24. Population Health Management (PHM) Program (Section 34.0 Population Health Management Program)

a. Provide a comprehensive description of the Contractor's proposed Population Health Management (PHM) Program, including the following at a minimum:

Consistent with our mission of helping people to live healthier lives, our population health management (PHM) program, implemented in 31 states and customized for Kentucky, uses innovative tools and practices to meet and empower enrollees wherever they are along the risk continuum. In 2019, Kentucky ranked 43rd in America's Health Rankings, which cited obesity, drug-related deaths, cancer, diabetes and mental distress as contributing factors. With this in mind, we understand that many of our future enrollees will be disproportionately on the higher end of that risk continuum. Through our partnerships with the Commonwealth, providers and community organizations, we commit to shifting where individuals are on the risk continuum with the purpose of improving health outcomes and creating a healthier Kentucky where individuals can more easily engage in behaviors that promote health and wellness.

To respond to Kentucky's immediate needs, we have designed our PHM program to assist individuals with chronic or complex conditions to manage their needs effectively. Using multi-modal engagement and interdisciplinary teams led by our chief medical officer, Dr. Jeb Teichman — including an innovative complex care management team who can provide behavioral and primary care in the home — our PHM program addresses enrollees' social, physical, behavioral, cognitive and functional needs. Dr. Teichman and our health service director will collaborate with our PHM teams to create bidirectional communication between the care management team and local health plan clinical leadership to make sure all levels of our staff are empowered to engage health plan leadership to support enrollees and providers alike. While we recognize the need for immediate, intensive support for many of our future enrollees, we have simultaneously embarked on partnerships to drive lasting change across the Commonwealth to create a healthier future for Kentucky.

In designing a program to meet the needs of our Kentucky enrollees today and to invest to shift those needs in the future, we assess and stratify our membership into three core risk levels, consistent with the NCQA's PHM components:

- Health promotion and wellness
- Management of chronic conditions (which includes those with emerging risk)
- Complex care management

Each risk level is classified into service tiers to help direct the manner and intensity with which we provide evidence-based care and targeted supports. Within each tier, we have specific programs and interventions to address our enrollees' specific needs. While stratifying enrollees by their calculated risk creates a structured framework for our PHM approach, our enrollee engagement remains person-centered and responsive to individual's needs and preferences, especially as these needs change over time. Our PHM program will progressively drive more of Kentucky's population into health promotion and wellness. Initially, we will focus on the most complex enrollees while also investing in health and wellness for the next generation of Kentuckians. We believe that by partnering with UnitedHealthcare Community Plan of Kentucky's (UnitedHealthcare) clinical leaders, backed by the national expertise and resources of UnitedHealthcare, Kentucky can move up from 43rd in America's Health Rankings and our enrollees can move down in their individual risk levels.

Population Health Risk Levels	Service Tier Definitions
Health Promotion and Wellness (Risk Level 0)	Healthy enrollees who do not otherwise fall into a risk category
Management of Chronic Condition (Risk Level 1)	▪ Enrollees with emerging risk, exhibiting risk factors ▪ Enrollees with a chronic condition
Complex Care Management (Risk Level 2)	▪ Enrollees with multiple chronic conditions ▪ Complex, high need enrollees in need of intensive stabilization and support

An example of our PHM in practice: A male enrollee with uncontrolled asthma at risk of developing diabetes may be identified as Level 1 (management of chronic conditions) initially. To confirm he receives appropriate care to regain control of his health, our care coordinator connects him with primary care and a local Diabetes Prevention Program provider. If this enrollee later experiences major life or health changes — such as becoming at risk for homelessness or experiencing a stroke leading to multiple hospital admissions and additional medical comorbidities including depression — he will be reclassified as Level 2 in need of intensive stabilization and support. This stratification triggers outreach and engagement from our local multidisciplinary care team (MCT). After performing a comprehensive assessment, the MCT will directly provide primary care to help him manage his health and prevent future strokes, counseling to treat his depression and connect him with the local, Kentucky housing navigator and/or our Housing + Health program to secure safe and stable housing. Once stabilized, he reverts down to Risk Level 1 where he has access to a community health worker (CHW) for ongoing care coordination as needed.

While this enrollee receives intensive services to address his uncontrolled chronic conditions, our team is also providing outreach and incentives to remind him to schedule and attend annual well visits for his teenage son – anchoring his connection to the health system from a young age. With funding from UnitedHealthcare, the after school program he attends has a computer where he can connect with a behavioral health care provider using tele-technology, so he can care for his physical and mental health. In addition to directly investing in our young enrollees, we also invest in our provider partners. Providers in their community have the opportunity to attend practice transformation courses on appropriate diabetes management provided by University of Kentucky's Regional Extension Center and funded by UnitedHealthcare. Consequently, individuals at risk for or with pre-diabetes can be identified early and receive timely care in their communities. Driving towards better health for the entirety of Kentucky requires a multi-step approach and community partners aligned with a common vision.

i. Innovations and program elements the Contractor proposes to incorporate into this Program to support the overall goals of improving health outcomes for the population and empowering individuals to improve their health and engage in their healthcare.

The ability to improve outcomes and support behavioral change in Kentucky requires a systemic shift in how we approach our enrollees and their health. Such a shift not only embraces innovation, but also threads it throughout our PHM approach. By incorporating innovation into our technological capabilities, enrollee engagement and provider community partnerships, we encourage enrollees to adopt and sustain healthy behaviors for improved health outcomes.

UnitedHealthcare®
Community Plan

Applying Technology-based Innovations

We deploy an array of innovative technological capabilities to empower individuals and engage them in their health care. The technologies we use to achieve this end include our Hotspotting tool (figure herein), Individual Health Record (IHR), Predictive Housing Instability Tool and Predictive Social Isolation Tool.

- **Hotspotting Tool.** Our proprietary Hotspotting tool magnifies the impact of our clinical staff by transforming real-time medical, behavioral and health-related resource needs data into practical insights that inform the day-to-day decisions of our team ranging from the health plan chief medical officer to our care managers. This strategic use of data allows us to target interventions addressing enrollee needs, improve outcomes and reduce spend among specific populations. For example, our team in Arizona recently used the Hotspotting tool to find 1,302 enrollees experiencing homelessness in Phoenix. The team used the tool to cross-reference the list of enrollees with disease conditions, resulting in a list of homeless enrollees most likely to benefit from the combination of a care manager and housing navigator. Our team worked with those enrollees to help them achieve the stability needed to engage in their health.
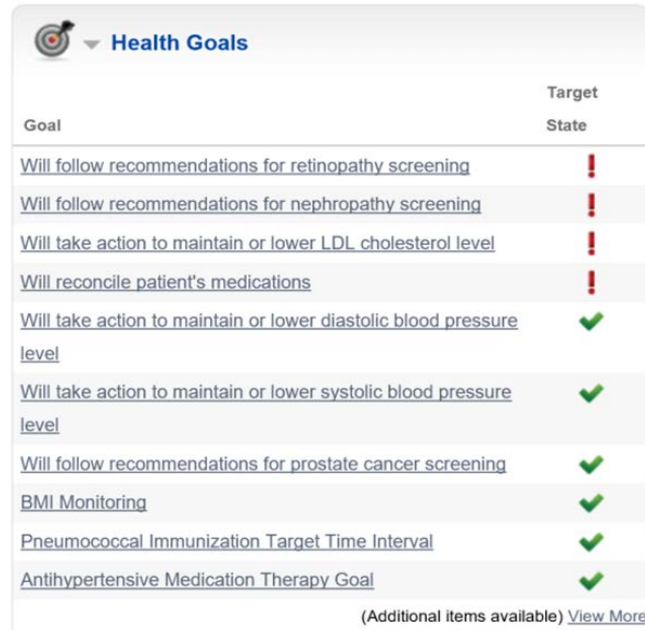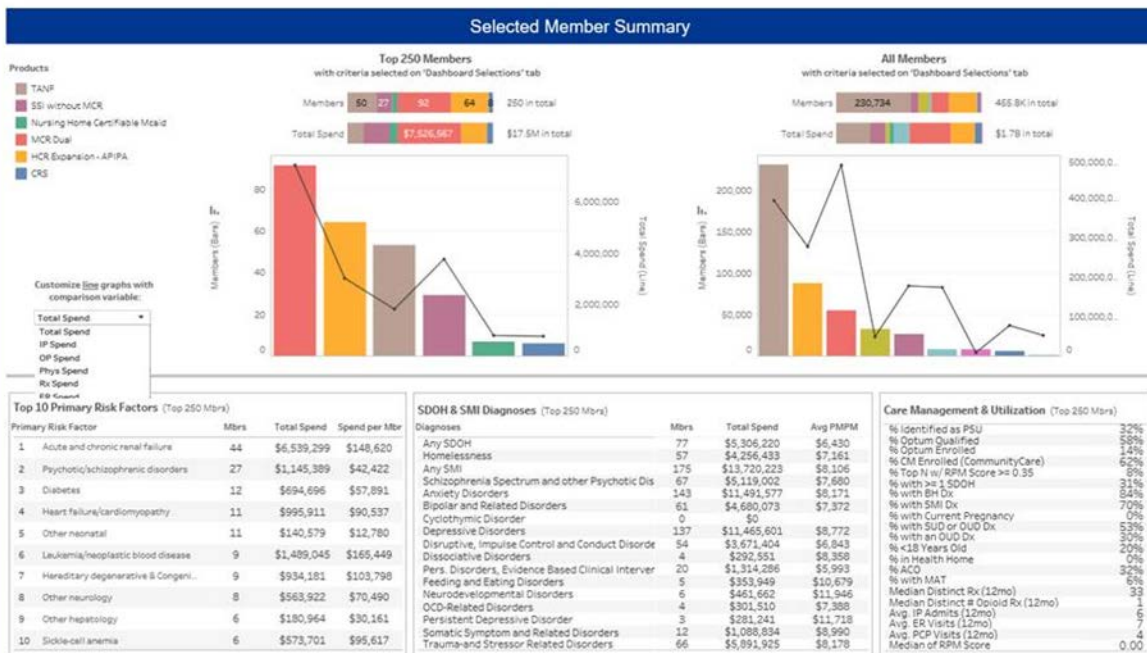

Figure 8. Enrollee Summary. This view summarizes statistics for cohorts of enrollees using filter criteria determined by the user. The view provides information such as the top 10 risk factors, SDOH and serious mental illness diagnoses and identifies care management utilization statistics within the cohort, such as the percentage of enrollees with an opioid prescription and average inpatient admissions.

- **Individual Health Record (IHR).** The IHR simultaneously compiles and translates disparate data sources from the last three years of an enrollee's medical history into a single consolidated view. It transforms how enrollees, providers and care managers

access and take action on an enrollee's health and health care data. The value of the IHR lies in its ability to combine clinical intelligence from data feeds into a single, complete, secure and easily digestible record. The information becomes meaningful and useful for providers, care managers and enrollees alike.

- **Predictive Housing Instability Tool.** We recognize the importance of housing security. We connect enrollees who are homeless and are experiencing housing insecurity with the necessary supports by using our housing navigator and our Housing + Health program. We also take active steps towards prevention by identifying early risks factors for housing instability so we can promptly intervene to help our enrollees avoid the catastrophic loss of their home. This predictive data tool applies 21 variables from nine

Figure 9. IHR Health Goals Portlet – Provider View. The Health Goals Portlet suggests actions based upon the individual's health record history. The language used in the tool adapts between provider and patient view (e.g., a reference to hypertension in the provider view would change to high blood pressure for a patient), but the easily readable indicators remain to quickly demonstrate whether the individual has already met a given goal or action should be taken.

different state and national data sources onto our enrollee data to identify individuals exhibiting a high probability of housing instability rate.

- **Predictive Social Isolation Tool.** While we encourage enrollees to engage social supports as a component of addressing their health and wellness holistically, many enrollees lack an informal support system. This data tool uses 30 different data points to determine an individual's risk of social isolation, which correlates with depression and other behavioral health conditions. It can serve as a powerful tool to pinpoint enrollees who may benefit from connections to behavioral health services to address untreated mental illness.

