

23. Behavioral Health Services (Section 33.0 Behavioral Health Services)

a. Provide a comprehensive description of the Contractor's proposed Behavioral Health Services, including the following:

We are committed to addressing access to care issues and delivering behavioral health services that improve the health and wellbeing of Kentucky residents. As Governor Andy Beshear cites in his 2019 *For Healthy Kentucky Families, Andy Beshear's Health Care Plan*, "Mental health care is as important as physical health care." We have built our programs on this basic premise – along with the overarching tenets that behavioral health is part of a person's whole health, and, therefore, should be accessible, empowering, trauma-informed and free of stigma.

As the Governor notes in his plan, many Kentuckians face behavioral health conditions. The Commonwealth ranks 49th for mental health and well-being and 49th for the number of people who suffer from depression. In 2015, the report states, suicide killed more Kentuckians than automobile accidents. Nearly 114,000 Kentuckians are living with schizophrenia or bipolar disorder. These statistics are compounded by the fact that over 2 million Kentuckians live in 107 Mental Health Care Professional Shortage Areas, according to the Kaiser Family Foundation. This represents an unmet need of almost 30%.

To address these unmet needs, UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare), as a collaborative partner with the Commonwealth, will introduce quality solutions such as new Integrated Behavioral and Physical Health Home models that improve accessibility and coordination of care for enrollees with serious mental illness (SMI) and other chronic conditions. We will offer prevention and education programs, support initiatives to expand the continuum of substance use disorder (SUD) services, and introduce value-based payment (VBP) strategies to incentivize providers and increase sustainability. This approach meets the requirements of Attachment C – Draft Medicaid Managed Care Contract, Section 33 requirements for Behavioral Health Services. In some instances, such as for continuity of care and follow up after discharge for individuals with complex needs, our approach exceeds requirements.

Building a Better System of Behavioral Care for Kentucky

During the past 2 years of Medicaid focused community outreach and stakeholder engagement, we learned about the systemic issues affecting Kentucky's behavioral system of care, such as a fragmented continuum of SUD services to address the rising use of opioids; poorly integrated, uncoordinated care for individuals with SMI with significant challenges in confirming follow up after discharge from psychiatric hospitals; and meeting children's complex needs given significant gaps in services, such as psychiatric residential treatment facilities (PRTFs). We incorporated this valuable input, and the requirements of the RFP to build a Kentucky-centric behavioral health program that will create enhanced services and innovative programs to empower the Commonwealth's most vulnerable citizens.



The ongoing opioid crisis presents a real opportunity for innovation and collaboration. We support the desire of the Commonwealth to work aggressively to address this crisis in Kentucky. We will leverage our experience by building a network that includes all levels of the American Society of Addiction Medicine (ASAM) continuum, with an initial focus on high quality SUD residential treatment providers and opioid treatment providers. We have expertise with the ASAM criteria as we use it for utilization management (UM) and contracting in every state where we manage substance use services, unless the state mandates

use of different criteria. We have successfully led initiatives both in Virginia and Louisiana, where we act as collaborative partners with the state and providers on innovative approaches to the opioid epidemic, including supporting office based opioid treatment providers and peer recovery support specialists.

In our outreach to stakeholders, we identified many key themes to inform our approach, all of which comply with Section 33 requirements.

Stakeholder Engagement	Key Themes Identified	Informing Our Approach
State Agencies		
<ul style="list-style-type: none"> ▪ Kentucky Department for Community Based Services ▪ Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities ▪ Kentucky Medicaid Advisory Group 	<ul style="list-style-type: none"> ▪ Enhance physical and behavioral integration ▪ Improve care management for enrollees with the most complex SMI, physical and social needs ▪ Address smoking as a contributor to chronic diseases ▪ Increase in-home services ▪ Increase PRTF beds ▪ Improve children’s mental health system of care with a focus on PRTFs, crisis, partial hospitalization, and psychotropic prescribing 	<ul style="list-style-type: none"> ▪ Introduce multidisciplinary care teams (MCT) for direct care/care management for individuals with the most complex needs. ▪ Introduce a smoking cessation program integrating smartphone texting, community/faith based organizations, local Quit Lines and provider education. ▪ Use MCT members for home visits to enrollees with SMI/complex needs discharged from psychiatric hospitals. ▪ Implement Community-based Assessment, Stabilization and Treatment (CAST), a residential/inpatient diversion program that uses appropriate interventions to keep children in the community.
Kentucky Behavioral Health Providers (Independent Practitioners, Community Mental Health Centers (CMHCs), Behavioral Health Services Organizations (BHSOs) and Multi-Specialty Groups (MSGs))		
<ul style="list-style-type: none"> ▪ Adanta ▪ New Vista (formerly Bluegrass) ▪ Centerstone ▪ InTrust Health Care ▪ Key Assets Kentucky ▪ Lee Specialty Clinic ▪ Maryhurst ▪ North Key Community Care ▪ Phoenix Preferred Care ▪ River Valley Behavioral Health ▪ Therapeutic Intervention Services 	<ul style="list-style-type: none"> ▪ Add provider incentives, value-based purchasing (VBP) and other alternative arrangements so providers share in savings delivery ▪ Advance physical and behavioral health integration ▪ Improve the bridge between state psychiatric hospitals and the community ▪ Improve consistency between MCOs’ prior authorization (PA) and UM processes ▪ Reduce providers’ administrative burden ▪ Advance Assertive Community Treatment (ACT) program for individuals with complex SMI needs 	<ul style="list-style-type: none"> ▪ Deploy VBP models for behavioral health providers. We will evaluate providers to determine which ones meet qualifications to participate in VBPs, designed to improve continuity and integration of care and reduce fragmented services for individuals with SMI/developmental and intellectual disability (DID). ▪ Deploy an alternative payment method for opioid treatment providers. ▪ Implement Integrated Behavioral and Physical Health Home VBP to promote integrated primary care at behavioral health provider locations. We will support

Stakeholder Engagement	Key Themes Identified	Informing Our Approach
		<p>behavioral health providers to address primary and behavioral health for individuals with SMI.</p> <ul style="list-style-type: none"> ▪ Integrate Genoa pharmacies into CMHCs and other providers that agree to and meet program qualifications. Genoa pharmacists will provide comprehensive medication management for physical and behavioral health and support providers to decrease behavioral health inpatient costs and improve quality outcomes to achieve shared savings. ▪ Develop partnerships with providers to bridge transitions between acute care and the community by integrating outpatient providers' clinical staff in high volume psychiatric hospitals to coordinate outpatient follow up, improve continuity of care, and link individuals back to services in their communities ▪ Support the Commonwealth's efforts to develop consistent PA format across all health plans ▪ Streamline PAs by leveraging online authorizations and claims submission. ▪ Remove PA for routine outpatient appointments and medication-assisted treatment (MAT) services. ▪ Offer a comprehensive array of psychotropic medications including long-acting antipsychotics available on Preferred Drug List with minimal prior authorizations. ▪ Support Commonwealth's efforts to develop consistent PA format across all health plans. ▪ Implement innovative payment strategies with behavioral health providers to increase financial support, which helps to fund ACT teams and pay for the outcomes of this evidence-based model.

