22. Special Program Requirements (Section 32 Special Program Requirements)

Describe the Contractor's approach to meeting the Department's expectations and requirements outlined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices." The approach should address the following:

a. Approach to ensuring Enrollees and Providers are aware of special program services.

To best support our enrollees and to meet Department for Medicaid Services (DMS) expectations and requirements, UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) works diligently make certain our enrollees receive services at the right level, time and place. This is a critical component of our overarching goal to partner with our community partners, provider stakeholders and the Commonwealth of Kentucky to realize a future where individuals access the support they need to more easily engage in behaviors that promote health and wellness. Consistent with requirements in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 32 and our broader commitment to promoting engagement with health and the health care system in Kentucky, we communicate to enrollees and their families about their available benefits, covered services and special programs, including how to access them using various mechanisms.

Our approaches to facilitate enrollee awareness of special program services range from low touch outreach to high touch interventions, including information shared through the *Member Handbook*, resources available online and through our mobile app, targeted mailings, automated calls, live outreach calls and enrollee incentives and the opportunity to talk with our highly trained member services advocates (MSAs) when enrollees call our Advocate4Me service line. For individuals seeking information on the appropriate setting of care, our MSAs can transfer calls to our NurseLine (staffed by RNs 24 hours a day, seven days a week) to help enrollees identify the appropriate place to receive care (i.e., whether to visit their PCP, an urgent care center or an emergent care center and which settings are in network).

Similarly, we use a multimodal approach to educate providers and increase awareness of special program requirements, including the use of online resources, such as *UHCprovider.com* which hosts our provider portal (*Link*), UHC On Air (for on-demand training, education videos and live broadcasts) and monthly network bulletins. We also have a Kentucky-based team of provider advocates who take a hands-on, in-person approach to provider education as they identify specific opportunities. On an ongoing basis, providers with a large UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) membership will receive touchpoints (in-person, by email or telephonically) at least monthly. During the course of these visits, our provider advocates promote self-service tools like our secure provider portal (*Link*), instruct on new or updated products or processes and discuss challenges experienced by the providers. If providers want additional support outside the course of these visits, they can access information by calling our provider services center.

a. Approach to Enrollee and Provider Awareness

Special Programs	Enrollee Awareness Mechanisms						Provider Awareness Mechanism				
	Member Handbook	Targeted Mailings	Outbound Calls	Inbound *Advocate4Me* Member Services Center and NurseLine	Mobile App	Enrollee Incentives	*Link* Provider Portal	Provider training available via *UHCprovider.com*	Provider Bulletins	Inbound Provider Services Phone Line	Outreach by Provider Advocates
EPSDT	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental	✓	✓		✓	✓		✓	✓	✓	✓	✓
Emergency Care, Urgent Care and Post Stabilization Care	✓			✓	✓		✓	✓	✓	✓	✓
Out-of-network Emergency Care	✓			✓							
Maternity Care	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓**
Voluntary Family Planning	✓			✓	✓		✓	✓	✓	✓	✓
Non-Emergency Medical Transportation	✓			✓	✓		✓			✓	✓
Pediatric Interface	✓			✓			✓			✓	
Pediatric Sexual Abuse Examination*				✓						✓	

*We do not undertake specific efforts to make enrollees or providers aware of the availability of pediatric sexual abuse examinations, except at the request and involvement of Department of Community Based Services (DCBS). We are, however, deeply committed to providing whole person care and support for our providers, particularly those engaging vulnerable populations by providing education and training on trauma-informed care.

**In addition to ensuring providers are aware of covered maternity services, we will support making programs like Baby Box available to pediatricians who want to provide a means to support AAPs Safe Sleep initiative and the state's focus on reducing Sudden Unexplained Infant Death. Baby box provides a family with an alternative sleeping place for their newborn as opposed to co-sleeping with caregivers.

b. Description of medical necessity review process.

As a managed care organization, we are driven by our mission to help people live healthier lives. In pursuit of this goal, our primary focus is making sure individuals access the care they need, ranging from the fundamental preventive care (e.g., EPSDT) to receiving care at the right time and place. An aspect of making sure individuals access appropriate care also involves limiting use of inappropriate care or services. Therefore, we engage in medical necessity review if and when necessary, as described in more detail in Section 10, Utilization Management. With respect to special program requirements, we only perform medical necessity reviews as applicable to EPSDT special services. To the extent enrollees have concerns or grievances with medical necessity review, we educate them on their right to appeal and the process to do so. The reasons for decisions clearly describe why the enrollee's condition fails to meet criteria for approval and includes references to the benefit provision, guideline, protocol or other criteria on which we based the denial and instructions for filing an appeal.

