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## Section J: Quality Management (Section 7 of RFP)

**J.1** *Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following: (All GSAs)*

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### Quality Assessment Performance Improvement (QAPI)

Our philosophy supporting quality assessment and performance improvement (QAPI) is to leverage our assets, capabilities and engage employees to provide our members, providers and state partners with cost effective, high value and high quality services. We engage all UnitedHealthcare Community plans to move our Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measurement rates to “the best” of all our competing plans and to state-specific goals.

DHH, in turn, will benefit from the shared experiences of our other Medicaid plans and from our flexibility to address the unique needs of the Louisiana Medicaid program. This approach to positively impact the health care status of Medicaid and CHIP populations, allows our national resources and organizational support to implement identified best practices, to continually measure their effectiveness, to assess and modify outreach and interventions for all UnitedHealthcare Community Plans across the country.

Identification of best practices is conducted within every UnitedHealthcare Community Plan as well as outside of our organization via comprehensive research analysis and partnering with health care collaborative quality improvement organizations.

There are two functions for a Best in Class initiative:

- (1) Identify best practice approaches and programs with our health plans.
- (2) Develop and facilitate the implementation of initiatives across all health plans.

One function is consultative, while the latter function is program development and implementation. The resulting “Best in Class” programs include Medicaid, Medicare and Long-Term Care membership.

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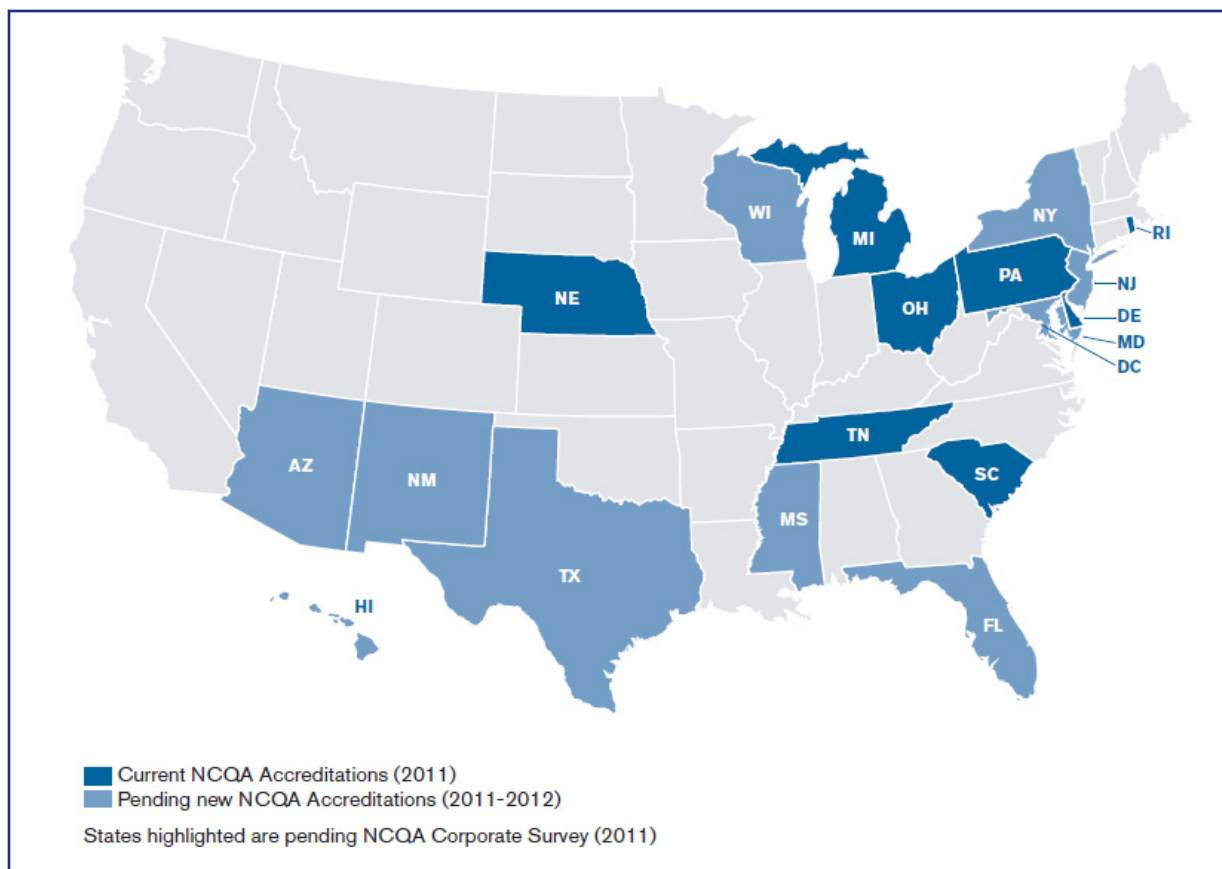
### QAPI Program Overview and NCQA Accreditation

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, to enhance customer service, to seek better health outcomes and to reduce medical costs.

We currently have URAC accreditation and National Committee for Quality Assurance (NCQA) for our commercial plan in Louisiana.

We will pursue NCQA accreditation for any the Louisiana Medicaid offering and will comply with the DHH’s requirements for attainment within two to four years after the start of our contract. Today, **nine of our Medicaid health plans hold NCQA accreditation** with additional plans expected to attain accreditation in 2011 and 2012, as shown below.

**Current and Pending NCQA Accreditations 2011-2012**



Our centralized Quality Improvement (QI) Program for all UnitedHealthcare Community plans also assures continuous compliance with NCQA accreditation standards. Our goal is to achieve and sustain successful accreditation for all our plans. We are working to achieve a Corporate Quality Program Accreditation for UnitedHealthcare Community & State, which will support the accreditation process for individual UnitedHealthcare Community Plans.

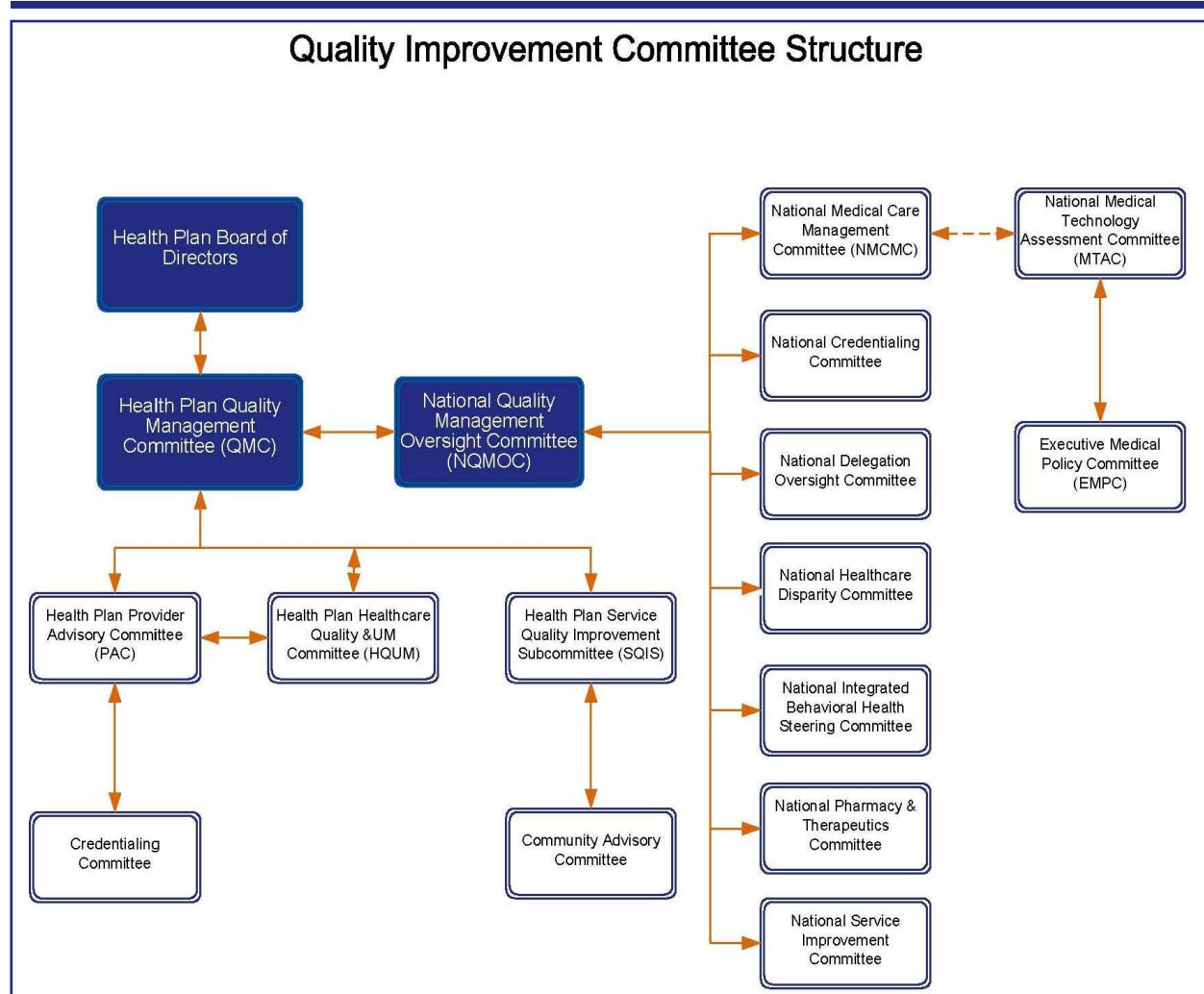
As we continue building quality measures and performance improvement into our health care programs, we anticipate 20 NCQA Health Plan Accreditation applications (including corporate, initial and new health plan accreditations, and reaccreditations) scheduled through 2013 for our Medicaid business. Our anticipated NCQA applications include:

<i>Year</i>	<i>Accreditation Applications</i>	<i>State Levels</i>
2011	7	One corporate level for UnitedHealthcare Community & State and six state levels for Maryland, Nebraska, New Mexico, Ohio, Pennsylvania and Rhode Island
2012	10	Ten state levels for Arizona, District of Columbia, Florida, Hawaii, Mississippi, New York, New Jersey, Tennessee, Texas, and Wisconsin
2013	3	Three state levels for Delaware, Michigan and South Carolina

## Governing Body

UnitedHealthcare Community Plan uses an integrated structure to our quality improvement oversight that includes **both local and national committees as shown in the following figure**. UnitedHealthcare intends to use this same approach for our UnitedHealthcare Community Plan, Louisiana. Ultimate accountability rests with the Louisiana Board of Directors whether the resource support emanates from a local committee or a national committee. UnitedHealthcare Community Plan collaborates with various national committees:

<i>National Quality Improvement Committees</i>	
<i>Committee</i>	<i>Description</i>
National Quality Management Oversight Committee (NQMOC)	The governing body responsible for monitoring and regulating at a national level the affairs of the Quality Improvement, Utilization Management and Outreach Programs.
National Credentialing Committee	Committee conducts initial credentialing and recredentialing of practitioners who may provide care and services to UnitedHealthcare/State government program member as indicated in the UnitedHealthcare Credentialing Plan.
Executive Medical Policy Committee (EMPC)	Committee is responsible for overseeing the development, implementation and evaluation of the medical policies across UnitedHealth Group.
National Medical Technology Assessment Committee (MTAC)	Committee 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.
National Pharmacy and Therapeutics Committee (P&T)	Committee is responsible for providing the clinical oversight for the development and maintenance of the Preferred Drug List and Clinical pharmacotherapy policies.
National Service Improvement Committee (NSIC)	Committee provides coordination of all customer and provider service and satisfaction monitoring activities on a national scope.
Delegation Oversight Committee	Committee's primary focus is to perform oversight of all nationally delegated entities.
National Healthcare Disparities Committee	Committee's primary focus is to formulate and apply a framework to assess and address significant disparities in health services and health outcomes between ethnic and racial groups. Committee is also responsible for ensuring cultural diversity education is provided for staff throughout the organization.



Further descriptions of the underlying operations and resources allocated to UnitedHealthcare Community Plan's Quality Assessment and Performance Improvement (QAPI) are provided in the next sections.

## Board of Directors

Blaine Bergeson, Chief Executive Officer is reportable to the Board of Directors (BOD) is the governing body of UnitedHealthcare Community Plan in Louisiana. The Board of Directors functions related to the quality assurance and performance improvement program include:

- Annual review and approval of the Quality Improvement (QI) Program Description, annual QI Work Plan, Annual QI Evaluation, and other reports and information as required or requested
- Provision of feedback and recommendations to the Quality Management Committee (QMC) related to summary reports, documents and any issues of concern
- Demonstration of senior level commitment to quality and to UnitedHealthcare Community Plan's QI Program including resource allocation.

The Board of Directors meets at least annually and has ultimate responsibility for the QI Program and related processes and activities. The Board of Directors delegates oversight of committee QI functions to the National Quality Management Oversight Committee (NQMOC) and the Quality Management Committee (QMC). The composition and responsibilities of these two bodies are described below.



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## **Committees for Development, Implementation and Overseeing the QAPI Program**

The National Quality Management Oversight Committee (NQMOC) and the Quality Management Committee (QMC) share responsibility for ensuring the quality improvement processes outlined in the QI Plan are implemented and monitored. Provided below is a summary of the membership and respective functions of each of these committees within UnitedHealthcare Community Plan's QAPI program.

### **National Quality Management Oversight Committee (NQMOC)**

The National Quality Management Oversight Committee (NQMOC) is UnitedHealthcare Community Plan national body responsible for the oversight and regulation of local quality improvement, utilization management, and outreach programs.

### **Quality Management Committee (QMC)**

The Quality Management Committee (QMC) is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan. The QMC meets at least quarterly and reports to our Board of Directors at least annually and to the National Quality Management Oversight Committee (NQMOC) at least twice per year.

This committee membership includes: Blaine Bergeson- Chief Executive Officer(Committee Chair), Mark Mahler MD-Chief Medical Officer, director of operations, case management administrator, director of quality management, network management representative, compliance officer, financial officer, dental services representative, behavioral health services representative and other representation as identified by the Mr. Bergeson

The responsibilities of the QMC include:

- Provide program direction and continuous oversight of quality improvement (QI) activities as related to the unique needs of the member and providers in the areas of clinical care, service, patient safety, administrative processes, compliance and network credentialing and recredentialing
- Formally evaluate, at least annually, the impact and effectiveness of Medicaid specific Performance Improvement Projects (PIPs) and recommend changes as necessary
- Review, prioritize and align the Annual QI Work Plan with strategic objectives of the organization
- Review and approve benchmarks, performance goals and standards for quality activities
- Analyze and evaluate the QI program annually and assess the overall effectiveness of the program. Recommend policy decisions based on this evaluation
- Submit the QI Program Description, Annual QI Work Plan and Annual Evaluation of the QI Program to the Board of Directors for review and approval
- Report annually or more frequently as needed, on quality activities to the Board of Directors
- Monitor annual HEDIS / CAHPS® results and other state clinical metrics and action plans to improve results
- Monitor Member complaints, appeals and grievances and results of Member satisfaction surveys
- Monitor action plans to address identified opportunities and improve performance
- Monitor network access and availability and review performance against standards at least annually
- Monitor, evaluate and implement improvement plans for access and availability of network providers
- Monitor and evaluate the cultural and linguistic needs of our enrollment
- Review and accept decisions of the National Quality Management Oversight Committee that have been delegated by UnitedHealthcare Community Plan's Board of Directors, offering feedback as

- appropriate
- Review reports and recommendations from other national and local committees, act upon recommendations as appropriate and provide feedback, follow-up, direction to the committees
- Recommend, monitor, and assure barrier analysis and follow up of quality activities
- Incorporate findings from the QI activities into strategic program and resource planning. Adjust programs to address identified needs
- Ensure practitioner participation in clinical aspects of the QI program, including advising on clinical and practitioner issues (Note peer review is performed by the Provider Advisory Committee, which is describe in a following section.)
- Ensure compliance with regulatory requirements and accrediting organizations
- Provide oversight to applicable UnitedHealthcare Community Plan Business Partners
- Provide local delegation oversight as specified by State regulatory requirements. Review and make final recommendation of approval or denial of delegation pre-assessment and annual audit results for delegates scoring <80 percent on audits or with Improvement Action Plans (IAP) to determine acceptance or denial of delegates to a given network
- Review and accept the National Credentialing Plan, with addendum for line of business regulatory requirements as applicable
- Review and accept PAC peer review decisions concerning clinical quality of care and service
- Recommend appropriate resources in support of prioritized activities.

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## **QAPI Program Resources, Staffing and Qualifications including Data and Analytical Resources**

UnitedHealthcare Community Plan bases its QAPI program upon the principles of “Continuous Quality Improvement and Total Quality Management.” We utilize ongoing data analysis to appropriately measure the current quality of Member services and to prioritize opportunities for improvement. The following data sources are used to support our QAPI activities:

- Claims database
- Population and demographic reports
- State agencies
- National, State and internal databases
- UnitedHealthcare Community Plan’s clinical management information system
- Member and provider satisfaction surveys
- GeoAccess analysis reports of provider availability
- Member grievance and appeal data
- Member treatment records
- Credentialing data
- Information collected through office site visit.

With guidance from internal data analysts and statisticians, we have developed, designed, implemented and validated various methodologies to access and use data to support our QAPI activities. In addition to the data above, several other sources of analytical resources are available. These resources include UnitedHealthcare Community Plan’s SMART data warehouse, ImpactPro, MedMeasures by ViPS and our Universal Tracking Database (UTD).

## **Service Quality Improvement Subcommittee (SQIS)**

One venue for data assessment to support changes in Member services is the Service Quality Improvement Subcommittee (SQIS). The SQIS monitors the quality of service delivered to our member and oversees non-clinical services and delegated functions to monitor and to support improved service to member. The SQIS meets at least four times per year and is chaired by the Director of Operations or designee. Members may designate surrogate attendees. The SQIS reports at least four times per year to the Quality Management Committee (QMC); cross reporting to the Healthcare Quality and Utilization Management Committee (HQUM) described below or to the Provider Advisory Committee (PAC) as appropriate for clinical issues and medical/peer review advice.

This committee membership includes: the director of operations or designee (Chair), member services representative, network management representative, grievance representative, dental representative (if applicable), pharmacy representative (if applicable), claims representative (if applicable), enrollment representative as needed, compliance officer, provider relations representative, quality management representative and other staff enrollees by invitation to lend subject matter expertise.

Responsibilities of the SQIS include:

- Oversight of Member and practitioner satisfaction activities
- Recommending interventions based on Member or practitioner satisfaction surveys; including submitting suggestions to Quality Management Committee (QMC) regarding goals for the Plan
- Monitoring of metrics and trends of Member complaint, grievance, and appeal activities, and recommending and monitoring interventions when opportunities for improvement are identified
- Monitoring of metrics and trends of Member and provider call center activities, recommending and monitoring interventions when opportunities for improvement are identified
- Monitoring of access and availability metrics and trends, recommending and monitoring interventions when opportunities for improvement are identified
- Review, approval, and monitoring of Member and provider service performance improvement activities (PIPs)
- Monitoring of provider service metrics (e.g., claims lag, frequency of office visits, complaint resolution timeframes), and recommending and monitoring actions as indicated
- Review and approval of UnitedHealthcare Community Plan's service-related Operational Policies and Procedures
- Provide a summary report of subcommittee activities to the QMC.

The SQIS activities are also supported by reports received from the following UnitedHealthcare organizational areas:

- Member Services providing Member Service Center metrics
- Network Management providing access/availability and provider satisfaction data
- Provider Customer Service Center provide Provider Service Center metrics
- Grievance and Appeal providing Member complaint reports and metrics.

## **Healthcare Quality and Utilization Management Committee (HQUM)**

The Healthcare Quality and Utilization Management Committee (HQUM) monitor all clinical quality improvement and utilization management activities within the health plan. The HQUM meets at least four times per year and is chaired by the Medical Director or designee. Members may designate surrogate attendees. The HQUM reports at least four times per year to the Quality Management Committee (QMC). Cross reporting to the Provider Advisory Committee (PAC) is made as appropriate for peer review and other matters.

This committee membership includes: Mark Mahler MD- Chief Medical Officer (Chair), medical director(s), director health services, director of quality management, network management and provider operations representative, maternal child health director, compliance officer, UM staff as designated by the Chair, and other staff enrollees by invitation of Chair to lend subject matter expertise.

Responsibilities of the HQUM include:

- Review and approve the Utilization Management (UM) Program Description, UM Work Plan and UM Program Evaluation at least annually
- Review and approve Disease Management Programs including Healthy First Steps
- Review and accept UM and QI Policies and Procedures at least annually to assure they reflect current standards of medical practices
- Oversee implementation of the UM and QI Programs and Work Plans
- Review and approve performance metrics from all clinical areas. Monitor progress on clinical performance improvement programs
- Review summary reports of quality of care investigation tracking and trending including quality of care and service provided within facilities as well as, by home health, Durable Medical Equipment (DME) and ancillary service providers, identify trends, and recommend corrective actions as needed
- Review reports on mortality and other clinical quality issues and advise actions as indicated
- Evaluate the consistency of the UM decision making process through inter-rater reliability reports. Recommend improvement actions as indicated
- Establish and evaluate data driven interventions to improve performance in identified areas
- Recommend and monitor special studies for quality improvement including targeted Quality and Performance Improvement Projects (QIPs/PIPs)
- Identify over- and under-utilization issues and recommend corrective actions as indicated
- Monitor continuity and coordination of care. Recommend improvement actions as indicated
- Review reports related to member in Care Management and Disease (Condition) Management and other health services functions
- Review clinical practice guidelines, utilization guidelines and critical pathways for UM approved by the National Quality Management Oversight Committee (NQMOC) using the National Medical Care Management Committee
- Review, accept and provide feedback on summary reports from the NQMOC
- Provide a summary report of subcommittee activities to the Quality Management Committee (QMC) at least four times per year.