Driving Outcomes and Sustained Engagement

When fueled by the right information, meaningful enrollee engagement results in improved health outcomes and empowered individuals engaging in their health and health care. Our PMH program is built on a data-driven analytical model and supported by technological tools, which identify health and wellness, emerging risk, chronic and complex membership. We use our advanced analytic tools to select from a variety of enrollee engagement modalities, evidence-based programs and care coordination approaches to deliver individualized interventions to our enrollees. The following summarizes how our enrollee engagement programs vary by intensity level to deliver a

Judy was living with dementia, COPD, diabetes and coronary artery disease. She had been to the ED 10 times in 2 years for preventable health issues.

After engagement with the multidisciplinary care team, Judy has learned warning signs for her conditions and when to contact her PCP. As a result, the number of ED visits and admissions have been reduced drastically.

– Judy, 78, Clarksville, Tennessee

customized and effective intervention to each enrollee:

- **Innovative care management, including direct provision of care.** Typical care management programs use teams with multidisciplinary clinical backgrounds to *inform* how the team manages high need individuals. Our transformative model, developed from our experience across multiple states, uses a MCT, which ***includes practicing medical and behavioral health clinicians working alongside care managers.*** Kentucky-based, UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) direct care providers will simultaneously serve as members of the care management team while providing primary and behavioral health care to our most complex enrollees at home. These regionally based teams will amplify the positive effect of care management because the direct care providers and care managers will work with the enrollee using a shared care plan to achieve shared goals and outcomes. In Tennessee, our enrollees who received care from this model experienced a 13% reduction in medical, surgical and intensive care unit admissions per 1,000 and a 16% reduction in ED visits per 1,000 within the first year.

- **Availability of on-demand care to avoid care in costly settings.** When someone experiences a moment of crisis, equipping them with appropriate on-demand resources is critical to stabilize the situation. Among our Kentucky enrollees in rural areas, including those who have visited an ED two or more times in one year, we will promote the UnitedHealthcare Doctor Chat capability. This program allows enrollees to initiate a virtual visit with an emergency medicine physician, board-certified and licensed in Kentucky. This innovative, chat-first workflow facilitates barrier-free access to care in 90 seconds or less to meet our enrollee's immediate need. In addition to the chat-based approach, this program differs from other virtual visit solutions because the providers want to understand thoroughly the enrollee's health concerns rather than addressing only the immediate need. The average encounter duration is 18 minutes. Visits not resolved through secure chat can be escalated to telephone or video. Ultimately, ***UnitedHealthcare Doctor Chat is able to resolve 90% of Medicaid enrollee issues without having to refer the individual to in-person care***.

- **Education to enable and encourage self-study.** Knowing each of our enrollees will look for and consume information through multiple channels, we provide information on prevention, healthy activities and self-management for a range of physical and behavioral health conditions. This information is easily accessible through our Welcome Kit; *Member Handbook* and other materials; through our member portal, *myuhc.com*, accessible via computer or a mobile device; and through additional online platforms, such as *liveandworkwell.com* and On My Way. We also have the opportunity to mail enrollees targeted disease management materials based upon their individual care needs. By equipping enrollees with the tools and resources they need to self-manage, we set them on a path towards sustained health and wellness.

Supporting Providers and Community Partners in Pursuit of Common Goals

We recognize the pivotal role of providers and community partners in supporting our enrollees' pursuit of improved health outcomes. By creating strong partnerships throughout Kentucky, we invest into our enrollee communities, better equipping them to pursue health and wellness. The practices and partnerships herein provide a snapshot of how we are building upon innovative collaborations with provider and community partners to improve health outcomes for our enrollees.

- **Care philosophy trainings.** To promote integrated care, we offer and encourage participation in care philosophy trainings for all UnitedHealthcare employees and provider partners. Our care philosophy emphasizes trauma-informed approaches and the importance of authentic healing relationships between organizations and the individuals they serve to foster behavior change. These trainings anchor our approach in person-centered care and establish a philosophy, distinctive for a company of our size, which serves as a guide for individuals and systems serving our enrollees.

- **Kentucky Regional Extension Center (REC).** We partnered with Kentucky REC (Spring 2019), to educate provider practices in Hazard and Bowling Green on evidence-based practices for diabetes and opioid use disorder (OUD) treatment. By supporting the dissemination of best practices among Kentucky's local practitioners, we improve providers' ability to change outcomes positively not only among future UnitedHealthcare enrollees, but also among all Kentuckians, these providers serve.

- **Kentucky Rural Health Association (KRHA)**. Working to increase provider awareness of effective treatment for hepatitis throughout the Commonwealth, we partnered with the KRHA on their 2019 annual meeting. To move from discussions about hepatitis treatment to action, we connected KRHA with Walgreens to explore using the Walgreens Connected Care Hepatitis C approach in their southeastern Kentucky retail pharmacy locations.

- **University of Kentucky and Kentucky Diabetes Network workgroup**. Recognizing the toll diabetes has taken across many Kentucky communities, we are partnering with the University of Kentucky to support the availability of the evidence-based national Diabetes Prevention Program across underserved regions in Kentucky, including Knox, Muhlenberg, Scott, Washington and Whitley. The current focus of this pilot centers on communities with diagnosed diabetes prevalence rates higher than the state and national averages to make sure this partnership has a meaningful impact.

- **Boys and Girls Club Glasgow.** Our innovative endeavor with the Boys and Girls Club in Glasgow embodies the sentiments of "meeting people where they are." Recognizing the limitations of engaging enrollees solely through the health care system, along with the reality of provider shortages in certain communities, we collaborate with a wide range of community-based organizations serving our most vulnerable populations. Because of our partnership with the Boys and Girls Club, children in after-school care can receive behavioral health visits enabled by tele-technologies. This flexible approach allows children to receive timely treatment of behavioral health conditions in a convenient setting instead of waiting months if they live in underserved communities with challenges accessing behavioral health services.

> We incorporate the culture of **trauma-informed care** into all of our interventions and care management. Our care teams are trained in evidence-based practices, such as trauma-informed care, adverse childhood experiences (ACEs), in addition to other principles like motivational interviewing, harm reduction, positive psychology and person-centered care into the care management process.

> "We believe UnitedHealthcare spouses the central tenants of the KDN Mission: Make Kentucky the best state for those affected by diabetes."
>
> —Terry Gehrke, Executive Director, Kentucky Diabetes Network

These partnerships are the first of many opportunities to pilot innovative, evidence-based programs in Kentucky's communities.

ii. If the Contractor, holds NCQA PHM Accreditation, describe the Contractor's implementation of related models, lessons learned, challenges and successes.

Since July 2018, NCQA has surveyed 40 accredited entities associated with UnitedHealthcare health plans, including six accredited Medicaid entities and 32 accredited Medicare entities. Each of these accredited entities was found to have PHM strategies and activities 100% adherent to NCQA requirements. One example includes the Medicaid program in the neighboring state of Tennessee. Each accredited entity incorporates the model required by NCQA and spans the continuum of care: keeping enrollees healthy, managing emerging risks, assisting enrollees with transitions of care and managing enrollees with multiple chronic conditions.

Our overarching PHM strategy supports the Triple Aim of promoting health outcomes, improving enrollee experience and reducing per capita health care costs. Programs for each risk level are designed to address the needs of the underlying population and include measures focused on one or more of the objectives of the Triple Aim. We embrace continuous quality improvement by evaluating our performance on these key measures compared to our goals and engaging in rapid cycle improvement to make certain we achieve our goals. In addition to our PHM programs that support our enrollees across the continuum of care and at various risk levels, we also implement complementary value-based payment (VBP) models to support our provider partners in their transition to value-based care.

Our VBP models reinforce and promote best practices regarding prevention, health and wellness, HEDIS and complex care. They also promote overall population health. Our extensive experience building VBP models within PHM in a variety of states has taught us that value-based care requires a customized approach based upon the providers' needs and readiness to take on risk. We will deploy VBP as a critical tool to engage providers in implementing our comprehensive PHM strategy by incentivizing providers to improve outcomes for our priority populations. For example, our OUD VBPs incent providers to deliver high-quality medication-assisted treatment (MAT) services, which will help decrease opioid overdoses among our OUD priority population.

One of the challenges of implementing a comprehensive PHM strategy for our enrollees' holistic needs is limited knowledge of the social determinants of health (SDOH) present in the populations we serve. To address this challenge, our leadership took initiative in partnering with the American Medical Association to adopt a long-term strategy to capture administrative data reflecting SDOH. Healthcare Innovation recently recognized these efforts with receipt of the 2019 Innovator Award. We will apply these new codes in Kentucky by encouraging providers to start using ICD-10 codes that capture SDOH, such as homelessness and food insecurity, in their billing. Our data analytics tools, including Hotspotting, will use this SDOH data to improve our understanding of the distinct SDOH needs of our enrollees and pinpoint patterns of SDOH needs across priority populations and regional variations, which we will incorporate into our PMH strategy.

As we continue to implement our PHM approach in Kentucky, we will apply lessons learned and new insights to foster continued quality improvement and adoption of innovations to support our enrollees, providers and communities achieve better health.

iii. Plan to ensure high levels of Enrollee participation across all priority populations and conditions, including innovative methods for contacting and engaging Enrollees to initiate completion of Health Risk Assessments and Enrollee Needs Assessments.

Completing the new enrollee Health Risk Assessment (HRA) and the Enrollee Needs Assessment (ENA) in a timely manner is critical to identifying and engaging enrollees who may benefit from care management and PHM services tailored to their needs. Yet, managed care organizations traditionally face barriers contacting and engaging enrollees. To overcome this potential barrier, we have a dynamic approach to obtaining up-to-date enrollee contact information. Building upon our deep experience serving Medicaid enrollees and our advanced data capabilities, our process to gain high completion rates of the HRA and ENA are contained in the following table:

> We bring to Kentucky experience and lessons learned deploying comprehensive HRAs and ENAs in 25 states.

Process for High Completion Rates for HRA and ENA	
Step 1	**Data Sources**
We strategically obtain and apply data to confirm accurate enrollee contact information from multiple data sources.	▪ 834 File ▪ Reconcile enrollee contact discrepancies using our Community Strategy Platform ▪ Individual Health Record ▪ Hotspotting data to identify recently visited pharmacies and providers
Step 2	**Outreach Methods**
We use a multi-modal approach to outreach and engage enrollees, including varying the time and type of outreach.	▪ Hospitality, Assessment and Reminder/Retention Center (HARC) outreach includes autodial (for every number on file) and live outreach ▪ Member services advocate (MSA) warm handoffs to HARC ▪ Specialized outreach to priority populations (e.g., maternity) ▪ In person completion by CHW ▪ Online reminders ▪ Paper copies available at community-based organizations

Based upon our average HRA screening rate across all states and our strategies to obtain enhanced enrollee contact information, we anticipate our HRA screening rates will be at least 30% in Kentucky. Once we identify enrollees, our HARC team will make three attempts to complete the welcome call and HRA within 30 days of enrollment, calling at different times of day and on different days to improve success. This is paired with five attempts (for each phone number on file) to auto-dial the enrollee. Our MSAsare trained to complete warm hand-offs to HARC when speaking to enrollees without a completed HRA. Among enrollees reached telephonically, our monthly HRA completion rates are as high as 94%.

> We will build upon our past experiences in Virginia to help identify hard-to-reach enrollees in Kentucky by searching for them with our Hotspotting tool. Then, engaging providers and pharmacies listed in their recent history to locate them. In Virginia, 18% of enrollees were located in the first month of using this approach.

In addition to the channels available for the HRA, we employ more intensive outreach for ENA completion and have experience conducting screenings for 100% of enrollees in care management. Our team of local CHWs locates enrollees for whom we do not have accurate

information. We partner with community-based organizations, including social service agencies and faith-based organizations, to remind enrollees to complete the assessments and to distribute paper versions of the assessments.

To bolster HRA and ENA completion rates, we send text message reminders to enrollees to complete their assessments. We collaborate with Accountable Care Organization (ACO) providers like Kentucky Primary Care Association (KPCA) and providers like Baptist, with whom we have a Letter of Intent committing to a shared savings arrangement. This permits us to engage in conversations regarding HRA completion rates and share data to help promote HRA completion as they are focused on population health and overall enrollee health outcomes. This collaboration can be effective given the volume of Medicaid enrollees assigned to these ACO practices.