The following table describes the medical necessity review process for special program requirements:

b. Description of Medical Necessity Review of Special Program Requirements		
Special Program	**Available *without* Medical Necessity Review**	**Additional Details**
EPSDT	Yes, except EPSDT Special Services	Medical necessity and or prior authorization may only occur with respect to EPSDT Special Services, as required through the contract. We will employ a private duty nursing (PDN) navigator as part of the care management team to maintain appropriate oversight of PDN, including enrollees who age out and step down in care.
Dental	Yes	We do not require prior authorization or perform medical necessity review for dental services. Services are provided according to the contract.
Emergency Care, Urgent Care and Post Stabilization Care	Yes	We do not require prior authorization or perform medical necessity review for emergency services. Urgent and post stabilization services are reviewed according to applicable state or federal regulations, MCG guidelines and medical policy.
Out-of-network Emergency Care	Yes	Emergency care is available without medical necessity review. Payment for out-of-network emergency services to non-contracting providers will not exceed the Medicaid fee-for-service rate.
Maternity Care	Yes	We do not require prior authorization or perform medical necessity review for maternity care, which includes prenatal, delivery and postpartum care, along with conditions that complicate pregnancies.
Voluntary Family Planning	Yes	Voluntary family planning is available without medical necessity or prior authorization review. To make sure individuals interested in family planning receive appropriate care, we provide enrollee access to qualified providers of family planning services without a referral from a PCP.
Non-Emergency Medical Transportation	Yes	Although we do not directly furnish NEMT outside of non-emergent stretcher ambulance services, we coordinate referrals to the Kentucky Transportation Cabinet, Office of Transportation Delivery and provide education on its availability to facilitate enrollee access.
Pediatric Interface	Yes	Consistent with the Contract, when a child's course of treatment is interrupted due to school breaks, we provide medically necessary covered services without prior authorization. To avoid duplication of services under an IEP, we will coordinate with the Department for Public Health and school-based clinicians as necessary and appropriate to confirm the appropriate continuity of care.
Pediatric Sexual Abuse Examination	Yes	These examinations do not require medical necessity review. Services are provided according to the Contract and at the request of DCBS.

c. Outreach methods to engage Enrollees.

Our overall approach to outreach and engagement involves using multiple touch points to make it easy for enrollees to receive needed information to understand their health benefits thereby promoting improved health outcomes and empowering individuals to take action to improve their wellbeing. The following table outlines the outreach methods we use to engage enrollees and educate them on special program requirements.

Special Program	Outreach effort
EPSDT	Our EPSDT coordinator oversees data collection, analysis and outreach efforts for EPSDT to make sure enrollees are receiving necessary care. Part of this outreach includes automated phone calls as reminders to schedule appointments and to close gaps in care. This schedule of outreach aligns with the American Academy of Pediatric EPSDT guidelines. Should individuals require assistance in scheduling an EPSDT visit or obtaining transportation to the visit, both our MSAs and EPSDT coordinator can facilitate scheduling. Additionally, our experience has taught us that engagement with health care often diminishes as children enter their adolescent years. To encourage engagement, instill early commitment to health and improve the health outcomes of the next generation of Kentuckians, we provide a $25 incentive for adolescent well care visits.
Dental	We address trends in underutilization of dental services and help enrollees obtain appropriate oral health through targeted mailings, automated calls and enrollee incentives. To help enrollees receive preventive dental care, we provide a $15 incentive for preventive visits. Given the effect of oral health on maternal and infant health, we place special emphasis on the importance of dental care for pregnant women.
Emergency Care, Urgent Care and Post Stabilization Care	We carry out various education and engagement efforts to help enrollees engage in healthy behaviors to avoid preventable ED utilization. Additionally, our MSAs can help connect individuals to resources, such as PCPs, FQHCs and urgent care centers to support access to appropriate care.
Out-of-network Emergency Care	We do not provide specific outreach or engagement to enrollees relating to emergency care received outside of network.
Maternity Care	We outreach to pregnant enrollees to engage in care primarily through our Healthy First Steps (HFS) maternal child care management program and our HFS Rewards program. These programs not only provide educational information, but also empower expecting women to engage in prenatal care through education, reminders and financial incentives for visit attendance. We take extra steps to encourage enrollees with high-risk pregnancies to enroll by providing them with additional maternity-focused care management resources to support their needs. Participants in this program have greater compliance with recommended appointments than non-participants, resulting in more favorable outcomes. HFS participants and their children across our states, on average, attend 15.3% more of their prenatal and postpartum visits, have 5.7% lower rate of ED use and have lower preterm birth and low-birth rates than their peers who do not participate.
Voluntary Family Planning	For sexually active enrollees of reproductive age engaged in care management, our care managers may encourage the individual to discuss family planning options with their provider. Otherwise, we do not provide specific outreach methods to engage enrollees in family planning services.
Non-emergency Medical Transportation (NEMT)	We recognize the critical role transportation can have on access to care and other activities that foster good health, particularly among Kentucky's rural areas where the distance to a provider may be significant. We engage enrollees in need of NEMT referrals primarily using our mobility coordinator, a position focused on helping enrollees troubleshoot and overcome transportation barriers including NEMT. An example of supporting transportation needs beyond referral to NEMT includes our collaboration with Calvary Christian to improve recovery for individuals with opioid use disorder (OUD) and determine whether easier access to transportation can help these individuals gain and maintain employment.
Pediatric Interface	Outreach with respect to pediatric interface will occur to the parent and caregiver by an in-person or telephonic care coordinator or nurse care manager, as appropriate given the child's risk level.

