29. Use Cases

Submit the Vendor's response to the following use cases. The Department encourages the Vendor to provide a thorough response and suggest innovative ways to fulfill the requirements of this Contract.

The use cases represent hypothetical Kentucky Enrollees, families, Providers, or entities. Responses must include, at a minimum, the program and services listed within each use case, but the Vendor is not limited to responding only to those areas. The Vendor should include any limitations or exceptions to providing the programs and services listed.

The Vendor's response may include a detailed narrative, diagrams, exhibits, or detailed information specifically tailored for the Kentucky Medicaid managed care program to demonstrate its ability to meet or exceed requirements.

Use Case 1

Rhonda is a 30-year-old Enrollee who recently learned that she was pregnant after visiting the Emergency Room, by ambulance, with severe nausea and dehydration. She has a history of high risk pregnancies. Of 5 pregnancies she has experienced one (1) live birth, three (3) miscarriages occurring early in the second trimester, and one (1) abortion in her teens. In addition to her history of complicated pregnancies she smokes a half pack of cigarettes per day and drinks approximately 2 -3 beers /week. During her pregnancies, Rhonda sporadically kept prenatal visits and had a history of noncompliance with routine care instructions.

Rhonda was shocked to learn that she was pregnant since she delivered a baby girl ten (10) months earlier. Her daughter, Amanda, was born at 32 weeks and was in the NICU for three (3) weeks. Amanda is feeding well and is steadily gaining weight. With that pregnancy, Rhonda experienced post-partum depression and was concerned whether she could care for Amanda. Rhonda's closet family is in Texas but visits are infrequent. She recently separated from an abusive partner who provides minimal financial and emotional support. Rhonda and Amanda sought safety in a family shelter on three (3) different occasions after her partner threatened to harm Amanda.

Rhonda became upset upon learning she was pregnant again and kept telling the ER nurse that it could not be true. She explained that she just moved out her apartment after splitting with her partner and was staying temporarily with friends. Rhonda does not have reliable transportation and often relies on friends to provide rides to the pediatrician and grocery shopping.

The ER nurse recommended that Rhonda talk with her OB/GYN and her MCO about her options. Rhonda's electronic medical record was updated and a referral was made to her OB/GYN.

Describe how the Vendor would address Rhonda's situation including a detailed description of prenatal programs and Quality Improvement Initiatives. At a minimum, address the following programs and services:

a. Applicable evidence-based Care Management practices;

b. High risk pregnancy initiatives;

c. Health Risk Assessment and Care Planning;

d. Environmental assessment;

e. Behavioral Health Services;

f. Family planning;

g. Enrollee and family engagement;

h. Linkage to community resources and support;

i. Social Determinants of Health;

j. Provider engagement; and

k. Transportation.

Keeping with our approach of putting our enrollees first, we developed our use cases to give a voice to the person portrayed by telling their journey in the form of a story. We take this person-centered approach in all of our interactions with enrollees and their support systems making

sure their voice and choice shine through from the implementation of their care plan and throughout their entire health care journey.

Rhonda is at a moment of crisis facing an unexpected pregnancy as a new mother with multiple social needs, including housing stability, personal support system and interpersonal safety. She has a history of sporadic prenatal care and non-compliance with routine care instructions. Rhonda's situation mirrors many of the social and environmental factors that negatively affect maternal health outcomes in Kentucky. Because of her previous history of a preterm delivery and tobacco use, Rhonda is at high risk for delivering another preterm and low birth weight infant. Since she left her abusive partner, she is at a greatly elevated risk for violence. The wraparound support of our **Healthy First Steps high-risk care management program** for pregnant moms will provide Rhonda with the intensive support she needs to secure safe and stable housing, stabilize and engage in her health and care for her family.

Based upon our extensive experience helping pregnant women like Rhonda, we build upon every opportunity to engage and empower Rhonda through education and supportive care management interventions. Rhonda's situation could be representative of a pregnant woman located in Winchester, Kentucky or throughout the Commonwealth. If Rhonda and Amanda resided in another area of Kentucky, the specific resources and providers we link them to would change, but our person-centered approach to care management would not.

The following table summarizes some of the key touchpoints for engaging Rhonda. We expand on these throughout the rest of the narrative, but we changed the order of our response to items a – k to better reflect the flow of our person-centered approach and how we will wrap services and supports around Rhonda and her daughter Amanda. We use bolded terms throughout the narrative to highlight where we discuss these key concepts in detail.

Programs and Services	Summary of Touchpoints to Address Rhonda's and Amanda's Needs
a. Applicable Evidence-based Care Management Practices	Rhonda's current smoking, housing insecurity and history of high-risk pregnancies make her eligible for our Healthy First Steps (HFS) maternal care management program. Rhonda will be supported by a local, multidisciplinary care team (MCT) who will help support her and her family.
b. High Risk Pregnancy Initiatives	We engage Rhonda in our HFS and HFS Rewards programs because early and consistent prenatal care, along with comprehensive postpartum care and pediatric visits, are fundamental to healthy pregnancies and healthy babies. Rhonda's case is also discussed during Maternity Continuum Rounds to engage the health plan chief medical officer, Dr. Jeb Teichman, and the full clinical multidisciplinary leadership team supporting Rhonda, her current pregnancy and her daughter Amanda.
c. Health Risk Assessment and Care Planning	Working closely with Rhonda to develop her person-centered care plan is one of the ways in which we reengage her in care. Our care team meets with Rhonda to understand her needs and concerns through completion of a Health Risk Assessment (HRA) and Maternity Initial Risk Evaluation to establish her immediate ante-partum needs. The licensed clinical social worker (LCSW) care manager then uses additional evidence-based pregnancy and behavioral health tools to gather essential information that will guide conversations with Rhonda. Information Rhonda shares through these assessments contributes to person-centered care plan to meet her needs, goals and preferences.

Programs and Services	Summary of Touchpoints to Address Rhonda's and Amanda's Needs
d. Environmental Assessment	Our immediate priority is to ensure Rhonda's and Amanda's safety and access to necessities. The LCSW care manager uses a trauma-informed approach to build a trusting relationship with Rhonda so she feels comfortable discussing her history of domestic violence. The LCSW care manager helps Rhonda develop a personalized safety plan since she is at high risk of violence after leaving her abusive partner. Our housing navigator makes sure Rhonda and Amanda have a stable and safe place to live.
e. Family Planning	Given Rhonda's unplanned pregnancy, close birth spacing, and our knowledge Rhonda has been in an abusive relationship and possibly a victim of reproductive or sexual coercion, Rhonda's LCSW care manager encourages her to discuss any concerns she may have with her provider regarding her safety and family planning options, including Long Acting Reversible Contraception. Education provided through the Healthy First Steps program also informs Rhonda of family planning options.
f. Behavioral Health Services	Our integrated assessments and multidisciplinary care team work to make sure Rhonda is screened for any high risk behavioral indicators and gets integrated care, including behavioral health services to address postpartum depression, her tobacco and alcohol use, along with any therapeutic supports necessary because of the interpersonal violence she has experienced. With guidance from the behavioral health director and insights gleamed from Maternity Continuum Rounds, Rhonda's LCSW care manager will refer her to a licensed behavioral health clinician with training in trauma-informed care who can provide counseling. We also explore Rhonda's interest in peer support, which will connect her with a personal team member one-on-one who has experienced some of the same trauma Rhonda is experiencing.
g. Enrollee and Family Engagement	We work with Rhonda in the modality of her preference, which may include in-person outreach, telephonic engagement, text message, or written material available online or in print. If Rhonda identifies any of her family in her care team, we will include them in our engagement and support of Rhonda.
h. Linkage to Community Resources and Support	We link Rhonda to relevant community resources, like New Beginnings, that will provide support for Rhonda through her pregnancy and as she parents Amanda and her sibling for the first 3 years of life. Additional referrals will be made, as appropriate, to local domestic violence shelters and support programs like Beacon of Hope and Clark County Health Department HANDS home visiting program.
i. Social Determinants of Health (SDOH)	To make sure Rhonda and Amanda have access to nutritious food, we refer her to a local WIC office and coordinate receipt of services if necessary. We also connect Rhonda with Clark County Community Services Food Bank to access additional food resources. We use *Healthify* to refer Rhonda to local supports addressing SDOH identified through assessments and discussions with her.
j. Provider Engagement	Rhonda's LCSW care manager actively engages Rhonda's providers in her care team through meetings and communal documentation in *CommunityCare* to support coordinated, collaborative care planning that will help Rhonda reengage in care and achieve her goals. We engage our providers in quality improvement initiatives aimed at supporting receipt of high-quality care using value-based payment (VBP) approaches, including our OB-PCPi program.
k. Transportation	To keep lack of transportation from impeding Rhonda's ability to care for herself or her family, we refer her to Federated Transportation Services of the Bluegrass, her local provider of non-emergency medical transportation. We make sure Rhonda has the information necessary to access the services she needs. If Rhonda requires additional transportation support, our mobility coordinator can provide specific assistance.