### **Community Advisory Committee (CAC)**

The Service Quality Improvement Subcommittee (SQIS) is supported by the Community Advisory Committee (CAC). The CAC provides a collaborative forum for member, community representatives, advocacy groups and community-based providers to share our successes, bring issues and ideas from their member to us, work together on opportunities for community outreach, identify common ground around legislative issues, obtain feedback on new and future initiatives and review how these programs fulfill our mission. Minutes from the CAC are reported to the SQIS, as described below.

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## **Senior Staffing Support Involvement with the QI Process**

Key senior staff at UnitedHealthcare Community Plan recognizes that the success of QAPI efforts is largely correlated with engagement of senior decision makers into the quality improvement (QI) process. The following are brief descriptions of senior level positions and their involvement with our QI process.

**Chief Executive Officer (CEO)**

Our CEO, Blaine Bergeson is responsible for oversight of the implementation of the QI Program and chairs (or identifies a designee to the chair) the Quality Management Committee. The CEO is responsible for monitoring the quality of care and service UnitedHealthcare Community Plan provides, and ensuring the appropriate level of resources is available for the QI Program. The CEO also ensures that fiscal and administrative management decisions do not compromise the quality of care and service provided to members.

**Contract Compliance Officer (CCO)/Chief Operating Officer (COO)**

The CCO is responsible for the overall management and integration of operations in all functional areas. The CCO interfaces with leadership in shared service functions and other functional areas as appropriate, manages management staff and is on the Quality Management Committee (QMC) membership. This position participates in the operationalizing of the Quality Improvement Program (QIP) by coordinating the overall administrative health plan functions in a manner consistent with the institutional / health plan's quality improvement activities.

**Chief Medical Officer (CMO)**

Our Chief Medical Officer, Dr. Mark Mahler, MD, is a licensed physician who is responsible for implementation of the QI Program. Dr. Mahler reports to the our CEO, Blaine Bergeson and provides the medical direction for health plan staff. Dr. Mahler or his designee chairs the Provider Advisory Committee (PAC) and the Healthcare Quality Utilization Management Committee (HQUM). The CMO participates in the credentialing process for the health plan and coordinates review and approval with the PAC. The CMO oversees and implements activities to measure health services efficacy.

**Director of Quality Management**

The director of quality management is responsible for oversight of the implementation of the QI Program, including monitoring the quality of care and service (QOC/QOS process complaints and provides the evaluation of quality improvement initiatives involving Member and provider engagement. The director of quality management maintains oversight of activities designed to increase performance on HEDIS and performance measures, prepares annual QI Program documents, submits quality regulatory reports, has day-to-day responsibility for implementation of quality performance improvement studies and patient safety initiatives and manages the health plan Quality Improvement infrastructure. The director of quality management is a point of contact for regulatory inquiries, specific to QI related inquiries/activities and works with the compliance officer to assure compliance with regulatory and accreditation standards. The director of quality management reports to Dr. Mahler, CMO to ensure that fiscal and administrative management decisions do not compromise the quality of care and service UnitedHealthcare Community Plan provides to members.

**Case Management Administrator**

The Case Management Administrator, a Registered Nurse, is responsible for clinical and administrative oversight of the notification, concurrent review, case management/ disease management, utilization management and health education activities and interfaces and coordinates with behavioral health staff, and pharmacy staff in the oversight of the delivery of care and services to UnitedHealthcare Community Plan member. This position participates in the operationalizing of the Quality Improvement Program (QIP) through inclusion on the QMC and by coordinating the Utilization Management program as part of the overall institutional and health plan quality improvement initiatives.



## **QAPI Program and Provider Participation through Planning, Design, Implementation and Review**

UnitedHealthcare Community Plan has created processes to ensure appropriate participation for our provider partners in our health plan's design, review and implementation. Provided below is a summary of current mechanisms used by UnitedHealthcare Community Plan to ensure provider participation in peer review activity and recommendations on clinical programs, as well as support of credentialing standards.

### **National Credentialing Committee (NCC)**

The National Credentialing Committee (NCC), comprised of licensed independent network physicians from varied specialties, reviews and makes participation decisions on providers applying for or requesting new or continued participation in the network. The NCC reviews and provides input on our Credentialing Plan and Policies and makes decisions concerning all provider organizations to which credentialing is delegated.

### **Provider Advisory Committee (PAC)**

The Provider Advisory Committee (PAC) performs peer review activities, including oversight of credentialing decisions decided by the National Credentialing Committee as well as review and disposition of concerns about quality of clinical care provided to member as requested by the Medical Director. In addition, the committee is responsible for evaluating and monitoring the quality, continuity, accessibility, and availability of the medical care rendered within our network. The Medical Director chairs the PAC. The PAC meets a minimum of four times per year, or more frequently as needed. Members may attend by teleconference if necessary. Members may not designate surrogate attendees. Members may not participate in peer review activities in which they have a direct or indirect interest in the outcome. Non-credentialing peer review must include at least one enrollee of the involved party's specialty and must meet state regulatory requirements. The Chair may vote in the case of a tie vote. The PAC reports to the Quality Management Committee (QMC) at least four times per year.

This committee membership includes: Medical Director (Chair), Network primary care and subspecialty physicians, other providers (for example, mid-level providers, hospitals) as designated by Chair, Director of Quality Management, Health Services Representative, Provider Operations Representative, Network Management Representative, Behavioral Health Services Representative, ad hoc health plan staff and specialty physicians, as needed. Voting for peer review issues is restricted to network physician and provider committee enrollees. A strict conflict of interest and confidentiality policy is in force for this committee. Responsibilities of the PAC include:

- Review summary status reports of clinical issues referred by other subcommittees
- Provide reports of committee activities to the Quality Management Committee at least four times per year
- Monitor performance on clinical indicators (e.g. HEDIS, state metrics, Performance Improvement Projects), over- and under-utilization, continuity and coordination of medical care, conduct/review barrier analysis and recommend actions, as appropriate
- Provide clinical review of national Care Management and Disease Management Program descriptions and evaluations, providing input as appropriate
- Review and accept nationally endorsed Clinical Practice Guidelines, providing input as appropriate
- Review summary data regarding quality of care complaints, appeals, and grievances; identify trends, conduct barrier analysis and recommend corrective actions as needed
- Review and accept decisions of national committees (e.g., the National Quality Management Oversight Committee (NQMOC) and Medical Technology and Assessment Committee (MTAC) that have been delegated by UnitedHealthcare Community Plan's Board of Directors and make



recommendations as appropriate

- Annually review and recommend approval of the annual QI & UM Program Descriptions, QI & Utilization Management (UM) Program Evaluations and QI & UM Work Plan to the Quality Management Committee and Board of Directors
- Review summary reports related to member in Care Management and Disease Management and other health services functions and recommend actions as indicated
- Review a provider's practice methods and patterns, mortality rates and all grievances files against the provider relating to medical treatment and recommend actions as indicated.
- Evaluate the appropriateness of care rendered by a provider. Perform peer review of care and service issues including recommendations for improvement action plans.
- Receive and review all written and oral allegations of inappropriate or aberrant service by a provider
- Develop policy recommendations to maintain or enhance the quality of care provided to member
- Review and accept UnitedHealthcare Community Plan's Credentialing Plan and Policies
- Perform peer review and provide oversight recommendations as needed of final decisions by the Credentialing Committee for the credentialing and recredentialing process
- Monitor process for compliance with regulatory and accreditation compliance
- Report to Quality Management Committee on PAC actions concerning provider terminations, sanctions or board notifications
- Review, track, identify opportunities for improvement and make recommendations relating to medical record issues, and potential quality of care trends
- Review network adequacy and accessibility indicators and make recommendations for improvement
- Review provider satisfaction survey results and make recommendations for improvement
- Educate member and health plan staff about the peer review process so that member and health plan staff can notify the peer review authority of situations or problems relating to providers.

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## **QAPI Program Education to Providers and Members**

Members and providers are educated on UnitedHealthcare Community Plan's QAPI program through Member and provider newsletters as well as Member and provider manuals. At least annually, the health plan provides specific information on current HEDIS rates for areas appropriate to and reflecting the status of the health care received by our member. Annually, both member and providers are provided the opportunity to request a copy of the QAPI program from the health plan as well as informed of the health plan's progress towards our QAPI goals.

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## **Our Quality Assessment and Improvement Plan**

We deliver a quality of care experience for our member that not only assures quality clinical interactions but also integrates integrity, compassion, innovation, dynamic and responsive relationships, and optimum performance. We maximize our member satisfaction and optimize quality metrics of received services through quality improvement efforts within our operations, provider network and information technology and with our clinical and ancillary partners across our organization.

Key elements of our Quality Assessment and Improvement Plan include:

- A consistent national health plan quality structure with customization specific to a state, its Medicaid member and its health rankings strengths and challenges
- Best in Class monitoring protocols developed with health care provider input
- Dedicated staffing supported by state-of-the art technology for claims analysis and data mining to identify areas of high Member and provider impact
- Ongoing analysis of performance, including barriers to quality of care and effectiveness of our

interventions

- Evaluation of Member and provider satisfaction with our services
- Implementation of innovation quality performance improvement projects that leverage resources of community partners to promote healthy living styles and extend access to care in Member neighbors
- An approach to quality improvement linking both physical and behavioral health through Member-centered care
- Streamlined and responsive utilization management to detect under- and over-utilization of services coupled with intervention programs to address detected issues – for example, initiatives to divert inappropriate emergency department use or to the availability of dental services and prenatal care
- Effective Disease Management and Care Management strategies aimed at Asthma (adult and pediatric), Heart Failure Disease, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Diabetes, Cancer Support and Depression (level 2-3) – addressing member with chronic conditions and co-morbidities
- Ongoing monitoring effectiveness through HEDIS measures.

UnitedHealthcare has 29 years of Medicaid experience and a strong commitment to improving quality of care and performance measures. Our expectation is that all employees throughout our organization share this commitment to quality.

Our Quality Improvement (QI) Program provides an integrated, coordinated and Continuous Quality Improvement (CQI) system to ensure compliance with contract, state and federal requirements. We employ a knowledgeable, multi-disciplinary Quality Management team and proven structures and processes that emulate national benchmarks, standards and best practices. We monitor performance measures and track them over time. We will also compare these performance metrics to Louisiana's minimum performance standards, goals and benchmarks as well as to national and regional data, with the objective of achieving sustained improvement year after year and meeting benchmarks as quickly as possible. We will submit data on our performance measures as requested. Measurement occurs at baseline and at intervals appropriate for the indicator but at a minimum every 12 months.

## **Impact in the Lives of Medicaid and CHIP Beneficiaries**

The above policies, processes, committees and people provide a rich source of knowledge that, when coupled with our 25 years of experience, allow us to develop programs to meet the unique needs of each member we serve. Our Personal Care Model™ (as described in detail in our E.1 response) allows us to understand the needs of each member and provide care management services appropriate for each person, with the most intensive care management provided to members at risk for adverse health outcomes. The Personal Care Model™, is a proven process that will improve the quality of care and quality of life of Louisiana Medicaid recipients.

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### **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 the guiding force throughout our operation and helps to ensure we can improve the health and well being of each member we serve.

• **Management of high risk pregnancy**

As described in our E.1 response UnitedHealthcare Community Plan will offer Healthy First Steps (HFS), our prenatal, postpartum and newborn care program to Louisiana Medicaid enrollees. HFS incorporates a multi-faceted, multi-disciplinary approach to improve pregnancy and birth outcomes. Through HFS, we decrease inpatient Neonatal Intensive Care Unit (NICU) lengths of stay, readmissions and save discharges. HFS is a comprehensive program that identifies, stratifies and most importantly, manages the care of all pregnant members, regardless of their risk, up to two months after delivery.

The Healthy First Step Program goals are to:

- Increase program participation
- Decrease inpatient Neonatal Intensive Care Unit (NICU) lengths of stay, readmissions and save discharge
- Decrease low birth weight and premature births
- Improve prenatal and postpartum HEDIS measures.

## State Experience

Our HFS program results demonstrate positive improvements for our UnitedHealthcare Community Plan Pennsylvania pregnant members in our HEDIS Measures Scores below. We are particularly proud of the improvement we have seen in the Frequency of Prenatal Care greater than 80 percent measure.

<i>HEDIS Measures Scores</i>				
<i>HEDIS Measure</i>	<i>HEDIS 2008 (CY'07)</i>	<i>HEDIS 2009 (CY'08)</i>	<i>HEDIS 2010 (CY'09)</i>	<i>2008 to 2010 Difference</i>
Timeliness of Prenatal Care	85.40%	86.62%	85.89%	+.49
Postpartum Care	59.12%	65.21%	63.75%	+4.63
Frequency of Prenatal Care > 80%	70.07%	78.10%	72.99%	+2.92

## Texas Initiatives to Improve Timeliness and Frequency of Prenatal Care

- Over the past 24 months, our Texas UnitedHealthcare Community Plan have retooled and enhanced our Healthy First Steps (HFS) program, which provides pregnant member with the information, education and care management support they need. Pregnant member, identified through State enrollment files, providers, claims data, or other ways, are referred to HFS for an initial assessment which includes an evaluation of medical, behavioral, nutritional and psychosocial risk factors. All members are provided education on the importance of prenatal care and post-partum visits and assistance in selecting a provider and arranging appointments. High-risk member are assigned to a

HFS clinical professional with neonatal or obstetrical expertise who provides support throughout the member's pregnancy, including education on risk factors.

- In 2009, we also implemented a \$25 incentive payment to obstetrical providers for each completed OB Needs Assessment Form submitted to the health plan following a member's first prenatal visit. This early notification enables us to assess the member's risk factors and provide tailored assistance early in the pregnancy. We also distribute "new mom" educational booklets (*Hi Mom*, from Krames), mailed directly to practitioner offices for distribution to their pregnant patients. Collectively, this initiative has resulted in sustained, statistically significant improvement in our HEDIS administrative measures since implementation in 2009.

<i>Data Year</i>	<i>Sample</i>	<i>Rate</i>	<i>2010 NCQA 90th Percentile</i>	<i>Z Score</i>	<i>Statistical Difference (Rej Z = 1.96)</i>
<b><i>Timeliness of Prenatal Care</i></b>					
2008*	468	72.90%		NA	NA
2009**	813	75.89%		1.1869	Increase
2010**	1143	82.90%	92.70%	3.8188	Statistically Significant Increase
<b><i>Frequency of Prenatal Care &gt; 81%</i></b>					
2008*	468	47.40%		NA	NA
2009**	813	51.54%		1.427	Increase
2010**	1143	60.40%	82.24%	3.8977	Statistically Significant Increase

\*Source: HEDIS 2009 Final Administrative Data Texas, UHC-Medicaid

\*\*Source: HEDIS2011 TX Medicaid admin compare march measure Run 3-11 (final 2010 rate may be greater)

## Other High Risk Pregnancy Specific Programs

### Depression

Healthy First Steps program is designed to address physical and behavioral health conditions. Two primary conditions the program focuses on are depression during and after delivery, along with smoking cessation and second hand smoke.

One out of five women will have symptoms of depression during pregnancy, which can be severe. Each member is assessed for depression upon the initial assessment and during each trimester, along with post partum. The case manager will assist in ensuring the member is working with a mental health professional by connecting the member with their Behavioral Health provider. The case manager will continue to follow the member, to ensure compliance with her behavioral health provider and working as cohesive team member.

### Smoking Cessation

Smoking cigarettes and second hand smoke not only affects the mother but it affects the baby, causing problems such as asthma, breathing issues, learning disorder and cancer. Reach shows third hand smoke is another hazard. Third hand smoke toxins left behind through clothes, hair, furniture and carpets are all hazards to a baby. Mothers are assessed and educated on the effects of smoking by clinical staff that is trained in smoking cessation. Mothers who are identified as smokers are considered a high-risk pregnancy and are encouraged to attend smoking cessation classes and contact the National Quitline website ([www.smokefree.gov](http://www.smokefree.gov), and toll free line (1-800-Quitnow). The case manager continues to educate, encourage and support the member to quit smoking. Members also receive additional information regarding smoking and depression programs when they sign up for Text 4baby.

## 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.

Members also receive a tri-fold brochure (English on one side and Spanish on the other) explaining the program and how to get started.

**Text4baby** is a free service to help you through your pregnancy and baby's first year of life.

Get FREE text messages on your cell phone each week. The text4baby messages will give you tips about:

- Keeping healthy
- Labor and delivery
- Breastfeeding
- The importance of shots
- Exercise and healthy eating
- And much more

Give your baby the best possible start in life. Sign up for text4baby.

**To sign up for text4baby**

Simply **text** the word **BABY** to **511411**.

You will be asked for a participant code after you sign up. The participant code is **HFS**. This code will let text4baby know that you are a member of our health plan. It will also let us know you signed up for the service.

Text4baby is an educational program of the National Healthy Mothers, Healthy Babies Coalition.

### • ***Reductions in low birth weight babies***

As described above and in our E.1 response, UnitedHealthcare Community Plan will offer Healthy First Steps (HFS), our prenatal, postpartum and newborn care program to Louisiana Medicaid enrollees.

The Healthy First Step Program goals are to:

- Increase program participation
- Decrease inpatient Neonatal Intensive Care Unit (NICU) lengths of stay, readmissions and save discharge
- Decrease low birth weight and premature births
- Improve prenatal and postpartum HEDIS measures.

#### **Positive Outcomes**

*UnitedHealthcare Community Plan's Healthy First Steps™ prenatal program **results for preterm birth rate of 9.48% in 2009**, this is significantly lower than the national average of 12.8% and a reduction from our 2008 rate of 8.3%.*

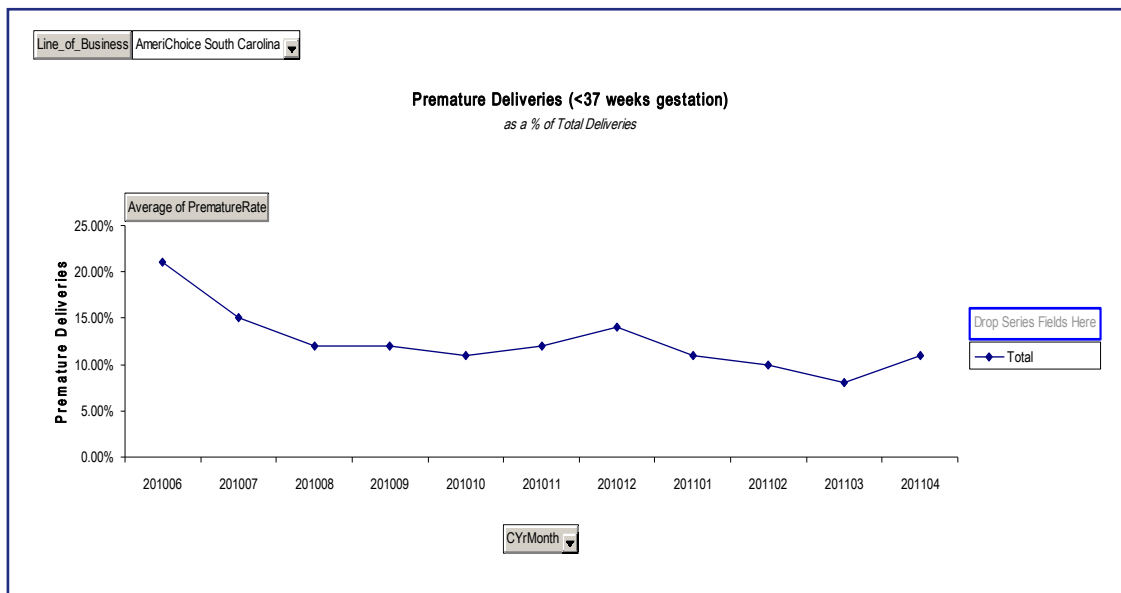
## State Experience

### **Healthy First Step Program Outcomes from South Carolina**

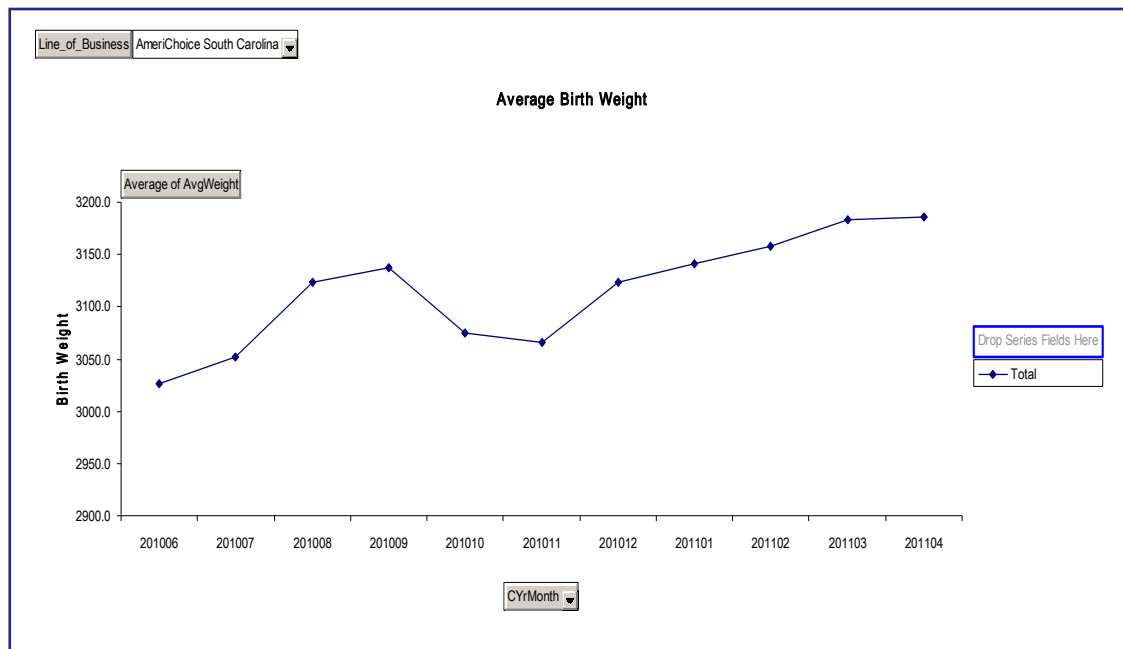
UnitedHealthcare Community Plan in South Carolina has had consistent reductions in low-birth-weight and premature delivered and an increase in member's timeliness of prenatal care, postpartum care and frequency of postpartum care over the past several years as indicated in the charts below.