Stakeholder Engagement	Key Themes Identified	Informing Our Approach
Kentucky Advocacy Organizations		
<ul style="list-style-type: none"> ▪ Kentucky affiliates of The National Alliance for Mental Illness (NAMI Kentucky) ▪ Kentucky Mental Health Coalition ▪ Mental Health America (MHA) Kentucky ▪ Kentucky Children’s Alliance ▪ Kentucky Behavioral Health Technical Advisory Committee 	<ul style="list-style-type: none"> ▪ Focus on Regions 1, 7 and 8 - underserved rural communities with limited access to behavioral care ▪ Improve access to behavioral health treatment in rural and outlying agricultural areas ▪ Decrease stigma through community education and training ▪ Improve behavioral health access for targeted populations including children and juvenile justice-involved populations 	<ul style="list-style-type: none"> ▪ Implement Genoa’s unique outpatient telepsychiatry model - tailored to enrollees with mental health, addiction and complex, chronic health issues - in PCP offices, behavioral health clinics, and community settings to increase behavioral care in rural areas. ▪ Partner with faith-based organizations to increase access and connect individuals with treatment ▪ Partner with Boys and Girls Club of Glasgow-Barron County to provide telehealth behavioral services in rural areas so children receive timely diagnosis and treatment of behavioral health conditions. ▪ Expand self-advocacy and reduce stigma through evidence-based training including Mental Health First Aid (MHFA), Question, Persuade and Refer (QPR) suicide prevention training, and Seeking Safety. ▪ Build upon our national experience to develop programs for justice-involved populations in Kentucky, such as diversion programs and intensive community supports.
Kentucky Consumer Organizations		
<ul style="list-style-type: none"> ▪ Participation Station (a consumer operated peer support program in Lexington) ▪ THE HOUSE (a peer-run program in Paducah) ▪ Peer Fit (Louisville) 	<ul style="list-style-type: none"> ▪ Identify health plan partners that understand and support peer services and a recovery philosophy ▪ Improve care coordination for SUD/opioid use disorder (OUD) treatment ▪ Increase PCP involvement in OUD screening/maintenance treatment ▪ Empower people to engage in their health status 	<ul style="list-style-type: none"> ▪ Engage peers in care management/continuity of care, whole health and wellness, system navigation, assertive community treatment and SUD Recovery ▪ Offer continuing education through the International Association of Peer Supports (iNAPS) to consumer run peer-support organizations. We are a sponsor of iNAPS -- a thriving community that publishes newsletters and news updates, develops and shares access to recovery and peer support information, conducts surveys,

Stakeholder Engagement	Key Themes Identified	Informing Our Approach
		and reports on the current status and trends in the peer workforce <ul style="list-style-type: none"> ▪ Build a Kentucky-specific MAT network including physical and behavioral health providers. ▪ Expand the use of SUD screening in primary care. ▪ Deploy a variety of supports including peers and self-management resources to empower individuals with SMI to improve their health status.
Provider Forums in Lexington and Louisville, May 2019		
Kentucky providers	Improve sharing of data among plans to help providers understand system needs and improvements	Use collaborative approaches, as we have done in Virginia and other states, to engage in shared planning between plans and state agencies to improve data sharing that can ultimately point to system needs and improvements.

Behavioral Health Advisory Committee (BHAC)

We will continue to incorporate the voice of Kentucky constituents using various mechanisms, including our Behavioral Health Advisory Committee (BHAC), which is part of our Quality Improvement structure. We have successfully established behavioral health advisory committees as part of integrated plans in Nebraska, Tennessee, and New York. The BHAC provides recommendations, input and helps to prioritize initiatives and issues that affect the behavioral health provider community. Along with input to the Clinical and Provider Advisory Committee (CPAC) on network development and management strategies and policies for the provision of BH services; the BHAC also provides input relative to clinical issues, policy development, service planning/evaluation, policy improvement projects (PIPs), and training.

The committee also delivers feedback on system enhancements and procedure changes to deliver integrated BH services, and input on strategies to improve care coordination and communication between providers.

BHAC membership will include enrollees, family members, certified peer specialists, and provider staff from multiple Kentucky geographic areas. Our health plan chief medical officer, Dr. Jeb Teichman, our health plan behavioral health director and manager, the quality director, clinical quality specialists, network program directors and behavioral health quality improvement specialists will participate on the committee. The committee will meet at least quarterly rotating geographic locations to ensure we can engage members across the state and will report up through the CPAC. The CPAC will report to the Quality Management Committee (QMC) at least four times per year.

A Valued Partnership

We value the Commonwealth's partnership and the relationships we have developed in Kentucky over the past two decades. For nearly 25 years, we have delivered behavioral health programs for Kentuckians enrolled in commercial and Medicare plans. Today, our behavioral health programs support approximately 253,000 Kentuckians. We will apply our local insight and established provider relationships, along with our outreach and lessons learned from Kentucky

state agencies, providers, consumers and advocacy organizations, to launch a Medicaid behavioral health program that incorporates the Commonwealth's core values of accessible, community-based, person-centered, trauma-informed, and recovery-oriented services.

i. Current or planned delegation to delegate all or part of the provision of Behavioral Health Services to another entity.

United Behavioral Health, operating under the brand name of Optum behavioral health services, is our internal partner responsible for many behavioral health functions including UM, crisis call-center management, and network development. Optum behavioral health services is an affiliate organization and part of UnitedHealth Group, our parent company.

This structure means that we work together with a higher level of accountability and integration. We address issues more quickly and effectively because we are one organization with a shared mission of improving health outcomes, reducing chronic disease and empowering enrollees through a comprehensive, holistic, person-first model. We created this model of care more than 17 years ago, and now have significant experience using it across 29 states and the District of Columbia.

Our integration extends to all core operations. Our integrated health assessment captures how individuals experience behavioral health — often not in isolation, but along with other comorbid physical and behavioral needs and social determinants of health (SDOH). It also identifies the preferences and strengths such that individuals with complex needs can show us how to best help them through integrated plans of care. Our multi-disciplinary care team of physical health clinicians, behavioral specialists and community providers support enrollees holistically, and draw on the deep depth of experience among our staff psychiatrists, pharmacists and other medical directors with various specialties.

As we strive to do in our network operations, we co-locate office-based behavioral health key personnel and staff with physical health personnel to break down barriers to care. Our clinical staff uses a shared care management platform, *CommunityCare*, based upon a common IT platform that facilitates sharing of notes and critical information. We share the same email system and calendar system, allowing us real-time access to schedules to promote interaction and the ability to quickly schedule meetings. Continuous quality improvement occurs through an integrated quality improvement program, which spans all clinical services including those delivered through our networks and clinical operations.

Ultimately, our accountability extends to our shared leadership. Within UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare), our health plan behavioral health director will serve as part of the executive team, with a deep partnership and accountability to the chief operating officer (COO) in collaboration with the chief executive officer (CEO) Amy Johnston Little and our chief medical officer (CMO), Dr. Jeb Teichman, to assure that behavioral health is seamlessly integrated into our clinical continuum.

ii. Process for monitoring and evaluating compliance with access and care standards.

Our process for monitoring and evaluating compliance with access and care standards is anchored in our data-driven, outcomes-based continuous quality improvement. We will develop quality goals based upon Kentucky's standards for behavioral health access and care, consistent with requirements in Section 28.4 Provider Network Access and Adequacy of Attachment C – Draft Medicaid Managed Care Contract. In addition to our formal quality management approach, we also will seek input from our front line staff (UM, member services advocates [MSAs], provider relations) and from external organizations, such as Commonwealth agencies and advocacy groups.

We will continuously monitor and assess the capacity of our network to deliver enrollee access to care within 30 miles of the individual's residence in urban areas, and within 50 miles in all other areas where providers are available, and whether the network meets the standards of access to care. We will evaluate the capacity to facilitate routine behavioral health visits within 30 days (typically less) from an individual's request, urgent visits within 48 hours and immediate emergency treatment.

Monitoring Network Trends and Gaps

To monitor network trends and gaps, and identify targeted recruitment needs, we perform network access reporting monthly, or more frequently when network assessment is required. Our monthly analysis considers out-of-network utilization, reported gaps in the service continuum, access and availability surveys, and provider and member advisory committee input. In addition, we actively monitor provider additions and terminations on a monthly basis to identify anomalies or trends. Annually, we review provider-satisfaction survey results and CAHPS member satisfaction surveys to pick up deviations from standards. We solicit provider feedback on access issues and capacity during face-to-face and online interactions.

Input from Front Line Staff

Our locally based front-line staff, including our UM team, provider relations, and MSAs, often has the closest contact with enrollees and understand access issues. To collect their input efficiently, we implemented online tracking tools where our staff logs potential new network providers. By listening to our front line staff, we get real-time information concerning enrollee access needs and are able to implement targeted network recruitment and single case agreements quickly.

Provider Oversight

Our provider quality audits include site visits at clinician offices, agencies such as CMHCs, BHSOs, MSGs, facilities, and other group provider locations. Onsite audits are routinely completed with CMHCs and facilities without national accreditation. In addition, audits are completed to address specific quality of care issues.

Audits measure appointment access, communication between behavioral health providers and PCPs, substance use referral and intervention, and coordination of care. In addition to monitoring access to care, we consider enrollee safety. Both onsite audits and treatment-record review audits include evaluation of how providers manage enrollee risk (completion of risk assessments and safety planning); onsite audits include an evaluation of the safety of the environment of care.