Priority Populations and Conditions

To truly drive the necessary behavioral changes to lead to sustained health and wellness, we engage enrollees as participants in, not as bystanders to the process. We create partnerships with enrollees, engage them in care and enable them to manage their health proactively by using a nimble, trauma-informed approach that meets each enrollee's preferences, needs and circumstances. Our approach to enrollee engagement uses multi-modal outreach. This includes telephonic and in field touchpoints, mailings and text-based approaches and methods to address geographic limitations (e.g., limited or no broadband access), which inhibit technology-based solutions and underscore the lack of rural providers in certain locations. The following table summarizes the diverse ways we engage enrollees with priority conditions:

Priority conditions,* populations	Specialized enrollee education	Specialized self-management tools	Targeted outreach	Engagement program
Asthma	✔			
Heart Disease	✔	✔		✔
Diabetes	✔	✔	✔	✔
Obesity	✔	✔	✔	✔
Tobacco use	✔	✔**		✔**
Cancer	✔		✔	✔
Behavioral health and substance use disorder	✔	✔	✔	✔
High Risk Pregnancies	✔		✔	✔
Adults and Children with Special Health Care Needs	✔		✔	✔
*Our high-risk pregnancy program includes engagement of pregnant enrollees who have higher risk for the priority conditions of infant mortality and low birthweight. **Specialized tobacco cessation program limited to pregnant women with OUD				

We use a customized approach to maintain engaged enrollees by "meeting them where they are" in their continuum of health care. While the PHM program holds particular importance among priority populations and conditions, our PHM program includes engagement efforts that foster partnership with our enrollees regardless of risk level or condition.

iv.   The Contractor's approach to each of the three PHM Program defined risk levels: health promotion and wellness, management of chronic conditions, and complex care management. Include information about the following for each risk level:

Consistent with contractual requirements in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 34.1, Program Overview, and our company's mission to help people live healthier lives, we strategically deploy our integrated services model to encourage people to adopt healthy and preventive behaviors, move toward self-management and adherence to their individualized care plan, close care gaps, increase engagement rates, improve quality of life and decrease inpatient and ED utilization. We help maximize individuals' independence within the community by using integrated support services and care coordination. Among each of the three PHM program defined risk levels, we use innovative, person-centered approaches and interventions to address medical and non-medical drivers of health while reducing inappropriate utilization and costs. Details on our approach are included in the following subsections.

a. Tools the Contractor will use to identify Enrollees and their risk levels and to support services provided.

The strategic use of data provides the backbone of how we engage our enrollees. Generally, the information tools we use to identify enrollee risk levels and subsequent service tiers anchor in the HRA and ENA, though additional assessments are used to stratify priority populations (e.g., pregnant women). We run our risk stratification tool on a monthly basis to reassess our enrollees to account for frequent changes in health status and adjust support services accordingly.

Even the most sophisticated tools may misidentify certain enrollees' risk levels because of claims data lag or lack of historical health information. Our program uses informational tools like our risk stratification system together with more direct mechanisms, such as direct referrals from enrollees, our provider partners and MSAs. Applying the insights and perspectives of our teams who directly hear from, listen to and engage with enrollees enables our risk identification strategies to account for nuances, which can be lost in data analytics.

> "I am confident that UnitedHealthcare's experience and depth of services as a provider of health benefits helps us provide our patients with the best possible healthier and wellness care."
>
> — Shelly Gast, System Vice President, Norton Healthcare

Tools to Identify Risk Levels

To identify additional risk levels among subpopulations, including those experiencing a care transition or pregnancy, we use the following tools:

- ***Tools used to assess risk of readmission.*** We identify enrollees at risk for readmission using multiple tools. Our **readmission predictive model (RPM)** supports our discharge planning and transitional care management programs for enrollees who have experienced an inpatient admission. This predictive modeling algorithm generates a risk score, which estimates the probability that, for a given admission, an enrollee will be readmitted within 30 days of discharge. The algorithm analyzes the enrollee's age and sex, several elements from the current admission (e.g., admitting diagnosis, length of stay and whether the admission itself was a readmission) and elements from the enrollee's claims history. Our **risk scoring tool (RST)** supports our discharge planning and transitional care management programs through predictive assessment. The RST identifies enrollees who are at risk for readmission when the RPM has not already triggered them for an intervention. The assessment comprises a series of eight questions addressing the enrollee's hospitalization history, age, current length of stay,

diagnosis, clinical condition, complexity of discharge needs, mental health status and medication use. The inpatient care manager (ICM) scores the assessment, which is positively correlated with risk of readmission.

- ***Predicting the likelihood of an enrollee being influenced by care management.*** Our integrated care management identification and stratification model, **Impact Pro**, uses claims and clinical data to identify enrollees who are most likely to benefit from care management. This tool provides a score for clinical risks (such as high inpatient utilization and costs, high risk of readmissions, multiple ED visits, multiple chronic conditions, mental illness or substance use disorder [SUD] comorbidity) and a score for opportunities for impact (such as a new diagnosis of chronic disease, medication non-adherence, or social needs such as economic or housing instability for each enrollee). These scores provide realistic criteria and inform the stratification of enrollees into different care programs providing the types of evidence-based interventions most likely to influence the enrollee.

- ***Tools to assess risk during pregnancy.*** Our **Maternity Initial Risk Evaluation** serves as the initial assessment used by non-clinical care team enrollees when a pregnant enrollee has not already been identified as high risk through other means (e.g., claims analysis, information provided through the HRA). Our **Healthy First Steps Clinical Assessment** provides a more thorough assessment of pregnancy risk completed during a nurse's initial outreach to enrollees.

- ***Tools to predict patterns of behavior affecting health risk.*** We recognize the importance of stable housing and social supports among our enrollees. To prevent our enrollees at risk of homelessness or social isolation from these destabilizing situations, we rely upon advanced data analytics using state, national and internal data to identify early predictors and to intervene with supports as necessary.

Tools to Support Services

Each of the previously mentioned tools identifies various aspects of our enrollee risk levels. Having these detailed insights on the conditions and utilization patterns of our enrollees and their predictive levels of care for the future enable us to identify and connect them to requisite support services that can mitigate risks for future utilization or adverse events. Once an individual's risk level is identified, the information triggers an entry into a queue in *CommunityCare*, our care management platform. This enables our care teams to begin outreach and support for a given intervention (e.g., transition stabilization, housing supports and disease management outreach). If the enrollee requires support for social determinants of health, our Healthify tool provides a library of resources available within each Kentucky community. Using this resource directory, our teams can connect enrollees to community-based organizations for a full range of support services.

b Risk stratification methodology and descriptions of the types of data that will be used.

Our population identification and stratification approaches use Impact Pro, an enrollee-centric modeling system with an integrated view of an individual's care history, their likelihood for near term acute events and opportunities to drive stability and approve their overall health and wellness through evidence-based practices. Its stepwise approach to understand enrollees as they are today and to predict risk for future events allows us to identify cohorts of enrollees for outreach and specific interventions. By taking into account multiple dimensions of an enrollee, we are positioned to outreach with the highest likelihood to influence improvement.

High Level Risk Stratification Methodology		
Step	**Action**	**Description and Types of Data Used**
1	**Analyze data**	Understanding an individual requires the review of various sources of data: ▪ System-reported (medical, behavioral and pharmacy claims, ADT and KHIE), ▪ Clinical information (lab results, biometric data) ▪ Self-reported data (social determinants of health, HRAs) Using multiple sources of data bolsters our ability to identify individuals for engagement at the appropriate level of care.
2	**Categorize entire population into profiles**	By segmenting populations into profiles, we are able to analysis individual risk with an eye towards priority populations and conditions in Kentucky (e.g., maternity, individuals with serious mental illness).
3	**Calculate each individual's clinical risk score**	We assign each individual a risk score based upon their clinical, behavioral and utilization characteristics. Risk scores take into account an enrollee's conditions and their severity, event history, likelihood of future events and relevant demographics (e.g., age) that might predict future adverse events.
4	**Calculate each individual's actionable opportunity score**	We determine an individual's actionable opportunity score by the number of opportunities they have to improve their health based upon medical, pharmacy, behavioral health and social characteristics. The types of opportunities considered include compliance with evidence-based practices, gaps in care and medication-regimen improvement opportunities.
5	**Combine both risk scores to identify highest impact enrollees**	Create a matrix combining an individual's clinical risk with their actionable opportunity score to identify enrollees with the most need and highest opportunity for improvement.
6	**Prioritize outreach based upon opportunity for impact**	With an individual's population profile and overall impact score, our care team is able to prioritize outreach for care management and connections to special interventions and programs that will most closely meet enrollees' needs

The following figure illustrates how Impact Pro uses multiple data inputs, identifies key factors to signal an enrollee's risk level and then weights these factors to predict an individual's risk profile.
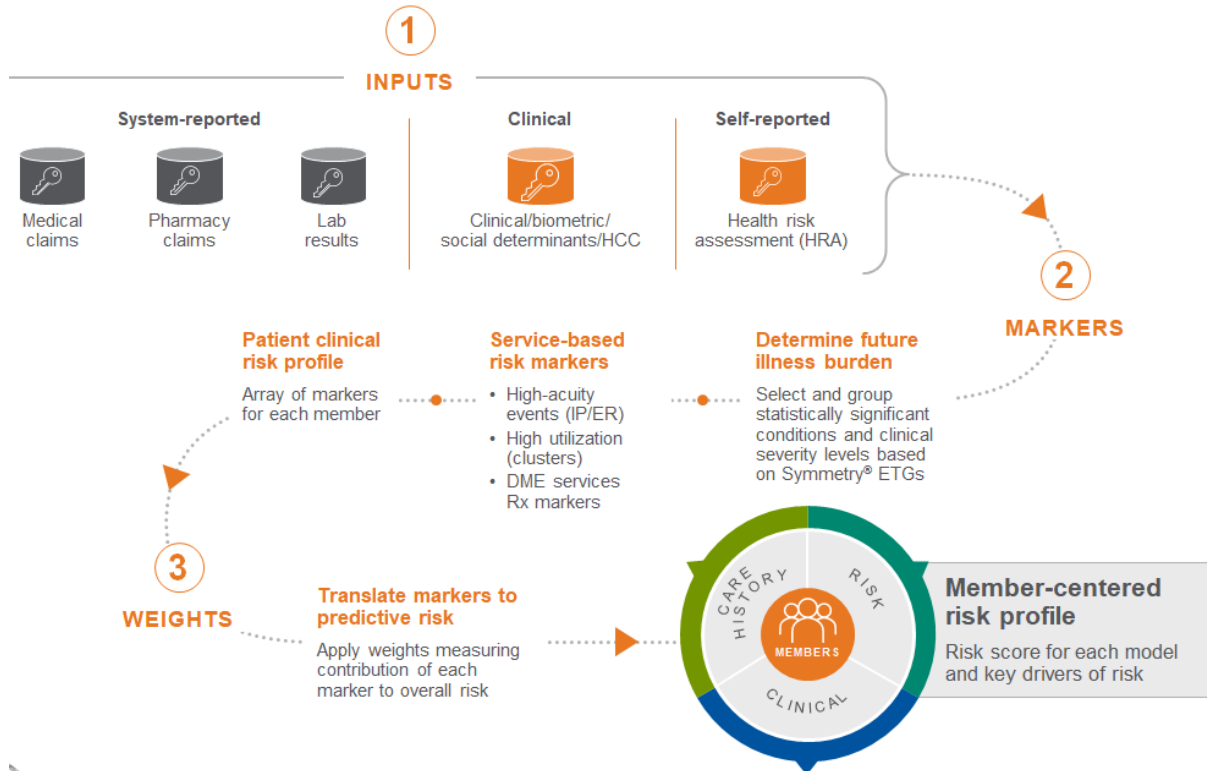
Figure 10. High-level Depiction of Impact Pro's Risk Process. Our Impact Pro tool uses claims, laboratory, biometric and social determinant data to identify enrollees with priority conditions and the priority populations most likely to benefit from care management because they have both clinical risk factors and manageable opportunities to improve their health.