**HEDIS Measures Scores South Carolina**

<b>HEDIS Measure</b>	<b>HEDIS 2007 (CY'06)</b>	<b>HEDIS 2008 (CY'07)</b>	<b>HEDIS 2009 (CY'08)</b>	<b>HEDIS 2010 (CY'09)</b>	<b>2007 to 2010 Difference</b>
Timeliness of Prenatal Care	80.77% (25th)	83.50% (25th)	86.54% (50th)	90.16% (75th)	^ <b>9.13%</b>
Postpartum Care	60.84% (50th)	58.58% (25th)	67.20% (75th)	77.39% (90th)	^ <b>16.55%</b>
Frequency of Ongoing Prenatal Care	59.79% (25th)	66.83% (50th)	65.97% (50th)	84.57% (90th)	^ <b>24.78%</b>







## New UnitedHealthcare Community Plan Initiative

### 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  $\leq 12.75$  percent), and to reduce our LBW rate to the Healthy People 2020 goal (to  $\leq 7.8$  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<sup>©</sup> 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.

- ***Pediatric Obesity (children under the age of 19)***

## Pediatric Obesity

Many families and children struggle with weight and weight management yet little support exists to help

them reach their health goals. UnitedHealthcare Community Plan is actively working with local, state and national organizations across all of our health plans to develop programs and services to educate, promote and support active healthy lifestyles for our members.

## State Experience

### Tennessee Obesity Performance Improvement Project (PIP)

For this project, we implemented two major components: a weight management program and innovative interventions with the YMCA, Boys & Girls Club and other community partners, as described below.

#### Tennessee Obesity Project

**Weight Management to Reduce Obesity Among All Tennessee Members** Obesity is a significant factor in the health outcomes and quality of life among many members in the Eastern, Middle and Western Tennessee regions of UnitedHealthcare Community Plan. The quality improvement leadership and organizational senior leadership recognized the need to improve health outcomes and reduce complications for members diagnosed as obese, as well as the challenge to develop innovative approaches to help members improve their overall health.

In 2009, the health plan developed an initiative to focus on member and provider education coupled with risk stratification to identify members. Health risk assessments using risk management software, claims data, and referrals into the program were used to identify members at risk. Referral sources included: welcome calls (HRA), utilization management nurses, care management and care coordination health plan staff, practitioner referrals, self referrals, and NurseLine follow-up (health information line).

Relevant measures were selected to assess the impact of the program upon members in all three regions. These include the HEDIS adult BMI assessment, child BMI assessment, weight assessment, and counseling for nutrition and physical activity for children/adolescents measures.

The program consists of a holistic weight management program to address the diverse needs of membership across the state, educational materials to impact both the members and providers, partnerships with existing community programs to offer unique weight management interventions for their members, and helping create programs in communities which have none in Middle Tennessee. A welcome letter/initial educational intervention is mailed to members. Level 1 risk member receives outreach calls, with scripts used by health educators. Level 3 and level 2 risk members receive outreach calls by clinicians. A clinical plan of care is sent to the practitioners for these members, and a member-friendly plan of care is developed with the member. By identifying and partnering with existing community programs, we are able to offer a variety of weight management interventions across the state. Although height and weight or BMI are gathered for reporting purposes on a quarterly basis, the main focus is on regular program attendance and participation. A parental involvement component is required for all child-focused programs.

## Innovative Interventions

### YMCA Facility Memberships

Risk level I, II, III members receive a written invitation to participate. YMCA facility memberships are provided to members, and the member can go to any YMCA to use general facility services. A minimum of 10 visits per month up to 6 months is focused on exercise. For adults, the health plan currently pays \$60 per month for adult memberships. Since this is a flat monthly rate, the health plan does require that each member attend at least 10 times per month. For children, anyone under the age of 18 is billed per visit at a rate of \$2.50 per visit. The total membership since the program initiated in June, 2009, has been 217 members.

### Meharry Children's Healthy Lifestyle Center

This is a weight management program for ages 5-18 that are considered to be obese or morbidly obese.

Members are referred after a medical evaluation at the medical college clinics. The program is centered in an exercise facility where nutritional education is provided at both individual and group levels, with a family focus. There are two phases: the initial phase is 12 weeks, with monitoring as the second phase up to one year. Members can attend the YMCA program after assessment. This program began in October 2010.

### **Church Health & Wellness Center**

The Church Health & Wellness Center (faith based medical clinic) in Memphis offers a membership based exercise, nutrition and health education program for their members. It is geared towards members ages- 5 -18 with family membership, with members older than 18 as adult memberships. The program lasts 12 weeks. Members can participate in group classes or exercise on an individual basis. The center offers a full exercise facility, yoga and dance classes. All children are required to attend a family session with a nutritional counselor each month. In addition, all individual and family memberships are \$50 per month, with no minimum attendance for children and a minimum of 10 visits per month for adults. Total membership since the program inception in August, 2009 has been 147 members.

### **Boys & Girls Club- Tennessee**

In October, 2010 the health plan started a partnership with the Boys & Girls Clubs of East Tennessee to offer a program called Triple Play. The program is a 12-week after-school program for children that focus on the healthy habits approach to nutritional education and fitness. Parents can attend with optional night sessions. The program consists of exercises and nutritional education. The clubs have key locations across the East Tennessee region with a capacity to serve 450 children each quarter. The cost per child for a 12 week session is \$35.25, and the health plan pays for 450 members per quarter.

### **Clinical Practice Consultants (CPCs)**

This new provider engagement program serves as a source for the ongoing communication of disease management information with a focus on HEDIS compliance. Nurses are sent to work within provider offices. They work with high volume practices to identify opportunities for improving HEDIS scores (all areas) including obesity measures. The CPCs encourage provider compliance with the current HEDIS measures (BMI assessment and counseling for nutrition and physical activity)-use of online member registries. They also educate providers on the weight management interventions in their community.

Due to these initiatives, the East and Middle regions of UnitedHealthcare Community Plan in Tennessee demonstrated improvement in the HEDIS measures focused on BMI and weight/nutrition counseling in 2010 from 2009. The following table illustrates the performance across the four measures selected to assess the impact of this performance improvement project:

<i>Tennessee – Pre and Post Measures</i>						
<i>Health Plan</i>	<i>Measure Name</i>	<i>Sc 2009</i>	<i>Sc 2010</i>	<i>year to year</i>	<i>2009 Percentile</i>	<i>2010 Percentile</i>
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	75%

<b>Tennessee – Pre and Post Measures</b>						
<b>Health Plan</b>	<b>Measure Name</b>	<b>Sc 2009</b>	<b>Sc 2010</b>	<b>year to year</b>	<b>2009 Percentile</b>	<b>2010 Percentile</b>
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

## Other Pediatric Obesity Programs

### Sesame Street - Eating Well on a Budget:

UnitedHealthcare worked with Sesame Workshop staff to develop “Food for Thought: Eating Well on a Budget.” This program is a bilingual (English-Spanish) multimedia outreach initiative designed to help support families who have children between the ages of two and eight, cope with uncertain or limited access to affordable and nutritious food.



The Food for Thought program provides families with an educational outreach kit, which includes an original video featuring the debut of four new Sesame Street Muppets, the “Super Foods.” The video also features Elmo and friends, along with real families as they try new foods, learn about the importance of healthy snacks, and discover that sharing a meal together is a perfect opportunity to connect as a family.

There is a special section for parents and caregivers that addresses the social and emotional issues related to food insecurity; and a segment with award-winning chef Art Smith, who shows families how to stretch a meal and shop locally while saving money.

About 400,000 kits will be distributed through UnitedHealthcare, The Merck Foundation.

Through our national partnership with the Sesame Workshop, we also are creating outreach materials to educate members who have been diagnosed with asthma and to encourage all children to have lead testing aligning with state EPSDT requirements.

### 4-H Healthy Living

In March 2011, UnitedHealthcare Community Plan announced a new, innovative partnership with 4-H, America’s largest child-focused organization, to implement 4-H’s Youth Voice: Youth Choice program to help tens of thousands of young people improve their health through exercise, diet and other healthy choices in three key states: Texas, Florida and Mississippi. Both 4-H and UnitedHealthcare share a commitment and mission to help young people live healthier, more productive lives. 4-H reaches over six million youth each year through clubs, camps and school enrichment programs. Our partnership focuses on providing resources for 4-H programs in underserved communities where health issues such as obesity and diabetes are disproportionately high. The young people who participate in the program are encouraged to take action for themselves, for their families and in their communities to promote healthy living priorities and achieve better physical, social and emotional well-being. The three-state pilot program will launch in April 2011. Children participating in the program will make commitments to “take

action” in improving their health through exercise, diet and other healthy choices. The program will be delivered in multiple ways, including in-school programs with high school students teaching younger children, after school programs, camps and community fairs.

### **UnitedHealth HEROES in the Fight Against Obesity**

UnitedHealth HEROES 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. Since the 1980s, the obesity rate for children has more than doubled. According to the Centers for Disease Control, more than 30 percent of young people are overweight or obese and a staggering 60 percent have at least one avoidable risk factor for heart disease. Among low-income and minority children, obesity rates are even higher than the national average. UnitedHealth HEROES seeks to reverse these daunting statistics by encouraging young people to design their own creative solutions that can help to break the pattern of unhealthy living. In 2011, 333 grants totaling more than \$210,000 is being awarded, including seven grants in Louisiana. The hands-on and peer-to-peer learning supported by UnitedHealth HEROES helps kids retain new information and can lead to improved behaviors and better educational outcomes.

- *Reduction of inappropriate utilization of emergent services*

### **Reduction of Inappropriate Emergent Services**

UnitedHealthcare Community Plans extensive clinical experience, both locally (in individual community plans) and nationally, allows us to provide programs to help lower utilization of emergent services medical costs and improve member outcomes.

### **State Experience**

#### **Pennsylvania Reduction of Inappropriate Emergent Services**

Reducing unnecessary Emergency Room (ER) use is a major health care system-wide challenge and a major goal by the state of Pennsylvania. In addition, a large number of hospital admissions come from the hospital ER. UnitedHealthcare Community plan is committed to achieving a continued reduction in inappropriate ER utilization, and a major goal of our Pennsylvania Plan.

To address the important issue of avoiding and reducing unnecessary ER utilization UnitedHealthcare Pennsylvania implemented the ER Diversion and the SECA (Significant Episodes of Cluster Activity) Programs.

#### **ER Diversion Program**

Our ER Diversion Program uses proactive communication and outreach to both members and providers to minimize unnecessary ER utilization and encourage strong and effective primary care. Our experience has demonstrated that improvement in ER utilization can occur by concentration on certain themes including:

- Providing support for members who actually have a crisis
- Preventing crises before they happen
- Encouraging members to use their primary care provider and not the ER.

The ER Diversion Program is a multidisciplinary approach to decrease inappropriate ER use through intensive health services coordination and Case Management. We know that members who make better use of planned services and have regularly scheduled primary care visits have fewer visits to the ER. The goals of the program include:

- Reduction of inappropriate ER utilization
- Reduction in hospital admissions due to a misuse of ER services
- Reduction in inappropriate medication prescriptions
- Provision of education and resources needed by the member, including a network of physicians,



providers and diversion services.

The ER Diversion Program is under the direction of the Medical Director and supported by Case Management, Member Services, Network Management, Pharmacy and the Benefits Determination departments.

### ***Identification of Members***

Using real time notification data and ImpactPro data our multi-dimensional episode-based predictive modeling software tool, we identify members who meet thresholds defined by any of the following:

- Four or more ER encounters within six months
- Pattern of ER encounters involving suspected drug seeking or a behavioral condition
- ER utilization for a “potential preventable admissions” diagnosis
- Newly enrolled members who demonstrate ER utilization.

Members with any of the established thresholds are identified for ER Diversion Program outreach and are assessed and triaged to Case Management as appropriate.

### ***Integrated Case Management***

Our case management services address medical and psycho-social issues for members at risk for admission to the hospital, who under-utilize appropriate medical resources and who may have minimal family or community resources. The program addresses network issues, including barriers to physician access and availability, and helps establish a medical home to provide a physician-patient relationship based on trust and respect. Case management activities include:

- Assuring that each member has a medical home, facilitated partially by the new member packet which includes information on the importance of the medical home
- New member outreach calls performed by HARC these provide valuable information including reinforcing appropriate ER use
- Educating members to identify warning signs of exacerbation of medical conditions
- Removing barriers to accessing care such as transportation, cultural differences, language, and behavior health and social issues
- Educating members on the use of urgent care centers, FQHC’s, and PCP offices with extended hours
- Identify additional resources for the member.

### ***Follow-Up and Interventions***

When we identify members as possible candidates for the ER Diversion Program, our care managers review all documentation on the identified member’s treatment history and current care, including pharmacy data, to gain an understanding of the factors contributing to ER over-utilization. After the case manager receives the ER report, she/he makes at least two attempts to contact the member. Once we make contact with the member and the assessment is complete, the member may be transitioned to complex case management program. The agreed upon plan of care between member, provider and case management is forwarded to the member’s PCP and is updated as needed. We pull data quarterly and share it with PCPs on the ER activity of their membership.

For populations that traditionally have been underserved, the availability of a broad health care network must go hand-in-hand with a strong member education and outreach program designed to inform and assist members regarding the appropriate use of a health care system that seeks to coordinate their care.

### ***Results***

Recent results, comparing 2009 vs. 2010 Emergency Department HEDIS Utilization Data by month, of our Pennsylvania Plan’s program showed a decrease in ER utilization.



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## SECA

Our Significant Episodes of Cluster Activity's (SECA) member centric approach has proven effective because it starts with a global assessment of all aspects affecting a member's needs: clinical, behavioral and demographic; and only then, drills down to clearly identify disease markers. At UnitedHealthcare Community Plan, SECA members enrolled six months or more have shown an average of a 60 percent reduction in ER visits and Acute Readmissions (1). The same continuously enrolled population has also shown a 22 percent reduction in overall annual medical costs (2).

(1) Targeted Population vs. Control Group July 2008 through June 2009

(2) ImpactPro™ Claims Analysis 2009

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- **EPSDT**

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## EPSDT

We have developed a number of innovative and successful EPSDT program in other states that have positively impacted the health care status our Medicaid Chip members. The following is an overview of our Pennsylvania EPSDT Performance Improvement Program that was established to improve early identification and effective treatment of health problems in children and adolescent members.

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## State Experience

### Pennsylvania

Pennsylvania designed an outreach strategy to ensure early identification and effective treatment of health problems in our children and adolescent members, by encouraging members to have regular and periodic exams at specific ages. They work closely with members and their families, and directly engaging providers. Their approach targets member outreach program promotes comprehensive, preventive health care for UnitedHealthcare Community Plan members.

### Identifying Members for Outreach

Their EPSDT program focuses on child well visits and EPSDT exams (e.g., vision, hearing, lab tests, immunizations, health education, overall health check-ups and dental referrals). Using data from their Universal Tracking Database (UTD), we identify members who are due for screening(s) based on their age or the date of their last screening. Members that are identified as due for preventive services are divided into two groups – those that will be out of compliance in 91 days or more (less urgent) and those that will be out of compliance in 90 days or less (more urgent). Members that are considered “less urgent” receive an automated outreach call reminding them to make an appointment with their provider for preventive health services. At the end of the automated call, members have the option to “zero out” and speak with a live agent, who can assist the member with scheduling a doctor appointment or arranging transportation.

### HARC Outreach Calls

Every new member receives a welcome call. Members who require preventive services in the next 90 days receive a call from the Hospitality, Assessment and Reminder Center (HARC), described in more detail below. We also inform members of incentive programs to encourage attendance. Examples include a \$10 gift card if children up to two years old see their doctor for regular preventive checkups and immunization, a \$5 gift card for Lead screenings, and a \$20 gift card for members who have not received a dental exam in two or more years. We make three attempts to reach each member; if those calls are unsuccessful, we distribute materials asking that the member contact us.

During the call, we identify other necessary services for the member and their family members, such as dental visits, to promote appropriate screenings and preventive care. We accomplish this through the UTD, which displays all of the member's family members and the services that they are due for. For example, when a member is called who is due for EPSDT services, not only is the call documented in

UTD, their representatives also sees in UTD if the member has siblings or family members in the same household that are due for other EPSDT or HEDIS-related services.

Therefore, while their program is targeted to address certain measures, it is by no means exclusive. The Pennsylvania health plan's data analytic tools allow us to communicate with members on a variety of preventive measures, while touching more members than originally targeted.

During the call, their team is available to assist the member in making an appointment with their physician or securing transportation services for their appointment. For example, the HARC outreach specialists work with call-scripts that proactively encourage caretakers to make a PCP appointment for their child immediately, e.g., "While you are on the phone with me, would you like me to conference in the doctor's office and we can make an appointment for you?"

The HARC is staffed with trained professionals able to initiate outbound calls and to handle inbound calls using tightly scripted and validated health plan information to outreach to members in need of screening and preventive services. Most calls are made between 5:30 p.m. and 8:00 p.m. on weekdays and prior to 4:30 p.m. on Saturdays, as we have found these are the best times to reach their members by phone. The call center employs bilingual staff and has access to a language line for those languages not spoken onsite. We will begin using local number as caller ID by spring, 2011 in an attempt to reach those members who may screen calls from unknown numbers. Key goals of HARC include:

- Educate members to better understand and use their benefits to improve their health and well-being. Ultimately, the HARC aims to increase members' adherence to EPSDT and HEDIS schedules
- Enhance responsiveness to members' "off-script" questions and provide better customer service.
- Better accept call-backs and respond to members' inquiries.

### **Supplemental Targeted Outreach Materials**

To supplement the actions of the Outreach Team, educational materials are mailed to members to remind them of the importance of well-care visits. Articles promoting well-care visits are included in the member newsletters quarterly, as are immunization tracking cards. Additionally, flyers are provided promoting their member incentive programs. Member communication and outreach includes:

- Member handbook
- Quarterly member newsletter
- Birthday cards, with a screening reminder notice
- Targeted care management mailings
- Welcome call and reminder calls.

### **Provider Engagement**

To encourage and promote physician engagement, we are using the UTD to monitor members' compliance with preventive health measures, through the Pennsylvania health plan's Clinical Practice Consultant (CPC) program. In turn, we combine this information with their provider profile, producing monthly reports that rank their 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:

- Initial assessment
- 'Action plan,' drawing on both UnitedHealthcare Community Plan and provider resources, to target non-compliant members for EPSDT measures such as adolescent well-care visits and lead screening
- Follow up, as needed.

Additionally, we augment CPC nurse efforts by provider Advocate liaisons and community outreach efforts. The CPC program represents their renewed and invigorated efforts to use the data analytic

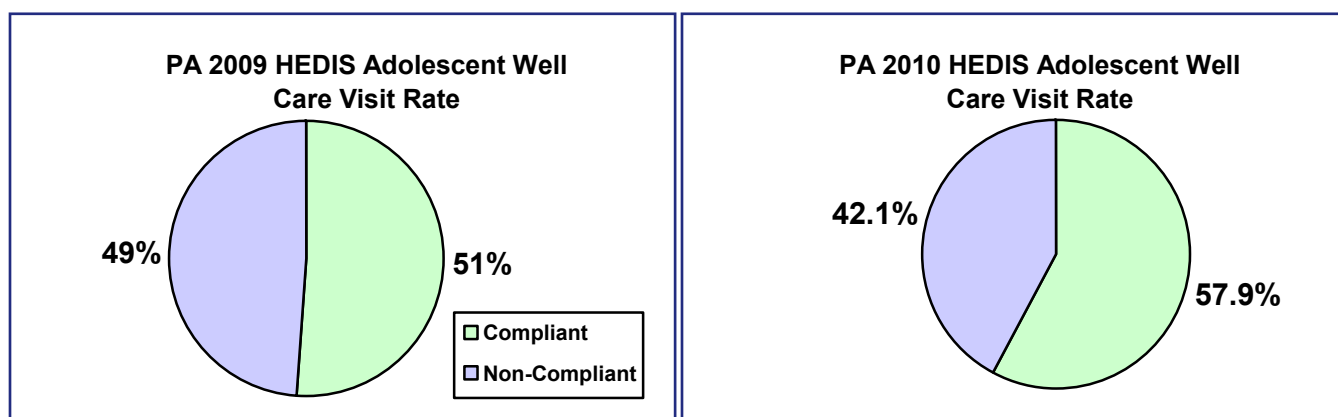
capabilities of the parent organizations to effectively partner with providers to enhance member compliance and quality of care. Efforts also include office orientations and recognition for high immunization or preventive service rates, encounter reporting and program compliance. Flu chart stickers are provided to physicians to assist in tracking members in need of immunizations.

## Measurable Results

The Pennsylvania health plan's outreach efforts, drawing on their HARC system resources, member incentive programs and provider relations have proven effective in improving clinical outcomes for, among others, their well-care visit rates for children and adolescents, dental visit rates and structured screenings for developmental delays and autism.

