17. Provider Services (Section 27 Provider Services)

a. Summarize the Vendor's overall approach to Provider Services, including initiatives and processes for providing effective services to providers to support the Kentucky Medicaid program. In the response, address the following at a minimum:

Our network providers are essential partners in improving health outcomes for our enrollees. We leveraged our relationships with providers throughout the Commonwealth, built over the past three decades of experience, to help us build and plan our MCO Program. Through this close collaboration, combined with our 44 years of experience in 31 other Medicaid markets, we designed an innovative and forward-looking approach to provider services that will meet and often exceed the support needs and preferences of our Kentucky MCO care providers and improve access to high quality care for our enrollees.

Our experience in Kentucky since 1986 and interactions with providers across the Commonwealth, including face-to-face meetings, town halls, surveys, listening sessions and network development activities, have given us the opportunity to learn about the current challenges they are facing in working within the Medicaid managed care program. For example, based upon recent Kentucky provider surveys and DMS-provided information, we know medical record requests (too many), claims (pay accurately and timely), lack of communication (data sharing), lack of physical-behavioral health integration, prior authorization and credentialing (disparate processes, data accuracy and loading time) are top areas of current concern and provider dissatisfaction. We commit to partnering with DMS and other MCOs to address the commonalities of these pain points.

Internally, we have charted a nationwide path to modernize the health care system — starting now and looking to the future, with Kentucky as a planned early adopter. We recognize that achieving our future goals will require working more effectively with Commonwealth providers big and small, from the multi-state hospital system to the solo-practicing family physician, and from the CEO to the office manager to the frontline caregiver. Our current provider service solutions have a strong focus on high-touch, proactive and efficient essentials (e.g., timely claims payment, ongoing education) that are paving the way for implementation of future enhancements related to integration, electronic health records (no chart chases), electronic banking and online capabilities.

Overall Approach to Provider Services and Support

Recognizing that proactive, efficient and effective communication is at the core of supporting our network providers of all types, we developed the Provider 360° Service & Support model. By putting the provider experience at the center of our process, along with provider preferences related to electronic, face-to-face and phone support, we can address issues of importance to providers while leveraging resources and technology that improve their experience. Our Provider 360° Service and Support model includes:

- ***Contracting Support:*** Our relationship with new providers begins with the provider recruitment, contracting and credentialing onboarding process, which leads to a comprehensive introduction to UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare). We have and, will continue to, conduct in-person and web-based town hall meetings, Lunch & Learn opportunities, and in-service sessions throughout the Commonwealth. We use these opportunities to welcome our providers, introduce our supporting programs and tools, solicit ideas and input, and provide a forum for any questions or concerns they may have.

- ***Provider Advocate Support:*** Described in detail in the following sub-section i, to eliminate confusion among providers regarding who to contact for assistance, our Kentucky-based provider advocates serve as the "One Face of UnitedHealthcare" — a single point of contact for network providers across all lines of business. Advocates visit physician offices routinely to educate and establish relationships with providers and their staff to foster collaboration in service delivery to our enrollees.

Figure 1. UnitedHealthcare's Provider 360° Service and Support model wraps around the provider to support their practice needs and maximize enrollee health outcomes.

- ***Practice Transformation Support:*** Our practice transformation support engages providers to assist their movement up the value-based payment (VBP) continuum from quality incentive programs to advanced Accountable Care Organization (ACO) arrangements, with resources that range from in-person clinical staff to robust and actionable population health reporting. The flexibility of our support model allows us to engage providers at their level of readiness, informed by a provider's experience, resources and sophistication. For example, we use our ACO shared savings VBP program for providers with a large UnitedHealthcare membership, and have developed the flexibility to use "nontraditional" ACO engagement models for providers with less than 1,000 enrollees to design reimbursement structures that drive both improved enrollee health outcomes and value for the provider. The supports we offer to network providers not participating in VBP arrangements improve program performance and create a framework that facilitates their shift to VBP, supporting the Commonwealth's broader goals. Additionally, we are partnering with the Kentucky Regional Extension Center in a one-year practice-transformation support effort for four provider practices in different geographic regions across Kentucky (e.g., Hazard, Bowling Green and Pikeville). This program will focus on diabetes care and support will include data collection and gap analysis; monthly calls and quarterly in-person meetings; and identification of improvement opportunities.

- ***Quality Management and Clinical Support:*** We support providers with provider-facing quality management clinical staff that share performance data through on-site visits and virtual support. They review performance on quality and incentive measures, gaps in care, utilization of services and suggest ways to improve practice results. This support helps drive the activities that will improve quality, reduce avoidable health care cost and subsequently trigger incentive payments within various VBP and other shared saving payment models to enable provider success.
- ***UnitedHealthcare Local Leadership Team Support:*** Our Kentucky health plan leadership has and will continue to develop relationships with providers throughout Kentucky. Engagement with providers will occur through attendance at (at minimum annual) Provider Information Expos, town halls, Joint Operating Committee (JOC)

meetings with key providers and our Provider Advisory Council (PAC), and for escalated issues as requested or needed.

- ***Provider Services Call Center Support:*** Our provider services call center will be available 24 hours a day, seven days a week for medical, behavioral health and pharmacy support; prior authorization service support; claims inquiries or concerns; and more. Please refer to sub-section b for additional information on our provider services call center.

i. A description of how provider representatives engage with providers initially and on an ongoing basis, including level of local presence and onsite visits to provider locations.

Today, we engage and support providers through our team of locally based representatives who fully understand the Kentucky provider landscape. Our provider representatives help network providers address administrative issues and aid improvements to quality of care. Our staff specializes in areas such as claim and administrative assistance, behavioral health and quality (e.g., transformation consultants).

Provider Advocate Testimonials

Here is what some of our current Kentucky Commercial and Medicare network providers have recently said about our provider advocates and their support; these same advocates also will serve our Medicaid product – allowing for one point of contact for all three lines of business:

- "Merinda is a wonderful help! She quickly takes on anything I ask of her and provides me with any information I request in a timely manner. It would not be an exaggeration to say that UHC is one of my preferred providers because of her!"
  - Commonwealth Eye Clinic
- "Molly is extremely helpful. She is always very kind and will investigate any issue that I have, be it on a single claim or an issue that is affecting many claims. She is also proactive, calling each month to ensure that no new issues have come up."
  - Capital Medical Group

Our current footprint includes 13 UnitedHealthcare staff in the Commonwealth who engage with providers across Kentucky as medical provider advocates, contracting and support staff. We scale our provider relations and engagement staffing model in response to the demands of the MCO program, provider service needs, claims capacity and educational opportunities of the provider community. Future staffing may include additional provider advocates/engagement representatives focused on medical, dental, and behavioral health. To ensure we maintain appropriate local engagement with providers through both telephonic and in person support, we consider the geographic distribution of our membership, special health care needs of enrollees and number/specialty of contracted providers when establishing our provider support staffing. Based on changes to these factors, we reallocate and shift staff as needed to support network providers.

Our advocates take a hands-on, in-person approach to provider education and issue identification. These advocates tailor their support relationship to fit each network provider group's unique needs. They have established relationships with Kentucky providers, which will allow for a seamless transition into the Medicaid business line and less disruption for our providers. These relationships also will help in the initial implementation and education of provider groups and health systems for the MCO Program.

MCO network providers, particularly those with integrated, multifaceted practices like Kentucky Primary Care Association (KPCA), will have a dedicated advocate who will serve as their single point-of-contact and be able to troubleshoot issues for any service area (medical, behavioral health or dental) with support and backing from our internal experts. This simplified, integrated approach will minimize administrative burden for care providers.

Initially, our provider advocates call to welcome both new and existing providers participating with UnitedHealthcare to our Medicaid program, share basic education materials, and offer the opportunity to engage and listen to provider requests and inquiries — with the goal of promptly addressing these issues within two business days.

During this initial engagement, we perform a provider assessment and tailor a **strategic ongoing education plan** for them that includes an array of in-person and virtual/on-demand engagement platforms to share ideas and concerns. We provide additional support to providers serving many UnitedHealthcare members through monthly touchpoints (in-person, email and/or call). During the course of these visits, the provider advocates promote self-service tools such as our provider portal (*Link*), instruct on new or updated products or processes, and discuss any challenges the providers are experiencing. Provider advocates play a critical role in easing providers' administrative burden and enabling a focus on quality care through increasing provider adoption of UnitedHealthcare tools and services available to help (described later in this section). In addition to being an integral part of UnitedHealthcare's provider education efforts, our advocates also participate in the ongoing forums held by key Kentucky partners, such as KPCA, Kentucky Medical Group Management Association (KMGMA), Greater Louisville Medical Society and Center Care.

The following table further highlights examples of what in-person visits to providers entail:

Provider Onsite Visit and Outreach Work Plan			
Meeting Type	**Targeted Providers/Focus**	**Frequency**	**Method**
UnitedHealthcare 101 Education	*Newly Contracted Providers:* Full working session with UnitedHealthcare overview, including focus on administrative topics, quality expectations, MCO program requirements and more.	Within 30 days of contract effective date	Face-to-face in the provider's office or via WebEx, whichever the provider prefers
On-Site Visit	*All participating providers*: We offer frequent engagement to foster relationships, maximize performance, improve quality, resolve issues, discuss participation in provider incentive programs, promote tools/programs and administrative efficiencies.	Frequency is tailored to providers' needs and ranges from bi-weekly, monthly, quarterly or as requested by the provider	Face-to-face in the provider's office or via WebEx, whichever the provider prefers
Town Halls	*All participating providers (e.g., medical, behavioral health, ancillary):* Multi-practice open forum designed to educate en masse on multiple or targeted topics at various locations throughout the Commonwealth. Based upon the topics and attendees of the event, town halls for Kentucky will be integrated and offer representatives from our medical, behavioral health and dental network service areas. Sample topics include *UnitedHealthcare 101* orientation, follow-up training, changes in prior authorization processes, priority quality improvement focus areas, claims submission and provider payment.	Quarterly post go-live as well as ad hoc when major changes or in depth topics are identified	Face-to-face in a local Kentucky location (e.g., hotel meeting room, banquet hall, college auditorium)

Provider Onsite Visit and Outreach Work Plan			
Meeting Type	**Targeted Providers/Focus**	**Frequency**	**Method**
Provider Information Expo	*All participating providers (e.g., medical, behavioral health, ancillary):* Education event that assembles multiple UnitedHealthcare business units, material subcontractors and external partners in one venue.	Annual event	Face-to-face in a local Kentucky location (hotel meeting room, banquet hall, college auditorium)
Lunch and Learns	*All participating providers (e.g., medical, behavioral health, ancillary) or specific specialties:* Primarily focuses on relevant topics, specific to the practice (e.g., HEDIS improvements, claims payment). Quality staff also participate for expert guidance.	Ad hoc, as needed	Face-to-face in the provider's office or via WebEx, whichever the provider prefers
Operational Meetings/Joint Operational Committee (JOC) Meetings	*Select provider groups:* Operations meeting focuses on operational performance and improvement strategies that ease administrative burdens. JOCs include leadership engagement that focuses on business strategies, quality and outcomes improvement, accounts receivable management and relationship management.	Operations – Monthly JOCs – Quarterly	Face-to-face in the provider's office or via WebEx, whichever the provider prefers

ii. Description of formal committees, workgroups, or other forums, if any, in which Providers can receive updates and instruction from the Vendor and offer input about the overall program and Vendor initiatives.

