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Kentucky Medicaid Oversight and Advisory Committee

Agenda

- Gainwell Overview
- Streamlining the Medicaid Claim Process
- Population Health Management (PHM) and Social Determinants of Health (SDoH)
- Questions

Gainwell Overview

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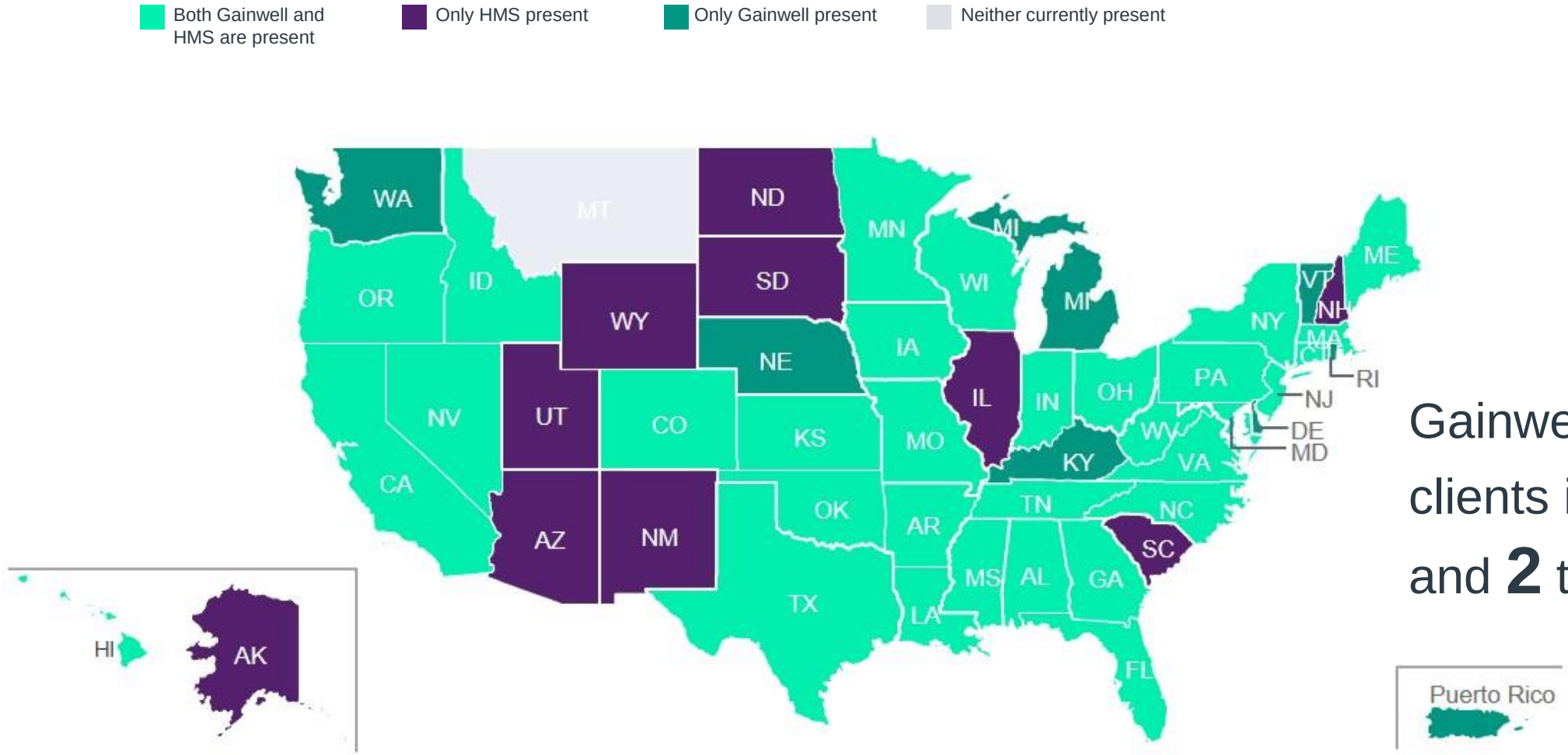
Gainwell in Kentucky