Closing Access and Care Gaps

We understand the challenges of behavioral health access in Kentucky, particularly in the rural regions. In monitoring access and care standards, we also will consider potential solutions such as telehealth and integrating behavioral health into primary care clinics, schools and community settings that allow us to expand access and meet individuals in their natural settings where they are already seeking care and support. We are leveraging our team of nurse practitioners and licensed clinical social workers led by a board certified psychiatrist and a medical director to provide

stabilization care addressing behavioral, physical and social determinants of health (SDOH)

Express Access

We developed a Kentucky Express Access network to improve enrollees' access to care. Through Express Access, enrollees receive appointments in five business days or less. On average, appointments occur within three days through Express Access, compared to an industry average of 10 days.

needs to enrollees with the most medically complex needs. This team will provide additional support where services may not be readily available.

We form effective partnerships with state agencies, advocacy and consumer groups to address system of care issues that affect access and care standards. In Virginia, we participated on a collaborative group that included providers, health plan CMOs and behavioral health medical directors to support their work around SUD. This included defining and implementing a new continuum of evidence-based Addiction and Recovery Treatment Services using ASAM levels of treatment including residential treatment, partial hospitalization, intensive outpatient, opioid treatment programs/methadone clinics, and peer recovery support specialists.



We are currently participating in a Behavioral Health Redesign Workgroup convened by the Virginia Medicaid agency and behavioral health agency to bring all the providers, MCOs, and consumer groups together to redesign the Virginia Medicaid community-based mental health services into an evidence-based, trauma-informed, and preventive-focused continuum of care. Through this workgroup, we are supporting the Commonwealth in developing and implementing new services such as assertive community treatment teams and mobile crisis services, integrated behavioral health services in primary care and school settings, and expanded telehealth behavioral services. We are also developing solutions to increase the competencies of the current behavioral health workforce through specialized trainings in evidence-based practices and expand the future behavioral health workforce through new workforce training programs.

In Kentucky, we will contract with all provider types identified in Section 28.2.6. We establish strong alliances with individual and organizational providers, advocacy and consumer organizations to build resources from the ground up. In Kentucky, we have already had numerous discussions with many providers including CMHCs, BHSOs, and MSGs to identify how we can support them in expanding capacity by building on their successful programs and launching new initiatives. We discussed and plan to work towards implementing an Integrated Behavioral and Physical Health Home initiative with CMHCs like North Key Community Care in Covington and MAT with Centerstone in Louisville, expanding integrated primary care services. We will initiate a pilot to expand assertive community treatment (ACT) services in rural areas with organizations, such as New Vista. Other conversations include ways to build upon our national experience with InTrust Healthcare as they work on jail diversion programs with Pulaski County. We also discussed approaches and signed a Letter of Intent to make sure enrollees with DID have access to appropriate, high-quality care with Lee Specialty Clinic.

We have established formal processes to address deficiencies and barriers, which include:

- Outreach to behavioral health providers interested in expanding their geographic footprint to address the shortage of providers that exists in many parts of the Commonwealth.
- Considering other provider types that can offer behavioral health screenings and services (e.g., FQHCs, rural health centers and PCPs). We have used this approach to broaden our MAT network by contracting with physician offices to offer services, and now offer 100% access to these services across all Kentucky regions. In Kentucky, we also will work with the BHSOs and MSGs to help to close gaps in access to care.
- Performing extensive network and claims analysis to help find needed specialists.
- Reviewing Master Provider files to identify providers with similar specialties contracted in our Medicare and commercial networks that we recruit for our Medicaid networks.

- Implementing single-case agreements with out-of-network providers for enrollee care when a network provider cannot be found to provide services within access standards.
- Targeting Medicaid registered providers within 50 miles in the seven states bordering Kentucky. We will benefit from our comprehensive Medicaid behavioral health networks in Missouri, Ohio, Tennessee and Virginia. We also will access behavioral health providers within 50 miles of the Kentucky border that serve our commercial membership in Illinois, Indiana and West Virginia.

iii. Proposed innovations to develop and maintain network adequacy and access.

In meeting and continuing conversations with the local community and provider network, we heard clear concerns around access issues from providers and consumers in Kentucky alike. We understand that traditional primary care settings are often ineffective at meeting the needs of individuals with SMI and physically complex conditions and often prescribe more medications leading to polypharmacy. The behavioral health system is too often siloed from the physical health system with little or no coordination between primary and behavioral care providers. PCPs outside of behavioral health settings often do not have the expertise or time to screen their patients for SUD and mental health (MH) conditions and lack the resources to refer or treat enrollees when they diagnose SUD or SMI.



INNOVATE

This is not our first opportunity to develop innovative network solutions that address these issues. We have successfully developed and implemented solutions in other states that we will adapt to Kentucky's unique landscape and needs. For example, our Colorado health plan developed an innovative VBP, coaching, and practice transformation model to support integrated behavioral health clinicians in primary care settings. We implemented a global payment to

PCPs with a defined practice budget for behavioral health personnel, integrated behavioral health interventions, and related infrastructure. The practices were accountable for participating in collaborative learning process and evaluation and measuring outcomes including chronic conditions management, patient activation, anxiety, depression, substance use, and practice productivity. The practices that received the global payments for integrated care demonstrated 5% lower total cost of care for attributed patients.



SIMPLIFY

Through a health home initiative in Missouri, we are simplifying and improving access to care for our enrollees with complex conditions. From this experience, we know that improving network adequacy and access, often requires a combination of approaches – integration of care, VBP, telehealth technologies and seed monies/small grants to connect services.

On a larger scale, it may also involve building new networks from the ground up, such as we have done with implementation of new SUD providers based upon ASAM levels of care in Virginia and Louisiana. In Kentucky, we will partner with DMS to build a continuum of evidence-based SUD services, based upon the ASAM continuum, and partner with providers to implement innovative strategies that will increase access and improve outcomes for our population with SMI and SUD. Below, we provide a summary of our strategies for Kentucky, which include telehealth, Integrated Health Home VBP, rapid network development of specialized services, and community and provider education to improve recognition of behavioral health conditions.

Telehealth

Building upon the innovative and progressive telemedicine regulations in Kentucky, our behavioral health telehealth approach, broadly defined, includes virtual visits, community-based telehealth, often in integrated settings, and specialized telepsychiatry targeted to special

populations. Overall, our enrollees are eagerly embracing telehealth. Between 2017– 2018, we experienced a **75% increase nationally in utilization of behavioral health virtual visits**. We have successfully deployed our community-based telehealth in many states, such as Kansas and Texas, which share similar geographies to Kentucky with large rural and outlying areas. We are able to promote greater access to telehealth because of the July 1, 2019 implementation of Kentucky’s new telemedicine regulations.

Telehealth Modality	How It Works	Experience
Behavioral Health Virtual Visits	Enrollees connect via a mobile device or computer to schedule virtual visits for diagnosis, medication management and to integrate behavioral health into primary care. Enrollees have direct access for a provider search, scheduling and document/resource sharing through smartphones, tablets and computers. We are working on functionality to allow caregivers to join a session for virtual group therapy sessions. We have seen a dramatic increase in the utilization of our virtual visits	Kentucky enrollees in our commercial plans are already using this technology. The highest volume behavioral condition addressed through virtual visits in Kentucky was depressive disorder, followed by anxiety disorders. In Kentucky, 21% of our virtual visit providers are prescribers; 67% attest to specialties that support complex populations.
Community-based telehealth	We provide access to a psychiatrist at any location that has access to high-speed internet. We use these programs to provide community clinics, FQHCs, CMHCs, MSGs, BHSOs, PCPs and community hospitals with access to dedicated psychiatric care (MDs, DOs and NPs), expanding access and maintaining network adequacy across underserved communities	In July 2019, we began implementing a telehealth program with the Boys & Girls Club of Glasgow-Barron County. Using computers donated by UnitedHealthcare, children now have access to mental health services delivered virtually by local behavioral health providers.
Specialized Telepsychiatry Delivery	Genoa Healthcare, an affiliated company, will deliver a unique model of outpatient telepsychiatry tailored to enrollees with mental health, addiction and complex, chronic health issues by meeting them where they are in the community, in PCP offices, behavioral health clinics, CMHCs, MSGs, BHSOs and other provider locations. Genoa also provides three consumer medication coordinators for North Key Community Care (Covington). These coordinators educate and support enrollees’ adherence to psychotropic medications.	Genoa currently serves five CMHCs at eight locations in Kentucky including LifeSkills, Inc. (Bowling Green), New Vista (Lexington), Centerstone of Kentucky (Louisville), Four Rivers Behavioral Health, Inc. (Mayfield and Paducah) and New Vista Regional Mental Health (Richmond). Most recently, Genoa Healthcare and Pennyroyal Mental Health Center (Hopkinsville) entered into an agreement whereby Genoa will provide Pennyroyal with dedicated psychiatrists that are experienced in addictions and have a DATA-2000 waiver. We are actively working with Genoa to identify other high-volume practices and providers in Kentucky where we can increase access to services for targeted populations including children with depression and individuals with SUD.