Our network providers can receive or offer input related to the overall Kentucky MCO Program or UnitedHealthcare's various initiatives **during any provider touchpoint**, such as during provider advocate visits, in multi-practice town hall meetings, reviewing online Network Bulletins and alerts, by calling our provider services call center or through our Provider Advisory Council (PAC).

KPCA Testimonial
"Solving the health challenges in Kentucky is paramount and we believe UnitedHealthcare's commitment to provide outstanding care to those who need it most will help the Commonwealth achieve its goal of increasing health outcomes and improving quality. We are eager for DMS to leverage UnitedHealthcare's many years of working with states' Medicaid programs and members to bring a wealth of knowledge, ideas and innovative programs to Kentucky."

— *David Bolt, CEO, KPCA*

We attend established DMS meetings and are eager to provide feedback from those meetings during our various planned provider contacts. We enjoy participating regularly in the DMS Advisory Council for Medical Assistance meetings, as it provides an opportunity to engage with other MCOs, provider associations, health care advocates and Medicaid recipients. As appropriate, we also will attend the various Technical Advisory Committees meetings (e.g., Behavioral Health, Consumer Rights and Client Needs, Physician Services, Primary Care, Hospital Care, and Intellectual and Developmental Disabilities committees) to remain connected with these key providers to support alignment and build strong relationships. Further, we welcome the opportunity to bring DMS, other MCOs and providers together to discuss alignment opportunities across key components of the MCO

Program (e.g., VBP models and associated metrics, data reporting, credentialing and more) to make certain provider needs and concerns are addressed.

As briefly noted earlier, in Kentucky, as with most of our Medicaid programs, we will form Provider Advisory Councils (PACs) to make sure we understand providers' concerns and issues and that we are prepared to provide the best information possible to providers and their staff. Councils meet quarterly, and they will consist of providers from across the Commonwealth with a variety of areas of specialty/expertise (e.g., medical, behavioral health, hospitals, ancillary, pharmacy and more). We will include representatives from Kentucky provider associations (e.g., KPCA, Kentucky Medical Association, Kentucky Hospital Association) on our PAC and request their input on targeted training needs and topics, the overall program, opportunities to improve and UnitedHealthcare initiatives. Similarly, we will form a Kentucky Administrative Advisory Committee (AAC) to capture direct provider feedback from the lens of practice administrators (including partners representing large, small, rural and urban organizations). During AAC meeting sessions, we present various administrative topics that allow committee members an opportunity to provide input on strategic direction and feedback regarding their daily experience with us. The AAC members will encompass influential practices, hospital administrators, health care-related national societies, health care leaders from multiple provider administrative and medical specialties from the Commonwealth, and UnitedHealthcare market leadership. We use both these formal committees to review new policies, deliver updates and instructions, and discuss emerging trends in the communities we jointly serve.

Listening to feedback from enrollees is critical for achieving the best possible access to care, as is facilitating connection and communication forum opportunities with both providers and enrollees in attendance. Our Kentucky Quality and Member Access Committee (QMAC) will include enrollees, health plan representatives, providers (medical and behavioral health), community groups and advocates, Commonwealth agencies and other critical community-based organizations that represent our enrollees and providers. Our quarterly QMAC meetings will offer enrollees and providers the venue to receive updates and educational materials from UnitedHealthcare and discuss current trends in their communities, the MCO Program, UnitedHealthcare initiatives, network issues, cultural/social needs and potential barriers to care.

iii. Methods and metrics used to collect provider feedback and to measure overall provider satisfaction, including frequency of doing so.

We use multiple strategies to assess and address provider satisfaction and obtain provider feedback— such as annual large-scale provider surveys, quarterly Physician and Practice Manager (PPM) surveys, provider training evaluations (offered after each training) and post-call/outreach provider advocate feedback (ongoing) —and employ progressive solutions to address and prevent concerns. Our annual provider surveys, conducted through an independent research company, monitor satisfaction regarding metrics such as enrollment, onboarding, our *Care Provider Manual* and printed materials, provider education and training, claims processing accuracy, specialist access/network coordination of care, customer service/provider relations relationship, and utilization management timeliness.

Further, as an innovative enhancement to collecting and tracking provider satisfaction, we have embraced the Net Promoter Score (NPS) concept that willingness to recommend a company is an outcome of putting the customer first. The NPS provides better insight into understanding how to create a differentiated, provider-friendly experience and is used by many other leading organizations (e.g., Microsoft, Delta Airlines and American Express). ***Our***

provider NPS process is based upon monthly feedback on experiences that measures key CAHPS-like metrics. The current NPS score for our Kentucky provider advocates is over 30 points higher than the national average of 50 points.

Beyond the annual provider surveys previously noted, we also use various touch points and processes on an ongoing basis to proactively monitor our performance on several factors that we know contribute to provider satisfaction, including but not limited to:

Operational Area/ Touch Point Tool	Method/Measured Metric
Provider Call Center/ United Experience Survey (UES)	We offer each caller to our provider services center the opportunity to participate in our UES, a brief post call survey conducted by a third-party analyst who was not part of the provider's call. We ask willing providers key questions that provide feedback about the service they received. For example, 2019 UES survey results from our bordering Tennessee Medicaid market showed an average provider satisfaction rate of 95.25% with service quality (against a monthly 92% standard). Other monitored provider services center metrics include call abandonment rate (Goal is <5%); average time to answer (Goal is 80% answered in 30 seconds or less); and hold time (Goal is 3 minutes or less). We also use Nexidia to record and analyze 100% of provider calls, enabling us to identify opportunities unique to each resolution specialist and provide one-on-one coaching to resolve issues and improve efficiency. This application delivers crucial information that helps hotline managers and supervisors identify process improvement opportunities, determine first-call resolution rates, analyze calls where first-call resolution was unmet and understand the reasons behind variability in resolution specialists' performance.
Provider Website and Portal Surveys	We provide the opportunity for feedback on our provider website *UHCprovider.com* and on our web-based, self-service portal *Link*. During any visit, providers from the Commonwealth are able to submit feedback on their satisfaction with the site, how we can improve the site and their ability to complete desired tasks. All survey responses are managed through a closed-loop process within our *Link* provider experience team. This process leverages both one-on-one provider contact and data and verbatim analytics to resolve issues while improving the overall process for all *Link* users. Our developers take this feedback seriously and are continually making updates/changes based upon this provider input. Since surveys launched in 2017, national results show significant NPS score improvement related to such *Link* applications as claimsLink (50+ increase) and Prior Authorization and Notification (PAAN) (70+ increase). Our current national task completion rate score (ability to complete task on *Link*) from providers is 83%.
Physician and Practice Manager (PPM) Survey	We use a quarterly, shortened PPM survey to complement and align with our NPS improvement and comprehensive annual survey efforts. Providers may answer by mail or online over a 6-week period. This touch point process helps us to monitor daily transaction interactions with care providers more closely. Measured metrics range from broad questions on likelihood to renew and overall satisfaction to focused questions on claims, credentialing/contracting, prior authorization, medical records and more. Results are tabulated, shared and reviewed for improvement opportunities. Results from the most recent Kentucky Commercial and Medicare PPM surveys (Q3 2019 to Q4 2019) showed a: 24% improvement in the likelihood to renew metric; 36% improvement related to ease of accessing information; and a 43% improvement related to satisfaction with our provider credentialing process. Tracking input since 2015, national results show a 93% improvement in prior authorization satisfaction and a 100% improvement in claims reconsideration and appeals satisfaction.

Operational Area/ Touch Point Tool	Method/Measured Metric
Provider Dispute Resolution Process	Our quality management leadership team analyzes local provider complaint data, identifies barriers and develops interventions and education via provider toolkits, provider communication/education or innovation.
Claims Processing Monitoring Process	Metrics monitored by our Facets' Community Strategic Platform (CSP) for claims processing include time to pay clean claims: business days, calendar days and combined calendar day.

All these described methods and measurements, along with a deep understanding of the Commonwealth's priorities, drive our specific actions and the way we implement provider services support and operational changes to drive continuous quality improvement.

iv. Methods the Vendor will use to minimize provider complaints and escalations to the Department.

We invest in people, processes and information sharing tools to identify provider issues and concerns quickly. This allows us quickly to develop plans and provider outreach efforts to address current issues and mitigate future concerns and potential escalations to the Department. Our provider advocates serve as the primary resource for reducing provider complaints and escalations related to claims, with the expectation of providers making only one attempt to resolve the issue directly themselves and then turning the issue over to their assigned advocate for final solution. We will add value for Kentucky network providers by bringing innovative solutions, meaningful data and information to reduce their administrative burdens; minimize complaints and escalations to DMS; and anticipate and address provider concerns proactively, using a systematic approach to resolution.

As part of our relationship building efforts with DMS, we met with David Gray, director of provider services, to discuss DMS's views on effective MCO and provider relationships, which helped guide and validate our approach for Kentucky. Our objective is to improve provider satisfaction and minimize provider complaints to DMS by asking provider partners for their feedback after every encounter (e.g., calls, visits and webinars). We use this information to support continuous program improvement and system efficiencies.

Minimizing Complaints and Escalations by Reducing Administrative Burden

We will educate, train, communicate and build upon our relationships with Kentucky providers to promote understanding, minimize complaints and continually evaluate areas of our processes that create unnecessary administrative burdens and can be simplified or streamlined. For example:
FAST: Through our Field Aligned Support Team (FAST), we quickly resolve escalated issues for providers. FAST is a single-point tracking and monitoring tool for our Kentucky provider services staff. Our FAST provides visibility into complex provider issues, enabling rapid response and resolution. As a single-point intake, FAST streamlines and integrates information from claims, enrollment, clinical episodes of care and utilization history, and provides an all-inclusive picture of provider concerns, root cause analysis and resolution.
Geographically Assigned Advocates: Our provider relations team, consisting of advocates assigned by region and provider type, takes a hands-on approach to identify issues early. We communicate proactively and foster strong, positive relationships with providers. We have implemented a number of proactive monitoring initiatives (e.g., CP-EWS, claims payment timelines and utilization management notifications of denials) to determine issues/trends proactively. We recognize that it is essential for us to have a strong process in place to address provider complaints and disputes quickly and efficiently.

Complaint/Dispute Tracking: We maintain a process and system for receiving, tracking and resolving all provider complaints and disputes. Our provider services call center is typically the "first contact" for intake, resolution and tracking of both in- and out-of-network provider complaints. We staff and train our provider resolution specialists (PRS) to resolve issues on eligibility, prior authorization, claim inquiries and other concerns.
Provider Satisfaction Feedback: Through our commitment to continuous improvement, we ask providers for their feedback after every encounter (e.g., advocate visits, town halls, and post-PRS call) and use this information to improve the provider experience.
Point of Care Assist Solution (future state): Our Point of Care Assist solution adds value to electronic medical records (EMRs) by delivering clinical, lab, claims and cost information when it matters most: at the point of care. Point of Care Assist integrates enrollees' UnitedHealthcare health data within the EMR to provide real-time insights of their care needs, aligned to their specific benefits and costs. This makes it easier for network providers to see potential gaps in care, select labs, estimate care costs and check prior authorization requirements — including benefit eligibility and coverage details. This will help providers to better serve our enrollees, achieve better results for their practice and eliminate administrative expense through automation of the most common health care transactions within the provider workflow. Availability for MCO network provider use in Kentucky is planned for 2021.