Over 25 years of service (as EDS, HP, HPE, DXC and now Gainwell)

Gainwell has a proven track record in Kentucky with reputation for its ability to build and deliver solutions that make a difference, such as:

- **2nd State to Implement Patient Access to Healthcare Data (as required by CMS by July 1, 2021)**
- **Rapid and Accurate Response to over 130 Changes to in Medicaid Claims and Encounters due to COVID-19**
- **Partnered with Medicaid, OATS and Tellus to Implement Electronic Visit Verification to meet the CMS Requirements along with Telehealth Visits during the Pandemic**
- **Partnered with Medicaid and the six (6) MCOs to Onboard and Implement Changes in the Medicaid Managed Care Environment**
- **Serve as the "Go-To" source on Analytics for Medicaid and CHFS for Medicaid Data**
- **Trusted Partner with over two (2) Years Meeting all Service Levels**

Long-standing client relationships



Gainwell serves clients in **49** states and **2** territories

Our Solutions

Medicaid

Address the evolving landscape and protect your community's health with flexible and agile solutions that cover all aspects of the Medicaid value chain

Health & Human Services

Increase process efficiencies, improve operational agility and pave the way for innovations in H&HS programs

Public Health

Achieve safer, healthier outcomes through more effective IT systems that drive better decision-making for individuals and their communities

Technology Services

Discover modern IT services designed to support interoperability and agility, with scalable delivery and a flexible architecture to help you deliver the services that matter most

Streamlining the Medicaid Claim Process

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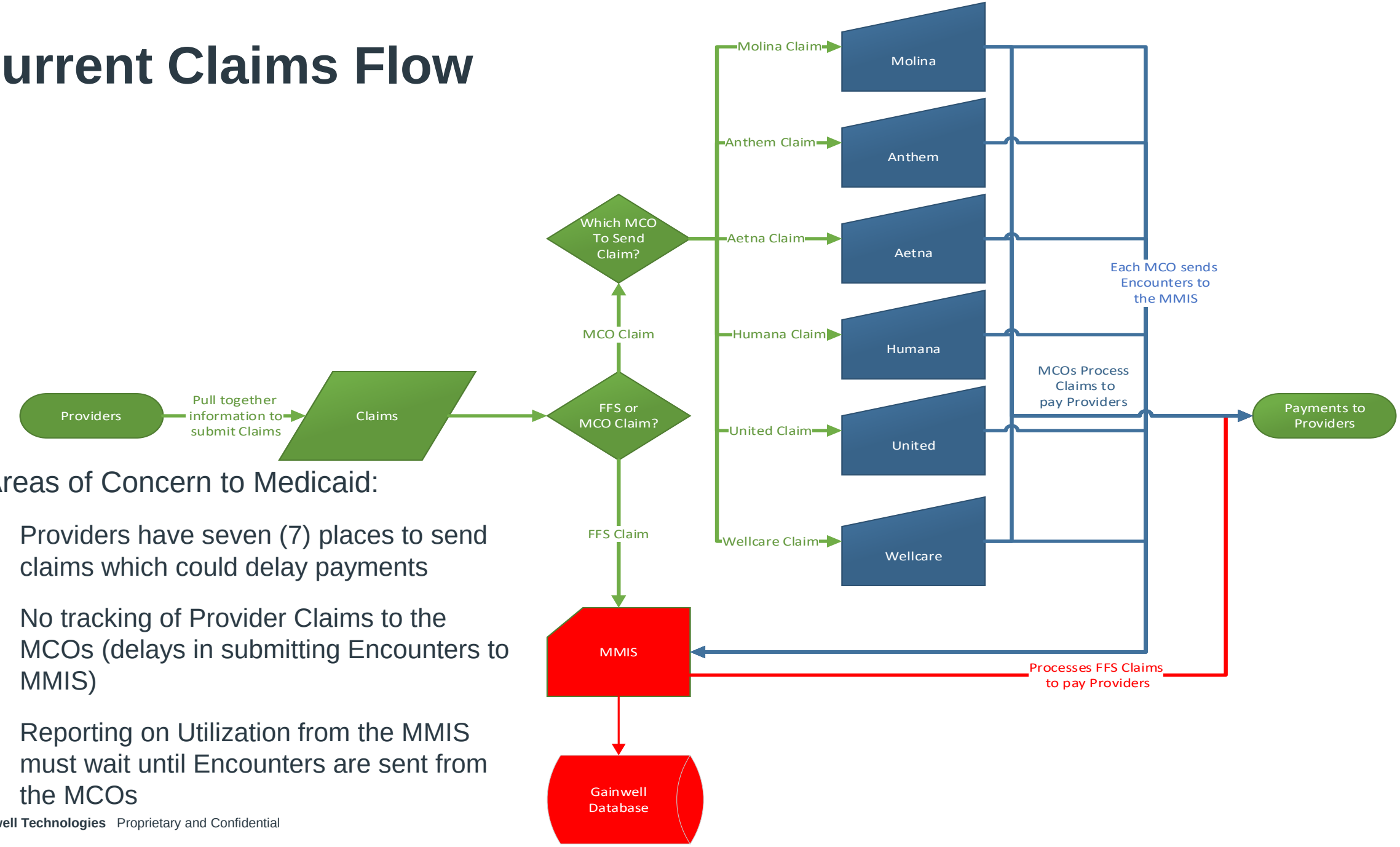
Current Claims Flow



