The QAPI team has access to reports that are updated at least twice a month with year-to-date performance on HEDIS and Commonwealth custom measures. We can view performance at not only the product or reporting population level, but

Data Collection Method	Description
	also by a variety of membership segments such as geography (e.g., rural areas), gender, age and race-ethnicity.
Enrollee-level Information	ClaimSphere software identifies enrollees who have gaps in care. We use this information for direct outreach activities to set up a needed appointment or support enrollee incentive programs.
Provider Reporting	Provider performance reports that include the practice's enrollees with care gaps are generated twice a month. Providers can access these reports through our online provider portal, *Link*. Our provider quality engagement consultants (PQECs) visit larger practices, review these reports with the staff and collaborate to close those gaps.
Strategic Management Analytic Reporting Tool (SMART)	The SMART data warehouse and analytics toolset contains claims information, enrollee data, provider data, authorizations, external subcontractor data and predictive modeling information. SMART captures information, including geographic information, diagnosis and level of care, disease management categorizations, provider contracts, revenue capitation by rate cell, claims/encounters for each service category, service authorizations, actuarial reserving completion factors and risk stratification scores by enrollee. We feed SMART data into our HEDIS rules engine and the results are fed back into SMART to enable more comprehensive assessments of performance.
Key Member Indicator Survey (KMI)	The key member indicators (KMI) enrollee survey tool provides monthly enrollee feedback on their experiences with UnitedHealthcare. It measures key "CAHPS-like" metrics to monitor affect, identify drivers of satisfaction and inform decision-making and improvement planning. The KMI program is a tracking survey conducted among enrollees/caregivers by a live telephone representative. Close data analysis helps us determine the percentage of people who are highly likely to recommend us.
Comparative Market Analysis and Reporting Tool (CMART)	CMART provides reporting on information needed to monitor and compare the performance of health plan goals and industry benchmarks, allowing us to drive value and quality-based decisions with accurate information.
CAHPS	We conduct the CAHPS enrollee survey yearly by a certified vendor and measure the enrollees' experiences with UnitedHealthcare during the prior 6 months. The CAHPS survey team analyzes and trends the results annually with review by the QIC to identify trends, opportunities for improvement and to make recommendations to improve enrollee experiences.
United Consumer Engagement Engine (UCEE)	The UCEE is a data engine used to house and track all enrollee touchpoints for quality programs. This includes data that are sent to a vendor or internal department to deploy a program and the outcomes of the program for an individual enrollee. The data can be used to orchestrate when and how an enrollee is reached out to, based upon outcomes and when they received outreach from the health plan for other quality programs. This allows us to be innovative in the hierarchy of programs and enrollee outreach to change behavior keeping enrollee abrasion to a minimum.
Enrollee Grievances and Appeals Data	We review and analyze complaint, grievance and appeal data to monitor, evaluate and effectively resolve enrollee concerns timely. We will use this data to identify opportunities for improvement in the quality of care and service provided to Kentucky Medicaid enrollees and to identify opportunities for improvement in our process. Data related to quality of care, quality of service, enrollee experience and administrative issues are collected, reviewed and trended to identify improvement opportunities.

Sharing Data with Providers

COLLABORATE

To strengthen our provider relationships further, we have a Provider Quality Engagement Consultants (PQECs) program, which includes a team responsible for fostering clinically oriented provider- and community-based partnerships. Experienced field-based professionals work directly with provider offices in Kentucky to build strong relationships with office staff. By using performance-based data and analytics, our PQECs focus on identifying and closing the maximum number of enrollee care gaps possible, leading to positive community health outcomes, generating increased year-over-year performance results and creating a sustainable population health impact. Our PQECs work directly with providers to improve their performance in clinical performance metrics, clinical care and service. Our PQECs reinforce our local presence and partnership approach to building trust and understanding between providers and our program administration staff and serve as a means of providing bidirectional feedback. Our PQECs use care gap data to identify network needs or potential network gaps that they can address. The PQECs use utilization data to tailor innovative network delivery solutions, such as telehealth (including telemental services), and use of mobile services to enhance access to services and close care gaps.

> **Provider Quality Engagement Consultants Story**
> "Our clinical background as nurses allows us to use a professional approach to patient care while representing UnitedHealthcare. The relationship is based upon lending a helping hand to the providers to meet their regulatory HEDIS obligations while encouraging their goal of the best patient care and preventive approach to wellness. It is a challenging assignment that is measured by closing gaps in care, providing healthy choices for individuals, and making the provider a partner in 'helping people live healthier lives.'" – Kathleen Grimm, RN, BA-HCA, Medicaid PQECs, South Florida

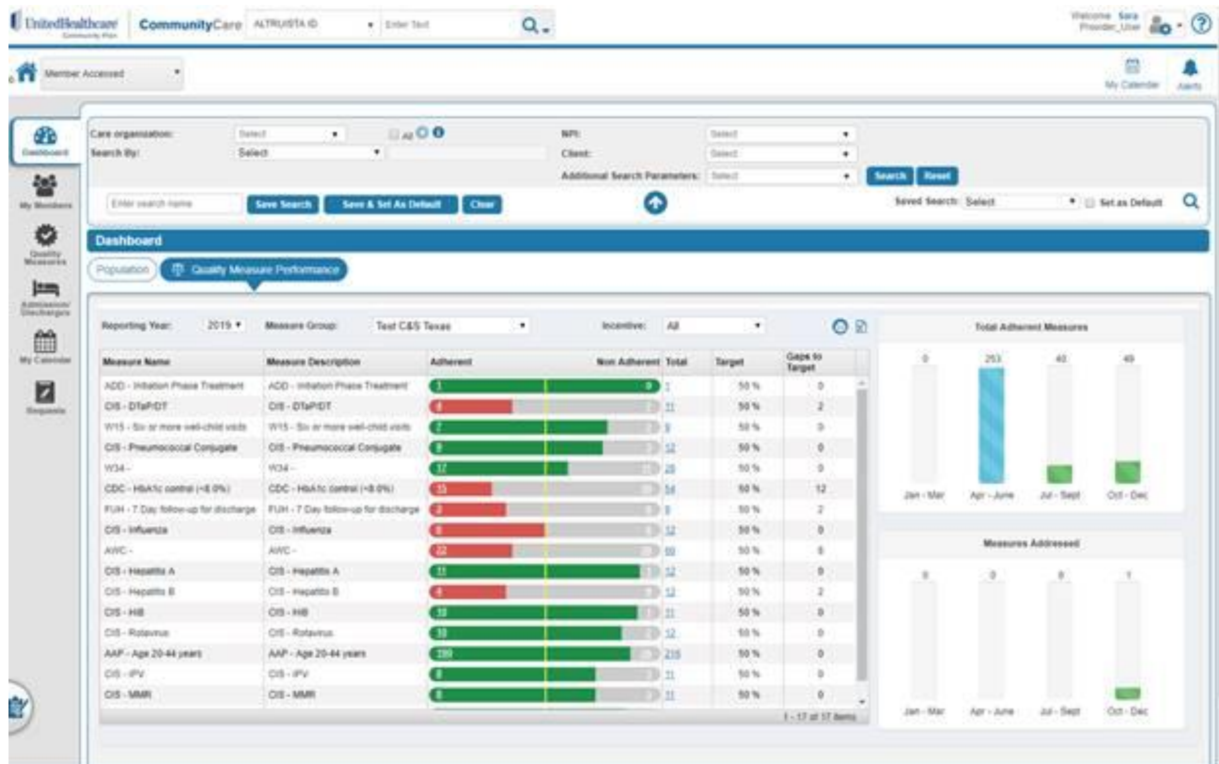


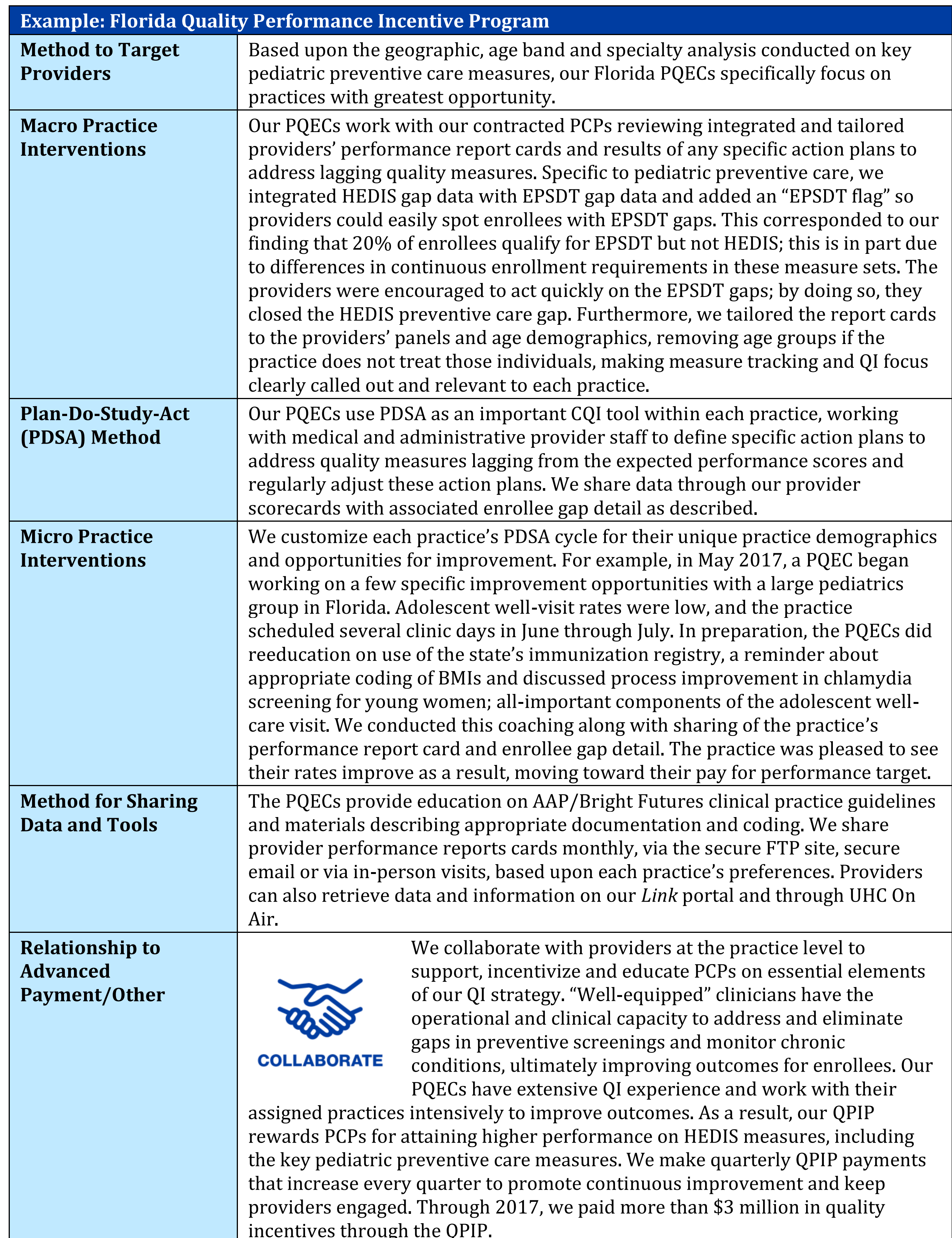
Figure 3. Quality Measures Dashboard. The dashboard provides summary scorecard of performance against HEDIS measures with quick-access links to identify those UnitedHealthcare enrollees in the provider's panel who have gaps in care.

Practitioner Performance Reports with ***Quality Measure Dashboards*** are important components of our integrated quality program. We use the captured data and analytics as key mechanisms to inform our QI initiatives for each population in each region. To simplify these reports for providers, our PQECs provide and explain the performance reports to providers through on-site visits and virtual support. During the interactions with the provider, the PQECs review performance on quality and incentive measures, gaps in care, utilization of services and suggest ways to improve their practice results. This support helps drive the activities that will improve quality, reduce avoidable health care cost and subsequently trigger incentive payments within various VBP and other shared saving payment models to enable provider success. In addition, the PQECs meet with the practitioner and office staff to review overall performance to improve the practice's processes, including addressing relevant clinical practice guidelines, use of online support tools (e.g., provider portal data, *UHCCareConnect* and Patient Care Opportunity Report [PCOR]), medical record documentation and coding.

Education on our easy to use provider focused online tools will further assist the provider in their understanding of progress in achieving enrollee's improved health outcomes:

Tool	Description	Use
Provider Portal Data	The secure provider portal is populated with information relative to individual enrollees' compliance with preventive health guidelines and the physician's experience. This information will be available on demand and updated regularly with claims.	We use our provider portal, *Link*, as a flexible, dynamic ongoing training tool to help transform care delivery and strengthen communication with dispersed providers and our field-based care teams.
UHCCareConnect	*UHCCareConnect* is an online tool that helps providers identify, address and manage open care gaps for enrollees. *UHCCareConnect* allows providers to submit supplemental data by uploading structured/computable data exchange.	Data submitted will close care gaps and will be reflected in the PCOR. *UHCCareConnect* can also assist providers in identifying enrollees who have had a recent hospital stay so they can provide appropriate and timely post-discharge care.
Patient Care Opportunity Report (PCOR)	The PCOR assists providers in identifying enrollees who have open care gaps related to preventive health care. The opportunities align with HEDIS performance measures and Kentucky custom measures. Addressing care gaps will help providers to achieve positive health outcomes for enrollees.	The PCOR offers current, at-a-glance information about open care gaps for our plan enrollees such as cancer screenings and immunizations. The report is based upon claims data and electronic medical record documentation from our enrollees' health care providers.

An example of the success of our PQEC program and the tools supported pediatric practices in Florida in improving outcomes. As part of our Florida QI initiatives focused on pediatric preventive care and our formal PIP, we collaborated with lower performing FQHCs and PCPs by sharing specific member level detail that enabled them to conduct targeted outreach and engagement to over 18,000 enrollees ages 10 and older in need of pediatric preventive care. The result was a **20% increase in enrollee outreach volume**. The PQECs educate and train administrative and clinical staff in more effective and efficient QI processes and then link this education back to PIPs and initiatives underway at the health plan. A key lever in this outreach campaign was our Florida Quality Performance Incentive Program (QPIP) pay-for-performance program, which incorporates pediatric preventive health measures and components and offers providers quarterly incentive payments for incremental improvement.



Example: Florida Quality Performance Incentive Program	
Method to Target Providers	Based upon the geographic, age band and specialty analysis conducted on key pediatric preventive care measures, our Florida PQECs specifically focus on practices with greatest opportunity.
Macro Practice Interventions	Our PQECs work with our contracted PCPs reviewing integrated and tailored providers' performance report cards and results of any specific action plans to address lagging quality measures. Specific to pediatric preventive care, we integrated HEDIS gap data with EPSDT gap data and added an "EPSDT flag" so providers could easily spot enrollees with EPSDT gaps. This corresponded to our finding that 20% of enrollees qualify for EPSDT but not HEDIS; this is in part due to differences in continuous enrollment requirements in these measure sets. The providers were encouraged to act quickly on the EPSDT gaps; by doing so, they closed the HEDIS preventive care gap. Furthermore, we tailored the report cards to the providers' panels and age demographics, removing age groups if the practice does not treat those individuals, making measure tracking and QI focus clearly called out and relevant to each practice.
Plan-Do-Study-Act (PDSA) Method	Our PQECs use PDSA as an important CQI tool within each practice, working with medical and administrative provider staff to define specific action plans to address quality measures lagging from the expected performance scores and regularly adjust these action plans. We share data through our provider scorecards with associated enrollee gap detail as described.
Micro Practice Interventions	We customize each practice's PDSA cycle for their unique practice demographics and opportunities for improvement. For example, in May 2017, a PQEC began working on a few specific improvement opportunities with a large pediatrics group in Florida. Adolescent well-visit rates were low, and the practice scheduled several clinic days in June through July. In preparation, the PQECs did reeducation on use of the state's immunization registry, a reminder about appropriate coding of BMIs and discussed process improvement in chlamydia screening for young women; all-important components of the adolescent well-care visit. We conducted this coaching along with sharing of the practice's performance report card and enrollee gap detail. The practice was pleased to see their rates improve as a result, moving toward their pay for performance target.
Method for Sharing Data and Tools	The PQECs provide education on AAP/Bright Futures clinical practice guidelines and materials describing appropriate documentation and coding. We share provider performance reports cards monthly, via the secure FTP site, secure email or via in-person visits, based upon each practice's preferences. Providers can also retrieve data and information on our *Link* portal and through UHC On Air.
Relationship to Advanced Payment/Other	COLLABORATE We collaborate with providers at the practice level to support, incentivize and educate PCPs on essential elements of our QI strategy. "Well-equipped" clinicians have the operational and clinical capacity to address and eliminate gaps in preventive screenings and monitor chronic conditions, ultimately improving outcomes for enrollees. Our PQECs have extensive QI experience and work with their assigned practices intensively to improve outcomes. As a result, our QPIP rewards PCPs for attaining higher performance on HEDIS measures, including the key pediatric preventive care measures. We make quarterly QPIP payments that increase every quarter to promote continuous improvement and keep providers engaged. Through 2017, we paid more than $3 million in quality incentives through the QPIP.

b. Indicate if the Vendor has received NCQA accreditation for the Kentucky Medicaid market, and if not, the proposed timeline for achieving accreditation.

We do not yet hold NCQA accreditation for a Medicaid product in Kentucky, but we will be accredited within 22 months following contract award. We also currently hold NCQA accreditation for six health plans operating within the Commonwealth. We have three Commercial plans holding Accredited NCQA status and three Medicare contracts holding Commendable NCQA accreditation. We have consistently achieved and maintained NCQA Accreditation for the Medicaid health plans we serve in other states. We have based commitments to quality management and performance in every aspect of our business by anchoring quality standards to our corporate values of *Integrity, Compassion, Relationships, Innovation and Performance*. Because we have experience obtaining NCQA accreditation, we have an established approach to quality that demonstrates achievement of plan requirements, documented processes and an operational infrastructure of continuous compliance, and in compliance with Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 19.1 NCQA Accreditation. Our timeline outlines the proposed schedule for achieving NCQA accreditation for the Kentucky MCO.