In addition, certain populations require special stratifications. To have an effect on the opioid epidemic, for instance, we have designed specialized methodologies for stratifying risk levels among individuals with OUD.

- **OUD Identification.** Identification of enrollees with SUD/OUD, including those at risk, is essential to connecting them to treatment and resources that meet their specific needs as soon as possible. In addition to our enrollee screening tools and provider education efforts to increase screening for SUD/OUD, we have use clinical and analytic insights gained across our enterprise, to develop claims-based reporting and our Hotspotting tool. These allow us to identify and engage those approaching an at-risk status, along with those high risk enrollees who need immediate connection to evidence-based care (e.g., recent overdose, inpatient with an OUD-related complication such as endocarditis, pregnant women with OUD and those with recent detox and no evidence of MAT). When we identify these individuals, we work diligently to make sure our enrollees struggling with OUD are connected to the right care management supports and a care team tailored to meet an enrollee's individual needs as early in the process as possible.

- **Pregnant with OUD Identification.** Pregnant women who are using opioids represent a significant concern and an acute opportunity to reduce harm and improve outcomes for both mom and baby. Our Hotspotting tool includes an algorithm, which allows us to identify pregnant enrollees who are at elevated risk for delivering babies with Neonatal Abstinence Syndrome. This identification lets us link them to appropriate and enhanced care management, prenatal care and behavioral health services, including MAT. By identifying these enrollees in a timely manner and making sure they receive proper care, we are making great strides in improving health outcomes for pregnant mothers and their babies in Kentucky.

c. Methods to identify Enrollees for each of Kentucky's priority conditions or populations.

Applying information and technology allows us to tailor our interactions with enrollees to meet their needs in an effective, person-centered way. We use a number of methods to identify priority conditions and populations. By layering additional analytical capabilities onto these tools, the identified populations can be stratified further to their appropriate risk level.

Our Impact Pro tool uses claims and clinical data to identify enrollees in the priority conditions and populations most likely to benefit from care management because they have both clinical risk factors and manageable opportunities to improve their health. The tool integrates data from the HRA to confirm clinical conditions, behavioral health conditions, social needs and functional status are incorporated into the risk stratification. In addition, Impact Pro updates the risk stratification monthly with admission, discharge and transfer (ADT) feeds to verify inclusion of an enrollee's most recent ED and inpatient hospital utilization and to identify enrollees in crisis who are becoming complex with multiple hospitalizations in short periods of time.

An integrated health profile is created for each enrollee and includes an overall risk score, physical and behavioral health diagnoses, assessment results, claims history, care team members, gaps in care and other key characteristics about the enrollee. This information gives care managers, providers and other members of the care team comprehensive view of each enrollee's specific needs.

	Asthma	Obesity	Diabetes	Tobacco Use	Heart Disease	Cancer	Behavioral Health and Substance Use	High Risk Pregnancies	Enrollees with Special Health Care Needs
Impact Pro Tool. This analytic tool uses claims data, clinical data, HRA data and ADT feeds to identify enrollees in the priority conditions and populations who are most likely to benefit from care management.	✔	✔	✔		✔	✔	✔	✔	
HRA/ENA. These assessments collect key information from enrollees to inform risk level and care planning.	✔	✔	✔	✔	✔	✔	✔	✔	✔
Claims. Proactive analysis of claims can yield timely insights on enrollee conditions.	✔	✔	✔		✔	✔	✔	✔	✔
ADT Feeds. Integration of real-time hospital data provides information on enrollees at acute points of care.	✔	✔	✔		✔	✔	✔	✔	
CommunityCare. Our care management platform enables information storage and exchange relating to enrollees' conditions, goals and care plans. Information can be applied to identify priority populations and conditions.	✔	✔	✔	✔	✔	✔	✔	✔	✔

Complex Care Management

We use our Impact Pro tool to identify our most complex enrollees with clinical, behavioral health, social and functional needs and who have the highest inpatient utilization since we view almost all inpatient utilization as preventable and as an opportunity for impact. We incorporate

clinical risk factors, such as the presence of multiple priority chronic conditions and multiple medications, multiple ED visits and polypharmacy to make sure we target the enrollees with the highest clinical risk. In addition, we capture opportunities for impact such as medication non-adherence and social needs like economic or housing insecurity.

By using ADT feeds, we can identify complex enrollees in real-time so they can be engaged at the hospital bedside while admitted or in the ED.

We evaluate our risk stratification approach to make sure we have an impact on the enrollees we identify and provide complex care management to so they experience improved clinical outcomes and decreased inpatient utilization and costs because of the intervention. The results of our evaluation inform regular updates to our risk stratification approach as we adapt our tool to meet the particular needs of our Kentucky population.

Management of Chronic Conditions

We also use Impact Pro to identify the population with priority chronic conditions and at risk of chronic conditions. Clinical risk factors such as gaps in evidence-based care, multiple medication adherence opportunities and lack of primary care office visits are incorporated. Opportunities for influence, such as new diagnosis of asthma, diabetes, heart failure and coronary artery disease; medication non-adherence; and economic or housing insecurity are also integrated. We are responsive to referrals from providers, enrollees, families and caregivers when prioritizing enrollees for care coordination.

We will continue to refine our risk stratification approach in Kentucky as we collect additional data on our population to make sure we are identifying the enrollees with the most opportunity for assistance with chronic conditions who will respond to the targeted, evidence-based interventions in our PMH program.

Health Promotion and Wellness

Although Impact Pro is used primarily to identify populations that would benefit most from care management, it can also be applied to identify those individuals who require more routine investment in health and wellness. In addition to using Impact Pro, we will monitor our enrollee population and regularly analyze our claims data for utilization and demographics to help identify and outreach healthy individuals who are missing a recommended annual exam or preventive service, such as a mammogram, cervical cancer screening or colon cancer screening.

d. Services and information available within each risk level.

Complex Care Management

INNOVATE

To meaningfully affect the outcomes and care experience among our highest risk, highest need enrollees requires the most intensive and innovative approach within our PHM program. To rise to this challenge, we will deploy cross-functional care teams dispersed throughout Kentucky. These regionally based teams provide care management services for our most complex, high need enrollees. While multidisciplinary care management teams are a national best practice, our MCTs distinguish themselves in the quality of trauma-informed care management they provide and their capability to provide direct medical and behavioral health care to our enrollees until they stabilize and can be reconnected to a PCP in their community.

Building upon our experience in telephonic and in-person care management, our model of care in Kentucky will include clinicians providing comprehensive physical, behavioral and functional assessments in the home of our enrollees and in conjunction with their local providers in offices

through a collaborative model. A PHM team who will provide ongoing case management and disease management support to meet the individuals' complex needs will support this team. This capability has immense value to support enrollees stabilizing after an inpatient hospitalization and for enrollees who are unable to receive care in their community because of unresolvable access issues, functional impairments, or other barriers. The ability for our care teams to dually perform care management and care delivery heightens our ability to wrap services around the enrollee and make sure we meet their comprehensive needs during their most vulnerable periods.

Each team will include a nurse practitioner, behavioral health clinician, a clinically trained care manager (i.e., RN) and clinical administrative coordinator. The direct providers will not supplant the role of an enrollee's PCP, but rather fill gaps, quickly stabilize the enrollee after a care transition and ultimately transition the enrollee to community providers under the continued support of the enrollee's care manager. The enrollee, their providers and specialists in the community and their designated enrollee caregivers will be invited to attend MCT meetings where the individual's care plan will be developed. The enrollee will continue to receive care management from the MCT until their needs are met and they are no longer identified as high risk with open gaps in care. The nurse practitioner and behavioral health clinician will engage only when the provision of direct care is appropriate, thereby using the care team's resources effectively.

The care team will provide three main service types for our complex care management populations:

- **Care coordination and supports.** Services include pre-discharge engagement, case management, assistance navigating the health care system and receiving health care services, telephonic support and identification of physical, behavioral and social needs with connection to appropriate resources and care planning development.
- **Short-term stabilization.** Services include post-discharge transition support, medication reconciliation, disease education, short-term direct care, HEDIS gap closure, collaboration with community providers for continuity of care and ongoing monitoring.
- **At-home primary care, behavioral health or specialized services.** Services include at-home primary care, individual therapy, family therapy, psychiatric consultation, palliative care, MAT services and SUD counseling.

To achieve the best outcomes for our homeless complex enrollees, we will implement the Housing + Health program alongside our multidisciplinary care teams (MCTs). This nationally recognized program will support our enrollees who are persistent health care users and are struggling with homelessness, addiction and transitions from incarceration. The Kentucky Housing + Health team will use the Hotspotting tool to identify subgroups of the most complex enrollees who are experiencing homeless. In addition, our Housing + Health team will use the ADT feeds to meet, engage and activate enrollees experiencing homelessness at the hospital bedside, in the ED, or at the shelters where they reside.

> Since October 2017, 248 high-risk, high-cost Medicaid enrollees have been housed in Arizona, Nevada, and Wisconsin through our Housing + Health program. This program decreased inpatient admissions and inpatient days resulting in a total cost of care reduction between 10% to 20%.

The social workers and nurses in the MCT will work with the enrollee to navigate toward housing, which will be provided by UnitedHealthcare at low or no cost for 12 months. Over the 12-month program, we will focus on helping the enrollee find safety, stability and move forward in life. This involves motivational interviewing, positive psychology and purpose

development, which leads them toward employment, volunteerism and back to their families. We also help them gain access to social entitlements like long-term housing vouchers, waivers, Social Security income and food benefits (SNAP) to create long-term self-sufficiency.

UnitedHealthcare will initially pilot housing for 10 homeless enrollees in our complex care management program. We will share the results with the Commonwealth and use the results to inform future pilots and decisions about expanding the program.

Management of Chronic Conditions

Individuals with a chronic condition require an individualized set of supports and tools to help them self-manage their condition successfully and prevent future exacerbations. We recognize the critical importance of engaging enrollees who fall into this category. Examples of the types of tailored supports we offer include:

■ **Remote monitoring.** Equipping enrollees with evidence-based end-to-end remote care management for enrollees with diabetes, heart failure or COPD facilitates active self-management of chronic conditions. The Bluetooth-enabled devices facilitate the collection of biometric data, qualitative feedback to questions about enrollee health and needs. Participation in the program provides enrollees access to video educational tools to support further engagement in health. Vivify Health's results include readmission reductions over 65% and adherence and satisfaction levels exceeding 95%.

■ **Diabetes Prevention Program (DPP).** Linking enrollees with prediabetes with the most effective, evidence-based intervention to prevent diabetes. We will build on our existing partnerships with Kroger and the Kentucky Diabetes Network to provide access to DPP for our enrollees.

■ **Weight loss programs**. Connecting overweight and obese enrollees with group-based education, such as Weight Watchers, can support them in achieving their weight loss goals.

■ **Specialized disease self-management tools.** Empowering enrollees to manage their conditions including heart disease, diabetes, obesity, behavioral health conditions and SUD with evidence-based tools.

■ **Virtual visits to avoid unnecessary ED use.** UnitedHealthcare Doctor Chat is a chat-first workflow with barrier-free access to care in 90 seconds or less. Visits that cannot be resolved through secure chat can be escalated to telephone or video. Ultimately, UnitedHealthcare Doctor Chat is able to resolve 90% of Medicaid enrollee issues without having to refer the individual to in-person care. In addition to using this capability to improve access to care for enrollees in rural areas, we will promote this program to enrollees who have visited an ED two or more times in one year as a way of reducing medical costs driven by unnecessary ED visits.

■ **Targeted enrollee outreach to promote appropriate care.** In addition to specialized value-added programs, we recognize the value of routine care that encourages engagement with the health care system and overall self-management. We apply multimodal approaches to encourage individuals to use appropriate, evidence-based care and services aligned with clinical guidelines. This could include, for example, outbound calls to diabetic enrollees experiencing a gap in care. This call would not only remind the enrollee to engage in care, but could also

> "UnitedHealthcare has chosen to activate their sponsorship in a unique way — trying to find the root cause — reasons why, if you will — that Medicaid patients do not attend their initial wellness screenings."
>
> *— Joey Maggard, Executive Director, American Heart Association, Central Kentucky*

connect the enrollee to appropriate supports to schedule an appointment with their PCP.

