20. Covered Services (Section 30 Covered Services)

a. Provide a detailed description of how the Vendor's operational structure and practices will support integrated delivery of services (i.e., staff, contractors, systems, calls centers, etc.). In addition, the Vendor's response should address:

Our experience providing services to individuals with Medicaid across 31 states, including 20 fully integrated states has taught us that only when we deliver services holistically, prioritizing physical, behavioral and psychosocial health, can we truly support our enrollees in their pursuit of health and wellness. The breadth and size of UnitedHealth Group gives us a distinct advantage in supporting integrated delivery of services. Having Optum behavioral health services under our unified governing body limits our need to rely on external contractors to support integrated care. Instead, we focus our efforts on cross training our staff and connecting them through unified systems, like our *Link* provider portal and CommunityCare care management platform. When we do use external contractors, we focus them on ancillary and value-added services that will support our enrollees. For example, contractors like *Healthify* allow us to coordinate and make referrals to non-covered supports and services addressing social determinants of health (SDOH).

In addition to our mission to help people live healthier lives, we have embraced a whole person care approach in other markets for years because we know enrollees with comorbid medical and behavioral diagnoses have complex care needs and total expenditures almost twice that of other enrollees.

We will bring our depth of experience to Kentucky, including our operational structure and practices to embody the philosophy that every door to the health care system should be a gateway to physical health, behavioral health and whole person care, while recognizing the importance of SDOH and empowering individuals to readily access necessary care. As illustrated in the figure and further detailed in this section, we encourage our enrollees to make the most of these opportunities by directly supporting them and the providers who serve them using:

- **Information.** We have created innovative ways of collecting, storing and sharing information on our enrollees' physical, behavioral and social needs to enhance our provision of covered services, coordination of non-covered services and share information back to enrollees and providers in cohesive, manageable platforms.
- **Education.** We provide multiple forms of education for our enrollees and providers alike to help make sure our enrollees not only receive integrated care, but also have the capability to actively pursue holistic health.
- **Enabling support.** We use a variety of high touch approaches to empower our enrollees and providers to make certain our enrollees receive integrated covered services, enriching value-added services and coordinated non-covered services centered on whole person care.

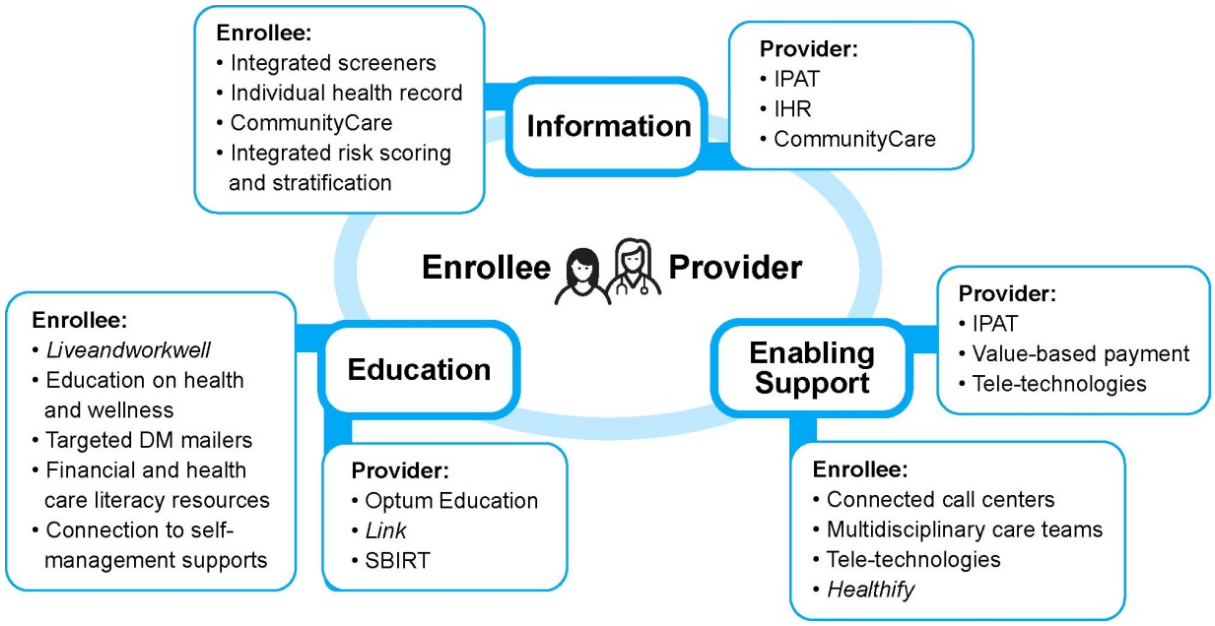

Figure 1. Our strategy to deliver whole person care begins with instilling an awareness of physical, behavioral and social needs and services among our enrollees and providers. We work to develop a comprehensive understanding of enrollee and provider needs and capabilities. Armed with this information, we provide tailored education, communication and innovative approaches to facilitate access and delivery of integrated care. We share information with enrollees and providers in cohesive, workable platforms to support learning, integration of physical and behavioral health care, coordination of covered and non-covered services and engagement between enrollees and their providers. (Abbreviations included in this graphic denote the following: IPAT stands for Integrated Practice Assessment Tool from SAMHSA-HRSA; IHR refers to individual health record; SBIRT stands for Screening, Brief Intervention and Referral to Treatment; and DM is short for disease management.)

i. Innovative approaches to ensure Enrollees experience whole-person care that integrates their medical and behavioral health benefits and addresses social determinants of health.

We have long recognized the importance of nurturing an individual's holistic health, including physical, behavioral, substance use and SDOH. We want to infuse this philosophy into each enrollee experience in Kentucky. Doing so successfully requires an adaptable approach that engages enrollees according to their preferences, needs and circumstances. It also requires a community of supportive provider partners who share this vision.

Creating an Integrated, Whole Person Enrollee Experience

We offer an array of innovative approaches to appeal to a wide range of individuals, from enrollees poised to self-educate and self-manage to those who require active, hands on support. The approaches herein summarize how we work to educate our enrollees about integrated care, how we understand our enrollees' comprehensive care needs and how we support their receipt of whole person care.

