PART II: TECHNICAL APPROACH

B. Qualifications and Experience (Sections 2, 3 and 4 of the RFP)

B.1 Indicate your organization's legal name, trade name, dba, acronym, and any other name under which you do business; the physical address, mailing address, and telephone number of your headquarters office. Provide the legal name for your organization's ultimate parent (e.g. publicly traded corporation). (GSA C)

UnitedHealthcare Community Plan

Legal Names and Trade Name

UnitedHealthcare Community Plan seeks the opportunity and privilege to serve as a Coordinated Care Network-Prepaid in Louisiana and to help ensure that Medicaid and CHIP members in the three designated GSAs have access to quality health care. Our legal name is UnitedHealthcare of Louisiana, Inc., d/b/a UnitedHealthcare Community Plan. Our trade name is UnitedHealthcare Community Plan. We are a part of UnitedHealthcare Community & State, a business segment of UnitedHealth Group Inc. UnitedHealthcare of Louisiana, Inc. is a wholly owned subsidiary of UnitedHealth Group. For the purposes of this RFP, hereafter, we will refer to ourselves as UnitedHealthcare Community Plan.

Physical Address

UnitedHealthcare Community Plan
3838 N Causeway BLVD
Suite 2600 LA035-1000
Metairie, LA 70002
504/849-1624

Mailing Address

UnitedHealthcare Community Plan
3838 N Causeway BLVD
Suite 2600 LA035-1000
Metairie, LA 70002
504/849-1624

May 28, 2011

"UnitedHealthcare is an experienced National leader in the managed care industry. We are very excited about this possible collaborative and partnership opportunity to serve, educate, and assist those children and families in our community in the necessity of quality healthcare."

Sincerely,

Regina Ashford Barrow
State Representative, District 29

Following a contract agreement with the State, we will expand our existing offices in Baton Rouge to accommodate expected increases in staffing.

Major Subcontractors

We have identified fellow UnitedHealth Group subsidiary organizations OptumHealth Care Solutions, Inc., and OptumInsight (formerly Ingenix) as major subcontractors. March Vision, not a UnitedHealth Group subsidiary, is also a designated subcontractor. Contact information and other requested information on these three companies is provided in Question B.11.

Describe your organization's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and detail the names, mailing address, and telephone numbers of its officers and directors and any partners (if applicable). Provide the name and address of any health professional that has at least a five percent (5%) financial interest in your organization, and the type of financial interest.

UnitedHealthcare Community Plan Form of Business

UnitedHealthcare Community Plan is a wholly owned subsidiary of UnitedHealth Group Incorporated, a publicly traded corporation.

UnitedHealthcare has served Louisiana citizens since 1995 after its acquisitions of MetraHealth and Community Health Network of Louisiana, Inc. Today, UnitedHealthcare is operational in all 64 Louisiana Parishes and holds three (3) licenses in the state (UnitedHealthcare of LA – HMO License, UnitedHealthcare Insurance Company – Insurance License and Golden Rule Insurance Company dba United Health One – Individual Insurance).

We provide health care services for Individual and Employer sponsored plans, and for Medicare products in the state. Employer sponsored programs are both fully insured and self-insured, where UnitedHealthcare provides administrative services only. These health care programs have a contracted medical delivery system in Louisiana that includes 161 hospitals and 8,900 physicians. Through its many health insurance programs, UnitedHealthcare presently serves over 344,000 plan participants in Louisiana, which represents approximately 20 percent of the commercial market share in the state in addition to more than 37,000 customers who have chosen our Medicare products.

Nationally, we are the **country's largest Medicaid managed care organization**, providing services to more than 3.4 million members in 24 states and the District of Columbia.

No health professional has a five percent financial interest in UnitedHealth Group.

UnitedHealthcare Community Plan Officers and Directors		
Name	***Title***	***Mailing Address and Telephone***
Daniel Cole	Director	3720 Davinci CT STE 400 Norcross, GA 30092 770/582-4470
Robert Friedrichs	Director	3720 Davinci CT STE 400 Norcross, GA 30092 770/300-3628
Glen Golemi	Director /Officer – President and Chief Executive Officer	3838 N Causeway BLVD Suite 2600 LA035-1000 Metairie, LA 70002 504/849-1624
Bridget Galatas	Director /Officer- Chief Financial Officer	3838 N Causeway BLVD Suite 2600 LA035-1000 Metairie, LA 70002 504/849-1609
Michael Radu	Officer - Regional President, Community & State	Suite 400 12018 Sunrisevalley Drive Reston, VA 20191 571/262-8940
John Matthews	Officer- Secretary	PO Box 9472 Minneapolis, MN 55440-9472 850/443-6996
Robert Oberrender	Officer- Treasurer	9900 Bren RD East Minnetonka, MN 55343 952/936-3123

Provide your federal taxpayer identification number and Louisiana taxpayer identification number.

Federal Taxpayer Identification Number: 72-1074008

Louisiana Taxpayer Identification Number: 7370182-0001

Provide the name of the state in which you are incorporated and the state in which you are commercially domiciled. If out-of-state, provider the name and address of the local representative; if none, so state.

UnitedHealthcare Community Plan is incorporated in the state of Louisiana. The company is commercially domiciled in Metairie, Louisiana.

If you have been engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state.

UnitedHealthcare Community Plan has not been engaged contractually with DHH within the past 24 months.

B.2 Provide a statement of whether there have been any mergers, acquisitions, or sales of your organization within the last ten years, and if so, an explanation providing relevant details. If any change of ownership is anticipated during the 12 months following the Proposal Due Date, describe the circumstances of such change and indicate when the change is likely to occur. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

Mergers, Acquisitions and Sales

UnitedHealthcare has carefully planned its strategic growth, including our history in the State of Louisiana. Known as Community Health Network of Louisiana, Inc. until 1996, the Health Plan was acquired by UnitedHealthcare, Inc., in May 1994. UnitedHealthcare Plan of Louisiana has otherwise not been involved in mergers, acquisitions, or sales within the last 10 years.

Our parent company, UnitedHealth Group, either directly or through various subsidiaries or affiliates of UnitedHealthcare of Louisiana, has been involved in a significant number of mergers, acquisitions and sale transactions over the past 10 years. The following involved entities with Medicaid business:

- ***February 9, 2001*** – UnitedHealth Group Incorporated acquired Lifemark Corporation (Lifemark) and its subsidiaries, (including among others, Lifemark Health Plan of Texas, LLC, and Ventana Health Systems, Inc.) through the merger of Leo Acquisition Corp. (a wholly owned subsidiary of UnitedHealth Group) into Lifemark.
- ***September 23, 2002*** – UnitedHealth Group Incorporated acquired 93.5 percent of the shares of UnitedHealthcare Community Plan Corporation and its wholly owned subsidiaries, through the merger of Cardinal Acquisition, Inc. (a wholly owned subsidiary of UnitedHealth Group Incorporated) into UnitedHealthcare Community Plan Corporation.
- ***February 26, 2004*** – UnitedHealthcare Community Plan Corporation acquired Great Lakes Health Plan, Inc., a Michigan corporation and licensed HMO. Great Lakes Health Plan, Inc. provides Medicaid managed care services in Michigan.
- ***February 24, 2006*** – UnitedHealthcare, Inc. acquired John Deere Health Care, Inc., with ongoing operations in Iowa and Tennessee.
- ***September 1, 2006*** – Great Lakes Health Plan, Inc. purchased the Michigan Medicaid business from Physician's Health Plan of Southwest Michigan, Inc.

- ***December 31, 2007*** – UnitedHealthcare Community Plan of New York, Inc., merged into UnitedHealthcare of New York, Inc., which provides Medicaid managed care services in New York.
- ***February 25, 2008*** – UnitedHealth Group Incorporated acquired all of the outstanding shares of Sierra Health Services, Inc. and its affiliates. Sierra provides Medicaid managed care services in Nevada.
- ***May 30, 2008*** – UnitedHealthcare Community Plan Corporation acquired all outstanding stock of Three Rivers Holdings, Inc., and its wholly owned subsidiaries providing Medicaid managed care services in Delaware, Ohio, South Carolina, Pennsylvania, and Washington, DC.
- ***December 11, 2009*** – Oxford Health Plans LLC, acquired Health Net of New Jersey, Inc., a New Jersey corporation and other Health Net affiliates.
- ***December 31, 2010*** – UnitedHealthcare Community Plan of Pennsylvania, Inc. and Unison Family Health Plan of Pennsylvania, Inc., merged with and into Unison Health Plan of Pennsylvania, Inc., which then changed its name to UnitedHealthcare of Pennsylvania, Inc.

No ownership changes affecting UnitedHealthcare Community Plan are planned at this time.

B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony and/or any Medicaid or health care related offense or have ever been debarred or suspended by any federal or state governmental body. Include an explanation providing relevant details and the corrective action plan implemented to prevent such future offenses. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

To the best of our knowledge and belief, neither UnitedHealthcare nor any of its employees, vendors, or providers in whom it has a controlling interest or who has a controlling interest in it, has ever been convicted of a crime related to, or been terminated from, a federally assisted or state-assisted medical program.

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization. This shall include but not be limited to litigation involving failure to provide timely, adequate or quality physical or behavioral health services. You do not need to report workers' compensation cases. If there is pending or recent litigation against you, describe the damages being sought or awarded and the extent to which adverse judgment is/would be covered by insurance or reserves set aside for this purpose. Include a name and contact number of legal counsel to discuss pending litigation or recent litigation. Also include any SEC filings discussing any pending or recent litigation. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

Litigation History

UnitedHealthcare of Louisiana

UnitedHealthcare of Louisiana does not currently have any open or pending litigation against it. In the past 5 years, it has been involved as a defendant in only six matters, four lawsuits and 2 arbitration cases; none of these matters involved Medicaid members or providers. Two of the lawsuits involved member disputes over coordination of benefits or benefits under commercial insurance coverage. The other 4 matters were initiated by providers related to disputes over contract payments. All matters were settled between the parties.

Public Sector Litigation

UnitedHealthcare of Louisiana's affiliates that engage in public sector business throughout the country have been and are currently involved in litigation. To the best of our knowledge, based upon a thorough

review of our available databases, there have been approximately 318 lawsuits or arbitrations involving said affiliates in the past five years relating to public sector products. Many of these cases involve very small dollar amounts at issue. The majority of cases involved provider/vendor disputes regarding the payment of claims and benefit disputes. These disputes do not and are not expected to impact UnitedHealthcare of Louisiana. UnitedHealth Group retains liability insurance for itself and its subsidiaries, including its commercial and public sector entities, in the amount of $50 million per claim, which is usual and customary for the health care insurance industry. Reserves for these pending matters have been established as appropriate under normal accounting procedures.

UnitedHealth Group Incorporated

UnitedHealth Group Incorporated and its other subsidiaries have been and are involved in various litigation matters incidental to providing management of health care services and administrative services for commercial products. UnitedHealth Group is also a defendant in actions in connection with the Company's historic stock option practices. This matter and any other material litigation concerning UnitedHealth Group, its affiliates and subsidiaries for the last five years are described in the most recent 2010 and previous Form 10-K filings. There is no material litigation other than what is described in the attached SEC 10-Ks.

Litigation Contact

Please contact Deputy General Counsel, Perry Sekus, at 952/931-5281, to discuss pending litigation or recent litigation.

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, provide an explanation providing relevant details including the date in which the Proposer emerged from bankruptcy or expects to emerge. If still in bankruptcy, provide a summary of the court-approved reorganization plan. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

Neither UnitedHealthcare Community Plan nor its parent organizations has ever filed a bankruptcy or insolvency proceeding.

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation, submit the most recent United States Securities and Exchange Commission (SEC) Form 10K Annual Report, and the most-recent 10-Q Quarterly report. (GSA C)

The UnitedHealth Group Form 10-K Annual Report for 2010 is provided as Attachment B.6.a and can also be viewed at this link on our website: http://www.unitedhealthgroup.com/invest/2010/UNH-2010-10-K.pdf

The UnitedHealth Group Form 10-Q Quarterly Report for Q1, 2011 is provided as Attachment B.6.b and can also be viewed at this link: http://www.unitedhealthgroup.com/invest/2011/UNH-Q1-2011-10-Q.pdf

Provide a statement whether there have been any Securities Exchange Commission (SEC) investigations, civil or criminal, involving your organization in the last ten (10) years. If there have been any such investigations, provide an explanation with relevant details and outcome. If the outcome is against the Proposer, provide the corrective action plan implemented to prevent such future offenses. Also provide a statement of whether there are any current or pending Securities Exchange Commission investigations, civil or criminal, involving the Proposer, and, if such investigations are pending or in progress, provide an explanation providing relevant details and provide an opinion of counsel as to whether the pending investigation(s) will impair the Proposer's performance in a contract/Agreement

under this RFP. Include your organization's parent organization, affiliates, and subsidiaries.

SEC Regulation

On December 22, 2008, the company entered into a settlement agreement to resolve a Securities and Exchange Commission investigation into the Company's historical stock option practices. Without admitting or denying the allegations, UnitedHealth agreed to a permanent injunction against any future violations of certain reporting, books and records and internal accounting control provisions of the federal securities laws. The Commission declined to charge the company with fraud or seek a monetary penalty, based on the company's extraordinary cooperation in the Commission's investigation, as well as its extensive remedial measures.

To the best of our knowledge and belief, there are no current or pending investigations being conducted by the SEC, which pertain to UnitedHealth Group.

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports for the parent organization. If there are one (1) or more intermediate owners between your organization and the ultimate owner, this additional requirement is applicable only to the ultimate owner. (GSA C)

Please refer to Attachment B.6.a – UnitedHealth Group 2010 10K. The ultimate parent, UnitedHealth Group, unconditionally guarantees our performance of each and every obligation, warranty, covenant, term and condition of the contract.

Include a statement signed by the authorized representative of the parent organization that the parent organization will unconditionally guarantee performance by the proposing organization of each and every obligation, warranty, covenant, term and condition of the Contract.

Please refer to Attachment B.7.a – Parental Guarantee Letter.

B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

UnitedHealth Group

Employees, client base and location of offices

For three decades, our employees have worked to develop innovative, practical and financially responsible ways to make higher quality health care more accessible and affordable for more people.

Number of Employees:

87,000 at UnitedHealth Group; 3,680 at UnitedHealthcare Community & State

Client Base:

UnitedHealthcare Community Plan is part of UnitedHealthcare Community & State, one of three UnitedHealth Group benefits businesses:

- ***UnitedHealthcare Community & State*** – Medicaid, CHIP and other public programs
- ***UnitedHealthcare Medicare & Retirement*** – serves Medicare beneficiaries
- ***UnitedHealthcare Employer & Individual*** – serves individuals, small- and mid-sized businesses, and large multi-site employers

UnitedHealthcare Community & State has contracts with 24 states and the District of Columbia, covering more than 3.4 million members. We also provide full-risk, long-term care programs in Arizona, Florida, Hawaii, Massachusetts, New Mexico, and Texas.

UnitedHealth Group also operates three services businesses:

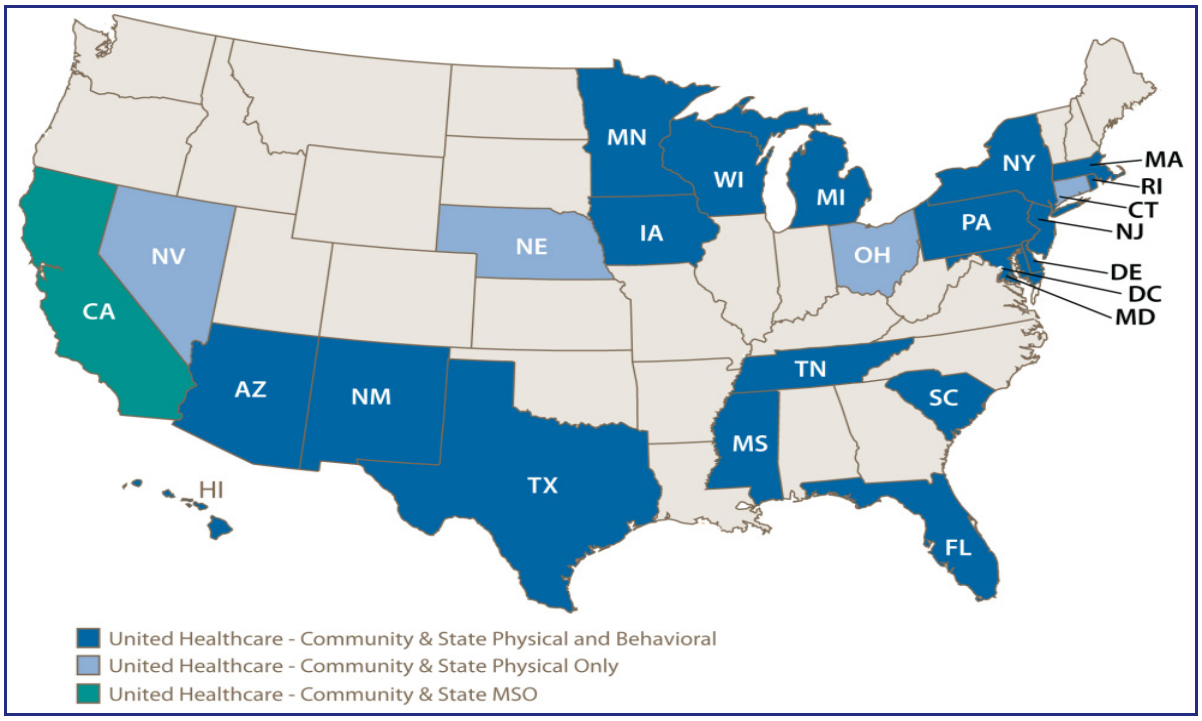
- **OptumHealth**, including United Behavioral Health (UBH) – health and wellness services.
- **OptumInsight** (formerly Ingenix) – Health care information, technology and consulting
- **OptumRx** (formerly Prescription Solutions) – Pharmacy Benefit Manager

Together, our family of six companies serves more than 75 million people, 6,200 hospital facilities, 246,000 health care professionals or groups, in all 50 states.

In 2010, the three UnitedHealth Group benefits businesses were privileged to serve a million more people than in 2009. They also transitioned smoothly and successfully to a single, unifying brand name, UnitedHealthcare. The alignment of UnitedHealthcare Community Plan with UnitedHealth Group will provide access to the full spectrum of the Company's products, services, and capabilities.

Location of Offices:

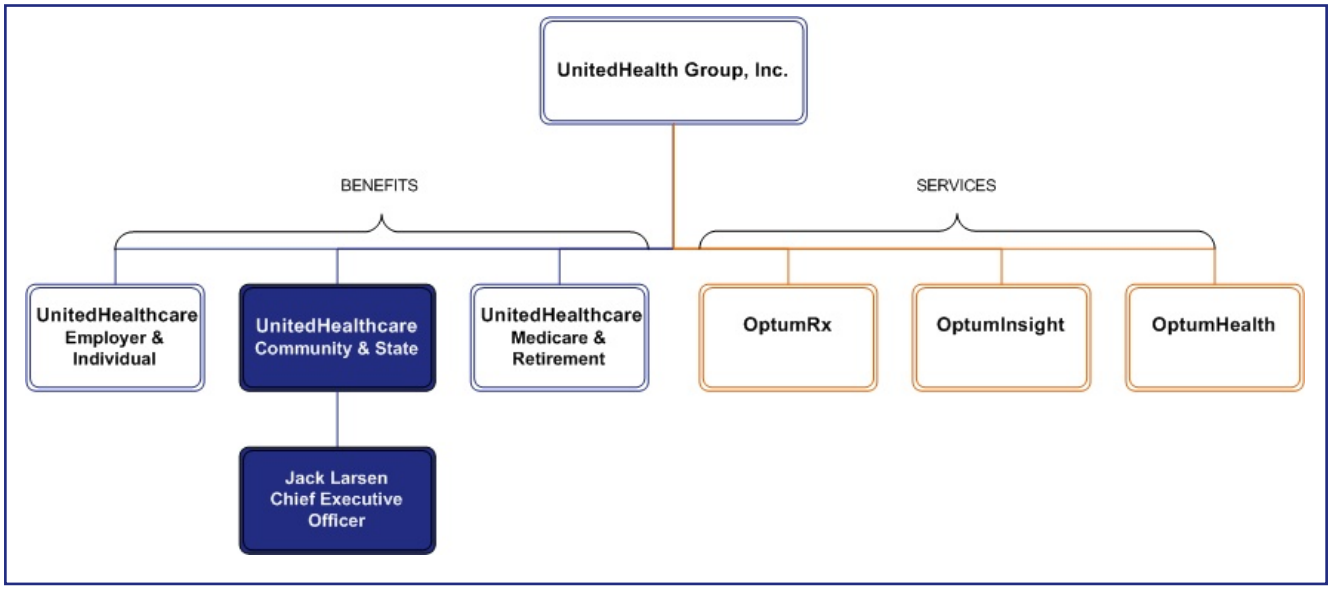
UnitedHealthcare Community & State is located at 9701 Data Park Drive, Minnetonka, MN 55343. Locations of our health plans are shown on the map below. We also utilize seven call centers throughout the country and maintain an administrative office in Pittsburgh.

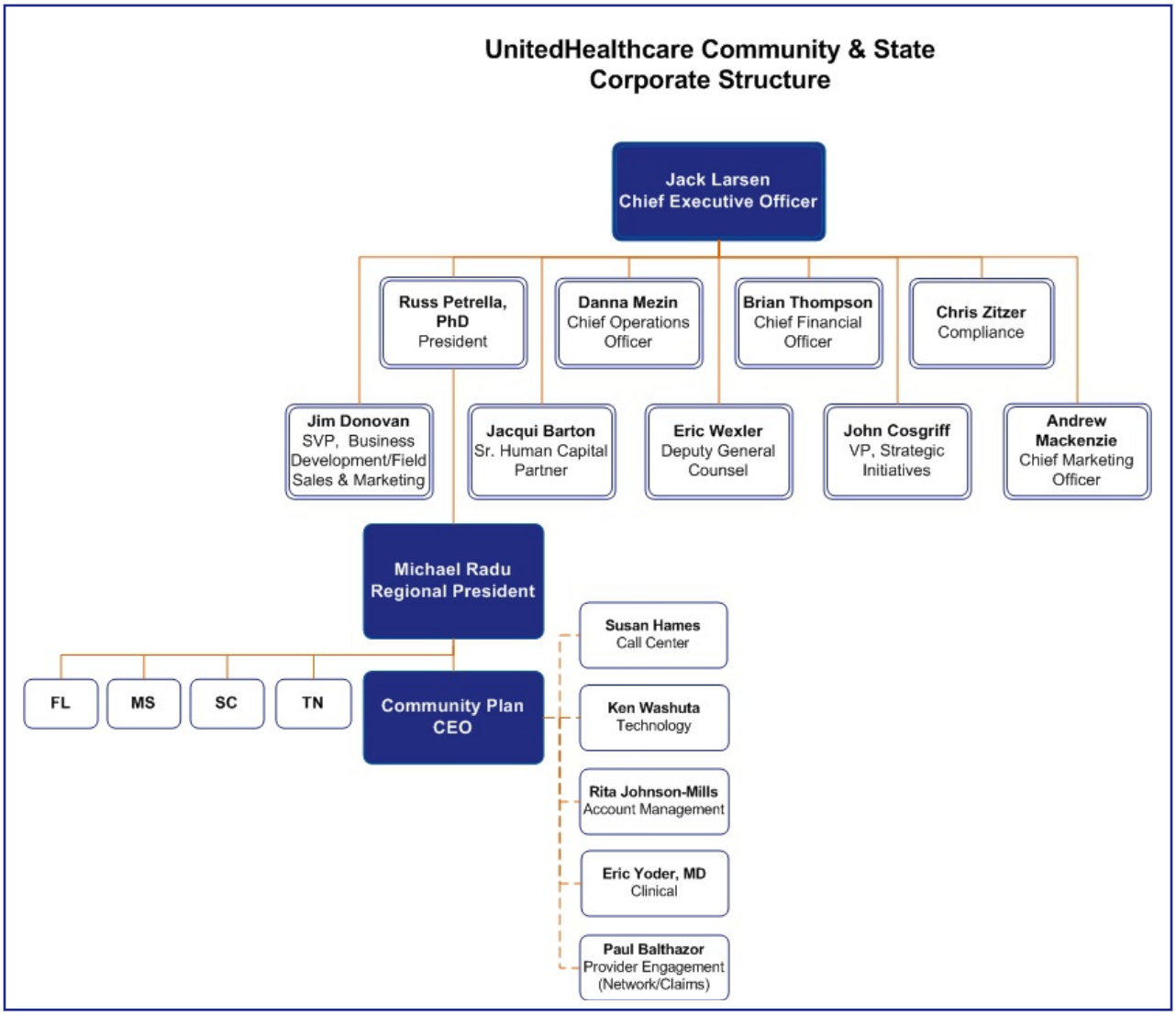


Company Organization Chart and Management

The charts below show the leadership and reporting structure for UnitedHealth Group and UnitedHealthcare Community & State.

Chart A. Corporate Structure




UnitedHealthcare Community & State
Corporate Structure
Jack Larsen
Chief Executive Officer
Russ Petrella, PhD
President
Danna Mezin
Chief Operations Officer
Brian Thompson
Chief Financial Officer
Chris Zitzer
Compliance
Jim Donovan
SVP, Business Development/Field Sales & Marketing
Jacqui Barton
Sr. Human Capital Partner
Eric Wexler
Deputy General Counsel
John Cosgriff
VP, Strategic Initiatives
Andrew Mackenzie
Chief Marketing Officer
Michael Radu
Regional President
FL
MS
SC
TN
Community Plan CEO
Susan Hames
Call Center
Ken Washuta
Technology
Rita Johnson-Mills
Account Management
Eric Yoder, MD
Clinical
Paul Balthazor
Provider Engagement (Network/Claims)

Major Subcontractors

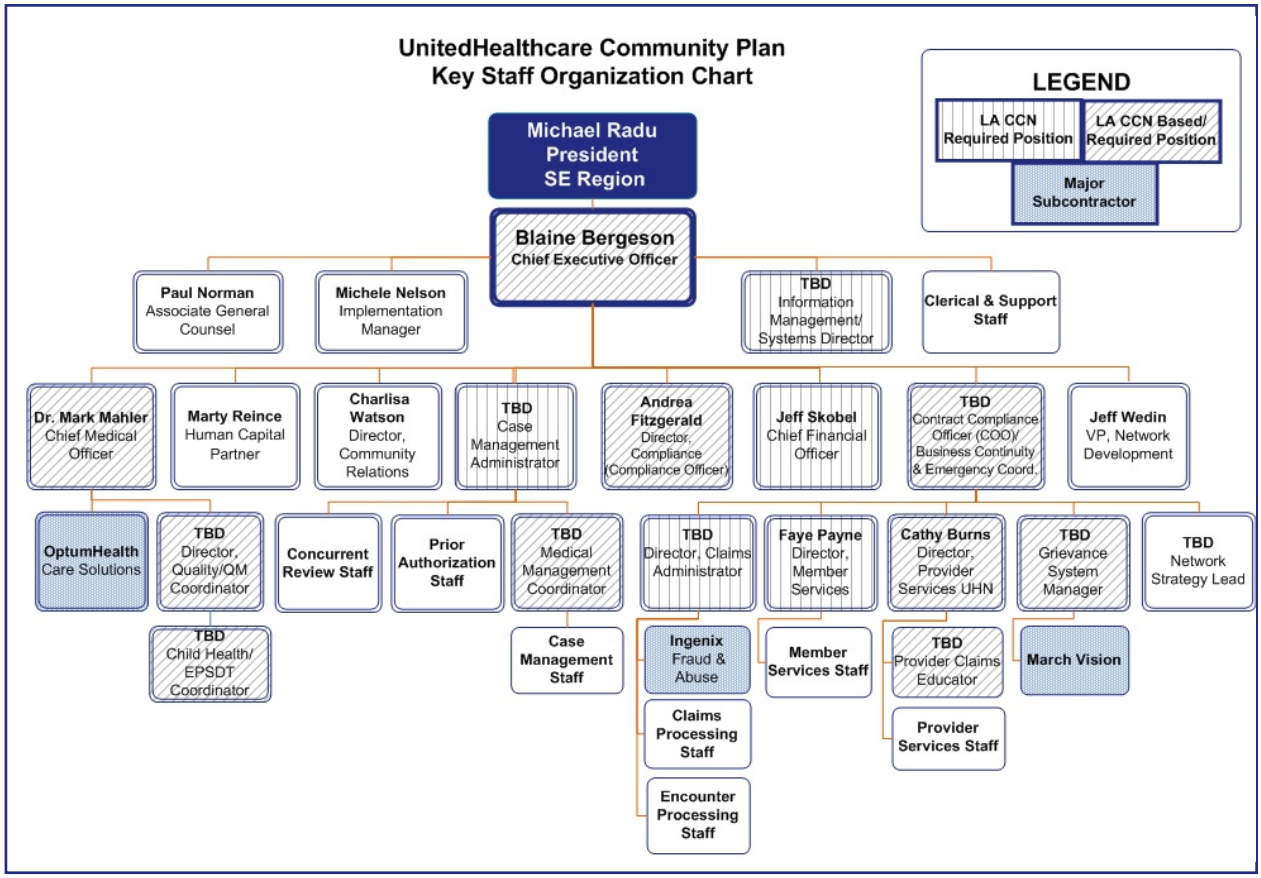
We have identified fellow UnitedHealth Group subsidiary organizations OptumHealth Care Solutions, Inc., and OptumInsight (formerly Ingenix) as major subcontractors. March Vision, not a UnitedHealth Group subsidiary, is also a designated subcontractor. Organizational information and other requested information on these three companies is provided in Question B.11.

B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure including an organizational chart showing the Louisiana organizational structure, including staffing and functions performed at the local level. If proposing for more than one (1) GSA, include in your description and organizational chart if: 1) the team will be responsible for all GSAs or 2) if each GSA will differ provide details outlining the differences and how it will differ. (GSA C)

CCN Key Staff Positions

Blaine Bergeson will serve as the interim Chief Executive Officer of UnitedHealthcare Community Plan for all Louisiana GSAs. Blaine is well qualified to lead the CCN project team in preparing for the January 2012 Health Plan implementation. A 20-year health care veteran, Blaine is well versed in Louisiana and has played a key role in establishing productive relationships with key health care provider groups and community based organizations in the state.

From the outset, our current Southeast Regional Executive Team will assume many of the key positions noted on the following key staff chart. After we name permanent replacements, Southeast Region President Michael Radu and his team will continue to have oversight accountability over operations for UnitedHealthcare Community Plan. Following a contract agreement with the State, we will promptly fill the positions not already identified on the chart below.



Together with UnitedHealthcare community development, Blaine Bergeson has worked with the Louisiana Medical Association, Catholic Charities, the YMCA, the YWCA and other groups to deepen connections and grow potential community partnerships in key areas throughout the state. One notable example is **Family Road of Greater Baton Rouge** – providing service to more than 35,000 families in prenatal care, parenting and Medicaid Enrollment. The organization works with more than 100 other organizations in public/private sponsorships. UnitedHealthcare is a leader nationally and regionally in cultivating local partnerships such as this.

May 23, 2011

"We are excited and look forward to partnering and collaborating with UnitedHealthcare on your Heart Smart Sisters cardiovascular disease initiative, Healthy First Steps and your Sesame Street Healthy Habits for Life program that targets low income families on a budget."

Melissa W. Bailey
CEO & President
Family Road of Greater Baton Rouge

Our CCN project team, listed in Question B.10, will be responsible for identifying and filling the unnamed positions in the chart above. Staffing and job assignments for all positions needed to operate the Health Plan will commence promptly, following a contract agreement.

B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work required by this RFP and illustrate the lines of authority. Submit current resumes of key personnel documenting their educational and career history up to the current time. Include information on how long the personnel have been in these positions and whether the position included Medicaid managed care experience. (GSA C)

Key Personnel

Blaine Bergeson will serve as the Chief Executive Officer of UnitedHealthcare Community Plan until a permanent CEO is named. Resumes for the following 12 key staff people are included in Attachment B.10.a The lines of authority are illustrated in the Key Staff Organization Chart in Question B.9.

UnitedHealthcare Community Plan – Key Staff Roster	
Name	***Title***
Blaine Bergeson	Chief Executive Officer
Mark Mahler, M.D.	Chief Medical Officer
Jeff Skobel	Chief Financial Officer
Jeff Wedin	Vice President, Network Development
Andrea Fitzgerald	Compliance Officer
Catherine Burns	Director, Provider Services
Faye Payne	Director, Member Services
Michael Policky	Director, Claims Administrator
Charlisa Watson	Director, Community Relations
Marty Reince	Human Capital Partner
Paul Norman	Associate General Counsel
Michele Nelson	Implementation Manager

As required in section 4.1 of the RFP we will designate qualified and experienced professionals for the following remaining positions and include job descriptions as required:

- Contract Compliance Officer (Chief Operating Officer)
- Director, QM (QM Coordinator & Performance/QI Coordinator)
- Grievance System Manager
- Case Management Administrator/Manager
- Maternal Child Health/EPSDT Coordinator
- Medical Management Coordinator
- Provider Claims Educator
- Information Management and Systems Director
- Additional required staff (as designated in 4.1)

If any of your personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and last four digits of the Social Security Number.

None of the named key staff people is a current or former Louisiana state employee. We will supply timely information to DHH, once staffing decisions are made for the remaining positions.

If personnel are not in place, submit job descriptions outlining the minimum qualifications of the position(s). Each resume or job description should be limited to 2 pages.

Key Staff Job Descriptions

Job descriptions for the open Key Staff Positions are included in Attachment B.10.b.

For key positions/employees which are not full time provide justification as to why the position is not full time. Include a description of their other duties and the amount of time allocated to each.

Justification for Non Full Time Key Staff

Our Southeast Regional Executive Team will initially assume many of the Key Staff positions noted on the personnel roster above. Their Louisiana Community Plan roles will consume whatever portion of their time is required until permanent replacements are named.

Contract Compliance Officer/Business Continuity Coordinator

This position will serve as the Chief Operating Officer of the CCN. As such, it also will be responsible for the role of Business Continuity and Emergency Coordinator (as permitted by the RFP) working with the robust Business Continuity team from UnitedHealth Group. We estimate that with this centralized support in Business Continuity, 80 to 90 percent of the position's time will be devoted to the responsibilities designated for the Contract Compliance Officer's position.

Quality Management Coordinator/Performance Improvement Coordinator

The Director of Quality Management will fulfill the dual roles as Quality Management Coordinator and Performance/Quality Improvement Coordinator for the CCN. One hundred percent of the position's time will be dedicated to the CCN program. The position will be responsible for directing quality improvement activities and improvement of outcomes. This person will develop quality initiatives to improve member care and work in collaboration with case management to monitor/measure performance and improve performance indicators plan-wide. As membership increases, we will adjust staffing resources to ensure effective quality management for the CCN program.

B.11 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than $100,000 annually. Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located. (GSA C)

Major Subcontractors

We have identified fellow UnitedHealth Group subsidiary organizations OptumHealth Care Solutions, Inc., and OptumInsight (formerly Ingenix) as major subcontractors. March Vision, not a UnitedHealth Group subsidiary, is also a designated subcontractor. Contact information and other requested information on these three companies is provided later in this Question B.11.

Monitoring and Evaluation

Our mechanisms for monitoring subcontractors are described below. Unless otherwise noted, we use these approaches for external subcontractors and for our affiliated entities within UnitedHealth Group.

- ***Delegation Oversight***: We are accountable for delegated functions and recognize the necessity of maintaining continued oversight of delegated activities to ensure consistent, quality performance, without compromise. Accordingly, Chief Executive Officer Blaine Bergeson, as well as our Contract Compliance Officer, will monitor the performance of subcontractors to ensure contract compliance and operational excellence. In addition, our compliance staff, headed by Compliance Officer Andrea Fitzgerald and in-house counsel, Paul Norman, are responsible for ensuring that the services and functions performed by our subcontractors, including external vendors and affiliate segments, are completed in accordance with state contract requirements.
- ***Operations Meetings***: As appropriate, representatives from our subcontractors will be invited to UnitedHealthcare Community Plan operations meetings, promoting understanding of how each functional area is dependent on the success of the others. During these in-person meetings our Executive Team will provide direction for our subcontractors and ensure that their quality and effectiveness is sufficient to meet our objectives.
- ***Joint Operating Committees (JOC)***: UnitedHealthcare Community Plan will establish Joint Operating Committees for key functions, such as our member and provider call centers, claims processing, transportation, and durable medical equipment. These JOCs are comprised of our Chief Executive Officer or COO, members of our management team, and representatives from the subcontractor. The JOC meets as often as is necessary to address concerns and encourage the subcontractor to implement solutions to quality issues. These committees focus fully on the operations of the specific subcontractor to identify the root cause of the problem and create a comprehensive working solution. JOCs have been created for functions including transportation, home health, and third party liability.
- ***Operating Agreements***: We rely on the operating agreement for a description of the required functions and service levels; the process by which we will assess performance; the recourse we have if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate); and the authority of our Chief Executive Officer and executive team to drive change. This agreement is put in place with the consent of UnitedHealthcare Community Plan, the subcontractor, and CCN.
- ***Sign-off Authority***: In certain instances, our operating agreements include sign-off authority for our Chief Executive Officer and COO to approve or deny proposed changes in a subcontractor's policies. If one of our partners wishes to change a policy, or their technology, or other key elements of their services for our members, part of this process must include explicit approval from UnitedHealthcare Community Plan and agreement that we understand the impacts for our constituents.

- ***Auditing***: We perform annual on-site audits of our subcontractors, to verify that their staff, policies, and resources are appropriate to meet the requirements of their agreement with UnitedHealthcare Community Plan. These audits are completed by our Contract Compliance Officer. The results of these audits are reported in our monthly Compliance Committee meetings, which includes our executive leadership. The Compliance Committee recommends steps that will be taken by UnitedHealthcare Community Plan, and required of the subcontractor, to remedy operational issues and maintain compliance with the CCN contract. These mandates may include sanctions, fines, or revocation of the delegation agreement. Our Contract Compliance Officer communicates these decisions to the subcontractor, and as appropriate, reports them to the Board of Directors and the CCN Administration.
- ***Dedicated Staff***: As needed, we will establish new staff positions to work with specific subcontractors that require additional attention. UnitedHealthcare Community Plan understands that such steps are necessary for quality and performance improvement. Our Chief Executive Officer and COO work through these staff members to both monitor and drive improvement in our subcontracted services.
- ***Statistics and Reports***: Each subcontractor will be required to submit daily, weekly, and monthly reports and statistics to UnitedHealthcare Community Plan that illustrate their effectiveness. Key indicators used monitor our subcontractors and include provider service levels, call center statistics, claims timeliness, and claims accuracy statistics.
- ***Surveys***: We typically perform member and provider surveys to gain feedback on the service of subcontractors. A recently-instituted example of this is the Insight Survey, which members are encouraged to complete immediately following a telephone interaction with our member service staff. These real-time surveys give us critical insight into member's reaction to call quality.
- ***Governance Calls***: For our affiliated entities within UnitedHealth Group, UnitedHealthcare Community Plan hosts monthly governance calls, on which our Chief Executive Officer, our COO, and executives from our affiliated Medicaid health plans meet with executive leadership from our sister organizations. This meeting is attended by representatives from our claims operations, member and provider call center, and provider contracting. These national calls allow for problem solving and sharing of best practices; they enable our leadership to provide direct feedback on service quality, and ensure that services for our Medicaid programs are prioritized to promote contract compliance.
- ***Aligned Incentives***: UnitedHealthcare Community Plan will work to develop direct incentives for staff within our sister organizations that provide services for members. We work to create a shared process for goal setting and evaluation to incorporate greater input from the Director of Member Services, which will place greater weight on CCN contract requirements and our member services group. Staff performance evaluations reflect the technical aspects of the position (Average Speed of Answer, Abandonment Rate, First Call Resolution); the remainder of the evaluations are based on feedback from CCN, members, and the Director of Member Services.

Subcontractor Services in Other States

March Vision

Based in California, March Vision also provides services for UnitedHealthcare Community & State in the District of Columbia, Delaware, New Jersey, South Carolina and Pennsylvania.

OptumHealth Care Solutions

Based in Minnesota, OptumHealth Care Solutions offers Medicaid Chronic Care/Disease Management programs in the District of Columbia and 19 of the 24 states where UnitedHealthcare Community & State operates Medicaid managed care plans. This includes 3.2 million Medicaid members.

OptumInsight (formerly Ingenix)

Based in Minnesota, OptumInsight is the primary subcontractor for Fraud Waste and Abuse in all 25 UnitedHealthcare Community & State markets where we operate Medicaid managed care plans. This includes 3.4 million Medicaid members.

In addition, as part of the response to this item for each major subcontractor that is not your organization's parent organization affiliate, or subsidiary, restate and respond to items B.1 through B.7, B.10, and B.16 through B.27.

March Vision

B.1 Indicate your organization's legal name, trade name, dba, acronym, and … (GSA C)

- ***Legal Name***: March Vision Care Group, Incorporated
- ***d/b/a***: March Vision
- ***Physical and Mailing Address***: 6701 Center Drive West, Suite 790, Los Angeles, CA 90045
- ***Telephone Number***: (310) 216-2300
- ***Ultimate Parent Legal Name***: March Vision Care Group, Incorporated
- ***Form of Business***: March Vision Care Group, Incorporated (MARCH) is a professional medical corporation with a single shareholder. Glenville March, Jr., M.D. holds greater than a five percent interest in March Vision.

March Vision Officers and Directors		
Name	***Title***	***Mailing Address and Telephone***
Glenville March, Jr., M.D.	Secretary, Treasurer, CFO, and Sole Director	6701 Center Drive West Suite 790 Los Angeles, CA 90045 310/216-2311
Cabrini March, M.D.	President & Chief Executive Officer	6701 Center Drive West Suite 790 Los Angeles, CA 90045 310/216-2312

- ***Federal Taxpayer Identification Number***: 95-4874334
- ***Louisiana Taxpayer Identification Number***: Not Applicable
- ***State of Incorporation***: March Vision, Inc. is incorporated and commercially domiciled in the state of California
- ***Local Representative***: MARCH does not presently maintain an office in Louisiana.
- ***DHH previous engagement***: March Vision has not been engaged by DHH within the past 24 months.

B.2 Provide a statement of whether there have been any mergers, acquisitions…..(GSA C)

Neither MARCH nor its affiliates or subsidiary have undergone a merger, acquisition, or sale of assets within the last ten (10) years. Neither MARCH nor its affiliates or subsidiary anticipate a future change in ownership during the course of the next twelve (12) months.

B.3 Provide a statement of whether you or any of your employees, agents, independent contractors, or subcontractors have ever been convicted of, pled guilty to, or pled nolo contendere to any felony ….. (GSA C)

MARCH, its affiliates, and subsidiary, and its and their employees, agents, independent contractors, and subcontractors have not, to MARCH's knowledge, (a) been convicted of, pled guilty to, or pled *nolo contendere* to any felony, or any Medicaid or health care related offense or (b), been debarred or suspended by any federal or state governmental body. MARCH performs monthly checks of its employees, providers, and vendors against the OIG LEIE Exclusions database, U.S. Treasury SDN List, and the GSA's Excluded Parties List System.

B.4 Provide a statement of whether there is any pending or recent (within the past five years) litigation against your organization….. (GSA C)

There is no recent or pending litigation against MARCH, its affiliates, or its subsidiary.

B.5 Provide a statement of whether, in the last ten years, you or a predecessor company has filed (or had filed against it) any bankruptcy or insolvency proceeding…. (GSA C)

MARCH and its affiliates and subsidiary never have filed or had filed against it, any bankruptcy or insolvency proceeding, and have never undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors.

B.6 If your organization is a publicly-traded (stock-exchange-listed) corporation…. (GSA C)

Not applicable. MARCH is a privately held, professional medical corporation. MARCH and its affiliates and subsidiary never have been involved in any SEC investigations.

B.7 If another corporation or entity either substantially or wholly owns your organization, submit the most recent detailed financial reports …. (GSA C)

Not applicable. MARCH is a professional medical corporation with a single shareholder.

B.10 Attach a personnel roster and resumes of key people who shall be assigned to perform duties or services under the Contract, highlighting the key people who shall be assigned to accomplish the work …. (GSA C)

See Attachment B.10 MARCH - Personnel Roster and resumes of key people presently assigned to perform duties or services under the Contract. None of the personnel named in the roster are, to MARCH's knowledge, current or former Louisiana state employees. See Attachment B.10 MARCH – Job Descriptions.

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. …. (GSA C)

See Attachment B.16 MARCH -

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. …. (GSA C)

MARCH and its affiliates and subsidiary have never had a contract covering Medicaid or Medicare enrollees terminated or not renewed within the past five (5) years.

B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken …. (GSA C)

Not applicable.

B.19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following …. (GSA C)

Not applicable. Neither MARCH nor its affiliates or subsidiary are an insurance company.

B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? …. (GSA C)

Neither MARCH nor its affiliates or subsidiary have been notified of being in breach of any contract to provide physical health services within the past five (5) years.

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. …. (GSA C)

MARCH has never sought, and is not currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation. MARCH plans to initiate NCQA accreditation procedures in the fourth quarter of 2012.

B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? …. (GSA C)

Not applicable.

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. …. (GSA C)

Not applicable.

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act for the Medicaid contract identified in response to item B.16 …. (GSA C)

See Attachment B.24 MARCH

B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. …. (GSA C)

MARCH paid $3,750 on July 25, 2007. The payment was made to a health plan customer serving public sector membership as reimbursement for a fine imposed by the Ohio Department of Jobs and Family Services (ODJFS) in connection with having one vision care provider less than required by ODJFS in 1 out of 34 counties. The deficiency was promptly remedied and is the only time MARCH and its affiliates and subsidiary has received a penalty or sanction from a state or federal entity.

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. …. (GSA C)

MARCH and its affiliates and subsidiary are not currently, and have not been within the past five (5) years, the subject of a criminal or civil investigation by a state or federal agency.

B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract have had with a state Medicaid agency …. (GSA C)

March Vision references have been submitted as specified in this question.

If the major subcontractor is your organization's parent organization, affiliate, or subsidiary, respond to items B.1, B.8 and B.9. You do not need to respond to the other items as part of the response to B.11; note, however, responses to various other items in Section B must include information on your organization's parent organization, affiliates, and subsidiaries, which would include any major subcontractors that are your organization's parent organization, affiliate, or subsidiary.

OptumHealth Care Solutions

B.1 Indicate your organization's legal name, trade name, dba, acronym, and … (GSA C)

- ***Legal Name***: OptumHealth Care Solutions, Inc.
- ***d/b/a***: OptumHealth Care Solutions
- ***Physical and Mailing Address***: 6300 Olson Memorial Hwy., Golden Valley, MN 55427
- ***Telephone Number***: (763) 797-4821
- ***Ultimate Parent Legal Name***: UnitedHealth Group Incorporated
- ***Form of Business***: OptumHealth Care Solutions, Inc. is a wholly owned subsidiary of UnitedHealth Group Incorporated, a publicly traded corporation. No health professional holds a five percent interest in OptumHealth Care Solutions, Inc. or its ultimate parent company.

OptumHealth Care Solutions Officers and Directors		
Name	***Title***	***Mailing Address and Telephone***
Dawn Owens	Director	6300 Olson Memorial HWY Golden Valley, MN 55427 763/797-2216
John Prince	Director	9900 Bren RD East Minnetonka, MN 55343 763/797-2692
Robert Webb	Director / Officer- Chief Executive Officer	6300 Olson Memorial HWY Golden Valley, MN 55427 763/797-2405
Jeffrey Grosklags	Officer- Chief Financial Officer	6300 Olson Memorial HWY Golden Valley, MN 55427 763/797-4610
Timothy Ryan	Officer- Secretary	6300 Olson Memorial HWY Golden Valley, MN 55427 763/797-2506
Robert Oberrender	Officer- Treasurer	9900 Bren RD East Minnetonka, MN 55343 952/936-3123

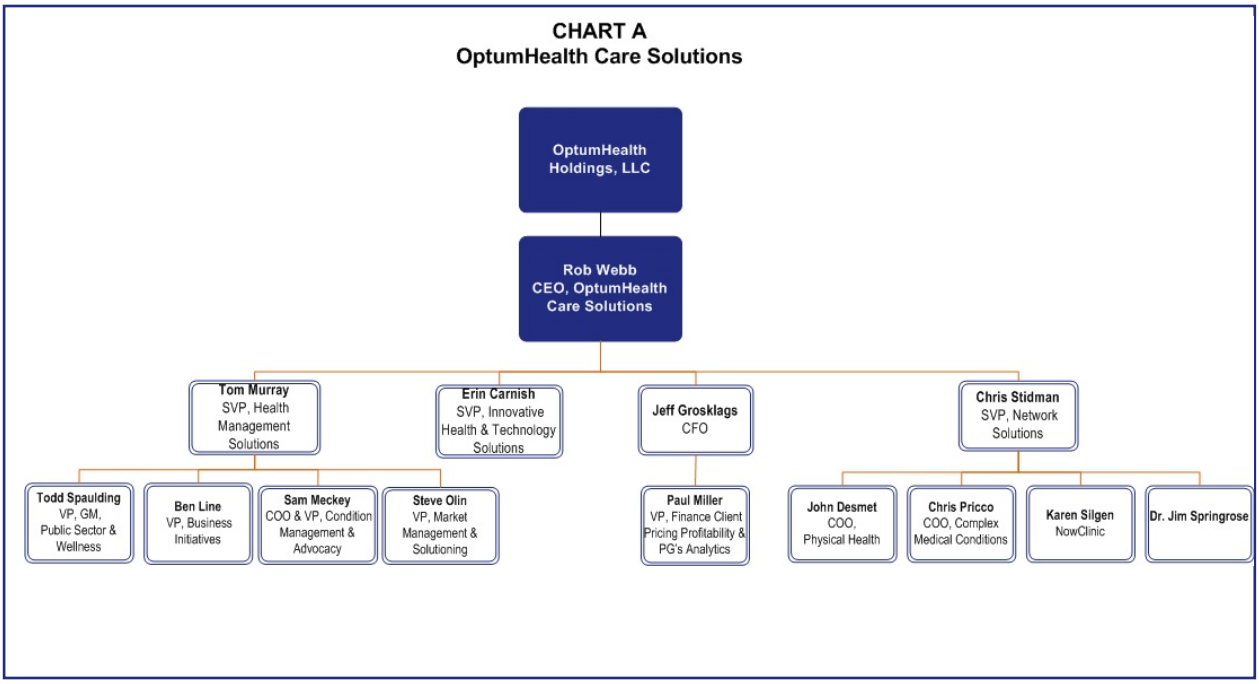
- ***Federal Taxpayer Identification Number***: 41-1591944
- ***Louisiana Taxpayer Identification Number***: Not Applicable
- ***State of Incorporation***: OptumHealth Care Solutions, Inc. is incorporated and commercially domiciled in the State of Minnesota.
- ***Local Representative***: OptumHealth Care Solutions does not presently maintain an office in Louisiana.
- ***DHH previous engagement***: OptumHealth Care Solutions, Inc. has not been engaged by DHH within the past 24 months.

B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart… (GSA C)

OptumHealth Care Solutions provides personalized health management support and services for more than 40 million Americans that enable them to stay healthy, get healthy, or live with health conditions. Services include holistic wellness and discount programs, customized portal options, decision support, disease solutions, complex medical condition support, case and utilization management programs, and physical health programs. Additionally, Care Solutions manages private health and wellness Internet portals that provide industry-leading content.

- ***Number of Employees***: 4,855
- ***Client Base***: More than 40 million members- approximately 10 percent Medicare, 7 percent Medicaid, and 83 percent Commercial.
- ***Location of Offices***:

  Headquarters: Golden Valley, Minnesota
  Operational sites for this proposal include:
  Louisiana – Baton Rouge, Metairie
  Texas – San Antonio
  Illinois – Lisle



B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure… (All GSAs)

OptumHealth will provide the CCN with Chronic Condition/Disease Management, NurseLine, community-based wellness programs related to childhood obesity and diabetes prevention and control, physical health network and Specialty Care Management programs. Below is a chart showing the specific staff positions that will directly serve Louisiana members:

OptumHealth Care Solutions – Key Louisiana Staff Roster	
Name	***Title***
Brian Cunningham, Implementation Project Director	Responsible for implementation of all OptumHealth program components
Medical Directors	■ Provide clinical oversight of Chronic Care/Disease Management/Care Management, Specialty Care Management, wellness programs and NurseLine ■ Assist in coordinating integrated medical/behavioral health care planning and treatment
Registered Nurses	■ Use Health Risk Assessments, results of risk stratification by ImpactPro and other health screening and assessment tools ■ Work cooperatively with members, family, providers and other appropriate individuals to develop, support and monitor individual care plans for members in care/disease management programs ■ Manage services and support members in Specialty Care Management Programs including: Healthy First Steps, Neonatal Services, Transplant, End State Renal Disease Staff ■ Answer NurseLine, available 24 hours a day, 365 days a year to triage member symptoms and support member decisions to seek appropriate site of care for their symptoms within appropriate timeframe and urgency ■ Assist in coordinating integrated medical/behavioral health care planning and treatment
Social Workers	Assist in coordination of treatment and support services to support member health and wellness goals
Behavioral Health Coordinators	Assist in coordination of behavioral health services for members who have mental health or substance abuse treatment needs
Health Coaches	Reach out to members who can benefit from education and support related to maintaining and improving health and wellness through nutrition, exercise, receipt of routine medical care, etc

OptumInsight (previously Ingenix)

B.1 Describe your organization's number of employees, client base, and location ….. (GSA C)

- ***Legal Name***: Ingenix Inc.
- ***d/b/a***: No formal d/b/a has been filed.
- ***Physical and Mailing Address***: 12125 Technology Drive, Eden Prairie, MN 55344

- ***Telephone Number***: (952) 833-6610
- ***Ultimate Parent Legal Name***: UnitedHealth Group Incorporated
- ***Form of Business***: Ingenix Inc. is a corporation, providing health care information, technology and consulting services and is a wholly owned subsidiary of UnitedHealth Group. Its services will be used primarily to identify and prevent fraudulent practices and abuses, which squander taxpayer resources. No health professional holds a five percent interest in Ingenix Inc. or its ultimate parent company, UnitedHealth Group.

OptumInsight (Ingenix) Officers and Directors		
Name	***Title***	***Mailing Address and Telephone***
Andy Slavitt	Director and Officer – President and Chief Executive Officer	12125 Technology Drive Eden Prairie, MN 55344 952/833--8448
Eric Murphy	Officer – Executive Vice President	12125 Technology Drive Eden Prairie, MN 55344 952/833-7510
Lee Valenta	Officer - Chief Operating Officer	12125 Technology Drive Eden Prairie, MN 55344 952/833-8446
Gerald Knutson	Officer- Chief Financial Officer	12125 Technology Drive Eden Prairie, MN 55344 952/833-6115
Karin Keitel	Officer- Secretary	12125 Technology Drive Eden Prairie, MN 55344 952/833-7221
Robert Oberrender	Officer- Treasurer	9900 Bren RD East Minnetonka, MN 55343 952/936-3123
Brigid Spicola	Officer- Assistant Secretary	12125 Technology Drive Eden Prairie, MN 55344 952/833-7213
John Kelly	Officer- Vice President, Tax Services	9900 Bren Road East Minnetonka, MN 55343 952/936-1252

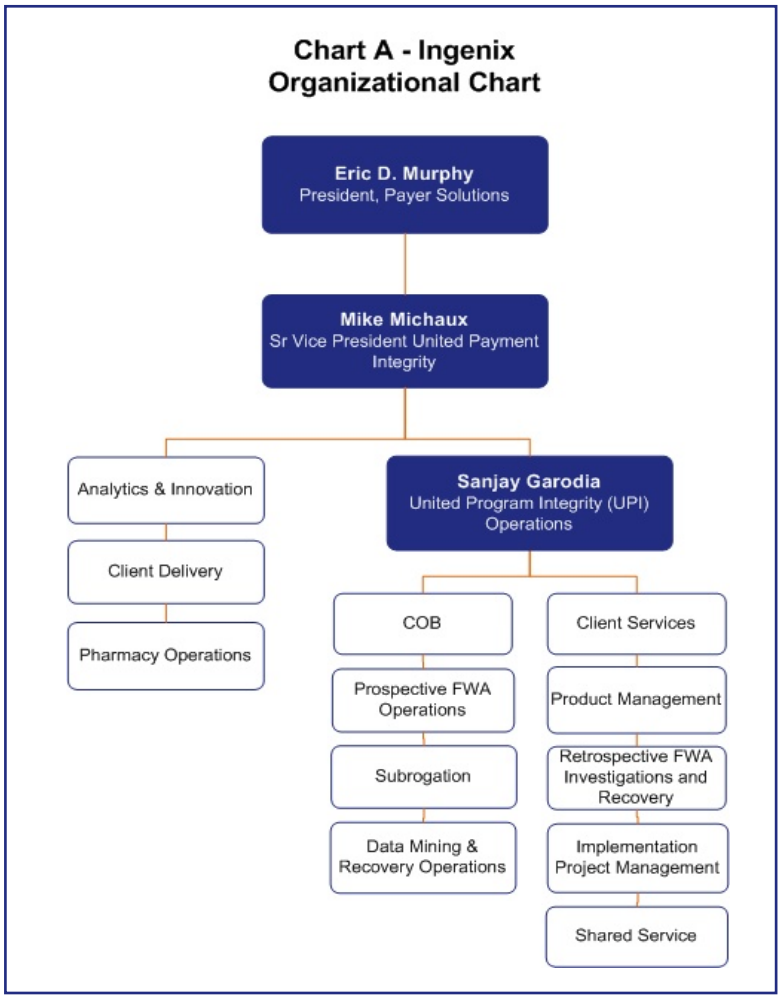
- ***Federal Taxpayer Identification Number***: 04-3574101
- ***Louisiana Taxpayer Identification Number***: Not applicable
- ***State of Incorporation***: Ingenix Inc. is incorporated in the State of Delaware and domiciled in the State of Minnesota where its corporate headquarters are located.
- ***Local Representative***: The local registered agent for OptumInsight is CT Corporation, 5615 Corporate Blvd., Suite 400B, Baton Rouge, LA 70808.
- ***DHH previous engagement***: OptumInsight Inc. has not been engaged by DHH within the past 24 months.

B.8 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart… (GSA C)

OptumInsight (Ingenix) is a leading provider of health information, technology, and consulting services. Organizations, institutions, businesses and government agencies that comprise the health care system depend on OptumInsight solutions and perspective to improve their performance. We help more than 14 million people use information to save lives, improve care and transform the health care system.

- ***Number of Employees***: approximately 14,000, including affiliates
- ***Client Base***: Our market groups include provider, government, life sciences, and payer. More than 250,000 clients depend on OptumInsight's consulting and technology expertise to provide the intelligence, connectivity, and workflow to help the health care system work more efficiently. Among our key clients are 31 Medicaid agencies in state governments across the country, including some of the nation's largest (CA, IL, MI, NJ, WA).
- ***Location of Offices***:

  Headquarters: Eden Prairie, Minnesota
  Other locations: OptumInsight has operational and client sites in states across the country, including teams in the capital cities of our key state government clients.



B.9 Provide a narrative description of your proposed Louisiana Medicaid Coordinated Care Network project team, its members, and organizational structure… (GSA C)

UnitedHealthcare Community Plan Claims Administrator Michael Policky and his Claims Processing Staff will be responsible for ensuring that fraud and abuse services delivered by **OptumInsight** (Ingenix) meet the requirements of DHH and UnitedHealthcare Community Plan. Chief Executive Officer Blaine Bergeson, and our Contract Compliance Officer, to whom Mr. Policky will report, also will have responsibility for the performance of OptumInsight through the tools detailed earlier in Question B.11. referring to subcontractor monitoring and evaluation.

The Louisiana project team for OptumInsight will utilize its experience in providing fraud and abuse support and services for UnitedHealthcare's other 25 Medicaid or CHIP managed care health plans that enable them to be good stewards of taxpayer resources.

B.12 Provide a description your Corporate Compliance Program including the Compliance Officer's levels of authority and reporting relationships. Include an organizational chart of staff (marked as Chart B in your response) involved in compliance along with staff levels of authority. (GSA C)

UnitedHealthcare Community Plan's Chief Executive Officer (CEO), Blaine Bergeson will provide oversight to our Compliance Officer, Andrea Fitzgerald, who works closely with UnitedHealthcare's Chief Medicaid Compliance Officer, Chris Zitzer. Our Corporate Compliance Plan is derived and supported directly by our UnitedHealth Group's (our parent company) Corporate Compliance Program. As one of the country's leading health and wellbeing companies, UnitedHealth Group's reputation ranks high among its most important assets. Customers, employees, regulators, health care professionals, investors and others expect honesty and integrity in their dealings with UnitedHealth Group. These qualities are included in our core values.

Because UnitedHealth Group is committed to the highest standards of integrity, an Ethics and Integrity Program ("the Program"). The Program promotes compliance with applicable legal requirements, fosters ethical conduct throughout our organization and provides guidance to our employees and contractors. Additionally, the Program focuses on increasing the likelihood of preventing, detecting, and correcting violations of law or Company policy. The implementation of such a program, however, cannot guarantee the total elimination of improper employee or agent conduct. If misconduct occurs, we will investigate the matter, take disciplinary action, if necessary and implement corrective measures to prevent future violations. Preventing, detecting and correcting misconduct safeguards our reputation, assets and the reputation of our employees.

As part of the Program, we have adopted the "Principles of Ethics and Integrity" (the "Principles"). The Principles is a guide to acceptable and appropriate business conduct by our employees and contractors. Following are key components of the Principles.

- Written Standards, Policies and Procedures
- High Level Oversight – Governance
- Effective Training and Education
- Effective Lines of Communication / Reporting Mechanisms
- Enforcement and Disciplinary Guidelines
- Auditing and Monitoring
- Response to Identified Issues.

Key Elements of Compliance

Written Standards, Policies, and Procedures

The Principles emphasize our strong commitment to compliance and ethical business practices. As stated, the Principles govern all of our employees, sub-contractors and serve as a blueprint for ethical and compliant business practices.

We have developed, published, and provided training and ongoing communications relating to expectations for managing our business in accordance with legal/regulatory and business requirements. The UnitedHealth Group Ethics and Integrity Office also maintains the "Shared Policy and Resource Knowledgebase" (SPARK) Policy Center. Policies and procedures are posted and easily accessed by all employees through SPARK. The Policy Center includes company-wide policies that apply to all employees of UnitedHealthcare Community Plan.

Employees are responsible for being familiar with the policies in SPARK. In addition to SPARK, there are policies that specifically relate to certain business units, departments, plans or products. Each business unit communicates these specific policies to employees and others who are affected by them and who must comply with the policies as they conduct business. For example, to further support UnitedHealthcare Community Plan, policies have been developed to reinforce the expectations of employees and provide additional resources for compliance with legal/regulatory and business requirements including: compliance reporting, investigations, training and education, and auditing and monitoring.

High Level Oversight – Governance

Our Compliance Office administers and provides organization-wide oversight to ensure compliance with the Corporate Compliance Program. The UnitedHealth Group Chief Compliance Officer conducts oversight of the Principles and provides routine reports directly to the UnitedHealth Group Board of Directors.

In alignment with the UnitedHealth Group Program, leadership for UnitedHealthcare Community Plan has appointed a Chief Compliance Officer, Andrea Fitzgerald, who is responsible for the strategy, implementation, and oversight of our Program. This Compliance Officer reports and is accountable to top leadership within UnitedHealthcare and to UnitedHealth Group Executive Vice President. Our Program is structured to include other dedicated Compliance Officers accountable for oversight of Medicare and Medicaid program activities.

Compliance Committee Structure

To ensure appropriate oversight, program implementation, and business engagement, oversight committees organized around the UnitedHealthcare Community Plan Corporate Responsibility and Compliance structure will convene on a regular basis for specific business areas, according to their unique requirements. Business area oversight committees include but are not limited to the Medicare Compliance Oversight Committee, the Medicaid Compliance Oversight Committee, and the Delegated Entity or Procurement Oversight Committee. These compliance committees have oversight of all state reporting and data submissions. The process is set up to ensure high level oversight and accountability for the accuracy and integrity of submitted information.

All oversight committees report to the executive level Corporate Responsibility and Compliance Oversight Committee (CRCOC) under the direction of the UnitedHealthcare Community Plan Chief Compliance Officer, Chris Zitzer. The CRCOC is comprised of other senior executives and has a primary objective of assisting our Chief Compliance Officer and top leadership in fulfilling their responsibilities of developing, implementing and monitoring our Program. Throughout the Corporate Responsibility and Compliance oversight committee structure, reports on the status of our Program will be provided to appropriate governing bodies.

Effective Training and Education

We maintain new employee orientation requirements that ensure training and provide tools for all employees to understand and follow the Principles and business practice expectations. In addition to general new employee orientation, we provides mandatory employee compliance training including but not limited to: Ethics and Integrity Program Overview; Handling Sensitive Data and Electronic Media; Privacy Overview; Privacy and Security Awareness; Records Management Awareness; Whistle Blowers; Information Security; Conflicts of Interest; Pharma Interactions; Harassment Prevention and Identifying Fraud, Waste, and Abuse.

Compliance training is required for all UnitedHealthcare Community Plan employees, managers and directors, applicable company contractors (for Medicare and Medicaid programs, contractors including first tier, downstream, and related entities), and those employees of other UnitedHealth Group segments who perform work on behalf of our programs. Training is required upon hire and at least annually thereafter. Specialized compliance training on issues posing compliance risks for an employee's job function also may be provided in areas of business functions or operations.

Organizational mandatory training is managed through our online ULearn System, which tracks required training and completion for employees. Targeted compliance or job function training for employees, contractors, agents, directors and membership of the compliance committees may be managed through this system or by the individual business units conducting the training.

As required by the DHH, UnitedHealthcare Community Plan staff will attend any training given by the State, its Fiscal Agent, or other entity – provided reasonable advance notice is given regarding the scheduled training.

The following chart provides an overview of our compliance training.

UnitedHealthcare

Corporate Responsibility & Compliance

2011 UnitedHealth Group Compliance Training & Communication Schedule

- This schedule outlines the compliance related training and communications that will be delivered to and / or impact employees within Medicare & Retirement, Community & State, and Military & Veterans.
- The schedule was developed by the Enterprise Compliance Training Council, which is comprised of compliance representatives from each UHG business segment. The UHG Compliance Office will manage the schedule.
- This calendar supports the Council's long-term goal of developing a 3–4 year compliance training and education strategy. This long-range strategy will include both formal training activities delivered via online training modules as well as ongoing educational activities such as targeted communications.

Definitions

Communications	Items noted as communications will include mass emails, business intranet postings, paper-based mail drops, table tents, posters, etc
Ethical Moments	Ethical Moments are brief video training vignettes delivered to employees via company intranet sites and mass emails. The content and delivery of these videos are managed through the UHG Compliance office.
UHG New Hire	Courses will be released and assigned via ULearn solely to newly hired employees.
UHG Limited Audience	Courses will be released and assigned via ULearn to a focused audience where the course content directly relates to specific job functions, responsibilities, and/or location.
UHG All Employee	Course will be released and assigned via ULearn to all UnitedHealth Group employees.
Course Retirement	Of the courses historically managed by the UHG Compliance & Ethics office, seven will be retired in 2011 due to expiring content. *(Records Management Awareness, Foreign Corrupt Practices Act, Ethics & Integrity Program Overview, Conflicts of Interest, Handling Sensitive Data & Electronic Media, Information Security, and Whistleblowers for Managers)*

2011 Required ULearn Training for Employees

	Month	Training Course	Description
All Employee	January	Privacy & Security – You Hold the Key	The course developed by UHG Privacy/Security in late 2010 was released for all employees in January 2011.
	April / May	Fraud, Waste, & Abuse Prevention	The 2011 Fraud, Waste, and Abuse prevention course will build on and replace the courses developed and managed by Corporate Responsibility & Compliance in 2009 and 2010.
	June / July	Code of Conduct Certification	In concert with the release of a revised UHG Code of Conduct, a 'read and sign' module will be assigned to all employees. This certification meets the expectations of our government regulators for annual code distribution.
	July / August	ERM & You	This course creates awareness of the Enterprise Records Management policy and supports employees in more effectively managing electronic records.
	January 2012	Privacy & Security *(2011 UHG Course)*	The 2011 privacy & security training course is anticipated to be released to employees in January 2012 to support employee focus on imperative Q4 2011 business objectives.
Limited Audience	March	Anti-Bribery / FCPA	Course content will focus on the Foreign Corrupt Practices Act, the pending UK bribery act and the recent increase in enforcement actions by the DOJ and SEC.
	March	Organizational Conflicts of Interest	Course content will focus on the handling of potential organizational conflicts of interest – i.e. those that could occur due to the interrelated nature and broad reach of UnitedHealth Group business entities.
	June	Sexual Harassment Training	Course will be required of all CA managers to comply with CA state requirements.
New Hire	June	UHG Code of Conduct	Course is expected to provide new employees a more in-depth review of the new UHG Code of Conduct than the 'read and sign' required of all existing employees.
	July	Manager Compliance Report Handling	Course is expected to provide managers with tools and information on handling compliance reports from employees, information on whistleblower actions, and the company policy on non-retaliation.

Effective Lines of Communication

Effective communication between our Compliance Officer and employees, managers, directors, compliance committee members, contractors, agents, and regulators is critical to the successful implementation of an effective compliance program and the reduction of potential for non-compliance or fraud, waste and abuse.

UnitedHealth Group and UnitedHealthcare Community Plan supports effective lines of communication through encouraging reporting through available resources including managers, senior management, compliance officers, and the organization's compliance hotline, the Ethics & Compliance Help Center. Our Program also requires the development of a communication and awareness strategy across business functions to ensure compliance resources, initiatives, and other projects are being communicated to employees, managers and directors, compliance committee members, and all other appropriate parties. UnitedHealth Group expressly prohibits retaliation for good faith reports. To the extent possible, we will take reasonable precautions to maintain the confidentiality of those who report integrity or compliance concerns. For more information on reporting resources, see the next section on Reporting Mechanisms.

Andrea Fitzgerald, Compliance Officer serves as UnitedHealthcare Community Plan's primary contact for escalated issues received through our state regulators. The account and relationship management staff receive, manage, and respond to the regulatory escalated issues and concerns. Those accountable for regulatory relationship management work closely with the business areas to assess identified issues and ensure corrective action as necessary.

Reporting Mechanisms

All employees are required to report known or suspected non-compliance. Failure to report suspected violations, misconduct or non-compliance violates the Principles and the expectations of all employees. Failure to report is grounds for employee disciplinary action. We expressly prohibit retaliation for good faith reports. To the extent possible, we will take reasonable precautions to maintain the confidentiality of those who report integrity or compliance concerns.

The leadership of UnitedHealth Group and UnitedHealthcare Community Plan, our Corporate Compliance Office and our Corporate Responsibility and Compliance team will ensure routine communication with employees about compliance and business expectations. These communications, including employees' responsibilities to report potential non-compliance, are communicated through the training programs described above and through a variety of methods including electronic mail, internal newsletters, posters, face-to-face meetings and other methods as appropriate. Ongoing compliance efforts and expectations also will be communicated through these mechanisms.

Our Program and other policies cannot address every situation our employees may encounter. We rely on the good judgment and values of our employees and managers to act with integrity. Recognizing that everyone brings professional skills and personal values to his or her job, our Program guides employees to ask these questions when faced with a difficult situation:

- *Are my actions legal?*
- *Are my actions ethical?*
- *Am I being fair and honest?*
- *How will it look in the newspaper?*
- *Will I sleep soundly tonight?*
- *What would I tell my child to do?*
- *Will my actions stand the test of time?*
- *How will I feel about myself afterward?*

If an employee is still not sure after asking these questions, every employee has the right and responsibility to request guidance. UnitedHealth Group and UnitedHealthcare Community Plans have established multiple resources for employees to obtain guidance from:

- A manager or a more senior manager in the business unit
- The UnitedHealthcare Chief Compliance Officer
- UnitedHealthcare Community Plan Compliance Officer
- A Privacy Lead or the Privacy Officer
- The Ethics & Compliance Help Center – Available 24 hours a day, 7 days a week
  - Frontier intranet, choose Ethics & Integrity/Help Center under Important Links
  - The designated contact to report suspected violations of the UnitedHealth Group, company policies, or the law
- HealthCare Fraud Tip Line – Available 24 hours a day, 7 days a week
  - Frontier intranet, choose Ethics & Integrity / Help Center under Important Links then Report Health Care Fraud
  - The designated contact for suspected health care fraud, waste, or abuse
- HR Direct
  - For anonymous situations for compensation and employment concerns, policy guidance and interpretation
- Risk Management
  - The designated contact to report unsafe conditions, workplace hazards, and potential claims against insurance policies.
- Corporate Security
  - The designated contact to report concerns regarding employee security including security breaches and theft.

Enforcement and Disciplinary Guidelines

We require that all employees – regardless of their position – comply with laws, regulations, company policies and other requirements applicable to our businesses. Unethical or illegal acts cannot be justified by saying they were for the good of the company or were directed by a higher authority in the company. No employee is ever authorized to commit, or to direct another employee to commit, an unethical or illegal act. In addition, employees cannot use a contractor, agent, consultant, broker, distributor or other third party to perform any act not allowed by law, the Principles, our Program, any company policy or any applicable contractual obligation.

The goal of the Principles and our Program is to promote proper conduct and avoid the need for discipline. However, all violations of the law, the Principles, our Program, or company policies and contractual obligations are taken seriously. We reserve the right to terminate an employee at any time for any reason with or without prior disciplinary counseling or notice to the employee. When we determine that disciplinary action is necessary, such disciplinary action may include verbal, written and final warnings, suspension, or termination. In addition, employees who commit criminal or illegal acts may face immediate termination and possible legal action.

Enforcement and disciplinary guidelines are publicized via the Principles, our Program, our Employee Handbook, the policy center SPARK, and through communication methods such as our intranet site, memos and newsletters. Our Program also collaborates with our Human Capital team to support communication of enforcement and disciplinary guidelines as well as ensure consistent discipline for identified compliance issues and demonstration that employees, managers, directors, and contractors are not retaliated against for reporting issues in good faith.

Auditing and Monitoring

Auditing

Our Audit Management team centrally manages, reports, and tracks audits and corrective actions for regulatory compliance audits or studies conducted by federal agencies including but not limited to the Centers for Medicare and Medicaid Services (CMS), Office of Inspector General (OIG), and General Services Office. Audit Management also tracks, reports and provides support to regulatory compliance audits conducted by state regulatory agencies and state contracted entities such as an External Quality Review Organization (EQRO).

Our Internal Compliance Audit team within Audit Management supports the organization by engaging in compliance audits pursuant to an approved audit plan. The purpose of these audits is to ensure the business and associated contracted entities are meeting expectations, the requirements of state and federal regulations, and other regulatory commitments made by UnitedHealthcare Community Plan to both internal and external stakeholders and regulators. The process also ensures high level oversight and accountability for the accuracy and integrity of all reporting and data submissions to the Department.

Monitoring

A key focus of our Program is not only to ensure compliance with laws and regulations but also to measure its own effectiveness. The monitoring activities performed by compliance, business functional areas, Medicare or Medicaid plan personnel or other organizational areas are intended to identify, prevent and correct regulatory risk for the organization. Monitoring activities are intended to provide verification that the compliance program is effective and drives routine feedback on organizational performance and compliance with applicable laws, regulation and internal policies. Our compliance infrastructure, under the leadership of our Chief Compliance Officer, Chris Zitzer, implements monitoring activities that support a business operations compliance program. Activities can include, but are not limited to, internal audits and reviews, internal operational/functional area reporting of key compliance metrics, and implementing appropriate corrective action where necessary. Results of those activities are tracked, trended and reported as part of an overall operations level compliance program.

Responding to Identified Issues

Our Corporate Responsibility & Compliance team supports coordination between the UnitedHealth Group Compliance Office, UnitedHealth Group Ethics and Integrity, our Legal department, the business unit and UnitedHealthcare Community Plan Compliance personnel to ensure appropriate corrective action and government agency reporting, if required, for identified non-compliance.