There are several tele-psych models that we employ around behavioral health, including work already active in UnitedHealthcare in Kentucky with our other lines of business and with the CMHCs. This work has shown improved access and outcomes in Kentucky as well as in other

states such as rural Missouri. Genoa's telepsychiatry intervention has demonstrated increased access and improved outcomes for individuals with SMI in rural Missouri. A 2019 study published in the American Psychological Association's *Journal of Rural Mental Health* conducted by Genoa Healthcare and Relias Health analyzed data from 242 Medicaid enrollees in rural Missouri following an inpatient admission or ER visit. Enrollees, who received a combination of telepsychiatry coupled with in-person visits, were seen seven days sooner and were 34% more likely to have regular follow-up visits.

Integrated Behavioral and Physical Health Home Value-based Payment



In ongoing conversations with leaders and clinical staff of Kentucky's BHSOs, CMHCs, MSGs and other providers (identified in the table), many shared challenges they experience providing integrated primary care to their most vulnerable clients including a lack of sustainable reimbursement to co-locate PCPs offering integrated care onsite at their clinics. To support organizations in providing the comprehensive integrated primary and behavioral health care that will result in the best outcomes for our enrollees with SMI and SUD, we will implement our innovative Integrated Behavioral and Physical Health Home VBP.

To test efficacy and measurable outcomes, we will evaluate all providers and pilot this model with high quality behavioral health providers that meet membership and service delivery requirements that have integrated primary care programs and who have expressed a strong interest and readiness in our VBP approach. During the evaluation process, we review data of enrollees who are eligible for health home services to identify the providers to partner with. The focus of this health home model is to improve performance on defined quality metrics and reduce the overall behavioral and medical total cost of care. If a behavioral health provider is able to reduce the total cost of care and meet defined quality metrics, they will be eligible to receive a percentage of the shared savings amount. The metrics will focus on medical and behavioral health measures including medication adherence measures. To align with the Commonwealth's priorities, we will include the 7-Day and 30-Day Follow-up after Hospitalization for Mental Illness measures. We will collect baseline data over a 12-month measurement period in Year 1 while focusing on a quality program preparing the provider for movement into total cost of care and launch the model in Year 2.

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

Our VBP recognizes that providers interested in launching new integrated primary care programs may need upfront funding to pay for their primary care clinical staff and better care coordination. In Year 1, we will explore the potential to include an upfront grant or monthly care coordination payment to support the integrated behavioral and physical health care for enrollees with significant needs in addition to targeted quarterly incentive payments for meeting performance metrics such as 7-Day and 30-Day Follow-up after Hospitalization for Mental Illness. Many providers could use these financial resources for infrastructure enhancements required to provide integrated primary care and behavioral health services, such as hiring primary care clinicians and developing MAT programs for OUD. In future years, we will move participating providers toward accountability for overall (behavioral and medical) total cost of care and awarding shared savings to the providers that meet our defined quality metrics that focus on both behavioral and physical health.

Our value-based program consultants will provide intensive face-to-face practice transformation and support that is uniquely tailored to successfully implement this model. The consultants will meet regularly with practice staff in our pilots in their clinic setting to:

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

Specialized Network Development

To improve access to services, we use creative solutions to quickly expand access by creating specialized networks, such as our Express Access and MAT networks. In addition, we use competitive procurements, bordering state relationships and community reinvestment to expand network adequacy and capacity.

Express Access. To improve timely access to prescribers and behavioral health services, we have launched a nationwide Express Access network. In Kentucky, this network includes 78 providers. Appointments are available in five business days or less, and on average, appointments occur within three days (the industry average is 10 days). Providers respond to enrollee requests within 24 hours. By assuring more rapid enrollee access, we help providers intervene earlier in an enrollee's care and decrease no-show rates. The Express Access network also diverts enrollees from accessing medically unnecessary higher levels of care due to delays in receiving outpatient care. This, in turn, provides the right level of care to the person at the right time, maximizing network capacity and reducing lost provider revenue.

MAT Expansion. We offer one of the largest MAT networks in the country. Our sophisticated data analytics helps inform interventions, evaluate outcomes and monitor trends. Across the nation, we have rapidly expanded MAT providers, leveraging both our behavioral and medical networks. We use a combination of independent practitioners, treatment programs and telehealth strategies to increase accessibility, with a focus on identifying and supporting high quality MAT providers. Using this strategy in Kentucky, we have already established a Medicaid MAT network of 459 unique providers, which assures coverage across all Kentucky regions, as shown in the map:

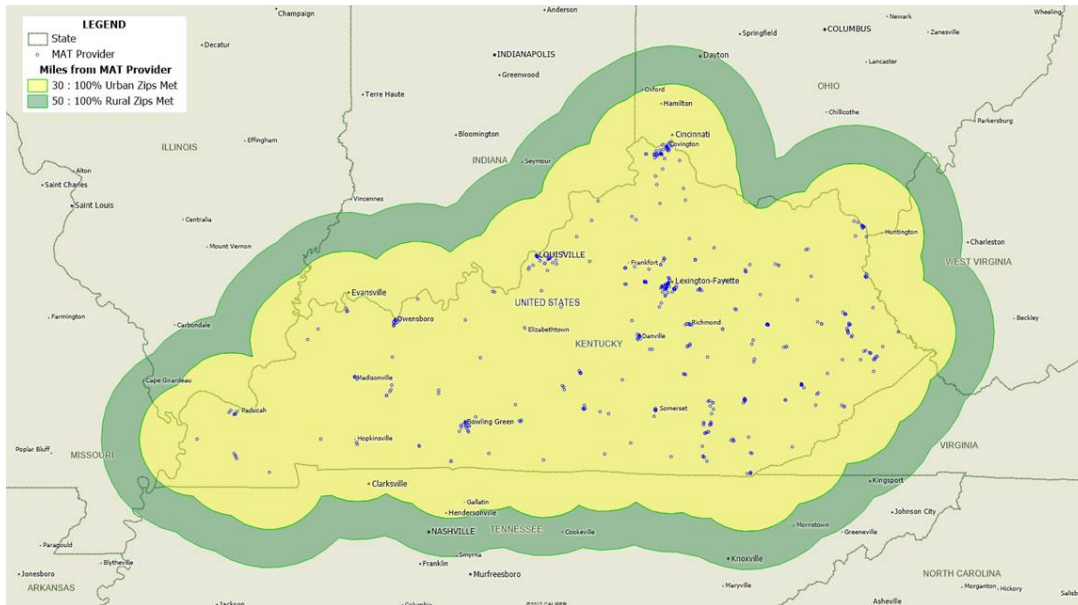


Figure 6. MAT Network. The map highlights the unique locations of 459 MAT providers in Kentucky, operating at medical and behavioral locations. This network offers 100% access to enrollees in urban and rural zip codes.