Redesigned in 2017, our website, *liveandworkwell.com*, includes information and tools to support comprehensive health and wellness. The website features assessments (such as depression, alcohol and tobacco), health calculators, searchable databases and directories (such as clinician, childcare, adoption and eldercare), important communications and links to expert resources promoting enrollee awareness and engagement in health. The site includes centers focused on resiliency, mindfulness, addiction, recovery, stress, parenting and caregiving. Resources include articles, videos, training programs, screeners, guides and links to expert information on one page. It supported 4.6 million visitors in 2019 — demonstrating its breadth and value in promoting health and wellness.

Enrollee Materials and Outreach

Making sure enrollees experience whole person care begins with understanding where they are in their health care journey and their goals. This allows us to effectively educate them about their medical and behavioral health benefits and available community and social supports. We recognize each of our enrollees will look for and consume information through multi-modalities. We have created communication methods to meet the unique needs and circumstances of the individuals we serve. We recognize that not all areas have access to reliable internet solutions and must rely on other modalities of information. We provide information on physical and behavioral health and related covered services through our Welcome Kit, *Member Handbook* and other enrollee materials and community outreach events. If enrollees have questions or need additional help, they can connect with our member services advocates (MSAs) who answer questions or resolve enrollee issues on medical and behavioral health matters through a single telephone line on the initial call, wherever possible. Our Kentucky-based MSAs will have enrollee data available to engage enrollees well beyond their initial reason for calling. For example, the MSAs can help enrollees find a local medical or behavioral health provider, remind them of gaps in care and schedule an appointment. Similarly, our enrollee portal, *myuhc.com*, accessible via computer or a mobile device, gives enrollees access to information about their benefits from a single sign-on and has educational resources about medical and behavioral health conditions. Our **UnitedHealthcare mobile app** has the same capabilities as *myuhc.com* but builds upon native device capacities to improve user experience.

Screenings, Risk Scoring and Stratification

Before we can provide integrated care, we need to understand our enrollees as individuals. We consider our enrollees' whole person needs and goals during our comprehensive screening, risk scoring and stratification process. The assessment tools we use for initial adult and pediatric Health Risk Assessment (HRA) and Enrollee Needs Assessments (ENA) include questions about medical, behavioral and SDOH (e.g., food security). For individuals with possible special health care needs (e.g., individuals experiencing high-risk pregnancies, homelessness), we use tailored screening tools to assess their needs comprehensively. Our care managers and community health workers (CHWs) use the information from our assessments to identify needs and design a person-centered care plan according to those needs. Using community resource inventory, *Healthify*, we refer individuals to social services and coordinate care with an integrated network of community partners and organizations to help enrollees sustain health and wellness. Additionally, we use medical, behavioral, pharmacy and health-related resource claims and encounter data to obtain a complete picture of an individual's needs.

> "With the help of UnitedHealthcare we are on our way to having one central hub in our community for families to receive true wraps around services."
>
> — Mary Lee England, Executive Director, Boys & Girls Club of Glasgow-Barren County

Increasing access to integrated services using tele-technologies: We understand access to health care may inhibit our enrollees from engaging in the health care system, particularly in Kentucky's most rural areas with scarcity of specialist providers. To help our enrollees overcome barriers to accessing integrated care, our CHWs can coordinate and refer enrollees to providers equipped with telehealth services, based upon an enrollee's specific needs. Additionally, we recognize that the existence of tele-technology alone does not always eliminate access barriers. In an effort to help the Commonwealth's most vulnerable receive appropriate care, we created a partnership with the Boys & Girls Club of Glasgow-Barren County to implement tele-technologies during after school programs as a way of bringing behavioral health services to children in need. For our highest risk members, we evaluate their situation, and depending on the needs of the individual, can offer in-home

services through the support of the CHW, RN, Behavioral Health Social Worker and/or Nurse Practitioner. This care team works to help re-integrate the person back into primary care in the community whenever possible and provides a stabilization safety net to ensure their unmet needs are addressed.

Local Multidisciplinary Care Management

Enrollees with high risk requiring complex care management receive support from local multidisciplinary care teams (MCTs) with the capability to provide physical and behavioral health care directly. The expertise and knowledge of our local partners combined with our national experience, operational expertise, clinical and technological infrastructure, offer a distinct, local approach to whole person care. Our evidence-based care management model has evolved to address medical, behavioral and health-related social needs versus medical needs only. RNs, social workers, CHWs, behavioral health professionals, nurse practitioners, peer support specialists, housing navigators, pharmacists, a licensed psychiatrist, medical physician and other health care professionals comprise our regionally based care management teams. Our enrollees have experienced many benefits from this integrated approach, including a nearly 10% reduction in inpatient stays among those assigned to integrated care management teams.

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Commitment to supporting our enrollee health through housing: We understand the destabilizing force housing insecurity and homelessness can have on an individual and the related negative effects on health. To assist our enrollees in achieving the best health outcomes, we will implement a housing navigator whose focus will be to help us build and strengthen capacity with housing providers and work directly with enrollees in need of housing supports. For our most complex, high needs individuals experiencing homelessness, we also will implement a targeted pilot of the Housing + Health program. This nationally recognized program will support our enrollees who are persistent health care utilizers and struggling with homelessness, addiction and transitions from incarceration. We focus on helping our enrollees find safety, stability and move forward in life. This involves the use of motivational interviewing, positive psychology and purpose development to encourage and support enrollees as they move toward employment, volunteerism or returning to their families. We also help them gain access to social entitlements like long-term housing vouchers, waivers, Social Security Income and food benefits (SNAP) to create long-term self-sufficiency.