All credible concerns that are either reported or identified through activities such as auditing or monitoring will be reviewed and investigated and, when appropriate, corrective and disciplinary action will be taken in response to the associated findings to promptly reduce the potential for recurrence.

Overview of Anti-Fraud, Waste and Abuse Program

Through the Anti-Fraud, Waste, and Abuse Program, UnitedHealthcare Community Plan's mission is to prevent paying fraudulent, wasteful and abusive health care claims, as well as identify, investigate and recover money it has paid for fraudulent, wasteful or abusive claims. UnitedHealthcare Community Plan will also appropriately refer suspected fraud, waste and abuse (FWA) cases to law enforcement, regulatory, and administrative agencies pursuant to state and federal law. We seek to protect the ethical and fiscal integrity of the company and its employees, members, providers, government programs, and the public, as well as safeguard the health and well-being of our members.

UnitedHealthcare Community Plan is committed to vigilant compliance with its Anti-FWA Program and all applicable federal and state regulatory requirements governing its Anti-FWA Program. We recognize that state and federal health plans are particularly vulnerable to fraud, waste and abuse and strive to tailor our efforts to the unique needs of our members and Medicaid, Medicare and other government partners.

All suspected instances of FWA are thoroughly investigated. In appropriate cases, the matter is reported to law enforcement or regulatory authorities, in accordance with federal and state requirements. We also cooperate with law enforcement and regulatory agencies in the investigation or prevention of FWA.

Overview of Privacy & Security Program and Policies

The UnitedHealthcare Community Plan's Privacy policies are built on and incorporate the UnitedHealth Group Privacy Program standards. The policies contain basic materials that describe privacy requirements applicable to the Medicaid segments and business units and are available via our SPARK policy center. The policies are updated periodically to reflect changes in legal and regulatory requirements and changes in corporate administrative practice.

In alignment with our security policies, the Privacy Office will identify and respond to potential or actual security and privacy incidents; mitigate, to the extent practical, harmful effects of actual security and privacy incidents; document security and privacy incidents and their outcomes; and collaborate with the UnitedHealth Group Privacy Office and others as appropriate. This process will also apply to security and privacy incidents involving contracted business associates. Failure by an employee to appropriately administer the privacy policies will result in disciplinary action, up to and including termination of employment.

An effective compliance program fosters a culture of compliance that begins at the highest levels and extends through the organization. The Principles and the Compliance Program are aligned to work as a cohesive program and to ensure the development and management of systems and structures to prevent, detect and promptly correct potential compliance concerns. We are committed to creating a culture that supports ethics, integrity and compliance in all of its day-to-day activities.

Chart B


Compliance Staff and Level of Authority
UnitedHealth Group Board of Directors
Corporate Responsibility & Compliance Oversight Committee
Committee Chair – Business & Compliance Leads
Members – Executive Leadership (includes Chris Zitzer, VP, Chief Medicaid Compliance Officer
UnitedHealthcare Community Plan Board of Directors
Corporate Responsibility & Compliance Medicaid Oversight Committee
Committee Chair – Business & Compliance Leads
Members – Community & State Executive Operating Committee
UnitedHealthcare Community Plan Oversight Committee
Committee Chair – Andrea Fitzgerald, Plan Compliance Officer
Members - Plan Executive Team (includes Blaine Bergeson, CEO)

B.13 Provide copies of any press releases in the twelve (12) months prior to the Deadline for Proposals, wherein the press release mentions or discusses financial results, acquisitions, divestitures, new facilities, closures, layoffs, significant contract awards or losses, penalties/fines/ sanctions, expansion, new or departing officers or directors, litigation, change of ownership, or other very similar issues, Do not include press releases that are primarily promotional in nature. (GSA C)

Copies of press releases in the past twelve (12) months, as requested, are presented in Attachment B.13.

B.14 Describe your plan for meeting the Performance Bond, other bonds, and insurance requirements set forth in this RFP requirement including the type of bond to be posted and source of funding. (GSA C)

UnitedHealthcare Community Plan currently has in place all of the policies required in sections 2.5.2. Workers' Compensation Insurance, 2.5.3. Commercial Liability Insurance, 2.5.5. Errors and Omissions Insurance and 2.5.7. Licensed and Non-Licensed Motor Vehicles. We also have an insolvency agreement in place between UnitedHealthcare Community Plan and UnitedHealthcare Insurance Company for Reinsurance. Should DHH require us to have an excess of loss agreement in place, we will enter into a new agreement with UnitedHealthcare Insurance Company for this coverage. We currently have a fidelity bond in place and can procure a performance bond from an approved surety once we are awarded the contract.

B.15 Provide the following information (in Excel format) based on each of the financial statements provided in response to item B:31: (1) Working capital; (2) Current ratio; (3) Quick ratio; (4) Net worth; and (5) Debt-to-worth ratio. (GSA C)

Please refer to Attachment B.15 – Ratios.

B.16 Identify, in Excel format, all of your organization's publicly-funded managed care contracts for Medicaid/CHIP and/or other low-income individuals within the last five (5) years. In addition, identify, in Excel format your organization's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP and/or other low-income individuals within the last five (5) years. For each prior experience identified, provide the trade name, a brief description of the scope of work, the duration of the contract, the contact name and phone number, the number of members and the population types (e.g., TANF, ABD, duals, CHIP), the annual contract payments, whether payment was capitated or other, and the role of subcontractors, if any. If your organization has not had any publicly-funded managed care contracts for Medicaid/SCHIP individuals within the last five (5) years, identify the Proposer's ten largest (as measured by number of enrollees) managed care contracts for populations other than Medicaid/CHIP individuals within the last five (5) years and provide the information requested in the previous sentence. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

Please refer to Attachment B.16.a Managed Care Summaries and Attachment B.16.b – Managed Care Summaries for Largest Contracts.

B.17 Identify whether your organization has had any contract terminated or not renewed within the past five (5) years. If so, describe the reason(s) for the termination/nonrenewal, the parties involved, and provide the address and telephone number of the client. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

UnitedHealth Group and its managed care subsidiaries comprise a large national organization in a highly competitive marketplace. We have participated in competitive procurement and re-procurement processes

where a customer opts to contract with our competitors. We are not aware of terminations or non-renewals of contracts for which our or an affiliate's performance was specifically cited as the reason for termination or non-renewal within the past five (5) years.

For Medicaid, we have not had any contracts terminated or not renewed where the entire program was not also terminated, other than one instance in 2007 where, subsequent to our 14 year tenure as statewide Indiana Medicaid enrollment broker, CMS determined that health plans could not operate as both a health plan and as the Medicaid enrollment broker, disqualifying UnitedHealthcare. For our Medicaid and CHIP programs, a mutual contract termination occurred on May 31, 2009, between Evercare of Texas and the Texas Health and Human Services Commission regarding the Integrated Care Management contract in the Dallas/Fort Worth area. Including Texas, there have been four plans where a state discontinued its program due to funding issues: WA (07), WA (08), GA (11), and TX (09).

B.18 If the contract was terminated/non-renewed in B.17 above, based on your organization's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination/non-renewal. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

Not applicable; we are not aware of terminations or non-renewals of contracts for which our or an affiliate's performance was specifically cited as the reason for termination or non-renewal within the past five (5) years.

B. 19 As applicable, provide (in table format) the Proposer's current ratings as well as ratings for each of the past three years from each of the following

- ***AM Best Company (financial strengths ratings);***
- ***TheStreet.com, Inc. (safety ratings); and***
- ***Standard & Poor's (long-term insurer financial strength. (GSA C)***

Current UnitedHealth Group Ratings

	Standard & Poor's	*TheStreet.com*	*A.M. Best*
UnitedHealth Group Senior Unsecured Debt	A-	A+	bbb+
UnitedHealth Group Commercial Paper	A-2	A+	AMB-2
Outlook	stable	Buy	stable

A.M. Best ratings were downgraded from a- to bbb+ January 29, 2008, otherwise the ratings above reflect our standings for the past three years.

B.20 For any of your organization's contracts to provide physical health services within the past five years, has the other contracting party notified the Proposer that it has found your organization to be in breach of the contract? If yes: (1) provide a description of the events concerning the breach, specifically addressing the issue of whether or not the breach was due to factors beyond the Proposer's control. (2) Was a corrective action plan (CAP) imposed? If so, describe the steps and timeframes in the CAP and whether the CAP was completed. (3) Was a sanction imposed? If so, describe the sanction, including the amount of any monetary sanction (e.g., penalty or liquidated damage) (4) Was the breach the subject of an administrative proceeding or litigation? If so, what was the result of the proceeding/litigation? Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

UnitedHealthcare Community Plan, UnitedHealth Group (our parent company), our affiliates and subsidiaries provide services to approximately 70 million members nationwide. To the best of our knowledge, we are not aware of any instance where there has been any formal allegation of breach of contract for our Medicaid, Medicare or CHIP products. We are committed to providing excellent service to all of our public sector clients and have never had a contract terminated or non-renewed due to any allegation for failing to meet a contract requirement.

We are also not aware of any instance where there have been any formal allegations of breach of contract as part of our public employee contracts or for non-public sector contracts covering more than 200,000 lives in the last five years.

As specified in other responses, UnitedHealthcare Community Plan, UnitedHealth Group, affiliates and subsidiaries, are subject to litigation, contractual and regulatory fines and penalties as well as corrective action plans in the normal course of business. Litigation and SEC issues are described in responses to B.4 and B.6 respectively. Fines, penalties and corrective action plans are addressed in the response to B.25, and the response to B.26 describes any additional investigations that we are aware of. While fines, penalties, and corrective action plans may be required under the contract terms, or the fines themselves may actually be paid as part of a contractual penalty, we do not believe that any of these would constitute formal notice of breach of contract. As part of our compliance program, as further described in B.12, we are committed to meeting the terms of our contract as well as all applicable state and federal regulatory requirements pertaining to our products. As delegates of the state's responsibility to the citizens and the legislature, it is our fervent desire to work closely with our public sector clients to proactively identify and address issues and to focus on improving quality, accessibility and affordability in the public programs we serve.

B.21 Indicate whether your organization has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status. If it has or is, indicate current NCQA or URAC accreditation status and accreditation term effective dates if applicable. (GSA C)

Committed to Quality: NCQA & URAC Accreditation Status

UnitedHealthcare of Louisiana holds a commendable NCQA accreditation and we are seeking to add NCQA certification for UnitedHealthcare Community Plan by 2012. UnitedHealthcare Community Plan is committed to providing quality health services to our Louisiana members. Achieving NCQA accreditation and maintaining it, provides health plans with industry recognized standards for quality and an independent evaluation of plan performance against these standards.

UnitedHealth Group: Committed to Quality

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Health Plans with Current NCQA Accreditations

To demonstrate our commitment to quality health care, we are building accreditation into our Louisiana programs—setting benchmarks and maintaining rigorous quality standards to improve care delivery and clinical practice, enhance customer service, seek better health outcomes and reduce medical costs. We continually seek new and creative approaches to provide quality care to our Louisiana members.

We believe in accreditation, and we value the opportunities provided through external reviews by independent organizations, such as NCQA. We strive to offer structurally sound managed care systems, **founded on quality member care and services that meet or exceed NCQA's rigorous requirements,**

while pursuing the highest range of HEDIS® and CAHPS® results and national performance scores, and we encourage NCQA endorsement for our publicly funded health care programs.[1]

Dedicated to Quality Performance and Improvement

Today, **nine of our Medicaid health plans hold NCQA accreditation**, with additional plans to develop our quality programs as shown below:

NCQA Accreditation – Medicaid HMO (Excellent)			
Health Plan Accreditation Programs (5)	***Initial Accreditation***	***Current Accreditation***	***Status***
Michigan – UnitedHealthcare of Great Lakes Health Plan	12.14.07	12.22.10 – 12.22.13	Excellent
Nebraska – UnitedHealthcare of the Midlands	08.12.05	09.02.08 – 09.02.11	Excellent
Pennsylvania – UnitedHealthcare of PA	01.24.03	07.31.08 – 07.31.11	Excellent
Rhode Island – UnitedHealthcare of New England	03.03.03	03.05.09 – 03.05.12	Excellent
NCQA Accreditation – Medicaid HMO (Commendable)			
Health Plan Accreditation Programs (1)	***Initial Accreditation***	***Current Accreditation***	***Status***
South Carolina – UnitedHealthcare of SC	01.11.08	01.07.11 – 01.07.14	Commendable
Tennessee – UnitedHealthcare Plan/River Valley	04.06	04.24.09 – 04.24.12	Commendable
NCQA Accreditation – New Health Plan (Passed)			
Health Plan Accreditation Programs (3)	***Initial Accreditation***	***Current Accreditation***	***Status***
DC – Unison Health Plan/Capital Area	08.01.09	08.01.09 – 08.01.12	Passed
Delaware – Unison Health Plan of DE	07.07.10	07.07.10 – 07.07.13	Passed
Ohio – UnitedHealth Community Plan of OH	12.29.08	12.29.08 – 12.29.11	Passed

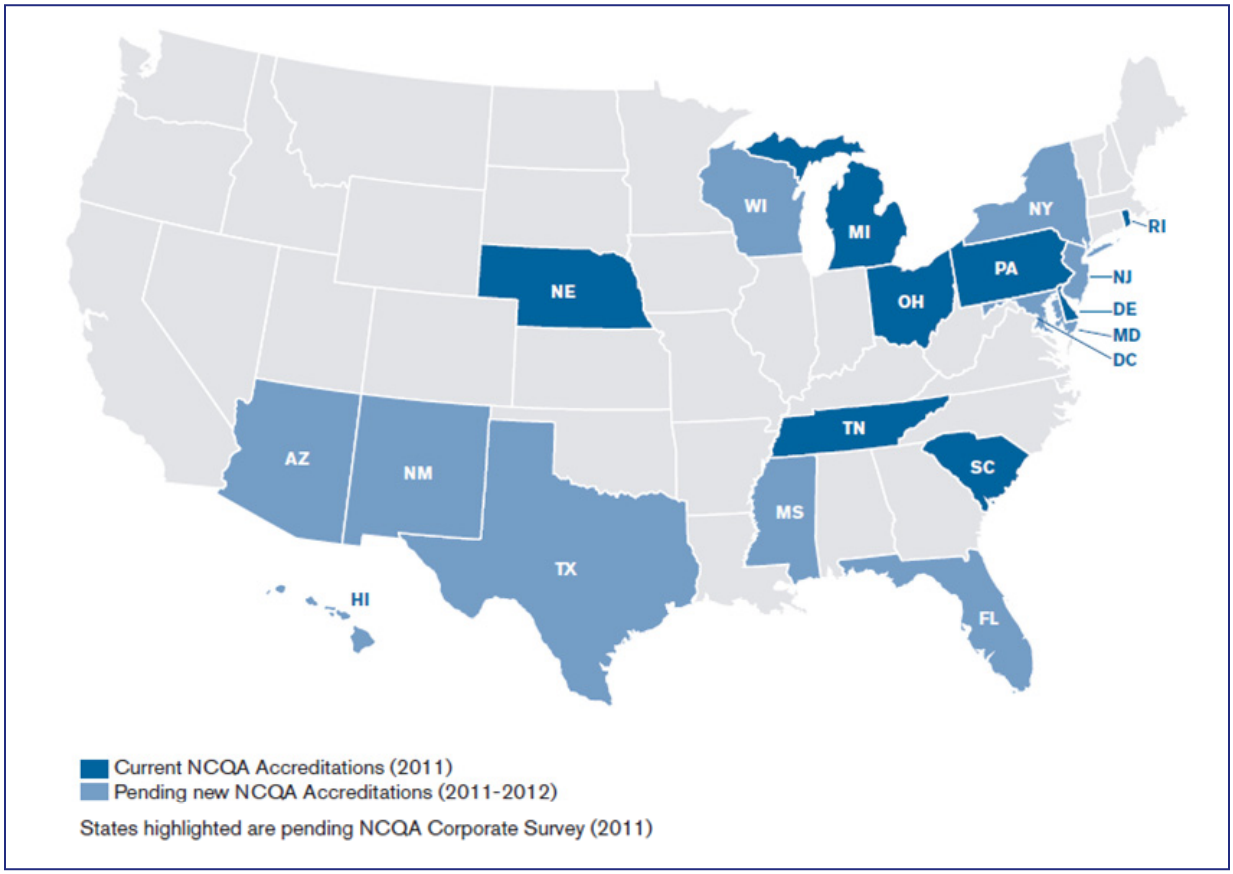
As we continue building quality measures and performance improvement into our health care programs, we have:

20 pending NCQA applications (including corporate, initial and new accreditations, and reaccreditations) scheduled through 2013 for our Medicaid business. They are:

- 7 accreditations in 2011:
  - 1 corporate level - UnitedHealthcare-Community & State
  - 6 state level - Maryland, Nebraska, New Mexico, Ohio, Pennsylvania and Rhode Island
- 10 accreditations in 2012:
  - 10 state level - Arizona, District of Columbia, Florida, Hawaii, Mississippi, New York, New Jersey, Tennessee, Texas, and Wisconsin
- 3 accreditations in 2013:
  - 3 state level - Delaware, Michigan and South Carolina

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Current and Pending NCQA Accreditations 2011-2012



B.22 Have you ever had your accreditation status (e.g., NCQA, URAC,) in any state for any product line adjusted down, suspended, or revoked? If so, identify the state and product line and provide an explanation. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

UnitedHealthcare Community Planhas never had an accreditation status suspended or revoked for any product in any state. Annually, NCQA re-evaluates the accreditation status of all accredited health plans in the nation based on the current year's HEDIS and CAHPS results. At this time, the accreditation status can be adjusted down or up.

UnitedHealthcare Employer & Individual (Commercial) has never had a health plan's accreditation status suspended or revoked. Each August/September NCQA re-evaluates the accreditation status of all accredited health plans in the nation based on that year's HEDIS and CAHPS results. The accreditation status could be lowered one level or accreditation or it can be increased. The commercial product line has over 74 health plans and this re-evaluation has been occurring since 2004.

Optum Health Care Solutions has never had any accreditation adjusted down, suspended or revoked.

UnitedHealthcare Community & State currently maintains 9 NCQA accredited plans. Due to the annual readjustment, one health plan, UnitedHealthcare of the River Valley previously accredited as Excellent was renewed in 2010 as Commendable.

B.23 If you are NCQA accredited in any state for any product line, include a copy of the applicable NCQA health plan report cards for your organization. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

Please refer to Attachment B.23 – NCQA Health Plan Report Cards.

B.24 Provide (as an attachment) a copy of the most recent external quality review report (pursuant to Section 1932(c)(2) of the Social Security Act for the Medicaid contract identified in response to item B.16 that had the largest number of enrollees as of January 1, 2011. Provide the entire report. In addition, provide a copy of any corrective action plan(s) requested of your organization (including your organization's parent organization, affiliates, and subsidiaries) in response to the report. (GSA C)

Please refer to Attachment B. 24.a – Annual Quality Surveys and Attachment B.24.b – Corrective Action Plans.

B.25 Identify and describe any regulatory action, or sanction, including both monetary and non-monetary sanctions imposed by any federal or state regulatory entity against your organization within the last five (5) years. In addition, identify and describe any letter of deficiency issued by as well as any corrective actions requested or required by any federal or state regulatory entity within the last five (5) years that relate to Medicaid or CHIP contracts. Include your organization's parent organization, affiliates, and subsidiaries. (GSA C)

Please refer to Attachment B. 25 – Regulatory Actions and Sanctions.

B.26 Provide a statement of whether your organization is currently the subject or has recently (within the past five (5) years) been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to item B.6. If your organization has recently been the subject of such an investigation, provide an explanation with relevant details and the outcome. If the outcome is against your organization, provide the corrective action plan implemented to prevent such future offenses. Include your organization's parent company, affiliates and subsidiaries. (GSA C)

Criminal or Civil Investigations

UnitedHealthcare of Louisiana is only involved in one current investigation, which involves a regulatory review by the Louisiana Department of Insurance (LDI) regarding the definition of chiropractic services in the commercial certificate of coverage. The LDI is in the process of reviewing this matter; additional information is due to LDI shortly.

UnitedHealthcare of Louisiana's Louisiana's ultimate parent and affiliates' businesses are also regulated at federal, state, local and international levels and are and have been involved in various governmental investigations, audits and reviews. These include routine, regular and special investigations, audits and reviews by CMS, state insurance and health and welfare departments, state attorneys general, the Office of Inspector General (OIG), the Office of Personnel Management, the Office of Civil Rights, U.S. Congressional committees, the U.S. Department of Justice, U.S. Attorneys, the SEC, the IRS, the U.S. Department of Labor, the Federal Deposit Insurance Corporation and other governmental authorities. Examples of audits include periodic market conduct and financial examinations, risk adjustment data validation (RADV) audits by CMS and a review by the U.S. Department of Labor of the Company's administration of applicable customer employee benefit plans with respect to ERISA compliance. The only ongoing investigations that we are aware of concerning Medicaid programs outside of standard market conduct or financial examinations are as follows:

1. A request for information from the Texas Office of Inspector General in May 2011, as to our affiliate, Evercare's, STAR+PLUS contract with the Texas Health and Human Services Commission.
2. In early 2011, Evercare in Hawaii received a data request from the US Attorney's Office for copies of the state's 820 and 834 Forms and certain claim information.

None of the foregoing current investigations have resulted in sanctions or corrective action plan are identified in the response to B. 25 above. Except as otherwise noted for the regulatory review, none of these other investigations currently involve UnitedHealthcare of Louisiana nor do we expect any of these investigations to impact or impair UnitedHealthcare of Louisiana's performance in a contract/agreement under this RFP. There have been no significant operational changes based upon any of the actions noted other than continued growth of our compliance education program to encourage early identification of potential issues across all employees.

B.27 Submit client references (minimum of three, maximum of five) for your organization for major contracts; with at least one reference for a major contract have had with a state Medicaid agency or other large similar government or large private industry contract. Each reference must be from contracts within the last five (5) years. References for your organization shall be submitted to the State using the questionnaire contained in RFP Appendix PP. You are solely responsible for obtaining the fully completed reference check questionnaires, and for submitting them sealed by the client providing the reference, with your Proposal, as described herein. You should complete the following steps:

a. Make a duplicate (hard copy or electronic document) of the appropriate form, as it appears in RFP Appendix PP (for your organization or for subcontractors, adding the following customized information:

- ***Your/Subcontractor's name;***
- ***Geographic Service Area(s) for which the reference is being submitted;***
- ***Reference organization's name; and***
- ***Reference contact's name, title, telephone number, and email address.***

b. Send the form to each reference contact along with a new, sealable standard #10 envelope;

c. Give the contact a deadline that allows for collection of all completed questionnaires in time to submit them with your sealed Proposal;

d. Instruct the reference contact to:

- ***Complete the form in its entirety, in either hard copy or electronic format (if completed electronically, an original should be printed for submission);***
- ***Sign and date it;***
- ***Seal it in the provided envelope;***
- ***Sign the back of the envelope across the seal; and***
- ***Return it directly to you.***

e. Enclose the unopened envelopes in easily identifiable and labeled larger envelopes and include these envelopes as a part of the Proposal. When DHH opens your Proposal, it should find clearly labeled envelope(s) containing the sealed references.

THE STATE WILL NOT ACCEPT LATE REFERENCES OR REFERENCES SUBMITTED THROUGH ANY OTHER CHANNEL OF SUBMISSION OR MEDIUM, WHETHER WRITTEN, ELECTRONIC, VERBAL, OR OTHERWISE.

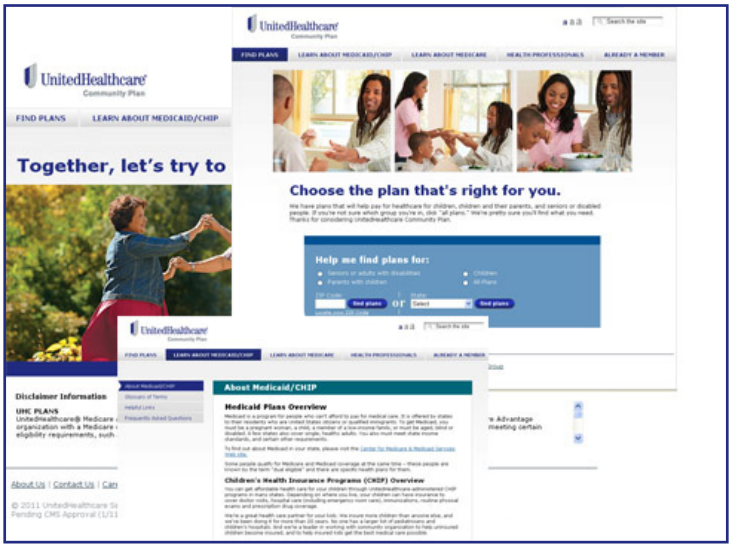
Each completed questionnaire should include:

- ***Proposing Organization/Subcontractor's name;***
- ***GSA (s) for which the reference is being submitted;***
- ***Reference Organization's name;***
- ***Name, title, telephone number, and email address of the organization contact knowledgeable about the scope of work;***
- ***Date reference form was completed; and***
- ***Responses to numbered items in RFP Attachment # (as applicable).***

DHH reserves the authority to clarify information presented in questionnaires and may consider clarifications in the evaluation of references. However DHH is under no obligation to clarify any reference check information. (GSA C)

UnitedHealthcare Community Plan references have been submitted as specified in this question.

B.28 Indicate the website address (URL) for the homepage(s) of any website(s) operated, owned, or controlled by your organization, including any that the Proposer has contracted to be run by another entity as well as details of any social media presence (e.g. Facebook, Twitter). If your organization has a parent, then also provide the same for the parent, and any parent(s) of the parent. If no websites and/or social media presence, so state. (GSA C)



www.uhccommunityplan.com will be the home for digital communication between UnitedHealthcare Community Plan and members, physicians and state partners. The new site was launched in 2011 after extensive testing by focus groups with consumers, physicians and state government employees involved in Medicaid program administration. This site will help all of our constituents better understand how to access CCN services along with the breadth and depth of our experience in state and federal programs. It will also showcase our efforts in areas of corporate responsibility at the local level.

www.unitedhealthgroup.com is the digital home for our parent company. This site provides information about all UnitedHealth Group Health Benefits businesses and Health Services businesses, as well as ongoing company financial and business news.

www.unitedhealthfoundation.org is the home of the United Health Foundation and its annual publication of America's Health Rankings, where readers can obtain a comprehensive perspective on our national health issues, state by state. The 2010 Rankings feature an interactive map to compare states health

data side-by-side, and learn what we can do to improve our health in the future. Detail on Louisiana's ranking is available on the website.

UnitedHealth Group utilizes social media on the LinkedIn site for recruitment and sharing best practices with other industry leaders.

B.29 Provide evidence that the Proposer has applied to Louisiana Department of Insurance for a certificate of authority (COA) to establish and operate a prepaid entity as defined in RS 22:1016 and in accordance with rules and regulations as defined by the Department of Health and Hospitals. (GSA C)

Certificate of Authority

Our Certificate of Authority is on file with the Louisiana Department of Insurance and a copy is included in Attachment B.29.

B.30 Provide the following as documentation of financial responsibility and stability: (GSA C)

- ***a current written bank references, in the form of a letter, indicating that the Proposer's business relationship with the financial institution is in positive standing;***

Please refer to Attachment B.30.a – UnitedHealth Group Bank Reference Letter.

- ***two current written, positive credit references, in the form of standard business letters, from vendors with which the Proposer has done business or, documentation of a positive credit rating determined by a accredited credit bureau within the last 6 months;***

The Dun & Bradstreet Credit Bureau ratings for UnitedHealth Group are summarized below:

Dun & Bradstreet Credit Ratings
The PAYDEX rating is 70.
Commercial Credit Score Class is 2.
Financial Stress Class is 3.
D&B Rating is ER1.

Please also refer to Attachment B.30.b – Dun and Bradstreet credit ratings.

- ***a copy of a valid certificate of insurance indicating liability insurance in the amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate; and***

Please refer to Attachment B.30.c – Certificate of Insurance.

- ***a letter of commitment from a financial institution (signed by an authorized agent of the financial institution and detailing the Proposer's name) for a general line of credit in the amount of five-hundred thousand dollars ($500,000.00).***

UnitedHealthcare Community Plan will have a restricted deposit (backed by cash) in the amount of $500,000.00 which would be set-up with a bank at time we are awarded the contract.

B.31 Provide the following as documentation of the Proposer's sufficient financial strength and resources to provide the scope of services as required:

- ***The two most recent independently audited financial statements and associated enrollment figures from the Proposer. Compiled or reviewed financial statements will be accepted. The audited financial statements must be:***

- ***Prepared with all monetary amounts detailed in U.S. currency;***
- ***Prepared under U.S. generally accepted accounting principles; and***
- ***Audited under U.S. generally accepted auditing standards. The audited financial statements must include the auditor's opinion letter, financial statements, and the notes to the financial statements. (GSA C)***

Please refer to Attachment 31a.1 – UnitedHealthcare of LA 2009 AFS and Attachment 31a.2 – UnitedHealthcare of LA 2010 AFS.

- ***The Proposer's four (4) most recent internally prepared unaudited quarterly financial statements (and Year-to- Date), with preparation dates indicated. The statements must include documentation disclosing the amount of cash flows from operating activities. This documentation must indicate whether the cash flows are positive or negative, and if the cash flows are negative for the quarters, the documentation must include a detailed explanation of the factors contributing to the negative cash flows.***

Please refer to Attachment 31b.1 – Q3 2010, Attachment 31b.2 – Q2 2010, Attachment 31b.3 – Q1 2010, Attachment 31b.4 – Negative Cash Flow and Attachment 31b.5 – Annual 2010.

- ***Verification of any contributions made to the Proposer to improve its financial position after its most recent audit (e.g., copies of bank statements and deposit slips), if applicable***

Proposer shall include the Proposer's parent organization.

The company made a cash infusion of $6M in early 2010. Please see Attachment 31.c – Bank Statement.

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Section C: Planned Approach to Project:

Describe how you will launch a network and set up operations capable of supporting its membership and meeting the requirements of the RFP by January 1, 2012 for GSA "A", March 1 of 2012 for GSA "B", and May 1 of 2012 for GSA "C".

C.1 Discuss your approach for meeting the implementation requirements and include:

- ***A detailed description of your project management methodology. The methodology should address, at a minimum, the following:***
  - ***Issue identification, assessment, alternatives analysis and resolution;***
  - ***Resource allocation and deployment;***
  - ***Reporting of status and other regular communications with DHH, including a description of your proposed method for ensuring adequate and timely reporting of information to DHH project personnel and executive management; and***
  - ***Automated tools, including use of specific software applications. (GSA C)***

UnitedHealthcare has demonstrated the success of our implementation model in Tennessee, Mississippi, Arizona and Connecticut, as well as many others. Following our proven implementation model, we have already launched our multifunctional Executive Steering Committee to ensure a flow of national resources to support a timely and effective January 1st implementation for UnitedHealthcare Community Plan. The team is led jointly Blaine Burgeson, Chief Executive Officer and Michele Nelson, Implementation Manager, to ensure all implementation activities are carried out in a smooth and efficient manner. As part of our desire for continuous quality improvement in all areas, every implementation is reviewed to ensure that all lessons learned are applied to future implementations.

> *"I would like to extend my sincere appreciation for your work with the Children's Health Insurance Program (CHIP). Making over 40,000 calls welcoming CHIP member-households this past December and conducting Health Risk Assessments were critical to the health awareness of our at-risk children."*
> ***– Phil Bryant, Lt. Governor State of Mississippi, June 4, 2010***

In any new statewide implementation of managed care, there is a level of anxiety among providers, advocates and members. As October 1st approaches, we will convene a second internal Louisiana-focused group, our UnitedHealthcare Command Center Model. The Command Center operates 24/7 and facilitates rapid resolution of any issues identified by our local management team. We have found the use of this approach successfully addresses concerns in a way that builds confidence among key stakeholders and lessens anxiety for providers, advocates and members. We will also provide a dedicated hot line to key stakeholders at DHH to ensure awareness of implementation progress challenges. Our entire senior management team, as well as other key personnel, will assist Command Center staff to ensure there is a smooth transition for new members and an effective transition for the providers who serve them. The following table summarizes our experience in implementing new or expanded programs in 2010.

State	Program	Award Type	Membership
Wisconsin	Medicaid	Re-bid/Re-enrollment	180,000
Mississippi	CHIP	New Program	67,000
Nebraska	Medicaid	Re-Bid and Expansion	50,000
Florida	CHIP	Re-bid and Expansion	45,000

We look forward to a partnership with the DHH that achieves the goals of high quality health care along with proven strategies to lower cost. Below is a summary of key features of our project management methodology which we believe will show our

experience and capabilities to assist you in this managed care implementation.

Project Management Methodology

We have a proven, reliable, replicable approach to ensure timely integration of multiple functions to create a smooth transition for members and providers who are part of the CCN program. In the past 36 months, UnitedHealthcare has successfully implemented two new Regions in Tennessee covering over 300,000 members, a state Long Term Care (LTC) program covering 20,000 members in TN, a statewide Children's Rehabilitative Services contract covering over 20,000 Arizona children, a new health plan in Connecticut and a statewide CHIP expansion in Florida. These effective implementations were achieved by using a replicable process and a dedicated team of experienced project managers who organize and manage the implementation process on a full time basis. In addition to our primary focus on members, our continuous improvement process has led to a very comprehensive project management tool that ensures that each functional team (clinical, technology, operations, etc.) simultaneously achieves the milestones within their units yet stay connected on those active interdependencies across multiple functions.

Our project management methodology is based upon a cross functional executive steering committee that meets regularly (typically weekly) to address progress toward milestones and to encourage rapid resolution of issues or barriers. Underneath the executive team is a functional "core" team comprised of functional experts in each functional area that meets weekly to achieve the objectives of the project. Each team reports progress and challenges and the resources of the organization are directed to ensure that key milestones are met. Our recent accomplishments in Wisconsin, Mississippi, Nebraska and Florida attest to the effectiveness of this project management methodology.

At each stage we are in constant communication with our staff assigned to this project. We are fully transparent on our progress and welcome close coordination as there are many dependencies that are required, especially regarding approval and data interfaces. Our experience in 24 states makes us confident that we can work effectively in the implementation to meet our mutual constituents' needs.

In preparing to implement CCN operations, we have identified an accomplished clinical and administrative staff to ensure management consistency and operational continuity from implementation to ongoing operations. We are pleased to have local experts working alongside national experts to guide the implementation and ongoing operations. In addition to UnitedHealthcare Community Plan staff, our project team includes staff from UnitedHealthcare's national organization and support from other organizations within UnitedHealth Group with expertise in key program areas, such as care management and predictive modeling. This team represents the core strengths of our organization and highlights the unique advantages that UnitedHealthcare Community Plan brings including individuals with local Louisiana knowledge to the CCN program.

Our successful implementation experience nationwide uniquely qualifies us to serve members in the Louisiana CCN. We will respond fully and thoroughly to all areas of implementation. Our project team approach is based on our successful experience in effectively implementing programs in 22 states and the District of Columbia. Our project management methodology will include:

- ***Executive Steering Committee***: Our Executive Steering Committee (ESC) includes Blaine Bergeson and other leaders from operational and functional areas who began meeting regularly in 2010 in anticipation of Louisiana's new program. This ESC will continue to work together throughout the duration of the contract. These individuals represent operations, network management, medical management, finance, technology and legal. They serve as the ultimate authority and will sign off on all CCN deliverables.
- ***Functional Lead Teams***: Functional Leads from all areas of health plan operations meet with their internal teams weekly and report to the ESC. Functional Lead experts for all areas including clinical

services, network development, member services, provider services, compliance, finance, and management information systems (MIS) manage department level pieces of our overall project plan.

- ***Work Groups:*** The implementation milestones are addressed by work groups of specialists in areas such as clinical operations, network, staffing and recruitment, and information systems. These work groups are comprised of the staff actually implementing each milestone. These teams meet weekly and as needed. They discuss the completed tasks and any anticipated issues with upcoming tasks to proactively address them or escalate resolution through their Functional Leads.

Issue Identification, Assessment and Resolution

UnitedHealthcare Community Plan takes a systematic approach to project implementation, issue identification, command center and resolution. Our work groups conduct implementation activities and identify issues early. Identified issues are reported to the work group's Functional Lead who can then escalate problems or issues to the ESC. If matters are urgent and cannot wait until the ESC convenes, the Functional Leads have ready access to the highest level leadership in our company.

Our Functional Lead teams maintain an issues, risks and decisions log in support of the overall implementation effort. The log classifies risks into one of three risk categories— high, medium and low— and includes the date identified, issue description, target resolution date, owner, status, priority, impact and resolution notes.

Resource Allocation and Deployment

Blaine Berguson will serve as the Chief Executive Officer of UnitedHealthcare Community Plan for all of Louisiana GSAs. Other key personnel deployed from the Southeast Regional Team include:

- Mark Mahler, M.D., Chief Medical Officer
- Jeff Skobel, Chief Financial Officer
- Jeff Wedin, Vice President, Network Development
- Andrea Fitzgerald, Compliance Officer
- Catherine Burns, Director, Provider Relations
- Faye Payne, Director, Member Services
- Michael Policky, Director, Claims Administration
- Charlisa Watson, Director, Community Relations
- Marty Reince, Human Capital Partner
- Paul Norman, Associate General Counsel
- Michele Nelson, Implementation Manager.

Our operations are backed by the financial and technical resources of UnitedHealth Group, the country's second largest health care company and the expertise of UnitedHealthcare Community & State, the country's largest provider of Medicaid managed care services. UnitedHealth Group has an unmatched range of health care service and technology capabilities readily accessible to meet the needs of the CCN.

Communicating with DHH

The goals and deliverables of the project plan will be shared with DHH at the outset of the implementation process to ensure that our goals and associated tasks are fully aligned with DHH objectives. DHH will also be given the opportunity to review and discuss our noted dependencies, such as contributions from their technical staff to develop interfaces and timely review of member and provider materials. Our communication plan includes opportunities for regular meetings with DHH and for reporting, thereby facilitating open communication and providing assurance to DHH that we will achieve our target date for readiness.

We will use several internal reports during the implementation to track and monitor the project including:

- ***Biweekly Report***: Completed by the Project Manager, Michele Nelson, the biweekly report is submitted to Senior Leadership as an overview of the program and includes: overall status, business owner, implementation/team lead, key issues/tensions, network activity, milestones, project description, licensure, clinical and platform.
- ***Issue and Risk Log Master Report***: Completed by the Project Manager with input from Functional Leads, the Issue and Risk log tracks issues brought forth by each of the Functional Leads during their weekly meetings with the Implementation Manager. We track issues to closure and include tracking of issues that are escalated to the Steering Committee, which also meets on a weekly basis
- ***Implementation Executive Team Report***: Completed by the Project Manager/Functional Lead; the Implementation Executive Team Report is one of the tools used during the Executive Steering Committee Meetings to review Issues/Risks, Network Targets and General Status updates for all Functional Areas in developing the program
- ***Go-Live Scorecard***: Completed by Michele Nelson, the scorecard is used during post go-live during the Executive Steering Committee to track and monitor post-go live activities
- ***Functional Area Drilldown Report***: Completed by each of the Functional Leads, this report is reviewed with the Leadership Team prior to Readiness Review and prior to go-live.

We will develop a customized reporting and meeting schedule for DHH during our initial implementation phase.

Automated Tools

UnitedHealthcare Community Plan uses Microsoft Office Project Standard 2007 project management tools, which has been used effectively in projects of similar size, scope and nature to the CCN program. The project management tools provide a reliable means by which our essential program deliverables will be aligned with DHH objectives and expectations. Office Project Standard 2007 will allow us a method to effectively manage and track progress on an ongoing basis. The project management team will use this automated tool to monitor all aspects of the project as well as identify probable risks in upcoming phases.

C.2 Provide a work plan for the implementation of the Louisiana Medicaid CCN Program. At a minimum the work plan should include the following:

- ***Tasks associated with your establishment of a "project office" or similar organization by which you will manage the implementation of the CCN Program; (GSA C)***

UnitedHealthcare Community Plan has prepared a detailed work plan beginning with pre-implementation activities and progressing through to enrollment at January 1, 2012, the contract effective date. Our detailed implementation plan is included in C.4. The proposed implementation plan includes the UnitedHealthcare Command Center Model. The Command Center will be established upon notification of the award and will be used to identify and address transition issues. The Command Center will be staffed with experienced clinical and operations executives on call 24/7 and will remain operational for 60 days after the implementation date. The entire UnitedHealthcare Community Plan senior management team, as well as other key personnel, will assist Command Center staff to prevent service delays for new members.

- ***An itemization of activities that you will undertake during the period between the awarding of this procurement and the start date of the CCN Program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP for deliverables.***
  - ***All activities to prepare for and participate in the Readiness Review Process; and***

Our project plan is a highly detailed and comprehensive approach to health plan implementation. It has been developed and is maintained using Microsoft Office Project 2007. Each implementation is guided by a comprehensive work plan that outlines each step of the implementation process. This work plan

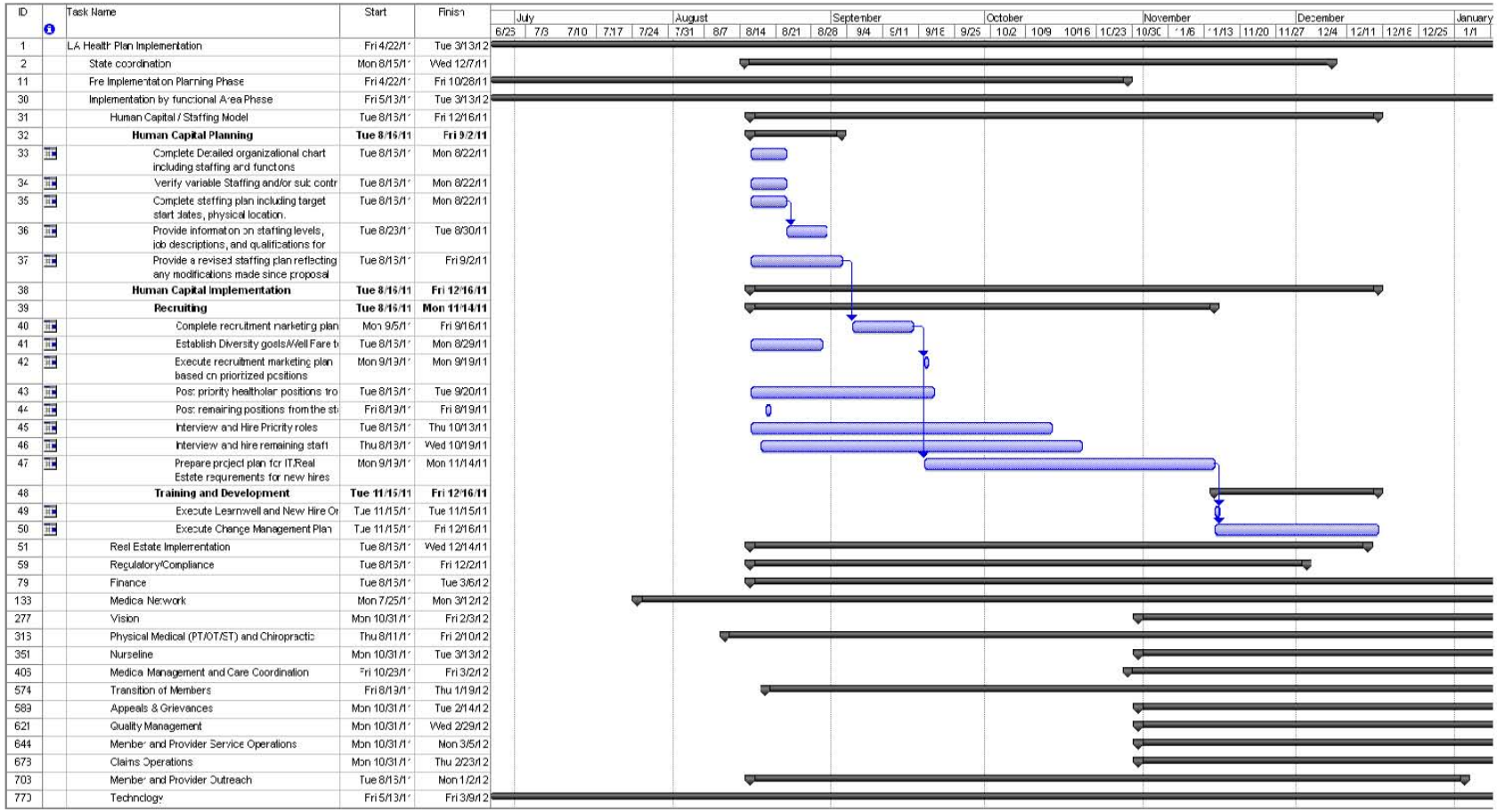
identifies the detailed steps, accountabilities and timeframes that must be achieved to assure a timely implementation. We are confident we have management and staffing in place to meet the requirements of the CCN and a detailed copy of our draft implementation plan can be found in C.4. Our project plan includes specific details for all health plan operations including but not limited to:

- Human Capital
  - Recruitment
  - Onboarding
  - Training
- Real Estate Implementation
- Regulatory /Compliance
- Finance
  - Reporting
  - Capitalization
- Network Development and Implementation plans
  - Medical
  - Vision
  - Physical Medicine
  - NurseLine
- Network Activities
  - Determine State Network Readiness
  - Outreach Materials
  - Network Reporting
  - Training for local teams
  - Credentialing
  - Provider Orientation and Onboarding
- Medical Management and Care Coordination
  - Strategy Development
  - Utilization Management program
    - Systems
    - Concurrent Review Program
    - Staffing
  - Standard operating procedures
  - Care Management
    - Program Design
    - Health Risk Assessment
    - Disease Management
    - Specialty Programs (e.g. Healthy First Steps)
  - Reporting
  - Systems Access
  - Training
    - Utilization Management

    - Care Management
  - Prior Authorization
  - Quality Management
    - Staffing
    - Operations
    - Develop QM Plan, Policies and procedures
    - QM Committee
    - QM EPSDT Outreach and performance Improvement
    - Provider Profiling – Utilization Patterns
    - Provider Incentives
  - HEDIS Reporting
- Transition of Members
  - Continuity of Care
  - Member Education and Onboarding
- Appeals and Grievances
  - Training
  - Volume and Membership Capacity Analysis
  - Document regulatory and compliance rules
- Member Service Operations
  - Materials – Welcome Call and New Member kit
  - Handbook
  - Provider Directory
  - ID Cards
  - Call Center
    - Provider Services
    - Member Services
- Provider Service Operations
- Claims Operations
  - Transactions
  - Staffing
  - Configuration
  - Training
  - Testing
  - Systems set up – including provider loading, PCP auto assignment , fee schedule loading and reports
- Technology
  - Project management and oversight
  - Benefits configuration and set up on our Cosmos platform
  - Interface development and testing, such as eligibility data (834), encounter date (837s), etc.
  - New plan set up to comply with CCN program requirements
  - Reports development and testing
  - Readiness review

- End to End testing and program launch
- Post launch close out.

The project plan allows us to track progress ongoing. It is a dynamic tool and the project management team will use it to monitor all aspects of the project and to identify potential risks in upcoming phases.

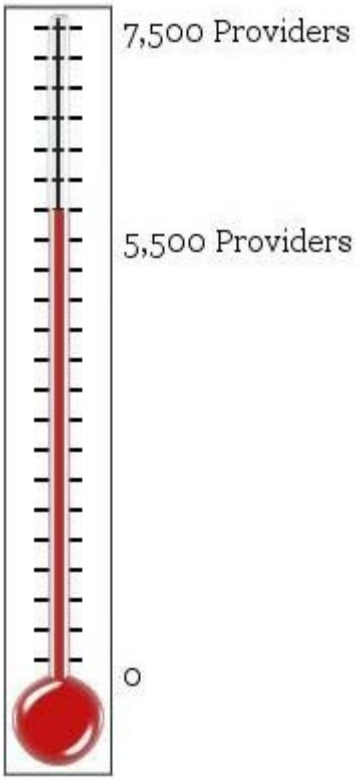


ID	Task Name	Start	Finish
1	LA Health Plan Implementation	Fri 4/22/11	Tue 3/13/12
2	State coordination	Mon 8/15/11	Wed 12/7/11
11	Pre Implementation Planning Phase	Fri 4/22/11	Fri 10/28/11
30	Implementation by functional Area Phase	Fri 5/13/11	Tue 3/13/12
31	Human Capital / Staffing Model	Tue 8/16/11	Fri 12/16/11
32	**Human Capital Planning**	**Tue 8/16/11**	**Fri 9/2/11**
33	Complete Detailed organizational chart including staffing and functions	Tue 8/16/11	Mon 8/22/11
34	Verify variable Staffing and/or sub contr	Tue 8/16/11	Mon 8/22/11
35	Complete staffing plan including target start dates, physical location,	Tue 8/16/11	Mon 8/22/11
36	Provide information on staffing levels, job descriptions, and qualifications for	Tue 8/23/11	Tue 8/30/11
37	Provide a revised staffing plan reflecting any modifications made since proposal	Tue 8/16/11	Fri 9/2/11
38	**Human Capital Implementation**	**Tue 8/16/11**	**Fri 12/16/11**
39	**Recruiting**	**Tue 8/16/11**	**Mon 11/14/11**
40	Complete recruitment marketing plan	Mon 9/5/11	Fri 9/16/11
41	Establish Diversity goals/Well Fare t	Tue 8/16/11	Mon 8/29/11
42	Execute recruitment marketing plan based on prioritized positions	Mon 9/19/11	Mon 9/19/11
43	Post priority healtholar positions fro	Tue 8/16/11	Tue 9/20/11
44	Post remaining positions from the st	Fri 8/19/11	Fri 8/19/11
45	Interview and Hire Pricrity roles	Tue 8/16/11	Thu 10/13/11
46	Interview and hire remaining staff	Thu 8/16/11	Wed 10/19/11
47	Prepare project plan for IT,Real Estate requirements for new hires	Mon 9/19/11	Mon 11/14/11
48	**Training and Development**	**Tue 11/15/11**	**Fri 12/16/11**
49	Execute Learnwell and New Hire Or	Tue 11/15/11	Tue 11/15/11
50	Execute Change Management Plan	Tue 11/15/11	Fri 12/16/11
51	Real Estate Implerrentation	Tue 8/16/11	Wed 12/14/11
59	Regulatory/Compliance	Tue 8/16/11	Fri 12/2/11
79	Finance	Tue 8/16/11	Tue 3/6/12
133	Medica Network	Mon 7/25/11	Mon 3/12/12
277	Vision	Mon 10/31/11	Fri 2/3/12
313	Physical Medical (PT/OT/ST) and Chiropractic	Thu 8/11/11	Fri 2/10/12
351	Nurseline	Mon 10/31/11	Tue 3/13/12
405	Medica Management and Care Coordination	Fri 10/28/11	Fri 3/2/12
574	Transition of Members	Fri 8/19/11	Thu 1/19/12
589	Appeals & Grievances	Mon 10/31/11	Tue 2/14/12
621	Quality Management	Mon 10/31/11	Wed 2/29/12
644	Member and Provider Service Operations	Mon 10/31/11	Mon 3/5/12
673	Claims Operations	Mon 10/31/11	Thu 2/23/12
703	Member and Provider Outreach	Tue 8/16/11	Mon 1/2/12
773	Technology	Fri 5/13/11	Fri 3/9/12

UnitedHealthcare Community Plan has the established structure and standard operating procedures for completion and sign off of all deliverables and major activities. Coordinated efficiently by our Project Management Officer, Michele Nelson, we offer a comprehensive approach to meeting our implementation deliverables.

- ***All activities necessary to obtain required contracts for mandatory health care providers as specified in this RFP.***

Network Implementation



UnitedHealthcare Community Plan has made tremendous progress in establishing a network of contracted providers to deliver services to CCN members in all GSAs. WE are fortunate to have a strong existing network for our Medicare and commercial products, and we are leveraging these relationships to serve Medicaid members as well as contracting with those providers who primarily serve Medicaid recipients. For more than 15 years UnitedHealthcare has worked with 8,900 Louisiana physicians and 161 hospitals providing health care services to more than 380,000 Louisiana citizens. By amending our existing contracts to add the Medicaid product line in GSA C, **1,958 credentialed physicians have agreed to work with us as contracted providers for Medicaid** and via Letters of Intent, 25 hospitals and an additional 442 physicians have agreed to engage in discussions to become contracted providers for Medicaid.

Our experience in caring for underserved populations, including other state Medicaid partners, confirms our understanding that a strong provider network is fundamental to serving CCN members. Federally Qualified Health Centers (FQHCs), mental health clinics and other community health centers are part of our strategy in building a successful network, particularly in underserved urban neighborhoods and rural counties. UnitedHealthcare Community Plan has served rural regions throughout the state for years and has an understanding of the distinct needs of both providers and members in rural communities.

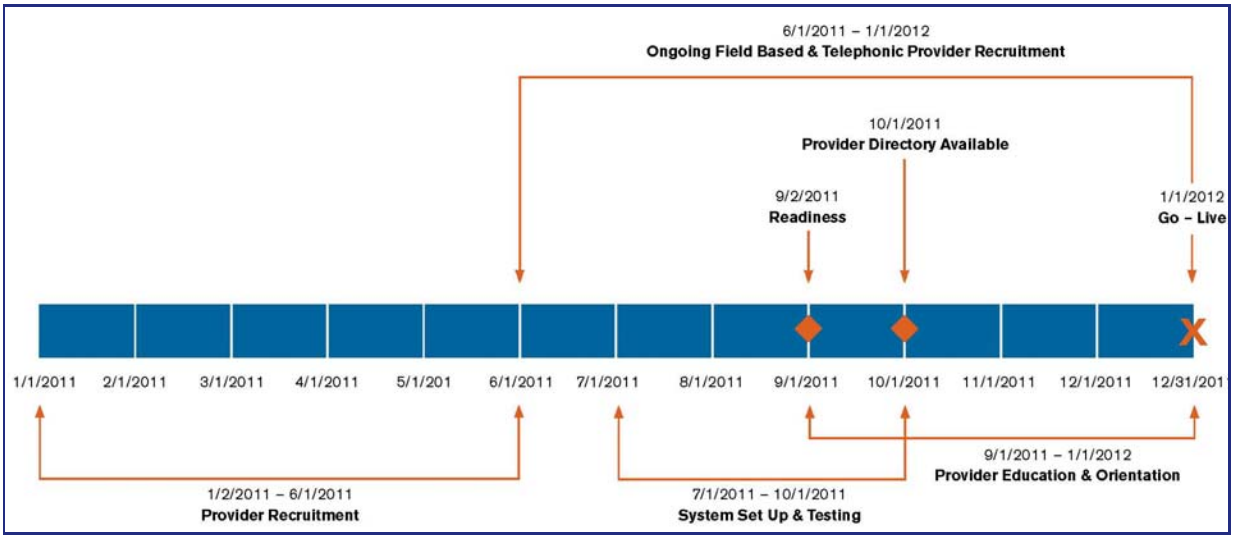
As the network rosters demonstrate, there are gaps in some GSAs. This is largely due to the desire of many providers to await contract awards before entering into an agreement. UnitedHealthcare Community Plan is certain that, if awarded the bid, all GSAs will be fully compliant with respect to network standards as required. We are confident that contracting/credentialing development activities made to date –along with our ongoing network development, combined with our ample, dedicated resources and operational infrastructure–enables us to successfully launch appropriate networks in every GSA as scheduled.

Summary of Network Development Timeline

UnitedHealthcare Community Plan has completed an implementation plan for GSAs A, B and C. We have developed a detailed action plan that includes the planning, implementation and evaluation elements necessary to ensure a successful network launch beginning January 1, 2012. Since the majority of our network development activity involves amendments to existing contracts, we are able to launch our expansion network in a very short period of time. Prior to the network initial launch of GSA A by January 1, 2012, we will:

- Convert letters of intent (LOIs) to contracts
- Meet staffing requirements for credentialing, contracting and provider relations
- Distribute Provider Directory
- Complete system set up and testing
- Complete provider education and orientation on referral procedures, claims submissions protocols and other provider responsibilities.

Network Development Timeline



UnitedHealthcare Community Plan has developed provider networks in each of the new GSAs based upon the network requirements set forth in the RFP. The networks are a combination of contract amendments to existing provider agreements and Letters of Intent. UnitedHealthcare Community Plan realizes that a series of operational activities will need to occur in a relatively short period before contract implementation.

The network expansion plan is in place and includes the following benchmarks:

- All contract amendments will be loaded and tested in the claims payment system. This represents the vast majority of new providers; it is anticipated that the provider load will be completed within 30 days from contract award.
- Convert all LOIs to provider agreements within 60 days of contract award.
- Complete all new provider credentialing within 60 days upon receipt of the provider agreement.
- Load and test all new provider agreements.
- Train and educate providers within 60 days of contract award on: appointment availability standards, CCN policies and procedures, CCN benefits, proper claim submission and payment (with an emphasis on electronic billing and fund transfers), prior authorization guidelines, clinical practice guidelines, the provider manual, drug formulary policies, how to access non-emergent medical transportation, cultural competency, fraud and abuse and the grievance and appeals process. Education will be provided face-to-face or in group settings. Provider Manuals will be supplied upon request. Providers are encouraged to use the website www.uhccommunityplan.com and the call center as additional information sources.
- Evaluation of provider networks in each GSA to ensure compliance with CCN network standards upon conversion of LOIs to provider agreements.
- Distribute a Provider Directory with updates provided throughout the contract year.

- ***An estimate of person-hours associated with each activity in the Work Plan;***

Implementation by Functional Area	Person Hours
Human/Capital/Recruiting	1,600
Regulatory/Compliance	800
Finance	800
Network Activities	1,600
Network Development and Implementation	5,600
Member and Provider Services	2,400
Technology	22,400
Readiness Review	4,000
Total	39,200

- ***Identification of interdependencies between activities in the Work Plan; and***

We update our implementation plan with each new project to reflect new program requirements and lessons learned from previous projects. The plan is developed in collaboration with all functional areas, and interdependencies are identified with all predecessors clearly marked. Our implementation team structure is uniquely positioned to address the multi-faceted structure of our operations. Through regular meetings of the cross functional ESC and each functional sub-team, interdependencies are readily apparent and thoroughly discussed. To assure coordination and analysis of impact on other functional areas, key issues are reviewed during the regular functional lead meetings to address and resolve cross-functional concerns

- ***Identification of your expectations regarding participation by DHH and/or its agents in the activities in the Work Plan and dependencies between these activities and implementation activities for which DHH will be responsible. (In responding the CCN shall understand DHH shall not be obligated to meet the CCN's expectation.)***

UnitedHealthcare Community Plan seeks transparency in our approaches, operations, negotiations with providers, community organizations, and with DHH. We will partner with DHH on all implementation steps. During the implementation, we will appreciate the opportunity to interact with the DHH on a regular basis, and we will follow DHH's protocols for communications. We suggest establishing two reporting structures. First, we suggest establishing an Implementation Steering Committee with executive representation and functional leaders from both DHH and UnitedHealthcare Community Plan. The Committee would meet on a weekly basis from the time of contract execution to post-implementation to ensure all operational, clinical and network issues are addressed and resolved. Clear lines of authority and responsibility will be established, identifying when issues are escalated to this level for resolution. The Committee will be co-chaired by Blaine Bergeson and the Director of DHH.

The second reporting structure is the establishment of daily meetings between UnitedHealthcare Community Plan's Project Management Officer and a DHH counterpart. The objectives of these daily meetings are to identify and review all implementation issues that need to be addressed by the committee and to track the status of each implementation item. These daily meetings are a great way to identify, track and resolve implementation issues. We believe that maintaining an ongoing, open dialogue with the DHH will assist both of our organizations in successfully implementing the CCN.

C.3 Describe your Risk Management Plan. (GSA C)

- ***At a minimum address the following contingency scenarios that could be encountered during implementation of the program:***
  - ***Delays in building the appropriate Provider Network as stipulated in this RFP;***
  - ***Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program;***
  - ***Delays in hiring and training of the staff required to operate program functions;***
  - ***Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;***
  - ***Delays in enrollment processing during the implementation of CCN; and***
  - ***Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.***
- ***For each contingency scenario identified in the Proposal, at a minimum the Risk Management Plan must include the following:***
  - ***Risk identification and mitigation strategies;***
  - ***Risk management implementation plans; and***
  - ***Proposed or recommended monitoring and tracking tools.***

- ***Delays in building the appropriate Provider Network as stipulated in this RFP;***

Our Functional Lead teams maintain their issues, risks and decisions log in support of the overall implementation effort. The log classifies risks into one of three risk categories high, medium and low and includes the date identified, issue description, target resolution date, owner, status, priority, impact and resolution notes. To assure coordination and analysis of impact on other functional areas, key issues are reviewed during the regular functional lead meetings to address and resolve cross-functional concerns. The Command Center operates 24/7 and facilitates rapid resolution of any issues identified by our local management team. We will also provide a dedicated hot line to key stakeholders at DHH to ensure you are apprised of implementation progress challenges.

UnitedHealthcare Community Plan has adopted a strategy to contract providers as part of our preparation for RFP response. Currently we have contracts with over 7,000 physicians for the CCN-P Program in the State of Louisiana. This strategy will mitigate any future post award deficiencies that we would expect from network adequacy preparedness.

Additionally, upon award of the contract with DHH, UnitedHealthcare will begin executing contracts with those providers who have executed LOI's or have indicated they are interested in participating and would like to be contacted post award. Between award and October 7, 2011 (deadline for GSA network

adequacy to DHH), we will build the provider network as stipulated in the CCN-P RFP. The status of the network is likely to change daily as providers sign contracts and we will closely monitor progress and identify gaps. When a network gap is identified, we will focus provider recruitment efforts to address the gap. Based upon our experience, we have been successful in network development within the required timeframes. However, once the program goes live and network gaps are identified, our Provider Services department, in collaboration with the Medical Management department, Chief Medical Officer and other involved parties, will immediately assess the availability of other providers in the community. The preferred intervention strategy is to refer the member to another contracted provider that is qualified and available. If a contracted provider is not available, the following short-term interventions are taken:

- ***Referral to a non-contracted provider:*** Special provisions such as a letter of agreement are made with non-contracted providers to accommodate the member's needs until an equivalent provider is located, or if possible, a contract with the non-participating provider is secured.
- ***Continuity of care:*** Utilize existing providers during the transition time and pay at the Medicaid rate.
- ***Build out of state network:*** Including access to nationwide centers of excellence.
- ***Transportation of a member to a provider outside the member's community:*** If a provider is not available in the member's immediate community, we make arrangements for the member to temporarily receive care from a provider located in another community. This solution is generally utilized until an appropriate provider is available within the member's immediate community.

  - ***Delays in building and/or configuring and testing the information systems within your organization's Span of Control required to implement the CCN program;***

Our Functional Lead teams maintain their issues, risks and decisions log in support of the overall implementation effort. The log classifies risks into one of three risk categories high, medium and low and includes the date identified, issue description, target resolution date, owner, status, priority, impact and resolution notes. To assure coordination and analysis of impact on other functional areas, key issues are reviewed during the regular functional lead meetings to address and resolve cross-functional concerns. The Command Center operates 24/7 and facilitates rapid resolution of any issues identified by our local management team. We will also provide a dedicated hot line to key stakeholders at DHH to ensure you are apprised of implementation progress challenges.

Anticipated Challenge	*Resolution*	*Risk Mitigation*
Short timeframe from award to go live, as well as readiness review preparation Myuhc.com member portal – analysis and impact for connectivity for C&S/Medicaid plan has not been done yet.	Pre-award funding needed for analysis, scope and assessment of development/implementation impacts. Include myuhc.com in analysis from pre-award funding (above). Integration Services team to assign PM and BA resources to begin and drive analysis, scope, assessments and project planning. Do less adjudication or contract testing Use real time claim testing and evaluation Extra staff deployed for claims;	Risk mitigation strategies include: ensure implementation is in the work queue/schedule for Cosmos, CareOne and associated / required systems to meet implementation commitment (escalate as needed). Identify resource gaps and needs to address early in the project, possibly use additional/available resources from UnitedHealth Group-IT. Business Alignment Program Manager should schedule and begin weekly Functional Lead and Project meetings to identify and address issues – make decisions, resolve or

Anticipated Challenge	Resolution	Risk Mitigation
	manual claims processing	escalate as appropriate. Coordinate with Int. Svs. Program manager.

- ***Delays in hiring and training of the staff required to operate program functions;***

Our Functional Lead teams maintain their issues, risks and decisions log in support of the overall implementation effort. The log classifies risks into one of three risk categories high, medium and low and includes the date identified, issue description, target resolution date, owner, status, priority, impact and resolution notes. To assure coordination and analysis of impact on other functional areas, key issues are reviewed during the regular functional lead meetings to address and resolve cross-functional concerns. The Command Center operates 24/7 and facilitates rapid resolution of any issues identified by our local management team. We will also provide a dedicated hot line to key stakeholders at DHH to ensure you are apprised of implementation progress challenges.

Anticipated Challenge	Resolution	Risk Mitigation
Delays in hiring and training staff	We will leverage existing staff within UnitedHealthcare with required skill set. We will leverage the existing enterprise strategy and tools for all onboarding activities We can rely on 87,000 UnitedHealth Group employees to quickly deploy qualified regional team members in interim positions. We also have the support of UnitedHealth Group's Human Capital partners to assist in recruiting efforts.	Risk mitigation strategies include: a project plan that ensures we have staffing levels in place by October 3, 2011 as well as all employees are onboard and trained by December 16, 2011.

- ***Delays in the construction and/or acquisition of office space and the delivery of office equipment for staff required to operate program functions;***

Our Functional Lead teams maintain their issues, risks and decisions log in support of the overall implementation effort. The log classifies risks into one of three risk categories high, medium and low and includes the date identified, issue description, target resolution date, owner, status, priority, impact and resolution notes. To assure coordination and analysis of impact on other functional areas, key issues are reviewed during the regular functional lead meetings to address and resolve cross-functional concerns. The Command Center operates 24/7 and facilitates rapid resolution of any issues identified by our local management team. We will also provide a dedicated hot line to key stakeholders at DHH to ensure you are apprised of implementation progress challenges.

Anticipated Challenge	Resolution	Risk Mitigation
Our existing office space proves to be too small for our needs Project delivery is delayed due to longer than typical lease negotiations	Lease temporary space; use conference rooms with temporary furniture; work from home or other UnitedHealthcare offices. Dedicated real estate transaction team works directly with landlord	Risk mitigation strategies include: assigning additional staff to project delivery to keep it on track; setting up staff in another UnitedHealth Group office temporarily; taking temporary space in the business

Anticipated Challenge	*Resolution*	*Risk Mitigation*
Project delivery is delayed due to longer than typical city permitting Project delivery is delayed due to unforeseen circumstances, site conditions during construction or force majeure	to come to terms Dedicated real estate project manager will work directly with the city; opportunity to hire a permit expediter if necessary Weekly project meetings with dedicated team to identify current project status, any potential issues and develop risk mitigation strategy	delivery area until the build can be completed; and setting up staff to work at home Real estate project manager and team specifically dedicated to direct oversight of build out of space from conception to delivery. Weekly real estate project meetings to review current conditions, scope of project & escalate any potential risks in timing or delivery

- ***Delays in enrollment processing during the implementation of CCN; and***

Our Functional Lead teams maintain their issues, risks and decisions log in support of the overall implementation effort. The log classifies risks into one of three risk categories high, medium and low and includes the date identified, issue description, target resolution date, owner, status, priority, impact and resolution notes. To assure coordination and analysis of impact on other functional areas, key issues are reviewed during the regular functional lead meetings to address and resolve cross-functional concerns. The Command Center operates 24/7 and facilitates rapid resolution of any issues identified by our local management team. We will also provide a dedicated hot line to key stakeholders at DHH to ensure you are apprised of implementation progress challenges.

Anticipated Challenge	*Resolution*	*Risk Mitigation*
834 File Mapping/Loading issues (i.e. significant fallout during load into claims system)	Implement a manual work around, utilizing FTE overtime to complete enrollments manually	Risk mitigation strategies include: thorough testing of all scenarios will be conducted prior to go-live, to ensure accurate and comprehensive system mapping of the 834 file to the claims system. Any issues identified will be researched to identify root cause drivers, and they will be retesting to ensure all scenarios pass. Additionally, go/no-go criteria will be developed, and manual work arounds will be identified.

- ***Delays in the publication of marketing and related materials and/or the delivery of these materials to DHH and/or its agents.***

Our Functional Lead teams maintain their issues, risks and decisions log in support of the overall implementation effort. The log classifies risks into one of three risk categories high, medium and low and includes the date identified, issue description, target resolution date, owner, status, priority, impact and resolution notes. To assure coordination and analysis of impact on other functional areas, key issues are reviewed during the regular functional lead meetings to address and resolve cross-functional concerns. The Command Center operates 24/7 and facilitates rapid resolution of any issues identified by our local

management team. We will also provide a dedicated hot line to key stakeholders at DHH to ensure you are apprised of implementation progress challenges.

Anticipated Challenge	*Resolution*	*Risk Mitigation*
Delays in Production of materials including: ■ New member welcome package ■ Member ID Cards ■ Value add flyers and other external facing marketing / branding materials ■ New member handbook ■ Provider directory	ID card production dates for initial batch of new members; distribution time line established with vendor for mailing New member kits; coordination with vendor for mailing; membership/data file requirements/set-up with vendor for timely distribution of new kits once vendor receives member data file Online access to all member materials (Handbook, Provider Directory, Welcome Letter); provider search function capability; Print on Demand Provider lists Dissemination of member handbook, provider directory, Welcome letter on CD disk as a back-up option to unexpected delays in printed materials Local supply of member materials, welcome letters, and provider directories disseminated to Community & Provider partners Dissemination of member roster to PCP offices within the first week of member assignment	Risk mitigation strategies include: assess the probability of the risk eventuating/occurring; assess the likely impact on the work area or organization if the risk occurs; determine an overall risk rating on the basis of probability and impact; record any existing controls or strategies which aim to reduce the risk; determine if the risk exposure is acceptable or not; and determine further action plans and contingency plans to manage the risk where appropriate

C.4 Provide a copy of the Work Plan, generated in Microsoft Project or similar software product that includes the aforementioned implementation activities along with the timeframes, person-hours, and dependencies associated with these activities. (GSA C)

Our work plan is included as Attachment C.4.

C.5 Provide a roster of the members of the proposed implementation team including the group that will be responsible for finalizing the Provider network. (GSA C)

Proposed Implementation Team

The following people will lead the CCN implementation for UnitedHealthcare Community Plan. Jeff Wedin will lead the team responsible for finalizing the Provider network.

UnitedHealthcare Community Plan Implementation Team	
Name	***Title / Function***
Glen Golemi	Chief Executive Officer Gulf States

UnitedHealthcare Community Plan Implementation Team	
Blaine Bergeson	**Chief Executive Officer** UnitedHealthcare Community Plan
Michele Nelson	Implementation Team Project Manager
Angie Beattie MaryKay Jones	National Quality Quality
Jeff Wedin Debbie Burke Douglas Doyle James Huang Heidi Kemmer	Vice President, Network Development Network Planning Network Development UnitedHealth Networks (UHN) Network Operations
Bridget Galatas Michael Frey Steve Meeker **Jeff Skobel** Mike Zenobi	Chief Financial Officer - Gulf States Finance Finance **Finance** Finance
Andrea Fitzgerald Adam Zunker	**Compliance Officer** Compliance
Lisa Ellis Kimsung Hawks **Mark Mahler, MD**	Medical Management Medical Management **Chief Medical Officer**
Daniel Denton Ken Anderson Stacey Plumb Stacey Thompson	Vendor Mgt OptumHealth Vendor Mgt OptumHealth OptumHealth
Jennifer Cykala **Faye Payne**	Provider Call Center **Member Call Center**
Jeff Drozda	Regional Government Affairs
Kurt Johnson	Encounters
James Joly	Service Center
Mary Anne Kelleher	Health Plan Operations
Paul Norman	Legal
Marty Reince	Human Capital
Dawn Vacheresse	Actuarial
Charlisa Watson	Community Development

C.6 Provide the resume of the Implementation Manager (the primary person responsible for coordinating implementation activities and for allocating implementation team resources). (GSA C)

Our Implementation Manager, Michele Nelson is responsible for ensuring the coordination and timely delivery of key implementation steps in Louisiana. She had her first integration experience for

UnitedHealthcare in 1989 so she is well versed in what needs to happen and when. Ms. Nelson added to her credentials with her recent Certification as a Six Sigma Black Belt in 2006. Her resume is included in Attachment B.10.a.

Section D: Member Enrollment and Disenrollment

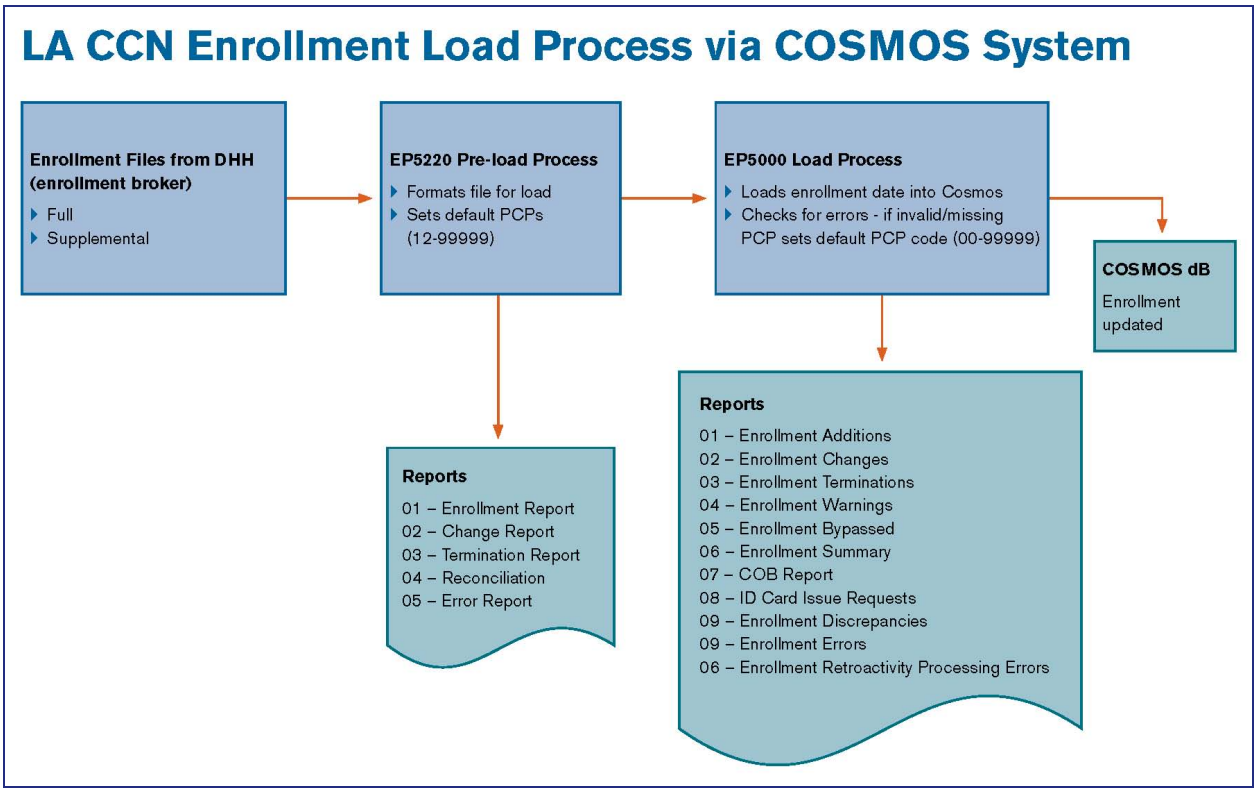
D.1 Describe your enrollment procedure requirements, including how you will ensure that you will coordinate with DHH and its Agent. (GSA C)

Enrollment Processing and Coordination

UnitedHealthcare Community Plan fully intends to meet the contract requirements related to DHH and its Agent for program eligibility and enrollment process. We ensure that:

- DHH and its Agent shall determine eligibility for its Applicants and members.
- UnitedHealthcare Community Plan may request that eligibility be reviewed for any member in accordance with the Contract but may not deny coverage or benefits to any member once DHH has determined that a child is eligible for the program.
- UnitedHealthcare Community Plan agrees to accept payments through electronic mechanisms, if DHH and its Agent so determines.

