18. Provider Network (Section 28 Provider Network)

a. Provide the Vendor's proposed Provider Network development strategy to ensure a comprehensive statewide network across all provider types. The Vendor's strategy must describe the following:

Proposed Provider Network Development Strategy

We have served enrollees in Kentucky for over 3 decades, with more than 409,000 Kentuckians currently in our Commercial and Medicare plans. Through our tenure, we have built, maintained and strengthened our Kentucky care provider network and formed strong relationships within the provider community through high-touch support and service. Major examples include the Kentucky Primary Care Association (KPCA), Community Mental Health Centers (CMHCs), University of Kentucky Healthcare (UK) and other key health systems (e.g., Baptist Health, Norton Healthcare, Owensboro Health and Center Care), and we will build upon their expertise to serve the Medicaid population. Using our national Medicaid network development experience, local provider input and innovative workforce development strategies, we are building a comprehensive, high quality statewide care network. This network will meet the unique needs of Kentucky MCO enrollees and their key health issues, including diabetes, obesity, tobacco, heart disease, opioid use disorder (OUD)/substance use disorder (SUD) and infant mortality.

UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) has focused our efforts during the last 18 months on research and understanding of the specific needs of Kentucky MCO enrollees in all regions, including conducting Consumer Need Studies. Our efforts as of proposal submission have included research into the demographics culture, geography, health disparities/needs and concerns of current Medicaid enrollees statewide. We have taken a "feet on the ground" approach, building relationships with key providers, provider groups, associations and community organizations to develop a better understanding of Kentucky's health priorities and social determinants. We evaluated this data to stratify network needs and refine our recruitment approach.

UnitedHealthcare Kentucky Medicaid Network Development to Date

Our provider network director, Margaret Enlow, leads our network development strategy and plan. A native of Harlan, Ms. Enlow has lived and worked in the Kentucky market and provider network arena for over 3 decades. Based in Versailles, she oversees the implementation of the holistic network development strategy and plan, along with other locally based provider advocates, supported by our national network teams as needed. She will coordinate workforce development initiatives and monitor network activities for compliance with all DMS requirements outlined in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 28.0 Provider Network. In early 2018, we implemented our three-pronged network strategy in preparation for the Kentucky MCO program:

1. We leveraged our contracted Commercial medical, behavioral, dental, ancillary and allied networks to identify and target care providers and health systems vital to serving Kentucky Medicaid enrollee's health needs; we extended a contract amendment for MCO network participation.
2. We targeted essential Medicaid providers such as local health departments (LHD), rural health clinics (RHC), FQHCs, CMHCs, school-based health centers (SBHC) and we offered them a contract for network participation.
3. We reviewed the existing MCO contract and Kentucky Medicaid website to identify any unique provider types serving the MCO population and offered them a network contract

(e.g., Critical Access Hospitals, Office of Children with Special Health Care Needs and prescribed pediatric extended care providers).

We used Quest Cloud geographic accessibility reporting data throughout our network development process to review provider adequacy and identify network access gaps where additional network development is required. We will continue to use geographic accessibility data for network adequacy monitoring and maintenance. We hosted various Kentucky provider education sessions (in-person and via webinar) to support our network development, and will continue to conduct outreach via telephone and face-to-face visits throughout the Commonwealth.

Building on Our Existing Kentucky Network Relationships
To date, we have ***over 16,724 contracts, LOIs and Commercial contracts pending Medicaid amendment***, including 13,500 physicians (4,081 PCPs and 9,419 specialists); 113 hospitals; 491 essential providers including FQHC/RHC/SBHC and LHDs; 855 pharmacies and 2,130 behavioral health providers.

Using this strategy, our local network team has already contracted, amended existing contracts, obtained Letters of Intent (LOIs) and targeted commercially contracted providers pending Medicaid amendment with nearly 16,724 providers statewide, including physicians, hospitals, behavioral health providers, essential community providers, dental, vision and other ancillary providers.

Post go-live, as appropriate, we will implement our No Closed Door strategy to help facilitate Kentucky enrollee access to care. We have established a resolution model that identifies access challenges and seamlessly refers these contracting opportunities to our network management team for accelerated response and resolution via No Closed Door. For instance, if an enrollee indicates they have had a challenge finding a physician during a conversation with our member advocate team, our network management team is notified immediately.

The following are status descriptions of each key, targeted MCO network provider type. For detailed information and numbers related to our current network development status, please refer to Attachments C.18.e.i - iii.

KPCA Testimonial
"...KPCA fully supports United Healthcare in their bid to become one of Kentucky's Managed Care Organizations. UnitedHealthcare's focus and mission to serve the underserved are aligned with the KPCA philosophy."
— *David Bolt, CEO, KPCA*

PCPs: Our proposed PCP network includes over 4,081 providers with signed contracts, LOIs and commercially contracted providers pending Medicaid amendments, consisting of family practice and general practice physicians, internists, OB/GYNs, pediatricians and PCP residents, with the goal of meeting and/or exceeding Kentucky Medicaid access requirements for adults and children. We have an LOI with KPCA, whose PCPs currently deliver health care services to 300,000 Kentucky Medicaid beneficiaries. This Independent Physician Association is made up of 23 FQHCs, 15 primary care clinics, RHCs and SBHCs — providing critical services across Kentucky, with many locations offering integrated behavioral health and dental services. Given their rich history serving this population, KPCA providers will play a key role in our Medicaid network.

Medical Specialists: Our proposed specialist network includes 9,419 providers with signed contracts, LOIs and commercially contracted providers pending Medicaid amendment for pediatric, adolescent and adult care. To meet enrollee needs across the Commonwealth and to help address Kentucky's public health priorities, we specifically targeted the following specialty types including cardiologists, endocrinologists, gastroenterologists, pulmonologists, opticians,

optometrists, audiologists, hearing aid vendors, speech language pathologists, physical therapists, occupational therapists and chiropractors.

Hospitals: Our proposed hospital network includes 113 hospitals with signed contracts, LOIs and commercially contracted providers pending Medicaid amendment, including key health systems such as LifePoint who serves multiple Kentucky regions and includes 10 hospitals. Other critical health systems with executed amendments or LOIs include Baptist Health, CHI Saint Joseph Health, Norton Healthcare, Owensboro Health, St. Elizabeth Healthcare and UK. These health systems are critical to our MCO care provider network, as each health system is positioned strategically throughout Kentucky and covers specific geographic areas with limited overlap. In addition, we have contracts and LOIs with teaching, critical access and community hospitals to ensure a comprehensive network of hospitals.

Essential Community Provider (ECP) Network: We are sensitive to the important role of ECPs in caring for traditionally underserved populations, promoting population health and supplying safety net services. In Kentucky, we have identified FQHCs, RHCs, SBHCs, experienced family planning providers, government-funded community-health centers, CMHCs, LHDs (via the Department for Public Health) and other CMS-certified entities throughout the Commonwealth. Our proposed ECP network includes 491 providers with signed contracts, LOIs and commercially contracted providers pending Medicaid amendment. This total includes a signed LOI with KPCA and their FQHCs/RHCs/SBHCs, and we are actively seeking network participation agreements with others to meet DMS's requirement of at least one FQHC and one RHC for each Medicaid region, where available.

Behavioral Health and SUD Providers: Our contracted behavioral health network includes over 2,130 behavioral health providers — including 240 MDs, 1,476 MSWs, 168 PhDs and 246 RNs; 43 facilities (of which 24 are substance use facilities), 452 providers with SUD experience, 467 SAMHSA-waivered medication-assisted treatment (MAT) providers and 39 providers who support telemental health. We focused our MCO contracting efforts around the three primary types of Kentucky behavioral health providers — CMHCs, Behavioral Health Service Organizations and Multi-Specialty Groups — as they are integral parts of our behavioral health network. In addition, our network also will include other behavioral health provider types noted in the Draft Contract to facilitate adequacy and choice for outpatient (including intensive home services), intensive outpatient, substance use residential, case management, mobile crisis, residential crisis stabilization, assertive community treatment and peer support services. **We have received network contracts or LOIs from 100% of Kentucky CMHCs.** We have also met with the largest Kentucky CMHCs to discuss behavioral/physical health integration and value-based payment (VBP) arrangements, and are exploring *pilots in these areas with New Vista, Centerstone, NorthKey and River Valley*.

Dental Providers: We will build upon our existing commercial dental network in Kentucky, which comprises 926 general and specialty dental providers with experience treating Medicaid enrollees, by amending and adding the MCO program to their contracts. Dental service providers are enrolled in accordance with 907 KAR 1:026. We are targeting additional dental providers for network recruitment and contracting throughout all regions and have already contracted or received LOIs for an additional 2,629 provider access points, including network participation agreements from Mortensen Dental and ImmediaDent and an LOI with KPCA.