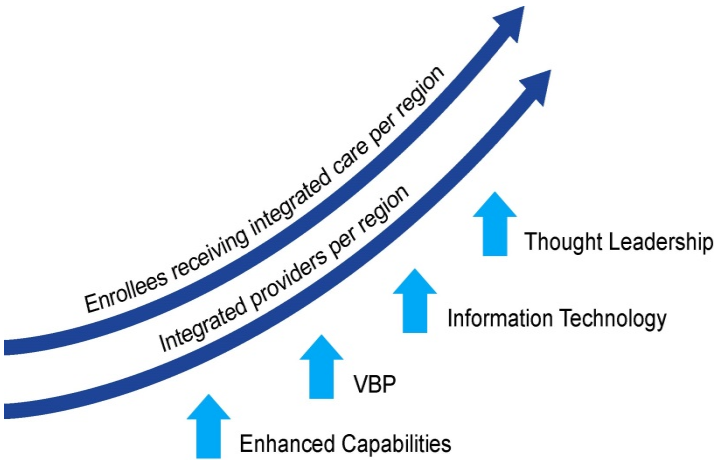

Figure 2. By increasing the number of providers who deliver integrated care, we increase the number of enrollees who experience whole-person care.

Provider-facing Initiatives for Whole Person Care

While we take our responsibilities to manage health and wellness among our enrollees seriously, we know we cannot and do not support them alone. Our innovations to improve the integrated care experience will have limited effect if our providers do not partner with us in this pursuit. For this reason, we are committed to partnering with practices that share our care philosophy, regardless of whether or not they are currently positioned to provide integrated delivery of services. Much like our enrollees who exist across a continuum, we recognize

providers have varying degrees of integration and we want to support them in delivering whole person care at each level. Increasing the number of providers who integrate care delivery increases the likelihood our enrollees will receive comprehensive care without the need for extensive coordination or follow up at multiple locations. We help providers achieve greater degrees of integration by understanding and enhancing provider capabilities, using innovative financial models as incentives and enabling and fostering a culture of thought leadership, education and training.

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

Partnerships with innovative providers: When searching for providers in a market, we work with those who share our vision for whole person care. Our partnership and integrated contract with the Kentucky Primary Care Association (KPCA) embodies our commitment to integrated delivery of covered services in Kentucky with the KPCA and other providers. We have engaged with KPCA to provide physical, behavioral and dental care to our enrollees, in many cases through co-located providers and supported by value-based payment (VBP) models. To help foster their commitment to bringing comprehensive care to their patients, we support their broader care management and coordination capabilities for individuals receiving services addressing their health-related social needs.

Understanding Provider Practices

To identify what support will be meaningful for each provider practice in its pursuit of greater integration, we apply evidence-based assessments, such as the SAMHSA-HRSA Integrated Practice Assessment Tool (IPAT), Patient-Centered Medical Home Assessment (PCMH-A) and the Maine Health Access Foundation (MeHAF) Evaluation Tool. Combined with other data, such as practice structure, financial performance and panel size, these assessment results help us gauge where integration support is needed and desired. For example, after conducting these surveys among providers in Washington, we took multiple steps to support increased provider integration by offering a contracted network of locally licensed psychiatrists available for peer-to-peer telehealth consultations in addition to facilitating consulting and referral relationships among providers to improve coordinated care and encourage warm hand-offs for our enrollees. We will explore similar solutions to increase physical and behavioral health integration in Kentucky based upon providers' expressed needs.

Innovative Financial Models: To foster and support integration among our providers, we apply innovative financial models. One such example we plan to implement in Kentucky includes our opioid use disorder (**OUD) *Quality Medication Assisted Treatment (MAT) value-based payment*** for PCPs, which provides a substantial monthly care management payment, in addition to targeted incentives for monthly MAT refills and a bonus for enrollees retained in treatment every 6 months. By supporting these practices with a care management

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

payment, PCPs will have the financial resources to build out the integrated infrastructure required to provide intensive care including:

- Comprehensive assessment of enrollees' medical, behavioral and social needs
- Development of an Addiction Treatment and Recovery Plan
- MAT and behavioral counseling
- Connection to social service and peer recovery supports
- Drug urine screens
- Screening for HIV and Hepatitis C
- Reproductive health counseling
- Naloxone education

Education, Training and Resources for Providers

We recognize that health care providers in Kentucky face a lot of challenges in engaging their patients. We do not want the lack of integrated care to be one of them. To ensure we are not only supporting but facilitating integrated care, we help providers understand its benefits and how to apply it in their practice by offering education, training and resources through our provider relations teams and online through our provider portal, *Link*. Examples of these resources include:

- ***Behavioral Health Toolkit for Medical Providers:*** This toolkit educates PCPs and medical specialists on mental health and substance use disorder (SUD) assessments and evidence-based practices. We also support behavioral health providers by educating mental health and SUD care providers on the benefits of completing ENAs (including mental health, SUD and medical needs) and requiring they conduct them as their standard course of practice. This confirms mental health providers screen for SUD and vice versa.
- ***Screening, Brief Intervention and Referral to Treatment (SBIRT):*** We provided free access to this evidence-based practice to reduce dependence on alcohol and illicit drugs through *Link,* our provider portal. By equipping providers with these practices, enrollees have increased likelihood of receiving necessary care.
- ***Access and instructions for how to administer evidence-based assessments*** such as the PHQ-9 for depression, GAD-7 for anxiety, and CRAFFT and DAST-10 for substance use. By understanding their patients' comprehensive health needs, providers are better positioned to provide or refer them directly to resources that will improve their health and wellness.

Integrated Behavioral and Physical Health Homes

We will pilot integrated behavioral and physical health home value-based payment (VBP) models to support Kentucky's behavioral and physical health provider partners in co-locating PCPs who deliver integrated primary care onsite at their clinics (e.g., at community mental health centers). This payment model will support behavioral health providers with incentives to provide comprehensive, integrated physical and behavioral health care resulting in the best health outcomes for our enrollees with serious mental illness and SUD. To test efficacy and measurable outcomes, we plan to partner initially with two community mental health centers (CMHCs), North Key Community Care and Centerstone in Louisville. Both have integrated primary care programs and have expressed a strong interest and readiness in our VBP approach, along with a willingness to pilot this model. The focus of this health home model is to improve performance on defined quality metrics for behavioral and physical health, while

reducing the overall behavioral and medical total cost of care. If our partners can reduce the total cost of care and meet defined quality metrics, they will be eligible for a percentage of the shared savings amount. We will closely monitor the data from this pilot and, if it shows positive outcomes, we will expand the model to additional behavioral health providers in other geographic regions within the Commonwealth.

