

13. Enrollee Selection of Primary Care Provider (PCP) (Section 23.0 Enrollee Selection of Primary Care Provider)

a. Describe the Vendor’s proposed approach to helping Enrollees to identify and make voluntary selections of PCPs, within specified timeframes, who meet their needs, ensure continuity of care. Include information about differences in the Vendor’s approach, if any, to supporting Enrollees without Supplemental Security Income (SSI), Enrollees who have SSI and Non-Dual Eligible, and Enrollees under Guardianship through the selection process.

Helping Enrollees Identify and Make Voluntary PCP Selections

Our national experience with Medicaid enrollees enables us to apply proven procedures for assisting and encouraging enrollee choice of health care providers in compliance with Attachment C – Draft Medicaid Managed Care Contract, Section 23.0 Enrollee Selection of Primary Care Provider and Section 26.0 Enrollee Eligibility, Enrollment and Disenrollment.

Our primary goal is to establish a culturally competent, high-quality medical home for all our enrollees, central to promoting proper access and coordination of care. Access to a PCP is a critical component of person-centered medical services. Once this important relationship is established, the enrollee is more likely to participate in their own health care by scheduling and attending appointments and engaging in the provider’s plan of care. The result is a healthier enrollee who understands how to access care and manage their individual health conditions.

Voluntary PCP Selection Process

We recognize the importance of enrollee linkage to a PCP as the first step in establishing a comfortable, respectful medical home for each enrollee. We treat each enrollee as a unique individual, regardless of their benefit status as a recipient or non-recipient of SSI or as an individual under Guardianship. We know the medical home is an important partnership between the enrollee, the enrollee’s family, their guardian and the enrollee’s personal physician. As such, we know that from an enrollee’s perspective, selecting a PCP is a personal decision, likely to be affected by a number of cultural preferences and values related to gender, language, location, community or cultural beliefs. As an organization, we are committed to providing culturally competent care through a diverse provider network, fully able to engage Kentucky MCO enrollees in better care and to support their preferences for selecting a PCP.

Guiding Kentucky MCO Enrollees to Better Care

Compared to national averages, we understand that a higher percentage of Kentuckians self-report poor or fair health¹. This is especially true in Regions 4, 7 and 8 where the number of adults who report “poor or fair health” are more than double the national average. We believe that to change enrollee behaviors — for those who have become accustomed to their poor health status — and understanding the overlay of social determinants of health (SDOH) — we will initiate and coordinate the following actions to engage enrollees and empower them to take action throughout the Commonwealth.

- **Assigning a PCP/Scheduling an Appointment:** Our member services advocates (MSAs) use our logic-based Provider Recommendation Engine (PRE). Within PRE, we have the ability to use the enrollees’ provider preferences based upon location, claims data history and important demographics (e.g., language), to locate a provider who can meet their needs. As described in the table to follow, enrollees always have the opportunity to choose a PCP from the network of providers.

¹ Community Commons.

- **Gift Card Incentives for Screenings/Well-care Visits:** Our MSAs are alerted through our *Advocate4Me* call center platform of needed PCP visits by the enrollee. MSAs can educate enrollees on the incentives available for visiting their PCP and help them arrange an appointment. We work with our community-based partners, our PCPs, clinics and FQHCs to collect claims data designed to identify enrollees at risk and set up opportunities for them to address gaps in care in their communities.
 - Complete *two or more* diabetic screening visits (\$15 gift card)
 - Complete *one* preventive visit for adult dental care (\$15 gift card)
 - Complete *one* adolescent well-care visit for their child (\$25 gift card)We use outbound calling (e.g., live or IVR calls) to remind enrollees of their gaps and to assist them in scheduling appointments with their PCPs.
- **Kentucky Health Benefit Exchange (KHBE) Application Assisters:** As trusted members of the community, Application Assisters play a unique role in best understanding the needs of consumers they serve, especially in providing health literacy supports — prior to and post enrollment — including the importance of having a PCP. We will partner with KHBE to produce additional health literacy resources involving PCP selection and how to use health insurance appropriately. It will support the programmatic goal of customizing a path based upon individual needs that will lead to better health. Through the partnership with KHBE, Application Assisters will have necessary supports to engage enrollees in their health care.