Our CHWs will support enrollees with a chronic condition or at risk of a chronic condition who need care coordination by making sure they can access a PCP, connecting them with a tailored set of the evidence-based interventions influential in improving their health and coordinating receipt of supports to address their SDOH.

Health Promotion and Wellness

Information and services provided to enrollees who fall into this risk level focus on orienting and enabling enrollees to be proactive participants in their health and wellbeing, emphasizing prevention, early detection and overall healthy behaviors.

- **Targeted outreach to promote preventive care among adult and pediatric populations.** Among our low risk enrollees, we will foster sustainable wellness, which includes their continued engagement in preventive and routine care. We engage our enrollees with outbound phone calls as reminders to schedule routine appointments.

- **Proactive efforts to promote screening and early detection.** An aspect of wellness is early detection. Among our enrollees at increased risk for chronic conditions, we support their early screening and prevention. For example, to encourage high rates of colorectal cancer screenings, we outreach to eligible enrollees and offer an at home screening kit. For our younger Kentucky enrollees, our EPSDT coordinator will assume an active role in engaging them in preventive and wellness care.

- **Multimodal support.** Generally, we engage directly with enrollees at wellness events hosted at local community partners, through outbound text messages or mailers and through our MSAs. With each of these points, we promote sustained wellness through education on healthy and preventive behaviors.

- **Available resources:** In addition to our NCQA accredited NurseLine and Behavioral Health Crisis Line available to every enrollee, we provide enrollees with information based upon our member services model, *Advocate4Me. Advocate4Me* brings together person-centric services, supportive technology and enrollee communications that adapt to enrollee's risk level. *Advocate4Me* has two levels of MSAs available to support enrollees within the health promotion and wellness risk level and another, more highly trained MSA to support those individuals with chronic condition or complex care-management concerns (e.g., PHM risk stratified as complex).

e. Description of the care planning process, including methods to ensure individualized and person-centered care plans, and summary of how the Contractor will include Enrollees, their caregivers, and multi-disciplinary teams.

Although the Commonwealth of Kentucky does not contractually require care planning among lower risk levels, we accomplish a form of care planning in all of our enrollee engagements, regardless of risk levels, starting with our initial welcome call. We help enrollees plan and address needs and preferences identified during this call and use this as a platform to build upon for further care planning if an enrollees' risk level increases.
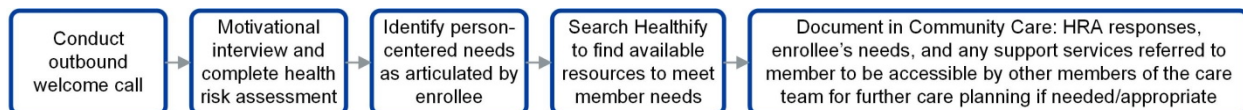
Figure 11. In every engagement with enrollees, we support them in identifying and accessing appropriate services. This form of care planning is threaded through all enrollee engagements, beginning with our welcome call.

Complex Care Management

Developing an individualized care plan with enrollee participation plays a critical role in how we support them in their path towards health and wellness. We empower our enrollees to drive the development process and actively participate in all aspects of care planning. This approach echoes our broader commitment to help empower enrollees as active participants in their health and health care. The enrollee's care manager, supported by the enrollee's PCP and MCT, advocates for the enrollee to make meaningful decisions about their health care needs and goals. The care manager works with the enrollee to develop a care plan supporting their needs and preferences. The care manager documents the plan and its progress as they help the enrollee achieve their expressed goals and desired outcomes.

By documenting the care plan in our *CommunityCare* platform, we create a single source of truth across the entire care team. This integrated, secure, web-based clinical care coordination platform facilitates the coordination of services by sharing vital enrollee information with the enrollee's care manager, MCT and enrollee. Having the capability to include real-time information and tools, the MCT can monitor the enrollee's progress toward achieving their goals, engaging in their health and sustaining long-term behavioral change resulting in improved health outcomes.

The MCT identifies care needs through a comprehensive assessment of the enrollee's physical health, behavioral health and SDOH. We review the assessment with the enrollee and together we develop a mutually agreed upon care plan. The person-centered care plan includes identified interventions and referrals for resources or specialized clinical consultation. The care plan is integrated and enrollee-driven with prioritized short- and long-term goals identified by the enrollee.

Figure 12. Care Planning Process. Using our care planning process, the care manager facilitates care plan development. The care plan includes social, behavioral health, medical and functional services and supports that meet the enrollee's needs and preferences and help the enrollee achieve their goals and desired outcomes.

The care plan is not static, but continually updated with the enrollee based upon changing needs and progress toward their goals. During each outreach, the care manager speaks with the enrollee about their health care and updates the care plan based upon identified or changing needs. Subsequently, the care plan is updated whenever an enrollee shows signs of deteriorating health, experiences a change in their health care status, or experiences an acute event such as a hospitalization. The updated care plan and progress can be accessed by the enrollee's PCP. Regular communication and feedback is provided to the enrollee regarding their progress toward care plan completion. The case is considered closed when the enrollee has completed the goals of the care plan and no new goals have been identified.

Management of Chronic Conditions and Health Promotion and Wellness

Engaging in care planning type practices before an enrollee requires complex care management may help to stop or prevent progression along the risk continuum. We anchor our enrollee interactions in person-centered approaches so we are positioned to care plan for enrollees' health and wellness goals better, regardless of their risk level. Among lower risk levels, we engage in individualized care planning by first identifying personalized information through:

- Assessments (e.g., health risk assessment, healthy first steps maternity assessment)
- Telephonic or in-person engagement with CHWs
- Analysis of health care utilization (e.g., identification of gaps in care)
- Review of priority conditions and risk factors (e.g., SUD use)

Equipped with this information, we are able to design a care plan and connect enrollees to interventions, services and supports based upon their individual needs. Among lower risk levels, the way in which we connect enrollees to appropriate care may differ, ranging from written, telephonic, or in-person outreach. Regardless of the form of the outreach, information surrounding individuals' needs and our plan to help address them are documented in *CommunityCare*. To the extent an enrollee wishes to create a more formal care plan and engage their caregivers or other members of their care team in the planning process, our MSAs have the ability to directly refer them to a CHW who can assist.

Care Planning Activities for Enrollees in Lower Risk Levels of our PHM Program
An example of how we engage in care planning type activities for enrollees stratified into lower risk levels of our PHM program (management of chronic conditions; health promotion and wellness) is illustrated in our response to Use Case 2 (Section 29 Use Cases) about a hypothetical Kentucky enrollee named Katy who lives in Bowling Green, Kentucky. In the scenario, 20-year-old Katy calls our *Advocate4Me* member services call center after a trip to the urgent care center. Katy speaks to a one of our MSAs who is specifically trained to address complex needs. Hearing that a change in Katy's health status has prompted the call, the MSA conducts an HRA, which populates Katy's needs and goals in *CommunityCare*, our care management platform. Our HRA incorporates questions from key clinical guidelines and touches on Katy's experience with health and health care; social determinant concerns, such as food, housing and transportation; and any diseases or conditions she is managing. This information is vital to the development of Katy's person-centered care plan and is available for care management staff to review. Based upon information Katy shares, our MSA can refer her directly to care management for care planning and support for her obesity and risk factors for diabetes and hypertension. In Katy's case, we connect her to a locally based CHW who will support Katy with care coordination and care management activities. Because Katy's CHW lives in or nearby Bowling Green, she can offer Katy additional support with an intimate understanding of available community resources. Together, Katy and her CHW, along with her chosen care team, develop a care plan with stated and measurable goals and interventions to help Katy achieve her

objectives: lose weight, avoid the ED and maintain positive lifestyle habits. Katy's care plan is dynamic and continually updated as she achieves goals, identifies new ones, or as her needs change. From the moment Katy calls our MSA team, she receives person-centered education and support to help her reengage in her health care and improve her health. We connect her with both online materials and in-person, group-based education to equip her with the knowledge and confidence she needs to self-manage her conditions.

f. Stakeholder engagement strategies, including involvement of community resources to meet social needs.

Strong partnerships with Kentucky's community-based organizations enhance our ability to successfully engage our enrollees in their health and wellness. As trusted resources for our enrollees, these community partners provide valuable opportunities for engagement outside of traditional health care settings. By investing in and collaborating with local stakeholders, we can extend our population health strategy even further. In so doing, we achieve our goal of creating systematic change to make good health the standard upon which Kentucky grows. Strategies to engage stakeholders and draw upon community resources to support access and meet the social and health care needs of our enrollees by risk level are described in the following table.

Stakeholder Engagement Strategies and Impact by Risk Level			
Engagement Strategy	**Health Promotion and Wellness**	**Management of Chronic Conditions**	**Complex Care Management**
Cultivate relationships and listen. This approach allows us to ground ourselves in the current state of affairs in Kentucky. It lets us learn what works so we can support and amplify those efforts. It also teaches us what does not work so we can bring solutions to close gaps. We will use this ongoing process to deepen our knowledge of the Commonwealth and make sure we are providing the best care possible to create a healthier future for Kentucky.	✔	✔	✔
Refer and connect enrollees to stakeholders with community resources and social supports that can help enrollees meet their health and social needs	✔	✔	✔
Bring innovation to stakeholders (i.e., technology) to help increase health care access in the community where individuals would otherwise get social needs met	✔	✔	
Partner with stakeholders (providers and community-based organizations), including through value-based payment arrangements to incent and reward high quality care and community-based care management, including opportunities for providers to address social needs that may impede an individual's access to care and general livelihood	✔	✔	✔

Using local leaders to help identify key opportunities for investments. When meeting with the Kentucky Diabetes Network and the Diabetes Prevention and Control Program within the Cabinet, we learned 1 in 3 Kentucky adults have prediabetes. If left untreated, prediabetes can lead to type 2 diabetes, heart disease, stroke and other serious health issues. Unfortunately, overwhelming lack of awareness regarding prediabetes in Kentucky has contributed to the

current state of unmanaged chronic conditions. To begin tackling this challenge, we worked with these stakeholders to develop a prediabetes awareness campaign directing Kentuckians to take the CDC risk test and see their PCP. The efforts involved 50 billboards across the Commonwealth, interviews with TV news stations in Lexington and Louisville, public service announcements on the radio and postcards in collaboration with Walgreens. We also worked with the UK Regional Extension Center to offer practice transformation guidance regarding diabetes to providers in targeted in Central and Western Kentucky to increase patient compliance, implement care teams, formalize education, use electronic health record capabilities and increase awareness of community resources, all in relation to diabetes management.

Using Healthify as a comprehensive bridge to local resources. *Healthify* is a web-based community resource tool used to identify and connect enrollees to available community resources providing assistance with food, housing, employment, utility bills, support groups, transportation, childcare and clothing. In Kentucky, our MSAs, care teams and other staff use *Healthify* to help bridge the gap between unmet health care and social needs for individuals at risk for poor outcomes or inappropriate use of health care services. *Healthify* users can also target cultural, linguistic and educational support for prevalent demographics, including rural areas where enrollees across all risk levels face numerous social barriers to improving health outcomes.

Collaborating among providers with a shared vision. We recognize the role providers play as both community resources and primary points of interaction with our enrollees. We build partnerships with providers who support their patients' whole person care, including their social needs. These partnerships with PCPs form at the individual level as a part of an enrollee's broader care team and at an organizational level. Our strong collaboration with the KPCA, including our integrated contract, is one such example of how we work with providers in the pursuit of whole-person care.

Partnering with stakeholders as extensions of our care teams. While we connect enrollees to resources directly, we also recognize community organizations, such as Community Action Agencies (CAAs), can do the same for our enrollees. Rather than duplicate resources, we have partnered with Community Action Kentucky, the statewide association supporting all 23 Community Action Agencies across Kentucky, to make certain our enrollees receive necessarily support even outside the bounds of our care. CAAs offer a diverse set of services supporting economic empowerment across multiple domains, such as workforce development, housing, asset building, home energy support and food security. Starting with select CAAs, we will create a direct referral linkage with CAA case managers, along with a bidirectional tracking and management system, to allow service level data and closed loop referral tracking.