Thought Leadership

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We deliver innovative health solutions in the local markets we serve and at the national level. One recent example includes our collaboration with the American Medical Association (AMA) to create and implement standard diagnostic codes for medical and behavioral health services targeting SDOH to more formally bring these needs into health care discussion and decision making within a provider's practice. In partnering with the AMA, we have led the industry in standardizing how data is collected, processed and integrated for social and environmental factors contributing to an enrollee's health and well-being in a way that can benefit individuals, regardless of payer. Integrating these codes into provider practices not only enhances the information available within the Commonwealth on enrollees' health-related social needs, but also works to increase the awareness of these needs within provider practices. Given the potential benefits, we are working with CMS and CDC to facilitate the nationwide adoption of these SDOH ICD-10 codes. In March 2019, **we were the first health plan to ever receive a Healthcare Innovation Award** in recognition of this work. Coupled with information on SDOH together with the Kentucky-based resources available in *Healthify*, we are positioned to support our enrollees' comprehensive needs, including their SDOH.

ii. Approach for coordination with carved-out services (e.g., transportation and transitions to long term supports and services).

As a part of our approach to whole person care, we work to make sure our enrollees receive all necessary care and support, including those carved out from their Medicaid covered services. Rather than duplicate these services, we support our enrollees in identifying needs for carved out services, help them access these services and coordinate them as appropriate. The figure illustrates the end-to-end approach our MSAs, CHWs and RN care managers take when coordinating care across multiple provider and support systems.

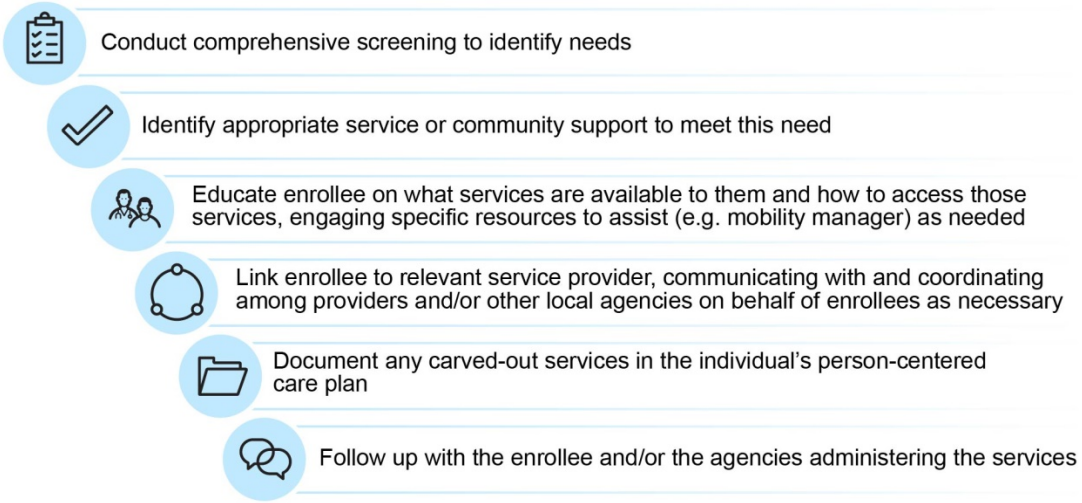

Figure 3. UnitedHealthcare's Process to Coordinate Carved-out Services. Educating our enrollees on the availability of additional services and how to access them, including direct support on how they can demonstrate their eligibility for these services, better positions them with the confidence and knowledge to engage in health and health-related supports in the future.

We have extensive experience coordinating carved-out services with respect to home visits, long-term services and supports (LTSS), non-emergency medical transportation (NEMT) and various other services, including other Commonwealth-based services and those provided by community-based organizations across multiple states. When one of our enrollees requires NEMT, our specially trained MSAs, locally based CHWs or care managers will educate them on the availability of transportation services, identify the local Human Service Transportation Delivery provider in their community and document the encounter in the enrollee's file in *CommunityCare*, our integrated care management platform.

Coordinating NEMT for our Kentucky Enrollees
An example of how we connect enrollees to NEMT is illustrated in our response to Use Case 1 (Section 29 Uses Cases) centered on Rhonda, a hypothetical 30-year-old enrollee living in Winchester, Kentucky. During our care team's conversations and interactions with Rhonda, including completion of a health risk assessment (HRA) and other comprehensive screening tools related to her pregnancy, Rhonda shares she "does not have reliable transportation and often relies on friends to provide rides to the pediatrician and grocery shopping." Linking Rhonda with community resources addressing her social determinants of health (e.g., lack of transportation) is essential to achieving long-term health and wellness. Together, Rhonda and her care manager discuss the various types of resources Rhonda needs to feel comfortable and confident supporting her family. To keep the lack of transportation from impeding Rhonda's ability to care for herself or her family, her care manager tells her about NEMT and refers her to Federated Transportation Services of the Bluegrass, the local provider of NEMT in the Winchester/Lexington area. Besides making sure Rhonda has the information she needs to understand and access NEMT transportation services, our care manager also offers to schedule transportation for her. If Rhonda has need of additional transportation support (e.g., to the grocery store), her care manager will work with our local Kentucky mobility coordinator to connect Rhonda to community resources and organizations providing supplemental transportation services. All information related to Rhonda's NEMT services or linkages to community supports are documented in CommunityCare and available to her care team for follow up.

iii. A description of any value-added services the Vendor proposes to provide to Enrollees.

We met and continue to meet with and listen to local providers and community-based organizations in Kentucky. We understand there are opportunities to enhance Medicaid covered services with value-added services. Based upon extensive local market engagement and analysis of the population and the Commonwealth's priorities, we thoughtfully designed the following value-added services to address health disparities and improve overall health outcomes.