Areas of Concern to Medicaid:

- Providers have seven (7) places to send claims which could delay payments
- No tracking of Provider Claims to the MCOs (delays in submitting Encounters to MMIS)
- Reporting on Utilization from the MMIS must wait until Encounters are sent from the MCOs

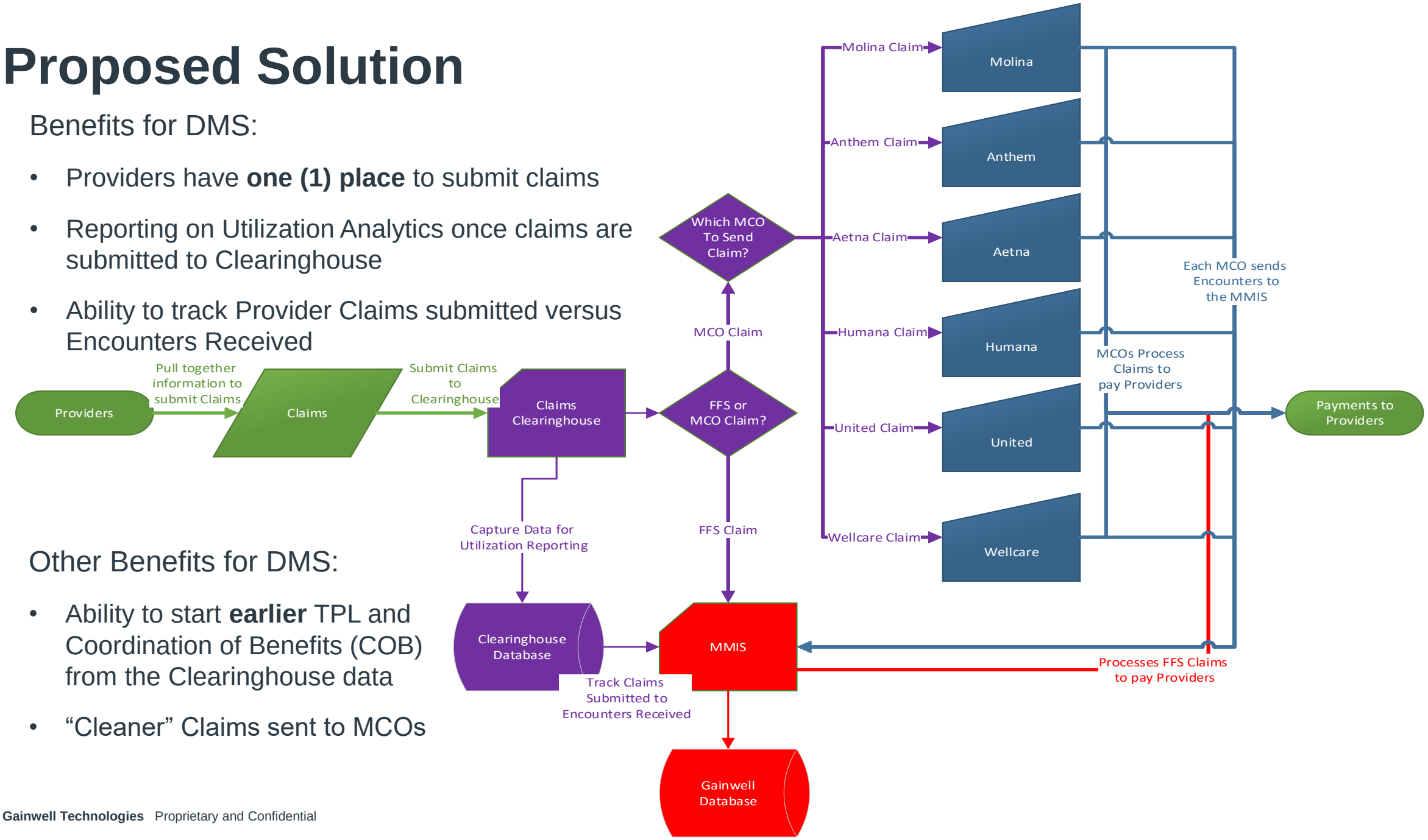
Proposed Solution

Benefits for DMS:

- Providers have **one (1) place** to submit claims
- Reporting on Utilization Analytics once claims are submitted to Clearinghouse