Becoming Aware of Rhonda's Situation and Initial Engagement

Based upon our extensive experience caring for moms during their pregnancies, we know that engaging women in early prenatal care plays a critical role in healthy deliveries and healthy babies. We take active steps to identify when our enrollees become pregnant and will use Kentucky's admission, discharge and transfer (ADT) feeds to provide real-time outreach to pregnant women seen in the ED or hospital. Integrating ADT feeds from Kentucky's health information exchange (HIE) into our *CommunityCare* platform lets us create triggers so our outreach teams and care managers are alerted in real-time when pregnant women are admitted to the ED or hospital for non-delivery-related visits, observation stays or admissions. Any non-delivery-related ADT alert is considered an indicator for a potential change in condition and warrants outreach by a care manager. We can engage immediately with these women and address their needs. In Rhonda's case, the ADT alert notifying us of her ED admission triggers immediate outreach to Rhonda by the **care manager** for our Healthy First Steps prenatal quality improvement program.

Healthy First Steps

Our Healthy First Steps (HFS) program focuses on early identification and engagement of pregnant women and provides **enhanced support for health care providers**. We use field-based care teams with community health workers (CHWs) to 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 admits, lower C-section rates, lower premature birth rates, lower infant mortality rates, higher prenatal and postpartum care compliance and higher well-child compliance**. Participants in our HFS Rewards program across all markets, on average, attend 15.3% more prenatal/postpartum visits, have a 5.7% lower rate of ED utilization, lower preterm births and low-birth rates than their peers who do not take part in HFS Rewards.**

Knowing Rhonda is pregnant, we want to reach her quickly to make sure she visits her OB for prenatal care for which we note she has no recent claims. However, her lack of a permanent address and disengagement with the health care system make contacting her a challenge. We use a robust, multi-channel approach to reach Rhonda, including at least three call attempts on 3 different days and during different times of the day within 30 days. If we are unable to reach her by phone, we send a CHW to her listed address. If necessary, we can use real-time pharmacy claims to help us find our out-of-contact enrollees by calling the prescriber or the pharmacy to see if they have Rhonda's more recent contact information to help us connect with her. Given Rhonda and Amanda's traumatic experience, it may take time for Rhonda to trust us. For this reason, we incorporate a **community health worker (CHW)** from Rhonda's community in the Winchester/Lexington area to outreach Rhonda in a meaningful way.

Understanding Rhonda's Needs and Goals: HRA and Care Planning

When Rhonda is willing to share her story, the CHW uses a trauma-informed approach and **evidence-based motivational interviewing** to conduct an **HRA and Maternity Initial Risk Evaluation**. This evaluation includes questions on physical health conditions (including dental), current and past behavioral health and substance use disorder (SUD) status, medications (prescribed and taken), social or peer supports, SDOH, exposure to trauma, among other factors.

Through this process, the CHW learns details of Rhonda's housing instability, interpersonal violence experience, current smoking levels, details regarding her alcohol use, and past pregnancy and birth complications. Using the information Rhonda shares and the CHW's assessment of Rhonda's current environment and circumstances, the CHW explains the ways in which we can support Rhonda during this time. Immediately, the CHW begins working with **our housing navigator** to identify a safe and stable place for Rhonda and Amanda to live.

> We embed 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 and adverse childhood experiences, in addition to modalities like motivational interviewing and principles such as harm reduction, positive psychology and person-centered care. These core concepts help us create a trauma-informed environment to better understand, engage and support enrollees like Rhonda who have complex social and clinical needs. Other trainings facilitating successful engagement with our enrollees include crisis intervention, addressing ER utilization and identifying an individual's readiness to engage through stages of change.

Although Rhonda has left her abusive partner, she is still at high risk for violence. Because of this, the CHW supports Rhonda in **developing a personalized safety plan** and assesses the need for a referral to legal resources.

The CHW talks to Rhonda about working with one of our LCSW care managers who can help her with some of her complex pregnancy and behavioral health concerns. The LCSW care manager reviews Rhonda's case with a peer RN to discuss approach options for managing Rhonda's needs. Recognizing the complexity of Rhonda's situation — involving mental health, substance use and social needs — the LCSW escalates Rhonda's case to **Maternity Continuum Rounds to directly engage the Kentucky health plan's CMO and the full clinical leadership team, including the local behavioral health director**, to support Rhonda's needs. The CHW uses our mobile platform resource library, *Healthify*, to identify and refer Rhonda to community organizations that can address Rhonda's social needs. Before leaving their visit, the CHW introduces Rhonda to our HFS maternal and child health care program and the ways we can support Rhonda, including staying up to date with appointments and earning incentives for her baby, such as a diaper bag.

Developing Rhonda's Care Plan: Together, Rhonda and her LCSW care manager develop a care plan based upon Rhonda's initial assessment results through **shared decision-making** and insights drawn from the Maternity Continuum Rounds. Ultimately, Rhonda holds responsibility for creating her goals, but her LCSW care manager helps her break them down into achievable steps to help her anticipate and overcome barriers. Although this process is deeply personal, her LCSW care manager discusses the importance of engaging **peer and familial support** and avoiding social isolation, particularly given the distance of her family.