## Adolescent Well-Care Visits

For children age 12-21, annual well-child visit rates have significantly improved between 2009 and 2010, from 51 percent in 2009 to 57.9 percent in 2010. Their three pronged approach – member incentives, HARC reminder calls and provider engagement – play important roles in increasing the HEDIS rates for this population and measure.



- *Children with special health care needs*

## Children with Special Health Care Needs

As noted earlier, our Personal Care Model (PCM) program is designed to meet the needs of medically underserved and low-income populations. Within the PCM, we have established child-oriented tools and procedures where appropriate. For example, our clinical team uses a specialized Pediatric Health Risk Assessment (PHRA) as the initial means of assessing children who have been identified for case management. Another example is our targeted program for CSHCN, which is staffed by pediatric specialists who work with the Members, families, and providers to ensure that these children receive coordinated services to meet all their health care needs.

We also provide high risk pregnancy management and discharge planning for NICU-admitted babies through our Healthy First Steps (HFS) program. HFS nurses conduct in-home post-discharge management of high-risk mothers and babies. Our first of life program within HFS provides newborns, including NICU graduates, with ongoing appropriate medical services. Those with challenging family circumstances or psychosocial needs are provided care management to age one. The HFS care managers assist with newborn educational needs as well as assistance accessing all needed services.

In addition to our core PCM services, we have initiated a number of activities and programs to meet the specific needs for our state customers and will do the same for Louisiana.

## State Experience

### In-Home Nursing Pay for Performance Program

Our Pennsylvania health plan initiated an innovative pay for performance program for providers of in home nursing services for children to increase availability of staff while monitoring quality of care and flexibility for Members and their families. The providers receive incentives to improve ongoing coverage of home care cases: Incentive payments are based on the achievement of the pre-defined benchmark identified by the homecare agencies as an opportunity to improve their service to our member. The incentives address weekend reimbursement, full coverage and quality improvement. In addition to providing incentives, the health plan hires, educates and deploys an experienced pediatric nurse for each agency to act as liaison to providers/families. The Liaison's responsibilities include oversight of the initiatives and managing the financial incentives. A UnitedHealthcare team comprised of the pediatric medical director, manager of pediatrics, shift care coordinator and clinical liaison evaluates indicators and outcomes.

### Maryland School Based Health Center Program

Our Maryland health plan established a program for co-management of care for students enrolled in Maryland's HealthChoice program and in a school based health center (SBHC). In this program, we reimburse SBHCs for the same types of services that would be provided in an office by a primary care provider (PCP). We also developed a communications protocol in conjunction with SBHCs that includes care coordination/ co-management protocols. The SBHCs agree to participate in our QI program activities, follow established practice guidelines, and meet our standards for medical record keeping. The benefits of a co-management model of care between a PCP and SBHC is that there is an increased likelihood of accessing quality health and mental health services in a setting that is easily accessible and where both students and their families are familiar and comfortable.

### Child Rehabilitative Services

In Arizona, the UnitedHealthcare Community Plan has a contract to provide carved out Child Rehabilitative Services (CRS) for 25,000 eligibles. 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 member; 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.

- *Asthma*

### Asthma Disease Management

We have been providing an Asthma Disease Management (DM) program since 1982, when UnitedHealthcare was first established. We have focused on optimizing the health and well-being of members with chronic illnesses and at high risk for adverse medical outcomes. The program continues to improve with clinical and technology advances. We estimate that over 55,000 participants are served through our Asthma DM programs in 23 health plans covering 2.3 million lives in 22 states.

Asthma is highly prevalent among CHIP member and a mandatory condition for increased management to reduce exacerbations and avoidable utilization. Our goal is to improve Member self- management of asthma, as evidenced by improved HEDIS scores and reduced avoidable utilization. Our interventions include improved identification of member with asthma for enrollment and participation in our Asthma

(DM) program and “A is for Asthma” Sesame Street asthma education program, increased asthma disease management interventions and increased culturally appropriate contacts to promote effective self-management. We teach effective self-management, provide culturally competent support and schedule or promote follow-up provider visits to improve Asthma outcomes.

### **Outreach and Identification Processes**

In UnitedHealth Care Community Plans across the country we have developed an extensive outreach program that supports real-time identification and referral for our Asthma DM services. Through community partnerships and relationships, our staff encourages and educates providers, ER staff and hospital discharge planners to refer program members for a greater intensity and frequency of asthma DM interventions when the situation requires it.

Our staff encourages and educates providers, ER staff and hospital discharge planners to refer program members for a greater intensity and frequency of Asthma DM interventions when the situation requires it. We also rely on partnering programs and agencies to identify those members most at need. Our DM staff is responsible for collaborating with other community partners such as program care managers, clinic staff, other health care team community partners and fiduciary entities in order to identify members. Finally, in addition to claims and pharmacy data, we integrate authorization and pre-certification information into the DM software system. This data provides real-time identification of members experiencing health care barriers and self-care deficits.

After a member has been identified, the asthma care manager contacts the member’s parent or caregiver by telephone and sends program and health education materials targeted to the member’s specific care opportunities. The accompanying letter informs the member’s parent or caregiver on how to use the asthma DM services, how the member became eligible to participate in the asthma program and how to opt out if they do not wish to participate.

Because our DM program provides benefits and quality-of-life improvements that ultimately impact the overall costs in care, our enrollment staff makes every attempt to enroll members in the asthma DM program. We employ a number of strategies to locate and contact the member’s parents or caregivers, including after hours calls, searching for updated member information by contacting the PCP/specialist office and reviewing prior authorization information, and sending written correspondence. We document and track contacts to ensure that all options have been exhausted prior to reporting failure to contact.

### **A is for Asthma**

UnitedHealthcare also supports Sesame Workshop’s *A is for Asthma* initiative to increase awareness 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. Partnerships with community organizations are key to raising awareness about the *A is for Asthma* program and to linking parents and children to free educational materials, which include posters, activity pages, booklets, etc.



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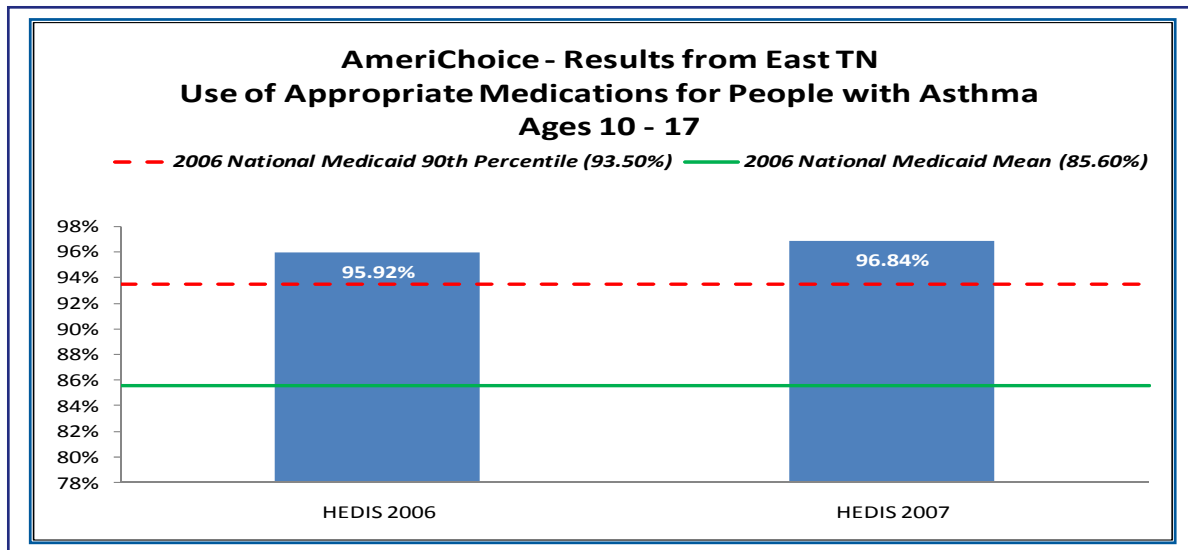
**"A" Is for Asthma – and for Active!**



## State Experience

UnitedHealthcare has a long history of successful engagement with our members in our asthma DM program in all of our plans. Our innovative outreach and educational efforts have significantly changed the behaviors of our members. For example, in Eastern Tennessee, our asthma program significantly increased the rate of appropriate use of medications for our TENNderCare members with asthma aged 10-17 years.

Our HEDIS measure for *Use of Appropriate Medications for People with Asthma* increased from 58 percent in 2000 to 96.4 percent in 2007. Our measures exceeded the 95th percentile for 2006 and 2007 as illustrated in the chart below.



- **Diabetes**

## Diabetes Disease Management

We have been providing a Diabetes Disease Management (DM) program since 1982, when UnitedHealthcare was first established, although the program has evolved with medical and technology advances. We have always focused on optimizing the health and well-being of members with chronic illnesses and those at high risk for adverse medical outcomes. We estimate that over 65,000 participants are served through our diabetes DM programs in 23 health plans covering 2.3 million lives in 22 states.

### Interventions

After a member has been identified, the diabetes care manager will contact the member's parent or caregiver via a telephone call and will send relevant program and health education materials to the member. The accompanying letter informs the member's parent or caregiver how to use the diabetes DM services, how the member became eligible for the program, and how to opt out if they do not wish to participate.

We make every attempt to enroll members in the Diabetes DM program. We employ a number of strategies to locate and contact the member's parents or caregivers, including after hours calls, searching for updated member information by contacting the PCP/specialist office and reviewing prior authorization information, and sending written correspondence. We document and track contacts to ensure that all options have been exhausted prior to reporting failure to contact.



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## State Experience

### Tennessee Diabetes Care

#### ***Initiative to Improve Diabetes Care***

UnitedHealthcare Community Plan's Middle Tennessee Region recognized the need to improve health outcomes and reduce complications for their members with diabetes and to work towards the improvement of compliance with clinical best practices. Diabetes is considered to be a high-risk condition in Tennessee and forms the largest segment of members in their disease management programs. In the first quarter of 2007, the health plan developed an initiative to focus on member and provider education coupled with individualized health coaching calls to members increase compliance with clinical best practices shown to improve outcomes and reduce complications associated with diabetes.

Baseline performance goals and benchmarks were set and selected for the following measures to evaluate the impact of interventions focused on diabetes as part of this improvement project:

- Members age 18-75 with diabetes (Type 1 or 2) who were continuously enrolled during the measurement year and who had an HbA1c test performed
- Goal 79 percent, benchmark 89 percent
- Members age 18-75 with diabetes (Type 1 or 2) who were continuously enrolled during the measurement year and who had a LDL-C test performed
- Goal 79 percent, benchmark 82 percent
- Members age 18-75 with diabetes (Type 1 or 2) who were continuously enrolled during the measurement year and who had a retinal screening performed
- Goal 37 percent, benchmark 71 percent.

Components of this initiative included the following interventions and activities to improve health outcomes and reduce complications for their members with diabetes:

- Welcome letters were mailed out to new program enrollees each quarter beginning in April, 2007.
  - These welcome letters explained the management program to enrollees and afforded them the opportunity to opt out of the program.
- Beginning in April, 2007 and on a continual basis, disease managers spoke with thousands of members one-on-one, via phone call, regarding management of their diabetes.
  - They answered questions from members about their condition, management, therapies, as well as discussed their option to opt out of the program.
- A diabetic self-care guidelines brochure was mailed out to current program participants annually.
- Each quarter since 2007, member newsletter articles were published about various aspects and specific approaches to manage diabetes for members.
- Provider newsletter articles were published reminding providers about the upcoming medical record review to find evidence supporting HEDIS measures, including Comprehensive Diabetes Care. Articles were also published giving providers information regarding their diabetes disease management program.
- In November, 2008, a diabetes/weight loss educational toolkit was mailed to members diagnosed with diabetes.
- Clinical Practice Guidelines selected for 2009 were distributed to all providers in 1Q2009.
- In 3Q 2009, the health plan's provider Portal was updated to include current lists of member care opportunities by provider for each of their Pay for Performance measures.
  - Those relating to DM included each of the CDC (Comprehensive Diabetes Care) measures.

Due to these initiatives, the Middle Tennessee Region of UnitedHealthcare Community Plan demonstrated sustained, statistically significant improvement in the HEDIS measures for diabetes care in 2008 and 2009. The following tables illustrate the performance across the three measures selected to assess the impact of this performance improvement project:

<i>Year</i>	<i>Sample*</i>	<i>Rate</i>	<i>Chi Square</i>	<i>Statistical Diff (&gt;=3.84)</i>
<b><i>Members age 18-75 with diabetes (Type 1 or 2) who were continuously enrolled during the measurement year and who had a HbA1C tested</i></b>				
2007	65	60.0%	NA	NA
2008	411	76.64%	8.155	p = 0.004 and is statistically significant.
2009	675	77.33%	0.069	p = 0.79 and is not statistically significant.
<i>Year</i>	<i>Sample*</i>	<i>Rate</i>	<i>Chi Square</i>	<i>Statistical Diff (&gt;=3.84)</i>
<b><i>Members age 18-75 with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and who had a LDL-C test performed</i></b>				
2007	65	52.3%	NA	NA
2008	411	72.99%	11.47	p = 0.0007 and is statistically significant.
2009	675	73.19%	.005	p = 0.94 and is not statistically significant.
<i>Year</i>	<i>Sample*</i>	<i>Rate</i>	<i>Chi Square</i>	<i>Statistical Diff (&gt;=3.84)</i>
<b><i>Members age 18-75 with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and who had a retinal eye exam performed</i></b>				
2007	65	16.9%	NA	NA
2008	411	29.44%	4.388	p = 0.036 and is statistically significant.
2009	675	32.00%	0.782	p = 0.3765 and is not statistically significant.

\*Per HEDIS specifications, and audited by NCQA-accredited external auditing organization.

## Other Diabetes Program Experience

In recent years, UnitedHealthcare Community Plan has focused particularly on disparities in diabetes care within the African American population. We contracted with a faith-based community health initiative designed to develop local African-American leadership in health promotion and intervention strategies. Using the train-the-trainer model to build community capacity, we have used the faith-based community health initiative to work with our African American members to best facilitate our member outreach and diabetes education efforts. As noted previously, we also, work directly through community events to engage the African American community and increase diabetes awareness. Such events range from presentations at a faith based luncheon on diabetes and women's health issues to pumpkin festivals where, in conjunction with an information booth and children's face painting, we encourage members to discuss, among other health issues, diabetes care.

Our community outreach efforts around diabetes care have yielded demonstrable results. Data comparisons over the past three years have indicated improvements in the following ER admit measures for all populations. While data is not available, broken out by race, the following table demonstrates

across the board, state-wide improvements in diabetes measures. We also assess certain HEDIS measures according to race as of 2010.

<b><i>Diabetes Measures: ER Admits State-wide</i></b>			
<b><i>Year/%</i></b>	<b><i>ER Visits/1,000 Members</i></b>	<b><i>Days/1,000 Members</i></b>	<b><i>Average Length of Stay (ALOS)</i></b>
<b>2007</b>	12.62	40.93	4.16
<b>2009</b>	9.43	23.21	4.26
<b>% Point Improvement</b>	3.19%	17.72%	.10%
<b>% Improvement</b>	-25%	-43%	N/A

### **The Centers for Healthy Hearts and Souls, Inc.**

UnitedHealthcare Community Plan provides diabetes education and support services to a target population comprised of adults with diabetes, with a special focus on low-income and African American adult populations. We provide this education and support through a series of eight meetings held twice a month and last two hours per meeting. During these meetings, members receive support on prior action steps and set new steps, participate in nutrition demonstrations and discussions, listen to various topic presentations and can take physiological and knowledge assessments.

### **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 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 prediabetes - the only evidence-based intervention program available in the commercial marketplace.
- 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 the YMCA and other community organizations, 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.

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.

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• ***Cardiovascular diseases***

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## **Cardiovascular Disease**

Cardiovascular Disease is one of UnitedHealthcare Community Plan's identified disease management programs (see our response to Section E: Chronic Care/Disease Management). Members with Cardiovascular Disease are referred to our Chronic Care/Disease Management program for assessment, care plan development, appropriate referral and ongoing monitoring as needed based on the individual member's needs. In addition, we specifically recommend targeting members with chronic obstructive pulmonary disease (COPD) and coronary artery disease (CAD) as part of our Chronic Care/Disease Management program proposal for UnitedHealthcare Community Plan, Louisiana.

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## **State Experience**

### ***Texas Initiative to Increase Rate of LDL-C Screenings***

Coronary Artery Disease (CAD) is a major cause of death for American men and women thus making identification and treatment of its risk factors a major health care priority. One of the important risk factors for CAD is an elevated Low Density Lipoprotein (LDL) cholesterol blood rate. In early 2010, our Provider Newsletter focused on CAD including the importance of LDL-C screenings and when it was considered a Best Practice to test for an elevated LDL-C. The percentage of member receiving LDL-C screens was included in the 2009 provider profile report. These activities resulted in a statistically significant increase in UnitedHealthcare's LDL-C screening HEDIS measure from a rate of 36.30 percent in 2009 to 63.58 percent in 2010. These findings represent a 75.15 percent increase.

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• ***Reduction in racial and ethnic health care disparities to improve health status***

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## **Reducing Racial and Ethnic Health Care Disparities**

Reducing racial and ethnic health care disparities plays a vital part in realizing our goal of supporting member recovery and resiliency in ways that are meaningful for individuals in their communities and appropriate and relevant to their unique cultural experiences. Developing and continually improving culturally relevant and linguistically appropriate services is an integral component of our integrated service delivery model, requiring foresight and a willingness to tackle complex service delivery problems, while respecting the integrity of the cultures and populations with whom we work. It also requires continued reference to our organizational mission and a clear sense of the operational resources needed to successfully develop and manage a health care program that serves unique populations. Cultural norms, values, beliefs, customs, histories and behaviors influence the manifestation of mental health problems, the use of appropriate care/services, the course of treatment, and the attainment of positive outcomes. Accordingly, we ensure that all aspects of our customer service, quality management/quality improvement, utilization management, care coordination, and grievances and appeals processes emphasize cultural competency, and we are committed to ensuring that every Louisiana member we serve receives culturally and linguistically appropriate services.

### **Multicultural Markets: Meeting Many Needs**

As the U.S. population grows more diverse, UnitedHealth Community Plan's mission is to help people live healthier lives means ensuring that every one of our members gets health care and health information targeted to their unique needs. One way we tailor what we offer is by creating products, tools, and services geared toward consumers' cultural preferences. This is an important strategy both for growing our business and for helping to reduce health disparities across multicultural populations. The UnitedHealthcare Multicultural Markets team has three multicultural Centers of Excellence for our brokers to include in every UnitedHealthcare plan at no additional charge: Latino Health Solutions, Generations of Wellness, and Asian American Markets.

### **Latino Health Solutions: PlanBien Expands**

The U.S. Census Bureau projects that the Hispanic/Latino community in the U.S. will nearly triple by the year 2050, growing from 46.7 million to 132.8 million, or 30 percent of the population. To serve this fast-growing market, UnitedHealthcare's PlanBien, already available in Florida, Texas and California, is expanding this month into Illinois, Colorado and Arizona. In South Florida, Texas and California, our PlanBien offering features a selection of our traditional health plans that are executed bilingually. Spanish-speaking customer service representatives help members locate physicians who speak Spanish, and online provider directories in English and Spanish list physicians' offices that have Spanish-speaking doctors or staff. PlanBien also offers health information in formats popular among Spanish-speaking customers, like award-winning fotonovelas that use a graphic format to illustrate the way one family talks about health topics that disproportionately affect Hispanic/Latino populations (e.g., diabetes and hypertension). We spread the word about PlanBien at community events like the recent National Council of La Raza conference in Chicago, where UnitedHealthcare was the title sponsor of the conference's health fair.

### **Generations of Wellness: Family Matters**

According to the U.S. Office of Minority Health and Disparities, "health disparities between African Americans and other racial groups are striking and are apparent in life expectancy, infant mortality, and other measures of health status." UnitedHealthcare's Generations of Wellness initiative aims to reduce these disparities with materials targeted to an African American audience. One unique tool, launched helps plan participants track hereditary conditions that have the potential to affect them. The Generations of Wellness Interactive Family Health History Tree lets family members fill in and share what they know about conditions that run in their families; collecting this information and discussing it with their health care providers can help people choose the best preventive strategies. Other Generations of Wellness tools include an online wellness center that features community resources and healthy recipes, and an online directory of African American physicians.



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**Asian American Market Initiative: New Ideas for Better Care**

UnitedHealthcare's extensive research with Asian American consumers shaped our efforts to customize our products with information and advertising in English, Chinese, Korean, Vietnamese and Japanese; specialized broker materials; a network of bilingual physicians; and a wide range of information available online. In 2007 and 2008, our extensive offerings were recognized with Innovation in Multicultural Health Care awards from the National Committee for Quality Assurance (NCQA), which measures health care quality. Our most recent innovation is currently in its pilot phase in Texas and California. In response to the current research that shows high incidences of cervical cancer among Asian American women, we created a screening reminder program in multiple languages. An earlier version of the program increased the screening rate of the test group by 100 percent.

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**State Experience****Health Literacy Task Force**

Formed in 2008, the Pennsylvania York County Health Literacy Task Force works to increase health literacy levels among vulnerable populations and to decrease health disparities among various populations. Our plan collaborates with this group at events and health fairs promoting their "Speak Up" initiative, which educates member on appropriate communication between patient and physician.

**Health Disparities – Screenings (Hepatitis B)**

The UnitedHealthcare Chinatown Community Service Center, which opened 6 years ago in the heart of Philadelphia's Chinatown, sponsors a series of healthy activities. Community residents participate in health screenings and educational sessions. Through these activities, UnitedHealthcare arranges for screenings for Hepatitis B, a condition that disproportionately affects the Asian population.