Other Network Development and Maintenance Approaches

Other Network Development Approaches	How It Works	Experience
Competitive Procurements to Promote Network Development	Working in partnership with communities, providers and other stakeholders, we develop and release competitive procurements (Requests for Information [RFI] and Requests for Proposal [RFP]) to identify innovations that close identified gaps.	In Tennessee, we released an RFI to develop co-occurring treatment programs in the Memphis area where few services were available. We used a similar RFP approach to identify and contract with a vendor for a community-based 24-hour crisis line in North Carolina.
Community Reinvestment	We are committed to reinvesting utilization program development.	In Idaho, we reinvested savings to fund intensive outpatient services and youth/adolescent outreach programs. In Washington, we invested savings and allocated other funds to Mary Bridge Hospital by funding a health van with services that include primary care delivered by a full-time physician/ARNP, RN care manager, case manager and certified peer support counselor. In Virginia, we used the community reinvestment funds to assist enrollees with SMI with expenses that are not covered by Medicaid, when being discharged from the State Hospital and for enrollees that need supplemental rental assistance to access housing.
Bordering State Provider Relationships	We have an extensive behavioral health network — contracting with over 214,000 clinicians, group practices and facilities, as of January 2020. We will use established	We will build upon our comprehensive Medicaid behavioral networks in neighboring states including Ohio, Tennessee, Missouri and Virginia. We also

Other Network Development Approaches	How It Works	Experience
	provider relationships in the seven states bordering Kentucky to extend access.	will access behavioral health providers within 50 miles of the Kentucky border that serve our membership in Illinois, Indiana and West Virginia. Bordering state providers that participate in Kentucky Medicaid will support all populations.

Education for Enrollees and Providers



Provider education can be effective to increase providers' competency in screening enrollees for behavioral health conditions and connecting them to treatment. Evidence-based training for communities and individuals reduces the stigma associated with behavioral health and encourages them to seek behavioral health treatment. While these activities are not tied directly to network development and maintenance, they are important to assure that providers are screening and identifying enrollees with behavioral health conditions and referring them into the network and that enrollees actively seek treatment without fear of stigma.

- To help PCPs and medical specialists understand the benefits of integrating care and how to apply it in their practice, we offer education, training and resources through our provider relations teams and online through our provider portal, *Link*. This includes our *Behavioral Health Toolkit for Medical Providers*, which educates PCPs and medical specialists on MH and SUD assessments and evidence-based practices. Training on how to use **Screening, Brief Intervention and Referral to Treatment (SBIRT)**, an evidence-based practice to reduce dependence on alcohol and illicit drugs, is available to providers free through *Link*. We also offer convenient access and instruction 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 in youth and adults, respectively.
- **Toll-free Substance Use Disorder Helpline.** To increase enrollees' access to SUD treatment programs, we launched a toll-free 24-hour SUD Helpline, which will be available in Kentucky and integrated with our toll-free line. When families and enrollees call with non-urgent questions regarding substance use treatment, our staff will warm transfer them to the SUD Helpline. Through this line, enrollees have confidential access to immediate support from substance use recovery advocates regarding addiction and treatment options. It is also available to families and caregivers.
- **Improving Access to Suicide Prevention.** Preventive education can often direct enrollees to care that they would not have sought otherwise. Our suicide prevention resources include access to online Question, Persuade, and Refer (QPR) suicide prevention training, 24 hours a day, seven days a week. QPR is an evidence-based practice shown to be effective with individuals who have experienced trauma, and for individuals recovering from the trauma of using substances. QPR can also help gatekeepers, such as teacher and parents, identify signs of suicidal behavior. We will educate the community and enrollees regarding these resources, particularly in cases when an enrollee is reluctant to place a crisis call or reach out to a provider.
- **Seeking Safety.** Seeking Safety is an evidence-based therapeutic group following a curriculum of 25 different topics to address care needs of enrollees with SUDs and/or trauma backgrounds. Curricula and groups exist for both adults and youth, with topics

relevant to their specific needs. We support and value the delivery of services through peer support specialists and will provide trainings across the Commonwealth to develop a network of peers certified to deliver Seeking Safety groups.

- **Mental Health First Aid (MHFA).** MHFA teaches people how to identify, understand and respond to signs of mental illnesses and SUDs in their community. One of the things that make MHFA unique is the ability to tailor courses to specific populations, such as young adults, public safety officers or residents of a rural community.

iv. Process for follow-up after hospitalization for Behavioral Health Services within the required timeframes.

Our comprehensive approach to confirm follow-up after behavioral health hospitalizations exceeds the basic contractual requirements in Attachment C – Draft Medicaid Managed Care Contract, Section 33.8 Follow-up after Hospitalization for Behavioral Health Services by bringing an array of innovative programs to Kentucky to make sure that follow-up and intensive care management occurs for our most vulnerable individuals with SMI and SUD. All contracts with behavioral health providers will require that they provide outpatient follow-up within 7 days after discharge and contact enrollees who miss an appointment within 24 hours to reschedule appointments. During our onsite meetings, we heard from many providers that they do not currently receive the information on when their enrollees are hospitalized and receive inadequate funding to provide the intensive care coordination to validate that individuals obtain follow-up. Our goal is that in partnership with our behavioral health team, we will provide behavioral health providers with useful data around admissions and discharges allowing for improved 7- and 30-day post hospital engagement.

In addition to post-discharge coordination with behavioral health providers; we will provide a comprehensive approach that uses our MCT to provide follow-up for individuals with the most complex needs. The MCT is designed to provide in-home/in-community stabilization to individuals who cycle between hospitalizations without more comprehensive support and partnerships to equip them with the tools and resources to facilitate successful follow-up for their enrollees.

Multidisciplinary Care Teams for Individuals with Complex Needs



We know that many of our enrollees with SMI also have complex physical health, addiction and social needs and will struggle to stay out of the hospital and thrive in the community without intensive case management and high quality integrated behavioral health and primary care. The MCTs are our innovative approach to provide direct care delivery and care management to our enrollees with the most complex SMI, physical health needs and social needs. The MCTs will be based in each region of Kentucky, and will include nurse practitioners, behavioral health clinicians, clinical administrative coordinators, and RNs. Working in a pod-like structure, the MCT will conduct weekly interdisciplinary care team meetings, where they invite the enrollee, providers, enrollee advocate or other persons of the enrollee’s identified care team and MCT members together to develop a plan of care for the enrollee aimed at improved health outcomes and stabilization in the community. A Kentucky board-certified psychiatrist and a physical health medical director will lead our MCT to consult, provide telemedicine intervention and support the MCT clinicians in managing individuals with SMI. To assure high quality clinical delivery and high enrollee engagement, our frontline MCT is trained in trauma informed care and motivational interviewing and receive additional training on specific topics when appropriate to meet the unique needs of enrollees.



The MCTs will provide home visits to individuals with SMI and the most complex needs within two days of discharge after a behavioral health

hospitalization. In addition to performing comprehensive assessments of individuals' physical, behavioral health and social needs, the MCTs provide direct behavioral health and primary care to meet the enrollees' individual needs. Clinicians on the MCTs will provide psychiatric and primary care, medication reconciliation and management, MAT for OUD, and trauma-informed counseling. The MCT care coordinator also will make sure social needs that increase the risk of readmission are addressed.

In the neighboring state of Tennessee, this model serves about 3,000 of our dual-eligible Medicare and Medicaid enrollees with complex disabilities – many have SMI and co-occurring SUD. On average, 98% of our enrollees are seen within two business days of discharge notification. When comparing 2017 to 2018, we saw 10% to 20% reductions in inpatient admissions and 23% to 33% reduction in ED visits. In addition to the utilization successes observed during implementation, this model closed over 18,300 gaps in care in 2018.

Integrating Clinical Staff at Psychiatric Hospitals



INNOVATE

During our conversations with outpatient behavioral health providers, many expressed their frustration that they are not informed when their clients are admitted or discharged from hospitals. Outpatient providers shared their strong interest in integrating their clinical staff at high-volume psychiatric hospitals so they can provide active discharge planning and confirm that follow-up occurs within 7 days through their organization. Since many of these individuals are already clients known outpatient providers, and these individuals' primary source for follow-up, integrated provider staff can provide active person-centered discharge planning from the day an individual is admitted.

We are exploring partnerships with high quality behavioral health providers participating in our Integrated Behavioral and Physical Health Home model in Year 1 and Year 2 to integrate their case managers in high volume psychiatric facilities. We will empower them with real-time alerts when our enrollees are hospitalized so the integrated case managers can proactively engage in discharge planning and verify individuals have a follow-up appointment scheduled with their outpatient provider in less than seven days and arrange transportation if needed. The co-located clinical staff will make sure that individuals with SMI receive the intensive, wraparound services they need to be safely discharged to the community and provide support post-discharge to verify they attend their follow-up appointment. Our staff will validate any needed authorizations are in place and support the discharge coordination efforts by removing barriers encountered (e.g., housing supports, and addressing social determinant of health barriers).