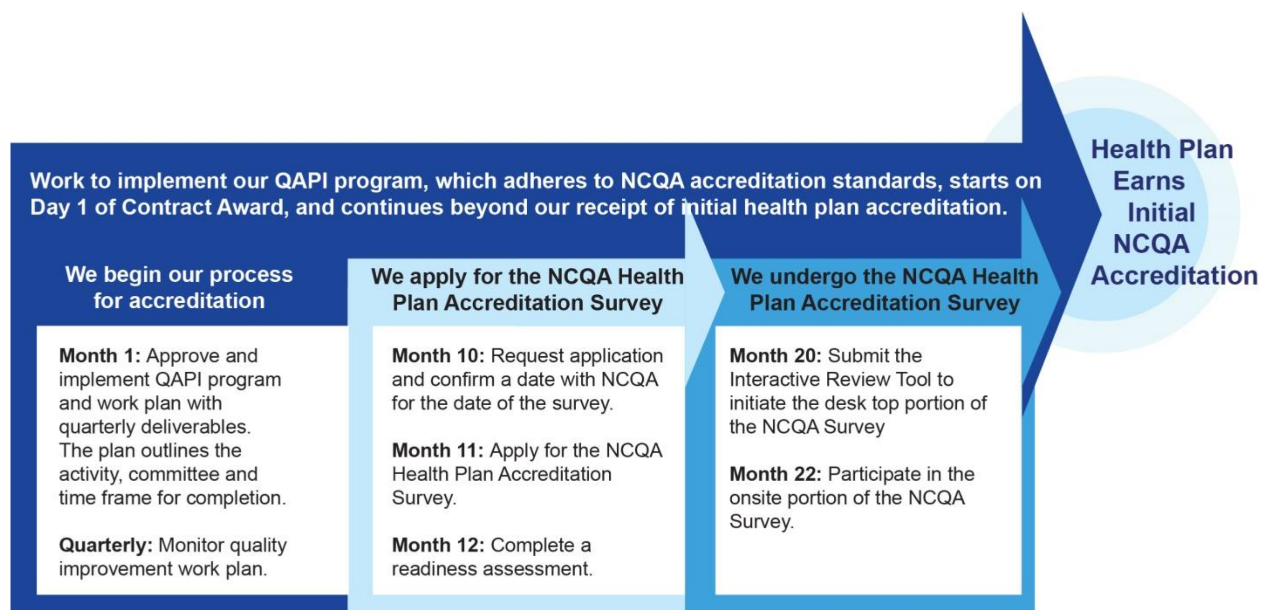


Figure 4. Our proven, streamlined flow of our proposed NCQA accreditation for the Kentucky MCO.

c. Provide the Vendor's proposed use of the Quality Improvement Committee (QIC) to improve the Kentucky Medicaid managed care program.

The UnitedHealthcare will use a comprehensive and integrated approach to quality management in Kentucky, including both local and national committees and resources, incorporating physical and behavioral programs together in CQI processes. As such, we benefit from the considerable resources and expertise of our national organization, while focusing those resources at the local level through deployment of a quality management structure and oversight by Kentucky experts in population health and quality management. This blend of local expertise and national resources can be seen in the interdisciplinary QAPI structure and committee functions. The QIC is chaired by the Kentucky CMO Jeb Teichman and is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all QI activities for the health plan. The QIC comprises the Kentucky health plan CMO, our quality improvement director, and will include medical and behavioral health clinical

staff and operational leaders from all areas of UnitedHealthcare, both locally and nationally making certain that we benefit from the bench strength of the entire enterprise while maintaining a focus on local needs and priorities.

Regular presentations to our QIC helps evaluate and drive performance measure improvements. This oversight process is led by expert clinical staff on a committee chaired by the CMO, and it includes implementation of rapid-cycle changes to interventions using PDSA processes. The QIC will prioritize, plan and allocate appropriate resources to continue or modify improvement efforts for each selected metric, and can reference best practices across 31 Medicaid plans. The QIC will annually provide a review of completed and continuing QI activities, corrective action plans, trending measures, recommendations or suggested modifications to DMS. Our local and national teams work together to develop new interventions or recommend eliminating ineffective programs. The QIC will improve the Kentucky Medicaid managed care program by:

- Providing program direction, oversight and evaluation of QI activities as related to the unique needs of the enrollees and providers in the areas of clinical care, behavioral health, service, enrollee safety, administrative processes, compliance and network credentialing and recredentialing.
- Maintaining records that document the QIC's activities, meeting minutes, findings, recommendations, actions and results. Records will be available for review upon request, during the annual on-site External Quality Review Organization (EQRO) review, and/or for NCQA accreditation review.
- Overseeing and approving the annual QI Program Description, Work Plan (reviewing at least quarterly) and Annual Evaluation.
- Evaluating annually the effectiveness of Medicaid specific PIPs and recommending any needed changes for improvement.
- Reporting on health plan quality activities annually or more frequently as needed.
- Reviewing and accepting decisions of the National Quality Oversight Committee and offering feedback as appropriate.
- Reviewing reports and recommendations from other national and health plan QI subcommittees, acting upon recommendations as appropriate and providing feedback, follow up and direction to the committees.
- Monitoring compliance with regulatory requirements and accrediting organizations.
- Providing local delegation oversight as specified by regulatory requirements.
- Recommending appropriate resources in support of Kentucky prioritized activities.
- Overseeing the PAC, HQUM Committee, SQIS and QMAC and using collected input to improve processes.
- Reporting trends, progress and results to our CEO, Amy Johnston Little and our UnitedHealthcare Community Plan Medicaid Advisory Board.

In our Tennessee health plan, our comprehensive and integrated QIC process was the foundation for the success of a PIP around improving EPSDT screenings. The QIC aided in everything from the root cause analysis to facilitating the intervention selection process driving the PIP, and successfully improving screening rates. Using month-long screening campaigns instead of 1-day screenings proved to be beneficial to the state, and they discontinued a contract risk-adjustment requirement to conduct 150 community outreach events per quarter and implemented requirements about provider-based screening campaigns for all TennCare MCOs. The QIC created a monthly workgroup with all of the state MCOs and the FQHCs in

Tennessee. While the focus was initially on EPSDT, it expanded to other areas such as OUD and diabetes.

d. Provide the Vendor's proposed use of the Quality and Member Access Committee (QMAC) to improve the Kentucky Medicaid managed care program, including the following information:

i. Proposed stakeholder representation.

ii. Innovative strategies the Vendor will use to encourage Enrollee participation.

iii. Examples of successful strategies the Vendor has implemented to obtain active participation in similar committees.

To empower and provide quality care to enrollees, we work with local Kentucky influencers (e.g., advocacy groups, CHWs and Application Assisters) to identify and engage with stakeholders to gain insight for operational change and improvement; and guidance for the design and benefit structures of our programs. We will benefit from the trusted relationships that CHWs and Application Assisters in Kentucky have established within their local communities and will enlist their input through quarterly meetings, enrollee surveys, grievance investigations and participation of family members on various boards and in community partner meetings. We recognize the importance of collaborating with stakeholders to address the changing mix of services needed by our enrollees. Our QMAC helps facilitate a collaborative dialogue between us and our enrollees and providers to make sure we understand what is working well in the program and what needs improvement. Our board's structure provides enrollees and family representatives the opportunity to discuss and direct the Kentucky MCO program in many ways, including:

- Allow enrollees to provide input into the planning and delivery of services
- Provide input QI activities, program monitoring and evaluation and any policies that may affect the enrollee
- Provide the health plan with perspective on enrollee materials and how to educate the community and enrollees on Medicaid basic benefits and value-added benefits
- Provide input on the grievance and appeals process and policy modifications based upon review of aggregate grievance and appeals data
- Gather recommendations on providing health and wellness education to the community and enrollees (e.g., *Member Handbook*)
- Recommend community outreach activities
- Obtain feedback on how best to remind enrollees of their rights and responsibilities
- Empower individuals, agencies and community members to engage with the enrollee's health care by having their voices heard
- Allow us to be proactive toward learning about the health care challenges our agencies, community members and enrollees face with the delivery of health care
- Provide an environment for open and honest communications
- Provide a venue for presenters to speak to agencies, community members and enrollees on specific health care topics

We consider feedback and share information from the QMAC at our internal leadership meetings and quality management meetings to make leadership and staff members aware of policies or operational issues raised during the board meetings.

Stakeholder Representation

The QMAC participants will include enrollees; family members/enrollee representatives or caregivers; Kentucky oversight representatives; providers; community groups and advocates; Commonwealth agencies; protective services; social service providers; and health plan representatives. We will intentionally identify a broad spectrum of participates to make sure representation that is diverse and culturally reflective of our enrollees and the Commonwealth. Participants are attending in a professional capacity and therefore enrollees and enrollee representatives are compensated through a $50 stipend. Board member mileage is reimbursed to verify participation is supported and barriers to attendance are alleviated. We hold meetings quarterly, and committee members determine the location of meetings to promote maximum attendance and participation in our respective service areas.

Innovative Strategies to Encourage Enrollee Participation

To encourage broad participation from our enrollees, we attempt to eliminate potential barriers, such as facility accessibility for persons with disabilities, phone accessibility, transportation issues and convenient meeting times to create a welcoming environment. To reduce these barriers and promote maximum attendance for the Kentucky QMAC, we will implement the following initiatives:

- Participants determine the locations of the quarterly meetings.
- We coordinate transportation for enrollees with difficulties securing transportation to the meetings, including the transportation expense.
- We reimburse enrollee and enrollee representative mileage.
- We provide interpreters and materials in alternative formats.
- We provide personal care and childcare assistance, in addition to respite care.
- Participants are attending in a professional capacity and are compensated through a $50 stipend.

We have successfully implemented similar strategies to encourage active participation with populations much like those in Kentucky. As an example, we offered QMAC meetings simultaneously in several counties with the largest populations and connected all stakeholders virtually to allow higher attendance from multiple locations (including rural areas) in the state at one time. Virtual attendees called in by telephone enabling enrollees who could not attend these sites in person to be able to be part of the meeting. Based upon the success of this approach, we will replicate this strategy for our Kentucky QMAC participants. We also will pursue extension offices, community organizations and provider partner sites as venues for these meetings in an effort to remove barriers, such as transportation.

In our Tennessee and Iowa health plans, we have successfully implemented two new methods to encourage enrollee participation, which we will bring to our Kentucky enrollees. We will evaluate times for meetings and offer participating enrollees a light meal when meeting times that coincide with lunch or dinner. We also will move the meeting venue to different locations across the state (in both rural and metro locations) to reach even more enrollees.

e. Provide a comprehensive description of the Vendor's proposed Quality Assessment and Performance Improvement (QAPI) Program that meets all requirements of this Contract.

Our QAPI program is tailored for Kentucky, using comprehensive population health analytics to identify trends, develop population-specific plans and apply individualized interventions, while monitoring the quality of care and service delivered statewide. The Kentucky QAPI is designed in compliance with the requirements of 42 C.F.R. 438.330 and Attachment C – Draft Medicaid

Managed Care Contract and Appendices, Section 19.3 QAPI Program and focuses on physical and behavioral health outcomes, health improvement and health-related social needs. Our integrated and cross-functional Kentucky QIC establishes the QAPI priorities, goals and objectives, under the direction of co-chairs Amy Johnston Little, CEO, and Jeb Teichman, CMO, in conjunction with our locally based QAPI team, integrating all departments, including local providers and subcontractors.

To make certain we bring the best practices into Kentucky and benefit from our national experience, we partner our local team with our national support. The QIC, regional QMACs and PACs, and the DVOC routinely review performance on quality measures. The QMAC, PAC and DVOC reviews are critical to verify their perspectives are taken into account when planning and assessing QI opportunities and interventions as related to the QAPI program. We also will obtain feedback from other MCOs, through future meetings with our partners in DMS, MCOs and providers. All committee input, response, conduct of performance improvement activities, and feedback to enrollees, providers and subcontractors is documented and available to DMS or its contracted EQRO upon request.

Integration to Improve Quality of Care

Integrated care is foundational to our QAPI. Enrollees with medical and behavioral needs, including SUD, often have poor health outcomes because their conditions are not treated holistically. Our commitment to medical and behavioral integration is evident in how we work with our enrollees and providers. We do this by developing interventions that address all aspects of the enrollee's care, developing PIPs that address both medical and behavioral health topics, developing VBP programs that include both medical and behavioral incentives, and continuously tracking outcomes based upon the whole person and not only one area of focus.

We incorporate ongoing monitoring of critical quality indicators, PIPs, ongoing application of rapid cycle improvement and PDSA methods, and compliance with federal and state regulations and NCQA health-plan accreditation standards. Our Kentucky leaders will set short- and long-term performance goals and our quality team will assist them in benchmarking our performance against state and national rates. Our Kentucky QIC will measure our successes through analysis of industry-standard measures of health plan quality, including, but not limited to, HEDIS and CAHPS measures, CMS Adult and Child Core Measure Sets, EPSDT screening ratios, access and availability data, and through the feedback we receive as part of compliance audits and accreditation surveys. For all Kentucky MCO quality initiatives, we will monitor and evaluate opportunities that may result in Kentucky-specific PIPs or other formal or informal QI activities. These activities are intended to improve the quality, timeliness or appropriateness of our care and service delivery. We monitor and measure our activities with the quality scorecard and other dashboards that may be developed that provide summaries of key metrics.

The QAPI uses a formal, documented QI Program Description and Work Plan, providing the basis for full integration across our functional areas, including UM, risk management, member services, grievances and appeals, population health management, provider credentialing, ombudsman services, provider services, behavioral health, subcontractors and providers. Functional area leaders take ownership of the components of the QAPI pertinent to their scope as documented in the Program Description and Work Plan. Through the forum provided by the QIC and its subcommittees, we can provide feedback to all areas and successfully integrate QI throughout our organization to enhance our service to our enrollees continually.

Success in Similar States with our QAPI Program

Critical to success in the Commonwealth is the ability to respond to our enrollees' needs quickly. Through our QAPI and rapid cycle improvement plans, we are positioned to quickly target populations at risk and deploy meaningful effective interventions to meet the enrollee where they are with the goal of reducing health disparities and improving health outcomes at a rapid pace. An example of our rapid cycle improvement occurred with our Michigan enrollees who needed to complete recommended immunizations for their children before they were 2 years old. It was critical for the enrollee to complete the shots according to the immunization schedule (particularly the 2-month, 4-month and 6-month doses).

We learned that the reminder call tool of the Michigan Care Improvement Registry, which collects and maintains immunization data across the state, could not be generated for anyone under 6 months old. Waiting until after 6 months to reach out to enrollees was too late (and could result in children being unable to complete the recommended immunizations before age 2). Our Michigan QAPI developed an outreach strategy to help keep enrollees on track. Currently, parents of children between the ages of 2 and 6 months are sent a reminder that shots are needed. These individuals are offered a $20 incentive if they complete all of the recommended 2-, 4- and 6-month shots. These individuals were also targeted with a live outreach phone call. The program started in April 2017 and continues to evolve and grow. Due to the timely identification of the barrier to receiving these immunizations and activation of meaningful outreach and incentive, enrollees who participated in the 2, 4, 6 Immunization Club achieved 100% compliance for the childhood immunization status combination 3 series (including vaccinations for diphtheria, tetanus, and pertussis, poliovirus, measles, mumps, rubella, and hepatitis, and influenza) and 51% were compliant for childhood immunization status combo 10 series for HEDIS 2019.

f. For each of the below quality measures, demonstrate how the Vendor will work to make improvements in Kentucky's Medicaid population. Include discussion of strategies and interventions specific to each measure, partners that will be necessary to achieve improvement, data analytics, and anticipated timeframes for success in achieving improvements. Describe potential challenges the Vendor anticipates, if any, and how those will be addressed. Provide examples of successes in other state Medicaid programs, and how that success will be leveraged in the Kentucky Medicaid market.

i. Medication Adherence for Diabetes Medications

Strategies and Interventions: Engagement in primary care and self-management of diseases are central tenets of enabling individuals to take a more active role in their health. We empower individuals, in collaboration with their physicians and other health care professionals, to manage their conditions and associated risk factors effectively. We help improve enrollee health outcomes while decreasing unnecessary costs through improved individual self-management and through guidance from PCPs and specialist physicians, community partners, and UnitedHealthcare networks where appropriate.

- ***Population-based disease management (DM)*** provides individuals identified with targeted condition(s), such as diabetes, educational materials and newsletters with diabetes-specific information, including recommended routine appointment frequency, necessary testing/monitoring and self-care. We design these materials to help enrollees take responsibility for their own health, and to equip the individual with the information necessary to manage conditions as successfully as possible and live a healthy lifestyle. We also tailor specific DM activities to individual needs to improve self- management of their disease.

- ***Our Diabetes Medication Adherence program*** uses a data-driven approach to identify enrollees who need help taking medications as prescribed across multiple drug classes. By identifying non-adherent enrollees, engaging early and staying connected — we can help individuals stay on track with their health and medications. In turn, this can lead to better outcomes and lower overall health care costs. OptumRx uses claims data and advanced analytics to identify enrollees taking medications at crucial points in their therapy. Outreach includes a new to therapy letter, primary medication non-adherence faxes and mailings, early refill and late to refill reminder interactive voice recognition (IVR) calls, an educational letter about low adherence, and fax/mailing to their provider alerting them of the non-adherence. Enrollees also have the option to connect with a live OptumRx pharmacist for telephonic consultation. The IVR collects barrier information reported back to the health plan.
- ***Remote Patient Monitoring:*** We will bring our partnership with Vivify Health to Kentucky to offer end-to-end remote care management for enrollees with diabetes. Participating enrollees use Bluetooth-enabled devices to facilitate the collection of biometric data, qualitative feedback to questions about their health and needs and access to video educational tools. Vivify Health's results include readmission reductions over 65% and adherence and satisfaction levels exceeding 95%.
- ***Telehealth:*** We will use telehealth to conduct education on importance of medication adherence. Monitoring through text messaging or video chat options with smartphone platforms is becoming more available, which is convenient for Kentucky enrollees in more rural regions.
- ***Home Delivery Prescriptions and Pharmacy Team Outreach:*** To make access to medications easier for enrollees, our pharmacy team can convert enrollees' prescriptions to home delivery for an automatic delivery and 90-day fills to increase adherence. Through outreach, our pharmacy team will remind enrollees about refills, assess barriers to taking medication as prescribed, educate regarding 90-day fills and mail order opportunities and provide referrals to pharmacists for more complex assessment and coordination with providers.
- ***Genoa Healthcare:*** We are looking into future strategies through our partnership with Genoa Healthcare in innovative ways such as the Meds-to-Beds Program. This program launches in-facility medication distribution to improve medication adherence and discharge planning.
- ***Performance Improvement Plans:*** We will develop regional PIPs to address areas within the Commonwealth with low adherence rates.