- Ability to track Provider Claims submitted versus Encounters Received

Other Benefits for DMS:

- Ability to start **earlier** TPL and Coordination of Benefits (COB) from the Clearinghouse data
- "Cleaner" Claims sent to MCOs



Population Health Management (PHM) and Social Determinants of Health (SDoH)

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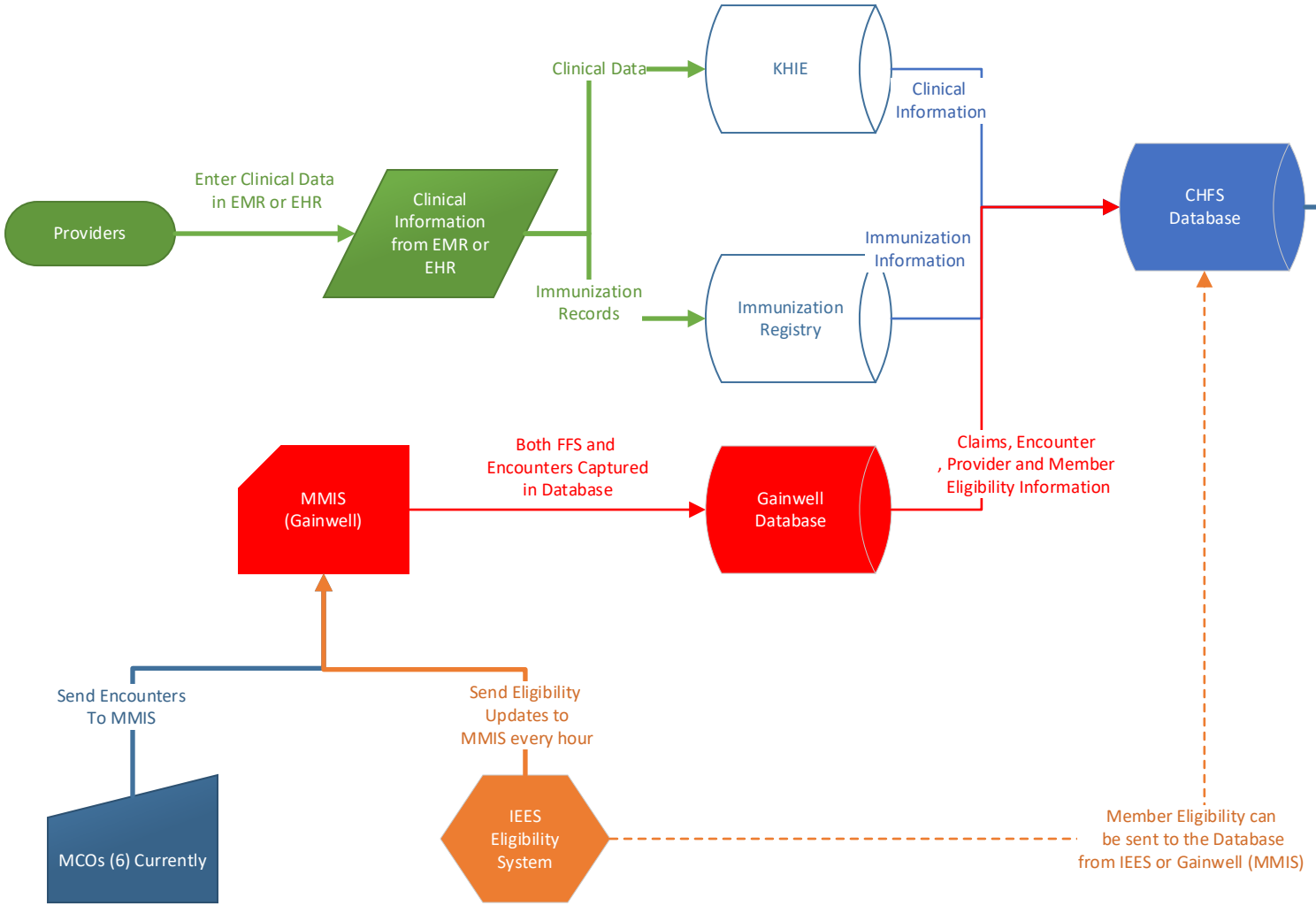
Population Health Management (PHM) Solution