As described below, our systems are programmed to accept initial enrollment files, supplemental enrollment files and manual adds and deletes to effect enrollments by the first of the month.



UnitedHealthcare Community Plan processes daily, weekly and monthly membership files using a three-tiered approach that includes an Electronic Data Interchange (EDI) translator/HIPAA Gateway, department specific Microsoft SQL stored procedures and Comprehensive Online Software for Management and Operational Support (COSMOS) Claims Processing and Management system.

Electronic Data Interchange

Arrangements with DHH will allow for timely processing of enrollment and disenrollment information. Given UnitedHealthcare Community Plan's experience and the automatic processing of the enrollment files, we can notify DHH if there are problems or errors found within the enrollment files.

Enrollment/Eligibility Subsystem

Our COSMOS technology platform processes enrollment automatically and enables manual entry for off cycle enrollment and error correction. The COSMOS system allows for the maintenance and verification of eligibility by storing detailed member information, including eligibility segments, addresses, and primary care providers. We process the enrollment data, transmission, or media to add, delete, or modify membership records with accurate begin and end dates. COSMOS can be configured to accept daily and monthly transaction files from DHH and its agent as the official enrollment record, and immediately report any inconsistencies to DHH and its agent for investigation. Our enrollment subsystem also maintains a history of changes and adjustments and audit trails for current and retroactive data. The system uses logging, journaling and audit tables to maintain a record of all changes to transactions and data within each application. Our platforms actively store seven years of membership, eligibility and claims data.

Membership and eligibility information can be received daily and the system automatically assigns the member to the appropriate primary care provider (PCP) that is listed within the enrollment file received. If a member requests a change of their PCP, he or she notifies Member Services, and the change is made in COSMOS. The COSMOS platform has edits to make certain the PCP is valid, and then the member record is updated. COSMOS is fully automated with automatic error alerting capability that triggers error correction processes and procedures. Membership roster and error reporting also can be included and configured to the specific formats required by DHH and its agent.

Enrollment/Membership Files

We have the ability to accept and process enrollment files and enrollment reconciliation files via HIPAA-compliant 834 transactions. In other states, our automated enrollment processing yields 99 percent throughput, requiring minimal manual intervention. Our systems are capable of numerous types and levels of information processing and data exchange and we have proven demonstration of this performance with other State Medicaid programs.

Enrollment File Feed

The enrollments file feed program processes the data file containing CCN enrollment information as received from DHH's enrollment broker. The data file contains all Enrollees from the CCN file as follows:

- Participants not on COSMOS are added to COSMOS
- Enrollees terminated on the CCN file are terminated on COSMOS
- Enrollees who are active on the CCN file and not active in COSMOS are reinstated
- Enrollees active on both the CCN file and on COSMOS are updated with demographic changes.

All enrollments, terminations and changes are listed in generated reports.

PCP Assignment

Individuals with the Louisiana Operations department are accountable for reviewing and processing the EP5220-01 report to assign a provider to Enrollees with the default PCP code (12-99999). UnitedHealthcare Community Plan acts as an on-going resource for the Enrollment Department in assigning providers as needed for Enrollees from the other report sections.

The enrollment team reviews the EP5220-01, EP5220 -03, EP5250-05 and EP5250-91 reports. The enrollment department coordinates with the Louisiana field office to obtain an appropriate PCP assignment when necessary.

Enrollment Load Process and Reports

The enrollment load program populates member information into COSMOS. Group information must be loaded before running EP5000. This program provides initial membership loads or transaction processing for membership enrollments, changes and terminations.

The Louisiana field office is accountable for reviewing and processing the EP5000-01, which will assign the default PCP code (00-99999) for any invalid or missing PCPs; otherwise members would have the default PCP code of (12-99999) previously set by the EP5220. The plan acts as an on-going resource for the enrollment department in assigning providers as needed for members from the other report sections.

The enrollment department reviews the EP5000-90 and EP 5000-04 reports. Enrollment functions coordinate with the Louisiana field office to obtain an appropriate PCP assignment when necessary.

For a new state program, the process should be that the Enrollment team uses the same process as the auto assignment process, which selects a PCP for the member. In addition, the enrollment department accepts faxed authorizations indicating that a member will be on supplemental eligibility file prior to the insurer's receipt of that file.

A brief description of the enrollment reports have been provided in the table below.

Enrollment Reports	
Report Name	***Description***
EP5220-01	Enrollment Report
EP5220-02	Change Report
EP5220-03	Termination Report
EP5220-04	Reconciliation Report
EP5220-05	Error Report

Revenue Reconciliation

UnitedHealthcare Community Plan has procedures that Reconciliation team follow to reconcile Medicaid enrollees through comparing the payment file to the invoice file from the processing system in the Medicaid Reconciliation System – RAM, once payment has been received and applied. This document also outline the manual reconciliation process followed for the health plans that do not the revenue reconciliation performed on the reconciliation tool.

It is the policy of the Enrollment Department to maintain accurate Medicaid enrollment account detail through identification and research of discrepancies based on the enrollment information and the payment received from the State. The identification and research of the discrepancies occurs on a monthly basis.

Unless otherwise specified, Enrollment Operations is responsible for performing the following procedure on behalf of the Health Plans includes:

- ***Medicaid Reconciliation Process:***
  - The revenue reconciliation is completed through membership and payment reconciliation and discrepancy resolution. The revenue reconciliation is completed on a periodic basis in the reconciliation system and verifies the payment from the State on a per member basis. The discrepancy reconciliation identifies and documents any discrepancies between the billed and paid amounts to facilitate the follow-up process and to verify accurate revenue reporting. The major function of reconciliation is to verify billed amount remains as accurate as possible by resolving issues identified in the payment process.

- The invoicing process is either run daily or on a periodic basis depending on the reconciliation tool. After the invoice runs, payments are applied at the member level to generate discrepancy reports between invoiced amount and the paid amount.
- The Invoice and Payment loads are verified via the process control totals in the reconciliation system. Once the loads have been verified, a rematch is completed in the reconciliation system. The rematch compares the invoice file to the payment file. When it is complete, the reconciliation system lists all discrepancies where an invoice did not have a matching payment.
- The discrepancies are researched by the Enrollment staff and assigned a status. This listing details the most common discrepancies discovered while reconciling Medicaid membership:
  - Subscriber invoiced per the state enrollment files in claims system however, the State did not reimburse for the subscriber **(BNP).** When a subscriber is identified as a BNP, an investigation is undertaken to verify eligibility using multiple verification systems (Claims systems, state eligibility system, etc). If the enrollee is not eligible, the enrollee is retroactively disenrolled in the Claims System. If the enrollee is eligible, the enrollee detail is placed on the Status Spreadsheet for resolution with the State.
  - State paid for subscriber, but subscriber was not invoiced based on the enrollment from the claims system (**PNB**) .When a subscriber is identified as a PNB, an investigation is undertaken to verify eligibility using multiple verification systems (claims system, state eligibility system, etc). If the enrollee is not eligible, the enrollee detail is placed on the Status Spreadsheet for resolution with the State. If the enrollee is eligible, the coverage (timeline) is opened in the claims system and subsequently in the next processing cycle, an invoice is generated to resolve the discrepancy.
  - Billed amount for subscriber does not equal paid amount by State (**PDR**). This situation exists because the State payment does not match the enrollee's information in the claims system (i.e. demographics, group # and rate cell). An investigation is undertaken to verify eligibility and the correct rate cell using multiple verification systems (claims system, state eligibility system, rate tables etc). If the enrollee is eligible, in the rate cell that matches the claims system or state eligibility system, the enrollee detail is placed on the Status Spreadsheet for resolution with the State.

  In addition to the above statuses, each health plan may have its own plan-specific categories.

  The designated health plan and Revenue Operations representatives receive a copy of the Status Spreadsheet.

- ***Medicaid Reconciliation follow up process:***
  - The Medicaid Reconciliation Coordinator must have the reconciliation completed within 90 days from receipt of the last payment for the month in question. This means the reconciliation will always have a 90-day lag time. **For example**: Payment for February's enrollment is received by the last week of January. Therefore, the reconciliation must be completed by the end of April.
  - Upon completion of the reconciliation, the Status Spreadsheet will be forwarded to the designated Health Plan and Revenue Operations representative. Revenue Operations will then work with the health plan to resolve the discrepancies with the state and track any resolution.
  - The Medicaid Reconciliation Coordinator processes and updates any discrepancies that can be resolved in the claims system (enrollment corrections, eligibility corrections, etc), based on feedback provided by the health plan.
- ***Escalation Process:***
  - Discrepancies that are unable to be resolved after 45 days from the release of the Status Spreadsheet are forwarded to the designated revenue operations and health plan representative. The Medicaid Reconciliation Coordinator will follow up with the designated revenue operations and health plan representative on a weekly basis until resolution is gained.

  - If the Medicaid Reconciliation Coordinator does not receive a resolution within 30 days of escalation to the health plan representative:
    - The enrollee's record is updated in reconciliation system.

- ***Manual Revenue Reconciliation***: The manual reconciliation is completed by the revenue operations team for the plans the member level reconciliation is not completed in the reconciliation tool like RAM. This reconciliation is not at the member level but at the rate cell level. The purpose of this manual process is to get the comfort level that there are no gaps between expected and actual payments including:
  - ***Reconciliation Process*** -The expected payment at the rate cell level is calculated by taking the membership at the rate cell level and applying the contracted rates to come up with the expected payment. The payments are applied against the expected payment to get the variance at the rate cell level.
  - ***Follow Up Process*** - The revenue operations team will review the rate cell level reconciliation report produced every month. For any rate category where there are large unexplained variances between expected payments and actual payments, further drill down will be conducted to look at the variances at the member level. If the variance needs to be researched at the member level, the discrepancy reports will be sent to the enrollment operations team for further research. Any un reconciled results will put in the status spreadsheet as discussed above in Section IV. B.
  - ***Escalation Process*** - The same escalation process will be followed for manual reconciliation as followed by the normal reconciliation process described in Section IV.C.

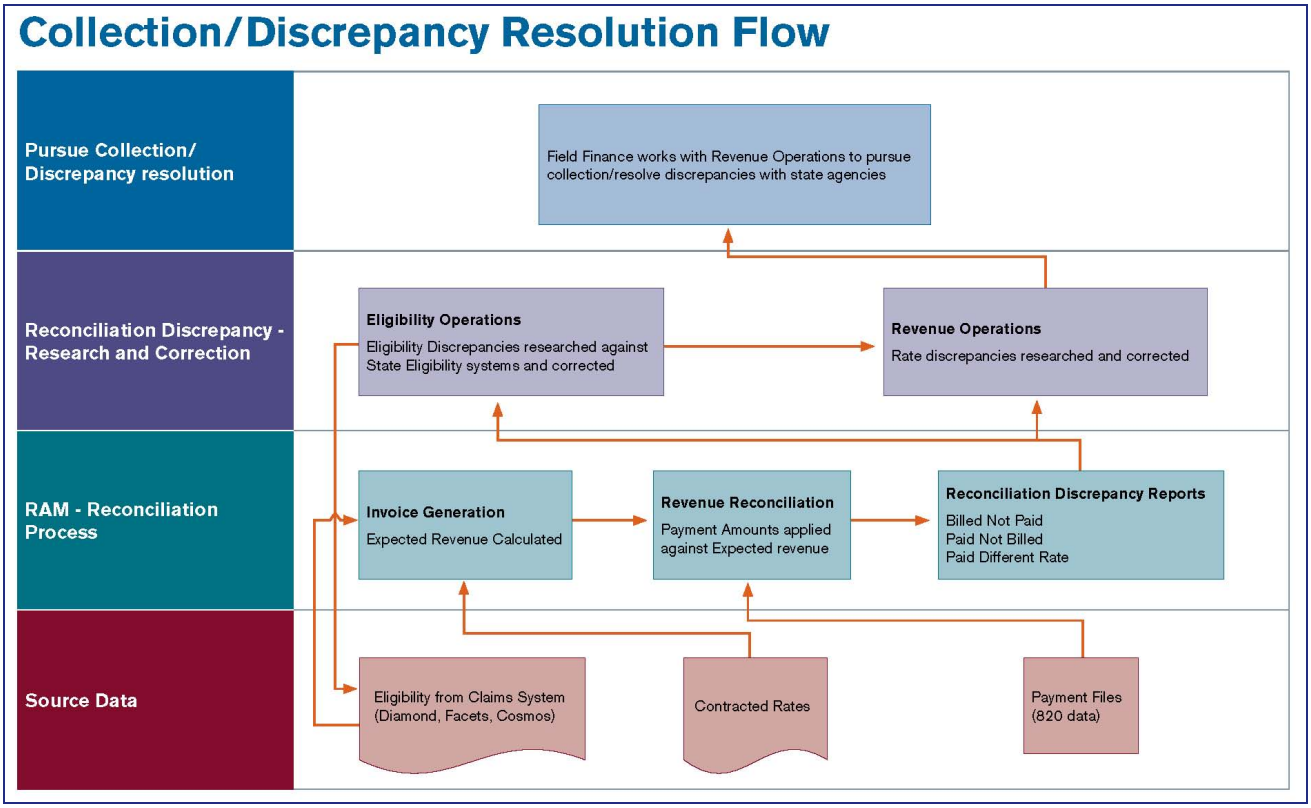
Discrepancies between our data and the 834 files received from DHH or the designated enrollment broker are resolved through our remittance advice (RA) 820 eligibility file reconciliation process by our Enrollment department. UnitedHealthcare Community Plan uses the data included in the 820 RA electronic eligibility file to reconcile monthly eligibility between DHH or the designated enrollment broker's eligibility system and UnitedHealthcare Community Plan's Enrollment team run reports to identify all discrepancies.

The Enrollment team runs a report showing members that are listed in our COSMOS system, but not in DHH's files and another report showing members in DHH's file, but not in our COSMOS system. UnitedHealthcare Community Plan Enrollment specialists verify the identified member's eligibility in the DHH or enrollment broker's system verifies where the discrepancy originated and then updates COSMOS with the correct data. Currently, most discrepancies are resolved within 60 days from the day the 820 file is received.

UnitedHealthcare Community Plan receives a monthly Remittance Advice (RA) 820 eligibility file. UnitedHealthcare Community Plan uses the data included in the RA 820 electronic eligibility file to reconcile monthly eligibility between the DHH or enrollment broker's system and UnitedHealthcare Community Plan's core system, COSMOS.

Each daily internal audit report is set up in the Inventory Control database. A general e-mail box is used to receive and communicate transaction numbers via e-mail. The Inventory Control report is pulled daily for supervisors to review and ensure all inventory is logged into the database and is being processed timely and completely. The Enrollment Processing staff also verifies the count of the members/transactions on the internal audit report is set up correctly.

Revenue Accuracy Manager Process Flow



D.2 Describe your approach to meeting the newborn enrollment requirements, including how you will:

- ***Encourage members who are expectant mothers to select a CCN and PCP for their newborns; and (GSA C)***

UnitedHealthcare Community Plan actively manages the care of our pregnant members through our Healthy First Steps™ (HFS) program. We designed Healthy First Steps to be a comprehensive program that identifies, stratifies and, most importantly, manages the care of our pregnant members ***and children through first year of life***, consistent with their needs.

Identifying members

It is critical to identify pregnant members as early in their pregnancy as possible to ensure the delivery of quality prenatal care in a timely manner. We identify pregnant members through:

- ***Lab Values:*** We receive a monthly report that identifies members who have had positive pregnancy tests.
- ***New Member Welcome Calls:*** As part of our welcome calls to all new members, we ask several questions including whether the member is pregnant.
- ***Referrals:*** members may be self-referred or referred from hospitals, outpatient offices, or social service departments
- ***Enrollment Files:*** The enrollment files received from the Enrollment Broker includes pregnancy indicators.
- ***Pharmacy Data:*** We currently receive a monthly file from our Pharmacy Department of all members who have received prenatal vitamins. Going forward we will request this information from DHH.

- ***Claims Data:*** We use diagnosis and CPT codes in our claims data to identify pregnancies.

To encourage collaboration from providers and other sources, we educate providers on HFS and the services we provide members. We will work with the local health departments throughout the state that currently provide obstetrical services to outreach and educate our pregnant members. Our goal is to work with the existing delivery system to improve the health outcomes for this population. We also educate members on the program through materials such as the member Handbook and brochures and through partnerships with community organizations.

Stratifying Members

Following identification of a pregnant member, a dedicated HFS staff member contacts the member via telephone to complete a health risk assessment. All contacted pregnant women regardless of risk level are enrolled in HFS; however, members who are identified as high risk receive a higher level of clinical services. We use a number of ways to reach the member including:

- Minimum of two phone calls
- Outreach to other family members identified in the member's records
- Contact with PCP, specialist, or OB to identify and attend the member's next appointment as appropriate and to request that the provider flag the member's chart to request updated demographics at the member's next visit
- Contact with the referral source for current member contact information
- Postcard requesting member contact the Care Manager
- Outreach to community organizations and significant traditional providers (e.g. Department of Health, schools, Planned Parenthood, etc).

After the HFS staff reaches the member and completes the assessment, we use assessment results to stratify the member as low or high risk. The characteristics of the members at both levels of risk are:

- ***Low Risk*** – Connected to an OB; No history of previous pregnancy-related complications
- ***High Risk*** – History of preterm labor; Substance abuse; Insulin dependent gestational diabetes; Pregnancy induced hypertension; Homelessness; Young teen (less than 15 years old); Tobacco smoker; Multiple gestation.

We may follow the initial assessment by a reassessment if a member:

- Is hospitalized for a pregnancy related condition
- Has an event that will jeopardize the outcome of the pregnancy as reported to case management staff by the member or her OB
- Has any high risk conditions identified as reported to case management staff by the member or her PCP
- Has any socio-economic factor, including non-compliance, which is impeding access to prenatal care.

Managing the Care of Pregnant Members

After a member's risk has been stratified, our Healthy First Steps Care Managers begin providing care management to the member based upon the member's risk level. HFS Care Managers are initially recruited from the communities in which they serve, and receive additional cultural competency training, enabling them to respond to the cultural, linguistic and environmental factors that could affect the member's ability to actively engage in the program. All members receive educational materials to encourage and support having a healthy pregnancy and baby.

We provide ***Low Risk members*** educational mailings regarding having a healthy pregnancy and baby and a phone number to reach the OB Care Manager should questions or concerns arise. We also call them

after delivery to encourage compliance with the postpartum exam and pediatric appointments.

For ***High Risk members*** we develop a care plan with their OB Care Manager in conjunction with their OB provider. OB Care Managers call the members on a schedule varying from monthly, to weekly, or even more frequently depending on member needs. The OB Care Manager will make a personal visit with the member at the provider's office, work with the maternity provider to coordinate necessary services, educate the member and involve community agencies as determined necessary. OB Care Managers engage community organizations when the member needs assistance with food, clothes, a crib, a car seat or other baby items.

The medical director for HFS, a board certified obstetrician or pediatrician conducts a weekly case management review of appropriate high risk cases with all staff involved. A medical director is available full time for case review if clinical circumstances change. We also work closely with providers to track member prenatal visits. Through our provider education, we ask OB practitioners to notify us if a member misses an OB appointment. The HFS staff will then follow-up with the member to investigate the reason for the missed appointment, identify barriers to care, and assist in resolution.

Managing Care of Mother and Newborn after Delivery

After delivery, the OB Care Manager will call the new mother to:

- Respond to concerns about such issues as breastfeeding, contraception, tobacco use, Shaken Baby Syndrome, domestic violence, and post partum depression
- Provide information on local community resources, such as WIC, faith-based parenting classes, and new mother support classes
- Verify scheduling of post-partum and well-baby visits
- Assist with scheduling and transportation as needed.

Regardless of the original risk level of the mom, our OB Care Managers follow babies detained in the NICU until the baby's first birthday. The OB Care Managers will assist in coordinating and referring the mom and special needs child to a variety of community programs including but not limited to WIC, and home and community-based services for developmental disability waiver program. The OB Care Managers will also coordinate specialty services such as therapies, durable medical equipment, regular home visits if warranted for high risk children.

Coordination with Nurse-Family Partnership in Louisiana

UnitedHealthcare Community Plan intends to build a strong relationship with Nurse-Family Partnership®, a community health program that helps transform the lives of vulnerable first-time moms and their babies. Through ongoing home visits from registered nurses, low-income, first-time moms receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children and become more economically self-sufficient. This evidence-based model of partnering nurses and first-time moms has more than 30 years of research from randomized, controlled trials that prove it works. The goals of the program include:

- Improve pregnancy outcomes by helping women engage in good preventive health practices, including getting prenatal care from their health care providers, improving their diet, and reducing their use of cigarettes, alcohol, and illegal substances
- Improve child health and development by helping parents provide responsible and competent care
- Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work.

- ***Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn.***

Clinical Administrative Support Unit (CASU)

Our Clinical Administrative Support Unit provides a national standard approach to ensuring newborn information is processed timely. The scope of the unit is to perform the administrative processes:

- Disenrollment
- Newborn Enrollment
- Kick Payment data collection
- 2/4 day Case Closure
- Tem ID member Merge/Reconciliation
- Birth Outcomes Statistics, which support the Healthy First Steps Program.

The goal is to obtain the required information according to department metrics and provide accurate and timely customer service to the health plans. The data elements collected by the CASU assist the health plans in meeting regulatory, financial and quality indicators.

The CASU should adhere to the following standard operating procedure related to authorization of routine deliveries, documentation of birth outcomes and referral of maternal cases requiring review:

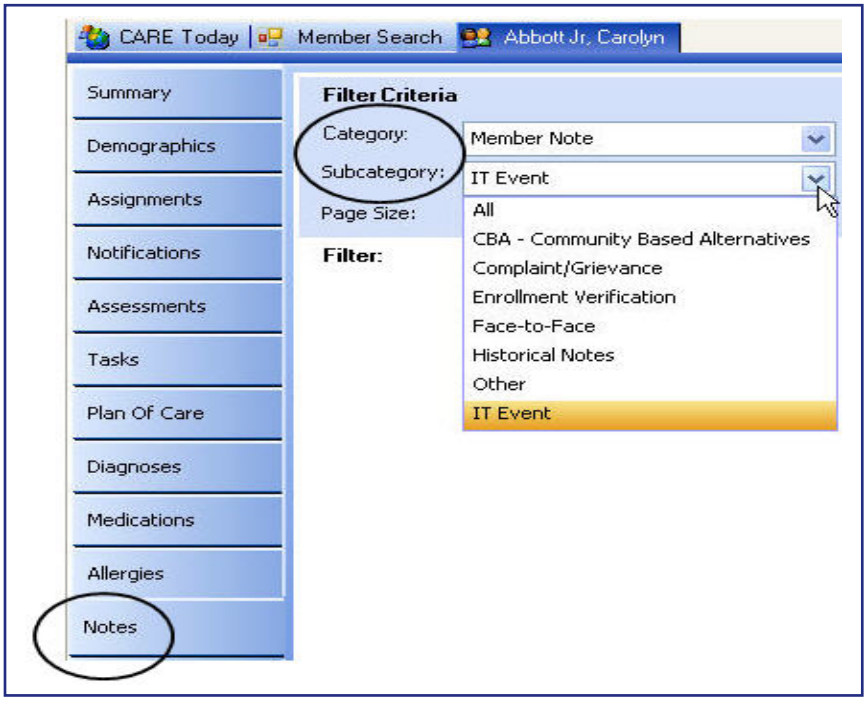
- Receives notification of inpatient delivery case in CareOne
- Contacts hospital for required maternal and infant information if not received in initial notification with requested information to be submitted to CASU within 48 hours of maternal discharge
- Determines the appropriate length of stay (LOS) based on assigned delivery code (vaginal or C-Section delivery)
- Establishes discharge date and birth outcome statistics from hospital provided information
- Documents required information in maternal electronic record and either:
  - Authorizes routine delivery and LOS (Vaginal delivery with 2 day stay or C-Section with 4 day stay) **regardless if the admission was a late notification** and completes required documentation ***or***
  - Routes the case to HFS Utilization Management queue for review of the following:
    - LOS greater than 2 days for vaginal delivery and 4 days for C-Section delivery
    - Ante partum admissions for management of complications or failure to deliver infant 24 hours after admission.
- Documents infant information in required CareOne and CarePlanner fields and specified KICK payment or birth statistical logs within 48 hours of receipt.

The CASU does have the capability to ensure that newborn notification information is submitted into the LEERS database within 24 hours of the birth of the newborn. For example, in Arizona, we ensure that newborn notification information is submitted into the LEERS database within one business day of the birth of the newborn.

Healthy First Steps would already be in contact with the Level II and III's at this point. In addition, HFS outreaches to all moms 60 days post partum. HFS will attempt to outreach to members 60 days for a post partum visit. CASU supports the HFS team on the back end of this process and could do Level I's as we would need to get this information when the MSO triaged the mother initially. This process would be a new sub-part of newborn enrollment for the CASU and we would need to staff accordingly. It is possible to create a member mailing to remind the mother to enroll the baby or assist in enrollment. The CASU could take this responsibility on as a new subset for the Level I triaged moms with proper staffing.

UnitedHealthcare Community Plan has the responsibility to ensure the PCP (hospital that delivered baby) registers the newborn within 24 hours of birth. If the PCP does not register the newborn, then the CASU would submitted into the LEERS database within 24 hours of the birth of the newborn. The CASU does not schedule staff on the weekends or holidays. The delivering hospital must therefore be held accountable to enter that information into the LEERS database during this time.

Validating a Successful Merge in CareOne

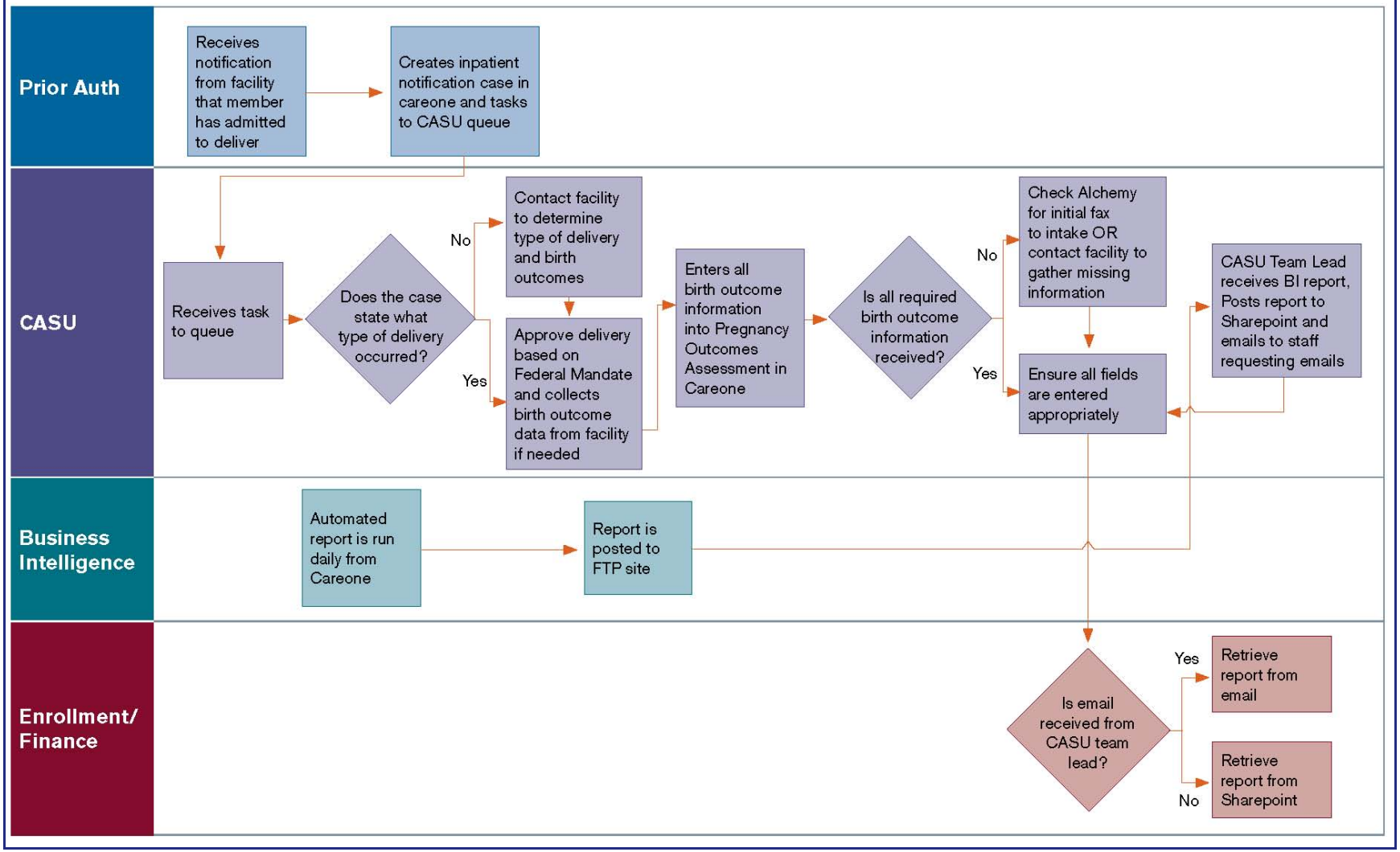


The system records successful member Merges in the **Notes** section for the "base" Record.

The member Merge Functionality release in version 4.20 of CareOne provides an automated solution for merging data between a temporary manually created member and an existing batched (i.e. COSMOS fed) member. Our approach provides the global requirements that must be satisfied prior to executing the member Merge Functionality.

With the **Category** "member Note" and **Subcategory** "IT Event" selected, the Notes window displays the User Name of the person who executed the member Merge, the Date/Time that the member Merge was executed, and a record of the CareOne ID of the "base" and "merge" records.

CASU process flow (multidepartmental)



D.3 Describe the types of interventions you will use prior to seeking to disenroll a member as described in CCN Initiated member Disenrollment, Section §11 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member. (GSA C)

Member Disenrollment

During the past three years, UnitedHealthcare Community Plan **has not disenrolled** a member for reasons other than the loss of managed care eligibility. All terminations are based on information sent by the State. Those disenrollments that have occurred because a member has elected the Medicaid hospice benefit, received a transplant, been placed in a long term care facility or relocated out of the service area.

UnitedHealthcare Community Plan understands that we must respect members' rights and address all restrictions imposed by DHH when requesting to disenroll a member. The only situations in which we would request that a member be disenrolled is either because we have sufficient documentation that the member's condition or illness would be better treated by another plan or we have documentation to establish fraud, forgery or evidence of unauthorized abuse of the services. If we do request to disenroll a member for one of these reasons, our Enrollment department will send a notification of the disenrollment request to the member at the same time that we sent the request to DHH. We will complete all necessary disenrollment paperwork and would continue to adhere to DHH's recommendations, timelines, documentation practices and protocol for handling disenrollments. DHH has defined the following disenrollment categories, which UnitedHealthcare Community Plan will use to process disenrollments:

- Loss of member's Medicaid eligibility or loss of CCN enrollment eligibility
- Death of a member
- Member's intentional submission of fraudulent information
- Member becomes an inmate in a public institution
- Member moves out-of-state
- Member becomes Medicare eligible
- Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities)
- Member becomes a participant in a home and community-based services waiver
- Member elects to receive hospice services
- To implement the decision of a hearing officer in an appeal proceeding by the Member against the CCN or as ordered by a court of law.

UnitedHealthcare Community Plan disenrolls the individual on the first day of the month following the decision, as long as DHH's MMIS system has terminated eligibility. If the member is in the hospital at the time of disenrollment due to a change in eligibility category or medical status, UnitedHealthcare Community Plan remains responsible for their hospitalization and the delivery of related services in the basic CCN benefits package. This situation continues until the member is discharged from the hospital or for 60 days, whichever is earlier. If a member is in the hospital, but had disenrolled and was transferred to another CCN program, UnitedHealthcare Community Plan would continue to provide services through the time of discharge. At that time, we would work with the other CCN physician to ensure the continuity of care and service delivered to that member. If the disenrollment is because the member has lost Medicaid eligibility or has added Medicare eligibility, UnitedHealthcare Community Plan is not responsible for any services as of the date of disenrollment.

D.4 Describe the steps you will take to assign a member to a different Provider in the event a PCP requests the Member be assigned elsewhere. (GSA C)

PCP Requests Member Assignment Elsewhere

PCPs have been provided information through their contracts with UnitedHealthcare Community Plan as well as the UnitedHealthcare Community Plan Administrative Guide regarding their roles and responsibilities as a PCP, including scheduling an initial appointment with each new member within 90 days of enrollment with UnitedHealthcare Community Plan. We will notify each PCP of the members assigned to them within five business days from the date on which we receive the enrollment report from the Division. We encourage all PCPs to develop their own outreach process to new members related to scheduling an initial appointment. We will offer sample telephone call scripts as well as sample letters that the provider can place on their own letterhead, welcoming the member to their practice and requesting the member schedule an appointment.

If the PCP's office encounters any difficulty in reaching a new member, we request the provider's office contact our Member Service Department for assistance. Similar to assisting the member with scheduling, the member service representative will place a conference call with the member to schedule the appointment. If the representative is unable to reach the member, they will follow the process outlined above for making three attempts to contact the member by telephone. If we are unable to contact the member within the three attempts, we will send the member a letter to the member requesting they either contact their PCP's office to schedule an appointment as soon as possible or contact our Member Service Department to obtain assistance in scheduling.

If a member has a life-threatening or degenerative and disabling condition or a disease that requires prolonged specialized care, the member's specialist may serve as the PCP. In these cases, a medical director must approve a treatment plan, in consultation with the PCP, the specialist and the member (or the member's designee). UnitedHealthcare Community Plan will approve only specialists who are participating in UnitedHealthcare Community Plan's network, unless no qualified specialist can be identified in the UnitedHealthcare Community Plan network.

When Member has Not Already Selected another PCP

In the event a PCP requests the member be assigned elsewhere and the member has not already selected another PCP, UnitedHealthcare Community Plan auto-assigns a member to a PCP, matching upon the member's geographic location and the PCP's capacity to accept new members. We allow a new member 30 days after their enrollment to make a PCP selection. To encourage existing relationships and minimize transition issues, we will first look to see if there is any indication of the member's current PCP on the file obtained from DHH. If no previous PCP is shown, our information system will match the member to a PCP assigned to a family member if the provider is appropriate for the member's age and gender (e.g., a male child would not be assigned to the mother's OB/GYN acting as a PCP). If no family member is assigned to a PCP appropriate for the Member, our auto-assignment process will then search by age, gender and available PCPs using zip code parameters. This process identifies PCPs with open panels no more than 60 minutes or 60 miles in rural regions and no more than 30 minutes or 30 miles in urban regions.

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Section E: Chronic Care/Disease Management (Section 6 of RFP)

E.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes. (GSA C)

UnitedHealthcare Community Plan understands Louisiana DHH's goal to improve health outcomes for Medicaid members. In a publication sponsored by the UnitedHealth Foundation, and as pointed out in community forums across the state, in 2010 Louisiana ranked 49 of 50 states in premature deaths per 100,000 populations in America's Health Rankings®. Deaths by cardiovascular disease and by cancer showed Louisiana ranked 47 and 48, respectively and infant mortality ratings showed Louisiana ranked 48 of 50 states. Focusing the most intensive care management efforts on members at risk for adverse health outcomes, as UnitedHealthcare Community Plan proposes with our Personal Care Model™ , is a proactive step toward improving these rankings for 2012 and beyond. This focus will also improve the quality of care and quality of life of Louisiana Medicaid recipients and bring more success to physicians who work on a daily basis to support and improve the overall health of their patients.

Personal Care Model™

Our Personal Care Model (PCM) is a holistic approach to care for members, across the entire continuum of care. It addresses the unique socio-economic and clinical challenges of our members from their interactions with primary care physicians through addressing the complex needs of the most chronically ill individuals. The Personal Care Model is designed to:

- Create a seamless member care experience
- Address the socio-economic, behavioral, environmental and clinical challenges of our members
- Leverage multidisciplinary care management teams
- Incorporate high-touch and personalized interventions
- Work in partnership with providers, members and the community
- Be sensitive to cultural differences and diversity
- Address health care disparities
- Leverage community based resources from governmental, private and faith-based organizations
- Offer specialized member communication, outreach, engagement and communication
- Include continuous measurement of process and outcomes
- Integrate network, members services, medical economics and information technology to improve care for members

Our Personal Care Model is a guiding force throughout our operation and has specific application to our management of members with chronic conditions.

Applying the Personal Care Model to Members with Chronic Conditions

As part of our Personal Care Model, UnitedHealthcare Community Plan views case management, chronic care management and disease management as points on a continuum of care. Individuals may move between population-based disease management to a more intensive level of chronic care management over time as their needs, preferences and the severity of their conditions change.

Regardless of changes in intensity, the care manager will remain the same, whenever possible, so that a stronger relationship between the member and the nurse can develop and remain intact. Care managers address the needs of members at all levels of intensity using standard disease specific, evidenced based

guidelines but address multiple chronic conditions through a single integrated approach. The goal is to empower individuals, in collaboration with physicians and other health care professionals to effectively manage their conditions, associated risk factors and co-morbidities.

Our programs are fully integrated with our other clinical support programs, ensuring the coordination of clinical resources across the continuum of wellness, health and medical decision support and care and disease management. Although we have guidelines based on member intensity, alignment with the members' own personal health goals and preferences is key to engagement. For example, if the member does not want as frequent or wants more frequent contact, the care manager discusses this with the member and they come to an agreement. This model is patient-centered and engages the family whenever appropriate to support the member's goals.

UnitedHealthcare believes that health care cannot be provided effectively without consideration of the environmental factors that affect a person's life, and through our Personal Care Model we take a holistic approach to health care, emphasizing practical programs to improve our members' living circumstances as well as their health.

The unique UnitedHealthcare Personal Care Model features direct member contact by clinical staff who work to build a support network for chronically and acutely ill members involving family, providers and government and community-based organizations. In addition, the PCM features advanced health care management technology applications to ensure that high quality, timely and appropriate health care is available to all members.

The Personal Care Model delivers high-touch, personalized interventions in support of overall wellness. This personalized care program is designed to help members avoid hospitalizations and emergency room visits while engaging them in their own health care decisions. Our approach improves members' health and keeps them in their communities, with the resources necessary to maintain the highest possible functional status – in short, UnitedHealthcare helps people live healthier lives.

The Personal Care Model is based on five steps and begins with Welcome Calls to **all new members**. These steps guide our care management staff from initial contact with the member through engagement in the program and ongoing monitoring of the member's progress toward health and wellness goals.

Personal Care Model – Our Member-Centric Integrated Care Model	
1. Identify	■ Welcome calls to **all new members** with opportunity to complete an initial health risk assessment ■ Initial risk score assigned based on health risk assessment and referral to care manager for further screening as indicated ■ Referrals from PCPs and community sources as well as internal referrals from other departments ■ ImpactProImpactPro® analysis of claims, pharmacy data and lab results ■ Frequent inpatient admission/readmission reporting ■ Population based identification of members with select chronic illnesses to send member education materials
2. Assess	■ Conduct Comprehensive Health Status Assessment (CHSA) which will drive adjustment to care management level and identify individual conditions ■ Perform condition specific disease management supplemental assessments ■ Clinical judgment employed to validate and augment risk scores ■ Refer to specialized programs based on Hierarchy of Diseases (e.g. Health First Steps based on pregnancy)
3. Risk Stratify	■ Risk stratification based on ImpactProImpactPro predictive modeling system and assessment results ■ Confirm risk stratification level based on member interactions and identify any necessary special care management programs
4. Implement	■ Develop member-centric plan of care implemented by multi-disciplinary health care team ■ Share care plan with PCP and other providers and invite physician adjustments to plan; care plans are available on our provider portal ■ Condition-specific interventions ■ Support self-management and self-efficacy ■ Involve family and community resources
5. Monitor	■ On-going monitoring of claims, pharmacy data, assessments, utilization, referrals and lab results ■ Identification of gaps in care, barriers to success and non-adherence to plan of care ■ Restratification with ImpactProImpactPro predictive modeling ■ Care management/disease management efforts continue

Existing Chronic Care/Disease Management Programs

As a national leader in Chronic Care/Disease Management and Medical Home initiatives, UnitedHealthcare has offered Disease Management (DM) programs for more than 30 years. We first offered DM programs specifically customized for Medicaid and dual eligible populations in 1998. As our screening process and interventions matured, we expanded to include a wide variety of chronic conditions in our care management programs. Management of chronic illness is vital to cost containment efforts, with 83 cents of every Medicaid dollar spent in the U.S. dedicated to treating chronic diseases like diabetes, asthma and hypertension, which are often preventable and highly manageable[2].

While there are some program differences due to state requirements, eligibility type or state-specific factors, these programs are largely uniform and are based on our strong belief that the most successful

[2] "PFCD and UnitedHealthcare briefing sheds light on proven state Medicaid programs that reduce escalating health care costs" *Partnership to Fight Chronic Disease* website, May 24, 2011.

chronic care management programs focus on whole person wellness. We do have the ability, as evidenced below, to customize the types of chronic conditions that receive disease management programs in line with state requirements as well as offer connections to local resources.

State Specific Requirements

Each of the states listed above have some state-selected areas of focus and are based on the unique requirements of the state, eligibility types included, and needs of the members. Below are brief examples of how our programs are customized to state specific factors:

Mississippi

In Mississippi, UnitedHealthcare provides care management for the CHIP population that includes all areas in the state with an emphasis on wellness and health promotion through a contract with the Mississippi Division of Medicaid. This program includes specialized child health assessments and a focus on EPSDT, dental, vision, medical and behavioral health services for approximately 87,000 eligible children from birth to age 19. In this program, we also manage dental care, prescription medications and provide a 24/7 nurse advice line. Chronic Care/Disease Management in Mississippi have a special focus on: asthma, cardiac care, diabetes, growth disorders, pregnancy, kidney disease and rheumatoid arthritis.

Arizona

In Arizona, UnitedHealthcare-APIPA- Children's Rehabilitative Services (CRS) provides family-centered medical care, rehabilitation and support services to 25,000 children and youth with chronic and disabling conditions or potentially disabling health conditions (for example, bone tumors, cerebral palsy, multiple sclerosis, muscular dystrophy, sickle cell anemia, etc.). CRS maximizes the quality of life and improves services for children who have chronic and disabling or potentially disabling health conditions. We transformed fragmented services into a single statewide, seamless service delivery system with maximized accessibility through a broadened statewide network, coordinated chronic care management and innovation through modern technology such as telemedicine. Because primary benefits were provided by separate health plans, we established mechanisms with the other Acute Care plans to coordinate care management of their CRS-eligible members; work with their claims departments to ensure that CRS claims did not adjudicate as Acute Care claims or vice versa; and to gather historical patient data to better assess and manage each CRS participant.

Tennessee

In Tennessee, we provide integrated management of medical and behavioral health services for over 550,000 members. This multidisciplinary approach provides personalized care and support focused on addressing the member's needs more globally, rather than focusing only on the condition needing immediate treatment, and offers consistent services to all Medicaid, Medicare, and dual-eligible members. One of the components of this program is a Peer Bridger Program. Members receiving inpatient services work with peer counselors who have first-hand experience with mental health recovery. Peers work with clients on discharge planning and provide a range of post-discharge supports and navigation assistance to help prevent readmissions.

In addition, we offer population-based disease management programs for the following diseases: CHF, COPD, asthma, diabetes, obesity, pregnancy, depression, bipolar, and schizophrenia.

New York Chronic Illness Demonstration Project

In August 2009, the New York State Department of Health contracted with us to manage the New York Chronic Illness Demonstration Project (NY CIDP). We provide services for up to 500 Medicaid fee-for-Service enrollees in the Bronx and Queens areas. As stated by the New York State Health Commissioner Richard F Daines, M.D., "Seventy-five percent of the state's $46 billion Medicaid budget is spent on 20 percent of its patients, who often have multiple chronic medical conditions, such as heart disease, diabetes, high blood pressure, kidney disease and sickle cell anemia. Many also have histories of mental

illness or are addicted to drugs or alcohol. We must help them manage their care, despite its medical complexity, to improve their health and save taxpayer dollars on New York Medicaid."

The program's goals are to establish innovative, quality-driven interdisciplinary models of care designed to improve health care quality, to ensure appropriate use of services, to improve clinical outcomes and to reduce the cost of care for Medicaid beneficiaries with medically complex conditions. Our care managers use a "feet on the street" model, which includes meeting with Medicaid enrollees in community settings to develop and execute individualized care plans and monitor progress in attaining health and wellness goals.

The program has expanded access to specialized services, with a focus on prevention and wellness goals, including those focused on losing and managing weight, healthy eating and smoking cessation. Additionally, the program has aggressively incorporated consumer feedback and involvement, focused on cultural diversity and sensitivity, and supported outcome evaluations through collaboration with the Manpower Demonstration Research Corporation. We have also successfully implemented processes that include: supporting medical practices in underserved areas, expanding Medicaid's physician network, and improving access to care beyond the typical business hours.

Proposed Program for the Louisiana CCN

UnitedHealthcare Community Plan offers a comprehensive, integrated approach to healthy living and management of chronic illness, built upon the experience described above and centered in our Personal Care Model. Our health advocacy and engagement program taps a unique combination of capabilities to help individuals navigate the health care system in achieving health and well-being goals. Our approach focuses on complex care needs through a whole-person wellness perspective.

Qualifications and Training of Chronic Condition/Disease Management Staff

Our Chronic Condition/Disease Management services are primarily performed by care managers who are licensed registered nurses, including managers. They are supported by a team of medical directors who are licensed physicians, social workers, pharmacists, quality managers, health educators and information systems personnel.

In general, these professionals have a minimum of three to five years of experience. Administrative staff supports all functions in the program. A comprehensive orientation is provided to all program staff. This includes several weeks of structured classroom training as well as on-the-job training using experienced preceptors. Training topics include but are not limited to:

- Role of the Clinician in Disease Management
- Motivational Interviewing
- Critical Thinking
- Milliman Overview
- Applying Evidence Based Medicine Guidelines
- Desktops, Milliman Workflows and Templates
- CareOne System Orientation
- Cultural Competency
- Benefits
- Provider network composition and expertise
- Community resources
- Member rights and responsibilities
- Role and composition of the Integrated Care Coordination Teams (ICCT)

- Diversity Training
- Ethics and Integrity.

Dedicated national and regional staff is also available to assist in the training. A standardized schedule and list of functions is provided to each employee at the start of their employment. Staff is also encouraged to participate in external educational programs and conferences to maintain their competency in care management.

A formal medical director training program is provided to new medical directors. In addition, and on an as needed basis, medical directors receive one-to-one training sessions with other experienced medical directors. Participating in regular Continuing Medical Education Programs is also a requirement for the medical directors.

Evidence Based Medicine Guidelines

Our care managers are trained on, knowledgeable about, and frequently reference nationally recognized evidence based medicine guidelines that have been vetted by our clinical leadership. These guidelines are used in developing the logic in our clinical information system to prompt outbound calls and letters to members and physicians regarding identified gaps in care. The evidence-based guidelines we use are posted on our provider portal, for viewing/reference on demand and are available on-line for our staff.

Our adopted evidence based medicine guidelines serve as the clinical basis for all levels in our Chronic Care/Disease Management program. These guidelines are systematically developed; evidence-based statements that help providers make decisions about appropriate health care for specific clinical circumstances. The effectiveness of the guideline is determined by scientific evidence or in the absence of evidence, expert opinion and professional standards. Our adopted clinical guidelines from recognized sources as defined by the National Committee on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC).

The inclusion criteria for UnitedHealthcare Community Plan does not allow a practice guideline developed and issued by an individual not officially sponsored or supported by one of the above types of organizations and not validated by a study published in a peer-review journal. In the event there is no existing guideline available from a recognized source, we convene a panel of professionals with expertise in the topic to develop a guideline based on the best available evidence including working with the State on their prior guidelines. These customized guidelines are reviewed and approved the local health plan Quality Management Committee (QMC).

The evidence based medicine guidelines are reviewed and revised annually. The UnitedHealthcare Executive Medical Policy Committee (EMPC) reviews and approves nationally recognized evidence based medicine guidelines. The guidelines are then distributed to the UnitedHealthcare National Quality Management Oversight Committee (NQMOC) and the health plan Quality Management Committee (QMC). Due to their size, our selected guidelines are not included in this proposal, but are available for review upon request.

Target Conditions for Chronic Care/Disease Management

As required in section 6.36 of the RFP, we will include members with asthma, diabetes and congestive heart failure (CHF) in our Chronic Care/Disease Management program. In addition, we will target members with chronic obstructive pulmonary disease (COPD) and coronary artery disease (CAD). We also have specialty disease management programs focusing on: Transplant, End Stage Renal Disease, pregnancy and neonatal services. However, due to our whole person wellness approach, our program will be designed to broadly identify and appropriately support all members who are at risk for adverse health outcomes, regardless of diagnosis. In order to effectively execute and individualize outcome-specific plans, we use various data sets, not only to identify specific member needs, but to allow us to stratify members into various levels of intervention. Our programmatic tools screen and analyze claims/utilization

data to identify individuals with asthma, diabetes, CHF, COPD and CAD on a monthly basis to identify and stratify individuals with other diagnoses who are at risk for adverse health outcomes.

Identification of Members who will Benefit from Disease Management

Through our extensive experience in operating Chronic Care/Disease Management programs, we have learned the importance of focusing our efforts on those members who are most at risk and able to benefit from personal intervention.

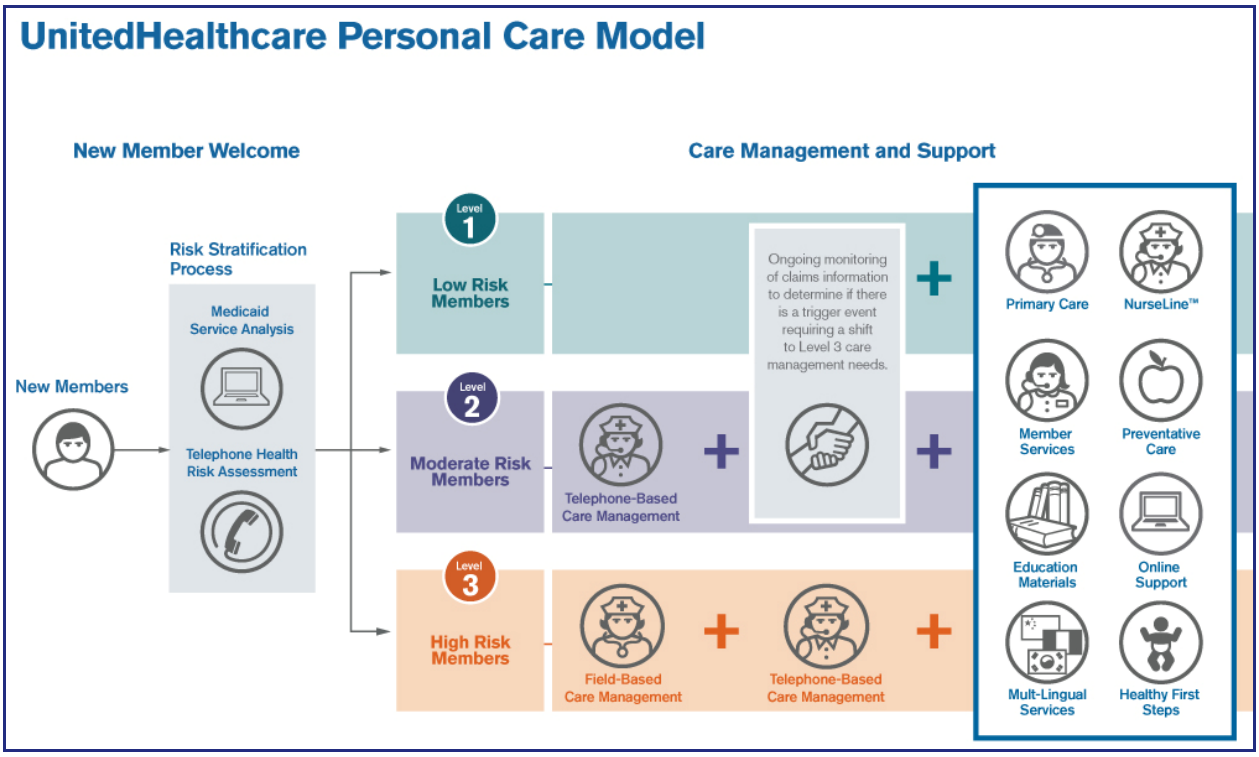
As described in our Personal Care Model, we identify members in need of Chronic Care/Disease Management through the following sources:

- Welcome calls to all new members with opportunity to complete initial health risk assessment
- Initial risk score assigned based on health risk assessment and referral to care manager for further screening as indicated
- Referrals from PCPs and community sources as well as internal referrals from other departments
- ImpactProImpactPro analysis of claims, pharmacy data and lab results
- Inpatient Admission/Readmission reporting
- Population based identification of members with select chronic illnesses to send member education materials
- Screening enrollment files for Special Health Care Needs indicator noted by the CCN Enrollment Broker.

Welcome Calls and Initial Health Risk Assessment

During the initial welcome call, new members receive a simplified Health Risk Assessment (HRA). We have separate HRA versions for adult members and for children (parent/guardian). We conduct live Welcome Calls to greet and education our members about their benefits and impart important information about the various programs available. We also seize the opportunity to ask basic questions about their current health state, using the HRA. The HRA instrument is algorithmically designed to assign risk scores, used to prompt further investigation into a member's health needs. If the results of the initial HRA score for higher risk, the member is referred for a more in-depth assessment.

Our Personal Care Model, as described in detail at the beginning of our response to this question, drives identification, placement of members in the right care management program for their needs and ongoing planning and monitoring of members. The following graphic displays how members are identified, screened and referred to the appropriate level of care management and support:



Comprehensive Health Status Assessment

Once a member is identified or referred to our Chronic Care/Disease Management program, a care manager performs a Comprehensive Health Status Assessment (CHSA). The CHSA identifies key high risk conditions, family history, family supports, current and past medical history, personal behaviors, social history and environmental risk factors. The CHSA includes, but is not limited to:

- Vaccine history
- Current and past health conditions, including behavioral health
- Exercise habits
- Height and weight, weight fluctuations
- Issues related to diet, the cost of food and any diet restrictions
- Sleep
- History of falling
- Wounds
- Trouble breathing and shortness of breath
- Heart pain
- Ankle/leg swelling
- Chronic pain
- A wide variety of additional health symptoms that might require further investigation and care
- Depression
- Current medications list and any issues related to medications
- Housing and safety
- Level of education
- Assistance needed for daily living activities
- Tobacco use, past and present

- Alcohol and other drug use
- Frequency of primary care visits and any transportation or other barriers to receiving routine care
- Emergency room use
- Surgery, history and planned
- Living Will and Power of Attorney
- Use of durable medical equipment
- Ethnicity and primary language spoken
- Emergency contact information.

Once completed, the CHSA helps determine the additional condition specific screenings needed and allows us to place the member into the appropriate care management level. Below is the first page of the CHSA tool:

CONFIDENTIAL

Enrollee Name: _____

Assessment Date: _____

UnitedHealthcare Comprehensive Health Status Assessment

1.0 Encounter Information

Encounter Information

1.1 * Were you able to contact the enrollee?

____ Yes ____ No

1.2 * Does the member agree to be interviewed/ assessed?

____ Yes ____ No

1.3 * Does the member or legal guardian give verbal permission to discuss PHI?

____ Yes ____ No

1.4 * Type of Encounter

____ Telephonic ____ Home Visit ____ Clinic/PCP Office

____ Hospital ____ Mail

2.0 About Your Health History

About Your Health History

2.1 Has the member received any of these preventative services?

____ None ____ Mammogram Screening ____ PAP/Cervical Screening

____ STD Education/Awareness/Protection ____ Family Planning Services ____ Prostate Screening

____ Colon Cancer Screening ____ Eye Exams ____ Hearing Test

____ Lead Screening ____ Health Exam in the last year ____ Lipid Profile/Cholesterol Screening

____ Osteoporosis screening ____ Dental Exam

2.2 Received influenza vaccination within the past year?

____ Completed
____ Not completed
____ Doesn't know
____ NA

2.3 Received Pneumovax (If the first dose received before the age of 65 and it's more than 5 years, and the enrollee is now 65 years or older, needs revaccination)

____ Completed
____ Not completed
____ Doesn't know
____ NA

2.4 Have you had a tetanus shot in the last 10 years?

____ NA
____ Doesn't know
____ Not completed
____ Completed

Blank Assessment Report

Other Sources of Identification

Along with welcome calls and use of the CHSA tool, we gain referrals from our ICCT, PCPs and other medical/behavioral professionals including state and community agencies. Individuals identified through

referrals are given our in depth CHSA and are assigned to particular care management levels or specialty programs.

In addition, we run claim-based analytics through SMART (our data warehouse) and ImpactPro to identify individuals with our targeted conditions. We use state based reports or specific "aid" categories to identify special populations needing disease or care management (e.g. pregnancy or children with special health care needs). In the absence of other identifying information, these individuals are enrolled in our Level 1 disease management program. Once further clinical information is known (through ImpactPro, welcome call or CHSA), the individuals are graduated to more intensive programs.

One final source of information on individuals suffering from chronic conditions is the real time utilization reports on frequent admission or any readmission. Our care managers work with our ICCT to identify members who have admitted to the hospital. Members with frequent admissions or any readmissions are referred into our care management process. Members are given a health risk assessment for enrollment into our disease management program as appropriate.

Assessment

Members are assessed to determine clinical intensity through two basic mechanisms. In addition to welcome calls and screening tools described above, we use start-of-the-art health care data analytics to mine administrative claims data to predict future risk of clinical needs based on our members profile through our ImpactPro tool. Our assessment process places members in the programs with the intensity level most likely to produce maximum benefit for the individual.

ImpactPro Risk Stratification Engine

ImpactPro is one tool that UnitedHealthcare Community Plan uses evaluate the quality and appropriateness of care and services provided to members. ImpactPro provides our utilization management team with predictive modeling, evidence-based medicine and tailored clinical and business rules to identify, stratify and assess member utilization. ImpactPro assists us identifying patterns of underutilization, overutilization and inappropriate utilization where intervention will be most successful.

Each month, member claim data are entered into the ImpactPro risk stratification engine. The data are then run through a series of algorithms and ImpactPro assigns the risk score to members. Depending on a member's score and risk level, a determination is made whether to enter a member into a care management program or other clinical intervention. Analysis of Impact reporting data also allows us to identify potential barriers to care that must be addressed.

Our care management programs help members with significant conditions receive quality care and avert potential problems by providing care management services to those who need it, by devising proactive, rather than reactive, programs. ImpactPro compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services.

One of ImpactPro's key strengths is its ability to predict health risk for our member. For example, diabetes patients are at risk for developing eye problems, and medically accepted guidelines recommend that diabetics see an eye care specialist. Using ImpactPro gives our care managers the ability to identify diabetes patients who have not seen an eye specialist. The implications of this tool assist us in reducing the prevalence of eye problems in the diabetic population. The health outcomes for those members can improve by anticipating the needs of the members on a very basic level.

At implementation and on a monthly basis thereafter, ImpactPro performs predictive modeling for individuals and groups. Using information readily available from medical and pharmacy claims (if available from the State), laboratory results as well as member enrollment files, it uses a variety of risk models to predict which patients are at greatest risk for severe problems in the future. These risk models are developed using historical information drawn from the population and allows us to identify members

at risk for severe health problems before they experience those problems. Certain members may not feel sick yet, and may not follow their care team's recommendations because they do not recognize the potential for developing severe problems.

From a disease management perspective, we are able to target our prevention activities in a more effective way. The risk scores provided from ImpactPro is just as useful in discovering existing members who may need care management services. For example with asthma, the algorithm takes into consideration inpatient and emergency room (ER) use. An "Overall Future Risk Score" is assigned to each member based on the ImpactPro algorithm and represents the degree to which the asthma DM program has the opportunity to impact members' health status and clinical outcomes. Again, this assists care managers in identifying members who are most likely to benefit from interventions.

ImpactPro also has the capability of producing provider letter notifications of members who have generated care opportunities for specific DM program. These evidence-based medical guidelines highlight opportunities for improving care. Additionally, ImpactPro produces reports that providers can use to identify at-risk members and all their missed care opportunities, which can be accessed through our secure online provider portal.

Risk Stratification

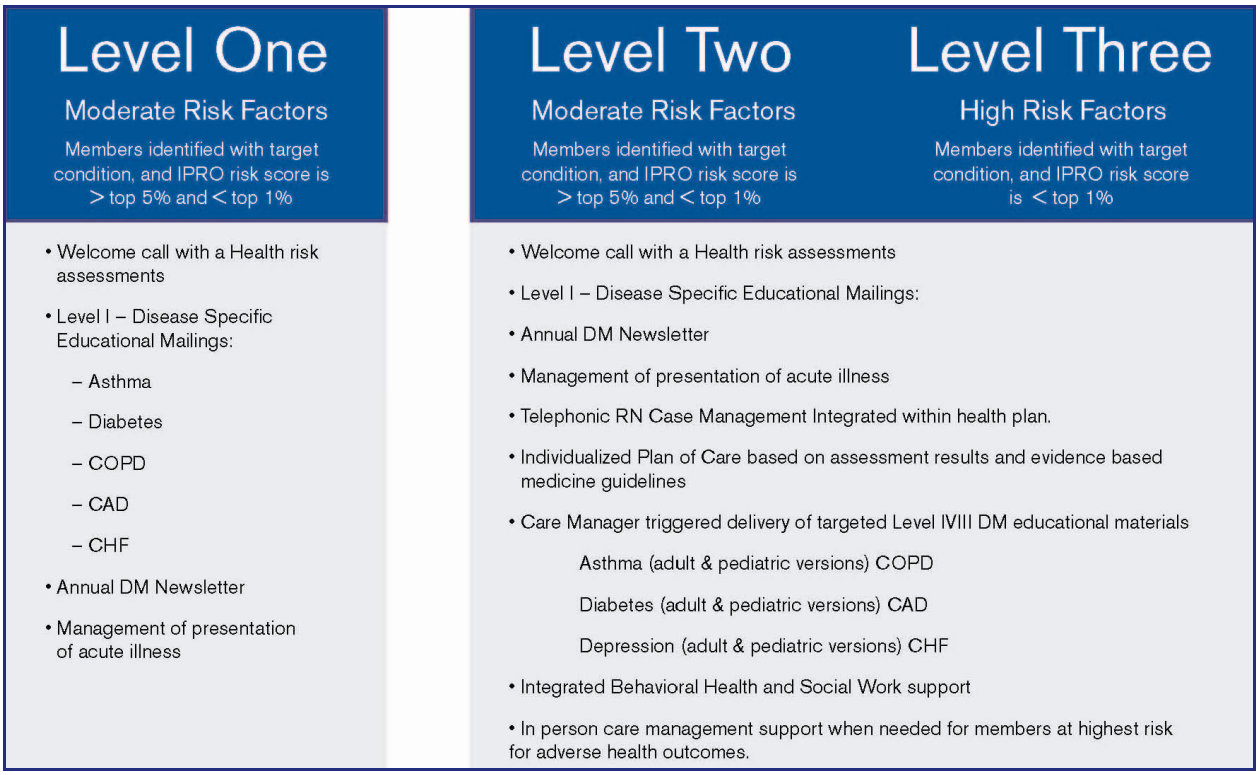
We supplement these analytics with other claims based reports to identify members who suffer from frequent ER use or preventable readmissions. In addition, our physicians or clinical staff can refer members into our care and disease management program.

We categorize members into levels of intensity. These care management levels allow us to set minimum guidelines in such as areas as treatment recommendations, staffing and contact intensity, prioritization of interventions and type of contact. These minimum guidelines are supplemented and adapted through the clinical judgment of our clinical team including individual care managers, Care Management Supervisors and our chief medical officer.

The risk severity levels are:

- ***Level 1:*** Single Disease Management
- ***Level 2***: Chronic Illness, Often With Comordities
- ***Level 3:*** High Risk Chronic Illness With Multiple Comoribities or Severe Chronic Illness.

The following graphic summarizes the interventions associated with each care management level:



Level 1-Low Risk Disease Management

Members who are stratified as having a chronic condition but as being at lower risk for adverse health outcomes are enrolled in our Level 1 disease management program. Note that risk stratification is run at least monthly. If at any time a member is re-stratified and in need of more intensive Level 2 or Level 3 care management, the member will be moved to the most appropriate level of interventions.

Our Disease Management programs are designed to empower members with the information needed to successfully manage their condition(s). Member education materials are sent upon identification and periodically throughout the member's enrollment in disease management. In addition to condition specific education materials, members receive an HRA form to be used to assess further risk and help to graduate members to a higher level of intensity if needed.

Further detail about our Level 1 (Low Risk) Disease Management interventions by condition is included below:

Asthma (Adults and Children)

Level 1 interventions for asthma include:

- Initial Intake Assessment once per year
- Health coaching/scripted calls for preventive health and clinical indicators
- Given care manager phone number to call, if needed
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program web-site
- Episodic educational interventions, as needed
- Post hospitalization and ER assessment as needed
- Educational material sent to member when assessment is completed

- Assess member's knowledge of causes, treatment and follow-up care related to asthma.

Diabetes (Adults and Children)

Level 1 interventions for diabetes include:

- Initial Intake Assessment once per year
- Health coaching/scripted calls for preventive health and clinical indicators
- Given care manager phone number to call, if needed
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program web-site
- Episodic educational interventions, as needed
- Post hospitalization and ER assessment as needed
- Educational material sent to member after completion of assessment
- Assess member's knowledge of causes, treatment and follow-up care related to diabetes.

Congestive Heart Failure (CHF)

Level 1 interventions for CHF include:

- Given care manager phone number to call, if needed
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program web-site
- Episodic educational interventions, as needed
- Post hospitalization and ER assessment
- Educational material sent to member.

Congestive Obstructive Pulmonary Disease (COPD)

Level 1 interventions for COPD include:

- Given care manager phone number to call, if needed
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program web-site
- Episodic educational interventions, as needed
- Post hospitalization and ER assessment
- Educational material sent to member.

Coronary Artery Disease (CAD)

Level 1 interventions for CAD include:

- Given care manager phone number to call, if needed
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program web-site
- Episodic educational interventions, as needed
- Post hospitalization and ER assessment
- Educational material sent to member.

Frequency of Interventions

Recommended frequency of interventions for members in Level I Disease Management are detailed in the following table:

Stratification Level	***LOW (LEVEL 1)***					
Intervention	***Frequency***	***Condition Monitoring***	***Patient Adherence***	***Other Health Conditions***	***Lifestyle Issues***	***Additional Resources***
Initial Intake Assessment: Health Risk Assessment (HRA) All Members	Upon enrollment	X	X	X	X	
Re-stratification	Quarterly	X		X		
Website	Ongoing	X		X	X	X
24 Hour Nurse-line (in specific health plans based on contractual requirements)	Ongoing			X	X	X
Member Newsletter	Quarterly		X	X	X	
Disease specific mailings	Annually	X	X	X	X	
Disease specific education – verbal (in specific health plans based on contractual requirements)	Annually	X	X	X	X	

Mailings/Member Education

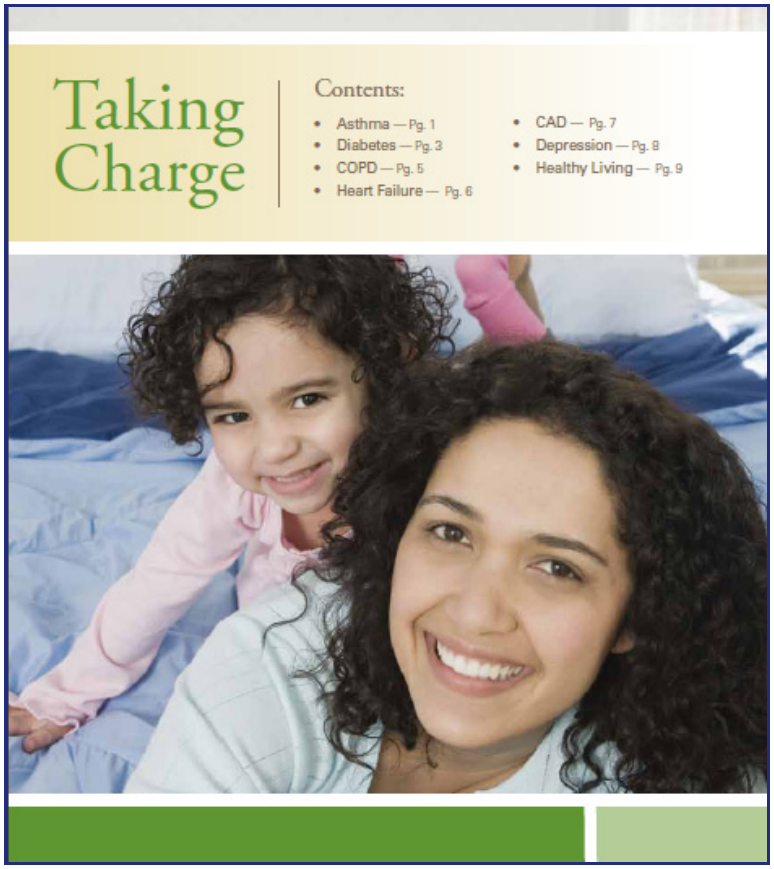
Member education mailings are sent immediately upon identification that a member has a particular condition, as part of our Level 1 population based disease management program. Once enrolled in the Chronic Care/Disease Management program at a Level 2 or Level 3, the care manager generates additional educational materials and other mailings based on conversations with the member and his or her physician(s). Our materials provide information about the member's condition(s) and make recommendations about necessary routine appointment frequency, necessary testing/monitoring and self-care. These materials are designed to empower each member to take responsibility for their health and to equip themselves with the information necessary to live a healthy lifestyle and to manage their condition as successfully as possible. All recommendations in educational materials are based on evidence-based medicine guidelines.

Materials that are Culturally Sensitive and Easily Understood

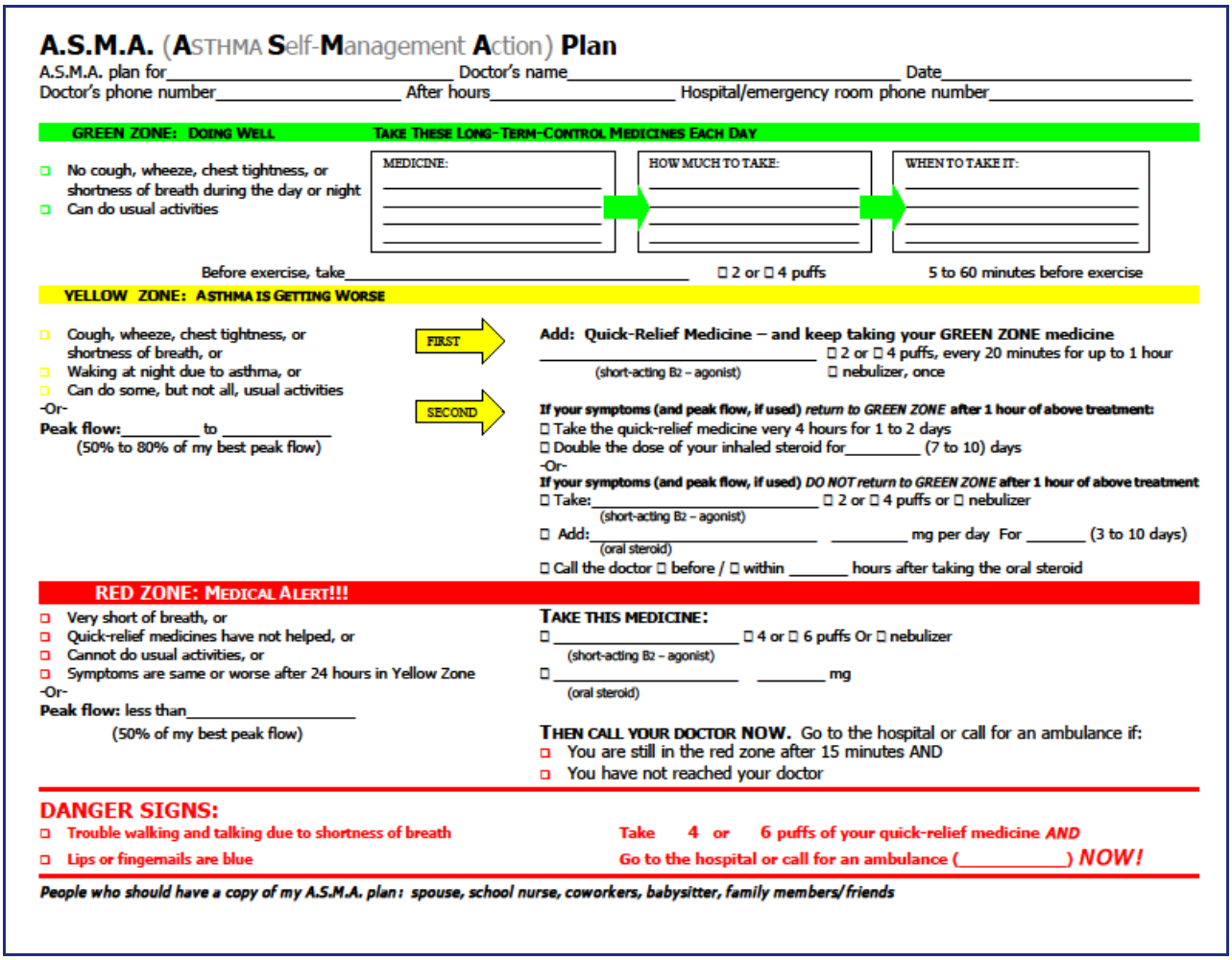
Our materials will comply with the translation requirements detailed in Section 12.19 of the RFP, including translation into Spanish and Vietnamese and into other languages as indicated by enrollment demographics. We are sensitive to the importance of ensuring that members have access to program information that they can easily understand. Materials will be written at no higher than a sixth grade reading level, per Section 12.9 of the RFP. All written materials are designed to be understandable for individuals with low literacy, to be culturally sensitive and are made available in the languages spoken by the covered population.

We have experience translating materials into Armenian, Chinese (traditional and simplified), Farsi, Khmer, Korean, Russian, Spanish, Tagalog and Vietnamese. In addition, whenever possible, before they are distributed, we request reviews by people who are part of the community/population for whom a communication is intended. Cultural relevance is as critical as correct translation. Because our staff have

been in Louisiana for several months, actively meeting with community organizations, we have established relationships which will help facilitate this review of materials. We can also make translations into large print, Braille and voice-recorded CD formats upon request for members with low vision. Please see the following is a sample DM Newsletter:



English and Spanish versions of a member Asthma Action Plan mailing are exhibited here:



A.S.M.A. (ASTHMA Self-Management Action) Plan

A.S.M.A. plan for_____ Doctor's name_____ Date_____
Doctor's phone number_____ After hours_____ Hospital/emergency room phone number_____

GREEN ZONE: DOING WELL — **TAKE THESE LONG-TERM-CONTROL MEDICINES EACH DAY**

- ☐ No cough, wheeze, chest tightness, or shortness of breath during the day or night
- ☐ Can do usual activities

MEDICINE:	HOW MUCH TO TAKE:	WHEN TO TAKE IT:

Before exercise, take_____ ☐ 2 or ☐ 4 puffs 5 to 60 minutes before exercise

YELLOW ZONE: ASTHMA IS GETTING WORSE

- ☐ Cough, wheeze, chest tightness, or shortness of breath, or
- ☐ Waking at night due to asthma, or
- ☐ Can do some, but not all, usual activities

-Or-
Peak flow:_____ to _____
(50% to 80% of my best peak flow)

FIRST — **Add: Quick-Relief Medicine – and keep taking your GREEN ZONE medicine**
_____ ☐ 2 or ☐ 4 puffs, every 20 minutes for up to 1 hour
(short-acting B2 – agonist) ☐ nebulizer, once

SECOND — **If your symptoms (and peak flow, if used)** ***return to GREEN ZONE*** **after 1 hour of above treatment:**
☐ Take the quick-relief medicine very 4 hours for 1 to 2 days
☐ Double the dose of your inhaled steroid for_____ (7 to 10) days
-Or-
If your symptoms (and peak flow, if used) ***DO NOT return to GREEN ZONE*** **after 1 hour of above treatment**
☐ Take:_____ ☐ 2 or ☐ 4 puffs or ☐ nebulizer
(short-acting B2 – agonist)
☐ Add:_____ _____ mg per day For _____ (3 to 10 days)
(oral steroid)
☐ Call the doctor ☐ before / ☐ within _____ hours after taking the oral steroid

RED ZONE: MEDICAL ALERT!!!