**Center for Health Care Strategies (CHCS)**

Great Lakes Health Plan – State of Michigan participates in the CHCS' Reducing Disparities for the Practice Site (RDPS) project. Over the next three years, the RDPS project will strengthen chronic care delivery and reduce disparities in care delivered in selected primary care practices by meeting minimum requirements for Level I NCQA Patient Centered Medical Home designation.

- *Hospital readmissions and avoidable hospitalizations*

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**Hospital Readmissions and Avoidable Hospitalizations**

UnitedHealthcare Community Plan's Personal Care Model (as described in detail in our E.1 response) delivers high-touch, personalized interventions in support of overall wellness. **This personalized care program is designed to help enrollees avoid hospitalizations and emergency room visits while engaging enrollees in their own health care decisions.** The goal is to use high quality health care and practical solutions to improve enrollees' health and keep them in their communities, with the resources necessary to maintain the highest possible functional status – in short, we help people live healthier lives. Through member education, outreach, and case management, UnitedHealthcare Community Plan emphasizes the importance of preventive health education and the use of primary care providers (PCPs) and or Significant Traditional Providers (STP). We believe that these are the first steps to **controlling avoidable hospitalizations and readmissions.**

To supplement our preventive care efforts, we use several well-coordinated strategies to effectively and appropriately control avoidable hospitalization and hospital readmission. Our strategies are developed by utilization of our predictive modeling tools including ImpactPro, practitioner utilization data, facility outcome data and Significant Episodes of Cluster Activity (SECA) methodology. Our recent efforts have proven very successful and we continue to see improvement with current data.

Strategies include:

- Disease management (DM) and case management (CM)
- Emergency room (ER) diversion
- Face to face with onsite inpatient case managers (ICM)
- Partnering with PCPs
- Case managers in ERs
- Hospital discharge planning
- Inspired Transitional Coach and Physician In-Home Visit Initiatives.

## Disease and Case Management

We first identify members who may be at risk for avoidable hospitalization and hospital readmissions through our Case/Disease Management (CM/DM) programs using health risk assessments and our predictive modeling software, ImpactPro. Our CM/DM programs are designed to optimize the health and well-being of members with chronic conditions or other conditions that require CM. Through these programs we help members establish a relationship with their PCP, learn techniques to self-manage their condition, and overcome barriers to care. Our CM/DM case managers identify members who need additional assistance, assess their health status, stratify them into 3 levels, and provide appropriate interventions. Interventions can include the development of a care plan, telephonic or in-person case management, and educational meetings. We also place case managers in hospitals to conduct discharge planning for members. These case managers identify and arrange for services members will need upon discharged and connect the member with a PCP. Case managers follow-up with all members within 30 days of their discharge from an inpatient facility to discuss the use of primary care and review the member's discharge instructions.

## State Experience

Our UnitedHealthcare Community Plan in Pennsylvania implemented two programs to help reduce hospital readmission and avoidable hospitalizations. The Pennsylvania Emergency Room (ER) Diversion Program and the SECA Program have had positive outcomes in reducing hospital admissions and readmissions.

### Pennsylvania ER Diversion Program

In our Pennsylvania UnitedHealthcare Community Plan program, we operate an ER Diversion Program to reduce unnecessary ER utilization. We have found that many members enter the hospital from the ER, and by diverting ER visits we can also divert avoidable hospitalizations. Our ER Diversion Program includes identifying members before an ER visit and educating members after a visit. Through this program we are able to provide case management to members who are frequent ER users or at risk of becoming frequent ER users. **The Pennsylvania Emergency Room Diversion Program includes:**

- **Partnering with Primary Care Providers (PCPs):** We partner with PCPs to improve access to care and to provide data on member utilization patterns. We contract with FQHC's to increase hours to improve access to primary care and thereby reduce avoidable hospital admissions. We educate members on the availability of extended hours and locations through our member newsletter and CM services.
- **Case Managers in ERs:** We have case managers in ERs to connect with members while they are in the ER, assist them with finding a medical home, evaluate them for enrollment in case or disease

### *Positive Results*

*PA UnitedHealthcare Community Programs' 2010 Hospital Admission Improvement Data:*

- 6% reduction in admission per 1,000 members
- 9% reduction in days per 1,000 members

management and resolve with continuum of care issues.

- **Hospital Discharge Planning:** Our inpatient case managers assist hospitalized members with discharge planning. We plan to enhance this process by developing a post-discharge telephone program through which case managers will call members to assess their understanding of discharge instructions and identify any post discharge needs and care management needs.
- **SECA Program:** UnitedHealthcare Community Plan – Pennsylvania has designed a program to address avoidable or inappropriate emergency room utilization and to reduce the number of inpatient hospital readmissions. The program called SECA (Significant Episodes of Cluster Activity) is designed around a fundamental principal to apply traditional and non-traditional case management interventions for those members who experience four or more emergency room visits or two or more inpatient hospital admissions during a six month period.

The SECA program is a member targeted outreach to members with a recent history of Significant Episodes of Cluster Activity (SECA). SECA is defined as two or more acute inpatient readmissions or four or more ER visits over the previous six months. This program is designed to identify and rapidly assist members with significant clinical or behavioral health issues who may not be captured in traditional Disease Management programs.

Member meeting the SECA criteria are identified. The case management team composed of inpatient case managers, behavioral health advocates, transitional nurses, a transitional coach, a health coach and a social worker work together as a team to identify issues and barriers affecting the member's health.

The case management team coordinates a variety of resources including, in-home physician visits, in-home lab draws, and total care coordination with the members PCP/Medical Home. Referrals are promptly made with behavioral health providers or other specialists. Members remain part of the SECA program for a minimum of 6 months following identification. Case management teams continue to monitor and discuss member compliance with treatment programs.

***SECA's member centric approach has proven effective***

*On average, SECA Members enrolled 6 months or more have shown a 60% reduction in ER visits and Acute Readmissions. The same continuously enrolled population has also shown a 22% reduction in overall annual medical costs.*

SECA's member centric approach has proven effective because it starts with a global assessment of all aspects affecting a Member's needs: clinical, behavioral and demographic and only then, drills down to clearly identify disease markers. Our UnitedHealthcare Community Plan Pennsylvania Southeast SECA member enrolled 6 months or more have shown an average of a 60 percent reduction in ER visits and Acute Readmissions<sup>1</sup>. The same continuously enrolled population has also shown a 22 percent reduction in overall annual medical costs<sup>2</sup>.

## Other Programs

### After-Hours NurseLine

UnitedHealthcare Community Plan's NurseLine is an always-available network extender that supports members in a variety of medical situations, from advice about a particular problem, to guidance on how to prevent a problem, to triage and support in a medical emergency. NurseLine value-added services are geared to deliver the following outcomes:

- Higher and more targeted levels of participation in disease management, quality improvement and

<sup>1</sup> Targeted Population vs. Control Group July 2008 through June 2009

<sup>2</sup> ImpactPro® Claims Analysis 2009

wellness

- Increased member satisfaction through the promotion of wellness, health literacy and 24 hours a day, 7 days a week access to help
- Health care decision support for people in remote rural areas where transportation challenges are common
- Reduction of emergency room use through timely and appropriate handling of medical concerns, including referrals to PCPs, specialists and urgent care (as appropriate).

Our NurseLine value-added services include quarterly utilization reporting and daily activity reports focusing on triage and referrals. Interpretation services are available for non-English speaking members.

**J.2** *Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.* (All GSAs)

## Identifying Quality Improvement Opportunities

Our QAPI program is designed to monitor, evaluate and improve the continuity, quality, accessibility and availability of health care and services provided to Members. QAPI opportunities may range from those targeted at a single individual (for example, provider or staff) to opportunities that result in the development of Performance Improvement Projects (PIPs).

### Process for Selecting a Performance Improvement Project

We identify QAPI opportunities through input from internal and external sources; direction from the State; direction from internal committees; trends identified from clinical and service quality performance indicators; analysis of diagnoses that occur frequently and follow-up actions from previous projects. We select and prioritize clinical and non-clinical focus area topics to achieve the greatest practical benefit for our members. Our continuous data collection and analyses enable us to identify appropriate PIPs.

PIPs are developed to address potentially systemic problems and to highlight significant aspects of clinical and non-clinical care that, through improvement, we expect to have a beneficial effect on health outcomes and member satisfaction. For instance, we may identify PIP topics through our regular evaluation of service delivery metrics, tracking and trending of complaints/allegations, and member and provider satisfaction surveys. We will consider historical data and national, state and local public health goals as they relate to our member population.

PIPs can address an entire population or a targeted subgroup of the population. We often base PIPs on state mandates or areas of special interest. Clinically focused PIPs may include prevention or care of acute, chronic or high-risk conditions and coordination or continuity of care concerns. Non-clinical projects may include accessibility, availability and adequacy of our delivery network, cultural competency, complaints, grievances and appeals, provider satisfaction, member satisfaction, claims disputes activities or interpersonal aspects of care.

### Process to be used to Improve Care or Services

Our PIP methodology includes the project purpose; the reason for choosing the topic; its importance to us; aspects of care, needs or services for members; identified barriers the PIP will address; and the data methodology used to select the project. We formulate PIP study questions with relevant clinical literature citations, national clinical practice guidelines and national benchmarks. Study indicators developed to monitor progress are objective, measurable, clear and substantiated with current knowledge or research. Population selection and process for data collection are clearly defined. Baselines are established to adequately measure improvements over time and regular monitoring is conducted. Cross-functional teams

are convened, depending on the nature of the PIP, with regular meetings to access progress on the initiative. Interventions conducted are tracked; outcomes are captured; and continued measurement is performed to ensure sustained improvement. Reports are reviewed and input given by the appropriate committees that include the Quality Management Committee (QMC), the Provider Advisory Committee (PAC), the Service Quality Improvement Subcommittee (SQIS) and the Healthcare Quality Utilization Management Committee (HQUM). When required, reports are delivered to the state according to identified timeframes.

### **Proposed Members of the Quality Assessment/Management Committee**

The Quality Assessment/Management Committee is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan. The QMC membership includes:

- Blaine Bergeson, Chief Executive Officer (CEO) or designee (Committee Chair)
- Chief Medical Officer (CMO)
- Contract Compliance Officer (Chief Operations Officer)
- Case Management Administrator
- Director of Quality Management
- Network Management Representative
- Compliance Officer
- Financial Officer
- Dental Services Representative (as applicable)
- Behavioral Health Services Representative (as applicable)
- Other representation as identified by the CEO.

The QMC meets at least quarterly and reports to the UnitedHealthcare Community Plan Board of Directors at least annually and to the National Quality Management Oversight Committee (NQMOC) at least twice per year.

The Provider Advisory Committee (PAC) performs peer review activities, including oversight of credentialing decisions decided by the National Credentialing Committee as well as review and disposition of concerns about quality of clinical care provided to members as requested by Mark Mahler MD, CMO. In addition, the committee is responsible for providing clinical input on the QAPI Program, PIPs, and clinical programs as well as evaluating and monitoring the quality, continuity, accessibility and availability of the medical care rendered within our network.

The membership of the PAC is composed of:

- Chief Medical Officer (Chair)
- Network primary care and subspecialty physicians\*
- Other providers\* (e.g., mid-level providers, hospitals) as designated by Chair
- Director of Quality Management
- Health Services Representative
- Provider Operations Representative
- Network Management Representative
- Ad hoc health plan staff as needed
- Ad hoc specialty physicians as needed.

\*Voting for peer review issues is restricted to network physician and provider committee enrollees. A



strict conflict of interest and confidentiality policy is in force for this committee.

The CMO chairs the PAC. The PAC meets a minimum of four times per year, or more frequently as needed. Members may attend by teleconference if necessary. Members may not designate surrogate attendees. The PAC reports to the QMC at least one venue for assessment of data to support changes in member services is the Service Quality Improvement Subcommittee (SQIS). The SQIS monitors the quality of service delivered to our Members and oversees non-clinical services and delegated functions to monitor and to support improved service to members four times per year.

One venue for assessment of data to support improvement in member services is the SQIS. The SQIS monitors the quality of service delivered to our members and oversees non-clinical services and improvement projects, as well as delegated functions to monitor and to support improved service to members.

The membership of the SQIS is comprised of:

- Contract Compliance Officer (Chief Operational Officer (COO)) or designee (Chair)
- Member Services Representative
- Network Management Representative
- Grievance Representative
- Dental Representative (if applicable)
- Pharmacy Representative (if applicable)
- Claims Representative (if applicable)
- Enrollment Representative as needed
- Compliance Officer
- Provider Relations Representative
- Quality Management Representative
- Other staff enrollees by invitation to lend subject matter expertise.

The SQIS meets at least four times per year and is chaired by the COO or designee. Members may designate surrogate attendees. The SQIS reports at least four times per year to the QMC; cross reporting to the HQUM or the PAC is made as appropriate for clinical issues and medical/peer review advice.

The HQUM monitor all clinical quality improvement and utilization management activities within the health plan. The membership of the HQUM is composed of:

- Chief Medical Officer (Chair)
- Medical Director(s)
- Case Management Administrator
- Director of Quality Management
- Network Management and Provider Operations Representative
- Maternal Child Health Director
- Director of Pharmacy
- Dental Director (as appropriate)
- Compliance Officer
- UM staff as designated by the Chair
- Other staff enrollees by invitation of Chair to lend subject matter expertise.

The HQUM meets at least four times per year and is chaired by the CMO or designee. Members may

designate surrogate attendees. The HQUM reports at least four times per year to the QMC. Cross reporting to the PAC is made as appropriate for peer review and other matters.

### **Member Advisory Council (MAC)**

The SQIS is supported by the Member Advisory Council (MAC). The MAC provides a collaborative forum for members, community representatives, advocacy groups and community-based providers to share our successes, bring issues and ideas from their members to us, work together on opportunities for community outreach, identify common ground around legislative issues, obtain feedback on new and future initiatives and review how these programs fulfill our mission. Minutes from the MAC are reported to the SQIS, which reports to the Quality Management Committee. Participants can include local representation from groups such as ADAPT, local AAA, Alzheimer's Association, Boys and Girls Club, religious affiliations or rehabilitation providers.

**J.3** *Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.* (All GSAs)

### **Examples of Performance Improvement Projects (PIPs)**

The following examples are of UnitedHealthcare Community Plan's program-specific, data-driven performance improvement project (PIP) experiences. They include: Delaware Lead Screening, Rhode Island Effective Prenatal/Postpartum Care, Tennessee Diabetes Care Project, Ohio Dental Care Services Project and the New York Behavioral Health Services Project.

#### **UnitedHealthcare Community Plan - Delaware**

##### **Lead Screening Performance Improvement Project**

Lead is a highly toxic substance that is especially harmful to children. High blood lead levels (i.e., 70 ug/dL) can cause serious health effects including seizures, coma and death. According to the US Centers for Disease Control and Prevention (CDC), blood lead levels (BLLs) as low as 10 µg/dL have been associated with adverse effects on cognitive development, growth and behavior among children aged 1-5 years<sup>3</sup>. Additionally, recent studies (Canfield et al) suggest that even levels between 1 and 10 are associated with an I.Q. decline of 7.4 points. Since the elimination of lead from gasoline and other consumer products in the United States, lead-based paint in homes remains the major source of lead exposure among U.S. children. Most commonly, children are exposed through chronic ingestion of lead-contaminated dust.

The CDC reported that 4.4 percent of all children under the age of six had blood lead levels at/or above 10 ug/dL in 1994. In the state of Delaware, in 1994, 17.3 percent of the children tested had elevated BLLs. Lead poisoning can affect nearly every system in the body; and, because lead poisoning often occurs with no obvious symptoms, it frequently goes unrecognized. Normally children with elevated BLLs in the 10-25 µg/dL range do not develop clinical symptoms. A screening is critical to identify children who need environmental or medical intervention to reduce their BLLs. Federal Medicaid regulations now require that all children receive a blood lead screening test at ages 12 and 24 months. To help identify and address lead poisoning in Delaware, the health plan developed a performance improvement project (PIP) for its Medicaid/CHIP children that served to increase the number of lead screenings performed for children between 12 and 24 months of age. Our health plan used HEDIS 2009 lead screening methodology and 100 percent administrative data (no sampling of data) to determine its

<sup>3</sup> Canfield, RL, CR Henderson, DA Cory-Slechta, C Cox, TA Jusko and BP Lanphear. 2003. Intellectual Impairment in Children with Blood Lead Concentrations below 10 µg per Deciliter. New England Journal of Medicine 348:1517-1526.

lead screening rates.

In 2009, UnitedHealthcare Community Plan of Delaware added information from the Delaware State Lead Registry to its administrative lead screening claims data. Duplicate screening data was eliminated so that only one screening per member was included in the final rate. All UnitedHealthcare Community Plan of Delaware Medicaid/CHIP children who turned 2 years of age during the measurement year and were continuously enrolled during the 12 months prior to the child's second birthday (with no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday) were included in this study.

As part of this project, UnitedHealthcare Community Plan of Delaware identified the following barriers to children under the age of two receiving a lead screening:

- Member focus – Lack of transportation to appointments
- Member focus – Lack of parental knowledge regarding the importance of lead screenings
- Member focus – Lack of compliance with keeping routine well-care appointments
- Member focus – Lack of incentive to comply with screening
- Provider focus – Lack of knowledge regarding Pediatric Preventive Health Maintenance Guidelines in performing timely screenings
- Provider focus – Lack of reminder system to encourage members to obtain well-care exams resulting in missed opportunities to perform lead screening
- Provider focus – Lack of knowledge of Medicaid requirement to perform capillary or venous testing in all cases rather than a question based screening
- Provider focus – Lack of encouragement to ensure opportunities are not missed for lead screenings.

UnitedHealthcare Community Plan of Delaware implemented the following interventions focusing on improvement:

- A \$5 incentive offered to the parent/guardian of any child that receives a lead screening at 12 months of age
- The Gold Star reward program for physicians includes blood lead screening rates as one of its quality of care measure criteria for participation
- The health plan emphasized the requirement for capillary/venous lead screenings as part of the provider orientation program and this is documented by their attendance at orientation
- The importance of lead screenings is emphasized in the member and provider newsletters.

These interventions were initiated in 2008; however, we believe that the full impact of the activities is not yet realized. In 2011, the initiatives are still in place; nonetheless, the health plan continued to drill down the data to determine if other barriers existed and continued to add new interventions.

In 2010, outreach calls were initiated to parents or caregivers to advise them that their child was due for a lead screening. UnitedHealthcare Community Plan of Delaware also worked with the State to receive routine updated files of lead screening data results from the State's Lead Registry. In 2011, the health plan has been working with Medtox, a toxicology laboratory vendor to provide lead screening kits to providers. Providers can mail the kits directly to Medtox for timely evaluations and reporting. Our Pennsylvania Plan program has had great success with improved CHIP lead screening rates with making Medtox kits available to its providers.

**UnitedHealthcare Community Plan of Delaware Lead Screening Rates  
for Children between 12 and 24 Months of Age**

1/1/2008-12/31/2008		1/1/2009-12/31/2009		1/1/2010-12/31/2010*	
Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
74.93%	40.00%	65.33%	79.55%	Interim Rates 68.13%	Interim Rates 75.71%

\*2010 data reflects interim data only. Final rates may show greater improvement

**UnitedHealthcare Community Plan of PA Lead Screening Rates  
for Children between 12 and 24 Months of Age**

1/1/2008-12/31/2008		1/1/2009-12/31/2009		1/1/2010-12/31/2010*	
Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
79.17%	61.40%	75.91%	66.67% East 67.10% West	Interim Rates 73.52%	Interim Rates 64.25%

\*2010 data reflects interim data only. Final rates may show greater improvement

The cost savings in providing timely and age-appropriate lead screenings are both quantitative and qualitative. Early identification of a child with an elevated BLL will help prevent costly medical care and treatment for lead poisoning. If not identified and left untreated, very severe lead exposure in children can cause coma, convulsions and even death. Lower levels cause adverse effects on the central nervous system, kidney and hematopoietic systems. Health effects can include reduced IQ, reduced cognitive functions, hyperactivity, reduced stature, reduced hearing, and headaches. Considering the lead exposure affects cognitive function, it could have long term societal consequences, as these children may not graduate from high school, affecting social functioning, employment, and long term personal earnings.<sup>4</sup>

**UnitedHealthcare Community Plan New England**

**Effective Prenatal/Postpartum Care Performance Improvement Project**

UnitedHealthcare Community Plan of New England (Rhode Island or UHCNE) has approximately 1,000 Medicaid members with live births annually. The 2009 Rhode Island KIDS COUNT Fact Book notes that between 2003 and 2007, 12 percent of women giving birth in Rhode Island either received no prenatal care or did not begin care until their second or third trimester; this is an increase from 9 percent as reported for the years 2001-2005. Using HEDIS methodology, UHCNE constructed a Performance Improvement Project (PIP) for its Medicaid program that evaluated the percentage of women with deliveries who received a prenatal care visit as a member of the organization in their first trimester, or within 42 days of enrollment in the organization; the percentage of women with deliveries that had a postpartum visit on/or between 21 and 56 days after delivery; and, the percentage of women with deliveries between November 6th of the year prior to the measurement year and November 5th of the measurement year that received > 81 percent the number of expected prenatal care visits.

Analysis of our HEDIS performance on these measures was performed by the UnitedHealthcare National Quality Management Team. This team includes National Quality Management and Accreditation staff and the health plan's national HEDIS project manager, all of whom have expertise with HEDIS and CAHPS® survey methodology. Local staff who participated in this evaluation included the health plan's quality manager, case management administrator, medical director, chief executive officer, Healthy First

<sup>4</sup> Grosse, SD, Matte T, Schwartz J, Jackson RJ. Economics gains resulting from the reduction in children's blood lead in the United States, *Environ Health Perspective*.