Laboratories: We are confident our current comprehensive network for laboratory services will accommodate the expected MCO membership. Currently, laboratory services are accessible through our national and local laboratory providers and include access points throughout Kentucky. Our network of reference laboratories will be further supplemented by participating hospitals, PCPs and specialists who also facilitate lab services by drawing blood, collecting

specimens and coordinating testing through laboratory providers and/or providing the lab services themselves. We continuously evaluate enrollee access and care needs to make certain key ancillary services meet or exceed the access standards for laboratory services. We also acknowledge and verify that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or a waiver of a certificate of registration, along with a CLIA number.

Pharmacies: We leveraged our existing, contracted Kentucky pharmacy network for the MCO program and we certify that both retail chain and independent pharmacies are available and geographically accessible. As of January 2020, we have 855 contracted pharmacy locations available for Kentucky MCO enrollees, including 419 chain locations. Additionally, instead of overly depending on national pharmacy chains, we have contracted with more than 436 small, independent pharmacies across the Commonwealth. We do this because we recognize the importance of the relationship many Medicaid enrollees have with their local, community-based pharmacists, and the importance of supporting economic development with local businesses.

Transportation Service Provider: We have contracted with LogistiCare to provide non-emergent stretcher ambulance services. Enrollees will be directed to call 9-1-1 for emergency ambulance services and UnitedHealthcare will pay for the service.

Additional Network Providers: We have and will continue to approach other provider types noted by DMS for network contracting or partnerships. These providers include teaching hospitals such as UK HealthCare; the Office for Children with Special Health Care Needs; pediatric prescribed extended care providers and charitable providers such as Shriner's Hospital for Children (already contracted with our Kentucky Commercial network).

i. Innovative approaches to recruit providers and to develop and maintain the Vendor's provider network to ensure network adequacy standards and highest quality care, including:

Beyond the traditional recruitment approach previously described for our Kentucky MCO network, we also used a unique and innovative "blank page" strategy. Instead of starting with contract negotiations, we met with major Kentucky health systems such as KPCA, UK HealthCare, Baptist Health, CHI Saint Joseph Health, Owensboro Health and Pikeville Medical Center one-on-one and, with a blank piece of paper and mapped out a partnership. This approach gave the providers the opportunity to choose what was important to them and what practices and programs they wanted to expand, and allowed us the opportunity to discuss creative ways for UnitedHealthcare to support their efforts. We asked them to help us design how we would work together to eliminate provider pain points, improve payment models and, most importantly, work together to better support Medicaid enrollees. Through these conversations, we developed true partnerships and broke away from the traditional payer-provider relationship.

Our partnerships with key Kentucky provider associations also assisted our network recruitment and development efforts. For example, we worked closely with the Kentucky Health Resource Association in scheduling network-participation discussion meetings with several behavioral health providers that are part of our network. These included CMHCs such as Adanta, New Vista, Mountain and River Valley, in addition to community-based providers InTrust, Key Assets, Maryhaven and Phoenix Preferred Care.

For all recruitment, ongoing development and network maintenance, we employ geographic accessibility reporting (Quest Cloud) to verify network adequacy and accessibility. Quest Cloud reports measure the travel distance between the ZIP code of the enrollee's residence and providers' service locations. Provider accessibility (time/distance) is measured by the

geographic distribution of providers by specialty. Our provider-to-enrollee ratio analysis provides insight into the number of providers, by type, and the location of the required specialties, to meet and exceed contracted access standards and calculate network sufficiency. We also conduct ongoing monitoring and ad hoc analysis as needed (e.g., changes in network participation of large physician groups, out-of-network provider utilization and claims), and take action to recruit identified providers, as necessary. We will adhere to provider network adequacy and access requirements as outlined in Section 28.4 of Attachment C – Draft Medicaid Managed Care Contract and Appendices.

1. Strategies to recruit providers in traditionally underserved as well as non-urban areas, by health need, and to overcome expected accessibility challenges.

Our providers are our essential partners in improving health outcomes of our enrollees, and we are committed to offering a network that enables access for all our enrollees, wherever they reside. Our Kentucky network strategy to recruit providers in traditionally underserved and non-urban areas included:

1. Research on the health needs of each region, including the use of consumer surveys, regional health analysis and provider/community organization listening sessions.
2. Outreach to vital care providers and health systems, including face-to-face and telephonic meetings to develop a targeted list of primary care, specialty, essential community providers and organizations needed for adequate access to care for our enrollees.
3. Targeting essential providers (including physician extenders such as nurse practitioners and physician assistants) currently caring for enrollees in the community who know existing regional health issues, social conditions and are experienced in local patterns of care for network participation.
4. Establishing and expanding partnerships with key Kentucky community resources to complement our care provider network to help us address the top health priorities in each region. For example, we are partnering with the Kentucky Fire Commission in 10 counties throughout the Commonwealth, including Mason, McCracken and Henderson, to understand opioid overdose and naloxone needs (training and supply) better in rural areas amongst volunteer fire departments. We are partnering with UK Barnstable Brown to transform diabetes care in five counties via a pilot program that will bring the CDC Recognized National Diabetes Prevention Program to individuals at risk for Type 2 diabetes. We are collaborating with the Kentucky Regional Extension Center (REC) to provide training to providers through workshops in Hazard and Bowling Green and REC working directly with four practices for 18 months to help improve hypertension and diabetes outcomes (CMS measures) among patients based upon evidence-based best practices.

Kentucky Fire Commission Testimonial

"We have taken great pleasure in working with UnitedHealthcare over the last few months with the development and delivery of projects of great importance to first responders and citizens across the Commonwealth of Kentucky. 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*

The following table summarizes our targeted network recruitment to address specific health needs in underserved areas. We recognize that in each region there are counties with no

hospitals; therefore, our targeted recruitment includes identifying alternative care options to overcome expected accessibility challenges.

Region/Underserved Areas	Top Health Needs*	Targeted Recruitment
Region 1/Hickman, Carlisle, Ballard, Lyon and Livingston counties	▪ Tobacco Use ▪ Diabetes ▪ Infant Mortality	Provider recruitment is focused on, but not limited to, primary care, endocrinologists, OB/GYNs and pediatricians to address noted regional health needs. In addition, we have contracted with Jackson Purchase Hospital and the employed LifePoint physicians in Graves county.
Region 2/McLean, Todd, Webster counties	▪ Infant Mortality ▪ Adult Obesity ▪ Diabetes	Provider recruitment to address the top health needs is focused on, but not limited to, primary care, endocrinologists, OB/GYNs, pediatricians, internal medicine providers and gastroenterology/bariatric surgeons. In addition, we are contracting with Methodist Hospital in Henderson County; Methodist Hospital in Union County; Ohio County Hospital; and Jennie Stuart Hospital (Christian County) to supplement access.
Region 3/Washington, Henry, Spencer, Breckinridge and Trimble counties	▪ Infant Mortality ▪ Adult Obesity ▪ Diabetes	Provider recruitment to address the top health needs is focused on, but not limited to, primary care, OB/GYNs, pediatricians, endocrinologists and gastroenterologists/bariatric surgeons. In addition, we are contracting with Baptist Health, CHI Saint Joseph Health, Norton Healthcare and LifePoint to provide alternatives.
Region 4/Russell, McCreary, Casey, Butler, Edmonson, Green, Monroe, Clinton, Metcalfe and Cumberland counties	▪ Tobacco Use ▪ Overdose Mortality ▪ Infant Mortality	Provider recruitment to address top health needs includes recruiting primary care, endocrinologists, OB/GYNs and pediatricians, and behavioral health specialists. In addition, we are soliciting providers waivered through SAMHSA to provide MAT for enrollees with OUD seeking treatment providers. These providers can be medical or behavioral health providers with expertise in MAT services, including PCPs and OB/GYNs. Lastly, we have the following hospital either under contract or a signed LOI including Lake Cumberland Hospital (Pulaski); TJ Samson (Barren); Russell County Hospital; HCA Greenview (Warren); The Medical Center Bowling Green (Warren); The Medical Center Scottsville (Allen); The Medical Center Franklin (Simpson); and Logan Memorial Hospital (Logan). We are also in active negotiations with Casey County Hospital and Jane Todd Crawford Hospital (Green) for our regional network.
Region 5/Nicholas, Owen and Jackson counties	▪ Births to Mothers who Smoked During Pregnancy ▪ Tobacco Use ▪ Adult Obesity	Provider recruitment to address top health needs includes recruiting primary care, endocrinologists, OB/GYNs and pediatricians, and gastroenterologists. In addition we are contracted with HCA Frankfort (Franklin); Georgetown Community Hospital (Scott); UK HealthCare; Baptist Health; and Rockcastle County Hospital.