Our Integrated Behavioral and Physical Health Home VBP will provide the sustainable funding to support this approach because participating behavioral health providers will receive the monthly care coordination payment to support integrated behavioral and physical health care and additional targeted incentives for meeting performance metrics including follow-up within seven days and 30 days of behavioral health admissions. Confirming that behavioral health providers have integrated staff in the psychiatric hospitals will prepare them to succeed when the VBP model transitions to shared savings with accountability for total cost of care (including behavioral and medical health) in future years.

Our value-based program consultants will provide regular reports to all participating providers including those in our VBP pilots with their performance on the 7-day and 30-day hospitalization follow-up measures and meet regularly with providers to develop targeted rapid cycle improvement plans with strategies to improve their performance on these measures.

Value-Based Payment: Shared Savings Approach

Our support and infrastructure for providers will be important to make sure they can succeed with the VBP we are proposing in which providers will have shared savings for the inpatient behavioral health total cost of care per member per month (PMPM) for their assigned enrollees. Our Shared Savings Model will focus on reducing the PMPM inpatient behavioral health cost over a twelve-month measurement period and meeting defined quality metrics. For each metric achieved, a certain amount of shared savings will be available for the provider. This metric will look at follow-up after hospital discharge appointments (7- and 30-day appointments) and medication adherence for CMHCs and other providers with a co-located Genoa pharmacy.

After meeting staff at many of the Commonwealth’s behavioral health providers, we understand the essential role of these providers in caring for the Medicaid SMI population. We heard how eager they are to provide their case management/coordination and engage in innovative VBP models such as integrated behavioral and physical health. To help providers succeed with care coordination and innovative VBPs (shared savings and integrated behavioral health/physical care), our value-based program consultants will provide an array of tools, supports, data and reports.

Maintaining Strong FUH Outcomes

We have the experience and expertise to deliver strong outcomes for FUH. Among Medicaid health plans, our Kansas Medicaid Plan (UnitedHealthcare of the Midwest, Inc.) has consistently remained at the 90th or 95th percentile for 7- and 30-day follow-up during the 2016-2019 measurement periods.

Provider Education to Improve Follow-up after Hospitalization

We continuously educate all our providers regarding follow-up after hospitalization (FUH). We monitor FUH through data collected throughout the measurement year, which provides us with a projected FUH rate based upon claims data. When provider outliers exist, we develop interventions to work with those inpatient providers to educate them regarding follow-up appointment requirements and verify they are aware of our network outpatient providers available for seven-day FUH appointments, including our Express Access providers.

Our Platinum Program identifies the top-performing providers in the network as it relates to quantitative and qualitative metrics (e.g., HEDIS). In our *Provider Directory*, we include an identifier to show those providers with platinum status. These providers receive increased referrals from our staff, and enrollee self-referrals, based upon achieving preferred provider status. The Platinum Program includes a FUH metric for facilities with a minimum of 20 discharges. Facilities receive an annual scorecard, which includes a metric for follow up after hospitalization within seven days.

v. Process for ensuring continuity of care upon discharge from a Psychiatric Hospital.



From our local experience serving other lines of business, as well as conversations with providers in the community, we know real challenges exist with continuity of care after a behavioral health hospitalization in Kentucky. Care is often fragmented and enrollees often have difficulty returning to community supports once they are admitted to acute care or discharged. Many providers often do not know when enrollees have been readmitted or discharged. **We will deliver a more comprehensive solution than what is currently required in Section 33.10 Continuity of Care upon Discharge from a Psychiatric Hospital of Attachment C – Draft Medicaid Managed Care Contract.** Our innovative solutions, including our MCTs and Integrated Behavioral and Physical Health Homes with

providers' clinical staff integrated in psychiatric hospitals and providing care coordination to facilitate continuity of care upon discharge from psychiatric hospitals far exceed the draft contract's requirements.

Through our population health management (PHM) program, we will identify enrollees who are at risk and are admitted to behavioral health facilities so our provider partners can immediately engage the enrollees. Our population health program uses innovative tools and practices to meet and empower enrollees wherever they are along the risk continuum. Each risk level is classified into service tiers, which help direct the manner and intensity with which we provide care. Within each tier, we have developed specific programs and interventions to address our enrollees' unique needs. While stratifying and then tiering the calculated risk of enrollees creates a structured framework for our PHM approach, our enrollee engagement remains person-centered and responsive to individual enrollee's needs and preferences, especially as these change.

Establishing Collaborative Relationships with State Psychiatric Hospitals

As part of our approach, we, along with our provider partners, will establish collaborative relationships with state-psychiatric hospitals, and with other DMS facilities that serve individuals with co-occurring behavioral health and DID. On a quarterly basis, we will participate in Continuity of Care meetings hosted by the Commonwealth's psychiatric hospitals.

As outlined in Section 33.10, we will require all providers (BHSOs, CMHCs and MSGs) to assign a case manager prior to the date of discharge to provide the appropriate level of medically necessary case management services (such as basic, targeted or intensive) for individuals with SMI and co-occurring conditions who are being discharged from a state-operated or state-contracted psychiatric facility or state-operated nursing facility for enrollees.

Continuity of Care Process: Data Sharing



Continuity of care planning begins at admission. We receive inpatient admission information from psychiatric and medical facilities via our provider portal; admission, discharge and transfer (ADT) data of all admissions including behavioral health facilities from inpatient hospitals directly; and from health information exchanges (HIE), such as the Kentucky Health Information Exchange. We will provide alerts to providers' clinical staff integrated in high volume psychiatric hospitals so they are aware of admissions or transfers of their enrollees. The primary responsibility of the care coordinator is to facilitate successful transitions and continuity of care to reduce the individual's readmission risk. We will directly refer enrollees with complex needs to our MCT and confirm that other enrollees are connected back to their behavioral health provider and to a PCP if one is not already assigned. If comorbid conditions are present, we will engage the appropriate specialists. When engaged, our MCT or the PCP/specialists will participate in transition and discharge planning, and make a plan with the enrollee/family to facilitate a seamless transition back to the community and address medical, behavioral health or social needs to help them to thrive in the community.

Continuity of Care: Discharge Planning

We are committed to effective transitions of care for enrollees and working with providers across the care continuum of physical and behavioral health. Our staff works aggressively to eliminate barriers to effective care transitions through an integrated multidisciplinary care program that facilitates both utilization and care management. Our Care Continuum program, led by our chief medical officer, Dr. Jeb Teichman, focuses on quickly and collaboratively identifying barriers and opportunities for coordination of care and authorizations of services that are often required

to successfully transition enrollees through various levels of care. This integrated behavioral and physical health program assures a holistic approach to care transitions.

We participate in discharge planning meetings to confirm compliance with federal Olmstead and other applicable laws. In preparing for the enrollee's discharge, we work with the co-located providers' clinical staff and hospital discharge staff to consider the individual's risk level and likelihood of readmission. For enrollees with a high risk of readmission, we engage peer specialists to bridge the enrollee's transition to the community.

In accordance with the requirements of Section 33.10, our discharge planning will focus on making sure needed supports and services in the least restrictive environment to meet the enrollee's behavioral and physical health needs, including psychosocial rehabilitation and health promotion. The goal of our combined team is to remove barriers to discharge and assure that the enrollee has the right supports in place for a successful transition back to the community, or to a lower level of care. In addition to confirming follow-up visits, we address supports and services, such as:

- Does the enrollee have an Integrated Behavioral and Physical Health Home or a PCP and/or the right specialists to address comorbidities/co-occurring conditions? If not, we help the enrollee/family select a PCP/specialist to improve post discharge transition.
- Is this an enrollee who could potentially benefit from our in-home complex care team, which includes behavioral and physical health specialists?
- Does the enrollee/family understand discharge instructions and any prescribed medication regimen, possible side effects, and the risk of missing doses? Will a long-term injectable be more effective? The plan of care is revisited as needed.
- Is the enrollee isolated? Are there natural supports? Would a peer support specialist improve the transition? Are there other community-based services and self-management tools (e.g., My Whole Health Tracker, crisis plan) that would support the enrollee's transition?
- Does the behavioral health service provider need to assist the enrollee in accessing free or discounted medication through the Kentucky Prescription Assistance Program or other similar assistance programs?
- What type of follow up is required to make sure the community supports are meeting the needs of the enrollee discharged from a state-operated or state-contracted psychiatric hospital?