Welcoming New Enrollees

New enrollee onboarding begins during the first 10 days after receiving the 834-enrollment file from DMS with a personalized welcome call from a member services advocate (MSA). This is an opportunity to have a conversation with the new enrollee, identify health education needs through the health risk assessment (HRA), help them find a PCP and encourage them to schedule an appointment. Our staff will assist enrollees who speak languages other than English or need materials in an alternative format (e.g., large print, audio formats).

We make multiple attempts to welcome enrollees by telephone (planned on different days, and at different times) after they have received written explanation of the PCP selection process. We will issue public notifications and mail letters to new enrollees with information about nearby “New enrollee Welcome” events scheduled in all regions, with DMS approval. Our welcome materials are available at community outreach events, and we will help enrollees print a temporary enrollee ID card, as needed. We are committed to making sure Kentucky MCO enrollees receive thorough support as they transition to the new program, and that we quickly and accurately identify their health care needs, and assist them with accessing care through a PCP.

Time Frames for Enrollee PCP Selection

In compliance with Attachment C – Draft Medicaid Managed Care Contract, Section 23.0 Enrollee Selection of Primary Care Provider requirements, we will communicate with enrollees regarding the selection of a PCP using the following timelines and process:

Contract Section	Kentucky MCO Enrollees	Enrollee Selection of PCP Requirements	Specified Timelines for Enrollee Communication
23.1	Enrollees Not Required to Have a PCP	<ul style="list-style-type: none"> ▪ Dual eligible enrollees ▪ Presumptively eligible enrollees 	N/A
23.2 23.3 23.4	Enrollee Choice of PCP	<p>Enrollees WITHOUT SSI: Will have the opportunity to choose a new PCP who is affiliated with the network or stay with their current PCP as long as such PCP is affiliated with the network</p> <p>Enrollees WITH SSI: Will have the opportunity to choose a new PCP who is affiliated with the network or stay with their current PCP as long as such PCP is affiliated with the network.</p>	<ul style="list-style-type: none"> ▪ Written explanation of the PCP selection process within 10 business days of DMS enrollment notification: <ul style="list-style-type: none"> • Enrollees can select, from all available, and at least two PCPs from the network • PCPs assigned in compliance with historically provided services and standards set forth in Attachment C – Draft Medicaid Managed Care Contract, Section 28.4 Provider Network Access and Adequacy ▪ Reassignment*: PCP reassignment within 30 days of auto-assignment (retroactive in initial enrollment) or at any time through the member services center. <i>*Reassignments require a new id card but are immediately available to the new PCP through on line provider tools and EDI transactions.</i> <ul style="list-style-type: none"> ▪ Written explanation of the PCP selection process within 10 business days of DMS enrollment notification: <ul style="list-style-type: none"> • After 30 days: We will send a second letter requesting PCP selection. • After 60 days: We will send a third letter requesting PCP selection. • After 90 days: At the end of the third 30-day period, we will use PRE to assign a PCP ▪ Reassignment*: PCP reassignment within 30 days of auto-assignment (retroactive in initial enrollment) or at any time through the member services center. <i>*Reassignments require a new id card but are immediately available to the new PCP through on line provider tools and EDI transactions.</i>
23.5	Guardianship	In addition to a change in the county of residence, adult Guardianship clients may change PCP selections at any time.	<ul style="list-style-type: none"> ▪ Enrollees under Guardianship with the Department for Aging and Independent Living are part of the Individuals with Special Health Care Needs (ISHCN) program. <ul style="list-style-type: none"> • ISHCN required service plan indicates legal guardian and level of responsibility for making medical decisions. • PCP changes are made based upon service plan level of responsibility and guardianship documents on file. • PCP changes are made through the Family Engagement Center.