Region/Underserved Areas	Top Health Needs*	Targeted Recruitment
Region 6/Gallatin and Pendleton counties	▪ Infant Mortality ▪ Overdose Mortality ▪ Diabetes ▪ Adult Obesity	Provider recruitment to address top health needs includes and is not limited primary care, endocrinologists, OB/GYNs, pediatricians and behavioral health specialists. In addition, we are soliciting providers waivered through SAMHSA to provide MAT for enrollees with OUD seeking treatment providers. We will implement VBP strategies for OUD. Lastly, we have signed a LOI with St. Elizabeth Health System.
Region 7/Robertson, Menifee, Elliott, Bracken, Bath, Morgan and Lewis counties	▪ Diabetes ▪ Adult Obesity ▪ Tobacco Use	Provider recruitment to address the top health needs is focused on, but not limited to, primary care, endocrinologists and gastroenterologists. Hospitals contracted to facilitate regional care include Meadowview Regional (Mason), Baptist Health, Fleming County Hospital and CHI Saint Joseph Health.
Region 8/Letcher, Knott, Magoffin, Martin, Leslie, Wolfe, Lee and Owsley counties	▪ Adult Obesity ▪ Tobacco Use ▪ Diabetes ▪ Births to Mothers who Smoked During Pregnancy ▪ Overdose Mortality ▪ Infant Mortality	Provider recruitment to address top health needs includes, but is not limited to, primary care, endocrinologists, OB/GYNs, pediatricians and behavioral health specialists. In addition, we are soliciting providers waivered through SAMHSA to provide MAT for enrollees with OUD seeking treatment providers. Lastly, we are under contracts or LOIs with key health systems including Baptist Health, CHI Saint Joseph Health and LifePoint.

** Data sources include, but are not limited to: https://www.ruralhealthinfo.org/charts and https://datacenter.kidscount.org/data/tables/8151-births-to-mothers-who-smoked-during-pregnancy-3-yr-aggregate?loc=19&loct=5#ranking/5/any/true/1564/any/15628*

2. Strategies and methods to address workforce shortages and network gaps, included proposed initiatives to collaborate with the Department and other contracted MCOs to develop innovative solutions to meet the healthcare needs of Enrollees.

We have identified counties with key provider-type network gaps (primary care, dental and behavioral health) across the Commonwealth, with the exception of Regions 3, 5 and 6 that have sufficient dental providers. We have also identified the top social determinants of health (SDOH) challenges, by county, within each Kentucky region. Using this knowledge, and as a primary component of our continuous network development efforts, we will work with DMS, other contracted MCOs and regional stakeholders to support efforts and drive new, innovative solutions to address workforce shortages and network gaps.

To do this, we will establish a committee that includes DMS, partner MCOs and providers to align on efforts to improve quality, share best practices and collectively discuss Kentucky gap areas and mitigation strategies to meet enrollee needs — understanding that together we can resolve issues not easily solved by any one entity. For example, we will discuss jointly establishing grants, scholarships or other funding with Kentucky colleges that have social work counseling and medical programs for individuals willing to commit to employment with Kentucky MCO contracted providers or partner agencies once they obtain their degree. We envision working with not solely UK, but also smaller schools such as Western Kentucky University, Murray State and the University of Pikeville to facilitate sustained statewide economic and workforce development. Additionally, we recommend the Kentucky Community and Technical College System as an entry path for many Kentucky residents to earn a health care-focused

Boys & Girls Club of Glasgow-Barren County Testimonial

"United Healthcare and Boys & Girls Club have collaborated in some programs that will make a positive change in our community. I can confidently recommend United Healthcare obtain a state contract in Kentucky."

Mary Lee England, Executive Director

Associates degree, such as the Hazard Community & Technical College, Owensboro Community & Technical College or Jefferson Community & Technical College. We can also provide information on our innovative program with the Boys & Girls Club of Glasgow-Barren County, where we donated laptop computers to fulfill a need for community organizations to connect with the vulnerable populations (e.g., youth, the elderly or people with disabilities) they serve digitally.

We plan to use the following innovative solutions in Kentucky to build the workforce of medical professionals, incent investment in areas with limited health care resources and fill network gaps. Collaboration with DMS and other MCOs will be a critical component to select, expand and scale initiatives.

INNOVATE

Expanded Use and Development of Other Professional Types

- Facilitated meetings between Addiction Recovery Care, Volunteers of America, KPCA and Goodwill to discuss workforce development opportunities for OUD/SUD addiction recovery care in all Kentucky regions, including exploring possible UnitedHealthcare funding to help in the expansion of recovery centers (e.g., add more beds) and how to initiate health care career paths for individuals in recovery
- Expanding use of community health workers (CHWs), psychiatric ARNPs, physician assistants, paramedics (if Commonwealth allowances change), locum tenens and other qualified credentials to assist in service provision, including leveraging UK's CHW certification program for primary care
- Partnering with the UK Center of Excellence in Rural Health (UK CERH) to launch and execute Students Striving Toward Better Health in Self and Community initiative. Initiative objectives are to prepare 23 juniors and seniors in high school for potential secondary study/professional roles in health care/science; 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/CHW Focused Curriculum:* Students completing this certificate will obtain skills in communication, outreach, advocacy, health coaching, organization and legal/ethical issues appropriate to community health work. Students will be awarded six credit hours.
  - *CHW Apprenticeship:* Students who successfully complete the coursework and are 18 years of age or older will be eligible to apply for a paid apprenticeship during the last semester of their senior year. UK CERH will fund this apprenticeship. 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 best to 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.

Value-based Arrangements & Financial Support

- Using VBP contracting arrangements to give participating network providers a financial bonus, which they can use to improve their staffing infrastructure or obtain needed resources (e.g., adding more providers or having existing providers offer extended hours or more services). For example, given the need for quality MAT providers in Kentucky to address the opioid epidemic, we are proposing to pilot a quality-based VBP model focusing on OUD/MAT, which is designed to provide primary care practices with financial resources to build out the infrastructure required to provide the services needed to support treatment retention and long-term recovery
- Continuing United Health Foundation's financial sponsorship of key Kentucky provider programs and

pilots, such as our $1M grant to the University of Kentucky's College of Dentistry to support additional dental providers for oral screenings and help address oral cancer in eastern Kentucky and our $930,000 million grant to Pathways CMHC to make mental health services more available for children in rural eastern Kentucky through telehealth technology

Provider Committees, Training and Education

- Continuously partnering with network providers, including using quarterly Provider Advisory Council (PAC) meetings to identify needs and possible workforce development solutions
- Conducted a provider training in eastern Kentucky on the evidence-base of MAT; and how to integrate MAT into clinical practice in an effort to increase the number of qualified MAT providers. We will continue to promote MAT waiver training offerings and educate providers on the National Health Service Corps Substance Use Disorder Workforce Loan Repayment Program to increase access to MAT treatment in high need areas

Virtual Solutions

- Closing network gaps via virtual/telehealth solutions, particularly in the areas of telemental health, school-based care, specialty care and remote monitoring. For example, our Project ECHO® solution increases access to specialty treatment in underserved areas by connecting local front-line clinicians with urban-based specialist teams to facilitate needed knowledge and support for managing enrollees with complex conditions.

Transportation and Other Social Determinants Tools and Resources

- Continuing to build community partnerships in Kentucky through our community resource tool, *Healthify*, a comprehensive compilation of community resources our care managers, CHWs and selected Kentucky community-based organizations (pilot program) can tap into to support enrollees
- Optimizing transportation services for workforce development (e.g., for future workforce training and education)
- Arranging transportation for enrollees to travel to network provider appointments, to address the challenges of enrollees (particularly those in southeastern Kentucky) with limited vehicle ownership or public transportation options
- Taking a holistic approach to network adequacy and evaluating not only if enrollees have reasonable access to needed network providers, but also if critical local community resources have the capacity in place to address SDOH barriers. These organizations will supplement the Kentucky provider community, expand clinical resource capacity and help to relieve provider burden by addressing non-clinical care issues

3. Strategies for contracting with providers in bordering states to help address network adequacy challenges, including lessons learned and successes or challenges with this approach.

When developing the network in rural areas where there may be a shortage of network providers and adequacy challenges, we target available providers in border states (e.g., Illinois, Indiana, Ohio, Missouri, Tennessee, Virginia and West Virginia). Border provider contracting is a best practice used in all of our Medicaid states. We will build upon our relationships with providers who are enrolled (or commit to enroll) in Kentucky Medicaid within 50 miles of the Kentucky border to increase access to care and maximize provider choice. We will include a link to the Kentucky Cabinet for Health and Family Services (CHFS) website on our provider portal to make it easy for out-of-state providers to enroll.

Based upon our knowledge of Kentuckians' established patterns of care from our Commercial and Medicare programs, we know MCO enrollees who live in close proximity to these bordering states may seek care across state lines to the nearest urban center — due to geography, physician referral patterns, lack of local specialty/tertiary care or simply due to personal preference. For example, due to the natural boundaries in southeastern Kentucky, we know many regional residents travel to Knoxville, Tennessee, for care. In the south-central area, Bowling Green residents are often referred to Vanderbilt Health in Nashville, Tennessee, for

tertiary care. Current Commercial and Medicare membership in both Louisville and Owensboro go to providers in southern Indiana.