Steps™ program manager and the manager of case management. Informal discussions also occurred throughout the HEDIS medical record review process and contributed to real-time process improvements that led to performance improvement.

(CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).)

In the process of constructing this PIP to improve prenatal care, the following barriers were identified by the health plan's Quality Improvement Committee staff:

- Lack of awareness or knowledge about the Healthy First Steps Program™ (member and clinician)
- Lack of awareness or knowledge about the Diaper Reward Program (member and clinician)
- Members may not realize (and thus not report) they are pregnant until after their first trimester
- Untimely receipt of completed prenatal risk assessment forms
- Incorrect number of spaces for prenatal visits on the Diaper Reward Program form
- Global billing requirement prevents the health plan from obtaining individual visit detail through claims data
- Untimely enrollment into the Medicaid program, i.e. some pregnant women may not join the Medicaid program until they are already pregnant
- Difficulties obtaining prenatal risk assessment forms from one of the plan's high volume providers
- Unsuccessful medical record pursuit at provider practices
- Pregnant members access prenatal care at multiple locations, making it difficult to obtain prenatal care information from one office location.

Staff identified opportunities and interventions to affect improvement including the following:

- Increase member awareness of Healthy First Steps Program and Diaper Reward Program
- Increase provider education re: Healthy First Steps Program and Diaper Reward Program through 1:1 meetings with key OB/GYN provider groups
- Allocate resources for ongoing and timely updates to the prenatal and postpartum administrative database
- Update the Diaper Reward Program form to include room for more prenatal visits and align with the specifications
- Revise member materials to improve member understanding about the importance of early prenatal care
- Send the postpartum packet of information and reminder to schedule a visit within a smaller window of time subsequent to delivery
- Access prenatal care visit information at Women and Infants' Hospital
- Maximize the efficiency and usefulness of the health plan's Access database for the Healthy First Steps Program by inputting data on an ongoing basis.

The intervention that was determined most influential and successful related to women accessing prenatal care at one major hospital as underlined above (Women and Infants' Hospital). Going forward, UHCNE will work more closely with the Women's Health Council and Quality Measures Subcommittee to identify opportunities for collaboration and performance improvement. Additionally, UHCNE plans to collaborate with two or more Medicaid health plans and the RI Department of Human Services to work more closely with the Women and Infants' Clinic (WIC) for improved and more active participation with UnitedHealthcare Community Plan's National Healthy First Steps Program. Lastly, our health plan's Diaper Reward Program brochure will be revised to allow for more spaces for prenatal visits.



<b><i>UHCNE Medicaid HEDIS Rates for Prenatal and Postpartum Care (3) Measures</i></b>			
<b><i>Measurement Year</i></b>	<b><i>Timeliness of Prenatal Care</i></b>	<b><i>Frequency of Prenatal Care (&gt;81%)</i></b>	<b><i>Postpartum Care</i></b>
11/6/2002-11/5/2003	70.80%	Not Measured	56.45%
11/6/2003-11/5/2004	73.24%	Not Measured	67.88%
11/6/2004-11/5/2005	80.78%	Not Measured	62.04%
11/6/2005-11/5/2006	80.04%	59.37%	62.04%
11/6/2006-11/5/2007	83.42%	52.51%	59.05%
11/6/2007-11/5/2008	81.46%	52.44%	57.07%
11/6/2008-11/5/2009	87.07%	75.85%	67.32%
11/6/2009-11/5/2010*	89.89% Interim Rates	73.2% Interim Rates	70.29% Interim Rates

*\*HEDIS Interim rates only. Final rates may show greater improvement.*

UnitedHealthcare Community Plan considers the advantages to the health plan for providing early and effective prenatal care and measures this both in financial savings and in the quality of life for the individuals we serve. With early detection and treatment of potential complications to pregnancy (e.g., gestational diabetes, cervical insufficiency, chronic hypertension or iron deficiency anemia), high-cost hospitalizations and pre-term deliveries resulting in NICU admissions can potentially be averted. In one study that evaluated the effects of augmented prenatal care on women at high-risk for a low birth weight (LBW) birth who were enrolled in a managed care organization, found a positive return on investment. The program included basic prenatal care, prenatal education, and case management. The program saved \$13,961.42 per single LBW birth prevented and \$18,981.08 per multiple (e.g., twins) LBW birth prevented. After program costs were considered, the return on investment equaled 37 percent; for every dollar invested in the program, \$1.37 was saved.<sup>5</sup>

Providing comprehensive prenatal care promotes the health and well-being of the expectant mother and increases the likelihood for a healthy newborn. Not only does this facilitate a cost-savings to the health plan, it also promotes the health and happiness of the family as a whole. Taking care of a pre-term newborn with multiple medical issues is burdensome to any family; however, more so for a family in the Medicaid program who have minimal financial support. Consequentially, pre-term newborn medical problems may persist throughout childhood increasing stress on the family and diminishing the quality of life for the child. We consider this quality of life more momentous than that of the cost of providing comprehensive and effective prenatal care.

### **UnitedHealthcare Community Plan Tennessee Diabetes Care Performance Improvement Project (PIP)**

The Middle Tennessee Region of UnitedHealthcare Community Plan recognized the need to improve health outcomes and reduce complications for their members with diabetes and to work towards the improvement of compliance with clinical best practices. Diabetes is considered to be a high-risk condition in Tennessee and forms the largest segment of members in their disease management programs. In the first quarter of 2007, the health plan developed an initiative to focus on member and provider education coupled with individualized health coaching calls to members to increase compliance with clinical best practices shown to improve outcomes and reduce complications associated with diabetes.

Baseline performance goals and benchmarks were set and selected for the following measures to evaluate the impact of interventions focused on diabetes as part of this improvement project:

<sup>5</sup>[http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2\\_cost-offset.pdf](http://www.businessgrouphealth.org/healthtopics/maternalchild/investing/docs/2_cost-offset.pdf)

- Members age 18 through 75 with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and who had an HbA1c test performed
  - Goal 79 percent, benchmark 89 percent
- Members age 18 through 75 with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and who had a LDL-C test performed
  - Goal 79 percent, benchmark 82 percent
- Members age 18 through 75 with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and who had a retinal screening performed
  - Goal 37 percent, benchmark 71 percent

Components of this initiative included the following interventions and activities to improve health outcomes and reduce complications for members with diabetes:

- Welcome letters were mailed out to new program enrollees each quarter beginning in April, 2007. These welcome letters explained the management program to enrollees and afforded them the opportunity to opt out of the program.
- Disease managers spoke with thousands of members one-on-one, via phone call, regarding management of their diabetes beginning in April, 2007 and on a continual basis. They answered questions from members about their condition, management, therapies, as well as discussed their option to opt out of the program.
- A guideline brochure on diabetic self-care was mailed out to current program participants annually.
- Member newsletter articles were published each quarter since 2007. These articles covered various aspects and specific approaches to manage diabetes for members.
- Provider newsletter articles were published reminding providers about the upcoming medical record review to find evidence supporting HEDIS measures, including Comprehensive Diabetes Care. Articles were also published giving providers information regarding their diabetes disease management program
- A diabetes/weight loss educational toolkit was mailed to members diagnosed with diabetes in November, 2008.
- 2009 Clinical Practice Guidelines were distributed to all providers in the first quarter of 2009.
- Our Provider Portal was updated in the third quarter of 2009 to include current lists of member care opportunities by provider for each of their Pay for Performance measures. Those relating to DM included each of the CDC (Comprehensive Diabetes Care) measures.

Due to these initiatives, the UnitedHealthcare Community Plan Middle Tennessee Region demonstrated sustained and significant improvement in the HEDIS measures for diabetes care in 2008 and 2009. The following tables illustrate the performance across the three measures selected to assess the impact of this performance improvement project:

### ***Tennessee Diabetes Care Program***

<i>Year</i>	<i>Sample*</i>	<i>Rate</i>	<i>Chi Square</i>	<i>Statistical Diff (&gt;=3.84)</i>
<b><i>Members age 19-75 with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and who had a HbA1c test</i></b>				
2007	65	60.0%	NA	NA
2008	411	76.64%	8.155	P = 0.004 and is statistically significant.
2009	675	77.33%	0.069	P = 0.79 and is not statistically significant.

<i>Year</i>	<i>Sample*</i>	<i>Rate</i>	<i>Chi Square</i>	<i>Statistical Diff (&gt;=3.84)</i>
<b><i>Members age 19-75 with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and who had a LDL-C test performed</i></b>				
2007	65	52.3%	NA	NA
2008	411	72.99%	11.47	P = 0.0007 and is statistically significant.
2009	675	73.19%	.005	P = 0.94 and is not statistically significant.

<i>Year</i>	<i>Sample*</i>	<i>Rate</i>	<i>Chi Square</i>	<i>Statistical Diff (&gt;=3.84)</i>
<b><i>Members age 19-75 with diabetes (type 1 or 2) who were continuously enrolled during the measurement year and who had a retinal eye exam performed</i></b>				
2007	65	16.9%	NA	NA
2008	411	29.44%	4.388	P = 0.036 and is statistically significant.
2009	675	32.00%	0.782	P = 0.3765 and is not statistically significant.

A study of comprehensive care for diabetes in a managed care environment demonstrated cost savings in as little as a 3-year period. The program, designed for six chronic diseases, found per member per month paid claims averaged \$394.62 per enrollee with diabetes in the comprehensive care program compared to \$502.48 per enrollee with diabetes not in the program. That was a total saving for the health plan of \$4.3 million in paid claims annually for diabetes care, which compared very favorably with an estimated \$1.81 million cost (including capital expenses) of the disease management program attributed to diabetes care. These cost reductions were accompanied by a higher proportion of diabetes patients receiving recommended tests and monitoring.<sup>6</sup>

## **UnitedHealthcare Community Plan Ohio**

### ***Dental Care Services Performance Improvement Project (PIP)***

In May, 2008, our UnitedHealthcare Community Plan of Ohio developed an initiative to focus on the implementation of a dental visit reminder intervention by the managed care plan for patients or caregivers to increase the percentage of patients 2 through 20 years of age who access dental care services. The health plan's goal was to promote dental care through member and provider education and awareness. We used member mailings and reminder outreach calls that focused on the importance of disease prevention by early, periodic dental check-ups. We recognized that the population they serve is high risk and is aware of the need to improve processes, educate and remove barriers to care thus impacting member wellness.

A performance goal of 40 percent was established for annual dental visits among all members aged 2 through 20 years. The health plan selected the Ohio Department of Job & Family Services (ODJFS) contractual provider agreement performance requirement of 40 percent for this goal. In contrast to this benchmark, the Unison Health Plan of Ohio 2007 baseline rate for annual dental visits was below 40 percent.

Our health plan staff also collected telephone service data using an external service that performed outreach reminder calls to all members age 2 through 20 years of age in all of our regions. The telephone service data that was reported back to the plan included the number of attempts made to get a live person prior to leaving an interactive voicemail, time of day and day of week that was most successful in making contact, volume of members in specific regions who were contacted and inactive phone numbers for

<sup>6</sup> <http://www.ahrq.gov/qual/diabqual/diabqguidemod1.htm>

members. This data was used to determine if there were specific barriers associated with the Dental PIP that needed to be addressed once identified.

Additional components of this initiative included the following interventions and activities to improve the annual dental visit rate among all members who were ages 2 through 20 years:

- Revised dental interactive voice response (IVR) script to add in additional information regarding the importance of good dental health
- Initiated dental IVR call reminders to members stressing the importance of good dental health
- Distribute toothbrushes in a regional mailer and used in the communities through the outreach staff
- Health Fair events focusing on dental care with brochures and toothbrushes available for members  
Foam display boards promoting good dental health included at these events
- Radio ads promoting dental visits
- Adopted Dr. Health E Hound mascot for use at health fairs, events, parades, etc. to help promote the importance of preventive health visits including dental check-ups
- Enhanced data report to include breakdown of race, gender, age for analysis of potential disparities in member population
- Performed ongoing monitoring of dental encounter data/claims for possible rate fluctuations in specific age groups or regions
- Distributed member newsletters focusing on importance of dental care
- Mailed an adolescent member survey referencing the importance of preventive health visits that include dental services
- Gold Star program focus on preventive health visit performance including dental for Unison PCPs.

Due to these initiatives, our Ohio health plan demonstrated sustained, **statistically significant improvement** in the HEDIS® administrative measures for annual dental visits among members ages two through 20 years of age. The following table shows that the initial performance was above the rate goal in 2008 as the initiatives were ramped up, and continued to improve to a **statistically significant improvement** when measured in 2009.

#### ***Results of the Ohio Dental Care Services PIP***

<i>Year</i>	<i>Sample*</i>	<i>Rate</i>	<i>Chi Square</i>	<i>Statistical Diff (&gt;=3.84)</i>
<b><i>Annual Dental Visit (Ages 2-20 years)</i></b>				
2007	23,153	46.8%	NA	NA
2008	30,855	48.1%	7.869	Statistically significant increase, p<.01
2009	42,786	49.7%	18.493	Statistically significant increase, p<.001

### **UnitedHealthcare Community Plan – New York**

#### ***Behavioral Health Services Performance Improvement Project (PIP)***

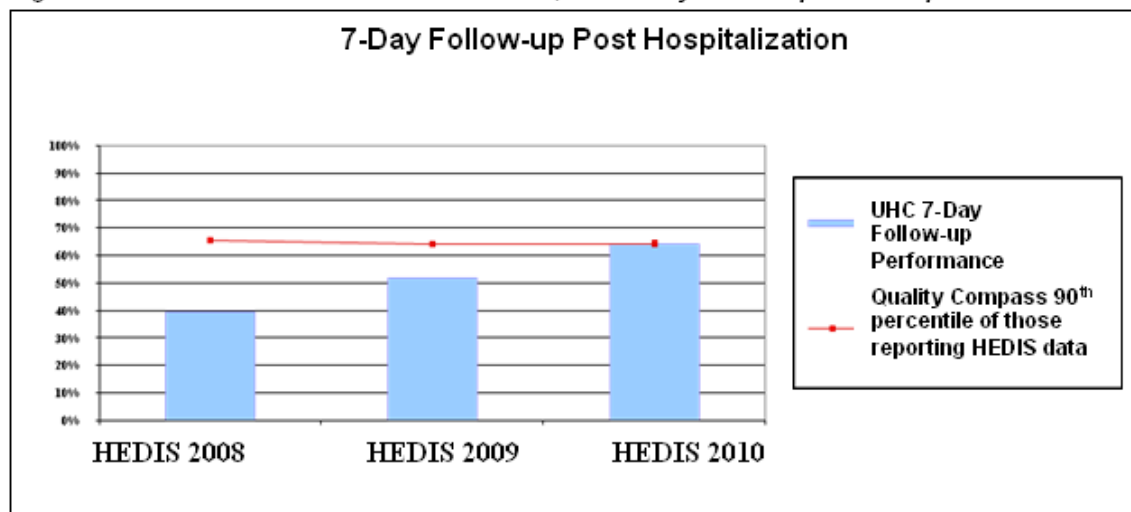
For UnitedHealthcare Community Plan of New York's Medicaid population, the ambulatory follow-up rates in HEDIS reporting year 2008 were 39.3 percent for outpatient services within 7 days following a hospital discharge. This rate was below the NCQA 2008 Quality Compass 50th percentile score of 43.2 percent. As a result, UnitedHealthcare Community Plan New York identified improving follow-up appointments after a hospital discharge as an opportunity for improvement.

Upon review of this data by various staff in the quality improvement committee structure, barriers were identified that revealed the need for education, monitoring and staff allocation/training. Throughout 2009 and 2010, we implemented multiple interventions to address these barriers including:

- Monitoring and reporting on facility performance
- Hiring specialized behavioral health clinical Care Advocates who traveled to facilities and assisted with coordinating aftercare for high-risk Medicaid members
- Educating discharge planning staff on-site at facilities and providing reminder postcards for distribution to consumers
- Increasing follow-up activities with high risk consumers to ensure they had timely appointments scheduled
- Training staff on motivational interviewing to assist consumers in overcoming barriers to attending aftercare appointments
- Implementing an interdepartmental audit procedure in the behavioral health team to provide staff feedback on their case compliance with aftercare follow-up appointments
- Implementing daily behavioral health-specific clinical team staffing to discuss discharge plans of Medicaid consumers
- Educating facilities and staff on the importance of aftercare follow-up.

The results are displayed in the table below and show statistically significant improvement in 7-day follow-up. The 7-day follow-up rate improved from 39.3 percent in HEDIS 2008 to 51.8 percent in HEDIS 2009, showing a 12.5 percentage point improvement. Furthermore, UnitedHealthcare Community Plan's 7-day follow-up performance the following year demonstrated continued improvement, resulting in a rate of 64 percent for HEDIS 2010, which was close to the 90th percentile threshold of 64.3 percent. This indicated that UnitedHealthcare's 7-day follow-up performance was better than almost 90 percent of other health plans who reported this data point. UnitedHealthcare Community Plan will continue to provide ongoing education and monitoring to ensure sustained improvement.

**Figure 14: New York Behavioral Health Services, Seven-Day Follow-Up Post Hospitalization**



**J.4 Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address: (All GSAs)**

- **The Performance Improvement Projects (PIPs) proposed to be implemented during the term of the contract.**

In addition to the two required Performance Improvement Projects identified in Section 14.3.8 "Performance Improvement Projects" and as detailed in Appendix DD:



- **Ambulatory Care Measures:** The number of ER visits per 1000 member months as measured by HEDIS® specifications
- **Breast Cancer Screening:** The percentage of women 40-69 years old that received a breast cancer screening.

We are also considering other QAPIs for UnitedHealthcare Community Plan, Louisiana including the following:

### **Reducing Neonatal Intensive Care Unit (NICU) and Low Birth Weight (LBW) Births**

We would work to reduce NICU and LBW births by enhancing identification of and providing resources for pregnant women with substance abuse, 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. 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) for their newborn. Effective interventions for pregnant women with these issues can improve the overall health and well-being of mothers and infants.

Our goal is to reduce NICU admissions and to reduce LBW rate to Healthy People 2020 goal (to  $\leq 7.8$  percent). Initiatives are member/caregiver-focused and include outreach to pregnant members 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 members by using the Wisconsin State method, and educate members on the availability of free cell phone service to help ensure continued contact with care managers, disease managers and providers.

We will modify our OB Needs Assessment form and require 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 available community resources.

### **Improving the Care of Members with Asthma**

Asthma is highly prevalent among CHIP members and a condition that lends itself well for increased management to reduce exacerbations and avoidable utilization. Our goal is to educate members on improved self-management as evidenced by improved HEDIS scores. Our interventions include identification of members with asthma for enrollment and participation in our Asthma Disease Management program, increased asthma disease management interventions, and increased culturally appropriate contacts to promote effective self-management as evidenced by reduced avoidable utilization. We will teach effective self-management processes, provide culturally competent support of the needed care, and schedule or promote follow-up provider visits to improve outcomes. Our partnership with **Sesame Street** offers a bilingual education outreach program focusing on asthma that we believe through **Elmo and friends** we can improve our connection to young families. The success of this initiative will be evaluated by the rate of our HEDIS scores for our members with asthma.

### **Improving the Care of Members with Diabetes**

The goal of this initiative is to promote effective clinical practice guidelines and care standards. We will improve its identification of members with diabetes for enrollment and participation in our Diabetes Disease Management program, as well as the Diabetic Preventive Control Alliance as described in sections E.1 and J.1, increase disease management services to improve member self-management

including weight management and increase culturally appropriate contacts to promote effective self-management. Focusing on providers, we will educate providers about our disease management program and encourage them to help our members improve self-management. The success of this initiative will be evaluated by the rate of our HEDIS scores for our members with diabetes.

- ***How the proposed PIPs will expand quality improvement services.***

### **Reducing Neonatal Intensive Care Unit and Low Birth Weight Births**

We will enhance our identification of pregnant women. This will be done by requiring physicians to provide an OB Needs Assessment Form within five days of the initial visit. Risk factors can then be identified early in the pregnancy so that interventions can be initiated. Multidisciplinary care management will then act to educate and support the enrollee while coordinating medical and nonmedical services. Data disparities will be analyzed to determine barriers to care so that focused interventions can be initiated as appropriate.

As discussed in our response to J.1, the Healthy First Steps (HFS) program works collaboratively to mitigate or prevent low birth weight. HFS incorporates a multi-faceted, multi-disciplinary approach to improve pregnancy and birth outcomes. Through HFS, we decrease inpatient Neonatal Intensive Care Unit (NICU) lengths of stay, readmissions and save discharges. HFS is a comprehensive program that identifies, stratifies and most importantly, manages the care of all pregnant members, regardless of their risk, up to two months after delivery.

The Healthy First Step Program goals are to:

- Increase program participation
- Decrease inpatient Neonatal Intensive Care Unit (NICU) lengths of stay, readmissions and save discharge
- Decrease low birth weight and premature births
- Improve prenatal and postpartum HEDIS measures.

### **Improving Care of Members with Asthma and Members with Diabetes**

UnitedHealthcare Community Plan Care Management (CM) Programs serve to optimize the health and well being of members with chronic illness or at high risk for adverse medical outcomes such as asthma and diabetes. To accomplish this, we developed comprehensive CM Programs that are member-centered and facilitate collaboration between members and their health care teams, as well as promote self-management, active decision-making, and participation in health care interventions and outcomes.

UnitedHealthcare Community Plan's care management philosophy is:

- Member-centric
- Offers comprehensive solutions
- Engages the health care team
- Measures, reports, and analyzes outcomes
- Improves quality
- Promotes cost efficiencies.