PCP Changes



We communicate to enrollees that they can change their PCP at any time, for any reason through our outreach materials, including the welcome letter and *Enrollee Handbook*, and we encourage them to contact us for assistance. Staff interactions (e.g., welcome calls, care coordinators) also facilitate communications to enrollees about their ability to change PCPs and enable assistance with appropriate PCP assignment. We believe this approach supports enrollee empowerment — encouraging enrollees to select PCPs with whom they are comfortable, and results in the enrollee being more likely to schedule and attend appointments. PCPs are also educated about ways to verify member's PCP assignments in real time in the event that a member has made a change and is still awaiting their new card.

Continuity of Care

To support continuity of care for all enrollees, we will assign the PCP voluntarily selected by the enrollee during the enrollment process, as noted in the enrollment file, or initially assign a PCP to all new enrollees who did not preselect during the enrollment process in compliance with historically provided services and standards. Some enrollees preselect a PCP during the enrollment process, and other enrollees will have a PCP of record identified on the Kentucky MCO enrollee eligibility file (834). For these enrollees, the continuity of care should be confirmed because of the enrollee's choice and the services historically provided.

Our care management team will be responsible for proactively identifying, triaging and coordinating access to services from the enrollee's MCO for enrollees identified as currently receiving or in immediate need of services — such as inpatient care, pharmacy, specialty providers and durable medical equipment (DME). Our early identification and intervention protocols enable our care management team to identify enrollees who are not high-risk but who may benefit from additional assistance during transition to maintain continuity of care. This includes proactively tracking prior authorization information in our system and establishing a more aggressive approach to continuity of care for these enrollees.

We support the continuity of care for enrollees whose current provider is not contracted but critical to access for our enrollees. We will enter into letters of agreement or single case agreements to facilitate continuity of care and uninterrupted services for enrollees such as maintaining the continuity of care for pregnant enrollees that transfer into our program by supporting their care with their current OB/GYN, and individuals with SHCN. Our approach to continuity of care makes certain that we coordinate the enrollee's care as their benefit coverage shifts to our plan. We place special emphasis on coordinating care for individuals with complex and comorbid needs, particularly those with frequent exacerbation of chronic conditions that require high utilization of medical services (e.g., uncontrolled diabetes or behavioral health recovery services). We have experience transitioning large numbers of vulnerable enrollees with complex medical conditions in a short time period. For example, enrollees may have one or more risk cohorts such as:

- Enrollees with active care plans and established home health supports
- Enrollees receiving both behavioral health and physical health services
- Enrollees who are hospitalized
- Enrollees recently discharged or in transition care
- Pregnant women who are high-risk or in their third trimester
- Enrollees who had a major organ or tissue transplant
- Enrollees undergoing chemotherapy or radiation treatment

- Enrollees with a chronic illness at risk for hospitalization or nursing facility placement
- Enrollees needing certain durable medical equipment (DME) services
- Enrollees with authorized procedures post transition
- Enrollees receiving outpatient treatment

We seek to obtain data from the Commonwealth and review internally developed daily reports to identify enrollees with complex medical conditions proactively, so we can apply our triage approach to assisting high-risk enrollees using high-touch intervention techniques to facilitate a seamless transition.

b. Describe the Vendor's PCP auto-assignment algorithm for Enrollees who do not make a voluntary selection, including how the Vendor will ensure an Enrollee's continuity of care.

Our primary goal is to establish a comfortable, high-quality medical home for all Kentucky enrollees, central to promoting proper access and coordination of care. To engage them in managing their health and well-being, we initially assign a PCP to all new members who did not preselect during the enrollment process.

Once preselected, we communicate to members that they may change their PCP at any time, for any reason through our outreach materials, including the welcome letter and *Member Handbook*, and we encourage them to contact us for assistance. We focus on the enrollee and their needs and preferences when identifying PCPs that will best meet the enrollee's needs.

Our auto-assignment process uses a logic-based Provider Recommendation Engine (PRE). Within PRE, we have the ability to review enrollees' location, claims data history and important demographics (e.g., language), resulting in a logic-based PCP assignment to a provider that can meet their needs. Enrollees can select a PCP from all available PCPs, but will always be provided with a minimum of two PCP in-network choices.