To help Rhonda overcome barriers to care, Rhonda's LCSW care manager takes the opportunity to ask her how she feels about her OB/GYN to make sure she has the right provider for her needs. If necessary, the LCSW care manager will connect Rhonda to another provider, perhaps someone like Dr. Andrea Tucker, so that Rhonda feels comfortable attending prenatal care. The LCSW care manager also offers to go with Rhonda to her next OB appointment if it will help Rhonda feel more at ease. To confirm Rhonda has the support she needs to meet her goals, her LCSW care manager encourages her to **identify friends or family to engage as a part of her MCT**. Rhonda's care plan might include the following:

Rhonda's Potential Goal	**Stated**	"Amanda and I need a safe place to live."
	Measurable	Rhonda is placed in permanent, affordable housing free from her abusive partner.
Opportunity	Our housing navigator helps Rhonda secure safe and affordable housing.	
Interventions	▪ Refer Rhonda to our housing navigator who can identify safe housing options ▪ Coordinate and assist Rhonda with accessing permanent, affordable and safe housing ▪ Connect Rhonda to Beacon of Hope for domestic violence support ▪ Support Rhonda in developing a personalized safety plan to make sure she is safe during this transition of leaving her abusive relationship	
Rhonda's Potential Goal	**Stated**	"I want to stop smoking."
	Measurable	Rhonda will stop smoking.
Opportunity	Connect Rhonda with Kentucky Quitline and Quit For Life® maternity program.	
Interventions	▪ Refer Rhonda to Kentucky's Quitline ▪ Offer to enroll Rhonda in our pregnancy-focused Quit For Life maternity program for coaching calls, text messaging and online support	
Rhonda's Potential Goal	**Stated**	"I want my kids to be healthy."
	Measurable	Rhonda will engage in prenatal and postpartum care. Amanda attends 90% of her scheduled prenatal and postpartum appointments over the next year.
Opportunity	Enroll and support Rhonda through our HFS and HFS Rewards programs.	
Interventions	▪ Coordinate with Dr. Tucker or the OB/GYN's designated point of contact (e.g., RN in office) to confirm Rhonda is attending prenatal visits ▪ Refer Rhonda to a local behavioral health provider who provides trauma-informed counseling for individuals who have experienced interpersonal violence and postpartum depression ▪ Educate Rhonda on the importance of regular well-child checks ▪ Assess Rhonda's rapport with Amanda's pediatrician and comfort in that office ▪ Screen for any developmental needs because of Amanda's prematurity; if any are identified, refer Amanda to the appropriate provider ▪ If Rhonda is not already enrolled in WIC, refer to WIC for appropriate nutrition ▪ If Rhonda is not already participating in HANDS, refer to HANDS for home visiting ▪ Confirm Rhonda is aware of non-emergency medical **transportation** options available through Federated Transportation Services of the Bluegrass ▪ Engage our mobility manager to identify additional support for transportation for non-health-care needs like grocery shopping	

Mom/Baby Dyad Care Plan: We recognize the importance of a safe environment for both Rhonda and Amanda. We also know that Rhonda and Amanda have similar, but very different needs that should be addressed both individually and holistically as a family. Because of this, our maternal care management team will focus on key family goals and interventions through our unique and innovative Mom/Baby Dyad Care Plan approach to address common needs both Rhonda and Amanda have in a more streamlined and comprehensive way.

Engaging Rhonda in Appropriate Prenatal and Postpartum Care

Recognizing that Rhonda's pregnancy was unplanned, her LCSW care manager suggests she connect with Dr. Tucker to discuss all of her **family planning options**. Assuming she chooses to continue her pregnancy, we notify Dr. Tucker of her enrollment in care management and coordinate with Dr. Tucker or her designee to make sure Rhonda is attending her prenatal visits. We work with Rhonda, Dr. Tucker, Rhonda's PCP and her behavioral health clinician to address her comorbidities (e.g., substance use with alcohol and tobacco, along with possible

depression) to reduce the risk of complications, including miscarriage or preterm birth. We share records, Rhonda's care plan and coordinate services, which make it easier for Rhonda's providers to deliver care. To **support provider engagement** with complex, high-risk pregnant moms, we develop and implement quality improvement initiatives, including VBP incentives to reinforce evidence-based care, innovative approaches to support practice transformation and to reward providers for high quality health outcomes.

Rewarding Providers for High Quality Maternal Care
Our Obstetrics (OB) PCPi Incentive program rewards qualifying OB specialist practices for performance related to closing patient care opportunities 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 HHSC's quality measures). The bonus is in addition to the practice's compensation for rendering enrollee services. Implementation focus areas for this program will include OB specialists in Regions 7 and 8, which have the highest rate in Kentucky of births to mothers who smoked during pregnancy.

Smoking Cessation: Since smoking increases Rhonda's already elevated risk of another preterm delivery and low birth weight infant, the LCSW care manager provides Rhonda with education on the impact of smoking on her own health, her pregnancy and Amanda. They also discuss the importance of smoking cessation to give her baby the best chance of being born full term. She uses motivational interviewing to elicit and strengthen Rhonda's motivation to quit and works with her to set a date to quit smoking and develop an action plan. In addition to referring Rhonda to Kentucky's Quitline, we offer Rhonda our pregnancy-focused Quit For Life maternity program, which provides 10 coaching calls, personalized interactive text messaging and anytime access to an interactive, mobile-friendly website. Her LCSW care manager may possibly recommend that Rhonda discuss the option of a prescription for a cessation aid with her PCP and/or Dr. Tucker, documenting this in *CommunityCare* to raise awareness across Rhonda's care team.

Behavioral Health Services: Because of the recent and pronounced trauma experienced by Rhonda and Amanda and the behavioral health risks identified through Rhonda's PHQ-2/9, her LCSW care manager refers Rhonda to a local, licensed behavioral health clinician like Loretta L. Gilmore who is trained **in trauma-informed care** and accustomed to treating people who have experienced interpersonal violence. This clinician performs an assessment for depression and provides counseling to help Rhonda process the interpersonal violence she recently experienced and to prepare her for the life changes of a second child. Given Rhonda's inconsistent attendance at provider appointments, the LCSW care manager recommends a provider like Loretta because they can provide services via telehealth. Telehealth may help Rhonda engage more readily in care without needing to find childcare or travel to appointments.

Linking Rhonda to Community Resources and Supports

Rhonda requires substantial support engaging in her physical and behavioral health. Because addressing social determinants is essential to achieving long-term health and wellness, our LCSW care manager links Rhonda with **community resources** to address her social needs**.** The LCSW care manager and Rhonda discuss various types of resources she will need to feel comfortable and confident supporting her family. The LCSW care manager connects Rhonda to HANDS — an early childhood development and home visiting program through the Clark County Health Department. This program offers free home visiting to support Rhonda during and after her pregnancy and to help her build a healthy, safe home environment. For food assistance, we refer her to local food pantries like First Baptist Church for their Family Food Pantry Saturdays and the Clark County Community Service food bank. We also connect

Rhonda to her nearest Clark County WIC office. After identifying relevant resources to support Rhonda, her LCSW care manager makes the referral and helps coordinate access to the services. Providing services and supports that wrap around her and Amanda, we can successfully engage and support her as she pursues a healthier life for herself and her family.

Use Case 2

Katy is a 20 year old female who is taking classes at a local community college while living at home with her mother to help take care of her younger brother. Katy's mother works two (2) jobs and has difficulty finding time to shop for and prepare healthy meals. Katy does not assist with grocery shopping or meal preparation. Katy is significantly overweight and rarely exercises. Most of her meals are from fast food restaurants and she only occasionally eats vegetables or fruit.

Recently, Katy became light headed after eating lunch and was taken to an urgent care center by a friend. The provider asked Katy about her symptoms and whether this has happened before. Katy stated that the dizziness happens frequently after meals and she is always thirsty. The provider asked Katy if she has diabetes and Katy stated she did not think so. She told the provider that she has not seen a doctor since she was in middle school. The nurse took Katy's vital signs and a blood glucose reading. Katy's blood glucose reading was elevated and her blood pressure was 162/90. Her BMI was computed to be 32.6. The provider recommended that Katy contact her MCO to find a PCP as soon as possible before her condition worsened and she ended up in the Emergency Room.

Katy contacted her MCO's Enrollee Call Center and explained her situation.

Describe the Vendor's Enrollee engagement process and Care Management. At a minimum, address the following:

a. Evidenced based practices for Care Management;

b. Health Risk Assessment and Care Planning and monitoring;

c. Provider engagement;

d. Cultural competency;

e. Patient engagement and education;

f. Community resources; and

g. Social determinants of health

Keeping with our approach of putting our enrollees first, we developed our use cases to give a voice to the portrayed person by telling their journey in the form of a story. We take this person-centered approach in all of our interactions with enrollees and their support systems making sure their voice and choice shine through from the implementation of their care plan and throughout their entire health care journey.

