Technical Proposal
PUBLIC VERSION

KanCare Medicaid & CHIP Capitated Managed Care Request for Proposal

RFP Number: EVT0009267

Proposal Submission Deadline: January 4, 2024, 2 pm CT

Bidder: UCare Kansas Inc., dba UCare
7900 College Boulevard, Suite 105
Overland Park, Kansas, 66210

Contact: Stephanie Minor
State Government Relations Manager
612-294-5945

ucare®
people powered health plans

Tab 1:
Table of Contents

Table of Contents

Tab 2:
Transmittal Letter

Transmittal Letter

December 27, 2023

Amanda Acuna
Kansas Department of Administration
Procurement and Contracts
900 SW Jackson Street, Suite 451 South
Topeka, KS 66612-1286

RE: EVT0009267

Dear Ms. Acuna:

UCare Kansas, Inc. dba UCare (UCare) is pleased to submit our proposal in response to the Kansas Department of Health and Environment and Kansas Department for Aging and Disability Services Bid Event EVT0009267 for KanCare Medicaid & CHIP Capitated Managed Care.

We welcome this opportunity to demonstrate our ability to support the State in achieving its goals to improve the experience of all stakeholders and health outcomes for KanCare Members. UCare offers the State and KanCare Members the benefit of nearly 40 years of experience successfully delivering Medicaid managed care. Recognizing that health care is local, we look forward to building from our experience to work with the State, communities, and providers to apply our capabilities and expertise to meet the particular needs of KanCare Members.

In compliance with Section 4.3C of the Request for Proposal, UCare attests to the following:

a. UCare is the prime contractor for this procurement. We intend to use the following subcontractors for KanCare:
   - Care Continuum, Inc.
   - Cecelia Health, Inc.
   - Certified Languages International, LLC
   - DentaQuest, LLC
   - Fulcrum Health, Inc.
   - Infomedia Group Inc., dba Carenet Healthcare Services
   - Medtronic Care Management Services, LLC
   - MTM
   - National Imaging Associates, Inc.
   - Navitus Health Solutions, LLC
   - Provider delegated credentialing: We will provide this list once the state approves our PPA and we execute provider agreements that include credentialing

b. UCare is a corporation.

c. No attempt has been made or will be made to induce any other person or firm to submit or not to submit a proposal.

d. UCare does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin or disability.

e. No cost or pricing information has been included in this transmittal letter or the technical proposal.

f. UCare accepts all provisions found in Contractual Provisions Attachment DA-146a, which are incorporated by reference and made a part of this CONTRACT.

g. UCare accepts all requirements, terms, and conditions of the RFP. For this reason, UCare is not including a Tab 2a.

h. UCare has no actual, apparent, or potential conflict of interest, direct or indirect, that would conflict with the performance of services under this contract. For this reason, UCare is not including a Tab 2b.

i. As Chief Executive Officer of UCare, the undersigned, Hilary Marden-Resnik, is authorized to make decisions as to pricing quoted and has not participated, and will not participate, in any action contrary to the above statements.

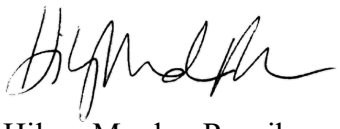
j. There is a reasonable probability that UCare Kansas will be assisted by our parent company, UCare Minnesota, in supplying services and/or furnishing supplies or equipment relating to the performance of this contract. A written certification and authorization granting the State and/or the federal government the right to examine any directly pertinent books, documents, papers, and records involving such transaction related to the contract, is included in this proposal as Attachment 2j to this letter.

k. UCare agrees that any lost or reduced federal matching money resulting from unacceptable performance in a CONTRACTOR task or responsibility defined in the RFP, CONTRACT, or modification shall be accompanied by reductions in state payments to UCare.

l. UCare has not been retained, nor has it retained a person to solicit or secure a state contract on an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except for retention of bona fide employees or bona fide established commercial selling agencies maintained by the bidder for the purpose of securing business. We understand that for breach of this provision, the State shall have the right to reject the bidder's proposal, terminate the CONTRACT for cause and/or deduct from the CONTRACT price or otherwise recover the full amount of such commission, percentage, brokerage, or contingent fee or other benefit.

UCare is excited to present our proposal for KanCare and we look forward to embarking on a successful partnership with the State to provide high-quality services to meet the needs of the State and KanCare Members.

Sincerely,

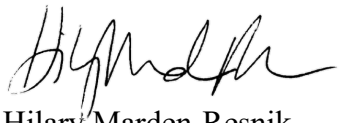


Hilary Marden-Resnik
President and Chief Executive Officer, UCare

Attachment 2j: Written certification and authorization from the parent, affiliate, or subsidiary organization granting the State and/or the federal government the right to examine any directly pertinent books, documents, papers, and records involving such transactions related to the contract.

I, Hilary Marden-Resnik, as President and Chief Executive Officer of UCare Minnesota, certify that UCare Minnesota may provide services or supplies or equipment to UCare Kansas, Inc., in support of the performance of UCare Kansas, Inc., under a contract with the State of Kansas. UCare Minnesota hereby certifies and authorizes the State of Kansas, and the federal government, the right to examine any directly pertinent books, documents, papers, and records involving such transactions related to the contract between UCare Kansas, Inc., and the State of Kansas.

Authorized and Certified this 27th of December, 2023.



Hilary Marden-Resnik
President and Chief Executive Officer
UCare Minnesota

Tab 3:
Executive Summary

Executive Summary

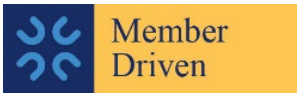
UCare's Vision:
"To lead the way in improving lives, supporting communities and achieving health equity."

Overview

As a non-profit Managed Care Organization (MCO) with a 40-year reputation of delivering stellar results for Medicaid members, not shareholders, UCare is uniquely qualified to fulfill the KanCare vision of "Partnering together to support Medicaid Members in achieving health, wellness, and independence for a healthier Kansas."

UCare thrives in serving populations with complex needs — an approach that embodies the State's motto of *"Ad Astra per Aspera": Through Hardships to the Stars*. We do this by building on our mission-driven employees, our core organizational strengths, and our commitment to partnering with the State on innovative ways to meet the evolving needs of KanCare Members. If selected, UCare will bring the state unique expertise in the following areas:

True Community Non-Profit: By engaging local stakeholders, we harness a wealth of knowledge and experience intrinsic to the community, leading to more effective and sustainable initiatives. *Upon contract execution, UCare commits to investing at least $2 million through the UCare Kansas Foundation to support KanCare priorities, such as workforce development, health disparities, and housing.*



Member Driven: Our member-driven model prioritizes personalized care, streamlined access to services, and transparent communication, all of which contribute to better health outcomes. *UCare continually achieves Medicaid Net Promoter Score — a cross-industry measure of loyalty, satisfaction, and enthusiasm — above our competitors and on par with experience leaders such as Costco.*

Authentic Provider Relationships: Collaborating with providers is essential in achieving optimal health outcomes and fostering a sense of trust and satisfaction among members. We are investing in a local Kansas-based team, in the communities we will serve, to be highly accessible to forge relationships and resolve issues. *Kansas will be the priority for our locally based provider relations team and not just "another market."*

Integrated Care Pioneer: UCare wrote the proverbial book on integrated (Medicare, Medicaid, and Long-Term Services & Supports) care. Providing technical assistance to Center for Medicare & Medicaid Services (CMS), the Centers for Health Care Strategies (CHCS), the Special Needs Plans (SNP) Alliance, and more, UCare is also the only MCO with a longitudinal study conducted by the federal government proving our success. *Our model is built from the ground up specifically for Medicaid, not as an add-on to commercial or employer-based insurance.*

Trusted Government Partner: UCare prides itself on developing strong local, State, and federal partnerships. The strength of our relationships allows us to adapt swiftly, maintain operational excellence, and ultimately deliver more favorable outcomes for members

and the broader health system. *The strength of our partnerships enables us to deliver quality consistently with just six state Medicaid corrective actions since 1985 — a number many plans reach in a year, if not a month.*

People Powered Health Care: We don't take shortcuts, ever. Everyone deserves the best care from a licensed clinician, a community health worker, or a customer service representative — not artificial intelligence. *And we back this up with a mission-driven staff with an astounding rate of only 3.2% voluntary turnover.*

All the above is grounded in the unique needs of Kansas. Over the past 14 months, we have met well over 200 providers, dozens of community-based organizations, and Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS) leadership and staff to gain a broad and deep familiarity with stakeholders and the needs of KanCare Members. We participated in public forums and follow listserv communications provided by KDHE, KDADS, the Department of Children and Families (DCF), and the Department of Corrections (DOC). We are confident we can help Kansans achieve health, wellness, and independence in an extraordinarily responsive and cost-effective manner.

True Community Non-Profit

We understand each Kansas community and region has distinct demographics and needs. We have met with more than 20 agencies and community organizations, and a few common themes we heard include the need for significant investment and collaboration to support Kansas workforce, particularly in frontier and rural areas. Second, we heard the desire for a relationship with the MCO that provides a seat at the table, not just a transaction. Finally, we heard the need to develop partnerships with community groups, local agencies, and advocacy organizations to deliver innovative programs and community-focused services throughout the State.

As an independent 501(c)(3) nonprofit health plan, UCare invests in our communities — not shareholders or a parent company. Our community focus ensures that our partners and members voices are part of our policies and developing new products and services through advisory groups and other forums. This input improves quality and demonstrates to our partners and members that they are valued and appreciated. Furthermore, this builds trust and encourages partners to share their challenges, needs, and priorities openly and candidly.

To demonstrate our commitment to supporting communities and organizations throughout Kansas, we will establish the UCare Kansas Foundation with our initial $2 million commitment, a community-directed initiative focusing on programs that improve the health and well-being of communities across Kansas through innovative services, education, community outreach, and research. Community benefit is not new to UCare, we contributed more than $36 million in the last five years to community organizations, providers, scholarships, and programs in our local market.

Member Driven

UCare's Values: Integrity, Community, Quality, Flexibility, Respect

Our Mission is as simple as it is profound — to improve the health of our members through innovative services and partnerships across communities. Improving Member's health starts with meaningful engagement of Members and caregivers and key to our approach is creating standing opportunities for feedback and showing how it affects and impacts our plan. This is reflected in our robust Member Advisory Committee and Disability Advisory Council, which also includes

subgroups to address topics such as changes to value-add benefits and concerns regarding caregiver burnout. This trust is built on respect and empowering Members and caregivers to define their health and wellness goals.

At the individual Member-level, we acknowledge the diverse health needs and goals of each Member to co-create individualized health plans. The approach of our local, trusted partners such as our Care Coordinators, community health workers, peer supports, or Community Care Coordinators will use motivational interviewing and empathic inquiry to gain an individual understanding of our Members and their personal health goals. Honoring Member unique goals and preferences builds trust and sets the foundation for longer-term achievements.

Authentic Provider Relationships

UCare is committed to establishing meaningful, collaborative, transparent, and mutually beneficial relationships with Providers across the State. To understand Providers' current experiences and priorities, UCare met with more than 200 Provider organizations of various sizes and specialties across Kansas. Our conversations have given us deep insight into the Kansas Provider landscape and the challenges of ensuring access to services for Members in various regions of the State. These invaluable meetings led to overwhelmingly positive feedback from Providers about our collaborative approach, commitment to relationship building, and strong operational performance. As a result, we secured 245 letters of intent and verbal commitments from Providers. UCare is *the* preferred plan for our current Providers in government health care programs. They look to us for authentic partnership; here's a sample of what we will bring to Kansas:

Minimized administrative burden: UCare keeps things simple through minimal authorization requirements, streamlined processes, direct access to Medical directors, timely credentialing and easy access Kansas-based executive and field-support staff.

Initiatives to address workforce shortages: UCare supports the expansion of emerging professions like community health workers, peer supports and dental therapists through grants and value-based payment.

Provider partnerships: UCare collaborates with provider partners to address systemic inequities by expanding initiatives to reduce health disparities underserved populations.

Integrated Care Pioneer

At the heart of our proposed service for KanCare is our member-centric Integrated Care Coordination (ICC) model, offering a comprehensive approach that places Members and their caregivers at the center of everything we do. Care Coordinators co-develop the service and support with Members utilizing our expert clinical and social support teams with specific knowledge of the populations they serve. These teams consist of Medical Directors, Behavioral Health Clinicians and Specialists, Member Engagement Specialists, Transition Coordinators and Pharmacists. In addition, a Social Services team that specializes in areas such as long-term care services (LTSS) and home and community-based supports (HCBS), housing and food, employment support, Early and Periodic Screening, Diagnostic, & Treatment (EPSDT), foster care, and the justice system is integrated into the ICC model. These local roles will work in close partnership with community care coordinators and targeted case managers in Kansas. UCare comes to Kansas with long-standing and successful model of local delegated care coordination to support this new requirement. This cross-functional approach ensures the optimal combination of roles needed to support Members and caregivers across the continuum of care.

UCare was one of the first plans in the nation to offer a fully integrated Dual SNP when it was just demonstration with CMS. UCare was instrumental in developing the national model for fully integrated dual eligible (FIDE) SNP it is today, and we remain the market leader in serving this population. In fact, UCare's expertise in delivering fully integrated managed care is so prominent it serves as the basis for many CMS dual special needs plan (D-SNP) requirements. Accordingly, we support the State's move to require all plans to stand up a highly integrated dual eligible (HIDE) SNP and are confident our proven model will produce positive outcomes for members and be a strong asset in our partnership with the State.

Trusted Government Partner

Success as a MCO for KanCare requires forging strong partnerships and adapting as the needs of Medicaid Members change and shift over time. UCare has a history of stepping up to fill other MCO gaps, implementing large enrollment transfers when plans have terminated their Medicaid contract or reduced their Medicaid service area. For example, we worked with the State and adapted to reduce Member disruption, including one mid-year transfer of 130,000 Members in 2017. We collaborated with the State through a data exchange, such as current prior authorizations or hospitalizations, ensuring Members did not go without needed care, and created a seamless Member experience.

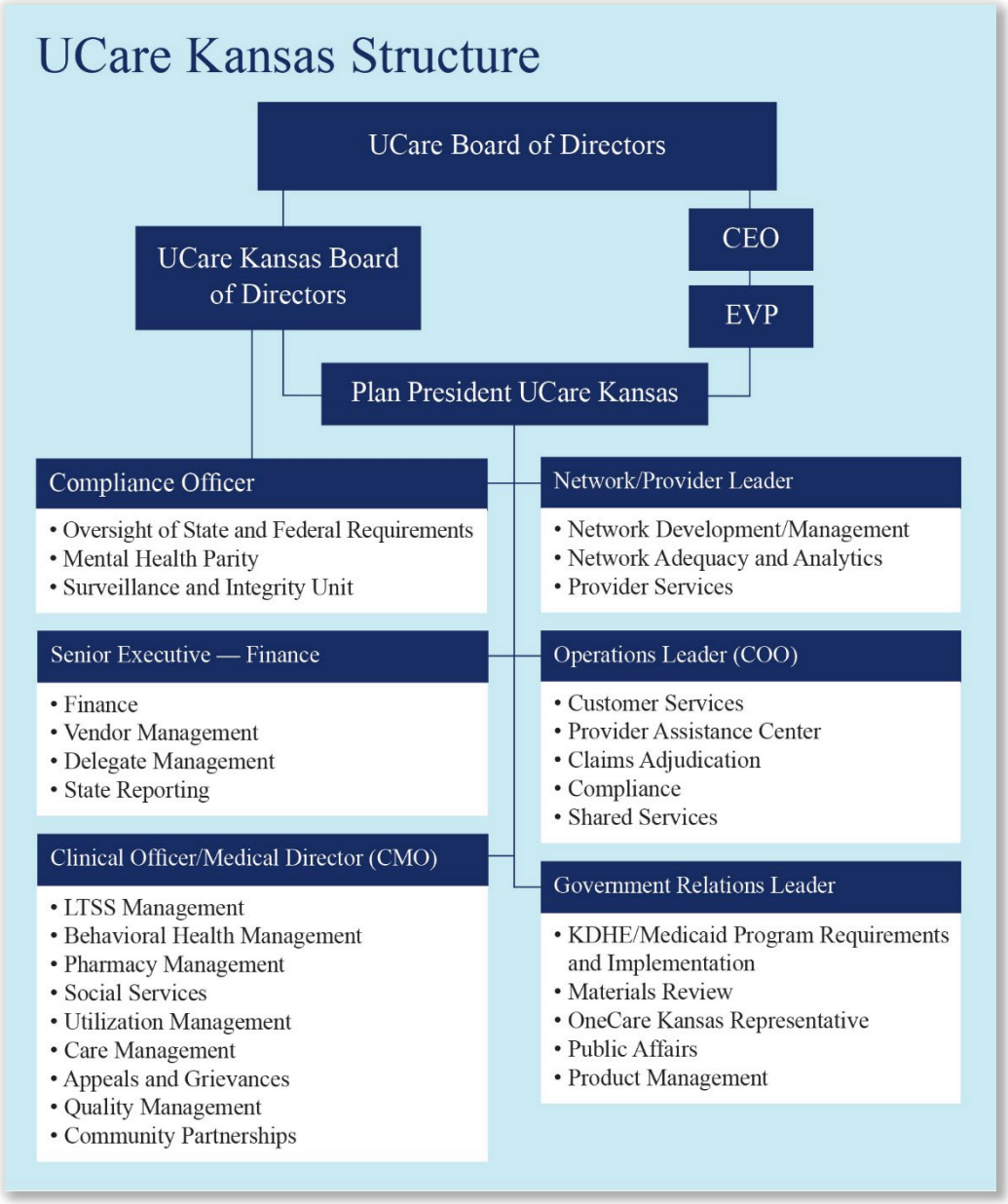
Our commitment began nearly 40 years ago and today UCare partners with the state to build a comprehensive, high-performing Medicaid program that is nationally regarded for its reforms and outcomes. This long-term commitment to community and our state partnership demonstrates why we are the market leader in government programs, covering over 600,000 members; and the third largest nonprofit government programs plan nationally.

People Powered Health Care

Inspired by our Vision, driven by our Mission, and operating by our Values, UCare takes tremendous pride in our workforce and culture, knowing that delivering an exceptional Member experience starts with having exceptional employees. Our employees live this promise every day and reinforced by our mission statement: *UCare will improve the health of our members through innovative services and partnerships across communities.*

Our people power is built directly into UCare's governance structure, as 40% of UCare's board are consumer Members. This sets the tone from the top of our Member-driven approach, which results in UCare recruiting leadership and employees dedicated to our mission with deep Medicaid expertise, including two former Midwest Medicaid Directors, and industry-leading experience coming from community, providers and plans.

Exceptional experiences start with local, not national, solutions. All aspects of our service for KanCare will be under the direction of our Kansas Plan President, who has been with UCare since early 2023, and brings a wealth of experience in KanCare and strong relationships across the State. The Plan President will oversee the program's implementation, serve as the State's direct contact, and manage a dedicated team out of our Kansas-based office. Reporting to our Kansas Board of Directors, the Plan President will directly oversee an executive team covering all aspects of the program and will include all required positions noted in Section 7.17 of the Request for Proposal (RFP) and draw from experienced professionals across Kansas communities. In addition to our primary Kansas office location, UCare is prepared to open satellite locations in areas such as Wichita and Dodge City to offer additional access points for Members and give us the opportunity to engage more deeply in various communities.



Summary

UCare understands and will comply with all requirements cited in 'Section 7: Scope of Services' of this RFP and we are confident our deep experience and authentic partnership approach to serving Medicaid Members will deliver a unique and highly effective program for KanCare based on our community-based roots, proven care coordination model, and Medicaid expertise. UCare is attuned to the diverse needs of our Members; from race, ethnicity, and language to disability status, and urban and rural/frontier communities. We are a leader in addressing social determinants of health that often lead to disparities, including employment status, health literacy, housing, transportation, and food insecurity. We meet members where they are, break down barriers to care, simplify their health care experience, and work with them attain their best health.

We look forward to partnering with the state of Kansas to ensure the success of KanCare.

Tab 4:
Required Forms

SIGNATURE SHEET

Item: KanCare Medicaid & CHIP Capitated Managed Care
Agency: Kansas Department of Health and Environment (KDHE),
Kansas Department for Aging and Disability Services (KDADS)
Closing Date: January 4, 2024, 2:00 PM CST

By submission of a bid and the signatures affixed thereto, the bidder certifies all products and services proposed in the bid meet or exceed all requirements of this specification as set forth in the request and that all exceptions are clearly identified.

UCare Kansas, Inc.
Legal Name of Person, Firm or Corporation

500 Stinson Blvd NE
Mailing Address

Minneapolis, MN
City & State

55413
Zip

866-457-7144
Toll Free Telephone

612-676-6500
Local Telephone

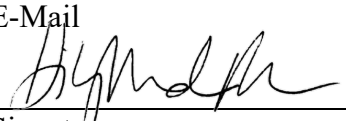
(612) 386-0080
Cell Phone

612-676-6501
Fax Number

93-2931013
Tax Number

CAUTION: If your tax number is the same as your Social Security Number (SSN), you must leave this line blank. DO NOT enter your SSN on this signature sheet. If your SSN is required to process a Contract award, including any tax clearance requirements, you will be contacted by an authorized representative of the Office of Procurement and Contracts at a later date.

hmarden-resnik@ucare.org
E-Mail


Signature

Date

Hilary Marden-Resnik
Typed Name

President and Chief Executive Officer
Title

In the event the **contact for the bidding process** is different from above, indicate contact information below.

Stephanie Minor
Bidding Process Contact Name

PO Box 52
Mailing Address

Minneapolis, MN
City & State

55440-0052
Zip Code

866-457-7144
Toll Free Telephone

612-294-5945
Local Telephone

612-889-6921
Cell Phone

612-676-6501
Fax Number

sminor@ucare.org
E-Mail

If **awarded a CONTRACT and purchase orders** are to be directed to an address other than above, indicate mailing address and telephone number below.

Stephanie Minor
Award Contact Name

PO Box 52
Mailing Address

Minneapolis, MN
City & State

55440-0052
Zip Code

866-457-7144
Toll Free Telephone

612-294-5945
Local Telephone

612-889-6921
Cell Phone

612-676-6501
Fax Number

sminor@ucare.org
E-Mail

Kansas
Department of Revenue

Laura Kelly, Governor
Mark A. Burghart, Secretary

www.ksrevenue.gov

CERTIFICATE OF TAX CLEARANCE

UCare Kansas, Inc.

ISSUE DATE
11/27/2023

TRANSACTION ID
TDGP-GHRS-4BGH

CONFIRMATION NUMBER
CDMR-3FXK-MDTG

TAX CLEARANCE VALID THROUGH 02/25/2024

Verification of this certificate can be obtained on our website, www.ksrevenue.org, or by calling the Kansas Department of Revenue at 785-296-3199

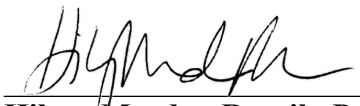
CERTIFICATION REGARDING IMMIGRATION REFORM & CONTROL

All Contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the Contractor as well as any subcontractor or sub-subcontractor. The usual method of verification is through the Employment Verification (I-9) Form. With the submission of this bid, the Contractor hereby certifies without exception that Contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination and any applicable damages.

Contractor certifies that, should it be awarded a contract by the State, Contractor will comply with all applicable federal and state laws, standards, orders and regulations affecting a person's participation and eligibility in any program or activity undertaken by the Contractor pursuant to this contract. Contractor further certifies that it will remain in compliance throughout the term of the contract.

At the State's request, Contractor is expected to produce to the State any documentation or other such evidence to verify Contractor's compliance with any provision, duty, certification, or the like under the contract.

Contractor agrees to include this Certification in contracts between itself and any subcontractors in connection with the services performed under this contract.



Hilary Marden-Resnik, President and CEO **Date**

POLICY REGARDING SEXUAL HARASSMENT

WHEREAS, sexual harassment and retaliation for sexual harassment claims are unacceptable forms of discrimination that must not be tolerated in the workplace; and

WHEREAS, state and federal employment discrimination laws prohibit sexual harassment and retaliation in the workplace; and

WHEREAS, officers and employees of the State of Kansas are entitled to working conditions that are free from sexual harassment, discrimination, and retaliation; and

WHEREAS, the Governor and all officers and employees of the State of Kansas should seek to foster a culture that does not tolerate sexual harassment, retaliation, and unlawful discrimination.

NOW THEREFORE, pursuant to the authority vested in me as Governor of the State of Kansas, I hereby order as follows:

1. All Executive Branch department and agency heads shall have available, and shall regularly review and update at least every three years or more frequently as necessary, their sexual harassment, discrimination, and retaliation policies. Such policies shall include components for confidentiality and anonymous reporting, applicability to intern positions, and training policies.

2. All Executive Branch department and agency heads shall ensure that their employees, interns, and contractors have been notified of the state's policy against sexual harassment, discrimination, or retaliation, and shall further ensure that such persons are aware of the procedures for submitting a complaint of sexual harassment, discrimination, or retaliation, including an anonymous complaint.

3. Executive Branch departments and agencies shall annually require training seminars regarding the policy against sexual harassment, discrimination, or retaliation. All employees shall complete their initial training session pursuant to this order by the end of the current fiscal year.

4. Within ninety (90) days of this order, all Executive Branch employees, interns, and contractors under the jurisdiction of the Office of the Governor shall be provided a written copy of the policy against sexual harassment, discrimination, and retaliation, and they shall execute a document agreeing and acknowledging that they are aware of and will comply with the policy against sexual harassment, discrimination, and retaliation.

5. Matters involving any elected official, department or agency head, or any appointee of the Governor may be investigated by independent legal counsel.

6. The Office of the Governor will require annual mandatory training seminars for all staff, employees, and interns in the office regarding the policy against sexual harassment, discrimination, and retaliation, and shall maintain a record of attendance.

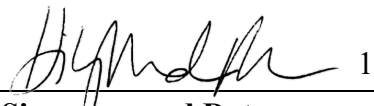
7. Allegations of sexual harassment, discrimination, or retaliation within the Office of the Governor will be investigated promptly, and violations of law or policy shall constitute grounds for disciplinary action, including dismissal.

8. This Order is intended to supplement existing laws and regulations concerning sexual harassment and discrimination, and shall not be interpreted to in any way diminish such laws and regulations. The Order provides conduct requirements for covered persons, and is not intended to create any new right or benefit enforceable against the State of Kansas.

9. Persons seeking to report violations of this Order, or guidance regarding the application or interpretation of this Order, may contact the Office of the Governor regarding such matters.

Agreement to Comply with the Policy Against Sexual Harassment, Discrimination, and Retaliation.

I hereby acknowledge that I have received a copy of the State of Kansas Policy Against Sexual Harassment, Discrimination, and Retaliation established by Executive Order 18-04 and agree to comply with the provisions of this policy.


12/29/2023

Signature and Date

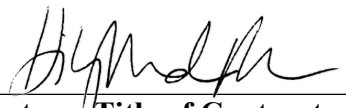
Hilary Marden-Resnik

Printed Name

CERTIFICATION OF COMPANY NOT CURRENTLY ENGAGED IN A BOYCOTT OF GOODS OR SERVICES FROM ISRAEL

In accordance with HB 2482, 2018 Legislative Session, the State of Kansas shall not enter into a contract with a Company to acquire or dispose of goods or services with an aggregate price of more than $100,000, unless such Company submits a written certification that such Company is not currently engaged in a boycott of goods or services from Israel that constitutes an integral part of business conducted or sought to be conducted with the State.

As a Contractor entering into a contract with the State of Kansas, it is hereby certified that the Company listed below is not currently engaged in a boycott of Israel as set forth in HB 2482, 2018 Legislature.



Signature, Title of Contractor **Date**

Hilary Marden-Resnik

Printed Name

STATE OF KANSAS
Event Details

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	1
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: UCARE KANSAS INC
500 STINSON BLVD NE
MINNEAPOLIS MN 55413
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Event Description
State of Kansas

Kansas Department of Health and Environment
Kansas Department for Aging and Disability Services

General Comments

- **********
  0005 - Request for Proposal pursuant to K.S.A. 75-37,102

- **********
  Pre-proposal Conference - A mandatory pre-proposal conference will be held at 9:00 AM, on October 16, 2:00, via Zoom:

  Please see section 3.2.2 of the Bid documents, for Prebid instructions on how to receive call in information.

  Attendance is required for this pre-proposal conference. Failure to attend the pre-bid conference will result in rejection of your bid. Questions requesting clarification of the Bid Event must be submitted electronically (MS Word) to the Procurement Officer (Event Contact) indicated in the bidding instructions, prior to close of business on October 23, 2023. Impromptu questions may be permitted, and spontaneous unofficial answers provided, however bidders should understand that the only official answer or position of the State of Kansas will be presented in writing.

  Failure to notify the Procurement Officer (Event Contact) of any conflicts or ambiguities in the Bid Event may result in items being resolved in the best interest of the State. Any modification to this Bid Event as a result of the pre-proposal conference, as well as written answers to written questions, shall be made in writing by addendum and dispatched to all bidders associated to this event. Only written communications are binding.

  Answers to questions will be available in the form of an addendum on the Procurement and Contracts' website, http://admin.ks.gov/offices/procurement-contracts

  It shall be the responsibility of all participating bidders to acquire any and all addenda and additional information as it is made available from the web site cited above. Vendors/Bidders not initially invited to participate in this Bid Event must notify the Procurement Officer (Event Contact) of their intent to bid at least 24 hours prior to the event's closing date/time. Bidders are required to check the website periodically for any additional information or instructions.

- **********
  0008 - Invitation for Bid

- **********
  BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE
  A “Tax Clearance” is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s).

  INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must:
  • Go to http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate
  • Return to the website the following working day to see if KDOR will issue the certificate
  • If issued an official certificate, print it and attach it to your bid response
  • If denied a certificate, engage KDOR in a discussion about why a certificate wasn’t issued

  Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response.

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	2
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: UCARE KANSAS INC
500 STINSON BLVD NE
MINNEAPOLIS MN 55413
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate.

Information about Tax Registration can be found at the following website:
http://www.ksrevenue.org/busregistration.html

Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award.

In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

- **********
The State of Kansas, as a matter of public policy, encourages anyone doing business with the State of Kansas to take steps to discourage human trafficking. If prospective bidders/vendors/Contractors have any policies or participate in any initiatives that discourage human trafficking the prospective bidder/vendor/Contractor is encouraged to submit same as part of their bid response.

- **********
During the 2012 Session, the Kansas Legislature enacted a Bidder Preference Program which created three (3) bid preferences. To see if you qualify for any of the preferences, please go to the following website for more information:
https://admin.ks.gov/offices/procurement-contracts/bidding--contracts/bidder-programs/certified-business-and-disabled-veteran-owned-business.

To claim this preference, the bid response must include the Preference Request Form and you must respond to the applicable Bidder Preference category in the question under the General Questions section on the following page(s).

****
During the 2014 Session, the Kansas Legislature enacted the Disabled Veteran Owned Business bidder preference program. For more information or to see if you qualify, please go to the following website:
https://admin.ks.gov/offices/procurement-contracts/bidding--contracts/bidder-programs/bidder-preference-program

To claim this preference, the bid response must include a copy of the letter from Procurement and Contracts certifying your company as a Disabled Veteran Owned Business and you must respond to the applicable Disabled Veteran Owned Business category in the question under the General Questions section on the following page(s).

General Questions

Question	UOM	Best	Worst	Response
Please select ONE category from the following list with regard to a Bidder Preference. If selecting a Bidder Preference category, supporting documentation must accompany this bid response. (Note: #3 "State Use Purchases" category does not apply to Requests for Proposals)				**Select One**
Options: Not claiming any Bidder Preference Category				X
Claiming the Disabled Veteran Owned Business Category				
Claiming the State Use Purchases Bidder Preference Category				
Claiming the Certified Business Bidder Preference Category				

Required: Yes Mandatory Response: No

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	3
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: UCARE KANSAS INC
500 STINSON BLVD NE
MINNEAPOLIS MN 55413
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
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Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Response Comments

Is a completed Boycott of Israel form included with your bid event submission?

Yes

Required: Yes Mandatory Response: No

Response Comments

Is a completed Sexual Harassment form included with your bid event submission?

Yes

Required: Yes Mandatory Response: No

Response Comments

Is a completed Immigration Reform and Control form included with this bid event submission (refer to Appendix B - Terms and Conditions, Event Details document)?

Yes

Required: Yes Mandatory Response: No

Response Comments

Does your organization accept the State of Kansas terms and conditions as stated?

Yes

Required: Yes Mandatory Response: No

Response Comments

Is a current Tax Clearance Certificate included with this bid event submission (refer to Appendix B - Terms and Conditions, Event Details document)?

Yes

Required: Yes Mandatory Response: No

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	4
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: UCARE KANSAS INC
500 STINSON BLVD NE
MINNEAPOLIS MN 55413
United States

Submit To: Department of Administration
Procurement and Contracts
900 SW Jackson
Suite 451-South
Topeka KS 66612-1286
United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Response Comments

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	5
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: UCARE KANSAS INC
500 STINSON BLVD NE
MINNEAPOLIS MN 55413
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Topeka KS 66612-1286
United States

Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

[redacted]

1

[redacted]

Description: KanCare Medicaid and CHIP Capitated Managed Care Services

[redacted]

Response
$927.99 PMPM

Required: Yes Mandatory Response: No

Response Comments

The bid price is the statewide blended capitation rate of $927.99 per member per month (PMPM).

STATE OF KANSAS
Event Details (cont.)

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	6
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: UCARE KANSAS INC
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United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Bidder Information

Firm Name: UCare Kansas, Inc.

Name: Hilary Marden-Resnik **Signature:** **Date:** 12/19/2023

Phone #: 612-676-6500 **Fax #:** 612-676-6501

Street Address: 500 Stinson Blvd NE

City & State: Minneapolis, MN **Zip Code:** 55413

Email: hmarden-resnik@ucare.org

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	7
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: UCARE KANSAS INC
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MINNEAPOLIS MN 55413
United States

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United States
Contact: Amanda L Acuna
Phone: 785/296-2376
Email: amanda.acuna@ks.gov

Appendix A - Line Specifications

Line: 1 **Item ID:** **Line Qty:** 1 **UOM:** Each
Description: KanCare Medicaid and CHIP Capitated Managed Care Services

Item Specifications

Manufacturer:			
Mfg Item ID:			
Item Length:	0	**Item Height:**	0
Item Width:	0	**Dimension UOM:**	
Item Volume:	0	**Volume UOM:**	
Item Weight:	0	**Weight UOM:**	
Item Size:		**Item Color:**	

Shipping Information

Schedule:	1	**Ship To:**	Procurement and Contracts
Quantity:	1		Procurement and Contracts
Due Date:	01/09/2024		900 SW Jackson
Freight Terms:			Suite 451 South
Ship Via:			Topeka KS 66612
			United States

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	8
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time	**Finish Time**		
10/02/2023 09:00:00 CDT	01/04/2024 14:00:00 CST		

Event Currency: US Dollar
Bids allowed in other currency: No

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Contact: Amanda L Acuna
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Email: amanda.acuna@ks.gov

Appendix B - Terms & Conditions

1. It is the bidder's responsibility to submit questions, acknowledge addenda and attend pre-bid conferences as indicated in this event or attachment(s). When communicating always refer to the Bid Event ID.

2. Conflict of Interest: With the submission of a response for this bidding event, you certify that you do not have any substantial conflict of interest sufficient to influence the bidding process of this event. A conflict of substantial interest is one which a reasonable person would think would compromise the opening bidding process.

3. BIDDER MUST OBTAIN A CURRENT TAX CLEARANCE CERTIFICATE A "Tax Clearance" is a comprehensive tax account review to determine and ensure that the account is compliant with all primary Kansas Tax Laws administered by the Kansas Department of Revenue (KDOR) Director of Taxation. Information pertaining to a Tax Clearance is subject to change(s), which may arise as a result of a State Tax Audit, Federal Revenue Agent Report, or other lawful adjustment(s). INSTRUCTIONS: To obtain a Current Tax Clearance Certificate, you must: 1) Go to: http://ksrevenue.org/taxclearance.html to request a Tax Clearance Certificate; 2) Return to the website the following working day to see if KDOR will issue the certificate; 3) If issued an official certificate, print it and attach it to your bid response; and 4) If denied a certificate, engage KDOR in a discussion about why a certificate wasn't issued. Bidders (and their subcontractors) are expected to submit a current Tax Clearance Certificate with every event response. REMINDER: You will need to sign back into the KDOR website to view and print the official tax clearance certificate. Information about Tax Registration can be found at the following website:
http://www.ksrevenue.org/busregistration.html. Procurement and Contracts reserves the right to confirm tax status of all potential contractors and subcontractors prior to the release of a purchase order or contract award. In the event that a current tax certificate is unavailable, Procurement and Contracts reserves the right to notify a bidder (one that has submitted a timely event response) that they have to provide a current Tax Clearance Certificate within ten (10) calendar days, or Procurement and Contracts may proceed with an award to the next lowest responsive bidder, whichever is determined by the Director of Purchases to be in the best interest of the State.

4. Immigration and Reform Control Act of 1986 (IRCA): All contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the contractor as well as any subcontractor or sub-contractors. The usual method of verification is through the Employment Verification (I-9) form. With the submission of this bid, the contractor hereby certifies without exception that such contractor has complied with all federal and state laws relating to immigration and reform. Any misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination for cause and any applicable damages. Unless provided otherwise herein, all contractors are expected to be able to produce for the State any documentation or other such evidence to verify Contractor's IRCA compliance with any provision, duty, certification, or like item under the contract.
Bidders must submit a Certification Regarding Immigration Reform and Control form with every event response. The form can be found at the following website:
http://www.admin.ks.gov/docs/default-source/ofpm/procurement-contracts/irca.doc.

5. Competition: The purpose of this Request is to seek competition. The bidder shall advise Procurement and Contracts if any specification, language or other requirement inadvertently restricts or limits bidding to a single source. Notification shall be in writing and must be received by Procurement and Contracts no later than five (5) business days prior to the event closing date. The Director of Purchases reserves the right to waive minor deviations in the specifications which do not hinder the intent of this Request.

6. Acceptance or Rejection: The State reserves the right to accept or reject any or all bid responses or part of a response; to waive any informalities or technicalities; clarify any ambiguities in responses; modify any criteria in this Event; and unless otherwise specified, to accept any item in a response.

7. Disclosure of Bid Event Content and Proprietary Information: All bid responses become the property of the State of Kansas. The Kansas Open Records Act (K.S.A. 45-215 et seq) requires public information be placed in the public domain at the conclusion of the selection process, and be available for examination by all interested parties. More information on this subject can be found at the following website:
http://admin.ks.gov/offices/chief-counsel/kansas-open-records-act.

PeopleSoft Strategic Sourcing

Event ID	Format	Type	Page
17300-EVT0009267	Sell	RFx	9
Event Round	**Version**		
1	5		
Event Name			
KanCare Medicaid & CHIP Capitated Managed Care			
Start Time		**Finish Time**	
10/02/2023 09:00:00 CDT		01/04/2024 14:00:00 CST	

Event Currency: US Dollar
Bids allowed in other currency: No

Bidder: UCARE KANSAS INC
500 STINSON BLVD NE
MINNEAPOLIS MN 55413
United States

Submit To: Department of Administration
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900 SW Jackson
Suite 451-South
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United States
Contact: Amanda L Acuna
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Email: amanda.acuna@ks.gov

8. Debarment of State Contractors. Any Contractor who defaults on delivery or does not perform in a satisfactory manner as defined in this Agreement may be barred for a period up to three (3) years, pursuant to K.S.A. 75-37,103, or have its work evaluated for pre-qualification purposes. Contractor shall disclose any conviction or judgment for a criminal or civil offense of any employee, individual or entity which controls a company or organization or will perform work under this Agreement that indicates a lack of business integrity or business honesty. This includes (1) conviction of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract or subcontract or in the performance of such contract or subcontract; (2) conviction under state or federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, or receiving stolen property; (3) conviction under state or federal antitrust statutes; and (4) any other offense the State determines to be so serious and compelling as to affect responsibility as a state contractor. For the purpose of this section, an individual or entity shall be presumed to have control of a company or organization if the individual or entity directly or indirectly, or acting in concert with one or more individuals or entities, owns or controls twenty-five (25) percent or more of its equity, or otherwise controls its management or policies. Failure to disclose an offense may result in disqualification of the Proposal or termination of the Agreement, as determined by the State.

9. Accounts Receivable Set-Off Program: If during the course of this contract the Contractor is found to owe a debt to the State of Kansas, agency payments to the Contractor may be intercepted / setoff by the State of Kansas. Notice of the setoff action will be provided to the Contractor. Pursuant to K.S.A. 75-6201 et seq, Contractor shall have the opportunity to challenge the validity of the debt. If the debt is undisputed, the Contractor shall credit the account of the agency making the payment in an amount equal to the funds intercepted. K.S.A. 75-6201 et seq. allows the Director of Accounts and Reports to set off funds the State of Kansas owes Contractors against debts owed by the contractor to the State of Kansas. Payments set off in this manner constitute lawful payment for services or goods received. The Contractor benefits fully from the payment because its obligation to the State is reduced by the amount subject to setoff.

Last Updated: 01/24/2019

Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Department of Administration

Phone: 785-296-2376
Fax: 785-296-7240
https://admin.ks.gov/offices/procurement-contracts

Adam Proffitt, Secretary
Todd Herman, Director

Laura Kelly, Governor

AMENDMENT

Date:	October 20, 2023
Amendment Number:	1
RFP Number:	EVT0009267
Closing Date:	January 4, 2024, 2:00 PM
Procurement Officer: **Telephone:** **E-Mail Address:** **Web Address:**	Amanda Acuna 785-296-5419 Amanda.Acuna@ks.gov http://admin.ks.gov/offices/procurement-and-contracts/
Agency:	Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Item:	KanCare Medicaid & CHIP Capitated Managed Care

Conditions:

1. The deadline for submitting written questions requesting clarifications has been extended to October 27, 2023, by 12 p.m. CT to allow adequate time for review and response.

2. Technical issues were experienced with the following two folders in the KanCare Bidder's Library and have since been resolved.
   a. De-Identified Claims Data
   b. EDI Companion Guides

A signed copy of this Addendum must be submitted with your bid. If your bid response has been returned, submit this Addendum by the closing date indicated above.

I (We) have read and understand this addendum and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: UCare Kansas, Inc.

SIGNED BY: _____

TITLE: President and Chief Executive Officer DATE: _____

It shall be the vendor's responsibility to monitor this website on a regular basis for any changes/addenda.
http://admin.ks.gov/offices/procurement-and-contract

Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Kansas Department of Administration

Phone: 785-296-2376
Fax: 785-296-7240
https://admin.ks.gov/offices/procurement-contracts

Adam Proffitt, Secretary
Todd Herman, Director

Laura Kelly, Governor

AMENDMENT

Date:	November 28, 2023
Amendment Number:	2
RFP Number:	EVT0009267
Closing Date:	January 4, 2024, 2:00 PM
Procurement Officer:	Amanda Acuna
Telephone:	785-296-5419
E-Mail Address:	Amanda.Acuna@ks.gov
Web Address:	http://admin.ks.gov/offices/procurement-and-contracts/
Agency:	Kansas Department of Health and Environment (KDHE), Kansas Department for Aging and Disability Services (KDADS)
Item:	KanCare Medicaid & CHIP Capitated Managed Care

Conditions: See response to questions and changes to RFP language below.

A signed copy of this Addendum must be submitted with your bid. If your bid response has been returned, submit this Addendum by the closing date indicated above.

I (We) have read and understand this addendum and agree it is a part of my (our) bid response.

NAME OF COMPANY OR FIRM: UCare Kansas, Inc._____

SIGNED BY:_____

TITLE: President and Chief Executive Officer_____ DATE: 12/29/2023

It shall be the vendor's responsibility to monitor this website on a regular basis for any changes/addenda.
http://admin.ks.gov/offices/procurement-and-contract

KanCare Medicaid and CHIP Capitated Managed Care
RFP # EVT0009267
Response to Potential Bidders' Questions

The State of Kansas response to potential bidders' questions received on or before the question submission date contained in the RFP are compiled in the below Microsoft Excel spreadsheet, KanCare RFP Q&A Final. Please note that due to size limitations of Excel cells, lengthy reference text or potential bidders' questions may not appear in full when printed in hard copy; however, all content is present in the electronic version.


KanCare RFP Q&A Final.xlsx

In reference to question #70, the updated crosswalk has been uploaded to the bidder's library as part of the "KS RFP Bidder's Data Dictionary 2023.10.27_Deliverable.xlsx" file.

In reference to question #186, the updated rate development narrative "KS - CY23 Rate Development Narrative 2023.11.21_Updated.pdf" has been uploaded to the bidder's library.

KanCare Medicaid and CHIP Capitated Managed Care
RFP # EVT0009267
Changes to RFP Language Based on Q&A

1. Section 3.3.7.A, page 16

From:

A. The bidder may request that proposal content that contains proprietary information, legally recognized as such and protected by law, be withheld from open record disclosures. To request that such proposal content be withheld, the bidder must:

1. Submit redacted/public versions of the bidder's technical and cost proposal to facilitate open records requests in accordance with the requirements in Section 4.1.A.4. The bidder may only redact information from its redacted/public versions that is legally recognized proprietary information; blanket redaction of the entire proposal or redaction of pricing information will not be considered proprietary.

2. Separately submit versions of the bidder's technical and cost proposals that highlight the content that has been redacted in the redacted/public versions of its proposals in accordance with the requirements in Section 4.1.A.5.

To:

A. The bidder may request that proposal content that contains proprietary information, legally recognized as such and protected by law, be withheld from open record disclosures. To request that such proposal content be withheld, the bidder must:

1. Submit a redacted/public version of the bidder's technical proposal to facilitate open records requests in accordance with the requirements in Section 4.1.A.4. The bidder may only redact information from its redacted/public versions that is legally recognized proprietary information; blanket redaction of the entire proposal will not be considered proprietary.

2. Separately submit a version of the bidder's technical proposal that highlights the content that has been redacted in the redacted/public version of its technical proposal in accordance with the requirements in Section 4.1.A.5.

2. Section 4.1.A.4 on page 18

From:

4. One (1) electronic/software version and one (1) paper copy of the redacted/public version of the bidder's technical and cost proposal to facilitate open records requests. Redacted/public versions must be clearly marked as "PUBLIC VERSION" on the first page of the electronic file and paper copy. The electronic file shall be provided on USB flash drive, in Microsoft® Word or Excel or searchable PDF®.

To:

4. One (1) electronic/software version and one (1) paper copy of the redacted/public version of the bidder's technical proposal to facilitate open records requests. The redacted/public version of the technical proposal must be clearly marked as "PUBLIC VERSION" on the first page of the electronic file and paper copy. The electronic file shall be provided on USB flash drive, in Microsoft® Word or Excel or searchable PDF®.

3. Section 7.4.2.B, page 75

From:

B. The CONTRACTOR(S) shall make reasonable efforts (three [3] attempts via phone and text and then follow up by mail within ten [10] Business Days from date of Enrollment for new Members) to contact Member in person, by phone, or by mail to complete a Health Screen and Health Risk Assessment (HRA). If unable to reach the Member, the CONTRACTOR(S) shall attempt screening again, at a minimum, every ninety (90) Calendar Days, or following HCBS Waiver requirements, and more frequently for hard-to-reach and high needs populations. The CONTRACTOR(S) shall use methods beyond the typical phone and mail to reach the Member, including hard-to-reach Members, but not limited to, contacting through a Provider or other community partner, contacting foster care CMPs for Members in foster care, etc. Hard-to-reach means those without a phone, identified as homeless, etc.

To:

B. The CONTRACTOR(S) shall make reasonable efforts (at least three [3] attempts via phone and/or text if a valid phone number is on file and follow up by mail within ten [10] Business Days from date of Enrollment for new Members) to contact the Member to complete or arrange completion of a Health Screen and Health Risk Assessment (HRA) (if applicable). If unable to reach the Member, the CONTRACTOR(S) shall attempt screening again, at a minimum, every ninety (90) Calendar Days, or following HCBS Waiver requirements, and more frequently for hard-to-reach and high needs populations. The CONTRACTOR(S) shall use methods beyond the typical phone and mail to reach the Member, including hard-to-reach Members, but not limited to, contacting through a Provider or other community partner, contacting foster care CMPs for Members in foster care, etc. Hard-to-reach means those without a phone, identified as homeless, etc.

4. Section 7.13.2.L.5.a.iv.2, page 200

From:

2. The difference between the Pricing Denominator PMPM and the Minimum Pricing PMPM will be applied to total membership for each month of the contract period used to calculate the Pricing MLR, resulting in calculation of a total annual remittance amount due for the twelve (12) month contract period.

To:

2. The difference between the Reported Denominator PMPM and the Minimum Pricing PMPM will be applied to total membership for each month of the contract period used to calculate the Pricing MLR, resulting in calculation of a total annual remittance amount due for the twelve (12) month contract period.

5. Appendix A, Definition of Community Care Coordination Provider, page 274

From:

Community Care Coordination Provider – A conflict-free entity that is under contract with the CONTRACTOR(S) to perform specific care coordination activities described in Appendix L (Care Coordination Matrix). These conflict-free entities may not be the same entities that provide Home- and Community-Based Services (HCBS) Waiver services, per 42 CFR 441.301(c)(1)(vi). See RFP Section 7.3.13, Conflicts of Interest, for more information.

To:

Community Care Coordination Provider – A conflict-free entity that is under contract with the CONTRACTOR(S) to perform specific care coordination activities described in Appendix L (Care Coordination Matrix). These conflict-free entities may not provide Community Care Coordination and Home- and Community-Based Services (HCBS) Waiver services for the same Member, per 42 CFR 441.301(c)(1)(vi). See RFP Section 7.4.14, Conflicts of Interest, for more information.

Tab 5:
Evidence of Certificate of Authority

KANSAS INSURANCE DEPARTMENT

CERTIFICATE OF AUTHORITY

Company Name:	UCare Kansas, Inc.		
SBS Company Number:	521632060	**State of Domicile:**	Kansas
NAIC Number:		**Effective Date:**	December 22, 2023

UCare Kansas, Inc. is hereby authorized and empowered, through this Certificate of Authority, to transact the following lines of business as a/an HEALTH MAINTENANCE ORGANIZATION:

ACCIDENT & HEALTH

within the state of Kansas, from December 22, 2023, until such certificate is suspended, revoked, or terminated by the Commissioner of Insurance of Kansas.

COMMISSIONER OF INSURANCE OF KANSAS EST. 1871

Vicki Schmidt

Commissioner of Insurance

December 22, 2023

Tab 6:
Financial Viability/Solvency

Financial Viability/Solvency

1. Tab 6 must be labeled “Financial Viability/Solvency” and include the following evidence that demonstrates that the net worth of the bidder is, at a minimum, $1.5 million:
   a. A copy of the audited financial statements for the bidder, prepared in conformity with accounting principles generally accepted in the United States, for the most recent three (3) years, if applicable; and

Non applicable. UCare Kansas does not have audited statements for the recently formed Kansas entity, due to lack of prior and current activity.

   b. A copy of the audited financial statements of the bidder’s parent company, prepared in conformity with accounting principles generally accepted in the United States, for the most recent three (3) years, if applicable.

Please see the following financial statements, reflecting 2020-2022.

UCARE MINNESOTA

STATUTORY FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2021 AND 2020

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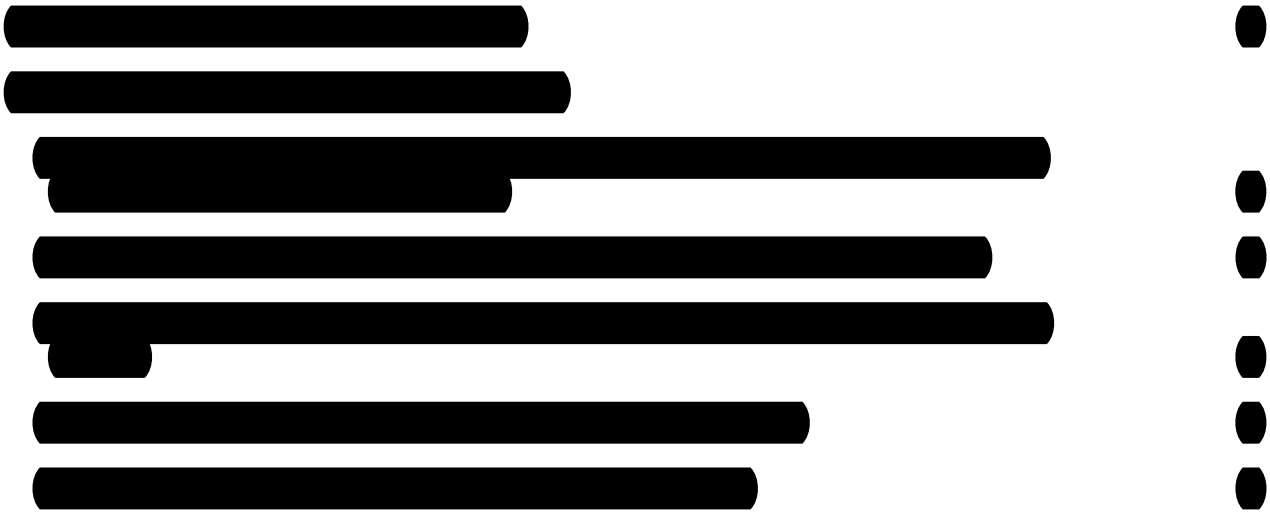

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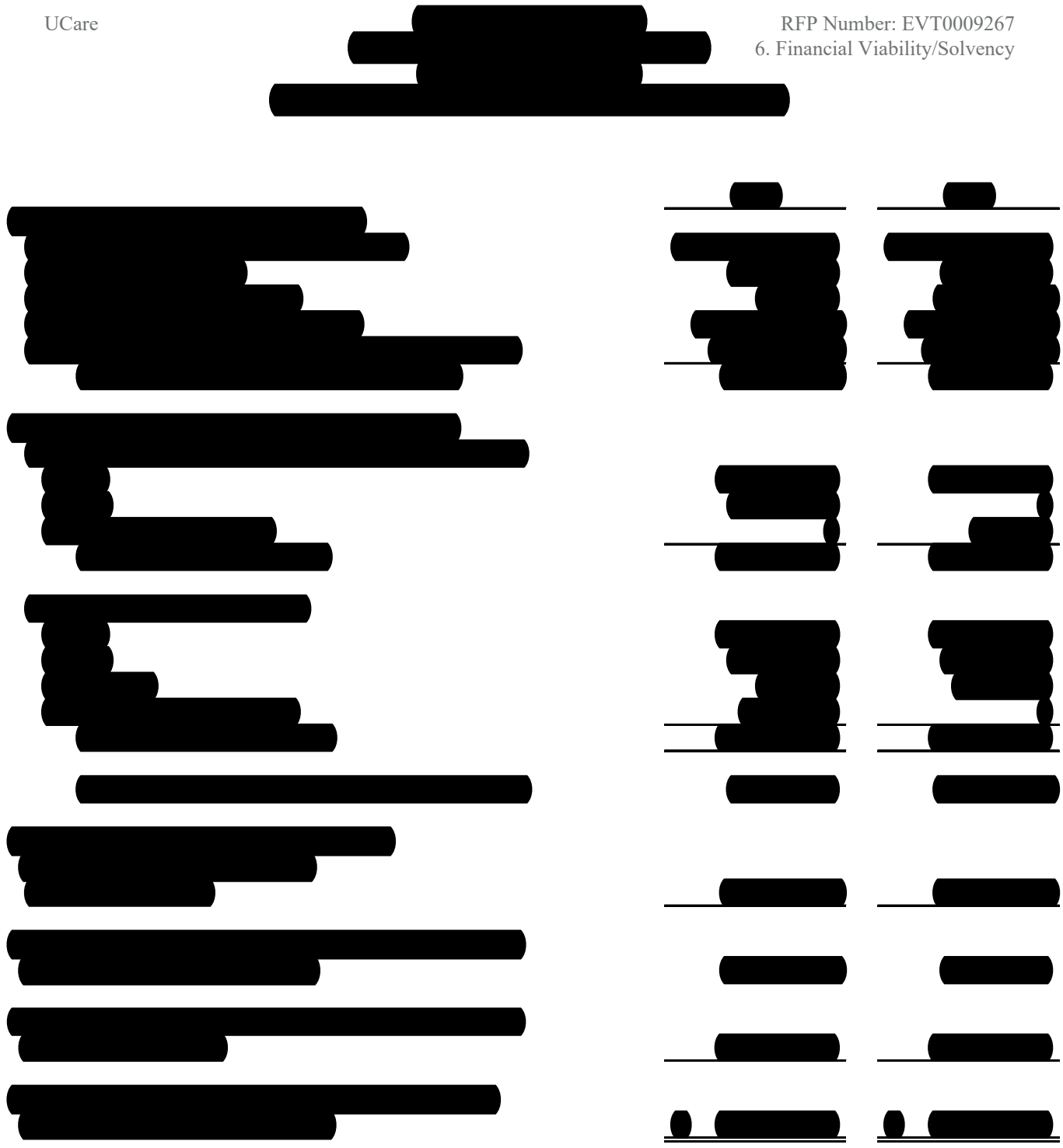

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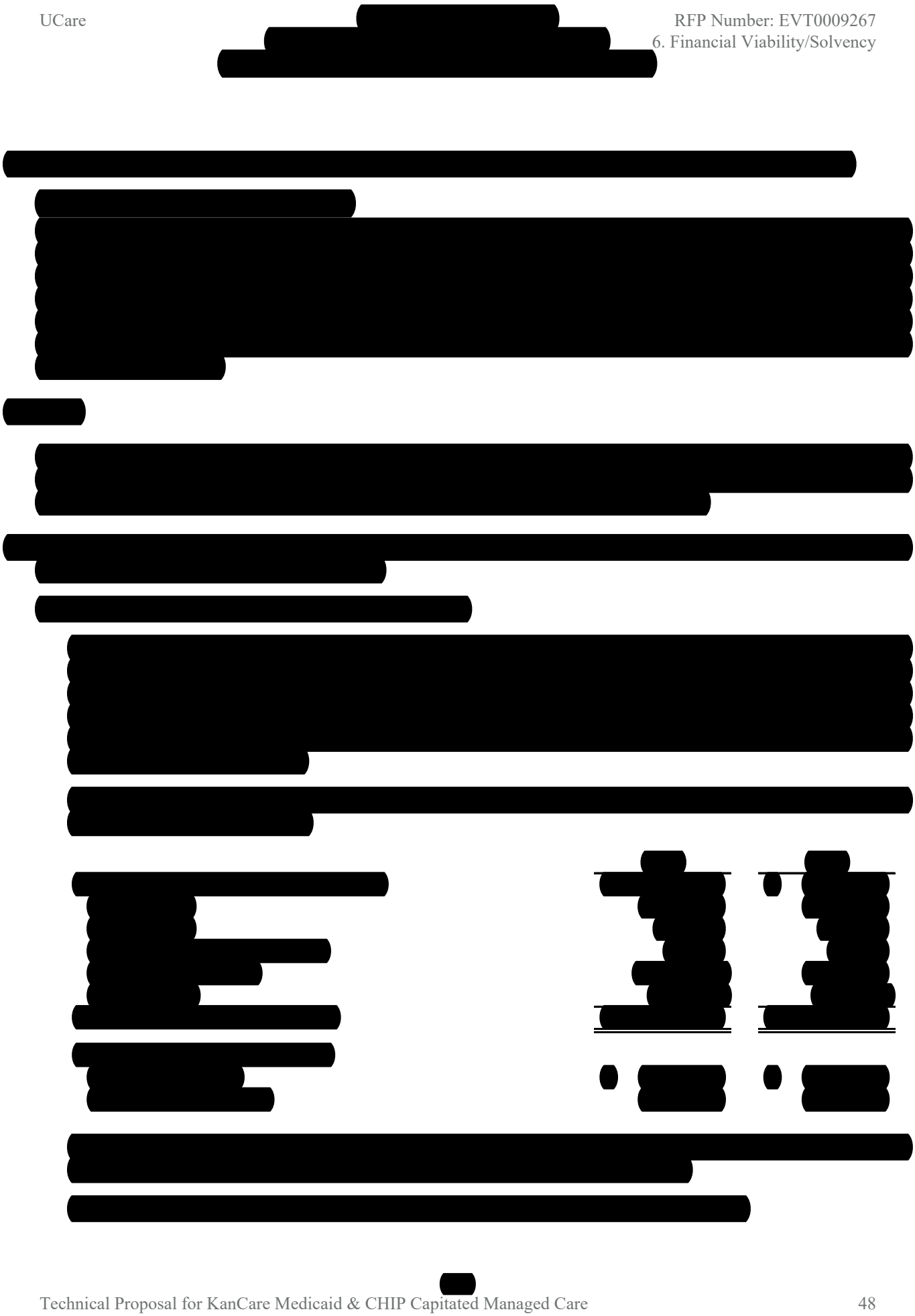

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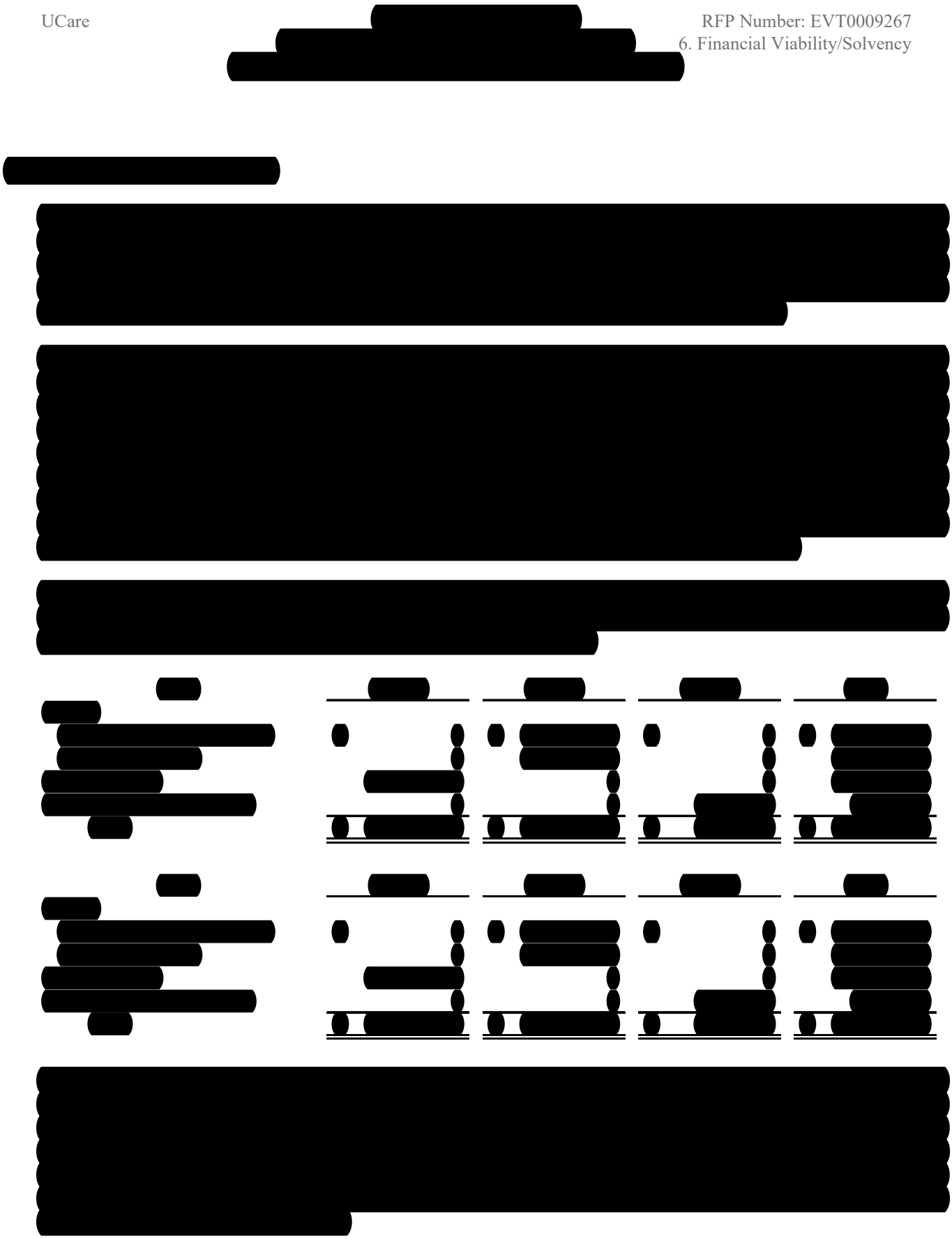

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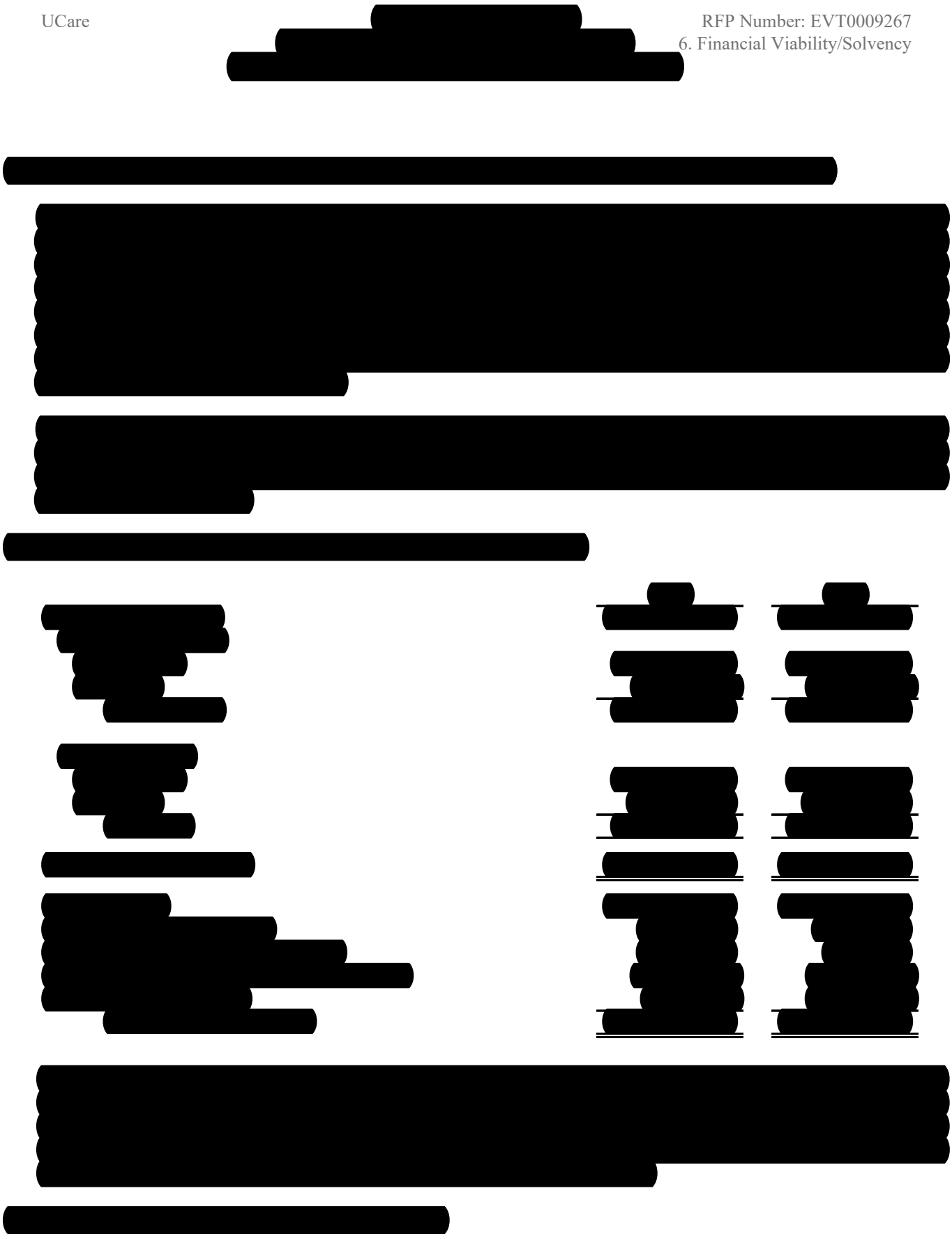

UCARE MINNESOTA

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2021 AND 2020

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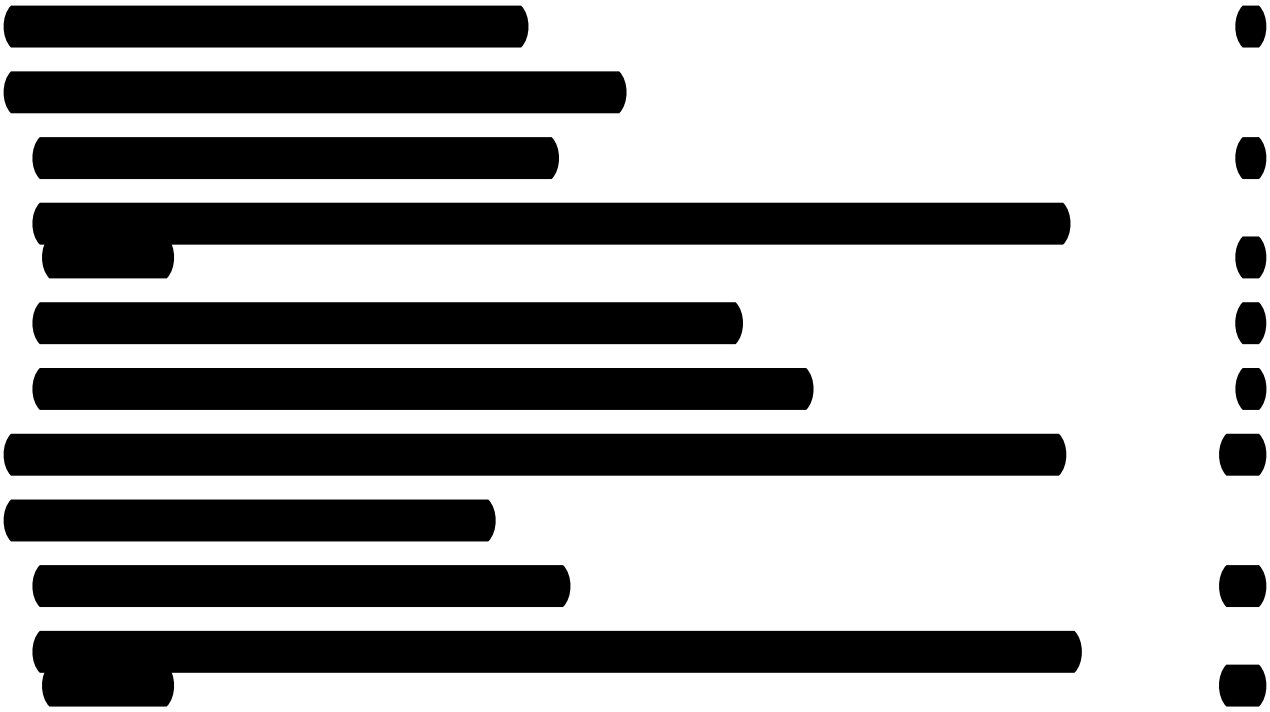
UCARE MINNESOTA
TABLE OF CONTENTS
YEARS ENDED DECEMBER 31, 2021 AND 2020



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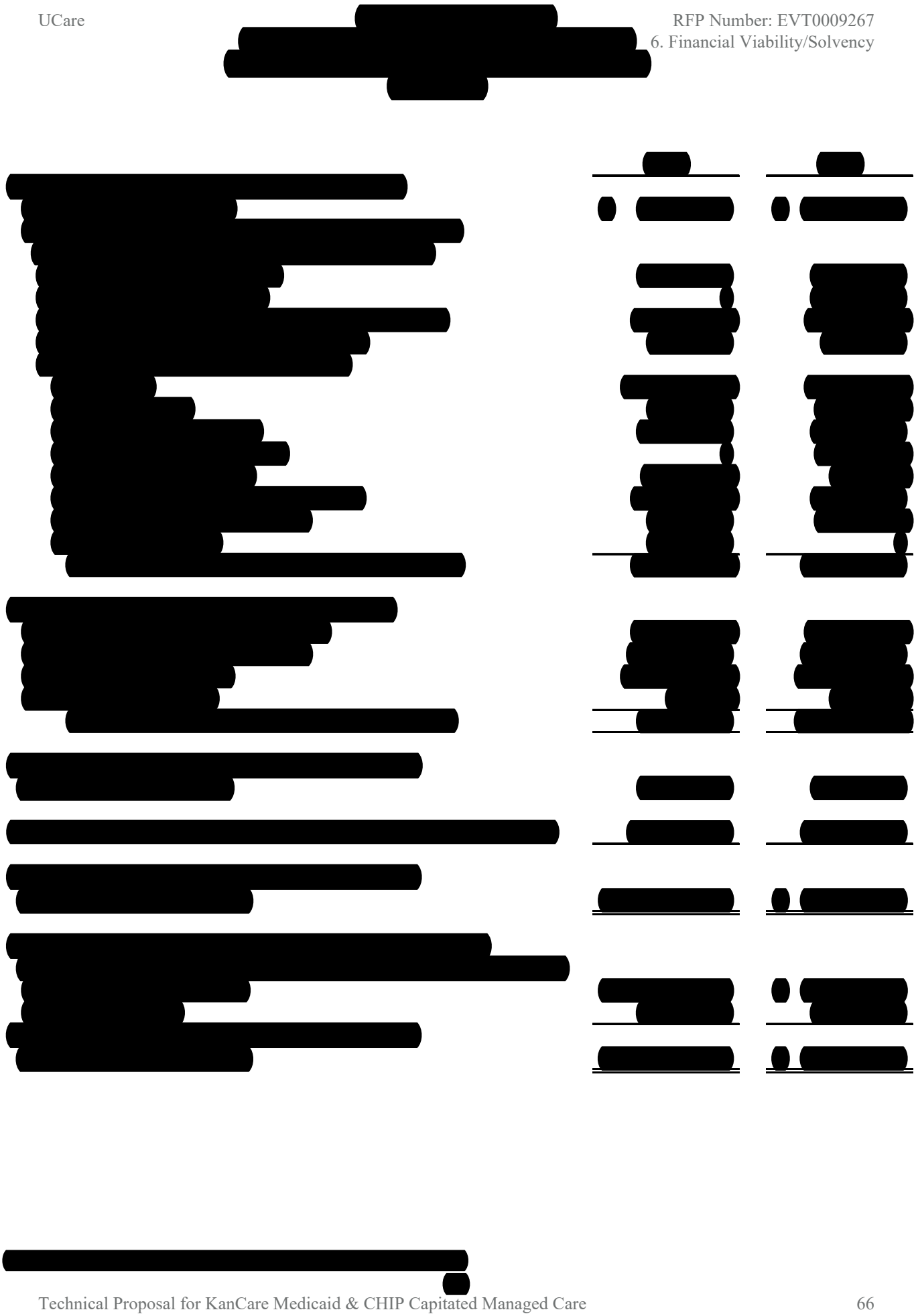

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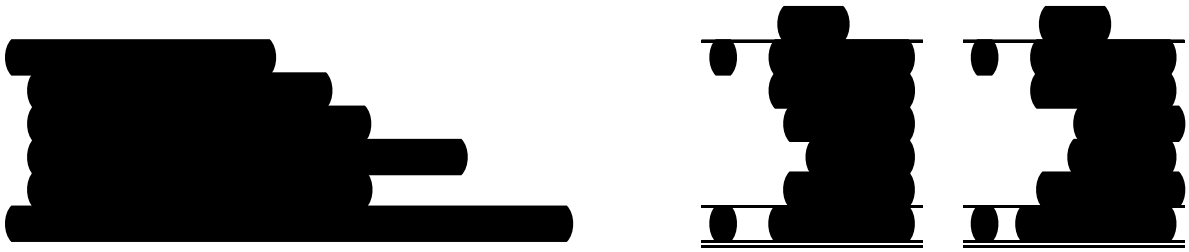

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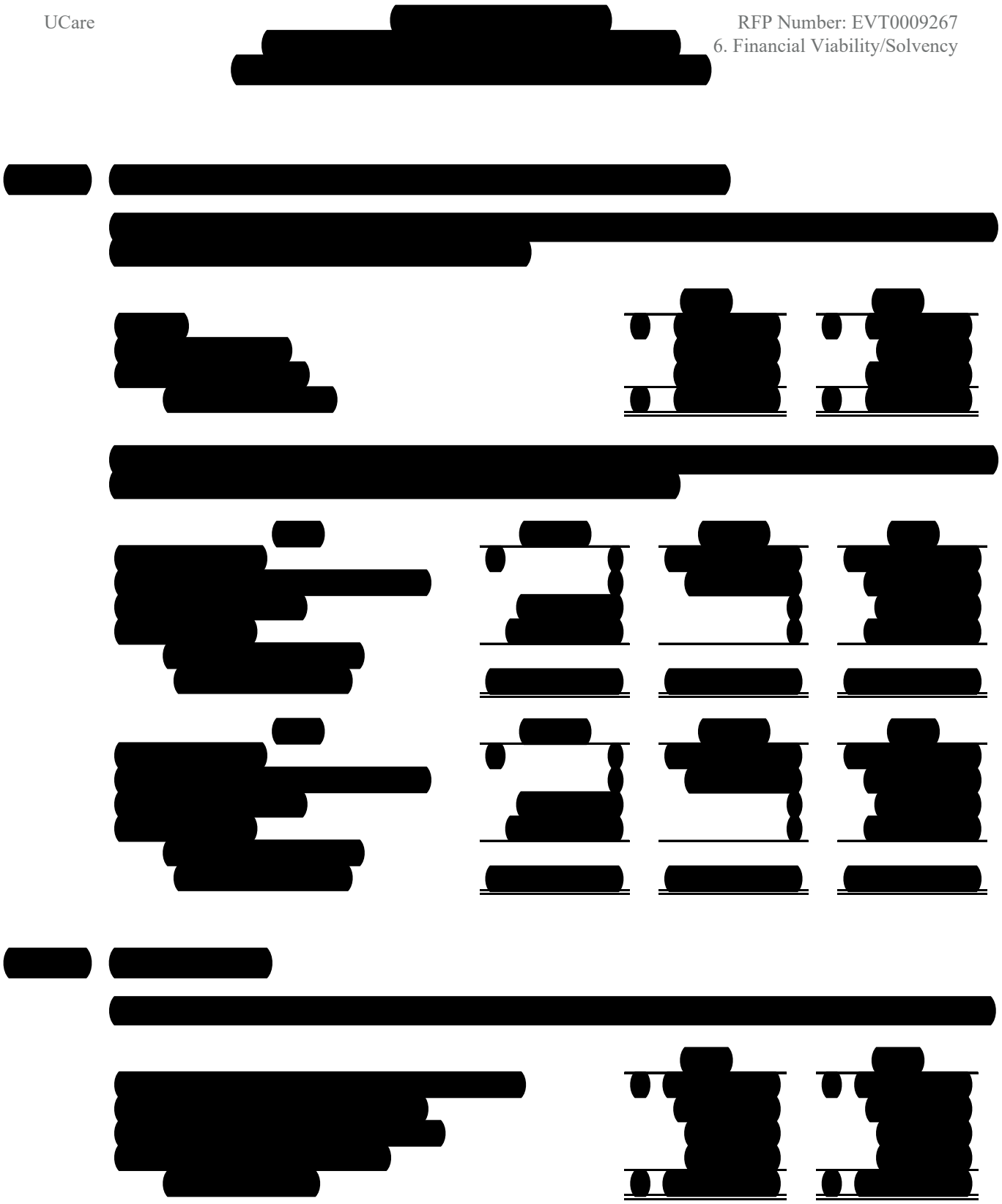

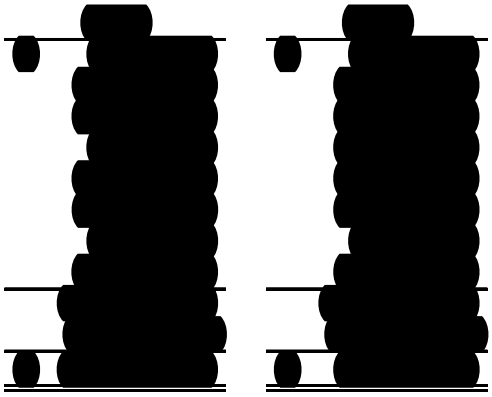

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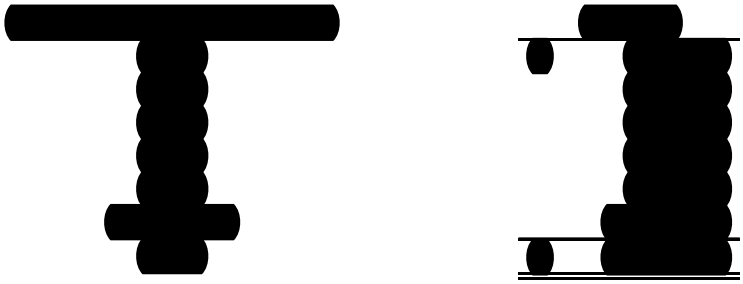

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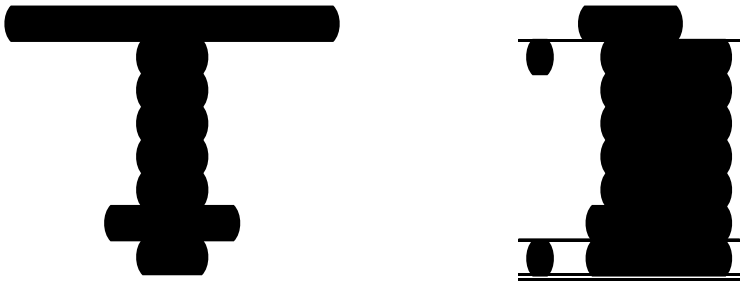

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UCare Health

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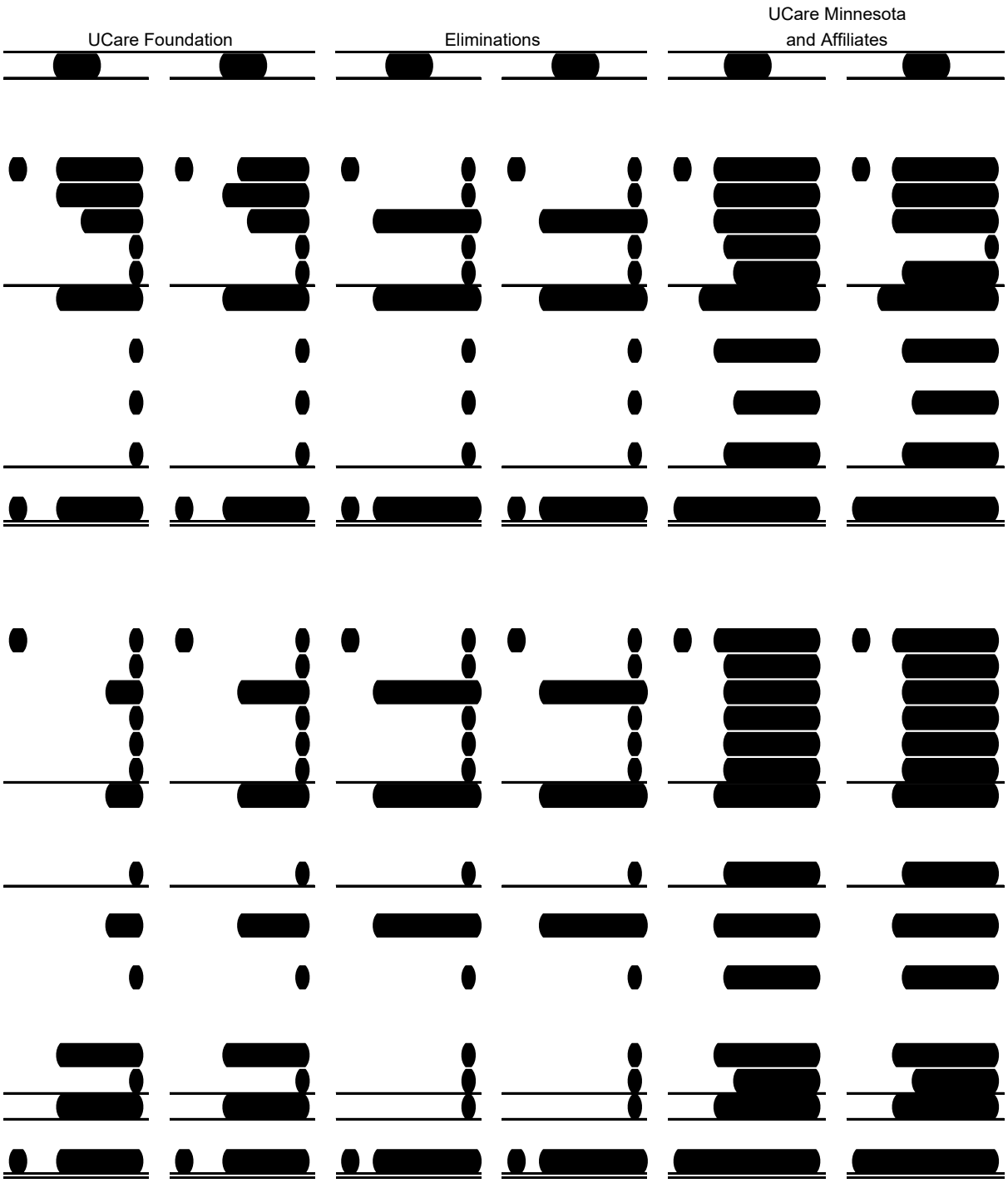
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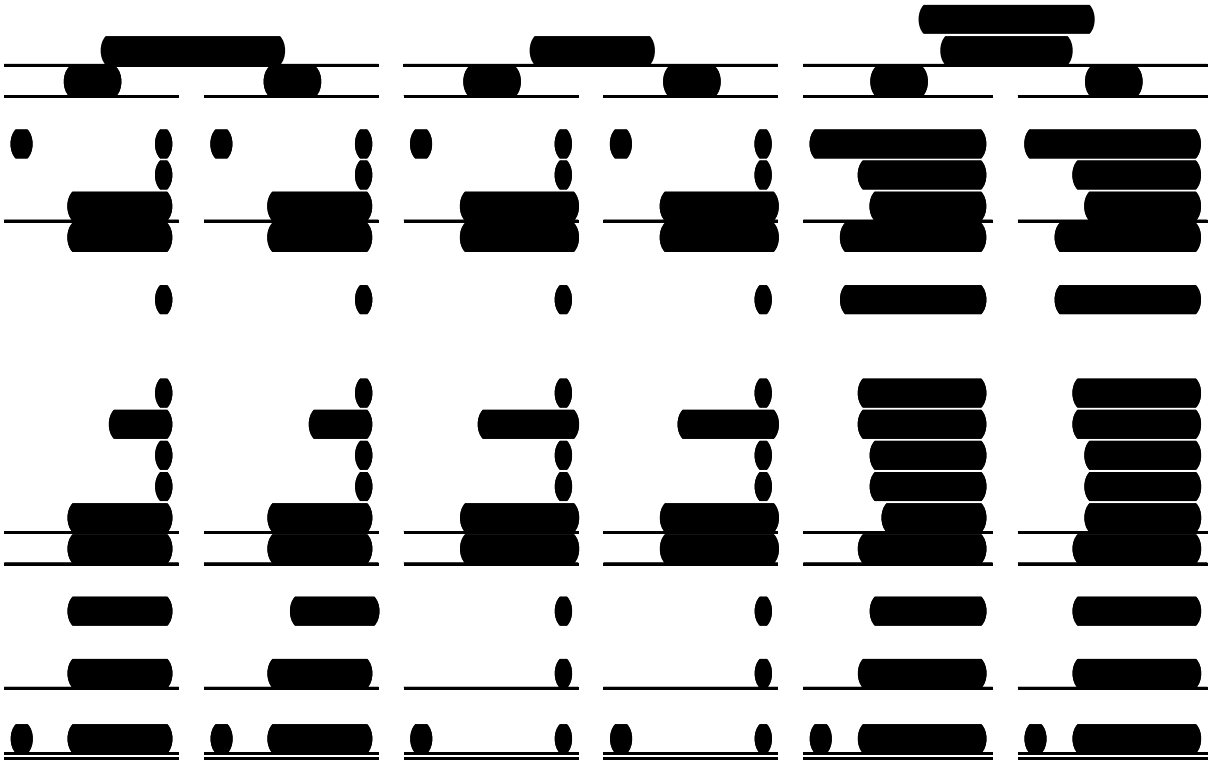
UCare Minnesota and Affiliates


UCare Minnesota
UCare Health



UCARE MINNESOTA

CONSOLIDATED FINANCIAL STATEMENTS AND SUPPLEMENTARY INFORMATION

YEARS ENDED DECEMBER 31, 2022 AND 2021

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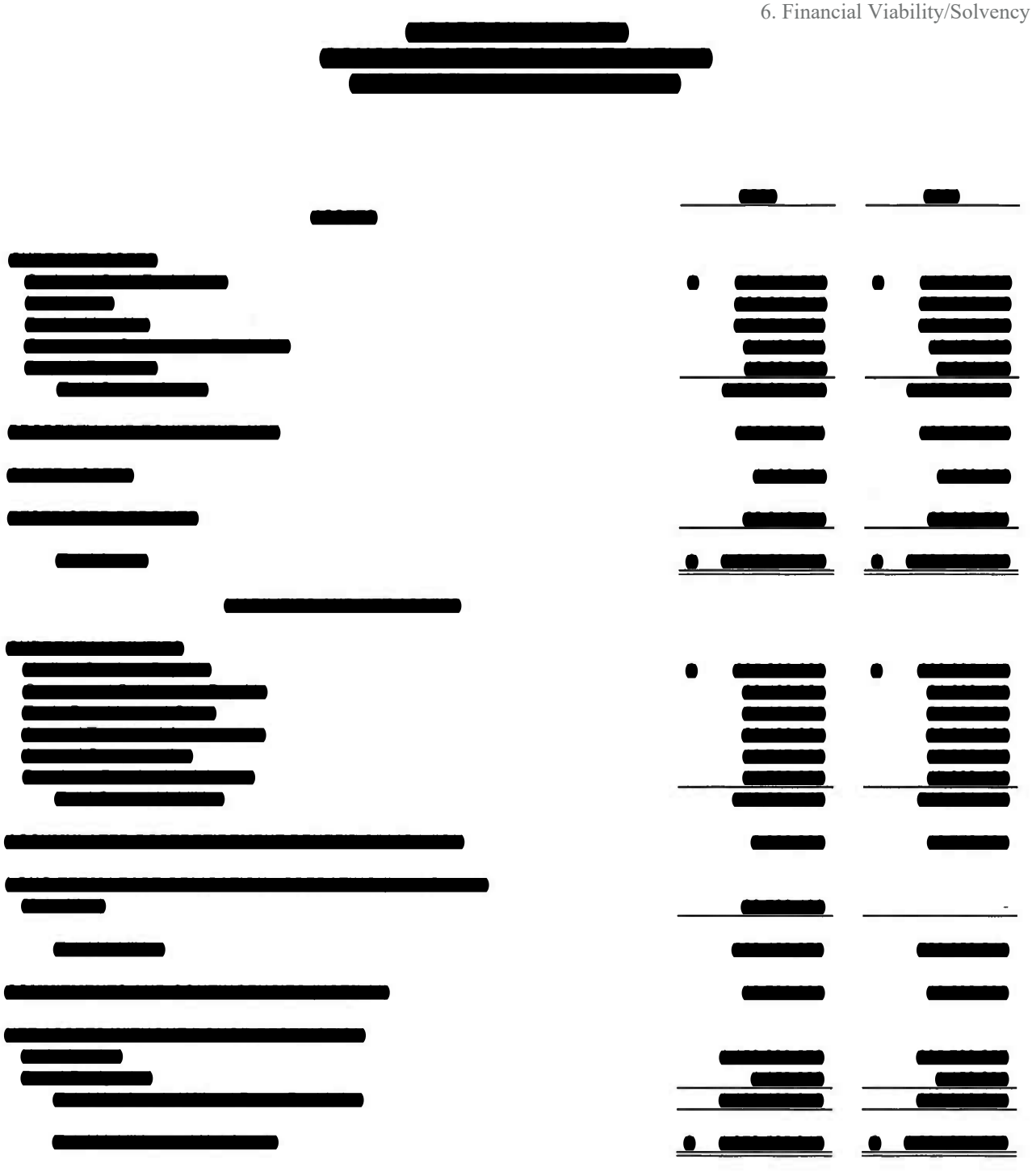