Healthy Weight Initiatives
Weight Watchers – Diabetes Prevention Program
Weight Watchers is a CDC-recognized national Diabetes Prevention Program (DPP) provider. Positive lifestyle changes, such as losing weight and being more physically active lower the risk of developing type 2 diabetes while improving overall well-being. The DPP curriculum is incorporated in the standard Weight Watchers program and offers lifestyle meetings, easy-to-use digital tools and activity tracking. As part of our efforts to promote health and wellness and reduce chronic conditions, we offer enrollment in the Weight Watchers program. Enrollees who qualify for the Weight Watchers/DPP will receive vouchers to attend official meetings where they will learn how to make healthier food choices and discover fun ways to move more each day to help lose weight.
Access to Care
UnitedHealthcare Doctor Chat – Virtual Visits
Enrollees will have access to UnitedHealthcare Doctor Chat, an innovative, chat-first platform supported by

live video to connect with a doctor from their computer or mobile device for non-emergent care. A board-certified emergency medicine physician will assess the severity of the enrollee's situation, provide treatment (including prescriptions) and recommend additional care. Virtual visits can improve access to care, reduce health disparities and reduce avoidable use of the ED. This program highlights our commitment to bring forward-looking solutions to expand and deliver access to care in Kentucky.
Substance Use Disorder (SUD) Helpline
Unfortunately, stigma stops many afflicted with SUD from seeking treatment. The SUD Helpline is an anonymous confidential helpline where people can call and speak with a licensed substance use expert for information on SUD treatment. Enrollees can get a treatment referral if they choose to explore their specific benefits.
Seeking Safety
Enrollees who have a history of trauma or addiction have access to Seeking Safety, which focuses on teaching coping skills to help individuals feel safe in their relationships, thinking and actions. Seeking Safety is the most popular and scientifically studied counseling model for trauma and addiction, with an emphasis on adapting to each person's needs.
Alternative Chronic Pain Management
Acupuncture – Evidence-based alternative for pain management
A key component of traditional Chinese medicine, acupuncture is a technique for balancing the flow of energy and stimulating nerves, which can boost the body's natural system. Acupuncture is believed to relieve discomfort associated with a variety of conditions, such as chronic pain management, low back pain and migraines. This service has also been known to help those with OUD. Payment for more than 30 acupuncture visits per benefit year requires prior authorization.
Mindfulness
Through *myuhc.com*, enrollees have access to online meditations for the use of mindfulness in the alleviation of chronic pain. Mindfulness is a type of meditation focused on being intensely aware of what an individual is sensing and feeling in the moment, without interpretation or judgment. Practicing mindfulness involves breathing methods, guided imagery and other practices to relax the body and mind and help reduce stress. Studied in many clinical trials, the overall evidence supports the effectiveness of mindfulness for variety of conditions, including stress, anxiety and alleviation of chronic pain.
Health-related Benefits
Quit for Life – Maternal Smoking Cessation Program
Targeted program for pregnant women to quit tobacco use throughout pregnancy and early postpartum. The program includes support from pregnancy quit coaches to provide motivation, encouragement, education and reinforcement in the quitting process. Quit For Life® is a national leading tobacco cessation program. Access includes coaching calls, personalized interactive text messaging and anytime access to an interactive, mobile-friendly online website. This benefit is especially relevant for Region 8 where Owsley County has the highest rate in the Commonwealth of births to mothers who smoked during pregnancy (42.7%), followed by Lee (42.5%) and Clay (39.5%).
Vivify Remote Patient Monitoring
Vivify creates a digital pathway to collaborative care that extends beyond remote monitoring of high-risk enrollees to providing ongoing care and education. This remote patient monitoring (RPM) program provides a customized solution using integrated monitoring devices to quickly and easily track biometrics, interventions and custom self-trending reporting. Vivify can also offer text to speech capabilities for vision impairments. RPM helps improve health outcomes by providing medication management, promoting adherence with 7-day and 30-day post-discharge visits and providing virtual clinic visits to enrollees in areas with the delivery of telehealth.
Online Education
Elsevier Direct Care Online Training Program
This competency-based curriculum includes 120 hours of customizable, flexible online tool offers accredited CE credits. The curriculum was developed with the University of Minnesota College of Direct Support based upon CMS guidance. It supports enrollees in managing the program and provides tools and supports to

maintain eligibility. Enrollees must have a computer to access the modules. Elsevier provides program engagement and completion rates to track metrics.
GED Assessment and Prep Course
The GED assessment and prep course includes advisor coaching to help Kentuckians complete the GED exam (includes coaching and exam) and make the most of the Commonwealth's program to waive GED testing fees. Enrollees must have access to a computer. The course offers online and telephonic coaching support and assessments to test out of subject areas or hold content to confirm prerequisites are completed to achieve better testing success.
Suicide Prevention/Question, Persuade and Refer (QPR) Training
This is a 1-hour online course that helps identify if someone is contemplating suicide through three simple steps: Question, Persuade and Refer, to encourage the person to seek help. Listed in SAMHSA National Registry of evidence-based practices, QPR helps community members reduce the fear or stigma that might get in the way of assisting a coworker, friend or family member considering suicide.
Dailystrength.org
Support groups have long since filled the gap between medical treatment and the need for emotional support. An individual's relationship with their clinician may not prove adequate emotional support and a person's family and friends may not understand the impact of a disease or treatment. Daily Strength is an online support resource that provides over 500 support communities for people facing similar life challenges, medical conditions and mental health issues.
Transition Supports
Community Care Package – Home-delivered meals to support transitions of care
For those eligible enrollees who are diabetic or pre-diabetic after hospital discharge from an acute inpatient hospital stay into a community setting and need nutritious prepared meals delivered this offers a customized solution. Enrollees will have the convenience of choosing their meals and having them delivered, regardless of their geographic location in Kentucky to aid with recuperation at home and managing their condition. Enrollees will have access to 14 prepared home-delivered meals.
UnitedHealthcare's On My Way
On My Way (OMW) is an interactive mobile and web-enabled game that takes the overwhelming transition from youth to adulthood for individuals aging out of the foster care system and those outside of the foster care system and breaks it down into bite-size, manageable steps. Users will find relevant, easy-to-understand information and step-by-step guidance for actions to take. OMW teaches practical skills like managing money, securing housing, creating a resume, finding job training and applying for college.
Outreach and Engagement
SilverLink – IVR
SilverLink – IVR provides automated outreach and appointment reminder calls to reduce gaps in care and encourage engagement in preventive services.
SilverLink – Live Calls
SilverLink provides live calls for enrollees with diabetes. Agents make live calls to enrollees to help schedule or reschedule missed appointments. Reminder calls and follow-up calls are available when scheduling is complete.
Enrollee Health Incentives – All of the following incentives are dependent upon DMS's approval and for enrollees at or below 100% federal poverty level (FPL).
Enrollee incentive for diabetic screening tests
We offer enrollee health incentives geared towards supporting effective outcomes and a culture of health. This incentive focuses on improving management of chronic conditions by providing $15 gift card incentive to diabetic enrollees who complete HbA1c screenings and retinal eye exams. Eligible population: enrollees at or below 100% FPL. This incentive is especially relevant in Regions 2, 7 and 8 where there is a high prevalence of adult diabetes.
Enrollee incentive for adolescent well-care visits
Keeping families healthy is important. This incentive promotes wellness and prevention by providing a $25