Minimizing Complaints and Escalations by Improving Credentialing and Contracting

We use internal and external resources to minimize provider burden with the application process, source verification and contract completion activities. We use the Council for Affordable Quality Healthcare's ProView, which is available to providers at no charge, and streamlines the provider data collection administrative process for credentialing. This process reduces overall credentialing turnaround time, which eliminates duplication of application efforts among providers.
Contracting and Provider Data Accuracy: Our contract analysts use our PREDICT tool to perform quality checks on contracts prior to uploading contract details into our provider data systems. We implemented PREDICT in early 2017 to identify errors during provider contract data entry. We audit our provider contracts for accuracy through multiple processes, such as end-to-end review of claims to the contract, random sample audits, and provider roster comparison to contract setup.
Timely Credentialing: We know DMS is moving toward a unified credentialing process by seeking to contract with one Credentialing Verification Organization (CVO), and we will work with the Commonwealth's selected CVO once implemented. In the meantime, using our established, NCQA-compliant process, we will meet or exceed DMS's timely credentialing requirements and complete provider credentialing/recredentialing within 90 days of receipt of all relative provider information, or within 45 days for substance use disorder (SUD) service providers. UnitedHealthcare has an internal goal to complete application-credentialing processing of 95% within 15 days. Our current application turnaround time for professional providers, from receipt of complete application to credentialing decision, averages less than 17 days.

Minimizing Complaints and Escalations by Streamlining Prior Authorization

The Prior Authorization and Notification app is available on *Link* for providers to review requirements, submit requests, upload medical notes, check status and update cases for providers preferring self-service. When we identify providers who need assistance or have difficulties submitting requests for prior authorization, we engage them in a variety of ways:
Link Adoption and Training: Our secure provider portal, *Link*, helps reduce the provider's administrative burden when requesting service authorizations. Available to providers and facilities 24 hours a day, seven days a week, it helps the provider submit all information required for a medical necessity review, provides access to our guidelines and review criteria, and allows the provider to track the status of prior authorization requests.
***Provider Services Call Center Support*:** We combined our prior authorization intake and provider services to decrease administrative burden on our providers. Our PRSs can help providers across the Commonwealth determine what services require authorization and assist them with submitting an authorization request.

This reduces provider burden by decreasing the number of calls needed and reduces the amount of paper forms required.
One-on-one Training: The staff educates providers about our prior authorization process and guidelines and criteria, during initial provider training, whenever UM protocols or criteria/guidelines change through our *Care Provider Manual*, on our secure *Link* provider portal, and in our newsletter, *Practice Matters*.

Minimizing Complaints and Escalations Improving Claims and Timely Payments

Prompt and accurate claims payment is a key concern among Kentucky providers. We promote financial stability for our providers by offering claims and payment processes that are efficient, timely and convenient via *Link* or through the provider's choice of clearinghouse, and continuously exploring alternate solutions for payment process enhancement. We proactively reach out to our Kentucky providers to avoid claim rejections and work to educate providers on identified errors to prevent future issues; *in 2018, we made 40,000 calls to providers to correct claims instead of rejecting, and are on track to make 100,000 calls in 2019*. Our flexible and effective methods include:
Pre-adjudicating Claims: *Smart Edits* are a pre-adjudicated claims editing capability we use to auto-detect claims with potential errors for preemptive claims support. Part of our electronic data exchange (EDI) workflow, *Smart Edits* delivers provider feedback within 24 hours of a claim submission. Using *Link*, providers can correct errors, reducing the complexity and provider concerns resulting from claims denials.
Claims Provider Early Warning System (CP-EWS): In other markets, we have significantly reduced the amount of claims rework and provider claims complaints via our CP-EWS. The CP-EWS tool conducts weekly reviews of high volume claim denials to proactively analyze and identify trends. The CP-EWS enables us to catch spikes in claims denial patterns and assist providers immediately if denials reveal the provider needs additional claim filing education. We will use CP-EWS for the MCO Program.
Online Banking (future state): We are undergoing an enterprisewide movement within UnitedHealthcare to fundamentally transform the way we work with network providers and, by doing so, help make the health system work better. As part of this, we are currently developing an online banking solution for faster, easier provider claims payments via direct deposit.

b. Describe the Vendor's proposed Provider Services call center, including an overview of the following at a minimum:

ii. Location of proposed operations.

Our Provider Services Call Center and Location

We are establishing a **new provider services call center at our existing Louisville location** specifically for the MCO Program. This center will meet DMS's standards and it will comply with all requirements in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 27.2 Provider Services Call Center. Providers can call our toll-free number to access a menu of both automated and live agent services. Our provider resolution specialists (PRSs) will respond to Kentucky Medicaid provider phone inquiries on a wide variety of medical, behavioral health and pharmacy topics, such as covered services, fee schedules, claims and eligibility verification, claims payment and dispute resolution, utilization management, credentialing/recredentialing status and prior authorization requests.

The PRSs will be highly trained on the Kentucky MCO program and will be dedicated to answering Kentucky provider calls. These specialists receive intensive orientation and education on call handling based upon DMS's requirements. Script and standard operating procedure development for use in our interactive training presents the PSRs with common inquiries they are likely to receive, along with special or emergency situations that may occur. The PSRs use these tools during live operations to respond to provider requests efficiently, consistently and accurately.

i. Approach to assuring the call center is fully staffed during required timeframes.

Approach to Fully Staffing the Call Center to Meet Requirements

Our provider services center responds to calls 24 hours a day, seven days a week to be responsive to all network providers. Live PRSs will answer calls from Kentucky MCO providers Monday through Friday from 8 a.m. to 6 p.m. EST; on federal holidays, we staff the same hours. We have experience in maintaining staffing levels on holidays based upon experience with anticipated call volume. In case of increased volume, we have backup plans from our national call center. We also benefit from our operations center, providing a dynamic staffing adequacy model with policies and procedures that factor in the hours of operation, staffing requirements and ratios, anticipated call volumes and performance standards to serve our network providers better. Our workforce management and forecasting includes the following:

- Monitor and make real-time adjustments based upon intraday delivery of call volume
- Monitor real-time staff schedule adherence; manage and maintain metric reporting (e.g., forecast to actual staffing, occupancy)
- Maintain historical data for reporting
- Monitor the system that tracks PRS performance metrics
- Manage scheduling software used to confirm appropriate staffing
- Meet with site leadership team weekly to discuss the staffing plan adjustments
- Determine capacity plans

During non-business hours, our automated interactive voice response (IVR) answers and provides information, with sufficient capacity for all callers to leave messages; all messages will be returned on the next business day.

Our planned staffing and hiring approach includes ***use of telecommuting PRSs to support economic development across the Commonwealth, including the employment-challenged Eastern and rural Western Kentucky regions.***

iii. How the Vendor will meet and monitor call center standards, and how the Vendor will use monitoring results to adjust operations, as needed.

Maintaining a high standard of quality for our provider call system is an important strategy to maintaining provider satisfaction with our plan. We track calls via several reporting areas, through:

- Our Management Information System (MIS) reporting tool that monitors call management metrics and service levels
- CSP and MACESS systems, which are available for PRSs to see previously collected applicable notes and call information to aid in resolution

Our MIS online report provides daily, week-to-date and month-to-date information and statistics on call availability, answering speed, on-hold time and abandonment rates. We provide state/Commonwealth and overall UnitedHealthcare provider call results breakdown with reports that track the daily availability of telephone service, the monthly telephone average speed of answer, the monthly average on-hold time and the average monthly abandonment rates. In addition, we supply

Responsive Provider Services Call Center Performance

Since 2017, our national provider services center representatives have handled more than 16.7 million provider calls with:

- An average hold time of 19 seconds
- An abandonment rate of 0.9%
- An IVR that ensures all calls are answered within 30 seconds

quarter-end and year-end telephone system reports no later than the last day of the month following the reporting period.

To confirm compliance with call performance standards and identify areas for operational adjustments based upon call monitoring results, we conduct the following:

- The provider services center management team monitors our call response rate using scheduling software, generates specialized reports to identify peak call times and quantifies individual resolution specialist productivity. The management team also measures the longest wait time for any caller by monitoring the number of calls holding in queue and makes adjustments in real-time as needed.
- To confirm the accuracy of our responses, we use a call monitoring system to perform evaluations, make and play recordings and perform live monitoring. Supervisors access the call monitoring system to review their team's quality evaluation details and scores.
- We record 100% of calls and randomly select PRSs for monthly quality reviews. We monitor no less than 3% of calls for compliance with customer care guidelines. The director of operations within the provider services center reviews the trended results and adjusts the training curriculum as necessary.
- We monitor calls daily and have supervisors provide immediate coaching and feedback.

c. Provide an overview of the Vendor's proposed provider website, including examples of information that will be provided through the website and any functionality that will be included to communicate with providers.

Provide sample screenshots of provider websites currently maintained by the Vendor.

Our interactive provider website, including secure and non-secure components, is an important part of our communication strategy with network providers and our goal of simplifying the health system for providers via streamlining interactions. We will provide and maintain a website for MCO Program providers that include webpages specifically designed to facilitate easy access to current program and provider-specific information, and meets all requirements of Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 27.3 Providers Services Website.

Public Provider Website

UHCprovider.com is our public website home for provider information, which includes connection to our secure provider portal, *Link*. *UHCprovider.com* includes a powerful internal search tool to help providers locate the information providers need quickly, with a responsive design that works for any mobile device or screen size. The site offers providers the opportunity to submit feedback on their experience to help identify opportunities to improve or enhance how we work together. Our public website for providers also facilitates open access to all network bulletins (which contain What's New updates) and other

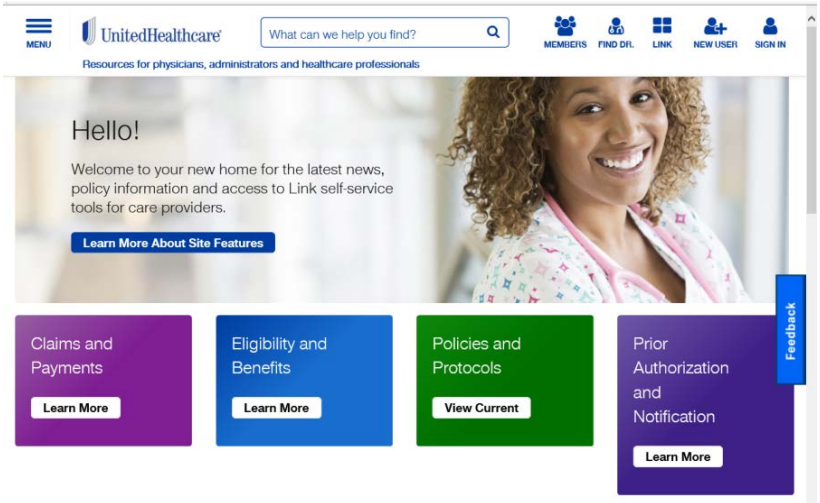

Figure 2. *UHCprovider.com* landing page. Our provider website receives more than 1 million visits annually.

materials important for them to serve MCO Program enrollees such as: contact information for our provider services call center and hotline; enrollee rights and responsibilities and information about Kentucky Health Information Exchange.