> "We have found the team at UnitedHealthcare to be eager to create innovative approaches that will improve health outcomes for the citizens of Kentucky. "
>
> — Roger McCann, Executive Director, Community Action Kentucky, Inc.

Innovating with community-based organizations to drive health and wellness. Forming local partnerships, like our relationship with the Boys & Girls Club of Glasgow-Barren County, allows us to engage enrollees outside of traditional clinical settings. In this way, we reach a broader set of enrollees and increase access to community services and supports. Through this partnership, we donated laptop computers that will provide access to behavioral telehealth services to youth at the Boys & Girls Club.

g. Technology and other methods for information exchange, as applicable.

Laying the right foundation for data exchange critically affects our ability to effectively care manage, to support our providers in their provision of high quality care and to empower enrollees to engage in their health and wellness. We depend on multiple tools, technology and otherwise, to provide information exchange and will deploy each in Kentucky to strengthen our ability to support our enrollees in each risk level.

Internal Information Exchange

To make sure our PHM program operates effectively, we use multiple forms of information exchange to underpin our approach to serving our enrollees.
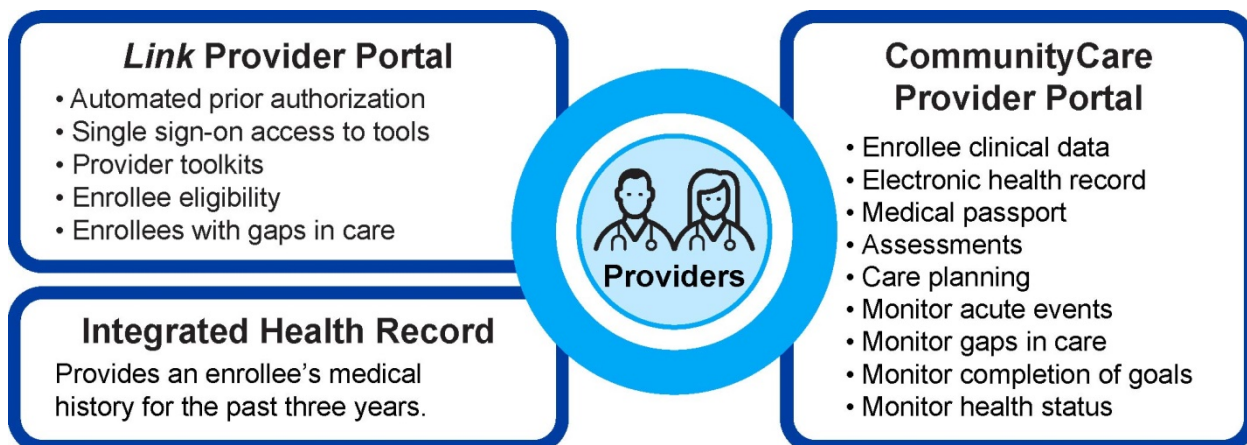
Clinical rounds: While technology has many benefits, our PHM program centers on people – the individuals we serve and the breadth of our local clinical care teams who support them. Holding weekly clinical rounds provides a structured opportunity for enrollees of the care team to elevate an individual's case for additional input and support. Besides clinical rounds, we encourage and empower our entire staff to elevate individual cases to local clinical leaders, including our population health director, our behavioral health director and Dr. Teichman, our chief medical officer.

CommunityCare, our integrated, secure, web-based clinical care management platform, facilitates the coordination of services by sharing vital enrollee information with the enrollee's care manager and MCT, including the enrollee. *CommunityCare* provides the care manager and MCT with real-time information and tools they need to monitor each enrollee's progress toward achieving their goals and make certain the enrollee is experiencing improved health outcomes.

Our Blended Census Report Tool includes daily admission and discharge data feed directly into the electronic care management platform multiple times per day, driving automated alerts and referrals for outreach to the enrollee based upon clinical rules. In addition, assigned service coordinators receive notification of enrollees' inpatient status or discharge date so they can initiate the hospital-to-home process.

Information Exchange with Providers

Our integrated systems provide a 360-degree view of enrollees to support our care teams in closing gaps in care and improving the delivery of high quality, cost-effective medical and behavioral health services to improve the health of enrollees. Examples include:

Link Provider Portal
- Automated prior authorization
- Single sign-on access to tools
- Provider toolkits
- Enrollee eligibility
- Enrollees with gaps in care

Integrated Health Record
Provides an enrollee's medical history for the past three years.

Providers

CommunityCare Provider Portal
- Enrollee clinical data
- Electronic health record
- Medical passport
- Assessments
- Care planning
- Monitor acute events
- Monitor gaps in care
- Monitor completion of goals
- Monitor health status

Figure 13. We invest in technology and systems to support our providers through simplified yet comprehensive information exchange. The *Link* provider portal houses many tools and supports for providers direct provision of care. Our *CommunityCare* care management system creates a forum for collaboration across an enrollee's entire care team. The Individual Health Record provides a comprehensive view of an enrollee's medical history.

Link Provider Portal and Registry: Our Provider Registry and portal supports providers by sharing population-based and individualized clinical and quality information. Users will be able to monitor gaps, receive admission and discharge notifications, extract relevant supplemental data from the practice's EMR and upload the data to the registry to reflect gap closure.

Individual Health Record – Provider View: The IHR synchronizes claims-sourced clinical information with other clinical sources to create unified, transformed records providing useful and usable clinical information for providers, caregivers and individuals to collaborate on health and disease management at the time of care. The centerpiece of the IHR from the perspective of a provider is the Patient Summary, which acts as a dashboard of patient information. This is where all information about a patient is brought together in a single understanding and a single presentation — this removes the 10 minutes in each visit in which the provider asks the patient to tell them "what all those other doctors told you." Rules for optimal care are simultaneously displayed, allowing coordination among physicians, other providers and patients.

Patient Care Opportunity Report (PCOR): The PCOR assists providers in identifying enrollees who have open care opportunities related to preventive health care. The opportunities align with HEDIS performance measures and Kentucky custom measures. Addressing care opportunities will help providers to achieve positive health outcomes for their patients. The PCOR offers current, at-a-glance information about open care opportunities for our plan enrollees such as cancer screenings and immunizations. The report is based upon claims data and electronic medical record documentation from our enrollees' health care providers.

Information Exchange with Enrollees

An informed enrollee is the first step toward an engaged enrollee. We take multiple steps to inform our enrollees about the care and the services we offer to support them in their pursuit of health and wellness.

Informational materials: We recognize each of our enrollees will look for and consume information through multi-modalities. We have created communication methods to meet each of them. We provide information on physical and behavioral health and related covered services through our Welcome Kit, *Member Handbook* and other resource and educational materials, at community outreach events and online through *myuhc.com* and our mobile application.

Telephonic engagement with live agents: If enrollees have questions or need additional help, they can connect with our MSAs who answer questions or resolve enrollee issues on medical and behavioral health matters through a single telephone line on the initial call, wherever possible. Our Kentucky-based MSAs will have enrollee data available to engage enrollees beyond their initial reason for calling. For example, MSAs can help enrollees find a local medical or behavioral health provider, remind them of gaps in care and schedule an appointment. In addition, our NurseLine, staffed by RNs 24 hours a day, seven days a week, can 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).

CommunityCare as an information repository: In addition to providing the care manager and MCT with real-time information and tools to monitor each enrollee's progress, *CommunityCare* (our care management platform) also serves as a source of information exchange for the enrollee as well. Through *CommunityCare*, we track and facilitate the coordination of services and share enrollee information. Along with members of the care team, enrollees can view up-to-date information related to their goals and needs, coordination of services, care transitions, discharge planning and associated progress. Another form of information exchange occurs

between the enrollee and their multidisciplinary care team (MCT). Individuals actively participating in our care management program engage directly with their RN care manager, behavioral health clinician or CHW who are the primary source of information tailored to the specific needs of the enrollee.

h. Frequency of provision of services.

The needs of an individual residing in Louisville will likely differ greatly from one living in Hazard. To respond to each of our enrollees' circumstances, we apply a person-centered approach guided by an enrollee's individual care needs. The frequency of services varies based upon an individual's risk level and type of need. For our complex care population, we emphasize engagement for a minimum of 60 to 90 days post discharge to confirm stabilization into the community; however, we remain engaged as long as needed to support our enrollees' involvement in their health and health care. The following table shows the types of services provided in complex care management, along with the timing and frequency of interventions and team member facilitating the interaction. We have designed the PHM program in Kentucky to flex based upon individual enrollee needs. At all levels, we empower our staff to engage health plan leadership to consult and directly intervene to help enrollees. Dr. Jeb Teichman, our CMO, is available to assist our staff with enrollees when opportunities or challenges emerge.

Illustrative Services Provided in Complex Care Management			
Service	**Timing**	**Frequency**	**Member of Care Team**
Initial outreach	Within 3 business days of referral	Minimum of three outreach attempts at different days/times	RN, behavioral health clinician or CHW
Transition of care with high RPM or RST score	Within 1 business day of referral	When appropriate	RN, behavioral health clinician or CHW, depending on circumstance and facility
Ongoing enrollee outreach	Post-initial outreach and or assessment, based upon enrollee need and preference	Typically weekly or bi-weekly, depending on enrollee preference	Differs based upon enrollee's primary need and preference
Comprehensive Assessment (e.g., Enrollee Needs Assessment)	Within 30 days of referral	Once annually or with change in condition or at enrollee request	RN or behavioral health clinician, unless CHW is engaged in person and electronically connects RN or behavioral health clinician
Care Planning	Within 30 days of completion of the comprehensive assessments	Updated as needed	CHW, RN or behavioral health clinician
Lifestyle and Chronic Condition Management	As it aligns with care plan and priority condition or risk factor	As needed to stabilize individual	CHW, RN or behavioral health clinician
Service Coordination and Planning	Within 30 days of completion of the comprehensive assessments	As appropriate to address individual's needs	CHW, RN or behavioral health clinician
Closing Gaps in Care	Within 30 days of completion of the comprehensive assessments	As identified	CHW or RN

Illustrative Services Provided in Complex Care Management			
Service	**Timing**	**Frequency**	**Member of Care Team**
Medication Reconciliation	As appropriate	As appropriate	Nurse practitioner, RN, behavioral health clinician or pharmacist

EMPOWER

We adjust and modify services provided in complex care management to match enrollee needs in lower risk levels. For enrollees engaged in chronic condition management, we emphasize ways in which we can facilitate access to necessary health care services and supports to address their needs. By providing education, tools and connections to community programs and providers, we support individuals to not only access, but also proactively engage in their health care. Enrollees stratified into this risk level receive services based upon level of need with respect to managing chronic conditions. For example, one way we engage enrollees with diabetes is through outbound IVR calls and inbound calls from live agents to remind them of appointments, help them schedule appointments and close gaps in care. Our locally based community health workers may also help identify and connect enrollees to programs offered in the community, such as a Diabetes Self-management Training course.

We take a similar approach for the health and wellness population. The focus is on providing preventive services to maintain healthy behaviors. For instance, outreach for EPSDT aligns with clinical guidelines and Bright Futures and American Academy of Pediatrics guidelines. Individuals eligible for EPSDT also receive appointment reminders through outbound IVR calls and can connect with live agents for help scheduling appointments with providers. For enrollees who want additional support, our *Advocate4Me* member services center and MSAs are always available and can escalate requests as appropriate. As we successfully shift more of our enrollees into the health promotion and wellness population, we expect the services provided to evolve alongside the changing risk concentration of our membership.

i. Priority areas (e.g., specific health risks, conditions, social determinants of health, etc.).

Our PHM program addresses enrollee needs across the continuum beginning with pediatrics and covering all age and gender bands. While our PHM program is designed to keep enrollees healthy, manage enrollees with chronic conditions and emerging risk and wrap services around enrollees with complex illnesses, we also recognize additional priority areas within our membership at each risk level. Maintaining an emphasis on particular populations while having an overarching plan for the entirety of our enrollees is a key component of our PHM strategy, which is to stabilize priority populations and improve health outcomes in Kentucky over time. The following table outlines how our identified priority conditions (internal and DMS priorities) and health risk factors, along with the SDOH factoring into the risk levels of our PHM program.