Partners: We currently partner with Vivify Health to offer their remote monitoring services to our enrollees, our PBM OptumRx to provide medication adherence programs, home delivery and pharmacy outreach. We have participated in Medicaid diabetes stakeholder meetings with the Commonwealth and worked with them within the Kentucky Diabetes Network (KDN) to enhance KDN's Diabetes Prevention Program campaign by providing funding billboards across Kentucky and by leveraging our partnership with Walgreens to place DPP postcards in their retail locations throughout Kentucky.

Data Analytics: We will use encounter data for tracking compliance through timely fills. While the NCQA does not

> "KDN has had the opportunity to partner with UnitedHealthcare around diabetes awareness and prevention. UnitedHealthcare has been instrumental in our diabetes awareness efforts and puts their mission of helping people live healthier lives to action."
>
> — Terry Gehrke, Executive Director, Kentucky Diabetes Network

currently have a measure for Diabetes Medication Adherence, CMS provides a technical specification for Measure D10: Medication Adherence for Diabetes Medications. These are written to Part D and Medicare beneficiaries, however, a modified version of this measure may be used as a basis for analytics for the Medicaid population. We will add this measure to the provider performance scorecard to verify medication adherence is addressed.

Time Frame: We will identify and locate enrollees and obtain baseline data, with interventions beginning as soon as the enrollees are identified in the first year. Full deployment will be in Year 2 with re-evaluation in Year 3 for effectiveness and determination of incorporating actions as permanent change.

A total of 622 out of 2,691 (23%) gaps were closed in a state with a similar population in 2018 with our 90-day fill program.

Challenges and Solutions: We have found that one of the primary reasons for non-adherence is forgetfulness. Our strategies make it easier to remind individuals about taking their medications (e.g., text-messaging programs delivered to smartphones, automatic refills).

Examples from other States to be applied in Kentucky: In another similar state, through the Diabetes Medication Adherence program, our pharmacy team provides targeted outreach to improve medication adherence for enrollees by providing education regarding 90-day fills and availability of medications for home delivery. They also screen for barriers is to make certain the enrollee is aware of the importance of taking their medication as prescribed. Pharmacy technicians reach out to remind enrollees about missed refills. If the enrollee is not adhering to their medication, a referral to the pharmacist is made. The pharmacist contacts the enrollee to complete a clinical assessment, provide counseling on the importance of taking medications as prescribed, and works with the prescribing provider to address any concerns regarding the medication, including assisting with provider appointment if necessary.

In our Massachusetts plan, through our interventions and partnerships with our providers and enrollees, we achieved a consistent improvement in our adherence rates and are at 84.12% adherence for 2019.

For Massachusetts enrollees, we developed a PIP focusing on diabetes mellitus and medication adherence for enrollees with certain diabetes medications. The development and interventions of this PIP were created by a multidisciplinary care team and recommendation from our enrollees through our QMAC and providers through our PAC. The success of this PIP was largely due to knowledge of the enrollees, and relationships with our providers and pharmacies. A few of the interventions that were effective in improving medication adherence rates that may be used in Kentucky are:

- Pharmacists receive monetary incentives that are geared toward converting individuals to a 90-day prescription when the enrollee is willing and the provider writes the updated prescription. Pharmacists also receive data identifying non-adherent enrollees and enrollee's at risk for non-adherence. Pharmacists reach out to individuals to identify any barriers and to help the individual problem solve for these barriers. For example, we have created medication labels in Spanish to communicate medication instructions to our enrollees more effectively.
- Distribution of a provider tip sheet and fax letter to help providers with information on how to best support at-risk individuals who are non-adherent, or have been identified as suggested to start a statin treatment, related to their diabetic condition. Providers were open to the new materials, and have committed to use the information during appointments with enrollees.

- Enrollees received direct outreach and educational materials from their PCPs and pharmacists.

ii. Tobacco Use and Help with Quitting Among Adolescents

Strategies and Interventions: Despite reductions in tobacco use nationwide and within the Commonwealth, Kentucky continues to have high use rates. Moreover, Kentucky leads the country in lung cancer related deaths, which are directly related to smoking prevalence. Reduction of tobacco use is an important strategy for improving the health of Kentuckians.[1] We will use the following effective strategies and proven interventions (including both state offered programs and UnitedHealthcare programs) to decrease tobacco use in Kentucky and assist adolescents in quitting:

- ***Smartphone Technology:*** A growing number of research studies show that texting enrollees can be an effective way to provide frequent, real-time text "nudges" that remind enrollees to follow their person-centered care plan consistently. We have mobile applications, texting and tools available that are tailored to teens that can improve outcomes in health care and are specific to smoking cessation. ***Smokefree Teen*** is a texting application that sends smoke-free texts three to five times per day for 6 to 8 weeks, depending upon the enrollee's quit date. ***The Quit Start App*** allows teens to design their own quit kit (the DipfreeTXT program***)*** and provides ability to chat with National Cancer Institute staff regarding any questions. There is a new vape application we will promote to our teen enrollees through the Truth Initiative which provides supportive texting to contemplate quitting and support once the enrollee has decided to quit (e.g., text messaging, an ability to live chat with a support coach).
- ***Quit Now Line:*** We will make referrals to the locally operated Quit Now Kentucky line, which offers educational materials on quitting smoking and tobacco use, coaching and online community resources.
- ***Provider Education:*** National clinical guidelines specific to tobacco use will be posted on the provider portal website. Our PQECs will review and reinforce these guidelines during office visits with providers regarding the importance and effectiveness of screening for tobacco use and providing guidance, including education or brief counseling to quit use. We will educate them on referring enrollees to counseling and cognitive behavioral therapy, which evidence shows has optimal results among adolescents. Among current smokers, recalled physician advice was also associated with reduced intentions to smoke in 5 years. Advised teens were more likely to plan to quit smoking in 6 months and teens who were screened by their physician reported significantly more quit attempts than those who were neither screened nor advised.[2]

Partners: Our key relationship is with Elizabeth Hoagland in the Department for Public Health (DPH) Tobacco Prevention and Cessation Program, whom we introduced to Walgreens to increase cessation throughout the Commonwealth across their retail pharmacies. As we look to

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[1] State Health Improvement Plan Committee. Kentucky State Health Improvement Plan 2017-2022 Frankfort, KY: Cabinet for Health and Family Services, Kentucky Department for Public Health; 2017 Published: September 1, 2017 Revised: April 16, 2018

[2] Physician Communication Regarding Smoking and Adolescent Tobacco Use DOI: 10.1542/peds.2010-1195 originally published online May 16, 2011; Pediatrics 2011;127;e1368 Ashley M. Hum, Leslie A. Robinson, Ashley A. Jackson and Khatidja S. Ali

further increase cessation related to traditional and electronic cigarettes among individuals in Medicaid, we will continue to deepen our relationship with the Foundation for a Health Kentucky and explore possibilities with others such as the American Lung Association and American Cancer Society of Kentucky.

Data Analytics: We will work with DMS to add a question to the initial HRA regarding tobacco use, and those enrollees who meet the criteria set for age range who have a positive response can be targeted for outreach and education regarding the risks of tobacco/nicotine use and tools to quit if contemplating quitting. We will educate providers to use code G9458, which will provide encounter data to determine tobacco users who were provided counseling.

Time Frame: We will identify and locate enrollees and obtain baseline data, with interventions beginning as soon as the enrollees are identified in the first year. Full deployment would be in Year 2 with re-evaluation in Year 3 for effectiveness and determination of incorporating actions as permanent change.

Challenges and Solutions: Many teens may answer that they do not smoke if they are vaping, as vaping is not usually identified as tobacco use, but through community outreach and educational materials, we can change this way of thought.

Examples from other States to be applied in Kentucky: In addition to promoting evidence-based covered benefits, such as counseling and pharmacotherapy, we develop state-specific models based to encourage reduced tobacco use. The following highlight some of the state-specific efforts we have taken to reduce tobacco use and will inform our thinking about developing additional solutions to improve health and wellness in Kentucky:

- ***Intensive Individual and Group Counseling in Nevada:*** In Nevada, we run a voluntary 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. Individuals are invited to participate in an initial orientation and one-on-one assessment. Our LADCs then develop individualized treatment plans with education, support and medication therapy, as appropriate. Enrollees are encouraged to attend at least 10 of 12 educational sessions in the form of group and one-on-one sessions, but may attend as many sessions as needed for an extended time. 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 individuals 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, we are steering individuals to the Tobacco Free Tennessee Coalition and collaborating with other health plans, universities, hospitals, political activists, policy writers and mental health organizations. We also support the Tennessee DPH's Baby and Me Tobacco Free program, which provides diaper reward vouchers to women who remain tobacco free. To encourage even more people to quit smoking, we developed a unique approach by partnering with providers. Understanding that individuals tend to follow physician instructions if they are provided with a prescription, we offer local providers "prescription pads" that contain the steps for facilitating tobacco cessation for our Tennessee 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, our Wisconsin health plan recently engaged with local providers to provide training, technical assistance and evidence-based research on treating tobacco dependence. They made information available to providers via webinar to make it convenient to participate. Topics included 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. 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 enrollees.

iii. Colorectal Cancer Screening

Strategies and Interventions: We provide outreach to enrollees to verify they have an assigned PCP and encourage annual wellness visits where preventive screenings can be addressed. Enrollee education is also sent to enrollees via mail and through telephone calls from care coordinators, CHWs and practice support staff regarding the importance and need for screening, options for types of testing and details on transportation.

Ongoing provider education regarding the importance of testing, covered options for testing and provision of outcome reports to providers identifying enrollees who need screening will be used. Provider incentives have also been successful in improving colorectal screening rates and we will consider including the colorectal screening measure in our provider incentive programming.

We also plan to explore the use of fecal immunochemical test kits (iFOBT) that can be mailed to enrollees' homes and explore the potential to support distribution by provider offices to increase compliance for enrollees who qualify for testing.

Partners: We met with Patty Frances, past Executive Director of the Kentucky Colon Cancer Prevention Project, to discuss health disparities and collaboration opportunities related to colon cancer. Possibilities to enhance care in the Commonwealth include provider education on care delivery options, colonoscopy comfort kits for individuals, targeted screening campaign in eastern Kentucky, and developing a navigator program for colon cancer. With these prospective initiatives, and as we continue to build further relationships, we will work with key stakeholders such as the DPH's Colon Cancer Prevention Program, Kentucky Cancer Consortium, Kentucky Cancer Program, and Kentucky CancerLink to co-build collective solutions in alignment with the Cancer Action Plan.

Data Analytics: We use our encounter data for screening identification, and EHR information with participating providers to capture historical data and identify enrollees with gaps in care who are due for their colorectal cancer screening.

For ongoing monitoring of program effectiveness and targeting areas with a large percentage of non-

> One of our enrollees saw our kit offering in an enrollee magazine and called in to our member services center to order a kit via our OnDemand campaign. The enrollee completed and returned the kit, which indicated abnormalities leading to them visiting their provider. This led to a diagnosis of colorectal cancer. Due to the kit, the enrollee was made aware much sooner about the diagnosis and was able to reengage with their provider to seek treatment. The enrollee was very appreciative of this service and credits it with helping save their life.

adherent individuals, we will develop a colorectal screening dashboard specifically for Kentucky enrollees. This tool is valuable in tracking enrollee-level detail, open and closed gaps and methods that closed the gap. Data updates to the dashboards run nightly and show almost real time management at the enrollee, program and provider level. This information will allow us to target practices and expand programs that are showing the most success. In addition, we will include this measure on our provider dashboards as a key quality measure so providers can track their performance and will be motivated to improve it.

Time Frame: We will identify and locate enrollees and obtain baseline data, with interventions beginning as the enrollees are identified in the first year. Full deployment would be in Year 2 with re-evaluation in Year 3 for effectiveness and determination of incorporating actions as permanent change.

Challenges and Solutions: Historical data regarding testing prior to enrollment may not be readily available, but we will use EHR data to look for any testing done previously. Enrollees may fear preparation or testing for this type of cancer due to its severity, so CHWs and MSAs will provide education on the option of iFOBT testing and assist with follow-up appointments.

Examples from other States to be applied in Kentucky: The iFOBT test kits were sent to our D-SNP enrollees across 13 states, a difficult population to engage in preventive care. Included below are the four ways an enrollee could obtain an iFOBT kit:

- ***Targeted Mailing:*** The kits are sent to the targeted enrollees who do not have evidence of a screening after telephonic contact. This engages enrollees and makes it more likely they will return the test (current rate is 12% to 16%).
- ***Continuous Re-Deployment Mailing:*** These kits are sent to enrollees in the measurement year who returned a kit in the previous year. The current annual return rate on this method is 60%.
- ***OnDemand Ordering:*** Enrollees may request a kit when calling into our member services center. The current return rate for OnDemand is 40%.
- ***Provider Office Handout:*** Providers who have a LabCorp account can obtain kits at no cost to hand out to our enrollees when they go to the office. Providers who do not have a LabCorp account can obtain a limited account with LabCorp and get the kits at no cost to them.

g. Describe the Vendor’s proposed approach to collaborating with the Department, other MCOs, and providers to ensure Performance Improvement Projects (PIPs) are effective in addressing identified focus areas and improving outcomes and quality of care for Enrollees, including the following:

For collaborative meetings with our partners in DMS, other contracted MCOs and providers, we propose monthly, in-person meetings for the first 3 months and web-based monthly meetings thereafter, quarterly in-person meetings ongoing and web-based or in-person meetings on an ad hoc basis. In-person meetings during the early months of the contract help to establish rapport and improve continued collaboration. We also propose DMS hold the standing in-person quality-focused meetings with all contracted MCOs quarterly to continue the connected collaboration that happens on-site. With DMS’s support, in these meetings, we will determine the priorities of the Kentucky MCO population and align outreach for all MCOs to providers and enrollees so our performance improvement activities deliver a united result. We will discuss our key drivers, the effectiveness of interventions performed at the MCO and provider levels, and share lessons learned. There is optimism that we can work toward common VBP programs to support health outcomes while making certain providers do not experience additional burden in implementation.

In our experience in other states, we have learned the importance of identifying shared focus areas with MCOs and providers alike, in addition to sharing the same goals for clinical and non-clinical PIPs. We will bring this same collaboration method to Kentucky. Other MCOs have used a learning collaborative approach, in which they use rapid cycle improvement tools and share best practices with each other. The states selected common measures for each PIP and specific targets for each plan based upon their performance. In a similar state, the MCOs collaborated on development and dissemination of provider education tools regarding better coding to capture outcomes on state PIPs. In this state, all of the MCOs used the same tip sheets when providing education via provider portals and to offices, decreasing the burden on providers who were previously obtaining multiple versions of similar information. Including providers in PIP design discussions will not only improve the ability to drive better outcomes, but also work to solve for similar efficiencies in Kentucky.

We have also found that quarterly Voice of the Customer meetings with each individual MCO are valuable, to confirm the State's ability to share what is working well and upcoming priorities and the MCO can share best practices and discuss any areas for improvement. This meeting allows for a successful collaboration. We would also value one-on-one, in-person quarterly meetings between our quality director and DMS to discuss quality issues that may lead to PIPs (e.g., opioid misuse, infant mortality).

i. Lessons learned, challenges, and successes the Vendor has experienced while conducting PIPs, and how the Vendor will consider those experiences in collaboration with the Department on identified PIPs.

Lessons learned: As an organization, we are constantly learning from our national experience, our local community partners and health plan outcomes. These lessons provide benefits in the creation of program improvements and the development of new initiatives. Our quality teams use all available data sources that help bring insight to potential barriers, population and sub-population trends and other causal factors. We conduct routine literature reviews, use information to develop interventions, and share our findings with our state partners and local health departments to develop opportunities for collaboration to improve the health outcomes of the state's Medicaid population. Through lessons learned and challenges from other states' experiences, we gain insight into which interventions will improve health outcomes in Kentucky.

Florida – Preventive Dental Services for Children	
Interventions	Enrollee intervention-automated phone calls to caregivers of non-compliant enrollees with benefit information (including transportation) and facts regarding importance.
Barriers	Enrollee education, transportation and the enrollee's belief that there is a cost to them.
Lessons Learned	▪ Enrollees are not assigned a dental provider by health plan so we are unable to provide a list of individuals to dental practitioners to help with enrollee outreach. ▪ Enrollee knowledge is deficient associated with school dental sealant programs as a substitute for a dental preventive care visit. ▪ Robocalls were ineffective due to low contact rate.
Successes	In 2015, 28% of enrollees were receiving preventive dental service. This increased to 32% in 2018. Due to project success, our Florida health plan is sharing engagement strategies of young individuals with University of Florida physicians and dentists.
How insight will improve outcomes for Kentucky	Autodialing calls are often not answered; therefore, our member services center will provide opportunities. MSAs receiving a call from an enrollee will be able to review their gaps in care, provide education regarding benefits and available resources for activities (e.g., smoking cessation).