Special Program	Outreach effort
Pediatric Sexual Abuse Examination	Given the sensitivity of this service, we do not proactively outreach to enrollees or their caregivers about its availability.

d. Approach to identify, enroll and encourage compliance with lockin programs.

Our experience managing the care of millions of enrollees nationally has taught us that appropriate utilization of care correlates to improvements in health outcomes. Therefore, we take active measures to educate our enrollees on appropriate settings of care and provide supports that will help redirect utilization appropriately.

Over and Inappropriate Utilization of Pharmacy Services

We are deeply committed to supporting our enrollees affected by the opioid epidemic and will bring our experience in helping to provide appropriate guardrails and safeguards to Kentucky. Our **Administrative Lock-In program** has been an effective and integral part of our comprehensive strategy to address the opioid epidemic. It has also served as a key component of our fraud, waste and abuse (FWA) program protecting the integrity of health services provided to our enrollees and supporting our overall quality management program.

A recent analysis of our New Jersey pharmacy lock-in found a 50% decrease in the number of targeted medication fills, prescribers and pharmacies comparing 6 months pre-lock-in to 6 months after the lock-in was lifted. These efforts also led to an overall savings of $1.4M in less than one year.

Our goal is to help the enrollee use their benefits in a safe and effective manner. The program identifies enrollees who demonstrate overutilization of services, exhibit abusive conduct or have fraudulently abused their medical benefits. This program allows us to limit an enrollee to one pharmacy enabling the pharmacists to know all medications the enrollee receives. The result is increased enrollee safety by reducing potential interactions or overdoses of medication. The specific therapeutic categories of medications targeted by this program are those with a high potential for misuse or abuse by themselves (e.g., opioids) or in combination with other prescription medications. We have seen improved utilization during lock-in and after the lock-in period is complete. For example, enrollees continue to use less than half the number of prescribers once lock-in is removed and continue to use minimal pharmacies to fill their medications.

Identifying enrollees: We identify enrollees in two primary ways: data analytics and reported tips. Data analytics identifies enrollees for further evaluation to determine if lock-in is appropriate. Criteria includes filled controlled prescription such as opioids written by multiple prescribers and filled at multiple pharmacies in the last 90 days or an enrollee with a drug, alcohol, substance use or poisoning diagnosis in the last 180 days. We do not include Medicare beneficiaries, enrollees with a cancer diagnosis, those who are receiving hospice or palliative care, or individuals experiencing homelessness. Using KASPER, the Commonwealth's prescription monitoring program as part of our lock-in strategy, will provide a view of narcotics and opioid use across the medical and pharmacy sectors to help us appropriately identify enrollees for lock-in.

Enrollees identified by reported tips may come through various sources such as our member and provider services call centers, UnitedHealthcare employees, FWA department, case management teams, network providers or pharmacies. All tips are referred to the pharmacy department to determine if a lock-in assignment is appropriate. We will work with DMS to develop other agreed-upon criteria for identifying enrollees as necessary.

Enrolling individuals in lock-in: We initiate the lock-in process by sending written notification to the enrollee. This written notification informs the enrollee about the action we will take, reasons for this action; instructions for the enrollee to choose a primary pharmacy as their only source for obtaining prescribed drugs; enrollee's right to file an appeal to us or right to file for a State Fair Hearing as applicable; effective date of the lock-in (at least 30 days after the letter); and other requirements under federal and state laws and regulations.

Encouraging compliance and tracking outcomes: Identified enrollees may be referred to one of our complex care managers for review and determination of appropriate interventions, which may include educational outreach, continued monitoring, or referral for substance use disorder (SUD) treatment. Once the lock-in assignment occurs, we will perform utilization review of the enrollee's paid pharmacy and health care services to determine if the enrollee meets the criteria for an extended lock-in. We will submit our lock-in program description to DMS for approval subject to Attachment C – Draft Medicaid Managed Care Contract, Section 4.4 Approval of Department. The MCT convenes for semi-annual meetings to discuss the enrollee's progress. Our care managers establish clear lines of communication with the enrollee's lock-in providers for targeted discussions regarding the enrollee's care. Thirty to sixty days before the enrollee's planned disenrollment, the enrollee's MCT, along with our Kentucky health plan CMO, Dr. Jeb Teichman, clinical leadership and other health plan staff meet to evaluate the enrollee's performance in the lock-in program.