Illustrative Examples of UnitedHealthcare and DMS's Priorities Applied at Each PHM Risk Level			
Risk Level	**Priority Risks factors**	**Priority Conditions**	**Priority Social Determinants of Health**
Complex care management	▪ High inpatient utilization ▪ More ED visits than office visits ▪ Polypharmacy with multiple medication adherence opportunities	▪ Heart Failure ▪ SUD/OUD ▪ Serious Mental Illness ▪ Cancer	▪ Housing insecurity ▪ Food insecurity ▪ Employment needs ▪ Social supports
Management of chronic conditions	▪ Tobacco Use ▪ Gaps in evidenced-based care ▪ Multiple medication adherence	▪ Asthma ▪ Obesity ▪ Diabetes	

Illustrative Examples of UnitedHealthcare and DMS's Priorities Applied at Each PHM Risk Level			
Risk Level	**Priority Risks factors**	**Priority Conditions**	**Priority Social Determinants of Health**
	opportunities	▪ Heart Disease ▪ COPD	
Health and wellness	▪ Missed annual exam ▪ Missed preventive care	Not applicable	

Priority Risks factors

Identifying and supporting enrollees to address risk factors is a key aspect of improving individual health and creating generational change for a healthier Kentucky. One priority risk factor includes the ***appropriate utilization of health care services.*** Because the appropriate utilization of services is important at all risk levels, we facilitate access to the right level of care at the right time and place. For individuals in the health promotion and wellness risk level, we confirm appropriate utilization by reminding enrollees to schedule annual wellness visits and routine care. Among those with more additional risk factors, we prioritize closing gaps in evidence-based care — for example, connecting enrollees who use tobacco to appropriate cessation supports.

Priority Conditions

Although our PHM program supports all individuals, we recognize certain conditions require priority attention. While we will reevaluate priority conditions once we gain membership in Kentucky, the priority conditions and populations identified by DMS and outlined in Attachment C- Draft Medicaid Managed care Contract and Appendices Section 34.2 closely align with the priority populations we have identified internally. Among these priority conditions, our MCT will connect and support enrollees with specialized clinical interventions. One such example includes high risk pregnancies:

High risk pregnancies with an emphasis on maternal-infant dyad: Supporting maternal health affects not only the woman's health and well-being, but also the child's. Our Healthy First Steps program focuses on early identification and engagement of pregnant women and provides enhanced support for their health care providers. We remove barriers to care and collaborate with community partners to engage, educate and support pregnant women. HFS provides continuity with postpartum mother and baby care with a seamless transition to well child and EPSDT management and targeted engagement of high-risk moms for more than 60 days post discharge.

Our population health management (PHM) approach addresses HEDIS and other evidence-based metrics applicable across all pregnancies. Targeted outcomes include fewer NICU admissions, lower C-section rates, lower premature birth rates, lower infant mortality rates, higher prenatal and postpartum care compliance and higher well-child compliance. In addition to directly supporting our enrollees, we also will support making programs like Baby Box available to pediatricians who want to provide a means to support AAP's 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.

Priority Social Determinants of Health

We take multiple approaches to support our enrollee across all facets of their health, including social determinants of health. One of the priority SDOH factors we are tackling in Kentucky is housing insecurity.

Housing insecurity: Maintaining good health is not a priority or even an option for our most vulnerable enrollees who lack safe and secure housing. To help overcome obstacles posed by housing insecurity and to achieve the best outcomes for homeless enrollees with complex conditions, we will implement the Housing + Health program. Nationally recognized, this program supports enrollees who are persistent health care users and struggle with homelessness, addiction and transitions from incarceration. The Kentucky Housing + Health team will use our Hotspotting tool to identify these subgroups and will use ADT feeds to meet and engage enrollees experiencing homelessness wherever they are — at the hospital bedside, in the ED, or at the shelters — and connect them housing supports. Social workers and RNs on the our multidisciplinary care teams will work with the enrollee and help them navigate toward housing, which will be provided by UnitedHealthcare at low or no cost for 12 months for 10 enrollees during the initial pilot.

j. Description of staffing for each risk level, including staff to Enrollee ratios, modes of interface with Enrollees, and use of care managers.

Each of our front-line staff interacting with our enrollees has an integral role in engaging and supporting our enrollees. We care for our enrollees within each risk level by using cross-trained and multidisciplinary teams. Whether these teams are regionally stationed care teams focused on our complex care management enrollees or our broader team of MSAs deployed more broadly across our membership, each are trained to focus on one person at a time to help the individual attain self-management in their pursuit of health and wellness. Our teams routinely collaborate using the clinical continuum, MCTs and integrated rounds to find solutions for identified barriers for the enrollee. The following table includes the staffing structure across each risk level of our PHM program, including staff to enrollee ratios, modes of contact and the use of care managers.

Staffing Structure across each PHM Risk Level	
Complex Care Management	
Description	Consists of a regionally based multidisciplinary care team including a nurse practitioner, behavioral health clinician, RN care manager and clinical administrative coordinator. The enrollee will engage with this team as a unit, with individual members of the team engaging based upon the needs of the individual and level of care required. Additionally, we will make CHWs available for targeted coordination.
Staff to Enrollee Ratios	Varies from 1:50 – 125 among different members of the care team.
Modes of Interface	Active telephonic and in-person outreach and engagement, including within the home. Ability to electronically interface through *CommunityCare* care management portal.
Use of Care Managers	Yes
Management of Chronic Conditions	
Description	Locally based CHWs, specially trained MSAs, mobility coordinator and other internal resources will support our enrollees with emerging risks and chronic conditions to coordinate access to care, facilitate connection to evidence-based practices and help to identify community supports to address SDOH.
Staff to Enrollee Ratios	Varies from 1:50-1518, based upon identified or requested need for enhanced support due to condition stability, number of unmet needs and opportunities for impact.
Modes of Interface	Telephonic care management, mailed outreach, text campaigns, automated outbound calls, live outbound calls, availability of inbound call centers, in-person interface at wellness events performed in the community.
Use of Care Managers	Yes

Staffing Structure across each PHM Risk Level	
Complex Care Management	
Health Promotion & Wellness	
Description	A blend of staff, including MSAs and individuals from our HARC will receive extensive training to help identify and meet the needs of our enrollees with no or low risks.
Staff to Enrollee Ratios	1:1518, leveraging multi-modal outreach methods for engagement
Modes of Interface	Mailed outreach, text campaigns, automated outbound calls, live outbound calls, availability of inbound call centers, in person interface at wellness events performed in the community.
Use of Care Managers	No

Though our staffing and style of engagement varies across each risk level, we design our PHM program to flex and reflect our person-centered approach to care. A recent example from Ohio showcases how we embody this approach in our daily engagement with enrollees. Routine telephone engagement between a CHW and a pregnant woman revealed that our enrollee, who was originally characterized as a low risk pregnancy and flagged for telephonic engagement, required additional support. During this phone call, the CHW learned that this enrollee had Hidradenitis Suppurativa, a rare autoimmune disease in which her body develops abscesses. With this information, our CHW escalated the case for additional support, which included face-to-face interactions with an RN care manager and supplemental support from the health plan's health services director. Although her pregnancy was stable and progressing without complications, the enrollee's main concern was not having sufficient dressing supplies for her wounds. Our health services director spent significant time talking with the enrollee, understanding each wound, the amount of supplies needed to dress it and the how often the dressing needed to be changed. The health services director also talked with the enrollee's providers to learn more about this type of wound care. Next, the health services director worked with Edgepark Medical Supplies to take care of this woman's wounds during and after her pregnancy. Working with the medical supplies company, the enrollee's care manager and health services director were able to obtain materials at significantly lower cost (saving more than $4000/month). This gave the enrollee peace of mind so she could focus on her pregnancy. The ability to escalate cases, levels of staff and engagement modalities underscores the nimble approach to person-centered care we plan to bring to Kentucky.

k. If applicable, value-based payment (VBP) or incentive models the Contractor will include in Provider agreements to support involvement in the PHM Program.

We will use VBP models to support provider involvement in the PHM program and adapt our models based upon further analysis of our membership in Kentucky.

Health Promotion and Wellness and Management of Chronic Conditions: CP-PCPi rewards providers for specific HEDIS measures and closing gaps in care with a focus on improving quality outcomes related to Kentucky's health priorities, such as tobacco use, diabetes prevalence and adult obesity. Participating providers receive fee-for-service reimbursement plus the opportunity to earn incentives for closing gaps in care. Our **Primary Care Physician Incentive (PCPi) Program** has been used in 18 states nationally, covering over 4,200 provider groups and more than 2.4 million UnitedHealthcare Medicaid enrollees.

Recognizing the critical importance of improving perinatal care and birth outcomes in Kentucky, we plan to implement our OB provider specialist incentive program, **Obstetrics (OB) PCPi Incentive (APM 2C, Year 2)**. This program rewards qualifying OB specialist practices for
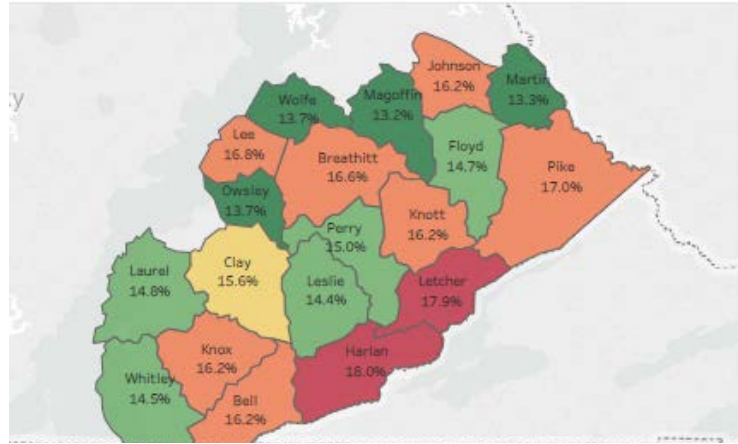
performance related to closing enrollee care gaps for certain HEDIS prenatal and postpartum measures and improving birth outcomes. As part of the program, a practice can earn bonus payments for achieving or exceeding target scores for select performance measures (in alignment with DMS's quality measures).

VBP Models for Complex Care Management (e.g.,high risk individuals with OUD): Because these individuals in complex care management require intensive supports, we will align our VBP models accordingly. Our OUD models are one example of using

Figure 14. Diabetes Prevalence. Percentage of adults with diagnosed diabetes (Statewide rate = 12.8%). Our primary care incentive model, CP-PCPi, focuses on closing care opportunities and improving quality outcomes for health priorities identified by the DMS, including diabetes prevalence (Region 8).

VBP to support providers who care for complex individuals to make certain enrollees with OUD receive evidence-based care and the comprehensive supports they need to sustain treatment over time. Aligned with the Kentucky Opioid Response Effort goals to increase access to MAT and recovery services, we have developed VBP models aimed to improve the quality and capacity of MAT providers and encourage treatment retention across different settings.

As part of our ***Opioid Use Disorder (OUD) VBP Models (APM 2C),*** we will pilot three opioid-related VBP programs in the Commonwealth:

- Our Medication Assisted Treatment (MAT) retention model VBP for PCPs includes incentive payments for care management service and MAT refills on a monthly and 6-month retention basis.

- Our ED MAT Induction and Referral VBP supports and enhances the Kentucky "bridge clinics" designed to provide MAT treatment on-demand, by incenting EDs to establish protocols for enrollees who need MAT services (e.g., initiating buprenorphine and referring to bridge clinics).

- The Maternal and Infant Opioid Health Home VBP focuses on the comprehensive needs of pregnant women with OUD, neonatal abstinence syndrome and support for the maternal-infant dyad from prenatal care through the first year of life.

l. Methods for evaluating success of services provided.