The PRE follows the hierarchy of rules configured by the health plan from the following (one or more can be selected):

1. Prior PCP lookup
2. Claims history
3. Family claims history
4. Family assignment
5. Provider Tax Identification Number address
6. Provider Tax Identification Number ZIP code

When we use the PRE, we also monitor the PCPs to verify that their panel size is reasonable, they are in good standing and that we have not experienced high volumes of complaints or grievances about their practices.

The MSAs can assist the enrollee in choosing among several PCPs by answering questions on the provider's location, hours of service, ability to schedule an appointment for themselves or their family, access to transportation or language preferences.

c. Describe the Vendor's approach for processing provider change requests, to include:

i. Enrollee request after initial assignment,

We communicate to enrollees that they may change their PCP at any time, for any reason through our outreach materials, including the welcome letter and *Member Handbook*, and we encourage them to contact us for assistance. Staff interactions (e.g., welcome calls, care

coordinators) also communicate to enrollees about their ability to change PCPs and enable assistance with appropriate PCP assignment. PCPs are also educated about the PCP change process including ways to verify member's PCP assignments in real time in the event that a member has made a change and is still awaiting their new card.

ii. For cause,

When enrollees have questions or concerns about their PCP, we recommend they call our *Advocate4Me* member services center. *Advocate4Me* MSAs work with the enrollee to resolve the issue to the enrollee's satisfaction while on the telephone. As outlined in the contract, enrollees have the right to change the PCP at any time for cause. PCP changes due to cause will occur no later than the first day of the second month following the month of the request. Often, we have the ability to make changes for an enrollee much sooner.

In a situation where an enrollee was denied access to needed medical services, received poor quality of care or the enrollee does not have access to providers qualified to treat their health care needs, the enrollee may choose to submit a complaint, grievance and appeal to resolve the issue. Our structured enrollee complaints, grievances and appeals process gives enrollees recourse to have their issues resolved professionally, consistently and timely. We resolve enrollee complaints, grievances and appeals as quickly as an enrollee's condition requires, not exceeding contractual and legal limits.

Our *Advocate4Me* MSAs are instrumental in resolving enrollees' questions or concerns. They will "own" the enrollee's issue from initial contact to resolution — even if they need a day or two to research a response. MSAs have the ability to seek specialized assistance from a team of experts, including medical and behavioral health staff, pharmacists and others, so that they can provide a thorough solution, regardless of complexity. Compassion is a core component of our cultural values. To help us "walk in the shoes" of the people we serve, we provide diversity training to staff that have direct contact with enrollees.

iii. When Enrollees regain eligibility,

We understand the importance of enrollee-reported status changes as these may affect eligibility and coverage. Our *Member Handbook*, delivered within our new enrollee welcome packet and available on our enrollee website, provides notification to Kentucky MCO enrollees of their responsibility to report any change in status (e.g., address, telephone number) to DMS and includes contact information. In addition, when our MSAs receive a call to report or ask questions about a change in status, they inform the enrollee to contact DMS and provide contact information to the caller. We then receive the Commonwealth changes to enrollee records via the 834 file.

Once we receive the new eligibility file, the enrollee will automatically be placed with their previous provider to assure continuity of care (unless the provider has been termed.) If the reinstated enrollee does not want to use their previous provider, they can call the member services center to select a new PCP. Using PRE, the MSA will offer the enrollee a choice of at least two providers, based upon the enrollees' preferences (e.g., location, claims data history, language) to locate a provider who can meet their needs.

iv. When the Provider is terminated, and

If a relationship is terminated — either by UnitedHealthcare or by the PCP — we inform each enrollee on the PCP's panel in writing. We also inform each enrollee who received primary care from, or made regular appointments with, the terminated PCP.