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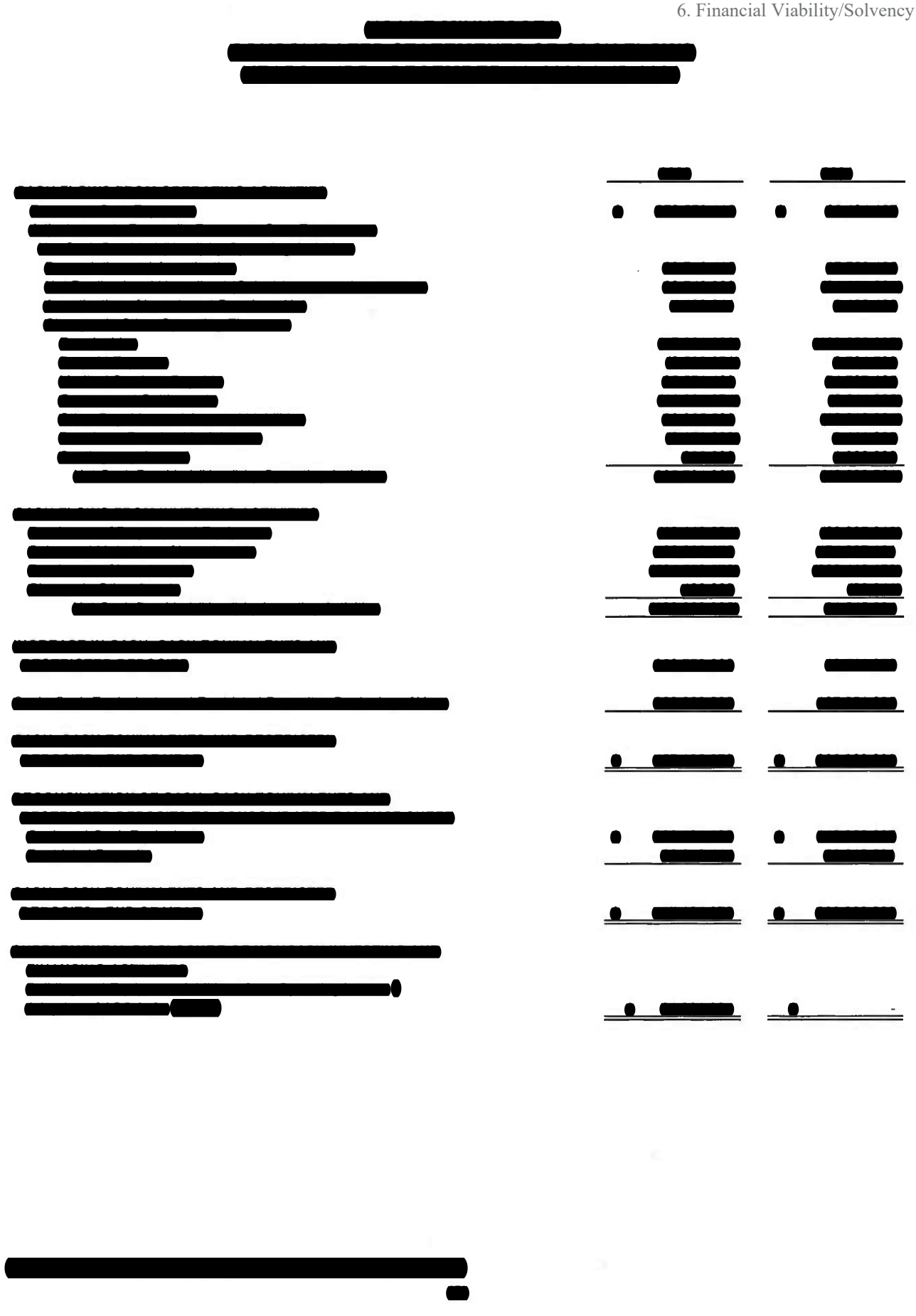

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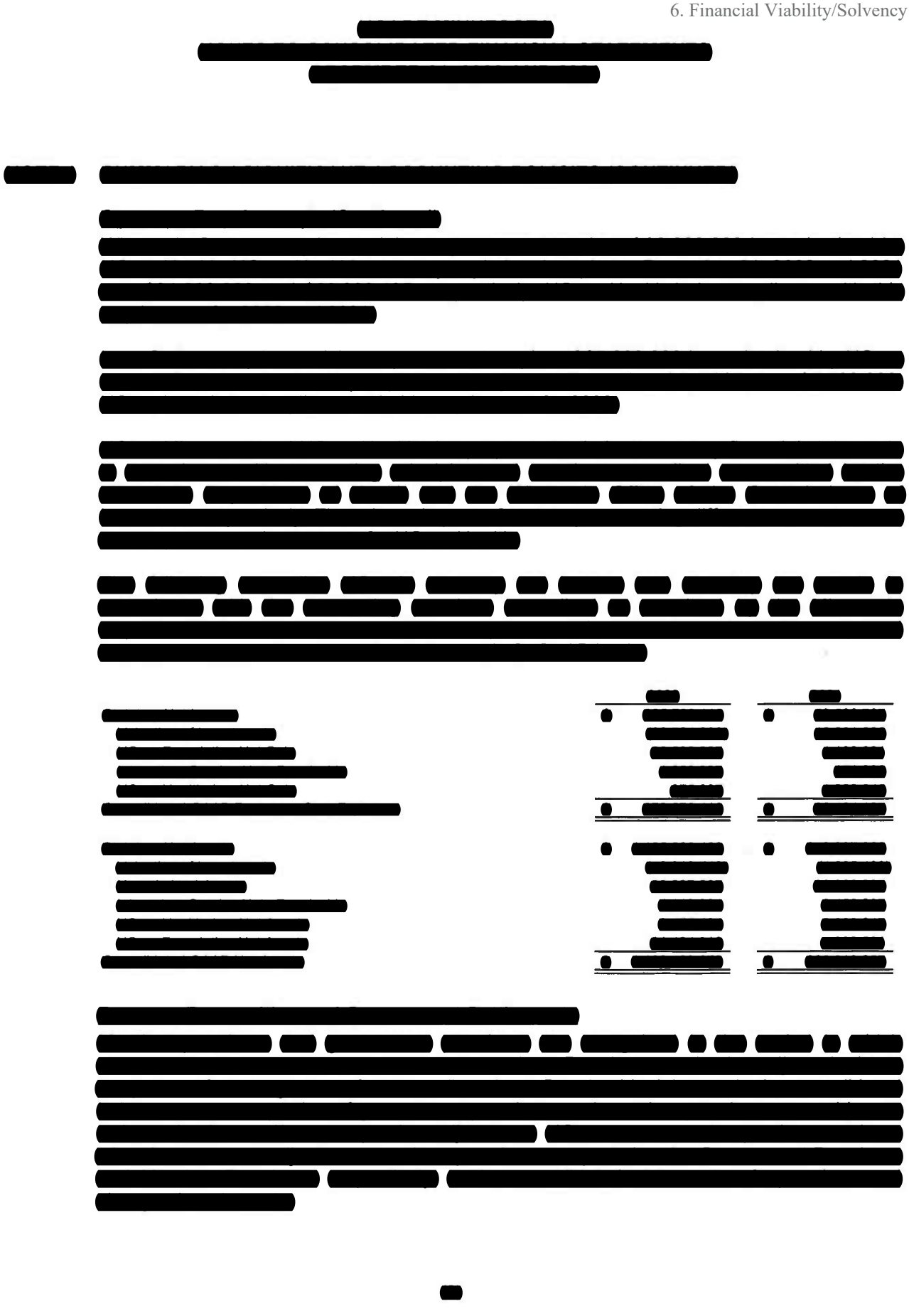

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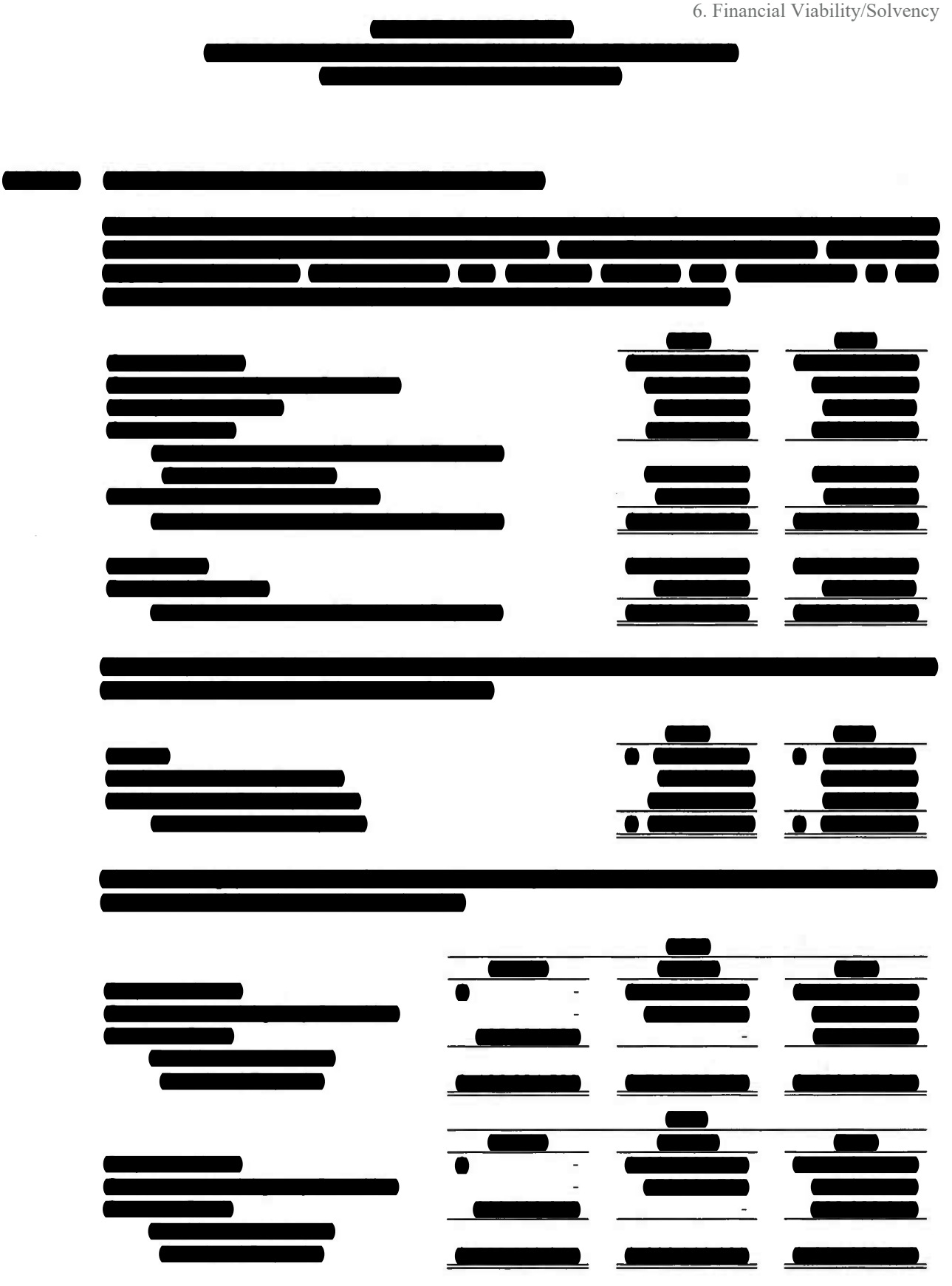

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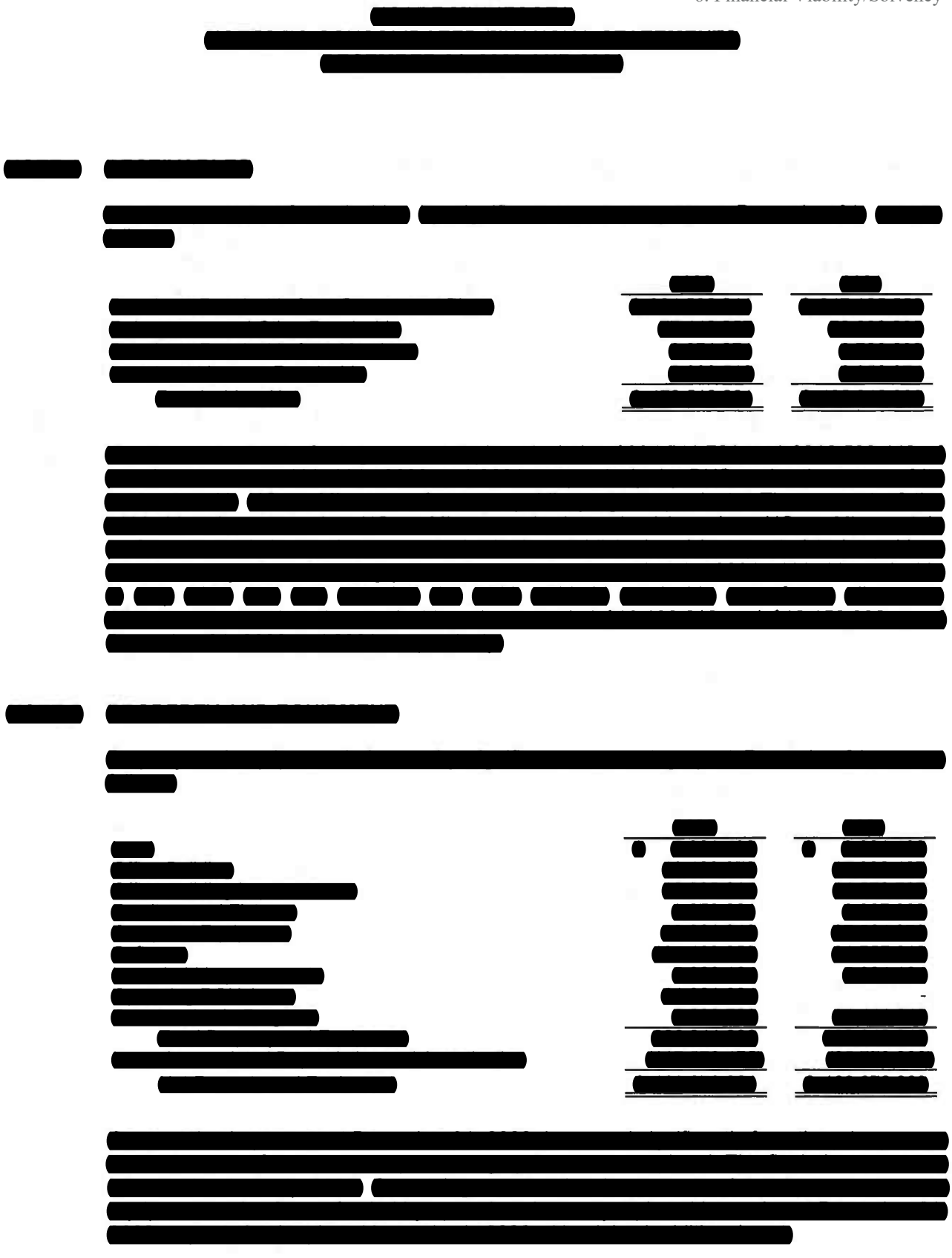

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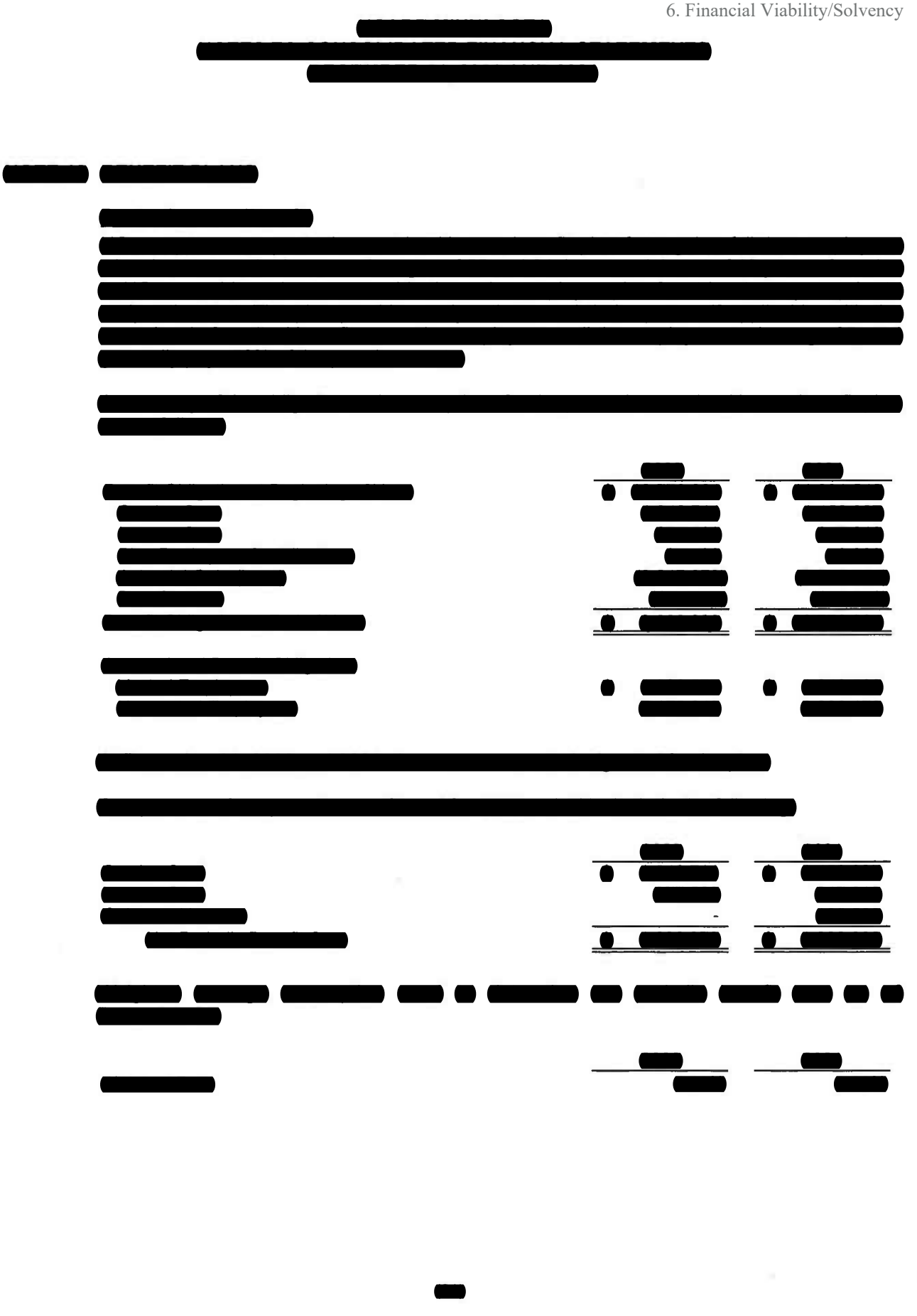

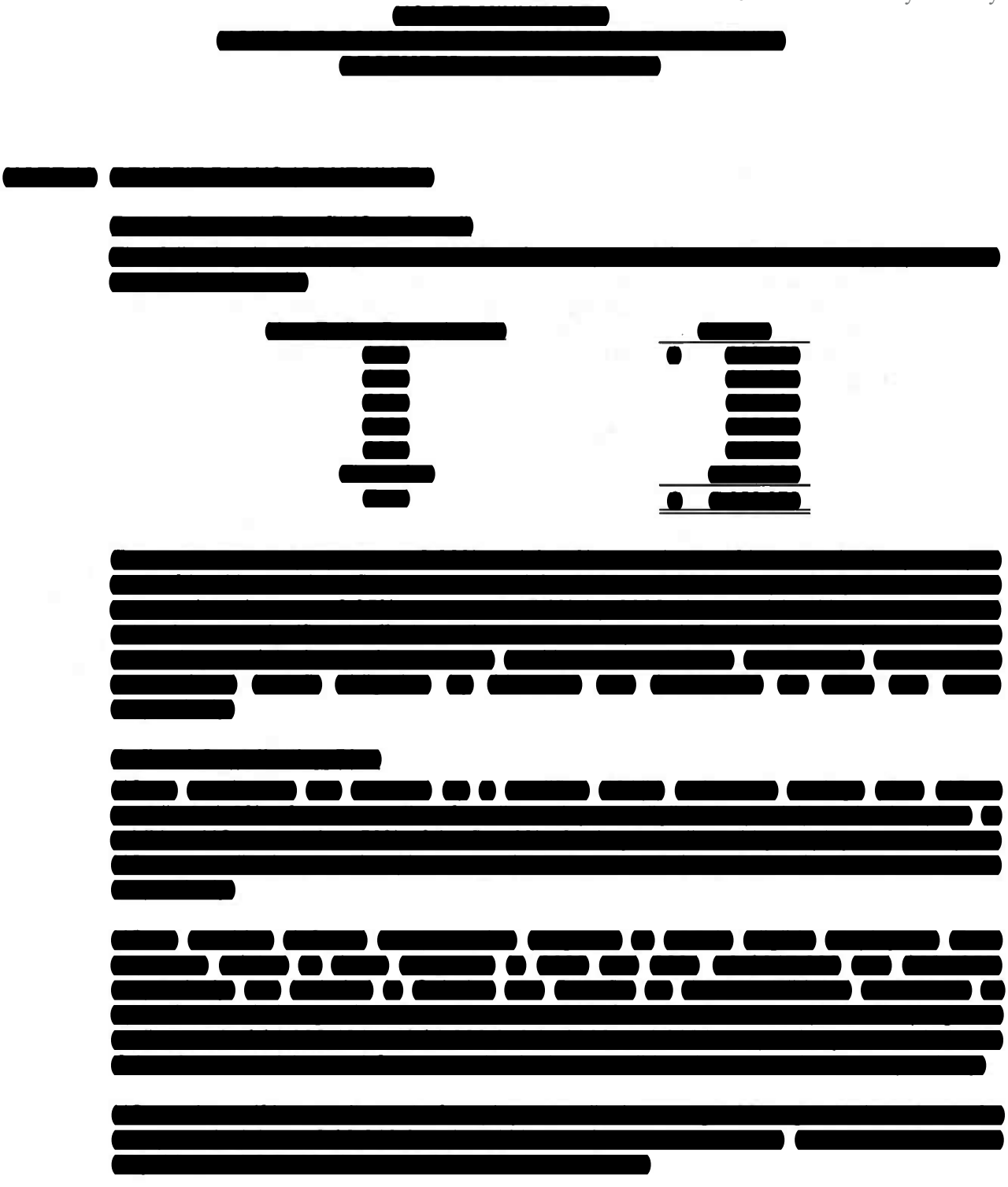

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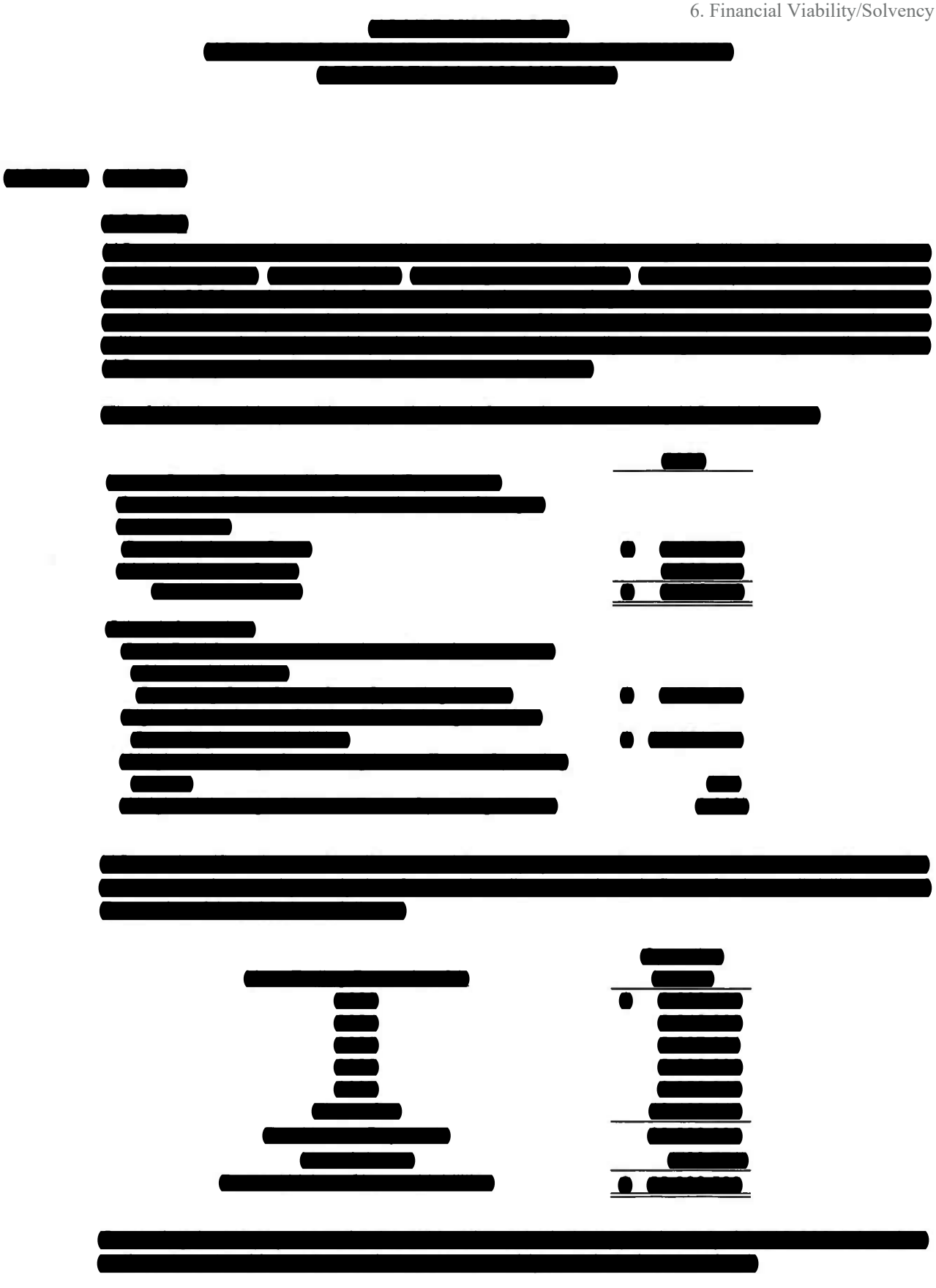

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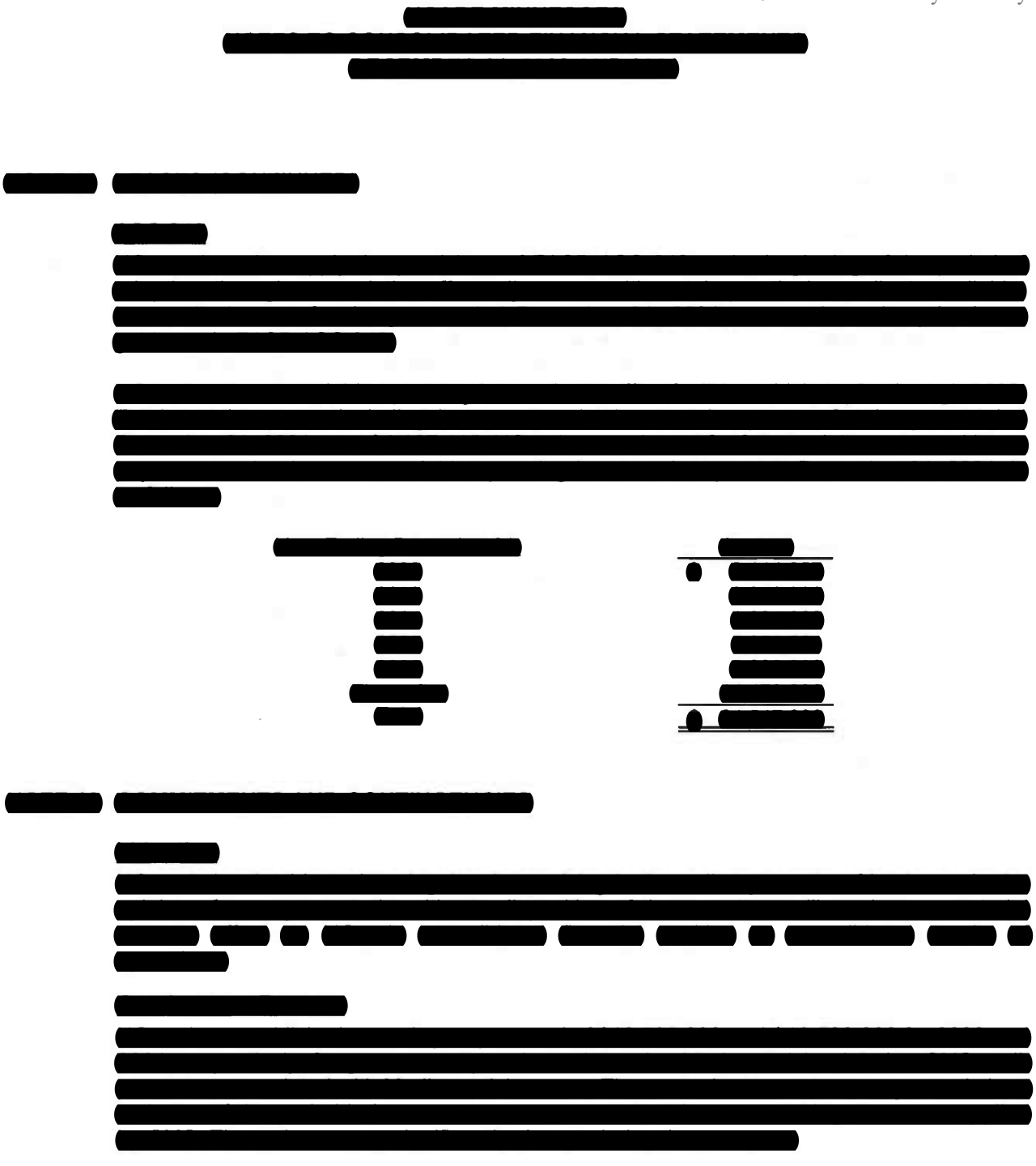

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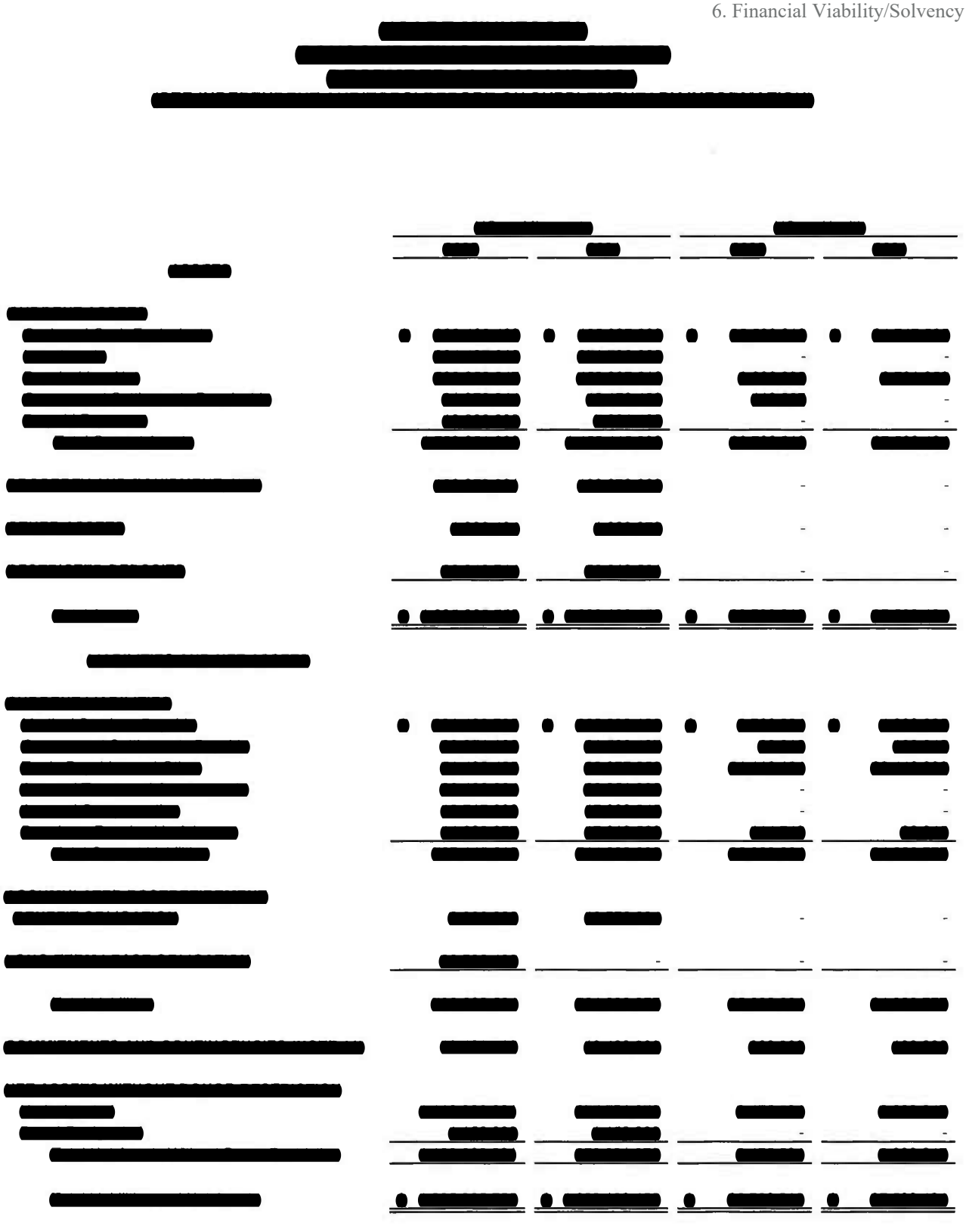

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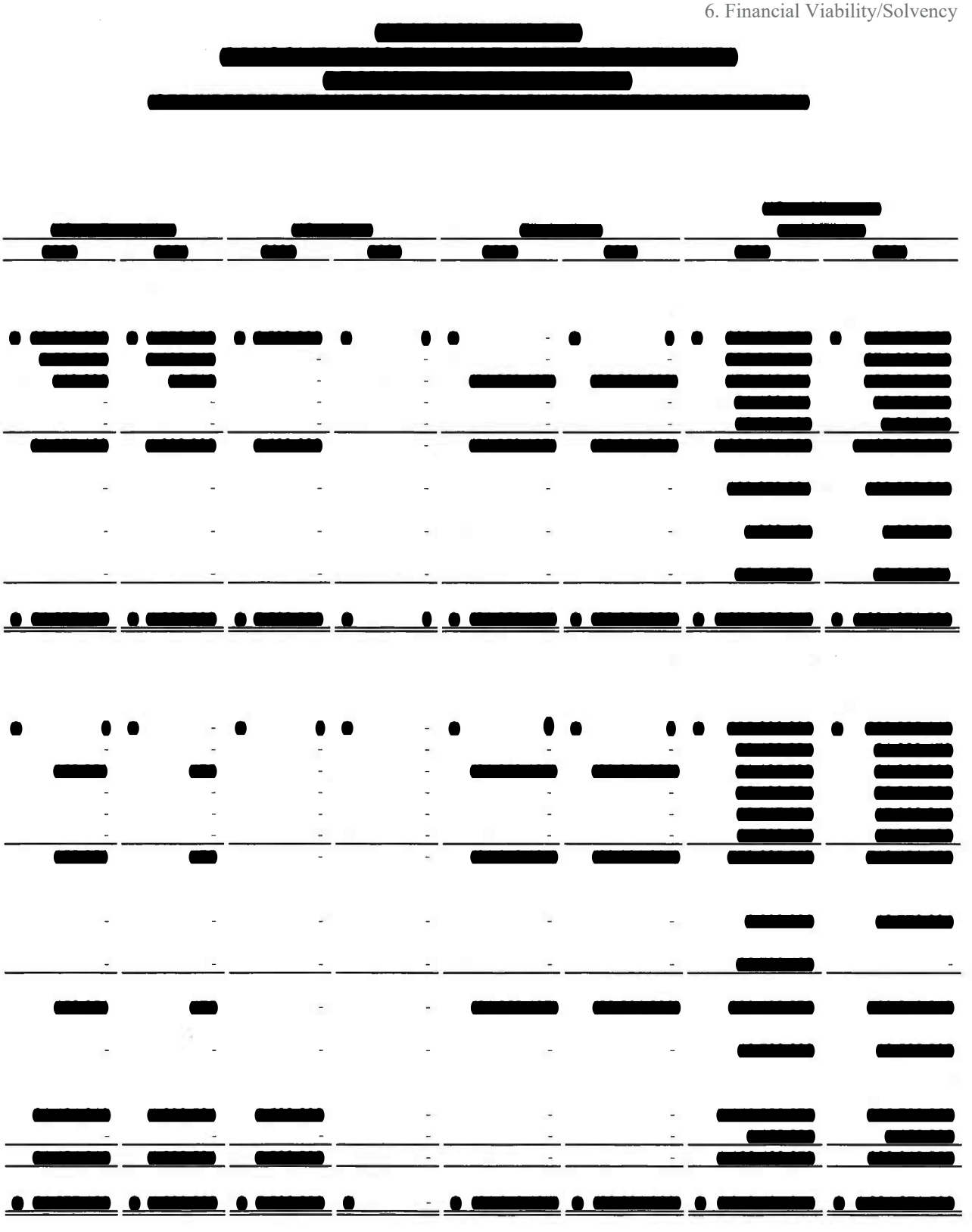

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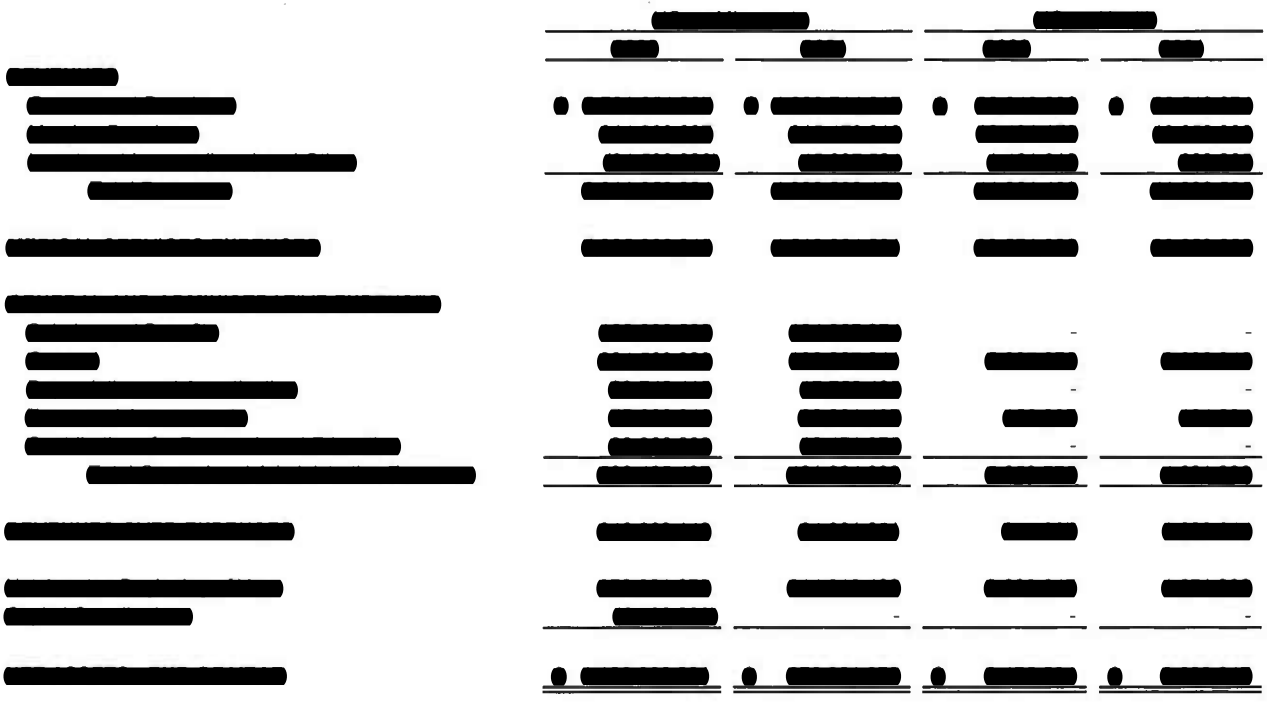

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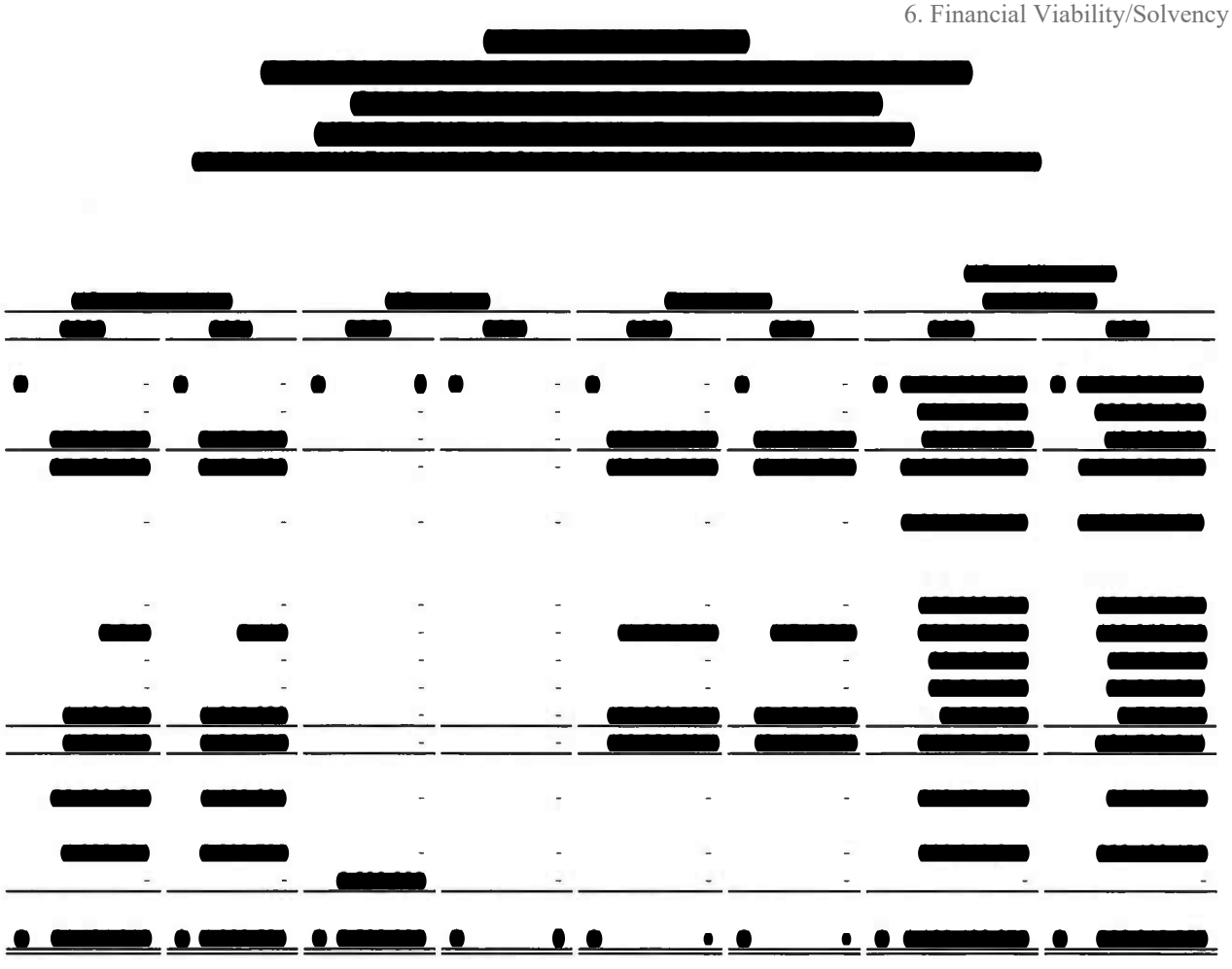

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UCARE MINNESOTA

STATUTORY FINANCIAL STATEMENTS

YEARS ENDED DECEMBER 31, 2022 AND 2021

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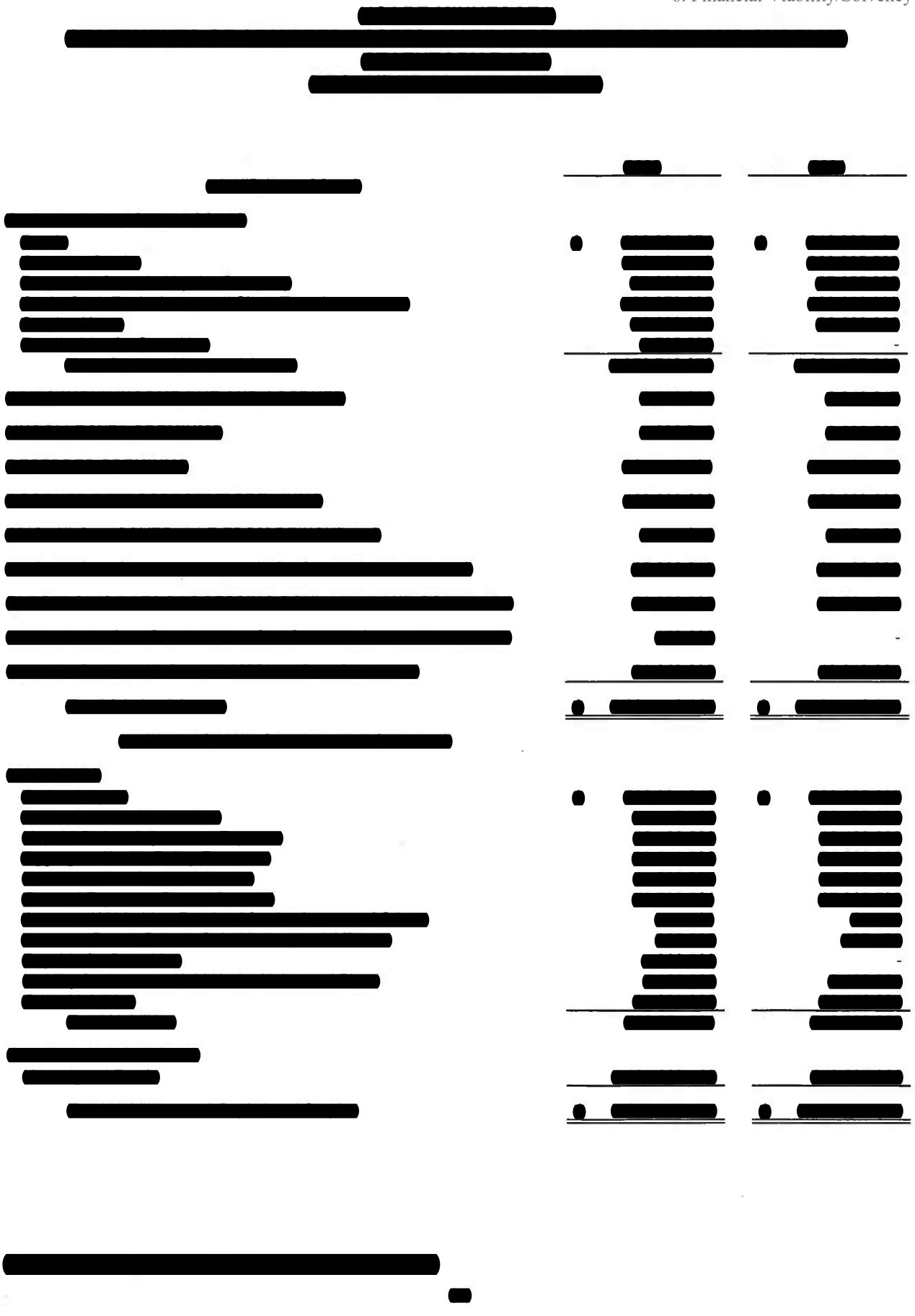

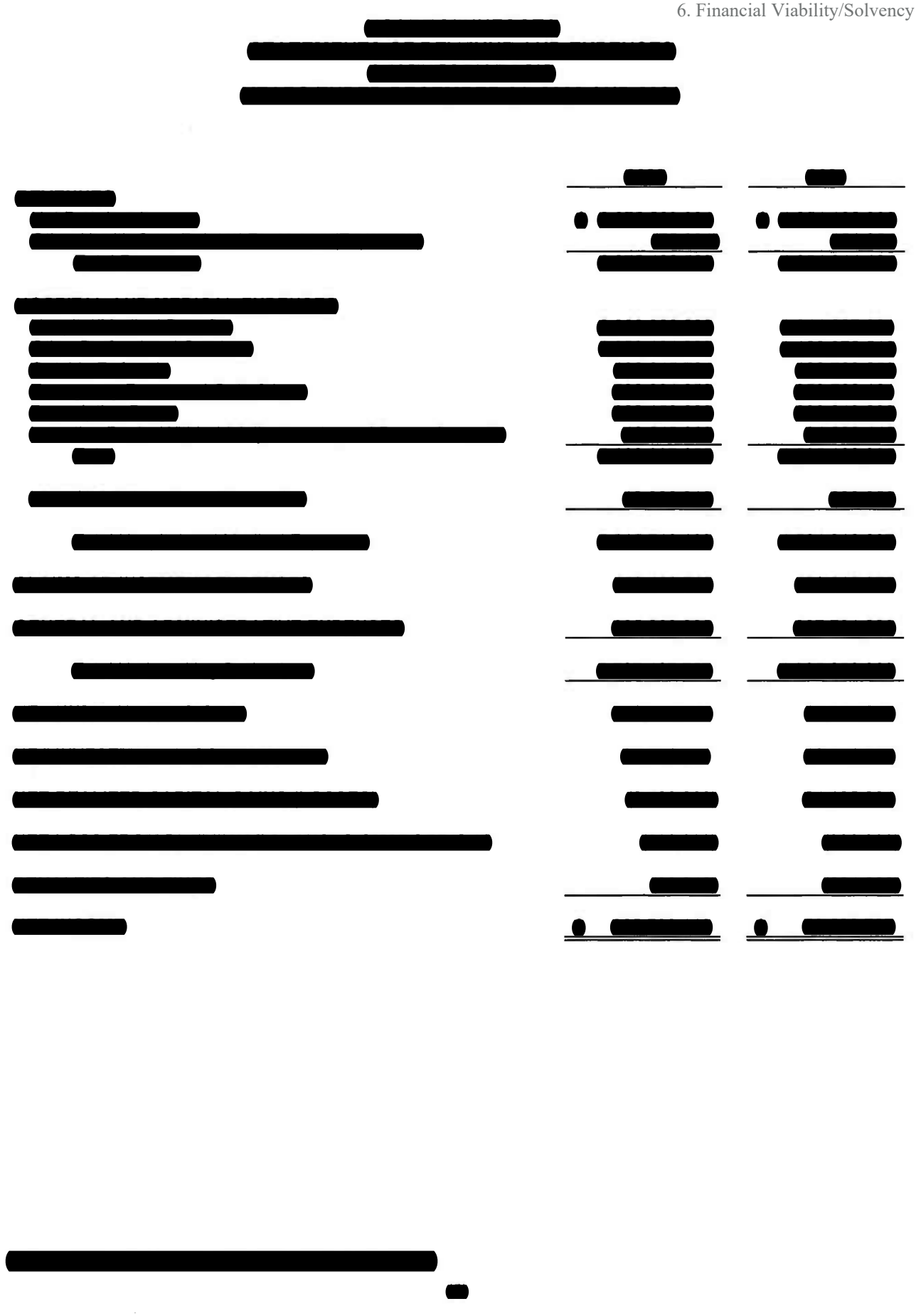

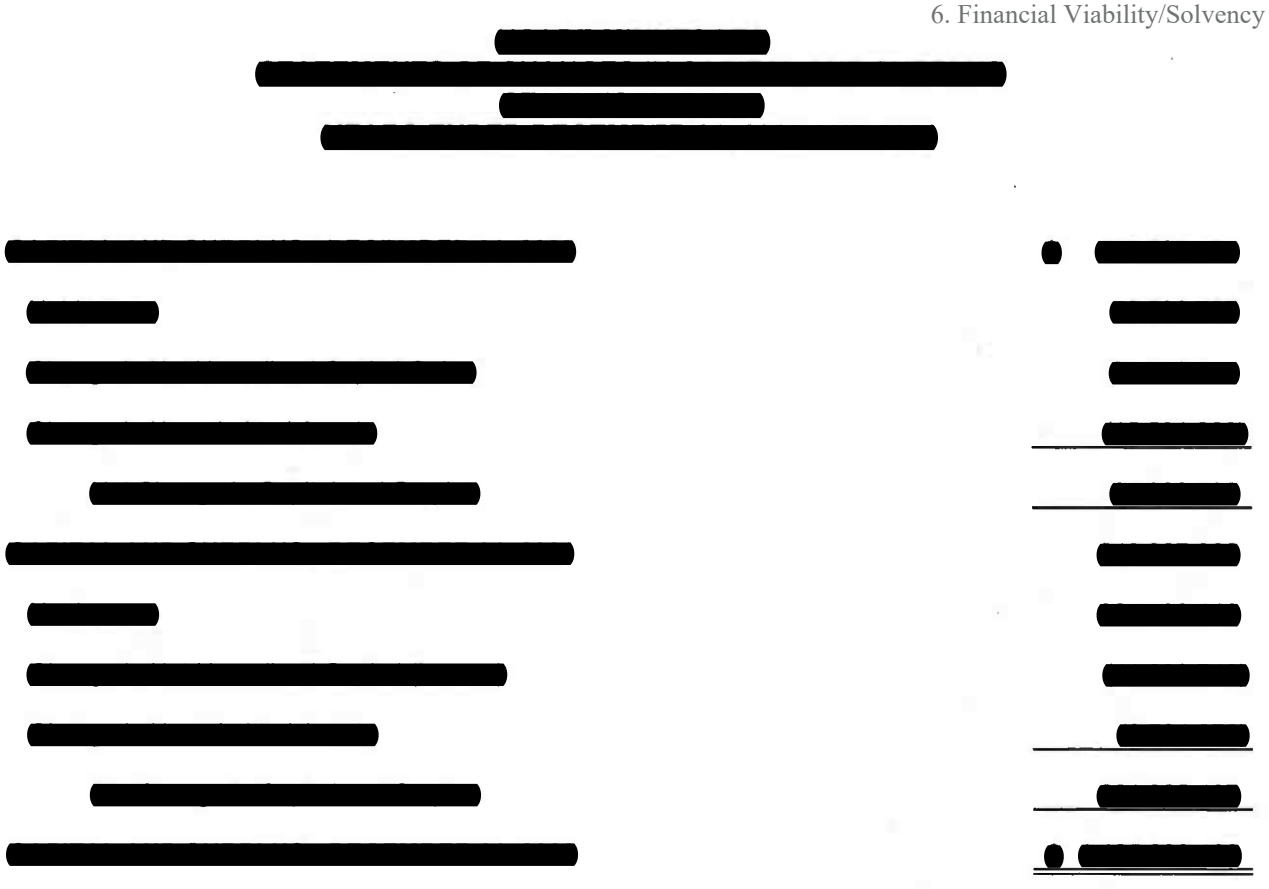

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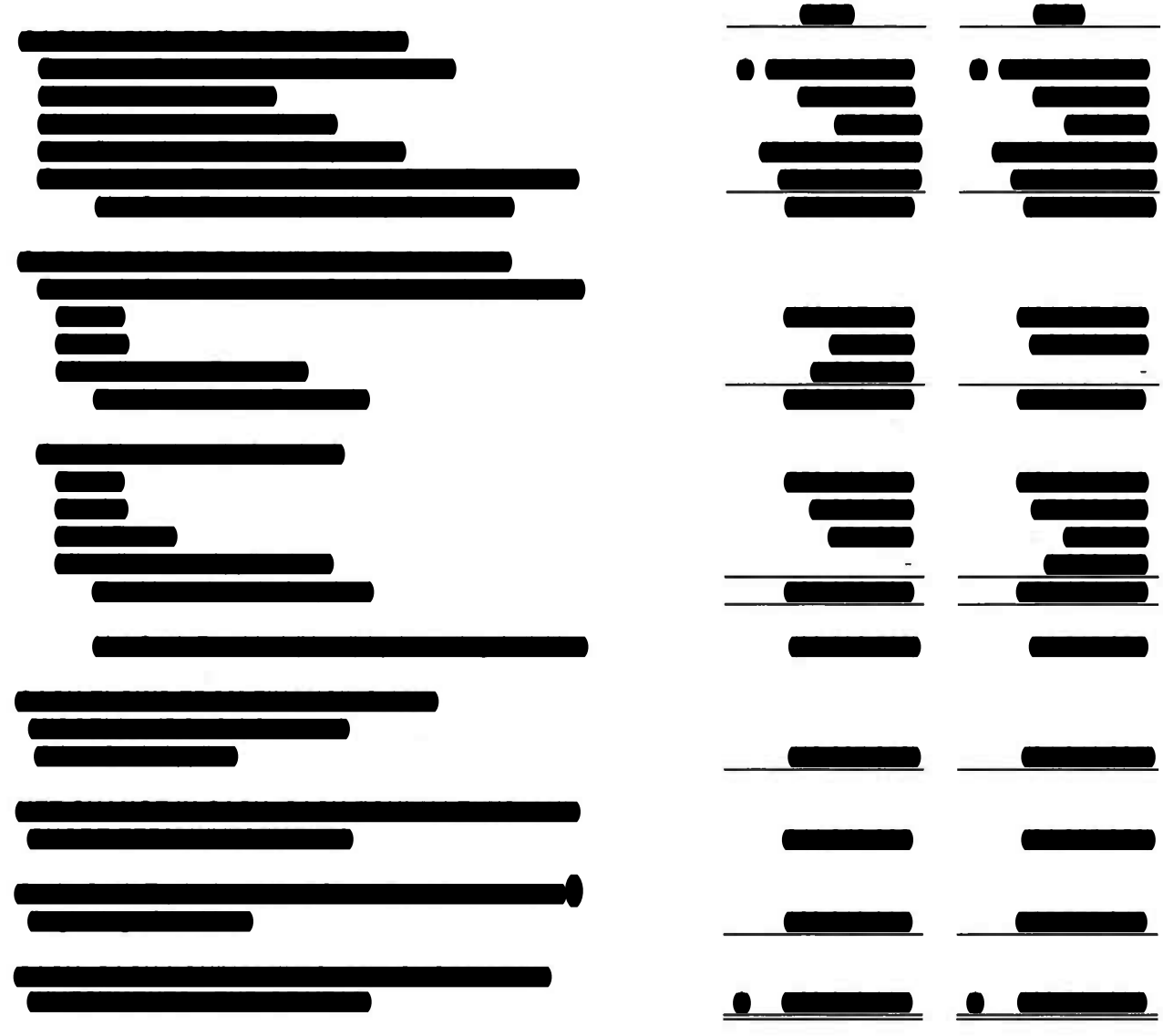

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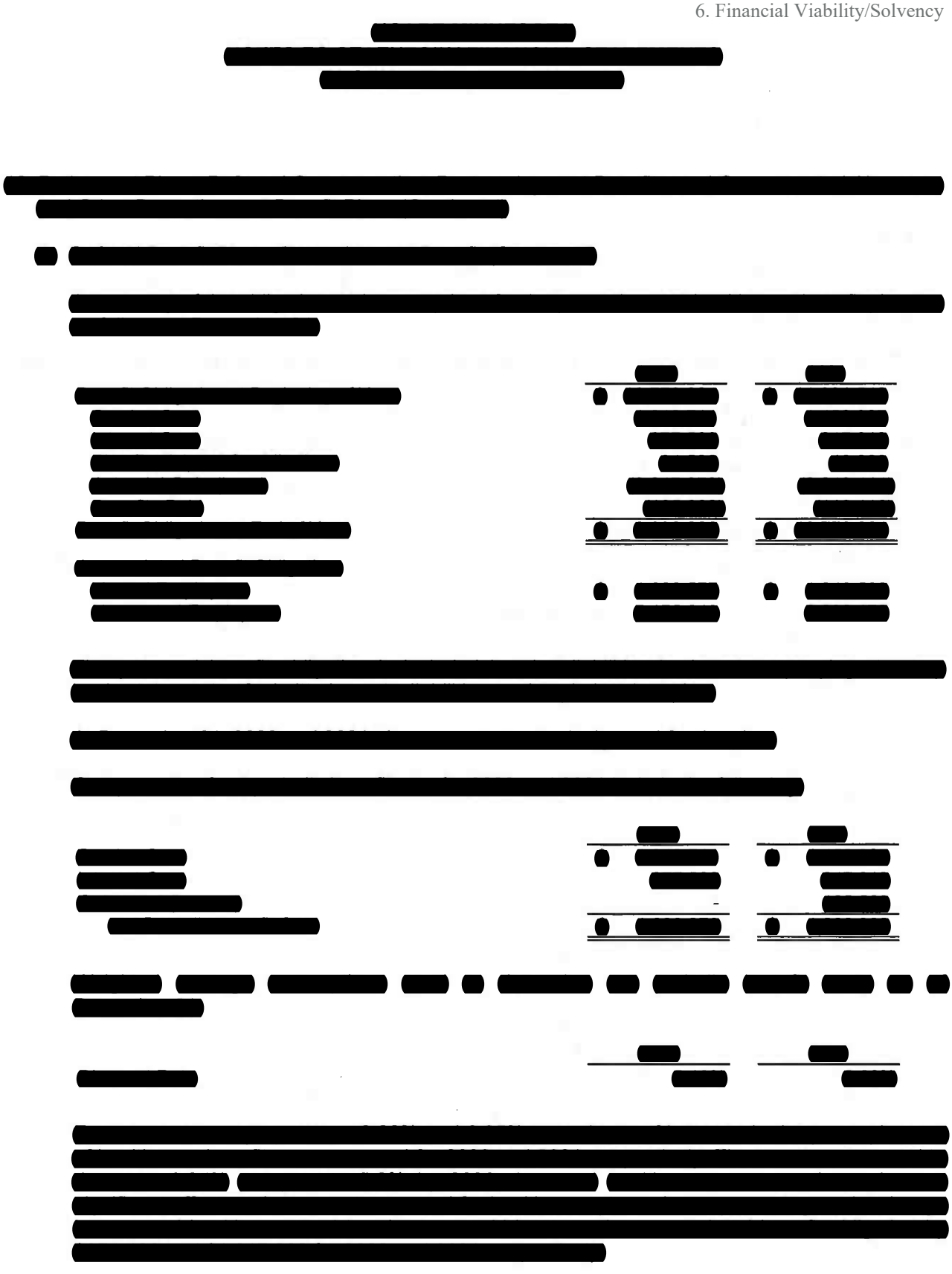

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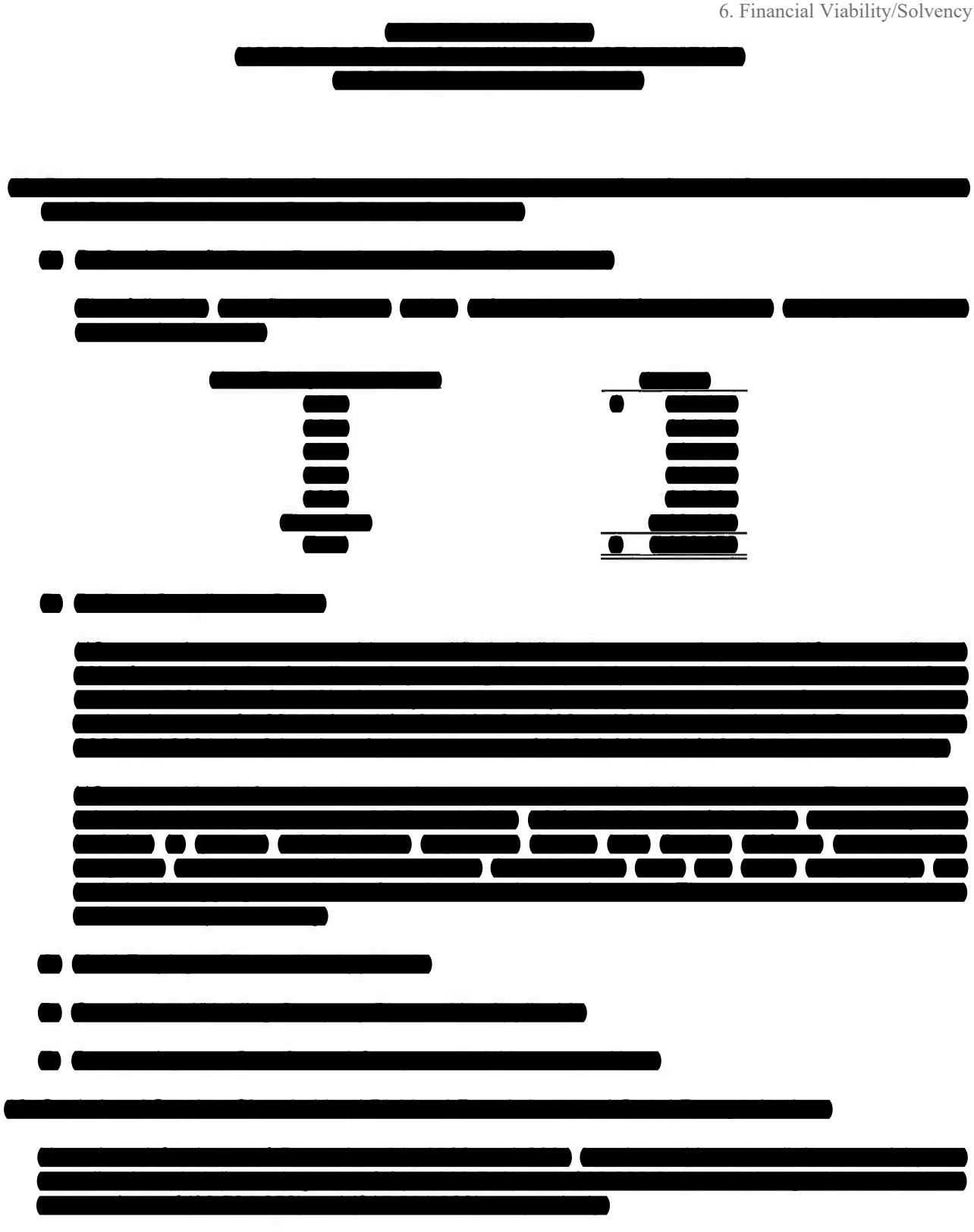

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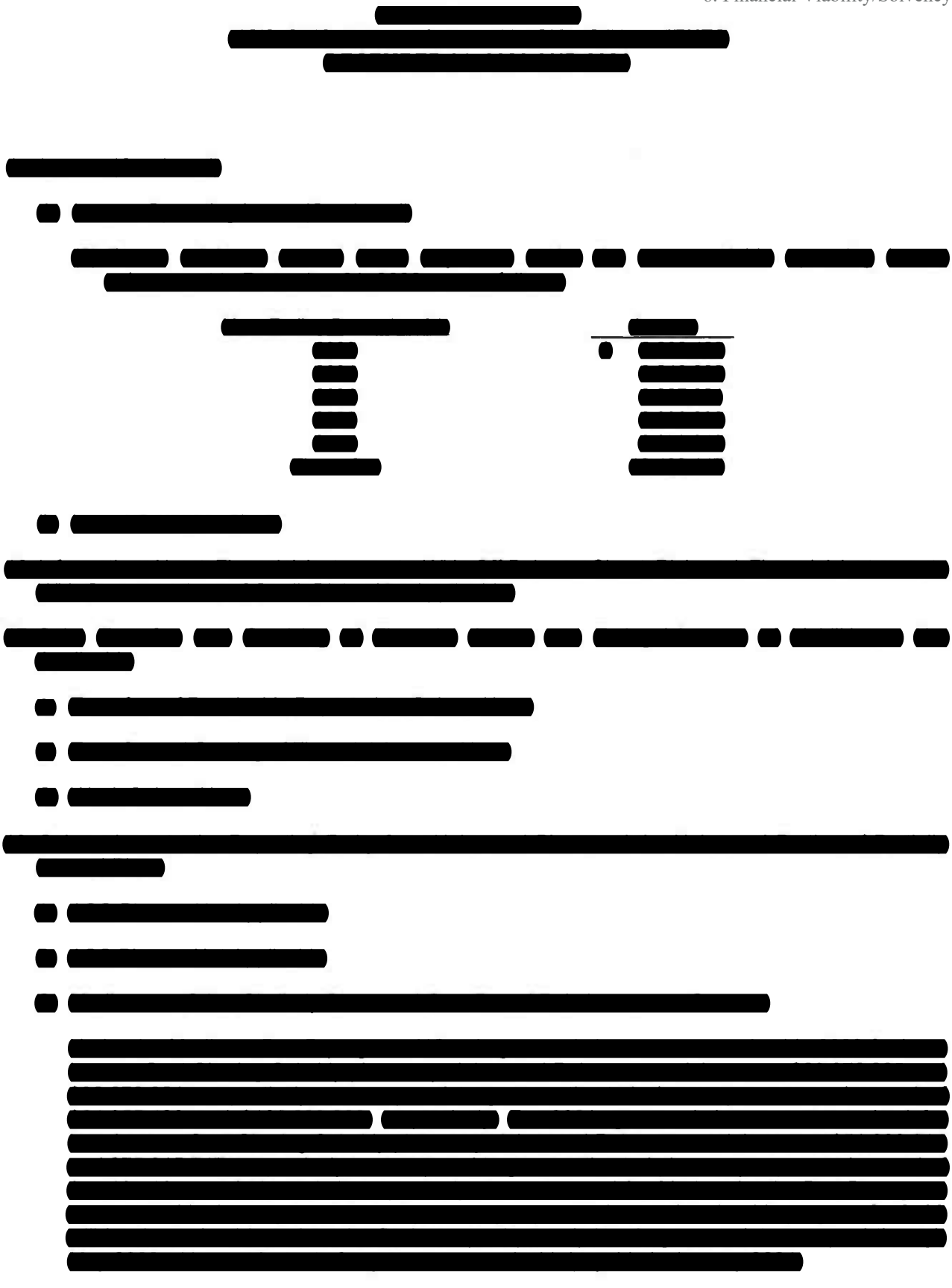

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Tab 7:
Responses to Technical Questions

Tab 7a:

TOPIC AREA 1

Experience and Qualifications

7a. Experience and Qualifications

1. Describe the bidder's Medicaid Managed Care experience in the past five (5) years by completing a table that includes the information listed below for each contract.
   a. Name of state and program name.
   b. Start and end date.
   c. Services covered under the contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation).
   d. Covered population(s) (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children.
   e. Average number of total Member months for the most recent twelve (12) months of the contract (or most recent period if the contract has been in place less than twelve [12] months).
   f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance.
   g. Instances of breach(es) of unsecured protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.
   h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed.

UCare Medicaid Managed Care Experience

Contract 1	Contract 2	Contract 3
a. Name of state and program name		
Minnesota	Minnesota	Minnesota
Families and Children Medical Assistance and MinnesotaCare	Minnesota Senior Care Plus (MSC+) and Minnesota Senior Health Options (MSHO)	Special Needs BasicCare (SNBC)

Contract 1	Contract 2	Contract 3
b. Start and end date		
UCare has held a contract for these plans since 1985. Last procurement was in 2021 with a start date of 1/1/2022. The UCare contract was renewed for 2024; contract renewals each calendar year through 12/31/2026 are allowable by the Minnesota Department of Human Services and Department of Administration before requiring another procurement.	**UCare has held a contract for these plans since 1997.** Last procurement was in 2022 with a start date of 1/1/2023. The UCare contract was renewed for 2024; contract renewals each calendar year through 12/31/2027 are allowable by the Minnesota Department of Human Services and Department of Administration before requiring another procurement.	**UCare has held a contract for this plan since 2008.** Last procurement was in 2022 with a start date of 1/1/2023. The UCare contract was renewed for 2024; contract renewals each calendar year through 12/31/2027 are allowable by the Minnesota Department of Human Services and Department of Administration before requiring another procurement.
c. Services covered under the contract (e.g., physical health Behavioral Health, Long-Term Services and Supports, Pharmacy, Transportation).		
• Physical Health • Behavioral Health • Care coordination based on needs • Dental • Pharmacy • Transportation	• FIDE-SNP • Physical Health • Behavioral Health • Care coordination • LTSS, which includes Elderly Waiver • Dental • Pharmacy • Transportation • 180 days of skilled nursing facility care	• HIDE-SNP • Physical Health • Behavioral Health • Care coordination, including for LTSS • Dental • Pharmacy • Transportation • 100 days of skilled nursing facility care

Contract 1	Contract 2	Contract 3
d. Covered Populations (e.g., families and children, including pregnant women; aged, blind, and disabled without Medicare; aged, blind, and disabled with Medicare; CHIP; Members enrolled in Home- and Community-Based Services (HCBS) Waivers; and foster care children.)		
Families and children, including: • CHIP • Pregnant women • Members enrolled in HCBS waivers (HCBS waiver services are paid directly by the state) • Children in foster care • Includes children and adults with Medicare if not eligible for coverage under other contracts	Ages 65 and older, including: • Individuals who are blind and disabled • Individuals with and without Medicare • Individuals on HCBS waivers	Ages 18 – 64 who are blind and disabled, including: • Individuals with and without Medicare • Individuals enrolled in disability waivers (disability HCBS waiver services are paid directly by the state) • Pregnant women who meet the above criteria
e. Average number of total member months for the most recent twelve (12) months of the contract (or most recent period if the contract has been in place less than twelve [12] months).		
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f. Instances of non-compliance under the Medicaid Managed Care contract resulting in one (1) or more of the following actions: corrective action plan, directed corrective action plan, notice to cure, liquidated damage, withhold of all or part of a Capitation Payment, financial sanction, non-financial sanction, suspension of new enrollment, temporary management, termination, or non-renewal due to performance concerns. For each instance of non-compliance identified, provide a description of the non-compliance, the action taken by the state or contract holder, the actions taken by the bidder to correct the non-compliance, and the length of time for the bidder to correct the non-compliance.

Minnesota Department of Human Services (DHS) Correction Action Plans/Non-Compliance

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Minnesota Department of Human Services (DHS) Correction Action Plans/Non-Compliance

Minnesota Department of Human Services (DHS) Correction Action Plans/Non-Compliance

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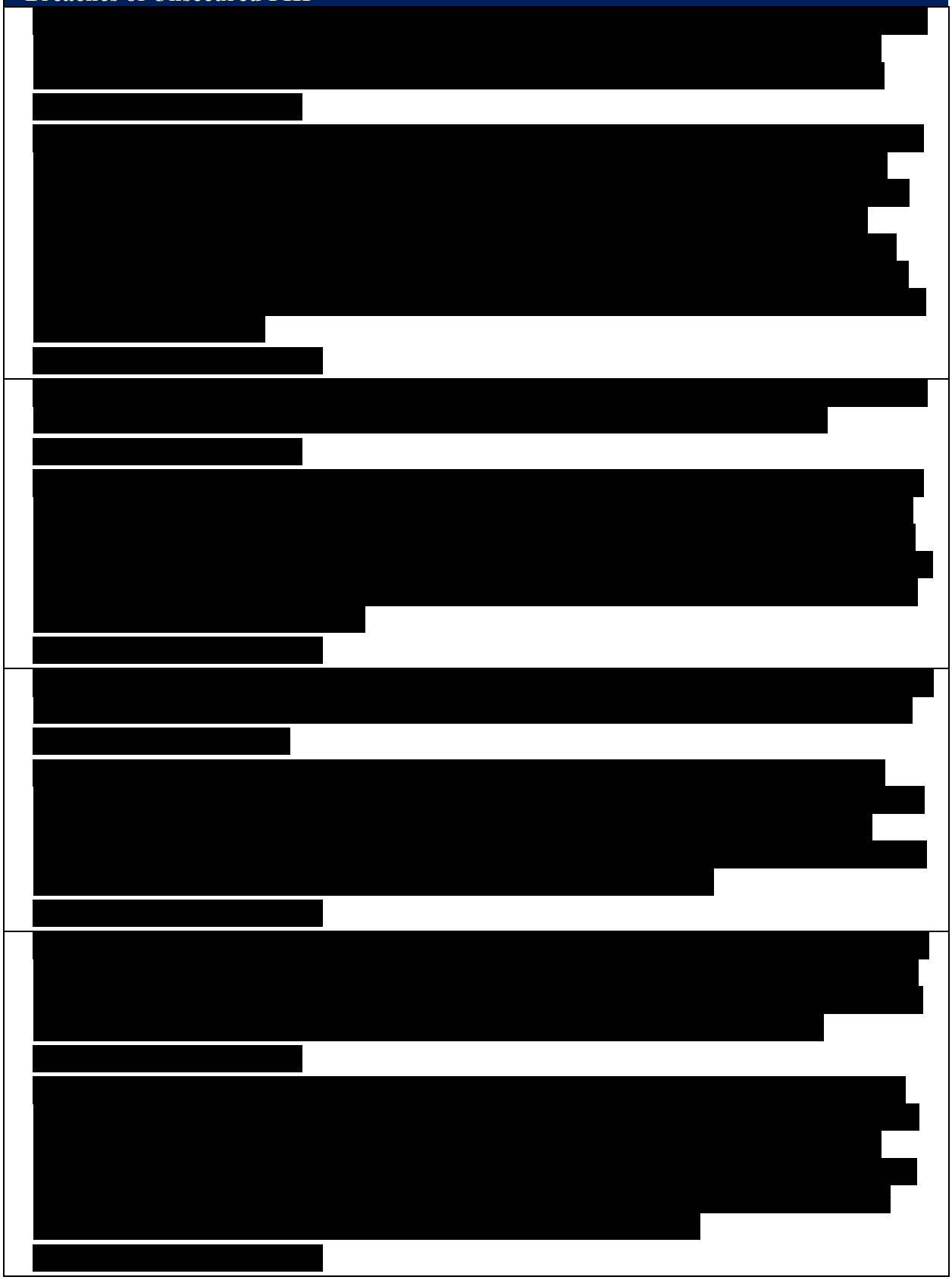
g. Instances of breach(es) of unsecured Protected health information (PHI) under 45 CFR § 164.400 et seq. under the Medicaid Managed Care contract. For each instance of breach identified, provide a description of the breach and the actions taken by the state or contract holder to address the unsecured PHI under 45 CFR § 164.400 et seq.

Breaches of Unsecured PHI

[redacted]

Breaches of Unsecured PHI



Breaches of Unsecured PHI

h. Subcontractors performing delegated Managed Care functions and the functions the Subcontractors performed

Note: These are current contractors used for current Medicaid managed care contracts.

Subcontractor Name	Delegated Functions
[redacted]	[redacted]
[redacted]	[redacted]
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Subcontractor Name	Delegated Functions
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[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
Subcontractor Name	**Delegated Care Coordination and Case Management**
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Subcontractor Name	Delegated Care Coordination and Case Management
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2. Describe an innovative approach the bidder successfully implemented in a program similar to KanCare that the bidder will use to improve timely completion of Member Health Screens in the KanCare program. Include the following in the bidder's response:
   a. A description of the innovative approach and targeted outcomes.
   b. How the bidder measured and monitored improvement.
   c. Lessons learned.
   d. The measurable improvement achieved; and why the bidder anticipates the approach will be successful for improving timely completion of Member Health Screens in the KanCare program.
   e. The projected impact on the KanCare program.

One of the most important aspects of providing quality health care services is understanding the health care needs of our Members. Member Health Screens and Health Risk Assessments (HRAs) are critical for identifying Member's health concerns and assessing risk factors and provide the foundation for developing a Member's Person-Centered Service Plan (PCSP) or Plan of Service (POS). Completion of these tools is dependent on engaging our Members in a holistic, person-centered, and compassionate manner that respects a Member's beliefs, history, dignity, race, and culture.

UCare's engagement strategy is grounded in respect for the Member and their lived experience and focused on meeting Members where they are in their health journey and remaining engaged throughout their enrollment with UCare. Evidence of this is our hiring practices. UCare recruits and hires staff, including Engagement Specialists, with diverse ethnic and cultural backgrounds so we can engage Members in their primary language, and with staff who share similar cultural backgrounds whenever possible. By leveraging our years of experience and expertise in our current markets, we are confident in our ability to effectively fulfill the requirements set forth in the KanCare RFP.

A. UCare's Innovative Approach and Targeted Outcomes

Member engagement is imperative to improve health outcomes and create positive Member experiences. Engagement between the Member and UCare allows us to build a partnership that supports and addresses the full spectrum of their physical, behavioral, and LTSS needs. We build these partnerships by developing trust over time, creating the best opportunity to help improve a Member's health and wellness. To increase our engagement rates, we have developed and implemented the following distinct and innovative strategy.

Incentivized Care Coordination Delegation

The importance of building positive and trusting relationships with our Members is also foundational to how we view and interact with our community partners, including our delegated community care coordination partners that conduct care coordination functions on behalf of UCare. Our Care Coordination Delegates are a critical part of our overall care coordination and engagement strategy and provide the framework for providing care at the local level. UCare's Integrated Care Coordination model was designed to provide care coordination at the local level, by working with local Providers (our delegates) whenever possible. This delegated approach facilitates a greater knowledge of local services available to the Members in their community and increases real-time access to care coordinators. With the majority of UCare's Care Coordination

being provided by community-based care systems, clinics, counties, and local nonprofit organizations, our Members receive a highly localized, specialized approach to their care.

Utilizing Local Delegates to Improve Member Engagement

To address low Member engagement rates, [redacted]

[redacted]

Local Response and Supports

People Powered

[redacted] UCare requires Care Coordination staff to participate in diversity, mental health first aid, trauma-informed and person-centered trainings. These trainings are also offered to our Delegate Care Coordination staff. In addition, to support our delegates' efforts, we routinely offer trainings to delegates related to care coordination best practices.

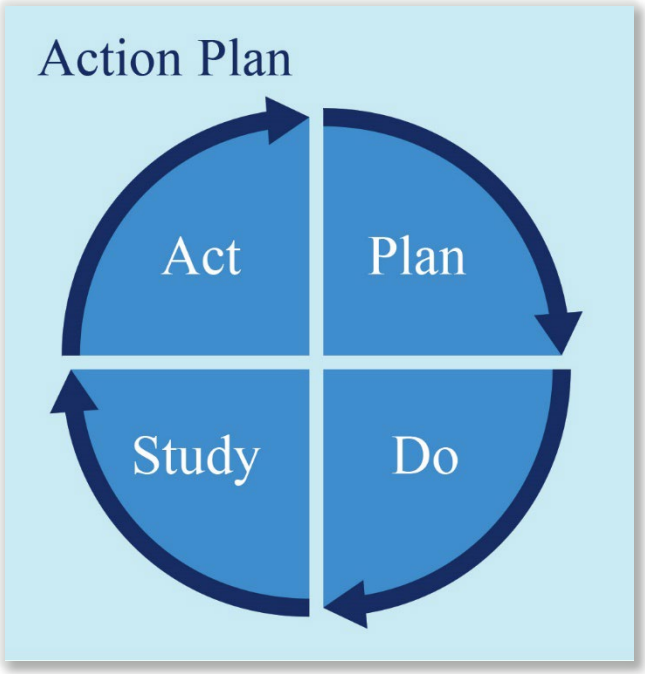
We stress the importance of identifying and delivering services in a respectful, culturally relevant manner that honors the lived experience of the Members we serve. This philosophy, enhanced by the trainings and tools provided and paired with the delegate's local presence and knowledge, contributes to the overall success of our delegation strategy. Through ongoing efforts from our delegates, we believe the upward trend will continue to support increased engagement success with all of our Members.

B. Measuring and Monitoring Improvement

We recognize the importance of measuring, monitoring, and identifying areas of opportunity for performance improvement, eliminating health care disparities, improving operational efficiency, and increasing program integrity for all UCare plans.

UCare uses the Plan-Do-Study-Act (PDSA) cycle — a systematic, formal framework to design, implement, and evaluate initiatives and document improvement efforts.

- **Plan:** Identify the objectives and make predictions by asking the following questions:
  - What are we trying to accomplish based on the data points and identified interventions?
  - How will we know a change led to improvement (i.e., quantitative measures)?
  - What change can we make that will result in improvement from this intervention?
- **Do:** Implement the intervention and analyze data.
- **Study:** Summarize what was learned based on the outcome data.
- **Act:** Identify changes for improvement of the intervention and repeat the PDSA cycle.



UCare uses the PDSA process for each identified program and/or initiative to determine intervention effectiveness, monitor data to ensure that program goals meet identified benchmarks and timelines, conduct qualitative analyses — including a barrier analysis when benchmarks and timeframes are not met — and identify opportunities for improvement. The PDSA cycle helps guide the process of continuing the program and/or initiative, identifying changes to improve the intervention, and sustaining the program.

C. Lessons Learned

Analyzing outcomes of our Member engagement interventions and acting on the lessons learned is an invaluable use of our process improvement tools and strategies. As we studied the success of our engagement rates, we noticed improved engagement when we pair staff and Members who speak the same language and can offer a culturally relevant approach to the engagement conversation. Providing culturally relevant care and hiring a diverse workforce are core values at UCare.

To enhance successful engagement efforts with KanCare Members, UCare will integrate Community Health Workers (CHWs) into the Engagement Team in Kansas. CHWs are key to engaging our hard-to-reach Members through their deep understanding of the local resources and cultural needs of the communities they support. UCare's CHWs reflect a variety of ethnic and cultural identities within communities and hence have a deeper appreciation of the barriers and difficulties faced when accessing health care. This shared understanding builds trust and provides an opportunity for authentic engagement with our Members.

Additionally, we have learned the importance of supporting and maintaining a positive partner relationship with our delegates. [redacted] The work of our delegates is critical to our Members' health outcomes and overall experience. With each strategy, UCare continues to emphasize and support the importance of Member engagement. Engagement is the first step toward completing timely screenings and assessments that are the very basis for identifying Members' health concerns and risk factors. Our ability to engage Members is the framework for addressing physical, social, and behavioral health concerns in a timely manner, and paramount to improving health outcomes and experience.

Provider Story

"The new contract has been very beneficial to our care coordination program. It has allowed us to implement an engagement team with specific training and tools to better support our Medicaid disability population."
—Bluestone (Care Coordination Delegate)

D. Measurable Improvement Achieved and Anticipated Success

Meet or Exceed State Expectations

[redacted]

Our innovative approaches stem from a continuous process improvement cycle, described above. As we establish partnerships throughout Kansas, we will focus on setting meaningful targets and measuring our progress. We intend to build on our established Care Coordination Delegate Incentive Payment Program as we partner with local entities in Kansas and, based on our early success with this model, [redacted]

UCare will also implement our successful Engagement Team strategy in Kansas. We will enhance this strategy by including CHWs, already established in the community, to support in-person engagement with Members we have struggled to reach by phone. We believe this dual approach of calling and in-person community outreach will continue to improve our success rate. More important, we believe this will continue to build trust in the community and instill UCare's values of respect and Member-first thinking among all of whom we have the pleasure of supporting.

Early Identification for Early Intervention, Needs and Care Coordination

Our successful approach to engagement strategies demonstrates that UCare is enthusiastic about hearing from our Members; and with each Member interaction we focus on respectful, holistic, person-centered care.

We support Members with timely interventions to improve health outcomes. Specifically, UCare will:

- Assist Members with arranging a Primary Care Provider appointment to complete a baseline medical assessment or wellness exam
- Review preventive screenings, as appropriate, and any value-added benefits associated with their completion
- Offer health education and information on wellness services and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for Members under age 21
- Identify a Member's physical, behavioral, functional, and social needs, including transportation, housing, employment, and food insecurity through our comprehensive assessment completed with the Member
- Stratify and place the Member into the appropriate Level of Care Coordination that will best meet their individual needs
- Understand and document within the Member's care plan the Member's self-identified goals, desired outcomes, interests, and preferences
- Identify immediate care and accessibility needs and address them in a timely manner

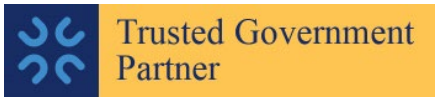
As part of our NCQA accreditation and our best practices, UCare offers an HRA for all Members regardless of their Health Screen outcomes. The HRA helps identify additional health risks that may not have been identified through the Health Screen and facilitates UCare's personalized care and support to its Members beyond that of requirements set forth by the State.

E. Projected Impact on the KanCare Program

We will prioritize early identification of our KanCare Members' needs to provide timely care and support. We are dedicated to identifying potential health risks and issues early to prevent them from escalating. UCare has devised innovative strategies to incentivize our delegates to enhance Member engagement and ensure the timely routine and ad hoc completion of the Health Screens and assessments set forth in RFP Section 7.4.2.

[redacted] within 90 days for initial implementation and 10 calendar days after implementation per 7.4.2 (E)(1) and completion of an HRAs (in-person) for Members whose health screen indicates a need for an HRA per 7.4.2 (F)(1) with a focus on keeping

Members engaged by improving Member outcomes as demonstrated by closing Member care gaps.



We recognize that increasing the rates of completed health screens is part of KanCare's Quality Management Strategy (Objective 2.6), with the most recently published rates ranging from 3.5 to 13%. UCare will implement a similar approach with subpopulations where we have experienced success, such as people with disabilities and over age 65, and apply lessons learned for using local Member engagement strategies for the broader KanCare population. We aim to exceed the higher end of the current range of completion rate and see similar results ranging from 15% to 30%, over the term of our contract.

Our approach represents an attributable shift in how MCOs manage and motivate their Members and Providers; we are proud to be at the forefront of this movement. By offering targeted incentives to our local partners, we have fostered a culture of active participation and engagement, resulting in improved Member outcomes. We will continue testing and refining our methods over time, and we are confident that they will continue to yield positive results.