One example of our successful border state contracting is related to Kentucky's Campbell, Kenton and Boone counties. These three counties are considered part of the Cincinnati, Ohio-metro area and serving current Commercial membership in these counties is challenging due to their tendency to travel into Cincinnati for care. To proactively avoid any access issues, we contracted with qualified Cincinnati providers at the Kentucky rate. Using lessons learned from this approach, we are doing the same for our MCO network.

ii. Approach to providing out-of-network care when timely access to a Network Provider is not possible, including the Vendor's approach to supporting Enrollees in accessing such care.

When timely access to needed care is not possible with a network provider, we authorize needed services with out-of-network (OON) providers and agree to cover OON services at a cost no greater than if the participating providers were to provide the services. We will continue to authorize OON care for as long as our participating providers are unable to provide the services within required appointment availability standard. Our care managers provide hands-on assistance to arrange care that meets enrollee needs, including compliance with our appointment standards. Our UM team and local health plan CMO, Dr. Jeb Teichman, will look at each request for OON care on an individual basis. We take into consideration the clinical and social needs of each enrollee when making a determination and strive to do the right thing for every enrollee and their family.

Our established, policies and procedures for OON care address enrollee needs across the care spectrum (urgent/immediate, short-term or long-term) in the following ways:

- ***Urgent/Immediate and Emergency Services:*** Enrollees have the right to access emergent or urgent care at any hospital, trauma center or licensed emergency facility/urgent care center. To mitigate potential delays in accessing urgent or emergency services for circumstances that threaten an enrollee's health or welfare, we do not require prior authorization of these services, regardless of a provider's network status. We will work with DMS on their expedited enrollment process to obtain a provider number for those providers not already enrolled in Medicaid for emergencies only.
- ***Short-term Intervention:*** If a contracted provider is not available to meet enrollee access and availability needs, we enter into a single case agreement (SCA) with the out-of-network provider to make certain the enrollee is able to receive needed care.
- ***Long-term Intervention:*** We allow for continuation of existing relationships with OON providers when considered to be in the best medical interest of the enrollee. For example, if a new enrollee previously received specialty/episodic services from an OON provider, we continue to authorize services for that treating provider for continuity of care purposes, in accordance with Kentucky's continuity of care requirements and guidance. As appropriate, we also work to recruit the provider to join our network and close network gaps.

Our *Member Handbook* communicates the expectation that an enrollee must seek care within the service area with in-network providers when possible, while providing enrollees with support and direction on meeting immediate and critical health care needs by clearly defining out-of-area instructions for emergencies; and how to seek medical attention at the nearest hospital. We will work with DMS on an expedited enrollment process to assign Medicaid ID for providers not already enrolled in Medicaid for emergencies only.

Facilitating Access through Use of Non-Network Providers

Engaging OON providers to facilitate member access to care is a standard UnitedHealthcare practice. For example, in Arizona where we serve individuals in the Developmental Disabilities population, a member with developmental disabilities and hearing loss, who only used American Sign Language (ASL), required a behavioral health Inpatient Facility/Residential Treatment Center that could manage her aggressive behaviors. She specifically needed a facility that could provide ASL translations 24 hours a day, seven days a week. To meet this member's unique needs, we established an agreement with a cross-border, non-network facility in New Mexico that provides ASL to assist in her rehabilitation.

As another example, in the Northeast Region, a member had an unusual arteriovenous malformation that was causing severe neurologic symptoms. An OON neurosurgical center in a neighboring state was the clear, acknowledged expert in treating this type of lesion, and we received a request for admission and treatment at that facility. Upon physician review of the case and request, and evidence of the specific expertise of the OON facility, the decision was made to approve the request and admission to provide the best treatment for the member.

iii. Approach to ensure Network Providers are physically accessible and have accommodations for Enrollees with physical or mental disabilities.

Providing and ensuring equal access to health care for people with physical and mental disabilities is a critical component of our overall network development strategy, as we know individuals with disabilities are more likely to neglect needed health care appointments due to problems with the accessibility or accommodations of a doctor's office or clinic. Through our network development and provider support, we address the physical accessibility and accommodation needs of our enrollees with physical or mental disabilities by:

- Supporting provider education and the understanding of disability competency (physical and mental), and its effect on health, by providing easy access to associated publications and trainings via our provider portal, *Link* and through ongoing face-to-face, on site provider interaction
  - This information is available to all participating practices, providing meaningful information for all staff with direct enrollee contact
  - The intent of this activity is to continually reinforce the importance of cultural sensitivity and disability competency and includes ways to incorporate best practices
- Asking providers to self-attest during the network application process to identify any special accommodations they offer (e.g., specially trained staff, adjustable exam tables)
- Identifying providers who are Americans with Disabilities Act accessible and have disability accessibility accommodations (e.g., wheelchair access, accessible exam room equipment and other key capabilities) in our *Provider Directory* so enrollees can easily identify practitioners who best meet their specific needs
- Supplying provider communication support for enrollees who are deaf, hard-of-hearing or speech-

Data Field	Description - English
	Wheelchair Accessible
	24-Hour Pharmacy - (Hours listed as: 12:00 am - 11:59 pm
	Provider is within one (1) mile of public transportation
	Telehealth Services
B	Board Certified
P	Parking
EB	Exterior Building
R	Restroom
E	Exam Room
T	Exam Table/Scale/Chairs
G	Gurney's & Stretchers
PL	Portable Lift
RE	Radiological Equipment
S	Signage & Documents
①	Home Infusion Pharmacy
②	Retail Pharmacy
③	Providing Extended Day Supply of Medication
④	Long Term Care Pharmacy

Figure 8. Example icons and information key for our *Provider Directory*, showing members what each network provider offers, including wheelchair accessibility; these can be updated per unique Kentucky MCO requirements.

impaired using TTY/TDD or a Telecommunications Relay Service (TRS)

- Making member services advocates (MSAs) available to assist enrollees who are unaware of UnitedHealthcare's resources, capabilities and tools related to serving individuals with disabilities

iv. Approach to ensure a comprehensive network to address the needs of all Enrollees, including the provision of services in a culturally sensitive and linguistically appropriate manner.

Increasing Bi-directional Awareness of Kentucky's Hispanic Population
To increase awareness and understanding of Lexington's Hispanic population, and provide them with knowledge related to cardiovascular disease, we partnered with the American Heart Association and UK in 2017 to hold an event targeted to racecourse workers at Keeneland to enhance education and screening for diabetes and cholesterol.

Understanding enrollee diversity is the first step to facilitating culturally diverse care and services. We design our network to incorporate enrollee needs, such as language fluency, the norms and values of different cultural groups, healing beliefs, communication preferences and family dynamics. In Kentucky, the majority of residents speak English, with Spanish being the second-most-spoken language. While Hispanic residents are located throughout the Commonwealth, particularly in agricultural areas, the highest concentrations are in Louisville and Lexington. There are also small pockets of individuals speaking Asian or African languages in Bowling Green, Lexington and Louisville. In February 2018, we facilitated a stakeholder meeting with Kentucky Homeplace's 32 CHWs to understand the geographic and cultural diversity needs of residents in Appalachia better. Using this gained local knowledge, in combination with Kentucky demographic analysis, we are recruiting providers critical to addressing the needs of all enrollees due to their cultural and language capabilities. As part of our ongoing work to improve our enrollee's experience through network development, we will build off of our successful collaboration with Kentucky Homeplace, our ongoing engagement with stakeholders, advocacy groups and community-based organizations to help identify and recruit additional providers aligned to the culture and language of the local Kentucky community.

We create, maintain and offer network provider education and trainings on cultural competency to support our network providers in delivering appropriate care to our enrollees. Providers receive ongoing education regarding cultural competency through a variety of tools including *Link*, provider forums, newsletters and our *Care Provider Manual*. We gather language proficiency information during our provider credentialing process and list provider languages offered in our *Provider Directory* for enrollees. Network providers can access our care collaboration platform, *CommunityCare* to view an enrollee's primary language preference and other demographic and clinical information before an appointment. We also facilitate access to real-time interpreter services for both providers and enrollees; providers have access to our interpreter service, with more than 240 supported languages. We train providers on how to use our translation services through initial orientation, the *Care Provider Manual* and ongoing provider relations visits.

v. Strategies the Vendor will implement to ensure the network adequacy and access standards are met if actual Enrollment exceeds projected Enrollment.

We have proven processes in place to facilitate access to care while accommodating enrollment growth. We are confident these processes will continue to serve us well as we add enrollees, even if enrollment exceeds projections. From experience, we know other factors can also create an influx of new enrollees, such as another health plan leaving the service area or receiving an enrollment suspension, and we will deploy the same strategies.