Overutilization of Non-emergency Care in an Emergency Setting

We use multiple analytic tools to stratify enrollees' risk levels. One of our risk stratification methodologies evaluates the appropriateness of where enrollees receive care. Enrollees identified as having high use of emergency settings compared to office visits within a period of time will likely risk stratify into the management of chronic conditions level of our population health management program, prompting outreach and support from a CHW.

Our Kentucky-based CHWs will connect with our enrollees to assess their needs and identify the cause of inappropriate ED use and link them to appropriate supports as issues are identified. In addition to educating the enrollee on appropriate care settings available, the CHW may work to identify a primary care practice with increased availability to meet the enrollee's health care needs, such as selecting a new PCP with evening or weekend hours or accessing telehealth technologies. Additionally, the CHW will educate the enrollee on the availability of NurseLine, with RNs who can help the enrollee find appropriate care in a given situation. The CHW can also connect the enrollee to our UnitedHealthcare Doctor Chat capability, a platform specifically designed for enrollees with high ED utilization. This innovative, chat-first platform allows enrollees to connect with an ED physician from their computer or mobile device for non-emergent care. Interactions can be escalated to live video if needed. This comprehensive approach to actively identify high ED utilizers, understand the cause of their utilization pattern and connect them with the supports to access and receive appropriate treatment helps contain overutilization of high cost care while engaging enrollees in more productive health care decision making.

e. Approach to coordination, including referral and follow-up with other service providers, like Women, Infants, and Children (WIC), Head Start, First Steps, School-Based Services, DCBS and the Kentucky Transportation Cabinet Office of Transportation Delivery.

Consistent with our philosophy of whole person care, we make sure enrollees receive needed services, including those requiring referral and follow up with *other* service providers. While we can and often do coordinate with external entities on behalf of enrollees, we also empower them to engage directly in their health and health-related services by helping them understand what

services are available and how to access them. By connecting our enrollees to other service providers, then following up with enrollees to make sure they successfully accessed what they needed, we support and empower the enrollee to conduct outreach for services themselves. If an enrollee prefers to have additional support and coordination, we can provide that, but our goal is to facilitate access directly between our enrollees and the providers they receive services from. This way, our enrollees are better positioned to access needed services in the future. Generally, our process to help enrollees receive necessary supports from other service providers involves:

> We are grateful for the UnitedHealthcare team's commitment to build relationships with local community leaders and find innovative ways to address the social determinants that will ultimately improve the health of Kentucky's children."
>
> — Terry Brooks, Ed. D, Executive Director, Kentucky Youth Advocates

1. Identifying person-centered needs
2. Identifying service providers to meet these needs
3. Informing and educating enrollees on the available services and eligibility requirements
4. Helping enrollees understand and obtain documentation to prove eligibility for services
5. Linking enrollees to service provider
6. Following up with enrollees to confirm receipt of services
7. Documenting receipt of services in *CommunityCare* to confirm awareness and appropriate coordination with other providers

Members of our local staff who will support the enrollee with other service providers will depend on multiple factors, such as how and by whom the need was identified, the enrollee's population health-management risk level or the existence of a specialized navigator. The following table shows coordination efforts for a broad range of services and programs and the UnitedHealthcare staff typically responsible for bringing together these services.

Department	Service/Program	Personnel Coordinating Services*				
		MSA	CHW	HFS CM	SKY CN	MC
Department for Public Health	Women, Infants and Children (WIC)	✓	✓	✓		✓
	Diabetes Prevention and Control Program	✓	✓			✓
	HANDS Program			✓		
	First Steps			✓		
Department for Medicaid Services	Child Targeted Case Management Program		✓	✓	✓	
	Adult Targeted Case Management Program		✓			
Department for Aging and Independent Living	Chronic Disease Self-management Program	✓	✓			
	Caregiver Support Services		✓			✓
	Hart-Supported Living Program		✓			
Office for Children with Special Health Care Needs	Family to family program		✓	✓	✓	✓
Department for Community Based Services	START program		✓	✓	✓	✓
	SNAP	✓	✓	✓		✓

Department	Service/Program	Personnel Coordinating Services*				
		MSA	CHW	HFS CM	SKY CN	MC
Kentucky Transportation Cabinet Office of Transportation Delivery	Human Services Transportation	✓	✓			✓
Other	School-Based services		✓		✓	
	Head Start		✓	✓		

* MSA: member service advocate; CHW: community health worker; HFS CM: Healthy First Steps care manager; SKY CN: SKY care navigator; MC: mobility coordinator who in addition to NEMT can be an asset to help members access transportation options facilitating access to agencies to set up/enroll in key services