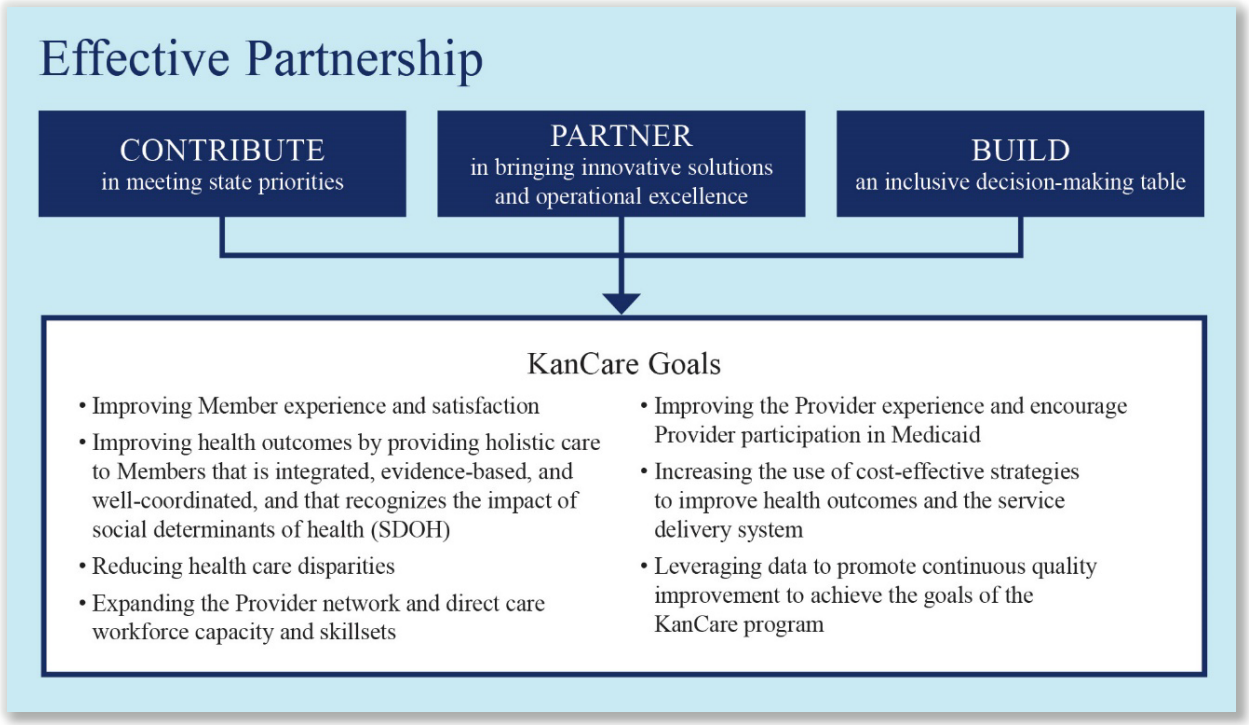
We know that Members and their caregivers want to engage and communicate with us in various ways. Our goal is to meet Members where they are on their health care journey by honoring their lived experience and local relationships.

As health care evolves, we remain committed to enhancing our approach to ensure our Members and the community benefit from the best possible care. Our mission and dedication to those we serve sets us apart and makes us a trusted partner in health care. We look forward to working with the State to further develop, deliver, and refine our approaches, focusing on Member engagement to increase the timeliness of Member screenings.

3. The State is seeking to contract with MCOs that will be collaborative, adaptable, and supportive partners with the State, Providers, Medicaid Fiscal Agent, and each other to achieve the State's vision and goals for the KanCare program. Describe the actions the bidder will take to be an effective partner. Include specific examples of the bidder's experience with such partnering in a program similar to KanCare and how that experience will be leveraged to promote partnering in KanCare.

Success as a managed care organization (MCO) for KanCare requires forging strong partnerships and adapting as the needs of Medicaid Members change and shift over time. UCare is an independent 501(c)(3) nonprofit health plan that now serves more than 600,000 Members through a full mix of Medicaid, dual-eligible, Medicare Advantage, and State-based Exchange plans. As a trusted government partner and pioneer in integrated care, and through the strength of our partnerships, **we are currently the market leader in government programs in Minnesota, and the third largest nonprofit government programs plan nationally, including both traditional Medicaid and special needs plans (D-SNPs).**

As a nonprofit organization, UCare's mission is "to improve the health of Members through innovative services and partnerships across communities." We have extensive expertise in implementing innovative and effective programs that engage Members, Providers, and communities to serve their most pressing needs, which we will apply to supporting the State's vision of achieving a healthier Kansas. We understand each state Medicaid program and local health care market is unique. We've met with Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS) leadership and staff, well over 100 Providers, and many community-based organizations over the past 14 months to gain a broad and deep familiarity with stakeholders and the needs of KanCare Members. We have participated in numerous public forums and events to listen and ensure we understand the priorities and key initiatives of the State. Through our true community nonprofit mission-based efforts, we improve both Member and Provider experiences and build engagement across all stakeholders.



Throughout this response we describe how we will collaborate using our intentional model to **Contribute, Partner, and Build** to meet the State's goals for KanCare, and examples of how we have collaborated with the State, Providers, Medicaid Fiscal Agent and other MCOs.

Contribute to KanCare's Initiatives and Priorities

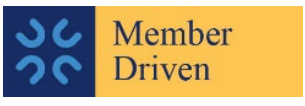
KDHE and KDADS have the significant responsibility of overseeing a compliant and high-performing Medicaid managed care program that works to achieve KanCare's vision and goals. This includes setting the priorities that must be accomplished to achieve this. We have reviewed program requirements as described in RFP Section 7 Scope of Services and are **committed to complying with all requirements,** but our true value goes beyond meeting contractual requirements. Being a contributor at UCare means working closely with our customer, the State, to identify opportunities for program and service improvement, to address issues and ensure that the objectives of the program are manifested in optimal service delivery.

Distinction and recognition as a trusted government partner begins with good leadership, founded on a strong understanding of Medicaid managed care, specifically KanCare and its history, and the populations and communities it covers. At UCare, our leadership reflects our deep expertise of Medicaid and SNPs as *programs*, not just as another line of business. Our KanCare-dedicated, Kansas-located team will be led by a well-respected local Kansas leader with vast Medicaid experience. Our Kansas Plan President, who has been with UCare for almost a year, will be responsible for oversight of all aspects of the program, with full decision-making authority and the support of UCare's corporate leadership. The Plan President reports directly to Marie Zimmerman, Executive Vice President and Chief Strategy Officer, herself a previous state Medicaid Director for five years who also represented the Midwest Region on the National Association of Medicaid Directors (NAMD) Board. Their combined experience in Medicaid ensures a deep understanding of Medicaid program administration is ingrained in our approach to partnering with the State.

This leadership experience and understanding extends throughout UCare, including with our CEO, Hilary Marden-Resnik, who has extensive experience at a large safety net hospital and other Provider health systems. UCare leverages our team's collective experience, values, and flexibility to provide a unique Medicaid-centric vision and appreciation for Members, Providers, and communities that sets us apart from our competitors.

Leverage data to promote continuous quality improvement to achieve the goals of the KanCare Program

Throughout our history we have responsibly managed our Members' care within prescribed capitation rates, providing financial predictability against a backdrop of a rapid rate of change in health and long-term care. Using robust analytic tools and data, UCare accurately forecasts Members' health care needs and related costs, which enables us to focus resources to expand services and benefits to meet program goals, such as increasing the availability of telehealth and other technology and further reducing health disparities.



UCare also has a history of stepping up to fill other MCO gaps, implementing large enrollment transfers when plans have terminated their Medicaid contract or reduced their service area. We worked with the State and adapted to reduce Member disruption, including one mid-year transfer of 130,000

Members in 2017. We collaborated with the State through a data exchange, such as current prior authorizations or hospitalizations, ensuring Members did not go without needed care, and created a seamless Member experience. We evaluated these enrollment transfers through qualitative studies and implemented improvements to our onboarding process, such as proactive outreach to local agency staff who work closely with our Members, so they understand the transition process. We bring that experience, commitment and adaptability to Kansas.

We have an exceptional track record of working with state agencies and third parties to ensure smooth operations for Members and Providers. This will include successful integration with KanCare's Medicaid Fiscal Agent, Kansas Medicaid Management Information Systems (MMIS) provided by the fiscal agent DXC Technology. MMIS serves as the backbone of Medicaid and enables Members' access to needed medical services and ensures payment to Providers. UCare will also collaborate with the Medicaid Fiscal Agent for data sharing, coordination of claims, technical integration, and ensuring that UCare staff are trained, ready and able to provide prompt reporting and adherence to performance metrics, as well as other required reports.

In our current market, one example of the scope of involvement with the Medicaid Fiscal Agent is updating assessments and Provider information for those on the Restricted Recipient Program. UCare understands the importance of this information that informs gaps in care, areas of success, and highlights where improvement is needed in programs and operations to ensure a healthier Kansas and Member safety. In addition, UCare is often a lead collaborator on state Medicaid Agency efforts to improve encounter data that is integrated into the state's MMIS, as this information is vital to identifying costs, utilization, value-based payment programs, and providing data for analysis. This expertise in engaging with state and local government agencies supporting each's efforts will be used to meet specific needs across Kansas.

We have staff with specific expertise dedicated to **understanding State systems and contributing input on system changes for LTSS**, such as UCare's participation as the only MCO representative serving all 87 counties as the State moves to a new comprehensive LTSS assessment system outside of its MMIS. UCare is at the forefront of this endeavor, providing input and guidance on the assessment system. The data it collects will not only ensure quality plans of care for Members utilizing LTSS, but also inform the State of where improvement is needed.

UCare is proud to be a pioneer in integrated care and share an important example of leveraging data and experience in promoting continuous quality improvement **through a 26-year collaboration with the State and CMS on Dual Special Need Plans (D-SNPs)**. UCare had one of the first national demonstrations for fully integrated care (Medicare, Medicaid and LTSS) for dual-eligibles over age 65, now a FIDE-SNP. UCare has been a leading and the largest MCO for this demonstration since its beginning, making significant contributions to evolve the program and provide technical assistance nationally to CMS, the Centers for Health Care Strategies (CHCS), the SNP Alliance, and other regional nonprofit Medicaid MCOs looking to establish a FIDE- or HIDE-SNP. The success of the program, which includes the only longitudinal study conducted by the federal government and site visits by CMS to learn about our efforts, was only possible due to the collaborative nature of our relationship with the State and contributions made by the State, CMS and UCare.

UCare will proactively engage with Kansas State officials and staff, whether KDADs, KDHE, DFC, or DOC, and work diligently to engage existing initiatives and priorities, committing our

time and effort to develop relationships in new communities. We will work closely with the State and Providers to understand and prioritize key needs and support goals focused on advancing the health of Members through collaborative, community-based efforts and approaches.

Investment in systemic change to improve health outcomes and the service delivery system

UCare invests in and has experience implementing innovative programs that engage communities and meet their most pressing needs, while addressing systemic change and alignment with other healthcare partners. UCare has already made beneficial investments in Kansas and will continue to do so. Several such examples, including one from Kansas, are:

- **Integrated Healthcare Partnerships (IHP):** UCare implemented this collaborative value-based payment model (Medicaid ACO) in 2013 and it now includes a wide range of 28 Provider groups across the care continuum and all Medicaid MCOs, including over 500,000 Medicaid enrollees. There is shared financial risk and data exchange between all parties.
- **Wheat State CMHCs Grants:** UCare is partnering with Wheat State Healthcare and providing $260,000 funding to support capacity-building grants for CMHCs/CCBHCs to participate in value-based health care initiatives that will increase access to behavioral health services in Kansas. Grants may support programs and initiatives such as enhancing the availability and quality of peer support services, expanding access to telehealth services, staff support for transition to CCBHC, skill-building, and developing community-specific solutions to address homelessness, among others.
- **Collaborative Performance Improvement Projects (PIPs):** UCare consistently works to contribute with other MCOs to create Collaborative Performance Improvement Projects that create projects to improve health outcomes. These efforts often involve collaborating with Providers and community organizations, thus improving the service delivery system. An example of these projects includes decreasing the use of opioids for new chronic users.

We look forward to working with Kansas State agencies and local Providers to contribute to and develop similar programs, participating in collaborative work groups to further KanCare's vision and goals of ensuring optimal access for KanCare Members. UCare will leverage our prior experiences, tailored through feedback from Kansas Providers and other stakeholders we've gathered over the last year, into innovative models and ongoing implementation.

Partner to Meet Community Needs

UCare's commitment to partnership dates to our founding. In 1984, as the State of Minnesota was moving Medicaid enrollees into managed care, UCare was created by the Department of Family Medicine and Community Health at the State's Medical School to manage the care of enrollees in the State's largest county. We answered the community's call for partnership that would meet the State's goals of implementing managed care and the community's needs for improved access, quality, and coordination of care. Partnership is foundational in our approach and operations. It is also built directly into UCare's governance structure, as 30% of our board are practicing physicians and 40% are consumer Members and this structure sets us apart as your KanCare MCO Partner. Partnerships with State agencies, like KDADS and KDHE, are forged through the authentic Provider, Member, and community-driven lens of our governing board to provide better care for a Medicaid population.

Improve outcomes by providing evidence-based and well-coordinated holistic care that recognizes the impact of Social Determinants of Health

Our Members can have unique, complex needs beyond traditional medical care. Person-centered care is key to achieving a Member's health goals, and we know some of our Members' needs cannot be met by UCare alone. We will tailor our whole person Member support in Kansas through assessment tools, and community engagement and investments. UCare provides a care coordination model that integrates physical and behavioral health services and LTSS, along with personal goal setting and promoting independence and wellness. Our Health Risk Assessment (HRA) exceeds the required questions, to identify the impact social determinants of health (SDOH) may have on each Member. We use the information from these assessments to create an individualized, holistic plan of care. Our Kansas implementation of this model is discussed throughout our response.

UCare has contributed over [redacted] in the last five years to community organizations, Providers, scholarships, and programs throughout our current market. These projects include access to culturally specific food, housing support for those experiencing homelessness, and Special Olympic athletes' health screenings. In 2023 alone, we provided a community benefit of [redacted] for service expansion at two safety clinics, recruitment of primary care in rural areas, access to mental health services in underserved areas, and access to geriatric services. Our support funds a wide range of care systems, community organizations, and community clinics; all Providers serving Medicaid Members with medical care and addressing the impacts of SDOH. It's important to note **UCare's community benefit contributions are part of long-lasting partnerships and co-development**, not just providing funding in procurement years.

Equally important are the partnerships we develop through community benefit investment efforts, which are vital to expanding the use of SDOH strategies, through evidence-based practices and services that lead to optimal health outcomes. Our community benefit efforts go beyond our everyday commitment to Members to reach the larger community by addressing social needs, strengthening Providers, and supporting research and programs to benefit health care quality and delivery.

> *"UCare has 40 years of government program expertise and uses a regional approach that provides a higher level of service and focus as local and community-based non-profit alternative to national, for-profit health plans. UCare has demonstrated this through investments in the health outcomes of the Midwest and its communities."*
> —Venus Lee
> CEO, GraceMed

In Kansas, we have demonstrated early commitment to partnering by providing grants that extend to the greater community, such as our support for GraceMed, a Federally Qualified Health Center (FQHC) in Wichita. UCare has provided $200,000 in funding to GraceMed to provide health screening and tests for residents in Wichita who may be impacted by a trichloroethene (TCE) spill that has affected local sources of drinking water. Kansas health studies have found elevated rates of liver cancer diagnoses among residents, and these funds will be utilized to evaluate liver and kidney function as well as to screen for cancers. By detecting any potential health issues early on, we can ensure prompt medical intervention and appropriate care for those impacted.

Upon contract execution, [redacted] through the UCare Kansas Foundation to support KanCare priorities. Through general and dedicated funding, the Foundation will focus on three primary areas — food security, workforce development and homelessness — based on regional needs. Our grants will not simply provide funds, they will provide opportunities for UCare to be actively involved with communities.

Reduce Health Care Disparities

UCare appreciates the need for MCOs and Providers to work together to ensure consistency and deliver on our mutual goal of improving the health and quality of life of Members, as well as reducing health disparities for all Kansans. We have found that collaboration among MCOs has positive effects on programs and the Member experience. For example, UCare has led the last two MCO Provider access surveys, on behalf of all MCOs, to identify the barriers Members with disabilities experience and Providers experience when serving them. Surveys on the topics of dental care and transportation needs have allowed the MCOs to work together, with Providers and the State, to take action to improve access. Outcomes and actions have included the creation of a toolkits for serving individuals with disabilities, consistent transportation processes amongst MCOs, and understanding, as well as escalating, barriers that require legislative change.

We have partnered with other MCOs and the State on a variety of topics, including quality improvement, appeals and grievances, call center metrics, and behavioral health. These collaborations ensure that processes for Providers and Members, expectations, and interests are all aligned. Examples of our MCO collaborative Performance Improvement Projects (PIPs) include reducing disparities in antidepressant medication management and interventions for a healthy start for children improving services for pregnant Members and infants, both focusing on those experiencing racial and ethnic disparities.

> *"UCare's priority on partnering with the State and working closely with community groups, organizations and counties was evident during the pandemic. UCare made many grants directly to counties and community organizations to provide flexible funds to meet the needs of agencies during the pandemic. As an example, on several occasions UCare provided iPads to community organizations to facilitate remote access to services for Medicaid enrollees. UCare provided thousands of masks to group homes and senior care facilities early in the pandemic."*
>
> —Jane Malcolm
> Former MN Health Commissioner of Health for Governor Tim Walz

Health Equity Partnership

At the beginning of the COVID-19 public health emergency, State Agencies in partnership with Providers, community organizations, and MCOs, created a Health Equity Partnership Work Group. As a leading MCO in this work group and an active partner, UCare led a Mask Distribution project at the height of the pandemic to distribute masks to community organizations and low-income housing, and now leads a Medicaid Redetermination One-Pager distribution project with the goal of educating Medicaid enrollees that renewals have begun. The targeted audiences of these efforts are always those experiencing health disparities, as they may be less likely to have access to non-medical supplies and education about their health care.

Through all these efforts, UCare has proven we are even more than a trusted and credible partner; we are often the preferred partner and approached by the State (and Providers) to lead or manage these types of efforts, due to our unwavering commitment to our communities — even beyond our Members. We will work with the same commitment and diligence to meet expectations in Kansas and look forward to new, collaborative efforts with MCOs, Providers, and other agencies such as Indian Health Services, Title V programs, local education agencies, and the Department of Children and Families in the State.

Expand the Provider Network and Workforce Capacity and Skill Sets

Providers are at the core of our authentic, intentional model of partnership. UCare is *the* preferred MCO partner for our Providers in government health care programs and they actively tell us this, as is demonstrated through our long-standing partnerships. One key is fostering creative ideas and partnerships with Providers to expand the workforce. UCare has shown we can partner with Providers on broad, far-reaching innovations throughout our current market, such as partnering with a dental school to train residents while traveling to rural areas, solving dental access issues through UCare's mobile dental unit. In our preliminary conversations with leadership from KDHE and KDADS, we noted that they wanted MCOs that could partner on systemic solutions to support the larger Kansas community.

Examples of how UCare demonstrates this include our efforts to address the widespread concerns about workforce shortages, including:

- A $714,000 grant to the Minnesota Hospital Association (MHA) to develop a roadmap and accompanying toolkit of best practices in workforce development for organizations to translate and use across the continuum of care. This includes standardizing evidence-based practices to support, strengthen, and improve the workforce across the continuum of care.
- A $90,000 grant to a state Medical Association as part of our work to mitigate physician and other health professional biases as a contributing factor in health outcomes, and to support the adoption of an anti-racist culture by health care institutions.
- In Kansas, we have already committed to addressing the workforce shortage, helping young Kansans, and expanding Provider access. UCare invested $25,000 in the Inspire Health Foundation, matched by the Community Health Center of Southeast Kansas, for a total investment of $50,000. This work will support activities for young people to learn about professions in health care. The foundation and community health center are in Pittsburg, Kansas, and will support activities in the surrounding communities.

> *"UCare has been a good steward of their nonprofit status, supporting health care improvement activities. In 2022, MHA collaborated with UCare to develop a workforce roadmap of best practices to bring much-needed resources to our hospitals & health systems to support recruitment and retention strategies to build a strong workforce."*
> —Joe Schindler
> VP, MHA

Providers are critical partners in supporting Members in achieving their best health and well-being. From initial network contract application through timely payment and beyond, our multidisciplinary staff and senior leaders ensure Providers a high-quality experience. UCare's transparency, fairness, and timely assistance are the key to maintaining our strong, long-standing

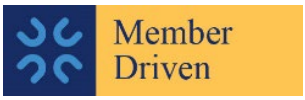
relationships with Providers. In addition, strong Provider partnerships achieve the quality outcomes and equity goals of KanCare.

Build Engagement Opportunities to Include All Voices

A hallmark of UCare's approach is to bring as many voices to the table as possible, in order to best serve the needs of KanCare Members and State agencies. We will build engagement that fosters trust and ultimately leads to well-rounded, Member-centric solutions. As a Medicaid-forward organization, we have honed our community-based model and understanding of Members, advocacy groups and cultural organizations, without the distraction of large group/employer-based commercial insurance. As a community-based health plan we understand how to bring together all voices that will support the State, and to engage all communities.

UCare's community engagement model is proactive and responsive. We build partnerships by reaching out to and being present in the community. In spirit, we have met with more than 100 different agencies and community groups throughout Kansas, including Community Care Network of Kansas, Disability Rights Center of Kansas, Kansas Children's Alliance, Kansas Association of Area Agencies on Aging and Disabilities, Members of the Kansas Council on Developmental Disabilities, Kansas Advocates for Better Care, Oral Health Kansas, and Big Tent Coalition, to name a few. Organizations also reach out to UCare often based on our body of community-focused work and as a trusted partner in the community.

Improve KanCare Member Experience and Satisfaction



Members should always have a voice in their care and feel empowered to make the best decisions for their health and wellness goals. Understanding this value and from the very beginning, UCare established Member Advisory Committees to proactively collect feedback to ensure we meet the needs of our Members. Specific to Medicaid, we have two Member Advisory Committees: families and parents of children on Medicaid (our Member Advisory Committee); and the Disability Advisory Council for adults with disabilities. In addition, we conduct listening sessions with Members over 65 focusing on specific concerns. We have also held listening sessions with the Somali and Asian communities. These advisory groups supplement surveys by ensuring ensure we hear all voices.

It is also important to obtain feedback from those working closest with Members, including community-based organizations, county, tribal, and local public health agencies. UCare was the first managed care organization in our market to establish a **County & Tribal Relations Team**, which includes a Tribal Liaison who focuses on partnerships with tribal communities and Providers serving them. This team offers regular meetings to all counties and tribes and conducts an annual survey to understand how to best support these agencies and our Members.

UCare has already begun planning to ensure Member Advisory Committees and a Kansas Community/County and Tribal Relations Team is in place to continue receiving the invaluable feedback from our Members and those closest to them. Without this feedback, we could not be successful in providing access to local, holistic, and quality care for our Members.

Improve Kansas Provider experience and encourage Medicaid participation

To understand the Provider experience, UCare has met with more than 200 Provider organizations of various sizes and specialties across Kansas, [redacted] Our

conversations have given us deep insight into the Kansas Provider landscape and the challenges of ensuring access to services for Members in various regions of the State.

Common issues we heard and our plans for addressing them include:

- **Delays in payments and Provider enrollment:** We will ensure our claims system meets or exceeds the requirements for efficient and accurate claims payments. We currently meet all expectations with Provider credentials and adding Providers into our claims system.
- **Burdensome Prior Authorization (PA):** Services that require PA are limited, especially compared to national health plans. We regularly review our PA list and remove services when necessary to reduce unnecessary administration burden for Providers, while ensuring we account for combating fraud, waste, and abuse, as well as over-utilization.
- **Unreasonable claims denial edits and post payment audits with take backs:** UCare will not implement these types of claim reviews unless required by State or Federal guidelines.
- **Transactional relationships between Providers and MCOs:** UCare invests in and values our relationships and will work closely with our Providers in every way, from our Provider Assistance Center for real-time assistance, to Field Representative engagement and support.

We will continue forging relationships and building partnerships with Providers in Kansas — through efforts like these, in support of forging a culture of continuous learning.

Summary

UCare is well positioned and poised to bring our history of successful people-powered ways in which we Contribute, Partner, and Build relationships in Kansas, offering our expertise, experience, innovative strategies, methods of approach, and capabilities necessary to advance the KanCare vision and goals. Our values and goals are aligned with the State's, ensuring that we can work together to provide comprehensive, quality care and services across Kansas.

Tab 7b:

TOPIC AREA 2

Member Experience

7b. Member Experience

4. Describe the bidder's approach to encouraging and engaging KanCare Members to actively participate in their health care and meet their personally defined health and wellness goals and cross service system needs. Provide an example of a strategy the bidder has successfully used in a program similar to KanCare, including the impact of the approach on outcomes.

UCare's Commitment to Building Trust

At UCare, we prioritize our Members' needs in everything we do. We share the State's goals to educate, engage, and empower Members to personally define their health and wellness goals as part of the aim to improve Member experience and satisfaction. UCare believes empowering Members and caregivers to make choices in their health care, who provides it, and what specific care delivery approach is best for them is a critical piece of improving the Member's experience and satisfaction.

Building trust with Members is a key first step to the goal-setting process. As a true nonprofit built on a foundation of active and open two-way dialogue, UCare values stakeholder feedback and we actively seek to learn and improve. This starts with the Member and includes caregivers, Care Coordinators, support teams, Providers, community supports, and other stakeholders. This feedback drives everything from how we communicate to how we provide services and is the cornerstone of our investment in building strong and lasting relationships.

Our approach is enhanced by business practices that help us identify, understand, and address issues disproportionately impacting Members and communities experiencing the most significant health disparities. UCare employs diverse communication channels and personalized outreach to reach all Members, even those traditionally harder to engage. We strive to ensure our Member engagement strategies are tailored to Member preferences and needs so we can establish the dialogue and relationship necessary to build trust as their health care partner. By honoring Members' unique communication preferences, we can build trust at an early stage and set the stage for positive long-term accomplishments.

Shared Goals to Educate, Engage, and Empower Members

Our approach is rooted in the principle of personalized empowerment, aiming to cultivate proactive and engaged KanCare Members. Recognizing the diverse health needs and aspirations of each Member, we prioritize individualized care plans. Our Member-centered approach begins by using empathic inquiry and motivational interviewing to gain a nuanced understanding of each Member's unique goals, needs, and preferences. We use health screens and assessments to enrich our understanding of their situation and co-create person-centered care plans with the appropriate interventions necessary to provide equitable and culturally relevant care. Our detailed health assessments exceed the required questions to identify the impact social determinants of health (SDOH) may have on each Member. We use the insights from these assessments to create an individualized, holistic plan of care. We also inform Members about value-added benefits that support their goals and assist them in accessing Providers. This high level of collaboration ensures that the healthcare journey is not a one-size-fits-all approach but rather a tailored roadmap that resonates with each Member's aspirations and creates positive and encouraging Member experiences that ultimately deliver better health outcomes.

Member Driven

Communication is at the center of co-creating personalized care plans. We understand that certain Members may be more challenging to reach than others. As part of UCare's Member engagement strategy, our Member Engagement Team identifies patterns and preferences that inform our communication, and we proactively engage with our Members. We assign dedicated team members to establish relationships with those who may be harder to reach, and we leverage technology to ensure that our communication is timely. Member preferences, values, and goals are shared across GuidingCare, UCare's clinical data platform and Member record. Direct involvement in the co-creation of their care plan inspires in Members a feeling of empowerment. This, in turn, supports their active participation in healthcare decisions and a shared journey between UCare, the Member, their Provider, and other care team members working toward their personally defined wellness goals and independence. Through these efforts, Members don't feel like they must start over with each Provider, and care team members understand where the Member is in their health care journey and can continue to emphasize Member-centered goals. Through our combination of people-powered strategies and accessible and user-friendly tools, our goal is to ensure that every Member is well informed about their health care and the resources available to them. By providing impactful engagement and relevant education opportunities, we will build trust, empower our Members, and improve satisfaction. Examples of our approach include:

Communication Preferences

UCare actively collects our Members' preferred communication channels, such as telephone, text, face-to-face, etc. as well as other preferences, such as timing, language, or alternative format. By honoring Members' unique preferences, we can build trust at an early stage and set the stage for positive long-term accomplishments. This approach assists Members in staying engaged with their primary care Provider, pharmacies, home and community-based service (HCBS) Providers, pharmacies, and community organizations/entities.

Community Partners

UCare collaborates with community partners to reach Members where they live, work, worship, and play. For example, we participate in community events to educate caregivers and Members about the importance of staying up to date on preventive care, including adult and well-child

visits, immunizations, dental care, and managing chronic conditions such as hypertension and diabetes. UCare also partners with a local Community Health Worker (CHW) organization to develop and broadcast educational topics through TV stations. The health topics are determined by identified health disparities within the community and delivered by trusted medical professionals from the community. Through these unique partnerships, we engage, support, and connect with our Members better.

Community Health Workers

CHWs are a core part of our Integrated Care Team, and we partner with CHW organizations and Providers to leverage CHWs in office and clinical settings. We hire staff who reflect our communities, often individuals who have been enrolled in a Medicaid program in the past, as shared life experiences is often essential to building trust and bringing deeper engagement with both the health plan and health care Providers. Strengthening our approach is proactive outreach with two community organizations in Kansas, the Community Health Council of Wyandotte County and Central Plains Health Care Partnership, related to how we will collaborate on CHW programs.

We are committed to ensuring that we reach out to all Members in a targeted and personalized manner. Our goal is to ensure that every Member feels heard, valued, and supported. UCare engages with Members in some additional ways, including:

- **Health Screen Call**s: When calling a new Member to set up an initial Health Screen, we discuss benefits and have a conversation to welcome and onboard the Member to the plan.
- **Value-Added Benefits Outreach:** Member Engagement Specialists conduct outreach calls to engage Members and provide information on value added benefits that are available to them, such as the Quit For Life Tobacco Cessation program that educate and provide resources to quit or stay off nicotine.
- **Unable to Reach Team:** UCare has a dedicated Member Engagement Team whose focus is to engage Members whom we have not been able to reach or who have previously refused care coordination.
- **Disease Management Messaging:** Our Disease Management Team texts Members with diabetes and asthma to provide education and increase engagement with their care.

Member Goals and Cross-Service System Needs

UCare recognizes that Members often have needs that span multiple services or systems. We understand Member circumstances can result in various needs critical to independence and quality of life. We empower Members by reviewing their circumstances and options, including describing relevant value-added benefits that support their goals, Whether their goal is to maintain their choice of housing or find employment, UCare offers comprehensive value-added services to support a bridge to independence. By extending the care model and benefits beyond the traditional health plan and Provider system, UCare creates unique, personal connections with Members, which empowers them to best utilize an array of services, tools, resources, and community connections. These efforts intentionally place the Member and their aspirations at the forefront of their healthcare experience.

Integrated Care Pioneer

UCare's Integrated Care Coordination model addresses Members' needs by coordinating cross-service systems with thoughtful consideration for those in rural frontier and urban regions, and tailored to meet the differing demographic needs across Kansas. Our Social Services Care Team as part of our integrated care model was purposefully designed to ensure Members have access to an array of culturally relevant and appropriate health care Providers and services to achieve their wellness goals and ensure all aspects of a Member's care are addressed. Focused on individual Member needs, our care model is Member-driven, trauma-informed, and person-centered, and is intentionally designed to ensure equitable access to care and reduce disparities across the State.

Example: Advancing Cross-Service System Needs with a Rural Clinic

Authentic Provider Relationships

UCare partnered with a rural clinic to address Member-identified barriers and SDOH needs to advance overall Member health and wellness goals. The project's goal was for Members to personally identify areas that impacted their health and wellness and to create lasting change through education and intervention.

As a part of this project, UCare Members receiving care at the rural clinic completed an SDOH screening questionnaire. If they screened positive for additional support needs, they were referred to a CHW for further outreach and assistance. CHWs then used a combination of on-site visits, telephonic outreach, virtual visits, and other strategies as appropriate to assist Members in arranging appointments and transportation to close gaps for preventive care, including but not limited to immunizations, chronic disease self-management, and cancer screenings.

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Summary

UCare understands that navigating the health care system can be complex and overwhelming for Members and their caregivers. We address this by prioritizing the Member and their caregiver through fostering communication, collaboration, and coordination among the Member's circle of care when establishing a Member's unique care plan and goals. UCare's commitment to building trust extends beyond traditional health care settings, encompassing authentic partnerships with local stakeholders, cultural relevancy, and the use of CHWs who reflect the communities they serve. Our multifaceted approach to educating, engaging, and empowering Members ensures that every Member, regardless of their circumstances, feels heard, valued, and supported in defining their individual health and wellness journey. By fostering trust, addressing Member needs across the system, and encouraging our Members on their journey, UCare will improve health outcomes and contribute to a more equitable and inclusive healthcare landscape in Kansas.

5. Describe the bidder's approach to soliciting and reviewing feedback from KanCare Members and their families and using this feedback to improve Member and family experience and the KanCare program.

Member Experience and Satisfaction

At UCare, Members are at the center of everything we do; we start with their needs in mind and build our processes from there. We understand the State is calling on managed care organizations (MCOs) to prioritize improving Member experience and satisfaction in the KanCare program. We proactively and continually seek Member feedback, acting on our learnings to help Members succeed on their individual health and wellness journey. We have studied the key challenges Members have expressed in the KanCare program, including delays in care coordinator response time, difficulties accessing certain services, such as non-emergency medical transportation (NEMT) and interpreters, cumbersome prior authorization processes (especially for durable medical equipment and pharmacy services), a need for more community employment connections, and better value-added services to promote maternal and infant health. We are well-versed in the seven KanCare priority areas established based on public feedback, and we stand ready to address these and other challenges through collaboration with Providers, Members, the State, and community stakeholders. UCare shares the State's vision of continuous improvement, and all of our employees have an opportunity and responsibility to shape Member experience each day, regardless of their role. Our philosophy to put Members first in all facets of our work positions us to deliver the experience KanCare Members expect and deserve.

40% of the UCare Board of Directors is comprised of UCare Members. This allows them to apply experience from their own lives and their communities to guide our work.

As a nonprofit health plan rooted in the community, UCare meets our Members where they are on their journey, whatever their circumstances may be. We strive to de-complicate health care and advocate for all our Members so they can better understand their coverage and engage more in their health and wellness decisions. Member experience is a critical indicator of our overall performance, so we place a high value on collecting holistic feedback and using what we learn for continuous improvement of our services. The Member journey is complex, so we follow an "outside-in" approach to study it – incorporating feedback from Members and their families, as well as Providers and community stakeholders alike to guide a better experience at all stages.

Member Story

Closing the Loop on Customer Service

Member Lyle requested a follow-up in one of our feedback surveys**:** *"I need new teeth and do not know where to turn for help with finding a dentist."*

UCare Representative: *"I called Lyle; gave him the names of two dental locations close to him that are accepting new clients. I also told him about UCare's Dental Connection Team that can help him. I advised if he has questions about dental or his medical coverage to give us a call anytime, we are here to help. He appreciated the help and had no further questions."*

Continuous Monitoring

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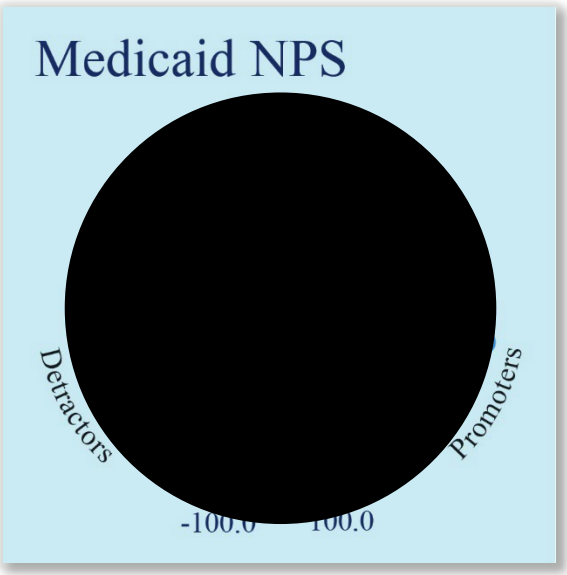

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Approach to Soliciting and Applying Member Feedback

UCare actively engages and captures Member feedback in a variety of ways—both when Members proactively reach out to us, and when we actively seek their input through different channels. Our key methods and channels for collecting Member feedback include:

- UCare's Customer Service Call Center
- Member Advisory Committee
- Disability Advisory Council
- Appeals and Grievances process
- Prior authorization process
- Feedback received through care coordinators and care managers
- Member satisfaction surveys
- Consumer Assessment of Healthcare Providers and Systems surveys

- Ucare.org website
- Social media
- Community events
- Additional market research, such as focus groups, retention surveys, conjoint studies, interviews, and more.

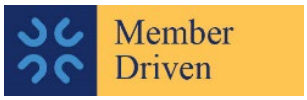
Customer Service Call Center

Our main touchpoint for collecting incoming Member feedback is through our Customer Service Call Center, which focuses on creating a positive and personalized experience to meet diverse Member needs. We listen to our Members with authentic curiosity, compassion, respect, and patience, regardless of whether their experience was positive or negative. We always create a safe space for our Members to provide feedback and we guide them through the process of filing a grievance or appeal if they are dissatisfied with a decision or service. UCare's dedicated Member Experience Team hosts a monthly meeting with a cross-functional work group to review Member issues and trends, drive operational improvements, and identify new programs and services to better meet Members' evolving needs. Findings are shared with UCare leadership and tracked to assess impact on Member satisfaction.

Feedback in Action

As our membership grew significantly between 2018 and 2022, UCare also experienced an increase in overall Member call volume and hold times, which significantly affected our transportation services lines. Members expressed feedback that getting through to an agent was increasingly difficult. UCare conducted a comprehensive evaluation of the issues and potential solutions. We restructured our Customer Service Team model and launched a new transportation platform, which significantly reduced the time a Customer Service representative spends to schedule transportation rides. These actions resulted in a 50% reduction in average speed of answer (ASA), allowing faster and more reliable rides for Members.

Member Advisory Committee and Disability Advisory Council



Using our connect, listen, and act approach, we use soft listening skills during Member feedback meetings, through calls and online portal messages, and when receiving input from care coordinators, case managers, and community partners. In accordance with RFP Section 7.10.12.D., UCare hosts in-person and virtual quarterly meetings with our Member Advisory Committee (MAC) and UCare's innovative Disability Advisory Council (DAC).

Member Story

"I have been a part of the UCare Member Advisory Committee for several years. I am grateful that my feedback is taken seriously and that UCare cares about what I think."
—Laura B., MAC Member

Agendas are carefully crafted to include both standing topics used for benchmarking — such as using coverage during the first 60 days of enrollment, understanding prior authorizations, and accessing transportation — as well as other, rotating topics to get a variety of fresh feedback on new programs or services. Both MAC and DAC feature dedicated sessions on health equity, include a representative sample of long-term services and supports (LTSS) and home and community-based services (HCBS) Members, and reflect the diversity of our

Members' race, ethnicity, gender, age, disability, language, and health needs (including physical and behavioral health).

Members and their families are invited to attend, and caregivers may participate when a Member is unable to attend. A skilled facilitator leads each MAC and DAC meeting to ensure the meetings are productive and diverse Member voices are heard and respected. UCare offers language interpreters, assistive devices, and free transportation. The meeting venue is always accessible, convenient, and comfortable for Members. UCare gathers highly valuable insight and feedback at these sessions as we build trust with our Members. The meetings provide us with a fresh understanding of Member needs that help guide informed decisions and enable more effective and responsive services.

Feedback in Action

UCare serves Medicaid Members who often have adult dependents and children on their plan, as well as family caregivers assigned as personal care attendants, guardians, or authorized representatives. We recognize the crucial role they play in our Members' lives, and we seek their feedback to continuously enhance our services. For example, we heard from caregivers that they are often in charge of managing care for a loved one and they ask us for help in making administration simpler. With their feedback, we launched a UCare Permissions and Preferences program, enabling caregivers to tailor how communications are sent to them and the Members they are supporting.

As part of the Medicaid Reenrollment Equity Workgroup, a coalition of the state, managed care organizations, and other stakeholders developed a one-page flier for community settings that included key calls to actions and who to contact for assistance with Medicaid coverage redeterminations. UCare took the initiative in gathering feedback on an early draft of the flier through our MAC to get Member feedback. Members shared that they did not relate to the image on the draft, found some of the messaging confusing, and after reading it still were not sure what to do. Members suggested changing the phrase "it's time to" to "Mark your calendar" and to use the word "renewal" throughout for consistency. UCare promptly relayed the feedback and the state integrated many of our Members' suggestions. Incorporating Member feedback early led to an easy-to-understand flier for Medicaid Members across the state.

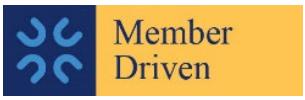
Member Satisfaction Surveys and Market Research

In addition to the examples above, we gather in-depth insights into Member preferences, opinions, and behaviors using a wide array of quantitative and qualitative market research, such as Member satisfaction surveys, retention surveys, conjoint studies, county and tribal surveys, focus groups with targeted topics, interviews, and other methods. In accordance with RFP Section 7.9.10, we will conduct the required Member satisfaction surveys (including a statistically significant sample of HCBS and behavioral health populations), incorporate results into our Quality Assessment and Performance Improvement program, and share results with stakeholders as appropriate to foster transparency and collaboration in improving KanCare Member experience. We will also conduct a dedicated mental health and substance use disorder (SUD) survey to understand the unique needs and perspectives of the KanCare SUD population.

These research studies offer valuable and detailed insights for developing programs and services, refining Member engagement strategies, and staying attuned to evolving Member needs and expectations. Learnings from incoming Member feedback, market research, advisory committees, and outreach efforts help identify strengths and weaknesses in quality of care and

operations, guiding our practical decision making, assessing where resources can be best allocated, and considering new products and services to meet evolving Member and market needs.

Feedback in Action



In 2022, UCare's DAC raised the need to add coverage of crowns to our dental benefits. Our Members often could not afford out-of-pocket dental work when it was not a covered service. We listened, validated the idea through additional research and market analysis, and acted by adding one crown per year to our integrated Special Needs Plan (SNP) for the 2023 benefit year. UCare Members have expressed excitement about this valuable addition and improvement to their plan.

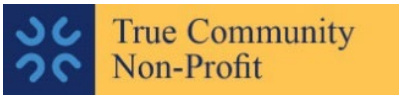
Consumer Assessment of Healthcare Providers and Systems Survey

Another important way UCare assesses our Members' experience is through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This survey asks Members about their experience with their health plan, Providers, and access to care. The "Rating of the Health Plan" and "How Well My Doctors Communicate" questions all point to Member experience and satisfaction. The results of our CAHPS survey showed that Members are satisfied with their ability to access care and if they need additional help, UCare is there to intervene by reaching out to Providers or finding Providers on their behalf. CAHPS scores guide our Member satisfaction analysis as they reflect well the quality and accessibility of health care services.

The CAHPS Experience of Care & Health Outcomes (ECHO) survey is the most effective tool for improving behavioral health care, treatment, mental health, and substance use program performance. This survey helps UCare understand how Members feel about these services and identify opportunities to improve quality of care and support higher Member satisfaction. All CAHPS and ECHO survey composite scores and data sets are integrated into our Quality Assessment and Performance Improvement Committee and Member Experience Committee Work Group to further review, analyze, prioritize, and implement strategies that improve health outcomes and support higher Member satisfaction.

Example results: from 2020-2023, UCare's Medicaid plan achieved a 93% score on "How Well My Doctors Communicate," a key reflection of the patient experience. In another example, our Dual Eligible Special Needs Plan achieved an 88% score on "Rating of Health Plan."

Elevating and Engaging Diverse Member Voices



A key UCare differentiator is our Health and Racial Equity framework, Just Health, which encourages Member, family, and community engagement, collaboration, and listening — and acts upon feedback by delivering solutions that truly meet each Member's needs, each family's needs, and each community's needs. The Just Health framework elevates the voices of diverse Members by incorporating inclusive practices throughout our processes, including:

- Ensuring we obtain feedback from diverse populations
- Involving Members from diverse backgrounds in decision making
- Offering language accessibility to make it easier for non-native English speakers, as well as Members who are deaf, hard of hearing, or visually impaired, to provide feedback

- Tailored outreach ensuring that we reach and engage Members who otherwise might be overlooked

By consciously designing and implementing these strategies within our continuous improvement framework, UCare can elevate and amplify diverse Member voices, leading to more relevant and effective improvements that consider the unique needs of all our Members.

UCare's model of community engagement is both proactive and responsive. We participate in regular association and coalition meetings as both a listener and presenter.

For example, we have given presentations to the Kansas Hospital Association, the Kansas Mental Health Coalition, and the Board of the Association of Community Mental Health Centers to introduce UCare and initiate conversations about how to serve KanCare Members better. UCare will continue to prioritize regular meetings with stakeholders and associations in Kansas. Additionally, UCare attended more than 100 individual meetings with Kansas stakeholders in the last 14 months to listen and learn, and we look forward to continued sponsorship of key associations that support KanCare, such as the Kansas Community Health Worker Symposium, Kansas Brain Injury Association Annual Conference, Kansas Recovery Conference, Kansas Healthcare Collaborative's Summit on Quality, and more.

Member Story

"I want to address whoever was responsible for a recent radio ad featuring a Hmong girl and her family. I am writing to express my sincerest appreciation of this radio ad. The whole ad made me feel so emotional. I shed tears hearing the story of someone like me, of someone who is of my own kind, of the struggles they faced and of my culture. It was so relatable, and I respect UCare so much for this ad."
—Bao, Member

Building a Culture Focused on Member Experience

As crucial as it is to capture Member feedback from multiple sources, it is even more important to designate a process and space within UCare to analyze and act on that feedback. We invested early by creating a dedicated Member Experience Team that grounds our experience work and sets direction for the entire organization. This team ensures that Member, family, and stakeholder input is captured, analyzed, applied, and shared with impacted partners across UCare to improve Member experience and health outcomes. Our various committees and teams meet year-round to foster a culture of continuous improvement and anchor every discussion with a Mission Moment — a Member experience story that highlights our commitment to those we have the privilege of serving.

Data-Driven Member Improvement

To monitor key Member experience performance indicators, UCare uses a Member Experience Dashboard to make Member and family satisfaction scores visible and transparent to the entire organization. The dashboard tracks multiple data sources, including quality improvement data analytics and reports, allowing UCare staff across the organization to monitor and analyze real-time performance in a centralized location. The dashboard also reflects monthly Customer Service Satisfaction and Customer Effort Scores, as well as our overall Net Promoter Score and Provider CAHPS data. These data sets are available to all employees, and they guide the development of our Member Experience Roadmap and other improvement initiatives across UCare. [redacted]

[redacted]

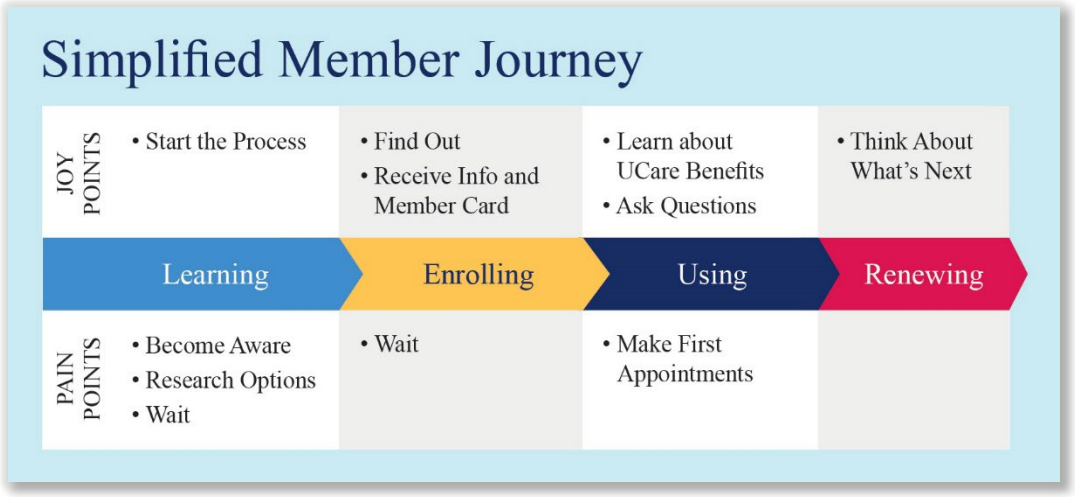
Mapping the Ideal Experience

Member Driven

For many years, UCare has actively engaged Members to understand and depict their Member experiences in different formats that we can in turn share with key stakeholders, such as our Providers, community partners, and regulators. Most recently, we embarked on a deep dive project to learn more from and about our Medicaid Members to map their current experience and design an ideal future state. For this process, we used data on our existing experience, key input from UCare staff, and most important, feedback from Members. The Mapping Member Journeys Project had 3 phases:

- **Discovery:** interviewed key UCare stakeholders and staff to create hypothesis journey maps.
- **Member Immersion:** consisted of 30 virtual interviews with a variety of Medicaid Members, which yielded invaluable insight and a heightened appreciation for our diverse Members.
- **Action:** organized a cross-departmental group to live and breathe the Member experiences we recorded in order to design a Future State map. The findings were analyzed and integrated into detailed, functional journey maps with a simplified example.

The added value of this exercise is that for many organizations, Member experience efforts get lost in a sea of spreadsheets and tables. When the Member Journey is highly visual and easy to understand, it becomes much easier to galvanize internal support. By concretely mapping touchpoints, pain points, and moments of engagement, UCare can identify areas where Member expectations may be met or unmet. This alignment allows UCare to tailor services to better meet Member needs, enhance satisfaction, and address pain points more effectively and quickly. UCare also uses Member journey maps as valuable tools for internal staff and Provider training by offering a comprehensive understanding of the Member experience.



Summary

As UCare looks to the future, we take immense pride in achieving unparalleled Member engagement and satisfaction. Through our steadfast dedication to understanding and meeting the diverse needs of our Members, we have fostered an environment where their well-being is at the forefront of everything we do each day. We achieve this by continuously monitoring performance, actively engaging Members in feedback, employing both quantitative and qualitative methods, analyzing and applying Member experiences, and mapping out Member journeys to enhance the Member experience to the highest standards of excellence. We look forward to applying our approach to serve the health care needs of KanCare's valued Members.

6. Describe the bidder's approaches related to the following with respect to the bidder's Provider directory for KanCare:
   a. The elements of information included, beyond those specified in the RFP, for each participating Provider.
   b. The bidder's approach to developing, maintaining, validating, and monitoring the accuracy of the information in its Provider directory.
   c. The features of the bidder's online, electronic Provider directory that promote Member usability.
   d. The bidder's strategies to reduce Provider burden associated with providing information to create and maintain an up-to-date Provider directory.

Ensuring KanCare Members can easily find a Provider best suited to meet their needs is foundational; therefore, it is essential to ensure that Members have access to the most current information. Our KanCare Provider Directory will include all attributes required by the State, per RFP Section 7.10.8, as well as other Provider characteristics we have found valuable for Members in choosing the type of Provider they need. Additionally, in meeting with Providers and Provider associations in Kansas throughout the past year, we often heard about the high administrative burden experienced by Providers, often amplified by workforce shortages. UCare employs effective strategies to address and reduce Provider administrative burden related to maintaining Provider Directory information. Together we are able to connect Members with Providers at the right time, in the right location, and in the easiest manner possible. UCare is committed to making available the most accurate, up-to-date Provider information for our Members, while continuing to improve processes for Providers to update their information as efficiently as possible.

A. Elements of Information

UCare consistently produces timely, accurate, comprehensive Provider Directories for our Members. In addition to the State's required directory elements, such as Provider types, demographic information, hours of operation, and group affiliation, UCare includes additional Provider information in our Provider Directory listing, such as licensure, accreditation, special needs accommodations, cultural competency training, and the Joint Commission quality information for hospitals. UCare's online Provider Search Tool also displays an interactive map with directions. Our Provider Directory will be available to KanCare Members on UCare's website and on paper in both English and Spanish. UCare is committed to exceeding compliance with RFP section 7.10.8.

Further, in 2024, we are adding a new search experience that includes the ability to collect and display customer ratings, Provider service areas, and public transportation availability.

B. Provider Directory Approach

UCare uses a multipronged approach to develop, maintain, validate, and monitor the accuracy of our Provider Directory, including:

- A dedicated team is responsible for producing a compliant, accurate, and timely Provider Directory. In compliance with RFP section 7.17.2, UCare will have a full-time Network Management and Contracting Director/Manager in Kansas to oversee this function.

- The team ensures the Provider Directory models are refreshed every 30 days and a printed copy can be sent to a Member within three days.
- Control Total Reporting and Monitoring ensure accurate daily refreshes.
- Cross-functional teams with one party responsible ensure final delivery.
- NCQA accreditation ensures we are producing directories appropriately and delivering the best product to our Members.

Step 1: Gather

UCare collects Provider demographic data elements during the initial network contracting process and provides various online tools and procedures for Providers to update this information on a regular basis. Providers are required to complete a series of contract intake forms with their legal, demographic (including hours of operation and if they are accepting new patients), and medical specialty and services information. Our contracting process also requires Providers to comply with the ADA for office accommodations, identify their spoken languages, and identify any cultural competency training.

We offer transparency tools for our Providers to view and update location names, addresses, phone numbers (including TTY capabilities), Provider types/specialties/special services, any restrictions (such as ages served), the Provider's group affiliations, hours of operation, after hours information, website information, accepting new patients indicators, cultural and linguistic capabilities, and accessibility information.

Tools

UCare uses ServiceNow, an electronic software tool, to collect, maintain and store our contracted Provider data. The State and UCare may determine we need to collect new and/or different Provider data elements in Kansas. The ServiceNow tool and corresponding data program, along

with UCare's dedicated Information Technology (IT) team, ensures flexibility to quickly shift gears and begin capturing those data elements. Our agile, experienced IT team and leading-edge technology can engage online survey tools to collect, store and report Provider data as rapidly as possible.

Step 2: Verify

UCare uses appropriate verification processes and tools to check Provider licensure, criminal history, if they are accepting new patients, ADA accessibility requirements, and completion of cultural competency training.

Provider Background and Certification

We check State and Federal exclusion from Medicaid or Medicare at the time of contracting and on a monthly basis. We send Provider data to Streamline Verify to check Providers against 46 exclusion databases to ensure Providers are eligible to be paid for Medicaid or Medicare services. These databases include 43 State and three Federal databases: CMS preclusion, Federal Office of Inspector General (OIG), and System for Award Management (SAM). We also check the National Provider Identifier (NPI) deactivation list and other available State-specific Provider files for changes in Providers' eligibility. If a Provider is found on any of these lists, UCare will either not contract, put the Provider on immediate payment suspension, or adjust our payment rates based on special status. UCare ensures appropriate licensure/certification, State Medicaid participation status as appropriate, proper insurance, and history of regulatory fines/citations.

Council for Affordable Quality Healthcare (CAQH)

UCare uses this nationally recognized practitioner application database system to obtain practitioner applications. This system allows practitioners to enter information once and share it with all plans they authorize, which reduces administrative burdens and errors and allows practices to focus resources on serving Members. Our Credentialing team works with our Provider Data Validation team when discrepancies in location data are found. Credentialing ensures that practitioner data is validated and accurate at the time of initial and recredentialing, or whenever any Adds, Changes or Termination requests are made.

Tools

We verify and update this information using a variety of internal and external third-party tools and databases, such as Quest Analytics and LexisNexis. These tools are state-of-the-art in the industry for maintaining reliability in Provider network information. To maintain UCare's network accuracy standards, dedicated staff personally contact a random sample of Providers each month to verify their information and correct any information that needs updating.

Step 3: Update and Maintain

UCare's Provider Directory is essential for our Members' access to and information regarding Providers' locations, types of services, cultural competencies, and disability accommodations. UCare continuously improves our management of Provider data by investing in the tools, processes, and people that help us better analyze and describe our Provider network. We ensure our Provider information is as current and comprehensive as possible. As our Provider Directory is dependent upon information from our network Providers, we offer them easy ways to notify us of changes, including UCare staff who reach out directly to Providers and self-service options for Providers to update their information.

In 2022, UCare implemented improvements in our contracting process by deploying a Provider Contract Management tool built with the configurable ServiceNow platform. The improvement reduced manual data entry and unified and automated the contracted Provider data collection process. Our Members benefit from the efficiency of UCare's streamlined and highly accurate process as our contracted Provider data and executed agreements exist within the same database. Several data quality checks are also included throughout the contracting processes.

UCare's monthly data accuracy monitoring process includes calling 100 to 150 randomly selected Providers to validate existing data and document updated data about Providers at the location, check appointment availability for established and new patients, and verify accuracy of phone numbers and addresses. Updates are promptly corrected in the Provider database. Any standards not met are reported to the Provider's UCare Contract Manager for outreach and corrective plan discussion.

Tools

We use several tools to provide up-to-date Provider information. We use the National Plan and Provider Enumeration System (NPPES) database and implemented NPPES as it was highly recommended by CMS and required to be used by Providers, though other health plans are not taking advantage of this national database. Once a month, UCare compares our Provider data to that in NPPES and corrects any discrepancies. We also use LexisNexis to compare UCare's Provider-reported location data to their market wide databases of Providers practicing at specific locations. We correct any discrepancies found by this tool, such as phone number, location, deceased or retired Providers, and other demographic changes. Since the beginning of 2023, UCare has been able to correct 6% of our Provider directory data using this tool.

C. Features that Promote Member Usability

In compliance with RFP section 7.10.8, within the Provider directory, Members will be able to search for a variety of Provider types by location, including:

- Physicians — primary care Providers (PCPs) and specialists
- Vision
- Dental, including sedation dental Providers
- Behavioral health Providers
- Hospitals and clinics
- Pharmacies
- LTSS Providers

UCare's easy to access, easy to use, comprehensive Provider Directory ensures our Members have access to the information they need to find the Provider that's right for them.

UCare's online Provider Search Tool landing page offers ease of use for Members:

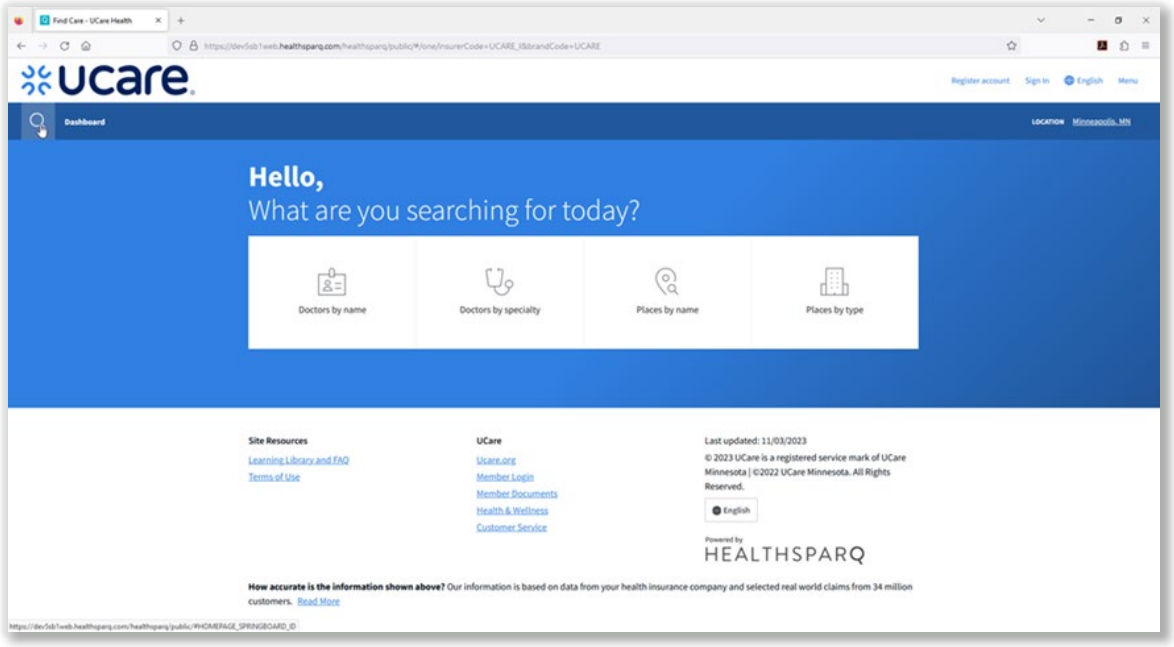


Figure 6.1: UCare's online Provider Search Tool landing page.

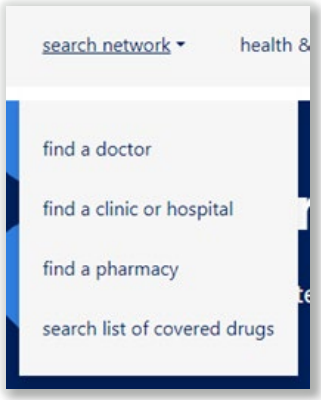
In accordance with RFP section 7.10.4, as well as to facilitate Member usability, our online Provider search tool is easy to navigate and worded at or below a sixth grade reading level.

Member Driven

UCare's Member Experience and Digital Marketing teams continuously review Member feedback and use Member research to improve our online tools and ensure they are best-in-class.

Our online Provider search tool makes it easy for Members to identify which physicians, hospitals, and pharmacies are within UCare's network. To ensure the highest standards for Members, the search tool undergoes routine, extensive usability testing. Our usability testing confirms that UCare's Provider search tool is efficient, convenient, and enjoyable for Members.

In 2022 we completed an analysis evaluating the usability of the Provider search tool. We uncovered overall system and specific search tool insights, derived from five key task flows that were identified as vital to the goals of the user group and the affordances of the tool. In line with user experience industry standards, we analyzed each task flow from a heuristic point of view, in reference to Jakob Nielsen's Ten Usability Heuristics. Our analysis results identified several strong qualities of UCare's online Provider search tool:



On ucare.org, **users can access the tool in various ways**. Specific links provide shortcuts for the user, linking them directly to the portion of the tool they are seeking. This provides flexible and efficient use, accommodating first-time users and returning users.

Figure 6.2: UCare's Provider search tool shortcut links.

The presence of breadcrumbs and the 'Return to results' button offer users **the opportunity to return to a previous page without losing their search results**. This affords the user control and freedom in their experience.

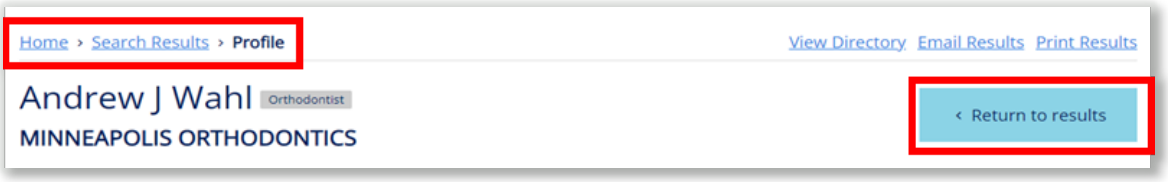


Figure 6.3: Example of 'Return to results' on UCare's Provider search tool

When a user switches search category tabs after initially entering search criteria, **their criteria remain in the fields**. This contributes to a flexible, efficient, and convenient user experience.

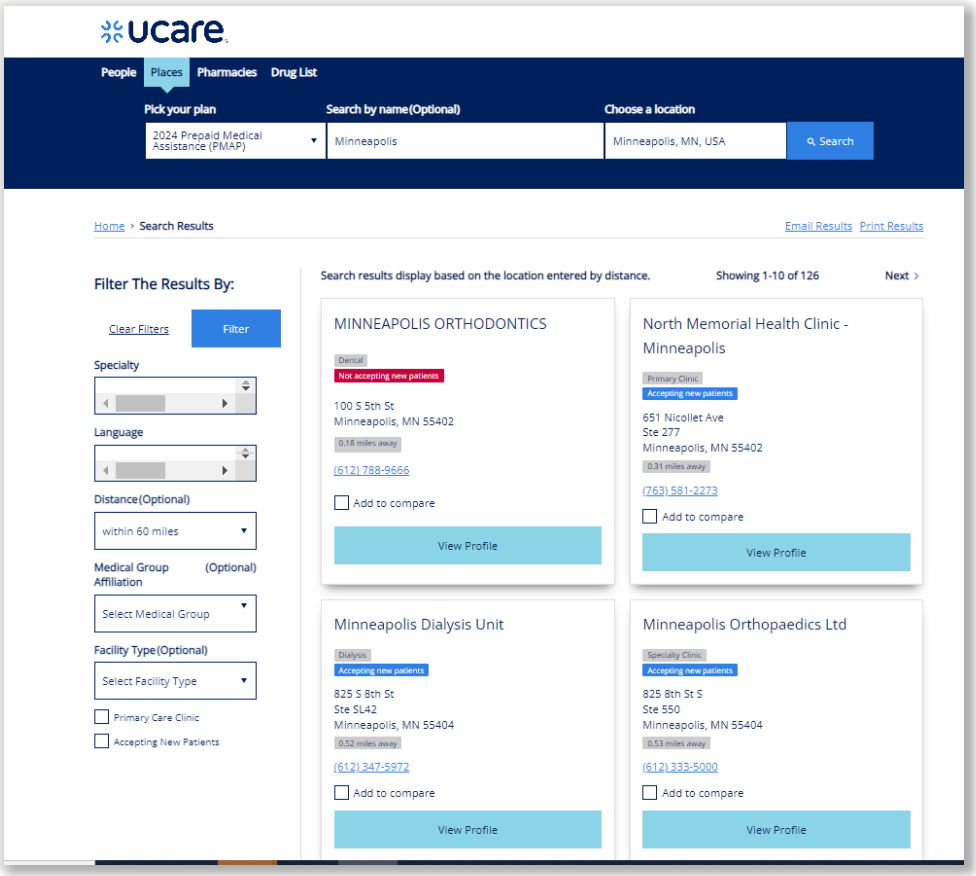
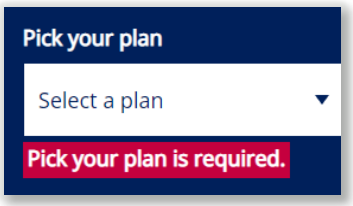


Figure 6.4: Screenshot of UCare's Provider search tool



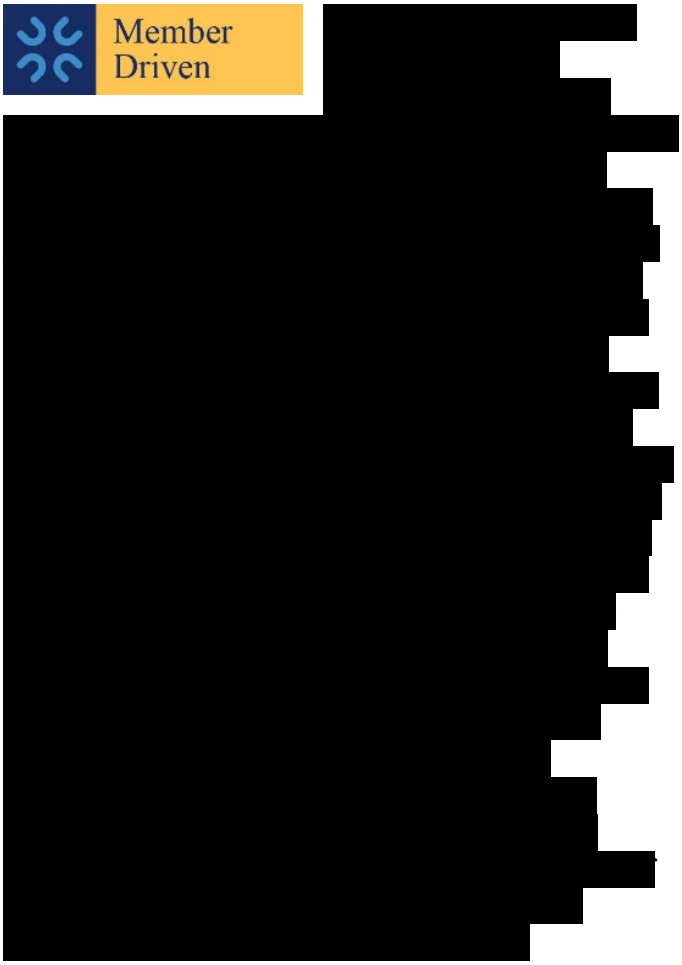
When a user attempts to search with insufficient criteria, **the system provides a visual cue to indicate where and how changes must be made**. This helps the user recognize, diagnose, and recover from errors.

Figure 6.5: Example of visual cues used in UCare's Provider search tool.

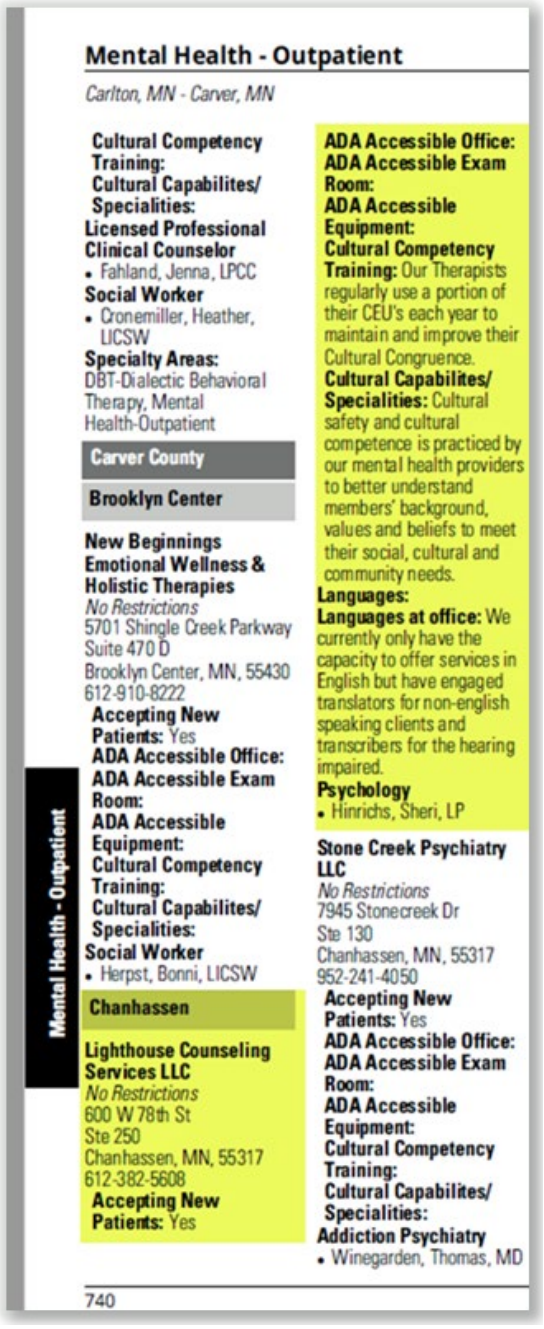
The results of the 2022 usability study were overwhelmingly positive: users are very happy with the search tool. Some of the top insights from this study include:

- 100% of participants could obtain directions to a location easily. This demonstrates that the tool's primary function is an easy experience for Members.
- Participants enjoyed the overall aesthetic of the website and noted that the pages are easy to read. This assures us that when Members engage with this tool, they are comforted by the simple and precise interface.
- Participants appreciated the option to use filters for their results. One participant noted, "It seems comprehensive...it kind of directs me. It gives me the answers that lead me to make choices that apply to its parameters." This tells us that Members appreciate the customized experience this tool offers.

Planned Improvements



In developing our online tools, we consider our Members' unique and varied needs and circumstances. UCare has evolved in the ways we



Mental Health - Outpatient

Carlton, MN - Carver, MN

Cultural Competency Training:
Cultural Capabilites/ Specialities:
Licensed Professional Clinical Counselor
- Fahland, Jenna, LPCC

Social Worker
- Cronemiller, Heather, LICSW

Specialty Areas: DBT-Dialectic Behavioral Therapy, Mental Health-Outpatient

Carver County

Brooklyn Center

New Beginnings Emotional Wellness & Holistic Therapies
No Restrictions
5701 Shingle Creek Parkway
Suite 470 D
Brooklyn Center, MN, 55430
612-910-8222
Accepting New Patients: Yes
ADA Accessible Office:
ADA Accessible Exam Room:
ADA Accessible Equipment:
Cultural Competency Training:
Cultural Capabilites/ Specialities:
Social Worker
- Herpst, Bonni, LICSW

Chanhassen

Lighthouse Counseling Services LLC
No Restrictions
600 W 78th St
Ste 250
Chanhassen, MN, 55317
612-382-5608
Accepting New Patients: Yes

ADA Accessible Office:
ADA Accessible Exam Room:
ADA Accessible Equipment: **Cultural Competency Training:** Our Therapists regularly use a portion of their CEU's each year to maintain and improve their Cultural Congruence.
Cultural Capabilites/ Specialities: Cultural safety and cultural competence is practiced by our mental health providers to better understand members' background, values and beliefs to meet their social, cultural and community needs.
Languages:
Languages at office: We currently only have the capacity to offer services in English but have engaged translators for non-english speaking clients and transcribers for the hearing impaired.
Psychology
- Hinrichs, Sheri, LP

Stone Creek Psychiatry LLC
No Restrictions
7945 Stonecreek Dr
Ste 130
Chanhassen, MN, 55317
952-241-4050
Accepting New Patients: Yes
ADA Accessible Office:
ADA Accessible Exam Room:
ADA Accessible Equipment:
Cultural Competency Training:
Cultural Capabilites/ Specialities:
Addiction Psychiatry
- Winegarden, Thomas, MD

Mental Health - Outpatient

740

Figure 6.2: Directory listing

collect Provider information and what information we collect, such as accessibility for individuals with disabilities and a Provider's cultural competency. Recent State Medicaid Provider directory requirement changes and our application efforts for NCQA Health Equity Accreditation have prompted UCare toward collecting richer data regarding Provider cultural competency. We work with our Providers to understand if they have had cultural competency training, and if so, what kind. We also collect and report to Members the types of cultural competency capabilities and specialties offered at Provider locations. We have also enhanced our current language collection process to include language services offered at Provider locations. These elements are reported in UCare's Provider Directory so Members can more easily navigate to Providers that offer culturally congruent care.

D. Strategies to Reduce Provider Burden

We know that administrative burden is a significant concern for Providers, who often spend a lot of time updating not just the Medicaid payers, but also Medicare, ACA-QHP, and commercial payers. To help reduce this burden, UCare offers online tools and other supports to make their work easier, including:

- **Online Forms:** We offer a variety of online forms facilitating directory efficiencies, including those associated with joining our network, credentialing and recredentialing, and managing Provider information.
- **Provider Data Accuracy Tool (PDAT):** Providers can review data and submit changes through the PDAT. In 2024, we will be rolling out an enhanced comprehensive tool that will be housed in our Provider Portal and will facilitate additional efficiencies for our Provider partners.
- **Call Center:** UCare maintains a dedicated Provider call center with live representatives answering the phone to assist Providers navigating our systems, provide information, and help them better serve our Members.
- **Provider Field Representatives:** These representatives are a single, dedicated point for contact for Providers to reach out to for information, education and training, questions, and assistance resolving any issues in order to avoid escalated problems.

UCare strives to ensure that our processes continue to be the most effective and optimized as possible, including ways to ensure quick and accurate Provider enrollment in our claims systems. In our Provider data section, this has been illustrated vividly over the last five years through claims platform upgrades, unified Provider contracting data system implementation, credentialing database enhancements and process automation through controlled, automated computer script.

[redacted]

[redacted]

Summary

UCare understands the requirements outlined in RFP section 7.10.8 and recognizes the importance of presenting the most current, accurate Provider Directory information for KanCare Members. Our goal is to make care easier for Members to find and ensure their experience is positive and supporting. Additionally, UCare acknowledges the administrative burdens faced by Providers, well beyond those tied to communicating information to payers and the State for Provider Directory output. This is backed by our continuous improvement to collect, validate and monitor data to ensure a positive Member experience and reduce Provider burden. UCare is dedicated to ongoing work with the State and Providers to continue to streamline, improve processes, and ensure accurate information in order to best serve our Members in Kansas.

Tab 7c:

TOPIC AREA 3

Integrated, Whole-Person Care

7c. Integrated, Whole-Person Care

7. Describe the bidder's proposed MCO staffed Care Coordination model for KanCare and include the following in the bidder's response:
   a. The bidder's proposed Care Coordinator staff distribution and location.
   b. The bidder's approach to avoiding duplication of Care Coordination with delegated or other models of Care Coordination (e.g., Community Care Coordination, targeted case management [TCM (Targeted Case Management)], Certified Community Behavioral Health Clinic [CCBHC], OneCare Kansas).
   c. The roles, responsibilities, and functions for staff performing Care Coordination responsibilities.
   d. The bidder's approach and strategies to effectively engaging Members, particularly those who may be more challenging to engage, to participate in Care Coordination.
   e. The bidder's proposed Care Coordination caseload ratios, process for establishing ratios, and the approach for monitoring to ensure ratios are adequate to meet Care Coordination requirements.
   f. Case assignment considerations and how the bidder monitors and manages vacancies to ensure Member's continuity of care.
   g. How the bidder's Care Coordination program will identify and support the needs of Members who are not on a 1915(c) HCBS (Home and Community Based Services) Waiver and have a temporary or transitional need for Care Coordination.
   h. How the bidder's Care Coordination program interfaces with its disease management resources and activities.
   i. The bidder's processes and systems that will be used to share and exchange information with those involved in the care and treatment of the KanCare Member to optimize integrated, longitudinal, whole-person care.
   j. The bidder's approach to monitoring and ensuring that KanCare Members receive necessary services, supports, and resources necessary to improve individual and population outcomes.

Integrated Care Pioneer

UCare brings more than three decades of successful Integrated Care Coordination and Managed Long Term Services and Supports (MLTSS) program operations to Kansas. We have been offering Integrated Care Coordination since 1989, and are recognized in our market and nationally as the expert health plan working with individuals with disabilities.

UCare's FIDE-SNP (Full Integrated Dual Eligible Special Needs) MLTSS plan utilizes the proposed Integrated Care Coordination model for KanCare. This model was part of a program evaluation sponsored by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

UCare is the largest FIDE-SNP MLTSS plan supporting older adults in our market meeting the needs of approximately 40% of program participants across nine MLTSS plan options.
Similarly, in the HIDE-SNP Medicaid managed care program for individuals with disabilities, we are the largest plan in our market, supporting about 60% of the population across seven plan options.

The study concluded that fully integrated care models such as the one developed by UCare improve outcomes, with the following key results for Members:

- 48% less likely to have a hospital stay
- 2.7 times more likely to have a primary care physician visit
- 13% more likely to access Home and Community Based Services
- 6% less likely to have an ED visit

Integrated Care Coordination Expertise: Our history with actively managing all Members needing physical, specialty, mental health, and social supports, including those receiving Home and Community Based Services (HCBS) and other Long-Term Services and Supports (LTSS), is long and tells a story of extremely close partnership with the state to evolve and innovate. We have consistently delivered integrated whole person care that positively impacts Member health outcomes. UCare has a well-earned reputation for excellence due to our close work with the state and meaningful partnerships with Members, community-based organizations, and Providers. UCare is widely recognized as a pioneer in the development of integrated care.

> UCare is a national leader in complex populations and integrated products. UCare is one of the first plans to offer a fully integrated Medicare & Medicaid product that includes LTSS.

UCare's deep expertise and proven record of accomplishment in providing care coordination to our Members positions us for new opportunities to further success and innovation that will benefit Kansans. Our care coordination approach to our Members meets all regulatory requirements and is focused on improving Member outcomes and experiences through integrated service that approaches care holistically, longitudinally, and with the Member at the center.

UCare's Integrated Care Coordination Model

UCare has developed the most comprehensive approach to engage and support Members. Our model is focused on meeting the needs of our Members and putting Members at the center of their care team. Our approach is guided by our organizational values of:

- Integrity
- Community
- Quality
- Flexibility
- Respect

Utilizing our mission and values as the building blocks for our care coordination model has led to the development of a model that is:

- Holistic
- Person Centered
- Goal Oriented
- Culturally Relevant

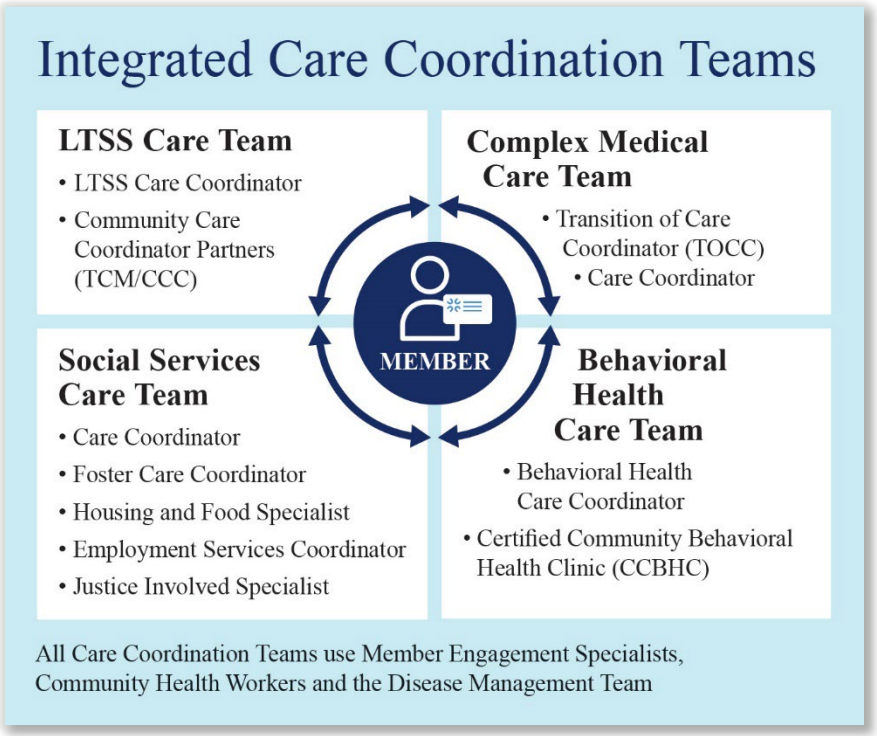
UCare's Integrated Care Coordination model takes a collaborative approach to evaluate, plan, facilitate, advocate, and provide comprehensive services to meet Members' needs. We do this in close partnership with our Members, their caregivers, and other interdisciplinary care team members, as identified by the Member, to provide person-centered care.

Our Integrated Care Coordination model is designed to address the needs of all Members with thoughtful consideration of their lived experience, environment, including rural, frontier and urban regions, service availability, and the goals of the Member, and is tailored to the varying demographic needs across Kansas.

Member Driven

We integrate all services the Member receives into a system of care, incorporating physical health, behavioral health (BH) and LTSS, including HCBS and social determinants of health (SDOH) factors that impact health outcomes and quality of life, such as transportation, housing, food, and employment.

The UCare model focuses on individual Member needs in an integrated, holistic, trauma-informed, person-centered strategy designed to provide equitable access to care and reduce disparities. UCare's program design allows for improved coordination while addressing the Member's short- and long-term needs to provide longitudinal care for Members. We understand our fiscal responsibility to Members and the State of Kansas, and we provide supportive, effective, timely, and cost-effective services in the least restrictive setting possible. Our Integrated Care Coordination model meets the requirements set forth in RFP Section 7.4. and will be submitted to the State for approval. UCare will be an active participant in the KanCare Care Coordination Collaborative to ensure services are consistent and best practices are used across Kansas (7.4.17).



[redacted]

People Powered

[redacted]

[redacted]

B. Approach to Avoiding Duplication of Care Coordination

[redacted]

[redacted]

Participation of the Member and Caregiver

The Member and caregiver are at the heart of our Integrated Care Coordination model. UCare's staff is responsible for coordinating care across the full continuum. This requires our Care Coordination Team to collaborate with Members, caregivers, community care coordinators, TCM, and Providers to engage, assess, develop, implement, coordinate, monitor, and evaluate Person-Centered Service Plans, Plans of Service, or care plans for any new, ongoing, or unmet Member needs. These processes support our longitudinal approach to Member care.

Localized Approach to Care

Authentic Provider Relationships

UCare's Care Coordination model was designed to provide Care Coordination at the local level, working with local Providers. This localized model provides a greater knowledge of all services available to the Member and caregiver in their local area with greater access to respond to any questions and needs they may have, with the most localized expertise possible. The majority of Care Coordination is completed by counties, care/clinic systems and local nonprofit community-based organizations so that our Members get the most localized approach to their care possible.

UCare has offered Care Coordination at the local level through delegation agreements with counties and CBOs. For more than 20 years, UCare has utilized delegated care coordinators in the Member's local community to perform all care coordination-related functions.

Delegated Model of Community Care Coordination Partners

[redacted]

[redacted]

OneCare Kansas

UCare also supports Members interested in OneCare Kansas (OCK), a Medicaid program option for eligible Members (as outlined in the OCK program manual), to receive coordination of physical and behavioral health care with long-term services and supports.

The OCK service delivery model is designed with care coordination and integration at the forefront to ensure access to appropriate services, improve health outcomes, promote the use of Heath Information Technology (HIT), and avoid duplicative services or unnecessary care.

[redacted]

UCare understands the value of the OCK program to our Members. To promote the development of the program UCare will invest in our OCK Partner relationships, participate in the OCK Learning Collaborative, and have a designated OCK Manager. To achieve this, we will foster effective and trusting relationships with our OCK Partners through regular collaboration, at

minimum quarterly meetings, and an annual audit. This communication and audit process enhances our ability to meet all the OCK program manual and OCK State Plan amendment requirements. UCare will also participate in the OCK Learning Collaborative to further enhance and support best practices with the OCK program. UCare's OCK Manager will serve as a State contact and participate in regular meetings with KDHE and stakeholders.

Shared Communication Platform

[redacted]

Process Oversight

Trusted Government Partner

It is imperative to ensure each person engaged with a Member and caregiver understands their roles, responsibilities, and the importance of seamless and transparent coordination to mitigate duplication and service gaps. To ensure efficient use of resources and avoid duplication, [redacted]

UCare is committed to improving health outcomes for all our Members with the support of our community partners. We will work with credible and trusted community partners and Providers to further our commitment of improving care.

When engaging external partners and Providers, UCare has established processes to avoid duplication of Member engagement, which improves Member experience and reduces Member abrasion. This partnership model has proven successful in our current markets, and UCare believes a similar model will be successful in Kansas in rural, frontier and urban counties.

C. Roles and Responsibilities of Care Coordination Staff

At UCare, we truly believe our staff are our greatest asset. We understand that the right hiring practices are instrumental in identifying and attracting the best talent, which is essential for the success of our organization. Our recruitment process is designed to ensure we hire individuals who share UCare's values and are enthusiastic about contributing to our mission.

By placing a strong emphasis on our employees and hiring practices, we strive to create a work environment that is both fulfilling and productive. We are committed to hiring individuals who share our core values of Integrity, Community, Quality, Flexibility, and Respect. Our goal is to connect with our Members personally and truly understand their unique needs. We are compassionate stewards of person-centered service, ensuring we are available for our Members as a part of our longitudinal approach to care.

UCare, as a culturally inclusive and sensitive organization, recognizes the importance of equitable opportunity for employment. [redacted]

Care Coordinator Functions

Our program relies on fundamental processes to ensure effective care coordination, including the following foundational elements:

- Conducting Health Screens and Health Risk Assessments (HRAs)
- Identifying and engaging Members in Care Coordination
- Ensuring compliance with the HCBS settings rule for Members enrolled in an HCBS waiver
- Coordinating and maximizing Medicare services for Members eligible for both Medicare and Medicaid
- Monitoring and oversight of Members' services and health and welfare, including outcomes
- Engaging Members and their physical, LTSS, HCBS and behavioral health Providers to ensure optimal communication and coordination
- Integrating services across Providers, including engaging Members and Providers to improve integration
- Promoting and supporting Providers treating behavioral health conditions in the primary care setting
- Conducting Needs Assessments as indicated by the Health Risk Assessment to ascertain additional information for targeted Care Coordination

- Ensuring a person-centered service planning process for developing and implementing the Person-Centered Service Plan (PCSP), Plan of Service (POS) or care plan
- Ensuring Transitions of Care across the continuum of care settings
- Providing information and referral processes for optimal care
- Effectively communicating with the Member, their family, PCP, other Providers, and members of the Member's Interdisciplinary Care Team
- Engaging Providers in Care Coordination and building working relationships
- Assuring referrals for Medically Necessary specialty, secondary, and tertiary care
- Providing trauma-informed care and evidence-based practices
- Identifying and addressing Members' SDOH needs and increasing community integration
- Engaging, contracting, and partnering with community-based organizations
- Subcontracting and partnering with local entities for the provision of Community Care Coordination
- Obtaining consent from Member to share PHI across physical health, behavioral health, and LTSS Providers when such consent is required
- Abiding by HIPAA and 42 CFR Part 2
- Assuring the provision of care in emergency situations

[redacted]

People Powered

[redacted]


Integrated Care Coordination Teams
Integrated
Care Pioneer

[redacted]

Key Personnel

Our staff members are highly skilled and dedicated to providing exceptional care to Members and caregivers, as well as collaborating with Providers and community partners. They have the skill sets necessary to provide exceptional care across populations and also bring a passion and thoughtful understanding of the critical roles they play in Members' and caregivers' lives. UCare will hire the required positions outlined in RFP Section 7.17.2, including but not limited to those outlined below.

- Full-time medical director or CMO (Chief Medical Officer)
- Full-time LTSS and HCBS clinical officer/medical director (LTSS CO/MD)
- Full-time care coordination director/manager
- Full-time transition of care coordinator
- Full-time staff person to oversee housing services and supports for LTSS, HCBS, and behavioral health programs and services.
- Full-time LTSS and HCBS director/manager
- Full-time behavioral health medical officer/medical director (BH-CMO)

One (1) or more pharmaceutical, LTSS and behavioral health Provider representatives

- Full-time EPSDT coordinator
- One (1) staff member responsible for oversight and coordination of subcontractors and delegated entities
- Designated OneCare Kansas (OCK) manager
- Designated oral health director/manager
- Designated workforce development director/manager
- Full-time foster care coordinator
- Three (3) full-time Member advocates
- One (1) for LTSS
- One (1) for Behavioral Health

- Full-time behavior supports director
- Full-time pharmaceutical director
- Full-time employment services and supports coordinator
- Dedicated staff trainer
- One (1) for HCBS
- Designated health equity director/manager
- Fulltime UM health services director/manager

UCare will review the needs of the population and hire additional staff to support our Members beyond these required positions, especially in areas of training, serving justice- involved individuals, workforce, and foster care.

In addition to our commitment to hire more than the required number of positions listed above. UCare has identified the following positions to further support our Integrated Care Coordination model in Kansas:

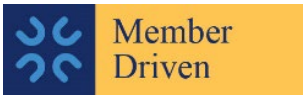
[redacted]

UCare will contract with local entities to perform community-based Care Coordination and TCM. Although these roles are not UCare staff, they are vital to the care of our Members and core to the interdisciplinary team imperative to the success of our model. The CCCs and TCMs will be in the Member's community, be knowledgeable about local resources, and function as the Member's primary contact.

At UCare, we understand that our Members have unique needs and challenges, and we want to provide care that is not only comprehensive, but also empathetic and compassionate. Our team,

along with our community partners and Providers, is committed to delivering person-centered care that respects and values our Members. We are dedicated to coordinating services and supports efficiently and without duplication, taking care to understand the diversity of our Members' needs. Our ultimate goal is to create a supportive, caring environment that helps our Members achieve optimal health and wellness, and we will be with them every step of the way.