We review the enrollees affected by any PCP termination to identify another PCP and confirm that the new PCP is a good fit for the enrollee based upon their health care and cultural needs. This process takes gender, age and location into consideration. For convenience, we match enrollees with PCPs who are located near their homes and are the most appropriate types of providers to assign (e.g., pediatrician assigned to child). We also coordinate the enrollee-PCP connection so that all family enrollees can see the same PCP, unless they request otherwise.

v. For a Provider request.

We understand that PCPs may decide they cannot continue to serve all enrollees. This can occur for various reasons, such as enrollee noncompliance or missed appointments. To initiate the enrollee removal process, the PCP submits a letter to us requesting the enrollee transfer to another PCP, along with the reason for the transfer request. We forward the PCP's letter and any relevant documentation to DMS for approval. If DMS approves the transfer request, we send a letter to the enrollee advising them of the transfer. If the enrollee does not select another PCP within that time frame, we will automatically assign a new PCP. In that situation, we send a letter to the enrollee to inform them that we have assigned a new PCP.

d. Describe the Vendor's approach to identifying, outreaching to, and educating Enrollees who do not receive services from their PCP within one (1) year of enrollment with the PCP. What information and support will the Vendor provide to Enrollees to obtain services?

Enrolling Kentuckians with high quality PCPs and engaging them in improved health care outcomes is a top priority. To drive enrollee compliance with health improvements, we review enrollee HEDIS rates and claims based utilization metrics monthly and quarterly across our entire enrollee population. We actively use this data to identify and initiate proactive pathways that engage enrollees and drive effective health care utilization. These include:

- **Outbound Calls:** By monitoring utilization rates and gaps in care, we initiate outreach to enrollees to remind them of appointments. Our customer service staff asks the member if there are any barriers to receiving care. They can then arrange their medical or behavioral health appointment for the enrollee and arrange transportation during the call. We also use subcontractors such as SilverLink to engage enrollees who have not seen their PCP in the past six months and have open preventive care gaps. For enrollees engaged with a PCP participating in Value Based Performance (VBP), a key program component centers around provider engagement of their patients to increase PCP visits and preventive care.
- **Inbound Calls:** Our MSAs are trained to check the Advocate4Me desktop tool for every call they encounter. For example, if an enrollee calls with a question about eligibility, the MSA can answer their question while steering the conversation toward the importance of preventive wellness care and offering to help them schedule a visit with their PCP.
- **Access to Care through Doctor Chat:** Enrollees can use the UnitedHealthcare Doctor Chat app or web portal to communicate via secure chat, telephone or video with an RN and M.D. if needed for care, seven days a week (9 a.m. to 9 p.m.).
- **Community Health Workers:** Our CHWs in Kentucky use their knowledge of local communities to locate and engage members, establish relationships, connect members to their PCP and coordinate appointments to remove barriers in care.
- **Community Health Fairs:** We continue adjusting our efforts to achieve the desired health outcomes by potentially implementing initiatives such as Community Health Fairs, and providing continued engagement of CHW field staff from our enrollees' communities, and culturally tailored enrollee materials and resources.

- **Enrollee Education Partnerships to Drive HEDIS:** In Louisiana, we partnered with our vendor, MARCH Vision, on an initiative to close gaps in HEDIS eye exams by calling enrollees identified with diabetes that had not had their eye exams and scheduled them for services. The result was a **14.6% improvement** in our 2017 HEDIS diabetic eye utilization score.
- **CAA Collaboration:** Our collaboration with local Community Action Agencies (CAAs) will help connect enrollees to needed care since CAAs are trusted service providers in local communities. These direct referral linkages between our care coordinators and their case managers can help identify and educate enrollees on the importance of visiting their PCP. The CAAs are a lifeline to hundreds of thousands of Kentuckians annually and this innovative partnership will help improve the health of enrollees in a cost-effective manner.
- **Coordination with Participating Providers:** As described in Section 9 of the RFP, we supply PCPs with Patient Care Opportunity Reports (PCOR) that include gap in care information. This information is supplied to both providers with Value Based Performance (VBP) contracts and those who are building their enrollee volume to engage in VBP programs. We work with providers to coordinate plan and provider outreach to eliminate gaps in care including missing visits or lack of engagement.