UHCprovider.com allows providers to access our searchable *Care Provider Manual*; claims and payment resources; tools to locate network providers; Kentucky-specific provider information and materials; UnitedHealthcare payment policies and procedures; and prior authorization information. We will offer hyperlinks on *UHCprovider.com* to provide access to DMS's website, our corporate website and other related key websites such as Kentucky Cabinet for Health and Family Services, DMS and the CVO(s), as required. We also will adhere to the monthly website review and update timeline requirement, and submit all provider services website materials and webpage change screenshots to DMS for review and approval (unless otherwise mutually agreed to in writing).

Secure Provider Portal Layout, Functionality and Communication Capabilities

Requests for administrative simplicity were among the most frequent recommendations we have received from providers in other states during recent usability surveys. Providers indicated they wanted a better, more intuitive way to get the information they needed with less clicking and entering repetitive data. Because of this feedback, we recently redesigned *UHCprovider.com* to be even more user friendly and intuitive to our Kentucky provider partners. Accessed through *UHCprovider.com,* our secure provider portal, *Link,* is the gateway to online self-service tools and offers providers access to critical applications while protecting sensitive enrollee information (e.g., PHI). *Link* brings value to all provider types by increasing staff productivity when getting information, providing superior documentation for internal records and reducing paper, postage and handling costs by replacing paper-based processes with electronic workflows. **We currently have 6,444 Kentucky providers/office staff registered and using *Link*, with an overall adoption rate of 90.8%.**

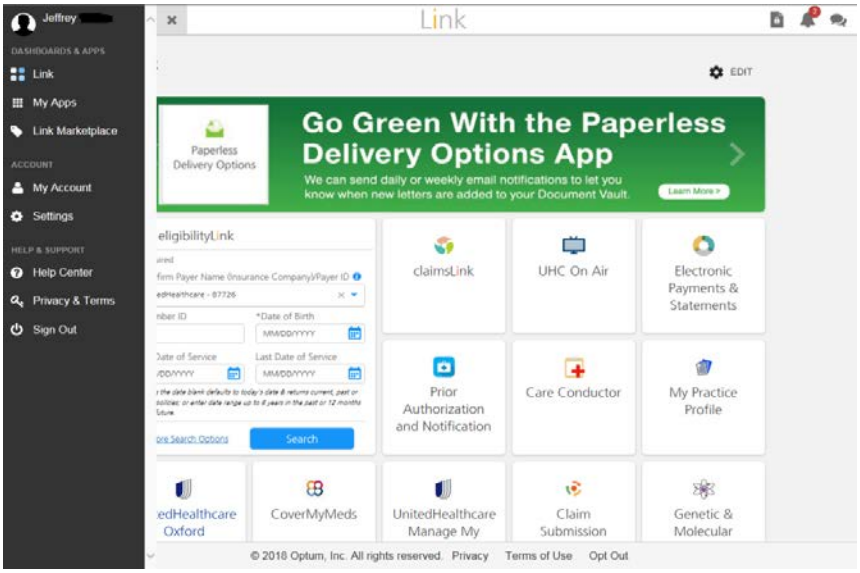

Figure 3. Sample *Link* Provider Dashboard. Much like the dashboard on a smartphone, each individual network provider can customize their *Link* dashboard based upon preference, applicable applications and authorization.

Link is currently the primary way we electronically receive and respond to provider inquiries. The provider website contained within our portal has "Contact Us" sections, where providers can access information on contacting UnitedHealthcare resources from customer service to technical support, and submit inquiry emails to key UnitedHealthcare network staff for a response within one business day. We will refer any provider inquiries related to items not within our scope of services to DMS.

Link provides a secure exchange of information between the provider and UnitedHealthcare, including our key subcontractors. We use *Link* to communicate with providers and connect them to current, accurate, compliant

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and searchable self-service information and documents. Through data analytics and targeted training, our provider advocates encourage providers to use this technology to minimize unnecessary manual work and decrease provider costs associated with practice management activities. *Link* offers providers the following interactive functionality:

eligibilityLink – Allows providers to search for covered enrollees, identify if prior authorization is required, view preventive care opportunities for some enrollees and see coverage details and limits.

claimsLink – Enables providers to look up claims status and determine how a claim was processed, submit corrected claims or reconsideration requests, upload attachments, track the status and outcome of reconsideration requests, and submit an online grievance/appeal.

OptumRx/RxClaim – *Link* connects to *OptumRx.com* and the RxClaim system, which holds pharmacy claims history and allows providers to submit, view and manage pharmacy prior authorizations. It also facilitates access to pharmacy coverage conditions and utilization limits.

User-friendly Functionality
We conduct ongoing website and portal usability testing to gauge ease of navigation, performance and overall satisfaction. Network providers in other markets have recently said:

- "We mainly use the link for prior authorization and it is VERY EASY to use. I wish all insurances that require prior authorization would use a link this easy."
- "Everything is SO easy to access. I absolutely LOVE this portal and its capability. Now all the other payers I have to deal with seem archaic! I especially love the ease in uploading records and doing claim reconsiderations. Thanks for all the improvements!"

PreCheck MyScript – Shows out-of-pocket costs for patients at selected pharmacies, displays lower cost prescription alternatives, alerts when prior authorization is required, and allows for submission of prior authorization request. This function integrates with the provider's electronic medical record. The Kentucky Pharmacy Preferred Drug List will be accessible through this feature.

Claim Submission – Enables original (new) online claim submission, with or without attachments.

Prior Authorization (PA) and Notification – Allows providers to request a PA online, including uploading attachments on initial submission or as requested as part of the PA review. They can also check the status and outcome of their PA request. Providers can perform a quick-check of whether or not PA is needed by reviewing current and clearly defined PA requirements and communicate electronically with our clinical staff. We inform providers of specific clinical information needed for medical necessity review and allowed to submit the required clinical information online.

MyPracticeProfile – Provides real-time visibility to the provider demographic data we have on file. Allows authorized users to submit updates and attest to the accuracy of the demographic information. Click to Chat functionality is available for providers to access and communicate with representatives without picking up the phone.

Document Vault – Enables viewing and management of electronic correspondence and secure provider reporting.

Referral Search: Providers may need to identify specialists or other provider types to participate in the enrollee's care. To facilitate this search, we include our online, searchable *Provider Directory* on *Link*. Our *Directory*, available in both English and Spanish, contains integrated physical and behavioral health provider information. It lists all contracted providers,

including PCPs, behavioral health and physical health specialists, hospitals, pharmacies, urgent care clinics, home health, and durable medical equipment providers and facilities. Mental health and SUD providers can be found by name, specialty or treatment. With the search function, providers can customize their search by location, name, specialty, languages spoken, accepting new patients or condition. The *Directory* facilitates easy access to directions via Google Maps. We update directory content within 3 business days of a network change.

CommunityCare Collaboration Platform via Link

Our cloud-based *Link* portal also enables health care professionals to connect and collaborate in ways that improve the cost structure and quality of their practices. A perfect example of this is our *CommunityCare* platform, an application accessible via *Link*. *CommunityCare* is an HIPAA-compliant, secure, cloud-based health care record and information sharing system that provides comprehensive support for the continuum of integrated, person-centered care coordination. The platform provides a mechanism to share the relevant and timely enrollee information essential to conducting ongoing care planning, management and coordination across a continuum of services and settings:

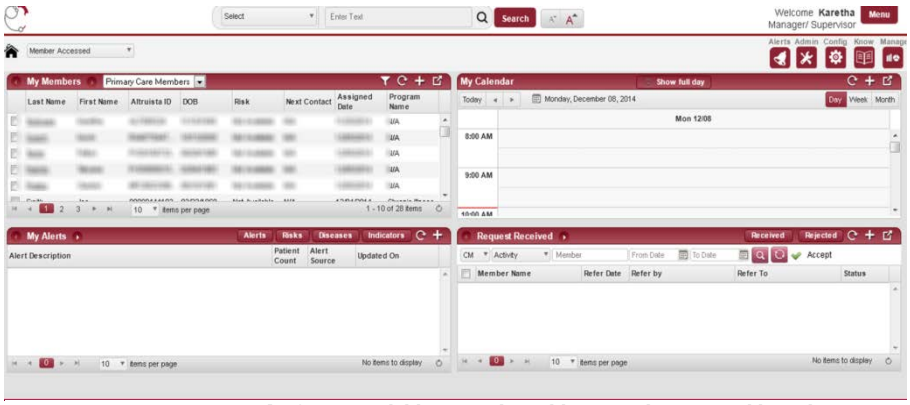

Figure 4. *CommunityCare* Platform, available via *Link*, enables providers to quickly and efficiently locate the type of enrollee information they need to coordinate primary, acute, chronic, specialty, behavioral health/substance use disorder, social support and long-term care services. *CommunityCare* seeks to redress health disparities by providing real-time coordination among multiple providers in different care settings.

- Interventions and previous medical documentation (e.g., medical history, physician orders, diagnosis, medications, service dates and outcomes, progress notes and case conference notes) across all encounters, including the authorizing provider's name, and any servicing providers (if different), and contact information
- Emergency contact information, prior authorizations, physician orders, documentation of contacts with family enrollees and persons giving informal support
- Reports about the enrollee's involvement with community agencies that are not part of the provider network, including any services provided
- Enrollee priorities, goals and important concerns

d. Provide a proposed table of contents for the Provider Manual and a brief description of the type of information the Vendor will communicate via the manual.

We will develop, issue and maintain a *Care Provider Manual* that complies with all requirements noted in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 27.4 Provider Manual and Communications and that specifically addresses the requirements, policies, covered benefits and goals of the Kentucky Medicaid program. As we work with the Commonwealth during the implementation period and thoroughly learn about the Kentucky Medicaid program, we will continuously validate the *Care Provider Manual* is Kentucky-specific and comprehensive to all contract requirements. We will undergo this effort so that upon go-live the resource is meaningful, inclusive of all priority areas and easy for providers to navigate. In the meantime, we have provided a sample *Care Provider Manual* for our Medicaid program in the bordering Ohio market for as Attachment C.17.d-1 for DMS's review and consideration.

The *Manual* serves as a tool for providers to have a better understanding of Kentucky Medicaid policies and procedures, and UnitedHealthcare-specific policies, to effectively navigate the system and provide better, more consistent care to our enrollees. Our proposed table of contents for the MCO Program, which is based upon lessons learned from our other markets and tailored to Kentucky, is included as Attachment C.17.d-2. Sample 2019 *Care Provider Manual* TOC.