D. Approach and Strategies for Member Engagement



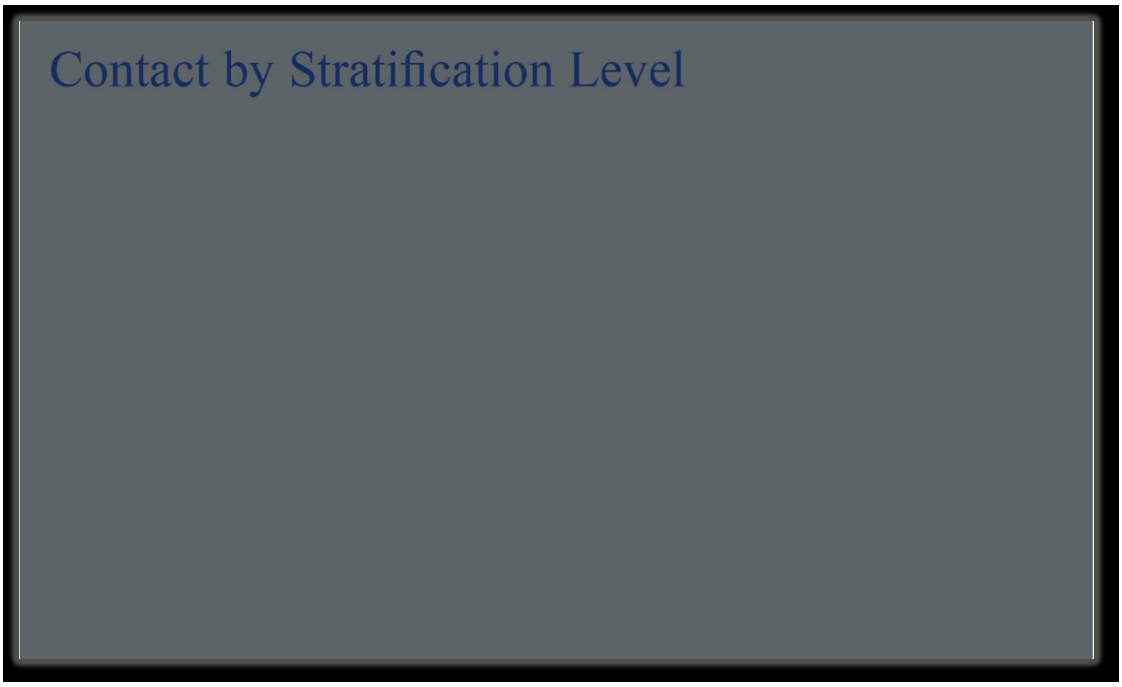
UCare's Member engagement philosophy is rooted in our belief in delivering care in a person-centered, compassionate manner that respects a Member's dignity, race, and culture. Connecting Members and caregivers to racially and culturally relevant care is an essential component of UCare's Member engagement strategy. Engaging Members in their primary language and with Care Coordinators who share their cultural background helps set a familiar tone for the Members' increased engagement in Care Coordination.

[redacted]

E. Establishing and Monitoring Care Coordination Caseload Ratios

UCare has intentionally developed our Care Coordination approach to support individuals who are aging, have behavioral health needs or disabilities, and may need LTSS and HCBS or other resources, such as maternal health services, housing, transportation, and food. To accomplish this, we are dedicated to care coordination caseload ratios that consider the acuity, complexities, and varying needs of the populations. Care Coordinators will meet fidelity model requirements. Our Care Coordinators are hired based on qualifications including educational degrees, licensure, years of experience and specializations, such as adult, child, complex, multiple chronic condition management, behavioral health, substance abuse, and waiver expertise. Our Care Coordinators, and support teams are well-trained and well-versed in meeting the requirements for the specific populations as defined in RFP Sections 7.4.10, 7.4.11 and Appendix L.

[redacted]



[redacted]

[redacted]

F. Case Assignment Considerations and Monitoring Vacancies

Member Driven

[redacted]

Best Practice — Transitioning Care Coordinators:

- The current Care Coordinator will introduce a new Care Coordinator personally.
- The new Care Coordinator reviews the member's PCSP/POS and utilization trends and discusses any other Member interactions or specific needs with the ICT support personnel who may have assisted or are assisting the Member.
- It is imperative to have seamless transitions for the Member and the Care Coordinator to understand the Member's past and current needs before meeting them.

[redacted]

[redacted]

G. Addressing the Temporary Care Coordination Needs of Members Not on an HCBS Waiver

UCare's Integrated Care Coordination model will identify and support the needs of Members and their caregivers who are not on a 1915(c) HCBS waiver and who have temporary or transitional care coordination needs. UCare will identify these Members using advanced analytics and predictive modeling as well as data provided from the State or CDDO.

[redacted]

[redacted]

Member Story

[redacted]

True Community Non-Profit

[redacted]

[redacted]

H. Interfacing with Disease Management Resources and Activities

Our Care Coordination Team works to identify the needs of our Members through various health screenings, assessments, and interactions with Members, caregivers, Providers, community partners, pharmacy, and others who regularly interact with the Member. Any of these interactions may result in a referral to our Disease Management (DM) programs for Members with certain conditions who may benefit from additional education and targeted care. Additionally, we analyze claims data to identify certain chronic conditions and utilization, and predictive modeling to ensure Members with conditions that will benefit from DM are identified and offered these exceptional programs. To meet the needs of those with certain chronic

conditions, our Care Coordinators and DM teams collaborate to provide specialized programs that enhance our Members' knowledge and control over their specific disease state.

UCare's DM programs improve Members' health through innovative approaches for asthma, diabetes, and hypertension. The programs take a holistic approach, as evidenced in our Education and Health Coaching programs focused on using in-house staff, vendors, and delegates to support Members in improving or maintaining their health. Our DM Team includes certified health coaches, respiratory therapists, registered nurses, and asthma educators.

[redacted]

[redacted]

I. Information Sharing to Optimize Integrated, Longitudinal, Whole-Person Care

[redacted]

[redacted]

[redacted]

[redacted]

J. Ensuring That Members Receive Necessary Services

UCare's Quality Program provides a formal process to monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and service objectively and systematically. A multidimensional approach with clinical, organizational, and consumer components enables UCare to focus on opportunities for improving processes, to determine program effectiveness in improving the health outcomes and satisfaction of Members and Providers, and to identify gaps. The Quality Program ensures that the health care and service needs of Members are being met and that continuous improvement occurs with the quality of the care and services provided by overviewing clinical processes (such as care coordination) and evaluating their effectiveness.

Member Driven

[redacted]

Summary

UCare's long-standing, leading model of Integrated Care Coordination positions us to surpass the requirements outlined in the bid request. With our collaborative approach, we will deliver a model that is comprehensive, efficient, and highly effective. Our team of experts will work to ensure that each Member receives the best possible care. UCare is committed to supporting the State's vision for KanCare as one of collaboration and partnership as well as excellence and optimal health outcomes for Members.

8. Community Health Workers (CHWs) and Community Health Representatives (CHRs) offer a unique and important role in outreaching, educating, and connecting KanCare Members to health care Providers, social service systems, and their MCO (Managed Care Organizations). Describe the bidder's approach to:
   a. Utilizing and promoting the use of certified CHWs/CHRs as MCO staff and/or Providers located within local communities across Kansas.
   b. Identifying the roles and responsibilities of certified CHWs/CHRs and providing the training necessary to support certified CHWs/CHRs to successfully perform their roles and responsibilities.
   c. Measuring, monitoring, and evaluating whether certified CHWs/CHRs are effectively fulfilling their roles and responsibilities to improve Member care, individual outcomes, and population health.

Over the last several decades, Community Health Workers (CHWs)/Community Health Representatives (CHRs) have been increasingly recognized for the unique role they provide Members in support of achieving their best health outcomes. CHWs/CHRs provide a foundation of culturally competent, local care, as well as bridge and rebuild trust, especially among Black, Indigenous, and immigrant communities. We applaud the recent steps Kansas has taken to integrate CHWs into Members' care teams, including the establishment of Medicaid coverage for certain CHW services in 2023. UCare was an early adopter of CHWs, beginning in 2007, and is a long-standing collaborator with CHW coalitions and advocacy groups. UCare also has demonstrated experience developing partnerships with organizations that employ CHWs/CHRs as well as finding unique opportunities to embed UCare-employed CHWs/CHRs into community Provider facilities. UCare will establish similar relationships and programs in Kansas to learn from and support the integration of CHWs/CHRs in unique ways to meet the preferred cultural and linguistic needs of Kansans and accomplish the State's KanCare vision and goals.

A. Utilizing and Promoting CHWs/CHRs

At UCare, we are dedicated to the enhancement of our Members' health and well-being. To support our responsiveness to Members' cultural and linguistic preferences, UCare has integrated certified CHWs within our care teams. We employ CHWs who represent the communities they serve to help identify and remediate health disparities Members may experience. UCare will employ CHWs/CHRs to serve and support KanCare Members and will work together with the State and local communities to promote integration of CHWs/CHRs into care teams. Our experience and proven outcomes with CHWs highlight our commitment to this objective and are detailed below.

CHWs/CHRs on the UCare Care Coordination Team

UCare has worked with CHWs for 16 years. Throughout these years, UCare's CHWs have successfully met the unique needs and preferences of Members. UCare's workforce looks like and has similar lived experience as our Members. This increases our ability to understand and better engage with our Members and meet their needs as they continue to evolve. For example, some of our Member-facing representatives or community-based workers have been enrolled in a Medicaid program in the past, including some who were UCare Members. This lived experience brings a high level of understanding and connection to the services we provide, especially as they screen for social determinants of health (SDOH) and follow up with resources to specific populations.

While Members open to care coordination will have a face-to-face visit with their care coordinator, CHWs help obtain additional information about the Member's situation and preferences. For example, a diabetic Member taking insulin needs to keep their medication refrigerated. The CHW may discover the Member's home has no electricity due to late utility bills and therefore does not have safe storage for their medicine, which may then contribute to more frequent emergency department (ED) visits or other challenges. CHWs are uniquely positioned to establish trust with the Member and support with referrals and applications for community resources (e.g., Low Income Home Energy Assistance Program) as needed.

UCare also recognizes that CHRs serve an important role for Native American and Indigenous populations, and we currently employ a CHR at UCare who works with our Members. We look forward to partnering in Kansas with CHRs employed by Tribal Nations such as the Kickapoo Tribe and other Indian Health Service and Tribal Health Facilities, as appropriate, in collaboration with our County and Tribal Relations Team. Additionally, UCare recognizes the importance of Promotoras for Hispanic/Latino communities and has partnered with and provided grants to organizations that employ Promotoras to bring remedies and health advice directly to Members. Our commitment to strong partnerships with community Providers allows UCare's Integrated Care Coordination model to engage with CHWs/CHRs already in the communities, and familiar with our Members, to coordinate with Members as part of the Interdisciplinary Care Team.

UCare's CHWs/CHRs will also walk alongside KanCare Members as part of the Interdisciplinary Care Team during their pregnancy journey. CHWs/CHRs offer connection to UCare's value-added benefits (VAB), and other supports such as connection to trimester education, scheduling obstetric appointments and transportation, finding solutions for any childcare issues the Member may have, advocate for the Member with their birthing plan, and coordinate postpartum and well-child/immunization visits. As part of our community-based approach, UCare-employed CHWs/CHRs will partner with Providers and Care Coordinators, and CHWs/CHRs in communities to help Members locate community resources, such as diaper drives or community baby showers for pregnant women, conduct outreach to communities where English is not the first language, and more.

[redacted]

CHWs within our Community Partnerships

UCare invests in and promotes the integration of certified CHWs as a part of our care teams. We have demonstrated experience and successfully collaborated with community Providers to bring UCare-employed CHWs directly to clinics. UCare also ensures that CHWs employed by community Providers who support UCare Members are included in discussions about Members' care. UCare also prioritizes relationships with professional associations and advocacy groups that support CHWs/CHRs. Currently, UCare's Senior Provider Relations leader serves as a Board Chair of a CHW Alliance. UCare will support and utilize similar collaborations in Kansas. For example, UCare sponsored and attended the Kansas Community Health Worker Coalition 2023 Annual Symposium in Wichita and looks forward to a continued a relationship with this group. Below are a few examples of the type of intentional partnerships we aim to tailor to and develop in Kansas.

Rural HUB Partnership

Authentic Provider Relationships

Since 2021, UCare has partnered with a Community HUB located in a rural/micropolitan area, similar to Pittsburg, Kansas. [redacted]

Due to the success of the Rural Hub Partnership, UCare hired additional CHWs to manage the volume of referrals for UCare Members from community partners to engage with the Hub.

[redacted] The SDOH pathways include needs such as employment, food security, housing, as well as health care-related pathways, including family planning, oral health, and postpartum care. In this partnership, UCare measured the success of this program by the number of SDOH pathways addressed and closed gaps in care. UCare was one of the first health plans to partner with a PCH and has seen significant success with this partnership.

[redacted] UCare will

share the success of this partnership with community organizations in Kansas as well as identify areas to bolster the CHW/CHR workforce in communities.

Pediatric Health System CHW Partnership

Authentic Provider Relationships

UCare recently partnered with a large pediatric primary care network, Children's Health Network (CHN), to fund a full-time CHW based in their clinics. This partnership arose from an identified need for better engagement with our pediatric population to address health disparities among Black, Indigenous, and People of Color pediatric Members. In the data, UCare and CHN worked closely to determine which clinics and populations had the most opportunity for improvement in well-child visits, immunization rates, and decreased ED utilization.

UCare and CHN collaboratively identified two clinics and populations that needed additional outreach support and Member engagement to access care. When the CHW connected with a family, the CHW provided education about well-child visits, immunizations, and the importance of dental health, and assisted with scheduling appointments. Further, the CHW received SDOH referrals (transportation, food insecurity, housing instability, etc.) for Members from the Providers at the CHN clinic.

[redacted]

UCare will support similar opportunities to embed and support CHWs/CHRs in Kansas. For example, in individual conversations with both Comcare and HealthCore, UCare learned about the unique support CHWs provide to the Vietnamese population in Wichita. Additionally, UCare met with the Community Health Center of Southeast Kansas (CHC SEK) several times over the past year and learned about the ways the CHC SEK employs their impressive CHW program, which includes roughly 100 CHWs, who serve the communities of Southeast Kansas. UCare has discussed delegated care management/coordination as a strategy to collaborate with CHC SEK, and utilizing CHWs as part of this potential model to conduct community outreach and identify and resolve SDOH needs.

> *"UCare took the time to learn about particular ways that it could partner to deliver stronger access to health care services, including dental and behavioral health care."*
> —Jason Wesco
> President and Chief Strategy Officer, CHC SEK

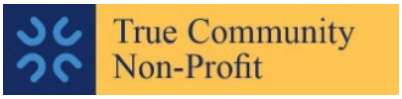
B. Roles, Responsibilities, and Training for CHWs/CHRs

The CHWs within UCare's Integrated Care Coordination Model take on many roles and responsibilities to assist our Members. While UCare Care Coordinators complete health assessments and have responsible oversight over Person-Centered Service Plans and Plans of Service, CHWs/CHRs provide a culturally competent approach to health care and community resource navigation. CHWs/CHRs also create a bridge between Members and their health care.

Here are a few roles and responsibilities CHWs/CHRs — both UCare employees and community Providers — bring to our Interdisciplinary Care Team Model:

- Engage Members with our health plan and provide education about their benefits
- Help Members find and establish care with a PCP (Primary Care Provider)
- Set up transportation as needed and address other SDOH barriers
- Provide appointment reminders and post-appointment follow-up calls
- Help Members obtain and facilitate social service assistance and referrals

Initial and Ongoing Training for CHWs/CHRs



UCare recognizes the importance of ongoing training for our CHWs/CHRs. UCare pays for CHW certification training courses and ongoing CEUs (Continuing Education Units) needed to maintain certification. UCare will also support Talance's CHW online training, formed in collaboration with the Massachusetts Department of Public Health, as well as Johns Hopkins' Patient Engagement Program Training. UCare will ensure trainings are aligned with the Kansas CHW Scope of Practice and the CHW Core Competencies.

Once our CHWs/CHRs have completed the certification program, we will ensure they know the requirement to complete 20 CEU hours every two years, including six hours of Ethics and Health Information Privacy and Portability Act (HIPAA) training. UCare offers training internally and ongoing learning through our relationship with Relias, a leading provider of workforce education. For our CHWs/CHRs who speak a language other than English, UCare pays for their Interpreter Certification so they can provide services in that language, per our NCQA Health Equity Accreditation and Limited English Proficiency plan.

In any contractual relationships with our community partner organizations and Providers, UCare ensures that CHWs/CHRs have completed all applicable background checks, required training (including the topics outlined in the Kansas CHW Training Program), and obtained certification in Kansas. UCare will develop relationships with key groups, such as the Kansas Community Health Worker Alliance and the CHR ECHO Program, to support existing training efforts in Kansas. UCare also plans to support and convene learning collaboratives with Providers, like the CHC SEK, to help other clinics and CHWs with their operations, trainings, and growth of the CHW/CHR workforce.

C. Measuring, Monitoring, and Evaluating Outcomes

In addition to the outcomes and evaluations highlighted above, UCare evaluates the impact of all programs through our Rapid-Cycle Process Improvement Plan, Plan-Do-Study-Act (PDSA). While UCare regularly achieves our NCQA goals, we actively seek opportunities to perform qualitative analyses to identify barriers Members may experience in achieving their goals. If barriers are identified, UCare's Quality Improvement (QI) teams, in collaboration with stakeholder departments and work groups, develop and implement interventions to address those barriers. The interventions are then evaluated year-over-year to determine effectiveness. A recent partnership between UCare and a rural clinic, highlighted below, provides an example of the ways UCare measures, monitors, and evaluates CHW-supported outcomes through our PDSA process.

Rural Health CHW Project

Plan: In this project, UCare partnered with a clinic located in a rural area to address SDOH needs that were identified as barriers to our Members' overall health. This included Members who were identified as needing assistance in scheduling appointments to close gaps for preventive care, including immunizations, chronic disease self-management, and cancer screenings as appropriate.

Act: UCare will share this collaborative and targeted approach with KanCare Providers and Members in rural and frontier areas to determine if similar or different interventions would support the unique needs of Kansans.

Summary

UCare has long been a leader in the recruitment, training, and integration of CHWs within our Care Coordination teams. We recognize and appreciate the critical role CHWs and CHRs bring to establishing trust with our Members and responding to cultural and linguistic needs while providing navigational resources to physical, behavioral, and social care systems. The work of CHWs and CHRs is integral across both larger cities and smaller communities, from Garden City to Wichita, and Kansas City to Pittsburg. To achieve our goal of providing holistic care to Members, we will continue to uplift and integrate CHWs and CHRs as a key role in meeting Members where they are along the care continuum, improving overall health outcomes, and reducing disparities for KanCare Members.

9. Describe the bidder's top three (3) strategies for advancing integrated, whole-person care for its KanCare Members and how the bidder will measure, monitor, and evaluate the effectiveness of the strategies.

Strategies for Advancing Integrated, Whole-Person Care

UCare has a long history of providing whole-person, Member-centered care that is responsive to our Members' comprehensive health and social needs. Our approach is guided by our core values, and grounded in deep awareness that our Members' diverse, evolving needs are best met through a holistic, individualized and culturally relevant care model. Our model is supported by Providers across the care continuum, aligned with the Member's goals, and focused on achieving improved outcomes. We promote equitable access to care and reducing health disparities by identifying and addressing Members' physical and behavioral health and social determinants of health (SDOH) needs, while incorporating their cultural considerations into care and services planning. We value the unique needs of each Member and the environment in which they live.

UCare measures, monitors, and evaluates the effectiveness of our strategies to ensure that our Members' needs are met, supporting their overall health and well-being. The State of Kansas envisions KanCare as a program that delivers excellence and optimal health outcomes for its Members. We will leverage our innovative care models to improve quality of care and health outcomes and ensure the best experience for our KanCare Members.

With decades of experience and expertise in integrated care, UCare understands the importance of coordinated, evidence-based, and well-managed care in achieving optimal health outcomes. To achieve our shared goals, UCare will advance three strategies into our model for Kansas.

UCare aligns well with the State's vision for KanCare as one of collaboration and partnership between the State, managed care organizations, Members, and Providers to realize program excellence and optimal health outcomes for Members — "Partnering together to support Medicaid Members in achieving health, wellness, and independence for a healthier Kansas." We are dedicated to making this vision a reality.

Strategy 1: Advancing Integrated Care for Dual Eligibles in Kansas with a Nationally Recognized, Tested Model

UCare is one the nation's pioneers in integrated, whole-person care for people who are dual eligible for both Medicare and Medicaid. The early days of our program helped CMS develop the flexibility and write regulations for D-SNP plans, six years in advance of the Medicare Modernization Act of 2003, which created this new type of plan. In partnership with our state Medicaid Agency, UCare was one of the first health plans in the country to launch a demonstration comprehensive care delivery model to serve dual eligible individuals. We have remained the largest D-SNP plan in Minnesota since 1997. What began as a demonstration is now one of the most successful FIDE SNP models nationally, with the only longitudinal program evaluation ever completed on this topic by the U.S. Department of Health and Human Services. Our D-SNP program practices have become the expected baseline for D-SNP plans across the nation. UCare quite literally helped write the book on Medicare and Medicaid integration and we are excited to bring these advancements to Kansas.

UCare now has 26 years of experience operating D-SNPs (and precursor), including the largest Fully Integrated Dual Eligible (FIDE) SNP Managed Long-Term Services and Supports (MLTSS) plan that supports older adults and the largest Highly Integrated Dual Eligible (HIDE) SNP for people with disabilities in our current market. UCare also operated as the sole plan for the first FIDE-like SNP pilot for people with physical disabilities from 2000-2010 and became the basis for the statewide expansion of managed care for people with disabilities in our market.

UCare's experience and national model will bolster KanCare's vision of partnership to support Members in achieving health, wellness, and independence for a healthier Kansas. Our whole-person model includes the foundational and innovative methods of integration below to improve outcomes for Kansans:

A Nationally Recognized and Evaluated Integrated and Comprehensive Coordination Model

Through our approach to holistic and integrated care coordination, over 91% of our Members have been able to remain in their homes with supportive services. [redacted] In Kansas, UCare will use our integrated, evidence-based, well-coordinated model to support our SNP Members in achieving health, wellness, and independence goals in a Member-centric approach to care.

[redacted]

[redacted]

Streamlining the KanCare Member Experience

Ensuring access to health care can be complex when dealing with one set of benefits; dual eligibles have a more significant burden navigating Medicaid as well as three parts of Medicare.

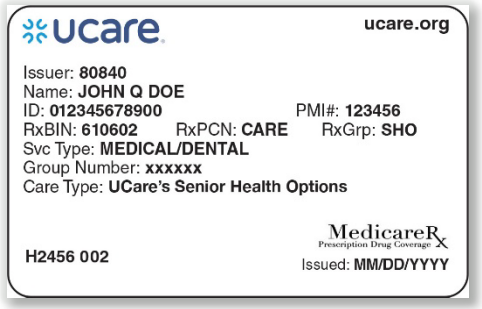


Figure 9.1: UCare Integrated Member card

As part of our original demonstration, UCare was one of the first health plans that worked to create integrated Member materials, including information on both Medicare and Medicaid benefits that met state and Federal requirements, in a simple de-complicated way. If enrollees have coverage questions, they need only review one material or make one call - to UCare. These combined efforts have significantly improved Member experience and satisfaction with UCare, with an "overall rating of health plan" CAHPS score of 88% for our FIDE SNP seniors.

Specialized Programs and Added Benefits

Member Driven

An effective and integrated model for Medicare and Medicaid leverages and appropriately coordinates the benefit sets of both programs as well as aligns the flexibilities (e.g., Medicare supplemental benefits, Medicaid VABs/ILOS) to offer effective and innovative goods and services that address whole person needs, such as social determinants of health. As the leading FIDE and HIDE D-SNP plan in our market, [redacted]

Measure, Monitor, Evaluate

Trusted Government Partner

As mentioned above, our FIDE D-SNP program (of which UCare is and has been the largest plan since the beginning of the demonstration) was the sole subject of a longitudinal

program evaluation conducted by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (APSE).

This Federal study concluded that fully integrated care models such as the one developed by UCare improves outcomes. Additionally, the study found Members were 48% less likely to have a hospital stay, 2.7 times more likely to have a primary care physician visit, 13% more likely to access HCBS, and 6% less likely to have an outpatient ED visit.

UCare's Robust Approach to Quality Oversight

UCare will measure, monitor, and evaluate its KanCare HIDE SNP through the same robust processes we utilize today for our HIDE and FIDE SNPs in oversight, quality improvement, Member feedback, and value-based initiatives, etc. One of the best practices that UCare will bring to Kansas is the use of our Quality Review Team, whose work goes beyond the required traditional Compliance oversight that ensures audit and regulatory readiness.

Our Quality Review Team embeds and motivates best practices across our internal and delegated care coordination teams and helps monitor care coordination services. This oversight team reviews clinical documentation, including but not limited to health risk assessments, POS/PCSPs, service plans and case notes to ensure best practices and requirements are met and exceeded. They provide feedback to the Care Coordination Teams regarding process improvements and best practices that will enhance quality and Member satisfaction. Our Quality Review Team is a key contributor to the successful oversight of our team, while also ensuring that Care Coordinators do not leave gaps in necessary services, supports, or resources.

Strategy 2: Supporting and Providing Integrated Care of Behavioral Health and Physical Health through Expansion and Innovation

UCare recognizes that integration of physical and behavioral health is critical to addressing whole-person care, as people with mental health and/or substance use disorder (SUD) diagnoses have a shorter projected life span, experience a greater number of high acuity chronic conditions, and are challenged by some of the biggest health disparities. We understand and believe that behavioral health is health care and are ready to support the foundation of key integration reforms being built in Kansas, including the addition of behavioral health services at Kansas FQHCs and community-based clinics, creation of evidence-based practice and tool kits for primary care Providers (e.g., KS KidsMAP), and most significant, the statewide implementation of the Certified Community Behavioral Health Clinic (CCBHC) model.

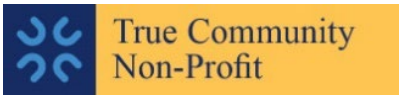
According to an analysis by the Kaiser Family Foundation, Kansas' share of Adults reporting Symptoms of Anxiety and/or Depressive Disorder who had an unmet need for counseling or therapy is 37.7%, higher than the U.S. reported 28.2%.

We applaud the State's recent efforts and investments in integrated behavioral and physical health, include the $10 million Federal grants announced this fall to integrate behavioral health services into four FQHCs and one Rural Health Clinic. UCare is committed to contributing, partnering, and building to increase behavioral health access and integration with physical health.

Supporting Integration across the Provider Continuum

UCare brings a breadth of experience supporting and implementing initiatives that aim to integrate behavioral and physical health, both bi-directionally with our Provider partners and within our own walls. We understand that one of the biggest priorities and challenges for Kansas is a lack of Providers and workforce to ensure adequate access, in particular the full array of outpatient services and mental health and SUD services in behavioral or primary care settings. UCare will focus on the following key strategies to support the expansion and integration of behavioral services across settings and directly providing access and promoting integration internally.

Access Initiatives and Workforce Development



UCare has experience working with the CCBHC model and understands the value it brings to add outpatient capacity for behavioral health services and treating the whole person through its required staffing model and quality measures. In our current market, we have provided support to our CCBHCs/CMHCs in developing their workforce; including providing funding to a CCBHC that provided stipends to students in training at various levels of mental practitioner licensure. This program allowed the student to complete their training and provided a pipeline of new mental health professionals to CMHCs, with particular focus on Black, Indigenous, and people of color students to provide culturally concordant care.

Kansas CMHC partnership: UCare has started our commitment to Kansas workforce development in behavioral health by partnering with Wheat State Healthcare on $260,000 in grants to CMHCs to expand access to behavioral services. Fourteen (14) subgrants, administered by Wheat State, across all regions of the State are supporting a range of capacity building staff and innovations. To highlight a few examples, grants in Western Kansas include:

- **High Plains Mental Health Center:** $12,160 to improve and expand access to telehealth
- **Compass Behavioral Health:** $30,000 for safe and timely transportation
- **Southwest Guidance Center:** $10,000 for Evidence Based Practice Initiative

One key focus for these subgrants is to support CMHCs preparing for CCBHC certification in 2024 but unable to secure SAMSHA grant funding. UCare will continue this partnership with Wheat State by co-developing a value-based model, as reflected in our current Letter of Intent (LOI), to support further capacity building.

Another area where UCare will support integration of behavioral health services and physical health is **through similar direct funding to FQHCs and RHCs that complement the State's investment** and to provide delegated care coordination opportunities for FQHCs that have already begun the integration journey, such as CHC of SEK, which can allow greater expansion of team-based care, telehealth, Community Health Workers (CHWs), and peer supports.

UCare Triage and Access Line

[redacted]

[redacted]

UCare's Kansas Team-Based Approach to Integration

UCare reflects with our staffing models what we encourage with our Provider partners: understanding of the whole person and addressing their needs, including providing screening, access and coordination of both behavioral health and medical care. This includes coordination across UCare's Integrated Care Model—specifically of Care Coordination, Behavioral Health Specialists, clinic teams that support medical and pharmacy needs—all tied together through a single point of contract for Members and for Providers. For Kansas, this will include:

Kansas-Based BH Care Coordination Staff and Clinic Support Teams

Integrated Care Pioneer

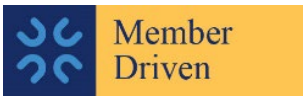
Behavioral Health Care Coordinators provide trauma-informed, person-centered support to UCare Members with mental health and SUD diagnoses. Care Coordinators collaborate with Members, their caregivers, and Providers to ensure Members receive the services and care they need. Our model embraces a holistic approach that addresses mental health, SUD, medical, and social factors. In addition, we will collaborate with TCM or CCBHC to ensure there is no duplication and that all Providers involved in the Member's ICT have the Member's most current PCSP. Care Coordinators assist with the following: transitions of care, referrals to CCBHCs, connecting to and coordinating services, as appropriate, including primary care or specialty services, and community-based resources.

[redacted]

[redacted]

Staffing Model for Special Populations to Facilitate Integrated Care

UCare will have experienced local staffing that focus on coordination and integration for key populations who often have both medical and behavioral health complexity. Examples of key populations include youth in foster care and people with intellectual and developmental disabilities, who also have co-occurring behavioral health and chronic conditions.



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Measure, Monitor, Evaluate

UCare's approach for many of these strategies and initiatives (e.g., BH Care Coordination, Integration for Special Populations) will utilize our data-driven continuous performance improvement framework, which involves quantitative and qualitative analyses to continuously identify opportunities for improvement, prioritize opportunities, and take action to improve health outcomes, Member experience, and access. These actions are evaluated for effectiveness and adopted, refined, or abandoned depending on the evaluation. This continuous cycle of data collection, analysis, and evaluation is demonstrated throughout our Quality Improvement (QI) Framework. UCare takes the following steps to design QI interventions to meet the Quintuple Aim goals: 1) Identify target populations; 2) Define aims and measures; 3) Develop interventions to improve population health; and 4) Evaluate and refine interventions based on project results. Our proposed KanCare quality improvement initiatives aimed at expanding access to and integrating behavioral health services will leverage the Plan-Do-Study-Act (PDSA) framework, focused studies, and a high-quality core set of Quality and Utilization Management documents developed based on KanCare Member data.

For grants and investments, we will work collaboratively with the UCare Kansas Foundation and grantees to develop priorities, application and reporting that provides clear goals and outcome measures. UCare may utilize our Quality Improvement Framework for larger projects as appropriate to further support improved health outcomes and reduced health disparities.

Strategy 3: Adopting Integrated Care Incentives across the Care Continuum

UCare values our relationships with Providers as foundational co-collaborators in delivering whole-person, integrated care. This means all Providers across the continuum of care — primary and acute care, behavioral health, LTSS, and SDOH — are supported and rewarded through financial incentives that encourage coordination and integration. Many payors solely focus on big systems, primary care, or quality measures that don't require Providers to consider all aspects of a Member's care needs, including those provided outside of their walls. UCare has extensive experience developing value-based payment arrangements (VBPs) that encourage and reward

integrated care, with a special emphasis on our D-SNP populations and Members utilizing LTSS. UCare brings this experience and commitment to our Kansas Provider partners.

Creating an Integrated Care VBP Model

UCare understands the important influence value-based payment (VBP) programs have on Member health outcomes and how improvements in outcomes can promote Member independence, improved quality of life and provide a greater sense of well-being. We design our VBP programs to support and reward Providers for creating behavior changes and adopting processes that increase access across the service continuum (even if they do not provide the service directly) and improve health outcomes.

More than a decade ago, UCare implemented an Integrated Care System Partnership VBP model with several different Provider types, including those that provide chronic disease management for older adults and people with disabilities, integrated community health care focused on primary care, community-based mental health resources to adults recovering from mental illness, and a senior care cooperative that provides LTSS. These agreements are aimed at improving care coordination and addressing whole-person care for our Medicaid and D-SNP Members.

UCare attributes the success of these VBP arrangements — and the increased participation and enthusiasm from our Provider partners — to ensuring these agreements have the following core elements:

- **Rewarding Providers** by utilizing quality measures and promoting integrated care across settings, including physical health, behavioral health, and LTSS
- **Supporting Providers** in executing their VBPs, including technical assistance, to enable success
- **Utilizing data analytic tools** to measure and inform quality care and efficiency

To ensure the success of any VBP arrangement, UCare and our Kansas Provider partners will co-develop mutually beneficial VBP arrangements and establish metrics and outcomes that are clearly defined and understood, similar to those outlined above. We will co-create a roadmap for achieving success in improved quality and cost management, convening Provider associations to encourage participation and collaboration as well as alignment for Providers. UCare will ensure Kansas Providers have the necessary tools and data to support the management of their populations under these agreements.

Not Your Hospital's ACO

One example of how UCare co-develops VBP with our partners is a collaborative agreement with a first in the nation Disability Services Provider/LTSS Accountable Care Organization (ACO) serving our Members with disabilities. [redacted]

[redacted]

Implementation in Kansas

Trusted Government Partner

In our many conversations with Kansas health systems, FQHCs, CMHCs, and LTSS Providers regarding VBAs — including more than a dozen Providers and Provider groups, often representing 20 or more individual Providers — they expressed interest and enthusiasm in developing similar arrangements. Providers will work with our team to develop a baseline to participate after the first year of UCare's KanCare implementation. UCare will implement a care management delegation model that starts with value-based contractual relationships to engage these partners in Member outreach and provide preventive care education, self-management support, and coordination. The contractual relationship will include a Kansas Provider and community thought partnership to tailor our program design to meet the needs of KanCare Members.

Measure, Monitor, Evaluate

For each Provider engaged in our VBP incentive programs, our Network and Quality teams have developed scorecards that we will share with Providers to inform them of their VBP performance results to date. UCare teams will review scores for each measure to identify challenges or barriers in achieving Providers' goals, develop mitigation plans and recommendations to assist Providers with goals, addressing challenges, and engaging Members in improving their health status and closing gaps in care.

UCare's Health Care Economics (HCE) Department is responsible for analyzing data from claims, Membership attribution files, and other sources to calculate the financial, utilization, and quality metric performance results and outcomes for each VBP arrangement. HCE is staffed with experienced and knowledgeable financial and clinical data analysts who have been building VBP measurement, monitoring, and evaluation tools and processes since the inception of such programs. For VBP measures that require chart abstracted data, UCare will coordinate with Providers to do the chart review or establish back-end audit processes to monitor Providers with VBP arrangements that allow for self-reporting of chart data.

Summary

Members bring their own unique lived experiences with them to UCare, some of which have led them to disengage from or avoid health care and social service systems. Often, individuals prefer to be engaged by a trusted messenger, like a CHW, care coordinator, peer support, or advocate to feel comfortable about agreeing to a home or community visit, a telephone assessment, or a referral to a new Provider or service. One key learning from UCare's decades of providing and promoting integrated, whole-person care is the irreplaceable value of community-based Providers and organizations in the lives of our Members. UCare care coordination and clinical teams — working along with trusted community partners — are effective at engagement if they can approach Members with similar lived experiences and work together with each Member to meet the whole of their needs and goals.

10. Describe the bidder's methods to identify, track, and address the social needs that impact Members' Health Social Determinants of Health (SDOH) for its KanCare Members, for Members in Care Coordination, and those who are not. Include the following in the bidder's response:
    a. The methods, strategies, and tools the bidder will use to identify and track KanCare Members' needs (e.g., Health Screens, Health Risk Assessments, and Z codes).
    b. The individuals (e.g., MCO Care Coordination staff, care coordinators in other Care Coordination models) responsible for following up on identified SDOH needs and the process for connecting KanCare Members to available resources.
    c. The bidder's approach to making SDOH resource information available to its staff and Providers for addressing Members' SDOH needs.
    d. The methods and tools the bidder will use to track Member access to necessary resources (e.g., geographic information system [GIS], "closed loop referral" platform).
    e. The bidder's efforts to engage, collaborate with, and support SDOH Resource Providers.

Social determinants of health (SDOH) significantly impact the overall well-being and health outcomes of people and communities across Kansas. The U.S. Department of Health and Human Services states that SDOH are the "conditions where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes." UCare recognizes and applauds the efforts of the Governor's Commission on Racial Equity and Justice to identify and suggest solutions that begin to dismantle SDOH, particularly the areas of focus that include economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

We recognize the intersectionality each of these five areas has on overall well-being and health of Members. As a community-based health plan, UCare designs our robust approach and programs, policies, procedures, and investments to address local needs of KanCare Members to:

- **Meet Members where they are at today and over time**: We use our people power and data analytics to design and meet Member needs. We integrate trusted individuals to build or rebuild connections to communities, including community health workers and community health representatives (CHW/CHR), and integrate community voices into the design of our programs. We also use our Integrated Care Coordination model, which is designed to meet Member identified needs over time. Additionally, we leverage data to ensure access to consistent, accurate, and actionable data also helps inform decision making, develop solutions to address needs, and are also critical to understanding population-level trends and systemic challenges.
- **Assess population annually**: We assess Member populations annually to identify their characteristics and physical and psycho-social needs. This assessment includes a multi-dimensional analysis of Member demographic data, diagnoses and chronic conditions, utilization patterns, and SDOH, which can include but is not limited to safe housing, food security, Transportation, employment and career training, and education. We complete ongoing assessments that note disparities, care gaps, and populations disproportionately impacted by health and racial inequities.
- **Create and invest in programming to match Member needs**: We drive the creation or refinement of existing programs as well as make key investments to match Member needs with appropriate interventions and resources. Program owners across UCare review

assessment results and collectively use SDOH data and key findings to shape initiatives, interventions, and their teams' work. We monitor all of our interventions to ensure we meet the State's goals and priorities, authentically partner with Providers to address the needs of their patients, and actively conduct outreach to hear directly from our Members.

A. Methods, Strategies, and Tools to Identify and Track Member Needs

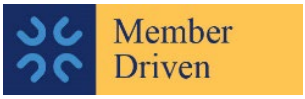
UCare is a leader in supporting Members by addressing SDOH needs. UCare's Quality Program aims to address health and racial equity in part by identifying, implementing, and measuring evidence-based strategies and metrics to address social factors that influence health, health care, and racial disparities and inequities. UCare uses data from partnerships and other sources to identify, track and address social needs that impact Members' health, including Health Screens, Health Risk Assessments (HRAs), and Z Codes. Additionally, we leverage Member outreach and engagement methods to identify and better understand Member needs and preferences.

Member Feedback

To create a shared understanding of what Members and their families want and need, we conduct active outreach to connect with Members, obtain their feedback, and engage in their communities. This direct feedback is shared with our Board (40% are UCare consumer Members), UCare departments and Quality committees. We use a Member Advisory Committee (MAC) and Disability Advisory Council (DAC) to guide and shape our engagement approaches. These committees include Members and their caregivers, both in-person and virtually, and are a valuable resource for gathering input on communication models, preferences for engagement, and how best to structure connectedness to UCare and our community partners and Providers.

Health Screens and Health Risk Assessments

UCare integrates a standardized Health Screen Tool for data collection and documentation, as required in Appendix E of the RFP. This tool gives us the best picture of the Members' health and social needs. The Pediatric Health Screening tool is for Members from birth through age 17. This tool has 38 questions covering health status, health conditions, home safety, education, and work. The Adult Health Screening tool is for adult Members aged 18 and over. It has 37 questions covering the same topic areas. This standardized Health Screen tool enables UCare to better assess our Members' clinical and non-clinical health needs to provide whole-person care. Using the information gathered, UCare can develop targeted interventions that address specific social determinants affecting a Member's health.



If the Health Screen response from the Member triggers follow-up in our system, they will receive an HRA. HRAs occur after a positive Health Screen, a Member's health status change, and annually, as appropriate. The HRA is a comprehensive assessment completed face-to-face with our Members. It covers utilization patterns, disease condition/progression, placement needs, and supports/SDOH needs. The information obtained from our Health Screen and HRA processes allows us to develop, in collaboration with the Member and caregiver, a Member-centered individualized care plan with prioritized outcomes, goals, and interventions specifically designed to meet the Member's needs. [redacted]

Health Screens and HRAs are crucial to keep track of a Member's health and social needs over

time. By continuously re-evaluating SDOH, UCare can monitor any changes or improvements and adjust interventions accordingly.

Data Driven Stratification

Provider Z Codes: Using data, including Z Codes, are essential to identify and track Members' social risk factors and unmet needs. Z codes are collected through health screening tools, HRAs, Providers, and other Member interactions where a Member may self-identify a problem or diagnosis. [redacted] into our existing programs and workflows. This data helps identify our Members' social needs and allows for need identification before outreach calls.

UCare enhanced view of each Member uses the Unite Us MarketView dashboard, leveraging a vast database of consumer insights and predictive models. This intelligence enables UCare to meet our Members where they are in their health care journey, powering effective risk identification, Member engagement, and population health management.

Unite US Data and Tools: Using Unite Us extensive consumer data, Unite Us created the Social Risk Grouper, which helps UCare understand, identify, measure, and quantify the social barriers and circumstances in which people live. UCare uses these aggregated insights through dynamic MarketView Health reporting dashboards and Member-level data outputs to better understand our Members and uncover opportunities to improve population health at multiple levels. Additionally, with these dashboards, we can:

- Establish a baseline of understanding of our Members and their care journeys
- Dive deep into demographic factors impacting health disparities
- Analyze areas for further improvements, such as organization workflow optimization, community service gaps, or opportunities for additional navigation support
- Explore methods to bridge health and social care in locations where gaps persist
- Drive positive outcomes by testing and deploying new interventions
- Evaluate network coverage and trends

The Unite Us dashboard is a comprehensive platform that is already providing services to the Kansas Department of Child and Family (DCF), as well as other Kansas agencies, county governments, and health care Providers. With this dashboard, our users will have access to closed-loop referrals to community-based organizations, enabling them to partner with UCare and effectively address the social care needs of our Members. By expanding the power of this platform, users will have the ability to seamlessly connect with the resources they need to provide the highest level of care to those who need it most.

B. How We Connect Members to Identified Needs and Available Resources

UCare is powered by teams that connect Members to resources and services provided outside the Medicaid benefit package, services that are essential for Member health. Our care team regularly connects with Members ensuring their SDOH needs have been addressed and any new or emerging needs are met in a timely way. All KanCare Members will receive a Health Screen. The Health Screen provides the opportunity to initiate immediate assistance and referrals. As part of our strategy to improve the health of KanCare Members we developed initiatives that combine identification and referral with direct services and support for Providers of those services. All documentation regarding outreach, further screening, referrals, and ongoing coordination is captured within the GuidingCare platform. The plan of service is updated as appropriate, and all activity is available for the entire Care Team and support staff to access when interacting with the Member. The appropriate team will discuss the SDOH needs with the KanCare Member and caregiver and address them promptly through closed-loop referrals and tracking of the referrals. This includes:

People Powered

[redacted]

[redacted]

Providers

UCare believes in a broad, community-centered approach, and supporting our Providers is vital to this work. We listen, hear, and respond to them when they identify gaps in care or services that UCare can address by supplementing Provider efforts to support our Members. Providers have multiple avenues to care coordinators, local CHWs, and can connect and directly make referrals to Unite Us. Providers can also follow up with specific inquiries, resource navigation

support, and connection to UCare's value-add benefits and In Lieu of Services directly with our Kansas-based Social Services Team.

C. Making SDOH Resource Information Available to Staff and Providers to Address Member Needs

UCare is committed to ensuring that the people serving our Members, including our own staff and Provider partners, have access to the information and tools needed to meet the SDOH needs of our Members. We employ a dedicated trainer who works with all relevant UCare departments to keep abreast of any operational changes and new technologies, as well as new resources and support programs such as SDOH needs. Staff training is provided at onboarding as well as annually and on an "as needed" basis as new resources are identified to meet the needs of the staff working with our Members. This role creates content and job aids with the latest information, significantly enhancing staff training. During training for SDOH, the trainer:

- Provides information on SDOH concepts and the corresponding non-medical factors influencing health outcomes
- Demonstrates how cultural competency impacts SDOH and how to overcome SDOH barriers
- Works with UCare departments to create critical job aides and talking points to uncover SDOH needs through motivational interviewing and person-centered planning
- Works with UCare staff to understand available resources in the community, including how to use Unite Us and the closed-loop referral system, In Lieu of Services, value-added benefits, waiver services, documentation of the SDOH needs, and tracking and follow-up processes and procedures to ensure services are received and working for the Member.

In our current market, UCare is the only Medicaid plan to offer Providers in-person and virtual, no-cost access to quarterly continuing education unit (CEU) events. We host virtual presentations with professional development content about topics suggested by Providers and

other key stakeholders. These sessions help expand their professional knowledge and provide opportunities for exposure to experts and peers across the state about various topics. Prior CEU trainings referencing SDOH included sessions about homelessness, supporting transition-age youth with disabilities, emphasis on the role that housing plays in successful transitions. UCare designs targeted, skills-based training to offer Providers the knowledge and skills to best support Members in a culturally congruent manner.

D. Methods and Tools to Track Member Access to Necessary Resources

UCare tracks and integrates SDOH and other important information through two primary sources, our direct partnership data and integration of SDOH data and care coordination workflow.

Direct Partnership Data

[redacted]

Integration of SDOH Data and Care Coordination Workflow

The Unite Us platform is embedded within the GuidingCare system and our Care Coordination workflows, making it easy for UCare staff to search for resources, make referrals, and connect Members to community partners for services in the Member's community. As SDOH needs are identified, a secure electronic referral is sent to the organization through the Unite Us platform. Unite Us communicates with Members about the referral through text or email, depending on the Members' preferences. The information can also be mailed or shared verbally for those without electronic devices. Unite Us offers a cutting-edge technology method to track referrals. We know what referrals are being utilized and obtain Member feedback through follow-up that the referral met the Member’s needs.

[redacted]

[redacted]

The insights and data gathered through the Unite Us tracking of referrals are utilized in the Population Health Management assessment cycle and inform and shape our initiatives and interventions. We gain a deeper understanding of the health needs of our population, which

allows us to develop more effective strategies to improve Members' well-being and to refine our approach to ensure we are delivering the most effective SDOH solutions to those we serve.

E. Efforts to Engage, Collaborate, and Support SDOH Resource Providers

The UCare Foundation and other community initiatives have long supported the social safety net and efforts to deliver quality health care to at-risk Members in their communities. UCare is increasingly focused on improving SDOH needs and combating health disparities among Members and their communities through grants and quality programs. UCare will bring the same or similar foundation grants as part of our initial $2 million investment, as well as other opportunities, to support Kansans. Examples of UCare partnerships supporting SDOH in communities include:

- **Culturally Connected Food Project:** UCare partnered with The Food Group to promote health equity and increase culturally connected food access. UCare funds free food credits used by partner organizations to receive culturally connected foods.

[redacted]

- **Eviction Prevention Support:** UCare partners with a housing organization focused on eviction prevention. UCare supports an outreach coordinator who works with Members to increase their housing stability through goal plans, tenant education courses, and support in accessing community-based resources and services.
- **Rural Dental Access:** UCare funded expansion of dental services at two Critical Access Dental Providers in rural areas of our current market.

Nearly a half million dollars was provided to two rural dental clinics to hire staff, expand capacity and reach, and to build a new clinic location to improve access.

- **Healthmobile:** UCare operates a mobile medical clinic which provides screenings (e.g., glucose, cholesterol, blood pressure, and body mass index) to individuals (UCare Members and others) at various community events. We've coordinated the screenings through partnerships with other nonprofit organizations since 1998, to provide health education and free or low-cost preventive health services, flu shots, and screenings to the community.

[redacted]

- **Food Specialists:** We've partnered with several organizations, including one of the largest food banks nationally, to eliminate hunger among our Members. Through a food access outreach program, we identify UCare households at risk for food insecurity and connect them with the food bank's specialists, who help them apply for Supplemental Nutrition Assistance Program (SNAP) food benefits, find local food resources, and address social needs. We conduct targeted Member outreach through an IVR call to connect Members with a specialist for immediate help or a callback. Collaboration with this food bank has provided relevant learnings for UCare to bring to KanCare, as its data systems are HIPAA-

compliant and works with health systems to integrate a SNAP referral into the electronic medical record.

Summary

At UCare, health care is about centering the needs of our Members and collaborating with them to ensure comprehensive integrated, and whole-person care. We engage Members and their families to support their needs and help them feel empowered to drive their own health care decision. We understand the important role of leveraging our trusted local community-based resources and Providers and ensuring we are also supporting their efforts, education, and knowledge to address SDOH. UCare is excited to extend our innovative partnership across Kansas and will have the people and processes to identify, track, and address SDOH.

11. Describe the bidder's approach to identifying and addressing health disparities for KanCare Members. Include the following in the bidder's response:
    a. The bidder's definition of health disparities.
    b. The bidder's approach to monitoring for unintended bias in Utilization Management and service delivery in KanCare. Additionally, provide an example of an identified concern in a program similar to KanCare and the actions that were taken in response.
    c. An example of a specific health disparity in KanCare, the bidder's proposed approach to addressing the disparity, and the anticipated impact on KanCare Members.

Addressing health disparities starts with understanding what makes a population unique. As a community-based health plan, UCare identifies health disparities by combining qualitative community feedback and quantitative population health assessments. We employ multiple methods to gather, track, and disseminate feedback from our Members, which helps us understand their cultural and linguistic needs and preferences as well as health literacy. In addition, we constantly look for ways to create innovative interventions to ensure Members have equitable access to quality services through rigorous population health analyses. Together, this combination acts as a starting point, allowing us to challenge our assumptions and address unintended biases. [redacted]

A. Defining, Identifying and Addressing Health Disparities

Defining Health Disparities

UCare defines health disparities as *health differences that adversely affect disadvantaged populations in comparison to a reference population, based on one or more health outcomes.* UCare understands and addresses the issues that impact many individuals, their families, and the communities in which they live. These include disparities in health outcomes and the impacts of social risk factors. Populations that experience health disparities often include racial and ethnic minority groups, people living with disabilities, people with lower socioeconomic status, underserved rural communities, and LGBT individuals.

Health disparities are the metrics we use to measure progress toward health equity. We adopted the Robert Wood Johnson Foundation definition of health equity: *"Everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."*

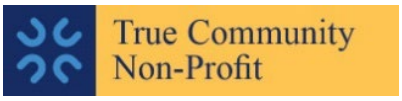
Identifying Health Disparities

UCare utilizes a multi-layered approach to identify health disparities. We identify disparities through our population health program, and by listening to community voices, utilizing Member advisory committees, and ensuring our network includes Providers who serve diverse communities.

- **Population Health Approach**: UCare's Population Health program utilizes an annual population health assessment to examine and discuss ways to increase our skills to identify disparities hindering health equity advancement. This assessment includes a multidimensional analysis of Member demographic data (e.g., race, ethnicity, language, gender, geography, age, eligibility group, household size, disability status), diagnoses and chronic conditions, attributed care systems, utilization patterns, and SDOH needs. We identify and segment data and tailor intervention strategies based on this data source and others, such as Unite Us Insights, to capture SDOH needs.
- **Community Voices:** UCare seeks feedback from communities about identified health disparities (e.g., community engagement events, surveys, and Member advisory groups) to learn more about people's lived experiences and the impact of these health disparities. We also seek feedback across geography and demographic backgrounds. In Kansas, this would include reaching out to Members living in rural, frontier, and urban communities, across diverse racial and ethnic backgrounds, and individuals with disabilities.
- **Member Advisory Committees:** UCare hosts Member advisory groups across our health plans, and we will do the same for our KanCare Members. Member advisory groups provide a forum for open dialogue, greater understanding, and awareness of healthcare issues, access barriers, and disparities that affect our Members. We share the learnings from these conversations with UCare's Board of Directors and quality committees. In particular, UCare hosts a Disability Advisory Council to ensure we gather feedback from Members with disabilities on how to support equitable access to quality services. Together, we identify potential interventions to remediate disparities in health outcomes and innovative ways to ensure Members have equitable access to quality services.
- **Provider Diversity, Equity, and Inclusion:** Providers are crucial partners in identifying health disparities, especially if they are situated in areas that serve diverse and underserved communities. UCare works continuously to ensure that these Providers are included in our network. Currently, 96% of Providers in our existing market are part of UCare's network. UCare also utilizes a diversity, equity, and inclusion questionnaire to ensure that Providers who serve underserved or diverse populations have an equal opportunity to be in the network. As a result of this work, we have added 35 additional Providers to our network who provide care to diverse and underserved populations.

Addressing Health Disparities

UCare's Health Equity Committee has implemented a four-pronged approach to continuously improve the way we identify and address health disparities experienced by Members. These four areas include: work centered on monitoring our clinical health outcomes, reviewing policies and procedures, engaging with communities, and promoting operations that impact equity.



Clinical Health Outcomes: UCare's Health Equity Team examines many clinical health outcomes to address identified health disparities. We are currently examining three HEDIS measures: prenatal and postpartum care, follow-up after hospitalization, and initiation and engagement after treatment. UCare aims to develop partnerships to support equitable access to quality services. For example, UCare partnered with an American Indian nonprofit organization providing community-centered holistic care for women, children, and families, and provided $100,000 to support their comprehensive and culturally relevant model of care for mothers and

infants. In Kansas, we will capture outcomes and partner with local Providers to address health disparities, including in Wyandotte, Wichita, and areas of southeast Kansas, which experience higher maternal and infant health disparities,

[redacted]

Community Engagement: UCare's Foundation developed a health equity grant application to solicit proposals in the areas of safe and supportive housing, employment security, accessibility for increasing physical activity in disinvested areas, and access to nutritious food. For example, one of UCare's 2023 health equity grants was a $100,000 donation to Comunidades Organizando el Poder y la Accion Latina (COPAL) Education Fund to launch several awareness campaigns around resources for stable housing, employment with benefits, and health care access points for Hispanic/Latino families and workers living in rural communities. UCare will stablish a similar health equity-focused grant application to reduce health disparities for KanCare Members. For example, earlier this year, UCare provided a $200,000 grant to GraceMed to support the cost of health screenings for individuals who may have been impacted by a groundwater contamination northeast of downtown Wichita.

Provider Story

"These funds focused on filling the gap between the needs of individuals who have been potentially exposed to contaminated water and the insurance companies who will not pay for the testing as they are exhibiting symptoms."
—Venus Lee
CEO, GraceMed

Operations Impacting Equity: UCare is committed to continuously assessing how we support and partner in new opportunities to address health disparities, increase equity, and improve Member health outcomes in Kansas. [redacted]

B. Monitoring and Addressing Unintended Bias in Utilization Management

Health equity ensures that each Member has access to the right resources at the right time and place. UCare's Health Equity Officer, referenced in RFP section 7.17.2, and Health Equity Committee work to develop, integrate, and measure health equity processes and metrics. This helps us ensure our policies, procedures, and projects are inclusive and advance health equity, as outlined in RFP section 7.5.4. [redacted]

[redacted] We have additional mechanisms to identify and address unintended bias within our UM program, as described below in our partnership with Wellshare. Finally, UCare recognizes that bias training for our employees is a central component of this work and is integrated into our training and development curriculum.

Monitoring for Unintended Bias in Utilization Management

UCare recognizes the importance of continuous improvement to address health disparities across populations, including actively looking for unintended bias within our operations, policies, and procedures. [redacted]

UCare maintains a continuous commitment to addressing social risk factors and health care disparities. Recognizing the continuous improvement required to address health equity, we continue to add data sets to reduce data bias in our UM Program, such as Unite Us Insights' Social Risk Grouper, a proprietary taxonomy for identifying SDOH needs. We also encourage Providers to use Z Codes to document SDOH data. We look forward to connecting with the Kansas Health Information Exchange and supporting the Kansas Department of Children and Families' new relationship with Unite Us, to broaden our ability to understand the needs of our Members and provide holistic care and integrated services.

Example: Addressing Unintended Bias in Utilization Management through an Innovative Community Partnership

True Community Non-Profit

UCare uses mechanisms to monitor over- and underutilization of services. We establish upper and lower thresholds for each data type based on historical data and available benchmark information and conduct analysis at least annually. [redacted]

UCare welcomes partnership with the KDHE and KDADS to select utilization data types each year to monitor for over- and underutilization (e.g., inpatient, emergency department, pharmacy, and behavioral health services utilization).

[redacted]

Recently, UCare noticed a high emergency department (ED) use in the Hispanic/Latino and East African refugee communities. We reached out to Wellshare, an organization that serves East African and refugee communities, with a mission of "partnering with diverse communities to promote health and well-being." Through Wellshare's partnership, expertise, and relationships with this community, we learned that Members were unfamiliar with how to use the American health care system, which contributed to lower connection to primary and preventive care. To address this, UCare contracted with Wellshare to reach out to Members enrolled in Medicaid with high ED use through visits by community health workers (CHWs) who speak the same language and are from the same cultural community as the Members.

To assess the impact of this outreach we conducted a quasi-experimental cohort design study. We collected claims and enrollment information for one year pre- and post-enrollment date for matching and analysis. We matched study Members to control Members with similar characteristics based on pre-period claims and Member demographic characteristics. Potential control Members were selected from UCare's general population who met program requirements but did not participate. [redacted]

Building upon the success our Wellshare partnership had connecting individuals with Medicaid coverage to appropriate care, UCare has continued to explore other areas to partner with Wellshare for outreach. UCare later partnered with Wellshare and other medical experts from diverse racial and ethnic backgrounds to conduct two live call-in TV shows to share information with the Somali and Hmong communities about the importance of resuming preventive care during the COVID-19 pandemic. UCare promoted these events on our social media platforms and uploaded recordings of the shows to YouTube for community Members to access following the events. UCare will look to establish similar partnerships across Kansas to support Member outreach by culturally congruent and trusted community partners to connect individuals and communities with resources and care.

This unwavering focus enables us to identify barriers experienced by individual Members that may impact a larger community, allowing us to make organization-wide changes to reduce structural racism. This feedback gathered through all the above processes, is brought to the Health Equity Committee. They review the feedback, identify any trends, and

UCare has a robust process of including and elevating Member feedback that relates to racial discrimination or health equity issues. It is important to shine a light on this feedback and make sure Members experiencing disparities have a strong voice in our work.

determine which lines of business are impacted. They then develop an action plan on how to address the concern.

Bias Training for UCare Employees

UCare continues to work toward being an anti-racist organization through engagement with communities that uplift and empower Members to achieve their best health outcomes. Racism oppresses and devalues marginalized groups, while anti-racism efforts elevate these same communities and appreciate their inherent value. We believe knowing, serving, and empowering these communities is critical to reducing barriers to health care.

Our Health Equity Officer works closely with the Equity and Inclusion Department to support bias trainings for UCare employees across all levels of the organization, including executive leadership. One goal is to increase awareness and bias training for UCare staff. Such trainings (e.g., Recognizing and Mitigating Unconscious Bias, Valuing and Managing Diversity, Understanding Trans Individuals, Race and Racism 101) enable staff to see their work through a health and racial equity lens, and empower them to identify structural racism within our own policies or procedures that may create barriers for specific groups or individuals. In addition, all UCare departments are required to have specific, reportable DEI goals and measures to help build a culture of reduced bias.

C. Example: UCare Will Address Maternal and Infant Health Disparities in Kansas through [redacted]

The literature is clear: institutional bias and racism are prevalent in health care and demonstrated explicitly in rates of maternal mortality and morbidity. According to the State's most recent Severe Maternal Morbidity and Maternal Morbidity report, Black individuals in Kansas experience worse pregnancy and birth outcomes than their white counterparts. Between 2016 and 2020, individuals identified as Members of a racial or ethnic minority accounted for 62% of maternal deaths. Further, individuals enrolled in Medicaid or from low-income ZIP codes were more likely to experience severe maternal morbidity, and 62% of maternal deaths were of individuals with Medicaid, no insurance, or unknown insurance status. Studies published throughout the last decade have shown the benefits doulas have on maternal and infant health outcomes, including reducing the risk of having low birth weight babies, cesarean section deliveries, and birth complications. [redacted]

[redacted]

Integrated Care Pioneer

[redacted]

We look forward to continuing to develop partnerships in Kansas, including with community organizations, such as HealthCore in Sedgwick County, to promote early notification and services wraparounds, and work toward racial and health equity, especially among new parents and families.

[redacted]

Community feedback shapes UCare's policies and procedures to ensure that all Members have equitable access to quality services. For example, UCare conducted focus groups in partnership with a community organization, the African American Babies Coalition. UCare heard feedback from Black pregnant Members that they were unaware of the availability and coverage of [redacted]

[redacted]

UCare recognizes that particular regions of the State experience heightened disparities. For example, Sedgwick County saw a 13% increase in infant mortality rates between 2010 and 2020. UCare will develop relationships with doula Providers in Kansas, such as Wichita [redacted], to establish a market price for [redacted] services for our Members. [redacted]

[redacted]

Summary

We believe that our community-centered, data-driven, and equity-focused approach aligns well with the State's goals to improve the health and well-being of mothers, infants, children, and youth. UCare understands and addresses the issues that impact many individuals, their families, and the communities in which they live. We will employ our multi-layered approach in Kansas. Through our population health assessment and community feedback we will identify health disparities that overburden particular communities. , to address unintended bias and health disparities across racial and ethnic groups as well as among individuals living with disabilities. Finally, UCare will continue to develop partnerships with Providers to increase their cultural competency skills and learn how to meet the needs of KanCare Members wherever they are and in their preferred linguistic and cultural needs.

Tab 7d:

TOPIC AREA 4

Utilization Management and Services

7d. Utilization Management and Services

12. Describe the bidder's strategies and approaches to ensuring appropriate utilization of services while reducing Provider administrative burdens.

Strategies and Approaches

Providing the highest quality care requires services to be well coordinated and properly utilized. UCare's Utilization Management (UM) Program provides a comprehensive structure designed to improve clinical care and service provided to KanCare Members. Our clinical and utilization decision making follows evidence-based and industry-leading standards along with local considerations to promote consistent care and service delivery across our Membership, including culturally diverse populations. Key to our strategies to ensure appropriate utilization of services is our approach to move from transactional relationships with our network Providers to establishing and maintaining authentic and strategic Provider partnerships. Through these partnerships, we will ensure alignment with the KanCare program goals that uphold the Quintuple Aim of enhancing Member experience, improving population health, reducing costs, and improving the work life of health care Providers.

UCare will work in collaboration with other KanCare MCOs, the State, Providers, and Members to develop and implement policies and procedures to standardize and streamline process for accessing care, including durable medical equipment (DME), assistive services, and home modifications to make the process more transparent and less administratively burdensome. Our approach includes but is not limited to having clear, standardized, and streamlined forms; supporting documentation requirements and billing procedures; providing clear and consistent information to Providers and Members regarding the requirements and review criteria; and assisting Providers and Members with submission, approval, and reimbursement processes. UCare will work collaboratively with Providers, including long-term services and supports (LTSS) and home and community-based services (HCBS) Providers, to achieve population health management goals by sharing data, providing practice transformation support, sharing decision-making aids, and other activities including, but not limited to, training and resources on equity, cultural competency, bias, diversity, and inclusion, to ensure the appropriate utilization of services for KanCare Members.

Ensuring Appropriate Utilization of Services

UCare has long-established, highly effective partnerships with an extensive network of Providers throughout our service area, fostering innovative approaches to drive quality care and outcomes as well as Provider satisfaction. We partner with Providers sharing data, supporting evidence-based practices, providing training, and promoting contracting models that reward appropriate utilization of services and improved outcomes. Examples of our Provider support activities include but are not limited to the following methods:

Sharing Data

UCare executes contracts with medical and behavioral health Providers that promote data sharing and support the delivery of care with appropriate programs and services. Reports include gaps in care reports/actions lists (monthly or quarterly), quality performance reports (quarterly or annually), and comparative HEDIS/Stars Quality reports (annually). UCare reviews Provider performance on quality and utilization metrics quarterly and annually.

Offering Evidence-Based Decision-Making Aids

UCare makes electronic resources available to Providers on evidence-based shared decision making to encourage and facilitate Provider and Member discussion on treatment options. These decision-making aids are distributed to Providers annually via Critical Business Reminders and are also available on UCare's website. We share resources from Stratis Health, the Agency for Healthcare Research and Quality (AHRQ), and Mayo Clinic. In addition, UCare offers Providers access to My Health Decisions (Healthwise), a resource that provides information to both Providers and Members to help Members understand a wide range of health conditions and treatment options so they can make informed and collaborative decisions on care options.

Providing Practice Transformation Support to Primary Care Providers

UCare provides technical assistance and practice transformation support to Providers through regular meetings (quarterly, annually, or ad-hoc). These meetings are highly valued by our current Providers as an opportunity to evaluate and discuss performance measurement and outcomes, identify collaborative efforts to support Members, and combine resources to share accountability for outcomes.

Providing Training on Equity, Cultural Competency, Diversity, and Inclusion

UCare makes training opportunities and resources available to Providers on equity, cultural competency, implicit bias, diversity, and inclusion. We distribute these trainings and resources to Providers annually via Critical Business Reminders, and through UCare's website. UCare shares resources from Culture Care Connection (developed by Stratis Health with support and partnership of UCare), Multilingual Health Resources Exchange, and Think Cultural Health. These resources are continually evaluated and updated.

These supports empower Providers to deliver the care they deem necessary for our Members (particularly those at highest risk) and reward them for quality results. We use data-informed approaches to create local initiatives that adopt national best practices, transformative clinical care coordination, and innovative value-based incentive models. We perform UM functions in a way that is seamless for Members and Providers while employing quality management (QM) and quality improvement (QI) efforts that are rooted in an evidence-based, person-centered continuum model that truly supports the Member's personal priorities and goals.

Reducing Provider Administrative Burdens

Our Provider Services Department supports operational effectiveness between UCare and our Provider partners. We employ an effective communication strategy and proactive educational approach to enhance the Provider experience for UCare Members. We provide in-person outreach, establish and manage relationships, and offer support and education as needed. We have a team specializing in systemic and complete resolution of sometimes complex Provider operational issues, including managing the resolution of any Kansas Department of Health and Environment (KDHE) raised Provider concerns. This department includes UCare's Provider Experience Program, which develops, implements, and monitors enterprise-wide workplans to improve Provider experience with UCare, ultimately improving services to our Members.

Based on the myriad of Provider, association, and advocacy organization meetings we have participated in across Kansas, the following theme emerged as key Provider pain points:

- Turnaround times for payment and authorization of services
- Ability for Providers to speak directly to Medical Directors, including timeliness of peer-to-peer reviews
- High administrative burden related to multiple calls/requests for chart pulls to support post-payment reviews, including UM post-review processes related to mental health services
- Limited opportunity for Providers to share input specific to coverage criteria/policy development

One of the biggest pain points reported continues to surround prior authorizations (PAs). While it is understood that PAs are intended as a tool to protect Members from potentially harmful treatments and serve as a vehicle for health plans to work collaboratively with Providers on complex cases, Providers shared that PAs have become a way for health plans to increase their profit margins.

To address pain points such as those identified above, UCare has taken the following actions to address Provider concerns:

Claim and Authorization Response Time and Best Practices

UCare conducts timely reviews of denial rates and trends, along with prompt root cause analysis, to minimize the occurrence of inappropriate claim denials and any undue administrative burden on Providers. Paying Providers accurately and promptly is vital to UCare's strategic pillar of operational excellence.

We are dedicated to streamlining the claims submission process and easing the administrative burden for all Providers, both out-of-network (OON) and in-network, and including HCBS Providers. This dedication is demonstrated through our current best practices, such as offering multiple ways for Providers to submit a claim and running payment cycles six days per week. UCare offers our Providers highly efficient means of submitting claims. Using an X12-compliant Electronic Data Interchange (EDI) transaction process, [redacted] For electronic claims that are not auto-adjudicated, UCare's claims processing team has a demonstrated history of managing turnaround of claims adjudication within State and Federal requirements, including paper claims submission for out-of-state Providers. E-prescribing is an important part of an integrated electronic health information system, helping to reduce prescribing errors, increase efficiency, and improve quality and safety.

Electronic health record (EHR) portal access reduces administrative burdens and results in 97% timely access to medical records, reduced claim rejection rates and duplicate claim submissions, and an increase in timely claim adjudications for inpatient claims.

Our Provider Services Department routinely shares UM operational reporting related to prior authorizations and other metrics during our regular meetings. For example, our average turnaround time (TAT) for medical necessity authorizations is 8 days.

In addition, we routinely seek Provider input about whether an authorization requirement is burdensome or unnecessary, and we systematically track Provider complaints by subject. We also identify Providers with outlier utilization trends and provide resources and retraining to prevent over- or underutilization of services.

People Powered

UCare offers a full complement of staff to ensure highly effective Provider service, including Provider Contract Managers, Field Representatives and Triage Liaisons, as described in the accompanying graphic. Our entire Provider Services Team has been trained, along with our UM Team, on procedures for routing Providers requesting a peer-to-peer discussion to one of our Medical Directors and how to directly reach our Medical Directors for subsequent requests.

Proactive Training and Education

UCare has evolved how we collect information about Provider cultural competency and accessibility for individuals with disabilities. We collect and report to Members the types of cultural competency capabilities and specialties offered at Provider locations. We have enhanced our current language collection process to include language services offered at Provider locations, and we strive to make access and coordinating care as simple as possible for our Members. We employ multiple communication approaches to connect with Members and meet their diverse needs to address race/ethnicity, language, disability, employment status, and other social determinants. We consider each individual Member element to effectively engage with them to promote preventive care and address gaps in care. We send all new Members a New Member Guide, explaining how to access care, find an in-network Provider, and to let them

UCare's UM Team identified an increase in mental health rehabilitation services year over year. This increase triggered an evaluation of claims to better understand the trend. In some instances, we found a lack of clinical appropriateness to support the necessity of the service; in others, we found evidence of Members receiving the service from multiple Providers without clinical justification or collaboration between Providers. To address this issue and ensure appropriate utilization of services, UCare retrained Providers and updated processes to require a notification if a Member was staring mental health rehab services, so we could have a line of sight into the clinical needs of our Members and to ensure Providers were effectively communicating and coordinating care with their peers concurrently working with Members.

know about services and the support they can get through UCare. Members can access more detailed benefit information by calling Customer Service or by visiting our Member Portal and consulting the Member Handbook. ***UCare believes in direct access to care: we do not require referrals to in-network Providers or specialists, and we require prior authorizations for only a minimal number of services, working directly with the Provider to review these situations to ensure appropriate utilization of services.***

Aligning Performance and Using Technology to Improve Provider Experience

Our goal is to reduce Provider administrative burden through technology solutions that offer real-time data access to improve Provider performance and operational effectiveness (e.g., confirming Member eligibility at appointment scheduling); enabling real-time chart exchange at time of Member encounter; and solving for real-time gaps in care information. When we reduce the administrative burden, Providers have more time to focus on Member health. By aligning technical value-based payment (VBP) metrics with other Federal, State, or community-required metrics, Providers work toward the same quality goals across agencies.

> *"UCare's non-profit status and community-based approach has been integral to our work together to advance care in ways that are both cost-effective and quality driven to support our patients. We would look forward to the opportunity to extend our partnership with UCare in Kansas. Based on our interactions, I recommend UCare to obtain a KanCare contract from the state of Kansas."*
> —Cameo Zehnder
> CAO, Pediatric Home Services (a Provider operating in both Minnesota and Kansas for medically complex children)

We align our reporting capabilities and Care Management system to capture data that meets State requirements. We further reduce the administrative burden on Providers by training them on how to best use data analytic tools, how to participate in our VBP programs, and how to develop solutions to improve performance and avoid unnecessary or high-cost care. Our Provider Relations Team meets with VBP-participating Providers at least monthly, and on a schedule determined by the amount of support the Provider needs, to motivate Providers to meet cost and quality goals and build capacity to progress along the Health Care Payment – Learning and Action Network (HCP-LAN) VBP continuum.

GuidingCare

[redacted] GuidingCare includes a suite of technology solutions that support more collaborative, analytics-driven, and person-centered approaches to medical management (including utilization management activities), care coordination, and population health management by providing:

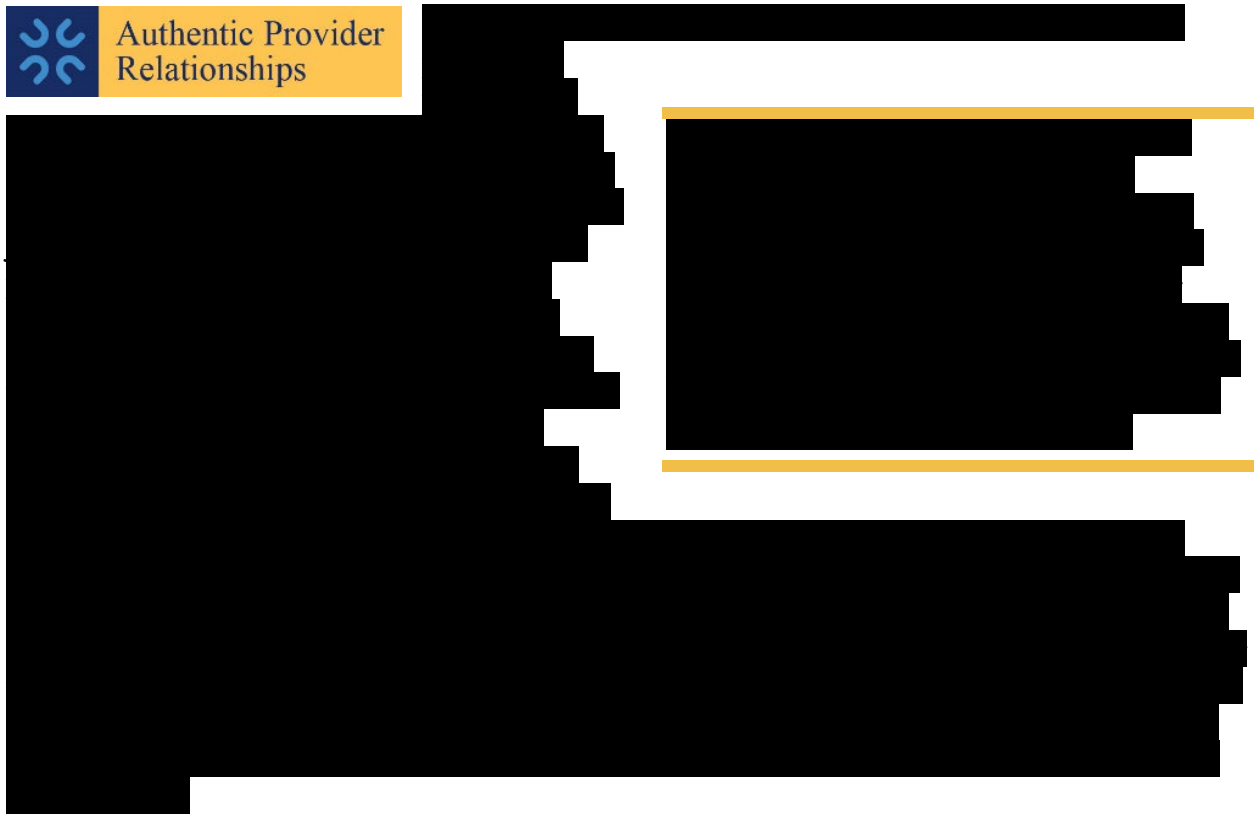
- Greater flexibility in deploying changes in regulatory reporting
- Enhanced person-centered approach through predictive analytics
- Better support tools for staff and Provider delegates to improve how we meet the needs of Members

- A comprehensive view of the Member by integrating multiple data points into one system (e.g., Appeals & Grievances, Claims, Care Management, Disease Management, and Utilization Review)

Electronic Prior Authorization Use for Pharmacy Review

Our state-of-the art electronic PA system (Navitus ePA) utilizes the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard, including the most recent version named by CMS, 2017071. Our system was built with future SCRIPT standards in mind and is flexible to quickly react when a new version of the SCRIPT standard becomes available. Additionally, the Navitus ePA system is capable of:

- Instantly responding to an ePA request with drug-specific criteria
- Presenting only required criteria questions, based on the prescriber's response to previous criteria
- Automatically approving the prior authorization, if appropriate, and responding to the prescriber within a matter of seconds
- Sending the request for a clinical review if the request was not instantly approvable
- Responding to the prescriber with details if a prior authorization is not required or is already on file
- Accepting a wide range of attachments
- Sending hard-copy letters to the prescriber and Member as a follow-up to the electronic request, if required



Feedback and Evaluation

We routinely review data published by CMS and the Centers for Disease Control and Prevention (CDC), as well as changes in nationally recognized medical necessity clinical guidelines. We adopt evidence-based clinical guidelines that are essential to informed decision making. [redacted] or higher rate of approval and those with over-utilization that may indicate inappropriate utilization or abuse. We review authorization requirements, trends in approvals and denials of services, and trends in utilization patterns not currently on our PA List and incorporate them into our QM and UM programs and workplans, including our LTSS annual program evaluation.

UCare deploys a multipronged engagement approach with Providers at the point of care and targeted Member outreach to identified at-risk populations. Provider partnerships and feedback are critical to our UM Program. We receive feedback and information through Provider surveys to understand ways to improve our UM process. Provider feedback has led us to update our Provider website, making it easier to navigate, and to improve the process for submitting an authorization request. Other examples of changes generated from Provider feedback include:

- **Prior Authorization Form:** We updated our prior authorization form to streamline data entry and make it easier to find and use the forms.

[redacted]

UCare also administers quarterly and annual Provider satisfaction surveys to gather additional feedback on opportunities for continuous process improvement.

For subcontracted UM, we monitor complaints, appeals, and UM trends in delegation oversight meetings.

UCare will work with the State and Providers in Kansas to ensure that services are well monitored and executed, with minimal administrative burden for Providers. We equip specialized UCare teams with the tools necessary to collaborate with Providers to accomplish a synergistic relationship that promotes ease of process and effective provision of services. UCare's internal and external trainings ensure that both UCare staff, and Providers, can utilize these tools to create a seamless collaboration.

13. Describe the bidder's approach to developing and monitoring its Utilization Management program, in writing (e.g., policy, guidelines) and in operation, to ensure compliance with Mental Health Parity and Addiction Equity Act (MHPAEA).

UCare supports access to behavioral health and recognizes it as health care in the same way as physical health. UCare's UM Program reflects this value and utilizes a cross-functional approach to monitor appropriate care delivery across the continuum of services available to KanCare Members (e.g., preventive, diagnostic) provided by physical and behavioral health, home and community-based services (HCBS), long-term services and supports (LTSS), and pharmacy Providers. We continually evaluate alignment of our UM Program with the goals of the Mental Health Parity and Addiction Equity Act (MHPAEA) by ensuring that:

- Any financial requirements or treatment limitations of mental health and substance abuse disorder (MH or SUD) benefits are no more restrictive than that of clinical or surgical benefits.
- MH and SUD benefits are not subject to any unique cost-sharing requirements.
- We cover out-of-network MH and SUD benefits the same as any other out-of-network benefit or service.
- Any denial of service can be reviewed by Members upon request, and we make public our standards for medical necessity.

UCare has historically and will continue to manage our own behavioral health benefit in house, including utilization management. This has not only fostered integrated, whole-person care, but has created the expertise and foundation for ensuring compliance with MHPAEA.

Developing the Program

UCare developed our comprehensive, integrated UM Program to address Member needs through a cross-functional and interdepartmental approach that strives to improve the Member's overall health while keeping care affordable. Our clinical and utilization decision making is focused on evidence-based and industry-leading standards, such as InterQual and American Society of Addiction Medicine (ASAM) criteria for SUD, along with local considerations to promote consistent care, as well as MHPAEA-compliant services delivery across our culturally diverse populations. In compliance with and to support KanCare program goals, UCare follows a UM strategy through which we:

- Uphold the Quintuple Aim to improve our Members' quality of life through person-centered care
- Focus on Member safety, coordination of care, care preference, and personal choice.
- Support Members receiving medically necessary and appropriate care that is provided in a timely manner and at an appropriate place/setting
- Foster highly effective Provider partnerships to relieve administrative burden through an easy-to-use prior authorization system and quick turnaround times
- Monitor data and trends to measure utilization among many different populations.
- Promote lower cost of care while maintaining effectiveness
- Deliver services with a keen awareness of health and racial equity issues

Integrated Care Pioneer

Under direct oversight by our Kansas-licensed Chief Medical Officer, our UM Program is designed to be seamless to the Member and Provider, and encompasses inputs from key UCare departments, including Case Management, Disease Management, Provider Contracting, Health Promotion, Clinical Quality, Community-Based Case Management, LTSS, and HCBS to improve health outcomes in a manner that ensures holistic care delivery for our Members. Embedded in this work is the integration of MH and SUD services within primary care, innovative pilots focused on addressing social determinants of health (SDOH) and improving health outcomes with care systems. As part of our inclusive and integrated approach, we have successfully added Providers to our committees that serve specific communities, including communities of color, rural communities, and American Indian populations, as well as adding Providers across behavioral health, MH and SUD disciplines.

UCare UM staff use utilization review criteria that are based on scientific evidence and accepted clinical practice guidelines. When making medical necessity and utilization review decisions, our clinical staff use nationally recognized criteria, accepted clinical practice guidelines and decision support tools, including InterQual. InterQual is a national evidence-based tool built on Centers for Medicare & Medicaid Services (CMS) medical necessity criteria. Throughout our process, we consider Member benefits as described in our Member Handbooks, KDHE contracts, and assessment of the Member's individual needs and situation.

UCare applies a hierarchy of utilization management criteria to authorization requests:

- InterQual guidelines (inclusive of Medicare criteria)
- [redacted]
- UCare Medical Policy
- Research from other government sources, such as Kansas Statutes, CMS, KDHE, KDADs, and the U.S. Food and Drug Administration

Monitoring the Program

UCare has improved the effectiveness of our programs by implementing best-in-class technology, including our GuidingCare data integration and workflow management platform. GuidingCare supports our collaborative, analytics-driven, integrated, and person-centered approach to medical management (including UM activities), care coordination, and population health management. By using one data platform, we can improve quality and engagement by identifying gaps in care and developing new efficiencies in our processes. For example, Providers have immediate access to gaps in care reports to target measures and drive key activities to improve the overall health of the Member.

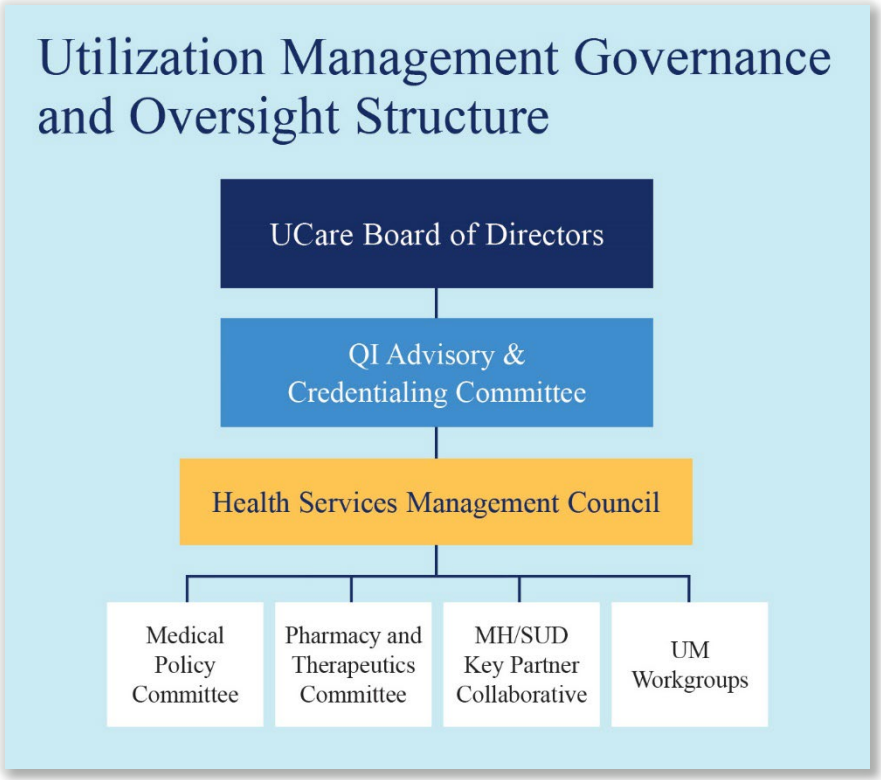
Key functionalities of the GuidingCare platform include:

- **Data Integration Capabilities:** GuidingCare serves as the single source of truth to interface with our UM delegates and various departments. A few of our internal and delegate data sources include claims, prescriptions, authorizations, clinical programs, and health risk assessments.
- **Risk Scoring and Predictive Modeling Tool:** GuidingCare takes claims and authorization data to generate a risk score for our Members. This capability, along with our predictive

modeling tool, guides the care management process and serves as a key input into our UM Program monitoring.

The GuidingCare platform has generated the following improvements:

- Enhanced person-centered approach to care coordination by enabling mobile delivery of assessments and auto-generation of care plans at the point of care (e.g., allowing Members to sign their care plan at home)
- Greater flexibility to deploy changes in regulatory reporting
- More comprehensive view of a Member for their care team and new process efficiencies by incorporating data into a single system (e.g., integrating data from Appeals and Grievances, Claims, Care Management, Disease Management, and Utilization Review)
- Increased support in our ability to initiate referrals for social services
- Improved use of predictive analytics



Our governance and oversight structure offers a venue for input into our UM authorization review process to ensure we use the most up-to-date, evidence-based guidelines (i.e., InterQual, ASAM), and that all biases are removed. In addition, the UM Program reports to our Chief Medical Officer, ensuring a clinical focus on managing utilization while incorporating UM into our population health strategy. The UM Program governance structure, our committees, and work groups are described below.

Quality Improvement Advisory and Credentialing Committee

The Quality Improvement Advisory and Credentialing Committee is composed of UCare medical directors, clinical services leadership, mental health and substance use disorder representatives, other UCare leaders, and community physicians. In support of UCare's mission and KanCare Members, this committee will actively promote improvements in quality and efficiency of care related to medical, MH and SUD, LTSS, disabilities, and pharmaceutical services by providing a clinical and practitioner perspective into our UM Program.

Health Services Management Council

UCare's UM Program is reviewed and approved annually by our Health Services Management Council (HSMC). The HSMC provides oversight and direction to improve utilization of appropriate medical care and ensure cost containment of medical services. The HSMC coordinates utilization management activities, medical policy development, and other medical management actions that support strategic KanCare objectives. Leaders from a variety of UCare departments are included on the HSMC, including Clinical Services, Quality Management, Health Care Economics, Provider Relations and Contracting, MH and SUD, Pharmacy, as well as UCare medical directors and other senior leaders.

The HSMC selects utilization data types (e.g., inpatient, emergency department, pharmacy, and MH and SUD services) each year to monitor for overutilization or underutilization. The upper and lower thresholds are established for each data type based on available benchmark information. The HSMC analyzes these data types quantitatively, at least annually, and reports, reviews, and discusses them with the UM committee quarterly. This analysis includes validation of compliance with the MHPAEA. If trends show utilization outside the established thresholds for three or more months, additional analysis is conducted to determine the root cause. We take action to modify any concerning trend or utilization patterns and measure the effectiveness of the action to determine if further efforts are necessary.

As the approving body of key utilization activities and metrics, the HSMC ensures that utilization initiatives are implemented, evaluated, monitored, and reviewed for effectiveness, and expanded or modified as appropriate. The HSMC consistently monitors and reviews over- and underutilization of services. In addition to these activities, the following initiatives will be incorporated for Kansas, based on best practices identified in other states in which we operate. These activities include:

[redacted]

- **Subcontractor Oversight:** Our delegate organizations present to the HSMC on an annual basis.

The following committees provide updates to the HSMC on at least a quarterly basis:

Medical Policy Committee

The Medical Policy Committee oversees the development, evaluation, and implementation of medical policies impacting our UM Program. The Medical Policy Committee evaluates the clinical evidence of topics and issues related to medical necessity for new and emerging health technologies. The committee assesses safety and effectiveness; establishes clinical indications for evidence-based application of the service, procedure, or treatment; and develops and updates medical policies in a consistent and timely manner. Keeping our medical policies up to date is a key part of ensuring strong mental health programming.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee is composed of practicing physicians and pharmacists and will include those based in Kansas. They oversee formulary management, prior authorization, step therapy, quantity limitations, and other drug utilization activities. The committee has Provider representation from clinics, health systems, Federally Qualified Health Centers (FQHCs), and Community Mental Health Centers (CMHCs) across the State. Providers that represent a variety of specialties participate in this committee and are a geographically and ethnically diverse group. The committee also advises UCare on pharmacy matters to continuously improve the delivery and quality of our pharmacy benefits. UCare's Pharmacy Team and our 2024 PBM, Navitus, have experience with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and both parties monitor for updates to mental health parity regulations. Annually, UCare's pharmacy team performs an analysis to ensure compliance with the requirements of the MHPAEA and reports the results of this analysis to the Pharmacy and Therapeutics Committee. This review ensures that our prior authorization, formulary design, and step therapy requirements are not discriminatory to the substance use disorder and mental health therapeutic classes. UCare and Navitus performs this Mental Health Parity analysis in compliance with State format and timeliness requirements.

Mental Health and Substance Abuse Disorder Key Partner Collaborative

UCare's MH and SUD Key Partner Collaborative promotes communication and integration of care among MH and SUD service Providers, medical practitioners' advocacy organizations, key community partners and UCare, demonstrating our strong local presence as a community-based organization. UCare's MH and SUD Key Partner Collaborative in Kansas will be composed of a cross-sectional group of Kansas network Providers and key community partners. The collaborative is responsible for reviewing UCare information and providing insight on MHPAEA compliance, enhancing the continuity of care and health equity of our Members as they receive care by medical and MH and SUD practitioners. The collaborative also provides a pathway of direct communication for UCare leadership to hear from collaborative members about the challenges they are facing, and to consider how UCare can help address those challenges.

Utilization Management Work Groups

The purpose of these work groups is to identify, monitor, and evaluate utilization metrics and trends that impact resources and Member outcomes focused on specific service areas: physical health, behavioral health, MH and SUD, HCBS, and LTSS. These work groups:

- Monitor Provider requests for provision of services to Members
- Monitor medical appropriateness and necessity of services to Members
- Review effectiveness of the UM process and recommend changes, as needed, to improve tracking, timeliness, and productivity performance
- Develop and update policies and procedures for UM that conform to industry standards related to methods, timelines, and individuals responsible for completing each task; and ensure compliance with KanCare regulations and National Committee for Quality Assurance (NCQA) standards

Ensuring MHPAEA Compliance

At UCare, benefit design, cost-sharing, and utilization management are critical functions that are appropriately scrutinized through the parity lens. We recognize our fiduciary responsibility to

follow parity guidelines and are compliant with the Mental Health Parity Rule (42 CFR 438 subpart K) regarding parity in cost-sharing requirements and benefit/service limitations for any MH or SUD service.