gift to enrollees who complete their adolescent well child visit. Eligible population: enrollees at or below 100% FPL. According to America's Health Rankings, Kentucky ranks 40 for adolescent immunizations, which makes this an effective incentive for improving health outcomes.
Enrollee incentive for dental preventive visits
Oral health problems are largely preventable through routine visits to the dentist and good oral hygiene. Because oral health is often overlooked, we are offering this incentive to promote wellness and prevention for a healthier smile. Adult enrollees who complete an annual dental exam can receive a $15 gift card. Eligible population: adults at or below 100% FPL. Since poor oral health and gum disease are often associated with diabetes and heart disease, this incentive is important in areas like Region 8, which has the highest diabetes prevalence rate and the highest heart disease death rates in the Commonwealth. We will place special emphasis on promoting this incentive for pregnant women as we recognize the benefits oral hygiene can have on a healthy pregnancy.
Maternity Incentive Program
These incentives are designed to help expectant enrollees and their babies stay healthy during and after pregnancy. Enrollees can earn up to eight incentives, which are specifically designed to promote babies' cognitive development and physical safety, including books, educational toys, home safety kits, digital thermometers and more. The incentives also promote wellness and prevention by providing a $15 gift card for enrollment in Healthy First Steps, our maternal and child care program and a $10 gift cards for completion of postpartum visits. This incentive can be especially influential in areas like Pendleton, Kenton and Campbell counties in Region 6, which have the highest infant mortality rate in the Commonwealth.

b. Provide the Contractor's approach to assisting Enrollees to access direct access services and second opinions, and referrals for services not covered by the Contractor.

Having access to services, second opinions and referrals for non-covered services is an important part of supporting an enrollee's needs and desires and to empower their care plan. Navigating a complex health issue with confidence often requires a second opinion. We work to bring a variety of quality providers into our network so enrollees have access to choice and second opinions, when needed. All enrollees, regardless of risk level, are provided with tools to help them understand how to access services and second opinions. Our *Advocate4Me* call center is staffed with MSAs who are cross-trained to respond to inquiries and concerns, such as gaining access to services, second opinions and referrals for services not covered. In addition, *myuhc.com*, our secure enrollee portal, provides benefit and coverage information. Enrollees can conduct *Provider Directory* searches to help them find an in-network provider suited their needs. When necessary, we will locate a provider and authorize a second opinion from an out-of-network provider for services not available in network or not available in a timely manner. Second opinions from an out-of-network provider are considered on a case-by-case basis and require prior authorization. Each enrollee's request is reviewed in terms of their individual needs to make sure they have access to and receive the most appropriate care based upon the expertise of the medical community. Medical directors for our local Kentucky health plan will assist with this process by helping staff and enrollees identify the right services and providers using their medical expertise and provider relationships.

If out-of-network care becomes necessary, we secure the services through a single case agreement. In addition, our care managers provide hands-on assistance to arrange care that meets enrollee needs, including maintaining compliance with our appointment standards. We work with, support and provide guidance to our enrollees throughout the entire process to reduce the impact of going out-of-network by helping enrollees obtain second opinions, answering their questions and sharing additional information so they can make informed decisions regarding their needs. By covering out-of-network services — at a cost no greater than if network providers were to provide the contracted services — for as long as we are unable to provide these services can help alleviate perceived challenges or enrollee concerns

regarding out-of-network treatment. We treat each enrollee's circumstances individually, taking into account their linguistic, cultural and mobility needs when locating a qualified provider.

Whether an enrollee is seeking direct access, second opinions or referrals for services not covered, all information pertaining and supporting the care plan is tracked and monitored within our care management platform, CommunityCare. Having a single, accessible platform for documentation allows care managers and other members of the care team, including the enrollee, to simply track and follow up on the status of a referral with ease. Meeting the enrollee's needs is the main goal of supporting any access to care, even if it includes non-covered services. Within our complex care management program, the multidisciplinary care team (MCT) monitors and helps enrollees navigate the use of non-covered services and keeps the care plan updated to reflect all services and supports the enrollee selects. Providers, identified as part of the enrollee's care team, can also see this information within CommunityCare.

c. Describe the Vendor's proposed approach to the following:

i. Interfacing with the Department and Department for Behavioral Health, Developmental, and Intellectual Disabilities.

We value the Commonwealth's partnership in delivering care to enrollees with behavioral health, developmental and intellectual disabilities. To facilitate this partnership and streamline communication, our behavioral health director will serve as the Commonwealth's primary point of contact for our behavioral health and developmental and intellectual disabilities (DID) work. To facilitate in person meetings, our behavioral health director will work out of the Kentucky office, located within 80 miles of the Commonwealth's Frankfort facility. Our behavioral health director will be available to address clinical issues working in tandem with our health plan's chief medical officer, Dr. Jeb Teichman, to ensure integration.