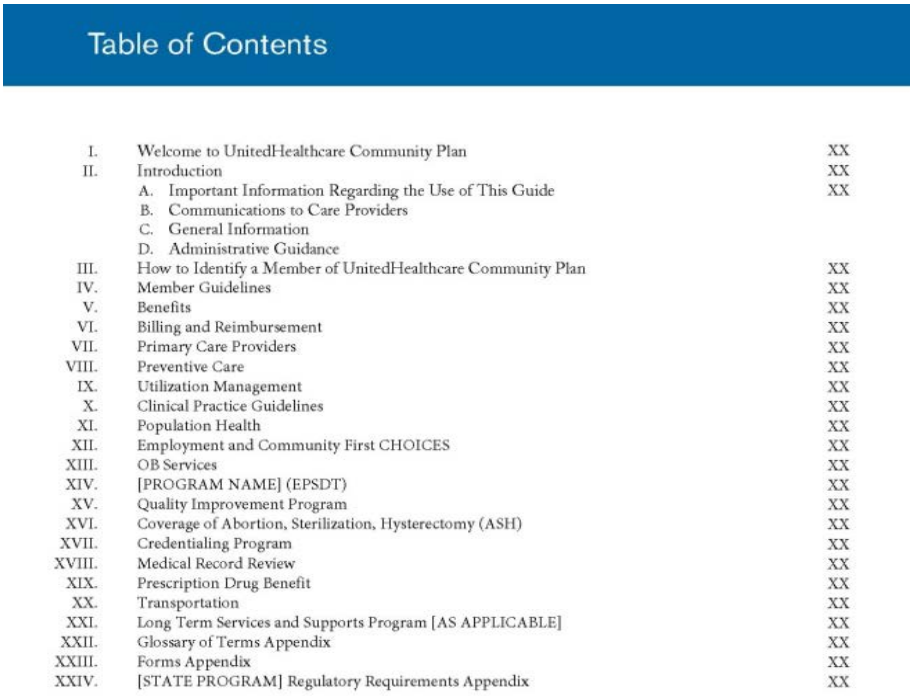

Table of Contents

Figure 5. Sample *Care Provider Manual* table of contents (high level) is shown here, with a detailed version, tailored to the MCO Program, included as Attachment 17.d Proposed Provider Manual TOC.

We update the *Care Provider Manual* periodically based upon feedback from providers who attend our focus groups and those who participate in the annual satisfaction survey. Our survey collects feedback directly tied to *Manual* via call out box that asks “Can you find what you are looking for?” and then asks a series of questions tied to the effectiveness of the *Manual*, including finding information, reason for accessing the *Manual* and a free form section that asks how we can improve. We also incorporate feedback from Medical Group Management Association and the American Medical Association/Foundation. Providers are made aware of changes to the *Manual* through online posts, published in Network Bulletin updates, and when significant and/or time sensitive, communicated via a coordinated email campaign.

All network providers have access to our *Care Provider Manual* (available on our provider website or in hard copy format); it is a comprehensive resource for physicians, health care professionals, ancillary providers and facility staff. Provider advocates communicate availability of the *Manual* and meet with providers to review its contents. We will, via the *Care Provider Manual*, communicate our policy and procedure information, including:

- Credentialing criteria
- Utilization management policies and procedures
- Billing and payment procedures
- Provider and enrollee grievance and appeal processes

- Network management requirements

The manual also includes prior authorization telephone numbers for all services. An extensive section of the manual addresses a PCP's role in continuity and coordination of care, emphasizing behavioral health screening opportunities. The *Manual* reinforces our expectations that all physicians involved in an enrollee's care will communicate and coordinate care with each other, including communicating significant findings and recommendations. The Medical Record Documentation Standards included in the *Manual* present our minimum standards for documenting information in enrollee charts. Each year, we complete medical record reviews to assess compliance with these requirements.

e. Provide the Vendor's proposed approach to provider orientation and education.

Provider education is an important part of our partnered approach to network management, quality improvement, member service and achieving improved outcomes at a population level. Our high-touch Kentucky MCO provider education and orientation methods will comply with all requirements noted in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 27.5 Provider Orientation and Education. Our education approach begins with an initial provider orientation for those providers new to our network, focusing on how to work with UnitedHealthcare and introducing the Kentucky MCO Program and its requirements to both new and our many existing network providers. Ongoing provider training focusing on building skills for administrative and clinical proficiency to serve our enrollees follows orientation. We designed our provider orientation and education approach based upon direct feedback from providers, incorporating both in-person and online methods so each provider can be trained at their convenience and using their preferred education method. We are also partnering with key Kentucky health systems and associations and using their established training infrastructure to aid our provider education and communication efforts, such as Jefferson County Medical Society and Center Care.

Training & Development Team for Providers

UnitedHealthcare has an exceptional training & development team, including provider advocates, who work tirelessly to ensure both our employees and providers have access to award winning training sessions. To provide our advocates with needed training tools and critical and current information, they are required to attend weekly Wednesday afternoon training sessions, as well as any additional training that is required for new programs, changes to policy and more. We expect our provider advocates to spend 25% of their time on training and development.

Together, our initial orientation and ongoing education tools for providers covers everything UnitedHealthcare and is delivered via several mediums, with primary methods/tools and associated training content highlighted in the following table. Many of our Kentucky Commercial and Medicare network providers have already been trained in using these tools and are quite proficient.

Training Method	Training Content/Topic Examples
On-demand, mobile-enabled training via *UHCprovider.com*	UnitedHealthcare offers the opportunity to earn CEUs/CMEs from 36 mobile-enabled courses available via the *UHCprovider.com*. Topics of available classes include: Considerations for Polysomnography, *Link* Certification, Breast Cancer Screening, Getting to know CAHPS and Basics of the CMS Medicare HOS Survey.
Live Instructor-Led Webinars	Kentucky providers can currently register to attend courses on the following topics: ▪ *Link* Training: Registration and Multi-TIN Access ▪ *Link* Training: claimsLink and eligibilityLink ▪ *Link* Training: Prior Authorization and Notification Tools on *Link*

Training Method	Training Content/Topic Examples
	▪ *Link* Training: My Practice Profile ▪ *Link* Training: Document Vault & Paperless Delivery ▪ EPS/Optum Pay Training
Provider Advocates	For any provider who requires training, we assist in providing training tools on the following topics: *Link*, Prior Authorization and Notification (PAAN), Eligibility & Benefits (eLink), claimsLink, My Practice Profile, *UHCprovider.com*, EDI Transactions and much more. We also offer claims education, guidance on best practices and other tips for doing business with UnitedHealthcare.
Provider Information Expos and Town Halls	These include focused training on various clinical and administrative topics, such as preventive screening coverage guidelines, how to locate our reimbursement and medical policies, prior authorization requirements and processes and our claim dispute resolution process.
Annual virtual conference for Healthcare Business Management Association members	Topics covered at this conference include: ▪ *Link* and electronic data interchange (EDI) training webinars – sessions exclusively for HBMA members ▪ Updated best practices from similar organizations to help streamline processes and increase efficiency ▪ A case study about a revenue cycle management company (RCM) that reduced phone calls to UnitedHealthcare by almost 37% in a single month* ▪ How UnitedHealthcare can help support your work on behalf of your clients ▪ Information about the new *Link* Certification program

Initial Orientation

Within 30 days of the contract effective date, network-contracting staff will alert our provider advocates of new provider contracts. The provider advocate will contact the new provider to schedule the initial orientation education meeting for the office, which includes:

- Familiarizing them with provider service resources
- Providing an overview of our simplified administrative processes (e.g., claims submission and payment, eligibility requirements, prior authorization processes and more)
- Orienting them on our secure provider portal (*Link*)
- Educating on specific Kentucky MCO benefits and requirements

Provider orientation is intended for providers newly contracted to UnitedHealthcare; providers new to a group; providers that have had a product added to their existing contract; and a practice that has had a line of business added (e.g., Medicaid, Medicare). After go-live, we will hold monthly webinars, with accompanying detailed materials, which will orient new providers on navigating processes in the managed care environment. New provider training topics and requirements will include, but not be limited to, cultural sensitivity; fraud, waste and abuse; quality reporting and analytics; telehealth services; medical records review; value-based payment (VBP) approaches; population health management; integrated health care; and the other noted topic in Attachment C – Draft Medicaid Managed Care Contract, Section 27.5 Provider Orientation and Education.

We also offer a variety of other educational opportunities and resources, such as site visits with key providers, Provider Information Expos (Expos), town halls, live webinars, self-directed online training, mailings and telephonic outreach. Because we recognize that proactive provider education and readiness is critical for the success of the MCO Program, our provider relations

team began hosting Medicaid educational sessions (e.g., Lunch & Learns, provider forums and behavioral health open houses) at key Kentucky locations in March 2019. However, through our Commercial and Medicare program relationships, we have been listening to and learning from our Kentucky provider partners for the past nine years through annual town halls, Expos and attending all relevant provider conferences. As we move toward and beyond the operational start date, we will continue to offer these critical collaboration opportunities throughout the Commonwealth and at different times to make sure all providers have access no matter their schedule or location.

Training Success Example: Tennessee Provider Information Expos

We have held free Provider Expos in Tennessee bi-annually for the past 6 years, with an average attendance of 200-350 per meeting. The interactive Expos allow us to engage providers of all types (PCP, hospital, ancillary, long-term care and behavioral health) in metro, urban and rural areas.

The Expos were recognized as a best practice in the state and we were asked to help train our partner MCOs on the format/structure. Expos offer a variety of breakout sessions, allowing providers to choose sessions by interest area. Session topics include regulatory, clinical and billing/claims processes and several have been approved for CEUs/CMEs.

Along with the breakout sessions, there is an exposition side where providers can network and meet UnitedHealthcare key contacts and important external partners such as LabCorp, Walgreens, Quest Diagnostics, TennCare, TN Medical Association, Cumberland Pediatric Foundation and many more.

Positive feedback received from our network providers via a post-Expo survey include the following comments from the most recent Tennessee Expos:

- *"… this Spring Expo was the best I've ever attended. So much great information!!"- McKenzie Medical Clinic*
- *"This is better than the All- Blues workshop I went to a couple weeks ago. I will never go back to their workshop again. This is the best!"- Ft. Sanders OB/GYN*

Ongoing Training

Providers will have the continual reinforcement of our Kentucky provider advocate team, who are located in the Kentucky communities they serve, to remind providers on the availability and advantages of our educational resources. After their initial orientation, beyond advocate support, providers have access to ongoing training and educational resources via *UHCprovider.com*. For example, through *UHCprovider.com*, we offer live events and on-demand education created specifically for providers. Providers can log in from their computer or mobile device at their convenience. Behind-the-scenes reporting allows us to track the number of people (e.g., total views for each program). We conduct surveys at the end of each program where providers can rank the content and give input on other topics they would like to see.

We upload program updates to our secure provider portal under "Provider Alerts" and in *Practice Matters*, our quarterly newsletter developed specifically for Medicaid providers. *Network Notes*, our behavioral health-specific newsletter, similarly informs behavioral health providers. Ongoing or re-training by our provider advocates also may be prompted if we identify a trend in billing issues, receive a request for training about a specific topic or note a network provider's practice has a high rate of office staff turnover and new staff requiring training on UnitedHealthcare processes, resources and the Kentucky MCO Program.

Through our OptumHealth Education, also available through *Link*, providers have access to free integrated training courses that offer CME credits for all provider types. Our portal also facilitates access to *providerexpress.com*, our behavioral health website that serves as a

resource for behavioral health providers to review clinical best practice documentation. Additionally, the site contains educational resources for non-behavioral health providers such as the *Behavioral Health Toolkit for Medical Providers* and the *I/DD Toolkit*.

Finally, we commit to participating in any DMS-designated Kentucky Medicaid Provider Educational Forums as an enhanced education effort as outlined in Attachment C – Draft Medicaid Managed Care Contract, Section 27.6 Provider Educational Forums, and will remit the required annual funding to support this outreach effort.