Katy contacts our member services center during a critical moment. Katy's current lifestyle, including poor eating habits, limited exercise and minimal health care engagement reflect issues many Kentuckians face today. With our community partners, provider stakeholders and the Commonwealth of Kentucky, we envision a future where making healthy choices is easier for Katy and many individuals like her. Earlier engagement opportunities and access to high quality primary and preventive care could have identified and allowed for earlier interventions to address her weight, poor diet and lack of physical activity. However, Katy is now at risk of developing multiple chronic conditions.

We have experience helping enrollees like Katy across each of our 31 Medicaid markets. With every opportunity we have to connect with her, we can empower Katy with information and resources to reengage her in her health care and ultimately partner with her to improve her health. Katy could be one of many young adults living in Bowling Green, Kentucky. Bowling Green is one of the Commonwealth's most populous cities with more than one-third of its adult population obese today. If Katy and her family lived in another, perhaps rural area of Kentucky, the specific resources and providers we connect her with would change, but our person-centered engagement approach would not.

Katy's story of increased risk for chronic conditions because of her health behaviors is, unfortunately, common in her community and among our membership. To meet her needs, we

offer tailored programs and services, including those outlined in the following table. The following table provides a summary of touchpoints, which we elaborate on throughout the rest of the scenario. We have adjusted the order of our answers to items a – g to mirror the flow of our care coordination approach. We also use bolded terms throughout the narrative to highlight where we discuss these key concepts in greater detail.

Program and Services	Summary of Touchpoints to Address Katy's Needs
a. Evidenced-based Practices for Care Management	Based upon information Katy shares with our *Advocate4Me* member service advocate (MSA), we connect her to a locally based CHW to help manager her care and coordinate services to address Katy's needs.
b. Health Risk Assessment and Care Planning and Monitoring	Our trained MSA conducts a health risk assessment (HRA), which populates Katy's needs and goals in *CommunityCare*, our care management platform. This information is available for care management staff to review. Based upon information Katy shares, our MSA could refer her directly to care management for care planning and support.
c. Provider Engagement	The MSA refers Katy to a high quality in-network PCP at Fairview Community Health Center who can screen Katy for diabetes and hypertension and address her obesity. We support Katy's providers in delivering high-quality, evidence-based care by partnering with the Kentucky Regional Extension Center to provide free in-person training on evidence-based practices for diabetes care to PCPs throughout Kentucky.
d. Cultural Competency	Our care management program is locally based to better understand and support Katy's needs. We recognize that her care must be recovery-oriented, culturally responsive and self-determined. Our care team training program includes self-study and instructor-led learning on cultural competency, health literacy and safety. We create a positive experience and relationship with Katy through direct knowledge of the Bowling Green community culture, values and resources.
e. Patient Engagement and Education	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. Community Resources	Based upon Katy's needs, we connect her to applicable resources, such as non-emergency medical transportation through Community Action of Southern Kentucky (CASOKY). CASOKY GO bg Transit can help Katy get to her doctor appointments. We provide Katy with vouchers to attend group-based weight loss programming and refer Katy to free nutrition and cooking classes at Community Education Bowling Green Warren County.
g. Social Determinants of Health (SDOH)	We work with Katy to identify SDOH needs and appropriately refer her to relevant supports such as meal planning education, community gardens or farmers markets in case Katy and her family experience food insecurity. To support Katy's transition to adulthood and fortify her financial literacy, we connect Katy to online resources with UnitedHealthcare's On My Way and provide hands on support to gain greater financial stability with a case manager at the Community Action of Southern Kentucky, a UnitedHealthcare partner.

Initial Engagement with Katy

When Katy takes the initiative to call, our Kentucky-based MSA listens to her story and quickly recognizes that she needs support to reengage in her health care and see a PCP as soon as possible. The MSA, specifically trained to address complex needs, lets Katy know that we are

here to help by fully understanding her situation. Hearing that a change in Katy's health status has prompted the call, the MSA **conducts an HRA** to understand Katy's needs fully and better position us to support her.

Katy had the opportunity to complete an HRA when she enrolled, but because of her change in condition, we complete a new HRA. 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.

Based upon the information Katy shares about her recent health status, the experience at urgent care and possible anxiety she has about emergency services in the future, Katy may ask for some additional support. The MSA discusses the opportunity for care management with Katy and can refer her directly into care management if needed. We can also accept referrals from Katy's family or providers via our member services call center. If her body mass index meets criteria for a diagnosis of obesity, Katy has one chronic condition. Based upon this information and her low utilization of primary care services, she will risk stratify into management of chronic conditions of our PHM program.

To meet her most pressing need, connecting Katy to a PCP, the MSA helps **educate Katy** on the benefits of routine care and offers to help schedule an appointment. Like all of our enrollees, Katy had the opportunity to identify a PCP upon enrollment. However, considering her limited engagement, it is unlikely Katy has a regular PCP. Our MSA works with Katy to make sure she is comfortable with the high quality local provider to whom she was auto-assigned and helps her change PCPs if Katy, for example, prefers finding a PCP closer to her school. If Katy does not have a designated PCP or strong preference for a specific PCP, the MSA recommends a nearby in-network PCP at Fairview Community Health Center.

Before helping Katy to schedule an appointment, the MSA asks Katy about any barriers or concerns. Because Katy is often busy with school or caring for her brother, she expresses anxiety about finding a PCP with evening or weekend availability. Fairview Community Health Center has extended evening hours on Tuesdays and Thursdays. If Katy has difficulty accessing transportation, the MSA connects Katy to CASOKY GO bg Transit, her local Human Service Transportation Delivery provider that facilitates non-emergency medical transportation (NEMT). Additionally, her MSA notifies her that since July 1, 2019, Fairview Community Health Center is equipped with telehealth capabilities, which should make follow-up visits more accessible for Katy. The MSA offers to help Katy schedule an initial appointment in the upcoming week and counsels her on what to expect.

Connecting Katy to Education and Community Resources

The MSA's engagement with Katy does not end after connecting Katy to a PCP and addressing Katy's primary reason for the call. By listening to Katy's story, conducting the HRA and reviewing any desktop notifications on our *Advocate4Me* platform, the MSA pursues additional opportunities to support Katy in her health journey. If this took more time than Katy has available, the MSA documents each of the follow-up items in Katy's file with associated completion deadlines to make sure we meet all of Katy's additional needs. To confirm Katy receives continuity of care, these items and other information shared during the call are documented in her file on our integrated system, *CommunityCare*. Information on this platform is accessible to other MSAs and/or Katy's future MCT to review.

We know the health care system is confusing, and even more so for a young adult with limited health care experience. We support Katy by starting with basic information to **empower her to be a well-informed consumer of health care** and to take a more active role in her health.

Once she has connected with her provider, her CHW will make a note to follow up with Katy and supplement her provider visits with tools and educational resources available online at *myuhc.com* or through our mobile application.