- ☐ Very short of breath, or
- ☐ Quick-relief medicines have not helped, or
- ☐ Cannot do usual activities, or
- ☐ Symptoms are same or worse after 24 hours in Yellow Zone

-Or-
Peak flow: less than_____
(50% of my best peak flow)

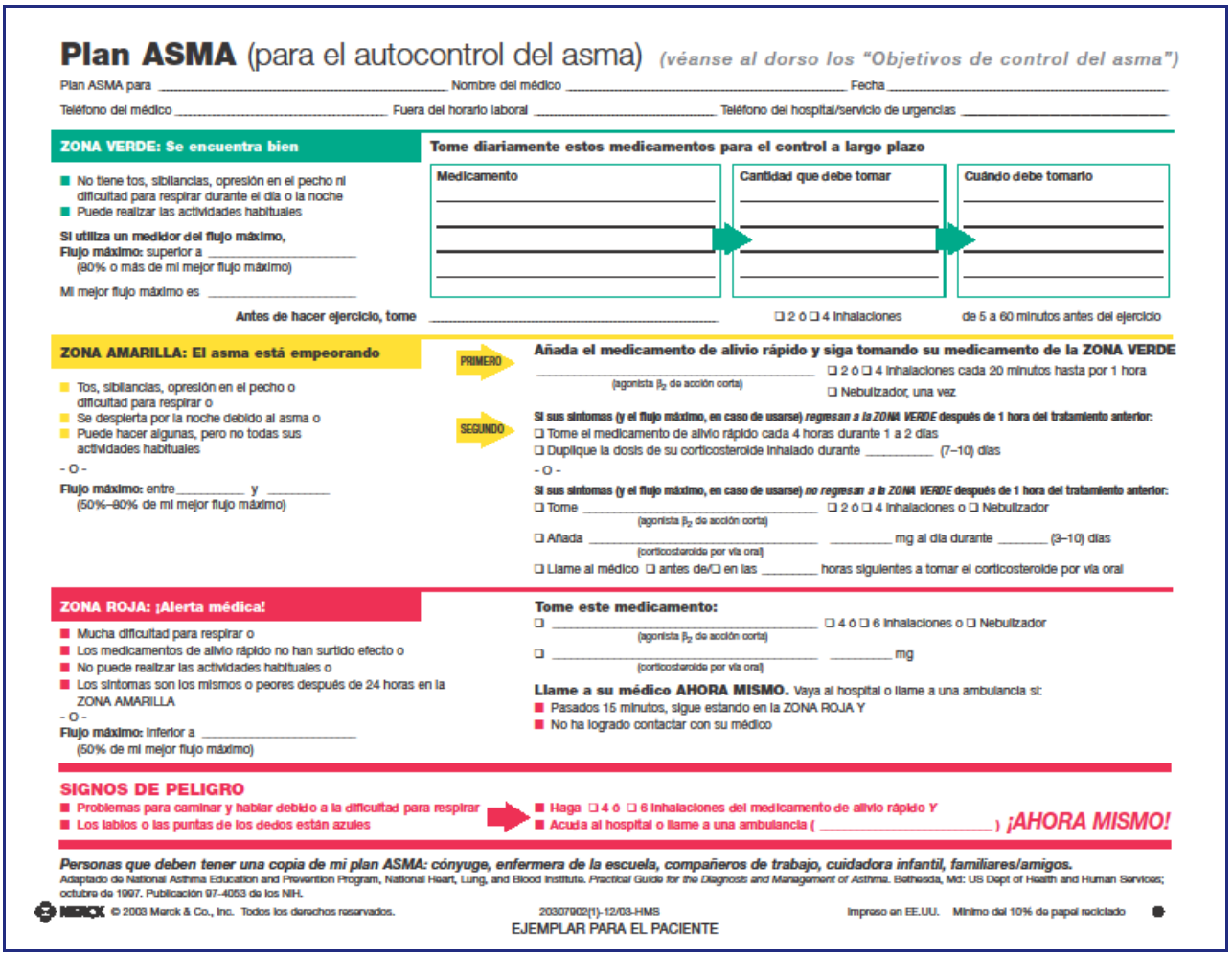
TAKE THIS MEDICINE:
☐ _____ ☐ 4 or ☐ 6 puffs Or ☐ nebulizer
(short-acting B2 – agonist)
☐ _____ _____ mg
(oral steroid)

THEN CALL YOUR DOCTOR NOW. Go to the hospital or call for an ambulance if:
- ☐ You are still in the red zone after 15 minutes AND
- ☐ You have not reached your doctor

DANGER SIGNS:
- ☐ Trouble walking and talking due to shortness of breath
- ☐ Lips or fingernails are blue

Take 4 or 6 puffs of your quick-relief medicine ***AND***
Go to the hospital or call for an ambulance (_____) ***NOW!***

People who should have a copy of my A.S.M.A. plan: spouse, school nurse, coworkers, babysitter, family members/friends



Plan ASMA (para el autocontrol del asma) *(véanse al dorso los "Objetivos de control del asma")*

Plan ASMA para _____ Nombre del médico _____ Fecha _____

Teléfono del médico _____ Fuera del horario laboral _____ Teléfono del hospital/servicio de urgencias _____

ZONA VERDE: Se encuentra bien

- No tiene tos, sibilancias, opresión en el pecho ni dificultad para respirar durante el día o la noche
- Puede realizar las actividades habituales

Si utiliza un medidor del flujo máximo,
Flujo máximo: superior a _____
(80% o más de mi mejor flujo máximo)

Mi mejor flujo máximo es _____

Tome diariamente estos medicamentos para el control a largo plazo

Medicamento	Cantidad que debe tomar	Cuándo debe tomarlo

Antes de hacer ejercicio, tome _____ ❑ 2 ó ❑ 4 inhalaciones de 5 a 60 minutos antes del ejercicio

ZONA AMARILLA: El asma está empeorando

- Tos, sibilancias, opresión en el pecho o dificultad para respirar o
- Se despierta por la noche debido al asma o
- Puede hacer algunas, pero no todas sus actividades habituales

- O -

Flujo máximo: entre _____ y _____
(50%–80% de mi mejor flujo máximo)

PRIMERO — **Añada el medicamento de alivio rápido y siga tomando su medicamento de la ZONA VERDE**

_____ (agonista β_2 de acción corta) ❑ 2 ó ❑ 4 inhalaciones cada 20 minutos hasta por 1 hora

❑ Nebulizador, una vez

SEGUNDO — **Si sus síntomas (y el flujo máximo, en caso de usarse) *regresan a la ZONA VERDE* después de 1 hora del tratamiento anterior:**

❑ Tome el medicamento de alivio rápido cada 4 horas durante 1 a 2 días

❑ Duplique la dosis de su corticosteroide inhalado durante _____ (7–10) días

- O -

Si sus síntomas (y el flujo máximo, en caso de usarse) *no regresan a la ZONA VERDE* después de 1 hora del tratamiento anterior:

❑ Tome _____ (agonista β_2 de acción corta) ❑ 2 ó ❑ 4 inhalaciones o ❑ Nebulizador

❑ Añada _____ (corticosteroide por vía oral) _____ mg al día durante _____ (3–10) días

❑ Llame al médico ❑ antes de/❑ en las _____ horas siguientes a tomar el corticosteroide por vía oral

ZONA ROJA: ¡Alerta médica!

- Mucha dificultad para respirar o
- Los medicamentos de alivio rápido no han surtido efecto o
- No puede realizar las actividades habituales o
- Los síntomas son los mismos o peores después de 24 horas en la ZONA AMARILLA

- O -

Flujo máximo: inferior a _____
(50% de mi mejor flujo máximo)

Tome este medicamento:

❑ _____ (agonista β_2 de acción corta) ❑ 4 ó ❑ 6 inhalaciones o ❑ Nebulizador

❑ _____ (corticosteroide por vía oral) _____ mg

Llame a su médico AHORA MISMO. Vaya al hospital o llame a una ambulancia si:

- Pasados 15 minutos, sigue estando en la ZONA ROJA Y
- No ha logrado contactar con su médico

SIGNOS DE PELIGRO

- Problemas para caminar y hablar debido a la dificultad para respirar
- Los labios o las puntas de los dedos están azules

→ Haga ❑ 4 ó ❑ 6 inhalaciones del medicamento de alivio rápido *Y*
Acuda al hospital o llame a una ambulancia (_____) ***¡AHORA MISMO!***

Personas que deben tener una copia de mi plan ASMA: cónyuge, enfermera de la escuela, compañeros de trabajo, cuidadora infantil, familiares/amigos.

Adaptado de National Asthma Education and Prevention Program, National Heart, Lung, and Blood Institute. *Practical Guide for the Diagnosis and Management of Asthma*. Bethesda, Md: US Dept of Health and Human Services; octubre de 1997. Publicación 97-4053 de los NIH.

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EJEMPLAR PARA EL PACIENTE

In addition to targeted mailings, members have access to disease specific education materials through our member website.

We also subscribe to a translation service from Language Line, offering translators for 170 languages, 24 hours a day, seven days a week, 365 days a year. We also subscribe to services for the hearing impaired. The services are for anyone who is deaf, hard-of-hearing, late-deafened, or speech disabled, and who uses a TTY/TDD or standard telephone to communicate. Once received, the message is relayed by a communications assistant, word-for-word, to the hearing person on the other end of the line. In response, the communications assistant types what the hearing person has said back to the TTY/TDD user. By law, each conversation is handled with the strictest confidentiality. We also help members learn to use the national 711 line that accommodates text messaging as well as voice.

Our care management staff will receive in-depth orientation and training, all of which will ensure their ability to identify and help the member build their capacity for handling their own medical condition(s). This training will include ethnic and cultural relevance, policies and work flows specific to working with Louisiana and their members, as well as orientation to the full scope of resources within and across UnitedHealthcare.

Level 2 and Level 3 - Chronic Condition/ Disease Management for Members who are at Higher Risk

Members who are stratified as at higher risk for adverse health outcomes than Level I Disease Management, are place in Level 2 (moderate risk) or Level 3 (high risk) chronic condition care management programs. In those levels, disease specific evidence based guidelines are embedded in our program and administered by the care managers as part of their holistic approach to member health.

Initial Contact

Telephonic outreach will be prioritized based on stratification of the member's level of risk for adverse health outcomes. Our preferred and recommended approach is an opt-out process whereby once a member is identified as eligible or appropriate for the program, he/she immediately begins to receive appropriate communications. However, all members are educated on first contact about their ability to "opt out" of a program. Should the member agree to participate in the telephonic program by participating in the health screening and plan development they will be considered actively engaged. If we are unable to reach a member after repeated attempts, or a member declines to participate, we will not contact the member again for six months unless a significant medical event occurs (e.g. hospitalization with a serious illness requiring coordination of post-discharge services or provider/specialist request).

Screening and Outreach to Members

Our Chronic Care/Disease Management program uses both telephonic and written outreach to contact candidates for care management. Once members are identified as appropriate for care management, a care management staff member will contact the member telephonically, or by letter, to inform members of available resources, such as our Center of Excellence programs and other services beneficial for the member's specific medical condition. As required, oral and written interpretation will be available to members per the specifications in Section 12.19 of the RFP. The assigned care manager will assume responsibility for the member's care for the duration of the member's participation in the program.

Additional telephonic screenings are completed based on the results of the initial HRA and the member's condition(s). These screening tools are use to help detail the member's health status and needs and to serve as a baseline for health and quality of life measures that we can use to measure outcomes of the program on an individual members basis and program-wide basis.

During the initial telephone contact, our care management staff will introduce UnitedHealthcare Community Plan and explain our role in helping an individual self-manage his or her illness and create a strong bond with his or her primary care provider. Our staff will respond to any questions and concerns the member may have and will assist the member in understanding how the process may impact them. Whenever possible, the staff will administer an assessment at the time of the initial telephone contact. At the member's request, we will schedule a more convenient time.

We know that many members will have more than one condition so our focus is on supporting engagement in all necessary routine care and adherence to evidence based medicine guidelines. Our care management model is "high-touch," with consistent telephonic outreach to members to provide education and support them in reaching care plan goals. Outreach is customized, based on the preferences of the member and condition severity. Each member will have direct access to his or her care manager so they can call when they have questions or concerns. They also will be given the toll free number for the care management program, customer service as well as other resources, specific to their home community. Because we view the nature of the nurse/member relationship as a partnership, we take care in respecting the member's preference of contact and frequency.

Interventions specific to each disease are detailed below. Note that members stratified to Level 2 and Level 3 Care Management receive all services in addition to the Level 1 Interventions for their condition, which were detailed above:

Asthma (Adults and Children)

Level 2 and 3 interventions for asthma include the following, with customization based on risk level and member preference:

- All Level 1 Interventions
- Comprehensive Health Status Assessment once per year
- Asthma Supplemental Assessment once per year
- Assess medication regime for evidence of prescribed inhaled corticosteroid, necromil, cromolyn sodium, leukotriene modifiers, or methylxanthines in the past year.
- Assess for documented spirometry testing
- Contact with PCP/pulmonologist as needed
- Multidisciplinary individualized care planning
- Interdisciplinary conferences and interventions
- Face-to-face visits as determined necessary by clinical staff
- Support from telephonic interventions
- Evaluation and coordination of the member total care to ensure quality care and appropriate use resources
- Interpretation of benefits
- Psychiatry contact as needed
- Disease specific education material is sent to member upon completion of the assessment
- Contact with PCP/pulmonologist as needed
- Letter sent to provider on CM involvement, intervention and point of contact
- Assess member's knowledge of causes, treatment, medication, and follow-up care related to asthma
- Educate member or CG on disease process and treatment
- SF12 at baseline, annually, then prior to discharge from case management.

Diabetes (Adults and Children)

Level 2 and 3 interventions for diabetes the following, with customization based on risk severity and member preference:

- All Level 1 Interventions
- Comprehensive Health Status Assessment once per year
- Diabetic Supplemental assessment once per year
- Ensure HgbA1C monitoring once per year
- Ensure fasting lipid panel once per year
- Educate regarding BP goal of >130/80
- PCP or endocrinologist contact as needed
- Provide member with a medical passport for record keeping.
- Multidisciplinary individualized care planning
- Interdisciplinary conferences and interventions
- Face-to-face visits as determined necessary by clinical staff
- Support from telephonic interventions
- Evaluation and coordination of the member total care to ensure quality care and appropriate use resources

- Interpretation of benefits
- Disease specific education material is sent to the member after completion of assessment
- Letter is sent to provider on CM/CM involvement, intervention, and point of contact
- Assess member's knowledge of causes, treatment, medications and follow-up care related to diabetes
- Educate member or CG on disease process and treatment
- Inclusive of low and moderate risk interventions noted below
- SF12 at baseline, annually, then prior to discharge from case management.

Congestive Heart Failure (CHF)

Level 2 and 3 interventions for CHF the following, with customization based on risk severity and member preference:

- All Level 1 Interventions
- Comprehensive Health Status Assessment once per year
- CHF Supplemental assessment once per year
- Assess medication regime
- Routine health coaching
- Develop comprehensive life care plan
- PCP or endocrinologist contact as needed
- A quality of life survey upon enrolling and repeated every 6 months
- Inclusive of low and moderate risk interventions noted below
- Interdisciplinary conferences and interventions
- Face-to-face meetings as determined necessary by clinical staff
- Medical director communicates with the member's provider on care considerations and POC
- Support from telephonic interventions
- Evaluation and coordination of the member's total care to ensure quality care and appropriate use of resources
- Educational material is sent to the member
- Letter is sent to provider on CM/DM involvement and intervention and point of contact
- Multidisciplinary individualized care planning
- Interdisciplinary conferences and interventions
- Face-to-face visits as determined necessary by clinical staff
- Support from telephonic interventions
- Evaluation and coordination of the member total care to ensure quality care and appropriate use of resources
- Interpretation of benefits
- Health Educator intervention to provide additional teaching
- Disease specific education material is sent to the member
- Letter is sent to provider on CM/CM involvement, intervention, and point of contact
- SF12 at baseline, annually, then prior to discharge from case management.

Congestive Obstructive Pulmonary Disease (COPD)

Level 2 and 3 interventions for COPD the following, with customization based on risk severity and member preference:

- All Level 1 Interventions
- Comprehensive Health Status Assessment once per year
- COPD Supplemental assessment once per year
- Assess medication regime
- PCP or pulmonologist contact as needed
- Routine health coaching
- Develop comprehensive life care plan
- A quality of life survey upon enrolling and repeated every 6 months inclusive of low and moderate risk interventions noted below
- Interdisciplinary conferences and interventions
- Face-to-face meetings as determined necessary by clinical staff
- Medical director communicates with the member's provider on care considerations and POC
- Support from telephonic interventions
- Evaluation and coordination of the member's total care to ensure quality care and appropriate use of resources
- Educational material is sent to the member
- Letter is sent to provider on CM/CM involvement and intervention and point of contact
- Multidisciplinary individualized care planning
- Interdisciplinary conferences and interventions
- Face-to-face visits as determined necessary by clinical staff
- Support from telephonic interventions
- Evaluation and coordination of the member total care to ensure quality care and appropriate use of resources
- Interpretation of benefits
- Health Educator intervention to provide additional teaching
- Disease specific education material is sent to the member
- Letter is sent to provider on DM involvement, intervention, and point of contact
- SF12 at baseline, annually, then prior to discharge from case management.

Coronary Artery Disease (CAD)

Level 2 and 3 interventions for CAD the following, with customization based on risk severity and member preference:

- All Level 1 Interventions
- Comprehensive Health Status Assessment once per year
- CAD Supplemental assessment once per year
- Assess medication regime
- PCP or endocrinologist contact as needed
- A quality of life survey upon enrolling and repeated every 6 months
- Inclusive of low and moderate risk interventions noted below
- Interdisciplinary conferences and interventions
- Face-to-face meetings as determined necessary by clinical staff
- Medical director communicates with the member's provider on care considerations and POC
- Support from telephonic interventions

- Evaluation and coordination of the member's total care to ensure quality care and appropriate use of resources
- Develop comprehensive life care plan
- Educational material is sent to the member
- Letter is sent to provider on CM/CM involvement and intervention and point of contact
- Multidisciplinary individualized care planning
- Interdisciplinary conferences and interventions
- Face-to-face visits as determined necessary by clinical staff
- Support from telephonic interventions
- Evaluation and coordination of the member total care to ensure quality care and appropriate use of resources
- Interpretation of benefits
- Health Educator intervention to provide additional teaching
- Disease specific education material is sent to the member
- Letter is sent to provider on CM/CM involvement, intervention, and point of contact
- SF12 at baseline, annually, then prior to discharge from case management

Frequency of Interventions

Recommended frequency of interventions for members based on stratification to Level 2 or 3 (moderate to high risk), are included in the tables below. Note that these are recommendations and interventions are customized based on the interactions between the care manager and the member:

Stratification Level	***HIGH (LEVEL 3)***					
Intervention	***Frequency***	***Condition Monitoring***	***Patient Adherence***	***Other Health Conditions***	***Lifestyle Issues***	***Additional Resources***
Comprehensive Health Status Assessment (CHSA) or Complex Needs Assessment (CAN)	Initial	X	X	X	X	
Disease specific supplemental assessment	1 x year	X	X	X	X	
Disease specific medical passport (mailed)	Annually	X	X		X	X
Plan of Care to member and PCP	1 x year and PRN	X	X	X	X	
Outbound Contact (face to face or telephonic)	Monthly	X	X	X	X	
Disease specific	PRN	X	X	X	X	

Stratification Level	***HIGH (LEVEL 3)***					
Intervention	***Frequency***	***Condition Monitoring***	***Patient Adherence***	***Other Health Conditions***	***Lifestyle Issues***	***Additional Resources***
mailings						
Member Newsletter	Quarterly		X	X	X	
Website	Ongoing	X		X	X	X
24 Hour Nurse-line (In specific health plans, based on contractual requirements)	Ongoing			X	X	X
Complete SF-12	Initial and upon case closure				*X*	

Stratification Level	***MODERATE (LEVEL 2)***					
Intervention	***Frequency***	***Condition Monitoring***	***Patient Adherence***	***Other Health Conditions***	***Lifestyle Issues***	***Additional Resources***
Health Risk Assessment (HRA) (All Members) Comprehensive Health Status Assessment (CHSA)	Upon enrollment Annually	X	X	X	X	
Disease specific supplemental assessment	1 x year	X	X	X	X	
Disease specific medical passport (mailed)	Once after completion CHSA Annually	X	X	X	X	X
Plan of Care to member and PCP	1 x year	X	X	X	X	
Disease specific mailings	PRN	X	X	X	X	
Member Newsletter	Quarterly Twice per year		X	X	X	
Website	Ongoing	X		X	X	X

Stratification Level	*MODERATE (LEVEL 2)*					
Intervention	***Frequency***	***Condition Monitoring***	***Patient Adherence***	***Other Health Conditions***	***Lifestyle Issues***	***Additional Resources***
24 Hour Nurse-line (In specific health plans based on contractual requirements) (in selected Health Plans)	Ongoing			X	X	X

Face-to-Face Outreach

For members who are identified or stratified at the highest risk for poor health outcomes, our Chronic Care/Disease Management program can include face-to-face interaction. These face-to-face meetings are used to conduct more in-depth health questionnaires, develop the individualized care plan and make changes to the plan over time, as the member's needs change. These visits can also be used to help the member locate valuable local community resources and supports to help the member reach health and wellness goals.

Disease/Condition Hierarchy for Members with Co-Morbidities

Members with chronic conditions often have multiple co-morbidities. Behavioral, social and environmental factors add to the complexity of the member's health needs and increase risk levels. In recognition of the multiple co-morbidities, UnitedHealthcare Community Plan uses a member-centric case management model to assess and track determinates of health and well-being across all conditions which may be present. Our model addresses medical, behavioral, social and environment factors simultaneously through a comprehensive, individualized care plan with established timelines/priorities for activities that maximize quality outcomes and cost benefit. Members requiring full-time case management will have "one face" coordinating all clinical programs and care. A Disease/Condition Hierarchy is used to assign the member to the most appropriate care/disease management program and to help target interventions first to the condition requiring the most immediate attention and support. We pair the Disease Hierarchy with an in-depth assessment of each care manager's clinical training and expertise to ensure the most appropriate match between clinical experience and the member's condition(s).

In addition, when a member finds success at managing one condition, the member often feels more empowered to address other conditions. The recommended hierarchy for the Louisiana CCN is included below.

Recommended Disease/Condition Hierarchy for Louisiana CCN:

- Pregnancy
- Behavior Health (Schizophrenia, Bipolar Disorder)
- Heart Failure
- Diabetes
- CAD
- Depression
- Substance Abuse
- Asthma
- COPD
- HIV/AIDS
- ESRD
- Chronic Kidney Disease
- Other Respiratory Conditions

We recognize that the bulk but not all of behavioral treatment will be provided by the State's a Statewide Management Organization for Behavioral Health. We have experience coordinating with "carved-out" behavioral systems, and as such, include behavioral conditions in our hierarchy. In particular, we have a clear understanding of how a behavioral health issue can interfere with an individual's ability to access routine care for comorbid medical conditions. This is why we include behavioral health conditions in the hierarchy above and why we have included Behavioral Health Care Coordinators in our staffing to facilitate behavioral health treatment and coordination for members. Once a behavioral health condition has been stabilized, a member is often much more prepared to address medical conditions by participating fully in the development of an individualize care plan and attending routine medical appointments.

Implementation: Developing an Individualized Care Plan

Once engaged, our care management staff work with each member to develop an individualized care plan and set individual goals. Our clinical information system automatically generates recommendations for the care plan, but the plan is customized based on the member's condition(s), evidence based-medicine guidelines for the condition(s) and their unique circumstances. The nurse customizes the plan to reflect the member's support system, available community resources and realistic inventories of the health and wellness goals the member decides are best suited to his or her individual situation.

If needed, the nurse will send or task any behavioral health or support issues to the Behavioral Health Coordinator, who will also input any recommended goals or objectives and helps coordinate services for members directly with behavioral health providers. Once implemented, the Behavioral Health Coordinators will also coordinate directly with the care management staff of the selected Statewide Management Organization for Behavioral Health. Providers can access the member's care plan by signing up for and accessing our provider portal. Providers can provide input in the member's care plan through the use of this portal. When the physician makes or suggests a change, our care manager is alerted to review this change. The member's family support and community support systems are vital parts of the care plan, tapping into existing community programs and resources. Goals and actions in the plan are adjusted over time to meet the changing needs of the member.

As part of their responsibilities, the care manager will assess each member's current status and needs. The care manager will then help the member establish individual health goals and make commitments to actions designed to reach those goals. In addition, the care manager will assess whether current medical and medication interventions are consistent with the member's medical condition. The care manager will discuss any recommended changes with the provider and will also assist the provider and member to obtain any additional services needed to continue with treatment without any disruption in care. In

addition, the care manager works with the Behavioral Health Coordinator for members with a psychiatric diagnosis or substance abuse issue to ensure that appropriate behavioral health treatment and supports are included in the care plan. The Behavioral Health Coordinator works actively and closely with the care manager to ensure the member is connected with necessary services and supports in the community.

CareOne Clinical Information System

Our CareOne system is the foundation for both the assessment and care planning processes. We designed our CareOne application to coordinate the information flow among caregivers, case managers, members, and providers. CareOne also includes behavioral health screening and assessment data. CareOne features include:

- Maintaining Health Risk Assessments (HRAs)
- Creating and maintaining Plans of Care (POCs)
- Managing prior authorizations
- Care/case management
- Utilization management
- Standard and ad hoc reporting.

Through CareOne, Health Risk Assessments and Plans of Care are also available to providers online, which gives providers the ability to submit comments and provide feedback through our Provider Portal.

CareOne includes embedded protocols which identify key areas that should be addressed in specific care plans. It is a global profile of the member's health record and therefore facilitates better understanding of our members' physical, behavioral, and social/environmental needs.

CareOne serves as the framework within which to share clinical information across clinical domains and departments and to serve as our virtual medical record, tracking clinical information longitudinally. CareOne supports disease, care, and utilization management for both physical and behavioral care. Follow up is facilitated by CareOne's automated tasking and reminder system. If a care manager does not close open tasks that meet evidence-based guidelines, the tasks automatically escalate to the Care Management Supervisor for intervention (i.e., coaching, load balancing, etc). CareOne can also produce reports that can be shared with providers to aid in treatment plan development and decision making. When our state of the art technology is combined with our experienced care managers and proven care management programs, the result is the finest "high-tech/high-touch" care possible for our members.

Maintaining Member Profiles

We maintain the member profile using our CareOne application to better understand our members' medical, behavioral and social/environmental needs. This data is dynamic and includes the following components:

- Classifies member health and risk status through customizable intake and screening questionnaires
- Provides in-depth supplemental triggers for full health risk evaluation, including triggers for behavioral health
- Determines the most appropriate clinical assignment based on criteria such as demographics, cultural need, individual preference, PCP, case type, and caseload availability of care manager
- Tracks comprehensive medical, social, behavioral, catastrophic, and long-term care assessments, including national tools sets that are trauma-informed
- Provides supplemental assessment screens for specific diseases to aid in disease management, including behavioral health issues
- Tracks key member clinical information, including diagnostic results, patient histories, advanced directives, and responsible party information

- Records medications and allergies
- Integrated pharmacy knowledgebase identifies medication-to-medication interactions, medication-to allergy interactions, and medication-to-condition interactions
- Verifies membership eligibility, responsible party, and other health plan coverage, if applicable
- Tracks network, affiliated physicians, and other health care providers, home and community based referral options, and other available long-term care resources
- Provides rules-based, set-up wizard features that allow the application to be customized to the workflow process of our customers
- Links to a clinical data warehouse for reporting functionality
- Includes an embedded task management system within the system that allows users to track, monitor, and enhance the information flow within the member care process including to-do lists, reminders, and daily work plan
- User-group and menu-based customizable security features that protect the privacy of members, Comprehensive case notes and member goal tracking
- Assessments/protocols systematically populate needs/goals/interventions to drive to best practice
- Capability for both real-time and batch interfaces with eligibility, provider, authorization, and reporting systems
- User-defined fields to ensure pertinent data can be captured
- Audit trails for addition, deletion and modifications to data

Monitoring Members Over Time

The last step in the Personal Care Model occurs repeatedly over time as we continuously monitor members. Each month, ImpactPro re-stratifies risk levels so that members may step up or down in Chronic Care/Disease Management program intensity based on current needs. Members in Levels 2 and 3 and their physicians continue to receive gap in care notifications to help align treatment with evidence based medicine guidelines. Our population based Level 1 disease management program will continue to send periodic member education materials to any member with one of the five identified chronic health conditions, regardless of the member's current stratified risk level.

Specialty Disease Management Programs

To supplement our general care management approach, we employ a number of specialty disease management programs based on individuals with sufficiently debilitating or high-risk conditions to warrant specialization, such as:

- Transplant Programs
- End Stage Renal Disease
- Healthy First Steps for members who are pregnant
- Neonatal Resource Services
- Childhood Obesity
- Diabetes Management

To further support members with chronic conditions, we offer 24 hour a day access to our NurseLine services and telephonic physician services. Detail about these programs is included below:

Transplant Solutions

The Transplant Solution program combines an intensive, specialized case management model with access to our Centers of Excellence (COE) network. Our specialized case management approach, designed for our Medicaid and Medicare Managed Care patients, includes full spectrum, integrated clinical and

psycho-social patient support from initial consultation through 365 days post-transplant with the following program features:

- ***Diversions:*** Reduction in the number of inappropriate cases sent on for full evaluation through pre-screening, evaluating both clinical and psychosocial case features for transplant appropriateness.
- ***Optimized Patient Outcomes:*** Caregiver evaluation/preparation, coordination of supporting services to reduce barriers to discharge, and other activities to optimize patient readiness and support. Additional value added by using quality COE providers and matching patient to program. Reduced hospitalization time through aggressive care coordination in all pre-transplant stages.
- ***Reduced Delays in Care:*** Shorter wait times for qualifying patients, reducing the pre-transplant expenses such as maintenance dialysis and hospital stays.
- ***Improved Quality:*** Improved graft survival rates through transplant appropriateness; program matching; utilization of paired donor program and multiple listing where appropriate; organ matching techniques; other clinical innovation. Lowered rate of re-transplant for kidney, liver, lung and heart cases. Reduced infection and other post transplant complications.
- ***Contractual Savings:*** Achieved through network discounts through all phases of the transplant episode. Includes full transplants and early term case savings.

Nationally, our transplant programs cover the most covered lives, the most transplant referrals and the most transplants in the United States. More than 3,000 commercial clients, representing more than 46 million lives, as well as our 24 state Medicaid programs, currently use our COE products and services.

End Stage Renal Disease (ESRD)

Through Our Kidney Resource Services (KRS) ESRD Management, renal-trained nurses deliver a comprehensive approach for managing the needs of ESRD patients that require ongoing dialysis therapy. Through telephonic outreach to the patient, the patient's dialysis care team and providers, a dedicated Kidney Resource Services nurse engages with members to educate the about treatment options, assist them in managing co-morbidities more effectively and helps the patient to avoid unplanned and costly hospitalizations. The program targets the largest cost drivers associated with the disease: inpatient and emergency room utilization -- achieving a reduction in inpatient admissions of 10-30 percent. Additional key clinical objectives include arteriovenous fistula (AV) access placement to reduce access related complications, early referral for kidney transplant evaluation, as well as monitoring hypertension, dialysis adequacy; managing anemia, nutrition, medications and preferred pharmacy utilization.

Throughout ongoing maintenance dialysis therapy, renal-trained, registered nurse advocates offer individualized care management and education based on patient-specific needs and national clinical guidelines for treatment. Disease specific interventions used by the ESRD program have been derived from the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (K/DOQI™) guidelines as well as additional well accepted, evidence based standards of practice. Program oversight is provided by an ABIM certified nephrologist medical director. The clinical operations for this program involve renal trained registered nurse advocates who become the primary nurse working with the patient to manage their kidney disease and co-morbidities. Close integration with other programs including behavioral health, transplant and advanced illness ensure members receive optimal clinical interventions throughout their disease progression. The program is accredited by both NCQA and URAQ and provides disease management services to over 7000 end-stage renal disease patients.

Primary interventions by KRS nurse advocates include:

- Education and information that allows members to make informed health care decisions
- Management of co-morbid conditions commonly related to end stage renal disease and dialysis such as diabetes, cardiovascular disease, hypertension, and anemia

- Management of dialysis treatment including dialysis access, dialysis adequacy, diet/nutrition management, fluid intake management and blood pressure management
- Aggressive case management to avoid hospital inpatient admissions
- Post discharge follow-up should a patient require hospitalization to avoid readmission
- Referral for kidney transplantation evaluation and ongoing clinical management of the patient as they move through the transplant evaluation/wait list stages.

Risk stratification is used to determine frequency of contact based on: hospital days, blood pressure, catheter access, dialysis adequacy, hemoglobin levels (anemia management), potassium levels, calcium levels, phosphorus levels and albumin levels.

As a component of disease management of a patient with End Stage Renal Disease, KRS interacts with the following programs and care providers:

- Nephrologist
- Dialysis Center Engagement
  - Charge Nurse
  - Social Worker
  - Nutritionist
- Providers
  - Endocrinologist
  - Podiatrist
  - Ophthalmologist
  - Wound Center
- Vascular Access Surgeon (AV fistula placement, Vein mapping)
- Family members/caregivers.

Contact with these individuals helps the KRS nurse both with monitoring the member's health and for building the right supports and services into the members care plan.

Healthy First Steps™

Louisiana DHH is dedicated to reducing infant mortality. The state currently ranks 48 out of 50 sates in deaths per 1,000 live births in 2010 according to America's Health Rankings. Efforts to improve the health of the mother and baby throughout pregnancy and after delivery are vital to this effort. The preterm birth rate across the U.S. has increased more than 20 percent since 1990. In 2005, preterm births cost the United States more than $26.2 billion in medical and educational costs and lost productivity. Average first year medical costs were about 10 times greater for preterm than for term infants[3]. Preterm infants are at high-risk for a variety of disorders, including mental retardation, cerebral palsy, and vision impairment. These infants are also at high-risk for long-term health issues, including cardiovascular disease (heart attack, stroke, and high blood pressure) and diabetes[4].

UnitedHealthcare Community Plan will offer Healthy First Steps™ (HFS) maternity management program to Louisiana Medicaid members. HFS seeks to identify members early in their pregnancy and

[3] More Babies Born Prematurely, New Report Shows, The March of Dimes Web site, Accessed May 22, 2008. http://www.marchofdimes.com/peristats/whatsnew.aspx?id=20&dv=wn

[4] National Institute of Child Health and Human Development, Accessed April 22, 2008. http://www.nichd.nih.gov/news/resources/spotlight/081307_preterm_birth_progesterone.cfm

evaluate risks that may impact pregnancy outcomes. Review of current and past obstetrical and medical history including a psychosocial assessment identify potential risks. Partnering with members and obstetrical providers to implement a multidisciplinary team approach for member education, community resource identification and referral have the potential to dramatically improve pregnancy and birth outcomes.

Improved pregnancy and birth outcomes result in decreased Neonatal Intensive Care Unit (NICU) admissions and lengths of stay. Post NICU care management for 30 days following NICU admission impact hospital readmissions.

Identifying Members

It is critical to identify pregnant members as early in their pregnancy as possible to ensure the delivery of quality prenatal care in a timely manner. We identify pregnant members through:

- Intensive Community and Provider Outreach: During implementation and throughout the contract, we will actively reach out to PCPs, obstetricians, Federally Qualified Health Centers (FQHCs), Planned Parenthood and other community organizations to solicit referrals to the program.
- Enrollment files: Enrollment files with pregnancy indicators are used to identify pregnant members for outreach early in the pregnancy and to determine if the members has been seen by an obstetrical provider. If the member has not identified an obstetrical provider or has not scheduled their first appointment assistance is provided as indicated .
- New member welcome calls: New members receive a welcome call and Health Risk Assessment which includes questions relating to pregnancy. If the member is currently pregnant, they are referred to the Healthy First Steps™ program for program enrollment and pregnancy specific assessment.
- Claims data: Claims data is used for ongoing identification of pregnancy related conditions and procedures.
- Additional Referral Sources: We will also accept self-referrals, referrals from our internal clinical staff in other departments such as utilization management, and referrals from government sponsored programs such as Women, Infants, and Children (WIC).

We encourage collaboration with medical providers and community agencies to educate on the benefit and services provided by HFS. Our goal is to work with the existing delivery system to improve the health outcomes for this population. We also educate members on the program through materials such as the Member Handbook and brochures and through partnerships with community organizations

Pregnancy Management

Members identified with pregnancy related risks receive the HFS OB Clinical Assessment. Completion of this assessment drives the development of an individualized plan of care with interventions designed to improve maternal and infant outcomes. Our care plan interventions focus on member education specific to pregnancy management, signs and symptoms of complications, breast feeding, nutrition, healthy lifestyles, reproductive life plan, community resources including WIC, smoking cessation, and ante partum and postpartum depression, among others. We educate on the importance of scheduling postpartum and well baby visits. Free text messaging program offers information throughout pregnancy and after delivery information related to the post partum period and infant care until the first birthday. In addition, every pregnant woman is offered a postpartum home visit from a case manager within 48 hours of delivery.

Healthy First Steps™ has demonstrated a positive impact on our members in other markets. The low rate of preterm births in our other markets is a reflection of the excellent prenatal care offered by our network providers as well as the impact of the Healthy First Steps™. For example, in Nebraska in 2006, one in eight babies (12.2 percent of live births) were born preterm. In 2008, only 9.6 percent of our babies were

admitted into the neonatal intensive care unit (NICU), which is lower than the State's average for pre-term births.

Identification of and Resources for Pregnant Women with Substance Abuse, Mental Health, or Social Issues that can Impact Pregnancy Outcomes

Substance abuse during pregnancy (alcohol, illicit drugs and smoking) is a risk factor for adverse birth outcomes, such as birth defects, developmental disabilities, preterm birth and low birth weight (LBW). According to the National Survey on Drug Use and Health, a significant number of women in the first trimester of pregnancy are past-month users of alcohol, cigarettes, or illicit drugs, and one in seven smoke cigarettes in the second or third trimester. In addition, mental health/social disorders such as homelessness and domestic violence can also impact prenatal care and outcomes. Without support, high-risk pregnant women have a higher probability of preterm births resulting in neonatal intensive care (NIC). Effective interventions for pregnant women with these issues can improve the overall health and well-being of mothers and infants. UnitedHealthcare Community Plan's goal is to reduce NICU admissions by at least 15 percent (to ≤12.75 percent), and to reduce our LBW rate to the Healthy People 2020 goal (to ≤7.8 percent).

Initiatives are Member/caregiver-focused and include outreach to pregnant member within 5 days to identify women at risk and in need of care management and to link them to needed services, identify risk factors for current pregnant member by using the Wisconsin State method, and educate member on the availability of free cell phone service to help ensure continued contact with care managers, disease managers and providers. We will utilize our social workers to identify/serve homeless pregnant member. We will modify our OB Needs Assessment form for identification of risk factors, track claims of pregnant women taking pain medications and track those accessing the ED for injuries by modifying our case management module to incorporate the 4P's Plus© screening and intervention. Focusing on providers, we will promote best practices to identify pregnant women with high-risk conditions and educate PCPs/OB providers on member's behavior health benefits and available community resources.

Text4baby

We are also pleased to partner with the National Healthy Mothers, Healthy Babies Coalition to deliver educational cell phone text messages to promote healthy mothers and babies. All members are encouraged to sign up for the no cost Text4baby program. Expectant mothers receive up to three text messages until their estimated due date. Members receive postpartum follow-up messages, along with well baby care/visit reminders up to a year after delivery. Text4baby tri-fold brochure (English on one side and Spanish on the other) is included in the HFS welcome mailing. Text4baby program information and instructions on enrollment are included in the brochure.

Through the use of HFS, we can reduce Neonatal Intensive Care Unit (NICU) lengths of stay. Our Neonatal Resource Services program is described below. By leveraging both of these programs, we support the best outcomes for both the mother and the infant.

Neonatal Resource Services

Neonatal care across the U.S. accounts for a significant portion of health care costs, due in part to rising preterm birth and multiple birth rates. We recognize that a comprehensive, specialized approach is needed to effectively manage the complex needs of these fragile patients. Our Neonatal Resource Services program (NRS) is designed to improve health outcomes and reduce neonatal costs using a dedicated team of specialized, experienced NICU nurse case managers, social workers and full-time medical directors focused on coordinating all aspects of care using a patient-centric, individualized manner. Their approach is comprehensive, and includes:

- Early identification and management of potential NICU patients through integration with our Healthy First Steps pregnancy program
- Evaluation and coordination of neonatal care plans and NICU facilities to oversee appropriateness of care
- Staff medical directors with a background in neonatology, pediatrics and obstetrics, to oversee high risk pregnancies and NICU admissions
- Interaction with treating physicians, using peer-to-peer consult where appropriate
- Discharge planning and facilitation of timely release
- Coordination of alternative care options, including home care, equipment and skilled nursing
- Post-discharge monitoring to avoid unnecessary readmissions and to provide support the families/caregivers once home
- Providing information to families and caregivers regarding local community resources and support services available to them.

UnitedHealthcare Community Plan Pennsylvania Plan programs have consistent reductions in low-birth-weight and very low-birth weight rates over the past three years also with a reduction in NICU 14-day readmission rate zero to 0.13 percent. This has been accomplished by early NICU case management services and discharge planning.

Nurse Family Partnership

UnitedHealthcare Community Plan understands that we will need to coordinate our pregnancy and neonatal programs with the Louisiana Nurse Family Partnership, which began supporting first time mothers in Louisiana in 1999 and is operated by the Louisiana Office of Public Health. We will meet with the Nurse Family Partnership during implementation to discuss our case management services and the services they provide and develop protocols to avoid duplication and to ensure members are receiving consistent information. Our shared goal of improving the health of mothers and infants provides the base for a strong alliance.

Childhood Obesity Program: The JOIN Program

Many families and children struggle with weight and weight management yet little support exists to help them reach their health goals. Our JOIN program will communicate to parents of children between the ages of 6 and 17 years of age and present JOIN participation to qualifying families. We will also partner with family pediatricians to ensure an alignment of weight outcome goals. This intervention is offered to children between the ages of 6 and 17 who also have a BMI percentage greater than the 85th and are able to actively participate in a group model. JOIN Offers:

- Communication and Enrollment strategies designed to engage and enroll qualifying families. This includes outreach and customer support for all participants.
- Community Based Intervention offering through a group session model to children/teens with a BMI rating ≥ 85th percentile and a parent/caregiver/guardian. Group sessions are lead in an onsite model through trained facilitators and with an evidence based curriculum. Self-study home sessions also support families through the duration of the six month program.

We have teamed up with YMCA to deliver group sessions for children/teens and their families. Sixteen sessions will be completed in a group model delivered over a maximum of 20 weeks. Group sessions are delivered by qualified and trained JOIN facilitators. The program design follows a 16 week course that encourages practiced and research based focused activities and strategies. These allow children/teens and their families to learn techniques for achieving a healthy weight. Sessions are administered by trained JOIN facilitators. Post program completion, monthly maintenance meetings are offered to families for up to a year. In total, JOIN offers 16 weekly core sessions and up to 8 months of maintenance monthly sessions.

JOIN leverages proven models that drive earlier intervention, improved individual compliance, better health outcomes and lower costs for the consumer and for the state. More specifically, the JOIN program provides a solution by offering children, teens, and their families' access to community-based networks of an evidence-based intervention designed to help manage and reduce excess weight. Techniques designed to deliver on evidence-based objectives:

- Parent involvement
- Self monitoring
- Reduction of sugar sweetened beverages
- Reduction of high fat, high sugar foods
- Reduction of screen time
- Physical activity
- Stimulus control

Our primary goal is to help children and teens reduce excess weight and prevent the progressing to adult complications at a later stage. Adult complications can include diabetes, heart attack, stroke, kidney failure, blindness and amputations. The JOIN program supports primary care physicians in current patient care, while improving health outcomes and reducing medical costs for our customers and their members living with obesity.

The JOIN program will begin as a pilot project and expand, based on positive outcomes, into additional geographic areas.

Diabetes Prevention and Control Alliance Session Topics

16 CORE SESSIONS

SESSION	TOPIC
1	Welcome to the Lifestyle Balance Program
2	Be a Fat Detective
3	Three Ways to Eat Less Fat
4	Healthy Eating
5	Move Those Muscles
6	Being Active: A Way of Life
7	Tip the Calorie Balance
8	Take Charge of What's Around You
9	Problem Solving
10	Four Keys to Healthy Eating Out
11	Talk Back to Negative Thoughts
12	The Slippery Slope of Lifestyle Change
13	Jump Start Your Activity Plan
14	Make Social Cues Work for You
15	You Can Manage Stress
16	Ways to Stay Motivated

Diabetes Prevention and Control Alliance

The Diabetes Prevention and Control Alliance offers access to the Centers for Disease Control and Prevention's (CDC) evidence-based Diabetes Prevention Program (DPP) through local community providers, and the Diabetes Control Program (DCP) that delivers additional points of routine diabetes care and complication prophylaxis via local pharmacists. This program is designed to help members prevent or manage diabetes and obesity. Introduced in 2010, the program has grown quickly to serve over 29 multi-payer entities. The primary goals of the program are to:

- Reduce the conversion to diabetes among people with pre-diabetes
- Reduce heart attacks, strokes, kidney disease, amputations, and blindness in people living with diabetes
- Support primary care physicians in comprehensive patient care programs
- Improve the overall health and quality of life for our members
- Two Community-based Provider Networks offering specific interventions to prevent members with prediabetes from progressing to diabetes and members with diabetes from developing complications. The two distinct community networks are:
- The Diabetes Prevention Program (DPP) for those with pre-diabetes. This is an evidence-based intervention program.
- The Diabetes Control Program (DCP) for those with diabetes. This includes routine diabetic lab tests (HbA1c, LDL), limited physical exams, review of routine diabetic care and complication prophylaxis, medication management review, nutrition and goal setting.

Services are provided through partnerships with local organizations such as the YMCA for pre-diabetic members and local pharmacies for diabetic members. Through community organizations such as the YMCA, we can offer a 16-session program (topics shown in box at right), one hour per week in a group setting. This program uses behavior modification and a "team spirit" to increase the chance for success. We focus on "achievable goals" through healthy eating and moderate physical activity. The program is offered at multiple neighborhood locations to allow easy, convenient access for members. This program has been rigorously tested and is endorsed by Centers for Disease Control (CDC).

In addition, through partnerships with local pharmacists, face-to-face consultations help members manage their diabetes. Specific consultation services to your participants include:

- Baseline diabetes assessment including height (initial visit only), weight, waist circumference, blood pressure, diabetes history
- Depression screening
- Medication review
- Review of Labs: HbA1C, total cholesterol, LDL, HDL, TG
- Review of recommended exam schedule per ADA guidelines: Annual Eye Exam, Dental Exam, Foot Exam, Flu Shot, Pneumonia Shot
- Self-Management Education on topics such as: Understanding Diabetes, Nutrition/ Meal Planning, Physical Activity, Medications, Monitoring Blood Glucose, Acute Complications, Chronic Complications, Psychosocial Issues/Concerns, Health and Behavior Change
- Goal setting.

"I took that class . . . LOVED it . . . have kept my blood sugar in good shape since . . . it's easy to control . . .and you will enjoy that class."

DPP Blog Participant

Additionally, pharmacy partners will conduct telephonic reminder outreach calls prior to consultations, provide diabetes management education materials to participants and provide a patient consultation update to the member's PCP. In the 5-year pilot program, the Asheville Project, mean A1c decreased at all follow-ups, with more than 50 percent of patients demonstrating improvements at each visit. The number of patients with optimal A1c values (< 7 percent) also increased at each follow-up. More than 50 percent showed improvements in lipid levels at every measurement. Annual net cost savings ranged from $1,622 to $3,356.

NurseLine Services

Through the use of our NurseLine services, our Symptom Decision Support approach can help improve outcomes and lower overall health care costs by connecting members get to the right care at the right time at the right place. For example, 70 percent of callers with intent to visit the ER choose a lower level of care after talking to a Registered Nurse. Registered nurses, with an average 15 years of experience are available 24 hours a day, 365 days a year, to deliver symptom decision support, evidence-based health information and education, and medication information. There is also an audio health information library available which provides access to over 1,100 health topics. Registered nurses support consumer activation and encourage and reinforce involvement in existing programs. Referrals to case and disease management, complex condition support, mental health, wellness services, and community resources bring value and positively impact behavior

Live Nurse Chat

For members with access to the internet, Live Nurse Chat provides health education via real-time internet chats and aids clients in navigation to credible medical information Websites. Symptomatic clients are referred to the correct NurseLine 800 number for telephonic triage. Live Nurse Chat provides one-to-one Internet chat access with our nurses 24 hours a day, 7 days a week.

Telephonic Physician Services

With telephonic physician services, members do not have to wait to speak to a doctor. They can call a toll-free number or logon to their account to request either a telephone or video consult. Once they place their request, a board-certified doctor will review their medical record and provide a consult. The doctor will then recommend the right treatment for their medical issue and, if necessary, call in a prescription to the member's pharmacy of choice. This service allows members to resolve their issues immediately, be it while on vacation, after hours, for lab results and much more, without the use of urgent care clinics or emergency room visits. These telephonic providers also coordinate with members' health care providers to ensure continuity of care.

Additional Health Support Programs

UnitedHealthcare Community Plan collaborates with community-based organizations to provide a wide variety of health support programs including, but not limited to *Heart Smart Sisters; Sesame Street Food for Thought, Lead Away and A is for Asthma; and the 4-H Youth Voice: Youth Choice Program.* These programs help support members in reaching their individual care plan health and wellness goals and are detailed in response to Question F7.

How Chronic Care/Disease Management Program Data is Analyzed and How Results are Used

UnitedHealthcare Community Plan will monitor and analyze a broad spectrum of clinical data. We will use the results to measure the effectiveness of our interventions and to identify opportunities for clinical quality improvement. To magnify the opportunity to improve health outcomes, we will align incentives for Primary Care Medical Homes with improvement in member health as measured by the clinical data we collect and monitor. Provider profiling will assist in measuring and monitoring individual primary care provider performance relative to the identified clinical indicators. In addition, the logic used to pre-populate care plans will be based on supporting improvement in member health relative to the selected clinical indicators. Finally, many of the gaps in care notification reporting relates closely to key clinical health and wellness indicators.

Performance Measures

We understand that, in compliance with RFP Section 14.3, we will be required to report on the Performance Measures listed in Appendix J of the RFP. These include, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, or other measures as determined by DHH.

Performance Improvement Projects

Performance Improvement Projects (PIPs) will be selected collaboratively with DHH. This will allow us to target improvement efforts on the indicators or areas most valued by the state. PIPs are multi-year projects which follow the Quality Improvement Cycle of Plan/Do/Check/Act. Once a topic is selected, we research our current performance and plan interventions targeted at improving performance. We then carry out those plans and check for improvement periodically. Once we have results, we act on those results to either adjust the interventions or keep them in place if we are obtaining satisfactory results. The process continues until we meet the performance goal and then the PIP goes into a maintenance phase to maintain the improved performance over time.

Suggested Key Data Elements

The following tables include data points we suggest monitoring directly in relation to the Chronic Care/Disease Management Program. Final data points will be selected cooperatively with DHH.

Suggested Data Points for Louisiana CCN Quality Monitoring
All Conditions under Care Management
■ As required by Section 6.38 of the RFP: – Total number of members; – Number of members in each stratification level for each chronic condition; and – Number of members disenrolled from program and explanation as to why they were disenrolled. ■ HEDIS measures ■ Participation rates in the DM Program and Complex Care Management activities ■ Adherence to prescribed medical treatment regimens ■ Influenza Immunization: Percent of eligible members who received an immunization or refused immunization during the recommended calendar period. ■ Member functioning - Quality-of-life measures ■ Total costs per member per month (PMPM) ■ ER visits/1000 ■ Hospital admissions/1000 ■ Physician visits ■ Member satisfaction with DM program and Complex Care Management Programs
Asthma-specific Measures
■ Use of inhaled steroids – population-based measure ■ Pneumococcal and influenza immunization rates – population-based measure ■ Use of space inhalers ■ Increased use of nebulizers ■ Increased use of peak flow meters ■ Decreased use of rescue medications ■ Participation rates in the DM Program ■ Percent of members whose smoking status was ascertained and documented annually ■ Percentage of smokers who were recommended or offered an intervention for smoking cessation (i.e. counseling or pharmacologic therapy) ■ Influenza Immunization: Percent of eligible members who received an immunization or refused immunization during the recommended calendar period.
CAD Specific Measures
■ Use of ACE Inhibitors/ARBs ■ Use of Beta-Blockers ■ Use of Aldactone ■ Echocardiogram performed once a year ■ Frequency of tests and distribution of values for total cholesterol, LDL, HDL, and triglycerides. ■ Percent of members with at least one LDL cholesterol test in the past year. ■ Percent of members with most recent LDL cholesterol <130. ■ ***Influenza Immunization:*** Percent of eligible members who received an immunization or refused immunization during the recommended calendar period. ■ Blood Pressure: Range of values for most recent systolic and diastolic blood pressure reading. Percent of members with most recent blood pressure <140/90. ■ Participation rates in the CM Program ■ Adherence to prescribed medical treatment regimens

Suggested Data Points for Louisiana CCN Quality Monitoring
Smoking Status
■ Percent of members whose smoking status was ascertained and documented annually ■ Percentage of smokers who were recommended or offered an intervention for smoking cessation (e.g. counseling or pharmacologic therapy)
CHF Specific Measures
■ Use of ACE Inhibitors/ARBs ■ Use of Beta-Blockers ■ Use of Aldactone ■ Echocardiogram performed once a year ■ Frequency of tests and distribution of values for total cholesterol, LDL, HDL, and triglycerides. Percent of members with at least one LDL cholesterol test in the past year. ■ Percent of members with most recent LDL cholesterol <130. ■ ***Influenza Immunization:*** Percent of eligible members who received an immunization or refused immunization during the recommended calendar period. ■ Blood Pressure: Range of values for most recent systolic and diastolic blood pressure reading. Percent of members with most recent blood pressure <140/90.
Smoking Status
■ Percent of members whose smoking status was ascertained and documented annually ■ Percentage of smokers who were recommended or offered an intervention for smoking cessation (e.g. counseling or pharmacologic therapy).
COPD Specific Measures
■ Use of bronchodilators ■ Use of corticosteroids ■ Decreased use of oxygen ■ Increase in exercise tolerance ■ Increase SpO2 and decrease FIO2 ■ Frequency of tests and distribution of values for total cholesterol, LDL, HDL, and triglycerides. Percent of members with at least one LDL cholesterol test in the past year. ■ Percent of members with most recent LDL cholesterol <130. ■ Influenza Immunization: Percent of eligible members who received an immunization or refused immunization during the recommended calendar period. ■ Blood Pressure: Range of values for most recent systolic and diastolic blood pressure reading. Percent of members with most recent blood pressure <140/90. ■ Participation rates in the CM Program ■ Adherence to prescribed medical treatment regimens
Smoking Status
■ Percent of members whose smoking status was ascertained and documented annually ■ Percentage of smokers who were recommended or offered an intervention for smoking cessation (e.g. counseling or pharmacologic therapy).
CKD/ESRD Specific Measures
■ Anemia management (hemoglobin, hematocrit, epoetin therapy) ■ Vascular access within 4-6 weeks ■ Dialysis compliance (minimum 3 times a week)

Suggested Data Points for Louisiana CCN Quality Monitoring
■ High blood pressure controlled (goal of <130/80) ■ Current diabetes lab screens (HbA1c, LDL, diabetic eye exam) ■ Frequency of tests and distribution of values for total cholesterol, LDL, HDL, and triglycerides. ■ Percent of members with at least one LDL cholesterol test in the past year. ■ Percent of members with most recent LDL cholesterol <130. ■ Influenza Immunization: Percent of eligible members who received an immunization or refused immunization during the recommended calendar period. ***Smoking Status*** ■ Percent of members whose smoking status was ascertained and documented annually ■ Percentage of smokers who were recommended or offered an intervention for smoking cessation (e.g. counseling or pharmacologic therapy).
Diabetes Specific Measures
■ Multiple HEDIS measures
Hemophilia Specific Measures
■ Increase percent of patients/families with the ability to self-infuse ■ Decrease percent of members experiencing repeat bleeds in target joints ■ Decrease in ER utilization ■ Decrease in hospitalization ■ Frequency of tests and distribution of values for total cholesterol, LDL, HDL, and triglycerides. Percent of members with at least one LDL cholesterol test in the past year. Percent of members with most recent LDL cholesterol <130. ■ ***Influenza Immunization:*** Percent of eligible members who received an immunization or refused immunization during the recommended calendar period. ■ ***Blood Pressure:*** Range of values for most recent systolic and diastolic blood pressure reading. Percent of members with most recent blood pressure <140/90. ***Smoking Status:*** ■ Percent of members whose smoking status was ascertained and documented annually ■ Percentage of smokers who were recommended or offered an intervention for smoking cessation (e.g. counseling or pharmacologic therapy).
HIV/AIDS Specific Measures
■ Percent of HIV members with at least two CD4 counts in a 12 month period. ■ Percent of HIV members with a viral load test every 4 months
Hypertension Specific Measures
■ Percent of members screened for lipids, diabetes, renal disease, cardiovascular and obesity risk (frequency of tests and distribution of values) ■ Percent of members with hypertensive retinopathy ■ Urine protein screening: Percent of members who received any test for microalbuminuria in the past year, or percent of appropriate patients (without existing nephropathy or previous documentation of nephropathy) receiving tests for microalbuminuria in the past year, or percent of appropriate patients (without existing nephropathy or previous documentation of nephropathy) receiving tests for microalbuminuria in the past year ■ Percent of patients receiving aspirin therapy (dose greater than or equal to 75 mg daily, excluding member <40 years of age and those with clinical contraindications who have co-morbid conditions of diabetes and ischemic heart disease ■ Documentation of hypertension education in appropriate members

Suggested Data Points for Louisiana CCN Quality Monitoring
■ Documentation of use of ACE inhibitors or ARBs in patients with microalbuminuria ■ Documentation of use of beta blockers in patients with hypertension and established CAD ■ Documentation of use of long acting calcium channel blockers in appropriate patients ■ Documentation of percent of patients using diuretics as a first line therapy ■ Documentation of the adherence to a salt restricted diet ■ Frequency of tests and distribution of values for total cholesterol, LDL, HDL, and Triglycerides. ■ Percent of members with at least one LDL cholesterol test in the past year. ■ Percent of members with most recent LDL cholesterol <130. ■ Influenza Immunization: Percent of eligible members who received an immunization or refused immunization during the recommended calendar period. ■ Blood Pressure: Range of values for most recent systolic and diastolic blood pressure reading. ■ Percent of members with most recent blood pressure <140/90. ***Smoking Status*** ■ Percent of members whose smoking status was ascertained and documented annually ■ Percentage of smokers who were recommended or offered an intervention for smoking cessation (e.g. counseling or pharmacologic therapy).
Lead Toxicity Specific Measures
■ Participation rates in the DM Program ■ Decrease in BLL ■ Adherence to prescribed medical treatment regimens.
Sickle Cell Specific Measures
■ Members greater than 24 months of age who have at least one PCP or Specialist evaluation during measurement period ■ Members greater than 24 months of age with a CBC.
Pregnancy Specific Measures
Delivery Outcome ■ Type of delivery ■ %NBW vs. %LBW and %VLB ■ % NICU admits ***Program Measures*** ■ Number enrolled vs. total eligible population ■ Number assessed/ stratified/reached vs. total eligible population ■ Trimester enrolled ***Smoking Status*** ■ Percent of members whose smoking status was ascertained and documented ■ Percent of smokers who were recommended or offered an intervention for smoking cessation (i.e. counseling or pharmacologic therapy) ***Additional*** ■ Maternal depression identified during pregnancy, post partum period with referral or intervention ■ Maternal complication at birth ■ Fetal complication at birth.

Internal Plan Performance and Quality of Care/Service Monitoring

UnitedHealthcare Community Plan also uses a variety of performance and operational metrics to evaluate program efficiency, identify trends and monitor directional indicators. These metrics are evaluated internally and also shared with our customers for oversight purposes. In summary, these reports provide detailed information on:

- Overall utilization of services including visits/days per 1000 members, readmission rates, PMPM Claims, etc.
- Care management outreach, engagement, and outcomes statistics
- ImpactPro reporting on under and overutilization based on members' individual conditions
- Utilization of transplant services
- End Stage Renal Disease program reporting
- End Stage Renal Disease network access
- Utilization of NurseLine services
- Utilization of telephonic physician services
- Outcomes of NurseLine services and referrals summary
- Emergency room reporting
- Pharmacy over- and under-utilization
- These reports also include definitions so the meaning of each data element is clear.

E.2 Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.

(GSA C)

Identifying Recipients for Inclusion in Chronic Care/Disease Management

UnitedHealthcare Community Plan's Personal Care Model, described in detail in our response to Question E1, supports a "no wrong door" approach to Chronic Care/Disease Management. We identify members in need of Chronic Care/Disease Management through the following sources:

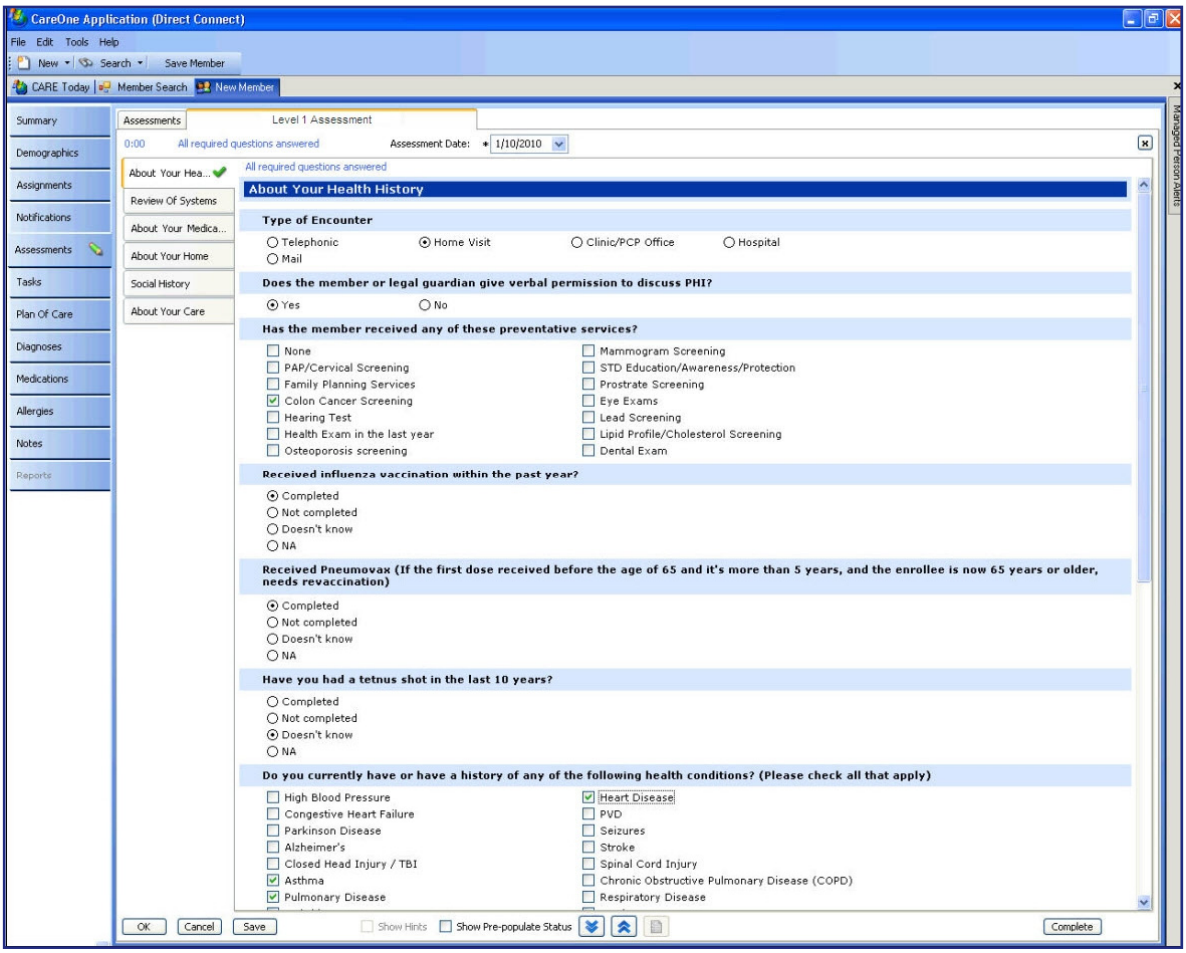
- Welcome calls to all new members with opportunity to complete initial health risk assessment
- Initial risk score assigned based on health risk assessment and referral to care manager for further screening as indicated
- Referrals from PCPs and community sources as well as internal referrals from other departments
- ImpactPro analysis of claims, pharmacy data and lab results
- Inpatient Admission/Readmission reporting
- Population based identification of members with select chronic illnesses to send member education materials
- Screening enrollment files for Special Health Care Needs indicator noted by the Enrollment Broker

Welcome Calls and Initial Health Risk Assessment

During the initial welcome call, new members receive a simplified Health Risk Assessment (HRA). We have separate HRA versions for adult members and for children (parent/guardian). We conduct live Welcome Calls to greet and education our members about their benefits and impart important information about the various programs available. We also seize the opportunity to ask basic questions about their current health state, using the HRA. The HRA instrument is algorithmically designed to assign risk

scores, used to prompt further investigation into a member's health needs.

Sample Health Risk Assessment Tool



If the results of the initial HRA score for higher risk, the member is referred for a more in-depth Comprehensive Health Status Assessment (CHSA) and condition specific screening tools performed by a care manager.

Once completed, the results from the CHSA and condition specific screenings are factored into the member's risk severity score. Each response is scored and includes branching logic that has the ability to prompt further investigation into more conditions specific questions. This branching logic includes, but is not limited to, supplemental questions on behavioral health conditions and related assessments. Because we adhere to HIPAA and respect the member's right to refuse, members are asked if we can share the information collected on the CHSA with their primary care provider.

Once the CHSA is completed, risk stratified and permission is obtained to share information with primary provider, the HRA is tasked to the appropriate care management area for outreach to the member. This outreach involves a detailed explanation of the Chronic Care/Disease Management programs, including how the member was selected for participation, opt-out procedures and a more in-depth assessment of the member's current and past conditions. Once the member accepts participation in the program and supplemental assessments are completed, a care plan is developed cooperatively with the member. Members are informed that participation involved collaboration and coordination with the member's PCP or other health team members. This also includes sharing the care plan with the PCP. We stress the

importance of keeping the PCP engaged in every aspect of the member's health care, in order to support the member's short- and long- term goals.

Other Sources of Identification

Along with welcome calls, we use a variety of sources to identify members in need of supplement assessment through our CHSA tool. We gain referrals from our ICCT, PCPs and other medical/behavioral professionals including state and community agencies. Individuals identified through referrals are given our in depth CHSA and are assigned to particular care management levels or specialty programs.

In addition, we run claim-based analytics through SMART (our data warehouse) and ImpactPro to identify individuals with our targeted conditions. We use state based reports or specific "aid" categories to identify special populations needing disease or care management (e.g. pregnancy or children with special health care needs). In the absence of other identifying information, these individuals are enrolled in our Level 1 disease management program. Once further clinical information is known (through ImpactPro, welcome call or CHSA), the individuals are graduated to more intensive programs.

One final source of information on individuals suffering from chronic conditions is the real time utilization reports on frequent admission or any readmission. Our care managers work with our ICCT to identify members who have admitted to the hospital. Members with frequent admissions or any readmissions are referred into our care management process. Members are given a health risk assessment for enrollment into our disease management program as appropriate

ImpactPro® Risk Stratification Engine

ImpactPro provides our utilization management team with predictive modeling, evidence-based medicine and tailored clinical and business rules to identify, stratify and assess member utilization. ImpactPro assists us identifying patterns of underutilization, overutilization and inappropriate utilization where intervention will be most successful.

Each month, member claim data are entered into the ImpactPro risk stratification engine. The data are then run through a series of algorithms and ImpactPro assigns the risk score to members. Depending on a member's score and risk level, a determination is made whether to enter a member into a care management program or other clinical intervention.

One of ImpactPro's key strengths is its ability to predict health risk for our member. For example, diabetes patients are at risk for developing eye problems, and medically accepted guidelines recommend that diabetics see an eye care specialist. Using ImpactPro gives our care managers the ability to identify diabetes patients who have not seen an eye specialist. The implications of this tool assist us in reducing the prevalence of eye problems in the diabetic population. The health outcomes for those members can improve by anticipating the needs of the members on a very basic level.

At implementation and on a monthly basis thereafter, ImpactPro performs predictive modeling for individuals and groups. Using information readily available from medical and pharmacy claims (if available from the State), laboratory results as well as member enrollment files, it uses a variety of risk models to predict which patients are at greatest risk for severe problems in the future. These risk models are developed using historical information drawn from the population and allows us to identify members at risk for severe health problems before they experience those problems. Certain members may not feel sick yet, and may not follow their care team's recommendations because they do not recognize the potential for developing severe problems.

Target Disease States/Recipient Types

As stated in our response to Question E1, and as required in Section 6.36 of the RFP, we will include members with asthma, diabetes and congestive heart failure in our Chronic Care/Disease Management program. In addition, we will target members with chronic obstructive pulmonary disease (COPD) and

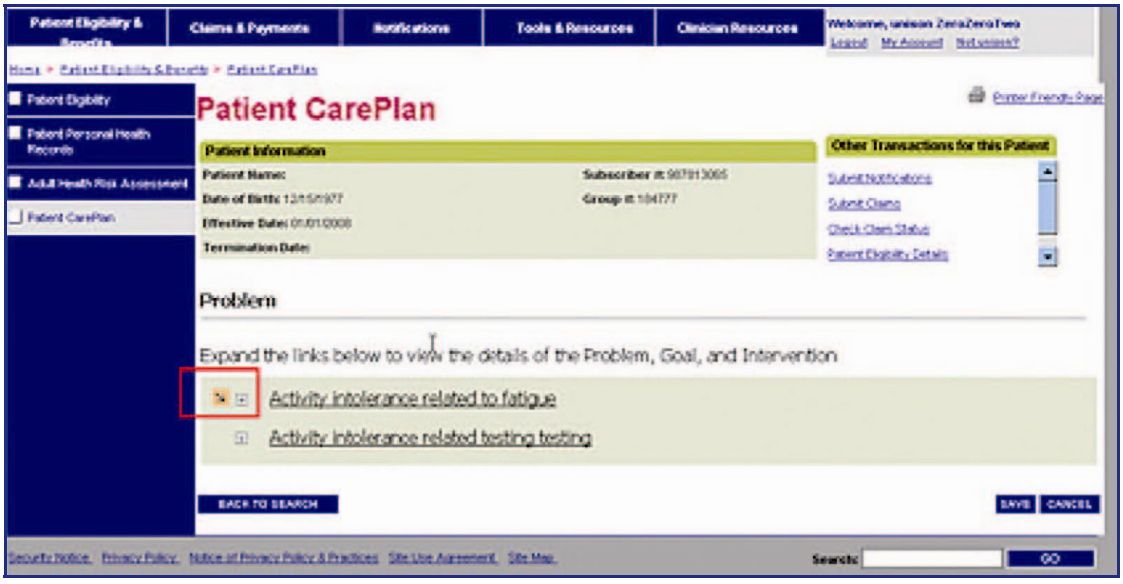
coronary artery disease (CAD). We also have specialty disease management programs focusing on: Transplant, End Stage Renal Disease, pregnancy and neonatal services. However, due to our whole person wellness approach, our program will be designed to broadly identify and appropriately support members who are at risk for adverse health outcomes, regardless of diagnosis. When a member has a primary or co-morbid behavioral health diagnosis, our Behavioral Health Coordinator will collaborate with the care manager to ensure the member accesses necessary services and supports through linkage with behavioral health providers and the Statewide Management Organization for Behavioral Health, once selected.

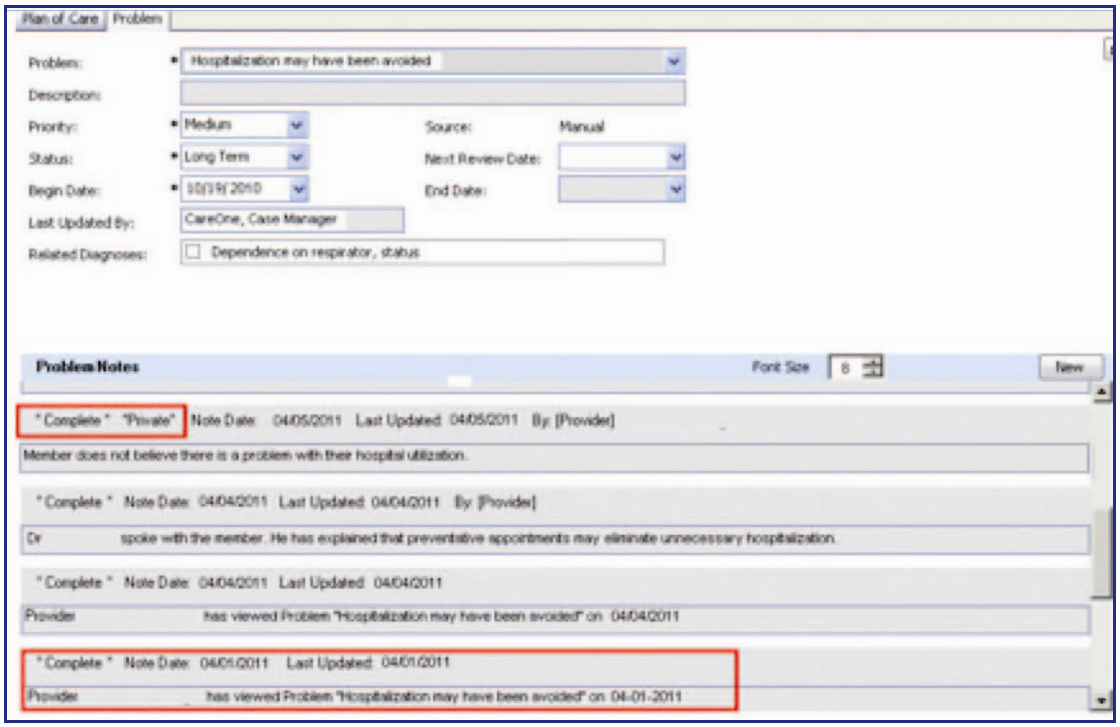
Coordination of Services with the PCP

The treating physician is always informed of the member's program acceptance and consulted in structuring care plans designed to meet member identified care goals. As part of this process, we will emphasize the availability of other specialty services, providers, or treatment plans that extend beyond our programs, such as behavioral health for Louisiana. As previously stated, we analyze claims/utilization data on an ongoing basis to detect variances from evidence-based medicine guidelines. When such variances are detected, a letter is sent to the member's PCP, noting this discrepancy and providing literature regarding the guidelines relative to the member's condition. In addition, our care managers contact the physician when changes to the member's care plan are recommended relative to their services or medications. We will also emphasize the importance of the PCP as a medical home in our interactions with members and encourage members to communicate openly and regularly with their PCP.