Evaluating Training Effectiveness

To make sure our training is as effective as possible, we capture real-time feedback on our training — regardless of modality or occurrence (initial or ongoing). As examples, videos and training viewed on *UHCprovider.com* include a post-presentation evaluation, and we deliver a survey at the end of every large group Provider Information Expo training and use that feedback to develop new or better content for future trainings.

f. Describe the Vendor's support of providers in Medicaid enrollment and credentialing, including the following:

Include copies of the Vendor's proposed credentialing policies and procedures, and procedures for coordination with the CVO(s).

We have 45 years of experience in 31 other Medicaid markets to build upon and, as described in the following responses, work continuously to make enrollment and credentialing as simple as possible for our network providers, while still ensuring we meet the highest quality standards. Required copies of our proposed policies and procedures are included as Attachment C.17.f-1 Credentialing Policies and Procedures-1-2 and Attachment C.17.f-2 Procedures for CVO Coordination.

i. Methods for assisting providers who are not enrolled in Medicaid with the enrollment process.

The Commonwealth has an established Medicaid program enrollment process that Kentucky providers are familiar with and prefer. During the implementation phase, we will partner with DMS for comprehensive training for UnitedHealthcare staff on this enrollment process so we thoroughly understand all the steps and requirements. Once our provider facing staff are trained, we can help facilitate the provider's application process with the Commonwealth, as described herein, and reinforce DMS's enrollment program. Our main goal is to be aligned with DMS so the provider enrollment and onboarding processes are streamlined and providers can start seeing Medicaid members as soon as possible. Further, we will work with DMS in sharing any provider feedback received related to enrollment and onboarding process enhancements so we can ensure parallel improvement efforts.

As part of our network development activities including countless face-to-face meetings and office visits, we mailed Kentucky providers materials on how to participate in our MCO network. If they are not currently enrolled in Medicaid, but would like to join our network, these new providers can contact any of our knowledgeable touch-points (provider services call center, provider advocates, network manager) for education and assistance. We will personally direct the providers on how to apply for a Kentucky Medicaid Provider ID number via the Provider Enrollment section on the Commonwealth's website. We also will look at overall Medicaid provider enrollment to identify geographic and/or clinical access gaps. Using this information, we are able to engage with non-enrolled providers in providing information proactively, education and support in making the enrollment process easy and attractive. Providers will have online access to specially designed FAQ sheets, tutorials, training videos and/or Quick Reference Guides on the Commonwealth's Medicaid enrollment process, created based upon knowledge gained via our partnership with DMS. We also will offer hyperlinks on

UHCprovider.com to provide access to DMS's website and other related key websites such as DMS and the CVO(s), to facilitate easy linkage to the application site. To socialize our plan to propose UnitedHealthcare for the Kentucky MCO Program within the provider community, and to encourage providers to sign-up with Medicaid and our network, we hosted webinar Lunch & Learns and Open Houses in Louisville and Lexington.

SIMPLIFY

Once enrolled in Medicaid, we employ our structured approach to onboarding and supporting providers that helps support the quality of our networks. The figure highlights components of our existing process and planned capabilities for onboarding Kentucky providers newly contracted with UnitedHealthcare. Our provider onboarding strategy has been designed to address many common issues faced by providers (e.g., no status transparency, incorrect or incomplete data loading and no orientation) and incorporates application features used by many major U.S. companies, such as tracking notification (borrowed from Amazon) and simple, easy scheduling (as used by OpenTable). We have designed and are continually enhancing this process to enable change management (people/process/technology), to align data sets with provider architecture and to increase provider satisfaction.

Our onboarding process for new providers is inclusive of welcome materials, training and outreach. Many Kentucky providers targeted for our MCO network are already participating with our Commercial and Medicare plans and are familiar with UnitedHealthcare; therefore, onboarding will simply consist of education and training on the Medicaid policies and protocols for prior authorization and other administratively different subjects.

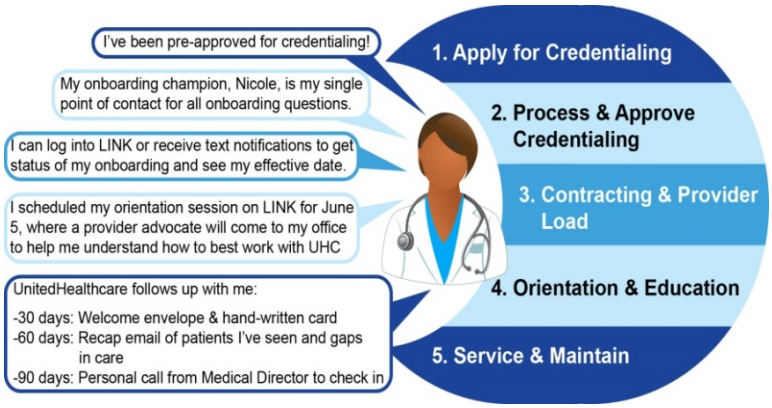

Figure 6. Our new, distinctive provider-centric onboarding experience. This new process is currently being piloted in Indiana, with roll-out planned for other markets, including Kentucky.

ii. Proposed process for conduct of credentialing until such time that a Credentialing Verification Organization (CVO) is contracted by the Department.

Proposed Credentialing Process until CVO Contracting by DMS

UnitedHealthcare understands DMS is exploring the procurement, implementation and operationalization of a Credentialing Verification Organization (CVO) to standardize provider credentialing and recredentialing processes across the Kentucky Medicaid program. Until a State CVO is implemented, we use the Council for Affordable Quality Healthcare ProView (CAQH ProView), which is available to providers at no charge and streamlines the provider data collection administrative process for credentialing. By using CAQH ProView, we conform to industry standards used by many other payers. **Currently, we turn around 95% of clean, complete applications from professional providers within 17 days.** Our process:

- Eliminates the time required to complete redundant credentialing applications for multiple health plans
- Eliminates the need to print and mail credentialing applications
- Reduces the need for costly credentialing software

- Minimizes paperwork by allowing physicians and other health care professionals to make updates online
- Provides standardization and portability, enabling physicians and other health care professionals to easily and securely access their information

Our credentialing process involves the following steps:

Step	Description
Initial Provider Application	To initiate a new credentialing application via CAQH ProView, Commonwealth providers contact our National Credentialing Center (NCC) via our 800 number. A credentialing specialist at the NCC captures basic provider demographic information and educates the provider on the scope of the credentialing process.
Universal Credentialing Identification Number	The credentialing specialist faxes the provider a CAQH ProView identification number with instructions for completing the Universal Credentialing application. Using their CAQH ProView identification number, providers or their staff submits their credentialing application information once, online or by fax, in a secure, state-of-the-art data center. The provider-submitted credentialing application information is only available once the provider authorizes access to UnitedHealthcare.
Provider Attestation	Applicants must complete and attest to the correctness of the credentialing application information submitted into the CAQH ProView. We then access and accept the provider credentialing applications submitted and maintained in the CAQH ProView.
Primary Source Verification	Our NCC staff extracts NCQA-required elements (based upon provider type) from completed credentialing applications on CAQH ProView daily. Physician reviews include, but are not limited to, education/training, board certification, license, hospital privileges, disciplinary actions/malpractice, and enrollee complaints and sanction history. Facility reviews include, but are not limited to, licensure, accreditation and certification.
Review of Materials	We present the provider's credentialing file to our Credentialing Committee once our staff completes primary source verifications.
Credentialing Committee Review	The Credentialing Committee considers all credentialing program criteria and renders a decision. We document this decision and submit it to our PAC. We send a letter to providers notifying them of the approval decision or denial of acceptance into the network. Denial letters inform providers of appeal rights, if applicable or mandated by Commonwealth law.
Contract Award	We award providers a network contract only after the Credentialing Committee renders a favorable decision and we confirm the provider is enrolled in the Kentucky Medicaid program. Once the committee approves the credentialing application, we communicate the decision to the provider network management contracting team.
Enacting the Contract	Network management staff verifies that the newly approved provider has a signed contract on file. Once the contract is fully executed, we load the provider's contract record into our core information system, allowing the provider to bill for covered services rendered to enrollees and to be listed in the applicable *Provider Directory*.
Ongoing Review	We monitor Commonwealth and federal reports for sanctions, debarments, license issues or other potential risks to the enrollee, for immediate and appropriate response and action.

Delegated Credentialing for Affiliates and Subcontractors

We know some large provider systems in Kentucky, such as KPCA, Center Care and University Physician Associates, conduct their own internal credentialing/recredentialing processes and will remain exempt from UnitedHealthcare's and the future DMS-contracted CVOs processes. As with other material affiliates and subcontractors, we will manage these entities under our delegated credentialing practices and procedures — understanding we are ultimately

accountable for verifying the same standards of participation are maintained throughout the provider network. We require the delegated entity to apply criteria as set forth in our credentialing policies and procedures. We employ stringent standards and mechanisms to oversee the delegated entity's performance of the credentialing function via:

- ***Written Agreements:*** UnitedHealthcare and the delegated entity execute a delegation of credentialing agreement that clearly defines each entity's expectations and the delegate's specific duties, responsibilities and activities. The agreement also specifies how we evaluate the delegate's performance and any remedies available for noncompliance, including revocation of the delegation agreement.
- ***File Audits:*** Before the initial delegation has been contracted, we review the potential delegate's credentialing policies and procedures and, if necessary, perform a file audit of the potential delegate's credentialing processes.

iii. Proposed process for transitioning credentialing activities to and coordinating with the Department's contracted CVO(s) to educate and assist Providers in completing the credentialing process with the CVO(s).

Educating and Assisting Providers on the CVO Transition and Process

UnitedHealthcare will collaborate with DMS to include the use of a new CVO that will be responsible for credentialing and recredentialing Medicaid providers enrolled or seeking to enroll with Kentucky Medicaid. We have prior experience in the shared CVO process across our health plans for Medicaid. For example, when the Arizona Association of Health Plans (AzAHP) launched an initiative in 2012 to reduce the burden of credentialing placed on Arizona physicians, we participated in the development and deployment of a statewide credentialing alliance, working with other state Medicaid partners as a member of the AzAHP. This effort was a useful strategy for alignment of credentialing cycles across all Arizona Medicaid plans, reduced duplication of efforts, and provided for administrative simplification. Additionally, as recently as April 2018, our credentialing team implemented processes in conjunction with the Texas Association of Health Plans to implement the CVO for providers. The CVO is used for provider credentialing and recredentialing for Texas Medicaid providers and provides a streamlined approach for all providers participating in the Medicaid program with other MCOs. Given our experience working with the chosen vendor, Aperture, we experienced a seamless implementation of this new CVO process. We are currently working with state agencies in both Virginia and Louisiana to help establish their centralized CVO or single-point verification processes.