Our comprehensive MSA training program, including lessons like *Health: Beyond the Clinic,* help to make MSAs attuned to recognizing the important role of health-related social needs. In addition to training our MSAs on the role of **SDOH**, we give them access to our online platform, *Healthify,* which serves as a library of local resources. When enrollees like Katy identify a social need where they need help, our MSAs link them to **relevant services and community organizations**. Given Katy's current struggle with her weight, unhealthy eating habits and her potentially limited experience with grocery shopping and nutrition, the MSA may possibly connect her with the following types of referrals. Again, these are based upon needs and preferences expressed by Katy:

- **Farmers market for nutritious food options.** If Katy attends Southcentral Kentucky Community and Technical College, the MSA might suggest Katy begin going to the *Community Farmers Market* held on Tuesday and Saturday afternoons. Less than 10 minutes away from her school, this is a convenient way for Katy to get healthy food.
- **Local classes to learn healthy lifestyle skills.** Given that Katy's family life is not helping to instill healthy eating behaviors, the MSA can connect Katy to one of the adult enrichment classes held at Community Education Bowling Green Warren County, such as their 2-day course on Cooking + Nutrition. To replace her fast-food habits, Katy might want to focus on learning how to prepare herself healthy, quick snacks and meals she can grab while she is in between classes or rushing home to care for her brother.
- **Online resources to encourage self-study.** Recognizing Katy's openness to learn, her MSA offers her additional online resources, including those available through her *myuhc.com* enrollee portal or through *ChooseMyPlate.gov*, which provides education and tools for healthy eating on a budget, including information on shopping, nutrition and healthy recipes.

In addition to building health-related skills through community resources, Katy may want to gain additional skills that can help her transition to independent living as a young adult. In this case, the MSA could connect Katy to two different resources, depending on her preference and the level of support required. For example, the MSA could introduce Katy to On My Way, a UnitedHealthcare tool designed to help Katy learn independent skills on her own. Developed primarily for enrollees between the ages of 14 and 26, On My Way provides access to an interactive, mobile and web-enabled game to help young adults prepare for real-world situations. **On My Way promotes independence and teaches practical skills**, such as managing money, securing housing, finding job training and applying for college. Alternatively, if Katy expressed a desire for additional hands-on support, the MSA can connect Katy to a case manager at one of our local partners, Community Action of Southern Kentucky. As a Community Action Agency (CAA), Katy's CAA case manager can help her navigate a diverse set of services to help enable economic empowerment across multiple domains, including, workforce development, housing, asset building, home energy support and food security, based upon Katy's needs and interest.

Care Management

Based upon what Katy shares about her obesity and risk factors for diabetes and hypertension, disengagement from health care, limited familiarity with the health care system and possible risk for preventable emergency services, the MSA directly refers Katy to management of chronic conditions (Level 1) of our PHM program.

Similarly, if Katy's PCP at Fairview Community Health Center diagnoses her with obesity or another other chronic condition (diabetes, hypertension) or with prediabetes (risk factor for chronic disease), Katy or her provider can refer her directly into chronic condition management. This referral initiates outreach from a locally based CHW to support Katy with **care management**. Katy's CHW lives in or nearby Bowling Green and offers Katy additional support with an intimate understanding of available community resources.

Katy's CHW reaches out to set up time to speak with her, which can be telephonic or ideally face-to-face. We know this initial meeting may touch on topics that are personal and uncomfortable, which is why **establishing a trusted relationship** between Katy and her CHW is so important. Katy's CHW avoids accusatory or negative language, focusing instead on Katy's goals and aspirations, such as finishing her degree and living independently in the future. Katy's relationship with her CHW becomes a safe haven where the two can discuss any of her needs. Katy's CHW has received extensive **evidence-based training** on topics such as person-centered care, stages of change and power of personal narratives. Through **motivational interviewing**, Katy's CHW activates her interest, acts as a non-judgmental support and provides insight into how services can support Katy. Katy shares her priorities, which may possibly include feeling healthy enough to focus on her studies or friends. Together, they explore the circumstances and behaviors that have led to her poor health status.

Assessing Katy's needs and goals. To understand Katy's needs, goals and preferences, her CHW uses shared decision-making tools, evidence-based practices and active listening to conduct our Enrollee Needs Assessment (ENA). Understanding that multiple diagnoses could trigger depression and anxiety, Katy is assessed using the PHQ-2/9 and GAD-2/7 screeners. Katy's CHW digs deeper into Katy's SDOH needs using our ENA, which includes 33 questions related to SDOH; our Access to Care assessment identifies barriers Katy may face, such as lack of transportation or access to healthy foods, increasing her risk of poor health outcomes. Since she is a young woman of reproductive age, Katy's CHW assesses if Katy is sexually active and desires pregnancy. If she does not desire pregnancy, the CHW provides counseling on reproductive health and encourages Katy to discuss contraceptive options with her PCP.

Developing Katy's Person-centered Care Plan with Shared Decision-making

Developing a care plan is a collaborative process, taking place over the course of a series of planning meetings with Katy, her CHW and her chosen care team. Katy's care plan is dynamic and continually updated as she achieves goals, identifies new ones, or as her needs change. The table herein presents Katy's possible goals, the expected outcomes and the services and supports to help Katy successfully pursue health and wellness.

Katy's Potential Goal	**Stated**	"I want to lose weight."
	Measurable	Katy loses 5% body weight over the next year, which, among other health and wellness benefits, is associated with decreased risk of progressing to Type 2 diabetes.
Opportunity	Katy changes her diet to incorporate more healthy foods and less fast food. Katy begins walking with her little brother and at campus to become more active.	
Interventions	▪ Counsel Katy on the importance of physical activity and develop action plan with concrete goals to increase physical activity, such as 7,000 steps a day ▪ Educate Katy with materials on healthy eating and physical activity, like those available on *ChooseMyPlate.gov* and set concrete goals for action plan, such as eliminating soda, decreasing fast food and increasing fruits and vegetables ▪ Provide Katy with vouchers to attend group-based weight loss programming by a CDC-recognized national Diabetes Prevention Program provider, Weight Watchers ▪ Refer Katy to free nutrition and cooking classes at Community Education Bowling	

	Green Warren County and reduce Katy's dependence on fast food ▪ Refer Katy to nutritionist who can provide additional counseling on healthy eating and weight loss	
Katy's Potential Goal	**Stated**	"I don't want to go to the ED."
	Measurable	Katy shifts her utilization and avoids ED visits for a year.
Opportunity	Katy proactively engages with her PCP and adheres to recommended behavior change.	
Interventions	▪ Help Katy schedule her initial PCP visit and counsel her on what to expect ▪ Care management team follows up with Katy to confirm appointment occurred and to answer any questions she might have after the appointment ▪ Refer Katy to resources that could facilitate appointment attendance (e.g., NEMT) if she has difficulty with transportation ▪ Empower Katy to talk to her PCP about telehealth visits	
Katy's Potential Goal	**Stated**	"I want to share positive lifestyle habits with my brother and continue them if I live on my own."
	Measurable	Katy takes a full load of classes at her community college while applying to potential part-time opportunities.
Opportunity	Katy begins envisioning and investing in a healthy future for herself.	
Interventions	▪ Connect Katy to financial literacy resources aimed at young adults at On My Way ▪ Connect Katy to a case manager at Community Action of Southern Kentucky that can Katy build skills of independent living, including financial literacy needed to meet her goal of living on her own ▪ Refer Katy to information and resources available on *myuhc.com* ▪ Refer Katy to available resume building sessions and job fairs	

Though we offer a range of provider education opportunities online, we recognize the important perspective and distinct expertise of local leaders. We are partnering with the Kentucky Regional Extension Center to instill evidence-based diabetes practices from the Barnstable Brown Diabetes Center to providers in community practices like Fairview Community Health Center where Katy receives care. On May 14, 2019, providers in and around the Bowling Green region gathered to learn about evidence-based best practices to improve diabetes outcomes in their communities. This event, also held in Hazard, marked a kickoff to a more intensive partnership between UK REC and UnitedHealthcare, which will support five different provider practices as they improve their diabetes care across Kentucky.