Provider Portal

With member permission, providers can access the member's Health Risk Assessment results and care plan by signing up for and accessing our provider portal. Providers can provide input in the member's care plan through the use of this portal. When the physician makes or suggests a change, our care manager is alerted to review this change. In addition, as needed, we can fax or mail the care plan to a provider and contact the provider via telephone for input into the members plan. Providers are also invited to send input via mail or fax. Please see the following screen shot:





Reporting for PCPs and Specialists

We will create the following reports for providers serving members in the Chronic Care/Disease Management program:

- ***Patient Roster***: A list of all members in their practice who are actively participating in one of our programs;
- ***Patient Exception Report:*** ImpactPro generates a one-page summary of actionable clinical information that is generated when a clinical event occurs that requires the physician's attention or to make appropriate treatment changes. Such events include ER visits and admission to an acute care setting. All exception report triggers are validated by internal clinicians before processing. These gaps in care notices also will be sent to the member, and to the member's care manager.
- ***Gap in Care Reporting:*** ImpactPro generates notifications to a physician when a member is noted to have a gap when evidence based medicine guidelines are applied to the member's service profile.
- ***Quarterly Trend Report:*** Shows trended vital signs and symptoms, current medications and changes, program compliance, and other events. In addition, it summarizes all Patient Exception Reports generated and sent during the reporting period.
- ***Annual Service Summary:*** A 12-month summary of information included in the Quarterly Trend Report.
- ***HEDIS Reporting:*** reports are sent to physicians which profile their performance related to HEDIS measures

These reader-friendly profile reports are intended to assist physicians in understanding their practice patterns and what, if any, improvements could be made. Through these profiles, we present a graphical depiction of recent claims activity for the provider's patients with comparisons to the patterns of physicians with similar practice composition. We will work to ensure that information in our reports can be integrated with, or used to support ongoing network management and quality management activities.

Section F: Service Coordination (Section 14 of RFP)

F.1 DHH intends to provide CCNs with two years of historic claims data for members enrolled in the CCN effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your CCN effective the start date of operations. The description should include:

- ***How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;***

(GSA C)

Receiving two years of historic claims information will be extremely helpful in identifying members with a need for service coordination. As a part of the implementation process, we will assign a single clinical executive to coordinate all aspects of our clinical transition. Also, as part of our implementation team, we assign we will assign Information Technology (IT) staff who will work very closely with the Louisiana's IT contact to develop a scope of work for acceptance and processing of this historical data. The scope of work typically involves the development of the transition data files specifications document. The purpose of this document is to outline the files specifications for the transition data that will be needed from the state. These file layouts represent a joint collaboration on our data requirements that can be loaded into ImpactPro, our predictive modeling tool as well as our SMART data warehouse.

ImpactPro™

Our multi dimensional, episode-based predictive modeling tool, ImpactPro™ compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services.

For purposes of transition, ImpactPro allows us to achieve two important goals:

- Identify members in need to ongoing care management and to facilitate their enrollment into our care and disease management programs. Because the tool allows us to stratify members, we can focus our attention on the most high-risk members first.
- In combination with custom transition reports out of our SMART warehouse, we can identify members in need for immediate service coordination. In particular, they are receiving recurring, ongoing services that require extra support during transition (e.g. hospice, home health, dialysis, DME, etc).

One of ImpactPro's key strengths is its ability to predict health risk for our member. For example, diabetes patients are at risk for developing eye problems, and medically accepted guidelines recommend that diabetics see an eye care specialist. ImpactPro gives our care managers the ability to identify diabetes patients who have not seen an eye specialist. The implications of this tool assist us in reducing the prevalence of eye problems in the diabetic population. The health outcomes for those members can improve by anticipating the needs of the members on a very basic level.

Initially during implementation, ImpactPro performs predictive modeling for individuals and groups. Using information available from medical and pharmacy claims, laboratory results, as well as member enrollment files, it considers a variety of risk models to predict which patients are at greatest risk for severe problems in the future. These risk models are developed using historical information drawn from large populations' health and claims data over an extended time and allow us to identify members at risk for severe health problems before they experience those problems. From a disease management perspective, we are able to target our prevention activities in a more effective way. The risk scores provided from ImpactPro is just as useful in discovering existing members who may need care management services. For example with asthma, the algorithm takes into consideration inpatient and emergency room (ER) use. An "Overall Future Risk Score" is assigned to each member based on the

ImpactPro algorithm and represents the degree to which the asthma disease management program has the opportunity to impact members' health status and clinical outcomes. Again, this assists care managers in identifying members who are most likely to benefit from interventions.

ImpactPro also has the capability of producing provider letter notifications of members who have generated care opportunities, or "gaps in care." These evidence-based medical guidelines highlight opportunities for improving care. Additionally, ImpactPro produces reports that providers can use to identify at-risk members and all their missed care opportunities, which can be accessed through our secure online provider portal.

We can also use claims data to:

- Identify individuals receiving ongoing critical services that would be at risk during transition such as: hospice, home health, recurring durable medical equipment, dialysis, etc.
- Identify members who have received any behavioral health services through their primary care provider
- Identify members with frequent ER visits or admissions to acute settings

Once identified, these individuals can be prioritized for initial outreach and Welcome Calls to get them engaged in appropriate care management programs as early as possible.

Our SMART data warehouse will allow us to store state historical claims file and match that to our ongoing claim experience to generate a more complete history of member experience during our initial transition period. We generate a list of service coordination reports targeting high-risk continuing services. care managers use these service lists to reach out to existing and future providers to ensure that services are not interrupted -- through both phone calls and letters. Care managers review patient rosters identified by provider and service type with the individual providers and solicit additional information on members. Among other topics, we take the opportunity to review our continuity of care plan with those providers.

In addition to claims analysis, Welcome Calls to all members will include a Health Risk Assessment (HRA). Information from this HRA will be used to identify the members in need of additional assessment/screening and referral to care management and chronic care/disease management programs during transition.

- ***What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;***

The key to facilitating a smooth transition is allowing enough lead time to identify members needing priority attention. We have found that the best results in transitioning members are achieved when we are able to obtain member data as early as possible, prior to the go-live date, including, but not limited to:

- Members with open authorizations
- Members awaiting a transplant
- Members currently enrolled in any type of care management
- Members who are pregnant
- List of members with their PCP assignments

We are prepared to transition members without the information above, particularly given access to the two year history file, but these additional elements will enhance our transition plan. Specific data elements are also crucial in helping us to identify specific needs for members already in care management programs. We are happy to provide a file format during implementation.

- ***How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;***

Continuation of Services

We are very sensitive to not only a smooth transition, but also the maintenance of care continuity. We have successfully implemented Medicaid programs in 24 states and we will use our well-tested protocols as a starting place to develop a customized transition plan for Louisiana. For example, in the last 24 months, we have successfully implement the following programs: Mississippi Coordinated Access Network (CAN), Mississippi CHIP, Tennessee CHOICES (long term care) in three regions, a Florida statewide CHIP expansion from 10 counties to all 67 counties, and several state renewals with changing benefits and other state requirements.

For our new program implementations, we establish a command center (described below) to coordinate all aspects of transition. As part of that team, we assign a single clinical executive to coordinate all aspects of our clinical transition plan including ensuring continuation of services, aligning our UM and non-participating provider approach to the transition, working with state agencies, coordinating with other service providers, and coordinating member and provider outreach including transportation.

Although we will coordinate and review services, we intend to waive prior authorization requirements for the first 90 days. For members in the hospital setting, we will perform utilization review and apply medically necessary criteria immediately. For members in non-participating facilities, we will seek to transfer members to participating facilities if safe and appropriate, but will reimburse the non-participating facility in the interim for up to 60 days.

In general, below are the steps followed to facilitate continuation of medical services:

- Refine the process to be used for open authorizations at the time of implementation and the grace period prior to an authorization being required for payment of services in line with state requirements
- Determine which members have open authorizations at the time of implementation using state data (mentioned previously) or through our provider outreach
- Review state historical claims file and determine order of priority for outreach regarding continued authorization
- Identify members who are currently receiving outpatient services such as home health, physical therapy, occupational therapy and speech therapy and arrange for assessments to determine the need for ongoing services
- Initiate contact with members to be transitioned, including identification of members currently receiving inpatient care, case management and those awaiting transplants
- Contact key providers through care management calls (using targeted service coordination lists), provider town halls and individual office visits, association outreach and general written communication – blast fax, eAlerts, mailings, continuity of care letters

For care management services, we:

- Identify members currently receiving care management services and our care management staff proactively reach out to these members to facilitate transition
- Review current claims and determine acuity levels associated care management activities
- Identify which members are in need of transplants as these members will have priority in transition to a care manager, to evaluate transplant benefits and reinsurance
- Reach out to new members telephonically with a Welcome Call to help transition services and to gather risk assessment data to help supplement our claims analysis
- Engage appropriate members in ongoing care management services

Based on the member's services at enrollment, we ensure that current services continue and that there are no breaks in services/treatment until our care manager is able to contact the member and coordinate a holistic review of the member's current needs. Our care manager, collaboratively with the member and service providers, determines the most appropriate services to meet the member's needs. We reimburse a member's current providers for medically necessary covered services that are delivered in accordance with the member's existing treatment plan until the transition plan is in place.

We also have special procedures to extend our continuity of care provisions for certain members, including pregnant women and individuals who have been diagnosed with terminal illnesses, including:

- Pregnant members in their third trimester – within 12 weeks or less of their anticipated delivery date – at the time of enrollment may remain under the care of their current OB/GYN through the member's post-partum check-up six weeks after delivery, regardless of the provider's contracting status.
- Members who are receiving treatment for a terminal illness at the time of enrollment may continue out-of-network services for up to nine months.

During the transition period, our provider relations team reaches out to in-area non-network providers to discuss the option of joining the UnitedHealthcare Community Plan network to ensure continuity of care without any disruption in services. We will educate all providers on our continuity of care payment provisions. When necessary, we will set up a single service level agreement with a provider, if the provider declines network participation, to keep a member with their current provider for a defined period of time or until a successful transition to an in-network provider is achieved.

Prior Authorization

In order to allow providers and members time to adjust to a new way of obtaining approvals and receiving services, we typically establish a grace period. We typically offer a grace period of 60 days, with special accommodations for members who are pregnant. This grace period includes the relaxation of prior authorizations, until we are able to contact the treating provider to discuss the care plan, educate them about our care management program, determine their interest in working with us as a contracted provider if not one already and if needed provide notice of our intent to transfer members to participating providers.

Use of Non-Contracted Providers and Transportation

In cases where a provider is not on our network and is considered key to a member's health we contact these providers and offer them an opportunity to become part of our network. If the provider declines, we establish a single case agreement to cover the current course of treatment and work on a transition plan with the provider and the member to transfer the member to an in-network provider after the current course of treatment is completed. This process applies to clinical and non-clinical service, to include transportation.

As part of our deep experience with implementations, we understand that non emergent transportation is a key aspect of a successful transition. We assign a transportation coordinator as part of our Command Center transition team. We reach out to all participating and non-participating transportation vendors in partnership with our vendor, Logisticare. We educate them on our continuity of care payment provisions and encourage non-participating providers to join our network. In addition, we seek a list of prescheduled and recurring trips that are set to occur after the transition date and either authorize that trip or transition the trip to a participating vendor. We have also found that transportation vendors can be an additional source to identify high-risk members that need additional help from our care managers during transition to ensure effective service coordination and continuity of care (e.g. members receiving regular trips for dialysis or chemotherapy). We incorporate those member rosters into our service coordination lists.

Implementation Command Center

A centralized Command Center is set up during implementation to address any issues that cannot be resolved through existing health plan resources. The Command Center is made available to providers, internal staff and state agencies. The Command Center is lead by our implementation executive, reporting directly to our Chief Executive Officer, Blaine Bergeson.

As part of our team, a single clinical executive is tasked with oversight of all clinical transition issues and will bring any issues needing immediate attention to the Command Center to be resolved. This executive will also be the main liaison between UnitedHealthcare Community Plan and DHH during implementation and after the "go live" date. Our Clinical Transition Coordinator will perform periodic clinical rounds (up to daily) with key providers, state agencies, the State's new behavioral health vendor and our internal clinical teams to ensure members are receiving necessary services. This executive is also responsible to see that that all necessary member data and provider outreach is performed ahead of transition including working with all internal departments (e.g. provider contracting, IT, operations, the ICCT), the State and providers.

The Command Center is staffed seven days a week and has on-call management personnel available 24 hours a day. The team has critical contact information and clear decision making authority to resolve clinical and other operational barriers in real time.

During the first month of operations, we will hold a daily Command Center meeting with key internal departments to review member and\or provider issues and urgent care coordination issues. Participation includes leadership staff in medical management, customer service, prior authorization and provider relations. Issues are documented and status updated daily until resolved. In addition, in order to facilitate a smooth transition, our team leaders, executives and trainers remain on site after implementation to help staff with training, urgent issues, and provide guidance based on their years of implementation experience. Daily meetings of management staff are used to document and track any issues that might arise, so that we can quickly resolve them with minimal disruption in service to members or providers. This includes clinical issues, transportation issues, provider issues, etc.

- ***What information, education, and training you will provide to your providers to ensure continuation of services; and***

UnitedHealthcare Community Plan offers training to providers and their clinical and administrative staff through a variety of venues including regional town hall meetings and virtual town halls to accommodate those who cannot or choose not to travel, engaging professional provider and practice management associations, direct outreach by our network staff to high volume providers, and online training and resources. Our Chief Medical Officer, Mark Mahler, MD and Chief Executive Officer, Blaine Bergeson will meet with large provider groups to discuss transition. We also distribute a provider manual, targeted electronic newsletters (eAlerts) and written newsletters, fax blasts, webinars, and access to our Provider Portal.

We offer both orientation and focused training events and workshops through regional town halls that are historically well attended. We also perform individual office visits for high volume providers. We supplement these visits with virtual provider trainings using conference calls assisted by web-based training tools for practices with internet access. We have also focused outreach with key provider associations through in person meetings and partner with them to provider additional training events or to distribute written material. As matter of practice, we provide the key associations with all of our materials including our more urgent blast faxes and eAlerts.

To assist with continuity of care, we will educate providers on pertinent topics such as:

- Any issues related to provider agreements/contracts

- Assistance in transitioning to us as a new health plan partner
- The prior authorization process and authorization grace period
- Access to the provider portal, walk through of how it works and where information is located
- Overview of our medical management model
- Care management program – how to refer and how a care manager will communicate with the provider
- Claims processing
- In-network, out-of-network definitions
- Cultural competency training
- Medical home (PCMH) training and support.

We will also send a letter to all providers during implementation, explaining our continuity of care policies and any steps they will need to take to request prior authorization of services on behalf of members.

In addition, our care managers contact key providers caring for members on our target service coordination list to ensure they understand our continuity of conditions. If the provider is not currently participating in our network, we seek to bring them into the network.

- ***What information you will provide your members to assist with the transition of care.***

Members are educated through a Welcome Packet of information, our Welcome Call process, member newsletters and through transition of care information posted on our website. We will also hold member town hall meetings and member orientation sessions at various locations across the service area. We have already reached out to many community and faith-based organizations, as detailed in our response to Question F7, and we will continue this outreach throughout implementation and after to educate members about the program and specifically about transition of care.

Welcome Call Process

As outlined above, members who have been identified through ImpactPro claims analysis or through other information received by DHH as being at higher risk will have the highest priority for Welcome Calls. We expedite transition services for members who are assessed as being at high risk (transplant, pregnancy, those in dialysis, etc.) and link them with care management staff as quickly as possible. Our care management staff help direct members to receive appropriate health screening and treatment services in a timely fashion and in compliance with evidence based medicine guidelines.

Through the Welcome Call process, our service representatives educate members on our program and answer member questions about their benefits, inform them about what programs are available and how to access them. As part of that call, we share access to their member rights and responsibilities.

We also gather information, using the Health Risk Assessment (HRA), about any existing medical conditions or concerns including helping to identify any critical service providers not currently in our network. Results from the HRA are used to identify members in need of additional general health screening and disease specific screenings by care management staff. In addition, if a member calls the NurseLine and notes that he or she has a chronic condition; our NurseLine staff will refer the member for additional screening by our care management staff. Once a member is identified through any internal or external source as having one or more chronic conditions, educational materials specific to the member's condition(s) are sent to the member.

F.2 Describe your approach to CCN case management. In particular, describe the following:

- ***Characteristics of members that you will target for CCN case management services; (GSA C)***

As detailed in our response to Question E1, UnitedHealthcare Community Plan uses a Personal Care Model. As part of our Personal Care Model, we view case management, chronic care management and disease management as points on a continuum of care. Individuals may move between disease management to a more intensive level of chronic care management/case management over time as their needs, preferences and the severity of their condition or conditions changes. Throughout this change in intensity, the assigned care manager will remain the same, whenever possible, so that a stronger relationship between the member and the care manager can develop and stay intact. The goal is empower individuals, in collaboration with physicians and other health care professionals, to effectively manage their conditions and associated risk factors and co-morbidities.

The RFP Glossary identifies individuals with special health care needs to be "individual of any age with a mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care requirements." Our program is consistent with this definition. Care Management services will be available to any member who has a serious condition or illness including members with asthma, diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or coronary artery disease (CAD) who are at risk for adverse health outcomes or who need the increased focus of a care manager. In addition, we target individuals with multiple, chronic conditions using a variety of approaches outlined below to predict future deterioration or exacerbation of their condition. This targeting is primarily through the scoring of our health risk assessments as well as the ImpactPro risk score determined by claims data.

Although we have standardized, robust clinical programs, we customize our targeting based on the particular characteristics of members in the CCN program as well as state requirements. As a starting point, we typically enroll approximately 5 percent of individuals into our care management programs.

- ***How you identify these members;***

Personal Care Model™

As described in our response to Question E1, our Personal Care Model (PCM) is a holistic approach to care for members, across the entire continuum of care. It addresses the unique socio-economic and clinical challenges of our members from their interactions with primary care physicians through addressing the complex needs of the most chronically ill individuals. Our PCM is designed to:

- Create a seamless member care experience
- Address the socio-economic, behavioral, environmental and clinical challenges of our members
- Leverage multidisciplinary care management teams
- Incorporate high-touch and personalized interventions
- Work in partnership with providers, members and the community
- Be sensitive to cultural differences and diversity
- Address health care disparities
- Leverage community based resources from governmental, private and faith-based organizations
- Offer specialized member communication, outreach, engagement and communication
- Include continuous measurement of process and outcomes
- Integrate network, members services, medical economics and information technology to improve care for members

Our Personal Care Model is based on five steps, as displayed below. These steps guide our care management staff from initial identification and contact with the member through engagement in the program and ongoing monitoring of the member's progress toward health and wellness goals.

Personal Care Model – Our Member-Centric Integrated Care Model	
1. Identify	■ Welcome calls to **all new members** with opportunity to complete an initial health risk assessment ■ Initial risk score assigned based on health risk assessment and referral to care manager for further screening as indicated ■ Referrals from PCPs and community sources as well as internal referrals from other departments ■ ImpactPro analysis of claims, pharmacy data and lab results ■ Frequent inpatient admission/readmission reporting ■ Population based identification of members with select chronic illnesses to send member education materials
2. Assess	■ Conduct Comprehensive Health Status Assessment (CHSA) which will drive adjustment to care management level and identify individual conditions ■ Perform condition specific disease management supplemental assessments ■ Clinical judgment employed to validate and augment risk scores ■ Refer to specialized programs based on Hierarchy of Diseases (e.g. Health First Steps based on pregnancy)
3. Risk Stratify	■ Risk stratification based on ImpactPro predictive modeling system and assessment results ■ Confirm risk stratification level based on member interactions and identify any necessary special care management programs
4. Implement	■ Develop member-centric plan of care implemented by multi-disciplinary health care team ■ Share care plan with PCP and other providers and invite physician adjustments to plan; Care plans are available on our provider portal ■ Condition-specific interventions ■ Support self-management and self-efficacy ■ Involve family and community resources
5. Monitor	■ On-going monitoring of claims, pharmacy data, assessments, utilization, referrals and lab results ■ Identification of gaps in care, barriers to success and non-adherence to plan of care ■ Restratification with ImpactPro predictive modeling ■ Care management/disease management efforts continue

As mentioned previously, UnitedHealthcare Community Plan believes in a "no wrong door" approach to case management. We identify members in need of care management through the following sources:

- Welcome calls to all new members with opportunity to complete initial health risk assessment
- Initial risk score assigned based on health risk assessment and referral to care manager for further screening as indicated
- Referrals from PCPs and community sources as well as internal referrals from other departments
- ImpactPro analysis of claims, pharmacy data and lab results
- Inpatient Admission/Readmission reporting

- Population based identification of members with select chronic illnesses to send member education materials
- Screening enrollment files for Special Health Care Needs indicator noted by Enrollment Broker

Additional detail regarding the use of claims and other data to identify members in need of case management services is included in response to Question F1.

- ***How you encourage member participation;***

UnitedHealthcare Community Plan believes that it takes time and effort to build a trusting relationship with a member. This is why we make every attempt to keep the same care manager assigned to the member throughout the member's enrollment in any form or intensity of care management services. A trusting relationship, built through consistent contact and engagement with a member, fosters compliance with testing and treatment regimens and improvement of member health over time. The care manager and the member celebrate small and large successes and work hard together to solve problems when challenges or set backs are encountered. Over time, they become a team working toward the same goal along with the physician and member's family. In addition, our care managers work closely with PCPs and Specialists, asking for sign off on the individualized care plan and supporting the member's relationship with their physician in all interactions. As an example of our effectiveness, for the Southeast Region of the U.S. during the first quarter of 2011, our engagement rate was 64.4 percent for our care management programs. Many Medicaid plans only engage 25-30 percent of members.

We also use readiness development tools to encourage member participation. We try to meet the member where he or she is at in their readiness for change and help support positive health and wellness choices.

Disease/Condition Hierarchy for Members with Co-Morbidities

Members with chronic conditions often have multiple co-morbidities. Behavioral, social and environmental factors add to the complexity of the member's health needs and increase risk levels. In recognition of the multiple co-morbidities, UnitedHealthcare Community Plan uses a member-centric case management model to assess and track determinates of health and well-being across all conditions which may be present. Our model addresses medical, behavioral, social and environment factors simultaneously through a comprehensive, individualized care plan with established timelines/priorities for activities that maximize quality outcomes and cost benefit. Members requiring full-time case management will have "one face" coordinating all clinical programs and care. A Disease/Condition Hierarchy is used to assign the member to the most appropriate care/disease management program and also to help target interventions first to the condition requiring the most immediate attention and support. Once a member has had success at managing one condition, they become more empowered to actively manage other conditions. The recommended hierarchy for the Louisiana CCN is included below.

Recommended Disease/Condition Hierarchy for Louisiana CCN:

- Pregnancy
- Behavior Health (Schizophrenia, Bipolar Disorder)
- Heart Failure
- Diabetes
- CAD
- Depression
- Substance Abuse
- Asthma
- COPD
- HIV/AIDS
- ESRD
- Chronic Kidney Disease
- Other Respiratory Conditions

We recognize that the bulk but not all of behavioral treatment will be provided by the State's a Statewide Management Organization for Behavioral Health. We have experience coordinating with "carved-out" behavioral systems, and as such, include behavioral conditions in our hierarchy. This is why we include behavioral health conditions in the hierarchy above and why we have included Behavioral Health Care Coordinators in our staffing to facilitate behavioral health treatment and coordination for members. Once a behavioral health condition has been stabilized, a member is often much more prepared to address medical conditions by participating fully in the development of an individualize care plan and attending routine medical appointments.

Using Model of Change

Our staff will guide and monitor member behavior change in accordance with Prochaska's Transtheoretical Model of Change, which says individuals move through a series of stages in the adoption of healthy behaviors or the cessation of unhealthy habits. These stages include:

- ***Pre-Contemplation:*** lack of awareness that life can be improved by a change in behavior. The individual has no intent to change behavior.
- ***Contemplation:*** recognition of the problem, initial consideration of behavior change, and information gathering about possible solutions and actions. The individual has no intent to change within the next six months.
- ***Preparation:*** introspection about the decision, reaffirmation of the need and desire to change behavior, and completion of final pre-action steps. At this stage, the individual intends to take steps to change usually within the next month.
- ***Action:*** implementation of the practices needed for successful behavior change (e.g. exercise class attendance). The individual has made lifestyle modifications for fewer than six months.
- ***Maintenance:*** consolidation of the behaviors initiated during the action stage. The individual has made changes and is working to not relapse.
- ***Termination:*** former problem behaviors are no longer perceived as desirable.

The member's state of readiness is tracked through the use of individualized care plans that are developed by the members and providers. Case management staff will document the current status of each member within the continuum of change to ensure appropriate interactions.

Using Inductive Call Anatomy

We also use inductive call anatomy to engage members. Inductive Call Anatomy enables efficient identification and prioritization of member needs as well as gaps in care. It empowers the case management staff to look at each situation individually and identify specific business and member needs. It also helps staff and members develop a mutually agreed-upon plan. The cornerstone of Inductive Call Anatomy is the "6Cs"—six components which guide a nurse through all aspects of a member interaction:

- ***Connect***: the foundation of every contact with a member. It includes rapport, relationship, and trust.
- ***Cues***: Active listening that enables a member's needs to be clearly conveyed
- ***Clinical/Critical Thinking:*** An expert assessment of the member's needs and his or her readiness for change.
- ***Compel:*** Ensures clear understanding of the member's needs. This includes clarification, summarization, and prioritization.
- ***Contract:*** Assists the member in taking action. This includes planning, strategizing, and activation.
- ***Complete:*** Confirmation and documentation.

Silent Call Monitoring

As described previously UnitedHealthcare Community Plan uses Silent Call Monitoring to help our case managers improve their outreach and engagement techniques. Our clinical manager listens to a sample of calls each month for each clinical staff member and provides them with feedback after the call to help them in engaging and supporting members.

- ***How you assess member needs;***

Our care managers assess member needs through combination of telephonic discussion with the member about their health, review of available data regarding the member's health status, their stratified risk score and results from a variety of available telephonic screening tools which help isolate symptoms, health status, and how health is affecting the member's overall quality of life. Combining these elements allows for a more complete understanding of both the member's current health status and the most powerful steps the member can take to improve his or her health over time.

Health Risk Assessments

Besides data analytical reports described previously (e.g. readmission reports, ImpactPro, and condition specific reporting from SMART), our care management staff assess members through two primary mechanisms:

- An initial abbreviated health risk assessment to determine basic level of need and to help us prioritize further clinical interventions. Although developed specifically for our needs, the assessment tool does incorporate nationally recognized tools within it specifically elements from:
  - PHQ-2 and PHQ-9 Depression screening tools
  - CAGE-AID tool for substance abuse
- A supplemental, more comprehensive assessment tool called the Comprehensive Supplemental Health Assessment tool (CHSA). As described below, this tool covers all aspect of a members' conditions and situation and, like the HRA above, includes elements from other nationally recognized tools including the SF12 to measure overall health and quality of life. More importantly, the tool triggers additional, disease specific assessments based on our evidenced-based clinical guidelines and the members individual condition (e.g. diabetes, CAD, asthma, etc).

Many of these tools are available in both adult and pediatric versions, as the needs and symptoms of children and youth can vary greatly from those of adults. Use of these tools is helpful both in initially

assessing the member's needs and developing an appropriate care plan and in measuring program success both on an individual member and program level.

CHSA Tool

Once a member is identified or referred to our program, a care manager performs a comprehensive health status assessment (CHSA). The CHSA identifies key high risk conditions, family history, family supports, current and past medical history, personal behaviors, social history and environmental risk factors. The CHSA includes, but is not limited to:

- Vaccine history
- Current and past health conditions, including behavioral health
- Exercise habits
- Height and weight, weight fluctuations
- Issues related to diet, the cost of food and any diet restrictions
- Sleep
- History of falling
- Wounds
- Trouble breathing and shortness of breath
- Heart pain
- Ankle/leg swelling
- Chronic pain
- A wide variety of additional health symptoms that might require further investigation and care
- Depression
- Current medications list and any issues related to medications
- Housing and safety
- Level of education
- Assistance needed for daily living activities
- Tobacco use, past and present
- Alcohol and other drug use
- Frequency of primary care visits and any transportation or other barriers to receiving routine care
- Emergency room use
- Surgery, history and planned
- Living Will and Power of Attorney
- Use of durable medical equipment
- Ethnicity and primary language spoken
- Emergency contact information.

Once completed, the CHSA helps determine the additional condition specific screenings needed and allows us to place the member into the appropriate care management level. Below the first page of the CHSA tool:

CONFIDENTIAL

Enrollee Name: _____

Assessment Date: _____

UnitedHealthcare Comprehensive Health Status Assessment

1.0 Encounter Information

Encounter Information

1.1 * Were you able to contact the enrollee?

____ Yes ____ No

1.2 * Does the member agree to be interviewed/ assessed?

____ Yes ____ No

1.3 * Does the member or legal guardian give verbal permission to discuss PHI?

____ Yes ____ No

1.4 * Type of Encounter

____ Telephonic ____ Home Visit ____ Clinic/PCP Office

____ Hospital ____ Mail

2.0 About Your Health History

About Your Health History

2.1 Has the member received any of these preventative services?

____ None ____ Mammogram Screening ____ PAP/Cervical Screening

____ STD Education/Awareness/Protection ____ Family Planning Services ____ Prostate Screening

____ Colon Cancer Screening ____ Eye Exams ____ Hearing Test

____ Lead Screening ____ Health Exam in the last year ____ Lipid Profile/Cholesterol Screening

____ Osteoporosis screening ____ Dental Exam

2.2 Received influenza vaccination within the past year?

____ Completed
____ Not completed
____ Doesn't know
____ NA

2.3 Received Pneumovax (If the first dose received before the age of 65 and it's more than 5 years, and the enrollee is now 65 years or older, needs revaccination)

____ Completed
____ Not completed
____ Doesn't know
____ NA

2.4 Have you had a tetanus shot in the last 10 years?

____ NA
____ Doesn't know
____ Not completed

ImpactPro Risk Stratification Engine

ImpactPro is one tool that UnitedHealthcare Community Plan uses evaluate the quality and appropriateness of care and services provided to members. ImpactPro provides our utilization

management team with predictive modeling, evidence-based medicine and tailored clinical and business rules to identify, stratify and assess member utilization. ImpactPro assists us identifying patterns of underutilization, overutilization and inappropriate utilization where intervention will be most successful.

Each month, member claim data are entered into the ImpactPro risk stratification engine. The data are then run through a series of algorithms and ImpactPro assigns the risk score to members. Depending on a member's score and risk level, a determination is made whether to enter a member into a care management program or other clinical intervention. Analysis of Impact reporting data also allows us to identify potential barriers to care that must be addressed.

Our care management programs help members with significant conditions receive quality care and avert potential problems by providing care management services to those who need it, by devising proactive, rather than reactive, programs. Our multi dimensional, episode-based predictive modeling tool, ImpactPro™ compiles information from multiple sources including claims, laboratory and pharmacy data and uses it to predict future risk for intensive care services.

One of ImpactPro's key strengths is its ability to predict health risk for our member. For example, diabetes patients are at risk for developing eye problems, and medically accepted guidelines recommend that diabetics see an eye care specialist. Using ImpactPro gives our care managers the ability to identify diabetes patients who have not seen an eye specialist. The implications of this tool assist us in reducing the prevalence of eye problems in the diabetic population. The health outcomes for those members can improve by anticipating the needs of the members on a very basic level.

At implementation and on a monthly basis thereafter, ImpactPro performs predictive modeling for individuals and groups. Using information readily available from medical and pharmacy claims (if available from the State), laboratory results as well as member enrollment files, it uses a variety of risk models to predict which patients are at greatest risk for severe problems in the future. These risk models are developed using historical information drawn from the population and allows us to identify members at risk for severe health problems before they experience those problems.

ImpactPro also has the capability of producing provider letter notifications of members who have generated care opportunities for specific conditions. These evidence-based medical guidelines highlight opportunities for improving care. Additionally, ImpactPro produces reports that providers can use to identify at-risk members and all their missed care opportunities, which can be accessed through our secure online provider portal.

- ***How you develop and implement individualized plans of care, including coordination with providers and support services;***

Once engaged, our care management staff work with each member to develop an individualized care plan and set individual goals. Our clinical information system automatically generates recommendations for the care plan, but the plan is customized based on the member's condition(s), evidence based-medicine guidelines for the condition(s) and their unique circumstances. The care manager customizes the plan to reflect the member's support system, available community resources and realistic inventories of the health and wellness goals the member decides are best suited to his or her individual situation.

The objectives of the care management program, as reflected in the care plan, include:

- Improve health outcomes and quality of life for members
- Increase member adherence to the physician's prescribed treatment regimen
- Help members implement self- management activities derived from evidence-based treatment plans
- Address any behavioral needs through coordination behavioral health providers

- Identify and address any barriers to receiving routine such as transportation, accessibility, translation/interpretation, environmental factors
- Encourage member adoption of healthy lifestyle behaviors
- Support early detection and treatment of changes in a member's health condition
- Involve members in informed decision-making about their health
- Reduce incidence of inappropriate health care utilization, including emergency room visits and inpatient admissions
- Promote delivery of cost effective care delivered in the right setting at the right time for members
- Provide the treating physician a link with UnitedHealthcare Community Plan to best facilitate the ongoing care and treatment of the member within the benefit structure available to the member
- Mobilize and engage community resources to address identified social issues that complicate the member's ability to manage their health condition.

This care plan is based on both the recommended actions based on evidence-based medicine guidelines and the member's own goals for health and wellness. The member's family support and community support systems are vital parts of the care plan is tapping into existing community programs and resources. Goals and actions in the plan are adjusted over time to meet the changing needs of the member.

If needed, the care manager will send or task any behavioral health or support issues to the Behavioral Health Coordinator, who will also input any recommended goals or objectives and helps coordinate services for members directly with behavioral health providers. Once implemented, the Behavioral Health Coordinators will also coordinate directly with the care management staff of the selected Statewide Management Organization for Behavioral Health. Providers can access the member's care plan by signing up for and accessing our provider portal. Providers can provide input in the member's care plan through the use of this portal. When the physician makes or suggests a change, our care manager is alerted to review this change. The member's family support and community support systems are vital parts of the care plan, tapping into existing community programs and resources. Goals and actions in the plan are adjusted over time to meet the changing needs of the member.

As part of their responsibilities, the care manager will assess each member's current status and needs. The care manager will then help the member establish individual health goals and make commitments to actions designed to reach those goals. In addition, the care manager will assess whether current medical and medication interventions are consistent with the member's medical condition. The care manager will discuss any recommended changes with the provider and will also assist the provider and member to obtain any additional services needed to continue with treatment without any disruption in care. In addition, the care manager works with the Behavioral Health Coordinator for members with a psychiatric diagnosis or substance abuse issue to ensure that appropriate behavioral health treatment and supports are included in the care plan. The Behavioral Health Coordinator works actively and closely with the care manager to ensure the member is connected with necessary services and supports in the community.

Provider Portal

With member permission, providers can access the member's Health Risk Assessment results and care plan by signing up for and accessing our provider portal. Providers can provide input in the member's care plan through the use of this portal. When the physician makes or suggests a change, our care manager is alerted to review this change. In addition, as needed, we can fax or mail the care plan to a provider and contact the provider via telephone for input into the members plan. Providers are also invited to send input via mail or fax.

CareOne Clinical Information System

Our CareOne system is the foundation for both the assessment and care planning processes. We designed

our CareOne application to coordinate the information flow among caregivers, case managers, members, and providers. CareOne also includes behavioral health screening and assessment data. CareOne features include:

- Maintaining Health Risk Assessments (HRAs)
- Creating and maintaining Plans of Care (POCs)
- Managing prior authorizations
- Care/case management
- Utilization management
- Standard and ad hoc reporting.

Through CareOne, Health Risk Assessments and Plans of Care are also available to providers online, which gives providers the ability to submit comments and provide feedback through our Provider Portal.

CareOne includes embedded protocols which identify key areas that should be addressed in specific care plans. It is a global profile of the member's health record and therefore facilitates better understanding of our members' physical, behavioral, and social/environmental needs.

CareOne serves as the framework within which to share clinical information across clinical domains and departments and to serve as our virtual medical record, tracking clinical information longitudinally. CareOne supports disease, care, and utilization management for both physical and behavioral care. Follow up is facilitated by CareOne's automated tasking and reminder system. If a care manager does not close open tasks that meet evidence-based guidelines, the tasks automatically escalate to the Care Management Supervisor for intervention (i.e., coaching, load balancing, etc). CareOne can also produce reports that can be shared with providers to aid in treatment plan development and decision making. When our state of the art technology is combined with our experienced care managers and proven care management programs, the result is the finest "high-tech/high-touch" care possible for our members.

Maintaining Member Profiles

We maintain the member profile using our CareOne application to better understand our members' medical, behavioral and social/environmental needs. This data is dynamic and includes the following components:

- Classifies member health and risk status through customizable intake and screening questionnaires
- Provides in-depth supplemental triggers for full health risk evaluation, including triggers for behavioral health
- Determines the most appropriate clinical assignment based on criteria such as demographics, cultural need, individual preference, PCP, case type, and caseload availability of care manager
- Tracks comprehensive medical, social, behavioral, catastrophic, and long-term care assessments, including national tools sets that are trauma-informed
- Provides supplemental assessment screens for specific diseases to aid in disease management, including behavioral health issues
- Tracks key member clinical information, including diagnostic results, patient histories, advanced directives, and responsible party information
- Records medications and allergies
- Integrated pharmacy knowledgebase identifies medication-to-medication interactions, medication-to allergy interactions, and medication-to-condition interactions
- Verifies membership eligibility, responsible party, and other health plan coverage, if applicable
- Tracks network, affiliated physicians, and other health care providers, home and community based referral options, and other available long-term care resources

- Provides rules-based, set-up wizard features that allow the application to be customized to the workflow process of our customers
- Links to a clinical data warehouse for reporting functionality
- Includes an embedded task management system within the system that allows users to track, monitor, and enhance the information flow within the member care process including to-do lists, reminders, and daily work plan
- User-group and menu-based customizable security features that protect the privacy of members, Comprehensive case notes and member goal tracking
- Assessments/protocols systematically populate needs/goals/interventions to drive to best practice
- Capability for both real-time and batch interfaces with eligibility, provider, authorization, and reporting systems
- User-defined fields to ensure pertinent data can be captured
- Audit trails for addition, deletion and modifications to data

- ***How you coordinate your disease management and CCN case management programs;***

As stated previously, UnitedHealthcare Community Plan views case management, chronic care management and disease management as points on a continuum of care. Individuals may move between case management to a more intensive level of chronic care management/disease management over time as their needs, preferences and the severity of their condition or conditions changes. Throughout this change in intensity, the care manager will remain the same, whenever possible, so that a stronger relationship between the member and the care manager can develop and stay intact. When a change in care manager is necessary, documentation of all interactions with the member and most updated care plan are stored in our clinical information system for review by the newly assigned care manager and the current care manager will explain the reason for the change to the member. In addition, If the member does not want as frequent or wants more frequent contact, the care manager discusses this with the member and they come to an agreement.

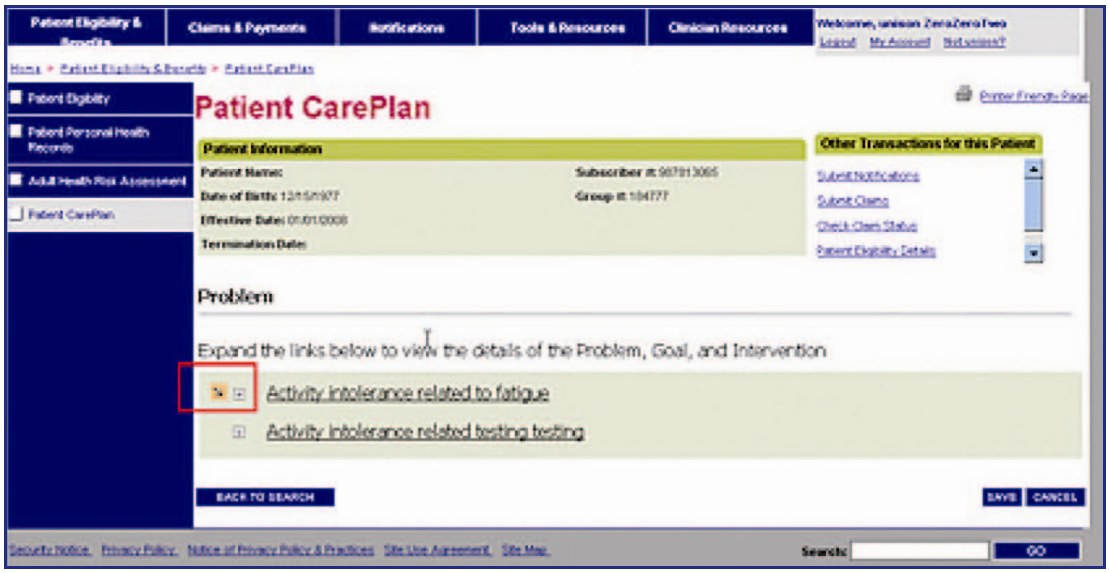
- ***How you will coordinate your case management services with the PCP;***

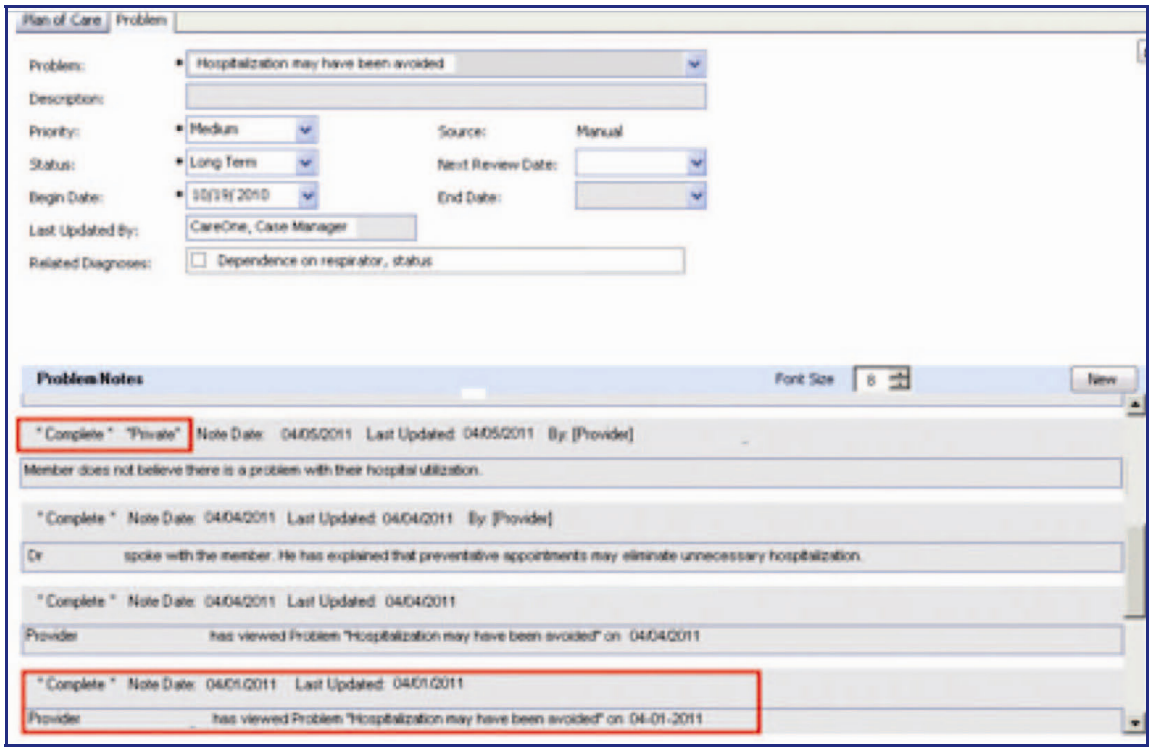
Care managers will be assigned to specific geographical areas and to specific Providers (including medical homes) within those areas. The care managers will become a trusted part of that physician's clinical team and will be accessible to both providers and members to help with all medical, social/environmental and behavioral health issues. This approach limits the number of care managers with whom Providers interact. The treating physician is always informed of the member's program acceptance and consulted in structuring care plans designed to meet member identified care goals. As part of this process, we will emphasize the availability of other specialty services, providers, or treatment plans that extend beyond our programs, such as behavioral health for Louisiana. As previously stated, we analyze claims/utilization data on an ongoing basis to detect variances from evidence-based medicine guidelines. When such variances are detected, a letter is sent to the member's PCP, noting this discrepancy and providing literature regarding the guidelines relative to the member's condition. In addition, our care managers contact the physician when changes to the member's care plan are recommended relative to their services or medications. We will also emphasize the importance of the PCP as a medical home in our interactions with members and encourage members to communicate openly and regularly with their PCP.

Provider Portal

As stated previously, with member permission, providers can access the member's Health Risk Assessment results and care plan by signing up for and accessing our provider portal. Providers can provide input in the member's care plan through the use of this portal. When the physician makes or suggests a change, our care manager is alerted to review this change. In addition, as needed, we can fax or

mail the care plan to a provider and contact the provider via telephone for input into the members plan. Providers are also invited to send input via mail or fax. Please see the following screen shot:





Reporting for PCPs and Specialists

We will create the following reports for providers serving members in the Chronic Care/Disease Management program:

- ***Patient Roster:*** A list of all members in their practice who are actively participating in one of our programs;

- ***Patient Exception Report:*** ImpactPro generates a one-page summary of actionable clinical information that is generated when a clinical event occurs that requires the physician's attention or to make appropriate treatment changes. Such events include ER visits and admission to an acute care setting. All exception report triggers are validated by internal clinicians before processing. These gaps in care notices also will be sent to the member, and to the member's care manager.
- ***Gap in Care Reporting:*** ImpactPro generates notifications to a physician when a member is noted to have a gap when evidence based medicine guidelines are applied to the member's service profile.
- ***Quarterly Trend Report:*** Shows trended vital signs and symptoms, current medications and changes, program compliance, and other events. In addition, it summarizes all Patient Exception Reports generated and sent during the reporting period.
- ***Annual Service Summary:*** A 12-month summary of information included in the Quarterly Trend Report.
- ***HEDIS Reporting:*** reports are sent to physicians which profile their performance related to HEDIS measures

These reader-friendly profile reports are intended to assist physicians in understanding their practice patterns and what, if any, improvements could be made. Through these profiles, we present a graphical depiction of recent claims activity for the provider's patients with comparisons to the patterns of physicians with similar practice composition. We will work with to ensure that information in our reports can be integrated with, or used to support ongoing network management and quality management activities.

Community Resource Database

The community partnerships we have in place and continue to build are vital in helping us compile a comprehensive database of community resources our care managers can tap into to support members. This database helps in discussions with PCPs regarding needed community supports and services. A designated member of our team will be responsible for updating our existing database of community resources with any additional available local and statewide resources. This database, which will be accessible to all those working with members, will include information on the service provided, location(s), contact names and numbers. One important responsibility of each care manager and Network staff will be to update the Community Resources Database every time they learn of a new service or program so that we can offer as many options and supports to members in their local communities as possible.

- ***How you will incorporate provider input into strategies to influence behavior of members.***

The care manager will consult with the provider when gaps in care are noted through data analysis or notification of an ER visit or inpatient admission. Care managers will also discuss the member's individualized care plan with providers, to keep consistency in treatment recommendations and goals and seek provider input into strategies to improve member health. In addition, as stated above, the PCP or specialty physician can also view and make change to the care plan through our online provider portal. When the physician makes or suggests a change, our care manager is alerted to review this change. Our care managers will also frequently reinforce the importance of establishing and maintaining a medical home in our interactions with members.

F.3 Describe your approach for coordinating the following carved out services which will continue to be provided by the Medicaid fee-for-service program: (GSA C)

- ***Dental***

As part of our care management discussions with members, we ask about receipt of routine dental care

and assist members by linking them with resources if needed to arrange for necessary dental evaluation and treatment. When dental issues are present, these are documented in the individualized care plan and monitored over the time that the member is enrolled in case management. In addition, our care managers will have access to the Medicaid dental directory for children under age 21 and dental resources for adults to facilitate referral to a local dentist when necessary.

Inappropriate use of emergency rooms due to dental pain is common. It is often more prevalent when an individual does not have dental benefits. We will use our member and provider newsletters and portals to provide education about alternatives to using an emergency room. For example, when a member or caregiver of a child contacts our NurseLine, a symptom assessment helps isolate if pain is associated with the need for dental care. If so, the nurse helps the caller to locate appropriate provider or agency to help the member, either through their dental plan or community resources. Our staff will have access to our community database of resources, which will include information on how to access dental benefits and low or no cost dental services provided in the community.

- ***Specialized Behavioral Health***

Because we recognize the importance of members receiving necessary mental health and substance abuse treatment to overall health and wellness, UnitedHealthcare Community Plan has built behavioral health coordinators into our staffing plan. The behavioral health coordinator provides an essential link between members and their health care providers by providing collaboration of medical, mental heath, and substance abuse care. These positions will be filled by licensed behavioral health clinicians skilled in coordinating services and ensuring members have appropriate behavioral health care to support their pharmacological and physical medicine care needs. Minimum requirements will include: active, unrestricted license; Master's degree in Psychology, Social Work, Counseling or Marriage or Family Counseling, Ph.D. in related field, or an RN. All candidates must have a minimum of two years experience in a related behavioral health environment.

Primary functions will include:

- Participating as part of an interdisciplinary clinical team serving the member
- Coordinating member mental health and substance abuse care needs with community based behavioral health service providers
- Developing processes to coordinate mental health and substance abuse care between the member's primary care provider (PCP) and behavioral health service provider
- Promotion of best practices for the care of BH disorders in a primary care setting
- Coordinating mental health and substance abuse care with medically necessary services
- Conducts training with clinical team on behavioral health issues
- Acting as a liaison between medical plan, state entities, and the provider community

Our behavioral health coordinators will develop relationships with community based mental health service providers in order to develop policies, procedures and communications that will foster coordination and collaboration of care for our members in the following ways:

- Defining case management roles and collaboration following inpatient treatment
- Assuring communication and coordination between PCPs and behavioral health provider
- Assisting PCPs in making appropriate referrals for behavioral health services
- Conducting monthly joint operation committee meetings with the behavioral health providers
- Referring members to behavioral health providers based upon health assessments or as identified by inpatient and outpatient case management staff
- Addressing concerns regarding access to care appointments and any barriers to care encountered by

our members for behavioral health services

- Defining the roles of engagement for common physical/psychological illnesses

Coordination with the Statewide Management Organization for Behavioral Health

UnitedHealthcare Community Plan understands that DHH is in the process of preparing a Request for Proposal for a Statewide Management Organization for Behavioral Health. Once a vendor is selected, we plan to meet with the vendor to establish protocols for:

- Joint rounds for members who have co-occurring behavioral health and chronic medical conditions
- Joint care planning for individual members who are enrolled in care management programs both with us and the behavioral health vendor
- Monthly or quarterly meetings to address any systemic coordination of care or service issues
- Education of primary care providers and specialists on screening for behavioral health conditions and when to refer members for additional in-depth screening and treatment by a behavioral health provider

In other states, we have found that establishing specific protocols and interaction points with the behavioral health vendor as well as keeping the lines of communication open at all times keeps messages to providers and members consistent and also supports the most productive coordination of care.

Members in Behavioral Health Crisis

At times our staff receive a call from a member who is in a crisis. If a member threatens to harm self or others, or perceives him/herself to be in crisis, our staff are trained to connect the member to appropriate resources or even send emergency services such as police or ambulance to the member's location. Our protocol for addressing a behavioral health crisis includes:

- Obtaining as much information from the caller as possible, including name, location and telephone number
- Listening carefully to get as much detail as possible about the member's situation, including access to medications, firearms, etc
- Keeping the caller engaged while alerting a supervisor or manager of the situation
- The manager/supervisor will help assess the situation and determine if the member should be referred to a behavioral health resource, such as a state-run or behavioral health vendor access line through a warm transfer, with all parties remaining on the line until the transfer is complete
- Keeping the caller on the phone if emergency services need to be dispatched to the member's location

Our employees are trained to remain on the telephone line with the member until the member gets the resources necessary to address the crisis. We are aware that Louisiana is planning to release an RFP for a statewide vendor to manage Medicaid mental health care and we will work with the selected vendor to confirm specific protocols.

- ***Personal Care Services***

UnitedHealthcare Community Plan is one of the largest managers of Long Term Care and Personal Care Services in states such as Arizona, Texas, New Mexico, Hawaii, Tennessee, Florida and Massachusetts. We have significant experience with Home and Community Based Waiver programs and other Personal Care Services offered through State Medicaid Plan Amendments. We have experience working with providers such as AAA Personal Care Services and have a clear understanding of when Personal Care Services should be called upon to support a member. We understand that Personal Care Services are often necessary to support a member with a developmental or physical disability, a catastrophic medical

condition or one with multiple co-morbid conditions, in order to maintain the member in his or her own home. As part of our overall care management process and as part of the individual care plan, our nurses determine whether the member requires any additional services. If an evaluation of the need for personal care services is necessary, the care manager will make an appropriate referral for an evaluation. If the member is already receiving Personal Care Services, the care manager will request the member's consent to obtain information about the member's health status as the Personal Care Service provider is an excellent resource of information on the daily condition of the member. These services will support the member's activities of daily living including eating, dressing and ambulation assistance.

- ***Targeted Case Management***

For members who are enrolled in targeted Case Management services, UnitedHealthcare Community Plan care managers will coordinate closely with the assigned case manager, especially in terms of the individualized care plan and for members with a physical or developmental disability. With the member's, permission, the care manager will have regular contact with the targeted care manager so that they can update each other on the member's health status, the need for routine assessment of health status and routine care, and the need to help the member in accessing community resources and support. Many of our care managers are experts in a particular diagnosis (HIV, for example), with extensive education and training. They attend conferences and continuing education events and are often involved in community programs and activities related to that diagnosis, and can serve as a resource to targeted care managers.

F.4. For members who need home health services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas. (GSA C)

Coordinating Home Health Service Planning and Delivery

As part of care management services while a member is in an acute care hospital, our UM staff identify the need for home health services post discharge. If the member already has an assigned care manager due to enrollment in case management or Chronic/Disease Management, this care manager actively tracks the member during their acute stay and works with the UM staff and with the home health provider to ensure a smooth transition to home health services. If a care manager is not already assigned to the member, one is assigned to assist with transition to community based services. As part of transition, management efforts focus on five key areas for post discharge:

- ***Care:*** Is the individual receiving appropriate care for the condition?
- ***Self-Care:*** Does the individual understand how to best manage his/her care? Does the individual understand the underlying condition? Can community services or local support groups provide additional support?
- ***Medications:*** Does the individual have the medications the physician prescribed? Does he/she understand how to take them correctly? If not, can barriers to adherence be addressed?
- ***Access to Care:*** Does the individual have a primary physician who coordinates care? Is an appropriate specialist or sub-specialist monitoring the individual's progress?
- ***Equipment/Supplies:*** Does the individual need home care services, equipment or supplies that will allow him/her to better manage at home?

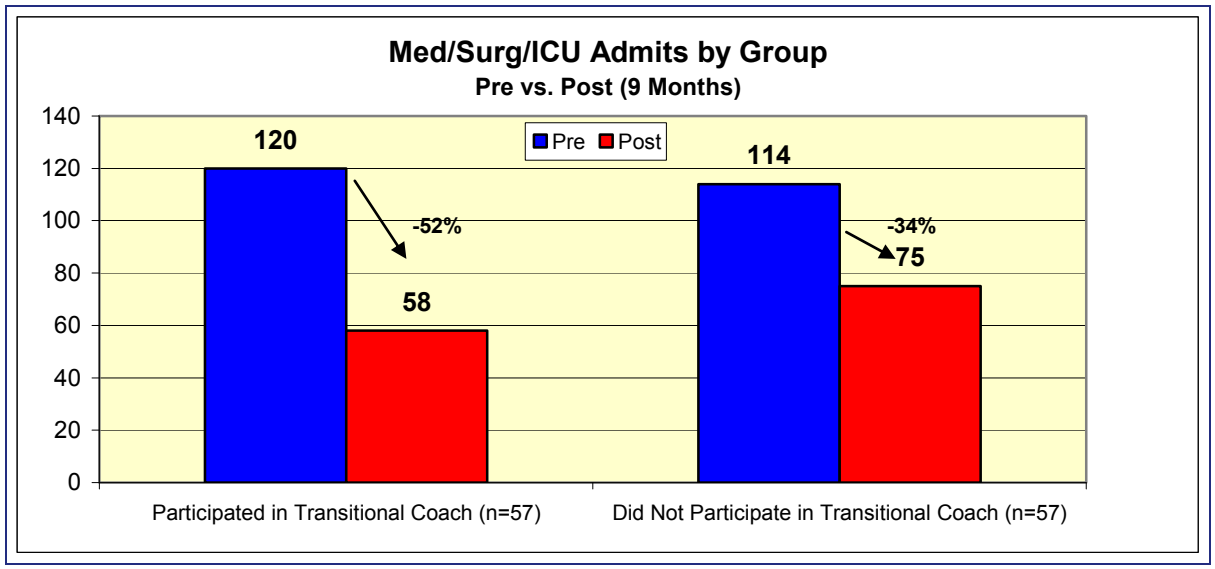
Our care management model provides an integrated approach to managing support for the member. Elements of this team include, Utilization Management, Behavioral Health Coordinators, Health Coaches, Transitional Coaches and care managers. The attention to members as they are admitted to an acute care facility is addressed within this model of care. To avoid issues during transition, we make every effort to

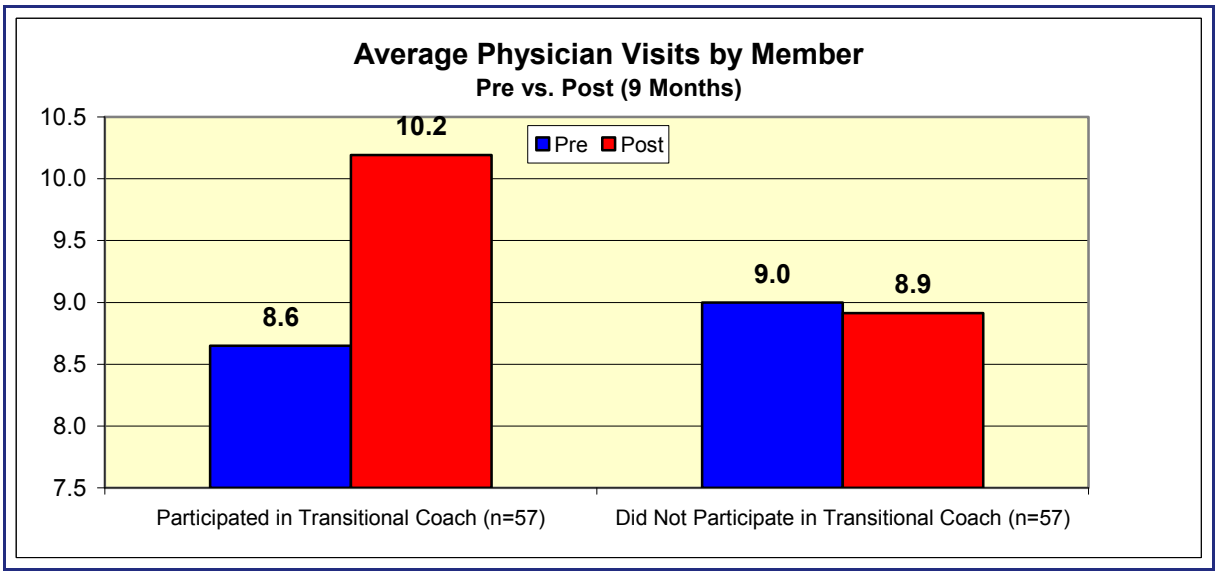
obtain information on the home situation and available family support. Our team works collaboratively to find community resources that allow the member to return home to a safe environment. We understand the psychosocial need for members to remain in their homes as long as possible. This approach appoints professionals with complementary skills for maximum contributions to the members needs. Our UM staff and the RN Discharge Planner discuss the transition plan and ongoing management is passed to the care manager at discharge. The care manager follows up to see that the member is receiving appropriate home health services after discharge and checks in with the home health agency as a key contact who is able to relate the member's health status. Having a provider visit the member in their homes is an opportunity to identify social or economical needs, support system or lack of, medication compliance and other services the member may need assistance with in order to access services and maintain community placement. Any issues or concerns identified both socially and medically, are communicated back to the UnitedHealthcare Community Plan care manager by the home health provider, to assist with coordinating services and supports the member needs to continue to live at home.

Transitional Coach Program

The Transitional Coach program provides a coach to members who are transitioning from hospital to home. This assistance includes a home assessment, a review of the member's medication, and the identification and arrangement of immediate services the member needs in the home. Our inpatient case managers will identify members who are in the hospital and begin discharge planning. The case manager will then refer the member to a Transitional Coach, a registered nurse, who will assist the member with their transition from hospital to home. The Transitional Coach will interview the member while in the hospital setting and then set up an appointment when the member returns home to conduct an assessment of the member's home environment. The Transitional Coach will also ensure that the member's prescriptions are filled, and the member is adhering to their medications, that the member has a follow-up appointment with his or her PCP, and that all other care coordination needs are arranged. This program will provide a level of intense discharge planning and follow-up to prevent long-term care admissions and decrease hospitalizations.

In Tennessee, we implemented the Transitional Coach program in 2009. During the 4-week transition program, patients with complex care needs and their family caregivers receive specific tools and work with a Transition Coach to learn self-management skills that will ensure their needs are met during the transition from hospital to home. Results from this program show both a decrease in inpatient admissions after coaching as compared to before and an increase in routine physician visits. Results were also favorable when comparing a control group which did not participate in Transitional Coaching with a group that did participate, as displayed in the following charts:





Monitoring Post Discharge Home Health Care for Members in Remote Areas

Monitoring of post discharge is accomplished through telephonic contact with the home care nurse for in-home evaluation and monitoring. A key aspect of the initial home health care visit includes a safety assessment, which identifies additional needs the member may require to maintain a safe environment. In addition, free cell phone programs through companies like Assurance Wireless and Safelink provide both a cellular telephone and a set number of free minutes each month, which can help members stay in touch with their providers and help us in monitoring the member and the services the member receives after discharge.

F.5 Aside from transportation, what specific measures will you take to ensure that members in rural parishes are able to access specialty care? Also address specifically how will you ensure members with disabilities have access? (GSA C)

UnitedHealthcare Community Plan will place an emphasis on coordination of care for members in rural parishes and members with disabilities and build accommodations into their individualized care plan for

transportation, any specific communication needs, and addressing any accessibility challenges faced at current provider sites.

Specialty Network in Rural Parishes

Our preferred strategy is to refer members to a contracted specialty provider that is qualified and available. If a contracted provider is not available, the following short-term interventions are taken:

- Referral to a non-contracted provider: Special provisions such as a letter of agreement are made with non-contracted providers to accommodate the member's needs until an equivalent provider is located, or if possible, a contract with the non-participating provider is secured.
- Referral to an out of state provider: A member may have to travel a shorter distance to see a provider who is across the state line. When necessary, we contract with providers just outside the state for this purpose.
- Centers of Excellence: We have contracts with Centers of Excellence around the U.S. which can offer specialty care to members when access closer to home is difficult.
- Recruitment of a new provider: To expedite the contracting process, providers recruited to fill a network gap are processed quickly through the use of a provisional and expedited credentialing process pending completion of the standard credentialing process. Our Chief Medical Officer may approve provisional credentialing applications within 14 days of receipt of the provider's completed application. Overall, our average credentialing turnaround time is 28 days. Upon the final approval of the provider by the UnitedHealth Care National Credentialing Center, UnitedHealthcare executes the provider agreement.
- Commercial Network providers: Because of our current presence in the state through commercial contracts, we can offer Medicaid members access to providers who may not choose to contract as part of our Medicaid network.
- Transportation of a member to a provider outside the member's community: If a provider is not available in the member's immediate community, we make arrangements for the member to temporarily receive care from a provider located in another community. This solution is generally used until an appropriate provider is available within the member's immediate community.

For members in active treatment, we ensure the member's care is not disrupted during the transition process. The case manager and Medical Management team work collaboratively with the Provider Network team to secure letters of agreement, if needed, if the member's current provider is not an UnitedHealthcare contracted provider. Our comprehensive continuity of care policies serve to reinforce our position that our members' needs come first.

Telemedicine

We will work to identify telemedicine solutions to expand access in the GSAs we serve. We understand that, through the Robert Wood Johnson Louisiana Rural Health Access Program, DHH has worked to expand access to telemedicine in underserved parishes. Telemedicine and distance learning sites are up and running in multiple locations in correctional facilities, Office of Youth Development facilities, Public Health facilities, private/community hospitals, state agencies/offices and other health care and educational facility locations. Our goal will be to support telemedicine access to enhance access to specialty care and follow-up care for members in rural and under-served areas and help us to monitor care for members in remote areas.

Telephonic Physician Services

Members who need to speak to a physician and have 24/7/365 access challenges can access telephonic physician services without leaving their house or waiting in the emergency room. This service is not intended to supplant the member's physician, but to be another layer of support. The member receives immediate access to a board-certified physician who will review their medical record and provide a

consult. The doctor will then recommend the right treatment for their medical issue and, if necessary, call in a prescription to the member's pharmacy of choice. This service allows members to resolve their issues immediately, be it after hours, for lab results or much more, without the use of urgent care clinics or emergency room visits. Physicians who provide telephonic services also coordinate with our members' PCP and specialty providers to ensure continuity of care.

In Tennessee, we are working with our PCPs to increase access to specialist through telemedicine. For PCPs who have telemedicine capabilities, we can arrange access to a specialist by having the member come to the PCP office and use the telemedicine link to attend an appointment with a specialist at another location.

Accommodations Individuals with Disabilities

Care Management Process

Individuals with disabilities would be considered "Individuals with Special Needs" according to DHH definitions. As such, they would be included in our care management program. As part of the care planning process, the care manager will work with member and provider(s) to identify any barriers to accessing care. If the member has a disability which is limiting access, we will strategize with the member and provider to address the barrier and facilitate routine care and monitoring for the member.

Network Access

Providers are required to comply with the American's with Disabilities Act (ADA) related to access to their facilities and offices and to attest to this. This includes requirements titled "Access to Medical Care for Individuals with Mobility Disabilities" which became effective in July of 2010. If a member files a complaint regarding access, our staff investigate the complaint and if the provider is found to be out of compliance with ADA, corrective action is required.

F.6 Detail the strategies you will use to influence the behavior of members to access health care resources appropriately and adapt healthier lifestyles. Include examples from your other Medicaid/CHIP managed care contracts as well as your plan for Louisiana Medicaid CCN members. (GSA C)

Strategies to Influence Behavior for Louisiana CCN Members

As stated previously, UnitedHealthcare Community Plan believes that it takes time and effort to build a trusting relationship with a member. This is why we make every attempt to keep the same care manager assigned to the member throughout the member's enrollment in any form or intensity of care management services. A trusting relationship, built through consistent contact and engagement with a member, fosters compliance with testing and treatment regimens and improvement of member health over time. The care manager and the member celebrate small and large successes and work hard together to solve problems when challenges or set backs are encountered. Over time, they become a team working toward the same goal along with the physician and member's family.

We also use readiness development tools to encourage member participation. We try to meet the member where he or she is at in their readiness for change and help support positive health and wellness choices. As stated in response to Question F.2, UnitedHealthcare Community Plan uses readiness development tools to encourage member participation. This includes using Prochaska's Transtheoretical Model of Change to assess the member's level of readiness to make the changes needed to improve health. This model dictates that, in order to be a positive and effective force in the member's life, the care manager must "meet the member where he/she is right now" rather than trying to push them to make changes the member is not ready for and will not yet accept. The member's state of readiness is tracked through the use of individualized care plans that are developed collaboratively with members and providers. Case management staff document the current status of each member within the continuum of change to ensure appropriate interactions. Inductive Call Anatomy is also used to engage members, because it trains our

staff to listen very carefully and strategize with the member and provider to support members' efforts on every step of their journey to accomplish health and wellness goals.

Value Added Services and Member Incentives

The following member incentives and enhanced benefits will be offered to Louisiana CCN members to reinforce and reward healthy behaviors:

- JOIN, a weight management program for obese children and teens
- Assistance for Asthmatics
- Healthy Habits for Life
- Food for Thought
- Get the Lead Out
- Heart Smart Sisters
- 4H Memberships
- Boys and Girls club memberships
- Start Walking
- 24 hour NurseLine
- Health First Steps
- Infant Care Book
- Baby Showers
- Diaper Rewards
- Home Health After Delivery
- Teladoc
- Text4Baby
- Annual Sports Physical
- Additional Vision Services.

Partnerships with Community and Faith Based Organizations

As described in response to Question F7 below, we have been actively working for many months to form partnerships with community and faith based organizations to support member health and wellness. We have already participated in and sponsored several community events focused on improving community health.

Health Coaching in All Levels of Care Management/Disease Management

We include a health coaching element designed to encourage members to life as healthy a lifestyle s possible. Telephonic and mail-based health coaching includes topic such as:

- Nutrition
- Exercise
- Stress
- Weight Management
- Tobacco Cessation
- Heart Healthy Lifestyle
- Diabetes Lifestyle.

Our care managers celebrate small successes and large accomplishments with members, and generate certificates of achievement for members who attain particular goals on a care plan.

In addition, our NurseLine and care managers can help support member decision making regarding medical procedures and medications. Our goal is to get members to the right care, at the right time, in the right setting.

Partnership with Walgreens in 143 Community Locations

UnitedHealthcare Community Plan and Walgreens have developed a strategic partnership in order to serve the residents of Louisiana; especially the patients served by the Louisiana Coordinated Care Network. This partnership is being formed to leverage the 143 Walgreens pharmacies throughout the entire State of Louisiana. With five Take Care Clinics currently open and the ability to expand within the 143 Walgreen retail pharmacies located in the State, there is significant potential for further clinic expansion. We anticipate using these sites to improve access to preventive, outpatient and urgent care services. At all locations throughout Louisiana, Walgreens provides consistent clinical support and therapy management to improve medication adherence levels, improve patient and physician satisfaction and improve clinical outcomes.

Our goal is to improve access to services, including Take Care Clinic-based wellness services, immunizations, health screenings and patient education. Walgreens is uniquely positioned to provide convenient health and wellness services, supported by member education and community outreach. We also plan to expand our presence within your at-risk population through the use of various outreach activities, such as Walgreens Wellness Buses and participation in community wellness activities, including health fairs and "Walk with Walgreens" events.

Our partnership will use Walgreens pharmacies and Take Care Clinics to administer childhood and adult immunizations and health risk assessments; including screenings in a targeted effort to improve HEDIS scores, as well as patient education in support of other health services. We intend to use our enterprise-wide assets to co-develop pharmacy-based patient outreach and education, gathering information from the patient to provide to the patient's medical home. Leveraging our technology, we can deliver customized point-of-care consultations that can be triggered for specific patients and patient attributes.

We can coordinate electronic data delivery to improve medical decision making and care delivery. In addition, we will collaborate to ensure patients go to the appropriate care provider in effort to divert inappropriate traffic away from emergency departments.

Universal Tracking Database

Our Universal Tracking Database (UTD) is a web based tool used by our staff to document and track preventative outreach activities to members and providers using HEDIS specific criteria. The UTD system allows look up by family link, so the care manager can educate the whole family on preventative services that are available, such as EPSDT services, well child visits, cancer screenings and adult wellness. Since this system is claims based, reporting is available to track and trend those members receiving education on the different measures and if the service was obtained within 60 days of education. The UTD uses HEDIS specific criteria including:

- Lead screening
- Well child visits
- Lead screenings in children
- Immunizations
- Annual dental exams
- Chlamydia screening for women
- Breast cancer screening
- Cervical cancer screening
- Comprehensive diabetes care
- Use of appropriate medications for individuals with asthma
- Colorectal cancer screening
- Cholesterol screening
- Controlling high blood pressure
- Glaucoma screening.

Upgrades to the system will soon allow ER tracking and education and State-specific elements to be added to the tool to encourage and monitor receipt of health and wellness services.

Involvement of the Primary Care Provider and Family

The member's primary care provider has a strong influence on member behavior change and we work to coordinate closely with the designated physician when developing and changing the care plan over time. We also invite providers to submit updates to the care plan online through our provider portal. In addition, our care managers often work with family members in development of the care plan and to encourage positive behavior changes in support of the member's health and wellness goals.

Gap in Care Notifications

UnitedHealthcare Community Plan analyzes claims/utilization data on an ongoing basis to detect variances from evidence based medicine guidelines. When such variances are detected, a letter is sent to the member and the physician noting this discrepancy and reinforcing the guidelines to be followed. These letters are followed up telephonically with the member to reinforce the benefits of following evidence based medicine recommendations in improving overall health over time

Examples from other Managed Care Contracts

While there is always some degree of customization to meet state specific needs, we use most of the strategies above in our programs in other states where we operate Medicaid managed care plans.

F.7 Many faith based, social and civic groups, resident associations, and other community-based organizations now feature health education and outreach activities, incorporate health education in their events, and provide direct medical services (e.g., through visiting nurses, etc.). Describe what specific ways would you leverage these resources to support the health and wellness of your members. (GSA C)

Leveraging Resources on a Program-Wide Basis Through Building Relationships and Partnerships

UnitedHealthcare Community Plan has been in Louisiana for many years building relationships with providers and communities through programs or current customers such as Tulane University, Shaw, Dupre and the City of Shreveport. Since mid-2010, we have focused on outreach for the Medicaid program, meeting with key community organizations including faith based, social and civic groups, resident associations and other community based organizations. So far, we have met with more than 75 community and faith based organizations, leaders and stakeholders. These organizations include, but not limited to:

- YMCA
- YWCA
- Catholic Charities
- Family Road of Greater Baton Rouge
- Boys & Girls Clubs
- FQHCs
- March of Dimes
- Several individuals churches
- School system representatives
- Scotlandville Community Development Corporation
- Southwest Louisiana AHEC
- Urban Restoration Enhancement Corporation
- Parents as Teachers Louisiana State Leader Center for Families
- AARP Louisiana
- LSU AgCenter 4H Club
- Southern University School of Agriculture
- National Kidney Foundation of Louisiana
- Walgreens We Care Days.

Our goal in these meetings has been first to listen to the challenges these organizations have faced in their efforts to improve the health of Louisiana residents and second to work cooperatively with them to detail ways in which we can support and complement their existing efforts. For example, in April, UnitedHealthcare Community Plan helped sponsor the Storybook Ball a fundraiser to benefit Family Road of Greater Baton Rouge. Their programs range from the Healthy Start Program which provides case management, home visitation, and community

education to expecting mothers and their families up to age 2 to fatherhood and couples programs. They provide breastfeeding classes, nutrition classes, car seat safety, safety in the home, classes on childbirth and after baby comes to prepare parents on what to expect and how to care for their infant. They also provide classes and programs on baby blues, post-partum depression, communication skills between parents, HIV and pregnancy, mental health and pregnancy, interconceptional care, SIDS classes and awareness. In addition, they work with teens for pregnancy prevention and teens who are pregnant to ensure healthy birth outcomes and goal planning/action plan for the teen parents.

In June, we sponsored Baton Rouge's Community against Drugs and Violence (CADAV) annual Health Fair and Pre-Juneteenth celebration in Scotlandvile Park. CADAV's mission is to combat drugs, violence and create a safer environment for children and families. Community empowerment is used as a tool as well as partnerships to enhance educational and economic opportunities. Throughout the year, CADAV activities focus on improving the health and safety of the local community.

We are also teaming up with the YWCA on their Family Empowerment Program to support healthy family initiatives such as food choices and exercise. We also sponsored a YMCA Mother Daughter Luncheon in May where they held their first ever combined health education event where we presented on UnitedHealthcare's Heart Smart Sisters Program. Heart Smart Sisters is designed to provide education to women about heard disease and relies heavily on faith- and community-based organizations to reach women who may be at risk for heart disease. Many of these organizations have written letters of support for our proposal, such as: Catholic Charities – Diocese of Baton Rouge, YWCA of Greater Baton Rouge, YMCA of the Capitol Area, AARP – Baton Rouge, North Baton Rouge Women's Help Center and March of Dimes Louisiana Chapter. These letters are available for review upon request.