Multidisciplinary Care Teams Provide In Home Support and Care Continuity



For enrollees with complex needs, we will introduce an innovative complex care management team — our MCTs — that can directly furnish at-home behavioral health and primary care services. Working directly with our provider partners, we will transition individuals with complex needs who require intensive supports to stabilize their complex physical, behavioral, and social issues to our MCT upon discharge from the hospital. Once the individual is stabilized; we can transition them to the wraparound supports available through the community-based organizations. With multiple providers participating on the treatment team, our community-based care platform (*CommunityCare*) facilitates data sharing by providing a shared view of the individual among the treatment team and our staff to identify gaps, needed interventions and other information, such as changes in medication. Through *CommunityCare*, the treatment team is able to stay abreast of the enrollee's services and address continuity of care needs.

Integrating Kentucky Peers in Continuity of Care



Kentucky has established a comprehensive network of peer support specialists. We will look for creative ways to integrate peers into continuity of care processes

to improve individual outcomes. We assign peers to individuals, based upon that person's needs, such as prior hospitalizations and readmission risk, using evidence-based guidelines.

Peers are most effective when they are used to target individualized needs. A peer support specialist may accompany enrollees to appointments, engage with them in shared-decision making and pinpoint care instructions. They also facilitate follow up to other services. Peers also introduce and work with enrollees on self-care and activation resources, such as our Recovery Toolkits, Whole Health Trackers or Wellness Recovery Action Plans. We have established peer support services in many states and have extensive experience integrating existing community-based peer support in our programs. The common goal among these programs is to reduce readmission rates; increase community tenure; and demonstrate measurable effects on enrollee recovery and wellness. We have seen significant reductions in readmission rates, some as high as 60%, with the successful integration of peers.

Funding Recovery Opportunities for Individuals with Substance Use Disorder

In collaboration with Calvary Christian Church and Achieving Recovery Together (A.R.T.) in Winchester, Kentucky, UnitedHealthcare is providing initial seed funding to improve recovery opportunities for individuals with SUD.

By combining the church's transportation surplus available during the week and the trusted capacity of A.R.T.'s peer support program, individuals with SUD now have the capacity and be more likely to get to their clinical appointments related to accessing treatment medication, 1:1 behavioral health appointments, and/or peer group support meetings. In addition to the availability of this reliable transportation, there are peer support mentors accompanying individuals on every ride. The peer support mentor works to understand the individual's ongoing needs and barriers to achieving recovery better. As needed, they refer individuals to additional services. The belief is that this will lead to improved recovery and outcomes related to the rider's health, employment, and overall long-term well-being.

The pilot links to related state agencies' efforts to explore the program's sustainability and opportunity to scale across the Commonwealth. From August 2019 through mid-December 2019, 240 total trips have occurred, serving 120 individuals at an approximate cost of \$37.44 per trip.

Linkages to Community-based Services

Our population health approach will identify the individuals with the highest risk upon discharge from the hospital. This approach exceeds requirements, and goes beyond the three levels of case management (basic, targeted and intensive) identified in Section 33.10. By paying for outpatient case managers to be in the inpatient setting, offering linkages and care coordination and analytics, we go beyond the three levels of case management. We continuously monitor access and availability of services to make sure enrollees have access to a needed level of care through mechanisms inclusive of our UM processes, complaint evaluation, provider quality reviews, access studies and network management.

Our proprietary Hotspotting tool magnifies the impact of our care coordination by transforming real-time medical, behavioral and health-related resource needs data into practical insights that can inform the day-to-day decisions of behavioral health providers, our team, from our chief medical officer to our care managers. This strategic use of data allows us to target interventions that address enrollee needs, improve outcomes, and reduce spend among influential

populations. For example, our team in Arizona recently used the Hotspotting tool to find 1,302 enrollees experiencing homelessness in Phoenix. In Kentucky, this will allow us to find enrollees who will benefit from our programs, by either referring the enrollee to the attributed behavioral health provider or directly outreaching to the enrollee.



To surround individuals with support when they return to the community, we integrate community-based services, such as assertive community treatment (ACT), targeted case management (TCM) and our Community-based Assessment, Stabilization and Treatment (CAST) program. Many community-based services are covered benefits that are available and aligned to care guidelines (e.g., MCG, LOCUS). We will contract the delivery of these services through our comprehensive provider agreements. If there are network gaps specific to ACT and TCM, we will close the gaps using innovative payment approaches, our network development strategies, such as competitive procurements, using providers within 50 miles in a bordering state. We will explore development of a pilot program with a quality behavioral health provider (such as New Vista CMHC in Lexington) to expand ACT services to rural areas.

Our CAST is an innovative service we use to keep children/youth with high risk in their homes. Through CAST, we wrap intensive supports around the youth/family as a less restrictive option to residential or inpatient care out of the home. We will target development of CAST at behavioral health providers in areas where we identify high residential/inpatient use by youth. During calendar year 2018, almost 50% of children and adolescents referred to our CAST program in Salt Lake County were diverted from inpatient care to a less restrictive setting.

We integrate community-based services into the individual's plan of care to create a coordinated and individualized system of care that encompasses the individual's entire care team. This prevents separate plans of care and facilitates a collaborative, personalized approach. Community-based behavioral health providers will participate on our MCT, and working together, we will identify individuals who benefit from these services using population health. As part of care planning, our care coordinator, the enrollee/family and treatment providers consider supportive community-based services pre- and post-admission. As we move to our total cost of care model, these services will be included in our VBP processes.

b. Describe the Contractor's approach to meeting the Department's requirements for operating seven (7) days a week, twenty-four (24) hours a day emergency and crisis hotline as defined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

We have operated a 7-day a week, 24-hours a day emergency and crisis hotline for 30 years, consistent with requirements in Section 33.6 Behavioral Health Services Hotline of Attachment C - Draft Medicaid Managed Care Contract. We also recognize the importance of a statewide crisis line, and are pleased to contribute to the Commonwealth's statewide behavioral health crisis line, based upon our



proportional share of Medicaid enrollees during the contract year.

We will establish a toll-free line to handle emergency and crisis calls. We will confirm our crisis center personnel have understanding of Kentucky

Deep Operational Expertise

Our public sector emergency and crisis behavioral health hotline serves over 5 million individuals nationally.

We continually monitor staffing and service levels to meet or exceed an average speed of answer in less than 30 seconds and an abandonment rate of less than 5 %.

In 2019, we answered over 402,000 calls within 12 seconds. Our abandonment rate was 0.8%, well below the Commonwealth's requirement of 7%.

resources including state-specific hotlines. Our system can immediately connect to the local suicide-hotline telephone number and other crisis response systems. It also has patch capabilities to 911 Emergency Service. In urgent and non-life-threatening situations, we will dispatch police well checks and mobile crisis. We will dispatch to 911 when a life-threatening situation is occurring.

Our clinicians use the Columbia Suicide Severity Rating Scale for administration when appropriate. During calls, our staff will confirm the location of the first caller and a call back number as a first step, so we can call back, in case the caller hangs up, or is disconnected.

Hotline Staff

We staff our hotlines with qualified, independently licensed master's-level nurses or doctorate level behavioral health professionals, holding licensure such as licensed professional counselor (LPC), licensed clinical social worker (LCSW), RN with psychiatric experience, and licensed clinical psychologist.

Our crisis team includes 82 licensed mental health professionals including 29 with a minimum of a masters-level license to support our crisis line during business hours. During after-hours, 53 clinicians with a minimum of a master's level are available to enrollees.

We require two years of prior behavioral health experience; along with completion of required continuing education including crisis management refresher training. In hiring, we consider the individual's passion and commitment to improve our enrollees' wellbeing. We actively recruit bi-lingual and multi-lingual clinicians. Our continuing training highlights use of Language Line interpretive services, local resources and cultural competency.

Call Triage Processes

To assess whether the enrollee believes they are experiencing a crisis, our staff will use a one-question screen: "Do you currently have concern for your safety, hurting yourself or someone else?" In instances where a caller responds with yes, and indicates that a life-threatening crisis is already underway, our nurse or member services advocate (MSA) will remain on the line with the caller and use our system patch to 911 for immediate intervention.