Kansas – Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	
Interventions	Offered enrollees in-home diabetes screening as alternative to office visit, with aim to increase access to screening services overall.
Barriers	The scheduling of appointments with the PCP for diabetes management was difficult for the enrollee due to dual diagnosis and transportation to appointments was difficult for enrollees in rural areas.
Lessons Learned	Meeting the enrollee "where they are" can be a successful intervention in improving compliance.
Successes	To date, we have seen a 9-percentage point improvement in screening rates.
How insight will improve outcomes for Kentucky	Transportation in rural communities is identified as a barrier in other states and in Kentucky, requiring other ways to meet individuals where they are by providing alternative solutions to close gaps such as mailed lab testing, home delivery of medication, and promotion of services available in schools.

Louisiana – Prenatal/Postpartum Care, Reduction of Risk for Preterm Births	
Interventions	▪ All identified OB practices received orientation to the PQECs program, to the high-risk care coordinator program, how to make enrollee referrals and information on the need to improve maternity outcomes. ▪ We provided education on the Notification of Pregnancy process, which is the key to our early identification of pregnant women and pregnant women at high risk. We investigated Notification of Pregnancy issues and made process improvements to simplify the process. We will offer providers incentives for form submission beginning in 2019.
Barriers	There was a lack of provider engagement and knowledge of programs to support pregnant enrollees and a lack of early notification of pregnancy.
Lessons Learned	Provider engagement in our QAPI training and activities was a key driver in maternity improvements for pregnant women in the Louisiana health plan. Provider incentives may be needed to increase early notification of pregnancy. Continued focus in this area is needed and will continue through both formal and informal CQI programs.
Successes	While we were pleased with improvements in most of our measures, we also noted that our prenatal and postpartum measures showed improvement since 2016 but did not gain the additional traction we expected between 2017 and 2018.
How insight will improve outcomes for Kentucky	Collaboration and engagement of providers is essential to success in helping to identify certain populations, and PQECs are central to developing relationships with providers and office staff and will increase engagement in projects. Outreach from a provider office may increase enrollee engagement and provider identification of targeted population for additional health plan outreach.

ii. Recommended focus areas, including those for regional collaborative PIPs, for the first two years of the Contract resulting from this RFP and rationale for these focus areas.

Factors such as socioeconomic status, education, surrounding physical environment, community conditions, employment and social supports critically influence Kentuckians' ability to thrive. To combat the negative aspects of these factors, we commit to collaborating with the Commonwealth and competitor MCOs to improve health outcomes and reduce health inequity across regions of Kentucky. Using data from publicly available sources, we evaluated Kentucky regions and counties through the lenses of health, social need and environmental conditions and, consistent with Commonwealth-identified priority conditions and populations. We would like to recommend collaborative PIPs supported across all MCOs around improving birth outcomes in pregnancy by focusing on SUD. By doing this we expect to increase access to treatment in pregnancy, which would reduce low birth weight deliveries, NICU admissions and length of stay.

As part of this initiative, we also hope to improve the care received by infants affected with NAS by working toward a standardized protocol for their treatment that involves decreasing their exposure to post-delivery opiates. We suggest PIPs for improving diabetes control, decreasing tobacco use in pregnancy and children including adolescent nicotine exposure via vaping.

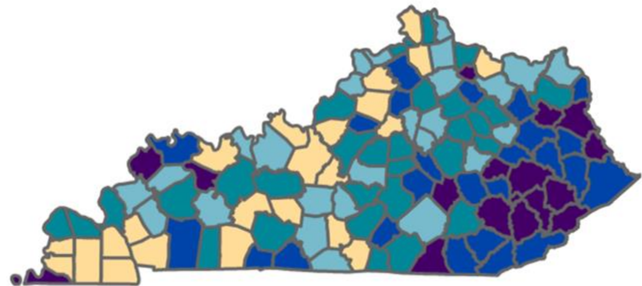

Figure 5. Kentucky State Data Center analysis of records from the Kentucky DPH Office of Vital Statistics on low birth weight.

Rationale for selecting these areas for focus is based upon our review of Kentucky's health data, with many of the PIPs affecting more than one health indicator:

- Based upon America's Health Rankings, Kentucky's percentage of low birth weight infants was 9.1%. Kentucky Youth Advocates cites cigarette smoking as the most important causes of low birth weight. For 2018, America's Health Rankings showed African American women had the highest percentage of low birth weight infants Kentucky at 15.1%.
- For 2018, America's Health Rankings showed diabetes has increased 22% in Kentucky, with the percentage of adults being told by a health professional that they have diabetes was at 12.9% compared to 10.5% national rates.
- The rate of opioid-related deaths in Kentucky in 2017 was 27.9 per 100,000 persons compared to the national average of 14.6 deaths per 100,000. Opioid use among pregnant women is also very high in Kentucky, the third highest nationally.
- The CDC behavioral risk factor surveillance system in 2016 showed 24.5% of adults in Kentucky smoked compared to the national rate of 17.1%. With the increase in the cigarette tax, more Kentucky smokers are cutting back or trying to quit. This provides an opportunity to support enrollees contemplating smoking cessation.

In our Louisiana health plan, we implemented a successful MCO and state collaborative PIP to reduce preterm births, which improved the number of women having at least one chlamydia test during pregnancy (which is a risk factor for preterm birth) from 64% to 88% over three years. Additionally, postpartum care visit rates increased from 58.72% to 64.48% during the same timeframe. This collaboration practice is a method that we will bring to our Kentucky health plan.

iii. Methods for monitoring and ongoing evaluation of progress and effectiveness.

As a health plan, our Kentucky CMO works with the quality director to establish multidisciplinary work groups based upon the project topic. These workgroups include internal staff from multiple departments, national partners, local community partners and other external stakeholders. The workgroup functions as a collaborative team defining the opportunities for improvement and the scope of the PIP. Once the PIP work group develops and implements interventions based upon knowledge of the population and the target outcome goals to be measured for success, they will:

Analyze Changes: We conduct a quantitative analysis to determine if a rate change occurred in the original selected measurement, or if we have attained goals and benchmarks. We determine if changes are statistically significant or if they correlate to the timing of the intervention. Based upon the findings, we determine if the interventions should continue, be adjusted, or if new interventions should be developed.

Measure and Remeasure: The PIP work group monitors progress routinely, including regular re-measurement to determine if actions taken have resulted in meaningful improvement. A 3-year cycle is common, but may extend longer depending upon the topic, design and results.

Monitor Results: Interventions that result in improvement are standardized and monitored to foster sustained improvement. We maintain a national repository for PIPs completed across the country that is accessible to all QAPI programs. Results from successful PIPs are reviewed and evaluated to determine if similar activities can improve results for Kentucky enrollees.

Report Recommendations: We will participate in the quarterly (or more frequent) quality meetings with DMS to review progress in achieving the identified goals and targeted improvements for the PIP focus areas. We present final project reports and recommendations to the QIC and review our findings with our Commonwealth partners and the EQRO prior to closing PIP activities. We will work with DMS and other plans in a learning collaborative approach to share our best practices and learn from the other plans' best practices so we can all work together to improve outcomes for the Medicaid population. Additionally, we document PIPs in the format required by DMS and the EQRO and submit for regulatory review.

Interventions are evaluated and refined to achieve demonstrable improvement. At least annually, the appropriate committee reviews the results of evaluations and recommendations.

h. Provide a description of opportunities the Vendor has identified to collaborate with the Department for Public Health to support improvement in public health outcomes. Where does the Vendor anticipate that collaborating on initiatives would have the most impact in addressing quality care and outcomes for Medicaid Enrollees? Explain the Vendor's rationale.

> **UnitedHealthcare:** Our mission is to help people live healthier lives and to help make the health system work better for everyone.

As a large enterprise with local ties, we have demonstrated that the pathway to changing health for our enrollees involves both individual and population level interventions. One individual at a time, we empower enrollees and partner with providers — and at the same time, address unmet health needs by creating population level care management and health transformation programs that help enrollees and providers meet their health goals and thereby address local health needs. These efforts require coordination to have a lasting effect. To reach our shared goals of improving the public health outcomes of the people of Kentucky, we need collaboration with the goals and efforts of the DPH.

Our Commitment to Collaboration with Kentucky

Kentucky's commitment to connecting health care and public health reflects multiple national level initiatives in which our leadership team have been deeply involved. The CDC launched the 6|18 initiative that describes 18 interventions for six key conditions, where collaboration between health care and public health can achieve meaningful change. For example, tobacco cessation is best achieved by combining individual level programs like access to nicotine replacement therapy, population level strategies such as funding for quit lines and public health strategies such as advertising for tobacco cessation. Our national CMO collaborated closely with the authors of that initiative and joined CDC on multiple occasions for collaboration and public engagement. Our national CMO worked closely with the authors of the CDC's call to action for Public Health 3.0 initiative, which Kentucky has embraced.

Based upon conversations with Commissioner Howard to discuss the vision for Public Health 3.0 in Kentucky, conversations with local partners, and our extensive expertise in this area, we believe we have specific opportunities that align the strengths of UnitedHealthcare, our provider

partners, our community partners and the DPH to transform health for the Kentuckians we collectively serve. These priorities include obesity, cardiovascular disease, lung cancer, COPD, and infant birth weight and mortality, and we will partner with the DPH on each of these priorities. For example, our strategies on tobacco cessation, in partnership with Elizabeth Hoagland, demonstrate our commitment to combining health outcomes and health care. Our continued efforts in Hotspotting and housing demonstrate our commitment to addressing non-medical factors that are key to the health of enrollees in Kentucky.

Figure 6. A local community stakeholder meeting UnitedHealthcare hosted with the American Heart Association in Winchester.

These national conversations help us to identify areas where collaboration can have the biggest impact on quality of care and health for the people of Kentucky. By bringing together efforts to empower individuals, engage providers and community partners, and efforts of public health, in pathways that have been proven most effective, together we can drive improvements in health for Kentucky Medicaid enrollees.

Experience with Collaborating with Public Health Departments

We will partner with the DPH in new ways and identify priorities where we can add the most value, identify specific actions we can take together, and follow up for improvement and adjust course if necessary. We will use our data analytic and technology capacities to enable Commonwealth and local public health leaders to dynamically identify local health issues and facilitate change with community stakeholders. Our scope and experience in our various Medicaid states has allowed us to pursue a wide range of collaborations with other DPHs. Following are examples of collaborations with local health departments in other states we serve and will use these best practices and lessons to design programs tailored to Kentucky.

North Carolina Local Health Department Collaboration

Our work in North Carolina demonstrates how we embrace collaboration with public health. There, we are bringing data and operational support to amplify the efforts of North Carolina's Local Health Departments (LHDs). North Carolina's 85 LHDs play an essential role in providing care management services, medical services and social and resource supports for high-risk pregnant Medicaid enrollees and at-risk children (ages 0 to 5). Through our relationship with the North Carolina Association of Local Health Directors, we maintained and built upon this arrangement by partnering closely with LHDs to identify pregnant individuals, conduct risk assessments and refer enrollees for care management, as needed.

Our LHD engagement teams led by our experienced LHD engagement manager closely coordinates with our LHD partners throughout the state. The teams comprise clinical and data specialists who drive data collection and analytics, scorecard preparation and reporting initiatives. Our LHD engagement team:

- Reviews roster of enrollees in care management, and discusses discrepancies
- Reviews population health data/trends, including trends of high-risk diagnoses, referrals to specialty medical care, enrollees who quality for 17 alpha-hydroxyprogesterone caproate (17P), MAT therapy, breastfeeding rates, birth weight, gestational age at delivery, C-section rate, NICU admission rate and case specific, NAS NICU rates, HEDIS maternity measures, well woman care, and pediatric EPSDT rates

- Provides technical assistance and validates practices are aware of evidence-based care to further empower LHDs to address population health. This includes support and guidance on critical maternal and child health topics such as 17P, NAS, enrollee education of 39-week birth initiatives, breastfeeding and family planning
- Participates in case reviews and coordinates among our local community partners to meet the needs of some high-need individuals

Additionally, we partner with LHDs on initiatives to support our enrollees and their communities. With a $25,000 community grant, we purchased over 10,000 books as part of *Reach Out and Read*, an evidence-based program incorporating books into pediatric practices and enabling families to read aloud together.

Collaborations to Locally Address Diabetes through Novel Partnerships

As far back as 2011, UnitedHealthcare has been a pioneer in collaborating with the YMCA and the Diabetes Prevention Program (DPP), where identified pre-diabetic enrollees can engage in a 1-year lifestyle change program, and attend in-person classes about healthy eating and physical activity.

With Dr. Connie White and her staff in the Kentucky DPH, we have participated in multiple Commonwealth-led Medicaid diabetes stakeholder meetings and worked with them within the Kentucky Diabetes Network (KDN) to enhance KDN's Diabetes Prevention Program campaign. We did this by providing thought leadership, funding for billboards across Kentucky and by leveraging our partnership with Walgreens to place DPP postcards in their retail locations throughout the Commonwealth.

Continuing this momentum in Kentucky, UnitedHealthcare is partnering with UK Barnstable Brown Diabetes Center to provide the CDC Recognized National DPP to individuals at risk for type 2 diabetes who reside in underserved communities with diagnosed diabetes prevalence rates higher than the state and national averages. The program will be offered in Knox, Muhlenberg, Scott, Washington and Whitley counties.

Local Collaborations to Address Opioids

The rising crisis of opioids dependence is a critical example of the need and opportunity to weave together individual level treatment, community level engagement, and public health interventions in collaborations between public health, providers and UnitedHealthcare. We have learned that a cohesive strategy can transform this crisis. Collaboration with the DPH and other key stakeholders will have the most influence in transforming the treatment ecosystem, reducing stigma, and improving long-term health outcomes for individuals, families and communities, and supporting the availability of naloxone across the community. Beginning with individual empowerment, we will create opportunities for enrollees with OUD to take positive steps in their recovery through medication-assisted treatment, peer supports. We will engage with providers in VBP arrangements, creating payment models to enable providers to better support enrollees in their journeys to recovery. Through our partnerships with community groups, we can enable drug take backs, naloxone administration and distribution. We look to partner with DMS on efforts such as stigma reduction and enhancing our ability to make people aware of these options. For states such as Massachusetts and Rhode Island that have taken these coordinated steps, we have realized measured improvement with opioid use, and we will replicate that success in Kentucky by deploying our organizational resources in collaboration with and to complement the work of DPH.

To support the efforts led by our local health plan CMO, Dr. Jeb Teichman, Dr. Katherine Neuhausen (one of UnitedHealthcare Community & State's senior medical directors) brought her expertise around efforts to transform this crisis in her prior role as the CMO for Virginia's Medicaid program. Her work on the ARTS program is the model for how leadership and collaboration can make a difference in this crisis. With the guidance of these thought leaders, we have tackled this issue in Tennessee, Ohio, Virginia, and other states dealing with the opioid and broader substance use crisis. In Kentucky, we anticipate a similarly close collaboration with the DPH, DMS, the Department for Behavioral Health, Developmental and Intellectual Disabilities, MCOs, providers and community partners. Together, we have taken on initiatives to improve access to and the quality of MAT and SUD treatment services, create opportunities to empower individual to engage in their own care by increasing the number of people engaged and retained in evidence-based treatment, and prevent the spread of the epidemic.

> "As our partner, UnitedHealthcare has shown the leadership, compassion and dedication to serve the citizens of the Commonwealth and will continue to do so if afforded the opportunity."
>
> — Gary Wayne Hall Jr, Industrial Training Coordinator, Kentucky Fire Commission

In other states, we collaborated to monitor the epidemic and to use data to drive action. In North Carolina, we actively participated alongside other payers in the North Carolina Payers Council, which was convened by the North Carolina Department of Health and Human Services. UnitedHealth Group's OptumLabs developed Key Performance Indicators for OUD, and after we shared these indicators, the North Carolina Council embraced these indicators for the entire state as we examined best practices for using data to identify need, drive resources and monitor trends and progress.

The heightened risk of HIV and Hepatitis outbreaks in Kentucky due to intravenous drug use presents a particular opportunity for collaboration with the DPH on strategies to increase use and awareness of harm reduction strategies and increase provider training on Hepatitis. We provided support at the Kentucky Rural Health Association Annual Viral Hepatitis Conference and a Project Lazarus community stakeholder gathering in London. We believe there are additional opportunities to improve provider training and capacity in this area to prevent such outbreaks. Community education efforts on evidence-based treatment, stigma, drug take backs, naloxone administration and distribution, and safe opioid disposal may also present opportunities for collaboration in an effort to prevent the misuse and abuse of opioids and other drugs.

In 2018, we funded the Northern Kentucky Health Department to provide training and distribute naloxone to first responders to prevent overdose deaths and increase the number of people connected to treatment. This year we worked similarly with the Foundation for a Healthy Kentucky, Kentucky Fire Commission and 10 local volunteer, county fire departments across the Commonwealth to provide training and naloxone in resource scarce communities. We envision additional opportunities for community strategies that increase awareness of and access to quality treatment providers to make sure Medicaid enrollees and their families have access to evidence-based care.

i. Describe the Vendor's approach to monitoring and evaluating progress in improving the quality of health care and outcomes on an ongoing basis. Describe the following:

i. How the Vendor will use data to inform and prioritize initiatives to address Enrollee needs.

Our clinical and quality teams bring deep and diverse skills coordinating services and supports, integrating behavioral health, providing effective monitoring and evaluation, and supporting cultural and linguistically diverse populations. Our teams tailor QI programming to meet the

needs of the individual and to target regional factors and health disparities affecting health outcomes of Kentuckians. To prioritize initiatives that address enrollee needs (e.g., preventive care, acute or chronic physical or behavioral conditions, SDOH and high volume, high risk, and special health care needs populations) members of our QAPI program will select quality and outcome measures that are meaningful for enrollee health and well-being through our CQI process as described in Question a, Part v.

We review current literature, bring together subject matter experts from across UnitedHealthcare and locally in Kentucky via advisory councils. We survey changes in the Medicaid environment and keep abreast of The National Quality Forum and the Agency for Healthcare Research and Quality best practice initiatives and the EQR annual evaluation. This work also includes querying NCQA benchmarks, analysis of regional and health plan variation across our businesses, and examining enrollee demographic data, condition prevalence and incidence rates. We then monitor these quality and outcome measures using standardized measure criteria, data accuracy reviews and reporting.