Plans for Ongoing Community Partnerships

In addition to continuing to find ways to partner with community organizations to sponsor and promote their current health and wellness initiatives, UnitedHealthcare Community Plan will to continue to work with faith based, social and civic groups, resident associations, and other community-based organization to offer the following programs:

Fit Cities

UnitedHealthcare Community Plan will continue to support the Fit Cities Challenge, a community based effort in Shreveport whose mission is "To inspire and challenge individuals, families, businesses and schools in our communities to take the first of many steps toward healthier lifestyles. To educate our residents by providing information that highlights programs, activities, tips and tools with which to fight obesity and unhealthy lifestyles." Partners in the Fit Cities Challenge include YMCA, Boys & Girls Club, Salvation Army, American Heart Association, schools, health systems, small businesses and other community organizations. These organizations work together to educate families and inspire them to make healthy choices. UnitedHealthcare will be sponsoring the first ever Fit Cities community wide health promotions and wellness screening event in the fall.

ENCOREplus

We have made connection with and plan to partner with the Encoreplus YMCA outreach efforts. The

mission of the ENCOREplus program is to raise awareness of breast and cervical cancer and to reduce the impact of these cancers on the lives of medically underserved women in the Greater Baton Rouge area. ENCOREplus is a community based outreach program that provides medically underserved women with breast and cervical education, screening referral services, and support services. ENCOREplus was created by the YWCA of the USA to reach out to all women who face obstacles to getting high quality, affordable breast and cervical exams. ENCOREplus is run by women for women, enriched by the YWCA's long tradition of supporting women in every aspect of their lives.

Heart Smart Sisters

Heart disease is the leading cause of death among women; more women die of heart disease than breast cancer, stroke and lung cancer combined. We plan to continue to work with faith-based and other community organizations to disseminate Heart Smart Sisters, an innovative program designed to educate women of color about the risk factors for developing heart disease and empower them to make the necessary lifestyle changes to improve their individual health status and reduce the overall incidence of heart disease. The YWCA, YMCA and Walgreens have agreed to be our partners in these critical efforts to empower the women of Louisiana to proactively take charge of their health and know their "numbers" and how to make healthy food choices for their families.

Healthy First Steps

We plan to collaborate with the March of Dimes NICU Family Support program and our Healthy First Steps program, which have very similar goals. Nationally, UnitedHealthcare has a strong partnership with the March of Dimes. At the end of 2009, their NICU family support program was implemented in 94 NICUs nationwide, providing information and support to over 63,700 families. Women's Hospital was the first site in Louisiana to host the program, and it is now in its fifth year. Building on the tremendous successes of the program at Women's Hospital, the Louisiana Chapter implemented a second NICU Family Support Program at Ochsner Foundation Hospital in New Orleans in January 2008. We are supporting the program at the Women's Hospital.

The March of Dimes NICU Family Support Program has several components that make it effective. These include a part-time (30 hours) March of Dimes NICU Family Support Specialist working with NICU families and staff, a volunteer action committee made up of hospital staff and former NICU families who guide program development, a base of direct service volunteers, a Parent Care Kit comprised of informative materials available to every NICU family, and Customized Modules developed to serve the needs of the Ochsner Foundation Hospital NICU and the populations it supports.

Together Baton Rouge

With a collective membership of over 30,000 people, Together Baton Rouge is one of the largest and most diverse coalitions of religious and civic institutions in the history of Baton Rouge. Together Baton Rouge has three basic goals: (1) to build relationships across our community based on trust and a willingness to listen to each other; (2) to equip members and leadership with skills and practices to get results; and (3) to achieve change on concrete issues, as part of a common call to justice. Members include congregations from the National Baptist, Southern Baptist, Catholic, Episcopal, United

Methodist, African Methodist Episcopal, Muslim, Full Gospel, non-denominational, Presbyterian and Unitarian denominations, civic associations, professional organizations and universities.

JOIN Obesity Program

The JOIN program is designed to help families and children who struggle with weight and weight management. Community partnerships are vital to the success of this program, as referrals to this program come from providers and community organizations and the program is delivered at community sites. This intervention is offered to children between the ages of 6 and 17 who also have a BMI percentage greater than the 85th and are able to actively participate in a group setting. We team with community organizations such as the local YMCA to deliver group sessions for children/teens and their families. The program design follows a 16 week course that encourages practiced and research based focused activities and strategies. These allow children/teens and their families to learn techniques for achieving a healthy weight. Our primary goal is to help children and teens reduce excess weight and prevent the progressing to adult complications at a later stage. Adult complications can include diabetes, heart attack, stroke, kidney failure, blindness and amputations. The JOIN program supports primary care physicians in current patient care, while improving health outcomes and reducing medical costs over time.

Diabetes Prevention and Control Alliance

The Diabetes Prevention and Control Alliance offers access to the Centers for Disease Control and Prevention's (CDC) evidence-based Diabetes Prevention Program (DPP) through local community providers, and the Diabetes Control Program (DCP) that delivers additional points of routine diabetes care and complication prophylaxis via local pharmacists. Services are provided through partnerships with local organizations such as the YMCA for pre-diabetic members and local pharmacies for diabetic members. Through community organizations such as the YMCA, we can offer a 16-session program, one hour per week in a group setting. This program uses behavior modification and a "team spirit" to increase the chance for success. We focus on "achievable goals" through healthy eating and moderate physical activity. The program is offered at multiple neighborhood locations to allow easy, convenient access for members. This program has been rigorously tested and is endorsed by Centers for Disease Control (CDC).

Sesame Street Food for Thought

This program is a collaboration between UnitedHealthcare and Sesame Workshop. This collaboration leverages the power of the beloved Sesame Street characters to provide families with information so they are better equipped to cope with the impact of food insecurity (limited or uncertain accessibility to enough food to fully meet basic needs because of financial issues). The partnership also aims to address childhood obesity and improve the health of members and the community. Food for Thought kits with an original DVD starring the Sesame Street Muppets, including the Super Foods, and a documentary showing families with children using a variety of strategies for maintaining Healthy Habits for Life despite limited financial resources. Food for Thought kits also include a parent/caregiver guide, child-friendly recipes, and a children's storybook and offers tools and resources to help families make choices that that lead to healthy growth.

4-H Youth Voice: Youth Choice Program

Together with 4-H, we have launched the Youth Voice: Youth Choice program in underserved communities in Texas, Florida and Mississippi. In addition to funding the program, our employees participate in local community events to support this initiative. The focus of this program is to develop

healthy living habits through community level activities such as after school programs, health fairs, educational forums, clubs, camps, etc. The youth who participate are encouraged to take action to improve the health of their families and communities. This partnership with the 4-H, helps to reach more than 6 million youth who are already involved in 4-H programs.

Lead Away and A is for Asthma

UnitedHealthcare also supports Sesame Workshop's Lead Away and A is for Asthma initiatives to increase awareness on lead poisoning prevention and to help families proactively handle children's asthma. A is for Asthma helps children with asthma understand what asthma is, what to do when they have trouble breathing, and how to live a fun and active lifestyle when diagnosed with asthma. Lead Away is an initiative aimed at educating parents about the serious health risks posed by exposure to asthma and how to reduce risk of exposure and obtain screening if needed. Partnerships with community organizations are key to raising awareness about the Lead Away and A is for Asthma programs and to linking parents and children to free educational materials, which include posters, activity pages, booklets, etc.

"A" Is for Asthma – and for Active!

HEROES Program

The UnitedHealth HEROES program is a service-learning, health literacy initiative developed by UnitedHealth Group and Youth Service America. The program awards grants to help youth, ages 5-25, create and implement local, hands-on programs to fight childhood obesity. Each grant engages participating youth in service-learning, an effective teaching and learning strategy that supports student learning, academic achievement, and workplace readiness. The grants encourage semester-long projects that launch on Martin Luther King, Jr. Day of Service (January) and culminate on Global Youth Service Day (April). Through the UnitedHealth HEROES program, UnitedHealth Group provides micro-grants of up to $1,000 to schools and community centers in all 50 states for service-learning projects that engage and educate young people on the issue of obesity.

Cooperative Planning and Presentations

Together with community based organizations such as Together Baton Rouge, the public school system, March of Dimes, YMCA, YWCA and other organizations, we will find ways to provide education to help prevent and limit the effects of illness and support to help those who already have at least one chronic health conditions. Our local staff will offer to present programs or meet with clients of organizations that also serve Medicaid beneficiaries who may be high cost or high risk such as homeless shelters, community food banks, housing agencies, senior centers, and churches, synagogues and mosques.

We can also become involved at local level events with onsite Health Coaching, biometric screening events, health fairs and flu vaccination clinics. At the events, care managers will be able to provide individualized review of screening results, engage consumers in other health and wellness programs and respond to questions regarding literature, online portal content or any other health information.

Volunteering and Volunteer Matching Funds

A total of 77 percent of UnitedHealth Group employees volunteer their time to charitable and nonprofit programs. We logged more than 200,000 hours of volunteer service in 2010, with an estimated value of more than $4.2 million. Our staff are encouraged to volunteer their time with the community organization of their choice. As an added incentive, when an employee logs a minimum number of volunteer hours, UnitedHealthcare matches that volunteer time with a financial contribution to the community organization of the employee's choosing. In this way, our employees are able to enhance the benefit of their volunteering efforts. As we implement the Louisiana CCN, we expect our local employees will leverage this program to get additional funding to the community organizations they support.

Leveraging Community Resources for Individual Members

For members who are enrolled in case management or chronic condition/disease management, access to community support resources can be a key factor in maintaining or improving health and even in their ability to continue to live independently in their homes. We maintain a database of community resources for this purpose. Our staff is well versed in community and area specific information as well as state specific Medicaid benefits, no cost or low cost resources, participation in local affiliations - such as the diabetes association, American heart association, WIC program, Nurse-Family Partnership, etc.

The care manager will help the client and the client's family coordinate all treatment services and supports based upon a care plan designed by the individual and their care team. An important part of the care manager's responsibility will be to help the member accept responsibility for managing his or her own condition and maintain a healthy lifestyle. Family members and other natural supports also will be instrumental in helping clients benefit from community resources and live the most independent lifestyle practical based on the member's condition(s). If segments of the care plan are not working as agreed upon by the member, the care manager and the team, the member can request the care manager's intervention with service providers ranging from the member's medical home to a family member. Care managers will also inform members about any locally based support groups available or resources they are aware of that may be beneficial.

NurseLine RNs also access the community resources database as well as plan and state-based web tools to connect members with high-level community resources including FQHCs, transportation programs and benefit eligibility offices. NurseLine is available to members 24 hours a day, 365 days a year.

Community Resource Database

The community partnerships we have in place and continue to build are vital in helping us compile a comprehensive database of community resources. A designated member of our team will be responsible for updating our existing database of community resources with any additional available local and statewide resources. This database, which will be accessible to all those working with members, will include information on the service provided, location(s), contact names and numbers. One important responsibility of each care manager and Network staff will be to update the Community Resources Database every time they learn of a new service or program so that we can offer as many options and supports to members in their local communities as possible.

F.8 Submit a statement of any moral and religious objections to providing any services covered under Section §6 of RFP. If moral and religious objections are identified describe, in as much detail as possible, all direct and related services that are objectionable. Provide a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc. If none, so state. Describe your plans to provide these services (e.g. birth control) to members who are entitled to such services. (GSA C)

UnitedHealthcare Community Plan, Louisiana has no moral or religious objection to providing the services covered under Section 6 of this RFP.

Our plan regarding the services herein listed is to work with physicians and other qualified care providers in our network to provide quality care in all the areas where members are eligible.

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Section G: Provider Network (Section 7 of RFP)

G.1 Provide a listing of the proposed provider network using the List of Required In-Network Providers as described in this RFP, including only those providers with whom you have obtained a signed LOI or executed subcontract. LOIs and signed subcontracts will receive equal consideration. LOIs and subcontracts should NOT be submitted with the proposal. DHH may verify any or all referenced LOIs or contracts. Along with the provider listing, provide the number of potential linkages per PCP.

The CCN should provide an Excel spreadsheet of their proposed provider network and include the following information: (Sample spreadsheet is available in the Procurement Library)

1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.

2. Practice Name/Provider Name - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.

3. Business Location Address - Indicate the business location address where services are provided including but not limited to, 1st line of address, 2nd line of address, City, State, Postal Code

4. Provider Type and Specialty Code - Indicate the practitioner's specialty using Medicaid Provider Type and Specialty Codes.

5. New Patient - Indicate whether or not the provider is accepting new patients.

6. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 19, indicate < 19; if a physician only sees patients age 13 or above, indicate > 13.

7. If PCP - the number of potential linkages.

8. If LOI or contract executed.

9. Designate if Significant Traditional Provider.

10. GEO coding for this location. (GSA C)

Provider Network Listing

For more than 15 years, UnitedHealthcare has worked with 8,900 Louisiana physicians and 161 hospitals providing health care services to more than 380,000 Louisiana citizens. **By amending our existing contracts to add the Medicaid product line, 1,958 credentialed physicians have agreed to work with us as contracted providers for Medicaid and via LOIs, 25 hospitals and 442 physicians have agreed to engage in discussions to become contracted providers for Medicaid.** Through our contracts and provider orientations we will ensure that each provider is aware of the unique features and requirements of the Medicaid program including access, copayments, balance billing and reporting.

Our experience in caring for underserved populations as health plan partners for other state Medicaid programs provides us unique insight of the value a strong provider network offers to CCN members.

We have established relationships with a large number of significant traditional Medicaid providers via contracts or LOIs as part of our strategy in building a successful network. UnitedHealthcare has served

rural regions throughout the state for years and this local knowledge coupled with our rural market experience in other state Medicaid programs provides us with a unique understanding of the distinct needs of both providers and members in rural communities.

We are engaged in an ongoing process to recruit providers and will continue our network building activities after submission of our RFP response to ensure we meet or exceed network requirements for the CCN program. Despite a general reluctance on the part of many providers to sign LOIs or contract amendments, until DHH announces entities awarded contracts, we are confident we will have a robust, quality network of committed providers by the required deadline.

We are also confident that contracting and credentialing tasks accomplished to date–along with our ongoing network development activities and substantial operational infrastructure–will enable us to successfully launch networks that meet the requirements to participate as a CCN in every GSA and that will meet the individual needs of the members we will serve.

A listing of the proposed provider network using the List of Required In-Network and Allowable Out-of-Network Providers as described in this RFP has been provided per your request as Attachment G.1.a. Attachment G.1 also provides the number of potential linkages per PCP.

Using providers, with whom you have signed letters of intent or executed contracts, provide individual GeoAccess maps and coding by GSA. for: 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) Specialists. You should provide individual maps as well as overlay maps to demonstrate distance relationships between provider types.

GeoAccess Maps

GeoAccess maps and coding by GSA for 1) hospitals, 2) primary care providers, FQHCs, and RHCs; and 3) specialists, has been provided as Attachment G.1.b per your request.

G.2 Describe how you will provide tertiary care providers including trauma centers, burn centers, children's hospital, Level III maternity care; Level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If you do not have a full range of tertiary care providers describe how the services will be provided including transfer protocols and arrangements with out of network facilities. (GSA C)

Providing Tertiary Care

Once members have been identified, our Hospitality and Reminder Center (HARC) team places outreach calls to members to complete the HRA, ascertain PCP, provider information and care transition needs. That information is then sent to the Intake, Prior Auth teams for input into CareOne. Also, should the HARC team identify any needs for care management resources, this information would be sent via our CareOne system to care management teams for review and action.

Care managers will coordinate the transition process of our members into UnitedHealthcare Community Plan. The care manager will request records from the member's prior care manager (including Comprehensive Health Status Assessment or equivalent results) and facilitate the transfer of medical records to a PCP, if necessary. We will support initiatives to work with the other Louisiana health plans to develop standardized transition forms and protocols.

Process for Identifying Existing Services

At program start-up and for any new members who are entering from the Medicaid fee-for-service system, we will honor all prior authorizations from DHH or its designees for 60 days so that there are no disruptions in services or treatment. Leading up to implementation, we will work with HHC to obtain information on prior authorizations and identify individuals with especially critical ongoing service for

close monitoring (for example, individuals dependent on home delivery of oxygen). For those individuals, we will prioritize assessments and contact providers to assure them that UnitedHealthcare will reimburse them for services during the transition period.

We authorize a member's existing out-of-network providers for medically necessary or functionally necessary services until the member's records, clinical information and care can be transferred to a network provider. We will authorize all medically necessary covered services without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. UnitedHealthcare will provide for the continuation of these services for the lesser of 90 days or until the member has completed the Health Risk Assessment or Comprehensive Health Status Assessment. As necessary we enter into single case agreements with out-of-network providers to ensure members' services are not interrupted during transition or to support a plan of care that cannot be met with a network provider.

Process for Transferring from Out-of-Network to In-Network Providers of Service

Member services or the care management team will conduct outreach to those members who have out-of-network providers. Our care management team conducts outreach to member to discuss potential transition to an in-network provider and provides the member with a listing of appropriate types and specialties of providers. Once they decide on a provider, our care management team works with the member to schedule an appointment with the new in-network provider. Provider services/care management team notifies the prior authorization team of change to in-network provider, and the out-of-network provider is notified of discontinuation of services. Our contractual relationships with Medicaid providers in Texas and Mississippi enhances our ability to coordinate care with out-of-f-state providers

G.3 Describe how you will handle the potential loss (i.e., contract termination, closure) in a GSA of a) a hospital and b) all providers within a certain specialty. (GSA C)

Monitoring Providers with Known Viability Problems or Potential for Closure

The ability to recognize and respond to potential critical gaps in service in a timely manner occurs through interdepartmental cooperation. Communication between all departments is critical in the process of developing immediate interventions that ensure that members receive medically necessary care within an appropriate length of time.

We maintain policies and procedures designed to ensure that:

- Ongoing monitoring of the potential for network disruption occurs so that, whenever possible, the disruption can be averted or its impact minimized
- Members receive adequate and timely care during periods of temporary network disruption, including health care facility closure(s) or loss of major provider(s)
- Post-disruption processes, including payment of claims, are addressed and that operational, financial reconciliation, member reconciliation, and claims payment issues are minimized when the network returns to normal.

These policies and procedures are incorporated in UnitedHealthcare Community Plan's Business Continuity Plan (BCP) as submitted to and approved by DHH, along with instructions for handling emergencies and disasters affecting UnitedHealthcare Community Plan's facilities and internal operations. The most recent BCP test was completed in January 2011. Below we summarize our policies and procedures relating to monitoring and potential for handling network disruption.

UnitedHealthcare Community Plan closely monitors providers with known viability problems. There are several areas that can signal problems:

- Notification from DHH or CMS of sanctions or potential sanctions
- Failure to obtain required insurance
- Complaints raised by members, family members, or caregivers or concerns brought to the attention of UnitedHealthcare Community Plan by facility employees
- Financial triggers – Requests for cash advances, filing of bankruptcy, communication from employees that they are not being paid, etc.

UnitedHealthcare Community Plan takes the following steps when a potential closure is suspected:

- Send a case manager to the facility to assess and make observations and have Provider Services contact the facility to discuss the concerns
- Request a corrective action plan, if warranted
- Cease new member placement to the facility
- Possible termination of the Contract.

Potential Hospital Loss in a GSA

Loss of Hospital Due to Contract Termination

In the event of a contract termination by a hospital, UnitedHealthcare Community Plan generally would have significant advance notice prior to the effective date of the termination. UnitedHealthcare Community Plan adheres to the requirement that it provide facilities and provider groups 90 days notice prior to a contract termination without cause.

Notice to members of Provider Termination

UnitedHealthcare Community Plan maintains procedures for notifying members in the event of contract termination or modifications affecting a facility or provider group, the highlights include:

- If UnitedHealthcare Community Plan receives timely notice at least 30 days written notice from a provider, we will notify the member in writing at least 15 calendar days of the receipt of the termination notice from the provider. For PCP terminations, members will be informed that UnitedHealthcare Community Plan has selected a new PCP for the member and that the member may change the selection by calling member Services.
- If UnitedHealthcare Community Plan does not receive timely notice from a provider in order to notify affected members 15 calendar days prior, our member Services staff will immediately reassign all affected members, effective no later than the day following the termination. A letter will be sent to members within 10 calendar days (from the date UnitedHealthcare Community Plan becomes aware of such and it is prior to the change occurring) of the assignment with the practitioner's name, address, telephone number and effective date with that provider.
- If UnitedHealthcare Community Plan makes a change that impacts the provider network that is not related to a provider termination, UnitedHealthcare Community Plan will inform the member of the change 30 calendar days prior to implementation.
- UnitedHealthcare Community Plan understands that failure to provide timely notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify us, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon UnitedHealthcare Community Plan becoming aware of the circumstances.

UnitedHealthcare Community Plan will notify providers, in writing or electronically, 30 calendar days in advance of a material change to our network composition that may affect the providers' ability to refer or place members for specialty care. Such notice will also be provided to the DHH Division of Health Care Management Operations and Compliance Officer 45 calendar days in advance of the proposed change.

Loss of Hospital Due to Unexpected Closure

In the event of an unanticipated loss of access to an inpatient facility, the UnitedHealthcare Community Plan leadership team would convene to develop and execute a situation specific plan of action. The following processes and action items are illustrative and can be adjusted to meet the needs of specific situation:

- UnitedHealthcare Community Plan is notified/discovers health care facility loss due to unexpected closure or natural disaster and the leadership convenes immediately to assess the situation
- Our UnitedHealthcare Community Plan Compliance Officer notifies CCN of closure and the Director, Medical Management or designee coordinates with facility representative to determine members, level of care and acuity level to develop transition plan
- The Director, Medical Management or designee coordinates with facility representative to notify affected members and identify, locate and notify family members about transition plan and the Director, Medical Management and Chief Medical Officer collaborate with the affected facility to evaluate the needs of our membership and create a safe and suitable transfer plan
- Provider Networking assists with contacting surrounding facilities to evaluate bed capacity and Medical Management notifies the member's PCP of the transition plan
- Medical Management collaborates with the facility to coordinate emergency medical transports for our members and the Director of member Services coordinates non-emergency medical transportation and team leaders reassign concurrent review nurses to receiving facilities as appropriate to balance workload
- Concurrent review nurse coordinates with receiving facility/team to ensure that patient history and other relevant information is available and creates a case in the medical management system to reflect admission to new facility
- Concurrent review and discharge planning is continued by our staff at the receiving facility and nurses are reassigned appropriately as conditions normalize.

UnitedHealthcare's TennCare Handles Potential Loss

Powerful thunderstorms drenched much of Tennessee in May of 2010, dumping over 13 inches of rain on the region in two days. UnitedHealthcare Community Plan's TennCare responded to the Nashville floods by operationalizing an emergency action plan. With respect to member-specific outreach, on Sunday May 1, within 24 hours of the disaster announcement, UnitedHealthcare Community Plan launched an outbound call campaign to verify member safety, provide news, disseminate information about local resources, ensure continuity of care, communicate an additional flood response command center toll-free number to expedite any additional needs or arrange for face-to-face visits where necessary. This outbound call campaign targeted staff, members and facilities, TennCare private duty nursing and members. In addition to the outbound call campaign, UnitedHealthcare Community Plan's customer service call center and health services departments were available for extended hours to ensure the seamless provision of services. **Our main goal was to take care of our members.** This included:

- ***Coordinating additional assistance:*** If a member discovered they had lost their ID card, they could contact the UnitedHealthcare Community Plan toll-free customer service number at 800-690-1606 to request a replacement. Additionally, if a member was seeking assistance with a contracted provider without their ID card, the provider called the UnitedHealthcare Community Plan toll free customer service number to verify enrollment. Our staff was acutely aware that members may have not had their card and were committed to ensuring that any member or provider who contacted us receive the verification they needed to receive services.
- ***Coordinated lost Durable Medical Equipment (DME) and /or other medical supplies:*** UnitedHealthcare Community Plan conducted an outbound phone campaign immediately to members in impacted areas to ensure their safety, identify any care needs, provide news, disseminate

information and coordinate additional assistance (including the replacement of DME or medical supplies) where necessary. If a member discovered he or she had lost his or her Durable Medical Equipment (DME) or other medical supplies, he or she called the toll free customer service number or his or her care coordinator/case manager to replace their equipment at no cost. Replacement supplies were not counted against benefit limits. UnitedHealthcare Community Plan utilization management staff had been instructed to accept all requests for equipment replacement and accept the member's or provider's report as "lost in flood" as evidence that the equipment was lost and needed replacement. We did not count lost supplies or DME replacement against monthly limits.

- ***Coordinated private duty nursing care, home health care or therapies:*** members continued to receive these services even if the member was displaced. We conducted an extensive outbound call campaign to our members who were impacted by the floods to ensure their safety and ensure there is no disruption in care. Many of the members contacted during the first few days of the flood were very pleased that we had made the effort to reach them and thanked us for verifying they were safe and services were continuing. **We coordinated with three nursing homes to evacuate members and all of whom had returned to their homes.** We continuously and actively managed the member's care during their displacement and their re-entry into their original nursing home.
- ***Coordinated locating members in the community who were displaced:*** UnitedHealthcare diligently worked to update its systems with new member locations. CHOICES care coordinators and home health/private duty nursing clinical staff completed outreach calls and updated the internal clinical system with call notes regarding member needs and member locations. The call center staff, who also was engaged in outbound calls, provided updates to the clinical team and all changes were noted in UnitedHealthcare's internal system. Additionally, providers collaborated with the Care Management Associates (CMA) team to update member locations when the providers were contacted regarding changes.
- ***Coordinated assistance with transportation to and from providers in light of flood-related difficulties:*** UnitedHealthcare continued to assist members in securing transportation to and from providers. While UnitedHealthcare could not arrange transportation into certain areas due to road closure or into neighborhoods which were still considered unsafe or hazardous, members could access transportation assistance by calling the UnitedHealthcare toll free customer service number.
- ***Coordinated communication with members:*** UnitedHealthcare continued to contact members via phone calls, direct mail, email (if known) and in some instances, direct contact with the members or their providers, to ensure their safety and continuity of care during this difficult time.
- ***Coordinated the procedure for billing a member at the in-network rate if the member had to see an out-of-network provider due to the disaster:*** UnitedHealthcare does not balance bill the member for any services including but not limited to out of network services or referral fees. UnitedHealthcare did not require a referral to any in-network specialists and worked with any member or out of network provider during the immediate post flood period to ensure that medically necessary care was provided. This included negotiation of single case agreements if necessary to ensure our members were not billed by out of network providers.
- ***Coordinated mental health services in light of the disaster:*** In addition to the initial outbound calls to behavioral health members, UnitedHealthcare had anticipated the need for increased mental health support within the communities impacted by the disaster. UnitedHealthcare worked with community organizations to promote and disseminate information about the toll free mental health support line. Promotion of this service was through community organizations, outbound phone campaigns and social media channels. This service is available to all members and the community at-large. UnitedHealthcare also reached out to mental health facilities in the affected areas to determine if they needed assistance and worked with them to identify alternative locations.
- ***Coordinated early prescription refills:*** members who had been displaced or did not have access to their medications, could call and identify that they have been affected by the floods. They could have

prescription medications filled if they had refills remaining on file at a participating retail or mail-order pharmacy.

Through a $500,000 annual commitment, UnitedHealthcare Community Plan participated in the Annual Disaster Giving Program of the American Red Cross, which is offered shelter, food, emotional support and other assistance to people in the affected communities.

Loss of All Providers within a Certain Specialty

UnitedHealthcare Community Plan continually works with both hospitals and providers to ensure needed care is provided within our contracted network of providers. With our Louisiana network, we expect a small volume of out-of-network service requests. However, there are times that it is necessary to provide for care outside of our network. When these requests are made, our Medical Management Team reviews cases on an individual basis and considers the needs of the member in relation to the available network of providers. We will make provisions for the use of out-of-network services when the contracted network cannot meet the needs of the member. With our commercial, Medicare and Medicaid services, we have contracted relationships with more than 24,000 providers in Louisiana that may be accessed outside of the CNN network for certain specialty services. In those instances, our network department generates a single case agreement to cover that case, and the provider is generally aware of how to work with us. In the instance we need to access a non-participating provider, we would also issue a single case agreement and supply the provider with more detailed information regarding our clinical and billing practices.

If we identify a pattern of out-of-network utilization due to a gap in our network, our Network Development staff approaches the provider identified for inclusion in the network. We recognize that there will be some specialty providers who will be unwilling to join our network so we will continue to provide access on an out-of-network basis to meet the needs of our members until the specialty care gap is cured.

Ensuring that members Receive Medically Necessary Services

UnitedHealthcare Community Plan recognizes it is our responsibility to provide our members with accessible services and providers, regardless of the ebbs and flows of contracts with providers. When a network gap occurs, we take immediate steps to address the gap so that a member's care is not compromised. Our Provider Services department, in collaboration with the Medical Management department, Chief Medical Officer and other involved parties, immediately assess the availability of other providers in the community. The preferred intervention strategy is to refer the member to another contracted provider that is qualified and available. If a contracted provider is not available, the following short-term interventions are taken:

- ***Referral to a non-contracted provider:*** Special provisions such as a letter of agreement are made with non-contracted providers to accommodate the member's needs until an equivalent provider is located, or if possible, a contract with the non-participating provider is secured.
- ***Recruitment of a new provider:*** To expedite the contracting process, providers recruited to fill a network gap are processed quickly through the use of a provisional and expedited credentialing process pending completion of the standard credentialing process. The Chief Medical Officer may approve provisional credentialing applications within 14 days of receipt of the provider's completed application. Overall, our average credentialing turnaround time is 28 days. Upon the final approval of the provider by the UnitedHealth Care National Credentialing Center, UnitedHealthcare Community Plan executes the provider agreement.
- ***Transportation of a member to a provider outside the member's community:*** If a provider is not available in the member's immediate community, we make arrangements for the member to temporarily receive care from a provider located in another community. This solution is generally utilized until an appropriate provider is recruited, credentialed and available within the member's immediate community.

For members in active treatment, we ensure the member's care is not disrupted during the transition process. If necessary, the Case Manager maintains care with the member's current provider to ensure continuity of care and the member's care is transitioned after his/her medical condition is stable. The Case Manager and Medical Management team work collaboratively with the Provider Network team to secure letters of agreement, if needed, if the member's current provider is not a UnitedHealthcare Community Plan contracted provider. Our comprehensive continuity of care policies serves to reinforce our position that our members' needs come first.

G.4 The CCN is encouraged to offer to contract with Significant Traditional Providers (STPs) who meet your credentialing standards and all the requirements in the CCN's subcontract. DHH will make available on www.MakingMedicaidBetter.com a listing of STPs by provider type by GSA. Describe how you will encourage the enrollment of STPs into your network; and indicate on a copy of the listing which of the providers included in your listing of network providers (See G.1) are STPs. (GSA C)

Significant Traditional Providers

UnitedHealthcare Community Plan's network development strategy is focused on delivering services to consumers in the communities where they live. The strategy is a Louisiana-specific, region-specific approach that takes into account all of the cultural nuances within each geographic location and ensures access to all covered services in the most appropriate setting. This network is built around providers that value diversity and are committed to serving traditionally underserved populations. UnitedHealthcare Community Plan operates a mixed care model with hospital-based, multi-specialty, and individual providers complemented by a strong network of safety net providers that typically include health departments, federally qualified health centers (FQHCs), rural health clinics (RHCs), school based health centers, and other safety net clinics, such as those operated by Louisiana State University Health System. Our experience in recruiting, contracting and credentialing community based safety net physicians and providers enables us to effectively enhance the member's access to quality care.

UnitedHealthcare Community Plan began outreach efforts to Significant Traditional Providers (STPs) in Louisiana starting in April of 2010. We have made a number of personal visits, sent LOIs or contract amendments, emails and faxes and made numerous phone calls to the majority of STPs and the associations that represent these entities.

As of the filing of our RFP response we have received LOIs from 3 of the 24 FQHCs operating in the state. The other FQHCs have indicated, due to their involvement in a competing entity, they do not intend to sign LOIs or contracts with UnitedHealthcare Community Plan. We will continue our efforts to work with FQHCs and are optimistic that if awarded a contract we would be able to recruit more FQHCs in to our network.

Additionally, there are 106 Rural Health Clinics in the state. To date, we have received LOIs from 23 of the RHCs and are continuing our recruitment efforts with these entities. We have offered LOIs to all the School Based Clinics in the state and are working with the leadership of the School Based Health Centers association in Louisiana to develop operating process that will simplify their ability to provide important services to our members.

We have used the DHH provided report summarizing member linkages to primary care providers and have network development staff working to recruit any significant providers that are not already in our network. Since November of 2010 we have had 2 FTEs concentrating exclusively on the recruitment of these providers.

We have had telephonic outreaches and on-site visits explaining our interest in serving this population and our desire to partner with them in this effort. Additionally, UnitedHealthcare Community Plan

Leadership have been conducting meetings with large organizations and associations that represent these providers' interests.

G.5 Based on discussions with providers in obtaining Letters of Intent and executed subcontracts as well as other activities you have undertaken to understand the delivery system and enrollee population in the GSA(s) for which a proposal is being submitted, discuss your observations and the challenges you have identified in terms of developing and maintaining a provider network. Provide a response tailored to each GSA of the following provider types/services:

- ***Primary Care***
- ***Specialty Care***
- ***Prenatal Care Services***
- ***Hospital, including Rural Hospital***
- ***Office of Public Health***
- ***Private Duty Nursing/Home Health Services;***
- ***FQHC***
- ***School Based Health Clinic*** ***(GSA C)***

Development/Maintaining a Network for the CCN Program

UnitedHealthcare Community Plan has met with providers and their respective associations for close to a year. We have developed an understanding of the Louisiana health care delivery system and its key components. There has been some reluctance on the part of providers to sign LOIs or contracts until DHH announces entities selected as CCNs. However, based upon our existing, contracted and credentialed network, we are confident that if selected we would be able to resolve any existing network deficiencies to meet the DHH access standards and needs of our members and to ensure that every provider understands CCN and Medicaid program requirements.

We are continuing our network development activities between the submission of this RFP response and announcement of selected entities to serve as CCNs. We have received many assurances from our providers throughout the state that if chosen as a CCN they would work with us to become part of our contracted network to serve our CCN members.

GSA A

Primary Care

We currently meet all primary care access requirements for the region with contracted and LOI providers.

Specialty Care

We currently meet many access standards for those specialties that we have identified as high volume. Many specialties may not have providers in rural areas of Louisiana and will require coordination of transportation to provide access to those services.

Prenatal Care Services

We currently meet prenatal care access requirements for the region with 218 contracted and LOI obstetrical providers.

Hospitals, including Rural Hospitals

We currently meet 99.3 percent access level in urban regions and a 100% access level in rural regions

with contracted and LOI providers. The following are our challenges:

- ***Louisiana State University Health System:*** The system reports that they and their affiliated physicians have made a decision to limit the number of LOI's they will execute to those entities with whom they have a long standing relationship (Children's Hospital) and perhaps as few as one other entity that is closely aligned with facilities involved in their medical education activities. We have enjoyed a long history of working with LSU serving members of our commercial programs and are optimistic that if we are awarded a CCN contract, we would be able to reach agreement to include LSU facilities and physicians in our CCN network.
- ***Children's Hospital and Children's Health Network:*** We have met several times with these organizations to discuss our interest in including them in our CCN network. However, as a result of Children's Hospital's intent to bid as a CCN-P contractor they are not willing to execute an LOI at this time. We feel that if we are selected we would have a reasonable opportunity to work out an agreement with them to participate as a network provider to serve our members.
- ***Louisiana Rural Hospital Association:*** They are very concerned about their role in the program moving forward. We addressed these concerns with them and have a level of support within the association. A large number of the hospital LOI's we have received have come from rural hospital which indicates their support. Many are awaiting an award before pursuing a contract and are not executing LOI's.

Office of Public Health

We currently have LOI's with all Offices of Public Health

Private Duty Nursing/Home Health Services

We currently meet access requirements for the region with 15 contracted and LOI providers serving the entire region.

FQHC

UnitedHealthcare Community Plan began outreach efforts to FQHCs in Louisiana starting in April of 2010. We have made a number of personal visits, sent LOIs or contract amendments, emails and faxes and made numerous phone calls to FQHCs and the Louisiana Primary Care Association that represents these entities. As of the filing of our RFP response, we have received LOIs from 3 of the 24 FQHCs operating in the state. The other FQHCs have indicated, due to their involvement in a competing entity, they do not intend to sign LOIs or contracts with UnitedHealthcare Community Plan. We will continue our efforts to work with FQHCs and are optimistic that if awarded a contract we would be able to recruit more FQHCs in to our network.

School Based Clinic

We recognize the important role that school based health clinics play in the role of caring for CCN enrollees. We have met with leadership and even presented at one of their association meetings. They are very concerned about their place in this program and we are committed to addressing their concerns and working with them to meet the needs of our members. We have their support as a CCN and have received LOI's from many of the clinics.

GSA B

We currently meet all primary care access requirements for the region with contracted and LOI providers.

Specialty Care

We currently meet many access standards for those specialties that we have identified as high volume. Many specialties may not have providers in rural areas of Louisiana and will require coordination of transportation to provide access to those services.

Prenatal Care Services
We currently meet prenatal care access requirements for the region with 139 contracted and LOI obstetrical providers.

Hospitals, including Rural Hospitals
We currently meet 98.9% access level in urban regions and a 89.2% access level in rural regions with contracted and LOI providers. Our challenges include:

- ***Verity (including Baton Rouge General):*** In order to secure a LOI with the Verity Network it was necessary for us to negotiate the terms of our agreement moving forward. We anticipate this negotiation to be a complex one. It is our interest to include them as a provider in our network should we be selected and dependent on our ability to agree to terms that are in the best interest of the enrollees of the CCN program and at terms that would ensure the long term viability and success of the CCN program.
- ***Louisiana Rural Hospital Association:*** They are very concerned about their role in the program moving forward. We addressed these concerns with them and have a level of support within the association. A large number of the hospital LOI's we have received have come from rural hospital which indicates their support. Many are awaiting an award before pursuing a contract and are not executing LOI's.

Office of Public Health
We currently have LOI's with all Offices of Public Health

Private Duty Nursing/Home Health Services
We currently meet access requirements for the region with 17 contracted and LOI providers serving the entire region

FQHC
UnitedHealthcare Community Plan began outreach efforts to FQHCs in Louisiana starting in April of 2010. We have made a number of personal visits, sent LOIs or contract amendments, emails and faxes and made numerous phone calls to FQHCs and the Louisiana Primary Care Association that represents these entities. As of the filing of our RFP response we have received LOIs from 3 of the 24 FQHCs operating in the state. The other FQHCs have indicated, due to their involvement in a competing entity, they do not intend to sign LOIs or contracts with UnitedHealthcare Community Plan. We will continue our efforts to work with FQHCs and are optimistic that if awarded a contract we would be able to recruit more FQHCs in to our network.

School Based Clinic
We recognize the important role that school based health clinics play in the role of caring for CCN enrollees. We have met with leadership and even presented at on of their association meetings. They are very concerned about their place in this program and we committed to addressing all of their concerns. We have their support as a CCN and have received LOI's from many of the clinics.

GSA C
Primary Care
We currently meet all primary care access requirements for the region with contracted and LOI providers.

Specialty Care
We currently meet many access standards for those specialties that we have identified as high volume. Many specialties may not have providers in rural areas of Louisiana and will require coordination of transportation to provide access to those services.

Prenatal Care Services

We currently meet prenatal care access requirements for the region with 146 contracted and LOI obstetrical providers.

Hospital, including Rural Hospitals

We currently meet a 98.3% access level in urban regions and a 70.4% access level in rural regions with contracted and LOI providers. Our challenges include:

- ***Willis Knighton Health System:*** We have had dialogue with them but their strategy at this time is not to execute LOI's and to negotiate with those CCN's that are awarded a contract.
- ***Louisiana State University Health System:*** The system and its affiliated physicians have made a decision to limit the number of LOI's it will execute to those CCN's with whom they have a long standing relationship with, even though they have been providers in our commercial products. They have indicated to us that they will participate with us, if chosen, if we can reach terms on an agreement.
- ***Louisiana Rural Hospital Association:*** The system reports that they and their affiliated physicians have made a decision to limit the number of LOI's they will execute to those entities with whom they have a long standing relationship (Children's Hospital) and perhaps as few as one other entity that is closely aligned with facilities involved in their medical education activities. We have enjoyed a long history of working with LSU serving members of our commercial programs and are optimistic that if we are awarded a CCN contract, we would be able to reach agreement to include LSU facilities and physicians in our CCN network.

Office of Public Health

We currently have LOI's with all Offices of Public Health.

Private Duty Nursing/Home Health Services

We currently meet access requirements for the region with 23 contracted and LOI providers serving the entire region.

FQHC

UnitedHealthcare Community Plan began outreach efforts to FQHCs in Louisiana starting in April of 2010. We have made a number of personal visits, sent LOIs or contract amendments, emails and faxes and made numerous phone calls to FQHCs and the Louisiana Primary Care Association that represents these entities. As of the filing of our RFP response we have received LOIs from 3 of the 24 FQHCs operating in the state. The other FQHCs have indicated, due to their involvement in a competing entity, they do not intend to sign LOIs or contracts with UnitedHealthcare Community Plan. We will continue our efforts to work with FQHCs and are optimistic that if awarded a contract we would be able to recruit more FQHCs in to our network.

School Based Clinic

We recognize the important role that school based health clinics play in the role of caring for CCN enrollees. We have met with leadership and even presented at on of their association meetings. They are very concerned about their place in this program and we committed to addressing all of their concerns. We have their support as a CCN and have received LOI's from many of the clinics.

G.6 Describe your process for monitoring and ensuring adherence to DHH's requirements regarding appointments and wait times. (GSA C)

Monitoring Appointments and Wait Times

UnitedHealthcare Community Plan will comply with DHH's provisions of service requirements regarding appointments and wait times. We continuously exam our networks to ensure our access standards are met. UnitedHealthcare Community Plan regularly monitors provider compliance with appointment access and wait times. We actively monitor our provider network to identify issues or trends with individual providers. We go above DHH requirements to provide transportation services to our members and arrange access to out-of-network providers when network providers are not available within the required travel distance.

Additionally we monitor many data sources that are precursors to extended member wait times including but not limited to:

- GeoAccess reports
- Normal member travel patterns for care
- Member complaints and appeals
- The CAHPS member satisfaction survey provider access questions
- Medical records reviews for targeted PCPs
- Provider onsite reviews (as needed)
- HARC call reminders
- Member Satisfaction survey results
- Secret Shopper surveys
- Case Manager's feedback and referrals.

Our Experience in Texas

From July 20, 2010 to August 31, 2010, 11% of network providers were found to be non-compliant after the first survey. After the education, they were re-surveyed between September 30, 2010 and October 1, 2010. The re-survey results indicated that 100% of providers were found to be compliant with appointment availability standards.

Our process for monitoring and ensuring adherence includes conducting annual provider access and appointment availability studies that include the evaluation of appointment access by provider type. If we find providers are non-compliant after the initial survey, we offer them education on their contractual requirements and re-survey them. We also contract with DialAmerica to conduct annual, quarterly and monthly calls to providers to survey providers and ensure that members have the ability to reach, schedule and interact with providers on a timely basis. Additional sources used to ensure appointment availability include monitoring of member complaints, case management and service coordination.

We actively monitor our provider network to identify issues/trends with individual providers. Initial review occurs at the departmental level and any identified trends are reported to the QMC. We notify noncompliant providers about contract requirements and develop, implement and monitor corrective action plans to address noncompliance issues.

Monitoring DHH 24/7 Hour Coverage Requirements

UnitedHealthcare Community Plan will comply with the RFP requirements for 24/7 hour coverage. We will maintain 24 hours per day, 7 days per week, telephone coverage to instruct members on where to receive emergency and urgent health care. To measure after-hours availability, we conduct annual provider access and appointment studies that include calling PCPs after hours to verify their compliance. If we find providers are non-compliant after the initial survey, we offer them education on their contractual and re-survey them. We use findings from member advocates, member complaints and annual member satisfaction surveys. Member satisfaction surveys include questions on the ease of seeing the member's personal doctor and the ease in getting care, tests, or treatment. These questions are not specific to after-hours coverage but help illustrate broader access to care issues. To supplement our medical provider network, we contract with freestanding Urgent Care Centers to assist our members after hours.

Monitoring DHH Travel Time and Distance Requirements

UnitedHealthcare Community Plan uses a GeoAccess mapping software to assess network compliance with travel time and distance standards. On at least a quarterly basis, we evaluate the entire network for adequate coverage and compliance with access standards using the GeoAccess mapping which enables us to identify and analyze potential gaps in coverage by location, specialty and provider type. Initial review occurs at the department level and any identified trends are reported to the Quality Management Committee (QMC). We educate noncompliant providers about contract requirements and develop, implement and monitor corrective actions plans to address noncompliance issues. Our QMC is responsible for monitoring all aspects of compliance with access standards. They consider the following when reviewing the GeoAccess reports:

- Provider/member travel distance ratios against DHH access standards (1:1500)
- Geographic and clinical needs for network optimization
- Any relevant member complaints trends or member satisfaction survey results.

In those rare occasions there are any gaps, such as a family member needing access, our network contracting team will try to put a single case agreement in place to ensure quality and continuity of care.

Requirements	*Time and Travel Distance*
Time and Distance to Primary Care Providers	■ For members living in rural parishes it should not exceed 30 miles ■ For members living in urban parishes it should not exceed 10 miles
Time and Distance to Hospitals	■ For members in rural areas—30 minutes of residence ■ For members in urban areas—30 miles of residence. If no hospital is available within thirty (30) miles of a member's residence, the CCN may request, in writing, an exception to this requirement
Time and Distance to Specialists	■ Travel distance shall not exceed sixty (60) miles for at least 75% of members residence ■ Travel distance shall not exceed 90 miles for all members
Time and Distance to Lab and Radiology Services	■ Travel distance shall not exceed 90 miles for all members ■ For rural areas, exceptions for community standards shall be justified, documented and submitted to DHH for approval ■ Other medical service providers participating in our network also must be geographically accessible to CCN members as outlined in this RFP

Monitoring DHH Appointment Access Requirements

UnitedHealthcare Community Plan continuously examines our networks to ensure timely access to care. Without timely care, members may present in the emergency room for routine care or delay care until their condition is serious enough to require emergency intervention or hospitalization. To ensure our members have ready access to medical homes, we have established access standards as set forth by DHH

and our comprehensive network enables us to ensure that we meet and exceed these standards. Our network standards for medical providers are published in our Provider Manual, which is given to each of our contracted providers and is also available on our Website in the section set aside for provider information. Our Quality Management Committee (QMC), which is comprised of senior management from UnitedHealthcare Community Plan's local office, is responsible for monitoring all aspects of compliance with appointment access standards to include methods such as "mystery shoppers".

All contracted primary care physicians have the patient capacity to care for CCN members unless otherwise indicated in our provider directory. Participating providers are required to attest to the number of active patients within their practice on an annual basis. The number of active patients permitted can not exceed 1,500 members per physician to provide members with timely access to physician services.

All medical providers are required by contract to comply with the appointment access standards stipulated in the contract. Providers have knowledge of the appointment access standards through provider orientation, the provider manual and updates provided annually through provider newsletters. UnitedHealthcare Community Plan regularly evaluates provider compliance through regular appointment access audits, which include test cases for arranging appointments of various kinds with a random sample of providers. In addition, provider non-compliance issues may surface through member concerns and complaints reports, satisfaction survey results and other provider reports.

To supplement our medical provider network, UnitedHealthcare Community Plan will recruit freestanding Urgent Care Centers if available to assist our members after hours. In addition, we require our contracted providers to provide after-hours coverage.

G.7 Describe your PCP assignment process and the measures taken to ensure that every member in your CCN is assigned a PCP in a timely manner. Include your process for permitting members with chronic conditions to select a specialist as their PCP and whether you allow specialists to be credentialed to act as PCPs. (GSA C)

PCP Assignment Process

To promote continuity of care, we initially auto assign PCPs to members who have not pre-selected one based on a list of preferences. First, historical enrollment files are searched and if the enrollee was previously enrolled with UnitedHealthcare, assignment of the PCP or Specialist as PCP of record will occur. Second, if there was no previous enrollment, the enrollment file is searched for family members who were previously enrolled and the PCP of record is assigned if the provider is appropriate. Thirdly, if there is no individual or family prior enrollment with UnitedHealthcare, a PCP will be assigned based on geographic proximity, age and sex.

To ensure timely access to care upon enrollment, all members will have a PCP medical home within 10 days of enrollment. Upon receipt of the enrollment roster from the Enrollment Broker, we create an enrollment record. For members who have pre-selected PCPs, the enrollment record reflects that choice of provider. If a new Medicaid member has not selected a PCP during the enrollment process, or has selected a PCP with a closed panel or an inappropriate provider based on specialty, that is, for example an adult selecting a pediatrician, the enrollment record PCP selection is left blank and UnitedHealthcare will auto assign a PCP based on criteria that seeks to optimize the medical home relationship.

For the Louisiana Medicaid Coordinated Care Program, our PCP auto assignment process will be as follows. Step one will auto assign a PCP based on the PCP of record from a previous enrollment with UnitedHealthcare Community Plan. If there was no previous enrollment, we will review Medicaid fee for service claims data to determine if there had been a historical relationship between the member and a PCP. If so, that PCP will be assigned to that member. If not, we will search our enrollment file for family members who were previously enrolled in UnitedHealth Community Plan and assign the PCP of record if that provider is appropriate, that is not a pediatrician if the member is an adult. If no family members

were previously enrolled, we will review Medicaid fee for service claims data to determine if any family member had a historical relationship with a PCP and, if so, that PCP will be assigned to that enrollee if appropriate. Lastly, in the event that there is no fee for service historical data for an enrollee's family member, we will use geographic proximity, age and sex to assign a PCP. In these assignments, travel time/distance standards will be applied. The auto assignment methodology will be submitted to DHH within 30 days from the date the contract is signed with DHH and will also be available on UnitedHealthcare Community Plan's website and in the member and provider handbooks.

We understand that basing PCP assignment on previous enrollment experience, personal or familial historical claims data or geography may not be the optimal approach for establishing a medical home. A manual error report is generated for all members who have been auto assigned a PCP. Our member outreach teams reach out to these members to educate them on the importance of a medical home and to assist them though the process of selecting a PCP if the one auto assigned is not acceptable to the member. Also, all members, including those members who were assigned a PCP, will be advised during new member orientation that they have 90 days to select another PCP without cause. Moreover, new members will also be advised that they may select a specialist as their PCP.

Specialist as PCP

Medically vulnerable populations, including members with special health care needs often have a level of need that is best met by a specialist who assumes the role of PCP. Therefore, if an enrollee requires specialized care for a disabling condition, acute or chronic illness or a child with a special health care need, they may request a specialist function as their PCP. Our care management staff may also initiate a specialist as a PCP in consultation with the enrollee.

Generally, members may choose a specialist as their PCP when the specialist had previously provided care to the enrollee or if the specialist has experience treating the relevant condition. Our provider advocates educate specialty physicians and their practices on the role of a PCP. Our care managers interact with members to ensure their preventive care service needs are being met. Access to the right PCP is especially important to a population with complex and potentially severe health concerns. Enrollees with special health care needs and chronic conditions may be more comfortable with a PCP who understands their particular health care needs and may receive better or more appropriate care by choosing a specialist as a PCP when they require regular care from that specialist.

G.8 Describe your plan for working with PCPs to obtain NCQA medical home recognition or JHCAOPrimary Home accreditation and meeting the requirements of Section § 14. (GSA C)

UnitedHealthcare Community Plan actively collaborates with practices to achieve practice transformation and deliver more proactive, coordinated and patient centered care. Our programs assist practices in achieving NCQA Medical Home recognition standards through active health information exchange, and providing the practice with the tools and processes to measure, monitor and manage health of their patient population on an ongoing basis. We hold regular meetings with practice leadership to review progress, including readiness to meet NCQA standards:

- Enhance access and continuity of care
- Identify and manage patient populations
- Plan and manage care
- Provide self care and community support
- Track and coordinate care and
- Measure and improve performance.

Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care of

adults, youth and children. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

UnitedHealthcare Community Plan collaborates with the PCMH clinical leadership to support them in achieving NCQA PCMH - medical home recognition (or other recognition programs if desired). We provide baseline analyses on the practices' population health, collaboratively set goals for improvement, and implement initiatives necessary to achieve NCQA standards. Initiatives are developed to (a) improve access to care, (b) reduce avoidable ER visits, (c) reduce unnecessary admissions/readmissions and (d) improve evidence based care of high risk patients with multiple chronic conditions.

Through weekly analyses of access to care trends for the practice, we identify opportunities to improve access at the individual clinic level. We complete a predictive modeling analysis of the practices' assigned population – identify risk of admission for the practice patients and support the practices' ability to use data for population management. UnitedHealthcare Community Plan provides each medical home practice with a web based population registry used for daily health information exchange to track and coordinate care, and measure and improve performance.

In order to achieve medical home NCQA recognition the PCMH must drive value and the practice must do things differently including:

- Expanding days and hours of access to care
- Increased focus on wellness education
- Increased use of screening for other conditions
- Ensuring a team-based approach to patient care management
- Spending more time out side of episodic care visits to manage the patient more holistically
- Using evidenced based guidelines and practice standards to monitor and manage care
- Using more effective information and decision support systems
- Pro-actively reaching out to patients with care opportunities or at risk
- Data collaborating for a holistic view of the patient's health
- Actively monitoring and improving the referral process
- Using a more rigorous approach for gathering patient satisfaction.

UnitedHealthcare Community Plan in Arizona has been actively working with medical home since 2009 with practices and hospitals in Maricopa, Pima and Yuma counties. All of the practices starting the program in 2009 have now achieved NCQA recognition, with several reaching NCQA recognition level 3. Today we have 60,000 members in active medical homes in Arizona.

In addition, UnitedHealthcare Community Plan will monitor and analyze a broad spectrum of clinical data. We will use the results to measure the effectiveness of interventions and to identify opportunities for clinical quality improvement. We will assist in measuring and monitoring primary care provider performance relative to the identified clinical indicators.

In Louisiana, UnitedHealthcare Community Plan will work with PCMH practices to promote and facilitate the capacity of their practices to meet the recognition requirements of NCQA PPC-PCMH recognition or JCAHO PCH accreditation. Within 90 days of the go live date we will submit to Louisiana our PCMH Implementation Plan that will identify our methodology for promoting and facilitating NCQA PPC-PCMH recognition or JCAHO PCH accreditation.

Our implementation plan will include:

- Reporting Process of PCMHs that achieve recognition or meet the requirements of NCQA or JCAHO Medical Home accreditation. The report will include how PCMHs are meeting established timelines

and thresholds for NCQA or JCAHO Medical Home accreditation and levels of recognition.

- Financing the practice to support their transformation to NCQA.
- Provisions of Technical Support (e.g. education, training tools, provision of data relevant to member clinical care management) that we will provide PCMHs to achieve NCQA or JCAHO accreditation.
- Facilitation of specialty provider network access and coordination to support the PCMH.
- Process and facilitation of data interchange between PCMH, specialist, labs, pharmacies and other providers.

We will meet or exceed the following timetables and thresholds for PCMHs to achieve Medical Home accreditations:

- Contract Year One
  - 20 percent of PCPs shall be NCQA PPC®- PCMH Level 1 recognized or JCAHO PCH accredited.
- Contract Year Two
  - 30 percent of PCPs shall be NCQA PPC- PCMH Level 1 recognized or JCAHO PCH accredited and;
  - 10 percent of practices shall be NCQA PPC- PCMH Level 2 recognized or JCAHO PCH accredited.
- Contract Year Three
  - 10 percent of practices shall be NCQA PPC-PCMH Level 1 recognized or JCAHO PCH accredited and;
  - 40 percent of practices shall be NCQA PPC-PCMH Level 2 recognized or JCAHO PCH accredited; and
  - 10 percent of practices shall be NCQA PPC-PCMH Level 3 recognized or JCAHO PCH accredited.

We also look forward to actively participating in any Patient-Centered Primary Care Collaborative activities that are initiated by the State of Louisiana.

G.9 Describe how you will monitor providers and ensure compliance with provider subcontracts. In addition to a general description of your approach, address each of the following: (GSA C)

In accordance with the model contract as contained in the RFP, DHH and CMS guidelines and applicable state and federal laws and regulations, UnitedHealthcare Community Plan will monitor and manage the performance of providers and ensure compliance with provider subcontracts. Specifically, we have written policies and procedures for selection and retention of providers which are in accordance with 42 CFR §438.214. UnitedHealthcare Community Plan will be responsible for the oversight of all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to any subcontractor, including, but not limited to those functions and responsibilities enumerated in Section 7.12.5 of the RFP.

Monitoring Providers

Our success as a managed care company is greatly influenced by the capability, commitment and capacity of our provider partners. Here in Louisiana we have spent more than 15 years building relationships with more than 8,000 physicians and more than 160 hospitals. These long standing relationships and experience provide us a wealth of knowledge about the strengths and opportunities for improvement among our provider partners. We are actively recruiting providers that have traditionally served the Medicaid population or who have proven themselves effective in improving the health and well being of

their patients. Selecting credentialed, proven providers helps to ensure members receive high quality cost effective care and is the first step in an efficient process to monitor provider compliance and performance.

We coordinate the following to educate providers and office staff about contract requirements and compliance including:

- Provider and staff training
- Resources available to answer provider and staff questions
  - Provider portals
  - Provider hotline
  - Manuals
  - Newsletters.

The following approaches will facilitate our oversight of subcontractors and allow UnitedHealthcare Community Plan to evaluate performance, especially with respect to contractual requirements. Unless otherwise noted, we will use these approaches with regard to external subcontractors as well as affiliated entities within UnitedHealth Group.

Operating Agreements **–**The operating agreement describes the required functions and service levels to be performed by the provider. The operating agreement also describes the process by which UnitedHealthcare Community Plan will assess performance; recourse if service standards or expectations are not met (including revocation of delegation or imposing other sanctions if the subcontractor's performance is inadequate); and the authority of UnitedHealthcare Community Plan to drive change. This agreement would be put in place with the consent of UnitedHealthcare Community Plan, the subcontractor, and DHH.

Sign-off Authority – In certain instances, operating agreements include sign-off authority for UnitedHealthcare Community Plan's President and COO to approve or deny proposed changes in a subcontractor's policies. If a subcontractor wishes to change a policy, technology, or another key element of its services for members, that process must include explicit approval from UnitedHealthcare Community Plan and an agreement that UnitedHealthcare Community Plan understands the impacts for its members.

Auditing – UnitedHealthcare Community Plan will perform annual onsite audits of its subcontractors to verify that their staff, policies, and resources are appropriate to meet the requirements of their agreement with UnitedHealthcare Community Plan. Such audits will be completed under the direction of our Compliance Officer. The results of these audits are reported in UnitedHealthcare Community Plan monthly Compliance Committee meetings, which include executive leadership. The Compliance Committee recommends steps to be taken by UnitedHealthcare Community Plan, as well as any action required of the subcontractor, to remedy operational issues and maintain compliance with the DHH contract. These mandates may include sanctions, fines, or revocation of the agreement. The Compliance Officer communicates decisions of the Compliance Committee to the subcontractor, and as appropriate, reports them to executive leadership and DHH.

Joint Operating Committees (JOC) – UnitedHealthcare Community Plan will establish Joint Operating Committees for key functions such as member and provider call centers, claims processing, transportation, and durable medical equipment. These JOCs are comprised of members of UnitedHealthcare Community Plan's management team and representatives from the appropriate subcontractor. The JOC will meet as often as necessary to address concerns and encourage the subcontractor to implement solutions to quality issues.

Operations Meetings – As appropriate, representatives of subcontracting entities are invited to UnitedHealthcare Community Plan operations meetings for the purpose of promoting understanding of

how each functional area is dependent on the success of the others. These operations meetings provide direction for subcontractors and ensure that their quality and effectiveness is sufficient to meet UnitedHealthcare Community Plan and DHH objectives.

Governance Calls – Along with affiliated entities within UnitedHealth Group, UnitedHealthcare Community Plan will host monthly governance calls with executives from affiliated Medicaid health plans who will meet with executive leadership from our sister organizations. These national governance calls allow for joint problem solving and sharing of best practices, provide opportunity for our leadership to provide direct feedback on service quality, and ensure that services for Medicaid programs are prioritized to promote contract compliance.

Dedicated Staff – In accordance with the requirements of the RFP, UnitedHealthcare Community Plan will establish staff positions to work with specific subcontractors that require additional monitoring or oversight. We understand that such steps are necessary for improvement of quality and performance.

Statistics and Reports – Each subcontractor is required to submit periodic reports and statistics to UnitedHealthcare Community Plan that demonstrate their effectiveness. Key indicators used to monitor subcontractors include provider service levels, call center statistics, claims timeliness, and claims accuracy statistics.

Surveys – UnitedHealthcare Community Plan will perform member and provider surveys to gain feedback on the service of subcontractors.

Monitoring Member Satisfaction

UnitedHealthcare Community Plan will monitor patient satisfaction through annual member satisfaction surveys and continuous monitoring of member complaint/grievance data, as explained below. Members can call member hotlines to register complaints also. In addition to the surveys, we use our Secret Shopper program to monitor providers.

Member Satisfaction Surveys

Understanding our members' experiences and acting on that feedback are critical to provide better service. We do this through a variety of ways. First, we use our annual **Consumer Assessment and Healthcare Provider Satisfaction (CAHPS®)** surveys as the primary barometer of our Member experience with our providers and with our health plan. We supplement the CAHPS survey with a smaller, more frequent survey (using a sample of randomly selected Members).

Our Marketing Team also conducts in-depth field research with Medicaid Members – including ethnographic research – to gather information on their attitudes about health, health living styles and barriers to health care services and to identify opportunities we have to support our members.

We view each and every inbound call to our Member Services Hotline as an opportunity to capture feedback from our Members and have implemented quick and easy survey capabilities. Our application, called **United Experience Survey (UES),** allows Members to provide feedback about the quality of the customer service they received. Members are asked if they would want to take part in a survey. Once initiated, Members answer six questions that are rated on a 1-5 scale (5 being best). All survey responses are fed into a system called INSIGHT. Supervisors and managers review results and identify areas for general staff training, individual Member Services representative coaching and development opportunities.

Member Complaints/Grievances

When Members and their families are not satisfied, we will take action to increase satisfaction on an individual level and a system level, as necessary. We recognize that Member complaints/grievances provide vital information about our performance and our providers' performance and help us target areas for improvement. We will apply a continuous quality improvement process to review data related to

complaints/grievances, and take any necessary actions to improve the performance of our operation and the performance of our providers as warranted.

Provider Satisfaction

UnitedHealthcare Community Plan conducts ongoing assessments of provider satisfaction as part of our continuous quality improvement efforts. Key activities related to the assessment and promotion of provider satisfaction include:

- Annual Provider Satisfaction Surveys and Targeted Improvement Plans
- Regular visits to key behavioral and medical health providers
- Provider involvement in the QI Committee structure.

Provider satisfaction surveys are fielded for both physical and behavioral health providers. Provider satisfaction surveys are designed to:

- Assess which services are important to health plan providers
- Determine provider satisfaction with health plan processes, including the utilization management process
- Evaluate satisfaction with services and support provided by us such as authorizations process, claims payment, care management staff, provider relations staff and coordination of care.

The survey results are summarized and reviewed by the QMC to identify areas for improvement and develop action plans, as appropriate, to further improve provider satisfaction. The results are compared by health plan year over year and also in comparison to other contracted plans across the country.

Provider Profiling

We use the following provider profiling tools:

- ***Strategic Management Analytics Reporting Tool (SMART):*** UnitedHealthcare's proprietary Strategic Management Analytics Reporting Tool (SMART) data warehouse, in combination with the Business Objects reporting tool, are robust data warehousing and decision support tools used for analytics and enhanced reporting. Our SMART data warehouse is an analytics system that allows us to aggregate all clinical and cost information and provides enhanced reporting for claims, utilization, unit costs, provider profiling (Emergency Room visit profiling for physician practices), member retention and other analytical capabilities.
- ***MedMeasures ™:*** UnitedHealthcare uses MedMeasures, an NCQA-certified HEDIS software package, to ensure our data is complete and accurate. The system's enhanced measure analysis function gives us access to member detail – providing information on specific members qualified for each measure. The system also provides provider profiling based on HEDIS results, allowing comparisons among peers and with established standards. One of the most important features is the ability to run HEDIS measures for any time period including on a monthly basis. UnitedHealthcare has been able to create measure reports with flexible analysis and reporting; giving us the ability to review data at the member or provider level and generate reports based on various data components. Data from the MedMeasures systems is compiled into "scorecards" which display: performance measures' start and stop dates for specific interventions, output of calls, mailers, health fairs and trended performance rates (expected versus actual results). These scorecards are populated and reviewed weekly and monthly by a team composed of our Medical Director and Quality Improvement Director.
- ***VIPs HEDIS:*** VIPs HEDIS profiling allows us to profile provider panel for preventive and EPSDT measures. Information is provided to providers three times a year, and includes HEDIS measures that

are appropriate for the PCP's practice (for example, Pediatric vs. Adult patients), as well as average for their peers in the state.

The scorecard trends and intervention outcomes are also reported three times each year to the UnitedHealthcare Healthcare Quality and Utilization Management Subcommittee, which in turn reports to the Quality Management Committee. Recommendations for improvements or changes in interventions and preventive health approaches are implemented by Quality Improvement Director.

This information can also be integrated into the Performance for Value Incentive Program for our high volume providers, as a way of rewarding high performance in HEDIS measures that the Department has identified as being of priority to its population. This program can also include such metrics as office hours outside the normal business day, open panel and ER utilization.

Data Shared with Providers

The data shared with primary care providers include HEDIS measures that are appropriate for the PCP's practice (for example, Pediatric vs. Adult patients), as well as averages for their peers in the state. Examples include Well child visits, Breast Cancer Screening and Diabetes Care measures. In addition, our reports are available via the provider portal. Provider profile reports are generated three times per year and will be available online through our provider portal.

Monitoring and Evaluation

The Universal Tracking Database (UTD) incorporates all preventive care measures into a quarterly PCP profile. The UTD information provides a list of Members who are in need of EPSDT or adult preventive care, based on quality indicators, and these are included in the provider profile which will be accessible electronically on UnitedHealthcare's web-based provider portal. This information provides helpful feedback to the PCPs, giving them specific Members who are in need of targeted services. UnitedHealthcare will work closely with those providers whose Member results indicate a high level of non-compliance or low rates on EPSDT and preventive measures. Our providers are also able to access information on their assigned Members regarding preventive/EPSDT services through our secure, web-based provider portal. Our program identifies upcoming preventive visits that are due and identifies missed care opportunities. Provider education, technical support and ongoing monitoring and feedback are offered along with assistance in appointment scheduling, transportation or other interventions to improve adherence to preventive health guidelines and measures.

As noted above, UnitedHealthcare also uses MedMeasures, an NCQA certified HEDIS software package to ensure our data is complete and accurate. The system's enhanced measure analysis function gives us access to Member detail – providing information on specific Members qualified for each measure. The system also provides provider profiling based on HEDIS results, allowing comparisons among peers and with established standards.

Data from the MedMeasures and UTD systems is compiled into "scorecards" which display: performance measures' start and stop dates for specific interventions, output of calls, mailers, health fairs and trended performance rates (expected versus actual results). These scorecards are populated and will be reviewed regularly by our quality and utilization management teams. The scorecard trends and intervention outcomes will also be reported quarterly to the UnitedHealthcare Healthcare Quality and Utilization Management Subcommittee, which in turn reports to the Quality Management Committee.

Example of Enhanced Monitoring and Evaluation— Arizona Physicians IPA (APIPA)

Following a rigorous assessment and scrutiny of APIPA's data collection, monitoring and evaluation processes, APIPA recognized the need for a new software program which would allow us to easily run HEDIS measures and generate results without manual intervention or involving extensive IT resources. APIPA began using MedMeasures, a powerful component of the SourceMeasures Suite offered by ViPS. The MedMeasures module features a host of analytical tools that ensure that HEDIS reports are complete

and accurate but also that local codes are mapped to values that will influence and optimize our HEDIS results. The system's enhanced measure analysis function gives us access to member detail – providing information on specific members qualified for each measure. The system also provides provider profiling based on HEDIS results, allowing comparisons among peers and with established standards. The software has allowed APIPA to verify the quality and completeness of our data and take corrective action to help improve measure results. One of the most important features is the ability to run HEDIS measures for any time period including on a monthly basis. APIPA has been able to create measure reports with flexible analysis and reporting; giving us the ability to look at the member or provider level and generate reports based on various data components. MedMeasures has obtained the NCQA certified 2007 HEDIS software status and is seeking certification for 2008.

APIPA has also made enhancements to our Universal Tracking Database (UTD) which functions as our tracking database. UTD is a powerful tool which allows us to log and track provider and member level data, intervention tracking such as call tracking and outreach activities. With the enhanced ability to generate monthly HEDIS and other measurements, APIPA is tracking and communicating the results through monitoring scorecards. Several scorecards are used across the evaluative process. For example, one scorecard measures begin and end dates for specific interventions related to specific performance measures. This tracking provides a type of control variable and furthers the understanding of each intervention's effectiveness. An overall Monthly Performance Measure Scorecard is populated each month with the latest performance measure rates. This scorecard illustrates the expected rate for each measure that month along with any positive or negative variances. The scorecard format also provides trend information based on current and year-to-date rates. This trend analysis assists in predicting what measures are lagging below APIPA acceptable rates and therefore require additional attention, resources and innovative interventions.

The scorecards are populated at regular intervals – weekly and monthly. The results are reviewed weekly by the Performance Measure Team which includes the Chief Medical Officer, COO, Director of Preventive Services, Quality Management Manager, VP of Health Services and other staff. The scorecard trends and intervention outcomes are reported on a monthly basis to the Health Quality Utilization Management Subcommittee (APIPA's Subcommittee that monitors all clinical quality improvement and utilization management activities), which in turn reports the findings to the Quality Management Committee on a quarterly basis.

Recommendations may be provided from the committees for improved interventions or changes in strategies which are executed under the direction of the Quality Management Department. Our Medical Directors are directly involved in several ways with underperforming physicians including face to face meetings, provider training and ongoing communications with the providers.

Identifying Opportunities for Quality Improvement

Quality improvement opportunities may range from those targeted at a single individual (e.g., provider or staff) to those opportunities which result in the development of a Performance Improvement Project (PIP). Quality improvement opportunities are identified as the result of input from internal and external sources; direction from the QMC; trends identified from clinical and service quality performance indications; analysis of diagnoses that occur frequently and follow up actions from previous projects. UnitedHealthcare Community Plan utilizes department scorecards to track and trend minimum performance standards as well as function specific quality indicators.

The monthly departmental scorecards are reviewed by senior management to ensure the appropriate levels of resources are available to meet or exceed minimum performance standards and to ensure the quality of care and services provided by us. On a quarterly basis, the minimum performance standards are reported to the Quality Medical Committee for review and recommendations. Other internal sources UnitedHealthcare Community Plan uses to identify quality improvement opportunities include member and provider satisfaction surveys; utilization management reports; provider profiling data; medical

management predictive modeling; peer review; on-site provider and medical record reviews; grievance and appeals data; credentialing/recredentialing information; inter-rater reliability studies of UnitedHealthcare health services staff including the Medical Directors and State performance indicators.

The following sources are used to verify a health care practitioner's qualifications and background during Credentialing/Re-Credentialing:

Category	*Verification*
Professional Licensure or Certification	State licensing agency using verbal, written, or Internet data. Review of reports released by the primary source.
Drug Enforcement Administration and Controlled Dangerous Substance Certificates	Obtain a current copy of the DEA or CDS certificate or confirmation with the National Technical Information Service (NTIS).
National Practitioner Data Bank (NPDB)	This source provides information on reported unacceptable performance and unprofessional conduct, previous or current Medicaid or Medicare sanctions, other federal exclusions or debarments and restrictions, or suspensions or limitations on scope of practice against licensure or certification.
Education, Training, Board Certification	Verify board certification or the highest level of training (e.g., American Board of Medical Specialties, American Nurses Credentialing Center). For health care practitioners who are not board certified, verify completion of the highest level of education.
Malpractice Coverage	Verify through insurance certificate, face sheet or attestation.
Malpractice History	Query of the National Practitioner Data Bank (NPDB).
Work History	5 years of relevant work history through the practitioner's application or curriculum vitae.
Medicare/Medicaid Sanctions	List of Excluded Individuals and Entities (LEIE) maintained by OIG State Medicaid Agency NPDB.
Hospital Privileges	Practitioner must have full admitting privileges without material restrictions, conditions or other disciplinary actions, at a Participating (Network) Hospital, or arrangements with a Participating Practitioner to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital.
QI Issues/Complaints	Provider performance data with respect to quality improvement activities, member complaints are an integral part of the re-credentialing review for reappointment.

Monitoring Subcontract Practices

UnitedHealthcare Community Plan's compliance program monitors provider and subcontract practices to ensure they are consistent with sound fiscal, business or medical practices. These practices safeguard against unnecessary cost to the Louisiana's Medicaid program or inappropriate reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Example of Monitoring Subcontracts— Ensuring Providers are Enrolled in MA-- Pennsylvania Medicaid

UnitedHealthcare Community Plan's Provider Administration team handles the processing of all provider

enrollment data, including provider credentialing applications, delegate and sub-contractor files and provider correspondence received for providers enrolled in the MA program. The Provider Administration team has dedicated full time employees who support processing provider data for the Pennsylvania Medicaid line of business. Each of these team members has been trained to recognize and understand the unique data requirements required by the Department, including a provider's MA enrollment status and provider PROMISe Identification number.

MA Enrollment Status

UnitedHealthcare Community Plan sends MCO provider files, PRV 640 files, on a monthly basis. We use the 640M file the state sends back to us to validate the accuracy of the providers' Medicaid participation status.

PROMISe, Provider ID and NPI Numbers

Provider Administration team members' access the Department's PROMISe System when processing new provider records and cross-reference the system to verify that the provider has a valid PROMISe ID number. PROMISe ID numbers are also verified through the credentialing and recredentialing process. Prior to providers' credentialing file being sent for Credentialing final review, Credentialing Associate confirms the provider has an "active" PROMISe number in the Department's PROMISe system. The

Credentialing Associate also confirms the provider has not had any Medicare/Medicaid sanctions or sanctions on their licensure by reviewing the DHHS, OIG report, PA, Bureau of Integrity, Medicheck reports. Once the file is audited and verified as complete, it is forwarded to the Credentialing Committee for review and decision.

Monitoring Subcontracts

Delegated and subcontract provider files are structured such that all necessary data elements, including the provider PROMISe and NPI numbers are included on the file submissions. Upon receipt, these files are reviewed by the Provider Administration team upon which all elements are verified, including MA enrollment status and all required provider numbers. Provider data is loaded into the UnitedHealthcare National Database (NDB) and the Facets system as indicated above. If any data elements are missing from the provider file including the PROMISe ID number, that provider is not loaded into the Facets system until the missing elements are obtained.

- ***Compliance with cost sharing requirements;***

Compliance with Cost Sharing Requirements

Any cost-sharing imposed on Medicaid members shall be in accordance with 42 CFR §447.50 through 447.58 and will not exceed cost sharing amounts in the Louisiana Medicaid State Plan. UnitedHealthcare Community Plan acknowledges that DHH reserves the right to amend cost-sharing requirements, and the our executive leadership and Compliance Officer will be responsible for ensuring open lines of communication with DHH as well as our prompt adherence to any such amendments. Our Compliance Officer will also ensure compliance with cost sharing requirements as outlined in the DHH contract, including, but not limited to, proper notice in the Member Handbook and adherence to contractual agreement not to seek cost sharing from members, or persons acting on their behalf, for health care services which are rendered to such members by UnitedHealthcare Community Plan and its subcontractors, and which are core benefits and services.