Our strategy for monitoring network adequacy, access and capacity includes reviewing geographic accessibility reports; CHFS Medicaid provider files; Zelis Network360 competitor analysis reports; out-of-network utilization reports; PCP panel reports; annual access and availability surveys; provider satisfaction survey results; CAHPS satisfaction surveys; enrollee and provider complaints/direct input; and PAC and Consumer Advisory Board feedback. We also review provider additions/terminations to identify anomalies, shortages or trends, and then address potential opportunities through provider relations outreach and additional provider recruitment when needed.

To build provider capacity, we recruit additional providers and work with existing network providers to expand their service ability. We will consider the following as we work with our network providers to improve access: extended hours and/or expand scope of services; convenience care clinics to assist with primary care; availability of physician extenders; application of telehealth solutions; and the auto-assignment of new enrollees to PCPs with adequate capacity.

For example, in a state similar in size to Kentucky, UnitedHealthcare's Medicaid membership more than doubled due to the exit of a competitor MCO. Our health plan built upon the strength and experience of our local and national teams to provide a **seamless transition of more than 200,000 enrollees in 27 days.** Our combined strength and experience allowed us to meet and even exceed the State's expectations for network and enrollee access.

b. If Subcontractors will provide Covered Services, describe how network development efforts will be coordinated with the Vendor's provider network development strategy and how the Vendor will monitor the Subcontractor's activities and ensure transparency of these activities to the Department.

For the Kentucky MCO program, we will subcontract with established vendors with whom we already have relationships and work history for several covered services — including OptumRx for pharmacy services; Optum behavioral health services for mental health and substance use services; Dental Benefit Providers, Inc. for dental services; and MARCH Vision for vision services. While these subcontractors are company affiliates and part of UnitedHealthcare, executive and clinical leadership at our Kentucky health plan will actively manage and monitor these relationships to ensure the highest level of service for our Commonwealth enrollees. As "internal vendors," we have stronger direct oversight of their services and performance. **We include subcontractors in our overall Kentucky MCO network development efforts and use an aligned, coordinated approach for provider recruitment, contracting and network monitoring.** Subcontractors are held to the same contractual requirements as UnitedHealthcare.

Our subcontractor oversight process is designed to enhance lines of communication, accountability and authority, and to provide transparency for our senior leadership and DMS about performance and regulatory issues. The process includes regularly scheduled meetings with appropriate documentation to demonstrate that our programs are effective. All subcontracts are supported by a written agreement that specifies delegated activities and reporting responsibilities, and provides mechanisms for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

We monitor, manage and evaluate subcontractor performance through several means to facilitate oversight and to adhere to Commonwealth contractual requirements. Unless otherwise requested, we use these approaches for our affiliated entities and for our external subcontractors.

Operating Arrangements: The operating arrangements document incorporates the following: a description of the required functions and service levels, our performance assessment process,

our recourse actions if service standards or performance expectations are not met (e.g., delegation revocation or imposing sanctions), and the authority of our executive team to drive change. Relationships are constructed, formalized and managed with the consent of DMS, the subcontractor and UnitedHealthcare. DMS has the right to review and approve or disapprove all subcontracts for MCO program services. All operating agreements will conform to DMS's terms and conditions.

Monitoring and Governance: Overall monitoring and governance takes place through our Delegated Vendor Oversight Committee (DVOC), which reviews monthly reporting from all delegated vendors to proactively identify issues related to vendor performance and compliance. In addition to the DVOC, we assign local executives as vendor relationship owners (VROs) who regularly contact vendors to review activities, monitor progress toward goals and discuss any issues. This established oversight process helps us to verify that subcontractors are meeting performance metrics, their staff, policies, network (as applicable), and resources are appropriate to meet requirements. Results of monitoring activities are reported in functional area and compliance committee meetings, which include executive leadership reviews.

Regular Operations Meetings: Our regular subcontractor operations meetings promote the understanding of functional area interdependencies. During these meetings, we provide direction to make sure subcontractors meet quality, access and effectiveness requirements. Subcontractor account managers report on subcontractor performance and measurements. Operations meetings include feedback and oversight; review of policies and procedures; training and education; key performance indicators monitoring; effective lines of communication; and responding to issues/escalation.

Delegated Vendor Oversight Committee: Quarterly, the results of the operations meetings are reported to the DVOC. The DVOC consists of the vendor management team, business and account representatives from the vendors and any additional functional enrollees (e.g., staff from business, clinical, legal, finance and compliance areas), as necessary.

Quality Review: The DVOC is accountable to the governing body, the Quality Improvement Committee (QIC). Minutes, reviews and any corrective actions from the DVOC navigate upward through our health plan Quality Assurance and Performance Improvement (QAPI) committee structure via the QIC. The QIC reviews performance indicators and an annual assessment evaluating compliance with established standards, including NCQA, state and federal requirements. The DVOC provides a recommendation regarding the entity's continued delegation based upon these reports. The QIC may provide guidance as needed to the DVOC based upon these reports.

c. Describe the Vendor's approach to use telehealth services to improve access. Include the following at a minimum:

i. Criteria for recognized sites.

ii. Education efforts to inform providers and Enrollees.

iii. Whether reimbursement will be available to the presenting site as well as the consulting site or only the consulting site. Include any requirements or limitations on reimbursement.

iv. Lessons learned and successes or challenges with implementation of telehealth services for other programs the Vendor has served and that the Vendor will consider for provision of telehealth services in Kentucky.

Telehealth is a crucial part of our strategy to provide all enrollees access to high quality, accessible care regardless of where they live. This starts with local providers. Recognizing Kentucky's progressive new

We owe tremendous thanks to Rob Sprang, UK's Director of Telecare, for collaborating with us to ensure we understand the future of telehealth in Kentucky and helping shape our program to meet the Commonwealth's vision.

telehealth regulations, areas of provider shortages throughout the Commonwealth and in compliance with all requirements noted in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 28.10 Telehealth, we will support our MCO network providers' efforts to expand the use of telehealth. We have established relationships with KPCA, Norton Healthcare, CHI Saint Joseph Healthcare and UK and we will partner with them on telehealth initiatives. As shown in the following table, we are already working on telehealth pilots tailored for the Kentucky MCO Program:

Telehealth Service	Description
New Pilot Telehealth Programs for Kentucky	
Child and Adolescence Community-Based Telehealth	Barren County has seen an increase in children living in poverty and being placed in out-of-home care. To address the effects of this among children and youth in Glasgow, alongside a shortage in outpatient behavioral health therapy providers, UnitedHealthcare is partnering with the Boys & Girls Club of Glasgow-Barren County, using Genoa Healthcare's telehealth technology and network of providers. A key local behavioral health provider, Cumberland Family Medical Center, recognizes the increased need for additional providers in their community and they have fortified this partnership. The Children's Alliance and Dr. Steve North and Amanda Martin from the Center will provide additional support for Rural Health Innovation. They will bring their experience and leadership of the North Carolina Health-e-Schools program to the Commonwealth. With 167 out of 254 Glasgow Club enrollees served by Medicaid, the fall 2019 collaboration will allow the children and youth to receive needed services toward improved emotional health outcomes during their usual routine at the Club.
Telepsychiatry	Our telepsychiatry programs allow us to distribute psychiatric access across the Commonwealth to any location that has a computer and internet access. Our telepsychiatry vendor, Genoa Healthcare, and Pennyroyal Mental Health Center (Hopkinsville, Kentucky) are planning to enter an agreement whereby Genoa would match Pennyroyal with dedicated psychiatrists who are experienced in addictions and have a DATA-2000 waiver. At this time, Pennyroyal has indicated they desire at least 16 hours of weekly care from our network providers to treat all their clients with SUD and dual diagnoses.
Teledentistry	We are piloting teledentistry programs in several markets nationwide that focus on collaboration with pediatric and family medicine clinicians to perform screenings for dental caries, providing anticipatory guidance to parents, applying fluoride varnish and providing a referral for a dental visit. In Arizona, to promote access, we are working with a pediatric dental practice to pilot a teledentistry program that uses remote dental care providers to support rural-area public health hygienists in treatment planning and follow-up. If coverage for asynchronous telehealth is restored following the expiration of emergency regulation 907 KAR3:170E, we will develop a teledentistry program in Kentucky, with KPCA's integrated sites targeted for potential implementation.

We also will employ the strength and experience of our national telehealth programs to benefit Kentucky MCO enrollees, with our Kentucky health plan leadership helping to bring these solutions to the Commonwealth. Our proposed telehealth service approach for Kentucky includes tracking utilization data and health outcomes for all programs to validate effectiveness.