We evaluate and improve upon selected measures through regular presentations to the QIC. This process provides a forum for feedback and allows for oversight by expert clinical staff including the Kentucky health plan CMO. We use rapid-cycle implementation for changes to interventions using PDSA processes. The QIC will prioritize, plan and allocate appropriate resources to continue or modify improvement efforts for each selected metric, and can reference best practices across 26 Medicaid plans. The QIC will annually provide a review of completed and continuing QI activities, corrective action plans, trending measures, recommendations or suggested modifications to DMS. Our local and national teams work together to develop new interventions or recommend eliminating ineffective programs.

We make a concerted effort to address health disparities in all of our health plans, and will make reducing and eliminating health disparities a priority initiative for Kentucky. We have provided examples from not only the plans that have received the NCQA MCH distinction but from other disparity action plans across our organization. The following table outlines several of the quality measures our health plans have analyzed, actions taken and outcomes realized. To determine whether a health disparity exists between two categories (e.g., individual’s race or ethnicity) we used the Index of Disparity on the health plan’s rates. This calculation is a nationally used and well-vetted measure to assess differences across groups.

Disparity Identified	Interventions	Results
Childhood Immunization Combination #3 in Michigan – Race data provided by the Michigan Department of Health and Human Services, HEDIS results using claims data		
HEDIS 2017 results highlighted a 10% gap affecting African-American enrollees and a 12% gap affecting Hispanic enrollees when compared to Caucasian enrollees **Goal***:* Reduce disparity rate by 2.95%	▪ Offered member incentives to get immunizations required by 6 months and to provide a greater opportunity for full immunization compliance by 24 months. ▪ Care coordination for children in low performing geographical areas ▪ Provider education on Immunization schedules and using reminders and shot-only clinics with gap reports ▪ Created focused UHC On Air training ▪ Partnered with local health departments in targeted counties	Interim increases indicate improvement in immunization disparities in targeted counties; for example, Wayne County offices improved by 60%

Disparity Identified	Interventions	Results
Prenatal and Postpartum Care in Ohio – HEDIS results using Claims data, enrollee data from enrollment files, state public health data		
▪ Mahoning County has been identified as an "Infant Mortality Hot Spot" ▪ Prenatal care Index of Disparity is 15.98% Postpartum care Index of Disparity is 37.43% **Goal:** Integrate intensive care management for high-risk enrollees in Mahoning County and improve postpartum care rates.	▪ Offer intensive care management once pregnancy is confirmed; enrollees are risk stratified as intensive and receive Level 4 care management. Once engaged, the care coordinator contacts enrollees twice a month and attempts quarterly in-person visits ▪ After delivery, the care coordinator does a "warm hand off" to the CHW to engage the enrollee through the first year of the infant's life	Prenatal visits: 77.3% for the county overall versus 88.9% for those engaged in the program; the Disparity Index fell from 15.98% to 6.88% over the same time period in Mahoning County Postpartum visits: 57.1% for the county overall versus 61% for those engaged in the program; the Disparity Index fell from 37.43% to 9.83% over the same time period in Mahoning County
Follow Up After Hospitalization for Mental Illness in New York – HEDIS results using Claims data		
Individuals with housing insecurity (homelessness) were less likely to receive the recommended follow-up visit with a behavioral health practitioner within 7 days of hospital discharge; this was particularly salient in urban areas. **Goal:** NYS QARR 75th percentile	Deployed Transition Program staffed by contracted transitional providers who travel into the community to enrollees in transition to aftercare. Initial visits occur during the inpatient hospitalization; after discharge, the transitional provider locates the individual through social services and continues to assist the enrollee for another three sessions. Focus is on transition to the community, safety, medication adherence and prevention of rehospitalization	Interim improvement in follow-up visits post-discharge from 38% to 60% from CY2016 to August 2017

ii. Methods for measuring provider performance against practice guidelines and standards adopted by the QIC, and follow up activities to be conducted with providers based on ongoing review of findings.

Through our integrated QAPI, we continuously monitor our service delivery program to provide insights into its effectiveness and verify that we provide the right services to enrollees at the right time and in the right setting. This includes assuring providers use evidence-based clinical practice guidelines and nationally recognized protocols. Some of the analyses that we conduct to evaluate the efficiency, effectiveness and appropriateness of service delivery include:

- Tracking system-wide UM measures that indicate the appropriate use of services, such as a reduction in unnecessary rehospitalization and ED visits; adherence with preventive measures standards and compliance with clinical care guidelines. In Ohio, we use our PQECs, who meet regularly with hospitals to discuss issues such as readmission, ED care and inappropriate diagnostic testing based upon UM data to evaluate the appropriate use of these services
- Monitoring compliance with a standard set of nationally recognized metrics, such as 7-day readmission rate or follow up after mental health hospitalization. For follow up after mental health hospitalization in our Tennessee health plan, our PQECs use the PCOR to monitor provider performance monthly. They work with the PCP to identify behavioral health practitioners in the medical home program for behavioral health for referrals where appropriate. The PCPs and behavioral health providers work together to make certain enrollees receive the care they need

- Monitoring provider fidelity to guidelines by assessing the care each enrollee is receiving against clinical practice guidelines
- Confirming that we apply objective criteria and evidence-based guidelines to prior authorization/pre-certification, prospective review, concurrent review, retrospective review, ambulatory review and requests for second opinion. This is done through IRR testing which is executed annually or whenever a major change in criteria is made. Audits are completed for adherence to documentation, review and decision standards
- Monitoring multiple data sources and looking for indications of multiple providers of services or the delivery of services that appear to lack coordination, such as data for high utilization of outpatient services (ED use, pharmacy data, preventive care and management of chronic conditions by multiple providers)
- Identifying gaps in medical and behavioral health care and services related to preventive health care and treatment adherence
- Tracking and trending enrollee complaints against providers regarding the care they are receiving; reviewing all potential quality of care and quality of service incidents; and trending HEDIS and CAHPS scores as proxy measures for provider quality
- Assessing enrollee and provider satisfaction with experience of care outcomes through enrollee CAHPS and other satisfaction surveys, annual provider surveys and provider feedback through provider forums

To measure provider performance against practice guidelines and standards adopted by our QIC, we use the following metrics:

Metric method	Metric Purpose
HEDIS Performance Metrics	HEDIS performance metrics measure the effectiveness of care based upon compliance with best practice guidelines and achieved outcomes, such as management of chronic conditions and treatment adherence. We can then compare HEDIS data from other health plans and national benchmarks.
CAHPS	CAHPS scores measure the enrollee's experience and perception of care. We can compare our collected CAHPS data to data from other health plans.
Patient Care Opportunity Report (PCOR)	Patient Care Opportunity Reports (PCOR) measures compliance with best practice guidelines and achieved outcomes at provider level with patient level detail to act on. The PCOR reports show useful information to improve outcomes at network or provider level.
Provider Satisfaction Survey	Our provider satisfaction surveys measure the provider's experience with our health plan.
Access Surveys (secret shopper)	Access surveys measure access and availability of care. These surveys show useable information for provider outreach and education.
Utilization	Utilization measures over and under-utilization of services such as use of ED for non-emergent services, length of stays, readmissions, missed opportunities for preventive care and treatment and pharmacy data (e.g., chronic condition management, prescribing patterns). Utilization shows useful information to provide targeted outreach and education for outlier practice patterns.
Complaints and Grievances	Complaints and grievances measures provider and enrollee experience regarding the care received. Complaints and grievances feedback provides useable data for outreach and education to improve our processes.

Our UM clinicians work closely with providers to manage outliers by identifying practice patterns that appear to fall outside typical patterns; identifying and resolving potential patterns that may constitute fraud, waste or abuse; and evaluating compliance with care coordination processes and contractual obligations. We forward practices with potential aberrant patterns to our PAC for

evaluation and implementation of appropriate interventions (e.g., conversations with and education for providers, peer-to-peer reviews; site or treatment record audits; development of corrective action plans or referrals to the Credentialing Committee).

iii. A summary of the Vendor's approach to annual evaluation of the overall effectiveness of the QAPI program and how the Vendor will use findings for continuous quality improvement efforts.

To improve health outcomes for Kentuckians, we will deploy our continuous quality assessment and improvement strategy. At the core of our QAPI is the analysis of data to monitor and improve the quality of care and service delivered across a wide range of clinical and health service-delivery areas, including subcontractors, health services, operations, network management, credentialing, compliance, appeals and grievances, member services and claims. For our enrollees, we place emphasis on the clinical areas related to preventive health, management of chronic diseases, mental health and substance abuse care, individuals with special needs and access to services for enrollees. By routinely analyzing key indicators that measure the processes and outcomes of care rendered to our enrollees, we can identify where we should focus improvement efforts.

We use the QIC structure to measure, evaluate and improve the delivery of care on an ongoing basis. The QIC will review service delivery and provide continuous review and feedback into quality measures, with a focus on functional outcomes and whole person care. To drive the clinical and operational performance that supports DMS's quality strategy, we also will set short- and long-term performance goals and benchmark our performance against Commonwealth and national rates. We will measure our successes through analysis of industry-standard measures of health plan quality as applicable to the Kentucky Medicaid membership, such as HEDIS measures, CAHPS surveys, CMS Adult and Child Core Measure Sets, EPSDT screening ratios, access and availability data, Commonwealth specific measures and feedback we receive as part of compliance audits and accreditation surveys. For example, our Tennessee health plan has a strong PQEC program, where large PCP groups are assigned a PQEC for ongoing support and HEDIS improvement initiatives. The PQEC reviews monthly PCOR reports for each provider group to identify focus measures and develops a customized action plan based upon each PCP group's performance. We also introduced our TennStar program, which provides an incentive bonus to providers for continued improvement on key measures. Through the use of our PQEC and TennStar programs, over the last three years, our controlling high blood pressure (CBP) measure increased from 59% to 79%, postpartum care increased from 68% to 81%, and our CDC HbA1c poor control (where lower is better) decreased from 28% to 20%.

For all Kentucky targeted quality initiatives, we will monitor and evaluate opportunities that may result in Commonwealth- or region-specific PIPs or other formal or informal QI activities. These activities are aimed at improving the quality, timeliness or appropriateness of our care and service delivery, the quality scorecard, and other dashboards that may be developed, that provide summaries of key metrics.

We may design PIPs or other QI studies for the entire Kentucky population. PIPs include effective interventions, measures of performance and timelines for monitoring. Performance improvement indicators are objective, clearly defined, based upon current clinical knowledge or health services research and capable of measuring outcomes such as changes in health status, functional status and enrollee experience. Interventions are evaluated and refined to achieve demonstrable improvement. The QIC and the PAC review the results of evaluations and recommendations at least annually. Rooted in both quantitative and qualitative analyses, we design our internal QI activities and studies to provide:

- Established baselines, measured interventions and transparent timelines for follow up and re-evaluations
- Objective and defined indicators based upon current clinical knowledge and research
- Intervention outcomes (e.g., changes in health status, functional status and enrollee satisfaction) or valid proxies of those outcomes
- Identifiable clinical improvement opportunities based upon population-specific needs, collaborative opportunities with community and Commonwealth partners, and feedback from our participating providers
- Feedback on the findings, initiatives and progress from the providers on our PAC and the members on our regional QMACs
- Structured processes and scientific methods set by the accrediting entity, regulatory agency or designated EQRO

We have in-depth experience operating various integrated and coordinated physical and behavioral health managed care programs with demonstrated outcomes and proven results. With national and local experience gained from operating these programs, we will access best practices, national clinical experts and resources to successfully develop and implement innovative PIPs for Kentucky enrollees.

j. Provide a summary of how the Vendor will collaborate with the Department and other Vendors in developing and implementing a value-based payment (VBP) program. Include proposed approaches for the following at a minimum:

Our commitment to rewarding providers for high-quality care through value-based purchasing (VBP) programs is integral to our mission to improve health outcomes for Kentucky Medicaid enrollees, and to reduce or eliminate Kentucky health disparities. According to *America's Health Rankings composite measure, 2018*, Kentucky ranks 45th in national health rankings, with a high prevalence of frequent mental distress in its population, increases in adults with diabetes and other significant quality improvement needs (obesity, cardiovascular disease and SUD).

We will work in partnership with DMS and other vendors to help address these issues through implementing VBP, using DMS-approved models and selected performance measures and related targets. Our VBP strategy was developed to support Commonwealth priorities, current Kentucky Medicaid and provider landscapes, quality priorities and local Kentucky health needs. **We will align with all DMS requirements noted in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 19.9 Value-based Payment.**

i. The Vendor's lessons learned in developing and implementing VBP models, examples of models that have been most effective in improving performance and outcomes.

The relationships we have already established with providers, and the lessons we have learned through our successful Kentucky Medicare and Commercial VBP programs, will help inform our approach to tailoring the best VBP strategy for the MCO Program. We currently have 10 Kentucky providers participating in performance-based models with our Commercial program and Norton Healthcare recently entered into an Accountable Care Organization (ACO) VBP arrangement. Within our Medicare business, UnitedHealthcare has established strong relationships with key Kentucky providers through VBP implementation. In 2018, 82 provider groups, serving 65% of our Kentucky Medicare enrollees, participated in our MA-PCPi program, which awards providers based upon their Star ratings. MA-PCPi achieved an average Medicare Star rating of 4 for its 2018 performance (up from 3.5 since its implementation in 2016).

Using both Kentucky and national experience, we have learned that our VBP programs need to be true partnerships with providers, DMS and other Vendors, where together we establish joint goals and objectives that are achievable based upon the individual provider's readiness and mutually share information to drive practice transformation. Our strategy and approach to developing VBP solutions is not stagnant and builds on our continuous efforts, leveraging feedback from providers, emerging industry best practices and lessons learned in other markets. Examples of this include:

Norton Healthcare Testimonial
"Norton Healthcare currently has a working relationship with the leadership team of UnitedHealthcare and supports its effort to become a Medicaid managed care organization in Kentucky. I am confident that UnitedHealthcare's experience and depth of services as a provider of health benefits helps us provide our patients with the best possible healthier and wellness care."
— Shelly Gast, System Vice President, Norton Healthcare

- ***HEDIS Gap in Care Model:*** To simplify our primary care VBP program and make it easier for participating providers to understand, we recently transitioned from rewarding quality on a PMPM basis to rewarding providers on a gap closure basis.
- ***Timely payouts:*** Though the standard national approach is to pay out VBP payments annually, we listen to our network providers and flex our programs to meet their needs. In Louisiana and Tennessee, we pay out bonuses during the measurement period, sometimes even quarterly, and saw an increased engagement in our quality VBP program and improvement in HEDIS scores. For the targeted measures in our PCP HEDIS Gap Closure model, we closed an additional 5,916 gaps in 2018 versus 2017 (after normalization). In addition, 63% of group/measure combinations improved or maintained performance year over year for those targeted measures.
- ***Useable, timely data:*** Over the last 13 years of implementing VBP programs, we have learned that the foundation to a successful VBP program is the availability of useable, timely data. To partner with and better support our providers, we enhanced our online tools and developed UnitedHealthcare Care Transitions, our comprehensive population health management platform that provides daily workflow guidance around key clinical transformation processes, including virtually real-time ED and inpatient discharge notifications. Additionally, our Patient Care Opportunity Report (PCOR) provides all groups with insight on HEDIS attainment and highlights enrollee-specific care improvement opportunities. When partnering with other Vendors and DMS on a multi-vendor VBP program, we have found that the Vendor scorecards should be consistent or the data should be integrated (e.g., KHIE) to increase provider adoption.
- ***Focusing on the right measures:*** For any VBP program to be successful, providers need to be able to affect the measures directly. Time and experience have shown a Benefit Cost Ratio (BCR) shared savings approach to measuring total cost of care to be challenging for many ACOs for various reasons (e.g., lack of ACO direct impact on revenue, inability to generate frequent BCR tracking reports). Thus, UnitedHealthcare is moving to deploy the Accountable Care Shared Savings (ACSS) PMPM model as the primary option for ACOs managing total cost of care.
- ***Vendor engagement:*** We have learned that it is critical that all Vendors are engaged and willing to work together to create a multi-vendor VBP model. If one Vendor is left out or is unwilling to participate, a multi-vendor VBP model will not be as effective. In Kentucky, we know from Section 19.9 it is required that the Vendors participate and are engaged in the development of a VBP program. We would ask that the representatives from each Vendor, such as the chief medical officer, be consistent. If there is frequent

participation turnover, we have experienced delayed decisions and a lack of understanding in our other markets with similar collaborative meetings.

- ***Provider input:*** When we design new VBP models, we ask providers how they perceive the incentive program and, most importantly, we ask for provider feedback after the end of the measurement period to determine what modifications are necessary for future years. In Kentucky, it will be important that providers are present when discussing multi-vendor VBP programs, as they will know how these models will affect their practice and most importantly, our enrollees.
- ***Identify a convener:*** Through our experience with multi-vendor partnerships in other markets, we discovered that a convener is an extremely important role to include as we build out and advance our multi-vendor models. As outlined in Section 19.9, DMS will be the convener and keep all parties on track, and identify priorities for the VBP program.

Examples of Models Effective in Improving Performance and Outcomes

UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) recognizes that a one-size-fits-all approach to value-based accountable care is not effective. Therefore, we have developed a continuum of VBP incentive models, directly aligning to the Health Care Payment Learning & Action Network Alternative Payment Model (HCP-LAN APM) Framework, which we use with providers based upon their level of risk and clinical readiness — ranging from performance-based quality incentive programs, to bundled and shared savings/risk models, to capitated arrangements. We recommend that when we partner with other vendors and DMS on VBP models, we create models across the HCP-LAN APM Framework to make sure we meet providers where they are and support them in their growth to more advanced VBP models. The following are examples of VBP models we have seen to be most effective in improving performance and outcomes; these programs, and their historical outcomes or planned focus areas for performance and outcome improvements, are explained in more detail in Question 9.k.i. UnitedHealthcare will have DMS approve all VBP programs before implementation.