Katy and her CHW continue to meet regularly to track her progress toward goals, address any of her concerns or barriers that arise to support her continued improvement. Katy's CHW will perform a new assessment annually, as Katy's conditions change, or per Katy's request. As Katy meets and even exceeds her goals, she gains confidence in a new, healthier lifestyle and graduates out of care management.

Provider Engagement

Our **engagement with Katy's providers** begins long before she reaches out for help. We know that we share a mission to help people live healthier lives with our network of providers and that better supported providers allow us to improve the health and wellness of our enrollees. For this reason, we began engaging with providers on how we could partner with them to improve the lives of Medicaid enrollees in Kentucky as early as 2018. We have grown and deepened these partnerships as we demonstrate our commitment to the provider community and the individuals they serve.

Our partnership with the Kentucky Primary Care Association (KPCA) significantly affects the way we support enrollees like Katy. Katy may feel uncertain about her new PCP relationship and will be learning for the first time about serious chronic conditions she is at risk for.

Finding the right PCP to support her and make her feel welcome will be essential to Katy's success in meeting her goals. Partnerships with local leaders and providers showcase our commitments to our communities and are one of the many ways we live our mission of helping people live healthier lives.

Use Case 3

The Vendor is implementing a two-year initiative to improve outcomes by addressing a variety of health behaviors (e.g., tobacco use and diet) and social determinants of health in the southeast region of Kentucky. The Vendor has enrolled several primary care and multi-specialty provider groups in the area to participate in the initiative and has developed relationships with various community agencies to support the effort. The Vendor has identified five (five) quality measures for which providers will receive incentives for meeting targeted improvements. The quality measures emphasize physical and behavioral health integration, social determinants of health, and critical community resources. The Vendor intends to make initial incentive payments 14 months after the start of the initiative. Six (6) months into the project, a multi-specialty provider group's Administrator met with the Vendor to discuss challenges the group is encountering with the initiative and to raise concerns about reporting. This provider group has 50 participating practitioners, including Advanced Practice Nurses, in four different locations. Specifically, challenges are as follows:

- Some practitioners in the group are very engaged while others are not interested in supporting the effort, indicating it is too complicated and administratively burdensome as the group is also participating with similar initiatives being implemented by the other contracted Medicaid MCOs, but that have different required measures.

- The provider group has a new electronic health record (EHR) system and experienced numerous onboarding issues that haven't yet been resolved. In addition, the provider group does not plan to contribute or retrieve information from KHIE until the EHR issues are resolved. The provider group does receive ADT data from Southeastern Kentucky Medical Center and the Baptist Health hospitals.

- The Administrator has made multiple attempts to outreach to a community housing agency that the MCO indicated is supporting the effort to discuss opportunities to collaborate; however, the agency has not returned calls.

- Enrollee compliance is lower than anticipated. Follow up and other outreach has been difficult due to Enrollees not returning calls and also incorrect Enrollee contact information.

- The Administrator is frustrated that the MCO had not provided feedback on the first set of required reports that were submitted three months after project initiation. Communication has been minimal and the Administrator is concerned about lack of support.

The Administrator and practice leadership are concerned with the extended timeframe for incentive payments and the ability to impact providers' behaviors.

Describe the Vendor's approach in addressing the Provider's concerns. At a minimum, address the following:

a. Provider engagement at local, regional, and statewide levels;

b. Provider education, communications, and support;

c. Simplification of provider administrative burden;

d. Enrollee engagement; and

e. Vendor assessment of internal operation challenges and mitigation strategies.

UnitedHealthcare's strategy for quality initiatives and provider incentive models is to become the participating provider's advocate and support base for quality measure achievement and success. Our support model surrounds the practice with the innovative resources, data and tools described within this response, which are assigned based upon provider sophistication and readiness. Some practices are advanced and self-sufficient in their initiative activities, while others require a more high-touch approach. Based upon the Use Case description, the latter appears to be the case with the struggling multi-specialty provider group, herein referred to as KY MPG. We recognize facilitating KY MPG's success within our initiative is critical to improving enrollee health outcomes in southeastern Kentucky — an area that consistently ranks low across almost all health and social determinant measures. For example, Region 8 has the highest concentration of poor health results, including obesity, tobacco use and diabetes prevalence; second highest overdose mortality rate; and third highest infant mortality rate.

We will actively encourage all KY MPG clinicians to engage in these health priority areas via our selected initiatives and incentivized quality measures to deliver high quality, efficient and effective care.

We use a holistic approach to provider engagement, incorporating Kentucky-based support on an individual practice basis; regional connections and solutions; and statewide guidance and opportunities. Local provider relationships are critical to tailoring support for multi-located practices like KY MPG, and our **local engagement team** will include the following resources.

Local UnitedHealthcare Support Resource	Role Description
Kentucky Chief Medical Officer (CMO)	Will visit KY MPG providers routinely to provide information and solicit feedback on the quality initiative, work with KY MPG's CMO on provider engagement strategies and help address MCO measure alignment concerns.
Kentucky Chief Executive Officer/Chief Operations Officer	Will be available to support KY MPG with any significant billing issues, and initiate the collaboration meeting for DMS, other MCOs and key providers like KY MPG to align on measures.
Provider Quality Engagement Consultant (PQEC)	Will provide KY MPG resources (e.g., tools, reports and educational materials) for engaging their enrollee panels and closing gaps in care. They also will explain how our quality incentive program uses CPT Category II codes to pull in data so providers will get credit for the gaps they closed without having to submit supplemental data. PQECs (field-based RNs) will engage primarily with KY MPG's practitioners, including advanced practice nurses.
Provider Advocates	Will provide further education on our provider portal and its many capabilities to reduce administrative burden, HEDIS specifications (billing/documentation requirements), our quality incentive program and other key topics during their monthly visits to KY MPG locations (or as requested), engaging primarily with KY MPG's provider administrative staff and billing representatives.
KY MPG Practitioner Advocate	Will identify and work with a KY MPG practitioner, who is very engaged in the initiative and achieving success within the program, to be our advocate within the group and help generate increased interest in participation.
Kentucky Housing Navigator	Will engage as needed with KY MPG to help resolve housing-related issues for enrollees, including outreach to community housing agencies for connection purposes. The housing navigator will build partnerships throughout Kentucky to understand available housing options and identify the southeastern Kentucky resources that provide housing and housing support.
Kentucky Manager, Mobility & Vendor Oversight	Will be an experienced logistics professional who will work with KY MPG as needed to address enrollee transportation needs at a local level, and is critical to enrollee outreach/assistance related to accessing needed transport services.
Care Manager and Community Health Worker (CHW)	Will help resolve enrollee engagement gap for KY MPG by connecting with their complex care patients, allowing KY MPG to continue working toward their incentive goals and focus on the quality of care they are providing.

UnitedHealthcare also will build upon our regional relationships with various community agencies, health systems and other key stakeholders to identify participation and alignment opportunities for KY MPG, such as the following examples.

Connected Regional Opportunity: Medicaid Innovation Zone

In a neighboring county, we have selected Hazard as the initial rollout location to implement our new Medicaid Innovation Zone development effort. These Zones are being created to accelerate rapid cycle delivery of Medicaid services for enrollees and, in collaboration with key partners, improve quality of care, population health and life outcomes, and reduce or eliminate health disparities. Regional stakeholders committed to developing the Medicaid Innovation Zone in

partnership with UnitedHealthcare include Appalachian Regional Healthcare, LKLP Community Action Council, Primary Care Centers of Eastern Kentucky and the Center of Excellence on Rural Health. We will work with these partners, and other identified stakeholders, on an ongoing basis to better understand potential barriers and best practices related to provider adoption of similar initiatives. As such, we look for opportunities to align and connect KY MPG's initiative efforts.