Telehealth Service	Description
Effective National Solutions to Support Local Telehealth Initiatives	
Medical Virtual Visits	Our UnitedHealthcare Doctor Chat program will enable enrollees to initiate a virtual visit from their home with an ED physician, board-certified and licensed in Kentucky. This innovative, chat-first workflow enables barrier-free access to care in

Telehealth Service	Description
	90 seconds or less while engaging enrollees via their preferred communication channel. In addition to the chat-based approach, UnitedHealthcare Doctor Chat is different from other virtual visit solutions because the providers seek to understand the enrollee's health concerns thoroughly rather than addressing only the immediate need. Any visit that is unable to 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. Overall, the program delivers a positive enrollee experience, leading to a 93% satisfaction rate. In Kentucky, we will use this capability to improve access to care for enrollees in rural areas. We also will promote this program to enrollees who have visited an ED two or more times in one year to reduce medical costs driven by unnecessary ED visits. We understand that a chat-based encounter may not meet the definition of "telehealth" in Kentucky and our Doctor Chat providers will not be submitting claims. As we believe this solution is a way to drive cost effective health care and increase access in rural areas, UnitedHealthcare will cover the cost of this program for our enrollees and share details of each encounter with the Kentucky Health Information Exchange.
Behavioral Health Virtual Visits and Telemental Health	We incorporate behavioral health virtual visits into our standard offering for enrollees and providers as an alternative method to seek and provide care, and will bring this solution to Kentucky for the MCO Program. For providers, we pay the same for virtual visits as we do for in-person care, as we believe telemental health can be used as an extension of the provider's office. We also will use Kentucky-licensed providers located in neighboring states to ensure a robust behavioral health virtual visit network. Our behavioral health virtual visit solution has been successful in many states and use continues to increase year-over-year (YOY). Nationally, from 2017 to 2018, we saw 70% YOY growth, with the top conditions treated including depressive disorders, neurodevelopmental disorders and bipolar and related disorders. In the Medicaid population, 70% of service utilization is currently for psychotherapy versus psychiatry. We also will bring the UnitedHealthcare Community Computer Program to Kentucky to help facilitate telemental health care access. Used most recently in Hawaii, the program consists of donating refurbished UnitedHealthcare laptops to rural PCPs offices. The computers are installed so enrollees can receive local behavioral health services from remote behavioral health clinicians. This innovative program allows our enrollees to be seen for routine therapy and drives quality — particularly for our enrollees who have been hospitalized for a behavioral health incident. We want to make sure these enrollees are seen within 7 days by a behavioral health clinician and, by using telemental health solutions, we can reduce barriers to accessing care. We understand the need to reduce barriers for our enrollees to access care and this program leverages technology and creates an integrated health environment amongst PCPs.
Remote Patient Monitoring	In addition to solving for Kentucky's (mostly rural) gaps in care, increasing enrollee access and addressing specialist gaps, we will develop programs to support Kentucky's unique populations, including enrollees with chronic conditions. We will bring our partnership with Vivify Health to Kentucky to offer end-to-end remote care management for enrollees with diabetes, heart failure or COPD. Participating enrollees use Bluetooth-enabled devices to facilitate the collection of biometric data, qualitative feedback to questions about their health and needs and access video educational tools. Vivify Health's results include readmission reductions over 65% and adherence and satisfaction levels exceeding 95%.
Provider Support and Education	Project ECHO increases access to specialty treatment in rural and underserved geographical areas by providing front-line clinicians with the knowledge and support they need to manage enrollees with complex conditions. In Kentucky, this

Telehealth Service	Description
	includes cancer, Hepatitis C and geriatrics. By connecting clinicians with specialist teams at academic medical centers in weekly virtual clinics or teleECHO™ clinics, PCPs, nurses and other clinicians in rural areas learn to provide specialty care in their own communities. We will promote the use of Project ECHO and its training site to our network providers to create awareness and drive participation.

Criteria for Recognized Sites and Telehealth Services Reimbursement

Pursuant to 907 KAR 3:170, we will reimburse any consulting site provider for any medically necessary telehealth (as defined by KRS 205.510(15)) services performed by Kentucky Medicaid-participating practitioners with an active, unrestricted license in Kentucky, regardless of the location of the enrollee. Telehealth services will be reimbursed at the same rate as a comparable in-person service, at a minimum.

Understanding that there is no limitation on patient location for telehealth services, we will reimburse a facility or host site fee for presenting site providers in accordance with guidelines ultimately established by the Kentucky DMS. We are supportive of the Commonwealth's efforts to expand access to telehealth and look forward to ongoing collaboration with DMS to develop innovative approaches to reimbursement. Additionally, we have established mobile access points (described previously) that do not require the presence of a provider at the presenting site.

We currently accept a 02 place of service code or GT/GQ modifiers for the consulting site and CPT code Q3014 for the presenting site. However, we will accommodate any requirements ultimately determined by the Kentucky DMS. We will make our Telehealth and Telemedicine Reimbursement Policy available to providers for support.

Education Efforts to Inform Providers and Enrollees

We support enrollee choice in how to receive physical and behavioral health services, whether in-person or through telehealth services, through a continued focus on providing a robust provider network that assures access to and availability of health care services. We will help enrollees and providers understand that telehealth options reduce wait times for access to specialty care, increase enrollee convenience and reduce the cost and inconvenience of traveling long distances. We educate enrollees and providers in a variety of ways, such as:

Enrollees

- Conducting education forums for UnitedHealthcare enrollees across the Commonwealth to provide information on telehealth benefits; where and how to access telehealth services; the accessibility of virtual health clinics through our free mobile application; and enrollee rights and responsibilities when using telehealth technologies, such as the ability to operate the equipment.
- Including telehealth information in our enrollee materials, such as our *Member Handbook*, newsletters and secure websites; this will include details about eligible sites and services.
- Publishing success stories regarding telehealth use on our enrollee secure websites and in our enrollee newsletter, *HealthTalk*.
- Identification of providers with telehealth capabilities in our print/online *Provider Directory* for enrollee consideration and selection

Providers

- For Kentucky Medicaid providers that are interested in telehealth but do not have the capability, our health plan staff will offer guidance on best practices, technology platform selection, billing processes and more.
- Educating providers, community-based and health plan staff who have direct or indirect contact with our enrollees, including our *Advocate4Me* MSAs, NurseLine staff, behavioral health staff, care managers, CHWs, peer support specialists and utilization management staff on telehealth to promote information sharing during enrollee interactions.
- Publishing success stories regarding telehealth use on our provider websites and in our provider newsletter, *Practice Matters*.

Telehealth Lessons Learned and Successes or Challenges

We have extensive experience creating telehealth solutions for the enrollees we serve. The use of telehealth has grown dramatically across all of our health plans in recent years, demonstrating the growing acceptance of the modality by Medicaid enrollees. We have also developed telehealth programs in many health plans, resulting in lessons learned about how to mitigate telehealth challenge areas and how to facilitate and achieve telehealth solution success. Examples of a national program and a local partnership include:

Lessons Learned: UnitedHealthcare Doctor Chat

Reducing unnecessary ED use is a tremendous challenge with the Medicaid population. Traditional virtual visit solutions using only live, two-way video are commonly deployed for this purpose. However, the potential of such solutions is limited by low enrollee engagement; utilization is often less than 1%. A key reason for this is that streaming video uses significant amounts of data, and many Medicaid enrollees have limited data plans. Additionally, traditional virtual visit solutions may fail to address the fact that enrollees use the ED for reasons beyond illness, such as unmet social needs. For this reason, we began piloting a different approach in 2019.

As described previously, UnitedHealthcare Doctor Chat is an innovative, chat-first virtual visit solution that still offers the ability to switch to video when necessary. We have deployed this program in Washington, Louisiana, Ohio, and Pennsylvania, with additional markets to follow in 2020. Utilization is nearly 10 times higher than traditional virtual visit solutions for Medicaid in use elsewhere. So far, we have learned that:

- Enrollees value being able to connect with a doctor via chat rather than using large amounts of their data plan on a video visit. It also eliminates the need to wait in a queue for several minutes, as is usually the case with video-only solutions.
- Enrollees also value receiving support for non-medical concerns. The providers on the UnitedHealthcare Doctor Chat platform are able to connect enrollees to appropriate resources to address social barriers.
- UnitedHealthcare Doctor Chat can also improve enrollees' engagement with care management support. In Louisiana, we have now added nurses from our Healthy First Steps program to the platform so that enrollees can connect immediately via chat or video. We will monitor the effectiveness of this approach for potential expansion into additional states.

Success Story: Local Partnership for Medical Specialty Telehealth in Kansas

In Kansas, we created and implemented an innovative and cost-effective medical specialty telehealth program with the southeast region's only FQHC, Community Health Center of Southeast Kansas, Inc. (CHC/SEK) to serve critically underserved communities. The project served the nine counties of southeast Kansas (population of 175,859) which rank in the bottom quartile of health

outcomes in the state. Within the first 12 months from the project's start in June 2017, successes include:

- 221 enrollees accessed specialty consultations via telehealth
- 100% (221) of enrollees in need accessed specialty care
- 86% (186) accessed care within 30 days of the initial referral
- 94% (208) of patients indicated satisfactions with the provider, support staff, information provided and environment/technology

These outcomes demonstrate that Medicaid enrollees value the ability to access specialists virtually and will take advantage of the opportunity to use telehealth when available.

d. Describe the Vendor's provider contracting strategies, including processes for determining if a provider meets all contracting requirements (at the time of enrollment and on an ongoing basis), as well as processes for corrective action and termination.