UCare has a robust process to ensure parity between medical, MH, and SUD services, including a cross-departmental work group that addresses parity compliance. Our process includes:

Parity Work Group

This work group, overseen by the Compliance Department, emphasizes the importance of coordination and communication among departments to ensure consistency when policy or practice changes are implemented that could impact parity. The work group reviews benefit design and financial responsibility for our Members, as well as the utilization review processes, to assess how decisions are made about whether to scrutinize and/or authorize care.

Parity Compliance Packet

UCare will complete a parity compliance packet annually to document our practices and procedures and will demonstrate our compliance with parity requirements to KDHE. We complete an annual review of all benefits, including financial requirements, quantitative treatment limitations and non-quantitative treatment limitations, and policy documents using standard tools and structured processes. Our process helps identify any parity discrepancies that would trigger a more targeted intervention to correct the gap.

UCare Health Services Staff

UCare's Health Services Department, which includes Clinical Services (medical/surgical reviews), Pharmacy, Quality (credentialing), and MH and SUD Services, reviews each benefit to identify any quantitative or non-quantitative treatment limitations in the service. Health Services staff review all prior authorization requirements, medical management standards, and standards for Provider enrollment that are in place for each service category (SUD, MH, and medical/surgical) to verify that parity among all categories of services is addressed. The results, including non-quantitative treatment limitations, payment rates, out-of-network Providers, and restrictions, are shared and reviewed with the Health Care Economics, Provider Contracting, and Health Services teams.

Summary

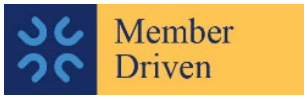
These integrated processes and reviews provide us a comprehensive view of all practices across our organization. This collaborative work is instrumental in UCare's achieving compliance with the KDHE Mental Health Parity Report.

14. Describe the bidder's ability and approach to collaborating with the State to design, implement, and evaluate pharmaceutical initiatives and best practices. In addition, describe in detail at least one data driven, innovative clinical initiative that the bidder implemented within the past thirty-six (36) months that led to improvement in clinical care, including how improvement was measured, for a population comparable to the ones described in the RFP.

As a Member-driven nonprofit, we listen to Members, invest in communities, partner with Providers, and collaborate with state Medicaid agencies. UCare will collaborate with the State to achieve its pharmaceutical requirements, priorities, and strategies for the KanCare program. We have demonstrated experience working with state Medicaid officials to design, implement, and evaluate pharmaceutical initiatives that have spanned over several years and areas. Across these clinical initiatives, we have found success through our Member-focused approach and Rapid-Cycle Process Improvement framework, Plan-Do-Study-Act (PDSA). Through this approach, our pharmacy initiatives result in significant, improved health outcomes. Our PDSA framework will also be used to support KanCare pharmaceutical initiatives that occur internally at UCare as well as those developed in collaboration with the State. UCare stands prepared to support the State in designing, implementing, and evaluating innovative clinical initiatives and best practices, including any potential move to a single Pharmacy Benefit Manager (PBM). We have highlighted examples below of our experience with pharmaceutical initiatives in collaboration with state Medicaid agencies, which include designing a COVID Vaccine Uptake Program, implementing a Preferred Drug List (PDL), and evaluating an Opioid Performance Improvement Plan (opioid PIP).

Designing a COVID Vaccine Uptake Program through a Health Equity Lens

Shortly after the COVID vaccine became available in 2021, UCare Pharmacy Services partnered with state Medicaid agency officials to design a COVID-19 Vaccine Equity Partnership. The goal of this partnership was to address gaps in COVID vaccine equity across the state's Medicaid population. UCare met monthly with the state, developed communication materials, shared data to support closing gaps in high social vulnerability index (SVI) ZIP codes, and designed innovative approaches to increase vaccine uptake. UCare's deep relationships with community and retail pharmacies across geographic regions played a key role in getting the public vaccinated.



As a part of the design of this partnership, UCare's Pharmacy Team worked with a rural pharmacy chain to gain access to their vaccine scheduling platform and directly scheduled vaccine appointments for our Members. UCare also worked with the state's health department to access immunization data for our Members via the state's immunization registry on a weekly basis. [redacted]

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UCare will design similar SVI approaches to support vaccine access in Kansas. We will also develop partnerships with pharmacies, pharmacists, and pharmacy technicians as appropriate, to implement these initiatives in areas like Wyandotte County, as well as rural and frontier areas such as Finney County. UCare Pharmacy Services looks forward to engaging in similar public health and pharmacy initiatives with the State, other key partners including local public health agencies, community and retail pharmacies, and other KanCare managed care organizations.

Implementing a Preferred Drug List

Trusted Government Partner

UCare worked closely with a state Medicaid agency to successfully implement the state Medicaid's first PDL in 2019. UCare's Pharmacy Team began engagement on this project with the Medicaid agency's pharmacy staff in regularly scheduled monthly meetings several months in advance of the implementation date. Early in the project, UCare Pharmacy staff identified a need for more frequent meetings with the agency's pharmacy staff to ensure successful implementation. The agency agreed, and through more frequent meetings, UCare and other MCOs in the market were able to discuss PDL data exchanges, ensure appropriate coding

of the PDL into PBM systems, and align Member and pharmacy communications. UCare successfully implemented the state's PDL and submitted required and requested claims audits and Member transitions to newly preferred drugs on time to the state. We will work in a similarly close fashion with the State to submit reports and documentation, regularly and on an ad hoc basis, to ensure compliance with the State's PDL.

UCare will engage in and establish similar methods of collaboration to support the State's broader strategic pharmaceutical goals and initiatives. We understand that the State reserves the right to contract with a single PBM and require contractors to contract with that PBM as outlined in RFP Section 7.3.1.H. UCare is prepared to implement any new PBM relationship to support KanCare Members and further the State's pharmaceutical objectives. We have experience implementing new PBM relationships as we are currently implementing a new PBM for 2024.

UCare recently chose to switch to Navitus Health Solutions for PBM services because they are a mission-aligned, Midwest PBM with a nonprofit parent company. Navitus Health Solutions also has a similar Member-first approach, as demonstrated by their 100% pass through to keep prescription drugs affordable for Members. As a nonprofit, UCare recognizes the inherent challenges and conflics associated with large, diversified corporate health care companies that include health insurers that also own a PBM. We are an active participant in collaborative meetings with state Medicaid agencies and other MCOs to ensure operational success, and broadly engage Members and Providers to guarantee seamless transitions. Our experience implementing large pharmaceutical initiatives, including both with a state Medicaid agency to establish a PDL and internally to a new PBM to support UCare's existing business, showcase our ability to support the State in future, large-scale clinical initiatives.

Evaluating an Opioid Performance Improvement Plan

From 2017 to 2020, UCare participated in an opioid PIP with other managed care organizations (MCOs) in our market. The goal of the opioid PIP was to reduce the rate of new chronic use of opioids among individuals. New chronic users of opioids were defined as "opioid naïve users who are prescribed an opioid for a 45-day or more supply over a consecutive 90-day period." The opioid PIP encompassed all Medicaid populations, including adults with disabilities, adults aged 65+, and families and children.

UCare worked closely with the state's Medicaid agency and other Medicaid MCOs through regular meetings to share information and develop initiatives that would address all Provider and Member needs in the opioid prescribing process. UCare supported and led many initiatives to support the opioid PIP. These initiatives included hosting opioid webinars for Providers, having a UCare Pharmacy Team member join the state's Opioid Prescribing Work Group, and developing Provider toolkits. UCare also convened an internal cross-departmental opioid work group that developed and implemented additional interventions including:

- Implementation of the state Medicaid agency's guidelines for opioid prescribing (seven-day limit, prior authorization for long-acting opioids, 90 morphine milligram equivalents, etc.) across all populations
- Continued tracking of appeals and grievance data related to the new requirements
- Identifying strategies to promote alternative pain management therapies

- Providing education and outreach for Members and Providers on opioids, including the use of these prescriptions, disposal sites, etc.
- Sending targeted mailings to Members to request a Deterra Deactivation Pouch for safe, convenient, and permanent disposal of unused, expired, or unwanted medications

UCare's Rapid-Cycle Process Improvement PDSA framework was used to support the evaluation of this initiative.

Plan: Before starting the initiative, UCare's Pharmacy Team reviewed the opioid data and prescribing trends. Through this review, we recognized that there was opportunity to decrease the rate of new chronic opioid users across all populations, but the largest opportunity was among adults with disabilities and adults aged 65+.

Do: The UCare Pharmacy Team, along with our partner MCOs and Providers, then planned the multifaceted interventions highlighted above with the goal of influencing opioid prescribing patterns and utilization. UCare reached out to prescribers, focusing on those who serve high numbers of adults with disabilities and adults aged 65+. Throughout regular intervals of assessment, UCare also received feedback from Providers and communicated with prescribers to ensure that both Members and Providers understood the changes.

Study: After the initiative began, UCare's Pharmacy Team studied, reviewed, and assessed opioid utilization data on a quarterly and annual basis, as Table 14.2 outlines.

Act: The Provider feedback and utilization data were used to inform which interventions should be sustained and which should be updated or ended. This consistent messaging and approach to management became the key tenet of the initiative. As a result of this work, UCare saw success in reducing the number of new chronic users of opioids across all Medicaid populations.

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***New Chronic Opioid User:** An opioid naïve user who has been prescribed a 45-day or more supply over a consecutive 90-day period following the first opioid prescription in the measurement year.

As evidenced by UCare's experience supporting statewide initiatives to reduce the number of new chronic opioid users, we are well positioned to collaborate with the State and Providers to reduce the rate of new opioid users, and in due course, drug overdose deaths. Based on the Kansas Department of Health and Environment's County Opioid Mortality Vulnerability Assessment from September 2022, all drug overdose deaths rose 73% from 2011 to 2020, and 53% of overdose deaths in 2020 were opioid-related. UCare Pharmacy Services will coordinate

internally with our Provider Relations and Utilization Management teams and externally with the State, pharmacies, and pharmacists to ensure smooth contracting and service authorizations, timely claims processing to support similar priority pharmaceutical initiatives.

UCare also understands that the State may have similar priorities that may require a parallel approach, including reducing the number of antipsychotic and psychotropic medications being prescribed to KanCare Members in foster care and residing in long-term care facilities. UCare has experience working directly with long-term care pharmacies on initiatives to ensure appropriate utilization of medication for Medicaid Members residing in a long-term care setting. UCare's Pharmacy Services, Pharmaceutical Director in compliance with RFP Section 7.17.2.D.10, and Pharmaceutical Provider Representative in compliance with RFP Section 7.17.2.D.18 will bring learnings from our long-term care pharmacy partnerships to this initiative. For example, UCare has developed a partnership with a long-term care pharmacy to administer medication therapy management (MTM) across our Members, which has reduced emergency department (ED) visits and inpatient admissions compared to similar populations not being served in this partnership. We have accomplished this through timely data exchanges, regular meetings on performance and interventions and continuous improvement discussions.

Innovative Clinical Initiative: Pharmacist Transition of Care

[redacted]

Integrated Care Pioneer

[redacted]

Member Story

A UCare Transition of Care Program pharmacist spoke with a Member who was hospitalized for mental health. When UCare called the Member to review her medications she kept saying she was waiting for medication to be delivered from the pharmacy; however, there were no recent claims for any mental health medications for this Member. The Transition of Care Program pharmacist directed a UCare Pharmacy Navigator to call the Member's pharmacy and found out that they had new prescriptions on file, but that the Member had "stopped communicating" with the pharmacy months earlier, so they were not filling anything for her. The UCare Pharmacy Navigator was able to provide the pharmacy with the Member's updated phone number and UCare checked in with her to confirm that she had been contacted by the pharmacy and that her medications were delivered.

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Member Story

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UCare believes this program that will benefit KanCare Members, especially those in rural or frontier areas where a local or retail pharmacy may not offer this service, and therefore turn to more expensive care. UCare has decades of experience operating high-performing FIDE SNP and HIDE SNP programs that we will bring to the State's HIDE SNP program outlined in RFP Section 7.1.1. UCare will also bring this collaborative model to Kansas to engage with health systems and community pharmacists to ensure Members are supported during transitions of care.

Summary

Designing a statewide public health outreach campaign, implementing a new state PDL, and evaluating an opioid PIP are three examples that showcase UCare's experience collaborating to achieve large-scale pharmaceutical initiatives and best practices. Additionally, the success of UCare's TOC program demonstrates our ability to support the State with developing data-driven and innovative clinical initiatives that will create positive outcomes for KanCare Members. UCare has a deep commitment to community-based partnerships and collaboration with the State and looks forward to supporting the State's pharmaceutical priorities and initiatives.

15. Describe the bidder's approach to ensuring KanCare Members, including Members residing in Rural and frontier areas of the State, receive non-emergency medical transportation (NEMT) services in accordance with the Access standards in Section 7.5.5.5 of the RFP.

UCare is excited to be able to provide KanCare Members access to Member-centered, reliable, and efficient non-emergency medical transportation (NEMT) services throughout the State. UCare has a multipronged approach we feel will meet the needs of KanCare Members that has been continuously refined throughout our decades of experience coordinating NEMT. UCare has engaged with Providers across Kansas who serve KanCare Members to gain a better understanding of the opportunities to improve upon current NEMT service delivery. We have used these insights, as well as feedback from the KanCare 2025 RFP Public Comment sessions to ensure we are meeting the needs of all involved in KanCare. Based on our personal research over this past year in the Kansas market and identifying a variety of options for transportation, UCare's approach will ensure KanCare Members, especially those in rural and frontier areas of Kansas, will have the NEMT services they need when they need them.

UCare's experience within our current market gives us a thorough understanding of the needs of Members as well as NEMT Providers. This experience comes from directly contracting with more than 100 NEMT Providers, both urban and rural. Our in-house NEMT call center in our current market arranges and schedules all Member rides through a recently implemented, technology based QRyde system. Our Transportation Customer Service Department also tracks, trends, and follows up on all transportation-related complaints. This differentiates us from health plans that solely use NEMT vendor network managers, thus removed from what Members, NEMT agencies, and Providers experience. UCare's work with managing an NEMT Provider network gives us the perspective of what it means to meet Member needs, especially when faced with geographic and/or complex health care barriers. We also ensure NEMT Providers are compensated and rewarded for providing high-quality services. We have established standards that we hold Providers accountable to, such as State certifications, regular background checks, timeliness of rides, and cleanliness of vehicles. We track complaints related to transportation and follow up on each one, ensuring our Members receive the best service possible.

NEMT Multifaceted Approach in Kansas

Based on our own experience and feedback from Kansas Providers, UCare recognizes the challenges with ensuring access to transportation services for KanCare Members across Kansas, especially in the rural and frontier areas of the State. Members' health and welfare often depend on receiving timely, accessible rides to and from health care appointments and other types of health-related services. As described in the Kansas Health Institute's June 2022 Issue Brief, transportation is a significant social driver affecting the health status of an individual. The brief speaks to how transportation in rural communities presents unique challenges for individuals in meeting their health care needs. These challenges may contribute to increases in health disparities and inequities, especially among those with special health needs, low socioeconomic resources, older adults, people of color and immigrant populations living in rural areas.

To ensure a robust network to meet these challenges, **UCare will implement the following multifaceted approach,** tailored to bring innovations to Kansas that exceed current program practices.

1. Transportation Network

UCare has selected MTM as our partner to provide NEMT services across Kansas. Established in 1995, MTM is the largest privately owned NEMT company in the country. They are an industry leader with a proven track record of meeting the complex and dynamic needs of NEMT services in both rural and urban settings. With their 2022 acquisition of Veyo, MTM greatly expanded their NEMT broker network and enhanced their integrated platform by leveraging Veyo's state-of-the-art advanced Member, Provider, and client technology platform. Through analytics and reporting, MTM (and UCare) will be able to monitor performance to metrics such as network capacity, demand changes, arrival and pickup times, wait times, and no-shows.

MTM holds their transportation Providers–including independent driver Providers (IDPs) to high standards for customer service and safety. IDPs meet strict health care standards and participate in ADA education, CPR certification, and HIPAA, Sensitivity, and Medical Needs training. They also undergo drug testing and multi-level background checks to ensure safety and the highest level of service quality.

UCare and MTM will have an innovative approach to meeting Members' transportation needs. Depending on the situation, MTM will provide services through a variety of options, organized in a comprehensive, rather than piecemeal manner. UCare's policy is to require a minimum of two calendar days' advance notice from Members requesting a ride, which exceeds the KanCare standards per RFP Section 7.5.5.5. We will apply this same policy in Kansas, requiring MTM to accommodate rides that are requested at least two days prior to the appointment, as well as urgent rides, facility discharges and transfers, same-day medically necessary appointments, and recurring appointments (standing orders).

MTM's Virtual Fleet model is designed to augment current transportation Providers across urban, rural, and frontier areas with highly qualified, NEMT-specialized rideshare drivers. These fleets will allow us to serve eligible KanCare Members in all regions, with a focus on reliability, efficiency, and cost-effectiveness. In addition to these fleets, UCare and MTM will utilize additional transportation options to meet Member NEMT access needs, such as:

2. Uber/Lyft

UCare is excited that KDHE allows the use of Rideshare-based medical transportation services for KanCare Members. We will implement this option to supplement our availability and access

for Member rides to and from essential medical services. Using an Uber or Lyft may not be accessible for Members with special circumstances, such as wheelchairs, but it will be a viable option for many Members, especially those needing same-day or urgent rides. UCare will arrange for direct reimbursement coverage under contract with Uber or Lyft, or a reimbursement arrangement directly with medical facilities that call Uber or Lyft as backup rides for their KanCare patients.

3. Metro/Bus Passes

When this type of ride is available, UCare will provide KanCare Members with public transportation passes; often this is the most cost-effective mode for NEMT.

4. Provider Partnered Rides

UCare has met with and heard directly from several Kansas medical Providers who shared their struggles with current KanCare patient transportation issues, including Starkey, OCCK Inc., Swope Healthcare, HealthCore, Johnson County Mental Health, and Salina Family Health Care. Themes that emerged from these discussions include:

- Challenges trying to find an available ride for Members with a clinic appointment
- Member/patients showing up late for appointments due to transportation issues, or delays/problems with the transportation vendor
- Arranging for and paying for an Uber/Lyft or taxi at the Provider's expense due to the transportation vendor not accommodating the ride
- Employing their own transportation services without funding
- Having their own NEMT vehicles but having to contract through the network vendor and their inefficient processes to schedule rides for their own patients/KanCare Members
- Using an innovative, but not reimbursable, Peer Support driver model that not only provides rides for Members but provides driver jobs for Members
- Challenges scheduling urgently needed appointments

Based on our personal research over this past year in the Kansas market and identifying the various options for transportation, UCare's approach to ensuring KanCare Members, especially those in rural and frontier areas of Kansas, have the NEMT services they need and when they need it, will be multifaceted. UCare will require MTM to contract with these Providers and include them in their NEMT network.

5. Provider Reimbursement

UCare will work with MTM to ensure we provide adequate payment to medical Providers who have their own NEMT transportation services for their KanCare Members/patients. UCare will establish a streamlined, efficient process to reimburse the Provider directly to cover these essential rides.

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Supporting Providers to meet transportation needs of their patients/KanCare Members illustrates UCare's commitment to ensuring KanCare Members get the care and services they need and illustrates UCare's dedication to financially supporting mission-driven work.

6. Mileage Payment for Friends, Family, or Member for Transportation

Especially in rural or frontier areas of Kansas, where traditional NEMT services are not readily available, UCare will arrange to pay mileage for driving a KanCare Member to medical services by a friend, family member, or even the Member themselves.

As described above, UCare will implement a comprehensive multipronged NEMT service delivery approach in Kansas to ensure we meet all Member needs no matter the geographic location.

Authentic Provider Relationships

[redacted]

Transportation Management

Appointment Scheduling

MTM's technology platform is custom built for NEMT management. It allows Members and caregivers to book trips online or through an app. It has real-time trip visibility for Members and MTM.

[redacted] to prevent the Member from incurring a more costly ambulance ride or extended facility stay.

Supporting Members on the Day of Their Appointment

Member Driven

On the day of the Member's appointment, their ride will arrive at their designated pickup location no later than 15 minutes after the scheduled pick-up time. We will educate Members on the process for requesting an alternate ride in cases of unforeseen circumstances that lead to a driver arriving more than 15 minutes after the scheduled time, as this would be considered a driver no-show. Given the longer travel times and distances for Members in rural and frontier areas, UCare staff will assist the Member with rescheduling their missed appointment.

Member Story

"I had multiple, complicated medical appointments that I needed help to schedule out over several months. UCare was like my guardian angel! I do not know where I would be without you (UCare)."
—'HA', rural UCare Member

Drivers shall ensure that the Member arrives to their appointment no sooner than one hour before their scheduled appointment time. Drivers will wait with the Member to ensure the building is open and the Member is kept safe and not left alone. Drivers will work with the Member to arrange a pick-up time following their appointment and will communicate with the Member if they are going to be delayed in returning to the pick-up location.

Value-Added Transportation Benefits

To support various transportation needs of Members beyond those to direct health services appointments, UCare will provide transportation VABs to KanCare Members to:

- Pregnancy, breastfeeding, and parent support groups
- WIC appointments
- Social service agencies that support occupational attainment and job interviews

Members on Frail Elderly (FE) or Physical Disability (PD) waivers will be eligible for an additional 12 rides per year for social activities or food supports.

Monitoring and Auditing NEMT Performance and Compliance

We will establish a cross-departmental group that will include UCare's Kansas Market President, Kansas Provider Network Management and Contracting Director, Provider Grievance and Appeals Director/Manager, MTM Delegation Oversight Manager, and others as needed. The group will meet at least monthly to monitor the performance of NEMT services and discuss various transportation topics, including, but not limited to:

- MTM Performance Reports
- Feedback from Providers
- Complaints against specific Providers
- Opportunities to enhance NEMT in service areas in which it is harder to find rides
- Strategic brainstorming to identify innovative solutions to enhance Member experience

By including departments from across the organization, we can receive and act upon feedback from many different perspectives related to transportation. UCare has established a team of specialists who work on escalated issues, whether a complaint from a Member, support for transportation Providers, or finding rides for complex cases, which may include paying no-load miles to Providers. This specialized team focuses on these escalated issues, allowing front-line transportation call center representatives to assist as many Members as possible without delay. We utilize a closed-loop process to utilize feedback gathered from escalated requests to inform enhancement to our NEMT processes.

Summary

Through our engagement and research efforts with stakeholders across Kansas, we understand the unique challenges faced by KanCare Members, particularly in the rural and frontier areas of the State. UCare is dedicated to working with the State, Providers, community organizations, and other constituents to continue to address the transportation needs through innovative partnerships and approaches. UCare looks forward to bringing our success in providing quality, timely NEMT services to the KanCare population.

16. Describe the bidder's proposed array of Behavioral Health crisis services and how those services will interface with 988 and other crisis resources within Kansas. Include the following in the bidder's response:
    a. The bidder's approach to collaborating with its Behavioral Health crisis Providers, first responders, and other crisis resources to create a comprehensive, well-coordinated, Behavioral Health crisis continuum for all Members.
    b. The bidder's approach to collecting data, measuring, and evaluating the effectiveness of its Behavioral Health crisis services, and implementing improvements based on its evaluation findings.
    c. The bidder's plan for evaluating and meeting network adequacy with Behavioral Health crisis services, like mobile crisis services and crisis stabilization services.
    d. The bidder's plan for promoting awareness of 988 and how to access local crisis services to Members.

Kansas demonstrated its leadership when it became one of the first states to implement 988. Further, Kansas has built a foundation of crisis services with the Community Mental Health Services statewide and implementation of the Certified Community Behavioral Health Clinic (CCBHC) model, which requires the availability of crisis services 24 hours a day, 7 days a week. We know gaps still exist as the State continues to expand its crisis services models for all populations. UCare will partner with crisis resources in the State, including 988 entities, community Providers, local agencies, families, and Members to provide our array of Behavioral Health (BH) crisis services. UCare works collaboratively with community mental health agencies that provide BH crisis services, including CCBHCs, as our service area was selected as one of eight states to pilot the CCBHC program in 2017. These years of experience have ingrained community-based care as best practice to deliver person-centered and trauma-informed care for our Members receiving BH services. Over the last 14 months, UCare has met several times with the Association of Community Mental Health Centers, Wheat State Healthcare, individual CHMCs across the State, NAMI Kansas, and the Kansas Mental Health Coalition to develop these important relationships with the shared goal of supporting KanCare Members in achieving their best BH outcomes, especially in crises.

Core community crisis services include crisis hotlines, mobile crisis units, and crisis stabilization services. UCare will coordinate and interface with existing crisis services in Kansas provided by 988, Community Mental Health Centers (CMHCs), and CCBHCs as we provide our array of crisis services. These services include:

- Crisis line (supported by Carenet)
- Warmline
- Peer support line
- UCare's BH Care Coordination Team
- Pre-purchased BH Appointments
- Crisis and mental health first aid training for community Providers

A. Collaboration with Behavioral Health Crisis Providers

Mental Health America's 2023 ranking placed Kansas last in the nation, indicating a higher prevalence of mental illness and lower rates of access to care across the State. UCare stands

ready to partner with the State and local Providers to achieve the goal of improving health outcomes through integrated, evidence-based, and well-coordinated care, especially related to BH.

> *"The Association and Wheat State Healthcare have both enjoyed a collaborative and supportive relationship with UCare before and during the RFP process. We believe there is alignment and mutual interests amount the organizations and UCare has continually reached out to better understand the needs of CMHCs in Kansas and how the CCBHC model can improve outcome for the tens of thousands of KanCare members that rely on our highly trained and innovative behavioral health providers."*
> — Kyle Kessler
> Association of CMHCs of Kansas and
> Colin Thomasset, Wheat State Healthcare

Authentic Provider Relationships

For example, UCare provided a $260,000 grant to Wheat State Healthcare to support increased access to BH services across the State. Among the subgrants, $10,000 was awarded to the Family Service and Guidance Center in Topeka to support purchasing supplies for a Kids Crisis Center. Another $11,880 went to South Central Mental Health Counseling in Iola to support the recruitment and retention of BH crisis staff and $24,200 was provided to Sumner Mental Health Center in Wellington to support after-hours crisis services and transition funding to achieve CCBHC status. Beyond direct community investments, UCare has built an array of BH crisis services that are designed to collaborate and partner across 988 entities, CMHCs, and CCBHCs in Kansas and meet Members across the crisis continuum.

This is accomplished through three phone lines designed to meet Members where they are, enhanced training opportunities for community Providers, and strong care coordination services.

UCare's Dedicated Phone Lines to Support Members' Behavioral Health

Member Driven

UCare has three phone lines available for Members to contact, depending on where they are along the continuum of care. The phone lines will also accept information from caregivers, family members, and community agencies as related to UCare Members, and UCare will ensure appropriate HIPAA regulations are followed regarding Members' personal health information.

- **BH Crisis Line:** UCare has an established 24/7 nurse advice line vendor, Carenet, that facilitates warm transfers from helplines and will bring this to Kansas to meet the requirement outlined in RFP Section 7.10.11.A and 7.10.11.B. Carenet utilizes the Schmitt-Thompson Clinical Content Guidelines. UCare ensures that Carenet is aware of local resources for Members. When Members call our BH Crisis line, the nurse will stay on the line while arranging for someone else to call 988, or a local CMHC or emergency medical Provider as appropriate. The nurse will continue to provide support to the Member until help arrives.

[redacted]

UCare Services to Support Behavioral Health Crisis Access

UCare recognizes that Members in crisis cannot wait for appointments, and as such, UCare has taken steps to support quicker access to BH services for those in crisis:

[redacted]

- **Training First Responders:** UCare recognizes workforce shortages across health care professions, and specifically in BH professions. These shortages impact the continuum of BH care available to individuals and our Members. As such, first responders remain a vital resource to Members in immediate crisis or located in areas where 24/7 crisis services are not yet available. UCare will support efforts embedded in communities to provide Mental Health First Aid to first responders.
- **Training for BH Providers:** A BH crisis is not the time for Members to have to learn how to navigate services available to them. UCare has found unique opportunities to connect Members with the right service at the right time and will bring these best practices to Kansas. For example, UCare partnered with and provided funding for the advocacy group Metro Children's Crisis Services. During the pandemic, children and families experiencing mental health crises waited longer to get help and often ended up in the wrong level of care when they did reach out. This project helped connect Members with crisis response teams who could assess the crisis and get them the right level of care. Through this partnership, we also made a significant investment in equity training. The result of this project created and implemented a culturally effective promotional campaign to help families and children know what resources are available to them when their children experience mental health crises. In particular, the campaign promoted

mental health crisis response teams. This included designing electronic and print materials and sharing them on social media, through trusted partners and traditional media. Also, this project created a centralized interactive web portal featuring the intake process for children who need placement, as well as local resources for community support. This helped free up crisis workers and hospital social workers' time to support the children and their families; help clarify to all parties what to expect when waiting for placement; and where possible, help the children and their families access resources and residential placements more quickly and smoothly.

UCare's Behavioral Health Care Team

UCare's BH Care Team, which includes a UCare BH care coordinator, single point of contact at a CHMC or CCBHC, Member engagement specialist, community health worker, and Disease Management teams as applicable, works to identify and address Member concerns before they develop into a crisis. Our BH care coordination integrates services and supports to address BH, physical health, and long-term service and supports (LTSS) needs, and includes unique care teams designed to meet cultural and linguistic needs. UCare's BH care coordinators support and assist Members find the right level of care, connect with local resources, including crisis services, and make referrals to our comprehensive BH Crisis response network that will meet requirements outlined in RFP Section 7.10.11.

UCare's Integrated Care Coordination model is intentionally flexible to meet individual Member needs and choices, trauma-informed, and intentionally designed to provide equitable access to care and reduce disparities.

UCare BH care coordinators identify Members with BH needs through the health screen and Health Risk Assessment (HRA) as part of the initial care coordination process, per RFP Section 7.4.2, or ensures that the single point of contact for the Member at their respective CCBHC completes the health screen and HRA. Members are also identified for BH care coordination if they have multiple experiences at higher levels of care, such as mental health or substance use disorder (SUD) inpatient, detox, crisis admissions, or Emergency Department (ED) visits. The BH Care Team also accepts referrals from local agencies, Providers, and CMHCs.

If a Member engaged in care coordination does experience a crisis, UCare's BH care coordinator follows up with the Member the next day to check in on their status and assist with the next steps toward stabilizing their BH needs, per RFP Section 7.4.10. The BH Care Team considers the Member's safety first and helps Members avoid unnecessary ED utilization. We guide the Member to engage in the right level and type of care when their need is greatest, with ongoing support to help manage their needs in the long term. We ensure Members interested in applying for a HCBS waiver and who may be placed on a waiting list (for example, the waiting list for the Intellectual and Developmental Disability HCBS waiver) still have their needs met through covered services, Early and Periodic Screening, Diagnostic and Treatment, In Lieu of Services, value-added benefits, and other SDOH referrals. UCare's BH Care Team will coordinate with the appropriate local Providers, internally with other care coordinators who have experience with other referrals that may benefit the Member and refer the Member to community-based organizations to support them as demonstrated in the following Member story.

Member Story

A UCare Member called our Member Services Department to file a grievance. The Member was extremely upset about her therapist canceling appointments and not notifying her. The Member was transferred to the crisis line due to suicidal ideation. During the call with the nurse, the Member was tearful throughout the entire call. She reported feeling hopeless, angry, and depressed. Also, she reported suicidal ideation but would not share if she had a plan, or a means to carry out that plan, and was not willing to complete a suicide assessment. She reported that she lived alone and had a dog who she loved dearly. She refused to go to the ED for evaluation due to a previous bad experience and did not want help from 988 or a county crisis team. She made mention of end-of-life plans and past suicide attempts. The Member attempted to end the conversation with the nurse multiple times. While one nurse talked with the Member, another nurse called 911 so that a welfare check could be completed. When the police arrived, the Member's mood was not as elevated, and she reported wanting to walk her dog.

A UCare BH Care Coordinator followed up with the Member the next day. The care coordinator performed a comprehensive assessment that showed the Member had many gaps in her care plan. We identified that she would benefit from additional mental health supports/services and in-home supports. Referrals were made to Targeted Case Management, to an entity for a waiver assessment, to UCare Disease Management for asthma, a therapist, and a psychiatrist for assessment. The Member said she had been asking for help for so long, and no one would help her. She seemed defeated by the system. Other resources given to the Member included a list of NAMI support groups in her area. Less than a month later, the Member was in much better spirits. She no longer had suicidal thoughts. She was meeting with all of her Providers. She was able to identify how to partake in self-care. She reported she was focusing on her mental health and wanted to see improvement in her symptoms. Our Member has not had any more hospital visits or crisis calls and continues to have services in place.

B. Collecting Data and Evaluating the Effectiveness of Crisis Services

UCare conducts an annual population health assessment to examine the characteristics and needs of Members. Findings and results of the population health assessment inform the design of our programs and services and identify areas to prioritize initiatives that will support reducing disparities, closing gaps in care, and addressing other SDOH factors. The population health assessment is also utilized to study the utilization of BH crisis services, and the interventions that best support Members in receiving the appropriate level of care to avoid another crisis.

Evaluating the Benefit of Community Based Behavioral Health Crisis Services

C. Network Adequacy for Behavioral Health Crisis Services

Our decades of BH experience have taught us that building and maintaining a comprehensive, high-quality Provider network is central to supporting our Members' best health. UCare will develop and maintain a comprehensive BH Provider network per RFP section 7.5.8.E., including a crisis response network to provide appropriate supports to Members with both emergent and non-urgent needs within the required time frame. UCare utilizes a multipronged approach to ensure network adequacy for BH crisis services. Central to this approach is partnership with BH Providers to expand and support access to services statewide. Additionally, UCare utilizes

several processes and tools to meet BH network adequacy including geographic accessibility analysis, monitoring out-of-network utilization, and collecting input on BH service access from an internal, cross-disciplinary committee. Finally, UCare uses two different tools to assess Network strength.

UCare's Partnership with Behavioral Health Providers

UCare recognizes that CMHCs are the safety net, entry point, and backbone of BH and crisis services across Kansas. To support their foundational and innovative role, UCare stands ready to provide additional support and ensure broad access to the array of BH services required to meet the needs of Kansans, as evidenced by our $260,000 grant program administered in partnership with Wheat State Healthcare. UCare has also initiated conversations about data sharing opportunities with CMHCs and CCBHCs to support ongoing development of BH crisis services and ongoing BH care. UCare will also partner with other BH Provider types such as Camber Children's Mental Health, Kansas University Medical Center, Ascension Medical Group, State hospitals, Psychiatric Residential Treatment Facilities, and other independent groups.

UCare will partner with these core Providers in our network for BH crisis services to seek feedback and develop creative solutions where Kansas communities may see gaps in crisis services. For example, some CMHCs that offer crisis services have not yet built capacity to offer 24/7 availability. At UCare, we recognize that it is not about just having a Provider network that includes crisis services, it is about having a system in place that can respond when a crisis occurs. As such, we also coordinate and collaborate with resources including 988 and public safety to avoid an adverse or fatal outcome. UCare commits to going above and beyond our existing network adequacy tools, to partner and support the State's continued development of a statewide crisis services system.

UCare's Processes and Tools to Meet Behavioral Health Network Adequacy

The network adequacy standards we monitor include, but are not limited to, access for rural and frontier Members, addressing Members' emergent and non-urgent needs, and coordination of care for Members being discharged from inpatient care. When UCare contracts with Providers, it is part of our process to inquire if they offer crisis services. If a Provider indicates it offers crisis services, it is reflected in our Provider Directory for Members to easily identify. Specifically, Members can search for adult crisis, crisis psychotherapy, children's crisis response, crisis assessment stabilization, crisis residential, and crisis intervention mobile services. UCare will use this process to assess the adequacy of BH crisis and crisis stabilization services network in Kansas and ensure our Member-facing Provider Directory is easy to navigate for Members to search and find BH crisis resources. UCare also utilizes the following tools and approaches to support and monitor our Provider network.

- **Geographic Accessibility Analysis:** UCare refers to State and Federal geographic standards to identify network needs. Ensuring access for rural and frontier Members is a UCare priority. In addition to ratio monitoring, we analyze our membership's addresses to ensure they are within the 30- and 60-mile distance standards established by the State.
- **Out-of-Network Utilization:** We evaluate this data to identify instances in which Members feel they cannot get the care they need in our existing network and conduct outreach to Providers to develop relationships and assess opportunities to contract.

- **Maximizing Provider Network Committee:** UCare's Provider Data and Network Analytics staff lead a committee focused on maximizing Provider networks. The committee includes representatives from several UCare departments, including Provider contracting and relations, clinical services, Member services, appeals and grievances, sales, product management, county and tribal relations, and community relations. The committee meets monthly to monitor our Provider network and identify opportunities to enhance network access to better serve our Members. The committee serves as a forum to aggregate community stakeholder input about Provider access gathered across the organization. UCare will utilize a similar committee framework in Kansas.

Tools to Assess Network Strength

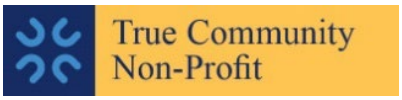
UCare constantly evaluates our Provider network to ensure it is meeting State and Federal adequacy requirements. UCare will establish a Kansas-based Provider Data and Network Analytics Department that will be dedicated to this work. We have continuously improved our network management through investment in the tools, processes, and people needed to help us better analyze and describe our Provider network. Over the last five years, UCare has installed newly developed tools, improved processes, and added staff to allow us to compile and report accurate and helpful data on contracted and non-contracted Providers. We use two crucial third-party tools to help assess our network strength:

- **Quest Analytics**: A state-of-the-art Provider network management platform also used by the Centers for Medicare & Medicaid Services (CMS). This tool allows us to evaluate our current list of network Providers by specialty and location and identify any potential gaps that need attention. UCare runs this program every week to find gaps and identify new Providers in our service area, which is especially important in rural and frontier areas.
- **LexisNexis ProviderPoint:** This tool allows UCare to evaluate the accuracy of our Provider network data by comparing our data with various other databases to identify inaccurate addresses, phone numbers, Provider location errors, and more. We run the program each month and update any changes in our Provider network database.

UCare recognizes that BH workforce shortages impact Member access to BH services. Through grant work already implemented in Kansas, UCare aims to support workforce development through partnerships, Provider and association relationships, and telemedicine access. For example, we have provided financial support to establish paid clinical internships for BH professionals with a focus on equity and accessibility to underrepresented Provider types and communities in our current market and will look to support similar initiatives in Kansas. We also offer Provider incentives, such as value-based payments, and monitor our Member experience to ensure the network is as comprehensive and adaptable as possible to meet our Members' specific needs.

D. Promoting Awareness of 988

With more than 20,000 calls made last year to the 988 Lifeline in Kansas, UCare recognizes the early work and investment made by the State to implement the 988 suicide prevention and mental health crisis hotline in Kansas. As a community-based health plan, we also know that several Providers and advocacy organizations supported the State in implementing the 988 line, such as COMCARE, Johnson County Family Health Center, and others.



To continue to support the State in ensuring that Members have equitable access to local BH crisis services across the State, including in rural and frontier areas, UCare recognizes the importance of promoting awareness of the State's robust 988 line, especially given the success rate of answering and responding to calls in the State. This connection to local resources is essential to support Members experiencing BH crises. UCare lists 988 on our public-facing website, and partners with other advocacy organizations, such as NAMI, to promote awareness of resources like the 988 line.

At the Kansas Association of Community Mental Health Center 2023 annual conference in Wichita, UCare staff had the opportunity to make several connections with local BH crisis service Providers and advocates, with whom we plan to collaborate in the future to improve our Members' well-being. UCare has also presented to the Kansas Mental Health Coalition about our BH services and priorities and has attended several additional monthly meetings over the past year to learn more about local entities in the State and their priorities. We look forward to developing similarly meaningful relationships with Providers and coalitions throughout Kansas to find the best ways to reach individuals, communities, and Members and offer awareness of resources such as 988. UCare has also made initial outreach to Kansas 988 to discuss the potential for data share/exchange, to assist 988 and UCare in ensuring people are connecting to the services they need, and how we can continue to support them in recovery.

Summary

UCare is committed to ensuring KanCare Members can easily identify, access, and receive local BH crisis services as promptly as needed. UCare's BH Care Team will support and promote Member awareness of local and community-based crisis services. UCare also has robust tools and mechanisms to evaluate our BH crisis services Provider network, and we will ensure our crisis network in Kansas meets regulatory adequacy standards, provides industry-standard appointment availability, and supports community patterns of care. UCare is also deeply committed to investing in communities to support the already existing efforts to build a robust and statewide BH crisis workforce and network across Kansas.

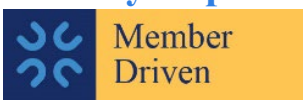
17. Describe the bidder's approach to increasing the provision of screening and tobacco cessation services to KanCare Members disproportionately affected by smoking and tobacco use. Include an example of a similar approach the bidder has taken with similar populations that was successful, the measurable impact achieved, and why the bidder anticipates the approach will result in improvements in KanCare.

UCare is committed to supporting our Members on their journey to quit tobacco and helping the Kansas Department of Health and Environment (KDHE) achieve the goals of the Kansas Tobacco Control Strategic Plan. We understand KanCare Members are disproportionately affected by tobacco use and that Kansas adults with Medicaid are three times as likely to smoke as those with private health insurance. We also understand that while overall tobacco use in Kansas has declined, disparities remain a key challenge among at-risk populations, such as people of color, individuals with disabilities, pregnant women and mothers, youth, and people experiencing mental health issues. For decades, UCare's tobacco screening and cessation programs have supported our Members, many of whom experienced similar disparities. Our organizational focus on health equity and social determinants of health uniquely positions us to support Kansas in addressing tobacco-related health disparities and offering equitable services for tobacco cessation.

UCare aligns with the State's goals to reduce health disparities, encourage Member engagement in wellness and prevention services, and improve health outcomes through cost-effective services. Tobacco screening and cessation programs have the potential to improve health and save thousands of lives, while decreasing Medicaid costs by lowering utilization of more costly services: research suggests that if just 1% of current smokers in Kansas quit, the State would save more than 10 million dollars in Medicaid costs the following year.

Our approach to this work is guided by our commitment to health equity and identifying disparities to remove barriers to care and improve the health of all Members [redacted]

Priority Populations in Kansas



Addressing tobacco control in priority populations presents a strong opportunity to reduce health disparities in Kansas. Our most vulnerable Members are at the greatest risk for targeted tobacco advertisements and are disproportionately affected by race, income, mental health status, and other characteristics. In alignment with KDHE's priorities for tobacco control, UCare's strategy focuses on priority population segments who are the most critical to achieving meaningful progress and are likely to be specifically targeted by the tobacco industry: youth, individuals with mental health or substance use disorders, American Indians, people of color, people with low income, people with disabilities, people who identify as LGBTQ+, and pregnant and postpartum women. We will

seek to collaborate with and support key organizations and agencies in Kansas who are involved in preventing and decreasing tobacco use in these populations, such as the Tobacco Free Kansas Coalition, Kansas chapter of the American Academy of Pediatrics, Kansas Department of Education, KDADS Substance Abuse Prevention, NAMI Kansas, community mental health centers, local health departments, and maternal and child health programs. We have had preliminary meetings with some of these groups regarding partnerships.

We have analyzed the yearly KDHE reports on priority populations in Kansas. The following are key examples of our approach to addressing cessation within these populations.

Youth and Young Adults

In Kansas, 90% of smokers begin smoking by age 18 and more than 60,000 Kansans currently under 18 will die prematurely from smoking. While the use of conventional cigarettes has declined, more than a third of Kansas high school students have tried electronic vapor products (EVPs). With youth being twice as sensitive to tobacco advertising as adults, preventing the initiation of tobacco use is critical to success. We have observed many of the same challenges in our current populations and have addressed them through a two-pronged approach. We have expanded our youth tobacco cessation services to help youth nicotine users quit. UCare is an active participant in the Minnesota Quit Line Network (MQN), a coalition made up of the state health agency and all managed care organizations (MCOs). MQN works on behalf of youth through a counter marketing campaign to combat targeted advertisement. The campaign educates young people about the effects of nicotine and seeks to prevent initiation. The design of the youth program has also been shifted to be more engaging for a younger audience, introducing short videos, animations, podcasts, and quizzes. In addition, we support Members for a Smoke-Free Generation, which advocates to address tobacco and vaping policy in the state.

Members with Mental Health and Substance Use Issues

Mental health plays an influential role in tobacco use at the national and state levels alike. Nearly a third (30%) of adults in Kansas with mental health issues smoke, more than double the smoking rate of those without mental health issues. This correlation is equally present among youth who use EVPs, with 60% reporting symptoms of depression, compared to 29% of non-users. We have tailored specific portions of our programming to support intake and aid for people with mental health conditions. Our behavioral health program includes eight outbound calls with a trained coach, a 12-week supply of gums or patches at no cost, and a letter to their behavioral health Provider to coordinate their care. Past results have shown that individuals with a behavioral illness are more likely to engage in the quit program and report higher quit rates when they receive support from specialized programs. Members are given the opportunity to identify any mental health struggles they may have, while health coaches who have experience with and relevant knowledge about their specific conditions offer specialized advice. This specialized approach has led to a 30% quit rate, exceeding the national average. In addition, UCare is an active participant in the Lung Mind Alliance – a statewide coalition made up of partners from mental health, substance use disorder, public health organizations, MCOs, and state and local government agencies with the goal of reducing disparities related to the impact of commercial tobacco on people living with mental illness and/or substance use disorders.

Pregnant and Postpartum Members

Smoking during pregnancy increases the rate of birth defects and even death for infants. Maternal smoking during early childhood development can also cause lung disease in children.

According to a 2023 study by KDHE, 17% of mothers in Kansas smoked cigarettes within three months of pregnancy and 9% smoked during. We have a special quit program tailored for Members who are pregnant or postpartum. Our maternity quit program includes 10 outbound calls from a specially trained quit coach from pregnancy through the postpartum period, offering a greater intensity of behavioral support with relapse prevention. We also provide a $25 gift card incentive to pregnant and postpartum women for completing an initial assessment. Our goal is to have more women who are pregnant or planning conception to enroll in our tobacco cessation program through enhanced incentives and support. In addition, proactive screening such as health screens and health risk assessments provide the opportunity to identify mothers with an amplified risk of smoking; for example, level of education and enrollment in nutrition programs can be indicators of nicotine usage.

The American Indian Quitline

The American Indian Quitline was created in partnership with the State Medicaid Agency and with guidance from the community to offer specially designed support to quit commercial tobacco. The program offers up to 10 calls with American Indian coaches who understand the culture and respect traditions. The service also includes 12 weeks of free nicotine replacement therapy such as lozenges, gum, or patches. We will seek to develop a similar program that provides support that is unique and effective to combat disparities faced by American Indians in Kansas.

Identification, Screening, and Referral for Tobacco Cessation Services

A primary goal of our tobacco cessation program is to educate Members and empower them to achieve their goal to eliminate tobacco from their lives. We identify Members for tobacco cessation outreach through:

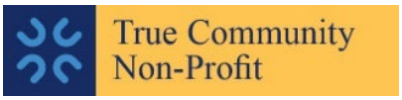
- **Health screening and Health Risk Assessments (HRAs)**: These tools enable Members to self-report their use of tobacco as well as any circumstances that might make them particularly vulnerable to tobacco use. We contact Members at least three times to encourage completion of the assessment. HRA data allow earlier identification of needs for new Members compared to relying on retrospective claims data alone.
- **Review of medical and pharmacy claims**: We initiate targeted calls to Members who have a pharmacy claim for nicotine replacement therapy or a Provider claim for tobacco cessation counseling. These Members automatically receive outreach to engage them in quit line or other cessation services.
- **Opt-in**: Members may also self-report any challenges with nicotine through their care coordinator or opting into the Quit for Life program directly.
- **General cessation education**: Many of our Member materials, including enrollment materials and targeted newsletters, contain information that can guide Members to the quit line and inform them about the importance of nicotine cessation.
- **Community and care advocates**: We work with and promote our cessation services in our community through our partnerships with local organizations.
- **Health management**: Our health management and coaching programs encourage Members to seek out cessation services.

- **Providers**: We collaborate with our Providers to inform Members of available cessation services and the benefits of quitting.

Care management teams receive monthly reports identifying Members who may benefit from a program or intervention based on HRA results. Identified Members then receive referrals to health promotion programs, including tobacco cessation. We assess all Members who enroll in our Tobacco and Nicotine Quit Line program, Quit for Life, to understand their specific needs and goals, and match them with the appropriate sub-program.

UCare's Tobacco and Nicotine Quit Line — Quit for Life

Our Tobacco and Nicotine Quit Line, Quit for Life, offers free support from coaches to help Members learn how to stop smoking, vaping, or chewing tobacco. This resource is available 24 hours a day, seven days a week, via phone and online.



The Quit for Life website (accessed through UCare's website) offers a unique experience for Members, including resources and tools, the ability to chat with a coach, peer support from other people trying to quit, and more. With the declining use of phone line support to help people quit, we added a mobile app in 2020 to promote easier access to services for all Members. Members are offered six outbound calls from a coach and unlimited inbound calls. Through the Quit for Life program, Members have access to an eight-week supply of nicotine replacement therapy (gums and patches), at no cost to them, that can be shipped directly to their homes. This benefit is in addition to their regular pharmacy coverage. Additionally, we encourage pregnant and postpartum Members who smoke or vape to engage in Quit for Life by offering a $25 incentive. Our youth Members, ages 13-17, also have access to the Quit for Life program, without being required to obtain parental consent to receive services. We understand that youth vaping has increased significantly in the last few years and are working to create appropriate services and resources to reach out to youth in the most effective manner.

We actively reach out to our Members to promote engagement in our Quit for Life program. We currently conduct outreach in two ways: 1) Outbound recruitment (OBR) calls (five attempts) by a quit coach, and 2) Mailing a quit line program brochure. As described above, our target population for the OBR calls are Members who have a pharmacy claim for nicotine replacement therapy or a Provider claim for tobacco cessation counseling. We target this specific population because we know that they are actively trying to quit and may benefit from additional support through the Quit Line program. For mailing outreach, we send our Quit for Life program brochure to all Members who have been identified as a tobacco or nicotine user.

Quit for Life Program Results

We understand the KanQuit program experienced a 23% quit rate during 2020-2021. We are proud of our Quit Life program's successful quit rate (33.5%) and will extend our program's reach to benefit additional Kansans. From 2018-2022, UCare had an annual participation rate of 4.83%, with a goal of 5% of the estimated population using tobacco and nicotine. Of

Member Story

"The coach was great, and the text messages were even better! Always a positive, realistic message. They also provide you with patches or other products to help your cravings and the coach educates on the reality of what it takes to quit."

all our enrollments into the program, 21% have asthma, 16% have COPD, and 13% have diabetes. For these Members, quitting tobacco makes an incredible difference for their health and safety. In our analysis of health care utilization by Members who enrolled in the program, we found that enrollees experienced favorable outcomes regarding emergency department visits and hospital admissions after enrolling.

[redacted]

In 2022, UCare saw a 19% increase in interaction with tobacco and nicotine cessation across all Medicaid populations. We believe the results are primarily driven by our enhanced online experience, where Members can access support groups and coaching through chats or texting. We are encouraged by these outcomes and continue to look for ways to promote quitting among Members who use tobacco or nicotine.

We receive both quarterly and annual updates on cessation, outreach, success, and satisfaction numbers in the Quit for Life program. This data is used to address any parts of our program that need improvement and populations that may need more outreach or attention.

Additional Avenues of Support

We continuously look for ways to expand our nicotine cessation programming, whether through improvements to our current services or through external partnerships. For example, we know that in-person services, given proper transportation and access, can be much more effective and engaging than digital or telehealth services. We are exploring a potential partnership with a Provider system with expertise in offering in-person cessation services. We look forward to exploring a similar partnership to address the needs of KanCare Members.

We will also collaborate with other MCOs through our association with the Alliance of Community Health Plans on industry trends in tobacco programs and value-added benefits, and in designing new programs to pilot and implement. By working with Providers, improving our own services, and altering our programs to work in conjunction with the Kansas State cessation program, we aim to improve the health of smokers, reduce costs, and increase awareness about nicotine usage in Kansas. Additionally, key UCare leaders are part of the Tobacco Free Kansas Coalition.

Summary

In addition to conducting our own market research, outreach, and assessment, we will work with KDHE to align our efforts and ensure that we work within the scope and needs of the State. We have evaluated the Kansas Tobacco Control Strategic Plan and will consider the goals, methods, policies, and designated partners of KDHE when tailoring our cessation program in Kansas.

18. Describe in detail the proposed value-added benefits the bidder intends to offer KanCare Members, including the scope of each benefit (including any limitations), the target population, and the anticipated benefit to KanCare Members. Include the bidder's approach to assessing the impact and value of the value-added benefits to Members.

Value-Added Benefits

To provide whole-person care to KanCare Members, UCare will offer the following Value-Added Benefits (VAB). Our VAB program includes benefits that align with the State's encouraged benefit areas.

Table 18.1: UCare's Value-Added benefits

Dental Care	
VAB	**Adult Dental Expanded Dental**
Description, Scope, and Limitations	Members ages 21 and older receive a $500 dental allowance. Including exams/cleanings twice a year, annual x-rays, filling extractions and specific root canals.
Expected Benefit	Dental Health is part of whole-person care. Covering additional dental expenditures ensures Members are receiving the full suite of services they need to stay healthy.
Vision and Podiatry	
VAB	**Vision**
Description, Scope, and Limitations	Members over age 21 can receive up to $60 annually in enhanced eyewear.
Expected Benefit	Enhanced frame coverage can support enrollees needing more complex/specialized eyewear to achieve stronger vision correction that can help them manage activities of daily living, obtain, and keep employment, and participate in community activities that increase independence and help to reduce isolation, including dementia prevalence in older enrollees.
VAB	**Foot Care**
Description, Scope, and Limitations	Members 21 and over are offered two routine foot care visits per year.
Expected Benefit	Regular foot care for Members with diabetes can help identify and avoid exacerbations of conditions that can lead to nerve damage or foot loss.

Pregnant and New Moms	
VAB	**MOMS Program and Incentives**
Description, Scope, and Limitations	All pregnant Members receive an outreach from a Maternity Care Coordinator to conduct a risk assessment to identify pregnancy needs and determine the appropriate level of care coordination for the Member. Members also receive a MOMS Handbook, available in English and Spanish which includes tips and resources on prenatal care, healthy eating, postpartum health, community resources, and more. Pregnant Members receive up to $75 in rewards annually for completing important health care services including their first prenatal care visit within the first trimester or within 42 days of plan enrollment., postpartum visit, and the Quit for Life program.
Expected Benefit	Members engaged with our Care Coordinators are connected to timely prenatal care, assessed for social drivers (such as food insecurity, financial instability) and mental health status, and connected to community resources (e.g., home visiting, WIC) and/or an appropriate mental health care practitioner. Member incentives encourage Members who are pregnant and postpartum to seek preventative care in order to have better health outcomes for both baby and mother. Members contacted about Timeliness of Prenatal Care had a 16% higher compliance rate than those who were not. Members who received the incentive(s) within the qualifying time period had higher rates of compliance for timely prenatal and postpartum care.
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]

[redacted]	
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]

[redacted]	
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]
VAB	**UCare Seats**
Description, Scope, and Limitations	Members who are pregnant or children under age 8 may receive a car seat and safety education at no additional charge from the UCare SEATS program.
Expected Benefit	Correctly fitted and installed car seat or booster seat significantly reduces the risk of death and serious injury among young children.
VAB	**Transportation to Pregnancy and Parenting Support Resources**
Description, Scope, and Limitations	Members can get rides to pregnancy, breastfeeding, and parent support groups. Members can also get rides to WIC appointments and to car seat education/installation classes.
Expected Benefit	By providing transportation to specific VABs and supports, we are increasing access to support groups and community contacts that can be vital during pregnancy and postpartum. The support can relieve stress and help parents find additional resources.
Programs for Youth	
VAB	**Fitness Kit**
Description, Scope, and Limitations	Members under 18 can request a Fitness Kit to keep kids fit and active at home.
Expected Benefit	Eliminating barriers for Members to stay healthy and active reduces social isolation and encourages healthy lifestyle. Members who are healthier and more active are less likely to experience anxiety or adverse health conditions.

Programs for Youth	
VAB	**Back to School Supply Kit**
Description, Scope, and Limitations	Members in Foster Care and under age 18 can receive a kit with supplies to help them get ready for school.
Expected Benefit	Supporting children in school readiness helps to create a stable environment and set them up for success. Providing school supplies can help children avoid falling behind socially and academically.
VAB	**Welcome Home Kit**
Description, Scope, and Limitations	Members in Foster Care and under age 18 are provided with a Welcome Home Kit to help with their transition into their new home.
Expected Benefit	Welcome home kits can give Members in foster care some of the things they need to feel more comfortable as they go through periods of transition.
VAB	**Weighted Blankets for Youth**
Description, Scope, and Limitations	Members ages 5 to 18 with anxiety, autism or on the SED waiver can receive one weighted blanket per year per Member.
Expected Benefit	Weighted blankets can help to de-escalate childhood anxiety, helping to avoid more acute behavioral health services or possibly even Emergency Department visits.
GED Programs	
VAB	**GEDWorks and Julius**
Description, Scope, and Limitations	Members who would like to earn their GED can participate in GEDWorks. Through GEDWorks Members have access to a personal advisor, online study materials, connections to local adult education programs, practice tests, and GED tests. Members can receive transportation to education programs and tests.
Expected Benefit	Our partnerships enable Members to gain the skills and education needed to support themselves. The knowledge and skills learned in preparation for GED tests help Members navigate the job market. Job readiness skills provided by the Julius education platform allow Members to be successful once they have found employment.

Healthy Rewards/Wellness Items	
VAB	**Preventive Care Rewards and Incentives**
Description, Scope, and Limitations	Members can earn rewards, up to $75 annually, for their completing health risk screening, and preventive care screenings and appointments such as cancer screenings, dental cleanings, postpartum visits and well child visits. Members can use the rewards to purchase items based on their own identified need.
Expected Benefit	Members who engage with our incentive programs see increase in compliance rates compared to Members who do not. Preventative care and screenings are important to maintaining health and identifying potential problems early on.
VAB	**Quit For Life Tobacco Cessation**
Description, Scope, and Limitations	Members can work with Quit For Life to support tobacco cessation. Coaching and support via phone, online or mobile app to stop smoking, vaping, or chewing tobacco. Members receive a $25 upon completion of the program.
Expected Benefit	The Quit for Life program helps to inform Members about the dangers of nicotine and supplies them with resources to quit and stay off nicotine. Participants in our program have demonstrated a 33.5% quit rate. Member incentives encourage participation and increase program completion rates.
Free Catalog Items	
VAB	**Over the Counter (OTC) Items**
Description, Scope, and Limitations	Members on PD, FE, BI, TA and I/DD waivers have $60 per quarter for purchase of select catalog OTC items online or by phone.
Expected Benefit	Enabling home delivery of handy OTC items helps Members with daily health maintenance and community independence.
Weight Management	
VAB	**Health Club Savings**
Description, Scope, and Limitations	Members age 18 and older who attend a participating gym location can receive up to $25 a month reimbursement towards their gym membership. UCare partners with a number of gym associations to offer a variety of participating locations for Members. Some popular locations include LA Fitness, Anytime Fitness, Snap Fitness, and many more. Members under 18 can request a Fitness Kit to keep kids fit and active at home.
Expected Benefit	Eliminating barriers for Members to stay healthy and active reduces social isolation and encourages healthy lifestyle. Members who are healthier and more active are less likely to experience anxiety or adverse health conditions.

Online Health Info/Cell Phone	
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]
VAB	**Cell Phone Coverage**
Description, Scope, and Limitations	Members 18 years and older are eligible for a cell phone with 350 minutes of voice minutes, unlimited text, and additional data.
Expected Benefit	Cell phones have become the primary way that people connect with each other and their environment. Having a cell phone makes applying for jobs, accessing the internet, and coordinating needs much easier and more accessible.
Transportation Benefits	
VAB	**Additional Transportation**
Description, Scope, and Limitations	Members can get up to 12 round trip rides per year to maintain or transition health care coverage, social service agencies that will support occupational attainment, GED tests and job interviews. Members on FE or PD waivers are eligible for 12 additional rides per year for social activities or food supports. Members can get rides to pregnancy, breastfeeding, parent support groups, car seat education classes and WIC appointments.
Expected Benefit	Helping Members maintain their Medicaid eligibility or transition to individual coverage helps ensure continuity of care and health maintenance. Supporting Members with attainment of employment and access to community activities builds independence and reduces social isolation.

Meals/Farmers Markets	
VAB	**Home Delivery/Post-Discharge Meals**
Description, Scope, and Limitations	Members 21 years and older who have been discharged from an inpatient or nursing facility stay longer than seven days and are at risk for readmission can receive two home-delivered meals per day for three weeks, are provided for.
Expected Benefit	Nutritional support following discharge aids in procedure recovery and reduces readmission rates.
Home	
VAB	**Asthma Benefit**
Description, Scope, and Limitations	Members with asthma receive supplies that mitigate the effects of asthma in their home, such as an air purifier and furnace filters. Members in our Asthma Education Program will also receive education about asthma triggers and ways to self-manage and minimize the effects of asthma.
Expected Benefit	Understanding asthma and knowing how to deal with the effects and triggers helps Members avoid long term, serious health conditions as well as reduce the risk of potentially costly treatment.
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]
VAB	**Pest Control**
Description, Scope, and Limitations	Members on the I/DD, PD, FE, BI, TA waivers or the waiver waiting lists who own their own homes can get up to $250 per calendar year towards pest control services.
Expected Benefit	Pest control has been shown to improve environmental health for individuals with complex health issues, reducing the need for acute care in ER or inpatient stays.

Respite Care	
VAB	**Respite**
Description, Scope, and Limitations	Members on the FE or PD waiver can receive up to 60 hours of respite care per year.
Expected Benefit	Respite care provides an important support critical to supporting enrollees to remain living safely in the community and contributing to reduced ER, inpatient utilization, and caregiver burnout, especially in situations where HCBS workforce shortages are a challenge.
Transition Services	
VAB	**Home Delivery/Post-Discharge Meals**
Description, Scope, and Limitations	Members 21 years and older who have been discharged from an inpatient or nursing facility stay longer than seven days and are at risk for readmission can receive two home-delivered meals per day for three weeks, are provided for.
Expected Benefit	Nutritional support following discharge aids in procedure recovery and reduces readmission rates.
Extras for Waiver Members	
VAB	**Over the Counter (OTC) Items**
Description, Scope, and Limitations	Members on PD, FE, BI, TA and I/DD waivers have $60 per quarter for purchase of select catalog OTC items online or by phone.
Expected Benefit	Enabling home delivery of handy OTC items helps Members with daily health maintenance and community independence.
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Expected Benefit	Pest control has been shown to improve environmental health for individuals with complex health issues, reducing the need for acute care in ER or inpatient stays.
VAB	[redacted]
Description, Scope, and Limitations	[redacted]
Expected Benefit	[redacted]

Understanding and fulfilling the standard Medicaid benefit set is the first step toward creating full coverage for the diverse needs of a population; the benefits provided in addition to the standard coverage play a significant role in ensuring that Members are safe and healthy despite their unique situations. UCare's Value-Added benefits (VAB) Program allows us to leverage numerous tools to meet Members' specific needs and create unique opportunities to improve their health. VABs make for more informed, health-conscious Members who can better address their health concerns and are more knowledgeable about how to approach their everyday needs. By informing our Members and working with community organizations, we can provide our Members with skills and preparation for health and independence.

Identifying and adequately meeting the needs of Medicaid Members presents a challenge to even the most experienced MCOs and State organizations. We would like to be a strong partner with Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS) in developing a VAB Program that meets the State's priorities and requirements and aligns with RFP Section 7.3.4. Doing so will require UCare to provide data and outcomes that allow the State to easily understand the value that our VABs bring to the larger Medicaid population of Kansas.

Ensuring Utilization

While developing our Value-Added Benefits Program for KanCare we have done considerable research into what is currently offered and how services are being utilized. We understand that all VABs must be approved by KDHE and KDADS. UCare's goal is to provide VABs that fill gaps in service while enhancing what is currently available, thereby ensuring the health of our Members and their families. Our proposed offerings include services that have proved successful for our current Medicaid Members. We evaluate our own VABs as well as the rest of the market annually to identify opportunities for improved engagement or revised benefit design to reach the highest number of Members.

A primary emphasis is working with the community to evolve our benefits program to meet their evolving needs. We understand that KanCare Members and those assisting them are aware of benefits available and how they can access them; however, we will leverage Member outreach to encourage Members to engage with our VAB Program. Making our offerings known through Member materials, care managers, UCare Member Services, ucare.org, and community-based organizations, will allow Members who are seeking additional offerings to easily locate benefits that fit their circumstances. We work with Providers to ensure that our VAB Program is available and operating at its best. We include VAB updates in our Provider newsletters, Provider Manual, and on our website. Additionally, we will educate our Care Coordinators on vulnerable populations and the benefits that suit them, allowing Care Coordinators to communicate with a Member's Interdisciplinary Care Team about additional coverage available to Members. For example, UCare has created a system of VABs that are designed to assist mothers and expectant mothers with monitoring their health and the health of their children. These benefits, going beyond the realm of traditional care, include health and wellness services such as car seats, home delivered meals, transportation to support groups, and mobile apps to assist with assessing and maintaining health. When Members are aware of support systems, Care Coordinators are equipped to offer recommendations for care. We have secured VABs that fit needs that arise outside of the traditional Medicaid benefits set, creating an ecosystem that operates smoothly and addresses Members' health concerns quickly, without excessive cost.

In Lieu of Services

UCare provides in lieu of services (ILOS) to promote greater access to services in an inclusive, culturally congruent way. ILOS present a unique opportunity to offer innovative, community-centered ways to meet our Members' needs. For eligible Members, we leverage Home and Community-Based Services (HCBS) and ILOS as well as our complete VAB service list to address a wide range of Member health concerns. Care Coordinators are trained to be aware of our ILOS and offer these when appropriate. UCare will offer the services approved and encouraged by the KDHE and KDADS, and any ILOS deemed important will be proposed to KDHE and KDADS for review and approval. For dual eligible Members on our HIDE-SNP Plan, UCare will provide competitive supplemental benefit coverage chosen to meet the needs of dual eligible KanCare Members. For these Members, supplemental benefits will be prioritized above VABs.

Assessing the Value of VAB

We continuously monitor our VABs to ensure that utilization remains at an acceptable level and that all VABs are relevant and cost-efficient. We monitor cost, utilization, and relevant appeals and grievances, to keep tabs on the services we provide. If a benefit's utilization dips below a certain level, or costs become excessive, we conduct an outcomes evaluation to determine the root cause. Underperforming benefits can be addressed by increasing promotion, adjusting the benefit limits or allowance, or addressing other access barriers experienced by Members. If attempts to increase engagement are unsuccessful, VABs are updated to benefit a more

Member Story

A Member was very excited to start the program to get ideas on how to eat better for his health. After receiving his first FoodRX box and using up what was in it, he went to the grocery store and used the food he received as a guide for his future purchases.

appropriate population, refined entirely, or removed if utilization becomes too low or the cost becomes too high.

VAB Reports

VAB monitoring culminates into reports that will be submitted on a schedule defined by the State. These reports accomplish three primary purposes: to ensure utilization, prevent excessive cost, and ensure adequate resources for benefit delivery. These three monitoring categories synergize to create a beneficial and efficient VAB program.

- **Utilization:** The number of Members who use a VAB is recorded for each VAB. This allows us to identify underutilized VABs as well as estimate cost and allocate resources as needed.
- **Cost:** The total cost of each VAB is tracked and compared to expected cost and utilization rates to ensure that there are no unexpected costs. If costs do not align with the usage or units shipped, we reevaluate or rework the program to better fit our expectations.
- **Resource Management:** Constant and continued oversight of the resources used to fulfill these benefits is essential to ensuring that Members can have the services they need when they need them. Establishing the proper number of units or resources needed to accomplish adequate delivery of VABs is the cornerstone of proper cost and utilization management.

The data and representation of the data will be used to inform and improve our VAB program, and reports will be prepared for the State as required or requested.

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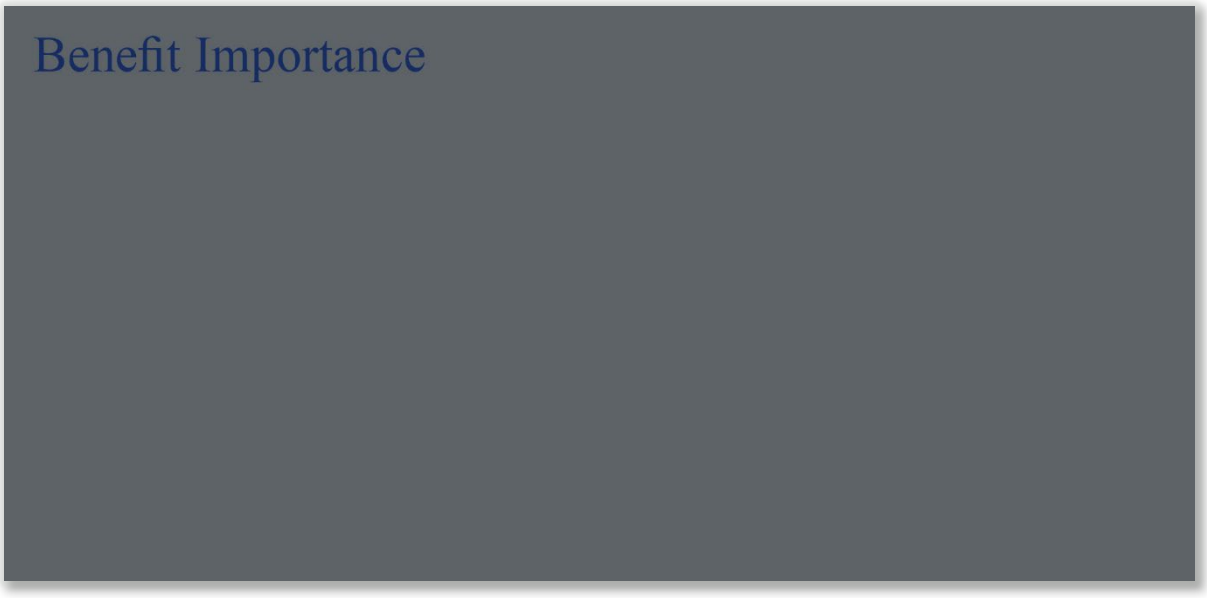
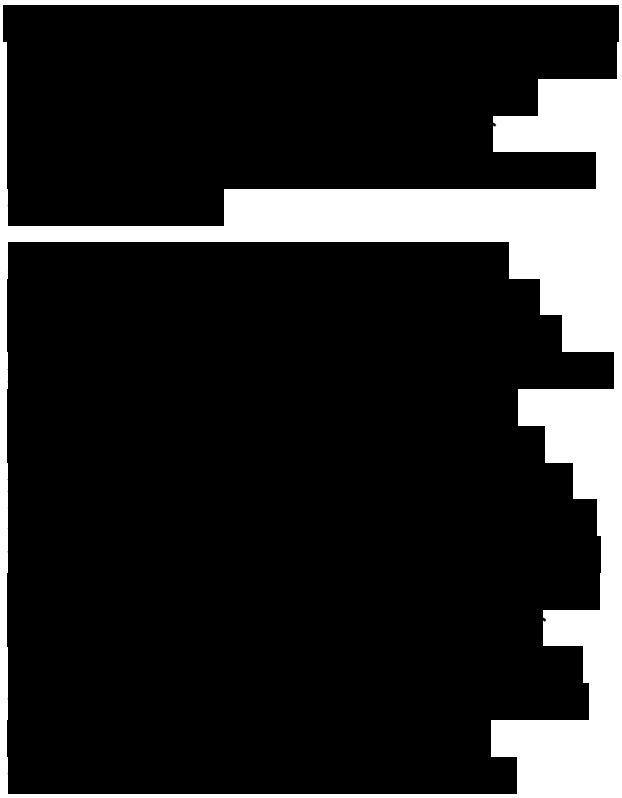


Ease of Using Benefits



Tab 7e:

TOPIC AREA 5

Quality Assurance

7e. Quality Assurance

19. Describe the bidder's quality program and the bidder's approach to implementing a quality program for KanCare that drives a program-wide culture of continuous quality improvement. Include the following in the bidder's response:
    a. The structure, composition, and responsibilities of the bidder's quality-focused committees and how the bidder will use its quality structures to promote changes in plan and Provider practices and operations.
    b. The bidder's capabilities to collect and examine quantitative and qualitative data and information to evaluate clinical and LTSS quality, including health outcomes and Member experience, and effective health care operations. Include the bidder's approach to utilizing data, information, and analytics to drive continuous performance improvement.
    c. The bidder's approach to regularly providing information available to the public about the bidder's program performance in KanCare, including the information the bidder proposes to publicly share and how the information will be shared.

UCare's approach to implementing Quality and Population Health Programs for KanCare illustrates our commitment to excellence, innovation, professional competence, and transparency. Our values of continuous learning and collaboration are cornerstones of UCare's programs. We prioritize the highest quality standards in every aspect of our organization to ensure Members receive the best health care and supportive services.

Our approach is built on a strong foundation of robust data collection and analytics with an understanding of the KanCare populations that goes beyond what the data say. This will be achieved through comprehensive quantitative and qualitative analysis and a data-driven approach to design interventions that mitigate barriers to care, target health care disparities, and address social determinants of health (SDOH), all with the aim of better supporting Members in achieving optimal health and well-being. This commitment extends to program-wide continuous improvement efforts while ensuring the cost-effective use of health care resources, and through systematic monitoring and evaluation of the services we provide. UCare is in active pursuit of opportunities to enhance these efforts and will look for opportunities that help advance the goals of the KanCare Quality Management Strategy (QMS):

- Improve the delivery of whole person, integrated, person centered, and culturally appropriate care to all Members
- Improve Member experience and satisfaction
- Increase employment and independent living supports to increase independence and health outcomes
- Increase telehealth usage through speech therapy, monitoring health indicators, pair rural health care Providers with remote specialist
- Remove payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare Members will result in improved beneficiary access to substance use disorder (SUD) treatment service specialists
- Improve overall health and safety for KanCare Members

Quality and Population Health Program Goals and Approach

UCare's Quality and Population Health Program is the foundation of our approach to implementing a quality management program for KanCare, focusing on advancing the Quintuple Aim for Members. Upon analysis of UCare's KanCare Membership, additional goals that are specific, measurable, and facilitate continuous improvement will be established. Our key goals, approaches and activities focus on:

- **Population Health Management:** Developing a robust population health strategy to address changing Member needs; promoting and implementing evidence-based strategies to address health promotion, disease management, and care coordination programs.
- **Access:** Providing access and availability to all KanCare services such as medical, behavioral and LTSS and HCBS, to match Member needs and preferences.
- **Quality of Care:** Improving the quality of Member care and safety; advancing the quality, coordination, and continuity of health care services to Members across the continuum of care; ensuring a high-quality network; and improving outcomes, experience, and safety of our Members.
- **Regulatory:** Achieving and maintaining National Committee for Quality Assurance (NCQA) Health Plan Accreditation, Health Equity Accreditation, and Long-Term Services and Supports (LTSS) Distinction; approval for the HIDE SNP Model of Care; and exceed compliance with local, state, and Federal regulatory requirements, and accreditation standards.
- **Health and Racial Equity & Inclusion:** Implementing strategies that address social drivers of health, reduce health disparities, and improve health and racial equity to support inclusion and improve health outcomes of our Members.

NCQA Accreditation

A key strategy in UCare's Quality and Population Health Program is to maintain accreditation from the National Committee for Quality Assurance Accreditation (NCQA). UCare is an industry leader when it comes to NCQA accreditation. UCare utilizes NCQA standards as a framework to ensure optimal levels of health for Members, control costs, and meet government and agency requirements. UCare has been awarded NCQA Health Plan Accreditation for all Medicaid products highlighting our mission of providing high quality of health care for our Members. UCare has maintained accreditation status since 2014 and in 2023 UCare received a score of 98.7 for the Medicaid product line.

In January 2023, UCare achieved NCQA Health Equity Accreditation for our Medicaid line of business. UCare was only the second Medicaid managed care plan to achieve this accreditation in our current market. UCare is among the 5% of health plans accredited by NCQA to receive Health Equity Accreditation. This recognizes UCare as a market leader in providing culturally and linguistically sensitive services and working to reduce health care disparities. NCQA awards Health Equity Accreditation to organizations that meet or exceed its rigorous requirements for health equity.

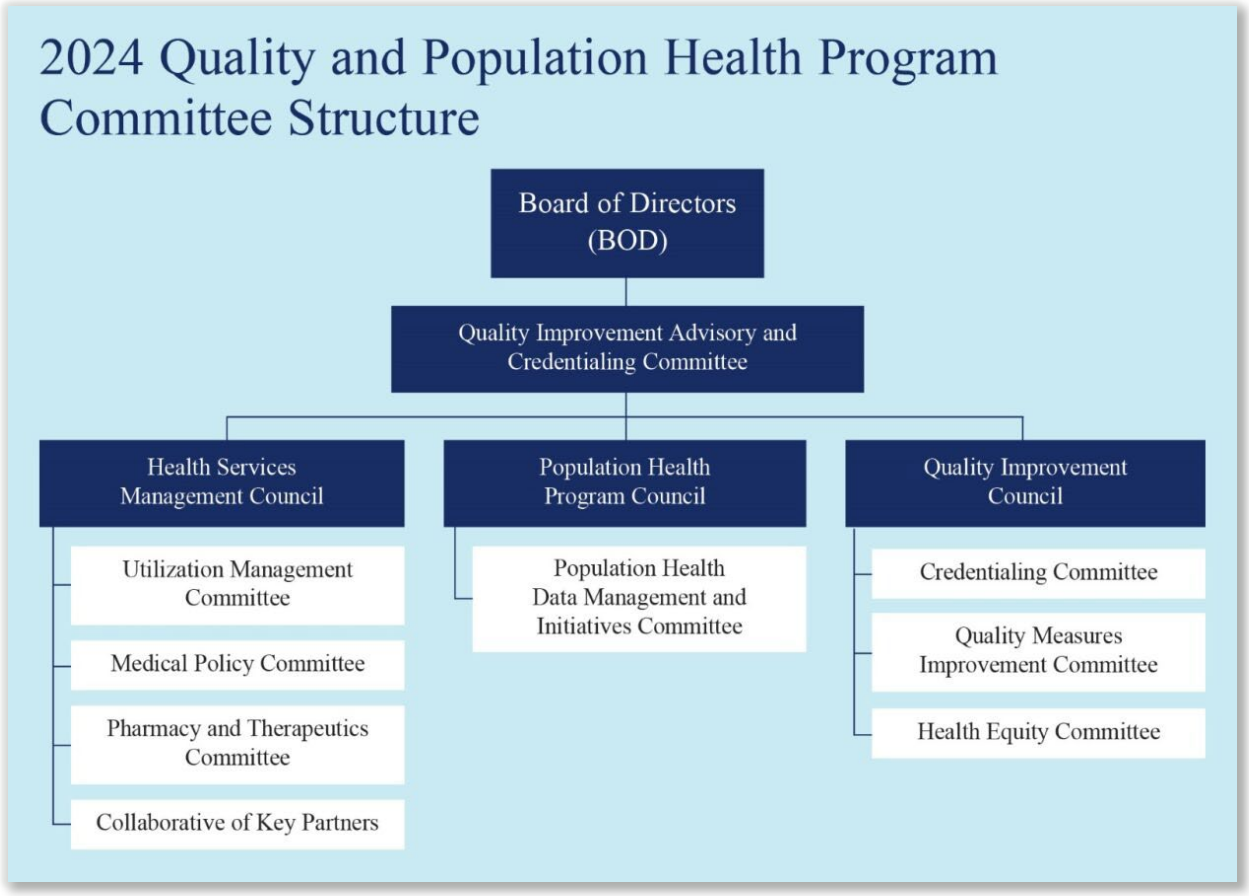
Upon contract execution with KDHE, UCare will initiate the accreditation process for NCQA Health Plan Accreditation for our KanCare program, in compliance with Section 7.9.7 of the

RFP. UCare will take the most expeditious path to achieving accreditation to meet contract requirements and continue our commitment to providing high-quality care to all populations and removing obstacles and disparities in the health care system. In addition to NCQA Health Plan Accreditation, UCare will also obtain NCQA Long-Term Service and Supports (LTSS) Distinction and NCQA Health Equity Accreditation within 24 months of the onset of delivering services to KanCare Members.

A. Structure, Composition, and Responsibilities of Quality-Focused Committees

People Powered

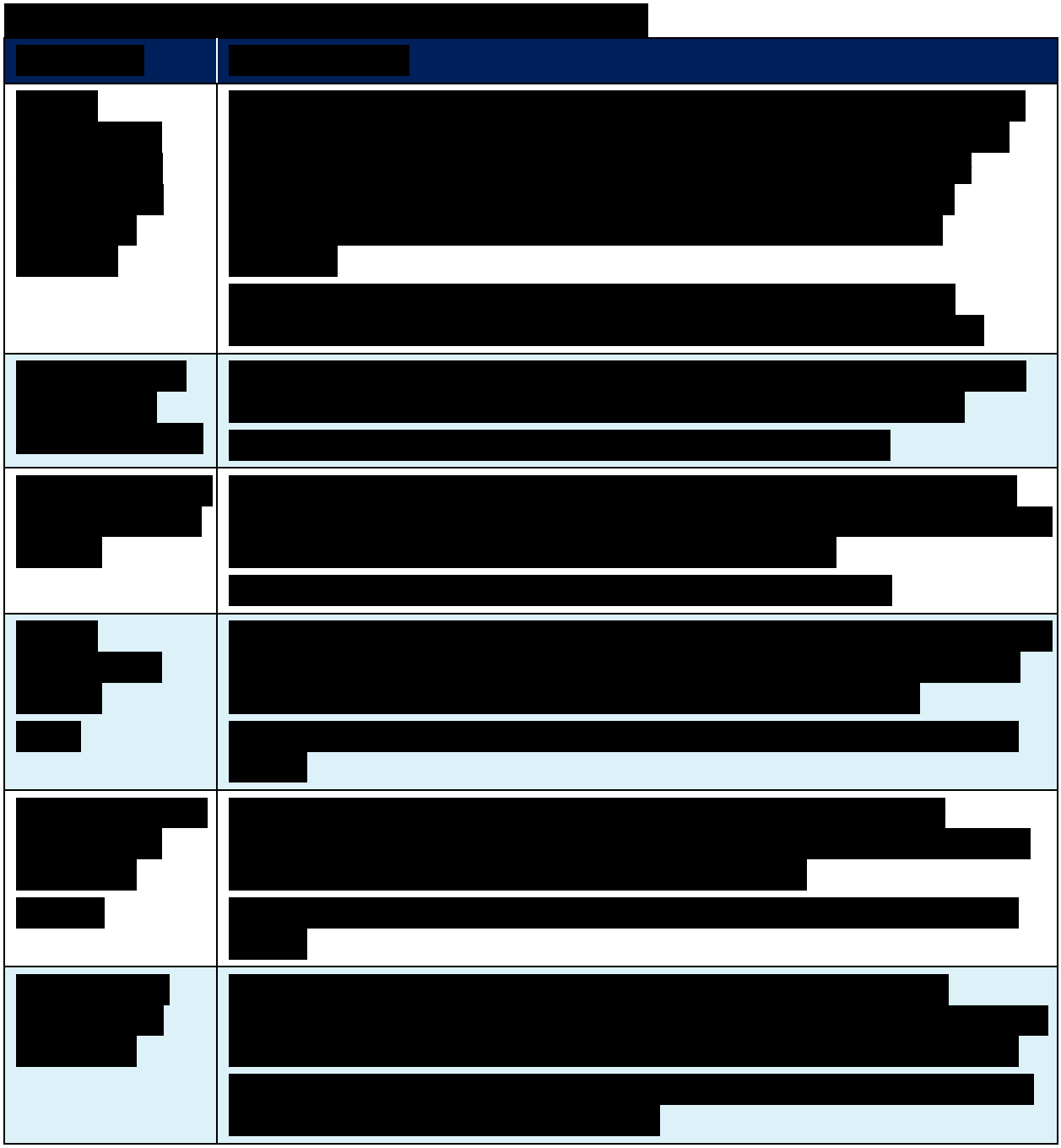
UCare is dedicated to ensuring we meet the health care needs of KanCare Members and continually improve the quality of care and services we provide. UCare's strong and effective Quality and Population Health Program structure will further quality goals for KanCare. Quality and population health activities are built into the foundation of our strategic plans for the organization. This ensures accountability for quality-related strategic initiatives from all teams, senior and executive-level leaders, as well as quality committees and the Board of Directors.



UCare's robust committee structure highlights our unique approach to integrating our population health principles and strategy into every aspect of the quality work happening across the organization. It includes subject-matter experts, cross-departmental executive leaders, medical directors. Network Providers actively participate in quality committees, councils, and workgroups. Our Kansas Quality Management (QM) Director, working through our robust

committee structure, will be responsible for supporting data collection, integrating Rapid-Cycle Process Improvement principles, and utilizing study design and evaluation approaches to improve the quality of care and service delivery.

This work will also allow UCare to execute the QAPI requirements found in Section 7.9 of the RFP in accordance with the State's KanCare QMS. Additionally, UCare's Kansas Compliance Officer will report directly to the Board of Directors and Market President to ensure that all quality improvement policies, procedures, and practices follow the State contract and to find opportunities to exceed expectations. UCare's overall Quality and Population Health Program is supported by multiple committees and teams at the corporate level, including:



Promoting Change in Plan and Provider Practices

Through our Quality and Population Health Program Committee structure, changes are promoted in plan and Provider practices and operations. Some key highlights of these changes include:

Performance Improvement in Action

The Quality Measures Improvement Committee (QMIC) is designed to identify and achieve areas of opportunity for performance improvement, improve Member experience and health outcomes, eliminate health care disparities, and increase operational efficiency and program integrity for Kansas Medicaid and HIDE SNP. Our cross-departmental QMIC Workgroups are led by quality experts to develop metric goals, implement interventions and strategies, and evaluate and report the impact of interventions. The work conducted within these workgroups impacts UCare's Strategic Plan goals relating to providing quality care for KanCare Members. Key examples of initiatives developed by QMIC include:

- **Embedding CHWs in key community partners** that service a high proportion of Medicaid Members (e.g., Children's Health Network, Community Dental Care)
- **Implementing Payment Incentives Partnerships** that reward integration and coordination of Behavioral Health Providers (e.g., Behavioral Health Home, CCBHC and TCM)
- **Promoting In-home Monitoring and Testing Initiatives**, including blood pressure cuff monitoring, diabetes testing, and colon cancer screening testing

Provider Appointment Availability

The accessibility of Primary Care, Mental Health and Substance Use Disorder, and Specialty Care Providers report is reported annually to ensure adequate coverage for UCare's membership including assessing access to appointments and care. **In 2022, UCare met all goals for primary care appointment availability.** We sampled 183 Primary Care Clinic locations and found Providers met or exceeded our posted guidelines.

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Strong Plan Outcomes for Dual Eligibles

Our integrated program for older adult dual eligibles received a 4.0 Star Rating for 2024. We achieved optimal performance in several measures meeting the 5- or 4-Star Rating, including:

[redacted]

Meeting and Exceeding State Medicaid Withhold Measures

Trusted Government Partner

As a true partner to state government and a highly compliant MCO, UCare strives to exceed state priorities, including withhold measures established in our MCO contracts.

In our current market, the State Medicaid Agency includes a withhold measure to encourage timely completion of initial screenings/risk assessments (within 75 days) for senior Members. The data must be sent annually to prove that the assessments were completed timely to complete the withhold requirement.

UCare closely monitors our timeliness by regularly reviewing the assessment data that are updated at least monthly by our care coordination teams. We provide ongoing education to care coordinators about the importance of regular and timely outreach.

UCare hosts regular internal meetings with care coordination, quality informatics, and health care economics leaders regarding this withhold measure. We discuss opportunities to improve our overall rate through innovative care coordination techniques, improving data collection, and ensuring accuracy of the information through quality controls. It was the collaborative discussion at one of these meetings that suggested we create a dedicated engagement team that would focus on those Members we were unable to reach.

As a result of our efforts, UCare has consistently met and exceeded the state's 90% standard for this withhold measure by completing the Member Health Screening of each new senior Member.

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[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

In compliance with 7.4.2, UCare understands and will follow the KanCare requirement to develop and submit a plan to the State for conducting health screens for all Members, for initial contract implementation, within 90 calendar days of enrollment (or as directed by State policy for HCBS waiver and behavioral health Members), whichever is less; and then subsequently conduct a Health Screen of all new Members within 10 business days of enrollment. UCare will aim to meet or exceed KDHE's Member health screening completion rate of 80% of the Members that MCOs are able to contact (per Appendix G) with our proven track record.

Member and Provider Inclusion in Quality Improvement

The voices of our Members and Providers form the cornerstone of our Quality program. We will incorporate feedback from Kansas Providers and KanCare Members throughout the committee structure through their participation, sharing survey results, Member and Provider stories, and/or ad hoc feedback.

We gain insights and feedback primarily through our Medicaid Member Advisory Committees and Disability Advisory Council. UCare views this engagement as a critical component (attended by CEO, executive and senior level leadership) to ensure a Member-driven approach to our culture of continuous quality improvement.

Provider partners will have a seat at the table, directly participating in the Pharmacy and Therapeutics Committee, Collaborative of Key Partners, and Quality Improvement Advisory and Kansas Credentialing Committee.

We ensure feedback received by our Members and Providers is infused in our decision making and part of the review of program outcomes and project expansions. Our conversations with Member and Providers are designed to capture insights, demonstrate how their feedback is incorporated, and to help us prioritize improvements.

B. Quantitative and Qualitative Data Collection, Analysis and Evaluation Capabilities

Our strong data collection, analysis, and evaluation capabilities are the engine that drives our Quality and Population Health Program for KanCare. UCare uses a Quality Improvement (QI) framework to put these capabilities into practice and drive continuous performance improvement across the organization. The data are used to evaluate clinical and LTSS quality measures, including Member health outcomes, Member and Provider experience, and effective health care operations – all to promote a culture of action for continuous quality improvement.