When an enrollee indicates that an urgent or non-life threatening emergency is occurring (e.g., *I am having suicidal thoughts lately and want to speak with someone*), the nurse or MSA warm transfers the call to a licensed behavioral health clinician. In these situations, our behavioral health clinician assesses the nature of the caller's situation, using our risk assessment guidelines derived from industry-accepted crisis call procedures. Based upon this assessment, the clinician may request local mobile crisis dispatch, a police well-check or set up an urgent appointment with a provider within 24 hours.

Our call operations are set up using a "no wrong door" approach. If an enrollee calls our general member services toll-free number or NurseLine, our nurses and MSAs are trained to triage callers experiencing a life-threatening situation to 911, or to warm transfer urgent or non-life threatening calls to a licensed behavioral health clinician.

Performance Reporting

Our hotline meets all performance requirements of Section 33.6, and exceeds the requirements for call abandonment. Our behavioral hotline currently performs at an abandonment rate of 4% or less, well below the DMS's standard of 7%. In addition, we will meet these standards:

- 99% of calls will be answered by the fourth ring
- No incoming calls will receive a busy signal

- Our system will immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and has patch capabilities to 911 Emergency Services

Each month, we will report prior month performance based upon call center abandonment rates and average speed of answer for the hotline serving Kentucky enrollees. Callers do not receive a busy signal, or blockage.

c. Describe the Contractor's approach to coordination and collaboration between the Contractor, Behavioral Health Providers and the PCP as defined in RFP Attachment C "Draft Medicaid Managed Care Contract and Appendices."

Our approach to coordination and collaboration between our health plan, behavioral health providers and PCPs complies with Section 33.8 Follow-up after Hospitalization for Behavioral Health Services of Attachment C – Draft Medicaid Managed Care Contract. We provide written policies, contractual requirements, training and oversight to assure that collaboration occurs between our health plan, behavioral health providers and PCPs. We will present our policies and procedures to DMS for approval according to the processes outlined in Attachment C – Draft Medicaid Managed Care Contract, Section 4.4 Approval of Department. Provider feedback is incorporated through behavioral health specific and integrated quality advisory committees in collaboration with the health plan.

At the heart of our provider care coordination is our shared clinical management system, CommunityCare. With multiple providers participating on the treatment team (inclusive of primary care and behavioral providers), our community-based care platform (*CommunityCare*) facilitates continuity and coordination of care by providing a shared view of the individual among the treatment team and our staff to identify gaps, needed interventions and other information, such as changes in medication. Through *CommunityCare*, the treatment team is able to stay abreast of the enrollee's services and address continuity of care needs.

Our *Care Provider Manual*, which is part of our provider contract by reference, outlines the processes and expectations that PCPs, behavioral health and other specialists use to coordinate and collaborate regarding enrollee care. We require all providers, including those working in facilities, to coordinate care with the enrollee's PCP and other treating medical or behavioral health clinicians. A signed release of information is maintained in the clinical record. If an enrollee/family/guardian declines consent to release information; their refusal is documented along with the reason for refusal. Our providers have responsibility to educate enrollees regarding the benefits of coordinated care and the risks of not doing so.

We require that behavioral health providers send summary reports of an enrollees' behavioral health status to the PCP, with the enrollee's or the enrollee's legal guardian's consent, following the processes in our *Care Provider Manual*. Behavioral health providers are expected to exchange appropriate treatment information with medical care professionals (e.g., PCPs, medical specialists) and/or other behavioral health clinicians (e.g., psychiatrists, therapists). Shared information includes a summary of the enrollee's evaluation, diagnosis, a treatment plan and a summary of any prescribed medications and the name of the PCP for other treatment providers.

We understand this is a considerable investment of the provider's time, but also recognize the importance of sharing information. To support bi-directional exchange of information, our shared clinical management system, *CommunityCare*, captures similar information and facilitates improved enrollee outcomes through the collaboration that occurs between the health plan and the various providers that are engaged with the enrollee.

The Role of the Primary Care Provider

Primary Care Providers play a large role in behavioral health screening and coordination. In accordance with Attachment C – Draft Medicaid Managed Care Contract, Section 33.7 Coordination between the Behavioral Health Provider and the PCP, we will provide training to network PCPs on how to screen for, and identify, behavioral health disorders and educate on our referral process for behavioral health services and clinical coordination requirements.

Our *Behavioral Health Toolkit for Medical Providers* (BH Toolkit) is a resource that guides medical professionals, including PCPs, to screening tools, resources and materials to enhance understanding of SUD and MH conditions. The referral processes for behavioral health and coordination are outlined in the *Care Provider Manual* and included in the BH Toolkit. During orientation, we review these processes with newly contracted PCPs and other non-behavioral health specialists.



Figure 7. Behavioral Health Toolkit. Our toolkit supports evidence-based screening, diagnosis and treatment in non-behavioral health settings.

We updated the BH Toolkit to include *Psych Hub* -- a visual training tool that helps non-behavioral health providers assess enrollees' behavioral health conditions. If a medical provider prefers a discussion with one of our staff psychiatrists, they can call via our provider services line to speak with one of our staff psychiatrists regarding appropriate prescribing and care for children, adult and elderly populations.

Through our *Care Provider Manual*, we require PCPs to screen for known or suspected behavioral health issues, such as depression, substance use, cognitive and developmental delays and to either treat within their practices or refer to an appropriate provider and coordinate care. We extend this approach by encouraging OB/GYN practitioners to screen for behavioral health conditions during pregnancy and postpartum, and to treat or refer the enrollee to care. Behavioral health providers are contractually required to refer enrollees with known or suspected physical health problems or missing preventive activities to their PCP for examination and treatment.

Providers access our free, online continuing education through *UHCprovider.com*. Courses focus on special populations and topics, (e.g., trauma-informed care) and evidence-based practices, such as person-centered care. Any provider -- including PCPs and other non-behavioral health providers -- can access the Behavioral Health Provider Video Channel, MAT Toolkit, Autism/ABA Corner, Cultural Competency Corner, Recovery & Resiliency Toolkit and other resources available on our provider portal.

We also support behavioral health providers by educating MH and SUD care providers on the benefits of completing Enrollee Needs Assessments (including MH, 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. Training on evidence-based practices, such as SBIRT, a practice to reduce dependence on alcohol and illicit drugs, is available to providers

free through our provider portal. We also offer convenient access and instruction 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.

Meeting Providers Where They Are in Integration

We recognize not all providers can deliver integrated care within their four walls. This is why we assess providers for their level of integration and sophistication, understand their ability to take on risk and accountability for population health activities and if they participate with integration activities. We tailor our support to meet providers where they are, help them grow their capabilities and advance along the continuum of integration, defined by the SAMHSA-HRSA Center for Integrated Health Solutions. We offer supports, such as integrated training and technical assistance, based upon providers' current and desired levels of integration.

Our network staff uses evidence based tools, 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 help us identify what support is meaningful for each provider practice in its pursuit of greater integration. Combined with other data, such as practice structure (e.g., primary care, behavioral or specialty care), financial performance and panel size, these assessment results help us gauge where integration support is needed and desired. We have experience performing similar analyses in other states, including Arizona and North Carolina.

The Plan for Kentucky

We have already begun this assessment process in Kentucky. In an initial outreach, one of our provider relations liaisons reviewed the IPAT with St. Elizabeth's Healthcare System in Northern Kentucky. We selected St Elizabeth because it is a multi-hospital system with a network of outpatient clinics, encompassing multiple specialty areas. A level of medical and behavioral integration is already underway at St. Elizabeth. Using the IPAT, we identified that St. Elizabeth is between Level 5 (Close Collaboration Approaching an Integrated Practice) and Level 6 (Full Collaboration in Transformed/Merged Integrated Practice).

We know there will be variable levels of integration across Kentucky providers, with some providers being at Level 1 with minimal coordination. The intent of our assessment is to establish a baseline and work to enhance integration at all levels in Kentucky. Upon award, we will complete the IPAT or a similar evidence based tool with providers across the Commonwealth. We will collaborate with the Department and other stakeholders to identify priority communities/regions where integration will enhance access to care. Our value-based consultants will then provide an array of tools, supports, data and reports to help providers move toward integration.

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