Include copies of the Vendor's proposed contract templates for individual practitioners and for facilities as attachments.

Contracting Strategies

Our contracting strategy is three-pronged and includes the standard provisions set forth in Appendix C Required Standard Provisions for Network Provider Contracts. First, we used our contracted Commercial medical, behavioral, dental, ancillary and allied networks as a foundation and resource to identify and target key care providers and health systems vital to serving Kentucky Medicaid enrollee's health needs and extended an amendment for network participation. Next, we targeted essential Medicaid providers such as LHDs, RHCs, FQHCs and CMHCs and offered them a written contract for network participation. Last, we reviewed the existing MCO contract and Kentucky Medicaid website to identify any unique provider types serving the MCO population and offered them a written network contract (e.g., CAHs, Office of Children with Special Health Care Needs and prescribed pediatric extended care providers).

Using this strategy, our local network team has already contracted, amended existing contracts, obtained LOIs and targeted commercially contracted providers pending Medicaid amendment with nearly 16,724 providers statewide, including physicians, hospitals, behavioral health providers, essential community providers, dental, vision and other ancillary providers. We have included copies of UnitedHealthcare's proposed contract templates as Attachment C.18.d Proposed Contract Templates**.**

Determining if a Provider Meets All Contracting Requirements

One of our major responsibilities as an MCO is to safeguard the quality and safety of services provided to our enrollees. We demonstrate this commitment by confirming that any provider deemed eligible to provide services to our enrollees has met or exceeded a threshold of qualifications and contracting requirements — at the time of enrollment and on an ongoing basis. Providers must sign an attestation that they meet all contracting requirements when completing our MCO network participation agreement, which includes the regulatory appendix. Initial provider credentialing is also a well-recognized mechanism for this necessary review of minimum professional credentials and adherence to standards. We require all providers to undergo our credentialing and recredentialing processes and pride ourselves on maintaining a stringent set of credentialing requirements that comply with national and state-specific regulatory requirements and professional principles. We require our delegated vendors and affiliates to apply the same criteria as set forth in our credentialing policies and procedures.

Once participating, we evaluate all relevant quality of care (QOC) and quality of service (QOS) data for network providers on an ongoing basis — including feedback from enrollees (e.g., from grievances and surveys) and our clinical support team, capacity reports and access surveys, performance against quality metrics, claims data and adverse events — and thoroughly document them in our tracking system, QCare. During recredentialing, which occurs every 3 years and mirrors the credentialing process, we also review the provider's history of QOC/QOS concerns. If a significant QOC concern arises, we may conduct a case investigation and the provider may be re-educated, placed on a corrective action plan (CAP), suspended or terminated with cause.

Process for Corrective Action and Termination

In situations of contractual non-compliance or poor quality of care, we adhere to the following established processes and policies for resolution, including provider education, CAP development and, as necessary, provider termination.

Process Step	Description of Activity
Notification	We work closely with the provider on non-compliance concerns, and we formally notify the provider of the non-compliance issue by letter.
Outreach	Our provider advocate contacts the provider by phone, confirming receipt of the letter, discussing the provider's ability to correct the situation and re-educating them.
Notification of CAP	If there is continued non-compliance, we notify the provider that they will be placed on a CAP.
Monitoring of CAP	We monitor the CAP at 30, 60 or 90 days, working collaboratively with the provider as needed or requested to support their remediation work.
Peer Review Committee	Our Peer Review Committee closely monitors QOC issues specifically, assures resolution and assigns severity levels to cases. If significant individual issues or QOC trends are identified, this committee may make recommendations to our Kentucky PAC for termination with cause. The PAC, a subcommittee of our QIC, may re-evaluate the provider's performance, request further corrective action, or determine the need for termination.
Provider Notification of Termination	The provider is notified of the termination, including the reason for termination, effective date, provider's right to appeal and instructions for requesting an appeal. Appeal rights are consistent with federal and state regulatory requirements and NCQA accreditation standards.
DMS Notification of Termination	We will notify DMS in writing of any decision to terminate a network provider, including the reason for and the effective date of termination. We will comply with termination requirements as indicated in the Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 28.0 Provider Network.

e. Demonstrate progress toward developing network capabilities for statewide access by providing evidence of existing contracts or signed Letters of Intent with providers by provider type (for the Vendor and Subcontractor). Include the following information at a minimum:

i. A Microsoft Excel workbook by provider type listing every provider that has signed a contract or Letter of Intent, including the provider's name, specialty(ies), address and county(ies), Medicaid Region(s) served, whether the provider is accepting new patients, accessibility status for individuals with disabilities, language spoken, and the provider's Medicaid Identification Number(s).

ii. A summary Microsoft Excel worksheet with total provider counts by provider type by Medicaid region and county.

iii. A statewide Geographic Access report of all providers with LOIs and/or existing contract color coded by provider type by Service Region.

Using both the traditional and innovative contracting strategies previously described, our

proposed comprehensive network for the MCO Program currently includes nearly 16,724 providers statewide. We have provided the following attachments as evidence of our proposed network to serve Kentucky Medicaid enrollees; these attachments demonstrate our progress toward developing network capabilities for statewide access, and include contracted providers, those with a signed LOI and commercially contracted providers with Medicaid amendments pending:

- ***Attachment C.18.e.i:*** a Microsoft excel workbook by provider type, listing every provider who has signed a Kentucky Medicaid contract or LOI and contracted commercial providers with Medicaid amendments pending in Kentucky and the bordering states of Ohio, Missouri, Tennessee, Virginia, West Virginia, Indiana and Illinois.
- ***Attachment C.18.e.ii:*** a summary Microsoft Excel worksheet with total provider counts by provider type by Medicaid region and county. Includes UnitedHealthcare providers who have signed a Kentucky Medicaid contract or LOI, and providers who and contracted commercial providers with Medicaid amendments pending in Kentucky, and the bordering states of Ohio, Missouri, Tennessee, Virginia, West Virginia, Indiana and Illinois.
- ***Attachment C.18.e.iii:*** a statewide Geographic Access report of all providers with LOIs color coded by provider type by service region; note, we included both contracted and providers with LOIs. We used CMS standard county designations to identify urban and non-urban counties. The map depicts UnitedHealthcare providers contracted for Kentucky Medicaid, providers who have signed LOIs for Medicaid and contracted commercial providers pending Medicaid amendments.

f. Describe proposed Enrollee to provider ratios by provider type, as well as the Vendor's methodology for considering a provider's FTE when calculating network adequacy standards.

Our proposed ratios are UnitedHealthcare national standards based upon CMS's federal regulations for Medicaid managed care. However, we will adjust our standards for enrollee-to-provider ratios for Kentucky, as we do in other Medicaid states, based upon the direction of DMS/Commonwealth.

To calculate network adequacy standards when considering a provider's fulltime equivalency (FTE), UnitedHealthcare assigns enrollees to an individual provider and not to a specific practice location. A provider will only be allowed the maximum number of enrollees per our ratios, irrespective of the number of practice locations, as stated in the following table.

For all provider types, we adhere to the reporting requirements indicated in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 28.4 Provider Network and Adequacy. This table highlights our proposed enrollee-to-provider ratios:

Provider Type	Proposed Enrollee to Provider Ratios
PCPs	
Physicians, advanced practice RNs, physician assistants and family planning providers	1,500:1 FTE PCP for a solo practitioner, including those for children under 21 and adults
Specialty Care Practitioners (high impact specialists)	
Cardiology, General Surgery, OB/GYN, Ophthalmology, Orthopedics	2,000:1
ENT/Otolaryngology, Gastroenterology, Neurology, Oncology/Hematology, Pulmonology, Urology	4,000:1

Provider Type	Proposed Enrollee to Provider Ratios
Dermatology	8,000:1
Endocrinology, Rheumatology	10,000:1
Behavioral Health and Substance Use Providers	
Prescriber (MD, DO, nurse practitioner, physician's assistant, medical psychologist, when available) and Doctoral (PhD) Clinician	2,000:1
Master's-level Clinician and Child/Adolescent Clinician	1,000:1
Acute Inpatient Care (mental health and substance use), Intermediate Care/Partial Hospitalization/Residential (mental health and substance use), Intensive Outpatient Care (mental health and substance use) and MAT	20,000:1
Dental Providers	
Dentists	2,000:1

g. Describe the Vendor's proposed methods for ongoing monitoring and assessment to ensure compliance with network adequacy and access to care standards, including tools used, the frequency of reviews, and how the Vendor will use findings to address deficiencies in the Provider Network. The response should also address how the Vendor monitors appointment availability and wait times.

Provide samples of tools and/or reports.