Data Collection Capabilities and Analysis

UCare's efforts to meet the unique health needs of KanCare Members are supported by effective collection, integration, access, and analysis of data. UCare collects and integrates data from a variety of sources that focus on:

- **Improving Member experience and satisfaction** (e.g., customer service trends, UCare population health programs and assessments, survey data, feedback from the Member advisory groups, disenrollment surveys and comments, appeals grievances, and complaints, etc.)
- **Improving Member health outcomes through holistic and evidenced based care** (e.g., medical, behavioral health, and pharmacy claims, ADT data, LTSS data, Kansas Health Information Network (KHIN) Inc d/b/a KONZA, HRAs, EHR records, immunization registries, Health Outcomes Survey, CAHPS and HCBS CAHPS® Quality Measure etc.)
- **Improving Provider experience** (e.g., Provider satisfaction survey, utilization management Provider satisfaction survey)
- **Encouraging effective UCare operations** (e.g., utilization management and prior authorizations, out-of-network requests, credentialing)

We built and continue to invest in our people and technology to support industry-leading capabilities in data analytics and data warehousing. Key features of our capabilities, tools, and analytics, include:

Analysis Expertise

People + Technology: Our experienced Health Care Economics (HCE) team includes a full complement of staff members responsible for the statistical analysis, quality improvement reporting, data mining in support of clinical and case management staff, and actuarial analysis. The HCE team includes certified actuaries and health care analysts with advanced degrees in Public Health and Statistics. Our deep understanding of health care analytics and statistics, and effective use of programming and modeling tools, such as Python and R, enables us to develop and adjust standard methodologies and achieve targeted and accurate results. We apply statistical precision to support our analyses, including attribution, clinical measures, cutoffs or continuous variable frameworks, confidence intervals, and data sufficiency minimums, particularly as related to clinical program evaluations, product pricing, and quality program measurement. In addition, the Data Center of Excellence (CoE) is a cross-functional team (HCE & IT) designed to support the ongoing enablement and growth of enterprise data management capabilities.

Data Integration and Sources

Enterprise Data Warehouse (EDW) Capability and Integrity: We continue to expand our state-of-the-art EDW to integrate, consolidate and store clinical, LTSS and HCBS, and non-clinical data (e.g., consumer, SDOH) for all Members and Providers. [redacted]

[redacted] This schedule ensures that UCare can create and distribute timely information both internally and externally to our Provider partners.

Analytic Tools

Actionable Reporting: Our data warehouse solution allows for a variety of tools to connect to the system such as SQL, SAS, or various Microsoft tools to perform analytics and reporting functions. Additional analytic tools used to enhance analytical capabilities and allow for flexibility in analyzing data include Business Objects, and Tableau. We also utilize [redacted] to and from the EDW from multiple disparate sources and to obtain and share data with external partners, including Kansas Providers and Community Care Coordinators.

Clinical & Social Risk Stratification: [redacted]

Integrated Care Pioneer

[redacted]

Quantitative Analysis

A critical component of every quality improvement effort and focused study is quantitative analyses using collected and integrated data. For a data-driven organization like UCare, this is the first step in understanding where there is a need or an opportunity for improvement that needs to be addressed among UCare Members, Providers, and other stakeholders. UCare has extensive experience conducting and documenting quantitative analyses that compare results against a standard or benchmark and also trending over time. UCare bases our improvement goals on local (KanCare contract/QMS) and national performance metrics, as applicable, and

strives for statistically significant improvement year over year. We use quantitative analysis to evaluate clinical, LTSS and HCBS quality, Member health outcomes, Member experience, and effective health care operations. For example, analyses are used to:

- Measure and Provider comparison (utilization and financial performance).
- Measure rates and patterns of utilization.
- Quantify gaps in care using equity-focused quality measurements to help narrow or eliminate health care disparities.
- Produce HEDIS reports and dashboards that are used to measure quality improvement projects, the effectiveness of care, utilization, and comparison data.
- Provide analytical support and predictive modeling to stratify our Members into programs.
- Analyze data to develop guidelines for population health programs.

Step 1: UCare identified significantly lower data trends in HEDIS quality metrics for Members with a Severe and Persistent Mental Illness (SPMI) - which includes individuals with disabilities, dual eligibles and utilizing HCBS - compared to our overall Medicaid population. Data trends were identified through our population health assessments and further analysis on disparities within our HEDIS data.

Qualitative Analysis

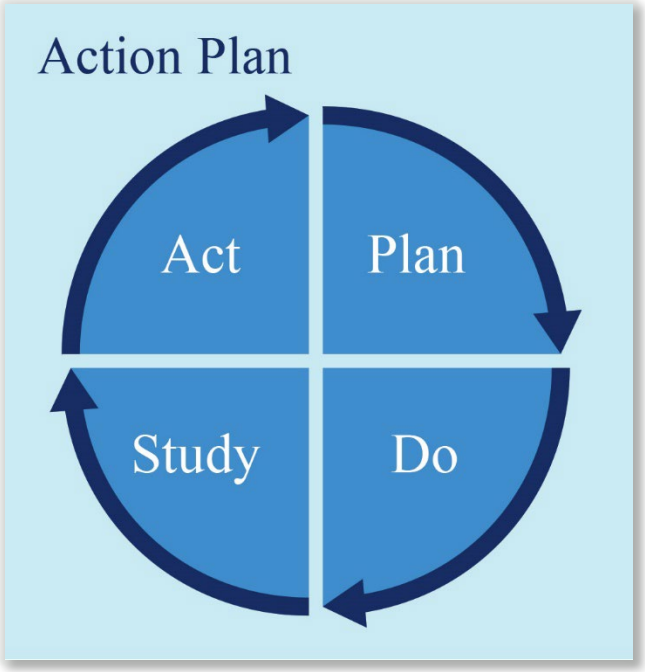
Quantitative analyses are followed by qualitative analyses to provide insight into the root cause of challenges that Members experience. This data helps UCare address barriers to care and improvement to create meaningful initiatives to improve Members health outcomes. UCare conducts qualitative analyses using input from cross-departmental teams, Members, and Providers. For example, qualitative analysis is used to:

- Understand patient barriers through the lens of the Provider, including specialty, primary care, mental health and substance use disorder, and dental Providers.
- Understand operational barriers through the lens of the Provider.
- Recognize the social barriers that Members experience that prevent them from prioritizing preventive care.
- Discern Member’s experiences, perceptions, and behaviors.

Step 2: Quantitative data on low performing HEDIS metrics were shared with our Mental Health Providers to engage on understanding the root causes of our SPMI population experiencing lower performance for addressing preventive care. Our Mental Health Providers gave qualitative data and insight that Members with a SPMI diagnosis lack awareness about preventive care, poor medical compliance, high degree of life instability, avoidance due to fear of being diagnosed with a chronic condition, poor quality relationships with clinicians and lack of continuity.

Data-Driven Continuous Performance Improvement — Quality Improvement Framework

UCare's approach to data-driven continuous performance improvement involves utilizing quantitative and qualitative analyses to continuously identify opportunities for improvement, prioritize opportunities, and take action to improve health outcomes, Member experience, and operational efficiency. These actions are evaluated for effectiveness and adopted, refined, or abandoned depending on the evaluation. This continuous cycle of data collection, analysis, and evaluation is demonstrated throughout the Quality Improvement (QI) Framework used by UCare.



UCare takes the following steps to design QI interventions to meet the Quintuple Aim goals:

- Identify target populations
- Define aims and measures
- Develop interventions to improve population health
- Evaluate and refine interventions based on project results.

KanCare quality improvement initiatives will leverage the **Plan-Do-Study-Act (PDSA)** framework, focused studies, and a high-quality core set of Quality and Utilization Management documents developed based on KanCare Member data.

Analysis and QI Improvement Framework in Action

Plan: Through quantitative and qualitative analysis of our quality performance metrics and population health assessment data, UCare identified opportunities for improvement in key prevention metrics within our Medicaid population. This was followed by a qualitative analysis by engaging voice of Providers to understand the root cause and barriers. *UCare identified that Members with Severe and Persistent Mental Illness (SPMI) that receive clinical and HCBS services often have lower rates of screening for preventive health.* This highlighted a need for education around the importance of preventive health among Members with a mental health diagnosis and addressing social stigmas and lack of access to services, a significant barrier for this population in engaging in preventive care service as well as promoting the integration and coordination of physical and behavioral health.

Do: As a result of this analysis, UCare piloted a unique and innovative gap closure project with Behavioral Health Home, TCM and CCBHC Providers, acknowledging the trusted and established relationship between mental health Providers and patients. This project minimized identified barriers to care by having trusted Providers communicate with the Member on why preventive care is important and supporting Members in accessing preventive services.

The pilot launched in 2021 and focused on eight HEDIS measures including: Breast Cancer Screening, Cervical Cancer Screening, Comprehensive Diabetes Care Eye Exam, CDC HbA1c Control, Annual Dental Visits (expanded to all ages), Antidepressant Medication Management, and Diabetes Screening for Patients with Schizophrenia or Bipolar Disorder.

Study: Providers participating in this pilot performed better than the overall Medicaid rate, which were very positive results and shared positive feedback on their pilot experience, such as appreciating UCare's supporting on prioritizing their patients' medical needs and concerns.

[redacted]

Act: As a result of the pilot's success, this project was continued into 2022. Through the process of continuous evaluation using the PDSA cycle, UCare evaluated the effectiveness of the second year of this program and found that participating Providers continue to perform better than the overall Medicaid rate for five measures. Given the results and overall success of this program, it expanded in 2023 to include an additional 13 participating Providers.

[redacted]

Throughout this project, results were shared at the QMIC and its Mental Health Workgroup to ensure cross-departmental engagement in the quality improvement process. In addition, UCare incorporated feedback from Providers and staff to refine our internal processes to better support Providers and Members. UCare will apply the approach and framework to KanCare quality improvement initiatives and focused studies and develop a high-quality core set of Quality Program Documents.

C. Public Reporting

UCare is committed to and places a high value on transparency. We regularly publish information about our programs' performance on our website, through annual reports, and community meetings. This information includes quality measures (annual dental visit rate, timeliness of prenatal and postpartum care, child well visits, diabetes care) and Member experience measures (customer service, rating of health plan), ensuring that the public can access our performance data.

UCare will maintain a Member-facing webpage for KanCare Members that will highlight Performance Improvement Projects and other focused quality studies in easy-to-understand, Member-friendly language. UCare will use various KanCare Member communications, including Member newsletters, to spotlight key quality initiatives and direct Members to the quality webpage. We will also share performance on key quality measures in appropriate community meetings or public forums and solicit feedback from Members and the community on how we can remove barriers to care, engage Members in care, and tailor population health management programs to effectively improve health outcomes. Additionally, UCare's Quality Program Description, Quality Program Work Plan, and Quality Program Evaluation will be published on the Member-facing website.

Summary

UCare has established a strong and effective Quality and Population Health Program for Medicaid and SNP programs with a proven track record of successfully improving health outcomes, reducing costs, and advancing health equity while also engaging the voice of the Member and Provider community. **As the largest Medicaid plan in our market, we have contributed to continuous quality improvement and positive health outcomes for one of the longest-standing Medicaid managed care programs nationally.** Core concepts of UCare's Quality and Population Health, including committee structure and QI framework, will be tailored to meet the needs and preferences of KanCare Members, Providers, and communities. We have demonstrated our ability to assess performance and understand root causes that limit the ability to achieve performance goals and drive health disparities. UCare has and continues to show its commitment to act on these analyses and develop and/or modify targeted interventions to mitigate barriers to care and improve access, outcomes, and experience for our Members.

20. Describe the bidder's experience and approach to improving performance for the following two (2) Health care Effectiveness Data and Information Set (HEDIS®) measures in programs similar to KanCare. Include the actions the bidder will take to improve performance on these measures in KanCare and the anticipated improvement for KanCare.
    a. Timeliness of postpartum care
    b. Lead screening

Approach to Improving HEDIS Measures Performance

Rooted in trust and communication among Members and their health care Providers, UCare is committed to improving Member-centered care with KanCare Members by aligning our quality improvement strategy with the Quintuple Aim to enhance Member care experience, improve population health, reduce costs, advance health equity, and support the care-team well-being. Specific to quality improvement efforts, UCare reviews Health Care Effectiveness Data and Information Set (HEDIS) measures regularly and sets high performance goals to achieve the 5 Star Rating, and the National Committee of Quality Assurance (NCQA) 75th percentile or higher. UCare consistently achieves above average Star Ratings and other performance rating programs. Currently, our Star Ratings align or achieve higher performance compared to the plans currently serving KanCare Members.

UCare will leverage our Kansas Quality Management (QM) Director and Quality and Population Health Committee structure to align with the Quintuple Aim. The QM Director will work with committees, including the Quality Measures Improvement Committee (QMIC), to meet and exceed the expectations of our KanCare Members and their health care Providers. The QMIC is designed to achieve significant improvement for our Performance Improvement Projects and quality studies that improve Member health outcomes and satisfaction. The QMIC supports HEDIS metric performance and other Medicaid performance measures by identifying opportunities to make meaningful change, eliminate health care disparities, improve operational efficiency, and increase program integrity. QMIC also promotes changes in Provider practices (e.g., improving documentation standards for well-child assessment), monitors UCare's quality performance (e.g., Star Ratings, NCQA Accreditation and Health Plan Ratings, Quality Rating System, Performance Improvement Projects [PIPs], and KDHE contract requirements), reviews and advises on resources and project actions related to quality measures, and assesses effectiveness of previous years' interventions and goals.

The QMIC is made up of cross-departmental leaders, subject-matter experts, and key stakeholders. Feedback from Kansas Providers and Members will be incorporated through their participation, Member and Provider stories, and ad hoc feedback. To ensure ongoing quality improvement for KanCare Members, UCare will leverage the QM Director and the KanCare-specific Quality and Population Health Committees, including QMIC and work groups.

UCare actively seeks opportunities to understand and address barriers to achieving our goals through robust quantitative and qualitative data analyses. UCare also uses a Plan-Do-Study-Act (PDSA) cycle to design and evaluate quality improvement (QI) initiatives and to document improvement efforts. The PDSA framework is used to support and evaluate clinical and long-term services and supports (LTSS) quality measures, health outcomes, satisfaction scores, effective health care operations, accreditation efforts, PIPs, focused studies, and initiatives. After barriers are identified, UCare's QI teams, in collaboration with KanCare stakeholder departments

and work groups, will develop and implement interventions targeted to resolve identified barriers.

A. Timeliness of Postpartum Care

Postpartum care is vital for KanCare Members and their infant's overall health and well-being. Timely access to postpartum care can be the difference in addressing adverse effects of giving birth, emotional and physical changes, and other general health issues that may arise.

The State of Kansas has recognized the importance of postpartum care during this crucial period by expanding postpartum Medicaid coverage up to 12 months and through the fourth trimester, a State initiative focused on studying and improving the experience of mothers and families in Kansas. The 2023 Kansas Maternal Mortality Review Committee Report stresses the importance of this work, revealing that from 2016 to 2020:

- Severe maternal morbidity increased (56.1 in 2016 to 71.0 per 10,000 delivery hospitalizations in 2020)
- Pregnancy-related deaths increased (11.3 in 2016-2018 to 17.2 per 100,000 live births in 2018-2020)
- Racial and ethnic minorities were disproportionately affected (62.1% of deaths)
- Women enrolled in Medicaid or from low-income ZIP Codes were more likely to experience severe maternal morbidity and death (62.1% had Medicaid, no insurance or unknown insurance status)
- Most importantly, the vast majority (79.3%) of these deaths were preventable.

Activity Description

UCare recognizes the importance of optimal postpartum care to promote the overall health and well-being of KanCare Members. UCare actively engages with all Members post-delivery through our Maternal Health Program, including assisting with scheduling a postpartum visit to ensure they can see their Provider. Our Maternal Health Team also provides health education on the importance of these postpartum visits and supports and guides Members on how to talk to their Providers about postpartum depression, birth spacing, healthy eating, exercise, or changes in their emotional state. Some of our Value-Added Benefits include pregnancy advisory nurse line (available pre- and post-delivery), home delivered meals, pregnancy digital app, and parenting peer support.

UCare prioritizes programming that improves timeliness to postpartum care. Using a variety of interventions, we focus on removing barriers for our postpartum Members to support them in achieving optimal health. We also focus on efforts to advance health equity by examining characteristics and needs of Members who identify as Black, Indigenous, or Persons of Color (BIPOC) or Members who experience significant barriers due to geography. UCare will leverage our long history of engaging pregnant and postpartum Members from various communities through maternity care coordination, health promotion activities, and innovative community partnerships with Providers through our local Care Coordination Team in Kansas. The UCare Kansas team will also collaborate with local communities and Providers and conduct outreach and care coordination for pregnant and postpartum Members in Kansas as outlined in RFP Section 7.4.11 to address

workforce challenges, particularly in finding innovative community partnerships that address the inequities faced by rural and BIPOC communities.

Quantitative Analysis

Prenatal and Postpartum Care (PPC) is a hybrid HEDIS measure that UCare monitors and uses to understand performance and identify opportunities for improvement. UCare also utilizes available administrative data (claims, CPT II codes) to identify and address health disparities by stratifying the data by race/ethnicity and geography. PPC includes:

Table 20.1: Percentage of UCare Members with Postpartum Visit on or between 7 to 84 Days after Delivery

Members	HEDIS MY2021	HEDIS MY2022	Absolute Change	Goal – NCQA 75th Percentile HEDIS MY 2021 (Medicaid HMO)
Parents and Children	77.13%	79.81%	↑ 2.68	88.86%

Through UCare's improvement efforts, UCare has seen improvements in the postpartum care measure by close to three percentage points for our Medicaid parents and children population from HEDIS MY2021 (January 2021-December 2021) to HEDIS MY2022 (January 2022-December 2022). Through additional analysis, UCare identified a disparity among populations of color, with the Asian and Pacific Islander population reporting the lowest rate of receiving postpartum care.

Anticipated Improvement for KanCare

Qualitative Analysis

UCare has several targeted programs and incentives to support and improve maternal health outcomes that include timeliness of postpartum care. UCare's data-driven approach and model for continuous improvement evolve and strengthen existing programs. We also continuously look to identify new and innovative approaches to improving maternal health and related screenings for postpartum visits, including conducting focus groups among Members and Providers.

Member Engagement – Care Management

UCare's Maternal Health Care programs are designed to provide culturally appropriate, whole-person, and evidence-based support to KanCare Members throughout their pregnancy and

postpartum period. Member outreach is a key intervention to improve health outcomes post-delivery and to address the social determinants of health (SDOH) needs of our Members. UCare recognizes the diversity in the KanCare population, and we individualize our support to meet the specific needs and goals of our highest risk Members. We also use the following strategies to increase postpartum utilization and to achieve the NCQA 75th percentile or higher.

Member Driven

The MCH Member Engagement Specialist and Community Health Worker (CHW) reach out to all Members post-delivery who did not enroll in the Maternal Health Care Management Program. The Member Engagement Specialist provides education about the importance of connecting with a Provider post-delivery and assists Members with scheduling that can include transportation and interpreter services, as needed. Members are also screened postpartum for mental health needs and food insecurity, financial instability, transportation and housing needs, among other social SDOH. Members are offered connections to community resources that can provide additional support (e.g., public health family home visiting program, WIC, etc.)

Members enrolled in the Maternal Health Care Management Program receive ongoing support during and after their pregnancy. During the post-delivery period, Care Managers provide education on the postpartum visit, facilitate appointments, schedule transportation, and provide incentives to attend postpartum appointments. Postnatal RN Case Managers also conduct a thorough assessment that focuses on the KanCare Members and baby's health to ensure they are recovering well and attending the recommended postpartum visits within the first three-to-six weeks, as well as any other follow-up visits. All postpartum Members are screened for mental health needs and SDOH. If needed, referrals are made for further support.

When analyzing the number of Members enrolled in the Maternal Health Care Management Program, 80% of these Members completed a timely postpartum visit.

UCare Resources and Incentives for Maternity Care

UCare works to ensure that our Members have the support to take care of their health post-delivery and has created resources and rewards to support this goal. Members are provided information on benefits and resources through Maternal Health Care Managers, CHWs, and/or direct Member mailings. This is to ensure that Members are aware of other benefits to support them and their baby postpartum, including information about car seats, a no-cost breast pump, a nicotine QuitLine incentive for moms interested in quitting smoking, a text-based educational app (Text4baby), and UCare's Management of Maternity Services (MOMS) Handbook that provides Members with important information to help them stay health during and after pregnancy. Breastfeeding resources such as lactation consulting are offered as well as access to doula services post-delivery.

Care Team: Education, Resources, and Tools

To improve maternal health and well-being, large scale systemic change is needed. That's why, for many years, UCare has collaborated with the other managed care organizations (MCOs) to address systemic issues in prenatal and postpartum care, such as clinician bias and access to culturally congruent care. Part of the work of this MCO collaborative included a webinar series developed around topics like doulas, perinatal substance use, etc., targeted at Providers and other care team members. UCare continues to work in partnership with these MCOs on community engagement activities that include:

- Partnering with county public health agencies and educating on best practices for engaging and supporting women earlier in pregnancy
- Education related to immunizations for babies
- Effective utilization of telehealth for prenatal, postpartum, and well-child visits
- Best practices and successful implementation of maternal depression screening during well -child visits

Acknowledging that the matrix of care Providers is complex, we will engage in collaborative efforts around this work, engaging other MCOs, local and statewide experts to share their knowledge, as well as partnerships with relevant State and professional associations, such as the Kansas Perinatal Quality Collaborative (Fourth Trimester Initiative), Kansas Maternal and Child Health, and Kansas March of Dimes, among others.

Application to KanCare

Recognizing the importance of timely postpartum care in ensuring the best health outcomes for our Members, UCare will use the following strategies to collaborate with the KDHE, Providers, community organizations, and KanCare Members to improve postpartum care and outcomes for KanCare Members. These strategies include:

Member Engagement

UCare will contact all KanCare Members post-delivery to provide information and education on postpartum care. Engagement Specialists and/or Care Managers will provide postpartum education, assist with scheduling appointments, transportation, and interpreter services, as needed. Members will be offered resources and rewards for completing timely postpartum visits.

Social Barriers to Care

UCare will work to address barriers to care connected to SDOH and follow American College of Obstetrics and Gynecologists (ACOG) standards of care for postpartum visits. UCare will focus on mental health, substance use disorders, tobacco cessation, nutrition, and infant wellness care, as well as education about their coverage and assistance to access value-added benefits. Breast pumps will be provided along with education by a lactation consultant on how to use them. UCare will coordinate with the Member's primary care Provider and other care team Members, including home visiting programs, to ensure UCare's Integrated Care Teams have insight to collaborate on the Member's plan of care.

Health Plan Collaboration

UCare will collaborate with Kansas Medicaid MCOs to work together to improve the health of our Members and reduce disparities. Collaboration between all health plans offers a unique opportunity to educate and spread a consistent message to a broad audience across the continuum of care. UCare will explore collaborating on a campaign that address disparities on postpartum care and resources that help to support Providers, community organizations, and Members.

Community Partnerships

UCare has relationships across Kansas with Providers and community organizations and will partner with county WIC offices and more for Member referrals. The UCare Engagement Specialists and/or Care Managers in our Maternal Health Program will also make Members aware of the resources available to them. UCare's history of strong relationships with county and Tribal partners and dedicated liaisons also allows for collaboration on how best to connect our pregnant and postpartum Members to county and Tribal Maternal and Child Health programs in Kansas.

Educational Resources

UCare will develop additional resources to address the unique needs of KanCare Members, as identified through data and Member and community engagement, and will tailor existing educational resources. These resources include the Caring for Baby Guide and Periodicity Schedule Magnet to KanCare Members. UCare will also partner with the KDHE, community-based organizations, and other stakeholders to collaborate on creating, modifying, and/or disseminating existing resources to optimize resources and maintain a unifying message for Members.

B. Lead Screening

There is no safe detectable level of lead in children's blood, as lead exposure can cause damage to the brain and other vital organs. Guidelines from the Centers for Disease Control and Prevention (CDC) designate blood lead levels above, or equal to, a reading of five micrograms per deciliter as an Elevated Blood Lead Level (EBLL). The *Kansas City Pitch* highlighted a study in October 2022 that revealed children living in Kansas have two times the risk of developing EBLL compared to children nationally. This means, that approximately 17,000 Kansan children between the ages of 0-5 develop an EBLL annually. Children living in rural Kansas are at even greater risk of elevated levels of lead in their blood, particularly in the Southeast region of the State, which has one of the highest areas of KanCare enrollment.

Activity Description

UCare will use an integrated approach to address the overall health of children in Kansas and utilize data and analysis as part of that approach to address persisting disparities, including lead levels. While UCare is not required to report on the Lead Screening in Children (LSC) HEDIS measure for our current Medicaid population, we recognize the importance of the LSC, and will incorporate it into our overall approach that supports Child and Teen Check-ups (C&TC) completion. Evidence shows C&TC are a critical component to lifelong health. Early screening and developmental assessments lead to prevention, early detection, and treatment of health and developmental concerns. Regular C&TC visits also help children and families establish a trusting relationship with a primary care Provider. By focusing on the completion of C&TC, we support key individual components, including labs (that include lead screening,), physical exams, auditory and vision tests, oral and fluoride varnish application, immunizations, mental and development health screenings, nutritional guidance, and screening for SDOH.

Attention to these areas directly contributes to improving the overall health and well-being of children and their families that go beyond a single screening, focusing holistically on the child while providing comprehensive support and resources.

Quantitative Analysis

UCare will configure our HEDIS systems and processes to improve results for Kansas. The LSC measure is typically produced under the hybrid HEDIS methodology and is collected and reported using the same eligible population and samples as the Childhood Immunization Status (CIS) measure.

UCare currently analyzes two of our key integrated approach measures to ensure children enrolled in Medicaid are seen for well-child visits: Well-child Visits (ages 0-15 months) - 6+ Visits, and Well-child Visits (Ages 16-30 Months) - 2+ Visits. These measures also span 0-2 years of age, the time when children receive lead screening tests.

Table 20.4: Well-Child Visits in the First 30 Months of Life

Measure	HEDIS MY2021	HEDIS MY2022	Absolute Change	Goal — NCQA 75th Percentile HEDIS MY 2021 (Medicaid HMO)
Well-child Visits (Ages 0-15 Months): 6+ Visits	47.45% (2,882/6,074)	48.84% (2,854/,5844)	↑ 1.39	61.19%
Well-child Visits (Ages 16-30 Months): 2+ Visits	59.71% (4,576/7,664)	62.93% (5,318/8,450)	↑ 3.22	72.24%

Table 20.5: Lead Screening in Children

Measure	Admin MY2022	Admin MY2022 (YTD	Absolute Change	Goal — NCQA 75th Percentile HEDIS MY 2021 (Medicaid HMO)
Lead Screening in Children*	72.11% (12,022/16,704)	69.14% (5,740/8,315)	-2.97	72.67%
*While LSC rates are not reported by UCare at present, we do have administrative only rates that can be run each month. The administrative rates average 70% and exceed the well-child visit rates and align with our goal of reaching the NCQA 75th percentile. Our rates compared to Kansas 2019 rates for 0 to < = 72 months exceed by almost 57% when compared to State and Medicaid enrolled Members.				

Through UCare's improvement activities, we experienced an increase in both measures from HEDIS MY2021 (January 2021-December 2021) to HEDIS MY2022 (January 2022-December 2022) for well-child visits.

UCare will produce audited Lead Screening in Children HEDIS rates for KanCare Members and monitor performance for Lead Screening in Children and Well-Child Visits in the First 30 Months of Life. UCare's goal for KanCare will be to exceed NCQA's 75th percentile for LSC, with an additional goal to demonstrate statistically significant improvement year over year. UCare will target resources and efforts toward areas and populations with the greatest disparities, including children living in rural Kansas and particularly children living in the Southeast region of the State.

Anticipated Improvement for KanCare

[redacted]

Qualitative Analysis

UCare's targeted programs and initiatives support integrated, whole-child health to improve well-child visits, and improve the rate of lead screening. Using a data-driven approach and a model for continuous improvement, UCare strengthens and evolves existing programs and consistently looks for innovative approaches to improve well-child and related screenings that occur during these visits.

UCare uses a multifaceted approach to Member engagement that promotes preventive care and behavior change. The strategy varies across communication type, such as a postcard, interactive voice response (IVR) or email, or a more tailored and personalized approach by providing direct live outreach. Members who experience access barriers often benefit from this direct outreach. This personalized touch provides the opportunity to understand social needs and address or remove barriers with strategic resources (e.g., Health Promotion rewards and kits, scheduling transportation or interpreters).

UCare will collaborate with community partners, such as University of Kansas Medical Center Project ECHO series; Kansas WIC program – screening for anemia and elevated lead levels; and Wyandotte County Public Health Department that managed the kNOw LEAD KCK initiative that supports residents with lead-based paint stabilization. UCare also will partner and support University of Kansas Medical Center Project ECHO series around equipping clinicians to address lead exposure in Kansas communities. UCare's approach to these efforts is to support existing work and innovations while reducing duplication of efforts to ensure Providers and Members are not receiving education and outreach from multiple entities.

Member Engagement

UCare created a Health Improvement (HI) Team made up of CHWs and public health professionals with the best knowledge of our Members and their communities to achieve positive health outcomes. The goal of our HI Team is collaborating with Members to close the gap between communities and health care systems, including C&TC.

CHWs are available to all Members. The HI Team provides services to help address Members' preventive care needs and concerns to help get their health and well-being on the right track. CHWs assess Member needs and identify Providers and/or clinic/care systems that are representative of a Member's race, ethnicity, language, and cultural background. In addition, when Members identify social needs, referrals are made to community organizations (e.g., food, housing supports) that also are representative and sensitive to their cultural and linguistical needs. Well-child visits show marked improvement after outreach by a CHW.

Additionally, all children with gaps in care for preventive services (e.g., well-child care) receive a personalized scorecard to help families and caregivers stay on track for preventive visits including information about being overdue, coming due, or up to date. This intervention provides the Members with a snapshot of their current health status. This personalized action plan was first sent via mail in 2021 and continues to be sent in the first and third quarter of each year.

Addressing Social Barriers to Care

UCare partners with Unite Us to integrate social care data into our existing programs and workflows, including for the CHWs to use when supporting Members. This data helps identify UCare Members' social needs prior to outreach and allows UCare staff to conduct a more Member-centric approach. When Members' needs are identified, UCare staff can utilize the Unite Us search engine to identify resources, make referrals, and connect Members to community partners for social service needs in their community, including resources to address lead exposure. CHWs can also address SDOH barriers that might be preventing a family from getting in for timely well-child visits, and therefore lead screening, as well as assist families in scheduling their well-child appointment.

MCO Collaboration

We will work in partnership with Medicaid MCOs serving KanCare Members to exchange information and identify community needs and priority health concerns within a community, including C&TC and lead testing. Methods with which we collaborate with other health plans to better support healthy children and lead testing from a collaborative perspective include educational webinars, blogs (A Reminder from your Health Care Provider), and community

partnerships (Kansas Association of Medicaid Health Plans, Kansas Home Visiting, regional C&TC groups, county public health and birth equity councils, and advocacy organizations, etc.).

Value-Based Contracts

UCare actively engages network Providers through alternative payment arrangements across all of our government plans. Our alternative payment arrangements offer a range of Provider incentives designed to reduce costs and improve outcomes for UCare Members.

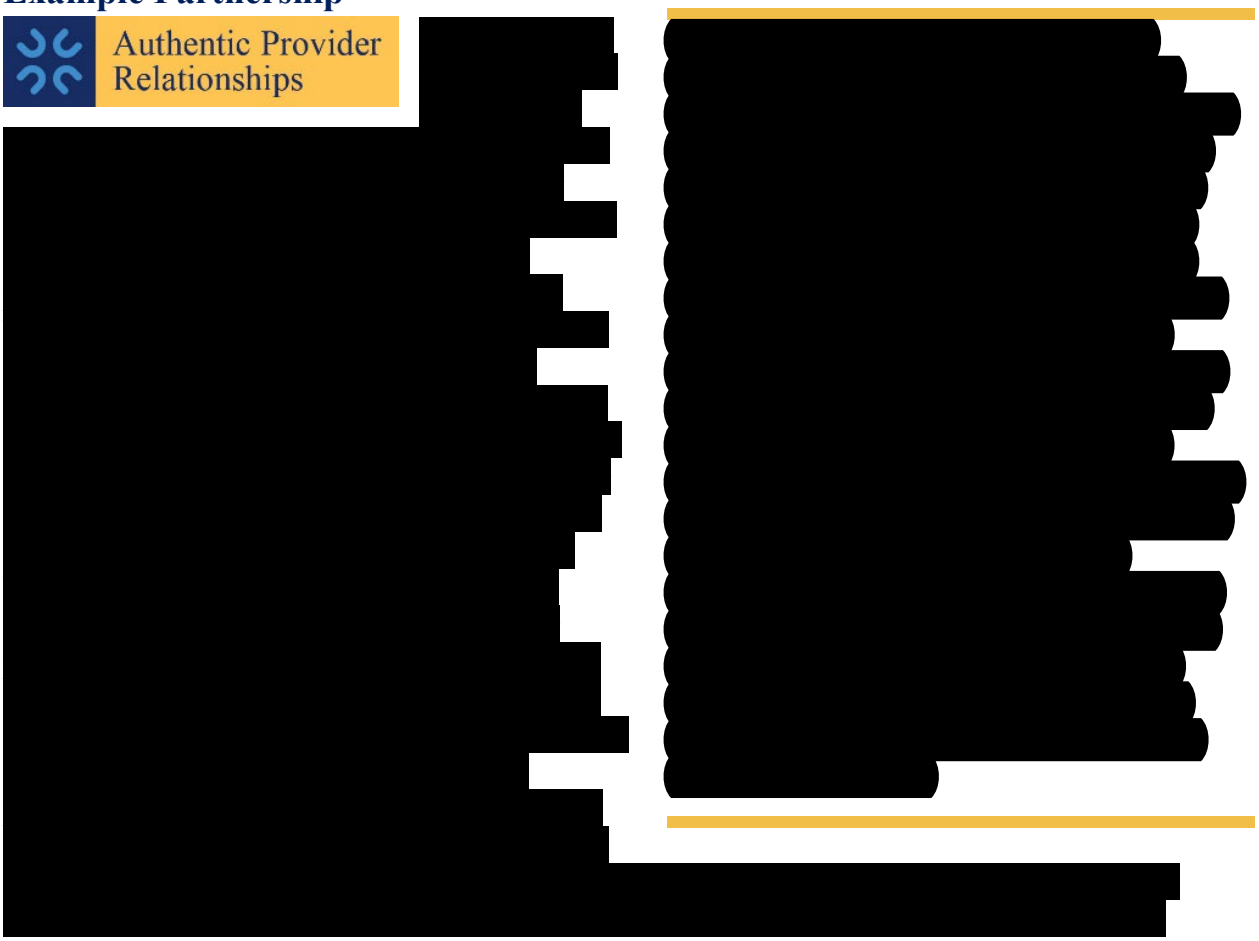
Community Partnerships

We are a strong partner in helping address community health needs and providing health education about preventive services and care, including hosting a table at various events. Information provided at these events to promote lead testing and well-child visits will include:

- Personalized scorecard that can be filled out onsite at community events
- UCare's Periodicity Schedule magnet
- Information on health promotion programs

UCare also has established partnerships in various Kansas community venues, including clinics, county connections, community nonprofits, and SDOH organizations. UCare partners with organizations through various grants, unique Provider partnership positions, tabling at events, and many other ways. Meeting the partners and our Members where they are is a key priority.

Example Partnership



UCare also believes in reaching Members through various channels including the entire community to educate on the importance and components of well-child visits. UCare collaborates with many community-based organizations, including Hmong and Somali TV stations, and respected medical Providers of the community to educate community groups on well-child visits, preventive care and immunizations, etc. Members of the community who tuned in to the shows were able to call-in live and ask questions directly with the medical Provider.

- Somali TV (live TV): 2,400+ views on Facebook, 223+ views on YouTube
- Hmong TV (live TV): 1.400+ views on Facebook, 2,300+ views on YouTube.

Application to KanCare

UCare has extensive experience and a proven track record of implementing strategies for continuous improvement in our HEDIS measures by developing effective and innovation interventions to support Members in obtaining the care they need. We developed a robust set of interventions to increase well-child visits, which directly increases lead testing in children age birth-two years. In Kansas, UCare will track and report on the HEDIS Lead Screening in Children measure, analyze performance compared to the State average and NCQA's 75th percentile, and implement interventions to increase rates to close the gap or exceed NCQA's 75th percentile.

UCare recognizes that children in Kansas are not universally screened for lead, which contributes to lower rates of screening. UCare has the following strategies to better collaborate with KDHE, Providers, community organizations, and Members to improve blood lead testing for KanCare Members. These strategies include:

Member Engagement

UCare will have a team of CHWs that reflect the race/ethnicity, language, and cultures of our KanCare Members. The CHWs will focus on a whole person-centered approach of well-child visits and developing a Member-Provider relationship. CHWs make educational calls to Members that also address key milestones of the child, what occurs during the visit, and promoting lead testing and immunizations. Through Member engagement activities, UCare will collect Member feedback on social barriers that impact scheduling well-child visits and completing necessary screens, such as lead testing, and work to mitigate those barriers.

Social Barriers to Care

Our CHWs have information prior to the call to identify Member needs, including food, housing, and transportation, to allow for a more person-centered approach. UCare will also continue using Unite Us in Kansas to provide resources and referrals for KanCare Members to mitigate barriers to care and SDOH. In September 2023, Unite Us has partnered with the State of Kansas, including Kansas Department for Children and Families (DCF) users, local Kansas agencies, and health care Providers to provide software and services to these agencies. This enhances UCare's

effectiveness when working with KanCare Members on addressing social needs, providing resources and referrals, and tracking closed-loop referrals within their community.

Provider Collaboration

UCare will work with primary care Providers to understand best practices that are used at their clinic to screen for blood lead levels. We will engage and listen to the voice of the Provider in supporting KanCare Members' needs and ensuring appropriate universal testing is occurring with our Provider network.

MCO Collaboration

UCare will collaborate with Kansas Medicaid MCOs to improve the health of our Members and reduce disparities through a variety of interventions. Collaboration among all health plans offers a unique opportunity to educate and spread a consistent message to a broad audience across the continuum of care. In addition, bringing in other State partners to support the effort can enhance the same unified messages from other programs that may include KDHE, Unified Government of Wyandotte County & Kansas City, Sedgwick County Kansas, Kansas WIC Program, etc. Messaging and education will be explored through webinar education series, collaborative educational materials for Providers and/or Members, etc.

Value-Based Contracts

UCare will strongly encourage the inclusion of Well-Child Visit HEDIS measures into our value-based contracts to ensure this is a focus area across our Provider partners and within our organization. UCare will also strongly encourage the inclusion of the Lead Screening in Children HEDIS measure due to the high need in Kansas, and specifically target Providers in the Southeast region of Kansas where there are the greatest disparities and highest need, and in partnership with the Community Health Center of Southeast Kansas, which includes a robust CHW staffing model, and other key Providers and organizations.

Educational Resources

UCare will tailor existing educational resources, including the Caring for Baby Guide and Periodicity Schedule Magnet, to KanCare Members and disseminate other educational resources. UCare will also develop additional resources to address the unique needs of KanCare Members, as identified through data and Members and community engagement. UCare will also partner with KDHE, community-based organizations, and other stakeholder to collaborate on creating, modifying, and/or disseminating existing resources to optimize resources and maintain a unified message for Members.

Summary

UCare will use an integrated approach following the Quintuple Aim to ensure the KanCare Member experience fosters trust, communication, and engagement between Members and their health care Providers. UCare's KanCare-dedicated Quality Measurement Improvement Committee and related work groups will utilize the PDSA cycle as the cornerstone to improving quality measures for KanCare Members. Our goals will be set to exceed the NCQA 75th percentile for our initiatives, including Timeliness of PPC and LSC. UCare will take an integrated approach to addressing the overall health of Kansas Members and children by supporting Child and Teen Check-ups, with targeted improvement efforts on lead screening, as well as supporting postnatal visits. With our proposed targeted interventions, we will be able to support KanCare Members to achieve optimal health.

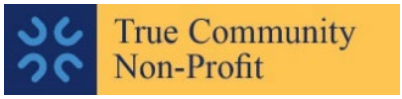
21. In practice, MCOs have experienced challenges in providing necessary HCBS Waiver services, including those that have been authorized for a Member, creating service gaps. Describe the bidder's approach to identifying and addressing HCBS service gaps to ensure needed services are provided to KanCare Members who are enrolled in an HCBS Waiver and what the bidder will do when Providers/direct care workers are not available to deliver an authorized HCBS Waiver service.

UCare recognizes the importance of understanding the needs of Members, families, and Providers when addressing gaps in service. As a longstanding Medicaid and long-term services and supports (LTSS) managed care plan and working with populations who access Home and Community-Based Services (HCBS), UCare appreciates the important role these play in ensuring that Medicaid Members receive integrated, whole-person care. Our holistic approach also integrates and positively impacts our Members' social determinants of health (SDOH), leading to improved health outcomes and quality of life. The COVID-19 pandemic highlighted strengths and challenges of the provision of HCBS in Kansas and nationwide. The pandemic's impact on Members, their families, caregivers, organizations, and funders surfaced multiple service gaps in the HCBS system.

Information Learned from Agencies, Providers, and Community Organizations

Local agencies, Providers, and community-based organizations are a valuable source of information regarding availability and access to culturally congruent care, as they work with Members every day. UCare's Provider Relations and Contracting Team (PRC) regularly meets with local agencies, Providers, and community-based organizations, bringing any updates and identified needs back to UCare to be reviewed and addressed. The PRC Team then finds solutions and informs teams within UCare about the experience of the specific agency or organization. Over the past year, UCare has engaged in a robust needs assessment to understand the HCBS landscape in Kansas. This needs assessment included conversations with:

- Kansas Childrens Alliance
- KanCare Advocates Network
- Bert Nash Center
- Minds Matter, LLC
- Disability Rights Center
- NAMI Kansas
- Pawnee Mental Health
- Interhab
- Kansas Association of Community Mental Health Centers
- Kansas Area Agencies on Aging
- Kansas Advocates for Better Care
- Kansas Association of Centers for Independent Living
- Community Developmental Disability Organizations



We are establishing and leveraging relationships with the above organizations to ensure care availability for Members by local Providers throughout the State and to address identified gaps in the HCBS service delivery system. UCare is in the process of negotiating Provider agreements and securing letters of intent with these Providers. [redacted] As part of our strategy to understand and meet Provider needs, over the past year we have attended hundreds of meetings with Kansas organizations, including community events, association meetings, conferences, and symposiums. These include attendance at the Interhab conference for Providers serving individuals living with intellectual and developmental disabilities, which was focused on

workforce shortages and best practices related to HCBS services. From these conversations, and other research,


Member
Driven

[redacted]

Technology to address social isolation and loneliness (Gaps addressed: 1, 2, 5)

UCare is committed to utilizing technology to combat social isolation and loneliness, which are well documented as significant public health problems and represent clear risks for death, depression, anxiety, and cognitive disorders such as major cognitive impairment (dementia). The evidence-based interventions by mental health professionals for social isolation and loneliness are limited and further impacted by documented workforce shortages. Family, caregivers, care coordinators, general practitioners, and mental health professionals may be some of the first to identify socially isolated and lonely older adults.

Figure 21.1: GrandPad tablet

UCare has historically leveraged available technology to support our Members who experience social isolation and loneliness. GrandPad is a simplified computer tablet designed with seniors in mind and comes to the Member complete with everything they need to connect with caregivers and family, plus the service to support social connections. It is specially designed to help Members stay connected, feel less isolated, and helps them manage their health as independently as possible.

Strategies for Identifying Future Potential HCBS Service Gaps

UCare is highly qualified to meet the HCBS needs of KanCare Members and ensure needed services are provided. Central to UCare's decades of experience supporting our Members' best health is our commitment to addressing service gaps and working with HCBS Provider networks to ensure Member access to high quality and comprehensive HCBS. The need and demand for HCBS will continue to increase over the next 10 years as the 65+ population is both growing and getting older. In addition, there has been increased federal interest in strengthening HCBS and expanding alternative options to institutional services. The increased demand for services coupled with known workforce shortages heightens the need for an experienced managed care

plan like UCare to successfully administer HCBS for KanCare Members. UCare will continue to develop partnerships with KanCare Providers. These relationships are the hallmark of ensuring that all Kansans have access to integrated, high-quality support services to work, live, and play in their community of choice.

People Powered

UCare's commitment to this is demonstrated in our proposed staffing plan. Integrated Care Coordinators and the PRC Team will monitor and be in constant communication with HCBS Providers across the State via electronic and in-person visits. [redacted]

Our HCBS Program is person-centered, goal-oriented, and culturally relevant, with logical steps to ensure our Members receive needed services in a supportive, thoughtful, efficient, and timely manner. We emphasize addressing SDOH and ensuring integration of Members into their communities so they may receive care in the least restrictive, most supportive environment possible. Under the KanCare HCBS waivers, UCare's Care Coordinators will collaborate with Community Care Coordinators (CCCs), Targeted Case Managers (TCMs), community-based organizations, and Community Disability Determination Organizations (CDDOs), as applicable, in accordance with Appendix L of the RFP, to assist Members with access to a variety of HCBS services depending on the waiver type. Such services may include adult day care, assistive technology, comprehensive support, enhanced care services, financial, management services, home telehealth, medication reminders, nursing evaluation visits, oral health services, personal care services, personal emergency response, and wellness monitoring. UCare will also assist Members with access to in lieu of services (ILOS) approved by the State. UCare provides ILOS to promote greater access to services in an inclusive, culturally informed way. ILOS are especially important for covering service gaps, strengthening access to care through expanding options to settings, and addressing many unmet physical, behavioral, developmental, long-term care, and SDOH needs.

Integrated Care Coordinator Input

Integrated Care Pioneer

Our Care Coordination Team helps facilitate availability and access to HCBS services and also alerts our PRC Team of service gaps. Often our Care Coordination Team will be the first to hear about a service shortage directly from Members or when attempting to initiate necessary services for Members. When our Care Coordinator, working in collaboration with our Community Care Coordinator (CCC), the TCM, or CDDO, as applicable, becomes aware of a service shortage or gap, the Care Coordinator brings the information back to our local Kansas PRC Team to determine if there are additional network options to support closing the service gap. If this is not possible through contracting, the Care Coordinator will work in collaboration with the above members of the Care

Coordination Team, as applicable, toward finding other community supports available to the Member through volunteers, faith-based organizations, or nonprofit agencies in the Member's service area.

Identification of service gaps occurs naturally as part of care coordination activities. Our Care Coordinators collaborate with CCCs and TCMs who are located in the community, have knowledge of local resources, and serve as the Member's primary point of contact, unless otherwise indicated, in accordance with Appendix L of the RFP. We will ensure a clear delineation between the responsibilities of UCare Care Coordinators and CCCs to avoid duplication or gaps in services, while at the same time appointing a UCare Care Coordinator as the single point of contact for the CCC (as required in Section 7.4.6.C of the Contract) to ensure efficient communications, support the CCC, facilitate efficient monitoring of the PCSP, and support ongoing collaboration regarding identification and closure of service gaps. The Health Risk Assessment (HRA) and needs assessment completed prior to developing the PCSP provide valuable insight and a rich opportunity for identifying Member needs and potential gaps in services. The HRA is used to evaluate a Member's health risks, quality of life, SDOH, and available services and supports. The needs assessment further assesses the necessity of services and supports and any gaps that exist.

Based on the HRA and needs assessment, a PCSP is developed to meet the Member's goals and preferences for services and supports, and to assure HCBS services are not only available, but are also accessible, acceptable, and relevant to the Member, and are well supported with appropriate accommodations.

Through a person-centered planning process in accordance with Sections 7.4.4.2 and 7.4.6 of the RFP, our

[redacted] Through the strong relationships built with Members through our Integrated Care Coordination model, we can identify and understand Member needs in a more profound way. After developing the PCSP, monitoring and follow-up activities continue,

which provide additional opportunities for identifying gaps and changing needs of Members, and ensure the PCSP adequately addresses the needs of Members over time.

Care Coordinators take this opportunity to work with the Member in providing a choice of service offerings that will help meet the Member's identified needs, including the option for self-directed care. Self-directed care gives the Member the opportunity to manage their own funding and pay for services, which often eliminates the barrier of Provider shortages if there is a known family member, friend, neighbor, or loved one they want to hire. This also allows for individualized training of the service Provider so that the Member can receive the focused, individualized person-centered support necessary to close any service-related gaps.

Monitoring Data

UCare has extensive experience monitoring our Provider network to identify service gaps through several mechanisms. To ensure that our network is available and accessible to Members, [redacted] The monthly meetings ensure our network is of high quality to meet Member needs. UCare is currently in discussions with a cross-functional group of Providers in Kansas, including but not limited to Minds Matter, LLC and LifeStreams, with a focus on care coordination and potential payment for value-based outcomes, as well as several Providers for providing transportation services.

Tracking Appeals and Grievances

Another way HCBS service gaps are identified is our review of appeals and grievances. Complaints regarding access and availability are sent to our PRC Team to be reviewed and addressed. UCare's PRC Team will be in constant communication with Providers across the State, via electronic and in-person visits.

Identifying Current HCBS Service Gaps

[redacted]

In accordance with Section 7.4.2.E and F of the RFP, service needs identification is initiated through the completion of the health screen, HRA, and needs assessment. Once a Member's needs are identified, our Care Coordinator works in collaboration with the CCC, TCM, and CDDO, as applicable, and the Member to develop a PCSP. The PCSP identifies the strategies to meet the goals and interventions selected by the Member for support in improving their health and SDOH through HCBS and other supportive services and community resources. Below are strategies used by UCare to identify service gaps.

Current Efforts to Address HCBS Service Gaps

Authentic Provider Relationships

UCare is committed to working with HCBS Provider agencies and partnering with the State to support initiatives that meet the challenges of network adequacy in the area of LTSS. According to the Kansas Department of Labor statistics, home health and personal care services are in high

> *"UCare's deep experience with similar local delegated models provides us confidence in the potential for this partnership."*
> —Kansas Advocates of Better Care

demand in Kansas. This is consistent with the U.S. Bureau of Labor Statistics, which estimates that the home health and personal care service worker industry will grow 22% from 2022 to 2032, much faster than the average of all occupations. The turnover rate is also high, which can result in service disruptions and inconsistent care. For example, the National Core Indicators Intellectual and Developmental Disabilities staff stability survey showed the weighted average turnover rate for I/DD Direct Support Professionals (DSPs) in 2020 across all states was 43.6%.

Network adequacy, payment rates and reimbursement, and quality are fundamental underlying factors to addressing the challenges in assuring services are available and accessible to Members. HCBS network adequacy means more than meeting time and distance standards, or the time it takes to initiate an appointment. It also means ensuring that services are available and accessible through creative and innovative ways that are acceptable to the Member. UCare is committed to overcoming workforce challenges through the overall design of our network and Care Coordination Program, partnering with the State, and working with Provider agencies to address workforce shortage issues.

Access to Non-Network Providers

When services a Member needs cannot be obtained from network Providers, UCare looks for Provider access outside our network, including through a single-case agreement with a non-network Provider. For example, Care Coordinators recently alerted a UCare Clinical Care System liaison about staffing shortages for an in-network home care nursing Provider and, in another instance, about the need for a participating home care agency to provide care aligned with the cultural needs of a Member. In both cases, UCare facilitated accessibility of services through single case agreements so the care could be delivered, and services covered affordably without additional delay.

New Provider Recruitment

If there is a gap in service for a certain Provider type, UCare reviews the need and contracts directly with that type of Provider. UCare reviews requests for needed services or treatments from non-contracted Providers and enters into participating Provider agreements with them if the network is determined to be insufficient to fully meet the needs of the population.

Back-Up Plans

Emergency back-up plans in the PCSP ensure that if a Member loses access to their HCBS care Provider there is a backup plan in place to address the gap, including without limitation, informal supports of family and friends. Our Care Coordinators follow UCare's continuity of care process developed in accordance with State and federal law and regulations to ensure Members continue to have access to care.

Member Supports

[redacted]

[redacted]

Utilization of Telehealth: [redacted] UCare has experience supporting telehealth in our current Medicaid market. In one instance, we worked with a rural county to create a space for telemedicine appointments and connected the county to a Provider for establishment of intensive autism services via telemedicine. [redacted] This pilot demonstrates how telehealth supports Members and closes gaps in care by making services available and accessible. UCare continues to support iPad initiatives and will support Providers, like Minds Matter, LLC, which have developed their own successful telehealth program.

Transportation: Based on our research in Kansas over the past year, UCare will ensures that KanCare Members, especially those in rural and frontier areas, have the non-emergency medical transportation services they need when they need them. We have met with and heard directly from several Kansas medical Providers who shared their struggles with current KanCare patient transportation issues, most related to not being able to find a ride for their patients. Like the current KanCare MCOs, UCare will contract with a network vendor to provide the majority of transportation services. However, we believe the vendor we have selected in Kansas, MTM, is superior in geographic availability, services, and innovation.

Technology: [redacted]

UCare Care Coordinators Close Member Service Gaps: UCare's Care Coordinators work closely with both Members and HCBS agencies, and through ongoing and routine communication are able to identify and address gaps in service. We look forward to our Care

Coordinators working collaboratively with our CCCs, TCMs, and CDDOs, as applicable, to meet the local needs of KanCare Members. Below are examples of how UCare's Care Coordinators have worked successfully with Members to find solutions to service gaps through available and accessible supports that are acceptable to the Member and accommodate their needs.

- **Alternative Solutions:** Upon identifying a service gap, our Care Coordinators work to find alternative HCBS Providers. If all Providers are unavailable, the Care Coordinator will determine what other covered services could provide needed support. For example, we work with Provider agencies and community-based organizations to find creative solutions to ensure an appropriate safety net for our Members.
- **Leveraging Technology:** We leverage technology to support Members, such as Grandpad. For example, an elderly Member living alone in a rural area relied on his grandson as his main support. Our Member suffered from depression and social isolation. His grandson was going to be leaving for college in the fall and the Care Coordinator worked with the Member to initiate adult companion services. Due to geography, they were unable to establish a companion service Provider. The care coordinator suggested a Grandpad, a simple and secure tablet that connects seniors to family and friends. The Member found this acceptable and agreed. Once received, the Care Coordinator made sure the new technology was accessible, and that the Member could effectively use the new technology. The grandson provided some training and the Care Coordinator also found online training resources printed in large type font and mailed to the Member to accommodate the Member as needed. The Member was able to connect with his grandson regularly, receive photos, and play games. He commented that his overall mood had improved, and he felt supported by the Care Coordinator's efforts to find an alternative to in-person companion services.
- **Transportation to Dialysis:** A Member on dialysis had transportation arranged by his Care Coordinator. The Member experienced transportation Providers arriving late and on occasion not showing up at all, causing the Member to experience increased anxiety. The Care Coordinator and Member reviewed other available and accessible options and services to better support the Member. The Care Coordinator knew that the Member's neighbor was now retired and often came over to assist with light housekeeping and drove the Member to the grocery store every week. The Care Coordinator reviewed self-directed services and recognized a budget for transportation that could be used for dialysis rides. The Care Coordinator suggested to the Member that he ask his neighbor if he could provide transportation to dialysis and the Member found this to be acceptable and agreed. Since the Member initiated transportation services with his neighbor, he has consistently made it to all appointments and has expressed he no longer feels anxious about missed appointments.
- **Leveraging Community Supports:** A Member received weekly HCBS-covered transportation to church. The transportation agency was closing, and the Member lived in a rural area. The Care Coordinator worked with the church and found a volunteer to provide transportation to and from church weekly until a new transportation agency was available.

Summary

As the above innovations, network management, and care coordination programs demonstrate, UCare is committed and able to meet the goals of the KanCare program, ensuring needed services are provided in a timely manner to KanCare Members enrolled in an HCBS waiver. Through strong partnerships with local Providers, we will thoughtfully identify and address service gaps and address them through innovative strategies and compassionate service.

Tab 7f:

TOPIC AREA 6

Provider Network

7f. Provider Network

22. Describe the bidder's approach (including methodology, data used to assess network adequacy, timeline, and use of selective contracting) to developing, managing, and monitoring an adequate, qualified Provider network for the KanCare program. Describe anticipated challenges, network gaps, and how the bidder will address those challenges, including the use of telehealth and other technologies.

UCare appreciates the State's goals of expanding the KanCare Provider network and improving Provider experience to ensure that Members have access to the right Providers to meet their clinical, cultural, and home- and community-based needs, whether they live in urban, densely settled rural, rural or frontier areas of the State. UCare's local, on-the-ground partnership approach with Providers will be instrumental in our ability to maintain a strong and stable network in which Providers feel comfortable with UCare and able to expend the bulk of their efforts on engaging with Members rather than with the administrative aspects of service delivery.

UCare has built strong expertise in Provider network management and relationships over nearly 40 years of serving Medicaid Members. From the time a Provider applies for UCare's network to the time of payment for services, our multidisciplinary staff ensure Providers a high-quality experience. Representatives from Network Analytics, Contracting, Credentialing, Claims, Compliance, and Provider Assistance teams meet regularly to determine and resolve network needs, review quality of Providers, and determine how to best support them. UCare applies a range of standards to monitor and maintain network adequacy and Provider quality. We also leverage workflows and automated tools to meet internal service-level performance metrics. Through all of these processes, staffing and tools, UCare ensures an accurate, efficient, and consistent experience for our Providers – an experience of ongoing partnership through in-person meetings, training, and education. It is the quality of these relationships that is UCare's greatest strength that in turn ensures access to quality care for our Members.

Developing Our KanCare Network

UCare understands that it is important to have a foundational understanding of the State's requirements for Provider network adequacy and KanCare Member access, as well as an understanding of the KanCare benefits that translate into the myriad of Providers, services, settings, and local health market dynamics that impact and influence Member access to care and services. Core to meeting these requirements is our Kansas-based team that is knowledgeable in their local markets and have strong relationships with Providers in their communities. In compliance with RFP Section 7.17.2, we will dedicate Kansas-based staff to oversee all aspects of our network development, management, and monitoring:

- Our Director of Network Management and Contracting will oversee network development in compliance with all requirements in RFP Section 7.5.2, as well as network adequacy and expansion of telemedicine and implementation of innovative strategies.
- Our Director of Provider Relations will oversee all Provider services and Provider relations, including payment issues, Provider education, development, and training in compliance with RFP Section 7.6. The Director will also serve as the State's single point of contact for escalated Provider issues.
- UCare has also developed a State and Federally compliant draft Participating Provider Agreement (PPA). We will submit the PPA to the State for approval immediately upon

contract award. Upon approval, we will work to effectuate a PPA during the State Readiness period with each identified Provider to ensure a full network on January 1, 2025.

To ensure convenient access in terms of both geographic distance and time, UCare meets and exceeds our Members' network needs through compliance with National Committee for Quality Assurance (NCQA) accreditation standards, which are more rigorous than State and federal guidance. In our current market, our Provider network includes 96% of all Providers in the state, enabling us to meet network adequacy for 100% of our Medicaid Members, including appropriate network exceptions and waivers as approved by regulators.

UCare commits to establishing and maintaining a KanCare network that will provide timely access to appropriate care for Members regardless of region, English proficiency, or social determinants of health (SDOH). In preparation for this procurement, UCare conducted a robust analysis of KanCare's incumbent networks to identify Providers who are currently being utilized, and reviewed network adequacy reports to determine where access needs and gaps still exist. We utilized Quest Analytics Suite to analyze geographic access and leveraged various data sources in addition to incumbent networks, including CMS Supply Files, National Plan and Provider Enumeration System (NPPES) data and local Provider websites, to ensure we are capturing all Provider types, settings, and locations. Over the past year, we have met with hundreds of Providers large and small, including a full range of Provider types, across the State, to develop relationships to ensure that we can provide KanCare Members with access to quality care on day one.

Of note, to date we have secured LOIs with nearly all of the Rural Health and Essential Community Providers in Kansas. Appreciating the critical importance of meeting the needs of all Members, UCare will continue to examine and address access gaps and concerns for Members who live in rural or frontier areas. We will also be in full compliance with RFP Section 7.5.2.G, to ensure a full range of specific Provider types in our network.

In addition, we have connected with numerous organizations throughout the State, including associations and advocacy organizations, to discuss partnership opportunities such as quality initiatives that can be undertaken should UCare be awarded a contract. Examples of these include Kansas Hospital Association, Kansas Medical Society, Kansas Rural Health Association, Community Care Provider Network, Kansas Association of Community Mental Health Centers, Kansas Advocates for Better Care (KABC)/Area Agencies on Aging, Interhab and more.

UCare is aware of the challenges Providers are experiencing, especially in densely settled rural, rural, and frontier service areas. Specifically, in the western portion of Kansas, we have engaged Providers to secure LOIs with health care systems and clinics to ensure as expansive a network as possible. UCare will also work to exceed standards for Home and Community Based Services (HCBS) that include day supports, home telehealth, medication reminders, occupational therapy, physical therapy, speech therapy, and transitional living. See Figure 22.2 for a map of long-term

services and supports (LTSS) Providers engaged to date. In addition to primary care Providers, we will ensure appropriate access to a full range of specialty Providers, including Indian Health Care Providers; dental Providers that offer sedation services; and specialists in caring for children, adolescents, and adults with developmental and cognitive disabilities, as well as individuals with behavioral health needs. As described below, where Providers are simply not available, we will implement innovative solutions, including the use of telemedicine. Moreover, we will work to ensure a comprehensive network that includes key Provider types, including State hospitals, Regional Alcohol and Drug Assessment Centers (RADACs), psychiatric residential treatment facilities, and other nontraditional Provider types.

Selective Contracting

For the first few years of UCare's contract with KDHE for KanCare we are committed to including all Providers in our network who meet State, Federal and UCare's contracting regulations and requirements. UCare wants to ensure the most comprehensive network possible to meet or exceed the needs of our KanCare Members. UCare has experience with selective contracting where a high-performing Provider has unique model and expertise, particularly in our SNP plans regarding care management, coordination, transitions, and in-home services and additional social supports. One example of this in our FIDE SNP where a Provider (in an

exclusive partnership with UCare) is embedded with local health systems (emergency department and inpatient) to handle transitions of care and is under contract to provide health services for several assisted living locations where our Members live. UCare will refer or assign Members to this Provider who are medically and socially complex and can benefit from their model, and where the Provider has demonstrated improved outcomes.

For our Kansas network, UCare will gain a baseline of experience and working with local Providers to ensure we have a more than adequate number of a certain type of Provider to meet or exceed Member needs. UCare will assess for higher performing Providers or centers of excellence through our value-based payment (VBP) arrangements, as often this is how we identify Provider partners for these types of arrangements and key partnerships. UCare is anticipating this would initially be limited circumstance and would require a thorough utilization analysis of Provider and Member needs, before implementing a selective contracting process.

Network Management

Through our experience, UCare understands that managing a Medicaid network, as well as other government programs, is different than commercial programs, given the complexity of requirements, services, Provider types, and availability within highly localized markets and geographies. Given these complexities, Providers can experience fatigue and abrasion when contracting with payors for Medicaid services. UCare's primary goal is to treat Providers as partners, remove unnecessary barriers, understand our role in appropriate oversight accomplished in ways Providers understand, and work together to address challenges and gaps.

We have well-established processes to ensure effective maintenance and service to our Providers, from recruitment through all stages of our relationships. A core part of UCare's approach to successfully managing a strong Provider network is ensuring we have processes and staffing that result in a positive Provider experience with UCare. This approach is key to our Provider retention. The primary features of our approach include the following:

Fair and Transparent Contracting

UCare's approach to managing the contracts of our Provider network is one built in relationship, trust, transparency, fairness, and collaboration. We actively work to update and maintain our contracts in a way that is clear and transparent, aiming to reduce Provider administrative burden as well as ensure the contracts are current and compliant with all State and NCQA standards. Key features and processes of our contracting approach include:

[redacted]

Kansas-Based Credentialing Team

People Powered

UCare will establish a local credentialing and re-credentialing operations with Kansas-based staff utilizing our existing process and structure, to support Kansas and border Providers. UCare will partner closely with KDHE on the implementation of its single credentialing process and ensure a smooth transition for Providers (and therefore Members), to eliminate or reduce any disruption to payment or service delivery. Our Kansas-based credentialing process will:

- Establish a credentialing committee chaired by our KanCare Chief Medical Officer
- Establish policies and procedures that implement a uniform credentialing/re-credentialing approach for acute, primary, behavioral health, and LTSS Providers who meet all applicable State and CMS requirements and complies with the HCBS Settings Rule
- Continuously review, improve, simplify and streamline our processes, incorporating Provider input, to reduce administrative burden on our participating Providers
- Provide quarterly reports to the State that demonstrate adherence to HCBS Waiver requirements
- Ensure that Providers are re-credentialed every three years
- Comply with all remaining KanCare contract requirements per Section 7.5.1

Subcontractor Oversight

UCare will use subcontractors to develop, manage, and monitor the Provider network for certain services: DentaQuest (dental), Navitus (pharmacy), and MTM (transportation). However, subcontractor oversight is critical for UCare to ensure we are meeting or exceeding State standards and, as we do, have robust processes in place to address gaps, continuity of care, and bring forward innovative solutions to address them. Subcontractors are required to submit recruiting and retention reports based on the network adequacy and network needs. These cadences are generally weekly, monthly or quarterly, depending on the network and subcontractor. This is followed up by an annual audit that is reviewed by UCare and the

subcontractor. UCare and our subcontractors also use care coordination reports to identify potential opportunities based on requests from the membership for out of network Providers.

Provider Services and Support

To maintain close contact and relationships with Providers, UCare will utilize our best-in-class [redacted]

We listened to Providers throughout Kansas who were looking for more than a transactional relationship with KanCare MCOs and the ability to have local staff with the knowledge and authority to resolve their issues in a timely manner. Provider Field Representatives are responsible for continuous relationship building, education and training, and identifying and resolving any issues to avoid escalation. Highlights of [redacted]

[redacted]

Through our partnership approach, each Provider will have direct access to designated staff to ensure productive, routine communication and prompt resolution of issues.

People Powered

[redacted]

[redacted]

Maintaining a Culturally Competent Network

Maintaining a culturally competent network is a high priority for UCare. Culturally competent health care contributes to better health outcomes, improves diagnostic accuracy, increases adherence to recommended treatment, and is potentially cost efficient. We ensure our network reflects the diversity of Members and provide resources and trainings to our Providers through our bulletins, newsletters and website:

- **Cultural competency resources:** A list of resources, found on ucare.org, provides articles and tools designed to increase cultural awareness within the Provider community.
- **Culturally responsive care:** "Culturally responsive Provider" is defined in UCare's Provider Manual and at ucare.org. These resources include information about treating patients in a culturally sensitive manner, such as making an accurate health assessment that considers a patient's background and culture, recognizing culture-based beliefs about health, and devising a treatment plan that respects those beliefs and a willingness to learn more about the effect a patient's cultures has on health outcomes.
- **Culture Care Connection:** Funded by UCare, this online learning resource center was created in 2008 in partnership with Stratis Health, a quality assurance organization that works with and across multiple states. This website features Culturally and Linguistically Appropriate Services (CLAS) Standards assessment and implicit bias training. UCare funded a major update to the online resources in 2021 to accelerate the pace of health equity changes and support community outreach and learning activities.
- **Multilingual Health Resource Exchange:** UCare also supports an online clearinghouse for Providers with resources in several languages, including a library of more than 6,000 translated health education materials, training resources with information about the impact of race, class, literacy, spirituality, language, and culture on health and health care, and a tip of the week about current cultural responsiveness topics.

Network Monitoring

To ensure we keep pace with our membership's evolving needs, we continuously monitor the network for access, appointment availability, and quality of care. Through data analysis an close partnerships with Providers, we are able to promptly identify service issues and offer appropriate support to help Providers enhance their performance and meet required service levels.

UCare will have a Kansas-specific Provider Data and Network Analytics Department dedicated to monitoring and maintaining compliance with access standards. As we have learned in other markets, meeting Provider network adequacy does not guarantee Member access, especially in rural areas and with specific Provider types. Providers may be accessible in terms of location but lacking in appointment availability for new and established patients, making it critical we evaluate and monitor both. UCare does this by setting access ratios and availability goals that exceed State and Federal requirements, as well as routine monitoring of the Provider network to help ensure appropriate Provider network coverage to meet Member needs. Following are among the methods we use to measure and monitor access.

Compliance with Geographic Network Adequacy

Network adequacy is a constantly changing standard, as dynamic as our Membership and Providers. UCare takes a data-driven and personal approach, listening and responding to Members, Providers, and county and community partners, which is especially valuable in areas with geographic challenges. Key methods we employ to monitor this include:

[redacted]

- **Outreach to any non-network Providers in the area to initiate a contract, particularly where a gap is identified.** This includes Providers who may not close the network gap but will reduce it. UCare scans the area to ensure we are networked with all available Providers, including Providers across State lines in Missouri, Oklahoma, Colorado, and Nebraska. If needed, we will offer enhanced rates to Providers to ensure our Members can access the care they need, without traveling long distances.
- **In cases where practitioners are termed from geographically relevant outreach sites, UCare follows up with the Provider group.** We work with the Provider to understand the decision and impact on their patients/our Members. Our partner Providers are generally receptive to our outreach and collaboration and work with us to find a resolution. An example of a solution may be to reduce appointments at that outreach site, rather than eliminating services completely.

Timely Access to Appointments

We review ongoing compliance with established appointment access requirements to ensure Members have access to care. This includes annual reporting that tracks access and identifies trends and patterns that may present opportunities for network enhancement.

Table 22.1 outlines the access and availability standards UCare has established for our Members.

[redacted]

Table 22.1: Appointment Availability Standards

Provider/Appointment Type	Emergency	Urgent	New Patient
Primary Care	Immediate or call 911	Within 24 hours	Within 60 days
Mental Health	Immediate or call 911	Non-life-threatening emergency: within 6 hours	Initial visit for routine care: within 10 days
High Impact / High Volume Specialty*	Not measured, no industry or local market standard	Not measured, no industry or local market standard	Within 60 days

**Cardiology, general surgery, neurology, oncology, and orthopedic Providers. These five Provider types provide the highest number of specialty services for our Members.*

We are aware that with a stressed Provider network, setting appointment access goals is a collaborative effort. UCare continues to work with Providers who do not meet our standards to close the gap. If we identify a Provider who is not meeting the standards, we work with them to understand the issues and, if necessary, implement an education plan or, if needed, a corrective action to ensure the Members in their care receive appropriate and timely access to care.

Verifying and Improving Provider Data Accuracy

UCare has a multi-pronged strategy to address any inaccuracies with our Provider data that is used in network analyses and our online and print Provider directories:

Monitoring the Cultural Competency of Our Provider Network

UCare is a national leader in developing and supporting culturally competent Providers, and assessing the cultural, ethnic, racial, and linguistic needs of our Members, in order to ensure that our network maintains cultural congruence with Member needs and preferences. Our approach to effectuate richer data collection on Provider cultural competency has evolved along with recent Medicaid Provider directory requirement changes and the standards of our NCQA Health Equity Accreditation. Data resources include:

- **Provider Data on Cultural Competency and Training:** We collect and report to Members, via our Provider Directory, the types of cultural competency capabilities and specialties (including languages) offered at Provider locations. We periodically survey our Provider network to update this information.

Cross-Disciplinary Network Evaluation and Input

Adequacy and access analyses are not complete without collaborative review and community input. UCare's Provider Data and Network Analytics staff lead a cross-disciplinary committee that includes representatives from several UCare areas, including Provider Contracting, Clinical Services, Member Services, Appeals and Grievances, Sales, Product Management, and Community Relations. The committee meets monthly to monitor our Provider network and identify opportunities to enhance network access to better serve our Members.

This committee is a forum to aggregate community stakeholder input about network-related information and feedback gathered across the organization. The committee then identifies specific Providers to recruit for contracting and monitors progress in securing these contracts. This forum incorporates qualitative and quantitative data to ensure that UCare's Provider network meets the needs of all our Members, including those who may be experiencing cultural and geographic barriers to care. Information about identified Provider gaps gives UCare staff who work with Members, potential Members, State officials or other community stakeholders a chance to provide feedback to improve our networks. This forum also provides cross-departmental transparency into UCare's Provider network.

During each meeting, the committee reviews the follow data and informative is analyzed, discussed and specific action items are developed:

- **Out-of-network authorization request, out-of-network claims, and single-case agreements.** On a monthly basis, we monitor and evaluate utilization of out-of-network Providers to identify potential areas of need and to recruit these additional Providers to enhance the network and meet Members' needs.
- **Complaints and grievances regarding Provider network access issues give us important insight into how our network is performing.** This information can show us areas we may need to work with our Providers to improve, encourage Provider outreach, and/or build capacity in the networks. If a Provider is available who isn't already contracted, UCare will explore contracting opportunities.

- **Provider market changes.** We monitor Provider clinic closures and openings, care system changes, and contract disputes for any indication of network gaps. This is especially pertinent in rural areas, where a single Provider leaving a community can have a large impact on community patterns of care. We also review newly contracted Providers or new service locations added to existing contracts, as well as any clinics that are leaving existing contracts or closing contracts with UCare.
- **Community, counties, and tribal input.** We evaluate input from community groups, counties, and tribal entities to assess information about access challenges, preferred Providers, and changes in local service patterns.

Provider Engagement on Meeting Access Standards and Continuity of Care

Continuity of care can be especially difficult in rural and frontier areas of the State. Our staff will work closely with these Members to identify services that can be delivered by other in-network Providers close to their residence. If such services are not available locally, we will authorize additional miles for transportation services to ensure the Member can receive care from a Provider who is farther away. We will also work with the Member to identify and determine whether care can be provided through telehealth and then connect Member to an appropriate telehealth Provider, which could be through their local Provider or UCare's virtual Provider.

UCare will work closely with Kansas Providers who are not meeting our standards, including providing education or issuing corrective action plans when necessary. We will develop a contingency plan regarding how to maintain access if a significant Provider of services can no longer provide those services.

Addressing Anticipated Challenges and Network Gaps

Through analysis and outreach, UCare has learned about the anticipated challenges with health care access in densely settled rural, rural, and frontier communities, which make up 84% of the counties in Kansas. Challenges include lack of access to basic medical care and avoidable emergency department (ED) utilization due to this lack of access, which in turn leads to disparities in health outcomes for rural/frontier residents. We understand that designated Health Care Professional Shortage Areas (HPSAs) need a multi-faceted strategy to address network adequacy gaps; this includes 88 of 105 Kansas counties including whole catchment areas in western, northeast, and southeast parts of the State.

At UCare, adequacy means more than having a certain number of Providers in a Member's community; it also means ensuring that Members have access to Providers with a range of competencies, close to home, to enable Members to address their health care needs. Geographic distribution is key, as is appointment availability, and listening to our Members and communities so we know we have the right mix of Providers available for them.

UCare has long embraced telehealth, virtual and mobile services for Members as additional strategies to reduce travel burden and reduce service gaps for rural Members. That is why we invest through grants and partnerships with Providers focused on workforce development, telehealth, and service gap resolution. UCare was one of the first plans in our market to develop a mobile dental clinic, and to cover the origination fees related to traditional telemedicine benefits *prior to* the COVID-19 Public Health Emergency. UCare's key advancements and innovations will be applied in Kansas to address gaps, particularly in rural and frontier areas as described below.

Identified Gaps and Challenges

Based on our analysis, Provider relationship development, and community insights in Kansas, we understand the current challenges are largely due to a lack of available Providers, particularly in rural and frontier areas. The primary gaps and challenges we initially identified include:

1. **Lack of Providers and Service Array in Rural and Frontier Counties**, this includes primary and specialty care, behavioral health, LTSS and overburdened Providers like critical access hospitals, FQHCs/RHCs and CMHCs.
2. **Low number of specialists** outside of urban, suburban, and some densely settled rural areas; in some areas no specialty Provider may be available for 60+ miles.
3. **Workforce shortages**, particularly for all levels of mental health practitioners, Applied Behavior Analysis (ABA) Providers, and HCBS Providers and LTSS staff, particularly in rural and frontier areas of the State.
4. **Availability and capacity to address SDOH,** especially in rural and frontier counties, Providers and community organizations have greater challenges identifying resources and support to address SDOH, often relying on neighbors and faith-based organizations for needs such as transportation and social isolation.

With our strategies and goals, UCare feels confident of our ability to achieve the time and distance requirements established by the State for Providers in densely settled rural, rural and frontier counties, as well as urban and semi-urban counties given our long history and experience serving similar geographic areas in the Midwest.

Advancing Solutions and Innovations

UCare understands that densely rural, rural, and frontier areas present specific adequacy and access challenges. It is important to note that these solutions can also improve access in urban and suburban areas of Kansas as well. In addition to Provider recruitment initiatives, UCare will employ the following methods to increase accessibility for Members in key areas of the State:

Telehealth/Virtual Care

- **Telemedicine**: UCare supports telemedicine as an important tool for Members to access care quickly and conveniently. Above and beyond already covered telehealth services, UCare provides unlimited virtual visits (or eVisits) at no cost to the Member through a 24/7 online clinic that can diagnose and treat over 60 common conditions. We have also expanded the types and locations of Providers we will pay for telemedicine visits (e.g., physical therapists, licensed social worker counselors, non-health care shortage locations, and Members' homes). Even with the public health emergency ending, UCare continues to advocate at the State and Federal level to continue coverage for telemedicine visits, especially in areas with geographic access gaps. *Gaps Address: 1, 2, 3, 4*

Workforce Development

UCare is committed to partnering with the State and Providers to address workforce shortages. Our position as an MCO

comes with a responsibility to contribute to capacity development in both established and emerging Provider types to have a positive impact on health disparities. We accept this responsibility and proactively work with the community on capacity building. For example, UCare's $260,000 grant to Wheat State Healthcare has provided several subgrants to individual Community Mental Health Centers to support the recruitment and retention of behavioral health staff, including patient navigators, housing outreach specialists, case managers, and crisis peer support Providers. Many of these grants were focused on building capacity for access to behavioral health services in rural and frontier areas Kansas including:

- High Plains Mental Health Center (Hays) is expanding access to telehealth
- Compass Behavioral Health (Garden City) is expanding access to safety and timely transportation; and
- Spring River Mental Health & Wellness Center (Riverton) is expanding access to assertive community treatment (ACT) and individual placement and support (IPS) services.

Provider Story

"This grant funding is extremely valuable as it will support some of our most vulnerable population as they seek stable housing and employment, which are critical factors in one's recovery. Due to your generosity, SRMHW will be better able to meet the needs of our ACT and IPS clients in our rural community."
—Stacy Manbeck,
Executive Director, SRMHW

We look forward to working on additional initiatives to enhance access throughout the State. *Gaps Addressed: 1, 3*

Transportation Support

Transportation is critical for Members in rural areas to access essential Providers. If a Member has no way to get to the Provider, the Member experiences an access gap. UCare's approach to addressing this gap is through transportation Provider recruitment and improved payment arrangements [redacted] We will actively explore this for Providers in rural and frontier areas of Kansas where immediate access to outpatient care could mean the difference in more expensive care with poorer outcomes, such as an ED or hospital visit. In these areas a trip to the critical access hospital may be the only option without supporting alternatives to provide access. *Gaps Addressed: 1, 2, 3, 4*

Interpreters Solution

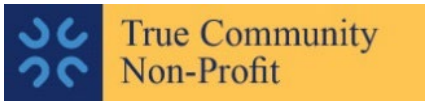
With the changing demographics in Kansas' rural and frontier communities, language support is needed by a growing number of Members for whom English is not their primary language. UCare will remove barriers to interpreter services by contracting with sufficient interpreter service agencies (e.g., Propio Language Services) that provide spoken language and American Sign Language (ASL) services for Members. This includes key rural and frontier counties, such as Finney and Ford, where 45% of the population speaking a language other than English at

home, as well as more urban counties of Shawnee, Douglas, Johnson, and Wyandotte. *Gaps Addressed: 1,2, 3, 4*

Partnership Opportunities

UCare will closely partner with community-based and nonprofit organizations as needed for essential services when other Providers may not be available in more remote locations. UCare has already initiated outreach to Providers in Kansas, such as Mid Kansas Doula Services, Kansas City Maternal & Child Health, and Kansas Home Care & Hospice Association to support home health services, case management, in-home nursing visits to our pregnant and post-partum Members, and well-child visits for newborns and early childhood development screenings. *Gaps Addressed: 1, 2, 3, 4*

Community Health Workers (CHWs) in Rural Health



CHWs are a critical resource to fill gaps in care when other Providers are not available in rural parts of the State. They assist with medical needs and can be an important part of the care delivery team by identifying and addressing SDOH. CHWs are especially important in rural communities to close racial or geographically specific gaps in a localized, culturally responsive way. [redacted]

23. Increased demand for HCBS and Behavioral Health Services has created challenges in ensuring an adequate workforce to provide HCBS and Behavioral Health Services. Describe the bidder's approach for addressing workforce development challenges for HCBS and Behavioral Health Services.

HCBS Workforce Landscape

The need and demand for Home and Community Based Services (HCBS) will continue to increase over the next 10 years as the age 65+ population is both growing and getting older. In addition, there has been increased Federal interest in strengthening HCBS and expanding alternative options to institutional services. The increased demand for services coupled with known workforce shortages heightens the need for an experienced managed care plan like UCare to successfully administer HCBS for KanCare Members.

Direct support professionals (DSPs) provide day-to-day support services to KanCare Members experiencing disabilities. DSPs provide the critical supports necessary to ensure the completion of activities that impact a Member's health status, personal cares, and hygiene. They also ensure that Members have the necessary supports in place to engage in meaningful employment.

DSPs also often act in the role of ambassador, ensuring that Members have access to recreation and community-based activities outside of their own homes. This is exemplified by their role in coordinating and providing transportation so that community-based services are more accessible. These examples illustrate the need and direct impact the DSP has on health outcomes of Members who experience a disability. The essential thread that makes this all possible is well-trained, consistent, and compassionate DSPs providing the services.

Assessment of Current State

Currently, the State of Kansas ranks 34th in DSP staff per HCBS waiver participant and 42nd in DSP wages. The statewide DSP retention rate is reported at 15.8%. The State requires minimum qualifications to become a DSP and once hired there is minimal training in the initial onboarding phase as well as ongoing.

The State does not have a defined DSP career ladder. Individuals who provide direct services have little opportunity for career advancement. The National Association of Direct Support Professionals reports that the COVID-19 pandemic has significantly impacted DSPs across the country; 54% report physical and emotional burnout, 51% report an increase in anxiety, and 41% report increased depression and sleep difficulties. The COVID-19 pandemic compounded what has been referred to as a perpetual DSP crisis.

The national turnover rate for DSPs is estimated to be approximately 46%. On average, 40% of DSPs leave their job within six months of being hired. High turnover can lead to a decrease in Member outcomes and is also costly to organizations, with each position turnover estimated to cost $4,200-$5,200. Workforce shortages of DSPs have created challenges for HCBS agencies in fulfilling the needs of Members utilizing HCBS and behavioral health (BH) services. These shortages are due to low wages, lack of benefits, lack of opportunity for career advancement, and limited workplace support.

UCare Approach

We consider these workforce shortages and challenges in our strategies to ensure UCare Members have adequate access to care, wherever they live. Our approach is bi-directional: we

engage directly with rural communities to listen and learn about their experience, and we identify trends through a robust data-gathering process. Our data analyses inform our stakeholder discussions, and our stakeholder discussions inform the conclusions of our data analyses. UCare evaluates rural challenges by gathering feedback from Members, counties, Providers, and community stakeholders, and by validating and exploring conclusions gained through our population health assessment.

Unfortunately, this shortage is not a short-term crisis but a systemic issue. DSPs are, according to the Bureau of Labor statistics, the fastest growing occupation in the United States. The demand for services far outpaces the supply of well-trained staff. To address this issue effectively, plans, Providers, and local governments will need to partner to thoughtfully consider innovative approaches to improve staffing rates in the future while providing care safely now.

Over the last two years UCare has engaged in a robust needs assessment to understand the HCBS landscape in Kansas. This needs assessment included conversations with the following organizations:

- Kansas Childrens Alliance
- KanCare Advocates Network
- Bert Nash Center
- Minds Matter, LLC
- Disability Rights Center
- NAMI Kansas
- Pawnee Mental Health
- Interhab
- Kansas Association of Community Mental Health Centers
- Kansas Area Agencies on Aging
- Kansas Advocates for Better Care
- Kansas Association of Centers for Independent Living
- Community Developmental Disability Organizations

We are establishing and leveraging relationships with the above organizations to ensure care availability for Members by local Providers throughout the State and to address the identified gaps in the HCBS service delivery system. UCare is in the process of negotiating agreements and securing letters of intent with these Providers [redacted] As part of our strategy to understand and meet Provider needs, over the past year we have attended a full range of community events, association meetings, conferences, and symposiums. One example is the Interhab conference for Providers serving individuals living with intellectual and developmental disabilities, which was focused on workforce shortages and best practices related to HCBS services.

Efforts to address workforce issues in Kansas are already under way, including the DSP+ registered apprenticeship program. This program allows new DSPs to work and earn while they develop a nationally recognized, portable credential. It is also an option for employers to develop their own internal apprenticeship program, with three sets of curricula to allow flexibility for what best meets the organization's needs.

Proposed Innovations to Address Current HCBS Workforce Issues

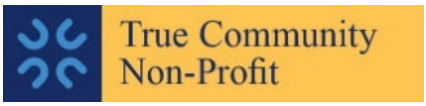
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]



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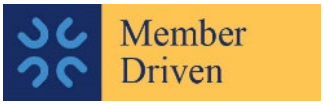


[redacted]

Previous UCare Initiatives to Support Workforce Development

We look forward to working in partnership with the State on initiatives to reduce the shortage of DSPs, such as a career pathway for students and leveraging community partnerships to give students college credits and hands-on experience. Programs of this nature have the added benefit of allowing current professionals to expand their skills within their role and support growth in other roles within the same field, which would be an advantage to UCare Members.

UCare will work with DSP agencies to facilitate DSP supports with the goal of encouraging workforce interest in providing HCBS and supporting workforce retention, easing administrative burden of DSPs, and helping DSPs to be better prepared to meet Members' HCBS care needs. UCare has engaged in these types of supportive initiatives in current market.

For example, UCare partnered with the local LeadingAge Foundation to fund two pilots in rural communities to provide seniors with integrated health care, social services, and community-based supports. A related community pilot coordinated and delivered a continuum of supports for socialization, meals, transportation, preventive and primary care, acute, post-acute and long-term care, and other services to support and enhance the quality of life for older adults. UCare provided $200,000 to support this partnership. Other ways in which UCare provides support to DSPs include:

Training and Technological Support

Video-based training for Members and their DSPs supports a deeper knowledge of chronic medical conditions and treatment, giving DSPs an increased sense of confidence in their ability to care for Members with more complex needs, promotes appropriate utilization of Provider services, and avoids unnecessary hospital readmissions.

Community integration for LTSS Members

Ensuring that Members have access to appropriate resources as they move from institutional settings to the community is an essential component of supporting Member independence. We will proactively identify and contract with HCBS Providers to meet Member needs. UCare supports early identification of LTSS Members who may be candidates for nursing facility diversion through staff training and screening.

Facilitated by our efficient and intuitive online forms and tools, UCare will comply with all provisions within RFP Section 7.5.1 in order to relieve administrative burden on Providers and ensure quicker access for Members.

UCare commits to creating a process to achieve Federal compliance with HCBS settings requirements detailed in §441.301(c)(4) and §441.710. UCare will provide education to HCBS Providers, both upon initial contracting and on an annual basis, to ensure Providers understand how to adhere to 1915(c) Federal requirements.

[redacted]

UCare will comply with additional network adequacy requirements specific to the LTSS population, as identified by the State, to demonstrate timely initiation of service and ongoing service in support of the Members' schedule for services.

Approach for Behavioral Health Services and Workforce

UCare has secured Letters of Intent with Providers across Kansas and is projecting the population distributions to be within time and distance standards for 100% of the State. We have already engaged all CMHCs and most of the large Provider groups to execute LOIs. UCare continues to work with local Providers to further enhance our BH network.

UCare has successfully served rural areas for decades. We will leverage this experience in Kansas to establish a program of assertive outreach and telemedicine programming capabilities for all areas, especially rural and frontier areas where BH services may be less available compared to urban areas. UCare will monitor utilization in regions across the State to ensure access and availability of all BH services in all regions.

UCare has a strong track record of contracting with a robust group of BH service Providers, including inpatient treatment centers, outpatient clinics, targeted care management, and adult mental health rehabilitation Providers. We are also well experienced in contracting with substance use disorder inpatient, residential, and outpatient service Providers. We address and meet the challenges of finding access to these essential Providers in urban, rural, and frontier areas [redacted]

[redacted]

Investments in HCBS, BH and Workforce Services and Solutions

As one example of UCare's commitment to crisis care, UCare provided funding and assisted in opening of a regional crisis center to fill a critical geographic gap in our current service area. The crisis center now provides services to individuals experiencing BH crises, in an appropriate setting for residential stabilization, and by initiating community supports.

Provider Capacity Building

True Community Non-Profit

[redacted]

Prioritized Services Support

The availability of ABA Providers is a common problem throughout the country. Through our monitoring and analysis, UCare identified that the waiting list for children to receive assessments for autism early intervention services in another market was approximately three months. To ensure access for children to needed services, UCare funded and developed a unique arrangement with a large Center of Excellence for autism and early childhood mental health services. The arrangement includes a prioritized pre-assessment screening, and an individualized bundle of services (approximately five hours) intended to provide support and education to families prior to, during, and after the evaluation process. We believe these services are vital to support early detection and intervention by connecting the child to care timely, addressing the long wait times that are often a key barrier to care.

As part of our larger workforce development initiatives [redacted]

[redacted]

UCare will prioritize continuous recruitment of Providers who specifically offer autism early intervention services to join our network, as part of our Provider network development plan. For Providers in remote parts of Kansas, such as Holcomb, UCare will leverage our experience with enhanced payment rates and incentive plans to recruit and retain Providers in the local community.

Cultural Competency in Workforce Development

UCare hosted a CEU presentation by the Alliance Wellness Clinic addressing specific aspects of the Somali culture, as well discussing services needed to address BH concerns within the Somali and East African communities. Participants included staff from the Alliance Wellness Clinic who were themselves in recovery, had been through treatment, and are now helping others who are seeking those same services. The response to the presentation was overwhelmingly positive. Care coordinators got to hear from community Members about the culture and history of the refugee status of many from these countries. Care coordinators also learned about their unique BH challenges, including particular challenges and stigma associated with mental health and substance use disorders in their communities. UCare provided financial support to Alliance Wellness Clinic for supplies and materials to help address stigma in their communities, and to help pay for Narcan for use in opioid overdoses.

UCare has already begun its commitment to building critical Provider capacity in Kansas in 2023, examples include:

- $12,000 grant to Elizabeth Layton Center supporting the creation and implementation of a patient navigator position
- $12,160 to High Plains Mental Health Center to improve and expand access to telebehavioral health services
- $11,880 to South Central Mental Health Counseling Center to support the recruitment and retention of a crisis clinical coordinator, two crisis case managers, and a crisis peer support Provider
- $12,000 to Valeo Behavioral Health Care to support a homeless outreach position and $24,200 to support after hours crisis/on-call transition funding to Certified Community Behavioral Health Clinic (CCBHC) status

Provider Story

"UCare partnered with Wheat State healthcare to establish a $260,000 grant program, which was funded by UCare and administered by Wheat State Healthcare. The purpose of this financial support was to support innovative program for CMHCs, support CCBHC certification, participation in value-based case, and increasing access to mental health services in Kansas."
— Kyle Kessler
Association of CMHCs of Kansas and
Colin Thomasset, Wheat State Healthcare

These initial investments, paired with UCare's track record of dedication and experience in our current market, demonstrate UCare's commitment to addressing workforce shortages so critical to addressing the needs of our Members.

We look forward to opportunities in Kansas to engage and understand the unique needs of KanCare Members, and work to improve health equities among all communities we serve.

24. Describe the bidder's identification of network gaps in dental Providers in KanCare and the bidder's approach to ensuring KanCare Members have timely access to quality dental care in Urban, Rural, and frontier areas. Include example(s) of the bidder's successful use of a comparable approach in program(s) similar to KanCare, the measurable impact achieved, and how the bidder will apply this experience to benefit KanCare.