We will meet with DMS and the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) at least quarterly (and more often if agreeable to DMS and DBHDID) on topics such as State Mental Health Authority and Single State Agency protocols, rules and regulations, and coordinate activities as outlined in Attachment C – Draft Medicaid Managed Care Contract, Section 30.7, Interface with State Behavioral Health Agency. Along with discussing what is contractually required, we will propose additional topics on how we can collaboratively serve our enrollees. Examples of possible topics include:

- Collaborating for independence and inclusion
- Effective advocating for today and tomorrow
- Supporting Partners in Policymaking – a program designed to bridge productive partnerships between the people who need and use services and those who form public policy

In addition to collaborating with DBHDID, our behavioral health director will look for opportunities to join local committees and coalitions throughout Kentucky to contribute ideas and resources to the mission of the organization and the Commonwealth. UnitedHealthcare Community Plan of Kentucky's (UnitedHealthcare) clinical leadership has experience taking part in similar committees in the states we serve. Examples include our involvement with the Employment Community First Program in Tennessee, which is a division of LTSS that supports individuals with DID. We actively partner with TennCare around program development and improvement opportunities, for example UnitedHealthcare facilitated a statewide training, **Skills**System by Dr. Julie Brown, PhD, last year to train local DID staff, caregivers, and providers. In Kansas, we participate on multiple subcommittees for the Governor Behavioral

Health Services Planning Council (GBHSPC) in Kansas. Building upon this experience for Kentucky, we will work with DMS to identify and address key behavioral health and DID issues in the Commonwealth, share information about our progress on improvements in behavioral health and services and review recent deliverables to the Commonwealth for full transparency into our operations.

Example: Clinical Leadership Collaboration with State Agencies in Virginia

In Virginia, our behavioral health medical director is actively engaged in a Behavioral Health Medical Directors Quality Collaborative that the chief clinical officer of the Department of Behavioral Health and Developmental Disabilities and the behavioral health medical director of the Medicaid agency convene monthly. This Collaborative brings all the health plan behavioral health medical directors together to work on initiatives, including improvements to utilization management of the current behavioral health services and redesigning Virginia's community-based mental health services into a continuum of evidence-based, trauma-informed, cost-effective and preventive-focused services. The Department of Behavioral Health is also leveraging this Collaborative to engage the health plan behavioral health medical directors in the Commonwealth's efforts to decrease Temporary Detention Orders and the census at Commonwealth psychiatric hospitals. An earlier version of this Collaborative, was influential in the workaround defining and implementing a new continuum of evidence-based Addiction and Recovery Treatment Services based upon the American Society of Addiction Medicine (ASAM) for residential treatment, partial hospitalization, intensive outpatient, opioid treatment programs, methadone clinics and peer recovery support specialists.

ii. Coordinating with the Department to establish collaborative agreements with state operated or state contracted psychiatric hospitals and other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use. Describe potential challenges and methods to address such challenges.

As a part of our commitment to provide whole person care, we will coordinate with DBHDID to establish collaborative agreements with state-operated or state-contracted psychiatric hospitals (such as ARH Psychiatric Hospital, Central State Hospital, Eastern State Hospital and Western State Hospital) and other facilities serving individuals with co-occurring behavioral health and development and intellectual disabilities. We confirm these agreements will not only meet the contractual obligations in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 33.10, Continuity of Care upon Discharge from a Psychiatric Hospital, but also will include close coordination with these facilities.

In our experience, the greatest challenges serving enrollees' with complex, co-occurring conditions often lie in continued access to specialty services. We know people served through state facilities need comprehensive discharge plans, which involve numerous stakeholders, including the individual, his or her caregivers and/or family, local behavioral health providers, along with other service providers. Another challenge is making sure everyone on the care team agrees with discharge and treatment plans to facilitate and support continuity of care for the enrollee.

To overcome these challenges, we will work with the Commonwealth to set up comprehensive and inclusive discharge planning protocols for the individuals in their care. In addition to establishing protocols that facilitate continuity of care, we will work aggressively to eliminate barriers to effective care transitions through multidisciplinary care coordination and our integrated UM program for physical and behavioral health. Our Care Continuum program focuses on quickly and collaboratively identifying potential barriers — for example service authorizations required to successfully transition enrollees through various levels of care — and resolving them. We will work collectively on removing barriers to discharge, verifying prior

authorization for next level of care services and connecting care coordination with UM. If these solutions do not adequately address an enrollee's challenges, we have multiple communication pathways to involve our local clinical leadership, including our health plan's chief medical officer and behavioral health director who will engage directly on cases, when appropriate.

Working through transitions of care, the concurrent review process for continued lengths of stay and complaints and grievances by the enrollee and their families may affect individuals with co-occurring behavioral health and developmental and intellectual disabilities. We will work through these processes with our enrollees and their caregivers to resolve challenges as quickly as possible. Upon the award in Kentucky, we will collaborate with staff in the Commonwealth to provide joint trainings with our staff, so everyone understands the policies and procedures of both entities.

The following example from our Kansas market demonstrates our experience in establishing collaborative agreements, which we will build upon in Kentucky. We will assist our enrollees with accessing care in the least restrictive setting possible. We monitor our provider network for access and availability to provide services and from a quality review and continuous quality improvement perspective.

Example: Our Experience Coordinating Services for DID Populations in Kansas

In Kansas, we contract with state mental health hospitals that serve DID populations. Working together with the state, we support our enrollees with resources in the community to help individuals avoid entering state institutions. When community resources do not sufficiently meet our enrollees' needs, we collaborate with the Kansas Department of Aging and Disability Services (KDADS) to assess the need for this high level of care.

Our contracts include the clinical staffing processes with multiple parties that take place when it is deemed appropriate to access these levels of care. The staffing for the individuals with DID include the state, all applicable service providers, internal clinical case managers and medical directors. Often, there are extensive wait times, so we look for community supports that may be outside of the benefit package, which can be accessed through our state's allowance of in lieu of services. For children with DID, we have our psychiatric residential treatment facilities (PRTFs) and other service providers that serve children with DID. We meet with stakeholders on a quarterly basis to address systemic challenges affecting this population.

We provide services in the least restrictive setting as possible. The stakeholder meetings include all PRTFs in Kansas, KDADS, Kansas Department of Health and Environment, Department of Children and Families for those children in protective custody, CMHCs and the Juvenile Justice Authority. We have built a strong relationship and solid reputation working with these entities for children and we use those relations to work with the most challenging cases.

iv. Complying with the Mental Health Parity and Addiction Equity Act.