Care Management is based upon the premise that collaboration between the member, support systems, and health care professionals result in the development of partnerships that promote targeted interventions and health care goals and that contribute to improving health care outcomes. This coordination of care provides an opportunity for an improvement in the quality of care continuum. This integrated CM Program offers services that address the entire continuum of clinical and psychosocial needs, using data analytical capabilities to assist in providing evidence on the improvement of care and services. We strive

to empower the individual member to become successful in managing their chronic disease or condition.

At the UnitedHealthcare Community Plan, we take extra effort to ensure that we meet the needs unique to our community. For example, our offered initiatives and programs for chronic illnesses related to asthma and diabetes include the following services:

### **Asthma**

- Purchase room air conditioners and air purifiers when asthma is allergy triggered
- Referral to and coordination with Home Care provider
- Asthma Program for assessment, education and support
- Referral to and coordination with asthma specialist
- Member educational information.

### **Diabetes**

- Referral to and coordination with a Diabetes Center
- Referral to and coordination with Home Care provider or diabetic educator
- Referral to and coordination with diabetic specialist
- Member educational material, including meal planning, recipes, exercise program and monitoring of Hemoglobin A1c levels.

- *How the proposed PIPs will improve the health care status of the Louisiana Medicaid population.*

## **Reducing Neonatal Intensive Care Unit and Low Birth Weight Births**

By reducing the rate of NICU births/low birth weight infants, the number of potential birth defects and developmental disabilities associated with preterm births is also reduced. By intervening early in the pregnancy, the risk of maternal complications should also be decreased.

## **Improving the Care of Members with Asthma**

UnitedHealthcare Community Plan understands how difficult it can be to change behavior. We have developed proprietary strategies to maximize success for our members. Members in our Asthma CM program receive ongoing disease-specific education and coaching regarding lifestyle changes and holistic support to address situations that may impede them from reaching health care goals in a culturally sensitive manner. We assign designated clinical staff, social workers or educators to members actively participating in the program. The one-on-one relationship built during regular contact between the member and the health professional creates a strong bond; encouraging active participation and adoption of healthy behaviors. Our Asthma CM Program brings together the collective strengths and experiences of our organization nationally to leverage and support the success of the Asthma CM Program.

Our Asthma CM Program emphasizes early identification based on predictive tools and other medical management approaches. The program clearly defines and evaluates member risk and the appropriateness of established monitoring. Members are taught self-management techniques regarding key indicators, such as vital signs and symptoms, for each particular chronic disease or condition. This data provides the basis for alerting health care professionals if early intervention is warranted, reinforces members' disease-specific education and further promotes behavior change, adherence and improved quality of care.

## **Improving the Care of Members with Diabetes<sup>7</sup>**

According to the Centers for Disease Control and Prevention (CDC), diabetes currently affects over 18

<sup>7</sup> <http://www.ahrq.gov/qual/diabqual/diabqguidemod1.htm>

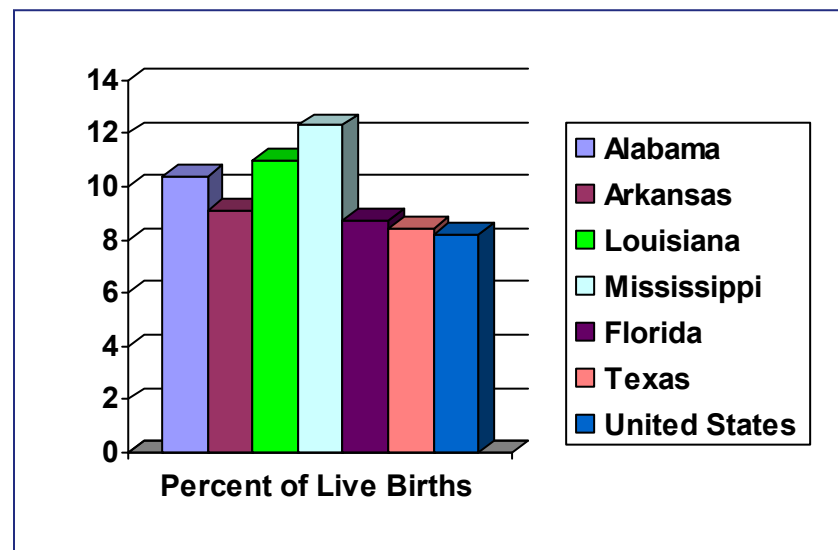
million people or 6.3 percent of the total population and ranks as the Nation's sixth leading cause of death at a cost of 200,000 lives a year. The development of diabetes has been strongly linked with obesity, aging and the increasing racial and ethnic diversification of the population. The prevalence of diabetes is also higher among certain racial and ethnic groups, including African Americans and Hispanics. The overall prevalence of diabetes in Louisiana is 10.7 percent (BRFSS, 2008). Diabetes is a common and serious disease in Louisiana and the fifth leading cause of death in the state. Without intervention now to prevent and control the onset of diabetes, rates could increase significantly as the large number of baby boomers move into retirement and live longer. With quality care and proper self-management, individuals with diabetes can prevent or delay the onset of complications. Diabetes has tremendous impact on both public and private health care spending and on the quality of life for those diagnosed with the disease. Research indicates that diabetes prevention works. Weight control and regular exercise can prevent or delay the onset of type 2 diabetes. Other studies have shown that proper health care and patient empowerment can help control and minimize the complications of diabetes for those who already have the disease. Patient self-management is particularly important for managing diabetes and preventing complications. Studies have demonstrated that patient self-management programs are effective tools for improving patient outcomes.

- ***Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.***

## Reducing Neonatal Intensive Care Unit & Low Birth Weight Births<sup>1</sup>

In the year 2007, 7,445 of the 66,063 infants born to Louisiana residents were low birth weight babies. This represents 11.3 percent of Louisiana's live births for the year. Both Louisiana and the United States have seen an increase in the percentage of infants with low birth weight in recent years. According to preliminary data published by the National Center for Health Statistics, Louisiana had the second highest percentage of low birth weight babies in the nation in the year 2007, outranked only by Mississippi.

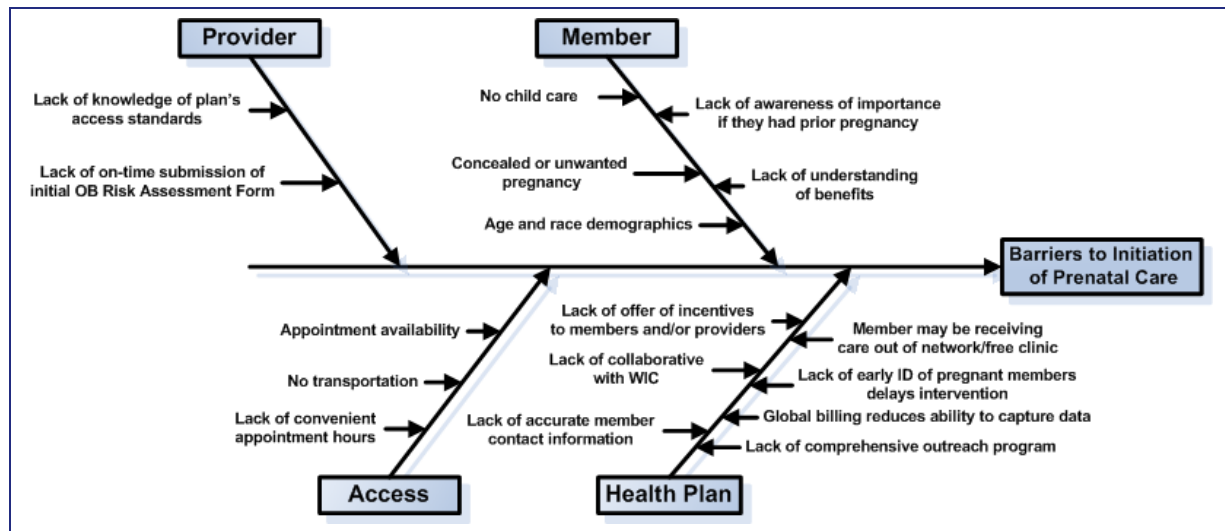
**Percent of Live Births Less Than 2500 Grams  
Louisiana, Neighboring States, and United States, 2007\***



\*Source: Morgan, K.O. and Morgan, S (Editors) 2008. Health Care State Rankings 2010 Health Care Across America. CQ Press, Washington, DC.\* Preliminary data for 2007.

African American women in the state gave birth to infants of low birth weight about twice as frequently as white women did, at 15.8 percent compared to 8.4 percent of live births, respectively. Infants weighing less than 1,500 grams (3 pounds, 4 ounces) at birth are considered to be very low birth weight and are at much greater risk of mortality and long-term disability. The risk of early death for very low birth weight infants is about 65 times that of infants who weigh at least 1,500 grams. In the year 2007, 2.2 percent of infants born to Louisiana residents weighed less than 1,500 grams, as compared to 1.5 percent of infants born to United States residents as a whole. As with infants weighing less than 2,500 grams, there were demographic differences in the mothers giving birth to very low birth weight infants. African American mothers in 2007 gave birth to very low birth weight infants at 3.7 percent compared to 1.3 percent of total live births in whites. Infants born to the youngest and the oldest mothers were more likely to be very low birth weight. In the year 2007, Concordia Parish had the highest percentage of low birth weight babies in Louisiana at 17.4 percent of live births, while Plaquemines Parish had the lowest at 6.9 percent of live births.

Our QAPI interventions will focus interventions that directly address the root causes identified by member, physician and other health care entities that impact low birth weight births. One of the areas other health plans have focused on is the barriers to initiating prenatal care and the impact on low birth weight outcomes. An example of this barrier analysis follows.



<sup>1</sup> [http://www.dhh.louisiana.gov/offices/publications/pubs-275/DHHHlthCreRprtCrd\\_2009.pdf](http://www.dhh.louisiana.gov/offices/publications/pubs-275/DHHHlthCreRprtCrd_2009.pdf)

## Improving the Care of Members with Asthma<sup>1</sup>

The national mortality rate for asthma in 2005 was 1.3/100,000. Although Louisiana has one of the lowest state prevalence for asthma, a three year aggregate of mortality rates found that the state ranked 13th in death rates due to asthma. In the years 1996-1998, mortality rates for asthma in Louisiana were 2.4/100,000 for all citizens and 10.1/100,000 for those over the age of 65. In the City of New Orleans, the overall mortality rate attributable to asthma was 6.9/100,000. For Orleans Parish residents over the age of 65, the asthma mortality rate is 2.5 times the rate for the same age group in the state as a whole (27.5/100,000 vs. 10.1/100,000). Furthermore, it is more than three times the 1998 rate for the United States in the 65 and older age group (27.5/100,000 vs. 8.7/100,000).

The UnitedHealthcare Community Plan QAPI interventions will focus interventions that directly address the root causes identified by barrier analyses of member, physician and other health care entities that impact the management of asthma for members.

<sup>1</sup> [http://www.dhh.louisiana.gov/offices/publications/pubs-275/DHHHlthCreRprtCrd\\_2009.pdf](http://www.dhh.louisiana.gov/offices/publications/pubs-275/DHHHlthCreRprtCrd_2009.pdf)



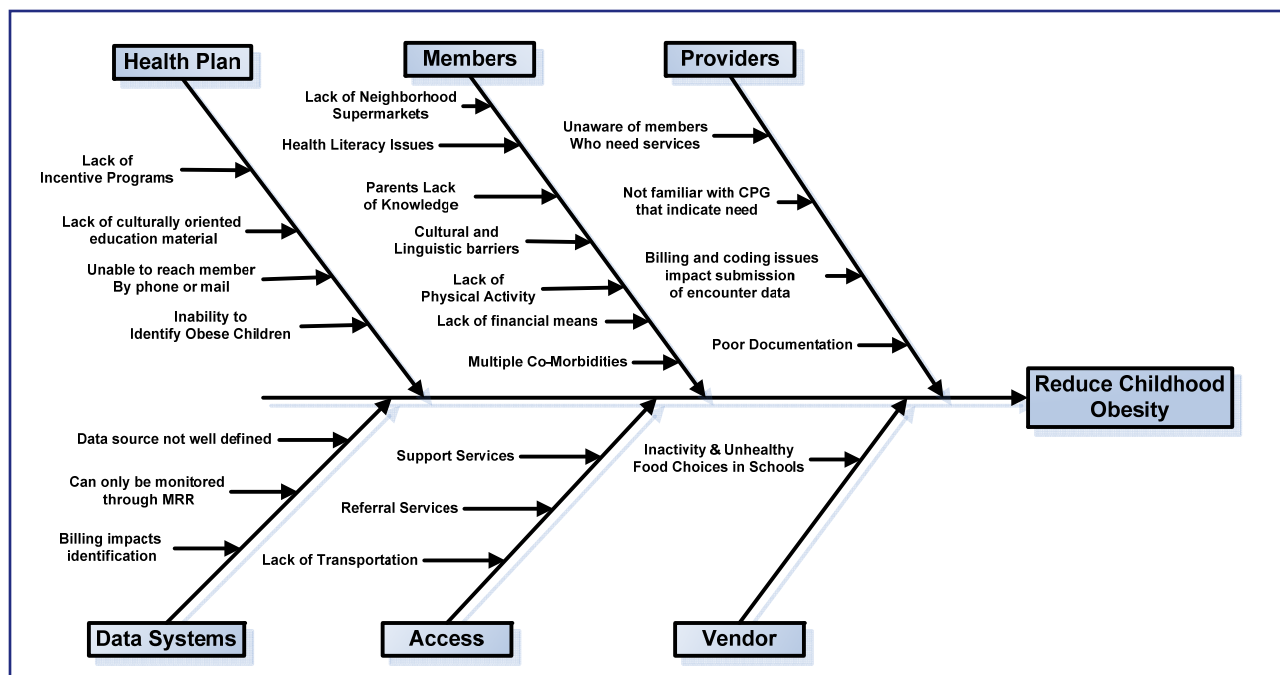
## Improving the Care of Members with Diabetes<sup>1</sup>

Even though an individual's Body Mass Index (BMI) is, for the most part, within his or her control, the percentage of people in the United States who are overweight or obese has been steadily and dramatically on the rise. 29.3 percent of Louisiana diabetics are overweight, and another 58.7 percent are obese. Hence, approximately 88.0 percent of all adult diabetics in Louisiana are overweight/obese. Overall, adult obesity in Louisiana rose from 16 percent in 1991 to 27 percent in 2008, with the largest jump seen in the 18 to 24 year old age group. Being overweight or obese substantially increases the risk of hypertension, high cholesterol, type II diabetes (adult onset), heart disease, stroke, gallbladder disease, osteoarthritis and various cancers.<sup>17</sup> During the period between 1991 until 2008, the percentage of overweight or obese Louisiana residents increased from 49 percent to 65 percent.

Elevated cholesterol is one of the strongest risk factors associated with heart disease. Cholesterol plays a direct role in the atherosclerotic process, the disease process that causes heart disease and stroke, where cholesterol accumulates on the arterial walls, building plaque and restricting blood flow. Lowering high total blood cholesterol levels can decrease the likelihood of death from heart disease. In 2007, the percentage of Louisiana adults who had not had their blood cholesterol checked within the previous five years was 2.2 percent; never checked was 22.5 percent. Of persons who had ever been checked, 33.7 percent reported having high cholesterol levels.

Regular moderate or vigorous physical activity can reduce the risk for heart disease. Healthy People 2010 recommends that adults should engage in vigorous-intensity physical activity three or more days per week for 20 or more minutes per occasion, or engage in moderate-intensity physical activities for at least 30 minutes on five or more days of the week. Only 35 percent of Louisianans met the recommendations in 2001. The proportion of those who met the recommendations increased to 38.6 percent in 2007, but is still below the national level of 49.5 percent.

Our QAPI interventions will focus interventions that directly address the root causes identified by member, physician and other health care entities that impact obesity and related chronic conditions, such as diabetes, high blood pressure and heart disease. An example of this barrier analysis is below:



<sup>1</sup> [http://www.dhh.louisiana.gov/offices/publications/pubs-275/DHHHlthCreRprtCrd\\_2009.pdf](http://www.dhh.louisiana.gov/offices/publications/pubs-275/DHHHlthCreRprtCrd_2009.pdf)

- ***How your will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.***

UnitedHealthcare Community Plan believes in an open and transparent relationship with our state partners. We will keep DHH informed of our QAPI program actions, recommendations and outcomes by measuring and reporting our performance, using standard measures and within the time frames as required by DHH and as specified in the final contract agreement. Our reporting will include submission of our Performance Improvement Projects within three months of the execution of the contract and at the beginning of each contract year thereafter as specified in the Quality Companion Guide and in sections 14.3.8.4 and 14.3.9.1. We will submit our QAPI Program Description for written approval within 30 days from the date the contract is signed. The QAPI Workplan will be submitted to DHH within 30 days from the date the contract is signed and annually thereafter, and prior to revisions.

The annual QAPI Program Evaluation, which includes an evaluation of the impact and effectiveness of the QAPI program and care management activities, will be submitted to DHH annually. Minutes from all QAPI committees and sub-committees will be submitted to DHH within 10 business days following each meeting. Provider Satisfaction Survey tools and methodology will be submitted to DHH for approval prior to administration and Member and Provider Satisfaction Survey results will be submitted to DHH within 120 days after the end of the plan year. UnitedHealthcare Community Plan, Louisiana will provide a copy of all correspondence associated with NCQA accreditation involving the application and the accreditation requirements. In addition, the DHH will be included on all correspondence to the Member Advisory Council, including all agenda and council minutes.

- ***How the proposed PIPs may include, but is not necessarily, limited to the following:***
  - ***New innovative programs and processes.***

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## Quality Improvement Program and Processes

Our experience and commitment to improving quality of care and performance measures includes more than 15 years of experience collecting, analyzing and reporting HEDIS measures. This commitment to improving quality and performance is shared by all employees throughout the organization.

UnitedHealthcare Community Plan has developed processes for internal monitoring of performance measure rates. Our quality management program and performance improvement projects report on performance levels, which are monitored through the quality improvement committee structure, up to and including the Board of Directors, UnitedHealthcare Community Plan's governing body.

In compliance with our QAPI Plan, data metrics are presented to the health plan Quality Committees using a standard set of reports. HEDIS data are presented using reports that are developed through our HEDIS-certified software, ViPS MedMeasures and all other metrics are tracked using dashboard reports.

UnitedHealthcare Community Plan has as its goal to achieve HEDIS quality of care measures comparable to the best of all competitor plans and state-specific goals. This initiative leverages national resources and organizational support to implement identified best practices and continually measure and report on their effectiveness, while continually assessing enhancements and modifications to ensure best practices are implemented at the local plan level. Our efforts include:

- Developing and reporting process and outcomes measures on a frequent basis throughout the year to determine progress towards exceeding state critical quality of care measure goals, as well as exceeding the HEDIS measurement rates of competing health plans.
- Analyzing data to identify practices that have been most effective in improving outcomes.
- Modifying initiatives as needed to maximize results.
- Performing iterative measurements to ensure sustained improvement.
- Sharing best practices across all UnitedHealthcare Community Plans to take advantage of efficiencies

of scale and provide the best care and services possible to our members.

We achieve these efforts by implementing the following activities:

- Providing effective monitoring and evaluation of patient care and services to ensure that care provided within the delivery system meets the requirements of standard medical practice, meets the cultural and linguistic needs of the membership, and is perceived positively by enrolled members and health care professionals:
  - Evaluating and disseminating clinical and preventive practice guidelines
  - Monitoring provider performance against established evidence-based medicine
  - Developing guidelines for quality improvement activities
  - Conducting and analyzing HEDIS data in order to develop programs to improve satisfaction and preventive services as identified
  - Collecting and analyzing data for population specific Performance Improvement Projects (PIPs)
  - Developing, defining and maintaining data systems to support quality improvement activities and encourage data-driven decision-making
  - Providing culturally proficient care and services
  - Providing disease management programs that improve the quality of life for chronically ill members.
- Ensuring prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up:
  - Identifying and monitoring important aspects, quality indicators, problems and concerns about health care services provided to members
  - Implementing and conducting a comprehensive Quality Improvement Program
  - Recognizing that opportunities for improvement are unlimited
  - Providing ongoing feedback to members and providers regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities
  - Supporting re-measurement of effectiveness and continued development and implementation of improvement interventions.

HEDIS serves as our standard set of indicators to continuously measure plan performance. Results are used to identify current gaps in care or service and are integrated into our quality improvement projects. Because we wish to be our members' most trusted source of health care information, we take every opportunity to enhance the member's quality of care and experience. HEDIS measures allow us to track performance across a wide span of health care activities, including:

- Preventive (e.g. lead screening, immunizations, cervical cancer screening, breast cancer screening, chlamydia screening and well-child visits)
- Chronic care (e.g. diabetes, cholesterol management, treatment of asthma)
- Access/ availability of care
- Preventive services are both population and condition based. Using multiple data sources, including HEDIS and claims data, members are identified for outreach. Outreach strategies include:
  - Optimizing the Hospitality, Assessment and Reminder Center (HARC), an outbound reminder calling program that includes live or automated preventive health calls to educate new and existing members who have been identified as needing HEDIS measured services in areas such as access to care, child's health, women's health, and chronic medical conditions
  - Routine educational mailings using a set of targeted, age and sex appropriate member health education and prevention reminder mailers

- Evaluating the effectiveness of member incentives and implementing corrective strategies where needed
- Using the Universal Tracking Database (UTD), a state of the art interactive online system whose functionality includes automated electronic tasking for member outreach, list generation for providers, and results integration into our provider portal
- Online access through the UnitedHealthcare website for members to access educational information on recommended preventive screenings and preventive care
- Quarterly mailings of member newsletters that contain educational articles on recommended preventive screening.

For providers, we strive to be most trusted partner in facilitating quality care. We do that by providing actionable information delivered conveniently and on a timely basis using a web-based portal strategy. Claims/encounter data are monitored on an ongoing basis to identify members in need of services and to provide feedback to providers on individual and plan performance through a variety of strategies.