- ***Compliance with medical record documentation standards;***

Compliance with Medical Record Documentation Standards

UnitedHealthcare Community Plan has well established internal policies and procedures which ensure compliance with the medical record documentation standards articulated in the DHH contract, Louisiana law, and applicable federal laws and regulations. We will conduct training sessions or distribute

educational materials as necessary to ensure that its subcontractors and employees are aware of applicable laws and regulations or any changes thereto. Additionally, UnitedHealthcare Community Plan will conduct periodic internal audits to ensure that the functionality of policies and procedures reflect compliance with medical record documentation standards. We require compliance with Medical Record Documentation Standards and include them in our credentialing and recredentialing process and our subcontract provider contracts.

- ***Compliance with conflict of interest requirements;***

Compliance with Conflict of Interest Requirements

Our parent company, UnitedHealth Group, maintains clearly a clearly articulated set of required practices and principles known as the "Principles of Ethics and Integrity," as well as a Corporate Compliance Plan. The Principles of Ethics and Integrity serve as a guide to acceptable and appropriate business conduct by UnitedHealthcare Community Plan's employees and contractors, including issues relating to conflicts of interest. Each employee and contractor is required to complete training to ensure each individual understands of the Principles of Ethics and Integrity. In addition, we will conduct training and disseminate materials to educate employees with regard to the standards imposed in the Louisiana Code of Ethics to ensure compliance with conflict of interest requirements. We require compliance with Conflict of Interest Requirements and include them in our subcontract provider contracts.

- ***Compliance with lobbying requirements;***

Compliance with Lobbying Requirements

In addition to the Principles of Ethics and Integrity as described above, UnitedHealthcare Community Plan will ensure compliance with lobbying requirements, including, but not limited to, the Byrd Anti-Lobbying Amendment and the Louisiana Code of Ethics, by and through monitoring, oversight, education and training conducted by our compliance department. Relevant compliance mechanisms include, but are not limited to, written internal policies and procedures (as submitted to and approved by DHH), provider/subcontractor/employee training, provider newsletters, internal audits and reviews, internal operational/functional area reporting of key compliance metrics, and implementing appropriate corrective action where necessary. Results of such activities will be tracked, trended, and reported as part of an overall operations level compliance program. We require compliance with Lobbying Requirements and include them in our subcontract provider contracts.

If we discover noncompliance with lobbying requirements by a provider, we report such noncompliance to the appropriate regulatory authorities within the timeframes and manner required in our contract with DHH, our policies and procedures, and appropriate state or federal regulations. Additionally, we take the appropriate level of corrective action, which may include a corrective action plan or sanctions up to and including termination of the provider's contract. We also support and abide by any disciplinary action taken by DHH, the state or federal regulatory agencies with respect to the noncompliant provider.

- ***Compliance with disclosure requirements in; and***

Compliance with Disclosure Requirements

Coordinated Care Network (CCN) shall establish written policies and procedures containing safeguards which restrict the use and disclosure of information concerning members or potential members to purposes directly connected with the performance of the DHH contract. The CCN written safeguards shall, at a minimum, fulfill the requirements articulated in Section 23.45 of the RFP. UnitedHealthcare Community Plan compliance officer shall be responsible for conducting the necessary training, education, and oversight relating to provider/subcontractor adherence to disclosure requirements. We require compliance with Disclosure Requirements and include them in our subcontract provider contracts.

- ***Compliance with marketing requirements.***

Compliance with Marketing Requirements

UnitedHealthcare Community Plan will conduct training to all provider subcontractors and their staff regarding limitations on provider marketing. We will conduct initial training within 3) days of placing a newly contracted provider, or provider group, on active status. We will also conduct ongoing training, as deemed necessary by UnitedHealthcare Community Plan or DHH to ensure compliance with Medicaid program standards or the DHH contract. Marketing materials, including UnitedHealthcare Community Plan's website and Provider Training Manual, will be submitted to DHH for approval prior to use, as required in the DHH contract. Our Compliance Officer, in conjunction with our Marketing Department, and Provider Relations Department, will ensure that all marketing materials and activities are compliant with the terms of the DHH contract and are timely/appropriately distributed to UnitedHealthcare Community Plan network providers. We will develop a marketing plan for each Geographic Service Area in which it operates and have such plan approved by DHH within the timeframe specified in the DHH contract. We require compliance with Marketing Requirements and include them in our subcontract provider contracts.

G.10 Provide an example from your previous experience of how you have handled provider noncompliance with contract requirements. (GSA C)

Previous Experience with Provider Non-Compliance

The intent for a provider not meeting compliance standards is to utilize a corrective action plan as a tool to bring the provider into compliance. In most cases, this process has produced extremely positive results as the provider is able to manage services in-line with expectations.

- ***Example 1:*** A UnitedHealthcare Community Plan provider was not meeting the state's expectation for delivery of Provider Initiated Notices (PIN) or discharge notices, which was identified from a routine audit process. At this point, the provider was put on a corrective action plan and provided education by our quality and compliance departments. The corrective action plan and the monthly PIN results were monitored monthly by the compliance department. The provider made great strides in submitting PIN notices to discharging patients, finally meeting the state requirements and the expectations of the corrective action plan. The provider continues to be successful at maintaining their ability to meet the PIN goals.

In some cases, the benefit has not been positive, below is an example of such a case and its outcome.

- ***Example 2:*** A UnitedHealthcare Community Plan provider was not meeting the state or CMS requirements around provision of services and documentation found through the regular audit process that is in place to monitor providers. The provider was placed on a corrective action plan with frequent monitoring to watch for improvement. A subsequent audit revealed that the provider was not making any progress on the corrective action plan and there had been little change in response to the plan. The information was presented to the credentialing committee with a recommendation to term the provider from the network. The credentialing committee agreed with the termination. The information was then presented to the health plan provider affairs committee and the committee also voted to terminate the provider from the network. As a result, the provider was terminated from the network.

Results

The rigorous initiatives we institute, described above, have resulted in improved subcontractor performance and better member and provider services. Our President and COO have used this overall monitoring mechanism to identify and prioritize areas for improvement, set quantifiable goals and metrics, and drive improved performance through setting clear expectations, communicating, and diligently monitoring indicators. By creating a systemic approach to continuously evaluate and improve

our operations, we have created mechanisms that will promote ongoing identification and remediation of operational challenges. We ensure the providers will follow our cautionary guidelines, and we ensure that by proactively monitoring complaints, whenever complains arise, we deal with them immediately.

G.11 Describe in detail how you will educate and train providers about billing requirements, including both initial education and training prior to the start date of operations and ongoing education and training for current and new providers. (GSA C)

Provider Services Education & Training Overview

Provider training is an important part of our approach to network management, quality improvement, and customer service. UnitedHealthcare Community Plan's provider education and training program is built on 29 years of experience with providers and multi-state Medicaid managed care programs.

As part of our recent experience implementing new health plans in Tennessee, Connecticut, Mississippi and the Florida expansion, we have a well developed pre "go-live" provider education program that includes educational mailings, on-site provider visits and group trainings that we will implement within 30 days of the Louisiana contract effective date. We invite providers to attend our training sessions and we also conduct customize training sessions for different types of providers. Additionally, we visit Tier I and II providers starting no later than 60 days before implementation. PCPs, high volume specialists and hospitals will receive on-site orientations based on volume of member contacts. We also have on-going provider training and education for current and new providers. Our provider trainings are held at different times of the day, in multiple locations throughout the region and in locations that will generate high local participation.

Our Provider Relations team will assess each provider's training needs, including billing requirements, at the time of contracting and may conduct in-person training if needed. To assess training needs, we will coordinate with all key provider associations along with our Quality Management Committee (QMC).

Provider Claims/Billing Support

UnitedHealthcare Community Plan acknowledges the need for additional training for those providers who have never submitted a traditional claim/billing form. To ensure these providers get the training and assistance they need, we employ Provider Advocates who work in the filed with providers to educate, train and provide ongoing support with claim/billing requirements and issues.

We provide upfront training to newly contracted providers and recognize when new providers may have a lack of experience when working with managed care.

Provider Advocate Team

We assign Provider Advocates to providers in our UnitedHealthcare Community Plan who are responsible for education and outreach to their assigned providers. These advocates assist providers in the field with claim issues, member complaints, compliance issues and training/education. They are the subject matter experts in their assigned area and conduct provider engagements visits on a regular basis targeting high volume facilities and outpatient groups. This local structure supports a single point of contact for all providers and a real opportunity for collaboration and innovative programming for members. By interacting on a personal level with providers, our Provider Advocates are able to better coordinate with them to provide access.

UnitedHealthcare Community Plan's Provider Advocate team expeditiously escalates and addresses urgent provider issues. Provider advocates typically have advanced training and experience in member services, claims processing and provider relations. Our Provider Advocate team, in conjunction with the provider service manager and provider operations director, offer regular trainings to providers in the field to supplement the distribution of literature, fax blasts, Web page announcements, and other written training materials. Ad hoc trainings are also available upon provider request. In addition, the Provider

Advocate puts a strong focus on those areas of concern identified through our annual survey during their regular provider outreach initiatives, which include regular provider service visits, re-orientations, town hall meetings and focus groups.

Our training program uses traditional approaches such as site/group visits as well as innovative methods such as Webinars. Provider training is an ongoing process and designed to incorporate changes in the administration of the local health plan programs as needed. Training topics include, but are not limited to:

- HealthChoices-specific billing policies and initiatives
- Encounter Reporting
- Service Authorization
- Understanding the Provider Claims Service Unit process
- Use of the Web Portal
- Understanding the Provider Claims appeal process
- Working with EDI (Electronic Data Interface)
- Importance of NPI (National Provider Identification).

> ***Experience in Pennsylvania***
>
> *From 2009 through October 2010 our Provider Advocate team conducted* **6,696 face-to-face visits** *with our providers, which represent approximately* **800 visits per month**. *This does not include telephonic outreach/education.*

Our Provider Advocate team provides basic training around billing processes and authorization requirements and procedures, while the provider operations director and provider services manager are available to provide more detailed technical training for providers needing assistance. We built additional resources into our model to improve our ability to adjust to an increase in training needs brought about by significant policy changes or other broad impact provider issues. Our UnitedHealthcare Community Plan Health Network (UHN) partners are available to augment the provider advocate team and additional business analysts are available to provide specific, detailed technical training related to the EDI.

Field based training is a key component of our continuous quality improvement efforts. We schedule routine trainings and educational forums to touch our highest volume providers and key facilities. The Provider Advocate Team holds quarterly meetings with "top tier", high-volume providers to present regular updates and refresher trainings. We hold Joint Operating Committee (JOC) meetings with key facilities to address operational issues, including training needs. Provider Advocate Representatives schedule weekly meetings with primary care practices to ensure key policies and procedures are reviewed and access and availability information is gathered, as well as to discuss any other pertinent issues.

In addition to standard training, both scheduled and requested, the Issue Resolution Tracking (IRT) process provides a mechanism for UnitedHealthcare Community Plan to identify special provider training needs through root cause analysis of claims issues identified by or referred to the plan. Through identification of claims issues with provider error as the root cause, we schedule a special in-office training to address the issue and provide resource materials and instructions specific to the billing error.

In addition, we will work with providers through the following methods to ensure they understand and are comfortable with all of the claims/billing processes:

- Face to Face training
- Group (Town Hall) trainings
- Webinar Trainings
- UnitedHealthcare Tutorials
- Educational materials and instructions.

Through provider complaints, staff feedback, trended claims data, associations and advisory councils, UnitedHealthcare Community Plan identifies common topics or opportunities for retraining as well as

specific providers for focused retaining. We monitor to ensure effectiveness and provide additional education when we identify common issues of interest. We send mailings and fax blasts to all providers on relevant training topics and update our training curriculum on an ongoing basis to better communicate information, especially on common issues such as billing and eligibility verification.

Clinical Practice Consultants (CPC) Program

The Clinical Practice Consultant (CPC) program, implemented in June 2010, is a targeted and comprehensive program dedicated to physician and community education and outreach, aligning with our individual plans goal to improve HEDIS complains and performance measures. Using our Universal Tracking Database (UTD), an automated tracking and reporting system based on submitted claims information, we monitor members' compliance with preventive health measures. In turn, we combine this information with our provider profile, producing monthly reports that rank our providers by percentage of non-compliant members. Outreach currently targets providers with the highest percentages of non-compliant members and is conducted by a CPC nurse across three on-site visits involving: (1) initial assessment; (2) 'action plan,' drawing on both UnitedHealthcare Community Plan and provider resources, to target noncompliant members across adolescent well care visits, diabetic and cholesterol screening, and lead screening; and (3) follow up, as needed. Additionally, CPC nurse efforts are augmented by Provider Advocate liaisons and community outreach efforts. The program represents our renewed and invigorated efforts to use the data analytic capabilities of our sister organizations to effectively partner with providers to enhance member compliance and quality of care.

Tennessee Pre and Post Measures

Health Plan	MEASURE NAME	Sc 2009	Sc 2010	year to year	2009 Percentile	2010 Percentile
Tennessee East	Adult BMI Assessment	28.5%	37.2%	improvement	50th	75th
Tennessee Middle	Adult BMI Assessment	24.6%	34.8%	improvement	50th	50th
Tennessee East	WCC - BMI Percentile Total	13.4%	31.9%	improvement	25th	50th
Tennessee Middle	WCC - BMI Percentile Total	17.3%	29.4%	improvement	50th	50th
Tennessee East	WCC - Counseling for Nutrition Total	51.3%	56.7%	improvement	50th	75th
Tennessee Middle	WCC - Counseling for Nutrition Total	52.8%	51.6%		50th	50th
Tennessee East	WCC - Counseling for Physical Activity Total	36.3%	49.9%	improvement	50th	75th
Tennessee Middle	WCC - Counseling for Physical Activity Total	37.7%	43.6%	improvement	50th	75th

Additional Support & Education

To support the Provider Advocate team and our CPC Program, UnitedHealthcare Community Plan also offers robust training, education, and communications programs to our providers on benefits, policies and procedures unique to the each of our individual health plans.

Provider Administrative Guide

Another key component of UnitedHealthcare Community Plan's provider education is our Provider Administrative Guide. Within 30 days of contract award, we will update the Provider Administrative Guide draft and post it to our provider Website for distribution to LA providers. The manual includes information about the LA program benefits and our policies and procedures, as well as information regarding payment terms and utilization review.

Provider Website Portal

UnitedHealthcare Community Plan also provides it's providers with access to a provider portal at www.unitedhealthcareonline.com. Our web based provider portal will support our Louisiana Medicaid providers through many innovative features and tools and is integrated with our key systems. Our interactive Website enables providers to electronically determine member eligibility, submit claims and

ascertain the status of claims. UnitedHealthcare Community Plan also offers an internet-based prior authorization system, iExchange, which allows providers who have internet access the ability to request their medical prior authorizations online rather than telephonically. The Provider Website will contain an online version of the Provider Manual, the Provider Directory, the Preferred Drug List (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements and educational materials such as cultural competency information, newsletters, recent fax service bulletins and other provider information. We will also post notifications regarding changes in laws, regulations and subcontract requirements.

Through a Provider Portal that would be created for Louisiana, providers can view their provider profiles, check member eligibility, submit claims and check claims status, request claim adjustments, view claim trends and view summary data. Our Provider Portal allows providers to monitor their own performance and progress toward goals by viewing their individual profiles and comparing their performance to overall plan performance. Underperforming providers can easily identify the specific areas they should target for improvement. The portal also supports clinical practice by giving PCPs a list of members with upcoming and missed preventive visits as well as other missed care opportunities that are in line with clinical practice (for example, a diabetic missing an annual eye or foot exam).

The Quick Reference Guide, electronic UnitedHealthcare Alerts and blast faxes and material are also available on the provider portal.

Provider Newsletter and Service Bulletins

We will also include training and educational information in our quarterly provider newsletter. The newsletters contain any program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, information on special initiatives and articles regarding health topics of importance to members. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements.

UnitedHealthcare will also use facsimile service bulletins (fax blasts) to distribute urgent information that impacts the entire network. We will e-mail service bulletins to providers' offices that have electronic communication capabilities. The service bulletins are also listed on the Website and recapped in the Provider Newsletter.

Ongoing Training

We offer yearly and ongoing trainings for all network providers to reinforce our initial new provider trainings. In addition, we initiate several outreach projects where we use a six touch approach to training providers:

- Welcome Letter
- Telephonic Outreach
- Face-to-Face Appointments
- Fax Blast
- Webinars
- Town Halls.

Through provider complaints, staff feedback, trended claims data, associations and advisory councils, UnitedHealthcare Community Plan identifies common topics or opportunities for retraining as well as specific providers for focused retaining. We monitor to ensure effectiveness and provide additional education when we identify common issues of interest. We send mailings and fax blasts to all providers on relevant training topics and update our training curriculum on an ongoing basis to better communicate information, especially on common issues such as billing and eligibility verification. We include representatives from provider associations on our advisory committees and always request their input on training needs and topics.

G.12 Describe how you will educate and train providers that join your network after program implementation. Identify the key requirements that will be addressed. (GSA C)

Educating and Training New Providers

We educate and train new providers within 30 days of their contract effective date through educational mailings, on-site provider visits and group training. Our Provider Relations team will assess each provider's training needs at the time of contracting and may conduct in-person training if needed. We provide upfront training to newly contracted providers and recognize when new providers may have a lack of experience when working with managed care. To assess training needs, we will also coordinate with all key provider associations along with our Quality Management Committee (QMC).

The Provider Relations team will review weekly reports from our provider contract management database to contact providers not yet trained to ensure they get the required training. Group trainings will be used for new providers and continuing education.

Provider Training Modalities & Training Topics

Our training programs, driven by service delivery imperatives, include four training modalities:

- ***Written Materials:*** Our provider manual is an essential reference document for all network providers. Quarterly newsletters and ad hoc mailings help reinforce policies and communicate changes, best practices, upcoming events, and quality improvement initiatives. Many materials are available at unitedhealthcare.com.
- ***Provider Orientation Meetings:*** Within 30 days of the provider's contract effective date, provider relation staff conduct orientation sessions for new providers. This in-person session is a chance to share documents, highlight requirements (e.g., 24-hour access for PCPs), and answer questions.
- ***Scheduled Training Workshops:*** We plan provider training workshops as opportunities to share information on services and issues, quality improvement initiatives, and other topics in interactive sessions. As we have in other service areas, we would schedule training sessions before implementation to educate providers on the plan.
- ***Ad hoc Training:*** As priorities dictate, we may conduct ad hoc trainings for specific providers or groups of providers.

Our training program utilizes traditional approaches such as site/group visits as well as innovative methods such as Webinars. New provider training is designed to incorporate changes in the administration of the local health plan programs as needed. New provider training topics include, but are not limited to:

- HealthChoices-specific billing policies and initiatives
- Encounter Reporting
- Service Authorization
- Understanding the Provider Claims Service Unit process
- Use of the Web Portal
- Understanding the Provider Claims appeal process
- Working with EDI (Electronic Data Interface)
- Importance of NPI (National Provider Identification).
- Provider Basics
- Special Programs (disease management, performance improvement projects, etc.).

Provider Advocate Team

As discussed in our G.11 response, we assign Provider Advocates to providers in our UnitedHealthcare Community Plan network, who are responsible for education and outreach to their assigned providers.

The Provider Advocate team provides basic training around billing processes and authorization requirements and procedures, while the Provider Operations Director and Provider Services Manager are available to provide more detailed technical training for providers needing assistance. We built additional resources into our model to improve our ability to adjust to an increase in training needs brought about by significant policy changes or other broad impact provider issues. Our UnitedHealthcare Community Plan Health Network (UHN) partners are available to augment the Provider Advocate Team and additional Business Analysts are available to provide specific, detailed technical training related to the EDI.

Field based training is a key component of our continuous quality improvement efforts. We schedule routine trainings and educational forums to touch our highest volume providers and key facilities. The Provider Advocate Team holds quarterly meetings with "top tier", high-volume providers to present regular updates and refresher trainings. We hold Joint Operating Committee (JOC) meetings with key facilities to address operational issues, including training needs. Provider Advocate Representatives schedule weekly meetings with primary care practices to ensure key policies and procedures are reviewed and access and availability information is gathered, as well as to discuss any other pertinent issues.

Topics Covered in Provider Education, Training and Communications

Our provider education, training, and communications program covers multiple topics and uses various channels that will give Louisiana Coordinated Care Program policy and procedure information to all new providers. **UnitedHealthcare Community Plan has a strong provider education and training program that begins when the provider first contracts to join our network** and provides ongoing general and targeted education and training. We will ensure that all providers understand contract requirements and plan processes related to the Louisiana Coordinated Care Program, including but not limited to:

- Louisiana Coordinated Care Program benefits, exclusions and limitations
- Integration of physical/behavioral health
- Emergency services not requiring authorization
- Timely provision of prenatal care
- Louisiana Coordinated Care Program services
- Coordination with CM program and specialty
- DM and CM programs (for example Healthy First Steps, Personal Care Model)
- HIPAA compliance expectations and protocols
- Louisiana Coordinated Care Program coding and reporting requirements
- Member rights and responsibilities
- UnitedHealthcare network requirements
- Member enrollment/eligibility verification procedures
- Access and availability requirements; including ED diversion
- Transportation access
- Specialty, behavioral health, ancillary, hospital network
- Web based tools clinical tools and evidenced based medicine
- Referral management and preauthorization procedures
- How to read the UnitedHealthcare explanation of payment
- Claims mailing address/EDI submission requirements
- TPL/Coordination of benefits process and requirements
- Provider disputes and claims appeal process
- Complaints and Appeals and process including emergency appeals

- Web-based services for provider claims inquiry/appeals
- Provider rights and responsibilities
- Fraud/abuse prevention and obligations to allow State access
- Level of care guidelines
- Louisiana Coordinated Care Program coding requirements
- Treatment/medical record documentation requirements
- PCP selection procedures
- Cultural competence
- Key contacts for UnitedHealthcare
- Provider billing requirements/claims processes
- HIPAA coding requirements
- UnitedHealthcare payor identification number and use of NPI
- Proper completion of billing forms
- Timely filing requirements for submission of claims
- Submission process for corrected claims
- Coordination with PBM re: authorization and payment
- Medical home model
- Requirements for language interpretation/translation
- Special needs accommodation
- State access to financial, clinical & administrative records
- Quality management participation & improvement initiatives
- Prohibition to balance bill members
- Correct billing for HEDIS related services.

UnitedHealthcare Community Plan will also provide education to all participating providers on the quality metrics that the State of Louisiana has identified relative to its membership, as well as any additional areas of quality performance improvement that the health plan has identified. This will include written explanation of how the quality metrics are calculated. Health plan staff, both network and clinical, will continue to reinforce this education during meetings with network providers.

Provider University

In addition to the programs mentioned above, we will roll out to Louisiana Providers a program that we have in place in Tennessee right now – Provider University. Provider University is an online resource for providers, a one-stop shop for providers' required and elective courses. Providers can visit the Website to view and RSVP for courses; all the courses are free and providers can take them as many times as needed. The online catalog includes such courses as:

- UnitedHealthcare Community Plan 101: An orientation class required by UnitedHealthcare Community Plan for all newly contracted providers to complete.
- UnitedHealthcare Community Plan 102: A refresher course on key elements about working with UnitedHealthcare Community Plan, this course includes information on claims, prior authorizations, service models and more.
- UnitedHealthcare Dual Plan 101: This course provides an in-depth education on many online functions available from UnitedHealthcare Community Plan's Provider Portal.

- Radiology Notification Program Overview: This course is a general overview of the notification requirements for advanced imaging services and includes information on making phone, fax and web-based requests.

Ongoing Training

We offer yearly and ongoing trainings for all network providers to reinforce our initial new provider trainings. In addition, we initiate several outreach projects where we utilize a six touch approach to training providers:

- Welcome Letter
- Telephonic Outreach
- Face-to-Face Appointments
- Fax Blast
- Webinars
- Town Halls.

G.13 Describe your practice of profiling the quality of care delivered by network PCPs, and any other acute care providers (e.g., high volume specialists, hospitals), including the methodology for determining which and how many Providers will be profiled. (GSA C)

Provider Profiling Policy

To deliver quality care to our members, UnitedHealthcare Community Plan's Provider Advocate team develops a close partnership with our provider network to ensure quality expectations are met. We believe a component of this oversight is through review of provider utilization patterns to ensure providers deliver the most appropriate, cost-effective, and medically necessary care possible. We also use this data to educate providers on their pattern of care and any areas they may need to address to enhance care. We believe the use of data in partnership with our providers will ultimately increase our members' quality of care.

Through our Physician Quality initiative, we measure physicians' and other health care providers' performance compared to accepted standards of care. Physician Quality reports are mailed to qualifying physicians at least annually in hard-copy format. Each report includes member/patient-specific information highlighting where potential gaps in care may exist. The measures in the Physician Quality reports are a subset of the overall quality measures in HEDIS. A new physician service, View360™is a highly advanced and multi-purpose portal currently available to UnitedHealthcare's commercial providers. By year-end 2011, the portal will include all members (commercial, Medicare, Medicaid) and has multiple dashboard and drill down capabilities including outcomes for HEDIS and other metrics. This includes interactive views of patient-specific gaps in care (updated monthly) based on 54 quality measures. The patient clinical information will be populated from multiple sources, including medical and pharmacy claims as well as with test results (when available). The system will offer physicians the ability to provide updates and corrections to the information displayed about their patients.

Additionally, we use a Pay for Value (P4V) model that rewards providers for increased collaboration, outcome-based results and improved cost efficiencies. These gain share arrangements improve population-level care coordination, align health plan and provider incentives, support clinical data sharing and result in patients who are engaged in advancing their own health and well-being. Provider profiles give providers an opportunity to identify areas to improve their performance and ultimately achieve P4V rewards.

Identifying High Volume Providers

UnitedHealthcare Community Plan conducts utilization profiles twice a year on Family Practice, Internal Medicine, and Pediatricians primary care providers (PCPs) who are the first and primary touch point for our members. Typically high volume providers are defined as those with greater than 100 members, We analyze and provide this data to each individual PCP. The profile measures the provider's level of care based on utilization patterns and quality indicators. The utilization indicators include data such as encounters, specialist visits, emergency room (ER) visits, and hospital days. The quality indicators

include data such as completed child/adolescent well care visits, child/adolescent immunizations, cervical screenings, or mammograms.

We distribute the results of the provider profiles to the providers, along with a snapshot of his or her utilization patterns and quality scores. We offer providers the opportunity to respond with questions and concerns. In addition, our Provider Advocate Team is available to schedule on-site visits to discuss the findings.

Profile data are case-mix adjusted and providers compared against same specialty peers. As appropriate, the profile data is further analyzed to identify providers whose utilization or quality scores fall below one standard deviation from the norm. We contact these providers and ask them to respond to the findings, and initiate additional investigations as appropriate.

UnitedHealthcare Community Plan uses claims and encounter data to develop the bi-annual Quality Management (QM) profile reports which provide an outline of the provider's general utilization pattern.

In addition, we have implemented a pilot Provider Data Sharing Program for a more targeted group of providers. Based on claims data, UnitedHealthcare Community Plan identifies the top 25 providers who have high ER and hospital utilization; high pharmacy utilization; and low HEDIS scores. We work with the identified provider to improve care and reduce costs. The goal of this program is to facilitate and monitor the delivery of appropriate care through the use of claims data, medical record documentation, and member complaints/grievances data; and use the resulting information to educate providers about age-appropriate care, drug formulary updates, and compliance and clinical practice guidelines.

- ***Submit sample quality profile reports used by you, or proposed for future use (identify which).***

See Attachment G.13 for sample Provider Profile Reports. The format in the sample would be the same for profiles generated for the Louisiana plan. The measures chosen from the Texas plan exhibit the same level of planning as would go into affect with the Louisiana plan if awarded the contract.

Each profile contains definitions and descriptions of UnitedHealthcare Community Plan standards and comparison to other provider benchmarks with a similar medical case mix. We offer providers the opportunity to respond with questions and concerns. In addition, our Provider Advocate Team is available to schedule on-site visits to discuss the findings.

- ***Describe the rationale for selecting the performance measures presented in the sample profile reports.***

Provider profiles are developed in conjunction with each of our individual plans in each state. Each plan can choose up to 10 quality care measures for their plan. Our plans typically choose quality measures based on Performance Improvement Projects, quality improvement goals identified by the state as well as those that may be identified by the individual plan.

For example, if the plan has identified through barrier analysis provider education on missed opportunities for member care as an improvement action for a health plan Performance Improvement Project, (PIP), they would choose the associated PIP quality measure to be included on the profile report. Another example may be that the state has a large gap in a specific rate of identified care such as Well Child Care visits. The plan may then choose a measure based on the state's expectation to improve the rate of Well Child Care visits.

If awarded the Louisiana contract, we would partner with DHH to match the measures Louisiana has identified as their quality initiatives. For example, the provider profile could include breast and cervical cancer screening rates, Well Child visits and childhood Immunizations.

- ***Describe the proposed frequency with which you will distribute such reports to network providers and identify which providers will receive such profile reports.***

The results of the Provider Profiles are distributed to the PCPs twice a year. Profiles will be generated for our High Volume PCPs as described above or Significant Traditional Providers. The Provider Profile provides a snapshot of their utilization patterns and quality scores. The Profiles are accompanied with non-compliant lists which detail the members in need of outreach. Providers are profiled for all measures listed on the profile.

Provider Follow-up and Education

Field based training is a key component of our continuous quality improvement efforts. We will schedule routine trainings and educational forums to touch our highest volume providers and key facilities. Education and follow up is provided by the Provider Advocates on a quarterly basis with High Volume Primary Care Providers. At the quarterly meetings the Provider Advocates review the PCP's performance as it relates to their respective UnitedHealthcare Community Plan assigned members. The following topics are reviewed at the meetings:

- ER utilization
- Rate of EPSDT completion
- Rate of members between the ages of 5-56 with an Asthma diagnosis that are receiving appropriate meds for Asthma
- Rate of completion of Blood Lead Screenings
- Rate of women ages 21-64 that have received a Pap Smear
- Rate of Women age 40 and older that have received a mammogram
- Rate of members ages 12-21 who received a well care visit
- Rate of members up to age 24 months that received appropriate immunizations
- Rate of members ages 18-75 with a Diabetes diagnosis who had and LDL screening as well as an HbA1c test.

In addition to reviewing their current rate of completion, the Provider Advocates supply their High Volume PCPs with a list of members that are being measured and advise which members we have record of completion for and which are still showing a need for the indicated screening.

G.14 Describe the process for accepting and managing provider inquiries, complaints, and requests for information that are received outside the provider grievance and appeal process. (GSA C)

Our toll-free Provider Hotline plays an important role in disseminating information to Providers by responding to inquiries on topics such as member benefits and eligibility, fee schedules, claims, remittance advices and copies of checks. The hotline also manages the intake for Provider complaints and will instruct the provider on the process of submitting a formal written complaint by mail. The provider will send the complaint to our Central Escalation Unit (CEU) who will then receive and handle or forward to the appropriate department. The complaints are captured in an electronic application in which the Customer Care Professional will be able to locate and provide status of the complaint that has been submitted. In 2009, we enhanced our local Provider Hotline by implementing new training curricula and additional call monitoring. As a result, we are currently operating a hotline that offers more accurate information and better Provider support than ever before. UnitedHealthcare Community Plan's toll-free Provider hotline is staffed Monday through Friday, 7 a.m. to 7 p.m. Central Standard Time (CST), excluding state approved holidays. We also maintain a 24-hour Interactive Voice Response system to provide hours of operation and enrollment verification.

To be responsive to our providers, we ensure that hotline staff are adequately trained, rout and track calls

from providers, monitor for quality and accuracy and monitor for adherence to program standards.

Provider Hotline Staff Training

Hotline staff complete training on the CCN program and UnitedHealthcare Community Plan's contractual requirements including, but not limited to:

- General orientation
- CCN program covered services, including categories of eligibility
- Plan structure, including medical management functions, claims functions, member service and provider services
- Cultural sensitivity and confidentiality training
- Integrity and compliance
- Live training, during which the trainee listens to calls handled by a trainer
- Trainees directly answering live calls with supervision
- Systems introduction (IT, telephone and contact tracking system)
- Professional and Institutional Claims Handling
- Language Line
- CCN lingo and acronyms
- Frequently asked questions by providers
- Appropriate documentation of calls via tracking systems
- Introduction to provider materials, including contracts, provider directory and the website provider portal
- Recognizing issues that should be escalated or transferred to another department.

PPRs' initial training includes a six-week Provider services training session covering benefits, eligibility, claims and two weeks of on-the-job training for handling live calls. We use a variety of training methods such as facilitated lectures, role-playing/simulation, question and answer sessions and computer-based training. Before placement in the hotline, trainees must demonstrate their ability to respond to Provider inquiries. Representatives also receive annual refresher training and ad hoc training as needed. Our training curriculum for representatives includes:

- Comprehensive information about Medicaid
- Training on the Provider systems
- Telephone etiquette and call quality
- Compliance requirements (e.g., HIPAA, confidentiality, and PHI)
- Corporate integrity and compliance courses (e.g., fraud, waste, and abuse)
- Fee schedules, contracts, and CPT, ICD-9, and other billing codes.

Call Routing

We are committed to being responsive to Providers calling the Provider Hotline. We use an automated call distribution system to route Provider calls efficiently and accurately. Our local call center management team utilizes a series of applications including Centre and IEX to aid in monitoring our call response rate on a daily basis and generates specialized reports to identify peak call times and quantify representative productivity. In addition, our call center management team monitors the number of calls holding in queue to determine the longest wait time for any caller. This advanced technology helps us channel calls to the appropriate subject matter experts. The system offers callers a menu of automated and live agent services; at any time during a call made during normal business hours, a provider can opt to speak to a live representative.

Our call routing process involves two levels of Provider Phone Representatives. Level 1 PPRs handle calls servicing claims, eligibility and benefits, while our Level 2 PPRs, who are more seasoned, handle difficult calls regarding complex claims and issues unique to RHCs, FQHCs and LTSS Providers. We train all representatives to support any type of call and provide first-call resolution to Providers. Our PPRs have the ability to submit the request while on the phone with the requesting Provider. We also use a number of performance standards to monitor that calls are being responded to in a timely manner.

We have also incorporated a new feature for our digitally recorded telephonic services including Text Search capability to identify emerging provider call trends leading to improved first call resolution.

Enhanced Provider Service Model

In addition to the services provided above, we have taken the initiative to enhance our Provider Hotline model to include Provider Claims Resolution Specialists (PCRS). This enhanced model maintains ownership of Provider issue(s) until they can either process the adjustment to meet the Provider's expectation or educate the Provider via an outbound phone call, ensuring a closed loop process. The Provider indicates, whether to a PPR, online or via paper request, what action they are expecting from us to close our portion of the claim in their practice management system. When using this model through the Provider Hotline, PPRs are able to route Providers' calls directly to a PCRS and initiate outbound calls to the Provider either when Provider expectations are not met or if they need additional information.

This information is documented for the PCRS examiner. If the adjustment meets the expectation provided by the physician or health care professional, the Provider will receive a Remittance Advice identifying the adjustment. If we are not able to meet the physician or health care professional's expectation, the PCRS will place a return call to the contact in the Provider office to discuss the claim outcome and bring the issue to resolution.

Enhanced Provider Service Model

"In our Wisconsin pilot of the PCRS model, provider satisfaction survey results were 99% and above for December 2010 through March 2011. Additionally, a focus on addressing root cause has resulted in nearly a 20% drop in the number of calls."

Monitoring for Quality and Accuracy

For a new representative, we monitor a minimum of 10 calls per month for the first 90 days. Once proficiency is established, we reduce the number of monitored calls to five per month. The supervisor or quality coach provides feedback after each monitored call. In addition to Qfiniti, our quality database, supervisors monitor live calls on a daily basis and provide immediate feedback. We track and trend the results of the call monitoring for all staff to highlight areas of improvement. The director of training reviews the trended results and adjusts the training curriculum as necessary. After training, hotline managers continually monitor performance. A quality coach is responsible for monitoring, scoring, tracking, and trending for Provider calls. The quality coach provides immediate feedback to individual staff to improve the quality of their calls, acknowledge positive behavior and change unwanted

Beginning in the third quarter of this year, we plan to roll out Behavioral Analytics™ and Desktop Analytics™ Services from eLoyalty to gather information from Provider interactions, including phone calls and agent desktop usage, and using algorithms to look for previously unknown patterns across our population of Provider interactions. With these tools the Provider Hotline staff will have information to:

- Coach agents on how to relate to customers with difficult issues
- Determine First Call Resolution (FCR) and analyze those calls where FCR was not met
- Identify process improvement opportunities
- Understand variability in PPR performance and coach on desktop navigation to improve efficiency.

Our staffing models factor for hours of operation, anticipated call volumes, average handle times, and

contract requirements. We use our monthly reports/data to predict monthly patterns of calls, schedule staff to meet forecasted demand and to monitor the provision of quality Provider services. We continually evaluate the Provider Hotline staffing levels to meet standards for resolution, abandonment rates and hold time requirements

Monitoring for Adherence to Performance Standards

We are committed to meeting or exceeding the call performance standards for the CCN, and we will submit reports to DHH summarizing hotline performance for the hotline as requested. We have implemented new quality assurance processes to improve the accuracy of reporting to HHSC. Before we submit the reports, our new pre-delivery process includes a formal acceptance process through the Reporting Team, Operations staff and members of the local health plan.

We will adhere to CCN's telephone standards for provider call center interactions. In our Arizona program, we exceeded standards for each measure in 2010 as shown below.

2010 Provider Call Center Performance Results		
Key Metric	***ALTCS Standards***	***2010 Results***
Maximum Allowable Speed of Answer	60 seconds	14 seconds
Monthly Average % Abandonment Rate	5.0% or less	1.11%
Monthly Average % Service Level	80.0%	93.06 %

Our performance against these standards is monitored on a monthly basis to ensure compliance. The call center adjusts staff size or staff schedules to ensure continuous coverage and consistent compliance with standards.

The following are statistics from our CHIP Provider hotline, administrated by MediView:

Months	***Monthly Call Volume***	***Calls Answered by 4th Ring***	***Abandonment Rate***
Jan-March 2011	15,349	15,349 (100%)	0.2%
Oct – Dec 2010	13,252	13,172	0.6%
July-Sept 2010	13,309	13,171	1%
April – June 2010	13,828	13,706	0.9%

Also, we administer automated surveys at the end of calls to gauge Provider satisfaction. At the beginning of the IVR call, the Provider has the option has to participate in our Provider satisfaction survey. Once the Provider opts-in to the survey, they are directed to an automated service to answer questions regarding the service they just received.

G.15 Describe in detail your proposed approach to providing non-emergency medical transportation (NEMT) services, including, at a minimum: (GSA C)

- ***What administrative functions, if any, you will subcontract to another entity;***

Proposed NEMT Services

UnitedHealthcare Community Plan contracts with LogistiCare, a national leader in providing quality transportation services specifically to Medicaid and Medicare members. LogistiCare is the most experienced non-emergency medical transportation (NEMT) provider in the nation. LogistiCare mirrors UnitedHealthcare Community Plan's commitment to quality, safeguarding and protecting Medicaid and Medicare members and helping to improve both rural and urban NEMT services and efficiencies.

As the most experienced NEMT full-risk broker in the country, LogistiCare performs 110,000 trips daily on a five-day weekly basis and provides hospital discharge and urgent transportation 24/7/365 nationwide across areas as diverse as dense metropolitan areas to remote rural communities. They are the largest NEMT broker in the country in terms of state contracts, lives covered, and trips provided.

The only services that LogistiCare subcontracts are the actual transportation services. LogistiCare's well-established Network Development Program is designed with safety and quality in mind. It begins with recruitment, orientation, and training and is followed by a hands-on, diligent approach to managing our full network of sub-contracted providers. LogistiCare is committed to developing and maintaining fully credentialed and compliant transportation networks and have centralized oversight of this function at our corporate headquarters where it is managed by a director-level employee reporting directly to the Chief Administrative Officer (CAO).

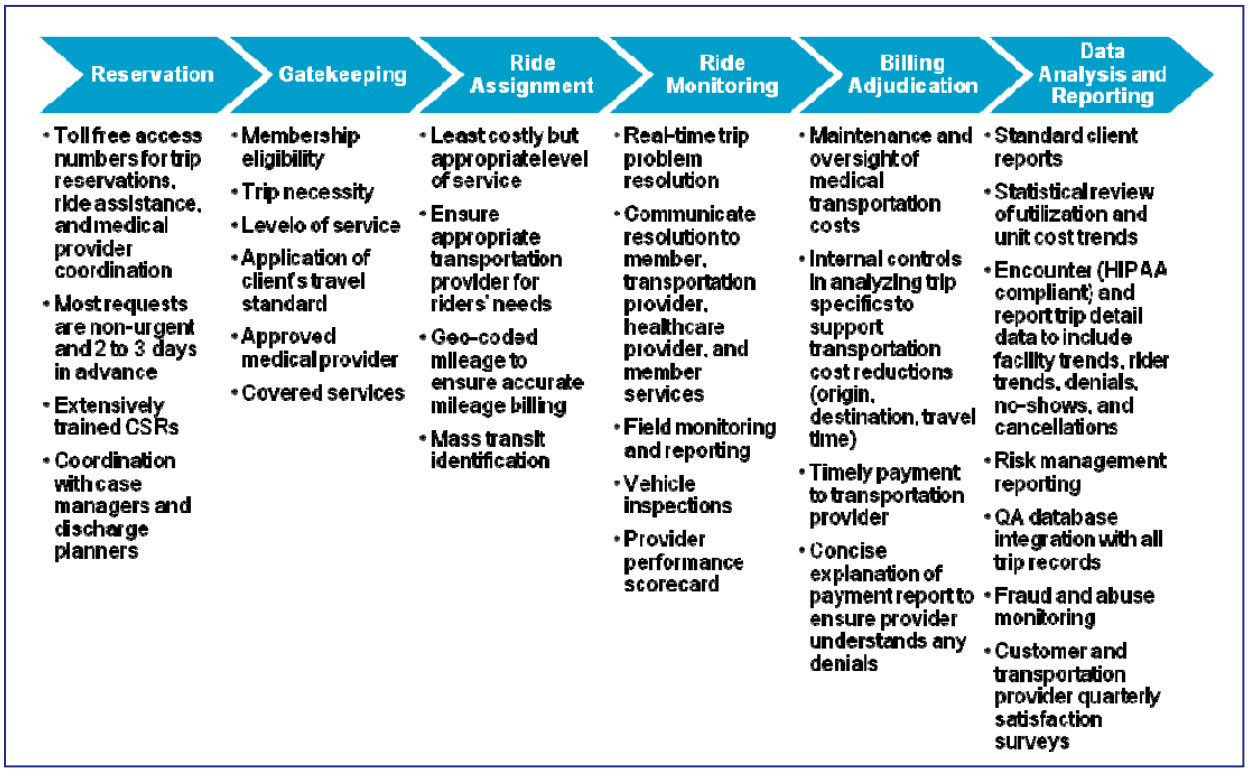
LogistiCare recognizes that continued compliance is critical for safeguarding Medicaid and Medicare members, and is vigilant in protecting and maintaining high-quality NEMT operations. All of the transportation providers must meet or exceed criteria for orientation, inspection, credentialing, evaluation, testing, and contracting. LogistiCare's goal is for every aspect of service delivery to be in compliance with Medicaid, Medicare, ADA requirements, state EMS, and all other applicable regulations and client contractual requirements.

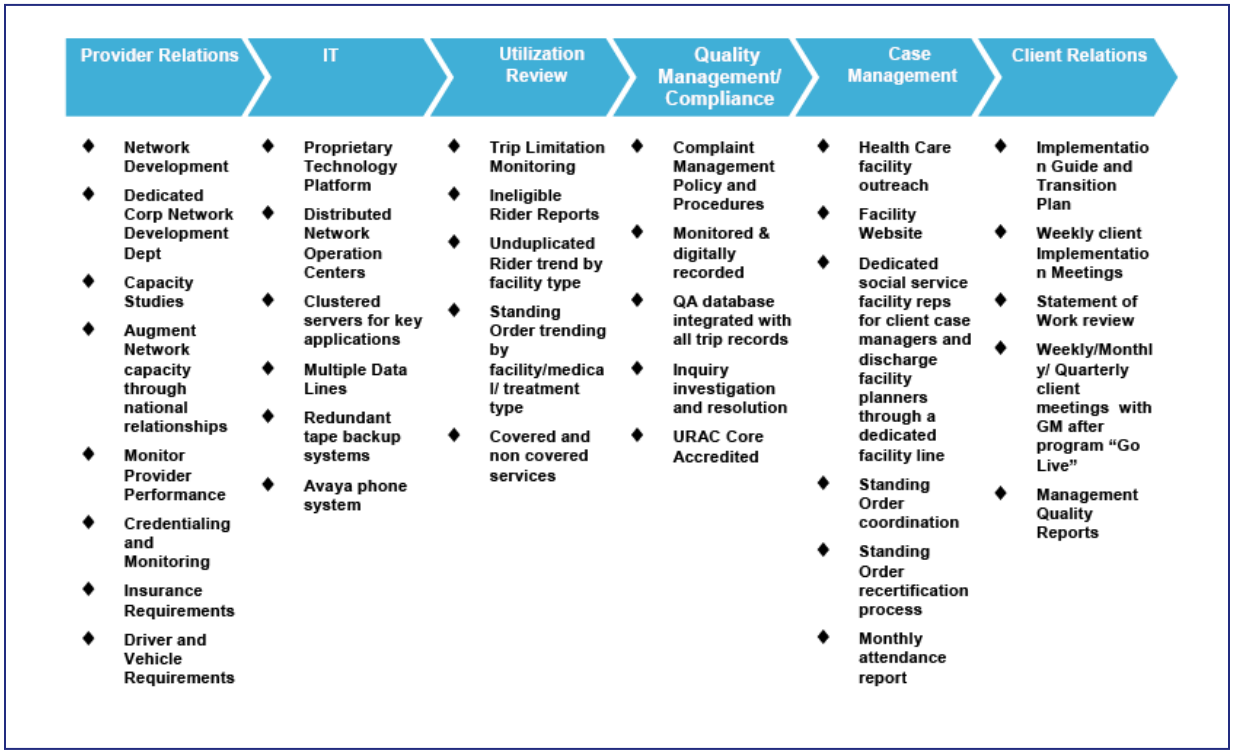
- ***How you will determine the appropriate mode of transportation (other than fixed route) for a member;***

Determining Appropriate Mode of Transportation for a member

As depicted in the diagram below, LogistiCare's model for managing non-emergent medical transportation services, including managing costs and utilization, starts with reservations taken by highly-trained Customer Service Representatives (CSRs) on a dedicated toll-free line. LogistiCare is sincere in concerns for the safety and well-being of members transported. LogistiCare promotes total confidence in CSRs' abilities to perform the reservation process, including careful screening and verification, with the highest levels of professionalism and customer satisfaction. CSRs are particularly sensitive to those members who have difficulties attributed to age or disabilities.

Steps in LogistiCare's Service Delivery Process





While on the phone, the CSR follows a customized Call Script, supported by a Statement of Work, Summary of Covered Benefits, and process flows that are specifically tailored for (and approved by) the HHS. The Call Script validates that CSRs are following protocol on *each call* so that *every trip* request is

processed accurately, politely, and efficiently. Once the caller indicates the intention to schedule a trip, the CSR will enter the member's name or program identification number (ID) into a proprietary LogistiCAD systems' reservations module in order to verify the member's eligibility. If for some reason the member's name or ID is not in the system, the CSR will check with UnitedHealthcare Community Plan, using the required method.

Obtaining Trip Details and Confirming Service Coverage

Once the member's eligibility has been verified, the CSR will obtain details of the member's request, including trip date and time, name, address, and telephone number of the health care facility, the member's name, telephone number, and Medicaid or Medicare number and any special needs which may affect the type of transportation needed. As the trip is recorded, the software automatically calculates the trip mileage based on the pick-up and drop-off addresses.

The core of LogistiCare's business is to provide NEMT to members who need and qualify for those services. However, LogistiCare takes many precautions to ensure that members are using these services only for the accepted and approved reasons. This is an important step to ensure that all trips are for compensable services and part of our fraud and abuse detection process.

Determining Level of Service and Assistance

If the request is for transportation to an approved service, the CSR will determine the least costly, most medically appropriate level of service (LOS) for the member's requested trip based on the member's medical condition and the medical provider's location. This is a very important component of the NEMT authorization process. This involves selecting the correct type of vehicle, transportation provider, and level of assistance. Level of assistance refers to the help required by the member from the driver (curb-to-curb, door-to-door, door-through-door, etc.), as well as the possible use of escorts, attendants, or child car seats. By strictly managing these cost factors, LogistiCare will ensure that the NEMT program is efficient and cost-effective for UnitedHealthcare Community Plan.

LogistiCare complies with our policies and procedures for NEMT transportation in determining the appropriateness of decisions made regarding LOS and mode of transportation for its Medicaid and Medicare members. LOS information will also become a part of the member's personal history file and will automatically display to aid the CSR assisting the member when subsequent reservations are made. Members will receive the same LOS that is appropriate for their circumstances on future trips unless their circumstances change.

Verifying Trip Information

Once all necessary information is entered, the CSR will verify accuracy with the caller and save the reservation. A reference number will be automatically assigned to the reservation, which the CSR will provide to the member or the member's representative. The CSR will also confirm details of the scheduled trip with the caller at this time.

Assigning a Ride

After the CSR has entered the approved reservation request, the system will automatically flag all ***urgent and same day trips*** for the transportation department staff who will immediately work to place the trip with a transportation provider.

LogistiCare assigns trips to providers in ways that promote the most efficient use of multi-loaded vehicles while complying with strict standards for trip durations. The trip assignment process, including the task of assigning trips to members' preferred providers, is greatly assisted by an Automated Trip Assignment function in our system. Additionally, where no preferred provider has been named, trips will be assigned on a rotational basis to ensure fair and efficient outcomes.

Auto assignment is a LogistiCAD system feature that enables our team to automatically assign a transportation provider at various levels. Because LogistiCare subscribes to a no-bidding policy, LogistiCAD's auto-assignment feature assigns trips to a single provider or a mix of providers based on algorithm rules. Our system goes through a hierarchy of trip assignment criteria until it finds a transportation provider that matches one of the criteria or until all possibilities are exhausted. While trip assignment criteria are configurable, the hierarchy of criteria typically used by LogistiCAD includes:

- Standing order trip with transportation provider assigned
- member-preferred transportation provider
- Facility-preferred transportation provider
- Preferred transportation provider by zip code
- Preferred transportation provider by city
- Preferred transportation provider by county
- Lowest cost transportation provider.

Although LogistiCare Transportation Coordinators use both auto and manual methods of assigning batches of trips to transportation providers, it is the provider's responsibility to assign a specific trip to a vehicle and driver. This enables transportation providers to route trips based on a familiarity with local road conditions and rider types.

This flexibility in routing allows transportation providers to multi-load riders based on their agreements to provide transportation for other entities, which helps to save money for the program. Multiple transportation providers can be linked with a single service area, and each can be assigned a particular percentage of service area trips. We can also automatically track the maximum number of trips that each transportation provider can run to ensure that auto assignment does not overload a provider with too many trips, which can result in reroutes and service failures.

Dispatching Assigned Trips to Transportation Providers

Before trip lists are distributed, LogistiCare's Assistant Transportation Coordinators (ATC) reviews the lists to ensure that appropriate volumes and trip types have been assigned. In addition, LogistiCare reviews each day's trip mix to ensure that trips are appropriately distributed throughout the day and appropriately located geographically to allow the transportation provider to route most efficiently. W LogistiCare also monitors transportation provider performance to ensure the provider is only sent the number of trips that can be handled effectively. The trip lists contain all the information needed by the transportation provider to select the most appropriate vehicle, driver, and additional assistance for the member.

Handling Last Minute Requests and Changes

LogistiCare is experienced in handling last minute requests and changes. When it is necessary to change a reservation or add information, the CSR retrieves the reservation in the LogistiCAD system. Teams can quickly and easily make changes or reassign trips "on the fly" in the event of a last-minute scheduling change. CSRs are responsive and flexible, and will go out of their way to accommodate reasonable requests.

It is important for quality control and accountability purposes to be able to track all changes made to a reservation, whether these involve notes, changed pick-up times, changed transportation provider assignments, or any other modification. The LogistiCAD system maintains all changes that have been made to a reservation or completed trip record, the users who completed those changes, and the date and time of the changes. If a reservation has multiple trip legs, changes for each leg can also be viewed.

Handling member and Vendor No-Shows

LogistiCare's main objective is always to minimize the number of no-shows for medical services and other health care appointments understanding that when an appointment is missed, it adds a burden to the facility providing service by wasting precious time that could have been spent treating other patients. It also adds administrative burden to the facility in terms of the rescheduling time required and can cause the transportation provider to waste valuable resources.

Member No-Shows

LogistiCare monitors cancelation reports from providers to track no-shows. Incidents of member no-shows will be documented by our CSRs promptly in our LogistiCAD database system and reported so that they can contact the members directly. The primary function is to provide all eligible members residing in the service areas with access to NEMT services when and where they need them.

To reduce the number of no-shows, members are contacted by telephone within 24 hours of their scheduled trips to remind them about their pick-up times and within what time frames they can expect the driver to arrive. The amount of advance notice given and the medical necessity for an NEMT request will result in the reservation being prioritized by the following categories: "Urgent," "Same Day," "One Day," "Two+ Days," or "Prescheduled."

Improvement Initiatives
LogistiCare is in the process of rolling-out a sophisticated outbound "Reservation Reminder" Interactive Voice Response (IVR) service that will deliver a robust, multi-channel communications solution. This will enable us to easily remind our members of scheduled ride appointments by voice, e-mail, or text message.

All member no-shows must be reported by the drivers to their dispatching department. Before allowing the vehicle to depart the location, the dispatch department must immediately report the no-show to the LogistiCare staff on either the *Provider Line* or the *Where's My Ride* line**.** The LogistiCare staff will attempt to verify the no-shows by placing a telephone call to the following:

- Home or cell phone of the member (for in-rides)
- Medical Provider site (for return rides).

The LogistiCare staff then makes notations in the trip notes regarding the status of the trip and cancels the trip. However, the transportation provider's dispatcher must report any pertinent information that would substantiate the no-show to LogistiCare staff who *may* take the following actions:

- Accept the verification of the no-show and allow the vehicle to depart the location
- Contact the member to verify the no-show
- Contact the facility to verify the no-show.

Before reporting a no-show to their dispatch department, it is the duty of the driver/attendant to knock on the member's door and ring the door bell, if one is available, or announce his or her presence at the medical provider facility. A driver/attendant is not considered to have fulfilled his or her obligation by merely sounding the horn and remaining in the vehicle, unless the ride has been specified as a curb-to-curb service. The normal wait time for reporting a member no-show to the dispatch department is five minutes. The driver/attendant is not to continue on with the route, unless specifically instructed to do so by LogistiCare through the provider's dispatch department.

If a driver has reported and verified five consecutive no-shows for members attending the same destination, dispatch is required to have the driver on standby before proceeding to the next scheduled pick-up that have the same destination. The transportation provider will fax LogistiCare with the

consecutive no-show information on the Cancellation Report, and the LogistiCare staff will verify whether or not the facility is in operation and supply dispatch with appropriate instructions.

When a transportation provider fails to report and verify a no-show and allows the vehicle to depart the location, the provider will be responsible for providing transportation for the member when the member contacts LogistiCare requesting a ride. If the provider can go back for the member, the trip will be billed under a new trip number.

If the provider is unable to provide transportation for an unverified no-show and LogistiCare staff must recruit another provider or field-monitor to provide the transportation, the original LogistiCare provider will be charged the amount that takes the added trip as well as a $25 late reroute fee.

Transportation Provider (Vendor) No-Shows

Not only can we rely on LogistiCare to improve our members' satisfaction with NEMT transportation, we will also save money by minimizing missed appointments. Capacity is managed to reduce the number of provider no-shows and reroutes that lead to missed appointments.

Provider no-shows cannot be totally eliminated. In the case of a no-show by a provider, the member or facility will call our *Ride Assist* line, which is staffed with dedicated transportation coordinators who will answer and immediately arrange return-trip pickups. Live operators will be available after hours and on weekends to handle *Ride Assist* calls and to resolve any related service issues immediately.

Managing Late Running Vehicles

Timeliness is a key performance measure for LogistiCare. If a member's vehicle is running late, the member or their medical facility can call our *Ride Assist* line, where they will reach dedicated transportation coordinators who will answer questions and immediately manage late-running transport situations. This service is available after hours and on weekends to process *Ride Assist* calls and to resolve any related service issues regardless of the day or time.

- ***Your proposed approach to covering fixed route transportation;***

To determine the appropriateness of fixed-route public transit services for members, a number of factors are considered through our CSR procedures for gate keeping during the reservation process. Unless the member has already been designated as ineligible for public transportation in the LogistiCAD system, the CSRs will ask a series of questions during the reservations process to guide the member to mass transit, if it is available and meets required conditions including:

- Is transit service running between the pick-up and drop-off locations?
- Is the service reasonably timely? Service may involve transfers, but the wait for transfers must be reasonably brief. In addition, the recipient must not be delivered to the health care facility too early, nor be required to wait for too long after the appointment.
- Are the mass transit stops within 1/4 mile of the pick-up and drop-off locations (mileage requirement may vary by state)?
- Does the member have any medical condition that prevents him/her from riding on public transit vehicles or accessing public transit stops?
- Is the member able to understand common signs and directions?
- If either the pick-up or drop-off location is too far from a transit stop for walking, would it be cost effective to provide a short ride to the closest transit stop?
- Will the treatment the member will receive mean they can utilize mass transit on the initial trip to the appointment, but need a vehicle to pick them up for the return trip because they may be too weak (chemotherapy, radiation, dialysis, etc.)?

If the member meets all of these requirements but does not wish to use public transit, LogistiCare will fax a physician confirmation form to the member's physician so that they may determine the appropriateness considering the member's specific needs and medical condition. The physician will complete and return the signed form to LogistiCare to relieve both members and case managers from the responsibility of obtaining that information. If the physician advises that the member can use public transit that is the level of service LogistiCare will assign to the member's trip. Otherwise, LogistiCare will assign an ambulatory/livery provider for the member.

- ***How you will ensure that pick-up and delivery standards are met by NEMT providers, including training, monitoring, and sanctions;***

LogistiCare uses a combination of oversight, field inspections, monitoring provider performance and transportation standards, and training to make sure providers are meeting stringent standards for quality and contract compliance to ensure that pick-up and delivery standards are met by NEMT providers. Each provider agreement contains a set of requirements for the contracts under which they supply NEMT services.

Ensuring Pick-up and Delivery Standards are Met by Providers

Any deficiency in the quality of transportation providers whether evidenced through complaint or inspection is addressed immediately. Should a problem with a transportation provider be verified, corrective action is taken by meeting with the provider to discuss what has happened and how to resolve the problem. LogistiCare works closely with providers to help them achieve and maintain high transportation expectations of them. If providers struggle to meet stringent requirements, reducing trip loads to help them improve their services occurs. While they are operating under reduced-trip circumstances, LogistiCare counsels with them on changes they can implement to maintain UnitedHealthcare Community Plan approved requirements with steadily larger trip loads until they have returned to normal service. Should a problem with a transportation provider escalate beyond this level of training and cooperation then further restrictions are enforced, and at all times LogistiCare retains the right to terminate any transportation provider.

Oversight

A valuable form of oversight and communication that continues to provide transportation providers engaged in meeting our member's transport needs is the Provider Report Card (PRC). We will issue the PRC monthly to each transportation provider in the network to provide an unbiased, documented assessment of performance quality.

The PRC scores each provider, comparing performance against standard measures. A copy of this PRC is provided monthly, and LogistiCare management staff meets face to face with each provider at least quarterly to discuss Provider Report Card ratings and the provider's standing in comparison to other providers in the service area. The Provider Report Card has demonstrated results as a management tool to improve performance. For example, Pennsylvania provider scores improved from a range of 54.2 to 90.2 percent in 2008, when the PRC was implemented, to a range of 86.3 to 99.3 percent in 2010.

Field Inspection

We will make both scheduled and unscheduled visits to the transportation provider's office to review records and procedures, and further, we have Field Monitors who regularly visit health care facilities and ride along on trips to observe driver behaviors first hand. (Field monitors may also monitor member behaviors during these rides. For example, in one case, a member was being transported via stretcher and her Field Monitor watched the member get up off the stretcher and walk into and out of a dialysis facility. This is the type of observation that initiates a change in Level of Service classification.)

Monitoring Provider Performance

We also measure provider performance on several aspects of service such as missed trips, timely pick-up and drop-off, complaints, accidents, etc. If a provider is not reaching the required contractual or performance standards, corrective action is taken, which may ultimately include removing them from the network.

Timeliness data illustrates that, in 2010, LogistiCare clients across all contracts nationwide were ***delivered on time to their medical appointments 93.2 percent of the time,*** *and trips were* ***complaint-free 99.5 percent of the time.***

Monitoring Transportation Standards

LogistiCare employs key quality indicators and internal targets related to transportation scheduling (detailed below) to ensure quality.

Transportation Timeliness:

- Riders delivered on time to their medical appointments — arrival time at appointment to be within 15 minutes of appointment time
- Pickup after appointment to be within 60 - 90 minutes of notification (dependent on the state the member resides in)
- Average wait time for initial pickups to be 15 minutes or less
- Average wait time for a scheduled return trip after an appointment to be no more than 15 minutes
- Wait time not to exceed 60 - 90 minutes for unscheduled pick-up times (dependent on the state the member resides in)
- Multi-loaded trip durations no more than 45 minutes longer than the average time for direct transport
- Drivers must provide notification of delays and estimated time of arrival; LogistiCare to advise rider and arrange alternate pickup
- Arrival time for discharge to be within 3 - 4 hours of notification (dependent on the state the member resides in)
- Call Center contributions to timeliness — CSRs correctly enter all information related to the trip reservation.

Provider Credentialing:

- No days in which ineligible drivers provide service
- No days in which ineligible vehicles provide service
- Transportation Customer Service
- Drivers must provide courteous, sensitive customer service and necessary mobility assistance
- 99.90 percent of trips must be free of complaints about the driver.

Transportation Safety:

- Vehicles must meet all maintenance and safety requirements
- Fewer than three accidents per 10,000 completed trips
- Fewer than one safety complaint per 1,000 completed trips
- Pickup times are scheduled to allow enough time for each trip to be made safely, while also allowing for efficient multi-loading, based on automatically calculated distance and LOS.

Assignment volume is carefully tracked for each transportation provider against performance measures to ensure that no provider is receiving more trips than they can provide. By managing the capacity issue, number of provider no-shows and reroutes that lead to missed trips is reduced.

Training for Drivers

When a driver is not acting in accordance with the training instruction, the driver is suspended from providing services for LogistiCare and is retrained. Once the driver has finished the retraining process, the driver is allowed to return to service and the certification of the retraining is kept in his or her credentialing file.

LogistiCare requires transportation providers to be immediately removed from service if any driver is suspected of violating drug and alcohol policy requirements until a satisfactory review has been completed. Additionally, LogistiCare reserves the right with transportation providers to remove from service any driver UnitedHealthcare Community Plan or LogistiCare feels is not in compliance with regulations.

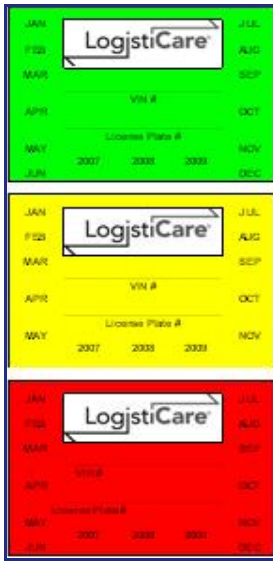
- ***How you will ensure that vehicles (initially and on an ongoing basis) meet vehicle standards, including inspections and other monitoring;***

LogistiCare will ensure that safe, reliable, and quality vehicles will be available to safely transport clients. Inspections are conducted according to appropriate levels of the Federal Motor Carrier Safety Administration's North American Standard Inspection requirements. All transportation provider vehicles will also continue to be inspected prior to beginning service under this contract and certified by LogistiCare to be compliant.

On-site Inspections for Meeting Vehicle Standards

LogistiCare's Field Monitors/Investigators conduct on-site inspections to ensure that operator fleets remain in compliance with specified vehicle requirements. The Field Monitors/Investigators will outline any deficiencies that need to be corrected and schedule a re-inspection within two weeks of the original inspection date. LogistiCare's *Vehicle Inspection Form,* used in the inspection process, outlines each inspection element and color of sticker the Field Monitors/Investigators give the vehicle including:

- ***Green --*** **V**ehicles that pass inspection.
- ***Yellow --*** Vehicles that do not pass inspection, but do not have violations that pose an immediate threat to the safety and comfort of clients, will be passed on a probationary status and given a dated, yellow sticker. Examples of conditions that might warrant probationary status include damaged upholstery and missing first aid kit items. The transportation provider will be given 10 days to bring the vehicle into compliance, after which time the inspector will schedule a re-inspection to confirm the required improvements have been made.
- ***Red --*** Vehicles that fail to pass the second inspection due to a health, safety, or serious comfort issue will be given a red sticker to indicate that it is "red-lined," and the vehicle will immediately be removed from LogistiCare service. Examples of these types of violations include no seatbelts, no fire extinguisher, malfunctioning brake lights, and similar problems. Any deficiencies and actions taken will be documented and become part of the vehicle's permanent record.



LogistiCare must verify that the provider has corrected all deficiencies before a red-lined vehicle may return to service. Transports that occur in a red-lined vehicle will not be reimbursed and may result in removal of the transportation provider from our network.

LogistiCare ensures that all vehicles meet vehicle standards by utilizing identification and compliance data to track for each vehicle in our NEMT transportation network including:

- Vehicle identification number
- Manufacturer's vehicle identification number
- Make, type and model year
- Vehicle's current transportation status
- Inspection histories on each vehicle, including:
  - Inspection date
  - Inspector
  - Results of inspection
  - Inspector's comments.

LogistiCare Field Monitors/Investigators will also perform unannounced vehicle inspections and immediately remove deficient vehicles from service in accordance with our service contract. These unannounced inspections are as needed in response to client comments, operational trending analysis, and our random vehicle inspection program at health care facilities as members are dropped off for appointments.

LogistiCare occasionally furnishes transportation providers with small items to keep their vehicles in compliance, thereby keeping vehicles that are truly safe from becoming inactive and potentially disrupting service. For example, a LogistiCare Field Monitor/Investigator may provide a transportation provider with a spill kit or seat belt extender instead of pulling the vehicle from service.

- ***Your approach to initial and ongoing driver training;***

Driver Training

LogistiCare requires all drivers to complete driver safety training, including CPR and First Aid training.

LogistiCare developed an extensive curriculum of online driver training for transportation providers in our network to promote compliance. The training is developed around the Defensive Driving curriculum of the National Safety Council and the Passenger Service and Safety (PASS) program developed by the Community Transportation Association of America (CTAA) and other nationally recognized driver training organizations.

The driver training program is made available to all transportation providers free of charge. LogistiCare continues to invest each year to maintain and enhance the program, and have trained thousands of drivers over the past four years in standards, requirements, skills, and knowledge needed to be a responsible NEMT driver.

The driver training program consists of 13 modules (one specifically about wheelchair transport), three assessments, and a course survey. Course modules include the following:

- Training Orientation (How to Get Around)
- Introduction to LogistiCare
- Your Role as a LogistiCare Driver
- Knowing Your Passengers
- How to Prepare for Your Day
- Passenger Transport: Ambulatory
- Passenger Transport: Wheelchair
- Passenger Transport: With a Service Animal
- Passenger Transport: Stretcher
- Responding to Incidents and Accidents

- Defensive Driving.

The training includes instruction in defensive driving techniques, securing wheelchairs and child safety seats, lift operation, passenger assistance techniques, and general customer service. It is highly interactive and includes audio, text, video, graphics, examples, and knowledge checks to optimize knowledge retention and facilitate diverse learning styles.

After taking this course, drivers will be familiar with LogistiCare as a company and the expectations it sets for drivers in the NEMT program. Each driver will be equipped with the knowledge and skill required to be a safe, responsible, and courteous driver.

Remaining Responsive to the Diverse Needs of members

LogistiCare *always* considers the member's personal situation and needs when arranging and providing transportation. All members receive the extra attention they deserve to ensure their trips are safe and timely. LogistiCare is particularly mindful of the importance of, for example, the safety of children during transport, the importance of dialysis patients receiving their full "chair time" and treatment, in addition to the special transportation concerns of the elderly, disabled, and culturally diverse members. LogistiCare provides, for example, extra assistance, including hand-to-hand services as well as special services for bariatric patients when needed, to help patients maintain their dignity and receive the services they need.

Call center staff and transportation providers are trained to understand and respect people who are members of diverse groups. The CSRs will make detailed member notes concerning NEMT members' needs within our LogistiCAD system. This information is relayed to transportation providers so that appropriate arrangements will be made for special needs members. All drivers and attendants receive special sensitivity and passenger-assistance training related to the various prevalent forms of special need.

Drivers and CSRs are not permitted to exhibit discriminatory or demeaning behavior toward anyone; it is not tolerated by LogistiCare. They are taught to respect each individual and to be patient with people who may be, for example, new to the customs and nuances of U.S. culture or slower moving due to age, disability or illness. To this end, our practice is to match our hiring and our provider recruitment to the local population being served, thus ensuring an appropriate reflection of the cultural mix.

- ***How you will ensure that drivers meet initial and ongoing driver standards;***

Each provider agreement contains a set of requirements for the contracts under which they supply NEMT services. Among other provisions, contracts with clients specify the activities and responsibilities of transportation providers, and state that they must adhere to standards including, but not limited to provisions such as the following:

- Provide proof that they continuously maintain at least the minimum automobile liability insurance required by state law or contract standard, whichever is higher
- Obtain and maintain all licenses and certifications required to operate the types of vehicles used to transport NEMT members
- Adhere to all laws, rules and regulations regarding driver and their vehicle types used to transport members
- Document each trip provided, including pick-up and drop-off points, trip mileage according to odometer readings, dates of transport, signatures and any other information required by LogistiCare or UnitedHealthcare Community Plan
- Be courteous, patient, and helpful to all passengers; refrain from smoking in the presence of any member, and abstaining from the use of alcohol, narcotics, or drugs that would impair performance while providing NEMT services.

LogistiCare continuously monitors and reports transportation provider adherence to contract standards such as those above through its systems and through on-site and field observations.

LogistiCare uses LogistiCAD database system to monitor compliance with requirements and records information such as insurance details, coverage area, and dates during which transportation providers were on active duty, and reasons for any termination or suspension of service, as well as extensive details, including renewal dates, for the various kinds of insurance required of transportation providers. LogistiCare captures specific data about individual vehicles and drivers, including information on driver identification, license status, training, screenings, and driving violations, and thus prevent a transportation provider from being reimbursed for any trip provided by a driver or vehicle not fully compliant and on active status. LogistiCAD has functionality built into its billing function to link trips submitted for payment to driver and vehicle compliance information. If a trip is submitted for payment using a vehicle or driver not currently in compliance, the system will flag the trip so that payment may be denied.

Rigorous Network Management and Oversight Ensures Compliance

LogistiCare's local and national transportation management teams employ stringent methods to ensure that all providers, drivers, and attendants comply with contracted and legal requirements. Performance standards are included in Provider Agreements, communicated to providers regularly, and reinforced in quarterly provider meetings.

LogistiCare strives to be consistent with transportation providers in all aspects of operations, and in enforcement activities enforcing the same rules with all transportation providers, evaluating performance based on a standardized provider report card that is shared with providers on a regular basis to help drive quality.

- ***How your call center will comply with the requirements specific to NEMT calls; and***

Call Center Compliance

During the contracting process, LogistiCare will work with UnitedHealthcare Community Plan to develop a plan-specific Statement of Work, Summary of Covered Benefits, and Call Script. The Statement of Work provides the transportation protocols that LogistiCare will follow for UnitedHealthcare Community Plan. The Summary of Covered Benefits defines the types of medical appointments LogistiCare will transport members to/from. The Call Script validates that CSRs are following protocol on each call so that every trip request is processed accurately, politely, and efficiently. The CSR follows these customized documents that are specifically tailored for (and approved by) HHS.

UnitedHealthcare Community Plan needs a partner with an approach to quality to help improve member satisfaction, secure quality ratings, and foster growth.

- ***Your NEMT quality assurance program (excluding vehicle inspection)..***

Tracking and Reporting on Call Center Performance

LogistiCare uses the Avaya Communications Manager with Automatic Call Distribution (ACD) in call centers to provide the required ACD functionality. TASKE Contact Call Management and Reporting System is used to carefully monitor, audit, and track all calls to measure performance for continuous improvement for responsive service. TASKE provides a complete reporting suite using data from the Avaya ACD system giving LogistiCare the flexibility to easily examine, aggregate, and report vital telephony data such as the following:

- Number of calls per hour/day
- Number of abandon calls per hour/day
- Average call length
- Average speed of answer

- Average abandon rate
- Average time to abandoned
- Average talk time.

Sample Reports

Detailed data reports can be pulled on a half hour, hourly, daily, monthly, and annual basis. Statistics are available in both real-time and retroactively, as reporting capability allows historical reporting to be viewed and exported on each ACD group.

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Section H: Utilization Management (UM) (Section 8 of RFP)

H.1 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan. (GSA C)

Providing Utilization Management (UM) requires a special understanding of the needs of the population and Medicaid provider networks. We have customized an effective UM process for Louisiana with policies and clinical decision tools to meet population needs, community standards, contractual obligations, and state and federal requirements.

Ensuring Services to our Members

Our UM team department functions as a multi-disciplinary team that places the member in the center of all activities. All UM decisions are based on appropriateness of care and service and the existence of coverage. UM decision makers are not rewarded for issuing denials of coverage or care nor do they receive financial incentives that encourage decisions that result in underutilization.

Members of the team include the following staff:

- Dr. Mark Mahler and other Medical Directors
- Case Management Administrator
- Manager of Care Management
- Manager of Utilization Management
- Regional Director ICCT (Acute Utilization Management Program)
- Care Coordinators (RNs, LVN, SW, other related degreed professionals)
- Utilization Managers
- Utilization Management Nurses, Intake and Prior Authorization Specialists
- Non-Clinical Support Staff (care coordinator associates, administrative coordinator).