Prioritizing whole person care, inclusive of mental health and addiction care, is integral in our mission to help people live healthier lives. Our goal is not simply to be parity compliant. Instead, we integrate behavioral health into how we approach the provision of care for all our enrollees. We design and maintain parity-compliant policies by consistently reviewing the process and evidentiary standards used to administer medical/surgical and mental health/substance use disorder (MH/SUD) benefits. We verify medical management techniques applied to MH/SUD benefits are comparable to, and applied no more stringently than, those for medical/surgical benefits. In line with the requirements of the Mental Health Parity and Addiction Equity Act, we use quantitative and non-quantitative treatment limitation data-collection tools, which support:

- Documentation of the quantitative testing required by parity (substantially all and predominant testing)
- Alignment of the non-quantitative treatment limitations applied to mental health or SUD benefits

Furthering our efforts to help facilitate parity compliance, we also participate in the following:

- Providing expert consultation and recommendations regarding compliance with the Mental Health Parity Law as specified in the benefit plan
- Making sure plan benefits include a clear description of the behavioral levels of care and services covered
- Offering comprehensive provider networks
- Monitoring the availability of providers and including an easy way for providers to note in our online directory if they are not accepting new patients
- Confirming the criteria for medical necessity determinations for MH/SUD benefits are available to any current or potential enrollee or contracting provider by making our Level of Care Guidelines available to the public online

It is important that our staff understand our commitment to mental health; therefore, we offer Mental Health Parity training to UnitedHealthcare employees through our enterprise-wide learning platform. Additionally, the following mental health parity resources and toolkits are available to our health plans: *Understanding Parity*, *Your Role in Parity*, *Benefit Change Parity Checklist*, *Parity Contacts and Resources* and *Glossary of Parity Related Terms*.

Beyond addressing parity of covered services, we are deeply committed to prioritizing enrollee access to behavioral health care. As a part of our commitment to whole person care, we include behavioral health clinicians as core members of our care management teams. These behavioral health specialists work hand-in-hand with our RN care managers and nurse practitioners to make sure enrollees who need mental health services receive them. The numerous ways we facilitate enrollee access to MH/SUD services include:

- Integrated behavioral health questions in our core assessments
- Care manager engagement in referral and scheduling of services
- Utilization management review and engagement in transition and discharge plans
- Quality audits of providers to confirm access within required standards (included in the *Care Provider Manual*)
- Assessment of enrollee complaints and appeals
- Network oversight (e.g., Quest Cloud measures; enrollee to provider penetration rates) to verify network adequacy

d. Describe initiatives the Contractor will implement to identify trends in provider-preventable conditions and to educate providers who are identified as possibly needing support in better addressing those conditions.

As a part of our commitment to high quality, safe and effective care for our enrollees, we have existing quality of care processes, reimbursement policies and procedures in place to identify and monitor provider preventable conditions. This includes a process for provider reporting and precluding payments to providers in compliance with the Provider Preventable Conditions initiative administered by CMS. Our approach is also in compliance with Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 30.8, Provider Preventable Diseases.

Provider preventable conditions (PPCs) are defined by CMS and fall into two categories: Health Care-Acquired Condition (HCAC) and Other Provider Preventable Conditions (OPPC).

Providers are required to report all PPCs or never events and are expected to waive all costs associated with the wrong surgical or other invasive procedure. Participating providers may not bill or collect payment from enrollees for any amounts not paid based upon the application of our reimbursement policies. We apply our analytic capabilities to monitor for the occurrence of PPCs regularly. If a PPC occurs, we investigate the issue and implement quality improvement action plans tailored to meet the severity level of the PPC. The following table outlines the level of severity and possible Improvement Action Plans.

Level	Severity of PPC	Improvement Action Plans
Level 1	Minor PPC	▪ Education letter and/or materials ▪ Policy and procedure documentation requested ▪ Verbal or written counseling
Level 2	Moderate or serious PPC	▪ Education letter and/or materials ▪ Policy and procedure documentation requested ▪ Verbal or written counseling ▪ Formal education/mandatory continuing medical education ▪ Medical system review ▪ Focused medical care review of an individual physician, other health care professional, delegated physician or health care professional, hospital-based physician or facility

Clinical reviewers conducting these investigations are licensed clinicians, employed by UnitedHealthcare or its affiliates, who review and assess all preliminary information gathered during the PPC investigation, including medical records, responses from the network participants and all other relevant sources.

Improvement Action Plans are communicated to physicians or health care professionals directly. Our chief medical officer for Kentucky, Dr. Jeb Teichman, will contact providers and facilities directly to discuss Improvement Action Plans for Level 2 and Level 3 issues related to moderate or serious PPCs. For Improvement Action Plans assigned to a facility-based physician, the Improvement Action Plan is communicated to the facility-based physician directly and, according to the discretion of the Regional Peer Review Committee (RPRC), will be communicated directly to the facility that employs or contracts with the facility-based physician. The facility will be asked to implement the Improvement Action Plan when appropriate. For Improvement Action Plans assigned to a facility, the Improvement Action Plan is communicated to the facility's management or administration.

We track and monitor completion of Improvement Action Plans. Generally, an Improvement Action Plan requires completion within 30 calendar days. Once an Improvement Action Plan is successfully completed, no further action is necessary. However, failure to comply with an implemented Improvement Action Plan will involve escalation, as necessary and appropriate, to facilitate successful completion. We also will communicate failure to comply with an Improvement Action Plan to correct a serious PPC issue with the state licensing authority, an applicable credentialing authority or delegation oversight process as applicable.

We provide ongoing provider education as a means of prevention. Providers can access reimbursement policies, along with education and reference materials on PPCs, through our provider portal.

Semi-annual trend reporting is brought to the RPRC, the National Quality Oversight Committee (NQOC) and our Kentucky Provider Advisory Council (PAC) supporting Medicaid membership or UnitedHealthcare Board of Directors (as applicable) for assessment of global and individual physician/provider trends. Physicians and other health care professionals who exceed the following thresholds within a 6-month period of time will be reported: more than one Level 3 case assigned; more than one Level 2 case assigned; or more than five Level 1 cases assigned.

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