We hold a strong commitment to continuous quality improvement and person-centered care. To support the overall PHM of our enrollees, we have defined strategies with measured outcomes for each section of the population health program. The disciplined use of data to guide decision-making at every phase of the care management process is the core mission of clinical analytics at UnitedHealthcare. Clinical analytics is the study component of the Plan, Do, Study, Act (PDSA) cycle and is tightly integrated with care team

Figure 15. By comparing observed outcomes to expected outcomes, we can evaluate program effectiveness while taking into account any regression to the mean that would occur absent the intervention. This allows us to identify the impact of the services we provide and then draw inferences on how to improve the impact and take action accordingly.

leadership to deliver seamless integration of findings into the Act phase. One way we evaluate program effectiveness while addressing an impact on regression to the mean is to compare observed outcomes to expected outcomes had the enrollee not received our care management services. We achieve this by implementing a pre and post framework, which compares the difference in utilization and cost between the intervention and control groups: 1) before and after the intervention and 2) between the two groups resulting in a difference-in-differences.

For example, in spring 2019, we conducted a pre and post analysis to evaluate the effect of care management on our enrollees with OUD across each risk level in Ohio. This study observed a reduction in inpatient cost at each risk level. However, enrollees engaged at the highest risk level, who received face to face services as opposed to telephonic engagement received in lower risk levels, experienced the most significant medical expense reduction, primarily driven by more appropriate utilization of services. The high risk intervention population experienced a 43% decrease in admission expenses and a simultaneous 21% increase in pharmacy expenses compared to controls at the same risk level. In addition to evaluating the positive impact these services had on our enrollees with OUD, conducting this study enabled clinical staff from our Ohio health plan to pivot their approach and increase face-to-face engagement among enrollees with OUD across all risk levels.

In addition to analysis conducted for a PDSA framework, we also work to evaluate our provision of services across key performance indicators. For each intervention across our population health management approach, we are setting key performance indicators to track success. Illustrative examples of measures include the following:

> "Please note that the KPCA fully supports UnitedHealthcare in their bid to become one of Kentucky's Managed Care Organizations. UnitedHealthcare's focus and mission to serve the underserved are aligned with the KPCA philosophy."
>
> — David Bolt, CEO, Kentucky Primary Care Association

- Statewide EPSDT percentage (80%) screening rates based upon form CMS-416 from the Centers for Medicare & Medicaid Services (CMS)
- Reduction in readmission rates (e.g., by 15% among the complex care population)
- Appropriate service utilization among ED, office visits and pharmacy to be measured by an reduction of inappropriate ED admissions (e.g., by 15% over initial year's baseline rates and increase in preventive care visits)
- Successfully increase enrollment rate for the Low Risk Maternity Healthy First Steps program (e.g., by 10% year over year)
- Completion of HRA within 60 days of MCO enrollment and referral to appropriate programs based upon stratification level.

m. Methods for communicating and coordinating with an Enrollee's primary care provider or other authorized providers about care plans and service needs.

Supporting individuals in their health and wellness requires a multidisciplinary care team (MCT) that includes the enrollee's PCP, other relevant specialists and key family and friends (if identified by the individual). When developing a care plan with an enrollee, we emphasize the importance of coordinating with their provider(s) and obtaining the enrollee's permission before doing so. By documenting a care plan into *CommunityCare*, the enrollee's entire care team has access to the information in real time. Using our platform this way allows our care managers, providers and enrollees to stay up to date in real time regarding an individual's goals, needs, care plans and any associated progress. Though *CommunityCare* provides a single platform to

collect, store and communicate about an individual among every person in their designated care team, we can also communicate and coordinate with individual's PCP and other authorized providers using other mechanisms, including:

- Direct outreach and engagement by care manager and members of the MCT
- Real-time notification (e.g., fax) alerting provider of acute events and transitions of care (e.g., readmissions)
- Discussion during joint clinical rounds
- Shared notes and documentation in *CommunityCare*

In addition to using a shared platform with consolidated enrollee information, multiple forms of proactive outreach help engage individual providers to participate in the enrollee's MCT. In addition, we communicate with providers regarding trends in their patient panels overall. By shedding light on patterns and trends across their patients, providers are positioned to recognize those patterns better and alter them accordingly.

For example, providers currently partnered with us to deploy our Medication Assisted Treatment (MAT) Retention value-based care model in Louisiana and Ohio receive monthly dashboards of their progress. We provide easy to read, facility-level dashboards on a monthly basis to enable our partners to readily see: 1) how many of their enrollees are receiving evidence-based care (i.e., measured by obtaining a monthly refill of a buprenorphine-containing product), 2) how many individuals have not received necessary care in a given month; and 3) the financial opportunity lost associated with the gap. This data helps practices better understand their effectiveness at engaging populations so they can deploy resources accordingly. In addition, we supplement these facility-level dashboards, which contain no personally identifiable data, with secured provider-level dashboards enabling providers to engage enrollees who are already or at risk for lost to follow up.

n. Role, if any, the Kentucky Health Information Exchange (KHIE) will play in the Contractor's PHM Program as a resource.

The KHIE is viewed in the Commonwealth as the definitive data source to support PHM given the volume and diversity of payer and provider data it draws upon and subsequently uses to power the DMS's data warehouse. We will use the KHIE to support our PHM program by using the real time data it provides to make rapid determinations on enrollee risk stratifications and to support subsequent care transitions and interventions with a focus on our highest risk enrollees.

> We will use ADT feeds to contact enrollees with OUD immediately after they are seen in the hospital or ER for an overdose. In real time, our staff can verify enrollees have naloxone to prevent future overdoses and conduct motivational interviewing to assess enrollees' interest in MAT and refer to high quality MAT providers.

Information from the KHIE will play a critical role in our PHM program, particularly in identifying enrollees in the complex care-management risk level who experience a transition in care. This real-time information provides us with visibility into ED and hospital admission data positioning us for optimal and timely outreach to provide appropriate transition and discharge planning support. Our transition support meets the individualized needs of the enrollee and includes a trained behavioral health advocate or CHW connecting with the enrollee to help assess situation and support the synchronization of follow-up care. This could include scheduling appointments with the enrollee's PCP or in certain situations using our regional direct care teams within seven days. Given the prevalence of OUD in the Commonwealth, ADT feeds may provide one such example of how our care team uses information from the KHIE.

v. Provide the Contractor's proposed approach to coordination with other authorized providers such as the WIC program and others.

To create a healthier Kentucky, we need to partner with local service providers. Demonstrated by our existing engagement with Commonwealth agencies in Kentucky, we are deeply committed to coordinating with authorized providers who similarly support and empower our enrollees in their pursuit of health and wellness. Given our common goals, we recognize the value of referring to and coordinating with the WIC program, Head Start, Kentucky HANDS, Family to Family program, Quit Now Kentucky and many others. The Commonwealth offers a significant amount of support to enrollees and we have a shared interest in helping our enrollees take part in these programs and services.

> "Our partnership with UnitedHealthcare has enriched our ability to connect local leaders to important data on children in their communities and foster collaborations that will help us toward our vision of Kentucky, the best place in America to be young."
>
> — Terry Brooks, Ed. D, Executive Director, Kentucky Youth Advocates

As part of our effort to support the health and wellbeing of our enrollees, our PHM program includes connections to WIC, SNAP and other Commonwealth or local support programs as appropriate among enrollees at every risk level. We have deep experience. Our care managers across 30 states work with pregnant mothers in establishing appointments with their local public health departments to determine eligibility for WIC. We further support potentially eligible mothers and their families by helping them obtain necessary documentation needed for the WIC appointment to enable a smooth process. In addition to supporting our enrollees, we commit to coordinating directly with WIC offices on referrals and providing critical information on nutrition-related metabolic conditions and other relevant health information as appropriate. We would welcome opportunities to work directly with Kentucky agencies to identify a more formal collaboration, including methods to optimize the provision of services. For example, working together to establish a method of cross communication to notify service providers upon referring an enrollee with the service provider notifying us when the referral is completed successfully.
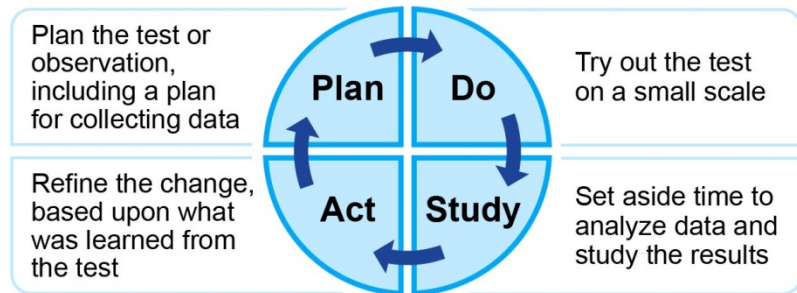
Given our commitment to partnership with the Commonwealth and local programming, we have already participated in numerous Department for Public Health (DPH) meetings on various topics to support our PHM approach. For example, because of meetings on the need for diabetes prevention with Deputy Commissioner Connie White, we collaborated with the Kentucky Diabetes Network workgroup in financially supporting and raising awareness about the availability of the evidence-based national Diabetes Prevention Program. In similarly productive meetings with the DPH on tobacco cessation, we extended our collaboration to external entities and facilitated a relationship between the DPH and Walgreens to bolster smoking cessation efforts in the Commonwealth.

These examples of our collaborations to date illustrate the initial steps of our PHM approach in action. Besides referring enrollees to Commonwealth-operated service providers to meet their individual needs across each risk level, we commit to working with the Commonwealth to realize a healthier Kentucky.

vi. Describe the Contractor's approach to ongoing review of its PHM Program, including potential real-time measurement, and how the Contractor will use results to address identified issues.

Given our bold goals for Kentucky, we have a strong and vested commitment to continuous quality improvement and have defined strategies with measured outcomes for each of our PHM risk levels. To validate our evaluation of PHM programs against these outcomes, we designed a specific tool to integrate clinical and financial insight into its performance.

Pre and Post Analysis: Through the Clinical Medical Economics Pre/Post Report, we evaluate the expense and utilization profiles of the enrollees who participate in our PHM programs against those who are eligible, but do not engage in PHM interventions. The tool summarizes enrollees' expenses and utilization before and after enrollment in a PHM

Figure 16. Plan, Do, Study, Act (PDSA) is one the standardized, evidence-based approaches we use for quality evaluation and improvements in our programs.

program and attempts to assess program effectiveness by comparing the observed changes to the control groups. Outcomes from these assessments help to inform the relative success of a PHM program in a given state and whether opportunities exist to modify the program and increase its effectiveness. This enables us to continually evaluate and adapt our approach to meet Kentucky-specific needs, consistent with the Plan, Do, Study, Act framework of continuous quality improvement.

Key Performance Indicator (KPI) Library: Incorporating and monitoring KPIs is a fundamental element of effective clinical program design and implementation. As part of our commitment to ongoing evaluation within and across the states we serve, we are developing a KPI library that will establish source of truth definitions for recommended process and outcome measures for each of our PHM interventions. By establishing a KPI library focused on research-based measures for process and outcomes measures, we can conduct specific review of the progress of our initiatives.

Real-time Measurement Tools: In addition to the ability to conduct a pre and post analysis across various interventions of our PHM framework, we have numerous real-time measurement tools to monitor our influence on enrollees and identify opportunities to improve outcomes

- **Hotspotting Tool**. This proprietary data tool enables our clinical staff to yield real time clinical insights and take action if and as needed. This tool segments enrollees into various priority cohorts (e.g., OUD, homeless) to narrow the scope of the evaluation. Within a cohort, it provides summary data of the financial impact, diagnoses and utilization patterns of individuals within the cohort, along with a geographic heat map view for swift and effective deployment of resources.

- **OUD Dashboard.** By second quarter 2020, we will have an OUD dashboard summarizing key measures of health risk among individuals with OUD. This dashboard will yield insight on MAT uptake and continuity at 30, 60, 90 and 180 days across enrollees with OUD and critical subpopulations, such as individuals with an opioid overdose, pregnant women with opioid use, individuals with OUD-related inpatient complications (e.g., endocarditis) and others. Analyzing this data real time will help our clinical team evaluate progress among this vulnerable population and allow us focus resources accordingly.

A high-level view of our PHM program will include key summary statistics across all PHM programs included in the report and includes a brief overview of analysts' findings. Monthly analysis of the data by category of service level will allow our clinical teams to identify claim patterns resulting in eligibility for various programs, and how these patterns evolve with and without intervention.