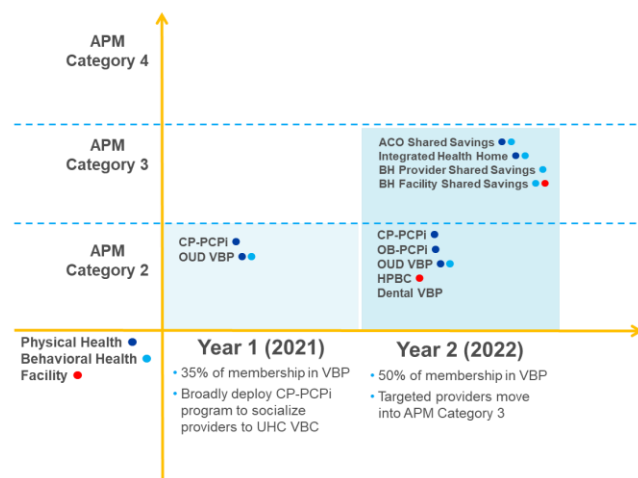

Figure 7. Our 2-year roadmap for Kentucky MCO Program VBP arrangement implementation.

- ***Primary Care Physician Incentive (APM 2C):*** Our primary care incentive model, PCPi, focuses on closing care gaps and improving quality outcomes that are critical to DMS. Participating providers receive fee-for-service (FFS) reimbursement plus the opportunity to earn incentives for closing care gaps.
- ***Opioid Use Disorder (OUD) VBP Models (APM 2C):*** We are developing three opioid-related VBP programs that we will pilot in the Commonwealth. 1) The OUD Quality Medication Assisted Treatment (MAT) VBP for PCPs includes incentive payments for care management service and infrastructure enhancements related to MAT, 2) The ED MAT Induction & Referral VBP supports and enhances the Kentucky "bridge clinics," designed to provide MAT treatment on-demand, by incenting EDs to establish protocols for patients identified as needing MAT services (e.g., referral to bridge clinics), and 3)

The Maternal and Infant Opioid Health Home VBP focuses on the holistic needs of pregnant women with OUD, neonatal abstinence syndrome and mom/baby support.

- ***Obstetrics (OB) PCPi Incentive (APM 2C):*** This program rewards qualifying OB specialist practices for performance relating to closing patient care gaps for certain HEDIS prenatal and postpartum measures and improving birth outcomes.
- ***Dental VBP Incentive (APM 2C):*** Dental providers participating in this model will receive a bonus reimbursement for achieving improved outcomes on selected quality metrics: annual dental visits (ages 2-20); oral evaluation (ages 0-21); cleanings (ages 0-21); topical fluoride application (ages 1-21 who are elevated risk); and caries risk assessment (ages 2-20 years).
- ***Hospital Performance-Based Contract (HPBC) Incentive Model (APM 2C):*** This program rewards hospitals for improving the quality of care provided to our enrollees and improving efficiency and performance. For each provider, we will incorporate customized, hospital-specific improvement targets, which align to DMS's performance metrics and priority areas. Hospitals have the opportunity to earn all or a pro-rated portion of an incentive based upon their performance against these measures.
- ***Behavioral Health Provider Shared Savings Model (APM 3A):*** This model for outpatient behavioral health providers will focus on reducing the PMPM inpatient behavioral health cost over a 12-month measurement period and meeting defined quality metrics. For each metric achieved, a certain amount of shared savings will be available for the provider.
- ***Behavioral Health Facility Shared Savings (Clinical Excellence) (APM 3A):*** This model for facility providers (inpatient, residential and partial hospitalization programs) focuses on a reducing the 30-day episode cost of care over a 12 month measurement period and meeting defined quality metrics. For each metric achieved, a portion of shared savings will be available to the provider.
- ***Integrated Behavioral and Physical Health Home VBP Model (APM 3A):*** To support organizations in providing comprehensive integrated primary and behavioral health care that will result in the best outcomes for our enrollees with serious mental illness (SMI) and SUD, we will implement our innovative Integrated Behavioral and Physical Health Home VBP shared savings model. The goal of this integrated model is to improve performance and reduce the overall behavioral and medical total cost of care. If a behavioral health provider can reduce the total cost of care and meet defined quality metrics, they will be eligible to receive a percentage of the shared savings amount. Metrics will focus on medical and behavioral health measures including medication adherence measures and align with the Commonwealth's priorities including the 7-Day and 30-Day Follow-up after Hospitalization for Mental Illness measures.
- ***Accountable Care Programs (APM 3A-3B):*** Our ACO models have upside/downside shared savings provisions based upon performance against the total cost of care and quality metrics. Bonus opportunities are based upon savings accrued against the total cost of care or utilization metrics such as non-emergent ED use or avoidable admissions. The distribution of shared savings providers can earn will be determined by performance against a suite of quality measures aligned with DMS-selected metrics.

ii. Recommended goals and focus areas in the first two years of implementation of the VBP program.

Based upon our experience developing VBP models, we align financial incentives to meet providers where they are, improving health care quality through data and collaboration. UnitedHealthcare recommends focusing on quality-only programs (APM Category 2) during Year 1, as they are simple in design, straightforward and are supported by useable timely data.

In Year 2, the focus should be on moving to shared savings models (APM Category 3), in alignment with DMS transformation goals. To breakdown provider silos, create administrative ease and lessen abrasion we recommend DMS create a unified VBP framework including:

- ***Obtain commitment from Vendors and key stakeholders:*** Gain commitment from all vendors and key stakeholders, such as KPCA or the Kentuckiana Health Collaborative, to collaborate with DMS in developing a unified VBP framework. We have learned from experience that having a unified VBP framework, which all vendors commit to, is an effective way to increase provider engagement and participation.
- ***Determine VBP Program Structure:*** Early in the process, we suggest collectively determining the framework of a unified VBP program with DMS, other Vendors and key stakeholders. Since multi-vendor models are new to Kentucky, we recommend starting with a model that will allow the majority of providers to participate in, such as a quality (APM 2) program and then move up the risk continuum (e.g., APM 3) in future years to align with DMS priorities.
- ***Define Participating Provider Requirements:*** We will collaborate with DMS, other Vendors and provider partners to define a Charter for VBP to include (minimally) the targeted membership, data sharing capabilities infrastructure and clinical leadership requirements for participation. Based upon the program's structure, it is important to define criteria and target the right providers from the start to maximize our efforts in the multi-vendor program and improve the health of MCO Program enrollees.

To meet these goals, as previously stated, we are willing to take the lead and bring together DMS, other Vendors and provider partners to implement Kentucky's multi-vendor VBP programs collectively. Our collaboration approach is described in the following sub-section.

iii. Proposed approaches to collaborate with the Department and other MCOs to develop the VBP program and to implement a coordinated approach to achieve statewide improvement in outcomes.

To collaborate and align on our previously stated objectives and solutions, we commit to working with DMS, other Vendors and providers, such as KPCA, to initiate VBP programs that align to Commonwealth priorities and help improve population health and quality outcomes — understanding that model and metric alignment, provider ease of engagement and commonalities in data sharing are the primary goals. This coordinated approach should lead to all participating providers across all Kentucky MCOs knowing and collectively attempting to achieve and affect the same goals and outcomes (e.g., improvement in a defined set of HEDIS measures).

Experience Collaborating with Other MCOs for a Coordinated Approach

Our experience in partnering with other MCOs will help us be thoughtful leaders as we create a multi-vendor VBP program in Kentucky. In Ohio, the Department of Medicaid asked for VBP models to help address the state's opioid epidemic. We shared three payment model options, similar in design to those proposed for Kentucky, with the Medicaid chief medical officer and committed to work with the State and other MCOs to improve Ohio's treatment landscape. In our multi-vendor experience in Tennessee, the State (TennCare) and the three MCOs (UnitedHealthcare, Amerigroup and Blue Cross and Blue Shield of Tennessee) are participating in the Episodes of Care bundled program. We have found this to be a successful approach and have expanded the program each year since inception in 2015, moving from three Episodes of Care in 2015 to over 48 in 2019. This approach and collaboration has led to a significant savings; from 2015 to 2017, the risk-adjusted savings of these programs totaled $53.9 million for all three MCOs.

Using lessons learned and gained experience from these examples and other states, our executive team members will lead discussions with DMS, other MCOs and select providers during collective planning and in-person meetings to agree on decisions, such as:

Consistent Measures: The measures for the multi-vendor VBP model need to be consistent across all MCOs. The consistency will limit provider administration and reduce complexity. All of our current VBP programs, for example our CP-PCPi model which focuses on PCPs closing HEDIS gaps in care, are flexible in design and can align with DMS and other MCOs. Our programs also offer the flexibility to modify the measures during the measurement period, to validate alignment to DMS if measures are changed during the contract term.

Focusing on the Right Measures: In addition to the need for consistency, the measures that are selected for the multi-vendor VBP program must focus on the specific needs of our Kentucky enrollees. They should align with DMS's priorities and be meaningful measures that providers can achieve. For example, the size of their membership panel, enrollee demographics and dedicated support staff should all be considered when selecting measures for participating providers. As we facilitate discussions, we will make certain DMS and providers are helping make these decisions, not only the MCOs.

Timeliness of Payments: We have learned from our quality models that timely payouts lead to increased participation and engagement. We will work with the other MCOs, DMS and providers to create a payment method that works for everyone, enabling timely payment for providers so they can properly invest in the necessary infrastructure improvements and resources to care for our enrollees.

Consistent Data Tools: Data availability and data sharing is the foundation for any successful VBP program. Providers need timely, useable data that is easy to use and understand. Providers often are required to use different reports and tools for every MCO's VBP initiatives, which can lead to a lack of engagement or confusion. Our recommended solutions include:

- ***Aligned Scorecards:*** In the short term, all MCOs could align their reporting tools to look and feel the same. Our quality VBP performance scorecards (PCOR reports) are updated monthly and available to providers online via our secure provider portal or electronic transmission. The reports are easy to read and filter, and include useful information such as a summary view of the group's current performance on targeted measures, enrollee-level data on open gaps in care and estimated earning potential for the VBP program. In Louisiana, the State used our quality VBP performance scorecard as the template and recently made it a requirement for other MCOs to use the same scorecard structure as ours. In Virginia, providers requested one VBP performance scorecard from the State to use across all the health care plans; to implement this change, all MCOs were required to submit data to the State in the same format — making it easier for the State to roll up and display this data for providers. In either scenario, having scorecards with a consistent appearance across all MCOs makes it easier for providers to be successful — spending their time on caring for enrollees and not on data searches.
- ***Integrated Data:*** All providers are required to connect to the Kentucky Health Information Exchange (KHIE) per Section 17.1 of the Model Contract. The KHIE allows providers to see all the information about their patients, regardless of MCO, which will reduce the administrative burden for practices that participate in a multi-vendor VBP program. This tool will assist providers in managing their entire population and will be critical to their success in the multi-vendor VBP program and more advanced APM

models. UnitedHealthcare will lead discussions with the other MCOs and DMS on how we can conduct provider trainings sessions (such as Lunch & Learn sessions) to inform and answer questions about the KHIE as it relates to the multi-vendor VBP program.

- ***Innovative Tools:*** Hotspotting is a data-driven process to map geographical areas with the highest concentration of enrollees who use a disparate amount of medical, behavioral and social resources. Launched in June 2018, our proprietary Hotspotting tool provides the timely identification and engagement of enrollee subpopulations such as those with inappropriate utilization patterns, complex social, behavioral or medical needs and high costs within a defined region. Its dashboard provides a host of filters to segment enrollees by demographics, SDOH, utilization, cost, diagnosis, risk factors and enrollment in case management. We are willing to share these reports with both DMS and other MCOs to help target key areas for VBP program implementation to help address noted health priorities.

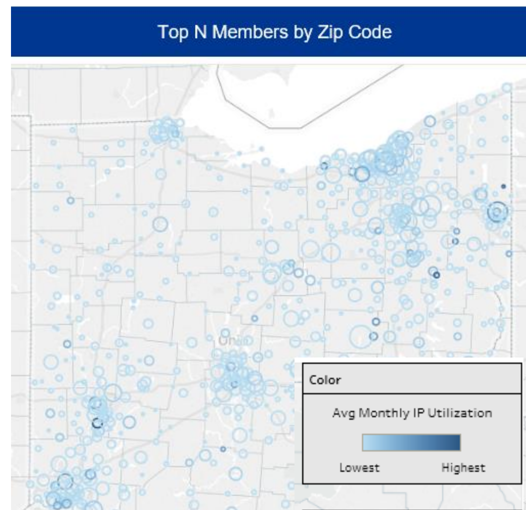

Figure 8. Our Hotspotting tool provides heat maps and summary statistics that offer our clinical team an understanding of subpopulations that could benefit from additional community support.

iv. Potential challenges specific to Kentucky and the Vendor's proposed methods for addressing identified challenges.

Based upon our VBP experience in Kentucky (through our Medicare and Commercial business lines) and states nationwide, we know the common barriers to implementing VBP programs, and have developed proven mitigation strategies to help overcome those challenges.

Potential Challenges	Methods for Addressing Challenge
Kentucky Provider VBP Hesitancy, Readiness and Willingness to Take on Risk	
The most significant barrier we encounter is provider readiness and bandwidth to engage in practice transformation and act upon clinical engagement opportunities, which is especially needed for providers within our ACO models to reach their highest success potential. This is mainly due to the lack of experience providers have with population health and performance improvement, as we have only one ACO in our Medicare and Commercial lines of business in Kentucky.	We continuously mitigate this barrier via our relationship building with provider practice clinical staff. In Kentucky, like we have in other Medicaid markets, we plan to assist VBP-participating providers in practice transformation and the development of their internal processes by: ▪ Comprehensive data sharing during regular meetings that supports the clinical process and clinical care coordination work ▪ Installation of a full-time employee at the provider practice's location (as applicable), who helps to identify care gaps, schedule follow-up meetings and get enrollees in for appointments to close gaps We also focus on quality incentive models at the beginning of relationships or in new programs to support provider readiness
Lack of Available Medicaid-specific Data	
A barrier to successfully advancing VBP programs in Kentucky is the lack of historical baseline data with which to establish performance metrics. Most programs require a minimum of 1 years' worth of	To mitigate this, we have learned to focus on APM Category 2 (quality only) programs in Year 1 to begin building the foundation needed for more advanced VBP models. As data becomes available in Year 2, we

Potential Challenges	Methods for Addressing Challenge
claims data. As we use each state's Medicaid-specific provider and claims history data to develop our VBP programs for implementation, this makes it challenging for us to identify specific quality and cost of care targets and measurements.	can then meet providers where they are on the VBP spectrum whether that is pay-for-performance quality programs or models that are more advanced like shared savings or capitation.
Kentucky Rural Providers	
We recognize many Kentucky providers are located in rural and/or frontier locations with small UnitedHealthcare membership. As such, the VBP models that depend upon scale and statistically valid panels for performance measurement (such as ACO shared savings) cannot easily be offered to many of our providers.	To address these issues, we will focus on model flexibility for our primary care-focused arrangements (APM Category 2). PCPs are a critical component to successful enrollee outcomes (they are the provider seeing the enrollee most often) and are best positioned to identify care improvement opportunities for the enrollee and to execute on clinical engagement and care management next steps. We also will explore collaboration with other MCOs to determine if there is an opportunity to aggregate data and align payments to support providers in achieving statistically valid panels.
Kentucky Provider Perception of Medicaid Programs	
Limited provider participation in the Medicaid program due to their perception of Medicaid programs (e.g., inadequate volume of Medicaid lives to make VBP rewards meaningful enough to change practice performance) or their focus on balancing their Commercial and Medicare portfolio are barriers to VBP program success.	To mitigate this, we will work with DMS, other MCOs and providers on developing and deploying a multi-vendor model with the same VBP measures and targets. Working toward the same targets with the same measures will ultimately increase the VBP rewards and increase their adoption. We could also align, where applicable, measures or scorecard structure with other business lines. This will make it easier for providers to focus on providing care to Kentuckians, rather than focusing on different VBP programs for each line of business.

v. Regardless of the model implemented, the Vendor's approaches to analyzing performance against targets, frequency of analyses, reporting results to DMS, and use of analyses to modify interventions that are not making progress towards achieving targets.

We monitor the status of provider performance against quality targets monthly, quarterly and yearly (based upon VBP model) and review analytical data to confirm we have the best outcomes for our enrollees. In addition to the quality reporting and in accordance to Section 19.9 of the Model Contract, we will submit required monthly, quarterly and annual VBP reports to DMS using a DMS-provided template, including a summary of all VBP costs, activities and achievements. In partnership with DMS's quality staff, we will review and enhance our reports as necessary to ensure transparency and inclusion of all desired information and outcome results related to our VBP arrangements. We also will work with both DMS and other Kentucky Vendors to develop a consistent method and medium for VBP reporting (e.g., monthly emails) — focusing on data transparency and a collective view for easy comparison and measurement. As we have in other Medicaid markets, we will work collaboratively with DMS to develop standard measure/metric specifications, data collection processes, baseline data and reports on VBP adoption efforts.

Each of our VBP programs has clear, defined targets and goals and as we review the results quarterly, we will make sure our programs are moving toward established targets. For our quality program, PCPi, we generate monthly files showing the performance of all participating

providers. We are then able to filter on high- and low-performing groups, and use this data to find trends and share best practices. For providers in more advanced VBP arrangements, we provide population health reporting and tools that include predictive analytics, claims data and information on peer performance.