Proposed Process for Transitioning to a CVO

Based upon our described experience and successful coordination procedures used in these states, we recommend that once the DMS has selected and contracted its preferred CVO(s) for the Kentucky Medicaid Program, a Credentialing Workgroup (Workgroup) be established. The Workgroup would include the DMS, the CVO(s) and all Kentucky MCOs. Collectively, we can discuss such critical topics as: simplifying the Medicaid enrollment; provider credentialing process improvements for efficiency and reducing administrative burden; uniform policies; provider submission of a single application; timing; best practices; information sharing; gap analysis; performance standards; linkages; and data type and transfer needs. All can participate in the analysis and design of the data exchange and exchange of files that will need to be transferred between the CVO(s) and each MCO. Data exchange includes initiating orders for files to be processed as well as returned data indicating files have been completed, data elements requiring update in MCO data systems and transfer of full data files containing credentialing information and images processed by the CVO(s).

Finally, we can build upon our CVO experience from other states to help facilitate the transition process for Kentucky Medicaid, including educating and assisting providers on the new credentialing requirements. Coordinating with the contracted CVO(s), we will discuss and mutually agree upon provider communication methods to create awareness. We also will align with DMS and other MCOs to ensure consistent and effective communication to providers. Approaches can be selected from our full continuum of provider relations tools, ranging from provider newsletter/bulletin articles to email alerts and provider portal postings/links (e.g., created Quick Reference Guide) to discussions during our day-to-day interactions with Kentucky providers.

iv. Approach for a timely contracting determination of providers upon receipt of information from a CVO that a provider's credentialing is complete, specifying timeframe for uploading a credentialed and contracted provider into the claims payment system to allow for payment of adjudicated claims.

Learning from our experience implementing CVOs in other Medicaid markets, UnitedHealthcare will participate actively in the design of data exchange processes in the Kentucky CVO implementation to assure that our systems align and can process data exchange files seamlessly. Data exchange includes initiating orders for files to be processed and returned data indicating files have been completed, data elements requiring update in UnitedHealthcare data systems and transfer of full data files containing credentialing information and images processed by the CVO. Notably, we currently use the credentialing application date as the provider's effective date for claims payment in both Texas and Tennessee and will use system configurations there to help guide our process in Kentucky; based upon this experience, we recommend that UnitedHealthcare also receive a copy of the provider's credentialing application to facilitate seamless payment.

By tracking each application through the credentialing process in our network database (NDB), we confirm credentialing of all service providers, with receipt of verified credentialing packets from the CVO completed within 30 calendar days. Our NDB system includes a wealth of demographic and practice information for all types of providers and is the source of truth for credentialing information. Credentialing activity screens are housed in NDB for each provider and credentialing cycles are maintained in the credentials status section. Our National Credentialing Center (NCC) creates a monthly report, which will be made available to our Commonwealth health plan, on completed initial provider credentialing applications. The data reported represents credentialing turnaround times of providers who have indicated they would like to be credentialed and contract with UnitedHealthcare for Medicaid and for whom credentialing is required for the provider type. The turnaround time begins when our NCC receives the verified credentialing packet from the CVO and ends when credentialing approves the provider's application. **Provider information will be loaded into the claims processing system within 10 days of an executed contract with a provider as participating. We will notify the provider if additional time beyond the required 10 days is needed to load the provider contract, which will not exceed an additional 15 days.**

UnitedHealthcare participates in 10 other Medicaid markets that have similar end-to-end credentialing and load regulations. Our provider contract and data management team developed regulatory requirement reporting, based upon State-specific contractual load requirements. The initial credentialing and load (ICL) reporting is a full end-to-end report on the provider's experience, from credentialing application receipt to complete claims platform load. Enhanced reporting allows proactive inventory management on monitoring providers through complete process against regulatory turnaround time. Implementation of the Kentucky MCO Program will occur in the ICL reporting structure.

g. Provide the Vendor's proposed approach for processing provider grievances and appeals. Include at a minimum:

i. The overall process to include description of interaction with providers, required correspondence and timeframes for acknowledging and resolving grievances and appeals.

UnitedHealthcare is committed to meeting the needs of our providers by identifying and resolving any problems that arise quickly with minimal burden to the provider. We will handle provider grievances and appeals promptly, consistently, fairly and in compliance with Commonwealth and federal law and DMS requirements, including the requirements outlined in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 27.10 Provider Grievances and Appeals. The following figure highlights an overall structure that can be adapted to fit the needs of the Kentucky requirements for the provider grievance and appeal process. The process affords a myriad of channels through which a provider complaint, grievance or appeal may be received. As illustrated, there is no "wrong door" for a provider to submit a complaint, grievance or appeal to us. A provider may file an appeal regarding the denial of health care services, the amount of reimbursement or the denial of a claim in addition to disputed contractual terms. We will ensure that a review and decision are completed and rendered to the provider within 30 days unless additional time is needed, in which case we will request or grant the provider, an additional 14 days to finalize review of the matter. This response then continues with descriptions of our management approach for each type of incoming provider dispute (complaints, grievances, appeals), including provider interactions, required correspondence and acknowledgement and resolution timeframes.

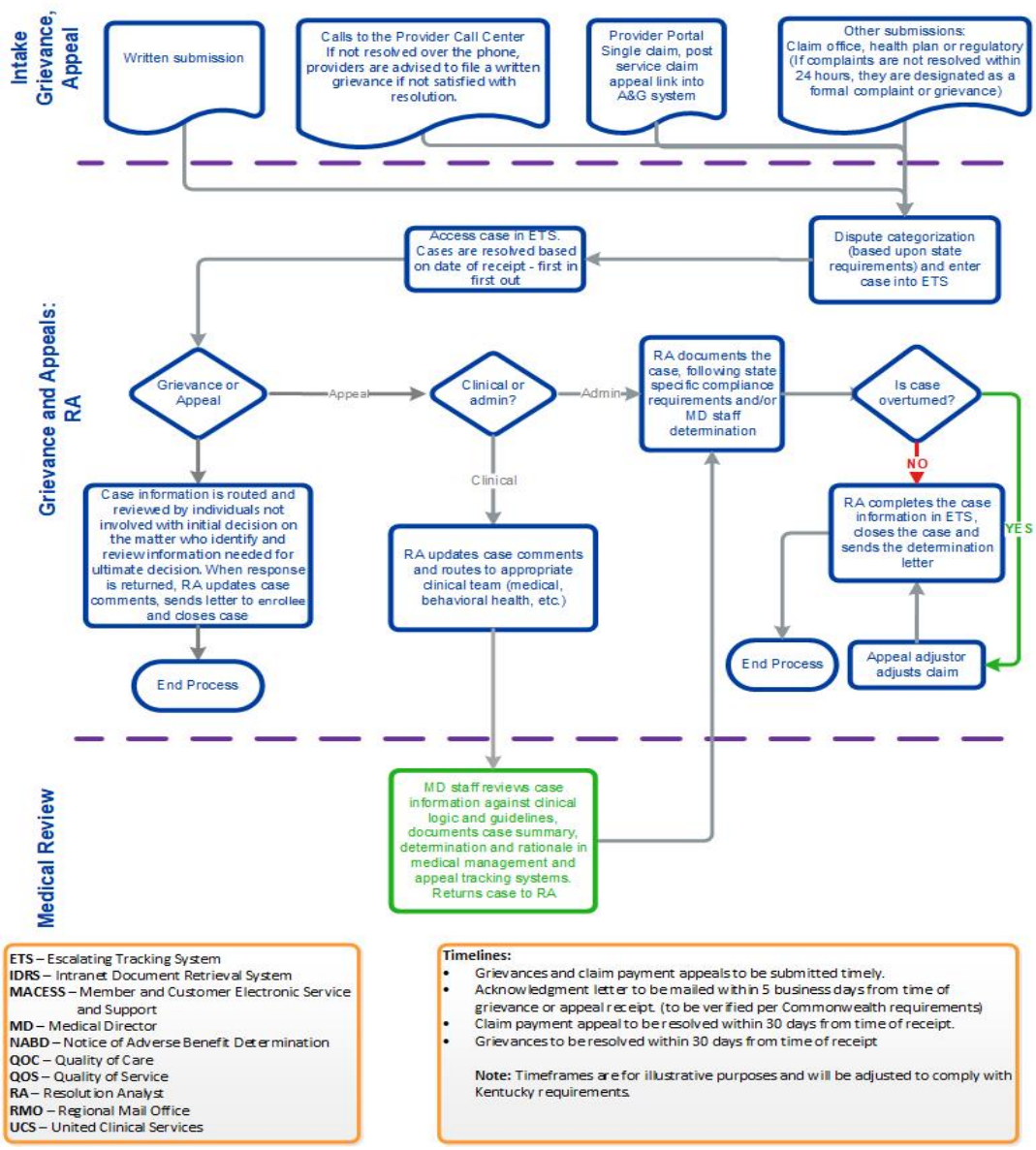

Figure 7. Provider Grievance and Appeal Process. Our process gives our providers recourse for having issues addressed, documented, investigated and resolved in a professional, timely, consistent and uniform manner.

As described later, our professional staff review and research each received provider appeal and grievance. The analysts, who review provider appeals, conduct detailed research to determine whether the provider's claim was processed accurately and take appropriate action if a claim needs to be adjusted. **In 2018, in over 30 states, we processed and completed 98.8% of received Medicaid provider appeals within our contracted time frames. On average, we overturn about 28% of provider appeals because new information is presented during the appeal that was not available when the original claim was processed. We carefully monitor appeal and overturn trends for improvement opportunities.** As part of our continuous quality improvement process, our grievance and appeals staff partner with our claims staff to identify opportunities to avoid unnecessary grievances and appeals by reaching out to providers to obtain needed information before the claim is processed. Our grievance and appeal staff also share information regarding trends for any specific providers with our network team and chief medical officer.

We understand the importance of gaining and maintaining provider trust in every way, beginning with how we work to address a provider's concerns before those concerns turn into a complaint, grievance or appeal. One example of our efforts to mitigate potential provider claims issues early is our proactive efforts to call providers. Across our national Medicaid business, we made 40,000 outbound calls in 2018 and increased this effort to 100,000 calls in 2019. This approach saves time and cost to providers, UnitedHealthcare and the entire system by reducing claim appeals. Our grievance and appeals process is transparent for providers, and it includes information regarding access to Commonwealth-level reviews. Because our providers are key partners in delivering quality services and experiences for our entire population, we continually evaluate processes and strive to remove unnecessary administrative burdens for our provider network. Our provider relations team takes a hands-on approach to identify issues early, communicate proactively and foster strong, positive relationships with providers to work through any differences. We have implemented several proactive monitoring initiatives (e.g., CP-EWS, claims payment timelines and UM notifications of denials) to identify issues and trends before providers recognize the concern. We further maintain a policy that prohibits punitive action against providers filing a grievance or an appeal to eliminate any possible chilling effect from providers in submitting issues for resolution.

From time-to-time, we still have situations where complaints occur and we have an effective process in place to address provider complaints and appeals quickly and efficiently for swift resolution. Our Kentucky provider grievance and appeals staff will be capable of reviewing outcomes to identify trends and existing operational or clinical opportunities to improve the provider experience.

Complaints

Our provider services call center and provider advocates serve as valuable entry points for provider complaints. In definition, most complaints are typically more informal or of a less serious nature (e.g., inquiries, misunderstandings or quick fixes) and can usually be promptly resolved by providing accurate information or support. If a provider files a more complicated complaint through our provider services center, our staff documents all pertinent information and promptly routes the information to our grievances and disputes resolving analyst. Providers are educated on the policies and procedures related to the filing of complaints and grievances. While we understand that providers may at times wish to file complaints, which do not require remedial action, it is our goal to inform and educate providers in response to all complaints within 2 business days.