Dental care, as a major component of oral health, is critical to a person's overall health and well-being. While lack of regular, adequate dental care can lead to problems with the teeth and mouth, the potential increase and spread of harmful bacteria can lead to heart disease, pregnancy complications, pneumonia, uncontrolled diabetes, and other conditions. A strong dental network is therefore a crucial factor to support recently expanded adult dental benefits in Kansas and meeting the State's goal of improving overall health outcomes. And meeting that goal requires a robust approach to meeting the State's parallel goal of expanding network capacity and Provider participation in Medicaid.

According to an April 2023 Conduent Health Communities Institute report, Kansas has an average of 62 dentists per 100,000 population. This trend is improving slightly; however, Kansas still ranks in the lower quartile in the U.S. for availability of dentists. Our initial research reveals that the current Medicaid network in Kansas has several gaps, particularly in northern frontier counties and southeast rural counties.

UCare sees this important challenge as an opportunity to partner with our dental network manager, dental Providers, community Members and others to make a healthy difference in the lives of KanCare Members through improved dental care.

UCare has a long history of meeting with and listening to advocacy organizations to ensure access to needed services at the right place and at the right time. To familiarize ourselves with the dental needs of KanCare Members, UCare met with a number of community dental groups and advocacy organizations, including:

- **Oral Health Kansas:** UCare met with Oral Health Kansas to learn about dental benefits that particular populations value. These include dentures for older adults, initiatives that may support access, including the dental passport, and innovative partnerships that could bolster dental care in the State, such as developing a potential Project Echo related to dental services. UCare understands that community organizations like Oral Health Kansas support uplifting the Member voice and experience in accessing and utilizing dental benefits across geography and populations and we will continue these meetings in the future.
- **Kansas Dental Association:** The Kansas Dental Association, the State's association representing the profession of

> *"Oral Health Kansas first met with members of UCare leadership in early 2023. During our conversations, UCare's community-based, non-profit approach stood out as we shared similar priorities around investing in communities, developing unique partnerships, and finding ways to address health disparities that are prominent in dental care. For example, we were pleased to learn that UCare has a strong relationship with Appletree Family Dental in Minnesota. Appletree is an innovative nonprofit dental care provider we have work with and learned from for many years, and we are heartened to know that UCare has a good relationship with our Minnesota partner organization"*
> —Tanya Dorf Brunner
> Executive Director, Oral Health Kansas

dentistry in Kansas, is a vital partner to managed care organizations to understand priorities for Providers delivering dental care to individuals in KanCare. When UCare met with the Kansas Dental Association, we learned that approximately 40% of dentists are enrolled to accept KanCare, but the rate of accepting new KanCare appointments may be lower. We expect to continue learning from the Kansas Dental Association in how it can partner to support dentists and dental practices to accept more patients enrolled in KanCare.

- **Kansas Dental Charitable Foundation**: UCare recognizes the importance of community dental events to support access to dental care, especially given the significant spread of the designated dental health professionals shortage areas across Kansas. Kansas Dental Charitable Foundation's Kansas Mission of Mercy (KMOM) events are a vital partner in this work, providing more than 30,000 patients free dental services since its foundation in 2002. With the geographic spread of its events, from Wichita to Topeka to Salina, Kansas Dental Charitable Foundation's KMOM events bring statewide access to Members across the State.
- **Community Care Network of Kansas**: In meeting with several Federally Qualified Health Centers (FQHCs) throughout Kansas over the last year, we know FQHCs are a vital partner in providing dental care to communities across the State. UCare met with Community Care Network of Kansas and discussed opportunities to support optimizing funding for their Member FQHCs, FQHC look-a-likes, and rural health clinics across the Kansas. UCare understands supporting emerging workforces such as community health workers and enhanced dental hygienists is vital to increasing access to dental services in Kansas.

Our Solution

UCare has chosen DentaQuest as our trusted network management partner to increase access to dental care, improve the quality of services, and work together with Members and community organizations to improve oral health. Like UCare, DentaQuest has been in business for several decades and is dedicated to serving Medicaid Members. Working with dental Providers and through innovative solutions, DentaQuest has a demonstrated approach to integrated care and exceptional Member experience. This was evident when UCare previously worked with DentaQuest for several years.

DentaQuest's current network includes a complete complement of specialties, including general dentists, endodontists, oral surgeons, orthodontists, pediatric dentists, periodontists, and prosthodontists. [redacted].

Building a Strong Dental Network in Kansas

DentaQuest will work to enhance its current Medicaid dental network in the State to serve KanCare Members. By engaging in-network Medicaid Providers along with key stakeholders, DentaQuest's main objective is to provide a quality dental network capable of meeting the needs of Members while minimizing Provider noise during the transition and ensuring continuity of care for enrollees. Our network development efforts will include the following stages:

[redacted]

We have identified all licensed Kansas dentists with a Medicaid ID; those Providers not in our network today are our first-tier targets for recruitment. From there, we will reach out to all licensed dentists in Kansas to enroll in the State Medicaid program and join our network. The dental network will include practitioners from every specialty, FQHC, and Rural Health Clinic (RHC) dentists. [redacted]

Specific efforts will also be directed toward Providers who have sedation capabilities to join our network so services can be performed in a dental operatory surgical suite rather than an outpatient medical facility.

In addition, an important access point for Members living in border counties are Providers in border states. DentaQuest currently has 1,066 Medicaid Providers in three of Kansas's bordering states—Oklahoma, Colorado, and Missouri. DentaQuest administers Medicaid dental benefits in each of these states and will encourage these border Providers to join the Kansas Medicaid network. To ensure access for Members in areas where we do not have a network Provider, we will develop single case agreements.

Ensuring Access to Dental Services

Authentic Provider Relationships

To ensure access to dental care, UCare will offer innovative solutions, as well as value-based programs and alternative

pricing models to incent Provider participation. Our goal is to meet Members where they are, whether at their physician's office, at school, or other convenient places near their homes. DentaQuest has been successful in deploying unique solutions to increase alterative care settings and we will employ our best practices for KanCare Members, such as working with Kansas Primary Care Association and the FQHCs that do not have dental clinics to establish schedules for a mobile dental group to bring oral health care to Members and provide their staff with education on the availability of teledentistry services. We already have a commitment from our national partner, Solvere Health, to establish operations in Kansas at our request. Solvere recently entered the New Hampshire market after DentaQuest began administering that state's Medicaid adult dental program in April 2023.

DentaQuest will work with general dentists trained and practicing advanced dental services and partner with FQHCs and DSO organizations willing to extend services for specialty care. Of the 23 FQHCs/CHCs providing dental care, DentaQuest partners with 24 locations, such as Benevis, Hero Dental, Lumio, MB2, and Smile America Partners (mobile) for school-based and adult-based care. DentaQuest also has a relationship with University of Missouri-Kansas City's dental school across the border in Missouri where we can partner to determine opportunities to help expand access to care or bring care through dentists to Kansas. UCare will also reach out to all Indian Health Clinics to extend care, such as Haskell Indian Center who offers dental.

Teledentistry

Teledentistry is a valuable option to increase access in underserved areas, offering Members flexibility and convenience by removing barriers such as transportation and the need to take time off from work. It has been shown to result in marked improvement in utilization and dental care access.

Through a national partnership with Teledentistry.com, we will provide access to licensed and credentialed Providers who can offer limited oral evaluation, prescribe medication, and make an appropriate referral to a dental home. Teledentistry will be a useful tool for Members in rural areas, as well as those with dental emergencies. Additionally, we will help facilitate the use of teledentistry to prepare Members and their caregivers for in-person visits. This service not only helps to quell any fears the Member or caregiver may have about the upcoming appointment but can also give the Provider insight into the Member's needs prior to the in-person appointment.

We will also offer Teledentistry's unique MESH (Member Engagement for Sustainable Healthcare) program to our KanCare Members. Through the MESH program, we raise awareness and use of available dental benefits and help identify oral disease. The MESH program provides:

- Initial oral health screenings prior to a first in-person visit
- Risk assessments and referral to a dental home
- Targeted outreach for under utilizers of preventive services
- Dental chronic care management with efficient, lower-cost at-home monitoring of dental hygiene
- Pediatric dental outreach, including at-home fluoride varnish guidance

Teledentistry.com uses an evidence-based triage protocol to assess the Member's situation. In addition, the Provider can prescribe antibiotics and/or non-opioid painkillers to address the Member's immediate needs—the same solution often provided in the ED but at a significantly lower cost for KanCare. The teledental Provider will also refer the Member to a participating Provider for follow-up care.

In 2023, DentaQuest initiated the Teledentistry.com MESH program in Michigan for its Medicaid adult population. The program conducted outreach to Members who have not utilized care in 12-18 months. In the first two months of the program, 718 surveys were conducted and completed through a teledent visit. Of those surveys, 141 Members engaged in a teledent oral evaluation service.

Value Based Purchasing

DentaQuest is at the forefront of providing accountable, Value-Based Purchasing (VBP) programs for Medicaid dental programs. Building on their experience in seven other states for 3.1 million Members, UCare will work with DentaQuest to implement a VBP model for KanCare that offers performance-based incentives and prepares Providers for outcomes-based alternative payment models to improve preventive dental service utilization rates.

The VBP model, designed using time-tested best practices from medical models, assigns responsibility to a Patient-Centered Dental Home (PCDH) for a panel of Members, provides high-tech solutions to help Providers manage their Members. The VBP model also assesses the PCDH using measures validated by the Dental Quality Alliance, has aligned incentives to improve access and preventive service utilization, and provides timely and transparent feedback to Providers on their performance. Above all, the program places no administrative burdens on Providers and their offices. The roll-out of the program will be undertaken in stages to ensure the understanding and engagement of Providers.

Alternative Payment Models

Providers will be offered a wide range of incentives and payment methodologies based on their VBP performance. The Alternative Payment Model (APM) has three elements:

[redacted]

DentaQuest has the flexibility to work directly with Providers to offer creative solutions in APMs that extend different levels of risk to the Providers so they can effectively treat Members. In addition to payments, the VBP offers a number of non-financial incentives, such as:

- **Express Pass for Service Authorizations:** This status allows Providers who demonstrate high performance and low clinical denial rates the ability to bypass clinical review on certain procedure codes.
- **Enhanced Member Assignment:** Higher-performing Providers meeting key metrics may be rewarded additional assignments of Members who do not actively select a PCDH, or reassignments of Members who were served by terminated Providers.

Mobile Dentistry Solutions

UCare was the first health plan in our market to own and operate a Mobile Dental Clinic, offering dental check-ups, cleanings, and simple restorative care to Members who have limited access to quality dental care. Education is also provided to the Member regarding prevention and early intervention in treatment for oral health. All care is provided by faculty-supervised dental, dental hygiene, and dental therapy students from the state’s dental school, UCare's Mobile

Dental Clinic (MDC) partner. The clinic is a specially designed, wheelchair-accessible, 43-foot "dentist's office on wheels."

We plan to bring this concept to Kansas through a similar partnership, DentaQuest's established relationships with national mobile dentistry solutions that bring dental services to Members in school-based settings, participate in community events, and travel to rural and frontier areas to address Member needs. These mobile dentistry Providers bring services to Members where they need care, and some even offer comprehensive care services that are provided in dental offices.

Monitoring

UCare will work closely with DentaQuest to ensure that high quality, accessible care is available to KanCare Members. UCare, as responsible for compliance to the terms and conditions of our contract with the State, will provide oversight to ensure payments and other terms for dental services are consistent with State requirements. UCare will perform a formal review at least annually and more frequently as determined by UCare or the State.

UCare's contract with DentaQuest will be subject to State approval. We will include all minimum State-required provisions in our subcontract with DentaQuest. Functions that will remain with UCare and not be delegated will conform with State requirements, e.g., Appeals and Grievances and Quality Management.

Monitoring Adequacy, Accessibility, and Availability of the Provider Network

DentaQuest maintains written policies and procedures on network access availability, reviewed and updated annually by its Quality Improvement Utilization Management Committee. Policies and procedures include standards for Provider selection, internal network access and availability analysis frequency, Provider service level monitoring standards, and subsequent remediation processes in the event of noncompliance. Noncompliance is measured in the following ways:

- Geo Maps
- Provider Report
- Request a Dentist Report
- Provider Complaints, Claims Appeals, and Member Grievance Reports
- Quarterly Service Accessibility Survey

Using these tools, we will ensure that all enrollees have access to care regardless of their level of need. In the event we find a Provider is not complying with policies, procedures, or regulations, we will reach out to address any concerns and work with the office to create a corrective action plan if needed.

Member Outreach to Improve Utilization of Dental Care

Ensuring access to dental care is only the first step to improving the oral health of Members. We make a concerted effort to educate Members about dental resources and the importance of regular dental care. UCare's efforts include:

Dental Rewards and Resources: UCare maintains and promotes UCare's Dental Connection webpage that identifies what help is available for Members to manage their dental care with one simple phone call. In addition, UCare provides free dental kits to Members, which include an electric toothbrush, toothpaste, and dental floss. UCare also provides a $25 incentive to Members that complete a dental visit.

Health Education Resources: UCare provides oral health resources to Members via Member mailings and UCare's website. Mailings include a preventive scorecard highlighting when

Members are due or overdue for preventive care, including annual dental visits, and a dental mailer encouraging Members to schedule a dental visit and highlighting resources.

Adult Dental and Expanded Dental Benefits: UCare will include a $500 dental allowance for adults as a value-added benefit for KanCare Members, as well as dentures for Physical Disability (PD) and Frail Elderly (FE) waiver Members, along with UCare's Dental Health kit.

We have a strong track record of improving access to dental services through direct outreach to Members and supporting them in scheduling needed dental care. We provide education on the importance of oral health and dental benefits through both Member outreach and disseminating educational materials.

Our efforts are particularly directed toward vulnerable populations. Members in low socioeconomic groups, certain racial and ethnic groups, older adults, low-literacy individuals, those in rural areas, and individuals with disabilities are at an increased risk for oral disease and associated systemic health problems. UCare targets outreach to these populations to minimize barriers to care, reduce health disparities and further health equity.

Member Driven

[redacted]

Community and Provider Partnerships

As we do in our current markets, UCare will conduct interventions in Kansas to identify and address barriers and improve dental utilization rates for KanCare Members. We will partner with

Kansas Department of Health and Environment (KDHE), DentaQuest, dental practices, the Kansas Dental Association, Oral Health Kansas, dental schools, and community organizations to develop intervention strategies to increase dental access and care.

We will bring to Kansas our experience and success in engaging Providers in our network and community-based organizations to partner through funding positions – people – who engage with our Members, provide health education, and connect Members to dental care. UCare is willing to invest in new and innovative ideas and develop authentic partnerships to address Member needs, reduce health disparities, and improve the overall health and well-being of our Members. UCare will identify Provider partners and community-based organizations in Kansas with whom to collaborate and develop models that are beneficial for the community and KanCare Members.

Examples of successful UCare initiatives and partnerships include:

[redacted]

- **Primary Care Providers:** We partner with the largest pediatric primary care network in our current market by funding a Community Health Worker responsible for care coordination services and outreach to patients that are due for (CHW) preventive care, including annual dental visits. The CHW educates parents about the importance of dental health, helps Members find dental Providers, and assists with scheduling appointments even though dental clinics are not part of the pediatric health care system.
- **Community Health Workers:** To address the needs of our diverse population, it is essential to provide culturally congruent care to Members within their community and home in order to better address preventive and dental care needs. UCare partners with community organizations that provide CHW services, training and technical assistance, and advocacy at the policy level to promote sustainable models for CHW services. We have experience collaborating with CHW partners through a gap closure bonus payment model to conduct outreach to Members who have not completed preventive care, including dental services. Our partnerships are focused on providing education in a culturally congruent manner for the Member(s) from a CHW who speaks their language and shares their culture.

- **Rural Partnerships:** UCare partners with rural communities to help improve dental access rates. We participate in a national demonstration project including the Pathways Community HUB Institute to support the most vulnerable and under-resourced Members of the community. The HUB contracts with CHW and Care Coordination organizations based in rural areas to conduct assessments on UCare and community Members to assess their needs based on the Pathways model. They provide training on the model and track, monitor, and report on Member progress. Their model engages community-based CHWs to provide care coordination that assesses Members on 21 evidence-based pathways and pays through an outcomes-based model, including an Oral Health pathway.

Funding to Support Dental Providers

UCare partners with and supports individual dental practices dedicated to serving Medicaid Members to increase access and improve quality of care. These types of relationships will be developed and supported in Kansas.

Member Story

"Dental grants for our county to use for outreach. This has helped so many families to have access to our monthly dental clinics."
—UCare 2023 County Survey Participant

True Community Non-Profit

Examples in our current market are:

[redacted]

Summary

Through our strong partnership with a nationally renowned dental plan manager like DentaQuest, UCare will ensure that KanCare Members throughout the State will have access to the services they need to maintain their oral health. We are committed to network expansion in addition to introducing innovative models of care to bring crucial services to our Members and overcome barriers to care.

25. Describe the bidder's strategies and approaches to encouraging Provider network participation and improving the experience of Providers participating in KanCare.

Provider networks are foundational to ensuring Members can access quality care at every point of their health and wellness journey. UCare is proud of the comprehensive and accessible network of Providers available to our Members across all of our current programs. We treat Providers as true partners and because of our fair, transparent, and responsive practices, UCare has always been viewed as the preferred health plan among our Providers. Our success is best demonstrated by a 96% participation rate of all applicable Providers in our current market, with only one Provider group (owned by another managed care organization) not participating.

[redacted]

UCare will work closely with KanCare Providers and bring our responsive, supportive relationship model that will encourage higher participation and improve their current experience. We will achieve this through a combination of collaborative strategies, intentional practices, and tailored support mechanisms that focus on the following goals: 1) Minimizing administrative burden for Providers and addressing known pain points; 2) Soliciting feedback from Providers and collaborating on solutions to barriers and challenges; 3) Having systems and processes in place to ensure claims are managed in a timely and accurate manner; and 4) Ensuring Provider issues are resolved quickly and they have a responsive managed care organization (MCO) partner.

What We've Learned in Kansas

UCare doesn't just assume that how we manage our Providers today will meet the needs of Kansas Providers. We know one size does not fit all, and we are creating a Provider service model based on what we heard from the local Provider community and our Kansas-based staff who have extensive experience and knowledge working with Kansas Providers. Along with UCare leaders, they have been traveling around Kansas to develop relationships with Providers, listen to their current challenges, and ask what we could do better. We have also heard and studied concerns through Provider associations, conferences, and public stakeholder meetings.

[redacted]

[redacted]

Below we demonstrate how we will meet Providers' needs and optimize their experience, so they are more engaged to participate in KanCare.

Minimizing Administrative Burden

Providers' main priority and primary focus should be taking care of our Members and doing so with the highest quality and in the most cost-effective manner possible. Unnecessary and inefficient operational rules and requirements imposed by MCOs are frustrating to Providers, add to the cost of care, and take valuable time away from Members. Reducing administrative burden for Providers also benefits UCare, as we would rather focus our time and resources on our services than costly administration. UCare will only require administrative work for Providers that improves Member care and payment processing, implementing the simplest and most standardized processes and procedures possible.

> *"This summer, UCare approached Valeo to learn about our experience with the KanCare program. We were able to share points of tension with UCare around the administrative burden managed care imposes on providers. Based on our conversation, we believe that UCare's community-based, non-profit status would be a supportive partner to find unique ways to address these burdens."*
> —Bill Persinger
> CEO, Valeo Behavioral Health Care

Fair, Transparent, with Efficient Contracting and Credentialing

Encouraging KanCare Provider participation cannot be achieved without a contracting process that is fair, transparent, and efficient. UCare uses ServiceNow for Provider contracting management, a user-friendly online program to accept Provider applications and manage them swiftly through the contracting process. Our ServiceNow program walks Providers through the application process and ensures all necessary information and documents are gathered and submitted. [redacted]

People Powered

UCare's local, Kansas-based Provider Contract Managers will engage Providers in open dialogue through the contract negotiation process to establish a mutually agreeable contract with fair and sustainable rates. They will also ensure our payment methodologies are in accordance with RFP Section 7.5.16. Fee-for-service payment rates will be based on the KanCare payment methodology and at least 100% of the KanCare fee schedule. UCare will not deviate from this methodology unless agreed upon by the Provider. If initial discussions are unsuccessful, UCare will continue to work with the Provider, presenting at least three reasonable offers to achieve agreement.

Credentialing and contracting occur simultaneously [redacted] We have experience with a statewide, centralized system to support a more standardized and efficient credentialing experience for Providers and MCOs. We look forward to working with Kansas' Gainwell Technologies enrollment program and we stand ready to support implementation of a centralized credentialing and re-credentialing system. UCare also welcomes any additional efforts to standardize processes across MCOs to further reduce administrative burden for Providers. [redacted]. We will also implement credentialing delegation agreements with larger Providers, making the credentialing process even more streamlined. Our Provider Contracting and Credentialing departments are ready to answer any Provider questions via email, phone, or in person.

Simple, Efficient Prior Authorizations

MCOs' prior authorizations (PA) and required notifications are a significant source of Provider frustration, administrative burden, and unnecessary cost. PAs were designed to protect patients, but for-profit MCOs often use them to protect profit margins. UCare has the fewest PAs in our current markets and will have the fewest in any market we enter. We recognize that some PAs are necessary and/or are required, however, we will keep the types of services, medications, and equipment subject to PAs to the minimum. Our PA process is evidence-based, managed by appropriate medical professionals, and will use the State's criteria when available. Our Medical Directors talk to the physician community every week to make sure we are doing the right thing with our PA criteria. If we see a rapid increase in utilization that looks to be an outlier, we first share the data with the Provider and work with them to understand the drivers and use an education-first approach. The PA process is electronic, using standardized forms and elements, matching with State requirements. UCare will work with other KanCare MCOs, the State, and Providers to develop a standardized PA form.

In accordance with RFP Section 7.8.3, UCare will implement a "Gold Carding" program, similar to what we have used in our current markets. We will waive the need for certain PAs if the Provider has demonstrated a high percentage of approvals for a certain service or medication. We will also implement automatic approvals through a clinical decision support tool for applicable services and medications. We will not use an automated or artificial intelligence-based process for denying any service. UCare will ensure any denials of a PA are judiciously reviewed by an appropriate medical professional.

The greatest need for PAs is in pharmacy services. While necessary due to the significant cost of drugs and to support safe prescribing, UCare will ensure the least burdensome process is implemented for our KanCare Members. Through UCare's Pharmacy Benefit Manager (PBM), an electronic PA (ePA) process will be available through three different clearinghouses, whichever is most convenient for the Provider: ExpressPAth, Surescripts, and CoverMyMeds. Providers may also submit ePAs through their electronic health record (EHR) system. UCare supports real time pharmacy benefit information at the point of prescribing that provides coverage information, including PA requirements, directly within the Provider's EHR.

Authentic Provider Relationships [redacted]

Provider Self-Service Tools

When a Provider has to spend time looking for a Member's eligibility, claims status, an MCO's policy, or other information, it takes away valuable time and resources from Member care. UCare has optimized our technology and Provider communications to ensure Providers can easily find and exchange information through user-friendly, self-service electronic tools and in our online Provider Manual and other related materials.

The Provider Portal that UCare will roll out in Kansas will include all required elements in RFP Section 7.6.3 and additional functionalities, including claims status and history, PA entry and tracking, messaging with UCare, updating Provider and practitioner demographic information, submitting claims, requesting claim appeals and adjustments, receiving and reporting on Member gaps in care, and receiving value-based payment performance reports. We will work to ensure we continually make the latest enhancements to optimize the Provider's experience. In addition to the Provider Portal, our website includes the information a Provider would need on our policies and procedures in an up to date, organized, intuitive and easily searchable manner.

UCare will work with Providers to reduce the burden of medical record chart requests needed for National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), and PAs. With some of our current Provider groups, we have secured ready access into the electronic health record, while with other Providers, we have implemented an electronic process of data exchange. We will work with Kansas Providers to continue expanding hands-off, electronic, low-cost processes that simplify our work.

Standard Processes

UCare has a longstanding history of collaboration with state agencies, Providers and other MCOs in designing and implementing standard requirements and processes with the goal to improve Provider experience and reduce barriers to participation. Examples of collaborations that developed standard processes in our current markets include the Credentialing Collaborative, which created a standard credential form and data repository for Provider materials;

implementation of a uniform medication formulary; the Minnesota Community Measurement, a non-profit data-driven collaborative with UCare as one of its original founders that operates the statewide collection and public reporting of a standardized set of quality measures; and Stratis Health Cultural Competency resources that can be used by all Providers and MCOs in the region.

Soliciting Provider Feedback

UCare will develop a system to solicit feedback from Providers proactively and retroactively to understand their issues, barriers, and needs so we can improve Providers' experience in KanCare. To fully understand all facets of the Provider experience, UCare will use several channels to gather Provider feedback, including:

- Targeted surveys and market research
- Direct Provider feedback and recommendations
- Meetings, conferences, and work groups

Provider Surveys

UCare will administer an annual Provider Satisfaction Survey that meets all KanCare requirements outlined in RFP Section 7.9.11, including approval by the State [redacted] Our Provider Survey will be tailored to KanCare-specific Providers, including HCBS and behavioral health Providers and their operations.

UCare will have a dedicated Kansas team within our Provider Experience Department that will be responsible to administer the survey, monitor and trend the results, and incorporate information in a Process Improvement Work Plan. This includes assisting the applicable departments within UCare to develop the needed improvement actions, adding them to their annual department strategic plan, implementing the plan, and monitoring results.

PAC Post-Call Survey

To ensure Providers are receiving accurate, consistent, and high-quality service, UCare solicits feedback through post-call surveys. We review these surveys weekly to monitor issue resolution, Providers' call experience, and PAC representatives' behavior.

Utilization Management Provider Satisfaction Survey

[redacted]

[redacted]

Local Approach to Provider Feedback and Recommendations

[redacted]

Provider Story

"Our patients are typically under-served, at-risk patients, many of whom use Medical Assistance with UCare. We have been very lucky to work with the amazing team at UCare who has continually helped us navigate the difficulties of medical insurance. The UCare staff are always attentive and very responsive whenever we call or email with questions or concerns. Our UCare Provider Field Representative has been especially attentive, kind, and helpful to our small clinic. We have been very pleased with UCare and would recommend their services to other clinics like ours"

—Nucleus Clinic
Coon Rapids, Minnesota

Meetings, Conferences and Work Groups

In addition to the personal meetings with our Contract Managers, Field Representatives, and other Provider Relations staff, applicable UCare staff will be closely involved with Provider associations and Provider-related conferences and work groups. We have already been active participants in these, meeting with or attending/sponsoring events associated with the following:

Kansas Medical Society, Kansas Hospital Association, Community Care Network of Kansas, Interhab, Kansas Dental Association, Kansas Mental Health Coalition, Association of Community Mental Health Centers of Kansas, Brain Injury Alliance, Sunflower (Kansas) Chapter of the Healthcare Financial Management Association, Community Health Worker Coalition, Kansas Association of Centers for Independent Living, and LeadingAge Kansas. These meetings offered valuable exchanges of information and feedback related to specific Provider challenges, what is working well, and how UCare can collaborate with them to improve their experience and enable optimal care delivery.

Ensuring Timely and Accurate Payments

The most fundamental element of an optimal Provider experience and desire to participate in an MCO's network is paying their claims timely and accurately. UCare's commitment to this is demonstrated by the significant investment we made in HealthRules, a state-of-the-art claims processing system. HealthRules eliminated most manual processes and created significant

efficiencies through automation of accepting, reviewing, editing, and paying claims. This best-in-class system will help us exceed KanCare claims processing requirements, such as paying all claims and adjustments within 90 days. UCare monitors claims processing timeliness on a monthly basis, reporting these statistics up to executive leadership. Currently, UCare processes:

[redacted]

Our implementation of HealthRules also allows efficient handling of alternative payment methodologies, such as capitation, bundled payments, carveouts, or tiered pricing. This flexibility creates opportunities to effectively administer value-based payment models.

Lastly, the process for Provider and practitioner enrollment into HealthRules is simple. We recently piloted a robotic process automation that automatically enters Provider data into the claims system. This creates both a much quicker turnaround time and also eliminates errors. UCare will easily exceed Kansas' seven-day turnaround time for Provider enrollment into the claims system after completion of credentialing.

Resolving Provider Concerns and Issues

Through multiple levels of dedicated teams and personalized service at the local level, UCare will respond to KanCare Providers' issues and concerns quickly and effectively. We know responsiveness is a key concern and we stand ready to deliver a higher level of service and partnership that Providers expect and deserve.

Supporting Providers through Dedicated Teams

People Powered

UCare will create the following teams to offer knowledgeable, responsive support and meaningful education to Kansas Providers. We will work to proactively prevent issues, but when they do occur, our teams will be ready to prioritize them and follow through until they are resolved. Our comprehensive support model is designed to provide a level of service that exceeds the requirements in RFP Sections 7.6.5 and 7.6.6

[redacted]

Summary

UCare's proactive and collaborative approach, coupled with a commitment to simplicity, transparency, and responsiveness, positions us to build strong partnerships with Providers in Kansas, contributing to an optimized Provider experience that encourages greater participation. The foundation of our approach is addressing the key challenges we identified by carefully listening to the local Provider community and engaging them as a collaborative partner in serving KanCare Members. From minimizing administrative burden to implementing fair and transparent contracting and credentialing processes, UCare aims to streamline operations and foster a more collaborative environment. Our commitment to simplicity and efficiency is well-demonstrated by our minimal prior authorization process designed to protect Members (not profits), and our investment in a state-of-the-art claims system that processes claims quickly and accurately. To deliver on our commitment to continuous improvement, we will bring to Kansas a robust system of soliciting and acting on Provider feedback collected through surveys, direct feedback mechanisms, and participation in relevant meetings and conferences

26. Describe the bidder's experience with developing and implementing value-based purchasing (VBP) arrangements designed to promote service quality, value, and outcomes over volume. Describe how the bidder will leverage its experience to successfully develop and implement VBP arrangements to improve the quality of care and Member health outcomes in KanCare. Include the following in the bidder's response:
    a. The bidder's priority areas for VBP (e.g., Providers or populations) and anticipated outcomes.
    b. The bidder's proposed alternative payment models (APMs).
    c. The bidder's approach to identifying and supporting KanCare Providers to implement VBP arrangements.
    d. The bidder's strategies to reduce administrative burden for participating Providers.
    e. How the bidder will measure, monitor, and evaluate the effectiveness of the payment arrangements and outcomes.

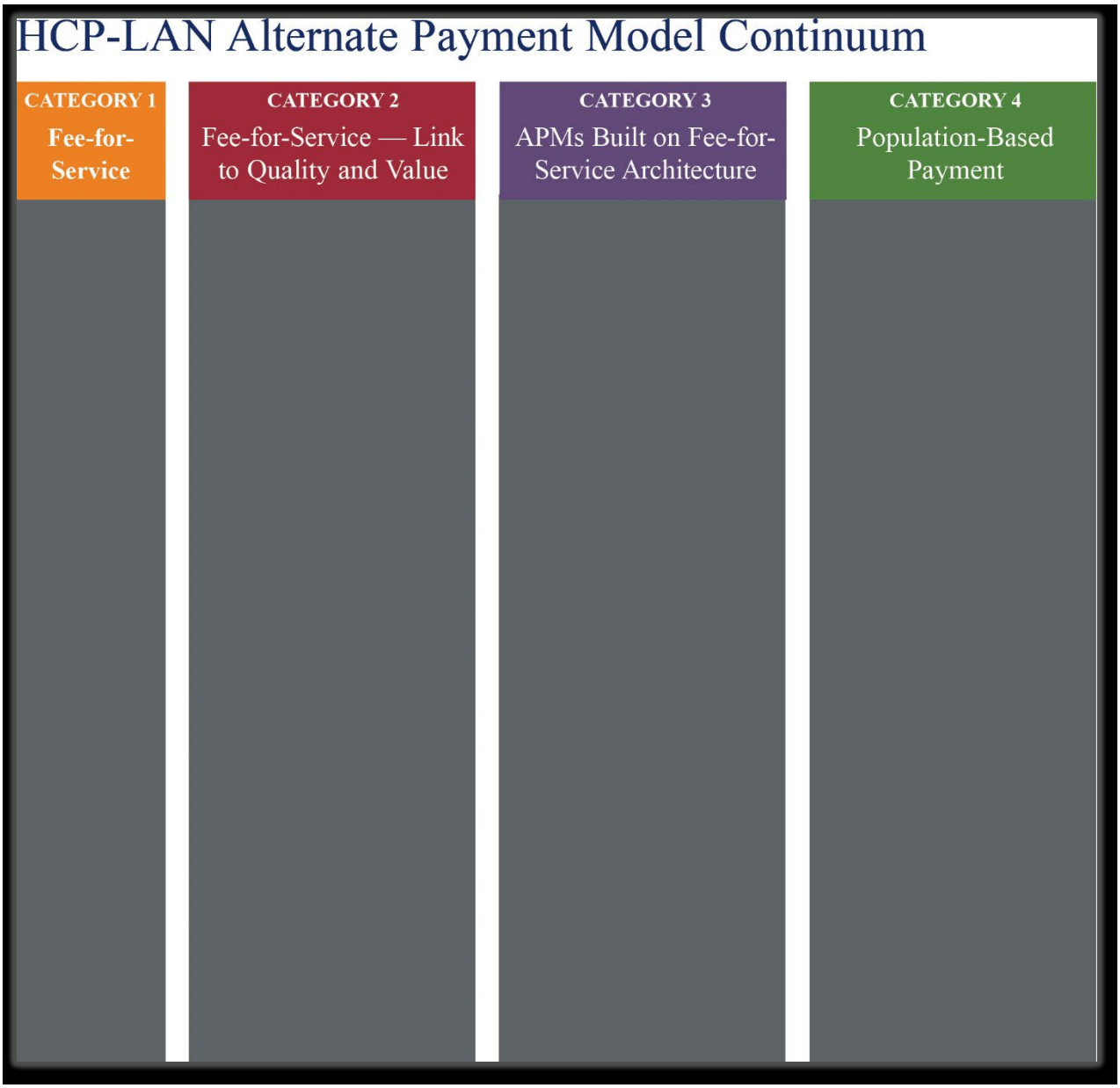
UCare is excited to collaborate with the State and Kansas Providers, including large care systems, primary care Providers, specialty Providers, behavioral health Providers, and home and community-based services Providers, among others, to design and implement alternative models of payment that incent and drive improved quality of care and health outcomes, service delivery, and cost management. These efforts are key to encouraging integrated, whole-person care while managing costs. With sensitive care coordination and risk stratification, we are able to offer optimal resources to care for Members at highest risk, ensuring their physical, behavioral, and social needs are managed to keep them as stable as possible while also improving their well-being and recognizing their own personal health goals. UCare is a national leader in developing value-based payment (VBP) arrangements for Special Needs Plan (SNP) populations, given our decades of experience as well as our commitment to developing deep partnerships with our Providers.

In preparation for the KanCare RFP, UCare's Kansas Market President, Kansas-based Contract Managers, Provider Relations staff, and Clinical and Mental Health and Substance Use Disorder (MH and SUD) senior leaders, visited with Providers across the State. Through these listening sessions, we learned more about current VBP arrangements, what the Providers found most valuable, and how UCare can support them without creating administrative burden. Our key takeaways, which align with UCare's foundational partnership approach, was the need to bring forth a comprehensive VBP educational program to ensure all Providers understand the continuum of VBPs, and alternative payment models (APMs) UCare will offer, the metrics monitored for each practice, as well as the opportunities for incentive payments. This includes building capacity for Provider readiness as well as sharing data and analytics that are actionable for the Provider and unique to their patient population.

Experience Developing and Implementing VBP Arrangements

UCare will leverage our years of experience and success with VBP arrangements in our current markets, and partnership models to tailor VBP arrangements for Kansas Providers that align with the KanCare Quality Management Strategy and with the Value-Based Purchasing Strategies outlined in RFP Section 7.7. Our VBP model of care is a person-centered approach that uses a blend of local market analysis and historical performance data from other markets in which we operate to provide care and services in the right place, at the right time, and with a value-based focus on cost and outcomes. Using the Health Care Payment Learning and Action Network

(HCP-LAN) Alternative Payment Model (APM) as our framework, we will apply lessons learned in other states to ensure that our strategy includes flexibility for customization, allows for Provider negotiations, and focuses on our population's needs according to their geographical area. Our VBP arrangements will include specific, targeted metrics for Providers. UCare will use a multi-year approach when developing and implementing VBP models with Kansas Providers, ensuring they can be successful as they are moved along on the HCP-LAN value continuum as appropriate to the Provider type.



All network Providers will be encouraged to submit a VBP arrangement recommendation to UCare, and we will work in good faith to establish a VBP arrangement with the Provider. UCare will also actively educate and propose VBP arrangements to Providers using local and aggregate data to identify opportunities for improved outcomes and cost management, which we have found to be key in engaging Providers and gaining confidence in participating in VBP. UCare

has developed, often in partnership with Providers, a range of innovative VBP arrangements that span the continuum of service and Provider type. For example, we have developed two types of VBPs related to transportation, one that encourages high Provider standards and one that addresses the gaps that can occur if Members do not have their necessary rides to receive methadone treatment. In addition, given UCare's long-standing experience with FIDE and HIDE SNPs compared to many competitors in the market, we have several arrangements we have developed that facilitate care coordination between disability waiver Providers and primary care, as well as with adult day centers. UCare will submit all proposed VBP models to the State for approval in compliance with Model Contract requirements.

Leveraging Experience for KanCare

Member Driven

[redacted]

UCare will include characteristics from high performing VBP models successfully deployed, such as our Care Incentive Initiative Program (CIIP). Our CIIP program provides enhanced, outcomes-focused payments to eligible network primary care groups, large and small. [redacted]

[redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

A. Priority Areas for VBP and Anticipated Outcomes

UCare understands the important influence VBP programs have on Member health outcomes and how improvements in outcomes can promote Member independence and improved quality of life. As such, we design our programs to support and reward Providers for creating behavior changes and adopting processes that increase access to care and improve health outcomes. We will accomplish this by implementing a blend of financial and non-financial incentives purposefully designed to promote behaviors supporting those ends, such as appropriate utilization of health care services and social determinants of health (SDOH) resources. We will

[redacted]

also ensure Providers take on the level of risk under a VBP agreement they have the financial and operational infrastructure to administer. UCare will gather specific claims, encounter experience and utilization data on KanCare membership to analyze opportunities for improvement, as well as the opportunity to develop new VBP priorities based on KDHE and Kansas Department for Aging and Disability Services (KDADS) priority areas. Once we have developed the data profile for our network Providers, we will deploy a comprehensive education, and communication campaign for those identified as immediate opportunities for VBP arrangements that meet prioritized areas.

Trusted Government Partner

We have developed best practice approaches in our current markets related to coordination with Centers for Medicare & Medicaid Services (CMS) and other managed care organizations (MCOs) to promote VBP goal alignment and to help reduce Provider abrasion and administrative burden. UCare understands effective VBP adoption by Providers is grounded in the relationships we form through consistent communication and transparency, earning trust by delivering on commitments made, and offering meaningful support. We will use State-developed registries, tools, health information exchange (HIE) and resources to assist in maximizing the impact of our VBP implementation. Our goal is to implement our VBP models statewide, with the intent to promote migration from fee-for-service to high-quality, outcome-based care — offering financial incentives to Providers across various care and service delivery models, practice size, or location (urban or rural/frontier). UCare has identified three main priority areas outlined in Table 26.2.

[redacted]

B. Proposed Alternative Payment Models

UCare's VBP and APM models align incentives across the health care delivery system to improve health outcomes and well-being for Members, contain costs, cut waste, promote delivery system transformation, and improve clinical quality and health equity. Successful VBP programs need three essential components:

- Tie financial incentives to quality measures promoting behavioral, LTSS and clinical transformation
- Support and technical assistance to enable Provider success
- Utilize data analytic tools to measure and inform quality care and cost efficiency

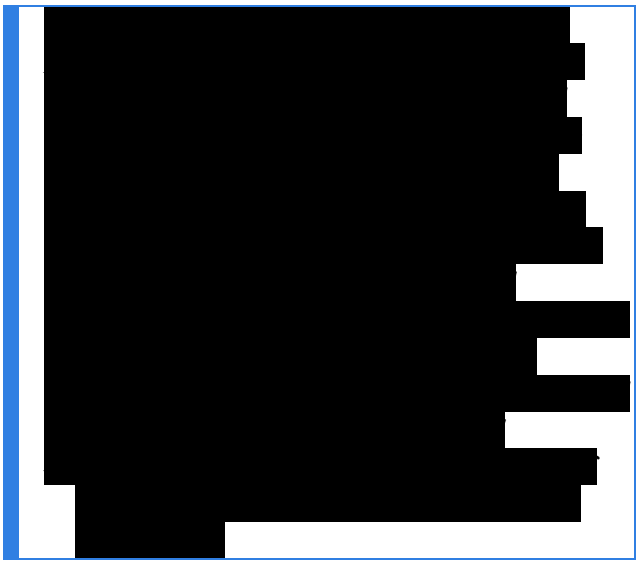
Our VBP and APM models focus on Members' health outcome improvement and are designed to objectively monitor, evaluate, and improve the quality, appropriateness, and safety of services delivered to Members. Our models promote a holistic view of Member health and encourage the development of primary care Provider relationships and health homes where Members can build a relationship with a trusted care Provider. We encourage Members to take a proactive role in their health care and work closely with our network Providers to address their unique physical, behavioral health, and SDOH needs and act upon opportunities identified.

In alignment with the basic tenets of the HCP-LAN APM classification system we measure progress in moving Providers to payment incentive models for reducing costs while improving quality. Table 26.3 provides a summary of UCare's current APMs and their alignment with HCP-LAN categories, and proposed timeline for implementation.

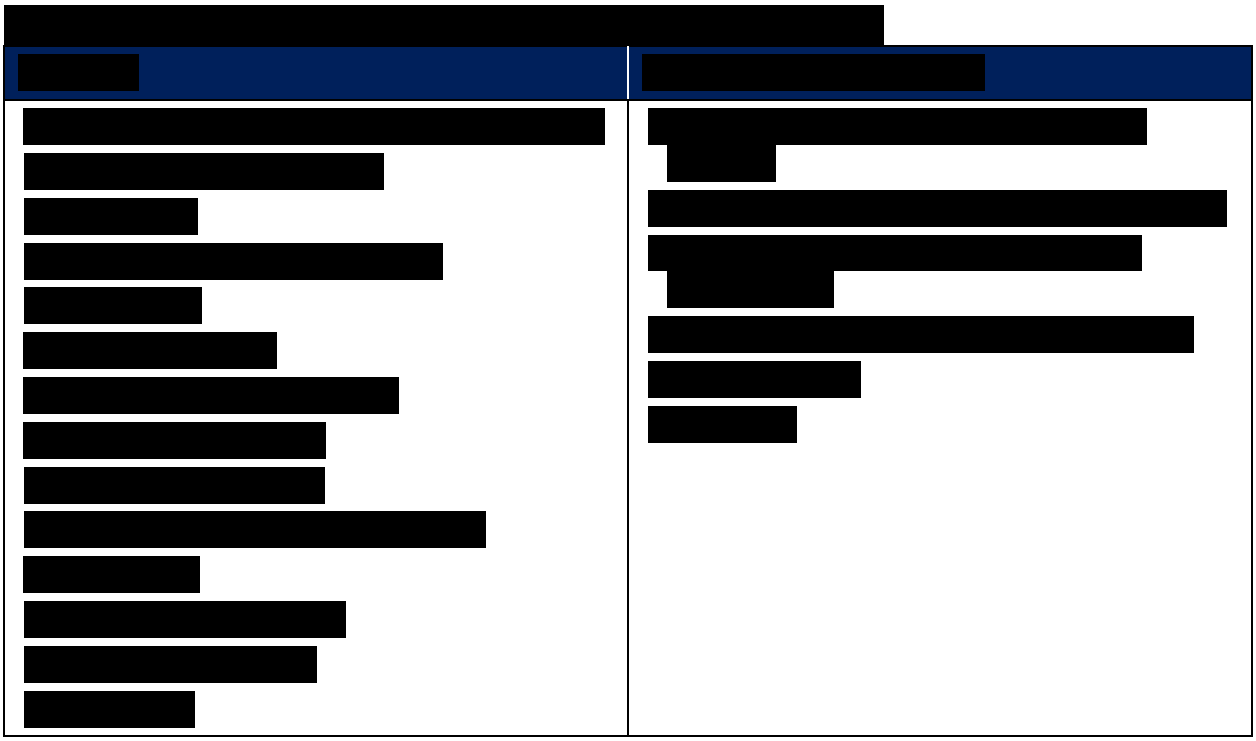
C. VBP Implementation Support for KanCare Providers

Identification of KanCare Providers to Implement VBP Arrangements

Over the past 14 months we have met with many Providers, including large care systems, Federally Qualified Health Centers (FQHCs), mental health Providers, Home and Community-Based Services (HCBS) Providers, and others. We discussed Provider willingness, readiness, and experience with VBP arrangements. This information was valuable in determining types of VBP arrangements as well as the various individual Providers' comfort levels. As a result of these meetings, UCare developed the timeline and roadmap found in Table 26.3. UCare will encourage Providers to enter a VBP arrangement voluntarily and provide support for readiness prior to any implementation.



An early example is a $260,000 grant program we funded and partnered with Wheat State Healthcare, which provides capacity-building funding for 14 CMHCs/CCBHCs in each region of the State to gain the staffing and interventions needed to participate in VBP. UCare also has committed to collaborating on a value-based agreement with Wheat State Healthcare in our LOI. The following Providers have already indicated to UCare they are ready and excited to partner with UCare in a VBP arrangement (Table 26.4):



A critical precursor to any VBP arrangement is developing a trusted and respectful relationship between UCare and our Provider partners. We realize it is important to ensure our traditional claims-based operations are functioning at the highest level, e.g., Providers are paid timely and accurately. In the first few months of UCare's KanCare contract, we will establish a baseline and prepare representative performance reporting so Providers can understand where they are currently in formulation of a VBP arrangement. Moving Providers away from comprehensive traditional fee-for-service payments to an incentive-based payment model is a strategic imperative for UCare across the KanCare program.

To ensure the success of any VBP arrangement, UCare will work in partnership with Providers to define and develop the VBP arrangement that will be mutually beneficial to both parties. We will develop a roadmap to success, inclusive of metrics (e.g., HEDIS) and outcomes (e.g., improved quality and cost management) that are clearly defined and understood. UCare will ensure each Provider has the necessary tools and data to support management of the population under the agreement, through use of VBP readiness assessment questions, such as:

[redacted]

Educational Support

Based on UCare's extensive experience, we will share best practice strategies and workflows with Providers regarding identification of gaps in care, high-risk Members, performance improvement opportunities, barriers to care, etc. UCare teams will then work closely with Providers to implement these strategies and workflows within their organization's infrastructure. We will provide training on how to access real-time, actionable data through HIEs and the suite of reports UCare will make available to them. We will work with Providers to develop a meaningful Member-centered care plan, inclusive of data-driven methods to identify SDOH barriers to care. We facilitate connections to and provide a listing of community-based resources in the Provider's service area to support Member referrals when needed and work with the Provider and community-based organization to ensure a closed-loop.

Data Support

UCare has a suite of reports and data feeds available to Providers, depending on need, Provider sophistication, and VBP arrangement terms. From our listening sessions with Kansas Providers, we heard this was a foundational component to success in a VBP arrangement. Providers expressed some frustration that the current MCOs do not consistently provide the actionable and Provider-specific reporting or transparently provide data for their patients inside and outside of the Provider's network or practice. UCare is open and transparent with our Providers as well as flexible to meet their data needs.

For example, for basic HEDIS measure pay-for-performance terms, UCare will provide a monthly report of the Provider's attributed Member population with:

[redacted]

Ongoing Support

In UCare's experience, successful VBP arrangements are supported through regular, meaningful partnership meetings. Frequency of the meetings is determined depending on need, ranging from a minimum of quarterly meetings to weekly touch-bases, often needed during the early phases of VBP arrangement implementation. We use these meetings to review performance on defined measures, discuss areas identified that need improvement and create a plan to address, as well as other collaborative opportunities. Core participants in these meetings include Provider office and clinical staff, UCare Provider Contract Managers, quality specialists, financial representatives, reporting/data analysts, clinical staff, and medical directors (as needed).

UCare's foundational relationship approach with Providers in our current markets have proven successful, mainly attributed to the flexibility of our approach and the transparency in our model development and data sharing. As a regional nonprofit, Medicaid-focused health plan, we believe meeting our Providers where they are achieves a common mission to provide Member-centered, high-quality, cost-effective, incentive-driven care. We create customized, mutually agreeable terms in our VBP arrangements and provide the data, financial, and operational support to improve health outcomes through a well-coordinated, whole-person approach that aligns with KanCare goals.

D. Strategies to Reduce Administrative Burden

UCare is committed to ensuring that the administration of KanCare VBP arrangements is done in the most efficient manner possible. We welcome the opportunity to work with KDHE and KDADS, as well as Provider associations and other organizations, in developing our VBP arrangement models and ongoing oversight processes. We have a decade of experience supporting a state sponsored standardized VBP model, with all Medicaid managed care plans and primary care clinics/care systems.

This model, called the Integrated Healthcare Partnership (IHP) program, works well with all parties. IHP is a standardized attribution, financial risk terms, standard set of quality measures, population-based payment, and incentives for including community-based Providers, closing health disparity gaps, and addressing Members' SDOH needs. This collaborative model demonstrates much less administrative and clinical work for Providers related to implementing and ongoing management of the program. Lessons learned from the IHP model will be applied in Kansas to address administrative burden. Other tactics UCare will deploy to reduce administrative burden for participating Providers in VBP arrangements will include, but are not limited to:

E. Evaluation of VBP Program Effectiveness

For each Provider engaged in our VBP incentive programs, our Network and Quality teams have developed scorecards that will be shared with Providers to inform them of their VBP performance results to date. UCare teams will review scores for each measure to identify challenges or barriers in achieving the Providers' goals, develop mitigation plans and

recommendations to assist Providers in achieving goals, addressing challenges, and engaging Members in improving their health status and closing gaps in care.

Measuring Performance

Whenever possible, UCare uses VBP measures that are based on nationally accepted measure sets, such as HEDIS or NOMS to: 1) standardize and align with other measures the Provider may already be working on with other payers, 2) use standardized measurement criteria that has been well-defined, and are recognized by NCQA, and 3) allow for comparison of outcomes across Providers and national benchmarks and to analyze and monitor outcomes data across Medicaid markets.

Monitoring and Evaluating Outcomes

UCare's Health Care Economics (HCE) Department is responsible for analyzing data from claims, Membership attribution files, and other sources to calculate the financial, utilization, and quality metric performance results and outcomes for each VBP arrangement. HCE is staffed with experienced and knowledgeable financial and clinical data analysts who have been building VBP measurement, monitoring, and evaluation tools and processes since the inception of value-based care programs. For VBP measures that require chart abstracted data, UCare will coordinate with Providers to do the chart review or establish back-end audit processes to monitor Providers with VBP arrangements that allow for self-reporting of chart data.

In 2019 UCare entered into a VBP arrangement with Disability Services Provider/LTSS [redacted]

Three committees within UCare are responsible for reviewing and evaluating VBP outcomes data on a regular basis to determine effectiveness of the model.

[redacted]

[redacted]

Summary

UCare's foundational partnership approach has proven successful in Provider recruitment and retention within our existing markets, across Medicaid and SNP products, and through engagement in VBP arrangements across the full continuum of Providers in VBP models. By tailoring our VBP program approach to meet the individual needs of Providers and a shared mission to improve outcomes and well-being of our shared Members, we can create dynamic VBP arrangements that enable Providers to focus on holistic care delivery to Members in an integrated, well-coordinated, and effective manner.

Tab 7g:

TOPIC AREA 7

Case Scenarios

7g. Case Scenarios

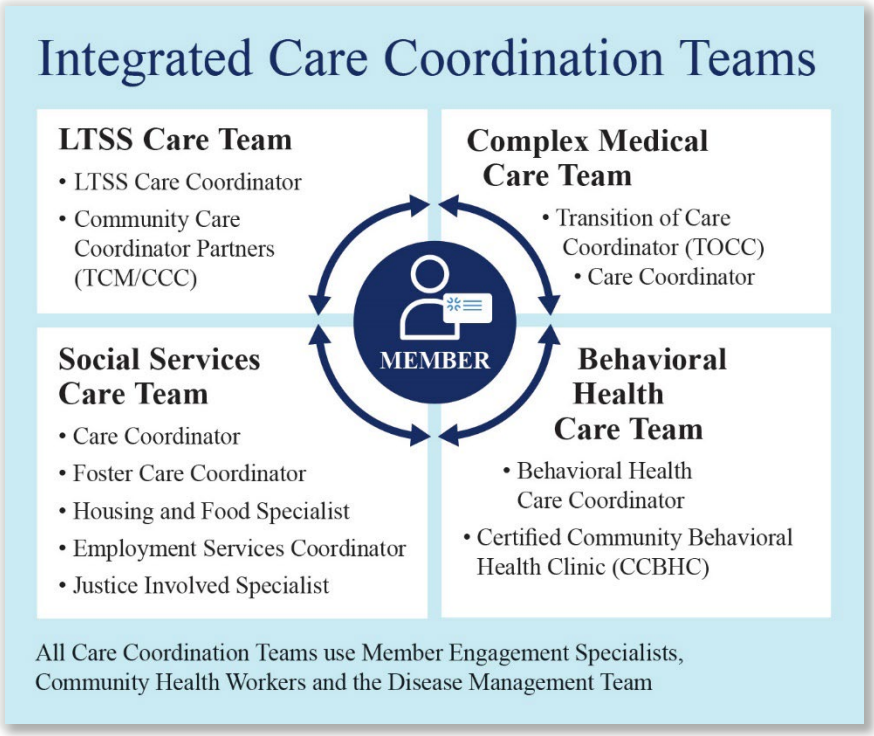
27. The bidder's Member services line receives a call from Maria, the mother of a twenty-two (22)-year-old, Hispanic, female KanCare Member named Juanita. Maria's and Juanita's primary language is Spanish. Juanita delivered a baby boy approximately two (2) weeks ago. Maria is calling out of her concern for the well-being of her daughter and grandson.

    Maria shares that the Member has been living temporarily with her until Juanita finds employment, transportation, childcare, and housing. Maria states while Maria works, she has been struggling to make ends meet and at times has been unable to buy groceries. Maria shares that she has recently noticed significant and increasing changes in Juanita, including bouts of crying, lack of appetite, listlessness, and frustration with caring for her baby. Maria reports that Juanita has not been sleeping much and is struggling to produce enough breast milk to meet the baby's needs. Maria thinks that the baby may be "colicky" because the baby "cries a lot" and is difficult to soothe. Maria stated that Juanita missed the first postpartum well check because the baby was finally sleeping, and Juanita did not want to wake the baby. Maria immediately called the Member services line when her daughter told her, "I can't do this anymore."

    Describe how the bidder will handle the call from Maria, and the bidder's approach to meeting the needs of Juanita and her baby.

UCare has deep expertise in maternal and child health. In Kansas, 1 in every 161 women who delivered a baby experienced severe maternal morbidity, and women of color are disproportionately overburdened by this outcome. Recognizing national and State disparities, UCare has developed maternal and child health programs that are responsive to the preferences of Members, address cultural and linguistic needs, and ensure that all Member have equitable access to quality services throughout their pregnancy and postpartum period.

In this scenario, our Integrated Care Coordination model and services reach out, assess, and respond to Juanita and her new baby's physical health, mental health, and social/environmental needs. Our initial focus is performing a comprehensive assessment of Juanita's condition and needs to ensure that she and the baby have access to the right clinical and non-clinical resources to help them both thrive.



Addressing the needs of Juanita and her baby, as well as her mother, Maria, requires a multistage process, including:

[redacted]

Our care coordination process for Juanita will be in compliance with all requirements of RFP section 7.4.11.

During Maria's call, our Member engagement specialist will engage Spanish interpretation services if needed to make Maria more comfortable in communicating the situation. Since Juanita is an adult, the representative will also ask for her consent to discuss her situation with Maria, in compliance with HIPAA requirements, and will request that Juanita join the call herself.

Phone Assessment and Appointment Scheduling

Because Juanita's care needs are urgent, the Member engagement specialist makes a warm transfer to Elena, a Spanish-speaking licensed R.N. on our Care Coordination Team to evaluate any immediate physical or mental health needs. In compliance with the requirements in RFP Section 7.4.11.D, Elena has more than two years of qualifying experience, including a year of experience with care coordination of individuals with complex health conditions, including behavioral health conditions.

[redacted]

Aware that complications in the postpartum period pose substantial risks to mothers and can result in significant maternal morbidity and mortality, Elena initially focuses on ensuring that Juanita and the baby are getting the health care they need, as well as educational and community resources. She also assesses the general health of the baby and addresses Juanita's questions and concerns. Her discussion with Juanita also includes identifying any other people in Juanita's life, such as Maria, who should be included in the plan of service. UCare's family-centered approach to postpartum care is a critical component of our holistic care coordination services.

[redacted] In addition, getting the baby to sleep has been so challenging that Juanita missed her first postpartum check-up because she could not bear to wake the baby, who had finally gone to sleep.

After addressing Juanita's immediate mental health needs Elena arranges an in-person home visit for an initial postpartum assessment within 14 days. Postpartum care that is not timely can be directly related to negative outcomes for the mother's physical and mental health. Elena learns that Juanita's current obstetric Provider is not culturally congruent. To ensure the best care, Elena arranges for Juanita to see a Provider who can provide the appropriate cultural fit along with integrated service to address both postpartum and mental health services. Since Juanita lives in the Wichita area, Elena connects her with HealthCore Clinic, a trusted FQHC in the community, to ensure a holistic approach to addressing all the needs of Juanita and the baby. [redacted]

In-home Visit and Plan of Service

In accordance with the requirement specified in RFP Section 7.4.11.B, Elena makes her first home visit with Juanita and conducts a Health Risk Assessment (HRA) using the Kansas-approved HRA as well as a pregnancy risk assessment, informed by the Center for Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS) guidelines. The guidelines offer a comprehensive tool for assessment, including questions ranging from Social Determinants of Health (SDOH) needs, preconception and prenatal care, breastfeeding, smoking, health insurance coverage, and physical and mental health.

Through this assessment, Elena identifies the immediate and ongoing health care needs of Juanita and the baby [redacted]

[redacted]

With Juanita's consent, Elena will include Maria in developing the POS for Juanita and her baby. She can also discuss with Maria any SDOH factors (including financial and food insecurity) that may be affecting her own health and well-being, and her ability to provide support for Juanita and the baby.

With Juanita's health goals developed, Elena identifies her care needs and appropriate interventions to address the full range of concerns, including physical health, mental health or substance use disorders, pharmacy and/or dental needs, as well as any social and cultural supports. Juanita's individual plan of service captures preventive care, acute care, and long-term care objectives, including housing, employment, and all other identified needs.

Coordinating Services

Throughout her care coordination efforts, Elena communicates Juanita's needs across all care Providers and advocates on her behalf. Coordination is enhanced by the colocation of services at HealthCore. [redacted]

Peer support can be of particular benefit for new mothers, so Elena asks Juanita if she wants to work with a Parent Peer Support mentor or participate in parenting or breastfeeding support groups. These are also UCare VABs offered to postpartum Members. If so, Elena will also arrange transportation to those groups. Through the support group, Juanita learns about the importance of eating regular, healthy meals and getting enough fluids to increase her breast milk production. Breastfeeding support may also include providing her with a breast pump and additional breastfeeding and nutrition education.

Elena is also able to offer an array of other UCare's VABs related to postpartum care that may be helpful for Juanita, such as incentives for postpartum visits and well-child checkups. To encourage Juanita to continue her postpartum care, she can receive $75 on a prepaid Visa card by going to her postpartum visit, and another $25 for bringing her baby in for his well-child visit through UCare's VABs.

In all interactions with Juanita and her baby, Elena is alert for any warning signs that should be shared with UCare's Behavioral Health Care Team, Juanita's obstetric Provider, or other Providers.

Table 27.1 summarizes the primary needs and priorities, interventions and services, and Providers which would be found within Juanita's POS, per RFP section 7.4.4:

Ongoing Care Coordination

After the initial home visit and screenings, and with Juanita's POS underway, Elena will check in with Juanita at least monthly, for one year postpartum and beyond. She will also conduct a repeat assessment at the end of the fourth trimester to track improvement from intervention and remaining needs. Based on what she sees and learns through these visits — including how Juanita and the baby are doing, progress toward Juanita's POS goals, and any gaps in services identified — Elena will adjust the POS as needed.

At HealthCore, Juanita will have access to computers and education about obtaining employment. To further support her goal of working, we will help Juanita access childcare options.

UCare will continue to support Juanita and her baby for the longer term through access to appropriate Care Coordination Team members who can best meet their needs and ensure they can obtain the support services required to successfully meet identified goals.

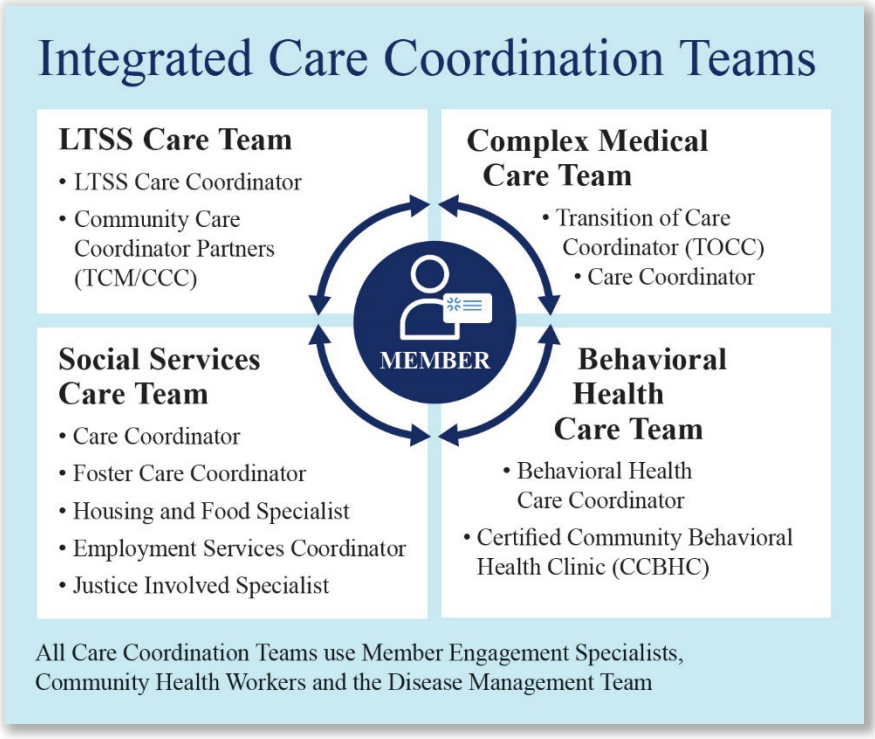
28. Shanice is a twenty-three (23)-year-old, black, female KanCare Member who was brought to the Emergency Department (ED) by police due to injuries sustained during a fight with another person in a downtown homeless shelter. While her injuries do not appear to be life threatening, Shanice sustained injuries around her face and head and exhibits odd behavior.

    Shanice has a history of opioid use disorder, benzodiazepine use disorder, and stimulant use disorder in addition to co-morbid schizoaffective disorder and major depression disorder with psychotic features. Her drug screens at the ED are positive for opioids and benzodiazepines.

    Shanice has been receiving services through a CCBHC, but has been inconsistently engaged in treatment and has presented to the ED multiple times for either drug intoxication or withdrawal in the past year. She is unstably housed and lacks any form of Transportation. Tests conducted during the ED stay indicate that Shanice is pregnant.

    Describe the bidder's approach to addressing Shanice's needs.

UCare has a long history and deep experience supporting Members like Shanice with holistic care and recognizing and addressing the impact of Social Determinants of Health (SDOH). UCare works with Members like Shanice who have both physical and behavioral health (BH) needs in an integrated fashion to ensure they receive quality services that promote their independence and wellness. As with all Members, our approach to supporting Shanice is to meet her where she is in the continuum of care through our flexible Interdisciplinary Care Team (ICT) that meets requirements of RFP Section 7.4.1, with a person-centered approach.



Given Shanice's BH history, she has an established relationship with COMCARE, the Certified Community Behavioral Health Center (CCBHC) located in Sedgwick County, where Shanice resides. The established single point of contact at COMCARE will work closely with a UCare Behavioral Health Care Coordinator as required in RFP Section 7.4.10. UCare will also have a Care Coordinator with maternal health expertise work with Shanice to ensure she receives timely access to prenatal care, throughout her entire pregnancy, and postpartum care that meets specifications of RFP Section 7.4.11.

Shanice's Emergency Department Presentation and Care

The emergency department at Ascension via Christi St. Francis in Wichita triggered an admission alert through the Kansas Health Information Exchange Acute Alert System to UCare that our Member, Shanice, a 23-year-old Black female, had been brought into the ED by police. Shanice's assigned UCare BH Care Coordinator, Carla, relays this information to Lauren, the assigned single point of contact for Shanice at her CCBHC, COMCARE. Carla is a licensed clinical social worker and certified addictions counselor, meeting the requirements of RFP Section 7.4.7.D

In accordance with requirements outlined in RFP Appendix L, all Care Coordinators involved in Shanice's care work closely together. Carla stays in touch with Lauren to ensure that necessary Health Risk Assessments (HRAs) and Needs Assessments for Shanice are completed as appropriate. Carla also supports Lauren with other resource coordination to meet the needs identified in the care plan that Lauren creates with Shanice. In their previous conversations, Lauren and Carla have discussed housing and transportation services for Shanice. Lauren and Carla also discuss the transition of care process and discharge planning. The coordination between Carla and Lauren ensures nothing is overlooked and there is no overlap in their roles and care for Shanice.

Connecting Shanice with Substance Use Disorder Services

After talking to the ED staff, Lauren updates Carla and talks to Shanice about her plans after leaving the ED. Shanice said she would just live on the street, since she assumed the homeless

shelter would not let her back in due to her fighting. At this time, [redacted]

Lauren also asks Shanice about why she missed her last two appointments at COMCARE. Shanice explains she didn't have a way to get to her appointments. Lauren tells Shanice that she can get to all of her health care appointments using UCare's transportation benefit and makes a note to follow up with Carla. After their conversation, Lauren adds all this information to Shanice's care plan, which Carla will ensure is documented.

Connecting Shanice with Prenatal Care

After assessing Shanice's current situation, Lauren consults with Carla and Shanice with support from Rachel, a UCare Maternal Health Care Coordinator, to help develop a treatment plan and make recommendations for referrals. As required in RFP Section 7.4.11.D, Rachel is an RN with several years of experience working with pregnant individuals, and high-risk pregnancies in particular. Rachel shares that Shanice can receive doula services as a part of her value-added benefits (VABs) with UCare if she is interested, and recommends that Shanice be connected with HealthCore, a federally qualified health center (FQHC) in Wichita, for prenatal services.

Given that Shanice's pregnancy is considered high-risk due to her BH needs, Rachel will meet with Shanice for an initial in-person visit within 10 days, and offer to connect her with prenatal care and other resources offered through VAB, such as a doula. During this visit, Shanice expresses that she is overwhelmed, but is eager to connect with prenatal care at HealthCore. She is uncertain about a doula but tells Rachel she will give it some more thought. Rachel will continue to connect with Shanice at least monthly over the phone through one year postpartum, and will coordinate with Carla and Lauren to ensure that Shanice's BH needs are being met.

[redacted]

Transitioning Shanice to Acute Medical Detoxification

Based on the ED information and Lauren's assessment, Rachel, Carla, and Lauren feel that

Updating Shanice's Care Plan

After detoxification, the UCare team supports the goal for Shanice to transfer to a residential treatment facility that can address her pregnancy and BH needs, and eventually secure longer-term housing options for Shanice. Because Shanice receives care from a CCHBC, Lauren continues to write an updated care plan, in accordance with RFP Section 7.4.4.1, and with Shanice's input uses SMART goals (specific, measurable, achievable, relevant, and time-bound) throughout the plan. Table 28.2 summarizes the primary needs and priorities, interventions and services, and providers which would be found within Shanice's care plan, per RFP 7.4.4.

Shanice's Medical Detox Admission

Following her ED visit, Shanice is admitted for five days to the medical detox at Ascension via Christi St. Francis. During the admission, she is assessed for withdrawal and monitored for persistent post-concussive symptoms. After Shanice signs a release of information, Lauren reaches out to the hospital social worker and inquires about Shanice's progress. Lauren learns that Shanice's providers at the hospital have discussed Shanice as a potential candidate for MAT (buprenorphine). Lauren consults with Carla, Rachel, and UCare's Behavioral Health Medical Director about the risks of MAT and pregnancy and will follow up with appropriate prescribers when she is moving out of acute medical detoxification.

Addressing Shanice's Mental Health Concerns

During the medical detox admission,

[redacted]

Lauren connects with the psychiatrist and relays that these services can be received through COMCARE, her CCBHC. Then Lauren schedules outpatient psychotherapy services for Shanice and a psychiatric appointment the following month to further evaluate Shanice's care and assess the need for medications. Lauren then coordinates with Carla, who coordinates across UCare's Social Services Care Team to ensure that Shanice can have transportation arranged to these appointments. Lauren and Carla discuss that these appointments may need to be rescheduled depending on Shanice's discharge plan from residential treatment.

Planning Shanice's Transition out of Acute Medical Detoxification

[redacted]

Both Lauren and Carla know that finding available SUD treatment services can be difficult. Carla is aware of the eight designated Kansas Behavioral Health Services treatment facilities that provide specialized SUD services to meet the needs of women and children, and both Lauren and Carla know that these programs give priority to pregnant women, women with dependent children, and women using IV drugs.

[redacted]

[redacted] Shanice is agreeable to this plan, though she admits that she feels anxious about going to residential treatment, based on her past experience. Shanice also shares that she has been thinking about her baby, and she knows this is the best option.

Shanice's Services While in Residential Treatment

[redacted]

[redacted]

[redacted] Rachel has connected Shanice to HealthCore, an FQHC in Wichita, for prenatal care and physical health care. HealthCore has a full-service clinic supporting patients' medical and dental needs all together in one visit. HealthCore is also on the list of resources Carla is gathering in coordination with Rachel and other members of UCare's Social Services Care Team because HealthCore also provides food, employment support, and kitchen utensils for cooking should a Member need anything. Shanice will be linked to a community health worker (CHW) employed at HealthCore who assists Shanice with learning about healthy behaviors and engaging in parenting skills training.

[redacted] During another conversation, Rachel discusses doula services with Shanice again. Shanice has given thought to receiving doula services and agrees for Rachel to connect her with Wichita Doula. Rachel makes this connection in collaboration with Lauren.

[redacted]

[redacted]

[redacted] With Shanice's approval, Carla is able to secure Shanice an apartment through the Mental Health Association of Southeast Kansas. Shanice has also had a first meeting with a doula and is excited

about the support and conversation about her pregnancy. Lauren will coordinate with Carla to arrange for transportation to appointments as a value-added benefit to Shanice.

Ongoing Care Coordination

Shanice steps down to longer-term BH services through COMCARE, where she can continue in her recovery and have education and supports for parenting and childcare. Her primary goal, in addition to SUD recovery and engagement in treatment, is to obtain permanent housing and employment. Carla and UCare's Social Services Care Team will continue to support achieving these goals in coordination with Lauren. Rachel will continue to provide care coordination through one year postpartum and longer if needed, to ensure that Shanice and her baby are linked to physical and behavioral health care as well as access to transportation, food, housing, and other social needs.

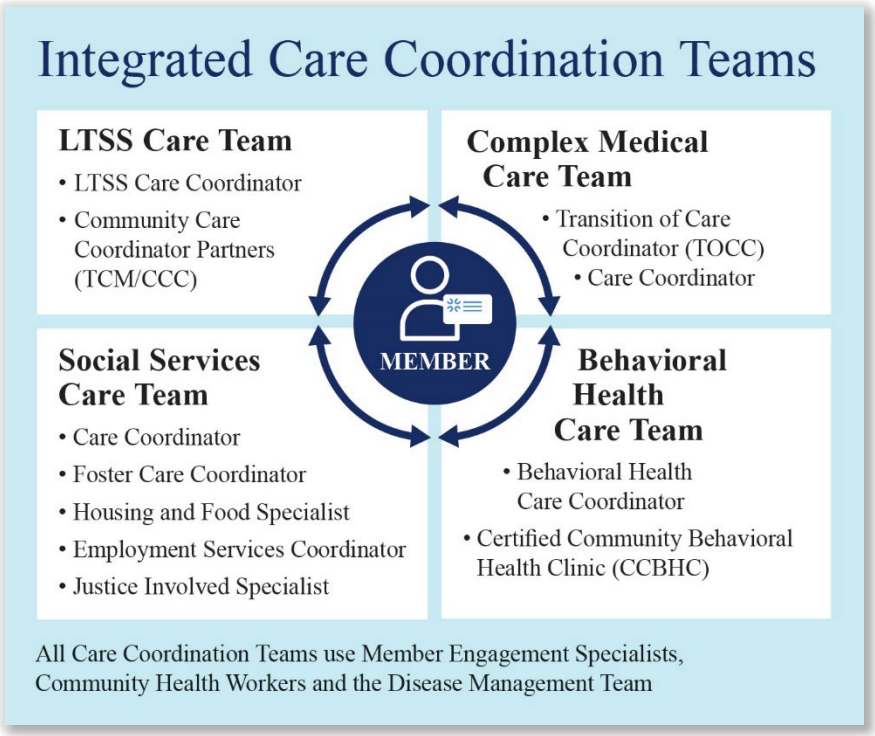
29. Robert is a twenty-five (25)-year-old, white, male KanCare Member with Cerebral Palsy enrolled in the IDD HCBS Waiver. He is currently being treated in an acute care hospital for an upper respiratory infection and is nearing discharge. In addition to having a limited ability to meet his basic personal care needs, Robert is wheelchair dependent and requires an augmentative communication device. Robert is currently living with his grandmother, Betty, who has been providing the majority of support for his personal care needs.

    Betty recently learned that she has stage 4 rectal cancer and is gravely concerned about her ability to continue to care for Robert when he is discharged, and anxious about who will take care of him when she dies. There are no additional family supports for Robert.

    Robert is very intelligent and close to getting a bachelor's degree in computer programming. He would like to live independently, complete his schooling, and obtain employment.

    Describe the bidder's approach to supporting the hospital discharge planning process and to initiating and managing Robert's follow-up care to assist him in meeting his short- and long-term needs and personal goals upon discharge.

UCare has decades of experience providing care to individuals with complex, long-term needs. Our highly successful Integrated Care Coordination model is focused on person-centered care to address all Member needs thoughtfully and holistically. Due to our experience and best-in-class Integrated Care Coordination model, we are prepared to meet and support Robert on his journey with dignity, respect, and compassion for his medical, physical, social, and emotional needs.



UCare's integrated and holistic approach to care coordination will provide the tools and resources necessary to support Robert. We assemble a comprehensive team of experts, putting Robert at the center of his care team. This team consists of medical, behavioral health, Long-Term Services and Supports (LTSS) and Home and Community-Based Services (HCBS) specialists, transition of care coordinators, targeted case manager, and social support, such as transportation, housing, food, and employment support. Our Integrated Care Coordination model and Interdisciplinary Care Team (ICT) bring these resources together by using the same Care Coordinator whenever possible to ensure that Robert's care transitions support continuity and familiarity for him.

Robert's Presentation

Robert is experiencing a significant medical and emotional time in his life. With his own medical issues and his grandmother's recent cancer diagnosis, Robert is facing challenges UCare is ready and honored to help him address. The ICT is comprised of highly skilled professionals who are dedicated to supporting Robert's transition home as well as his chronic care needs related to his cerebral palsy. Additionally, Robert is facing an emotional time, knowing that his grandmother is terminally ill and the uncertainty around how this circumstance will change his support and care.

Since Robert is already a KanCare Member living in Topeka and enrolled on the Intellectual and Developmental (I/DD) Waiver, he already has an assigned UCare LTSS Care Coordinator (CC), Miguel. Miguel is a licensed clinical social worker who has extensive experience working with individuals served by the I/DD Waiver and meets the qualifications requirement outlined in RFP Section 7.4.7. Miguel will work closely with Olivia, Robert's Targeted Case Manager (TCM), who is the primary point of contact for the Member. Robert has been risk-stratified and assigned to level II given his chronic needs and enrollment in the I/DD Waiver. Together Miguel and Olivia will facilitate a safe transition of care for Robert. Throughout the transition, Miguel will collaborate with Olivia and work with and coordinate care with Robert's ICT, which includes all of Robert's Providers, Olivia, and with Robert's permission Betty, to work together to understand Robert's needs and coordinate services.

Miguel and Olivia will work closely with Robert's Providers and Betty to transition Robert safely out of the hospital into the least restrictive setting possible that meets Robert's needs; in this case he will be able to return to his home. Miguel and Olivia will routinely communicate and coordinate with the Shawnee County Developmental Disability Organization (CDDO) and utilize the I/DD Waiver services to ensure the appropriate services and Providers are engaged in Robert's care and can support his short-term, long-term, and personal goals.

Robert's Care Coordination and Interdisciplinary Care Team Collaboration

[redacted]

While at the hospital, Miguel closely evaluates and explores any changing needs with Robert and his hospital care team. Robert and his hospital team report that he is almost back to baseline and will be ready for discharge in the next day or two. The ICT will review, and with Robert's input, jointly identify the supports and services Robert needs to ensure his safe transition. [redacted]

[redacted]

Previously, Robert and Betty have received help from United Cerebral Palsy of Kansas and Cerebral Palsy Family Network and Miguel is planning to engage these organizations again to assist with identified family support needs. Robert has previously received his speech augmentation device and home modifications through the I/DD Waiver funds. Olivia and Miguel will continue to consider his equipment and home environment needs in his discharge planning process. Miguel and Olivia also review residential supports and personal care services offered through the CDDO to assist with new support needs and are ready to engage those options for Robert as additional needs arise.

Robert's Person-Centered Service Plan

During the discharge meeting, Robert and his treatment team discuss his updated needs and adjust his current PCSP. Robert would like to add goals specific to a safe transition home, receiving additional services to meet his needs, and eventually, obtaining independent housing. Robert, his treatment team and Providers, Betty, Miguel, and Olivia participate together in a person-centered planning discussion to ensure Robert's needs are considered and planned for and ensure resources are in place to address them [redacted] The goals center around ensuring Robert has the proper teams involved and they are collaborating to meet all his physical, social, and emotional needs, and support his independence. In coordination with Olivia, Miguel assists with arranging necessary medical and therapy appointments and the transportation to and from them.

Knowing about the changes in Betty's health, [redacted]

Providing emotional support for Robert will be paramount as he navigates the changes in his grandmother's illness and her impending inability to provide the same level of personal support to him. [redacted]

Through the discussion, Robert also expresses longer-term goals to finish school, become successfully employed, and live independently. Based on Robert's medical, mental health, social needs and individual goals, his treatment team identifies community resources and additional benefits for which he may be eligible, including what he needs for the continuity of his care. Olivia also works with the CDDO in Shawnee County, which Robert is already connected with, to determine additional access to services from the community service Providers in Robert's area. Robert and his treatment team discuss the Provider options available to support him in these areas and with Robert's approval, Miguel and Olivia initiate referrals on Robert's behalf.

All of Robert's goals are designed as SMART goals (Specific, Measurable, Achievable, Relevant, Time-Bound) and are reviewed by Robert, Betty, Miguel, and Olivia during an in-person meeting. Table 29.1 summarizes the primary needs and priorities, interventions and services, and Providers which would be found within Robert's PCSP, per RFP Section 7.4.4:

Robert’s Discharge and Progress toward His Goals

Robert, Olivia, and Miguel are provided with a complete discharge summary detailing Robert’s hospital stay upon his discharge. Olivia and Miguel coordinate with the hospital’s discharge planning team to ensure all of Robert's needs are addressed and he and his grandmother are aware of what follow-up needs to be completed to continue with his treatment plan. As part of this process, Olivia and Miguel assist Robert with scheduling follow-up appointments based on his care plan in order to prevent readmission and deterioration of his overall health. This includes appointments for his mental health and occupational, physical, and speech therapy.

Olivia and Miguel review the discharge instructions with Robert and confirm with him all dates and times of his follow-up appointments with physical therapy, occupational therapy, speech therapy, mental health therapy, housing specialist, and employment specialist. Miguel ensures that Robert will have transportation scheduled in advance and provided for all appointments. He also confirms that Olivia will complete an in-person visit to ensure Robert has safely transitioned home, confirm assistive services have started, review upcoming appointments and transportation details, and make sure Robert feels supported in achieving his educational, employment, and independent housing goals. All of these supports and follow-up measures are part of UCare's longitudinal approach to Robert's care.

Ongoing Care Coordination Support

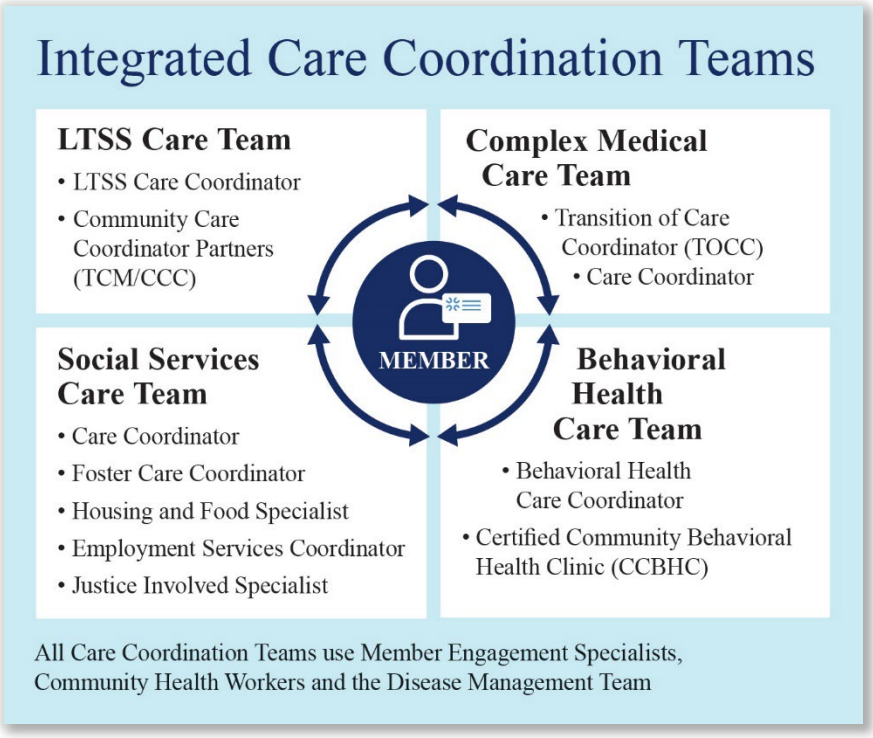
As Robert's Care Coordinator, Miguel plays a vital role in supporting Robert by ensuring that his short- and long-term health care needs and goals are met holistically and effectively. Miguel and Olivia collaborate and ensure Robert receives regular ongoing contact from his care team. At minimum, Robert will receive monthly telephonic contact and in-person visits from the Care Coordinator or TCM every three months. UCare's Integrated Care Coordination model and services for Members like Robert support strong health and wellness outcomes. Our model helps Members establish and maintain physical and mental health, social engagement, and well-being, including independent living and employment in Robert's case. With each interaction with Robert, we will review and update the PCSP as new needs or goals arise. We ensure that Robert's and each Member's lived experience is honored and respected, by delivering compassionate care and equal access to services that facilitate opportunities to achieve their life's full potential. UCare supports Members through our whole-person approach to health and wellness, increasing quality of life.

30. Billy is a thirty (30)-year-old, white, male KanCare Member currently residing in a skilled nursing facility (NF) as a result of injuries sustained in an automobile accident, including a traumatic brain injury. Billy has been living in the skilled NF for the last 14 months. Billy receives physical and speech therapies but continues to struggle with slurred speech, coordination, and balance. He is eager to move back into his home, eventually go back to work, and "get his life back".

    Billy recognizes that he may still need assistance in order to manage basic needs in his home, but finds being in a "nursing home" is depressing and lonely. In addition to his physical and speech challenges, Billy is overweight and developed a stage 3 pressure ulcer. He also experiences periodic incontinence.

    Describe how the bidder will assist Billy in planning for and implementing Billy's transition, including monitoring post-transition and assisting him to achieve his personal goals.

At UCare we are experienced and prepared for the privilege and duty to provide persons like Billy with high-quality, exemplary plan-based care coordination. As one of the longest-serving, community-based, nonprofit Medicaid managed care plans, we are proud to be a leader in managing health care services for Members with complex needs. We will leverage our decades of experience developing innovative, integrated, service coordination programs to assist Billy. UCare's Integrated Care Coordination model and collaborative Interdisciplinary Care Team (ICT) will offer him optimal health outcomes through evidence-based, high-quality care coordination and person-centered care planning.



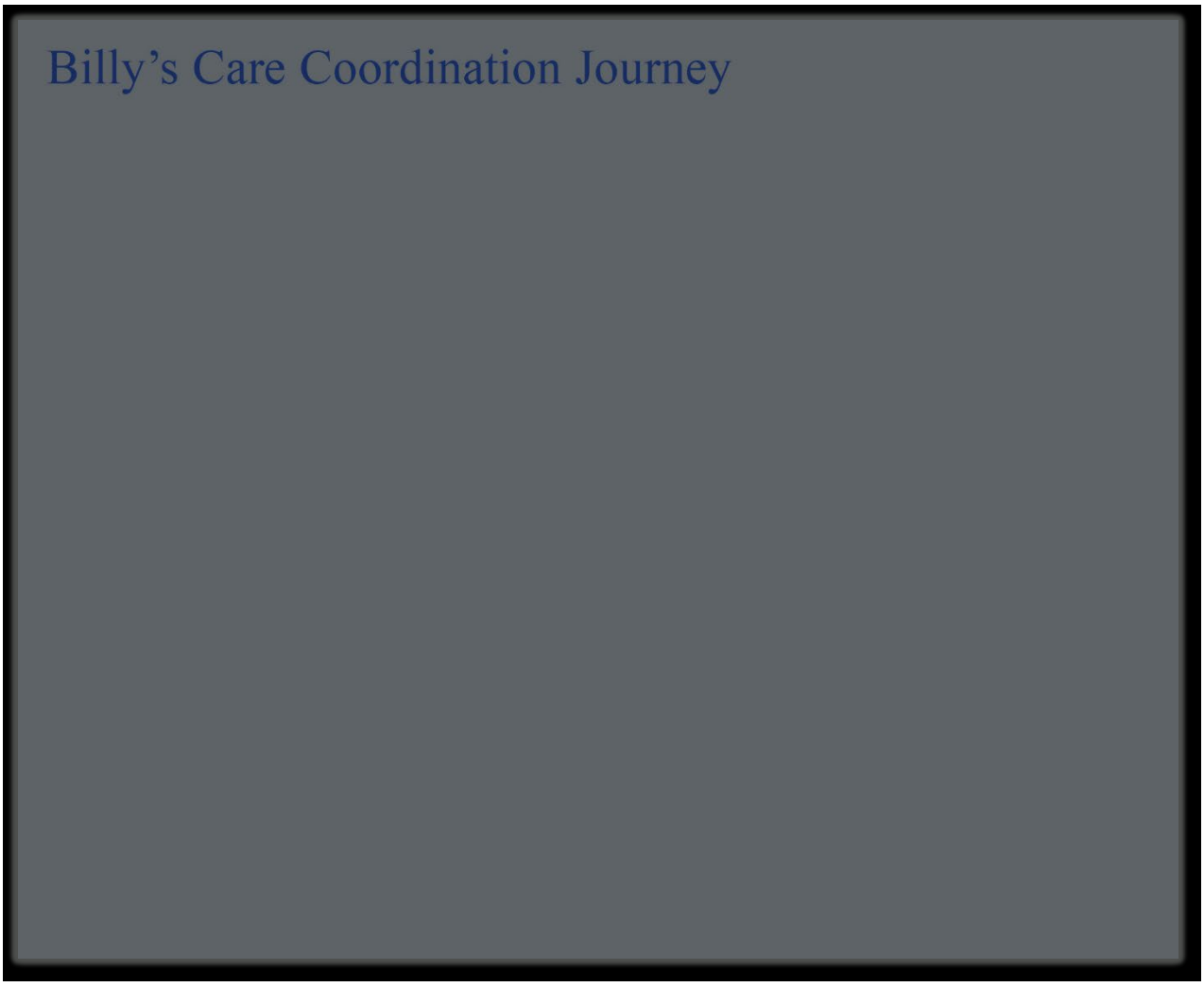
Billy's Care Journey

As UCare assumes the managed care of Billy, we first review and consider his unique situation. He is a 30-year-old white KanCare Member who has lived in the Wichita area for the last 10 years. Billy was admitted, semi-comatose, to a hospital 15 months ago after accidentally driving his car off the road. He awakened the following day and was kept for observation for eight days due to ongoing symptoms of sleepiness, slurred speech, coordination problems, confusion, headaches, incontinence, and nausea. He was then discharged to a rehabilitation skilled nursing

facility (NF) with a diagnosis of non-penetrating traumatic brain injury (TBI) with neurologic complications.

After 14 months at the NF, Billy finds his current situation depressing and lonely and is eager to move back into his home, to go back to work, and "get his life back." His sedation, headaches, confusion, and nausea have all improved. However, he continues to struggle with slurred speech and difficulties with coordination and balance. [redacted]

[redacted]



[redacted]

Throughout any Member's journey, UCare focuses on identifying and integrating any behavioral health (BH) needs with relevant services. We will assess Billy's situation, supports, and coping skills with a focus on his depression and loneliness.

We will also collaborate with Billy's current and potential care partners, including the rehabilitation NF, his attending primary and specialty medical care Providers, BH care Providers, and long-term services and supports (LTSS) or other community or social services, such as housing and transportation Providers.

Member Engagement, Health Screen, and Health Risk Assessment

As a new UCare Member [redacted]

Billy's Health Screen indicates the need for a Health Risk Assessment (HRA) and potentially a brain injury (BI) waiver based on his residence in a NF and his wish to return home. UCare assigns Members to the best-suited care team based on their Health Screen [redacted]

Julie's priority is to provide Billy with support based on his unique needs that will be identified in the HRA, including his behavioral health, physical health, LTSS, and SDOH needs. Julie introduces herself [redacted]

Julie reviews Billy's HRA along with information received from the NF, medical record, and utilization data. Julie learns from Billy that he is single, has no children, and his only family are his two parents and a sister who lives in another state. He was close to his sister in the past but has fallen out of contact since the accident. Billy has generally preferred to be alone since graduating from high school. He has had few visitors at the NF, with only a couple of co-worker friends from his old job who have stopped by [redacted]

[redacted]

Referral for LTSS BI Services

Julie notes that Billy's TBI diagnosis flags the need for referral to LTSS BI waiver services and initiates that referral within two business days of administering the HRA. She follows up with this referral and learns that Billy will be eligible for the program upon discharge from the NF. In the meantime, Julie connects and collaborates with the UCare LTSS care team to plan for eventual internal transfer of care coordination services from the Transition of Care (TOC) team to the UCare LTSS care team. Billy is assigned to David as his LTSS CC. While awaiting discharge from the NF, David suggests that Julie share BI support group resources with Billy, such as the Brain Injury Association of Kansas.