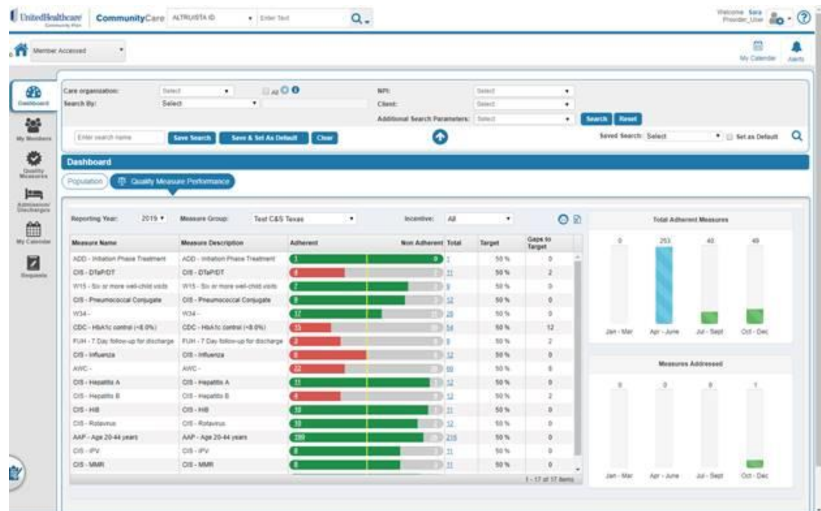

Figure 9. Quality Measures Dashboard. Available to all PCPi participating providers, the dashboard provides a summary scorecard of performance against HEDIS measures with quick-access links to identify those UnitedHealthcare enrollees in the provider's panel who have gaps in care.

During the first year of the MCO Program, we will compare the Kentucky results to other Medicaid markets to see how they compare to one another. As the program continues in future years, we can compare year-over-year trends specific to Kentucky, which we can use to project outcomes and improvement. If the results of the program are not trending toward our goals, we will work with providers and DMS and suggest an alternative approach. Most of our contracts allow for mid-year updates; therefore, if providers are not participating in the program due to lack of financial reward, we would be able to increase the potential earnings of the program to drive participation and properly reward providers for delivering high quality of care.

If we note that a network partner is struggling within a VBP program and experiencing challenges achieving targets, we will deploy flexible intervention methods through our provider support model. We offer dedicated staff to support providers in reaching goals and intended outcomes, and provide data analytics and training sessions. Our Kentucky provider quality engagement consultants (PQECs) will meet with practices regularly and review goals, data, quality outcomes and technology training needs to make certain each staff member is using the tools and the data to effectively track outcomes. For example, they may re-educate the provider on the many resources available to them through our provider portal (*Link*), such as real-time alerts on medical encounters that signal opportunities for the provider to intervene and follow up with enrollees and on-demand reporting on VBP/HEDIS measures. We also provide service interventions for providers who are working to meet their VBP targets but are facing staffing or communication barriers, such as offering a cobranded enrollee communication program, assisting the practice in scheduling appointments or using community outreach (e.g., Clinic Day or health fair) to bring patients into the practice to close gaps in care.

k. Will the Vendor and Subcontractors implement VBP arrangements with providers? If so, describe the following:

Yes, UnitedHealthcare and our affiliate subcontractors (e.g., Optum behavioral health services and Dental Benefit Providers) **will collaborate to implement VBP** arrangements with our Kentucky network providers. For the MCO program, we will subcontract with established, currently used Kentucky vendors for several covered services — including, but not limited to, OptumRx for pharmacy services; Optum behavioral health services for behavioral health and substance use services; Dental Benefit Providers, Inc. (DBP) for dental services; and MARCH Vision Care Group, Incorporated for vision services. Although technically

subcontractors, these vendors are company affiliates and are part of UnitedHealthcare. As "internal vendors," we have stronger direct oversight of their services and performance. Subcontractors are held to the same contractual requirements as UnitedHealthcare.

Of the subcontractors previously listed, we are looking to partner with DBP and Optum behavioral health services to benefit from their vast knowledge and established Kentucky provider relationships to help implement VBP programs. While VBP contracting is new in the dental market, DBP is leveraging its robust experience and infrastructure to engage dental providers in new methods of payment and incentives for performance. We anticipate these initiatives will substantially shift the focus of the dental delivery system toward an emphasis on preventive care, improved care coordination and reduction of adverse outcomes. Optum behavioral health services has piloted Medicaid VBP programs with CMHCs over the last year, with current programs in eight states and additional planned expansion. As outlined in the following sub-section, we plan to roll out dental and behavioral health VBP programs in Year 2. In the development of these programs, we will align with all DMS requirements noted in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 19.9 Value-based Payment.

i. The types of VBP arrangements the Vendor and Subcontractors plan to use and why these models were selected. As part of your description, map your proposed VBP arrangement to the HCP-LAN APM Framework maturity level.

Based upon our national experience in developing and implementing VBP programs, we understand that if we approach a new market with the intent of directly and immediately entering into VBP arrangements, we limit our VBP partnerships to those providers who are operationally, financially and clinically ready and qualified (e.g., appropriate membership panels). Often, to be most successful with VBP arrangements, we first need to build our network, build relationships with providers and build our knowledge base of how our membership is distributed across the network. Once we have done these activities, we can then approach not only more but the ***right*** providers about VBP model implementation — becoming their advocates and support base for VBP measure achievement. We will continue to use the relationships we have already established with providers through our successful Kentucky Medicare and Commercial VBP programs to help inform our approach to tailoring the best VBP strategy for the MCO Program.

We recognize that a one-size-fits-all approach to value-based accountable care is not effective. Therefore, we have developed a continuum of innovative VBP incentive models, directly aligning to the HCP-LAN APM Framework, which we use with providers based upon their level of risk and clinical readiness — ranging from performance-based quality incentive programs, to bundled and shared savings/risk models, to capitated arrangements.

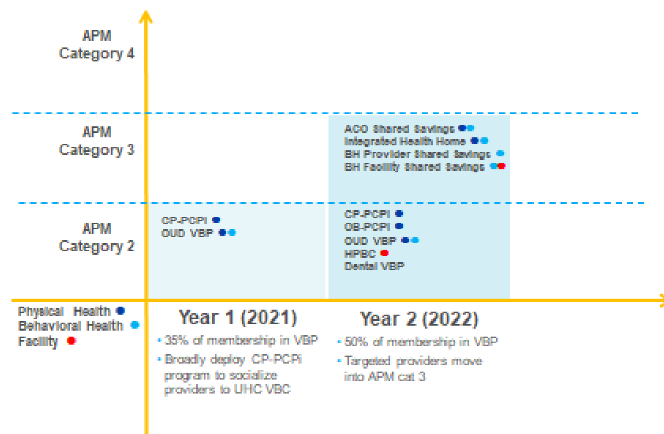

Figure 10. Our 2-year roadmap for Kentucky MCO Program VBP arrangement implementation.

In extensive review of Kentucky's Medicaid landscape, we have set a comprehensive 2-year VBP strategy plan that includes the Commonwealth's priority needs, deploys programs focused on improving outcomes,

encompasses the entire care delivery system and maps out a focused progression of providers taking on greater risk over time. Of note, our VBP strategy for Kentucky initially focuses on performance-based models in HCP-LAN APM Category 2. For many providers, this APM category serves as an entry point to a pay-for-quality environment, and we see this as a crucial engagement platform to build provider best practices that can mature into future VBP opportunities that entail greater risk at higher APM categories.

We recommend and will deploy the following primary goals and focus areas as part of our VBP program strategy in the first 2 years of implementation, in alignment with DMS transformation goals:

- Align financial incentives to meet providers where they are, improving health care quality through data and collaboration
- Introduce VBP to Kentucky network providers by rolling out APM Category 2, upside only programs (performance-based models); they are simple in design, straightforward and are supported with useable, timely data
- Gather needed historical baseline data from claims during Year 1, then move or introduce network providers into APM Category 3 arrangements in Year 2 and beyond
- Achieve **35% of membership served by VBP-participating providers** in Year 1, and **50% of membership** in Year 2

To achieve these goals, as outlined in the accompanying roadmap graphic and explained here in detail, the following are our proposed VBP programs for Kentucky Medicaid providers and the planned implementation year; the models were selected due to their proven success in improving performance and outcomes. These programs will be approved by DMS, align to DMS priorities and withholds and align with other MCOs.

For each model, we describe the selected regional deployment, which is based upon targeted Kentucky health priority prevalence. As these models achieve (and even exceed) targeted performance outcomes in the initial areas, we will expand their implementation to other affected regions of the Commonwealth — using the model's proven success as a provider recruitment tool for VBP program participation.

Primary Care Physician Incentive (APM 2C, Year 1): Our primary care incentive model, PCPi, focuses on closing care gaps and improving quality outcomes around health priorities identified by DMS, such as tobacco use (Regions 4/7/8), diabetes prevalence (Regions 7/8) and adult obesity (Regions 7/8). The structure of the PCPi allows us to customize incentivized HEDIS improvement metrics (including integrated measures for behavioral health or vision) that require the greatest focus in a particular population and market. Participating providers receive FFS reimbursement plus the opportunity to earn incentives for closing care gaps.

> Our **Primary Care Physician Incentive (PCPi) Program** has been used in 18 markets nationally, covering over 4,200 provider groups and 2.4M+ UnitedHealthcare Medicaid enrollees.

For program deployment in Year 1, we will target PCPs in the market such as Kentucky Primary Care Association (KPCA), Baptist Health and the 180+ Kentucky Patient Centered Medical Homes (PCMHs), and annually assess the inclusion of additional providers. This includes providers in rural settings — verifying we target not only our most concentrated Kentucky MCO populations, but we also incent providers wherever they are seeing enrollees in the Commonwealth. This incentive program is foundational to our VBP strategy in helping providers

> **KPCA Testimonial**
> "We have discussed our intent to collaborate with UnitedHealthcare on a value-based payment model, case management projects including targeted case management and chronic case management as well as our centralized value-based payment management system. These programs hold much promise to improve quality outcomes and reduce health disparities and we are excited to implement them upon UnitedHealthcare receiving a contract award."
> — David Bolt, CEO, KPCA

succeed within a pay-for-quality reimbursement environment. It allows us to introduce quality and VBP best practices and prepare providers to move into future higher risk VBP arrangements. For example, many of the ACOs we are targeting for Year 2 will be introduced to the PCPi program in Year 1 to assure their VBP and quality readiness. We also will apply this program to promote and incentivize provider's use of the EHR by paying a higher gap closure bonus for those providers who are connected. With the current EHR incentive program expiring in 2021, this will help provide the financial support to providers in order for them to continue leveraging the EHR.

In 2017, we introduced the PCPi program to 402 provider groups in our Tennessee market incentivizing up to 20 different measures depending on the provider group. Over 56% of participating providers had improved outcomes from prior years across incentivized measures. With the goal of having 50% or more of our enrollees aligned to VBP-participating network providers by Year 2, this program will be of primary importance and can directly improve Kentucky's HEDIS rates due to the high number of PCP participants.

Opioid Use Disorder (OUD) VBP Models (APM 2C, Year 1): Aligned with the Kentucky Opioid Response Effort (KORE) goals to increase access to MAT and recovery services, we have developed the following three VBP models aimed to improve the quality and capacity of MAT providers, verify enrollees with OUD receive comprehensive evidence-based care and incentivize treatment retention across different settings. We will deploy these pilot programs in partnership with select providers, such as the University of Kentucky (UK) and KPCA, within the higher risk regions of Kentucky (Regions 6/8), where opioid-related deaths are the highest in the Commonwealth. We already have a signed letter of intent with KPCA to align our PCP MAT VBP pilot program with their KORE project, which is building MAT infrastructure in Federally Qualified Health Centers and Rural Health Centers across the Commonwealth. We are engaged in conversations with UK about how to implement our OUD VBPs to support the UK ED Bridge Clinic and Perinatal Assessment and Treatment Home (PATHways) program and align with the goals of the UK-HEAL grant.

- The ***OUD Quality MAT VBP*** for PCPs includes a substantial monthly care management payment, in addition to targeted incentives for monthly MAT refills and a bonus for enrollees retained in treatment every 6 months. PCPs can use these financial resources for infrastructure enhancements required to provide intensive care management services such as comprehensive assessment of medical, behavioral and social needs; development of an Addiction Treatment and Recovery Plan; MAT and behavioral counseling; connection to social service and peer recovery supports; drug urine screens; screening for HIV/Hepatitis C; reproductive health counseling; and naloxone education.
- The ***ED MAT Induction and Referral VBP*** supports and enhances the Kentucky "bridge clinics" which are designed to provide MAT treatment on-demand. We have learned there is a need to incent ED physicians/departments to establish needed protocols and culture shifts related to enrollee assessments for substance use; MAT treatment initiation (when indicated); and getting enrollees linked to quality MAT providers, such as the bridge clinics, for ongoing care. To help address this need, our payment model will

provide a bonus to EDs when they initiate MAT, with a second bonus when the individual fills a prescription for MAT in the days following the initial ED visit — indicating successful referral to ongoing care. With this model, we hope to prevent opioid overdoses and unnecessary admissions by connecting high-risk enrollees to evidence-based care at the initial point of engagement within the health system.

- The ***Maternal and Infant Opioid Health Home VBP*** is designed to address the medical, behavioral and social needs of pregnant women with OUD; reduce the severity of and costs related to neonatal abstinence syndrome; and support the mom/baby through long-term recovery, child development and parenting resources. This model includes monthly care management fees during the prenatal and postpartum period, with bonuses tied to achieving certain indicators of evidence-based care.

Obstetrics (OB) PCPi Incentive (APM 2C, Year 2): Recognizing the critical importance of improving perinatal care and birth outcomes in Kentucky, we plan to implement our OB provider specialist incentive program. This program rewards qualifying OB specialist practices for performance relating to closing patient care gaps for certain HEDIS prenatal and postpartum measures and improving birth outcomes. As part of the program, a practice can earn bonus payments for achieving or exceeding target scores for select performance measures (in alignment with DMS's quality measures). The bonus is in addition to the practice's compensation for rendering enrollee services. Using this incentive in a similar market, targeted providers' prenatal and postpartum rates increased 39% year-over-year. Implementation focus areas for this program will include OB specialists in Region 6, which has the highest infant and overdose morality rate, and in Regions 7 and 8, which have the highest rate in Kentucky of births to mothers who smoked during pregnancy.

Dental VBP Incentive (APM 2C, Year 2): This model will drive innovation, action and alignment among dental providers statewide, as dental issues are a noted health concern of the Medicaid population across the Commonwealth, but especially in western Kentucky, the Appalachia region and areas with high Methamphetamine use. The model is based upon the quality of care versus the volume of care. Providers will receive a bonus reimbursement for achieving improved outcomes on selected quality metrics. Experience in our other markets demonstrates the effectiveness of selecting a small number of quality metrics that are within the control of primary dentists and investing in the measurement and tracking of those metrics. Based upon DMS review and approval, we will target one to four program metrics around annual dental visits (ages 2-20); oral evaluation (ages 0-21); cleanings (ages 0-21); topical fluoride application (ages 1-21 who are elevated risk); and caries risk assessment (ages 2-20 years). Our plan is to pilot this program in Year 2 with key dental providers, using Year 1 to gather clinical experience and market specific analytics to support the program. We have targeted KPCA's Federally Qualified Health Centers (FQHCs) with integrated dental services for this incentive.

Hospital Performance-Based Contract (HPBC) Incentive Model (APM 2C, Year 2): Our hospital incentive model supports both national and Indiana health care initiatives such as, but not limited to, reducing readmissions, decreasing infections, avoiding improper use of EDs and reducing early elective deliveries — all of which affect costs and quality of care. The program rewards hospitals for improving the quality of care provided to our enrollees and improving efficiency and performance. For each provider, we will incorporate customized, hospital specific improvement targets. This model centers on collaboration among our local medical director, DMS and hospital leaders. It also includes mutually agreed upon performance measures in relation to performance-based compensation that will ultimately encourage these providers to enhance access to our enrollees. Hospitals have the opportunity to earn all or a pro-rated portion of an incentive based upon their performance against these agreed upon measures and aligned with Kentucky's performance metrics.

Behavioral Health Provider Shared Savings Model (APM 3A, Year 2): This model for behavioral health providers (Community Mental Health Centers, CMHCs; Multi-Specialty Groups, MSGs, Behavioral Health Service Organizations, BHSOs and other outpatient providers) will focus on reducing the PMPM inpatient behavioral health cost over a 12-month measurement period and meeting defined quality metrics. For each metric achieved, a certain amount of shared savings will be available for the provider. The metrics will focus on medication adherence (as a preventive measure to help avoid behavioral health hospitalizations) and/or follow up after hospital discharge appointments (7/30-day appointments). The behavioral health provider must meet quality metrics to receive distribution from the shared savings pool. We have discussed this program with many of Kentucky's CMHCs — including Adanta, New Vista, Centerstone, North Key and River Valley — and plan to begin the necessary data collection at contract go-live. We will make the program available to all behavioral health providers who are interested and qualified to participate.

Behavioral Health Facility Shared Savings (Clinical Excellence) (APM 3A Year 2): This model for facility providers (inpatient, residential and partial hospitalization programs) focuses on a reducing the 30-day episode cost of care over a 12 month measurement period and meeting defined quality metrics. For each metric achieved, a portion of shared savings will be available to the provider. The metrics focus on 7-day follow up after hospitalization, length of stay outlier rate and readmission rate. The prover must meet quality metrics to receive distribution from the shared savings pool.

Integrated Behavioral and Physical Health Home VBP Model (APM 3A, Year 2): One of the many challenges we heard in ongoing conversations with leaders and clinical staff of Kentucky's BHSOs, CMHCs, MSGs and other providers, in providing integrated primary care to their most vulnerable clients was around lack of sustainable reimbursement. To support organizations in providing comprehensive integrated primary and behavioral health care that will result in the best outcomes for our enrollees with SMI and SUD, we will implement our innovative Integrated Behavioral and Physical Health Home VBP shared savings model.

The goal of this integrated model is to improve performance and reduce the overall behavioral and medical total cost of care. If a behavioral health provider can reduce the total cost of care and meet defined quality metrics, they will be eligible to receive a percentage of the shared savings amount. Metrics will focus on medical and behavioral health measures including medication adherence measures and align with the Commonwealth's priorities including the 7-Day and 30-Day Follow-up after Hospitalization for Mental Illness measures.

We will pilot this model with high quality behavioral health providers who already have robust integrated primary care programs and expressed a strong interest and readiness to participate in a value based program. In Year 1 we will collect baseline data while focusing on a quality incentive-based program preparing the provider for movement into total cost of care and launch the model in Year 2

In addition, we will work with behavioral health providers who have the space and a strong interest in building integrated primary programs to identify potential providers for possible expansion of the model by the end of Year 2. We will collect robust data on our initial pilots and use this data to inform our decisions to scale up and add additional sites.