We recognize the importance of a comprehensive, easily accessible and available network in promoting enrollee health and satisfaction, and to facilitate a successful relationship with DMS. We will continuously measure our network against DMS's access, adequacy and availability standards. Our network development team uses the following tools to perform a comprehensive network analysis:

Monitoring Method/Tool	Description	Frequency
Geographic Accessibility Reporting	Maps the travel time between enrollees' ZIP codes and providers' service locations. Analyzes access and availability performance and identifies provider types and locations needed to meet State requirements.	Monthly
Membership and Capacity Reports	Review of membership-to-provider counts and capacity reports to confirm appropriate access to providers.	Quarterly
Utilization Data	Review of out-of-network prior authorization data by specialty type, location and program to identify and close network gaps.	Quarterly
Physician Profiles	Benchmarks providers across the health plan to identify utilization and access to care outliers for preventive care, chronic care and utilization management measures.	Reviewed and mailed to PCPs three times/year
Additional Surveys and Feedback	Input received via CAHPS enrollee and provider satisfaction surveys; enrollee and provider complaints; quality of care concerns; feedback received from provider and enrollee advisory groups; and informal feedback relayed from our front-line staff (e.g., care managers, provider advocates, enrollee advocates).	Ongoing (e.g., surveys reviewed annually; work group meetings at least quarterly)
Review of Requests	We monitor requests for out-of-network providers, transportation requests and requests for telehealth services to identify geographic patterns that may indicate an access issue in a particular part of Kentucky.	Ongoing

Monitoring Method/Tool	Description	Frequency
Community Engagement	We work in partnership with local groups, who help us identify community-specific network gaps and give us the perspective of local providers on changes and updates to the operations of our networks.	Ongoing
Quality and Member Access Committee (QMAC)	Listening to feedback from enrollees is critical for achieving the best possible access to care. The QMAC will include enrollees, health plan representatives, providers, community groups and advocates, Commonwealth agencies and other critical community-based organizations that represent our enrollees and providers. Our quarterly QMAC meetings will offer enrollees the opportunity to discuss current trends in their communities, network issues, cultural needs and potential barriers to care related to language, health care and current policies. Information gathered is shared with the network teams to resolve gaps and inform network growth and expansion.	Quarterly (minimum)

Monitoring Appointment Availability and Wait Times

Our primary means to evaluate provider compliance with appointment availability and wait time requirements is via our contract with DialAmerica, a vendor with national expertise in conducting phone surveys. DialAmerica conducts an audit via phone surveys to a random sampling of network care providers. Audits are performed monthly, quarterly, biannually or annually (as needed). Survey types vary based upon each market's regulatory requirements (e.g., secret shopper or alternate surveys). We solicit information about appointment availability and access based upon need, including routine care, sick care and urgent/emergent care. Survey results are measured against contract requirements and in accordance with our internal appointment and access policy, which requires corrective action plans to improve outcomes based upon survey findings.

We will assess enrollee wait times against scheduled appointment time as well during these survey calls. We ask the practice staff to assess their wait time at the time of the call, based upon whether patients are presenting for a pre-scheduled appointment or as a walk-in. Additionally, these metrics will be monitored through real-time observation by our Kentucky field-based clinical and provider advocate staff who frequently visit participating providers' practices to provide support and education. During their visits, they will do a time check with the office staff regarding appointment wait times and determine whether the practice is providing updates to waiting enrollees if they are running behind.

Phone surveys to assess after-hours availability are also conducted; these calls occur after standard working hours, and we document the length of time for a provider to call back.

Using Findings to Address Network Deficiencies

We use and review the results of all of the methods and tools described in the preceding table to monitor and assess the strength and depth of our care provider network, identify opportunities for improvement and implement timely actions as required or necessary. For example, if we identify any network access issues or special needs of the enrollee, we will identify if there is an available provider within the geographic area and conduct outreach to the provider to discuss network participation. We may also assess whether our telehealth solutions could be applied to deliver needed services to the enrollee. We have provided a sample Quest Cloud geographic accessibility report as Attachment 18.e.iii. Other samples include Attachment C.18.g-1 Provider

Appointment Availability Survey-Sample Questions and Attachment C.18.g-2 Medicaid Top Enrollee Call Drivers Report (which highlights how we track enrollees that call our member services center due to not being able to get a timely appointment and other provider-related issues).

h. Describe how the Vendor would respond to the network termination or loss of a large provider group or health system. Include information about the following at a minimum:

i. Notification to the Department and Enrollees.

ii. Transition activities and methods to ensure continuity of care.

iii. Analyses the Vendor will conduct to assess impact to network adequacy and access, and how the Vendor will address identified deficiencies.

We recognize fluctuations in our provider network can be challenging for enrollees, other network providers and our Kentucky health plan, and we have an established plan that applies successful solutions used in other Medicaid states to address network variations due to large group terminations or losses. Our goal is to retain the contractual relationship whenever possible; however, we have established specific procedures to address provider terminations or loss of a large-scale provider group or health system. Our policy reflects our commitment to help affected enrollees make a smooth transition to a new provider and maintain care continuity, when needed. We will notify DMS via email within 3 business days of any network provider termination in compliance with Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 28.10 Termination of Network Providers, and we will comply with Section 28.10.E provider-exit survey requirements.

Notification to Enrollees and DMS

Enrollee notification and communication to DMS is part of our comprehensive termination process. We will provide DMS with a summary of the circumstance surrounding the termination or loss of a large-scale provider, in addition to actions taken to make certain enrollees have continued access to care. For any terminations, we will identity affected enrollees by generating an Enrollee Impact Report and notify all who have received a service by the terminating provider within the previous 6 months. These notices will be mailed within 15 days of the action taken for terminating PCPs, and within 30 days for any other provider type.

Should a sudden, unanticipated network provider contract cancellation occur (e.g., due to the death or urgent departure of a provider) or be required (e.g., due to a discovered sanction imposed by any governmental agency or authority, including Medicare or Medicaid), we have established policies and procedures for responding, assisting affected enrollees and providing notification of the network change. Our internal member services and clinical staff are trained to identify these types of reactive situations and will support enrollees prior to the enrollee receiving formal notice by assisting them to locate an alternative, acceptable provider for needed care. For example, the enrollee affected by the sudden provider loss could contact our member services staff or their assigned care manager and they will rapidly assist the enrollee in locating a new provider and scheduling an appointment. Our clinical staff, led by our Kentucky CMO, Dr. Jeb Teichman, also will proactively identify other providers that could meet the enrollee's individual needs.

Transition Activities and Ensuring Continuity of Care

To facilitate care continuity, enrollees affected by the termination or loss of a provider may call our member services center to receive assistance from MSAs in transitioning to a new provider, while enrollees in active care management are assigned to care managers to help them through the transition of care process. Our care management, network strategy and provider relations

teams immediately assess the availability of other providers in the community that meet the enrollees' distinct language and cultural preferences. The preferred strategy is to refer the enrollee to another qualified, contracted provider.

In relation to PCPs, if enrollees do not select a new PCP within 30 days, we assign them to a new provider to avoid disruption in care using our Provider Recommendation Engine (PRE) auto-assignment process. Within PRE, we have the ability to review enrollees' locations, claims and important demographics (e.g., language), resulting in a logic-based, quality and affordability-driven assignments to an open-panel PCP that can meet their needs. We notify enrollees of their PCP assignment and mail them new membership cards that list their newly assigned PCPs. We advise enrollees how to request a different PCP via our member services center and verify our member services staff are aware of and available to assist with any large group terminations. Our MSAs may also assist enrollees with selecting a new PCP, using PRE and other resources as needed, and they will help schedule an appointment with the new provider. If an enrollee is in an ongoing course of treatment or has a special condition, we allow the enrollee to remain with their current provider for an additional 90 calendar days to facilitate continuity of care.

Analyses to Assess Network Impact and Address Identified Deficiencies

We build comprehensive networks to allow enrollee choice in providers, increased capacity and flexibility to absorb the termination or loss of a large provider group or health systems, in the rare event terminations occur. We conduct ad hoc analysis activities (e.g., Quest Cloud geographic accessibility reporting, review referral patterns) prior to a group/system exiting our network to assess the effect on our adequacy and accessibility, and make concrete plans to serve enrollees including:

- ***Recruit network providers:*** If the termination results in a gap in our network, we will conduct a targeted network recruitment campaign to make sure our affected enrollees have adequate access and continuity of care.
- ***Refer enrollee to a non-contracted provider:*** If there is no available contracted provider, we will execute a single case agreement with the non-contracted provider to accommodate the enrollee's needs until we locate an equivalent contracted provider, or if possible, secure a contract with the nonparticipating provider.
- ***Transport an enrollee to a provider outside the enrollee's community:*** If a provider is not available in the enrollee's immediate community, we arrange for the enrollee to temporarily receive care from a provider located in another community and provide transportation at no cost to the enrollee for covered services.

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