Referral for Behavioral Health Services

Billy's responses on the Health Screen and HRA flags a need for behavioral health care. Julie collaborates with the UCare Behavioral Health Care Coordinator to discuss options. [redacted]

Person-Centered Service Plan (PCSP)

With information from the Health Screen, HRA and other records, Julie next meets with Billy to develop a person-centered service plan (PCSP). The HRA and other records verify that Billy has several sub-acute medical issues that need attention. Together, they begin to consider both shorter-term and longer-term service needs and goals. Julie meets with Billy along with the nursing staff and the physical and speech therapy Providers at the NF to create his initial PCSP for addressing his coordination, speech impairment, incontinence, and skin lesion. Julie learns that the NF has a skin lesion specialist nurse serving Billy. Julie reviews the nursing care plan and enters information into the PCSP as appropriate.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]

[redacted]	[redacted]	[redacted]
	[redacted]	
[redacted]	[redacted]	[redacted]

Julie notes all of this in the PCSP along with the communication plan, including anticipated frequency and method of contacts. Julie shares Billy's PCSP (in either written form or using the UCare electronic signature platform) with Billy and his care team Providers who then sign it before she signs it herself. Copies are sent to Billy, his care team, and stored in GuidingCare within 30 days of the PCSP meeting.

Ongoing Care Coordination

Julie continues to maintain regular contact with Billy to support his engagement with, and adherence to, his PCSP. Julie follows the UCare approach to care coordination by conducting holistic evaluations of Billy's situation to identify and quickly resolve issues. Billy is always at the center of the process while Julie and the ICT take measures and perform activities that encircle Billy and his unique needs.

[redacted] Billy will then complete a change in condition HRA and receive updated PCSP regarding condition changes and new/additional services needs if warranted.

Transition Planning

Julie participates in NF care rounds, in which they discuss Billy's progression toward discharge planning. She schedules a transition planning meeting with Billy, the NF discharge coordinator, nurses and therapists, his mental health counselor (with Billy's consent) and Maria, a Minds Matter Community Care Coordinator (CCC) (see Minds Matter information, below). [redacted]

[redacted]

With Billy now just a few weeks from discharge, Julie moves ahead with the LTSS application by completing the home and community-based services (HCBS) BI waiver tool. When she follows up with that application, she learns that Billy's case has been referred to Maria, [redacted]

Julie now begins the warm transition of Billy's CC to David, the UCare LTSS CC, as his primary UCare CC following discharge from the NF. Julie invites David to the NF for a shared meeting with Billy to complete all required paperwork. David will assume primary responsibility for Billy's CC needs along with Maria at Minds Matter post-discharge. Julie also reaches out to Maria to coordinate care before discharge occurs. Julie and Maria meet and arrange to complete all required paperwork with Billy while he is still in the NF. Julie also initiates referrals to the Kansas Institutional Transition process and the Kansas Money Follows the Person (MFP) programs. Billy is encouraged about these plans and eager to get home.

Julie and Maria work with the NF discharge planner and rehabilitation staff to complete a home safety check to ensure Billy's living environment meets his needs.

Transition Management

Julie collaborates with the NF and obtains a copy of Billy's discharge plan. She integrates the information from the discharge plan into Billy's PCSP, updating it with the new LTSS CCC (Maria) and the UCare LTSS CC (David). Julie works with Maria and David to coordinate a seamless transition of the care coordination duties (see table 30.2, below). Julie conducts a follow-up meeting with Billy within 48 hours of his discharge. Following discharge, Maria serves as new single point of contact for Billy's transition care, including hospitals or any other facilities. Maria also assumes the lead role in updating Billy's PCSP, in tandem with David.

[redacted]

Shared CC/CCC Roles and Duties (David and Maria)

[redacted]

The overall goal of UCare coordination with the LTSS team is to provide Billy with seamless, comprehensive, efficient, and effective care coordination with minimal care disruptions. As Billy transitions to his home, Julie, David, and Maria work together to ensure that Billy's doctors and other care Providers, along with all appropriate internal UCare departments, receive timely notification and discharge information. Maria revises the PCSP as Billy transitions to ambulatory care at home.

Follow-up after Transition

Weeks later, Billy is doing remarkably well in his home placement. David continues to coordinate with Maria to monitor Billy's success and wellness post-discharge from the NF. Billy is encouraged by his own improvement and proud of his active role in attending his care visits and following recommendations. Maria and David continue to update Billy's PCSP as his clinical situation changes.

[redacted]

[redacted]

One year after his discharge, Billy continues to trend toward improvement. He has met most of his physical, occupational, and speech therapy goals. He has begun work as a coordination assistant at the Wichita Transit Department. As it has been 12 months since his last HRA, Billy repeats the HRA and PCSP process, adding new information, including and updating his SMART goals for maintaining his well-earned health and wellness improvements.

Summary

All UCare staff strive to provide every Member with excellent, community-based, coordinated care to achieve the kind of outcomes experienced in Billy's example. Through our many years of providing innovative community-based services we know that the best care is provided through thoughtful attention to engagement and relationships, along with partnership and coordination with care Providers, all delivered to Members in a person-centered, respectful, and humble manner. We are always gratified when Members like Billy experience great outcomes, confident they are at least in part a result of their membership with UCare.

31. Mary is a twenty-eight (28)-year-old, white, female who is incarcerated at a correctional facility serving a two (2) year sentence for a felony conviction. Her estimated release date is in two (2) weeks. Prior to her incarceration, Mary was enrolled in KanCare; however, her KanCare enrollment was suspended upon incarceration. Mary will be a Member of the bidder's plan upon release.

    Mary has a history of schizoaffective disorder and substance use (marijuana and alcohol). She has been receiving medication for her mental health condition (Abilify and Depakote) throughout her incarceration but has not received treatment for substance use. Mary does not believe she has had or has a problem with substance abuse, though her prior usage led to her inability to maintain employment and housing.

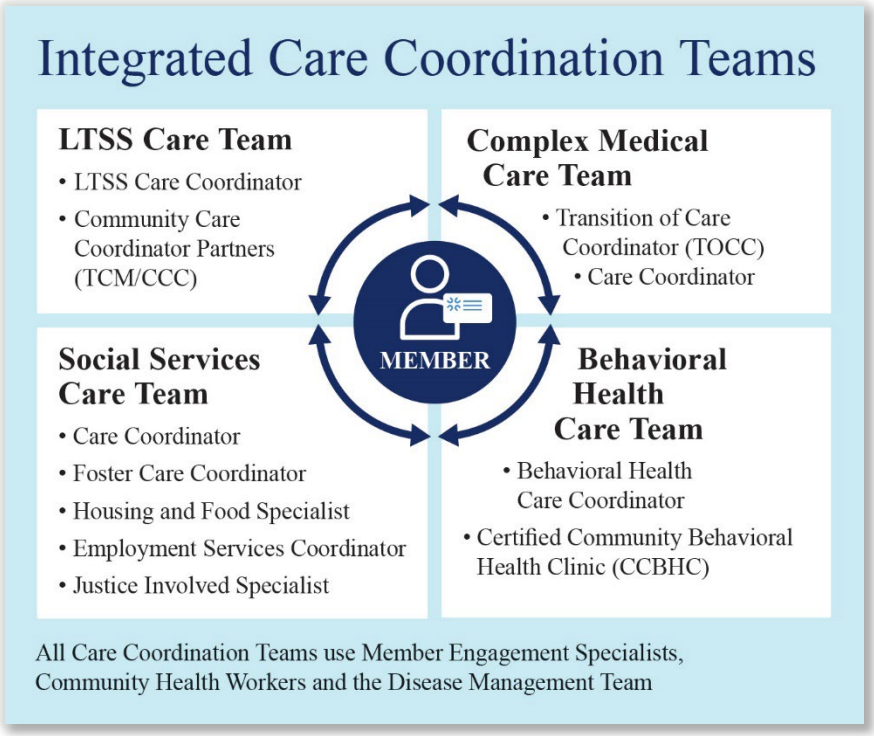
    Mary has "burned bridges" with her family and friends and will not have a place to live upon her release. She is, however, optimistic about her future and is willing to do "whatever it takes" to get back on track.

    Describe the bidder's approach to planning for and addressing Mary's needs to support her

UCare approaches serving Members who have complex needs and barriers to quality health outcomes with dignity and empowering them to achieve their goals and best outcomes. We support Members like Mary by leveraging our flexible Integrated Care Coordination model and working with a person-centered approach.

Preparing to Support Mary

UCare uses health screening data for early identification of new Members' needs. Due to the outcome of the health screen and in anticipation of Mary's release from prison, Mary is assigned a Behavioral Health (BH) care coordinator, Dara, who will work in coordination with UCare's justice-involved specialist, who works with adults and youth to support transitions from incarceration to independent, community living.



Dara begins planning to complete the HRA for Mary, which will help engage Mary and earn her trust. In compliance with RFP Section requirement 7.4.7, Dara holds a bachelor's degree in social work and has more than two years of experience working across service systems, including human services and justice systems. Dara is trained in empathic inquiry, motivational interviewing, person-centered service planning (PCSP), and

trauma-informed care. Dara also has been trained to write SMART (specific, measurable, achievable, relevant, and time-bound) goals for Members and has worked for many years with individuals who have co-occurring behavioral health needs.

Dara connects with the Kansas Department of Corrections (DOC) and gets their information about Mary, including health information, assessments, and any potential support that might be available to ensure a successful community reentry plan. Dara understands that Kansas is working on innovative approaches to community reentry through their Transitions from Prison to Community (TPC) Initiative. [redacted] This will determine Mary's level of supervision and offer some guidance on service options.

[redacted] The information from the LSI-R and the HRA will be incorporated into the care plan in GuidingCare. Dara will develop a PCSP with Mary that will be coordinated and approved by the assigned DOC reentry staff and built with Mary's input as options are developed for her successful transition to the community.

Engaging Mary and Building a Relationship

One key component of UCare's Integrated Care Coordination model is ensuring Members are empowered to lead their PCSP, or at a minimum, to ensure the Member's stated goals are being addressed as the priority. Dara will engage Mary and build a PCSP based on Mary's ideas and defined best outcomes into SMART goals. Dara will consistently include the reentry team member assigned to help Mary transition to the community from the DOC.

Dara makes an appointment for a phone call to meet Mary and establish a relationship. Dara is focused on moving at Mary's pace while assessing her needs and starting to build a plan for her transition to the community. Before beginning the HRA, she uses open-ended questions to encourage dialogue and sharing. She affirms Mary for being interested in change. Dara gets a sense that Mary wants to focus on housing and her mental health. Dara reflects back to Mary what she hears to confirm her understanding. She describes person-centered planning and that she will support Mary as they build her PCSP.

[redacted] Dara emphasizes that their work together is a partnership and Mary's voice is critical to their process. While Mary is interested and even a bit enthusiastic, Dara does not want to overwhelm her, so she schedules a follow-up visit to complete the HRA.

Building a Support Team around Mary

Dara also engages UCare's Interdisciplinary Care Team (ICT) to support Mary's successful transition. UCare's goal is to ensure seamless communication, collaboration, and coordination among the teams that will be needed to successfully support Mary in the community. Dara explains to Mary that UCare has a team of specialists experienced in housing and justice-involved services, and they will partner with Mary and Dara to explore the Oxford House Model (where recovering individuals can live together in a democratically run alcohol- and drug-free living environment, which supports the recovery of every resident). Given Mary's history of

substance use and lack of housing, [redacted]

With Mary's approval, Dara also reaches out to family contacts to determine if there are truly no housing options available. After a conversation with them, she learns they are not willing to engage until they see actual change from Mary.

Developing Mary's Person-Centered Service Plan

Dara learns that Mary will have a probation officer assigned to her when she leaves prison. [redacted]

The probation officer agrees, so Dara builds into Mary's PCSP establishing a relationship with a nearby CCBHC for Mary. The probation officer informs Dara of the consequences if Mary uses marijuana or alcohol. They are both worried about Mary's use because Mary does not associate the negative consequences she has experienced with her substance use. In addition, Mary needs housing and transportation to get to treatment, drug testing, and other supports. They agree to communicate weekly after Mary reenters the community until her support system is well established.

UCare's Integrated Care Coordination model was created to serve Members like Mary who have multiple care needs. [redacted] Dara then schedules a follow-up meeting with Mary. The support she is proposing to Mary includes integrated support through a Certified Community Behavioral Health Center (CCBHC). When this relationship is established,

Mary will be able to receive her BH support from one agency and develop a care plan with the CCBHC's single point of contact. When this occurs, Dara will continue to support coordination of dental and other health-related and social needs. Dara connects with a CCBHC and arranges for a care conference that will bring Mary's BH, medication, peer support, and housing needs together in a coordinated approach for her transition. Mary's medications will be reviewed and managed by the integrated PCP and psychiatrist at the CCBHC.

After learning more about it, Mary likes the idea of the Oxford House and UCare's Housing Specialist, Maria, assists Dara in developing a list of gender-specific programs and helps with completing an application for Mary. Dara continues to consult with the UCare experts on housing and justice-involved services to be certain she is not missing key pieces of support for Mary. Dara also stays in contact with the DOC reentry team. They also like the idea of the Oxford House option to support Mary's transition to the community.

Dara also searches for supported employment options, hoping an IPS program may be available. The Kansas Department of Aging and Disability Services identified this as the preferred evidence-based model of employment for individuals with serious mental health needs and has invested in building out the model. Agencies like Four County Mental Health Center provide this service, and Dara will research the best combination of housing and work supports as she builds the plan with Mary.

Table 31.1 summarizes the primary needs and priorities, interventions and services, and Providers which would be found within Mary's PCPS, per RFP Section 7.4.4:

	[redacted]	
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Supporting Mary's Physical and Behavioral Health Needs

[redacted] Dara shares she has found Mary an Oxford House Re-entry Program unit in a community close to Mary's preference. The unit is also close to the CCBHC Dara has previously discussed with Mary, and throughout the discussion Mary agrees that the unit is her best option.

[redacted] Dara then schedules a meeting with Mary at an FQHC to ensure coordinated physical health and dental needs can be addressed as needed going forward. Dara also assists with scheduling transportation for Mary. UCare's GuidingCare tool will be integral for Dara, the CCBHC single point of contact, and other members of Mary's ICT to remain in contact on Mary's health status and needs going forward.

Addressing Mary's Health-Related Social Needs

Dara uses the UCare-supported Unite Us tool to identify potential resources with support from other members of the ICT. With this tool and collaboration with UCare's food specialist, Dara finds a list of food support Providers and transportation options that can help create a comprehensive community support plan for Mary.

[redacted] Kansas has a federal grant that supports their Enhancing Supported Employment in Kansas (ESEK) utilizing the evidence based IPS model. Dara shares information with Mary about the Kansas Supports and Training for Employing People Successfully (STEPS) program, which helps people with disabilities and/or behavioral

health conditions seek a path to employment without jeopardizing their health care coverage, as well as the availability of GED supports and services through her value-added benefits (VABs).

Communication, Ongoing Support, and Connections

Dara continues to contact and check in with Mary regularly. Mary really wants to reconnect with her family, and Dara reinforces all the support Mary can leverage to show the family she is engaged in change.

Mary meets her peer recovery specialist virtually for the first time and they are a great fit. Their shared experiences and the peer's knowledge and insights into her own journey help Mary focus and feel supported. The BH care is established at a CCBHC and Dara has scheduled an in-person meeting with the assigned single point of contact at the CCBHC for a warm handoff. Part of this meeting includes securing agreements to share information across service systems to support Mary with an integrated approach. With Mary's approval, her peer agrees to attend with Mary to help her through the intake meeting and adjust to her new support system. Additionally, the local FQHC agrees to an employment assessment to help Dara and Mary understand her skills, interests, and needs related to gaining meaningful employment and potentially prepare her to participate in an IPS program.

Quality Assurance — Documentation, Coordination, and Reporting

Our GuidingCare tool remains the foundation of documentation and care coordination across the many services Mary will receive. Dara will share summary reports from the system with the CCBHC and coordinate with the CCBHC single point of contact for Mary's care on an ongoing basis. Dara documents and monitors the steps required for Mary's care plan to be followed by service Providers and ensures that it remains appropriate for Mary's needs and preferences. Dara also sets reminders within the clinical documentation systems that will trigger monitoring steps in the case management record to remind her to evaluate Mary's progress toward her goals. Monitoring may also include reaching out to service Providers and Mary to check progress toward goals. Dara will coordinate with the CCBHC single point of contact to ensure that necessary health screens, HRAs and needs assessments are completed in accordance with requirements outlined in RFP Section 7.4.6 and Appendix L, and that Mary's care plan continues to reflect her progress toward her care plan goals or barriers to achieving them, and review any changes in her condition. Dara will support the CCBHC single point of contact with coordinating Mary's other physical and SDOH needs including transportation, employment services, housing supports, and more as required in RFP Section 7.4.6.

32. Pedro is a seventeen (17)-year-old, Latino, male KanCare Member living in foster care. Pedro was diagnosed with asthma at four (4) years old and uses an inhaler to manage his symptoms, with varying success.

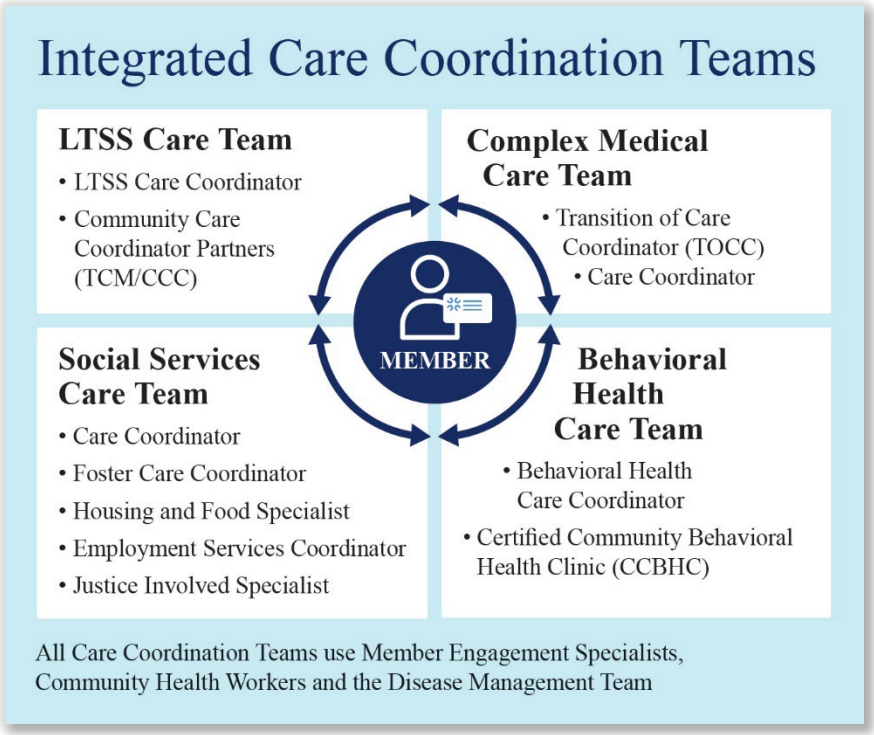
    At his last health care visit, Pedro and his foster mother shared with Pedro's Primary Care Provider (PCP) that Pedro is having more difficulty breathing and more frequent asthma attacks. When the PCP inquired about the precipitating circumstances, the PCP learned that the breathing problems and asthma attacks have been occurring when Pedro is at home — not at school or other locations, leading his PCP to think that there may be an environmental trigger in the home.

    Pedro has had four (4) ED visits in the last twelve (12) months due to his asthma. Pedro's case file also states he experienced significant physical and emotional abuse during his early childhood, resulting in his placement in foster care. Pedro was once active in school and extracurricular activities but recently has become more withdrawn, leading his foster parents to suspect marijuana or other substance use, which they have expressed to his PCP.

    Pedro's PCP has contacted the bidder's Care Coordination team to request assistance with assessing and addressing the potential environmental trigger exacerbating Pedro's asthma, and to make the care coordinator aware of Pedro's possible behavioral needs.

    Describe how the bidder will respond to the PCP's request and how the bidder will support and coordinate Pedro's health needs.

UCare is a leader with extensive experience in improving the health and well-being of Members like Pedro. UCare's Integrated Care Coordination model and collaborative Interdisciplinary Care Team (ICT) support a rapid and comprehensive response to the primary care Provider's (PCP) request to assess and address the potential environmental trigger exacerbating Pedro's asthma, childhood trauma from previous physical and emotional abuse, and behavioral health (BH) needs. Further, our sophisticated use of technology supports the sharing of data to enhance coordination across Providers, which helps us proactively close gaps in care and support Members like Pedro in managing their health conditions to achieve well-being. As a community-based nonprofit, UCare has deep connections with Providers and long-standing experience



collaborating with state agencies.

To serve Members like Pedro, and avoid Member abrasion, UCare will cooperate and coordinate with the Kansas Department of Aging and Disability Services (KDADS) and foster care case management Providers (CMPs) as specified in RFP Section 7.1.7.I. For example, our UCare Pharmacy Services Team has demonstrated successful collaboration with long-term care pharmacies and community pharmacies to reduce the use of antipsychotic and psychotropic medications across Members, a priority outlined in RFP Section 7.4.1.B.6. We accomplished this by establishing partnerships with Providers to exchange data and discuss continuous improvement in prescribing trends in regular meetings.

Building upon our long history of creating a culture of health and wellness for Members like Pedro, our Integrated Care Coordination model is designed with unique care teams comprised of experts in specific Member types working together to support Members. Our support for Pedro begins with outreach from our member engagement specialists and completing the Health Screen and Health Risk Assessment (HRA), which includes questions related to BH, risk stratification, and assignment to Care Coordination, as outlined in RFP Section 7.4.1.C.

We place deep value on cultural competency. Pedro has access to our fully trained and culturally competent care coordinators and Community Health Workers (CHWs) to ensure services and supports are culturally sensitive to his Latino background. To address Pedro's needs, he is assigned a culturally congruent foster care coordinator, Sam, to work with him, his foster family, and other members of his ICT, including his local foster care agency, St. Francis Ministries, to ensure timely assessment, identification, and support for his care needs. Sam meets the qualification requirements of RFP Section 7.4.7 and has a bachelor's degree in social work and experience working with foster youth. Sam also serves as UCare's single point of contact for CMPs as specified by RFP Section 7.4.10.F. Pedro's profile, current health status, and potential barriers impacting his positive health outcomes are detailed in Table 32.1.

Identification of and Addressing Pedro's Care Needs

Our approach to care coordination is grounded in deep awareness of our Members' evolving, diverse needs that will be best met through a *person-centered, goal-oriented, culturally relevant care model.* Our model is focused on meeting Pedro's needs while putting him at the center of his ICT, which is actively listening to what he is specifically communicating about his feelings and needs.

[redacted] Assignment to the Social Services Care Team ensures Pedro — a foster care youth with physical, behavioral, and social needs — receives the care and coordination to educate and empower him to voice his feelings and needs regarding the ways he wants to improve his health and well-being. This is critical for Pedro to engage as he begins the transition to adulthood.

UCare's dedicated care teams work in close collaboration and intersection with each other to provide a comprehensive and personalized care experience for Pedro. Our care teams work together seamlessly to create a tailored Person-Centered Service Plans (PCSP) for Pedro that considers the specific needs he has shared with Sam. This fluid approach enables Pedro to receive timely, appropriate, and effective care.

Following contact from the PCP, [redacted] Sam will continue to connect with Pedro and others by phone at least twice a month, and more frequently if additional changes are discovered, as required by RFP Section 7.4.7.F. Finally, Sam double-check's that Pedro's Member identification card has been shared with both his foster family and St. Francis Ministries, as outlined in RFP Section 7.10.9.

Sam serves as the primary point of contact for Pedro, his foster parents, his ICT, and St. Francis Ministries, and explains the Care Coordination approach, focusing on Pedro's needs, preferences, and goals. Sam encourages Pedro to express his preferences, concerns, and expectations in support of open and transparent communication and to ensure the highest standard of care while honoring Pedro's individual needs and preferences.

Sam works in coordination across the model to ensure EPSDT are provided, as required by RFP Section 7.17.2 [redacted].
As a member of the ICT, Pedro's PCP is kept up to date on his service, disease management, and crisis plan to address the triggers resulting in the increase in asthma attacks.

Engaging and Collaborating with Pedro's Support System

Sam is trained in trauma-informed practices and experienced in using these with foster care youth. He collaborates with Pedro's ICT, including Pedro's CMP, St. Francis Ministries, other local service Providers, and his foster family to meet his needs. Sam ensures that members of Pedro's ICT understand their roles, responsibilities, and authority in decision making on his behalf. Through Sam's continued conversations with Pedro, they have discussed access to the services and supports that meet the needs Pedro has voiced. Sam also discusses the type of skill-building opportunities Pedro may be interested in to support his learning, development, and transition into adulthood. In addition to the support Pedro receives from UCare, his foster parents play an essential role in helping him navigate resources and services to help him achieve health and well-being.

Sam lives in Pedro's community and maintains contact via phone and in person as required to ensure his needs are met. Pedro has access to an array of evidence-based practices (EBPs) designed specifically to address the unique needs of foster care youth. Aligned with the Family First Prevention and Services Act, EBPs are intended to help stabilize and prevent placement disruption. UCare uses the Unite Us state-of-the-art resource directory and referral communication tool to find and connect with local resources, assist with shared accountability and collaboration with community partners, and identify customized resource referrals best suited to meet Pedro's needs.

Sam works with Pedro's foster family to ensure they have access to the services and supports they need as caregivers. He also connects Pedro's foster family with the Children's Alliance of Kansas for training and support, using the Model Approach to Partnerships in Parenting

(MAPP), to help them gain skills they'll need to help support Pedro's healing from his past trauma.

Developing Pedro's Person-Centered Service Plan

Our Integrated Care Coordination approach and collaboration among the ICT members helps ensure Pedro's PCSP outlines the coordination of care, services, setting of care and Providers, details the frequency of contacts and services, and includes timelines set to achieve his goals. In addition, the PCSP includes goals developed by Sam in partnership with Pedro to help him as he transitions into adulthood, as these are critical to the transitional period for foster care youth.

Working with Pedro to develop his PCSP is also essential to supporting him in learning to direct his own care. [redacted] UCare's intentional integration of community support with medical, behavioral, and pharmacy services helps Pedro avoid preventable hospitalization, use of emergency departments (ED), and disruption in foster care placement.

The HRA completed with Pedro and the ICT identified several areas of concern. Following a discussion with Pedro, his PCP, and foster family the following concerns were identified and Sam worked to develop a PCSP to identify resources that can address and prioritize Pedro's goals.

Table 32.1 summarizes the primary needs and priorities, interventions and services, and Providers which would be found within Pedro's PCSP, per RFP section 7.4.4.

[redacted]

Through UCare's high-touch engagement strategy, including monthly communications and frequent face-to-face meetings, Sam is well-informed of Pedro's status and quickly adapts the PCSP to address any new or changing needs voiced by Pedro or his foster family. The crisis plan provides detailed instructions and contact information for care team members to ensure access to immediate medical care and crisis intervention for Pedro, as necessary.

Coordinated Care and Intervention

Sam's main goal is to coordinate services that allow Pedro to live a fulfilling and self-sufficient life in the community of his choice. His approach to care coordination is hands-on and active. Sam is a part of Pedro's community and works to foster a trusting relationship with the ICT. Sam conducts regular assessments and check-ins, routinely gathers and monitors information, and adjusts strategies and interventions to address Pedro's needs through weekly telephone contact and in person visits every other month.

UCare's comprehensive case management platform, GuidingCare, supports coordination, collaboration, and effectiveness of care for Pedro. To assure Pedro's needs are addressed and coordinated across his support team, members of the ICT interface with one another through a coordinated system of communication and collaboration including:

- **Communication and Coordination**: Sam ensures communication and coordination between respective teams to ensure information sharing and service coordination.
- **Referrals and Consultations:** Sam assures that the needs voiced by Pedro are met and initiates specialized care, service referrals, or consultations for services that may fall under the expertise of another area, sharing relevant medical or psychosocial information to assure continuity of care.
- **Multidisciplinary Meetings:** As necessary, to discuss his care and provide an opportunity for collaboration and expertise across the ICT to assure the best possible care for Pedro.
- **Transitional Support:** As Pedro continues to voice his needs, if they are changing, or if he requires services outside of the ICT, Sam helps facilitate and support any required transition. Sam's goal is to ensure seamless communication, collaboration, and coordination to provide Pedro and his foster family with the most appropriate and effective care based on what Pedro needs.

Addressing Pedro's Health Needs

Following the development of Pedro's PSCP, Sam works to connect him to the services that can address his needs. To address Pedro's recent ED usage, Sam uses a person-centered approach to medical management to monitor and link Pedro to appropriate services. The goal for Pedro is reducing unnecessary ED visits while ensuring he receives appropriate services, including follow-up services.

Pedro's Physical Health Needs

To address Pedro's asthma needs, Sam shares information about UCare's Disease Management (DM) program with Pedro and his foster parents. Our DM programs are designed to meet Members like Pedro where they are in their health care journey. These programs and interventions include interactive voice response, text message education with follow-up support; availability of an asthma educator for telephonic support to assist in asthma education and goal setting, self-management, learning about the importance of an asthma action plan, reminder communications, potential environmental triggers, and educational resource newsletters. After a discussion with Pedro, Sam makes a referral to UCare's DM Team, who follow up with Pedro to further discuss asthma programs and enroll him into a program. Sam is later notified of program enrollment and learns that Pedro has updated his asthma and environmental plans, and conducts further follow-up as needed throughout Pedro's participation in the program.

Pedro's Behavioral Health Needs

To ensure timely access to BH services that address Pedro's BH and SUD needs, Sam coordinates and collaborates with the UCare BH Team on Pedro's behalf and also initiates a referral to the CCBHC for services. When Pedro initiates CCBHC services, he will work with a single point of contact and develop a care plan. Sam will ensure appropriate HRA updates, needs assessments, and a care plan are completed. Throughout this process, Sam learns that Pedro has shared that he has been using drugs. Sam, Pedro, and the CCBHC single point of contact have a conversation about next steps, Sam initiates service referrals and assists Pedro in arranging appropriate follow-up care.

Through Sam's coordination and support, Pedro has access to UCare's BH Provider network and BH care coordination services. Sam ensures Pedro understands all the services available to him, such as assistance with referrals and scheduling, education about additional BH services that may be beneficial to Pedro, and identification and access to community resources that align with his service plan goals, such as the 988 Crisis Line. Sam will continue to coordinate with the single point of contact assigned to Pedro at the CCBHC to ensure the CCBHC-developed care plan and the services for Pedro are appropriate and seamless.

Resource Coordination

Sam plays a vital role in supporting Pedro's needs across his physical and behavioral health and social determinants of health (SDOH), ensuring his needs are effectively met. Sam assists with

identifying community resources to provide personalized support based on Pedro's needs and risk stratification level. With Pedro, and support from his foster family and delegated foster care agency, Sam works to connect him to necessary resources and supports, such as:

- Coordinating necessary medical appointments and ensuring timely access to health care services.
- Behavioral health support and SUD education through a CCBHC.
- Collaboration with health care professionals, including the ICT, to ensure comprehensive and coordinated care.
- Providing information on community support groups, counseling services, or specialized programs to address Pedro's behavioral health and past trauma, such as MAPP and Comprehensive Home-Based Services.
- Facilitating communication between Pedro and the ICT to address any concerns or questions.
- Sam will continue monitoring Pedro's progress, evaluating outcomes, and making adjustments to his POS as needed.

Additionally, Sam utilizes Unite Us, a platform that supports closed-loop social service resources and navigation, accountability, and collaboration between community partners to ensure Pedro receives timely referrals to necessary community-based resources.

Educating and Empowering Pedro

Pedro is approaching critical years of transition into adulthood. UCare's Member-centric, integrated, and coordinated approach to his medical, environmental, and behavioral health needs will help him understand and prepare for the transition.

We understand the importance for Pedro, as a foster youth, of education and empowerment through the coming years. Former foster care youth are at a higher risk of housing instability and of homelessness upon aging out of foster care. To support Pedro, Sam helps him understand the importance of maintaining his health and well-being, how to access community and other supports than can be helpful for him and offers resources for skill building in areas (such as financial and money management) that will be important for Pedro's success in adulthood. Additionally, Sam works to connect Pedro to the local resources and programs for transition age foster care youth and connects with the Kansas Department for Children and Families (DCF) Independent Living Program to begin the enrollment process.

Ongoing Monitoring and Follow-Up

Sam helps ensure Pedro has access to the services necessary to support his health and well-being. Our goal is stabilizing Pedro's health and preventing adverse outcomes; UCare's integrated and cross-functional teams help ensure Pedro receives the optimal services, at the right time and right level.

Sam continues to document and routinely monitor Pedro's progress and ensure that his needs and goals are addressed and supported.

[redacted]

Sam will coordinate with Pedro's CMP and single point of contact at the CCBHC to complete a HRA at least annually and adjust Pedro's care plan upon identifying any changes in circumstance or status. In the event a transition of care is necessary, Sam completes a reassessment and assists with the transition and Pedro's access to necessary supports and services. To ensure we know that Pedro and his support team are satisfied (or become aware of any concerns), Sam administers targeted satisfaction surveys to understand Pedro's experience, identify barriers and identify opportunities for improvement.

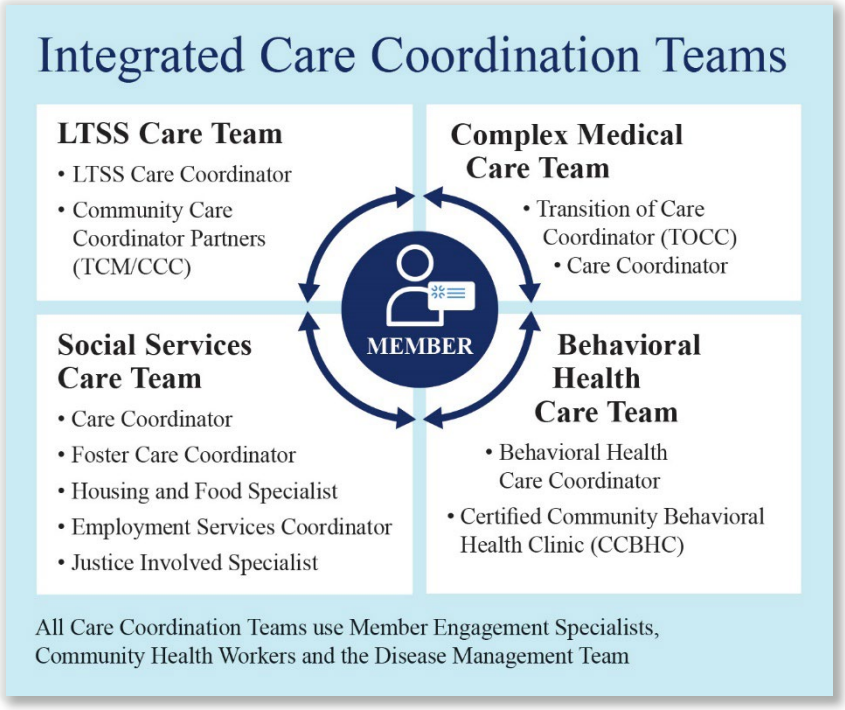
33. Henry is a twelve (12)-year-old, white, male KanCare Member who has complex medical needs, including significant IDDs with co-occurring severe Behavioral Health issues. In recent months, Henry has become increasingly aggressive towards other people and the family pet, with behavioral episodes that are both more frequent and more severe. These episodes have resulted in repeated crisis interventions, visits to the hospital ED, inpatient psychiatric stays, and calls to law enforcement. Henry's most recent episode of aggression resulted in his current stay in a psychiatric hospital.

    Henry's mother, Shauna, is a single parent to Henry and his two (2) younger siblings, a brother who is eight (8) and a sister who is five (5). Shauna has been very involved in and supportive of Henry's treatment. While Henry has not harmed his siblings to date, his increasing aggression has left her afraid both for her own safety and the safety of her other children.

    As part of the planning for Henry's discharge from inpatient psychiatric care, Shauna requested residential treatment for Henry to stabilize his Behavioral Health condition and work on managing his aggressive behaviors before Henry is returned to her home. The team involved in Henry's discharge planning is encountering difficulties in identifying an appropriate and available placement option to meet Henry's IDD and behavioral health needs. The inpatient facility is pressing for the Member's discharge and has suggested intensifying outpatient services until a suitable placement is available. Shauna has stated that while she wishes things were different, she is unable to allow Henry to return home in his current condition — that the threats to the safety of the family have grown to an unacceptable level, and that if forced, she will request that he be placed in state custody.

    Describe the bidder's approach for addressing the Member's discharge needs, including how the bidder will support care planning and transitions to meet Shauna's goal of having Henry return home to his family.

UCare has developed a robust Integrated Care Coordination model that supports children with complex needs, like Henry, and their families. Caregiver support is foundational to this model. UCare uses Health Screens, Health Risk Assessments (HRA), data analytics, and admission reports and referrals to identify children with complex needs who may require early intervention services.



To start to support Henry, UCare will assess and address his needs along with

those of his family through a Health Screen, HRA, and care planning tools. These tools help us learn about the needs and goals of Members and support the care plan development with the Member and their family.

Supporting Members with Intellectual and Developmental Disabilities

One of the first tools UCare uses with Henry and other Members [redacted]

UCare will partner with network Providers to offer the same trainings to local clinicians and direct support professionals. This will ensure that from screening to providing services, each Member who experiences I/DD will receive integrated, whole-person care, allowing them to live as independently as possible while receiving person-centered supports, regardless of their geographic location.

Responding to and Addressing Henry's Needs

Safety plays a critical role in supporting Henry, his mother, and his siblings. When meeting Henry and his mother, Shauna, his Care Coordinator will immediately work at building trusting relationships with Henry, Shauna, and their family. Our Care Coordination program is person-centered, goal-oriented, and culturally relevant, with logical steps to ensure our Members receive needed services in a supportive, thoughtful, efficient, and timely manner. We also emphasize addressing Social Determinants of Health (SDOH) and ensure Members are integrated into their communities so they may receive care in the least restrictive and most supportive environment possible.

UCare identifies Henry for care coordination through his recent emergency department (ED) visits, and repeated use of behavioral health (BH) crisis services. Henry is assigned a UCare BH Care Coordinator, Ned, who has a master's degree in social work and extensive experience supporting children with BH needs. Ned also meets requirements specified in RFP Section 7.4.7.

Ned meets with Henry in the inpatient psychiatric facility to discuss his goals after discharge. Ned then coordinates across [redacted] they discuss Henry's needs and Ned begins an HRA with Henry and Shauna.

[redacted] Shauna shares that she feels nervous and scared about the level of aggressive behaviors she has seen from Henry and is concerned about the safety of his two younger siblings and herself. Although Shauna expresses that she would prefer for Henry to remain in residential treatment, she also understands the limited options and long waiting lists for other care settings. Ned discusses additional options that would allow Henry to return home and receive holistic care to address his ongoing BH needs. Shauna remains hesitant but is open to learning more.

Henry's Journey

Developing Wraparound Supports for Henry

With Shauna's consent, [redacted]

Ned also suggests connecting Shauna with Families Together, Inc., which provides access to parent-to-parent support for parents raising a child with a disability. Ned lets Shauna know that if

she is interested, she may be paired with a parent peer who has a similar experience through Families Together, Inc., or through the Southeast Kansas Mental Health Center Family Caregiver Program. Shauna seems interested in this and would like to connect. Ned also tells Shauna about her local NAMI (National Alliance on Mental Illness) Kansas chapter to learn about family support groups and to talk with other parents who have been through these demanding situations and big decisions. Ned helps Shauna get connected to the caregiver support and also supports her in making some decisions about services that will be needed upon Henry's discharge to support his reintegration into the home. Shauna is hopeful that with these supports things can work out.

Applying for Home and Community Based Waivers

Ned assists with the SED and I/DD Waiver applications, which are completed within two business days of the HRA. He follows up with Southeast Kansas Mental Health Center to ensure receipt of the SED Waiver application and confirms Ned has a functional assessment screening date, which he shares with Shauna and Henry. Ned also stays in contact with the Community Developmental Disability Organization of Southeast Kansas (CDDO SEK) to ensure Henry is scheduled for and able to complete the functional assessment.

Together they complete the State-prescribed tool designated for the SED Waiver to assess which waiver services will be needed. Shauna is particularly interested in getting a wraparound facilitator involved to build integrated support services for Henry and the family, if and when Henry's waiver application is approved.

Henry's Person-Centered Service Plan and Family Supports

[redacted]

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Implementing Henry's Person-Centered Service Plan and Family Supports

Ned consults across UCare's Integrated Care Coordination model and Henry's ICT as he coordinates services and resources to support Henry and his family for a successful transition home. [redacted]

[redacted]

Interdisciplinary Care Team Collaboration and Ongoing Support

Care Coordinators document the monitoring steps required in the PCSP to verify that the support plan is being followed and that it remains appropriate for Henry's needs. [redacted]

As Henry is discharged and moves home, Ned maintains ongoing contact with Shauna, and coordinates with the CMHC, to ensure Henry's needs are included in the PCSP and are being addressed. Ned meets with the family face-to-face and telephonically to support meeting goals, removing barriers to achieving them, and to reevaluate when any changes in condition occur. Ned treats the PCSP as a living document that he updates as Henry's needs change or as his plan evolves and ensures that it meets the requirements outlined in RFP Section 7.4.4.2.

Ned is later alerted when Henry is approved for the SED Waiver, and a TCM is assigned to Henry. An updated PCSP will be developed within 14 days, and applicable Needs Assessments completed, in accordance with RFP Section 7.4.2. Ned will stay in touch with the TCM through case notes and phone calls, and the TCM will set up the identified services with Shauna and Henry's consent and based on Henry's ongoing needs.

Anticipated UCare Resource Development

[redacted]

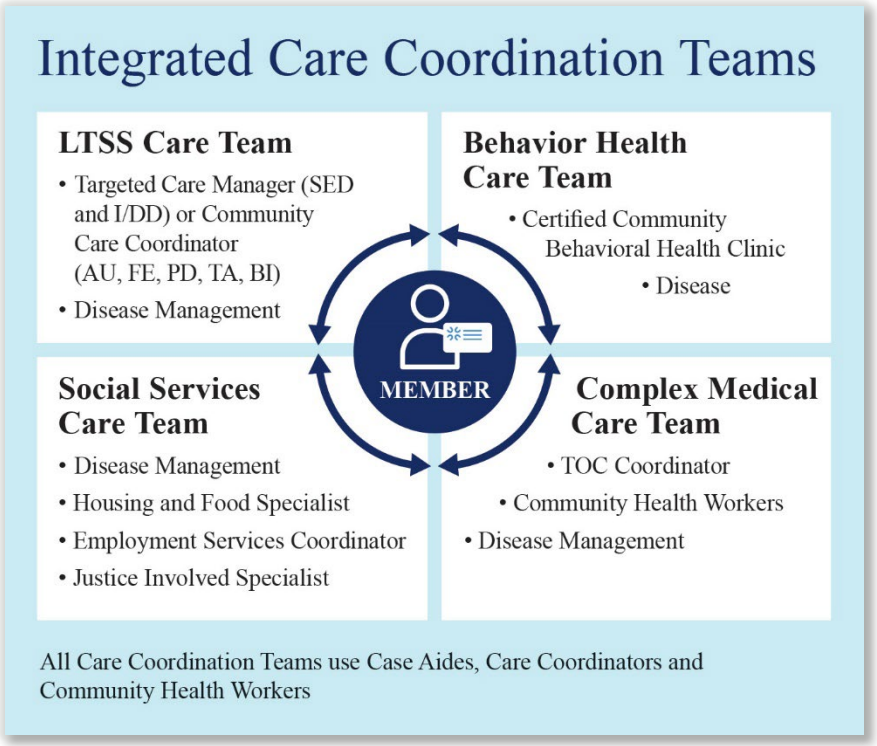
[redacted]

34. Alice is a three (3)-year-old, white, female KanCare Member who lives in Holcomb and was referred by her pediatrician to a developmental pediatrician for further assessment. Alice is an only child. She started using words at 16 months of age, but her use of language has regressed. She communicates primarily using hand and body gestures.

    In order to provide an opportunity for social engagement, Alice's parents enrolled Alice in day care. Alice attends day care three (3) days out of the week for four (4) hours per day. Contrary to Alice's parents' intentions, daycare staff report Alice isolates from and is unable to effectively communicate with other children and staff. Staff also report Alice engaged in head banging and hand flapping when they tried to engage her in activities.

    Alice was assessed by the developmental pediatrician as being at risk for autism. The developmental pediatrician recommends Applied Behavior Analysis (ABA) therapy for Alice, specifically, early intensive behavioral intervention. The developmental pediatrician's office has contacted the bidder's Provider services line to assist with locating a Provider because the coordinator was unable to find an ABA therapist within a reasonable distance from the Member and her family.

    Describe the process the bidder will follow to respond to the Provider's call and assist the Member and her family to ensure adequate and timely access to ABA therapy services.



UCare recognizes that early diagnosis of and interventions for autism spectrum disorders (ASD) are more likely to have major long-term positive impacts on symptoms and later skill development. Early interventions not only give children the best start possible, but also offer them the best chance of developing to their full potential. UCare promotes and supports autism early intervention services, in alignment with our mission to improve the health of our Members through innovative services and partnerships across communities. Our goal is to provide these children and their families/caregivers with the resources and supports to access early intervention services and remain in the community. We leverage our strong Provider partnerships and care coordination processes to connect children to these services and ensure early access to care.

Our early detection and engagement approach to autism services ensures children are connected with the services they need quickly, through early identification of the child's needs from well-

child visits and assessments. UCare acts as a resource and liaison as the child moves through the continuum of autism early intervention services, with many touchpoints along the way to ensure the child's needs continue to be met. We take a distinct approach to engaging children and youth in their autism care and support their needs through case management, transportation, and social supports. Our team is committed to meeting the needs of children like Alice, as part of our mission to elevate Member health and experience.

Our Approach to Assisting Alice and Her Family

When we receive the call from the office of Alice's developmental pediatrician, Dr. Findley, through UCare's Provider Assistance Center, the Provider representative learns of Alice's risk for autism and the doctor's desire to find an Applied Behavior Analysis (ABA) Provider to address her needs. Given the lack of ABA Providers, specifically near Holcomb, the navigator supports Dr. Findley's coordinator by gathering options for telehealth ABA services, including Kansas Behavior Supports, to share with Alice's parents.

[redacted]

UCare's care coordinators include, but are not limited to RNs, master's-level social workers, or licensed marriage and family therapists with varying backgrounds, including working in public schools with children with ASD and related conditions, ABA programs, therapy for children and adolescents, and inpatient hospital settings for adolescents and children. UCare's Integrated Care Coordination model provides culturally aligned services from Care Coordinators who speak their language and understand their concerns.

Deirdre reaches out to Alice's family to schedule a time to meet with Alice and her family in person and complete an in-depth Health Risk Assessment (HRA) that meets the requirements of RFP Section 7.4.2. [redacted] During the visit, Deirdre sees that Alice is communicating primarily using hand and body gestures. Alice's parents express that they had enrolled her in daycare part of the week thinking this may be a good intervention to support her level of social engagement, but instead have received reports that Alice is isolated and unable to communicate with other children at the daycare. They express the most concern over recent reports from daycare staff that Alice has started to bang her head when they try to engage her in activities.

Deirdre discusses options available to support Alice, including ABA services, knowing that Dr. Findley has also discussed this with them. Alice's parents stated that upon referral from Dr. Findley, they reached out to Kansas Behavior Supports to get Alice on a waiting list to receive services. [redacted] They express further concern for Alice as she will be entering preschool in the next few years, and they hope for her to be socially connected with peers and engaged with her education and extracurricular activities.

[redacted] Alice's parents are relieved about the prospect of these services and agree for Deirdre to search for Providers that are local and available to support Alice while they wait for ABA services to become available to Alice.

[redacted]

Health Risk Assessment and Plan of Service

After Deirdre completes the HRA, Deirdre creates a Plan of Service (POS) that outlines immediate next steps to address Alice's needs and her parents' concerns [redacted]

[redacted]

Together, Deirdre and Alice's parents develop a POS that addresses Alice's needs will be drafted utilizing SMART (specific, measurable, attainable, relevant, and time-bound) goals. For each intervention, we will identify local or telehealth Providers and resources, as appropriate. For example, Deirdre follows up with Alice's parents to ensure they received the information from Dr. Findley regarding using Kansas Behavior Supports for ABA services. Table 34.1 summarizes the primary needs and priorities, interventions and services, and Providers, which would be found within Alice's POS.

[redacted]

[redacted]

Supports for Alice's Parents

Alice's health and progress depend on her parents' knowing what to do and having their own emotional needs met. The effects of ASD on a family must not be overlooked. Deirdre notes that Alice's parents show signs of being under a great deal of stress — concerned for their daughter, frustrated by the difficulties they've had in finding appropriate care, and worried about their ability to give her what she needs in the long term, as well as the continuing strain they anticipate in raising a child with ASD. Deirdre listens carefully to their concerns and assures them that their feelings are valid. She reinforces the fact that *they* need support, as well, and encourages them to seek adjustment counseling with a behavioral clinician. In addition, she refers them to Families Together, Inc., a statewide resource for information, training, and support from other parents of children with ASD. For further support, Deirdre refers Alice's parents to Help Me Grow Kansas, which provides education on child development and can help them connect to resources in their school district, as well free resources they can use at home.

Neuropsychological Evaluation Results

[redacted]

[redacted]

Deirdre connects with Alice's parents and, with Alice present, Deirdre updates Alice's HRA [redacted] Deirdre lets Alice's parents know that UCare will help connect them to services they feel would be helpful to Alice. Additionally, Deirdre discusses the Autism Waiver with Alice's parents as well as an application for the Autism Waiver. Deirdre organizes a meeting with Alice's ICT to discuss these services, and Alice's parents express that since they are still waiting for ABA services to be available to Alice, they are interested in any services that Alice's ICT indicate would be beneficial to her.

Autism Waiver Application and Waiting Period

Deirdre will support Alice's parents complete Alice's application to the autism waiver, and also discusses the role that Compass Behavioral Health, the local Community Mental Health Center in Garden City, will have if Alice is accepted on to the waiver. When the application is submitted to the program manager at the Kansas Department of Aging and Disability Services (KDADS), they inform Alice's parents that if Alice is eligible for the waiver, she will be placed on a proposed recipient list and will be alerted of her numerical position. Deirdre also lets Alice's parents know that Alice will then be evaluated by KVC Health Systems, the State's contracted entity for initial evaluations. Deirdre reassures Alice's parents that she and Alice's ICT will continue to coordinate with them in the meantime and will stay in touch on the coordination of services if Alice is found to be eligible for the waiver. If she is, Deirdre will ensure proper needs assessments are completed and a Person-Centered Service Plan (PCSP) is developed.

Ongoing Support

Deirdre will stay in touch with Alice's parents throughout establishing services with new Providers and ensures that transportation needed to get to and from Alice's appointments is available as needed. [redacted] When ABA therapy services become available to Alice, Deirdre continues to maintain regular contact with Alice and her family and continues to coordinate across the ICT to ensure that Alice's ongoing needs are addressed.

Ensuring Adequate and Timely Access to ABA Therapy Services

UCare recognizes the challenge faced by families like Alice's in finding the services needed to support their children. Prompt assessment and support in the early years are crucial to helping a child with ASD develop the tools and skills they need to function comfortably and lay the groundwork for a fulfilling life.

The availability of ABA Providers is a common problem throughout the country. Through our monitoring and analysis, UCare identified that the waiting list for children to receive assessments for autism early intervention services in a similar market was approximately three months. To ensure access for children like Alice, [redacted]

UCare will prioritize continuous recruitment of Providers who specifically offer autism early intervention services to join our network, as part of our Provider network development plan. For Providers in remote parts of Kansas, such as Holcomb, UCare will leverage our experience with enhanced payment rates and incentive plans to recruit and retain Providers in the local community.

35. Ernest is a senior executive with a hospital in a Rural area of the State. He reaches out to the bidder's Provider services call center seeking to find someone to speak to at an appropriate level in the MCO who will "take this situation seriously" and "has the authority to do something to try to fix this." Ernest explains that, as a Rural hospital, the ED provides a particularly important service for the community and surrounding area. The ED has, however, been struggling with the challenge of KanCare Members who present at the ED with significant psychiatric issues and who end up staying in the hospital's ED for extended periods because of a lack of available and suitable discharge options for them.

    Ernest reminds your Provider services representative that the ED is small and that as a Rural area, the community heavily depends on being able to access ED services. He shares that providing "psychiatric boarding" in the ED for these Members is problematic for many reasons, including: the loss of available treatment space; the challenges presented to his staff, who are not trained to provide psychiatric care; Members' agitation and other disruptive behaviors that escalate as the ED stay lengthens; and the effect of the Members' behaviors on other ED patients.

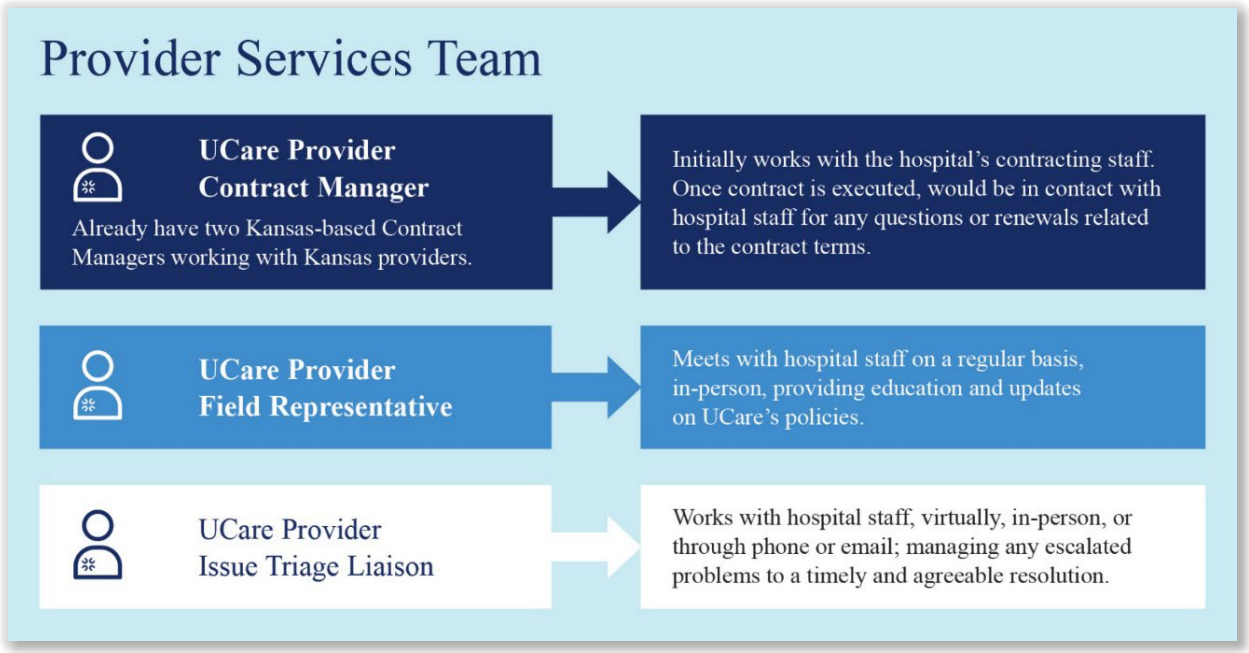
    Ernest states that he is concerned about the ED's ability to continue to ensure access to other patients in need of ED services, and that his staff, already under significant strain, may begin to leave hospital employment. Additionally, Ernest shares his concern that KanCare Members with psychiatric conditions do not have appropriate discharge options. Ernest says that while he recognizes this problem is not just limited to the bidder's MCO, your MCO is a contributor to the issue. Earnest wants to speak to the "right person" to understand what the bidder will do to address his concerns.

    Describe how the bidder will route and handle the call from Ernest, and the bidder's approach to addressing the Provider's concerns.

Providers are critical partners in UCare's work to support Members in achieving their best health, and we make it a priority to address their inquiries and requests for information promptly. Because of the close working relationships that we build with our Providers, this is a rare scenario, that a senior executive such as Ernest would reach out to our Provider Services call center. In addition to our Provider Field Representative staff assigned to his hospital, Ernest would have direct access to our Kansas Director of Provider Relations as well as our Kansas Market President to escalate any issues that need to be addressed. As a KanCare managed care organization, UCare's executive leadership structure is dedicated and responsive to KanCare issues and concerns, and Ernest and his peers in the Provider community will know our leaders' names, emails, and phone numbers.

UCare has a strong reputation for establishing and maintaining positive partnerships with Providers. In Kansas, this work is already underway as UCare senior leadership, Market President and Kansas-based Contract Managers have been connecting with hundreds of Provider groups across the State. Our commitment to partnership is particularly invaluable for situations serious enough to rise to the level of a senior executive.

UCare offers a full complement of staff to ensure highly effective Provider service, including Provider Contract Managers, Field Representatives and Triage Liaisons, as described below:



When Ernest calls our Provider Assistance Call Center (PAC), whose phone number and email are posted on ucare.org as well as in many of our publications, he will reach an experienced representative within eight seconds. Once Ernest identifies himself as a hospital senior executive, the call is immediately routed to UCare's Kansas Director of Provider Relations & Contracting (PRC). If not readily available, the Director will call Ernest back as soon as possible. The Director will talk with Ernest to understand the issue in greater depth, and will engage other UCare staff as needed, including our Kansas Market President.

For purpose of this scenario, in the initial conversation we learn that Ernest is the Chief Operating Officer of Kiowa County Memorial Hospital (KCMH), a 15-bed Critical Access Hospital with emergency department services located in Greenburg [redacted] The hospital serves a four-county area. Greenburg has a population of 740 and approximately 2,400 people reside in the county of Kiowa.

UCare's Kansas-based PRC Director will pull together a cross-functional team from both UCare and KCMH to discuss the situation in greater depth, brainstorm and elevate possible solutions. This meeting will include team members with experience in behavioral Health (BH) care coordination.

Together, UCare staff and Ernest's team will develop strategies, both short-term and long-term, to address the problems experienced in the Emergency Department (ED), as described below.

Understanding the Issue

The identified situation is unfortunately common across the country, as increasing financial struggles and staff shortages put rural hospitals at risk for closure. A recent study by the Center for Healthcare Quality and Payment Reform indicates that 56 of Kansas' 105 rural hospitals are at similar risk. An additional burden for rural hospitals is the dramatic volume of BH cases presenting to their EDs. Most rural hospitals do not have sufficient expertise to treat the range of behavioral health issues, nor do they have the space available to house Members with these

conditions for extended periods of time, when referral centers are often at capacity and there are no appropriate programs available to which the patient may be discharged. Under these circumstances, hospitals are limited in their capacity to appropriately treat other patients presenting to the ED, while the stress felt by ED personnel increases.

Rural hospital EDs must find ways to streamline access to outpatient BH services so patients can be treated for the root cause of their distress and avoid boarding in EDs, delaying necessary care.

UCare supports more than 200 hospitals in our current market network, including 76 Critical Access Hospitals. Many have reached out to UCare with concerns similar to Ernest's.

Addressing the Immediate Need

Our primary goal is to reduce ED overutilization by redirecting patients to a stable care setting with qualified BH Providers who can address their immediate and long-term needs and prevent avoidable ED use.

[redacted]

Timely engagement in substance use disorder treatment services is critical to Members' connection with other necessary services to prevent further hospitalizations and readmissions. [redacted]

Long-Term Solutions to Minimize Unnecessary ED Utilization

Given the urgency of the problem of "psychiatric boarding" in EDs, long-term solutions are required. UCare will take a multipronged approach to addressing the issue, including both network development and innovative clinical strategies.

Proactively, UCare will ensure there are in-network, accessible behavioral health service Providers convenient to KCMH and other rural areas. These can be through:

- Primary Care Clinics
- Community Mental Health Centers (CMHC)
- Certified Community Behavioral Health Clinic (CCBHC)
- Federally Qualified Health Centers (FQHC) Behavioral Health Services
- Behavioral Health Telehealth Services

Primary Care Clinics

It is essential for UCare's KanCare Members with a behavioral health condition to be initially diagnosed and if possible, start treatment. We therefore make a concerted effort to identify primary care clinics that can support Members in need. In KCMH's service area, for example, we would refer Members to nearby clinics such as Greensburg Family Practice Center, Pratt Regional Medical Center, and Midway Clinic. UCare has reached out to most of the Providers in this part of Kansas, and we have secured letters of intent from many of them to contract with UCare for our KanCare program.

While primary care clinics play an essential role in diagnosis and immediate support, referrals to specialty centers will ensure ongoing behavioral health treatment and management for Members in need.

Community Mental Health Centers

CMHCs are critical Provider partners for ongoing management of BH issues. UCare will ensure we include all necessary CMHCs in our network across the State as a referral source for primary care Providers, hospitals, social service agencies, and UCare. CMHCs are charged by statute with providing community-based public mental health safety net services, in addition to providing the full range of outpatient clinical services, including comprehensive mental health rehabilitation services, such as psychosocial rehabilitation, community psychiatric support and treatment, peer support, case management and attendant care. Rehabilitation services have been proven to be key factors in supporting adults with severe and persistent mental illness (SPMI) and children/youth with severe emotional disturbance (SED) in their recovery. Kansas law designates CMHCs as the responsible entity for admission to State mental health hospitals. Under contract, CMHCs also carry out similar functions for nursing facilities for mental health, psychiatric residential treatment facilities, and Medicaid-funded community hospital psychiatric services. One such CMHC, headquartered in Greensburg, is the Iroquois Center for Human Development (Iroquois Center). They service the counties of Kiowa, Clark, Comanche, and Edwards. UCare is actively working with them to secure a partnership agreement for KanCare.

Certified Community Behavioral Health Clinics

UCare recognizes that the CCBHC model requirements call for a broader array of services and expanded crisis service availability. UCare has already provided support to CMHCs in Kansas to meet CCBHC requirements ahead of the transition to a prospective payment system. In 2023, UCare initiated a grant program to provide support for CMHCs across the State to expand access to BH services and some of these funds were used to support resources and staffing required for the transition to CCBHC status. The Iroquois Center is an example of a CMHC that is transitioning to a CCBHC in 2024, and UCare looks forward to continuing to partner and support CMHCs and CCBHCs into 2025.

Federally Qualified Health Centers

FQHCs are also a valuable resource for Members in need of BH services, and we would refer to them as needed to effect ED diversion. In this instance, there are three FQHCs with which we have secured letters of intent that provide BH services within one hour of Greensburg (Heart of Kansas Family clinics in Larned and Stafford; and Genesis Family Health in Dodge City). Because of the distance to these locations, UCare will provide transportation services for Members.

Telephone Options

Particularly in rural communities, where in-person access can be challenging, innovative options, notably telehealth, are especially important. To meet this need, UCare offers the following:

Nurse Advice Line

All UCare Members have access to our Nurse Advice Line 24 hours a day, seven days a week. UCare contracts with an external vendor for this service, which provides important access to medical and behavioral health advice. Nurses answer Member questions and offer health advice, including on behavioral health issues. They can also help direct Members to appropriate localized, in-person services when necessary, such as Iroquois' Crises Intervention support. Nurse Advice Line services have been shown to have a marked effect on decreasing ED visits.

Telehealth

Throughout the pandemic, the vital role of telehealth was on clear display, particularly its value for BH services. At the beginning of the pandemic, many health services—particularly preventive care services—came to a halt, creating significant uncertainty for Members and Providers. [redacted] We look forward to opportunities to support their KSKidsMAP program and further develop their ECHO series. UCare will also contract with other behavioral health professionals who provide telehealth services under the KanCare requirements to support Members in need and provide an alternative to ED utilization.

Assessing the Impact of Interventions

The KCMH and UCare team would continue to meet on a regular basis. We would analyze ED visit data each month to identify progress toward goals and develop additional action plans, as necessary. Other data we would track and measure is Member adherence to follow-up visits, where and by whom, in-person or via telehealth. These data and team analysis would help determine the effectiveness of our interventions.

36. Lola is a black female KanCare Member who just turned sixty-five (65) years of age and enrolled in the bidder's dual eligible special needs plan (D-SNP). She lives by herself in Abilene. Lola has high blood pressure and kidney disease. She receives dialysis twice a week and requires Transportation to access care because she does not have a vehicle. Lola has a difficult time hearing, making it difficult for her to communicate on the phone, schedule appointments and Transportation, and understand treatment recommendations from her Providers. While Lola's Primary Care and dialysis Providers are in the bidder's D-SNP network, her Nephrologist is not.

    Describe the bidder's approach to meeting Lola's needs.

Lola, a 65-year-old Black woman living in Abilene, is enrolled in UCare's Dual Eligible Special Needs Plan (D-SNP). She has been diagnosed with end stage renal disease (ESRD) and high blood pressure (hypertension, HTN) requiring regular medical appointments. Lola is hard of hearing and lives alone without any family presence or support, and she does not have any source of transportation. Her hearing loss makes communication difficult for her, especially over the phone, which makes scheduling and keeping medical appointments challenging. Lola is fortunate to be a part of a health plan — UCare — with years of experience in offering the largest Fully Integrated Dual Eligible (FIDE) SNP Managed Long-Term Services and Supports (MLTSS) plan that supports older adults in our current market. We will bring our experience to Kansas to achieve the State's vision of partnership to support Medicaid Members in achieving health, wellness, and independence.

Lola wishes to remain as independent as possible in her home, where she has lived all of her adult life. UCare's multidisciplinary team of care coordinators, housing and food support specialists, engagement specialists, Member advocates and community health workers (CHWs) will use their collective knowledge and expertise with this population, as well as their understanding of resources in the Abilene community, to work collaboratively with Lola and her support system to improve her quality of life and achieve her health care goals. We are confident that with our care team and comprehensive approach to providing holistic and culturally appropriate care coordination, we will successfully help Lola, as we have managed to help over 91% of our Members who have been able to remain in their homes with supportive services with our Integrated Care Coordination Model (D-SNP Care Coordination Model). We have a proven track record of engaging the populations we serve and have maintained [redacted] In Kansas, UCare will use our integrated, evidenced based, well-coordinated model to support Lola in achieving her health, wellness, and independence goals in a Member-centric approach to her care.

Lola's Story

Lola exemplifies many of the health disparities experienced by Black Kansans, who have the highest rates of ESRD and second highest rates of HTN compared to other racial/ethnic groups in the State. According to the 2022 Dickinson Community Health Needs Assessment, 54.9% of the county's Medicare population is diagnosed with HTN. In addition, 17.6% of the Medicare population have ESRD, and 15.6% have depression. With hearing loss and isolation, Lola is at greater risk for experiencing depression. The Centers for Medicare & Medicaid Services (CMS) Mapping Medicare Disparities data goes further to show that dually eligible women (32%) with Medicare in Dickinson County have higher rates of depression than dually eligible men (25%)

and 12% higher rates than the statewide population of women. These are all conditions experienced, or that could be experienced, by Lola and will be addressed by her skilled multidisciplinary team.

Lola lives alone in Abilene, a smaller rural town of 6,000 people in Dickinson County. She is a widow, having lost her husband to illness several years ago. She has no children and no family who see or support her. Abilene is 30 miles east of Salina, which has a population of 50,000 people, and is 90 miles west of Topeka, which has a population of 125,000 people. Lola's primary care Provider (PCP), Dr. James, is part of the Salina Family Health Center, a Federally Qualified Health Center (FQHC) in Salina. Her current nephrologist is Dr. Mills, who is not currently in UCare's Provider network. While we will make efforts to contract with Dr. Mills, we know of a nephrologist at the University of Kansas Medical Center in Salina and Manhattan who is available and in our network, if Dr. Mills chooses not to work with UCare. While she likes Dr. Mills, Lola is willing to try out a new, in-network nephrologist if necessary.

As we begin working with Lola, we will focus on four objectives to help support her care, all aligning with RFP section 7.4 Care Coordination of the Scope of Services.

1. We want to ensure that UCare meets Lola's needs, honors her preferences and that we provide an outstanding Member experience. During the care coordination process, we actively listen to Lola and work collaboratively with her to provide information about chronic condition management, ***engage*** her in additional programming to improve her health outcomes, and ***empower*** her to direct her care team as they collaborate to meet her identified health care goals.
2. We will work collaboratively with Lola, her Providers, and other care team members to provide integrated ***holistic*** care that addresses her physical, behavioral and social needs.
3. Lola has experienced ***health care disparities*** that have negatively impacted her life. As an older Black woman with hearing impairment living in a rural community, Lola lives in a setting where institutional racism, sexism, ableism, ageism, and geographical resource constraints often multiply barriers to obtaining health care and achieving desired outcomes. According to CMS Social Vulnerability Index, Dickinson County scores a 0.45 out of 0.80, with 36% of the population having only high school or lower educational attainment. The Area Deprivation Index for Abilene is 7 on a scale where 10 is the highest amount of socioeconomic disadvantage. Our integrated team will work with Lola to address these disparities.
4. ***Provider access*** is a challenge in rural Kansas. While Lola's PCP is in UCare's network and within her community, her current nephrologist is not. We will address this and ensure appropriate access for Lola by either bringing her current nephrologist in-network or assisting her in transferring to an in-network nephrologist of her choosing.

Care Coordination

Care coordination is integral to our overall success as a HIDE-SNP program. UCare's care coordination program follows RFP section 7.4 of the Scope of Services and uses a collaborative, culturally relevant, person-centered approach to assess, plan, facilitate, evaluate, and advocate for options and services to meet Lola's identified needs and align with her health and wellness goals. Our team, led by a full-time Care Coordination Director, provides clinical and social support expertise to Members like Lola through activities, including but not limited to self-management techniques, pharmacy consultation, disease management, behavioral health

(BH) services, social service support, transitions of care (TOC) support, and integration with primary and specialty care. As part of our approach, we promote culturally relevant, trauma-informed, Member-centered care that will respond to Lola's unique challenges. [redacted] Our teams deliver care that respects, meets and values the diversity of the Members we work with.

Assessment

As a new Member enrolling in our D-SNP plan, Lola receives a health screening to assess her immediate social and health needs, including difficulty hearing, lack of transportation, and dialysis sessions scheduled twice weekly. Her hearing impairment has likely impacted her ability to follow through on treatment recommendations from Dr. James, her PCP. Lola's health screening triggers the need for a health risk assessment (HRA) by one of our care coordinators, Ashley, an RN who worked at a dialysis clinic before joining UCare and has deep experience working with individuals over age 65. UCare endeavors to staff our care coordination team with professionals from a variety of areas of expertise that are relevant to our older Members' health needs. Ashley becomes Lola's primary point of contact with UCare. After reviewing Lola's health screening, Ashley contacts Lola to introduce herself and schedule her initial HRA in person. The comprehensive HRA identifies needs and potential gaps in medical, psychosocial, cognitive, functional, and behavioral health services and social determinants of health (SDOH) needs. Ashley identifies Lola's unique needs from the HRA during their in-person meeting, Ashley and Lola begin identifying resources that can assist her, and Ashely begins to make the appropriate referrals.

Care Planning

The information gathered during this screening and assessment process drives the development of Lola's plan of care, known as her Individualized Care Plan (ICP). 42 CFR § 422.101(f)(1)(ii); 42 CFR § 422.152(g)(2)(v) stipulate that all SNPs must develop and implement an ICP for each individual enrolled in the SNP. The ICP is a Member-centered, culturally appropriate, comprehensive care plan with identified and prioritized goals, outcomes, and interventions. Ashley is part of Lola's Interdisciplinary Care Team (ICT), acting as a bridge to coordinate services and facilitate communication between Lola, her PCP, her nephrologist, community health worker (CHW), long-term services and supports (LTSS) Providers, and other health care Providers.

This collaborative and iterative process is detailed in the following figure.

Ashley works closely with Lola to identify cultural needs through the care planning and relationship building process, such as validating the historical and generational trauma in Lola's community. They discuss Lola's culturally relevant medical, behavioral, and social needs to ensure the plan is actionable and to help Lola attain and maintain optimal independence and engagement.

During the assessment process, Ashley can hear and readily recognize the sense of isolation that Lola has been experiencing. She confirms with Lola the difficulties she has experience in accessing necessary care.

[redacted]

UCare has more than 16 years of experience working with CHWs. We realize and appreciate that they are trusted members of their communities, with a meaningful understanding of the issues facing communities like Abilene. Navigating the health and social systems is challenging for everyone, and especially for Lola, due to her hearing, transportation, physical, emotional, social, and health challenges, as well as historical and generational trauma. Margaret helps Lola navigate the physical, social, and behavioral health systems, supports her in self-advocacy,

provides culturally appropriate trauma-informed care and support, and assists Lola in coordinating her care while honoring Lola's preferences. The assessment completed with Lola and her care team identifies several areas of concern that initiate the care planning process. After additional discussion with Lola, her PCP, Dr. James, and her nephrologist, Dr. Mills, the following needs and barriers are identified, with proposed services and interventions:

Implementation of Care Plan

UCare uses trauma-informed care and empathic inquiry to engage our Members in the care planning process and ensure that the goals reflect their choice and preferences. We know that change and engagement take time. We are here for Lola, supporting her and providing positive reinforcement as she takes steps toward improving her health. [redacted] through her UCare D-SNP. Being able to hear has been clinically demonstrated to reduce social isolation and depression as noted by the National Institutes of Health. Ashley, Netty, and Lola also develop an emergency backup plan as a part of the care plan process to ensure that Lola has a plan and is cared for in case of an emergency.

Communication of the ICP/PCSP

PCPs and other ICT members are encouraged to review and participate in developing the ICP/PCSP, following RFP section 7.4.4 Plan of Service and Person-Centered Service Planning of the Scope of Services. The Member greatly benefits from collaboration from the ICT because it identifies health care-related needs from a multidisciplinary approach. If a member of the ICT cannot participate in developing the ICP/PCSP, they will receive a copy of the ICP/PCSP and will be asked to review the care plan, so they know the services that are in place or planned for Lola. Enclosed with the ICP/PCSP is a letter providing instructions on how the recipient (Member) may add clinical input, including expressing other active concerns.

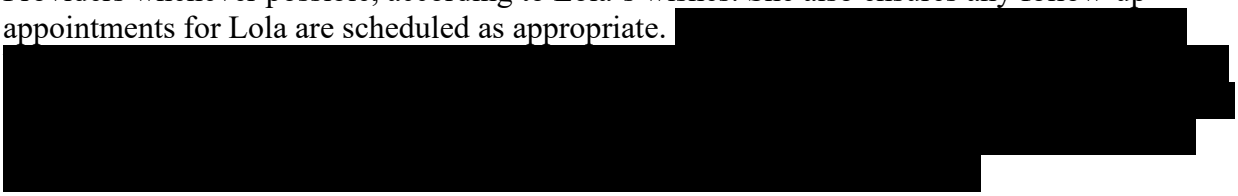
Providers are sometimes unaware of services that a care coordinator, like Ashley, or a CCC, like Netty, or a CHW, like Margaret, arranges outside of their practice. For example, Dr. James may

not be aware of the hearing or fitness services available through our health plan that would benefit Lola. Reviewing the ICP/PCSP helps broaden the knowledge of everyone involved about Lola's services, needs, and goals; this communication will help them identify gaps in service, decrease service duplication, identify ways to improve Lola's health status, and facilitate communication between Providers.

After the ICP/PCSP is developed in partnership with Lola, Ashley distributes a copy to the identified ICT Members, including:

- Dr. James, her PCP
- Lola
- Dr. Mills, her nephrologist
- Margaret, her CHW
- Other specialty Providers as identified by Lola

Ashley and Netty monitor the provision of services and benefits to ensure services are appropriate and delivered on time. For example, Ashley ensures that Lola has transportation and is attending her scheduled dialysis sessions. As services are set up for Lola through the FE waiver, Netty ensures that those services are planned and provided through culturally aligned Providers whenever possible, according to Lola's wishes. She also ensures any follow-up appointments for Lola are scheduled as appropriate.



Lola's Success

UCare's D-SNP experience has been evaluated and shown to be successful by the US Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE). In a 2016 study of the success of the Minnesota Senior Health Options (MSHO) program (of which UCare has been a lead contributor since its inception), the following were observed: MSHO enrollees were 48% less likely to have a hospital stay, and those hospitalized had 26% fewer stays; enrollees were 6% less likely to have an emergency department visit, and those that did had 38% fewer visits; and enrollees were 13% more likely to receive home and community-based services (HCBS) and LTSS. Lola is the type of Member who excels within UCare's successful D-SNP care coordination model.

As Lola moves through the active phase of her care coordination and her needs are addressed, Ashley reaches out to Lola less often, though she is always available for Lola to contact her. Ashley always ensures that Lola and her ICT team have her contact information in the event Lola

needs additional support. Ashley stays in close contact with Netty and maintains availability to jump in as needed. Finally, Ashley reminds Lola of the following:

If Ashley cannot reach Lola or loses contact, she will work with the ICT to identify alternative contact information. This would include reviewing medical claims, pharmacy records, and transportation authorizations. UCare's internal care coordinators, CHWs, and community partners may make home visits to reestablish contact as needed. Finally, we would send a written communication regarding our attempts to contact Lola via her preferred method of communication, including US Mail, email, and text.

Summary

Lola's decision to enroll in UCare's D-SNP program proved to be a turning point in her life. With UCare's exceptional care coordination program, Lola's needs were identified and addressed effectively. Before she joined UCare, Lola was struggling, and her condition was deteriorating, which could have led to long-term care placement. However, with the help of Ashley, Netty, Margaret, and UCare's long-term services and supports, Lola can now remain in the community and in her home where she has lived for almost 50 years and continue to achieve her health care goals.

37. Jason is a twenty-eight (28)-year-old, male, American Indian who is currently living with his family on the Potawatomi Indian Reservation, but intermittently moves off and on the Reservation. The bidder has just been notified of Jason's Enrollment in the bidder's MCO. Not only is Jason a new KanCare Member, he is also new to managed care.

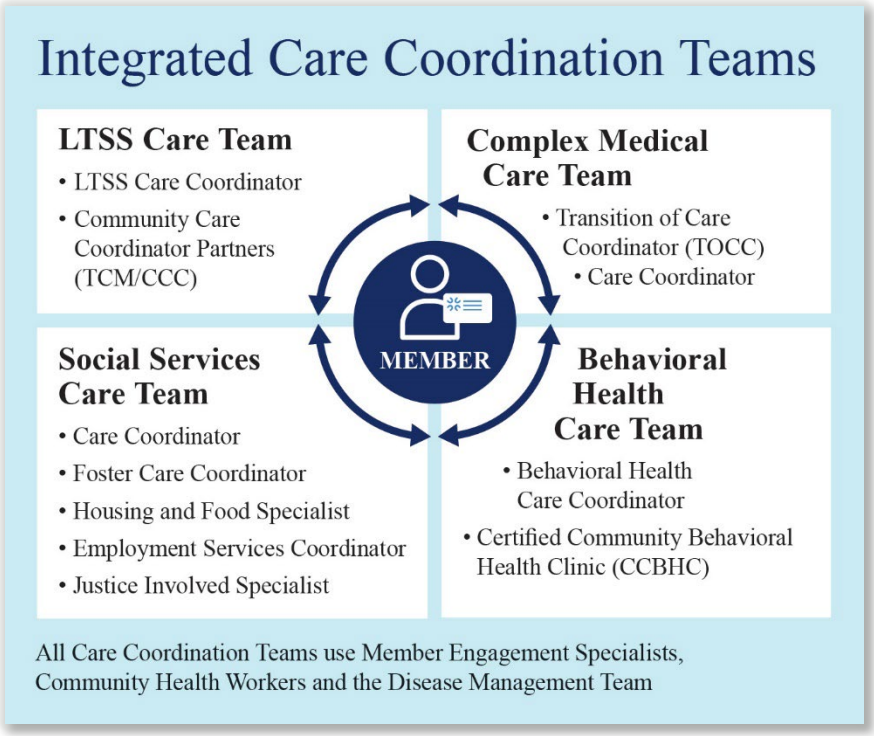
    Jason moved home after he was evicted from his apartment in Topeka for non-payment of rent. He has been unable to maintain ongoing employment due to inconsistent attendance.

    Prior to Enrollment with the bidder, Jason was recently seen at a nearby non-participating Indian health care Provider (IHCP) where he was diagnosed with type 2 diabetes. Jason has a Hemoglobin A1C of 8.76 and has a history of binge drinking since age sixteen (16). He said he drinks when he is depressed and that his drinking and depression have created problems for his maintaining work and in his relationship with his family and friends. The nurse practitioner at the IHCP prescribed Metformin, recommended Jason consider participating in a special diabetes program offered through the Tribe and provided Jason with a referral to a non-participating Provider for a Behavioral Health assessment and treatment. Jason has not followed up on either the recommendation or the referral.

    Describe how the bidder will identify the needs of this KanCare Member, the bidder's approach to meeting the needs of the Member, and how the bidder will coordinate the Member's care.

UCare is a leader in identifying and coordinating care needed to meet Members' physical, behavioral, and social needs, and we are therefore well-positioned to quickly identify, respond, and coordinate care for Jason. Our experience in leveraging culturally competent Providers, community partners, and use of innovative programs to identify and address gaps in care provides a strong foundation in coordinating Jason's multiple care needs.

UCare's Integrated Care Coordination model is guided by our core values, grounded in deep awareness of our Members' evolving, diverse needs that will be best met through a ***person-centered, goal-oriented, culturally relevant care model.*** Our model is focused on meeting Jason's needs while putting him at the center of his care team.



Jason a 28-year-old American Indian male with diabetes, has a history of housing and employment instability, depression, and alcohol use. He also has a history of gaps in care and a lack of follow-through

regarding referrals for care. Jason is newly assigned to UCare, which has a proven track record of responding to Members with needs similar to Jason's.

Integrated Care Coordination Model

UCare's Integrated Care Coordination model takes a collaborative approach to evaluate, plan, facilitate, advocate, and provide comprehensive services to meet Jason's needs and provide person-centered care. To ensure Jason has seamless access to services across our program areas and care teams, we foster a culture of collaboration among internal teams and manage programs that integrate services from various Provider types. [redacted] Our integrated approach also provides individualized care for Jason across the care continuum, and serves as the link between health care, social services, and the community, facilitating access and improving the quality and cultural competency of service delivery for Jason.

We are experienced in developing community partnerships that share our same vision for supporting Members like Jason, such as our partnership with Valeo Behavioral Health Care, a Certified Community Behavioral Health Clinic (CCBHC). Our framework for addressing cultural norms and values helps us make a greater impact for Members and the communities in which they live.

To address Jason's needs, UCare's Behavioral Health Care Team works together to ensure timely assessment, identification, and support.

Jason's Journey

Initial Welcome and Health Screen

UCare plays an important role in educating Jason about the services and supports offered by his plan. As we welcome Jason, our goal is to make sure he understands how to get information about his plan benefits and support services. Our focus is on building trust with Jason by providing clear, accurate information that addresses his most immediate needs without overwhelming him.

Within the first 10 days of Jason's enrollment as a UCare Member, one of our American Indian Member Engagement Specialists contacts Jason to welcome him to UCare and complete an initial Health Screen. To facilitate increased engagement, [redacted]

As a new UCare enrollee, Jason is sent new Member materials that provide critical information about his plan benefits, and a summary of UCare's service offerings, including our Value-Added Benefits (VAB). The Engagement Specialist also uses the outreach call to address any questions

Jason has about this information. Our goal is to ensure Jason has easy access to the information he needs when he needs it. We also send Jason two emails encouraging him to sign up for our Member Portal, provide him with information about the availability of self-service tools and resources, and describe the option for private messaging with our Member Services Team.

The Engagement Specialist documents the call and all information discussed within GuidingCare, UCare's clinical platform.

Identifying and Coordinating Jason's Care Needs

Assessment

[redacted]

Additionally, Corey ensures Jason understands his rights, the role of UCare as his MCO, and the role Corey will play in helping him achieve his health and well-being goals; they also determine Jason's Provider preference. Corey excels at helping Members like Jason identify issues or concerns, assisting him with exploring his options, and working to eliminate barriers by offering a continuum of services to address Jason's needs. Cory will begin by addressing those issues that are most urgent and important to Jason. Aware of Jason's history of lack of follow-through on his Nurse Practitioner's (NP's) referrals, Corey actively engages Jason to better understand his history and current desire in addressing his health and well-being. Corey works with Jason to understand his health care goals, identify the services available to help him achieve those goals, and collectively determine the scope, duration, and services that Jason identifies, reinforcing Jason's role in directing his own care.

Provider Care

Jason has access to a diverse mix of Providers across UCare's network to meet his cultural, behavioral, and physical needs. UCare actively invests in identifying and building the availability of culturally congruent Providers in our network. By identifying Providers' cultural competency capabilities and specialties (including languages spoken) we can align our Providers with the Members they serve. [redacted]

UCare has a long history of working with Indian Health Care Providers (IHCPs), and we recognize the important role they play in the communities we serve. To ensure Member access to these valuable Providers, UCare pays IHCPs – whether participating in the network or not – at negotiated rate not less than the level and amount of payment that would be made to non-IHP Providers.

We look forward to further developing key relationships with tribal partners in Kansas to ensure our American Indian Members like Jason have access to appropriate, culturally competent care and resources. For example, UCare's County, Tribal, and Public Health Manager connected with

Kansas public health leaders at the 2023 Governor's Public Health Conference. Leaders included the Bureau Chief of Community Health Systems, representatives from KDHE Epidemiology, county public health directors, and the CEO of United Methodist Health Ministry Fund. UCare heard about various challenges leaders faced with current MCOs, including the need for more dedicated outreach from MCOs to tribal leaders to develop relationships and partnerships. We look forward to continuing these important conversations and working together to develop relationships with tribal, county, and public health leaders in Kansas.

Since Jason has worked previously with the NP at the Potawatomi Health Center, and Corey assures him his appointments will be covered by UCare, Jason chooses to continue working with the NP.

Based on his identified needs and health priorities, Corey talks with Jason to explain the benefit of working with a Certified Community Behavioral Health Clinic (CCBHC) and Jason agrees to give it a try. Corey refers Jason to services at Valeo Behavioral Health Care (Valeo), located near the Potawatomi Indian Reservation, and helps Jason schedule his first appointment with Kylee, his primary contact at Valeo, for care coordination services.

Addressing Jason's Physical, Behavioral, and SDOH Needs

CCBHC

Since Jason is now being served by a CCBHC, his point of contact will be Kylee. Corey will continue to collaborate with Kylee and will remain on Jason's Integrated Care Team (ICT). Aligned with KanCare's principles, Kylee educates, engages, and empowers Jason to personally define his health and wellness goals.

SDOH

To begin to address some of Jason's basic SDOH needs, Kylee connects Jason to an array of additional programming at Valeo, including Section 8 housing and food assistance to help meet his immediate needs.

Connecting Jason to a suite of resources at Valeo helps ensure he has access to the services he needs to stabilize many of his SDOH, including access to additional services if his housing and other issues become more acute. Programs at Valeo, such as the Mobile Access Partnership (MAP) - a unique collaboration between Valeo, Topeka Rescue Mission, Shawnee County Health Department, Stormont Vail Health, and the Topeka Police Department's Behavioral Health Unit - assists those experiencing homelessness with basic needs and medical care. In addition to the services available to Jason at Valeo, [redacted]

Substance Use Disorder Services

Kylee also connects Jason to Valeo's Recovery Center and Peer Support services. Through these programs, Jason has access to one-on-one or group counseling to address his drinking. Simultaneously, he has access to a Certified Peer Specialist trained to provide services and support Jason throughout his recovery journey, while removing perceived judgment or assumptions of bias. A key learning from decades of experience with integrated care

coordination is the irreplaceable value of community-based organizations and Providers in the lives of our Members. Jason comes to UCare with his own lived experiences, which have likely led to disengagement and avoidance of health care and social service systems. Our experience with Members like Jason has shown us he is more likely to engage in services when approached by peers with similar lived experiences. Additionally [redacted] Should he need it, Jason also has access to Valeo's 24/7 mental health Crisis Center.

Employment Support

Corey and Kylee understand that Jason's employment instability contributes to his inability to maintain housing. Jason is connected to employment support at Valeo as well as to the Working Healthy program. [redacted]

Diabetes Management

Through conversations with Jason, Kylee learns he is interested in focusing on diabetes self-management. Kylee coordinates with Corey to share information about available programs to help Jason manage his diabetes, such as the UCare Disease Management (DM) Program for diabetes. This program includes the option of interactive voice response (IVR) and text education and telephonic health coaching,

[redacted]

Jason also receives diabetes educational newsletters and is encouraged to download the Brook Health Companion app for additional support. Brook Health Companion is a phone app that helps Members turn their health goals into sustainable habits — including medication adherence, chronic condition education, meal planning, goal achievement, reminders, and healthy lifestyles. To help Jason practice a healthy lifestyle and behaviors, his care coordinator encourages him to sign up for a gym membership. Through UCare's VAB, Jason is eligible to receive $20 per month reimbursement towards this membership.

[redacted]

Jason's Care Plan Development

Jason's care plan represents the culmination of his various assessments and includes documentation of the services and supports identified to help Jason achieve his SMART goals, live in the setting of his choice, and receive the services best designed to meet his needs. Kylee collaborates and coordinates with Jason, Corey, and other members of Jason's ICT, including his Providers, to develop Jason's care plan. Jason's care plan includes all required elements per RFP Section 7.4.4.

Table 37.1 summarizes the primary needs and priorities, interventions, and services, as well as the Providers that would be found within Jason's Care Plan, per RFP section 7.4.4.

[redacted]

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Resource Coordination

Kylee plays a vital role in supporting Jason's needs across different stratification levels, ensuring his health care needs are met effectively. She identifies community resources to provide personalized support based on Jason's needs and risk stratification level. Kylee is the primary point of contact for Jason and is charged with keeping all the information about him organized and captured in one place to ensure the ICT is coordinated and moves forward together. Kylee ensures the appropriate screenings and assessments are completed, updates Jason's care plan as necessary, and ensures continued collaboration and information exchange among members of Jason's ICT.

Like all UCare Care Coordinators, Corey has access to Unite Us, which supports closed-loop social service resource identification and navigation, and accountability and collaboration among community partners. Corey shares all of this information and coordinates with Kylee to ensure Jason's timely referral and access to community-based services.

Ongoing Monitoring and Follow-Up

Over time, Jason shows positive progress toward meeting his health and well-being goals. To support his continued improvement, Kylee monitors and works with Jason and all members of his ICT, and documents his progress, updating his care plan to ensure it remains appropriate for his needs.

[redacted] Kylee maintains regular communication with Jason and facilitates all scheduled visits. She also maintains regular communication with other members of the ICT. Through regularly scheduled meetings, as well as routine monitoring of claims and utilization management data, Kylee is able to ensure timely identification of any new or emerging needs and to adjust Jason's care plan accordingly.

Kylee, Corey, and other members of the ICT continue to participate in care coordination meetings to review Jason's status and ensure cross-organizational and departmental collaboration. These routine ICT meetings help ensure they can proactively identify any barriers to care, gaps in care and indicators that may lead to poor outcomes for Jason.

UCare provides Jason the opportunity to complete a Member survey to tell us about his care experience, and to help us identify any barriers and opportunities for UCare to continue to improve our services. The input of Members like Jason is crucial to our continuous process improvement, to ensure that all Members receive the services they need.