We recognize that providers interested in launching new integrated primary care programs may need up-front funding to pay for their primary care clinical staff and robust care coordination. In Year 1, we will explore the potential to include an upfront grant or monthly care coordination payment, in addition to targeted quarterly incentive payments for meeting performance metrics

such as 7-Day and 30-Day Follow-up after Hospitalization for Mental Illness. Many providers could use these financial resources for infrastructure enhancements required to provide integrated primary care and behavioral health services such as hiring primary care clinicians and developing MAT programs for OUD. In future years, we will move participating providers toward accountability for overall (behavioral and medical) total cost of care and awarding shared savings to the providers who meet our defined quality metrics that focus on both behavioral and physical health.

To support providers participating in this program, our value-based program consultants will provide intensive face-to-face practice transformation including:

- Provide data on admissions and discharges, on-site coaching, training and resources
- Support a learning collaborative to create the opportunity for peer-to-peer learning with other integrated practices participating on our pilot
- Provide reports with performance on the measures
- Develop tools and resources to support the advancement of integrated primary care in Kentucky CMHCs, MSGs, BHSOs and other providers

Accountable Care Programs (APM 3A-3B): UnitedHealthcare's ACO Program is critical to our VBP strategy, as it has proven effective at improving the patient and provider experience, improving population health, and reducing avoidable health care cost. Our ACO models offer shared savings or shared risk (upside/downside) incentive potential to health care providers based upon their management of enrollees' total cost of care or management of more targeted, avoidable utilization like ED visits and inpatient admissions. The level of incentive earned (or liability owed) from any surplus (or deficit) off of a total cost of care or utilization baseline is determined by performance on selected quality measures that would align with DMS priority measures. This validates that providers stay focused on state-priority quality measures and that enrollee quality of care does not suffer in pursuit of cost efficiency.

Nationally, our ACOs show 9% lower admission rates and 2% fewer ED visits compared to non-ACOs, which can lead to substantial cost savings as we expand VBP to include over 50% of our enrollees in Year 2.

Provider candidates for the ACO Program include PCPs, PCMH's, FQHCs, and multi-specialty provider groups with a minimum of 1,000 UnitedHealthcare Medicaid enrollees. Additionally, these candidates must commit to open care access for new enrollees and extended hours to offer care on weekends and/or evenings.

In addition to providing incentives, UnitedHealthcare supports ACOs with data, consulting, and technology to help them transform their practices from a reactive, volume-based care strategy to a strategy based upon proactive population health and high-value care coordination. We already have an LOI with KPCA to work together on implementing a total cost of care ACO arrangement within the first contract year. Vital to program success is the layer of provider-facing support we will deploy as part of the overall ACO performance strategy in Kentucky.

Additional VBP Models for Future Consideration

In addition to the programs outlined in our 2-year strategy, we will continually pursue additional VBP opportunities as providers are ready. Examples of such programs might include the implementation of bundled/episodic VBP arrangements with providers in high-risk regions of Kentucky, such as maternity bundles to help address the high infant mortality rates in Regions 2, 6 and 8 and our episodes of care program for asthma and COPD in Regions 4 and 8. As a prioritized goal in future contract years, and as providers are capable, qualified and willing, we

also will enter into risk-based, capitated arrangements (APM Category 3 or 4). These arrangements support a comprehensive population health approach by giving providers a monthly cash payment along with timely clinical data to support proactive enrollee engagement and to manage high-risk patients optimally. Sub-capitated arrangements like this are only successful with providers who have demonstrated strong population health management and quality improvement capabilities.

Expected outcomes for planned **future Kentucky bundled/episodic VBP arrangements** are based upon experience in other Medicaid states where episode-based shared savings models have been implemented. In other markets, we have seen follow-up care increase by 3% and smoking cessation increase by 5%.

Further, UnitedHealthcare, OptumRx and our pharmacy partners are working together to implement strategies where our pharmacy partners take on more risk, and will be responsible for delivering defined services to a specific population at a predetermined price and quality level.

ii. How improvement in health outcomes will be addressed through the VBP arrangements implemented.

We have developed our suite of VBP models to drive clinical outcomes that achieve measurable and quantitative results, as described previously in 9.k.i. Our APM approach directly aligns with the HCP-LAN APM Framework. Our continuum of programs rewards provider movement from traditional FFS arrangements (Category 1) to accountability and risk incentive models (Categories 3 and 4). All our VBP programs link quality to value through metrics aligned with DMS's priorities. We also place significant emphasis on the program's top utilization- and cost-driving conditions.

For all incentive programs, we incorporate state goals as our target measures. If there is no established state goal, then we refer to NCQA Quality Compass 50th, 75th or 90th percentile (selecting the next available percentile based upon current outcomes). We offer FFS plus reimbursement incentives for integrated care coordination for quality and value (APM Category 2), quality with shared savings/shared risk (APM Category 3) and capitated/quality and performance (APM Category 4) for ancillary providers. Our continuum of VBP offerings drives improved quality and health outcomes, as demonstrated in the following examples:

Accountable Care Programs: With this program, we target providers who are committed to clinical integration and comprehensive population management. We set collaborative goals with participating providers and measure access to care, ED trends, admissions, readmissions and adverse event trends for their high-risk target populations, such as complex enrollees who have persistent high utilization. As we mentioned previously, we have already targeted two Kentucky providers that are willing to partner with us in an ACO program, KPCA and Baptist.

Accountable Care Program Success Example: Altus ACE Collaboration

Altus ACE in Texas has been a highly engaged, dynamic and innovative ACO partner for the metro-Houston area since Jan. 1, 2017. Their four-pronged approach to closing health care gaps includes: 1) a proprietary risk stratification algorithm, 2) population health tools, 3) practitioner performance evaluation, and 4) shared savings opportunities for network physicians. Collaborating with our shared savings specialist, Altus ACE consistently achieves monthly clinical integration metric goals. For example, they regularly exceed the established goal (85%) for quarterly PCP engagement with a high-risk cohort of individuals, as shown in the table.

METRIC	GOAL	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG
Percent (%) of high-risk cohort population seen in last 90 days	85%	98%	100%	98%	98%	100%	100%	93%	97%

Primary Care Physician Incentive Model: This model focuses on closing gaps in care and improving quality outcomes. We make it easy for the provider to enroll in this program; our simplified approach accelerates our speed-to-market and APM membership growth. Our PCP HEDIS Gap Closure model is a population health-management program aimed at driving better health outcomes for our enrollees (children and adults). For example in Louisiana, membership in an APM Category 2 VBP has increased significantly because of this program — from 47,000 enrollees in 2017 to over 408,000 enrollees in 2018. Louisiana program outcome results during the first year include: after normalization, an additional 5,916 gaps closed in 2018 versus 2017; 63% of group/measure combinations improved or maintained performance year-over-year for targeted measures.

Behavioral Health Programs: Our behavioral health provider model, planned to roll out in Year 2, focuses on reducing the PMPM inpatient behavioral health cost over a 12-month measurement period and meeting defined quality metrics. These arrangements and the bonus payment serve as foundation for the behavioral health providers to fund their internal clinical integration activities and assist their progressive efforts in becoming a behavioral health home. Future iterations of the behavioral health home APM will benefit from the work currently being launched in Florida and Texas, including a focus on the serious and persistent mental illness (SPMI) population, with attention to HEDIS measures like seven-day post-hospital follow up, enrollee engagement in clinic monthly and reduction in adverse events. Both programs include medical and behavioral measures targeted at children and adults to promote integration and coordination of care for all our enrollees.

Obstetrics (OB) Incentive Programs: By leveraging our Obstetrics (OB) PCPi Incentive Program and Maternal and Infant Opioid Health Home VBP, we help providers identify the medical, behavioral, and social needs of pregnant women with OUD and improve perinatal care and birth outcomes. We would also consider rolling out our bundle/episode of care model to address the high infant mortality rates in Regions 2, 6 and 8 as providers move up the APM continuum into upside/downside risk arrangements.

iii. Methods for evaluating the effectiveness of VBP, including tracking of costs and improvement in health outcomes.

We previously described our methods for evaluating VBP effectiveness in our response to Question 9.j.v. To summarize, we evaluate the effectiveness of all of our VBP programs, for all of our Medicaid markets, once runout has occurred. We will use our findings to identify opportunities for improvement or evolution, which includes sharing best practices across our Medicaid markets. Most importantly, we review each program as it relates to the specific goals and outcomes for our Kentucky enrollees, to confirm we met and exceeded any targets and goals set forth by DMS. This review includes a review of the program costs, improvement in the targeted measures or clinical outcomes, feedback from providers and feedback from DMS. Armed with detailed analysis and collected vital feedback from DMS and participating providers, we decide whether to continue or modify an existing VBP program, try other support tactics or pursue a completely different strategy. For example, if DMS adjusts the priority performance measures, we will integrate the new measures in our models. Similarly, if we identify emerging trends in Kentucky using our various data analytic tools, such as our Hotspotting tool, we will work with DMS and providers on implementing new methods to address those concerns quickly, even mid-contract. We build all of our models to allow for this type of flexibility and detailed review because we want to partner with providers and provide them with the tools and financial reward that improve the health of our enrollees in Kentucky, rather than rolling out standard programs based upon national trends.

l. Provide results of any provider satisfaction survey reflecting the Vendor's performance in Kentucky or any other state Medicaid program over the last three (3) years. Where results identified provider dissatisfaction, Describe strategies the Vendor has implemented to address improvement, and examples of how those strategies have been effective.

COLLABORATE

Provider satisfaction and engagement are crucial components of facilitating quality care for our enrollees. Our approach to supporting, assessing and addressing provider satisfaction is to use multiple approaches to obtain feedback and employ progressive solutions to address and prevent concerns. Our strong satisfaction results start with our close and constant collaboration with our network providers, and not simply waiting for survey results before acting upon feedback received during all our many provider touchpoints.

Provider Satisfaction Survey Approach and Results

We conduct large-scale assessments of provider satisfaction as part of our commitment to continuous quality improvement. Our surveys that monitor provider satisfaction for medical/behavioral health providers, vision, dental and other provider types include the following:

Medical Provider Satisfaction Survey: Through an independent research company, we send an annual provider satisfaction survey to a randomized sample of our provider network in each market. Areas assessed include utilization management processes, credentialing, claims processing, reimbursement, service support, availability of care management resources, information exchange and the availability of network providers and referral sources. This survey is anchored on 10 domains with additional key driver items, and an overall section that drives a Net Promoter Score (described later in this response). An aggregate report scorecard is developed to summarize findings for the current year and past year findings for trend comparisons.

Behavioral Health Clinician Satisfaction Survey: Also using an external vendor, we conduct an annual satisfaction study of behavioral health clinicians. The objectives include: present clinician loyalty; evaluate levels of clinician satisfaction based upon the five key areas of service; identify key drivers of clinician satisfaction; and analyze trends in performance. We provide our vendor with a random sample file of usable records. Qualified clinicians received a personal email invitation to participate in a 10-minute web-based survey. For any score on the annual provider survey that scores below 85%, we develop a formal action plan to improve the results. We also annually share the results with our providers.

United Experience Survey (UES): We offer each caller to our provider services center the opportunity to participate in our UES, a brief post-call survey. We ask providers who opt in to the survey to provide ratings on six questions and give informal feedback about the quality of service provided by the resolution specialists. For example, 2019 UES survey results from our bordering Tennessee Medicaid market showed an average provider satisfaction rate of 95.25% with service quality (against a monthly 92% standard). As appropriate, we report out for action on individual issues and concerns. Corrective action plans can include calling providers to discuss issues or taking action with employees in the provider services center. We also use aggregated information gathered during these surveys to trend provider services center satisfaction rates and formulate topics for ongoing resolution specialists training.

Satisfaction survey results for providers using these three methods for our Louisiana Medicaid program over the last 3 years are:

Survey Description and Louisiana Provider Satisfaction Results in a 3-year Period			
Survey Name	**2016 (%)**	**2017 (%)**	**2018 (%)**
Combined Average for Annual Medical Provider and Behavioral Health Clinician Satisfaction Surveys	73	70.5	75.5
United Experience Survey (UES) Satisfaction/Quality Service	95.5/99.2	97.4/96.8	94.12/99.28

Net Promoter Score (NPS) Tracking

As an innovative enhancement to collecting and tracking provider satisfaction, we have embraced the NPS concept that willingness to recommend a company is an outcome of putting the customer first. Our NPS provides better insight into understanding how to create a differentiated, provider-friendly experience and is used by many other leading organizations (e.g., Microsoft, Delta Airlines and American Express). Our provider NPS process is based upon monthly feedback on experiences that measures key CAHPS-like metrics. With the national average around 50 points on a scale of negative 100 to positive 100, the current NPS score for our Kentucky Commercial/Medicare provider advocates is over 30 points higher than the national average (NPS tracking began in May 2018).

We use a quarterly, shortened Physician and Practice Manager (PPM) survey to complement and align with our NPS improvement and comprehensive annual survey efforts. Providers may answer by mail or online over a 6-week period. This touch point process helps us to monitor daily transaction interactions with care providers more closely. Metrics that are measured range from broad questions on likelihood to renew and overall satisfaction to focused questions on claims, credentialing/contracting, prior authorization, medical records and more. Results are tabulated, shared and reviewed for improvement opportunities. Results from the most recent Kentucky Commercial and Medicare PPM surveys (Q3 2019 to Q4 2019) showed a: 24% improvement in the likelihood to renew metric; 36% improvement related to ease of accessing information; and a 43% improvement related to satisfaction with our provider credentialing process. Tracking input since 2015, national results show a 93% improvement in prior authorization satisfaction and a 100% improvement in claims reconsideration and appeals satisfaction.

We also provide the opportunity for feedback on our provider website *UHCprovider.com* and on our web-based, self-service portal *Link*. During any visit, providers from the Commonwealth can submit feedback on their satisfaction with the site, how we can improve the site and their ability to complete desired tasks. All survey responses are managed through a closed-loop process within our *Link* provider experience team. This process leverages both one-on-one provider contact and data, and verbatim analytics to resolve issues, while improving the overall process for all *Link* users. Our developers take this feedback seriously and are continually making updates/changes based upon this provider input. Since surveys launched in 2017, national results show significant NPS score improvement related to such *Link* applications as claimsLink (50+ increase) and Prior Authorization and Notification (PAAN) (70+ increase). Our current, national task completion rate score (ability to complete task on *Link*) from providers is 83%.

Effective Improvements through Lessons Learned

We take the results of our provider satisfaction surveys very seriously. Our Quality Management (QM) Team reviews and analyzes the root cause of provider issues, identifies barriers, creates interventions and studies outcomes of concerns identified through provider feedback and surveys. We monitor feedback data ongoing and respond through direct outreach, new programs, enhancements or even clinical education via our provider toolkits. To close the loop on the quality of provider interactions, we present survey results to our Service Quality

Improvement Subcommittee (SQIS) at least annually for review and development of an action plan to improve overall scores.

From listening to and reviewing network provider feedback, in our Louisiana Medicaid program, we identified several areas for growth in provider satisfaction during the most recent contract term.

- We have and are continuing to enhance our provider website, *UHCprovider.com*, with current plans including the incorporation of our online webcasting platform. This provides an improved provider education and onboarding experience that addresses their need for information at their convenience.
- As we reviewed our original value-based payment (VBP) program, we identified an opportunity for improvement after recognizing many providers were not attaining stated incentive goals. As a result, our new VBP model provides incentive money for every gap in care closed and the feedback from providers has been positive.

The following is an in-depth example of our commitment to the quality provider relationships in Louisiana and the additional efforts we have undertaken to put our values into action. A similar but customized strategy could be applied in Kentucky, as needed.

The Weather Report

Following the results of our annual Louisiana provider satisfaction survey, we wanted to understand the results, so we took a deep dive and developed a focused remediation process to resolve issues around claims payments and other business processes (e.g., credentialing, prior authorization) with key providers called “The Weather Report.” The Weather Report was a direct survey that contained nine simple, focused questions on issues providers may have experienced and how we could improve. A leading question was how they would rate us on a scale of 1 to 5 based upon “The Weather” (e.g., with Hurricane=1; Sunny=5). The initial survey score provided an overall score of “Cloudy.” The remediation efforts included:

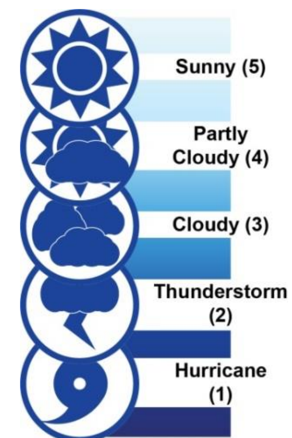

Figure 11. Our Louisiana “Weather Report” provider survey rating system.

- Identify 45 critical providers (physical and behavioral) and scheduled weekly meetings to obtain feedback to support the identification of trends and root causes
- Engage and support of our leadership team
- Create an escalation team to resolve issues/provide ongoing support for 90 days
- Meeting with the State’s section chief and the provider relations manager to share remediation results; updated results moved our Weather score to “Partly Cloudy”

Key network provider Louisiana Women’s Healthcare (LWHA) provided an initial Weather Report score of “Hurricane.” As part of their remediation, we provided an on-site claims specialist and an expanded claims team via a webinar to address their issues and provide additional training. The support continued with a claims supervisor meeting weekly with the providers to address any issues. We also designated a nurse to work with LWHA to develop new specialist incentives. A post survey response from the CEO confirmed the turnaround efforts resulted in a 4-point improvement on The Weather Report.

VBP arrangements can be a crucial foundation for provider engagement and alignment with health-outcome improvement goals. We have already begun meaningful conversations with

providers in Kentucky and have identified key areas that will need to be incorporated for success around VBP. Leveraging our lessons learned from health plans like Louisiana, we plan to identify key quality metrics and begin with an all upside approach to help our providers ease into VBP and work through date exchange, partnership building and the identification of meaningful opportunities for improvement.