This collaboration has expanded our understanding of successful local practice management approaches, which we will discuss with KY MPG for consideration. An example of multi-located practices improving care is the consolidation of previously multi-located clinical services (pharmacy, diabetes management and medication assisted treatment for pregnant women) to one Primary Care Centers of Eastern Kentucky (PCCEK) location — a promising method that meets the needs of both providers and enrollees. PCCEK now offers a fully integrated, centrally located health care resource delivering holistic patient care that has proven to be very successful and invaluable to regional enrollees. As a rural health clinic actively involved in the Kentucky Primary Care Association (KPCA) membership, we will build upon our strong partnership with KPCA to share best practices, improve integration efforts and support better enrollee outcomes across providers in southeastern Kentucky, including KY MPG and throughout the Commonwealth.

We will offer KY MPG an opportunity to participate on UnitedHealthcare's **statewide** Provider Advisory Council (PAC) to discuss the initiative's progress and objectives with peers and to hear how providers in other Kentucky regions manage challenges and achieve success. The PAC is designed to glean Kentucky Medicaid-specific feedback from providers on operational challenges, experiences and specific administrative or system delivery issues, while promoting collaboration. Information gathered from KY MPG during PAC meetings also will be shared during appropriate Technical Advisory Committees (TAC) and Advisory Council for Medical Assistance (MAC) meetings. Additionally, we will regularly participate in any meetings with statewide-focused groups such as the Kentucky Medical Association, Kentucky Hospital Association, Kentucky Association of Regional Programs, Community Action Kentucky, KPCA, Kentucky Association of CHWs and more to better understand how to maximize best practices for KY MPG and alleviate barriers to initiatives across Kentucky.

The following sections outline our approach to address each identified area of concern for KY MPG on their health care transformation journey. We understand the group's challenges and desire to improve their practice abilities and patients' health.

Use Case Response Guide
Each proposed mitigation strategy herein discusses DMS-required topics as applicable to the specific challenge, with key words identified for review convenience. As a guide:

- A = Provider engagement
- B = Provider education/support
- C = Reduce/ease administrative burden
- D = Enrollee engagement
- E = Internal operation improvements

Challenge: Practitioner Interest and Initiative Complexity/Burden (Provider Engagement, Provider Education, Ease Administrative Burden)

We recognize, from our 6-month meeting with KY MPG's administrator, that we need to enhance and modify our **provider engagement** process to address their specific challenges. To increase provider interest in our initiative across all KY MPG practitioners and alleviate concerns related to administrative processes, we apply the resources of our local leadership, quality, clinical and provider relations engagement teams and take the following approaches. During regular KY MPG practitioner touchpoint, we **educate providers** on how best to participate in the initiative; how to best reduce administrative burden using UnitedHealthcare technology (e.g., provider portal, *Link*); and how we will modify internal operations and the incentive's payment schedule to be more frequent to encourage additional provider engagement. We will ask KY

MPG's administrator for a list of the practitioners currently not engaged. Using this information, our CMO, PQEC and provider advocates, along with the internal KY MPG practitioner advocate, host an in-person Lunch & Learn meeting to educate and share best practices. At this meeting, we discuss the providers' quality data, how the provider can use their Patient Care Opportunity Report (PCOR) report to close gaps in care and maximize their earning potential under the quality incentive. In addition, we communicate how they can access and use our provider-friendly online tools and support resources. We have weekly check-ins until the provider is engaged and comfortable with the program.

To address KY MPG's concerns around program complexity specific to different quality measures across MCOs and **ease administrative burden**, at DMS's direction, we encourage collaboration with other MCOs, as other MCOs are most likely experiencing similar operational challenges and receiving the same provider feedback. Assuming the multi-MCO VBP meetings are already ongoing, we address these concerns via that forum. If those meeting have not started, we address these concerns in the MAC and TAC meetings as the other MCOs will be present. If another forum is needed to specifically address KY MPG's concerns, we offer to host, with DMS's direction, a statewide meeting for all Kentucky MCOs and DMS's staff to collaboratively discuss how we can best align on targeted metrics and other initiatives (e.g., performance reporting), interventions and solutions. If necessary, our programs are flexible enough to change measures mid-year to align with other MCOs.

Challenge: Onboarding Issues with New Electronic Health Record (Provider Engagement, Provider Support)

We **support** KY MPG to continue to resolve onboarding issues related to their new electronic health record (EHR) system by connecting them with a UnitedHealthcare resource that has specific expertise in EHR connectivity. The designated resource assists KY MPG until the issue is resolved and once it has been, they ensure KY MPG initiates participation in Kentucky Health Information Exchange (KHIE). Until EHR barriers are resolved, UnitedHealthcare **engages**, deploys and **supports** alternative solutions to confirm KY MPG receives the comprehensive, real-time data necessary to affect enrollee outcomes. Our application teams provide customized data extracts (e.g., ADT hospital feeds and ED encounters) to KY MPG based upon agreed specifications. These medical encounters signal opportunities for the provider to intervene and follow up with enrollees; manage cost drivers such as avoidable ED visits, potentially avoidable admissions and readmissions, medication adherence and manage transitions of care. For these data exchanges, we can use a variety of transport mechanisms, including secure File Transfer Protocol (FTP) or posting on *Link* and its direct connection to our *CommunityCare* care collaboration platform. Our PQEC and advocate teams work directly with KY MPG to advise, train and continue to **support** during this interim time. In addition, we advise KY MPG, if it has not already done so, to complete a KHIE participation agreement and sign up for direct secure messaging services so clinical information can be shared securely with other providers in their community. We are engaged to support KHIE and to support our providers by investigating ways to exchange data to support better enrollee outcomes. We can facilitate discussion between KY MPG and KHIE to develop an appropriate action plan on beginning this process. If KY MPG has questions about the agreement, we facilitate discussions between their practice manager and DMS for answers. We can also arrange a meeting with the Regional Extension Center in southeast Kentucky to help KY MPG with their EHR onboarding issues.

Challenge: Nonresponsive Community Housing Agency for Collaboration (Provider Engagement, Reduce Administrative Burden)

Enrollees' unmet social needs lead to worse health outcomes and are as important to address as medical conditions. As KY MPG's administrator has already made multiple, unsuccessful

attempts to contact the recommended housing agency, our Kentucky-based housing navigator **engages** to help connect the recommended agency and KY MPG. The housing navigator takes the lead by scheduling and facilitating meetings (relieving **administrative burden** from KY MPG's administrator), or if our attempts are unsuccessful, they provide and recommend other community housing agencies for collaboration purposes. To locate alternate options, we use the Kentucky-customized version of *Healthify*. *Healthify* is a web-based tool, easily accessible by mobile device, that helps make connections to relevant and available social resources that deliver services (e.g., housing, food, legal resources, employment assistance, energy, support groups, childcare and clothing) to individuals at risk for poor health outcomes or inappropriate use of health care services. Mirroring pilots used in Arizona and Ohio, we also will give select Kentucky community-based organizations (CBOs) access to *Healthify*, choosing three Community Action Agency (CAA) locations to initially pilot, then scaling, where appropriate, to other CAAs across the Commonwealth.

UnitedHealthcare will convene key Kentucky stakeholders, including providers like KY MPG and the local CAAs, to explore private/public partnerships and solutions that will help address SDOH-related issues specific to housing (e.g., affordable housing options, supportive housing solutions and integrating SDOH/physical/mental services to address the rapid rise of homelessness across population segments). Our CMO and community partnerships director participate in the UK Accountable Health Communities (AHC) Advisory Board that is focused on SDOH screening, community referrals and identifying resources gaps in parts of southeastern Kentucky, then working with partners to develop tangible solutions. We will build upon our national efforts collaborating with the American Medical Association to support the creation of 23 new ICD-10 codes relating to SDOH. The new codes will standardize how data about SDOH is collected, processed and integrated into enrollees' person-centered care plans, thereby simplifying social services referrals. We share any information related to this effort with KY MPG as it becomes available, including the timeline of when new coding is expected.