Population health management refers to the process of **improving clinical health outcomes of a defined group of individuals** through improved care coordination and patient engagement supported by appropriate financial and care models.

Integrating the following sources of data to improved healthcare outcomes is a critical part of a strong PHM solution:

- Eligibility Data (including demographics of members)
- Provider Data (including the demographic and locations of all facilities)
- Claims Data
- Clinical Data
- Other Social Program Data (SNAP, LIHEAP, etc.)

Data Transfer to PHM Platform



PHM Platform Benefits

- Quality Reporting (HEDIS)
- Create Episodes of Care and Care Plans
- Integrate with Provider EMR platform
- Baseline for Value-Based Contracting
- Integrate other CHFS Programs (SNAP, DCBS, etc.)
- Adding SDoH Assessments and Referrals

Medicaid Social Determinants of Health (SDoH) Operational Model

As an expansion on the Pilot performed by CHFS, developing a full Social Determinants of Health (SDoH) Operational Model to increase clinical outcomes and decrease medical expenditures over time.

There are four (4) important areas to truly make a Social Determinants of Health (SDoH) Model Work:

- Building the SDoH Network for important areas of food, transportation, housing and utilities
- Education and adherence for Providers to perform the Assessment to determine the SDoH referrals
- Member adherence to the referrals for SDoH and are other areas needed (Ex. Is there a referral for transportation needed for a housing appointment?)
- Easily closing the referral out by using apps or voting emails because many of the SDoH Providers don’t have IT Departments

ARPA Funds can be used to setup the model on the next page and the operation of the model can be funded from the MCO Capitation Rates.

The model on the next page is an example of a complete operational setup:

Medicaid Social Determinants of Health (SDoH) Operational Model

TECHNICAL SOLUTION

- Capture Network Demographics
- Assessment Tools, Referral Tools to Choose SDoH Support
- Care Manager Alerts, Member Alerts
- Care Manager Alerts, Referral Tools for SDoH Providers
- Analytics, Algorithms, and Care Mgmt. Functions

OPERATIONAL SOLUTION

- SDoH Support Network Development
- Provider On Boarding - Education and SDoH Assessment Adherence
- SDoH Support – Referral Adherence for Members
- SDoH Support Providers Adherence for Satisfying PCMH Referral and Reporting
- Reporting and SDoH Continuous Needs Assessment

Questions

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