Grievances

Exceeding Performance Standards
Our national provider appeal resolution time for non-urgent/emergent care averages 20 days, and grievance resolutions average 22 days.

Through our CMS-compliant definition, a provider grievance includes an expression of dissatisfaction received orally or in writing about any matter or aspect of UnitedHealthcare or our operations, including the quality of care or service-provided aspects of interpersonal relationships (e.g., our staff or network providers). Network providers are educated on how to submit a grievance, encouraging them to do so within 30 calendar days of the event causing dissatisfaction. All providers have the ability to submit disputes via *Link*, our secure provider portal. Alternatively, our regional mail operations receives written grievances or appeals (disputes) from providers. When received, the grievance is date stamped and logged into our Escalation Tracking System (ETS) database. We then send a letter to the provider that confirms receipt, explains the processing time frame and provides a contact number. The handling, recording and tracking of provider grievances and

appeals will be performed consistent with the rules of the Commonwealth. In the meantime, we forward the matter to the appropriate department for assessment and resolution. We thoroughly investigate each matter using applicable statutory, regulatory and contractual provisions, collecting pertinent facts from all parties and applying our written policies and procedures. Our grievance and appeal (dispute) team gives each provider a reasonable opportunity to present evidence and allegations of fact or law; date stamps and incorporates into the case file any information received during the resolution process; and gives providers an opportunity to examine the file. All of the information will be provided to a three-person review committee for DMS to determine the ultimate internal decision in the matter. As mentioned earlier, our policy prohibits punitive action against providers filing a grievance or an appeal to eliminate any possible chilling effect from providers in submitting issues for resolution. There is no disruption or interference with enrollee care throughout the provider grievance and appeals process.

We document and track time frames for resolution daily to validate compliance with all resolution requirements**.** Upon completion, we update results in ETS to maintain history and documentation of the matter and send a resolution letter to the provider. If we uphold our original position, the letter explains this and informs the provider of the right to file an external third party review after internal appeal processes have been exhausted.

Appeals

In many markets, our appeal process follows two steps: reconsideration and then appeal. A provider can first file a dispute or reconsideration. We have the flexibility and skill to create a process that adapts to the specific requirements of markets we serve. As part of our current reconsideration process, we furnish our providers written notice including the information used to make our decision and notifies them, when appropriate of their appeal rights. This written notice also explains the method providers should use to seek independent third party review, when applicable, through our secure provider portal. Our grievances and appeals policy is included in our *Care Provider Manual* and is included in provider onboarding training. It outlines the process for reconsideration and appeals as a 2-step process that a provider must exhaust before seeking recourse under any other process permitted by contract or law. This process will be modified for Commonwealth specific requirements.

Claims Dispute Resolution Process

UnitedHealthcare has an established Medicaid claims dispute resolution process that we will customize to Kentucky requirements (e.g., timelines and other guidelines). For example, in our Ohio Medicaid market, providers must submit a claim reconsideration form within 90 business days of their claim's original processing if they dispute a claim denial. If this fails to result in successful processing, they may alert their provider advocate of the issue for escalation prior to filing an appeal. If the advocate team is unable to resolve the claim, the provider will be advised to file a formal appeal. Once submitted by an advocate for escalation, our Field Aligned Support Team (FAST) works the claim issue directly with our adjusters. If provider education is needed, they will reach out directly to the provider with the outcome. Providers may continue to work the claim with the FAST representative if they still disagree. If the original processing is upheld and further research finds that an appeal is needed, the provider will be advised that they need to follow the formal appeal process. All processes are explained in our *Care Provider Manual*. We have the ability to develop processes that are consistent with Commonwealth requirements, reduce provider administrative burdens and ensure transparency within the process.

When received, we will document receipt as required by contract, ensuring the appeal is date stamped and logged into our ETS database. In most states, we accept written requests for a second level review from providers within 30 calendar days of issuing the written internal

decision rendered after research and review by individuals not previously involved in the initial decision. **We will acknowledge receipt of each appeal request within 5 calendar days** (time frames will be based upon Kentucky's requirements).

Appeal Review Committee

We will develop a provider grievance and appeal process that conforms with the specific requirements of the Commonwealth. To that end, we will establish a Kentucky-specific Appeal Review Committee to make decisions on provider appeals, and provide any information regarding provider appeals to DMS upon request. The committee will consist of at least three qualified individuals who were not involved in the original decision, action or inaction that has given rise to the right to appeal. The committee also will include an external peer reviewer when the issue on appeal involves whether the provider met Objective Quality Standards. We will provide written notice of the Appeal Committee's decision, including information regarding further appeal rights if any, within 30 calendar days of receiving a complete appeal request, or if an extension is granted, the date on which all the evidence is submitted to UnitedHealthcare.

ii. Process for tracking reasons for grievances and appeals to identify trends, and how the Vendor will use this information to improve internal operations, provider relations, and provider satisfaction.

Process for Tracking Grievances and Appeal Reasons and Identifying Trends

Our Escalation Tracking System (ETS) maintains, records, and stores all provider dispute, grievance and appeals activity from end to end. It provides us significant flexibility to provide reporting based upon multiple data elements, filters and sorting options. Our ETS allows us to track grievances by type or status; identify resolution of all cases with open, closed or outstanding disputes, grievances or appeals; track staffing resolution time frames for disputes, grievances and appeals; track referrals to other entities; and develop customized reporting and inquiry capabilities on multiple data elements for trend identification purposes. We can configure internal reporting to provide specific information needed to address provider relations issues.

To engage internal controls and deliver positive impact to provider relations, issues are reviewed, reported and remediated in a daily inventory call for capacity planning, inventory control, correct issue categorization, performance-guarantee status checks and any other compliance issues. Our grievances and disputes staff also develops daily and monthly managerial reports that track key metrics and help identify trends related to provider grievances and appeals. Reporting will be conducted per Commonwealth requirements (e.g., monthly, quarterly). Reports and data are shared within the health plan leadership and operations team to ensure they have visibility to trends and opportunities for improvements, provider education or innovation.

Ongoing data analytics and trending for grievance and appeal process improvements are a core component of our grievance and appeal structure. For example, in Maryland, we trended a significant increase in provider appeals related to two claims codes and an increase in the State's overturn rate of our appeals related to these claim codes. We conducted a root cause analysis and determined that our claims processing system was incorrectly denying these claims. By redesigning the auto pay list, restructuring the appeal versus claims review process and improving the process to review appeals, we have reduced the appeal volume for these claims codes approximately 94%. Our remediation efforts allowed the applicable claims to process normally without entering the appeal process — thus improving processing efficiency, claims payment turnaround time and provider satisfaction with UnitedHealthcare.

Using Data to Improve Internal Operations, Provider Relations and Provider Satisfaction

As a component of our continuous quality improvement efforts, we gather grievance and appeals outcome data through self-audits of our determinations, including frequency and how the results are used to drive improvements. Our quality management team collaborates with our compliance department and provider services team to track and trend cases; conduct root cause analysis on the reasons for provider grievances and appeals; and develop improvement activities based upon findings. Root cause evaluation is used to improve staff quality and improve systems or processes; The quality team audits each grievance and appeal resolution analyst at a minimum of five cases per week for seasoned analysts and up to 100% for new analysts. To drive improvements, we incorporate grievance and appeal data in decision-making activities to refine operational process and to enhance the quality of our service delivery.

Each quarter, our Quality Improvement Committee (QIC), Service Quality Improvement Subcommittee (SQIS), PAC and Healthcare Quality and Utilization Management Committee (HQUM) will review the analyses, oversee action plans to refine our operational processes and enhance the quality of our service delivery. We analyze trend data in our annual program evaluation, driving quality improvement recommendations in various operational areas based upon year-over-year data. We also will maintain a standing monthly meeting between key Kentucky health plan staff and our national appeals and grievance (A&G) team to review A&G data and identify any national issues that may affect Kentucky.

We continuously review and assess our provider contracting and claims processing procedures for quality and provider-satisfaction improvement opportunities and to mitigate provider complaints, grievances and appeals. We maintain a commitment to transparency and collaboration by addressing any actual or potential complaints in full partnership with DMS to identify trends. We audit our provider contracts for accuracy through multiple processes, such as end-to-end review of claims to the contract, random sample audits and provider roster comparison to contract setup. These edits allow us to review a claim in question and take action to validate accurate claim payment.

- ***Using PREDICT to Verify Claims Accuracy:*** We validate accurate claims payment and avoid errors that may lead to disputes, and have created several tools to minimize claims disputes. Provider Error Detection & Correction Tool (PREDICT) checks the accuracy of claims and provider data loading during the contract and demographic load process. Our contract analysts use our PREDICT tool to perform quality checks on contracts prior to uploading contract details into our provider data systems to catch errors during data entry. It has significantly reduced provider complaints and inquiries related to claims, incorrect claim payment and coding errors tied to contract data entry.
- ***Supplementing Routine Claims Audits with CP-EWS:*** Our proactive CP-EWS, designed to prevent provider grievance and appeals, supplements routine claims audit efforts by alerting us to the risk of claims denied in error, fluctuations in claims receipts, rejected claims and cash flow paid to providers to improve provider satisfaction. Smart Audit Master conducts both pre- and post-disbursement systematic claim edit reviews.

iii. Process for ensuring transparency to DMS of grievance and appeal types, resolutions, and any Vendor actions to decrease such grievances or appeals in the future.

To facilitate transparency, we will comply with reporting requirements and submit information to DMS on grievances and appeals in the format/template and frequency requested (e.g., weekly, monthly, quarterly). We use our ETS database to create reports that include the volume and types of grievances and appeals received, the resolution of those issues and any trends. This

process of creating reports directly from the source data ensures transparency of information to DMS. In other Medicaid markets, we have submitted this information to the state agency via email, secure FTP transfer and/or dashboard reporting, with reports showing quantity/volume, status, quality metrics and statistical analysis. We will share specific information that is uncovered by the aforementioned analytics with DMS and any potentially affected providers. We can trend disputes, grievances and appeals data on a daily, weekly, monthly or ad hoc basis.

Further, there are instances where our research and reporting analysis of provider complaints, grievances and appeals indicates that there is an upstream issue or error that needs to be fixed to avoid future similar issues. These provider issues often can be addressed through internal-analysis and configuration, provider education and process enhancement, as illustrated in the following examples.

Examples of Actions Taken to Resolve Received Provider Complaints and Disputes

Configuration

A recent claims configuration project was completed to correct claims for hearing tests for newborns that had been denying because of a set-up error. Hearing screenings were incorrectly denying for a required notification/authorization. The appeals and grievances team's review identified the issue, which was corrected promptly through new configuration to pay through first pass.

Provider Education

The appeals and grievances team evaluated prior authorization grievances related to non-payment of claims and balance billing, and identified PCPs that were directing members to non-participating providers. The appeals team worked with network management to educate PCPs to send members to in-network providers to reduce members from being balance billed by out-of-network providers.

Process Enhancement

We implemented the clinical reconsideration process to alleviate provider submissions that needed additional information. The clinical reconsideration process also puts the provider's submission through the reconsideration process prior to an appeal, thereby eliminating the need for the provider to appeal to get the issue resolved.

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