Utilization Management Functions and Responsibilities

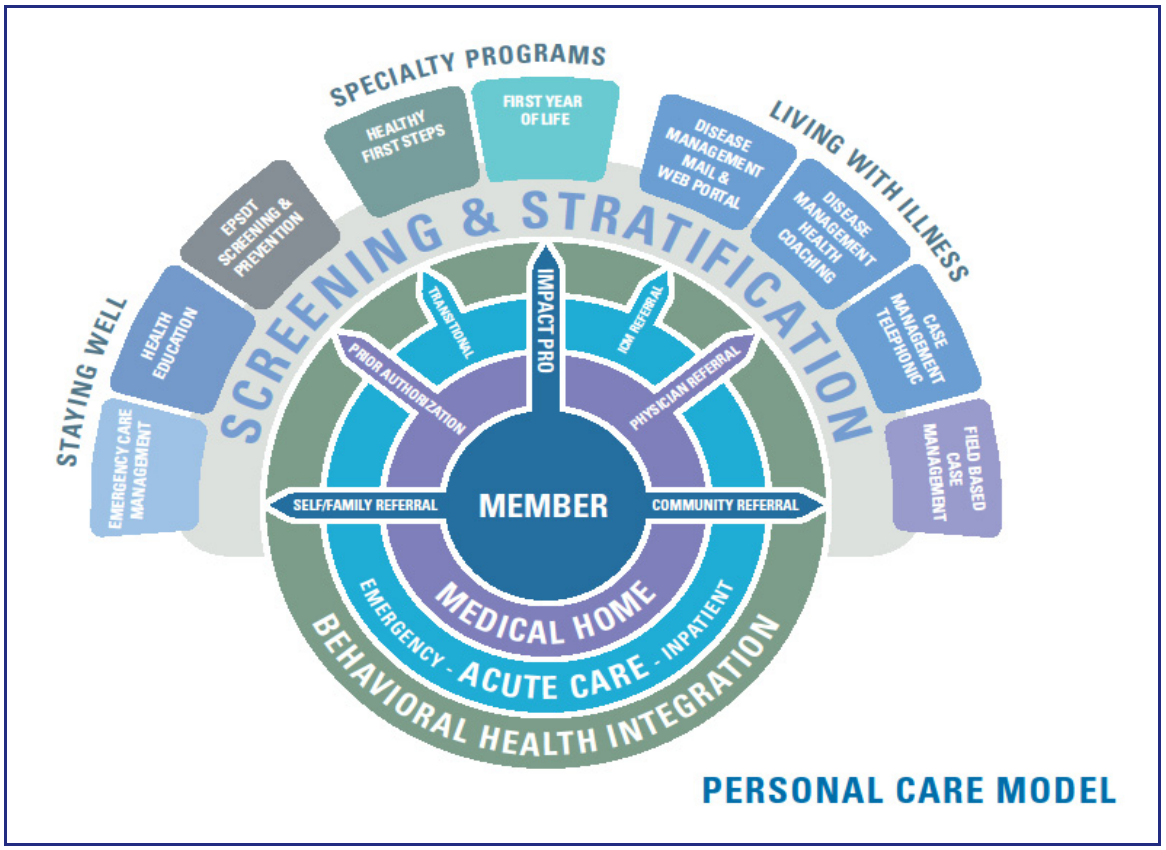
The Utilization Management (UM) Program is designed to employ a comprehensive approach to health care. The goal of the UM Program is to manage the services of our Members by effectively using existing resources while assuring that quality care is delivered. We avoid arbitrarily or inappropriately denying or reducing the amount, duration or scope of services by using nationally recognized guidelines to determine medical necessity. We also take into account the Members individual circumstance, which goes beyond the standard guidelines. However, clinically, medical necessity of services is determined by severity of illness, intensity of service and the appropriateness of level of care. Emphasis is placed on coordinating the Member's transition throughout the full continuum of care.

UnitedHealthcare Community Plan works collaboratively with its Members, practitioners and other health care providers to promote a seamless delivery of health care services. UnitedHealthcare Community Plan's UM Program integrates the medical benefits package for behavioral health and pharmacy benefits, if applicable, as defined by the state's contractual requirements, reimbursement structure, Member and practitioner education, and quality management, to monitor cost and quality of services to its Members. **Further, our UM Program works in concert with our proprietary case management program called the Personal Care Model (PCM), our Integrated Care Model (ICC) and our Transitional Coach Program as described in the following.**

Personal Care Model™ (PCM) is our hallmark care management program. Through our Personal Care Model we take a holistic approach to health care, emphasizing practical programs to improve our members' living circumstances as well as their health. The unique Personal Care Model features direct

member contact by clinical staff who work to build a support network for chronically and acutely ill members involving family, providers, government and community-based organizations. In addition, the Personal Care Model features advanced health care management technology applications to ensure that high quality, timely and appropriate health care is available to all members. **The Personal Care Model includes:**

- Creating a seamless Member care experience
- Optimizing the effectiveness and efficiency of our clinical programs
- Leveraging multidisciplinary care management teams
- Incorporating high-touch and personalized interventions
- Working in partnership with providers, members and the community
- Creating sensitivity to the member's economic, cultural and environmental experience
- Addressing health care disparities by providing education, access and quality chronically ill members
- Engaging with community-based organizational resources and government social service programs as elements of a comprehensive support structure for the member.



Integrated Care Coordination model (ICC) is a multidisciplinary approach to providing personalized care to members. The goal of the program is to provide continued support to members with complex medical conditions, co-morbidities, or who may be at risk for a medical condition as identified by Health Risk Assessments or predictive modeling. The ICC model emphasizes the importance of a team approach by working with its members, practitioners, and other health care team members to promote a seamless delivery of health care services. A Member may receive services and support from all or just a few of the ICC team members, depending on that member's individual needs. **The ICC model includes:**

- Engaging Members/caregivers to enhance the development of trusting relationships
- Designing and executing interventions that are comprised of telephonic care management, home visits/on site care management, and access to community resources
- Referring and enrolling Members, as appropriate, into disease management programs
- Providing disease specific educational mailings of educational materials, and outreach component
- Performing Member stratification according to diagnosis and severity of medical and psychosocial conditions
- Designing individualized treatment plans with the involvement and support of family members, PCP, community based organizational resources and various government social service programs, as elements of a comprehensive support structure for the member. **The ICC team consists of:**
  - Assessment team
  - Inpatient Care Management (ICM) team
  - Transition Nurse
  - Telephonic Case Management team
  - Behavioral Health Advocate
  - Social Worker
  - Health Coach
  - Care Coordinator.

Elements of the ICC are important components of our Personal Care Model.

Transitional Coach Program is a program designed to provide a smooth transition into our care management program. The program's design is based upon the care transition model designed by Dr. Eric Coleman, at the University of Colorado Health Sciences Center. The model is designed to encourage patients and their caregivers to assert a more active role during care transitions. The goal of the program is to improve care transitions by providing Members with the tools and support that promote knowledge and self management as they move from hospital to home ultimately reducing readmission.

Positive Results

UnitedHealthcare Community Programs' 2010 Hospital Admission Improvement Data:

- *6% reduction in admission per 1,000 members*
- *9% reduction in days per 1,000 members*

The program is supported by the role of the Transition Coach who has the critical role of employing the key attributes of the program. This unique role includes, but is not limited to:

- Ability to shift from a "doing" role to a coaching role
- Demonstrates skill and knowledge to manage and reconcile medications
- Ability to empower patients and caregivers
- Ability to engage in critical thinking within the framework of a care plan.

The Transition Coach prepares members for what to expect beyond their discharge, and helps to prepare the member or caretaker in negotiating the health care system. This also includes role-play on how to get questions answered and communicate with providers. Transitional Coaches are highly trained in the uses of the Four Pillars as a guide for coaching tasks and understands the importance of working with members "'where they are." The model is specifically designed to focus on the member's personal health goals. It is a partnership, with the member taking the lead. The interventional components of the program focus on these conceptual areas or "pillars":

- Medication self-management

  - Patient is knowledgeable of medications and has med management system
  - Identify medication discrepancies between pre and post hospital meds
- Use of Patient-Centered Record
  - Patient understand and uses a "Personal Health Record" (PHR) to facilitate communication and ensure continuity of care
- Primary Care and Specialist Follow-up
  - Patient schedules and completes follow-up appointments.
- Knowledge of Red Flags
  - Patient is knowledgeable about indicators that suggest condition is worsening.

Transitional Coach Program Process

Members who are identified for the program are contacted by the ICM RN prior to discharge (typically hospital visit). A designated in-home RN visits within 48-72 hours of hospital discharge, to review content area in these pillars:

- Reconcile pre and post hospital medications
- Review medication management system
- Assure follow-up appoints have been made and "coach" in preparation for follow-up visit
- Provide education explaining self management of chronic disease and "red flags" that indicate worsening condition
- Discuss use of Personal Health Record and value of keeping up to date and taking it everywhere.

There is ongoing follow-up in home or phone call using 7 and 14 days as a guideline (based on clinical judgment/need) to reinforce and ensure follow-up on agreed upon goal. If the member needs additional support, the member will be referred to Case Management for long-term support.

Purpose and Goal of Discharge Planning

Discharge planning should begin as soon as the health plan is made aware of an inpatient confinement. Included in this document are several models currently being employed by UnitedHealthcare Community Plan health plans with their accompanying policies and procedures. Staffing of the function has as much variability by health plan, and these variables are taken into consideration when a health plan configures their unit or makes a decision as to who shall be responsible for the execution of the discharge process. The decision is typically driven by the contractual requirements for remote or onsite utilization review. Emphasis is then placed on metric development, outcomes measured, and all interventions documented in the Clinical Information system.

The purpose of discharge planning is to anticipate the Member's needs by performing a thorough assessment the members needs (psychosocial and medical), problems, capabilities and limitations. This facilitates a safe discharge to the member's home or community and prevents untoward incidents after discharge from hospital. The goal of discharge planning is to deploy early interventions by the discharge planning team in the development of a comprehensive discharge plan for the patient designed to:

- Identify the appropriate level of care for the member
- Reduce or decrease the risk of inpatient hospital readmissions
- Reduce or decrease the risk of ER utilization.

Identifying the appropriate level of care may include setting up home care, establishing comfort care for medically fragile members who meet the criteria for hospice services (inpatient or home). ICMs also assist with transitioning the member into a skilled nursing facility. If a member needs to continue treatment, the ICM supports the member's ongoing therapy in a specialized environment, by arranging the admission and transfer of the member into a rehabilitation facility-acute or sub acute. Coordinating the

member's transition a more stable environment, like an assisted living, shelter or hotel, is crucial in supporting the members healing and health maintenance.

We do this by ensuring that the Member is the appropriate level of care. We are very successful at developing and implementing clinically appropriate transition plans, because we include the member or caretaker, attending Physician, Specialists, PCP, facility Social Worker/Discharge Planner, health plan Discharge Planner, Health Plan Case Manager or the health plans Outreach Coordinators/Non-Clinical Assistants as our key team members. Targeted discharge planning focus on identified high risk, high cost health plan members with frequent hospital admissions or excessive ER utilization due to:

- Progressive chronic disease (adults/pediatrics)
- Substance abuse
- Limited mobility (bed bound, wheelchair bound)
- Dementia
- Homelessness or lack of sufficient financial resources
- Wound care needs
- ImpactPro score indicative of potential for hospitalization, re-admission or other targeted diagnosis.

Criteria for Individuals Targeted for Discharge Planning Activities

Based on the assessment of member's needs (psychosocial and medical), problems, capabilities and limitations our ICC team identify members in need of post-hospitalization follow-up. The medical management team meets regularly to discuss and mitigate the following types of complexities that require discharge planning (the list is not exhaustive):

- High Risk (can be members with known chronic illnesses)
- High Cost (e.g., NICU babies, multiple trauma, CVA)
- Readmissions with a rolling 30-day period
- Frequent Emergency Room utilization (metric should be that used in the health plan's ER Diversion Program)
- Identified by ImpactPro
- Social issues that would impact the recovery process (e.g., homelessness, lack of family or other support system)
- Member with a dual diagnosis, i.e., a behavioral and physical health condition.

ImpactPro is an excellent tool to use in the discharge planning process. If the Member has been identified in the ImpactPro database their scores are used to determine the need for follow-up or potential for future hospitalizations.

Steps in Discharge Planning

Discharge plans can be initiated by (1) health plan discharge planning staff (RN, LPN, SW, ORC) or an Inpatient Case Manager. Our ICC team is proactive and does not wait for the hospital to identify the need for a discharge plan, but performs identification process as soon as the member is hospitalized. We take the lead in forming the team necessary to accomplish the tasks and desired outcomes.

Staff engaged in the discharge planning process reviews the inpatient census for the targeted diagnosis or other defining criteria (based on health plan utilization and experience) for those members who require after hospital care and follow up. Once the member is identified, the concurrent review notes are reviewed to ascertain the status of the member's condition. ImpactPro specific member data are included in the review of pertinent information. This has proven to be an extremely valuable tool in developing the plan of care.

ICMs also access the Milliman discharge planning guidelines to ensure that no stone is left unturned. If the health plan staff is coordinating the discharge plan with hospital staff, the pertinent details relative to the members needs are documented and describe the expected outcomes of the discharge planning activities. These details are then communicated to the hospital through a hospital log. The log contains, at a minimum, the following information:

- Member name
- ID number
- Admission date
- Potential discharge date
- Diagnosis and ICD9 code
- Anticipated needs and the vendors required to meet these needs.

As part of the member or caretaker engagement, the discharge planning staff contacts the member/caretaker while the member is still in the hospital. Once all the post hospitalization plans are in place, the plan is reviewed with the member/caretaker is educated about each and focuses on every step and expected outcome. During this process, the member/caregiver has the opportunity to scrutinize or identify any additional barriers not covered by the plan.

Additionally, because we consistently and appropriately use the medical necessity guidelines, Members gain the benefit of the services needed to support their health transition to their highest functional level.

Guidelines and Criteria

Guidelines

We use evidence-based acute care, behavioral health, and community-based LTC UM guidelines i.e., Milliman Care Guidelines as components within our broader UM program that facilitates the most appropriate medically necessary services in the least restrictive setting. We have shaped our UM policies and procedures, management, and oversight to promote fair and consistent application of our review criteria and ensure that quality of care is not adversely impacted. Our chief medical officer (CMO) has the ultimate accountability for UM and is involved in any decision to deny or limit services and watches for trends of over- or under- utilization. We describe the UM guidelines below.

- ***Acute Care UM Guidelines:*** Our UM program uses the **evidence-based** Milliman Care Guidelines for acute care services. The guidelines function as checklists that help prevent errors and omissions by providing a list of considerations and criteria for each step in the care process. The Milliman Care Guidelines provide information on services that must be initiated and are needed for an appropriate Member discharge.

Data analysis drives our UM program by identifying areas for improvement and priorities such as a reduction of inpatient bed days, reduction of readmission within 30 days, and reduction of emergency room encounters and appropriate utilization of home and community based services. We involve our physician providers in our UM program by trending their Members' ER admissions and acute care admissions in our annual provider profiles. Our UM program focuses on suspected problematic areas, develops strategic goals specific to these problem areas, and incorporates senior leadership initiatives as well as directives mandated by policy and contract deliverables. Once action plans are implemented, the UM department evaluates and adjusts for efficacy and impact. Quarterly monitoring is critical once we achieve our desired outcome. We review our UM initiatives monthly and report findings quarterly to the Medical Advisory Committee to ensure the effectiveness of our process.

Criteria

Inpatient case managers conduct medical necessity reviews for admissions and continued stay requests. UnitedHealthcare uses Milliman Care Guidelines to determine the goal length of stay. These guidelines are integrated into the Health Management System.

UnitedHealthcare uses Milliman Care Guidelines, which state: The guidelines are, quite simply, guidelines for providing the right care at the right time in the right setting. They show what can be accomplished under the best circumstances and are not meant as a substitute for a physician's judgment about an individual patient.

Updates are licensed and distributed as they become available. The guidelines are reviewed annually by the National Executive Medical Policy Committee, The National Quality Management Oversight Committee (NQMOC), and the health plan UM Committee. UnitedHealthcare Community Plan also uses Milliman USA or Interqual for the following areas where applicable criteria or guidelines exist:

- Hospice
- Home health care
- Skilled nursing facility
- Inpatient rehabilitation.

In instances where national criteria do not exist, the CMO consults with internal clinical subject matter peer experts or makes the medical decision based on clinical judgment specific to that case. When appropriate, alternate level care criteria are also used during discharge planning and case management processes.

Prior Authorization Process

Another method of avoiding arbitrary or inappropriate denial or reduced services is through our prior authorization process. Because UnitedHealthcare Community Plan understands the need for providers to know what requires prior authorization, we are very transparent in our process. We take the time to continuously educate providers, in and out of network about how the process works. We require health practitioners and providers to notify us and obtain authorization for certain clinical interventions, elective procedures and referrals. UnitedHealthcare Community Plan does not require practitioners or providers to obtain prior authorization or give notification before rendering emergency services to Members.

Authorization and referral requirements are governed by our policies and procedures and state and federal regulations. Providers are informed in the UnitedHealthcare Community Plan Administrative Manual and in provider training sessions about services and referrals requiring prior notification. In these forums, they are made aware of our toll-free phone number if and when they need assistance with referrals. Prior Authorization requests are addressed 24 hours a day, seven days a week. Prior Authorization management reports are reviewed daily to ensure timeliness of requests and review of Notice of Action (NOA) letters for appropriateness and accuracy. Prior authorization decisions are communicated to the practitioner, provider, or Member within the following timeframes:

- ***Standard Requests:*** Requests are processed as expeditiously as the Member's health status requires, but not later than 14 calendar days following the request. **However, we will attempt to make a final determination within two business days of receipt of the initial request for a routine authorization. Prior authorizations for urgent services are made within 24 hours.** The provider is contacted within five days of receipt of a standard authorization request, if any additional information is required, but has not been received and a decision cannot be made. By the fifth day, and if no information has been received, the request is sent to our Clinical Review Unit for consideration. If the Clinical Review RN or MSW is unable to approve the request, then efforts are made to contact the provider again. If the provider is unresponsive by the tenth day and before day

14, and it is in the best interest of the Member to extend the review process, the Member is notified of our intent to extend the process and is made aware of the specific information needed to make a decision. A Notice of Extension letter is issued and a decision is made within 14 days.

- ***Expedited Requests:*** Requests for which the provider indicates, or UnitedHealthcare Community Plan determines, that the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, **are resolved within 24 hours.** If not possible, a decision is made within three working days from the date of receipt. If the request does not meet minimum requirement standards, it is elevated to the CMO for consideration. If additional information is needed to make a determination, the provider is notified and a Notice of Extension letter is issued to the Member before the third calendar day. Expedited requests are completed, and a notice issued, as expeditiously as the Member's health condition requires, with a possible extension of up to 14 days when it is in the Member's best interest and additional information is needed to make a determination.

Prior notification presents an opportunity to determine medical necessity and appropriateness of services, procedures and equipment prospectively, as well as the opportunity to collaborate with our provider community to resolve Member issues and improve communication. For example, we are able to assess whether the services, procedures, or equipment are a covered benefit for the Member and whether the Member can be directed towards in-network services, where applicable and appropriate.

A Member's primary care provider (PCP) usually initiates and coordinates the prior authorization process. As needed, specialists and other providers may also contact UnitedHealthcare directly to initiate the process. Requests are processed through the Prior Notification Unit either by phone, fax or an electronic submission and must include the Member's identification number, the place of service, the ordering practitioner/provider, and the current applicable CPT, ICD-9, CDT and HCPCS codes. For medical services, an electronic submission allows providers to enter requests for prior authorization via a webpage linked to UnitedHealthcare's provider portal and is seamlessly integrated with our care management system. Providers receive an authorization tracking number and a response that the request is either automatically approved or pended for further review. Additional information specific to the review criteria is requested at the time of contact and those requests that meet minimum requirements are approved real time, if received telephonically or electronically. Providers using an electronic submission have the advantage of being able to check their request's progress anytime, and if they feel that waiting for a response jeopardizes the Member's health, the request may be escalated and reviewed expeditiously.

UnitedHealthcare Community Plan's Prior Notification Unit is principally responsible for reviewing authorization requests and issuing authorization numbers for most medical services. This is one of the dedicated units within our Health Service's Department. Prior authorization reviews are carried out by designated staff under the direction of the CMO. Designed staff evaluates requests for authorization; document the requests, related information, benefit determinations; and initiate the notification process to inform practitioners, providers and applicable Members of the decision. The review includes, but is not limited to, the following steps:

- Verification of the Member's enrollment
- Verification that the requested service is a covered benefit for the Member
- Determination of whether additional documentation, information, medical records, etc., are required
- Determination of whether the requested service is medically necessary and appropriate
- Determination of whether the request requires CMO review
- Determination of whether the requested service will be provided by a participating provider in a participating facility at the appropriate level of care.

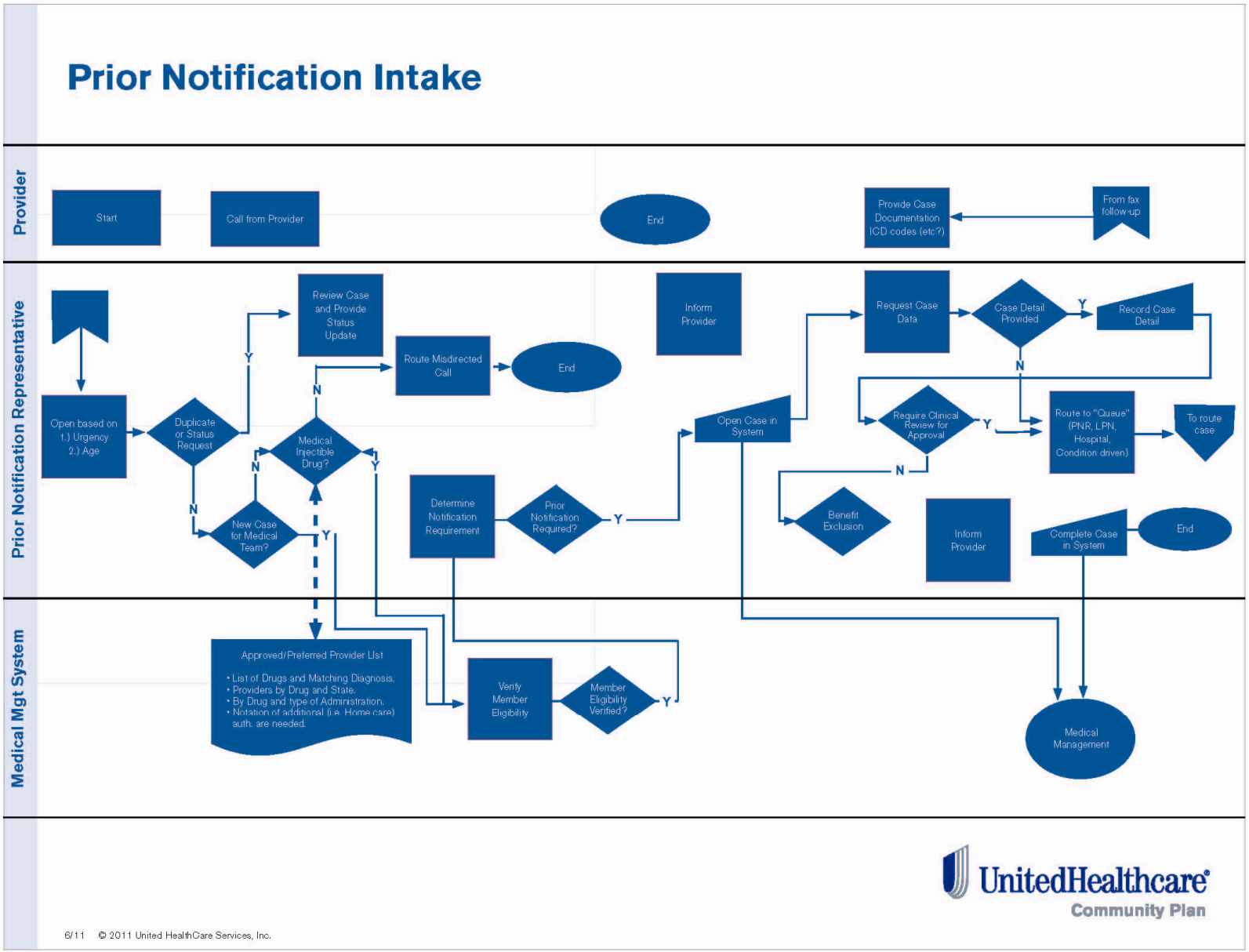
Medical directors review all potential benefit decision denials based on documentation of the condition per the guidelines in the applicable UnitedHealthcare Community Plan Prior Authorization policies. Written confirmation of a final decision to deny, reduce, suspend, or terminate services is mailed to the practitioner, provider, and Member within the timeframes for standard or expedited requests as outlined previously. The Member's Notification of Action letter describes how to submit an appeal.

If ongoing services are being reduced, suspended, or terminated, the letter gives the date on which the reduction, suspension, or termination of services becomes effective, which is at least ten days from the date of notification; additionally, the notification explains that if the Member decides to appeal the denial, they may request that the services be continued during the appeal. If our initial response is not in writing, we give the provider written confirmation of the decision within two working days of providing notification. At any point in the review process, a provider may request an expedited review on the Member's behalf if a delay in decision-making might seriously jeopardize the Member's life or health. The provider is informed how to request an expedited review on the Member's behalf. Expedited review decisions are made and notification given to the provider **within 24 hours.**

When UnitedHealthcare makes a decision to deny or issue a limited authorization of a service authorization request, or reduces, suspends or terminates a previously authorized service, we mail a Notice of Action to the Member. Providers are also informed via written notice of the decision to deny or reduce a service authorization request. We provide a Notice of Action to the Member as expeditiously as his/her health condition requires, but not later than 14 days following the receipt of the authorization with a possible extension of up to 14 days if the Member or provider requests an extension, or if we establish a need for additional information and delay is in the Member's best interest. If UnitedHealthcare does not make a decision within the applicable timeframes, a decision is made on the date that those timeframes expire.

For expedited authorization requests, UnitedHealthcare Community Plan provides the Notice of Action to the Member **within 24 hours** following the receipt of the expedited authorization with a possible extension of up to 14 days if the expedited determination is not granted. We comply with the advance notice requirements and timeframes for the Notice of Action when there is a termination or reduction of a previously authorized service or when there is a denial of an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.

Each Notice of Action includes at a minimum the following: the action taken or intended to be taken; the reason for the action; the Member's right to file an appeal with UnitedHealthcare; the procedures for exercising appeal rights; circumstances when expedited resolution is available and who to request it; and procedures for continued benefits and the Member's potential financial obligation for them. UnitedHealthcare also includes all appropriate parties to the appeal, including the Member, legal representative, or legal representative of a deceased Member's estate.


Prior Notification Intake
Provider
Prior Notification Representative
Medical Mgt System
Start
Call from Provider
End
Provide Case Documentation ICD codes (etc?)
From fax follow-up
Open based on 1.) Urgency 2.) Age
Duplicate or Status Request
Review Case and Provide Status Update
Route Misdirected Call
End
Medical Injectible Drug?
New Case for Medical Team?
Approved/Preferred Provider List
• List of Drugs and Matching Diagnosis.
• Providers by Drug and State.
• By Drug and type of Administration.
• Notation of additional (i.e. Home care) auth. are needed.
Verify Member Eligibility
Member Eligibility Verified?
Determine Notification Requirement
Prior Notification Required?
Inform Provider
Open Case in System
Request Case Data
Case Detail Provided
Record Case Detail
Require Clinical Review for Approval
Benefit Exclusion
Inform Provider
Route to "Queue" (PNR, LPN, Hospital, Condition driven)
To route case
Complete Case in System
End
Medical Management
Y
N
UnitedHealthcare Community Plan
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UM for Inpatient Care

Preadmission Certification Process for Non-Emergent Admission

For non-emergent admission, such as surgery, prior authorization is required. We design our prior authorization process to determine the medical necessity and appropriateness of care, to make plans for the course of treatment to improve outcomes, identify Members who may need more intensive care coordination or be appropriate for disease management, and avoid inappropriate use of or duplication of services. We use the Milliman Care Guidelines to guide the authorization decisions and to determine medical necessity for inpatient admission and surgical procedures. Our review process involves an initial stage of clinical review performed by a prior authorization nurse. In cases where these individuals cannot authorize the services requested, the medical director performs a second stage of review to determine the medical necessity. Only a medical director can deny services. We review our prior authorization process monthly and report findings quarterly to the Medical Advisory Committee to ensure the effectiveness of our process.

Concurrent Review Program

We implement concurrent reviews to promote continuity of care, appropriate utilization of resources and mange length of stay in inpatient settings. The UM nurse or behavioral health care coordinator reviews the inpatient care plan of the Member with the facility's utilization designee for appropriateness and to monitor the quality of care being rendered to the Member.

The goal of the concurrent review nurse is a collaborative process to monitor the Member's response to the treatment plan and proactively plan to support the Member's needs after hospitalization. Inpatient concurrent review nurses collaborate with internal and external staff practitioners and their representatives. They insure that discharge needs are met in a timely manner and that continuity of care is provided. Assessments are conducted concurrently by onsite visits, telephone, or fax. Procedures for completing reviews in a timely fashion and notifying providers of all decisions have been established.

In DRG reimbursed facilities a concurrent review is conducted during low and high trim point periods and at the midpoint of the DRG to evaluate discharge planning needs.

Denial notice letters are sent to providers and Members. The letters included information regarding their appeal rights. For cases admitted to the hospital through the emergency room, UnitedHealthcare performs concurrent review to determine medical necessity and appropriateness of the admission and the need for continued inpatient stay.

On a concurrent basis, UnitedHealthcare UM nurses work collaboratively with hospital staff to consider the Member's health care needs post discharge. UnitedHealthcare encourages providers to begin the discharge planning process as early in the hospitalization as feasible. The goal is to affect a timely discharge at the same time ensuring that the Member will not return to an acute phase secondary to lack of access to appropriate health and support services.

Admission Review for Urgent or Emergency Admissions

UnitedHealthcare does not require prior authorization for emergency admissions. However, once admitted the provider or Member should notify us within 24 hours for a concurrent review to take place. We implement concurrent reviews to promote continuity of care, appropriate utilization of resources and manage length of stay in inpatient settings. An inpatient care manager uses the Milliman Care Guidelines for the review process, and the medical director reviews any variances. To promote the continuity of care, even after an inpatient visit, we develop a discharge plan for all of our Members.

Review of Same Day Surgery Procedures

Same day surgery procedures are regarded as outpatient services. No prior authorization is needed when the provider has spoken to the Member's PCP and when an in-network facility is used. Prior authorization

is needed for out-of-network facilities. Our prior authorization process is detailed in our response above.

H.2 If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised. (GSA C)

UnitedHealthcare Community Plan maintains clear and comprehensive policies and procedures that guide our process of review, approval, adoption and development of medical necessity criteria. We use a combination of nationally recognized, evidence-based clinical criteria to guide our utilization review decision, including Milliman USA™, Apollo Medical Review criteria for occupational and physical therapy and CMS medical policy guidelines. Milliman USA is widely regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length of stay goals, best practices care templates and key care steps and milestones for the best possible treatment and recovery. These criteria and guidelines are industry standards for medical necessity review in compliance with federal and state requirements. They provide a rules-based system for screening proposed medical care based on patient-specific, best medical care practices and consistently match medical services to member needs based upon clinical appropriateness.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of our adult, adolescent and child members. When using the criteria to match a level of care to a member's current condition, our UM staff considers the severity of illness and co-morbidities, as well as episode specific variables. Our goal is to view the member in a holistic manner to ensure he/she receives necessary support services within a safe environment that is optimal for recovery.

UnitedHealthcare Community Plan adopts clinical practice guidelines as the clinical basis for the care management program. Clinical guidelines are systematically developed; evidence-based statements that help providers make decisions about appropriate health care for specific clinical circumstances. The effectiveness of the guideline is determined by scientific evidence, or in the absence of evidence, expert opinion and professional standards. We adopted clinical guidelines from recognized sources as defined by the National Committee on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC). A clinical practice guideline developed and issued by an individual not officially sponsored or supported by one of the above types of organizations and not validated by a study published in a peer-review journal does not meet the inclusion criteria for UnitedHealthcare Community Plan. In the event there is no existing guideline available from a recognized source, UnitedHealthcare Community Plan may elect to convene a panel of professionals with expertise in the topic to develop a guideline based on the best available evidence.

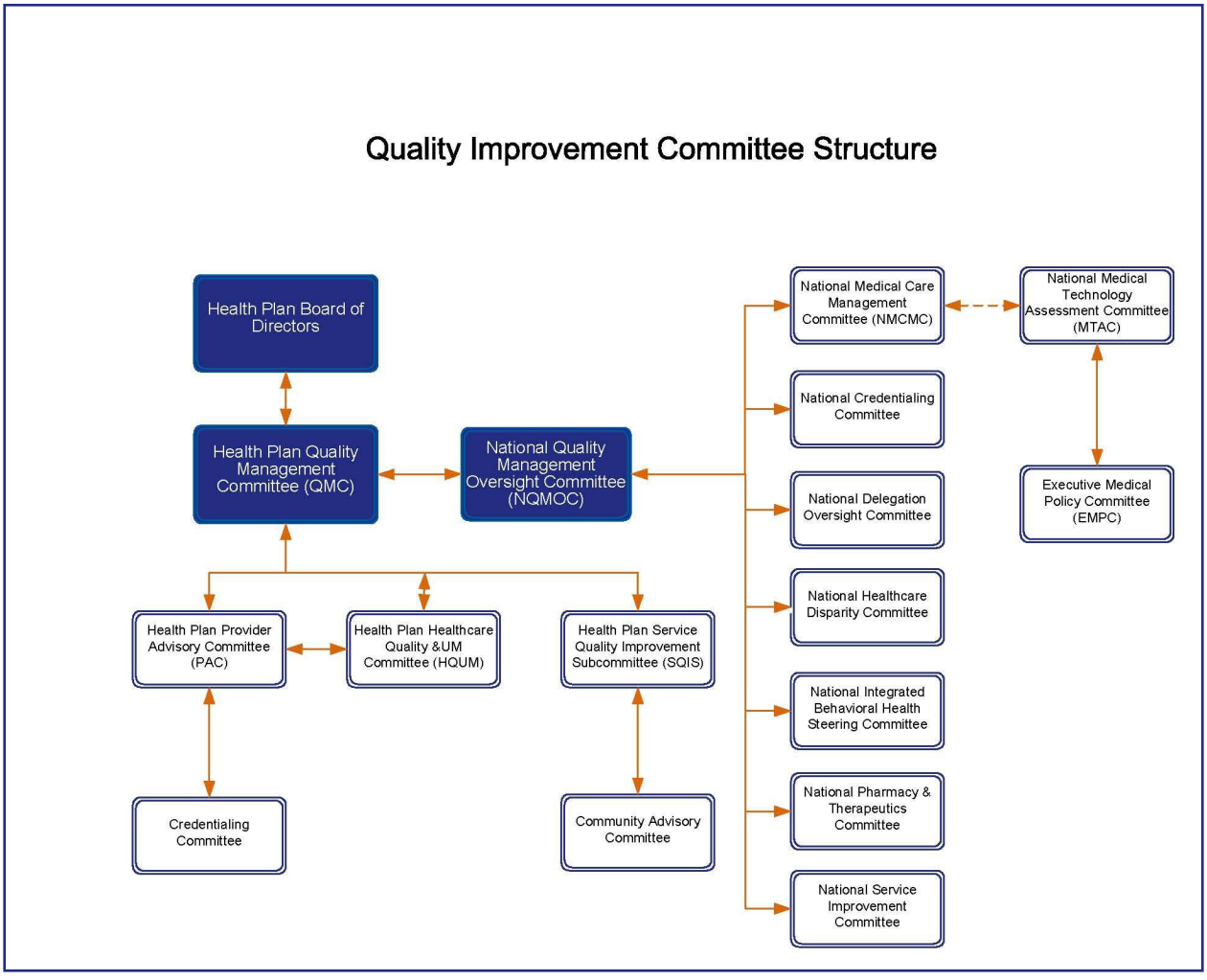
All medical necessity and medical guidelines are reviewed and revised annually to ensure they are responsive to local health plan needs. Criteria may be reviewed more frequently if a new version of the criteria is published before the review date. Guidelines are reviewed and approved by the UnitedHealthcare National Medical Technology Assessment Committee (NMTAC). The NMTAC is responsible for the development and management of evidence-based position statements on selected medical technologies. In addition the committee is responsible for assessment of the evidence supporting new and emerging technologies as well as new indications for existing technologies. The NMTAC's approved guidelines are presented to the UnitedHealthcare National Quality Management Oversight Committee (NQMOC) for approval and then reviewed by the local plan's Provider Affairs Committee (PAC) and Quality Management Committee (QMC) for acceptance and adoption. The QMC for each plan is responsible for overseeing the integration of guidelines into all components of the program such as business processes, assessments, interventions, and provider distribution.

The objective of the NQMOC is to serve as the responsible governing body monitoring and regulating the affairs of the clinical guidelines and community and state programs in all applicable functions. The responsibilities of the NQMOC include, but are not limited to:

- Actively facilitating guideline adoption and ensuring consistency of program content; and
- Providing guidelines and directions to the clinical program through approval and oversight, or requiring and monitoring to completion any necessary course improvement and correction.

NQMOC meetings are held at least semi-annually. Member composition may include:

- Corporate legal counsel
- Senior vice president of clinical and medical operations
- National chief medical officer
- National vice president of clinical operations
- National vice president clinical program development
- National vice president of quality management
- National director of the healthy first steps program.



The following stratification describes the hierarchy of use of medical policies and clinical guidelines within UnitedHealthcare Community Plan for benchmarking and peer-to-peer discussion:

- ***Medical Technology Assessments in the Knowledge Library*** – Our Knowledge Library houses all approved materials for national UnitedHealthcare Community Plan use.

- ***National guidelines and consensus statements***, e.g., United States Preventive Services Task Force (USPSTF), National Institutes of Health (NIH) clinical statements, Agency for Health Care Research and Quality (AHRQ) – National guidelines and recommendations are reviewed regularly to ensure UnitedHealthcare promotes the most current guidelines throughout its programs.
- ***Clinical position papers*** of highly reputed professional societies, e.g., American College of Physicians (ACP), American College of Cardiology (ACC), American College of Chest Physicians, when their statements are based upon referenced clinical evidence – Nationally recognized society clinical position papers are reviewed for relevant guidelines for all UnitedHealthcare programs.
- ***Externally-licensed clinical guidelines*** (e.g., Milliman Care Guidelines) – Licensed clinical guidelines assist in UnitedHealthcare guideline promotion nationally.

Providers (and members) will receive access to and encouragement of UnitedHealthcare Community Plan, Louisiana clinical guidelines via a multi-pronged dissemination approach. We make our guidelines available online to providers and members at our Website. We promote our Website address in the Provider Manual (sent to 100 percent of our providers), our Website in targeted member mailings (condition-specific) as well as national member handbooks. Finally, we disseminate our guidelines to providers and members via our provider newsletters and member newsletters.

H.3 Regarding your utilization management (UM) staff: (GSA C)

- ***Provide a detailed description of the training you provide your UM staff;***

Every member of our staff undergoes intensive immersion training. This includes, but is not limited to the usual and customary new employee orientation. There is also ongoing mandatory training that involves job specific updates, policy change processes/workflow and the maintenance of job specific performance standards. Before a new market is implemented, staff is thoroughly trained on the contractual, State specific nuances for that line of business.

In preparation for the immersion training, staff is required to prepare, at least one week prior to the commencement of the New Employee Orientation training, to complete the crucial groundwork of clearly understanding the scope of their job. The hiring manager is responsible for the following:

- Assigning UnitedHealth Group Webex - computer based New Employee training (4 hrs)
- Touring of facility
- Obtaining an ID badge
- Providing parking instructions and office safety standards
- Orientating the new hire to the work stations
  - Supplies
  - Name Plates
  - Printers, copiers, faxes
- Providing instruction on the UnitedHealth Group Dress Code
- Discussing and providing access to the Holiday Schedule / Work Schedule
- Ensuring that the new hire has a thorough understanding of their job duties and provide a job Description
- Providing the Phone System Orientation, policies and etiquette
- Introducing the Employee Phone Directory
- Orientating to how to Locate Plan Specific Policies & Procedures for Review
- Ensuring the Completed Equipment Check List done

- Registering the clinical staff for the Nursing Spectrum Courses (Clinical Staff Only)
- Assigning a Preceptor for a clinical new hire, who will expose the new hire to the clinical system.

Additionally, within 30-90 days of hire, all of our employees are required to complete a series of ULearn courses. Staff is directed to go to our Human Resource site, HRDirect, to obtain and print the list of required courses. Timelines and courses include:

ULearn Courses - Within 30 Days of Hire

- UnitedHealthcare HIPAA Disclosure Tracking Training
- UnitedHealthcare Managed Care 2008
- Living the Culture the UnitedHealthcare Way
- Cultural Competency
- For Clinical Staff Only
  - Nursing Spectrum computer-based training (CBT)
  - Completion within 30 days: Cultural Competency for the Global Nurse
- For non-clinical staff: ULearn Cultural Competency Course
- Your Role In Authorization Process Controls
- Pass Monthly Quality Case Audits.

ULearn Courses - Within 90 Days of Hire

- Harassment Prevention Training for Employees
- Harassment Prevention Training for Managers
- Legal and Compliance Interviewing for Managers.

During the clinical immersion, UM nurses are educated on the global aspects of health services. This includes, but is not limited to, a summary of the quality management program, critical thinking, compliance with HIPAA, fraud and abuse, the concepts of medical necessity and various condition specific programs. During this time, the UM staff is exposed to the referral process and specific contacts. They are introduced to the community outreach and behavioral health teams. We expose them to their role in the managed care setting, while educating them about the application of the medical necessity guideline. If there are State specific policies that require adherence, we integrate those aspects into the appropriate course content area. By the end of the first week, the nurses are learning and practicing on the clinical management system.

A critical aspect of the UM process is the consistent application of the medical necessity guideline. In order to ensure the same utilization review standards are maintained by each individual reviewer and promote consistency surrounding the decision-making processes, it is the policy of UnitedHealthcare Community Plan that all clinical staff makes medical necessity decisions based on national evidence-based guidelines. We test this consistency by performing Inter-rater Reliability Testing (IRRT) on all UM nurse. The IRRT is a process based on systematic review that determines congruence in outcomes among clinical peer reviewers and other health care professionals. Included in this process is the evaluation of evidence-based guideline criteria application, guideline navigation, understanding of workplace policies and procedures and knowledge of regulatory agencies requiring compliance and timeliness guidelines.

The Inter-rater Reliability (IRR) process begins with quarterly, instructor-led sessions that aim to provide a standardize approach to assessing cases, clinical information obtained, diagnoses and evidence-based guidelines when clinical staff make determinations. The instructor-led sessions are conducted quarterly during the mandatory IRR Grand Rounds. The Grand Rounds has a facilitator noted by UnitedHealthcare Community Plan to be a Subject Matter Expert in the fields of Milliman and Interqual, critical thinking and utilization review.

The Grand Round facilitator ensures that standardized approaches to case scenarios are followed and proper critical thinking skills and evidence-based guidelines are used when clinical staff encounter a case which requires a medical determination. Additionally, on an annual basis, IRR case scenario testing is administered for all clinical staff through the Learning Management System (LMS).

Automatic e-mail communications are generated directing staff that the course is assigned in their development plan in the Learning Management System.

Annual IRR testing is mandatory for all clinical staff. During the IRR annual testing, clinical staff is tested on guidelines usage for the following areas: inpatient, outpatient, home care and long term care case scenario guideline application. Clinical staff is expected to achieve a score of 90 percent. If 90 percent is not achieved, training and retesting will be done. Clinical Staff are able to retake the IRR test up to three times, with retraining needs addressed in between each test that was failed. If a staff member does not pass after the third IRR test, then a 30 day corrective action plan will be derived by the hiring manager in order to correct any deficiency. After the 30 day corrective action period is completed, the employee will take the IRR for the last and final time. If the employee does not pass, the hiring manager must determine if the employee is suitable to remain as part of the clinical staff of the health plan.

The IRR is typically connected with the employee's Maximizing Accountability and Performance goals and objectives for the year. This will maintain that employees are responsible for being proactive in their success within the company and share the accountability to patient care. Completion reports are run to determine scores and staff that have completed the IRRs. Results will be reported to the ICCT (Integrated Care Coordination Team) leadership. The ICCT Leadership will be responsible for providing feedback to the team at large and to individual team members when the scores become available. The IRR score results are also forwarded to the national training consultants to make them aware of future training needs. The audit results are also presented to the appropriate Health Plan and the National Quality Management Oversight Committee (NQMOC) on at least an annual basis.

Describe any differences between your UM phone line and your provider services line UnitedHealthcare Community Plan's UM phone line and provider service lines are different only in that we have a designated UM phone line team who are trained on how to deal with UM questions and issues as well as requirements for the individual health plans. Upon receiving a call, our UM call center staff create "cases" for caller requested services from the prior authorization list. These cases are referred to the UM Clinical team who make the medical necessity determinations.

Our UM phone lines have Qfiniti software, a program that audits individual performance and records/captures individual audio and data entry information. An auditor reviews and evaluates calls for accuracy and professionalism. In addition, our workforce team continuously monitors the UM phone lines to ensure performance standards are met. We have daily UM phone system reports that include abandonment rate, average speed of answer, calls offered and calls handled tracking information.

Our prior authorization phone lines are area code routed and auto-routed to staff assigned to answer calls for specific plans. Our UM phone system has a transfer destination list that houses commonly used phone numbers in order to quickly transfer any calls as needed. We also have Language Line and TTY available to any callers with special needs. We inform providers and members of our 1-800 UM phone line via our member cards and our member and provider handbooks and websites.

Interactions with other customer service lines such as those maintained by the state, parish or city organizations could be routed to our care management team who interfaces directly with these type of organizations and would help coordinate such situations.

For those who may call after hours, we have 24/7 UM live phone staff coverage. Also, we have our 24/7 Nurseline available to members and our UM phone staff can transfer a member to Nurseline if needed. In addition, emergency services do not require prior authorization at any time.

- ***If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls,***
  - ***explain how you will track CCN calls separately; and***
  - ***how you will ensure that applicable DHH timeframes for prior authorization decisions are met.***

Our UM phone line staff will handle both Louisiana CCN and non-Louisiana CNN calls. Our membership calls are routed based on the area code of the caller so the UM phone staff would have the correct information for the location where the member is currently located. In addition all UM phone line staff can verify the member's eligibility regardless of location. Our UM phone system has the capability to track and report how many calls would come into our Louisiana UM phone line daily.

As stated in the previous response, upon receiving a call, our UM call center staff create "cases" for the services needed by the caller. These cases are referred to the UM Clinical teams who make the medical necessity determinations. Our UM Clinical team are required to follow and meet all DHH agreed to prior authorization time frames. Our UM prior authorization phone staff may authorize, as appropriate, any health plan services (that have been given permission to by the state) on the initial call.

H.4 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. (GSA C)

UnitedHealthcare process for gathering, analyzing and reporting utilization data is detailed in our response. We collect data including, but not limited to: claims data, prior authorization, and delegated entities from our health information system. We employ a systematic approach to the production of utilization information. Under the direction of the health plan Chief medical officer, UnitedHealthcare medical management committees hold the primary responsibility for analyzing utilization data and our executive management team is accountable for monitoring and evaluating the utilization data.

UnitedHealthcare has a comprehensive medical management/utilization management (MM/UM) program. This program ensures the provision of timely, appropriate, coordinated and cost-effective health care services to members, driven by the desire to assure optimum health outcomes across the full continuum of care. As previously mentioned, under the direction of the plan chief medical officer (CMO), our MM/UM program is a system-wide, integrated process in which data is systematically gathered internally (such as claims data and prior authorization) and from delegated entities such as the pharmacy benefits manager (PBM). Data is analyzed to identify and develop interventions to address over- and under-utilization, ensuring that services are coordinated across the continuum from prevention to end-of-life care. The scope of services within the MM/UM program is comprehensive and includes, but is not limited to: pharmacy management, prior authorization and referrals, clinical practice guidelines, concurrent review, care coordination, monitoring of over- and under-utilization, new medical technologies and chronic care or disease management programs. Our philosophy and method is a holistic, cross-functional team approach to analyzing data and managing members through outreach, targeted discharge planning and disease/care management and by working closely with our members, their families, providers and community support systems. **All UM reports and activities are reported to our Healthcare Quality Utilization Management Subcommittee (HQUM), which is accountable to our Quality Management Committee (QMC).** The health plan CMO is responsible for all MM/UM activities and chairs the HQUM and QMC. The QMC reports directly to our Board of Directors.

Data Gathering, Analysis and Reporting

UnitedHealthcare gathers utilization data from several sources including but not limited to: data from our clinical management system, our claims data, data from participating providers or delegated entities,

and state-supplied information. We collect, analyze, evaluate and report data. Reports generated on a regular, scheduled basis fall into the following general categories:

- ***Inpatient (IP) Utilization Data*:** Daily Admission Report (generates daily IP census), Daily Admission Extract (pulled monthly to create re-admission report), IP Data Extract (approved versus denied days compared to claims data for payment accuracy), Admits/1000, Days/1000, Average Length of Stay (ALOS), and other admissions statistics
- ***Variant Day Analysis (VDA):*** The VDA is a tool used to analyze over 3 years of claims data integrated from all of our major UnitedHealth Group sources and entities. The VDA also provides hospital and DRG length of stay and readmission opportunity information at various levels of aggregation. The VDA is organized as a series of Excel pivot tables that are easy to navigate with drill down Excel functionality for analysis and printing. The VDA allows analysis of the following:
  - Length of Stay Analysis
  - Adjusted Readmission Rate within 30 Days
  - One Day Stay percentage, Short Stay percentage
  - Top Variant APR-DRGs for Opportunity Days
  - Top Variant APR-DRGs for Readmissions
  - Top APR-DRGs for Observation Conversions
  - New Readmission Metrics
- ***Outpatient Utilization Data*:** Emergency Room Visits, Physician Office Visits, Laboratory Utilization, Imaging Utilization, Immunization Rates (influenza and pneumonia)

Within UnitedHealthcare, we have access to data contained in our Operational Data Store (ODS), clinical management system, and our Strategic Management Analytic Reporting Tool, (SMART). SMART provides extensive reporting capabilities for UM related to medical and behavioral health management and case management. SMART links with and receives data from the clinical management system, to allow reporting on operational performance. ImpactPro®, a powerful claims-based predictive modeling tool, helps us identify our most at-risk members related to medical and behavioral health conditions and gives us the ability to coordinate care for Medicaid members.

Our SMART database and its state-of-the-art reporting capabilities allow us to gather, analyze, evaluate and report data on a global basis or drilled down to a specific member or provider. We can report eligible membership and on specific defined geographic areas at a sub-GSA level. With SMART, we have access to comparative cost data, cost trends, utilization data from both a lagging claims perspective and a leading authorization perspective, and profiling and predictive modeling capabilities.

The MM/UM committee (HQUM) has primary responsibility for analyzing data. In addition, UnitedHealthcare managers and directors from multiple departments receive, review, and analyze reports on a regular basis to ensure that appropriate care and services are being provided to our members in a cost-effective and cost-efficient manner that meets their individual needs. Our CMO meets regularly with the QM Director (biweekly) and the CM Director (weekly) to review reports. Our UM process includes the evaluation and approval (or denial) of procedures, health care services, or settings based on appropriateness, efficacy, efficiency and medical necessity, incorporating prospective, concurrent, and retrospective review with case management to meet program objectives. All reporting, including our performance and trends, is reported to the MM/UM Committee (the monthly HQUM), the quarterly QMC, monthly operational meetings, executive management and ultimately our Board of Directors. **The health plan CMO, reviews the data and chairs both the HQUM and QMC.**

Upon identification of variances in our review and analysis of data, **the MM/UM Committee develops an action plan to address the variances.** The action plans include steps necessary for monitoring utilization reports and creating strategies to address over- and under-utilization and disease management

needs. Additionally, the action plans address performance gaps (actual results versus established goals set internally or by state contractual requirements), communications between multiple departments, and working collaboratively with providers, members, UnitedHealthcare staff and the state to achieve shared goals. Specific strategies may include:

- Creating metric-based scorecards to assist with evaluating data against state standards, clinical criteria and internal performance standards
- Implementing daily rounds to analyze medical management reports and respond appropriately to urgent matters and trends
- Cultivating a culture of ownership amongst the multi-disciplinary team participants
- Improving automated standard reporting available through SMART
- Advanced care management interventions and outcomes reporting
- Coordinated Joint Operating Committee meetings with contracted providers to improve utilization outcomes.

Monitoring Under- and Over- Utilization for Members/ Providers

On an ongoing basis, our MM/UM Committee (HQUM) review and analyze data, interpret the variances, review outcomes, and develop or approve the interventions based on findings. Our regular review and analysis of data and reports is the first step in our process to detect and correct utilization variances (both over- and under-utilization) to UnitedHealthcare targets and national standards. We also monitor under-utilization through care management, prevention and wellness using submitted claims, encounters, laboratory and pharmaceutical encounters. Reporting of our analysis within our various departments and to our multi-departmental committees is the next step in our process. We recruit the necessary and appropriate individuals to meet and develop a member- or provider-specific plan to correct the variance and monitor ongoing performance. Interventions include but are not limited to education, training, or further investigation such as case reviews. If our analysis identifies a systemic problem, we develop communication tools and education or training for our case managers to use during member interactions or to make available to our provider network in general. If the issue is broad enough, we incorporate the change in our member or provider manuals, in our member and provider newsletters, and post the information on our UnitedHealthcare website. Reports are presented at the monthly MM/UM (HQUM) and quarterly QMC meetings where decisions on effectiveness and continuation of programs are addressed. Reports typically include a description of the variance, the intervention, responsible party, evaluation, and any further recommendations or modifications.

Care Opportunities

UnitedHealthcare monitors care utilization patterns, cost/expense variances and care gaps, analyzing data on a global basis and drilled down to a specific member or provider. We use ImpactPro®, our claims-based tool, to identify care opportunities that include potential medication interactions, compliance with clinical care guidelines, and recommended health screening customized for each member. Using this tool, we profile care opportunities by provider and by member. Review of this information by the case manager and by medical management leads to direct interactions with members and providers and is a powerful tool to address under-utilization, care opportunities, potentially harmful treatments or adverse medication interactions.

Concurrent Inpatient Review

Our inpatient concurrent review process identifies and improves member and provider over-utilization by evaluating the appropriate use of resources and the medical necessity, including levels of care and service for institutional stays from admission to discharge. We review daily, weekly and monthly reports, and report our data and trends regularly to HQUM and QMC meetings. Inpatient admissions, length of stay, admission diagnoses, utilization patterns and discharge needs are compared to professionally recognized

standards of care (Milliman) and other metrics to determine the overall success of the program. The daily census reports are also used to trend the inpatient admissions per 1000, days per 1000 and ALOS of members versus targets.

Section I: EPSDT (Section 6 of RFP)

I.1 Describe your system for tracking each member's screening, diagnosis, and treatment including, at minimum, the components of the system, the key features of each component, the use of technology, and the data sources for populating the system. (GSA C)

Universal Tracking Database System for Tracking

A central component of our approach to EPSDT service coordination is through the technology we use for our Universal Tracking Database (UTD) software developed by UnitedHealthcare Community Plan. This software has enabled our health plans to improve adherence to EPSDT periodicity schedules and other necessary screenings by containing member-specific information on use of preventive services. UTD monitors how well members and providers adhere to EPSDT schedules, and enables us to target interventions where they will be most effective, identifying members prospectively who will are in need of targeted services. The key differentiator of UTD is that its automated tracking and reporting capabilities are based on submitted claims, as opposed to paid ones, as most systems are. As a result, it provides access to information quickly, and is far superior to data that has been delayed due to claims payment lag times. The key features of each component is enhanced through rapid availability of information, along with other capabilities of UTD providing our customer service and care management staff critical advantages in managing EPSDT services, including:

- ***Quick access to information means quick opportunities for management**:* When our staff is speaking with a member on the phone, they can easily navigate UTD through point-and-click and query functions to learn if the Member is due for EPSDT services. In addition, via query functions in UTD, our staff can also determine others in the home due for EPSDT or other services. At the time of each member call, all services needed for each member in the household are proactively addressed, including but not limited to other members in the household for whom EPSDT services will soon be due.
- ***Robust internal and external reporting**:* UTD was built with exceptional reporting capabilities, so that information can be generated for targeted outreach. We generate reports based on the specific household, so that our staff can maximize time on the phone by reaching out to as many enrollees in that home as possible. UTD is also capable of generating reports across the population, which can be used to drive Member outreach efforts for those that are behind on EPSDT services, or by provider, so that we can target outreach to physicians that require improvement. In the case of physician-based reporting, we are able to generate reports for specific providers noting which individuals are late for EPSDT services so that they can build those services into future office visits.
- ***Flexibility to support collaboration**:* One of the key strengths of the UTD is its flexibility, which allows us to collect information from various sources to enhance tracking across the population. This strength enhances our ability to integrate claims-based data from State health departments, which are often important immunization and lead screening providers. Additionally, we are able to incorporate data collected through local initiatives for immunization and lead screening services.

I.2 Describe your approach to member education and outreach regarding EPSDT including the use of the tracking system described in I.1 above and any innovative/non-traditional mechanisms. Include: (GSA C)

Member Education and Outreach Approach

UnitedHealthcare Community Plan recognizes that EPSDT visits are an important component of child health and set the stage for healthy adulthood. As we have in other states, we will develop a Louisiana-specific comprehensive, cross-functional EPSDT strategy designed to increase member participation in the EPSDT Program and to ensure that members under 21 years receive EPSDT services. Our plan will be designed to meet the EPSDT requirements as set out in the Louisiana EPSDT contract provisions defined

in Section 6.5 EPSDT Well Child Visits of the Department of Health and Hospitals Medicaid Request for Proposals.

We have developed a proven process for reminders, follow-ups, and outreach to our members and their parents or guardians. No later than one week from a member's initial enrollment, we will use a combination of oral and written methods to contact the member. We will include methods for communicating with members with limited English proficiency, low literacy, and members who are visually or hearing impaired. In addition to the on-line access members have with our website information, the members or their parents/guardians will receive the following education:

- A member Handbook within 10 days of receipt of notification of enrollment detailing EPSDT information, with an annual tri-fold EPSDT informational brochure thereafter
- A Welcome Call within 14 days of receipt of notification of enrollment that includes information related to EPSDT services
- member newsletters containing EPSDT information including easy-to-understand encouragement to obtain screenings and preventive services
- Telephonic and mail reminders that a screening is due, which shall include an offer of scheduling assistance, transportation, and support for other barriers identified (e.g. interpreter services).

Proactive outreach is the primary component of our program. Members or parents will be contacted by our outreach staff, which will make arrangements to support the member in scheduling appointments. Automated call services will include, at minimum, English and Spanish languages. For languages other than English and Spanish, staff will use translation services in all calls where necessary to enhance communication and understanding of call purposes. Preventive health calls will be made during normal business hours in order to facilitate scheduling of provider appointments. Outreach calls will be made at alternate hours to members who were not reachable during normal business hours (i.e., evenings or Saturday).

Support services and arrangements made during each call may include transportation, interpreter services, or PCP selection. Barriers to receiving services are also discussed and information or assistance are provided to address identified barrier(s). As necessary, referrals are made to the appropriate unit (case management, Healthy First Steps program, member services).

If the members or care giver cannot be reached, a postcard is sent to the household with instructions to call member Services. We monitor utilization of preventive services and develop additional outreach strategies as necessary. Our Universal Tracking Database, described in detail above, includes information on appointment compliance and tracks all outreach and education efforts to assure appointment compliance. Reports from our UTD that detail EPSDT compliance specific to the provider's membership will be made available to providers. These reports will include a detailed listing of the provider's members that are in need of EPSDT services. We plan to load historical claims into UTD as long as we have the data elements to map the members. Typically, we target to have UTD ready within 90 days because the Welcome Calls cover the initial EPSDT education. As long as UTD is up at the time of implementation, EPSDT outreach can begin.

- ***How you will conduct member education and outreach regarding EPSDT including any innovative/non-traditional methods that go beyond the standard methods;***

Innovative/Non-Traditional Methods for member Education and Outreach

Through UTD, we drive strong EPSDT results by ensuring that our outreach efforts are targeted toward those members and providers that need them the most. However, we also believe that our outreach **must go beyond standard informational materials and phone calls**, so that we can truly have an impact on results across the population. Some of our innovative/non-traditional methods are depicted in the following examples.

Text4baby Program

The text4baby program is a free service that provides pregnant women and new moms with free text messages on pregnancy and well child care. These messages are timed to a woman's due date or the baby's date of birth, and the topics range from exercise and fitness & nutrition to labor & delivery, car seat safety and breastfeeding. Women who sign up for the program receive texts two to three times a week.

DocGPS 2.0 Application

UnitedHealth Group has pioneered software applications for Smart-phones designed to assist our members. This application enables users to locate an in-network doctor or hospital within our nationwide care provider network of more than 600,000 physicians and care professionals and 5,000 hospitals. After locating a doctor or hospital *DocGPS* shows the provider's location on a map, provides detailed directions and enables the user to call the medical professional or facility with a single tap on the search result. It can then show the care provider's location on a map, give detailed directions and enable members to call the medical professional or facility by simply tapping on the search result. DocGPS 2.0 is now compatible with select BlackBerry devices, Android smart phones and iPhones, including the new iPhone 4.

OptumizeMe®

OptumizeMe is a new, fun and engaging health and wellness application for iPhone® and Android™ devices. Integrated with Facebook®, OptumizeMe allows you to invite friends, share motivation or create competitions. OptumizeMe builds on UnitedHealth Group's increasing focus on mobile technology which began with last year's successful launch of DocGPS. OptumizeMe can:

- Allows users to create health challenges or join existing ones
- Motivates participation through shared goals and rewards
- Allows users to invite friends, family or even total strangers to join challenges
- Allows users to post to Facebook and encourages each other with direct in-app messages, earn badges and more.

Targeting Teens for EPSDT

Issues for children in the transitional age group of 14 to 20 are uniquely different from younger members aged birth to 13. In other states, we have developed a successful program for adolescents in the transitional age groups, which we will tailor for Louisiana. The program for teens includes a newsletter that features topics of interest to pre-teens, teens and young adults, such as tobacco, obesity, vaccines, anger management and violence prevention, stress management, nutrition, acne, sexually transmissible diseases (STDs), car safety, sports safety, and general teen wellness.

To make our outreach efforts more effective we seek to partner with other entities that can help us deliver education to as many members as possible in a way they will listen. Schools are an ideal example of this type of partner, as are settings such as the Boys and Girls Clubs located across Louisiana. We will also identify churches, mosques, and synagogues that provide after-school programs for teens and ideally focus on health issues. Our educational approaches are targeted to reach the right population where we know they will be. For example, to specifically reach males we will strive to work with YMCAs, either to distribute educational materials or to provide direct in-person outreach.

Healthy First Steps (HFS) Program

Pregnant women will be informed of the EPSDT benefits prior to delivery to promote EPSDT services for the child at birth, and to establish preventive care as an ongoing part of health care promotion. We will assist pregnant women in making appointments for prenatal care.

Through the Healthy First Steps program, as discussed in our J.1 response, outreach specialists will

contact pregnant women to discuss EPSDT screening and immunization schedules and to provide educational materials. In addition, every pregnant woman is offered a postpartum home visit within 48 hours of delivery. Discussions will focus on self-care and general baby care. All HFS program moms are stratified into risk assessment rankings. The members identified as high risk receive ongoing communications, including monthly follow-up calls, and as necessary more intense onsite assessments.

Baby Shower Program

UnitedHealthcare Community Plan has created a "baby shower" program for members as a way to impart prenatal care education and to encourage members to have healthy pregnancies. As we identify pregnant members, our case managers contact them to invite them to a "baby shower"— an event at which we provide educational materials on prenatal care and EPSDT services, as well as small gifts that promote wellness, such as baby thermometers and periodicity calendars. This type of interpersonal contact strengthens our relationships and enhances communication with members. HFS supports our health plans with the showers by distributing educational materials and reminding members about the date and time of their scheduled appointments.

Rhode Island Medicaid – RIte Smiles Plan for Children

UnitedHealthcare Community Plan created UnitedHealthcare Dental-RIte Smiles, a dental plan in Rhode Island. The goal was to increase access to dental services for Medicaid children born on or after May 1, 2000. We aggressively implemented a broad range of approaches to improve access to dental services for this member population. Some of the more innovative and effective approaches include:

- Targeted outreach to RIte Smile members, who (based on our claims history) did not see a dentist within the last nine months
- Outreach to all newly-enrolled members with an offer to do three-way appointment scheduling, which involves us working directly with members to schedule an appointment with network dentists
- Participation in the Rhode Island Oral Health Coalition, resulting in the creation of a Safety Net Provider Network to address dental access issues for members
- Integration of medical claims review to determine members at risk and in need of dental care
- Targeted education to members on the impact of broken dental appointments
- Automated phone call campaign.

RIte Smiles
Dental Care for Kids

Rhode Island is the sole Dental Benefits Manager which administers dental benefits for the nationally recognized RIte Smiles Medicaid dental managed care program. This program, which was initiated in 2006, has ensured access for approximately 40,000 children to preventive and palliative dental services.

Community Partnership Innovations

UnitedHealthcare Community Plan is experienced in working with community based organizations to improve EPSDT screening efforts. Working with these organizations, we conduct outreach and coordination of EPSDT services. In Tennessee, we participated in a collaborative work group of all Medicaid health plans. The goal of the collaboration was to increase well-child (EPSDT) screening rates in the 15 to 20 year-old population. The collaboration partners agreed to promote the message that well-care check-ups could detect serious problems before they become life-threatening. We also sent the

message that well-care check-ups could identify conditions such as Attention Deficit Disorder and STDs that may create more long term problems if left undetected. Teen newsletters were sent to 15 to 20 year-old members enrolled in our plan. HEDIS data reports indicate adolescent immunizations from our Tennessee population increased by over 100 percent in most categories in 2005, indicating that similar future efforts may be effective.

State Partnership Innovations

To coordinate and enhance the services provided to Louisiana Medicaid members under 21, we will also develop and execute a Memoranda of Understanding with the following programs: Nurturing Families Network, Healthy Start, WIC, Birth-to-Three, Head Start, InfoLine's Maternal and Child Health Project, and other State programs as designated by DHH.

Through our contracts in other states, we have a great deal of experience coordinating with programs that can benefit our members.

In Michigan, UnitedHealthcare Community Plan has partnered with over a dozen local organizations to better serve our members, including:

- Michigan State University to create an EPSDT Provider Toolkit.
- The Michigan Childhood Lead Poisoning Prevention Program to support consumer and provider education on the effects of lead poisoning and importance of early testing.
- The Berrien County Public Health Department, Michigan Department of Community Health and two Medicaid MCOs to reduce racial disparity in women's health.
- The Michigan Department of Community Health and other Medicaid health plans to share HEDIS outcomes and improve access to PCPs by focusing on low performing PCPs on a statewide basis.
- The Detroit Immunization Coalition, a collaborative to improve administration of flu vaccine in the city and child and adolescent immunizations through school based programs.

In Wisconsin:

- UnitedHealthcare Community Plan and the Southeast Wisconsin Medicaid program facilitate blood lead testing of one and two year olds through the Women, Infant and Children (WIC) program. An in-home testing program pilot is also being evaluated. UnitedHealthcare Community Plan purchased two Lead Care II Analyzers to loan to providers who wish to try in-office testing prior to committing the resources on their own. These are being piloted at offices that do not have in-house labs and have larger pediatric clientele.

In Florida:

- UnitedHealthcare of Florida works with a vast number of community-based organizations to provide education across the state about Florida Healthy Kids. In addition to our local community organizations, UnitedHealthcare of Florida strives to partner with local chapters of children and family advocate groups in every county we currently serve. UnitedHealthcare of Florida provides outreach materials, participates in health fairs and other events and conducts presentations to benefit the members of all our community partners. The following listing is a limited sampling of the many local and state-wide organizations we routinely work with to promote Florida Health Kids:
  - Head Start
  - YMCA- Early Care and Education Consortium
  - The Early Learning Coalition
  - Early Education Group
  - Florida Coalition for Children

- Florida Head Start Association
- Partnership for Strong Families
- Safe Kids Coalition
- Florida Developmental Disabilities
- Vocational Rehab of Ocala, Inc. Council.
- Childhood Development Services.

In the District of Columbia:

UnitedHealthcare Community Plan has experience providing a Health Navigator Program for a Medicaid plan in the District of Columbia where the navigators are used for EPSDT education along with new member education to promote compliance and retention. Potential partners in Louisiana who are willing to work with us on this initiative include the Family Road of Baton Rouge, YWCA and Southwest Louisiana Area Health Education Center. It is important the health navigators are from the community in which they will be working to promote member retention and acquisition.

Community Impact

UnitedHealthcare APIPA (AZ) has designed a quality management program to achieve, thorough ongoing measurements and intervention, significant improvement, sustained over time, in the areas of clinical care and non-clinical care that are expected to have a favorable effect on health outcomes and member satisfaction.Our audited HEDIS results show statistically significant results from for several critical areas including:

- Timeliness of Prenatal Care
- Children's Access to PCP (25mos-19 yrs)
- Well Child Visits (0-6 yrs)
- Adolescent Well Care
- Annual Dental Visits

*Medicaid Population (includes DDD eligible members) for 2009-2010

These are just a few of the examples of how UnitedHealthcare Community Plans work with community and state organizations to improve quality and access to care for our members. We consistently strive to connect members to other resources in the community to help receive wrap-around services and services not provided through Medicaid.

- ***How you will work with members to improve compliance with the periodicity schedule, including how you will motivate parents/members and what steps you will take to identify and reach out to members (or their parents) who have missed screening appointments (highlighting any innovative/non-traditional approaches); and***

Improving member Compliance with the Periodicity Schedule

We will use member demographic data to identify members due for EPSDT services. Postcards are sent to members reminding them of upcoming services. Our proprietary UTD is used to identify members who have missed scheduled services, conduct outreach programs and to encourage these members to access services. In addition, Health First Steps will remind pregnant members to schedule their well baby appointments. **Text4baby** will also send out reminders regarding EPSDT/well baby appointments.

Automated reminder calls are made to members who are identified as non-compliant for EPSDT services and require a service in > 90 days. On all automated calls, the member will have the opportunity to speak with a live agent who will be able to initiate a three way call with a provider in order to schedule the requisite appointment(s). For distribution of calls, a member list will be generated monthly for each call campaign. Each member will appear in the list quarterly as long as the member remains non-compliant.

Live outbound calls are initiated to members who require the recommended services within the next 90 days. A member list will be generated monthly for each call campaign. During live reminder calls, with member authorization, staff will attempt to initiate a three-way call with a provider in order to schedule the requisite appointment(s). Staff will also provide assistance with obtaining transportation if indicated.

If, at the time of member contact, the member indicates the service has already been received, the staff will obtain the name of the provider and approximate date of service(s) provided.

Staff will make up to three attempts at different times of the day/evening to reach the member for automated and direct member calls. If the member cannot be reached telephonically, the Hospitality and Reminder Center (HARC) will send the member a postcard providing an inbound phone number for the member's return call. This cycle will continue throughout the year as long as the member remains non-compliant.

In addition to outreach calls, our quarterly member newsletters provide information on recommended preventive health services including the recommended timing of such with the encouragement for members to obtain these services.

- ***How you will design and monitor your education and outreach program to ensure compliance with the RFP.***

Ensuring Education and Outreach Program Compliance

Education and outreach are important initiatives to improve member compliance. Specific activities are determined based on population needs, cultural competencies, and ability to impact behaviors thereby improving outcomes. Service utilization and results are regularly reviewed to determine areas for quality improvement. A committee, usually consisting of (at a minimum) a medical director, quality director, and a case management administrator identify barriers and perform root cause analyses. Interventions deemed most appropriate to the targeted population are then designed or selected with the goal of affecting change.

Education can take a number of delivery formats such as a newsletter article, a flyer/brochure, booklet, provider request, case management discussion, as well as automated or live educational outreach calls. A dedicated UnitedHealthcare Community Plan outreach team Hospitality, Assessment and Reminder Center (HARC), routinely contacts members telephonically to educate members on the importance of screenings and encourages them to schedule visits with their physician. Members who are case managed for a chronic disease or pregnancy are also educated about self-management of their condition and offered assistance and encouragement to seek regular care with their primary physician or medical home. In order to monitor the effectiveness of the education and outreach activities, the Plan reviews process and outcomes data after the interventions have been implemented.

On a monthly basis, claims data from physicians is uploaded into a data warehouse for analysis and reporting. This claims data will be analyzed via the calculation of HEDIS well child annual visit rates, immunization rates, and other relevant EPSDT and HEDIS measures for this population.

Monthly Process Measure Analysis

The health plan will determine the success of its intervention by establishing process metrics that will assess outcomes via process measures (e.g., number of members who were contacted as a proportion of members identified to be contacted) pre and post intervention. Processes or interventions will be adjusted based on the results of the findings. Measurement and analysis of process measures will be performed monthly.

Monthly Outcomes Analysis

The health plan will analyze the outcome measure rate(s) via monthly reporting updates for relevant measures provided to the Quality Director by comparing the rates to the initial measurement, the prior year's rate, the goal, and the benchmark for each relevant measure. Other state data may also be used in the analysis when appropriate. However, interim rates will be reviewed internally on a monthly basis, and analyzed quarterly. Outcome rates are also reported annually for all measures of quality care.

Statistical testing will be performed to determine if a statistically significant change has occurred from a previous/comparative time period. UnitedHealthcare Community Plan will use statistical confidence rates and intervals as well as statistical significance. The percent of change and percentage point change for each measurement period is also noted.

As part of the data process to determine where to focus interventions, member level detail data (disparity analysis plan) will be analyzed, such as:

- Age
- Race, ethnicity
- Member primary language
- Area (county/zip code).

By monitoring the success of the education and outreach activities and drilling down data, UnitedHealthcare Community Plan is able to identify the prevalence of noncompliance by the available factors. This analysis will allow for more focused interventions moving forward.

I.3 Describe your approach to ensuring that providers deliver and document all required components of EPSDT screening. (GSA C)

Our UTD system (described in detail in I.1) monitors how well members and providers adhere to EPSDT schedules, and enables us to target interventions where they will be most effective.

UTD is also capable of generating reports across the population, which can be used to drive member outreach efforts for those that are behind on EPSDT services, or by provider, so that we can target outreach to physicians that require improvement. In the case of physician-based reporting, we are able to generate reports for specific providers noting which individuals are late for EPSDT services so that they can build those services into future office visits. Reports from UTD that detail compliance with EPSDT services specific to the provider's membership will be made available to providers.

Through UTD, we drive strong EPSDT results by ensuring that our outreach efforts are targeted toward those members and providers that need them the most.

In addition, as required by contract (Section 8.2.2.9) and ad hoc when EPSDT documentation issues are identified, the Louisiana plan will facilitate a medical record review of identified providers to assess delivery of appropriate preventive services, including EPSDT components, and documentation of such.

I.4 Describe how you will ensure that needs identified in a screening are met with timely and appropriate services. (GSA C)

UnitedHealthcare Community Plan continuously monitors the services members receive as well as identify missed opportunities for the Members to receive recommended services. In addition to the reports described above, we produce monthly interim HEDIS reports and semi-annual provider profiles that identify member populations that are in need of services. We have member and provider outreach processes that address these gaps in care that include follow-up with both members and providers detailing specific recommended services needing to be delivered.

Additional monitoring that we do to ensure the member's needs are met with timely and appropriate services include:

- ***Preventive Health Reminder Programs:*** In addition to screening articles in member newsletters and focused condition specific mailings that provide members with information on obtaining needed services, we use our UnitedHealthcare Community Plan Hospitality, Assessment and Reminder Call Center (HARC) to provide a consistent and coordinated member contact experience that ensures we capture the unique needs of our members and encourage timely follow-up on needed services.

- ***Case Management:*** For Members receiving case management services, the Case Manager will follow up with the member to confirm they are receiving needed services and if the services being provided are meeting their specific needs.
- ***Provider Manual, Provider Web Portal and Provider Education and Training:*** Through all of these resources we inform providers that they can refer our members to our case management services for needed services.
- ***Retrospective Medical Record Reviews:*** Review of medical records to confirm services have been provided in accordance with recommended clinical and preventive guidelines. Providers are informed of the medical record documentation standards in the Provider manual.
- ***Welcome Calls:*** We use our Welcome Call as an opportunity to conduct an initial Health Risk assessment (HRA). This assessment allows for early identification and risk stratification of members with disease management program conditions. During the welcome call, we can detect chronic and other conditions and issues not routinely otherwise captured as well as educate the member on any needed services.

Texas CHIP Initiative to Improve Percentage of Lead Screening

It is well documented that the risk of lead poisoning falls disproportionately on low-income children. In 2009, we implemented interventions to increase the percentage of both STAR and CHIP children receiving at least one capillary/venous blood lead test on or before their second birthday.

UnitedHealthcare Community Plan alerted members of the need for a blood lead test by way of a Member newsletter, lead-specific outreach materials and reminder calls and letters to caregivers. In cases where Providers were found deficient in providing needed tests (as a result of an audit), they were educated on lead screening requirements and expectations.

Due to these initiatives, the HEDIS administrative rate for our STAR program improved significantly. In 2009, 17.74 percent of members received appropriate screens compared to 27.80 percent in 2010* (310 and 309 children in the samples respectively). As the CHIP population has similar characteristics as STAR, we expect to achieve similar rates for our CHIP program; however the results are not yet statistically significant.

**Source: HEDIS2011 TX Medicaid admin compare march measure Run 3-11(final 2010 rate may be greater)*

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