Challenge: Low Enrollee Compliance, Call Response and Contact Data Reliability

(Enrollee Engagement, Ease Administrative Burden)

UnitedHealthcare wants to help providers like KY MPG to **engage enrollees** at the right time, in the right way. The following are previously deployed example strategies and tools we use to **ease the administrative burden** with enrollee engagement:

Engagement Strategy	Description
Enrollee Contact Information Updates	Share updated enrollee contact information with KY MPG as we receive it either in our enrollment files, pharmacy files and/or as our care team makes contact, particularly if an enrollee has been engaged with our housing navigator. We also partner with local CAAs for updated contact information, as enrollees go to them locally for support.
Enrollee Transportation	Offer transportation for appointments at KY MPG, as we know transportation is a primary issue in southeast Kentucky. In other markets, we have offered tokens, rides and other alternatives. We will partner with Kentucky's NEMT provider statewide for enrollee transport, with our mobility and vendor oversight manager collaborating on and developing alternative transportation solutions with all Kentucky partners. We also use telehealth by conducting enrollee education forums to provide information on telehealth benefits; where and how to access telehealth services; and the accessibility of virtual health clinics through our free mobile application.
Enrollee Appointment	Assist KY MPG in scheduling appointments via off-site staff or, as we have done in other states, place staff within the practice to help with enrollee scheduling. Additionally, we

Engagement Strategy	Description
Scheduling and Telephonic Outreach	make live or automated preventive health calls to educate enrollees who have been identified as needing recommended services. In Florida, for noted gaps in care around the Comprehensive Diabetes Care – HbA1c Control measure, we implemented an improvement action plan targeted by geography and age group that included outreach to enrollees for education and assistance with appointment scheduling. Based upon our targeted, regional interventions, final HEDIS 2018 results for this measure improved by 3.4 percentage points and exceeded the State's performance goal.
Enrollee Educational Mailings	Provide cobranded, regular educational mailings using a set of targeted, age- and gender-appropriate enrollee health education and prevention reminder mailers. We can develop and produce the communication pieces, and then assist in their deployment.
Enrollee Incentives	Use our Kentucky enrollee incentive programs such as Healthy First Steps Rewards, which we designed to parallel our provider incentive goals and track to encourage enrollees to access appropriate prenatal, postpartum and well-child care. Nationally in 2018, we have seen lower preterm birth and low birth-weight rates, and 15.3% higher rates of physician visits among enrollees using this incentive.
Reminder Call/Texts	Provide appointment and preventive care reminders to KY MPG-assigned enrollees through IVR calls or texting campaigns.
Field-based Resources	Use CHWs, as trusted resources in the community, to conduct focus groups with enrollees to better understand their lack of engagement and what additional needs they have before actively participating. We also will use our regional field-based CHWs to help find and encourage enrollee's participation in care management for care appointments; KY MPG's assigned CHWs work hand-in-hand on enrollee engagement. In Kansas, our CHWs schedule appointments, conduct enrollee follow-up, provide weekly educational opportunities and arrange other health support services for 200 low-income enrollees in two targeted rural areas. Through these efforts, we anticipate 60% of appointments made by CHWs will be kept, and compliance with medication and treatment will increase by 30%.
Mobile Care	Discuss setting up a mobile clinic at CAA locations for primary care delivery with KY MPG, as there are CAAs in every Kentucky county highly used by enrollees.
Clinic Days and Health Fairs	Promote and help administer clinic days and health events to educate enrollees and close gaps in care, in partnership with KY MPG and relevant CBOs. In a similar Medicaid market, we had clinic days in rural areas targeting 4,277 enrollees for diabetic testing for A1c and eye exams over 2 years; 194 enrollees obtained testing, a rate of 22% for a most difficult to reach population.
Partnerships with Local Key Organizations	Work with local CBOs and faith-based organizations to identify opportunities for solution partnerships around enrollee engagement (e.g., locate, transport, educate or update contact data), and facilitate connections between them and KY MPG. For example, we will work with southeastern Kentucky Family Resource and Youth Services Centers, school-based family advocates who engage with enrollees/their families on a regular basis, to assist with enrollee engagement. In other regions, we are partnering with local churches to transport enrollees with OUD to clinics for care and will look for similar collaborations in southeastern Kentucky.

Challenge: Lack of MCO Feedback and Minimal Communication (Provider Engagement, Provider Education/Support)

UnitedHealthcare takes provider feedback to heart and will adapt our support programs to align with KY MPG's needs. We acknowledge, based upon KY MPG administrator's stated frustration around lack of communication and support, that we need to improve our responsiveness, engagement and training to assist with their success within our quality initiative and incentive program. KY MPG's assigned PQEC will play a primary role in addressing KY MPG's

engagement and support concerns. The PQEC arranges an in-person meeting with KY MPG staff to review and explain the practice's monthly performance scorecard (PCOR) and provides collaborative opportunities through educational Lunch & Learns. The PCOR includes enrollee-specific information highlighting potential gaps in care for provider action. Reports are generated using claims and encounter data, and monitored on an ongoing basis. PCOR shows performance by individual KY MPG providers and by the overall practice. It is delivered conveniently and timely via in-person PQEC visits and *Link* posting.

The PQEC also provides further **education** on future expectations and other available UnitedHealthcare provider tools and resources that will help them track their performance, meet targeted initiative improvement metrics and achieve incentive bonus rewards, such as path training documents and UHCCareConnect. ***Path training documents*** are a user-friendly guide designed specifically for PCPs and offer an at-a-glance, checklist-type reference for the recommended adult and pediatric preventive health services and they summarize the HEDIS requirements for each measure. UHCCareConnect is an online tool that helps providers identify, address and manage open care opportunities for enrollees. It allows providers to submit supplemental data by uploading structured/computable data exchange with CCD, CCDA or C-32 formats. The data submitted will close care opportunities and is reflected in the PCOR. UHCCareConnect can also assist providers in identifying enrollees that have had a recent hospital stay so they can provide appropriate and timely post-discharge care.

Challenge: Timing of Incentive Payments Impacts Provider Behavior (Internal Operation Improvements, Reduce Administrative Burden)

We acknowledge KY MPG's concerns around the 14-month payout schedule and its direct effect on provider interest and engagement in the initiative. Our mitigation strategy to **improve this internal operations challenge** is to deploy a more frequent incentive payout for the 2-year incentive. We are flexible and able to modify reimbursement and contract terms to help providers succeed in achieving their quality goals. KY MPG could use the interim payment to reinvest in their practice, such as in their support staff, EHR and other infrastructure enhancements — all of which will lead to a more efficient KY MPG and **reduced administrative burden** on current resources. The following is an example of how we were able to directly influence provider behavior through use of more frequent incentive payouts.

Example: Frequent Payouts Leading to Increased Engagement

We have experienced increased engagement in our Louisiana and Tennessee quality VBP program and improvement in HEDIS scores by implementing more frequent incentive payouts. Though the standard national approach is to pay out annually, we listened to our network providers and addressed their needs. For the targeted measures in our PCP HEDIS Gap Closure model, we closed an additional 5,916 gaps in 2018 versus 2017 (after normalization). In addition, 63% of group/measure combinations improved or maintained performance year over year for those targeted measures. We will deploy this strategy in Kentucky for VBP quality incentive models.