### **ImpactPro™ – Predictive Modeling Tool**

Our care management programs help members with significant health care conditions receive quality care and avert potential problems by devising proactive, rather than reactive, strategies of care. Our multi dimensional, episode-based predictive modeling tool, ImpactPro compiles information from multiple sources and uses it to predict future risk for intensive care services. Health outcomes are improved by anticipating the needs of the members. For example, diabetics are at risk for developing eye problems, so medically accepted guidelines recommend that diabetics see an eye care specialist regularly. ImpactPro allows our care managers to identify diabetic members who have not seen an eye specialist. The tool assists us in reducing the prevalence of eye problems in the diabetic population.

ImpactPro performs monthly predictive modeling for individuals and groups. Using information readily available from medical and pharmacy claims, laboratory results and member enrollment files, it employs a variety of algorithms and models to predict which members are at greatest risk for severe health care 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 to these members more efficiently. The risk scores provided from ImpactPro also are useful in discovering existing members who may need care management services. For example with asthma, the algorithm takes into consideration inpatient and emergency room 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 a member's health status and clinical outcomes. Again, this assists care managers in identifying members who are most likely to benefit from our DM interventions, particularly those with chronic conditions and with existing co-morbidities.

ImpactPro also can produce provider notifications on members who have generated care opportunities for specific DM programs. Included are evidence-based medical guidelines that highlight opportunities for improving care and reporting that providers can use to identify at-risk members and missed care opportunities. This information can be accessed through our secure online provider portal.

### **Collaboration with Community Organizations and Agencies**

Through UnitedHealth Care Community Plan's Vice President of Community Development, Charlisa Watson, UnitedHealthcare Community Plan has been working the last several months in Louisiana making contacts and establishing partnerships with a number local community organizations and health care related agencies and services. Many of these programs have submitted support letters for our proposal. This approach has been built on the strategy that UnitedHealthcare Community Plan uses

effectively in other communities

Ms. Watson has been meeting meet face-to-face with community-based organizations and agencies. Through these community collaborations and partnerships, UnitedHealthcare Community Plan works together with local organizations and entities that also serve Medicaid-eligible populations to more effectively reach underserved and special needs populations. By working closely with organizations that also touch the member, although not from a medical perspective, we are able to connect our members more effectively to the support and non-medical services available. This also allows us to address our member's needs from a more holistic perspective.

Through the activities described above, we will develop a resource guide that provides information about these organizations and agencies. This resource guide will be used by our staff and care coordinators to help our members connect with local services. This resource guide will also be available to members on our website.

Acknowledgement of our community partnership efforts is evidenced by our 2010 award from Bridgeport Mission, an organization that provides food, housing and assistance to low-income individuals and families in Connecticut. The Bridgeport Mission awarded us a Corporate Compassion in Action Partner Award, recognizing the work and support from our employees and company.

To extend health education and outreach to a larger segment of our members, UnitedHealthcare Community Plan established unique partnerships on a national scale. Some examples of these programs include:

### ***Sesame Street Initiative***

UnitedHealthcare worked with Sesame Workshop to develop "Food for Thought: Eating Well on a Budget." This program is a bilingual (English-Spanish) multimedia outreach initiative designed to help support families and cope with uncertain or limited access to affordable and nutritious food. This program provides an educational outreach kit that includes an original video featuring the debut of four new Sesame Street Muppets, the "Super Foods." The video also features Elmo and friends, along with real families as they try new foods, learn about the importance of healthy snacks, and discover that sharing a meal together is a perfect opportunity to connect as a family. Through this partnership we are also creating outreach materials to educate members who have been diagnosed with asthma and to encourage all children to have lead testing, which supports EPSDT requirements.



### ***4-H Healthy Living***

In March 2011, UnitedHealthcare Community Plan announced a new, innovative partnership with 4-H, America's largest child-focused organization, to implement 4-H's Youth Voice: Youth Choice program to help tens of thousands of young people improve their health through exercise, diet and other healthy choices in three key states: Texas, Florida and Mississippi. Both 4-H and UnitedHealthcare share a commitment and mission to help young people live healthier, more productive lives. Our partnership focuses on providing resources for 4-H programs in underserved communities where health issues such as obesity and diabetes are disproportionately high. The young people who participate in the program are encouraged to take action for themselves, for their families, and in their communities, to promote healthy living priorities and achieve better physical, social and emotional well-being.

### ***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.

### ***UnitedHealth HEROES in the Fight Against Obesity***

UnitedHealth HEROES 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. UnitedHealth HEROES seeks to reverse the rising childhood obesity statistics by encouraging young people to design their own creative solutions that can help break the pattern of unhealthy living. **In 2011, 333 grants totaling more than \$210,000 are being awarded, including seven grants in Louisiana.** The hands-on and peer-to-peer learning supported by UnitedHealth HEROES helps kids retain new information and can lead to improved behaviors and better educational outcomes.

### ***Diabetes Prevention and Control Alliance***

This alliance is a unique approach to helping members with prediabetes and diabetes live healthier lives via successful evidence-based programs that improve outcomes and reduce cost. Primary goals are to reduce diabetes conversion among members with prediabetes; reduce heart attacks, strokes, kidney disease, amputations and blindness among members with diabetes; and support Primary Care Physicians (PCPs) in comprehensive patient care programs. We partner with other local trusted health and wellbeing organization in a non-traditional manner to broaden the care delivery opportunities to members at risk. Examples are diabetes prevention programs with YMCAs to reach prediabetic members and diabetes control programs with local pharmacists to reach diabetic members.

### ***YMCA Diabetes Prevention Programs***

Studies from the National Institutes of Health have shown that a five percent loss for prediabetics results in a 58 percent reduction in diabetes conversion. This program works to reach attainable goals, through health eating and moderate physical activity. Participants have easy access to a neighborhood YMCA location. Participants are enrolled in a 16-session YMCA program, which is delivered over 20 weeks. Included in the session is one hour per week in a group setting to review behavior modification techniques and add a "team spirit" to increase changes for success.

### ***Diabetes Control Programs with Local Pharmacists***

A study from the City of Asheville, North Carolina and the North Carolina Association of Pharmacists found that a pharmacy care program for diabetics reduced participants, A1c levels over 50 percent and reduced a participant's annual direct medical costs between \$1,200 to \$1,872. Our diabetes control program provides a convenient network of pharmacy-based adjunct providers. Pharmacists at these locations schedule private meetings with participants to monitor medications, blood pressure (BP), weight, and laboratory results. Participants reported high levels of satisfaction interacting with a trusted pharmacist, which increased the success of the program. Studies show an accurate Member assessment helps identify early signs of debilitating complications and improves outcomes. Costs have been proven to decrease with the improved control of BP, LDL and Hemoglobin A1c.

### ***Clinical Practice Consultants (CPCs)***

The Clinical Practice Consultant (CPC) Program is a Community strategic initiative designed to enhance the relationship between the health plan and the provider to support the QAPI program of the health plan to:

- Maintain regulatory compliance with quality program requirements
- Improve the quality of care received by our members, as measured by HEDIS and other quality metrics
- Enhance the relationship between providers and the health plan and act as a conduit of information regarding state and health plan expectations of providers as relates to:
  - Improving member care
  - Proper coding and billing
  - Knowledge of state quality regulatory requirements
  - Understanding of data specifications for quality metrics.

The CPC staff work collaboratively to:

- Builds trust and rapport with office staff and practitioners
- Relays barriers to the appropriate plan personnel to assist practices in resolution of issues (e.g., claims, capitation, case management and UM issues)
- Readily shares ideas and best practices
- Provides a list of assigned members in need of preventive services
- Gives provider education about non-compliant member's needs and develops an action plan; works with practices to arrange or contact non-compliant members into care
- Assists in community projects and health fairs to reach members in the community
- Serves as a Knowledge Library to the practice staff, acting as a HEDIS specification expert.

### **Universal Tracking Database**

Universal Tracking Database (UTD) is an internally designed, custom relational database that accommodates multiple data inputs and has a web-style interface which enables secure but efficient online queries by UnitedHealthcare Community Plan staff, ensuring comprehensive, timely encounter and service information on each unique member. Using UTD, our staff can focus on the members in need of outreach or interventions, and monitor adherence to care in existing treatment regimens.

### **Physician Quality Initiative**

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.

HEDIS reports are generated through MedMeasures by ViPS, NCQA-certified HEDIS measurement software. We also produce dashboard reports to track all appropriate indicators. Measurement occurs at baseline and at monthly intervals appropriate for the indicator. Through MedMeasures, we identify and measure various key quality indicators, such as well-child visits, to ensure our data are complete and accurate. The system's enhanced measurement analysis function gives us access to Member-level detail, thereby providing information on specific members who qualify for each measure. This also provides information for provider profiling, allowing comparisons among peers and with established standards.

Data from the MedMeasures tool can then be used for compiling “scorecards” that display performance measures, as well as data for identifying populations for specific interventions. UnitedHealthcare Community Plan then develops an appropriate intervention for these populations, which may include things such as member outreach calls, member mailings or health fair promotion topics. The advantage of regular reporting from MedMeasures is that it provides the QM program trended performance rates (expected versus actual results) to identify early opportunities for intervention.

As described above, UnitedHealthcare has designed a quality management program to achieve, through 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.

- ***Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics. (All GSAs)***

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## **School District and School Based Health Clinic Partnerships**

UnitedHealth Care Community Plan’s Vice President of Community Development, Charlisa Watson and our Chief Executive Officer, Blaine Bergeson, have been working the last several months in Louisiana making contacts and establishing partnerships with a number of school-based health related programs and services. Many of these programs have submitted support letters for our proposal. These partnerships include:

### **Louisiana YWCA Early Head Start Program**

The purpose of the YWCA Early Head Start program is to enhance the educational status and economic outcomes of primarily adolescent parents and their children. This purpose is accomplished by providing early, continuous, and comprehensive child development services, parenting training, family support and assistance, and health services to effect positive long-term outcomes for children and families. The program is a generational approach starting with adolescent parent families as a beginning point to systematically address the realities of children and families living in poverty. In addition to children of adolescent parents the program also serves pregnant adolescents, children with disabilities and children in poverty (age birth - 3 years). The YWCA Early Head Start Program services include:

- Child Care (early care and education)
- Transportation
- Parent education and support
- Physical and mental health services
- Ongoing parent support and guidance
- Male involvement activities
- Family wellness activities.

Ms. Watson has been working with several of the YWCA Early Head Start Programs that are also connected to local school systems. Recently we cosponsored the 3rd Annual YWCA Mother Daughter Health Expo and Luncheon. In addition, plans are being developed on bringing our Sesame Street collaborative initiatives to their program participants including the Sesame Street “Food for Thought”, a healthy eating program, and “Lead Away”, a program highlighting the hazards of lead based items.

### **Louisiana PROMISE/PIRS**

A statewide parent focused program where services are based on the premise that the more involved parents are in their children’s education the more successful their children will be in school. The program offers statewide services and educational opportunities, toll-free information line for parents,

parent/family workshops and informational literature. Louisiana PROMISE/PIRS goals include:

- Assist parents and educators in knowing and understanding the provisions of the No Child Left Behind Act
- Develop effective partnerships between schools and parents to garner greater parental participation in education
- Create a supportive network of Louisiana education and family strengthening programs to promote greater resources for Louisiana families
- Provide technical assistance to the Louisiana Department of Education, local education agencies, and schools to promote effective parental involvement policies
- Provide programs and resources for parents to prepare their children for school.

We have established a partnership with the Louisiana PROMISE/PIRS and will be doing a number of back to school events with them and are planning a number of health related collaborations over the next several months.

### **Louisiana School Based Health Care Centers**

We recently presented at the School Based Health Center Association's (SBHC) annual meeting where we provided an overview of UnitedHealthcare Community Plan and discussed the merits of the Louisiana CCN program. We also had a follow up meeting with Tracy Parker, President of the Louisiana School Based Health Center Association, as well as representatives from several of the largest SBHC in Louisiana, where we discussed our interest in working with them. Sue Catchings, CEO of Health Centers in Schools, contacted us after this meeting and she and several SBHC Directors had identified four specific areas of interest that their SBHC programs would like to focus on as part of collaboration with UnitedHealthcare Community Plan. The suggested areas identified by the SBHC Directors include:

- Asthma and school-based intervention that keeps kids out of the ER in local hospitals
- Diabetes—how we screen certain children and how we work with children who are already diagnosed to help them understand how to control their disease
- Immunization rates (and expanding it to other schools close to the SBHC sites)
- Integration of primary care and mental health.

UnitedHealthcare Community Plan is in the process of collaborating with SBHC to develop specific plans to focus on one of their identified areas.

**Istrouma High School Health Center** is one of eight schools that are part of the **School Based Health Care Centers**. Istrouma High School is in a targeted Medicaid community where 85 percent of students are below the federal poverty level. The high school also has a Head Start program. Ms. Watson has had initial meetings with the parent community liaison of the school and plans have been finalized to hold a health fair and back to school event in collaboration with the school.

Other Louisiana School related programs we have contacted and begun partnerships with include:

- **Parents as Teachers:** A statewide program where certified parent educators use the latest research in the brain development of a child to provide comprehensive training, information, and support services that will develop and strengthen the parent/child relationship with an emphasis on education and school readiness. Home visits, group meetings, and resource referrals are provided to teen parents at local high schools and to the community at-large.
- **Parent University:** A program that provides assistance in navigating the school system, coordinating parental involvement activities and building positive relationships between parents and teachers. Baton Rouge Parent University Community Summits are held periodically throughout the year and by request in schools, churches, and community centers and have focused on topics such as post-

secondary education and access, high-stakes testing and school accountability, addressing learning differences, and reading and literacy.

- **Lights on AfterSchool:** A nationwide event celebrating after school programs and their important role in the lives of children, families and communities.

**J.5** *Describe how feedback (complaints, survey results, CCN Consumer/Provider Committee, etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts. (All GSAs)*

## Member Satisfaction

Member satisfaction is a key component of our quality management program. We assess member satisfaction by monitoring and trending member complaints, by on-going call center feedback through the United Experience Survey, through our Community Advisory Committee and through the Consumer Assessment of Healthcare Providers and Systems (CAHPS® 4.0H) Child or Adult Medicaid Consumer Satisfaction survey process/tools. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

NCQA has led the effort to develop uniform measures that can be used by employers, consumers and others to compare the performance of health plans. The CAHPS instrument provides the member satisfaction component of the Healthcare Effectiveness Data and Information Set (HEDIS) measurement set for health plan reporting. Plans seeking accreditation from NCQA must use the NCQA-approved CAHPS 4.0H questionnaire and survey protocol. The NCQA protocol includes an audit of Enrollee files by an NCQA-certified auditor and the use of an independent, NCQA certified survey vendor to administer the study.

Unless instructed otherwise by our state partners, our surveys are conducted by the Center for the Study of Services (CSS). CSS is an independent, nonprofit, consumer research organization certified by NCQA to conduct the CAHPS 4.0H survey. In addition to survey results, we monitor member complaints and grievances received by the health plan on an ongoing basis. Taken together, the results of our surveys give us a complete picture of the satisfaction level of our members. Our surveys look at customer service, physician appointments, care coordination and our written materials. Year-over-year CAHPS results, member complaints and other plan benchmark data are shared with appropriate health plan quality committees and activities identified for improvement specific to membership needs are incorporated into the Quality Workplan. We identify barriers and trends as well as opportunities for improvement, and work with involved parties to resolve the trend and to produce measurable improvements.

## United Experience Survey (UES)

Our United Experience Surveys are offered at the conclusion of all member and provider calls. This information is used to trend call center satisfaction as well as an on-going training tool for staff. Members will report on issues and concerns that are reported out for action as appropriate, in addition to the individual member follow up. In addition, our Call Center uses Text Search on digitally recorded calls that enables us to trend new concerns or issues. This new capability is recently deployed on a limited basis but has the promise of a truly unique tool to track trends in our members own words.

## Community Advisory Committee (CAC)

The Community Advisory Committee (CAC) provides a collaborative forum for member, community representatives, advocacy groups and community-based providers to share our successes, bring issues and ideas from their member to us, work together on opportunities for community outreach, identify common ground around legislative issues, obtain feedback on new and future initiatives and review how these programs fulfill our mission. Since our members rely on other community based and faith-based organizations to meet a variety of needs, we find these organizations have a valuable perspective on both



our members needs and on effective outreach methods.

### **Member Feedback Example**

We take our CAHPS results seriously, as a key indicator of our members experience with their individual providers and with the health plan. Additionally, we leverage the information from the results to drive action to improve our member experience. The survey question of “Treated member with courtesy and respect” has been a key driver for three years. Of those members who tried to get information from the health plan’s customer service, 87.18 percent indicated that the customer service staff “Usually” or “Always” treated them with courtesy and respect. This score was similar to the 2009 score (87.01 percent) and higher than the 2008 (84.38 percent) score. The difference from the 2008 score was statistically significant at the 95 percent confidence level.

Through a national workgroup, we worked with our call centers to create a dedicated campaign around “Build Community” to ensure our representatives understood the importance of providing helpful service and treating all of our members with courtesy and respect.

The “Getting help from customer service” question was identified as a key driver in 2010 and 2009. Of those members who tried to get information from the health plan’s customer service, 70.40 percent indicated that they were “Usually” or “Always” able to get the information or help that was needed. This score was similar to the 2009 score (70.42 percent) and higher than the 2008 (65.44 percent) score. The difference from the 2008 score was statistically significant at the 95 percent confidence level.

A specific example of how these results from our CAHPS survey has driven change includes our focus to improve call center staff’s ability to assist members in selecting a PCP. We developed a process that allowed our call center staff to “screen share” with the provider, member and other call center teams at the same time. This “screen share” process helped improve the ability of our staff to more effectively communicate and provide accurate information to help the member select the PCP that would best meet their needs.

The following CAHPS related activities are used with call center staff to educate and raise awareness of our CAHPS goals:

- **CAHPS Scavenger Hunts:** Weekly questions from the CAPHS website
- **Reminder Cards:** Created small reminder cards with two CAHPS questions and placed the cards on the call center staff monitors
- **CAPHS Bulletin Boards:** Placed in all sites
- **Secondary Survey:** Two CAHPS questions offered after every 10th call
- **United Experience Survey (UES) Calibrations:** Bi-weekly meetings with call center staff to listen to calls at member’s perspective
  - UES is our process for capturing member/provider satisfaction through our call center. Callers have the opportunity at the beginning of the call to complete a survey after the call, offering a rating scale of 1 to 5 (5 being excellent) on 6 questions in relation to the call and the service. Callers also have the ability to provide verbal feedback as well.
- **UES Voice of the Customers:** Collecting and saving the findings followed by a meeting to discuss outlier calls.

In addition to the work in our call centers, each of our individual health plans creates individual action plans, based on their specific CAHPS results. For example, the Maryland plan identified member dissatisfaction because of inability to access practitioner office for scheduling as an opportunity for improvement based on analysis of the 2010 CAHPS results. As a result the following improvement actions were implemented:

- An EPSDT telephone line to address EPSDT and other preventive services became operational during

October 2010. Members are accessing the line seeking assistance in scheduling appointments with providers. EPSDT staff complete follow-up telephone calls to members to ensure the appointments were kept with the providers.

- An article appeared in the Fall member newsletter informing members how to contact the health plan directly when they experience problems scheduling preventive care visits.
- Outreach Coordinators assist with appointment setting by contacting the practitioners directly to make the appointment for the member or by facilitating a conference call with the member and the practitioner.
- Outreach Coordinators continue to respond to calls received on the EPSDT phone line. The number is manned by the team of four. During outreach calls, team members inform members that this is the number to call for specific questions regarding the appointment setting process. There is a voicemail attached to this number which is checked daily by the Outreach Coordinators and follow-up to members occurs to address their specific issues.

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## **Provider Satisfaction**

Annually, UnitedHealthcare Community Plan conducts large-scale assessments of provider satisfaction as part of our continuous quality improvement efforts. We utilize structured provider satisfaction surveys as our most consistent and structured tool but we also gather feedback from our Call Center team, Provider Advocates, Provider Advisory Committee and our Provider Forums.

Our Provider Satisfaction Surveys and Targeted Improvement Plans ensure thorough assessment and promotion of provider satisfaction. We share survey results with our executive team and staff at a national and health plan level and ensure that the results are communicated and acted upon throughout the organization. In response to the survey results, we create and execute specific work plans to address areas rated as primary and secondary improvement targets. To improve the value of the provider survey and to expedite the resolution of issues, we will encourage (but not require) providers to identify themselves in their response. Identification will allow us to follow-up directly with providers to address their concerns and improve our relationships and performance.

Objectivity is our utmost concern in the survey process. UnitedHealthcare Community Plan works with Survey Research Solutions, a product of our sister company, Ingenix, and the Center for Study Services (CSS) to conduct our annual provider satisfaction survey(s). We survey primary care physicians (PCPs) and high volume specialists. CSS draws the survey samples of eligible physicians working within UnitedHealthcare's networks from lists provided by Ingenix. The survey protocol includes a pre-survey notification letter addressed to the practice manager of the physician, followed by two mailings or faxes of a cover letter and questionnaire to all physicians in the sample. There is typically a four-week interval between the initial survey mailing and the replacement survey mailing. In some areas, our provider relations team hand delivers the replacement survey to non-responding physicians.

Survey results from all UnitedHealthcare Community Plans are aggregated annually and reported to our National Quality Management Oversight Committee (NQMOC). The results are compared by health plan year over year and also in comparison to other UnitedHealthcare Community Plans across the country. The survey results include key strengths, secondary strengths, key improvement targets and secondary improvement targets.

For 2010, UnitedHealthcare Community Plan's key strengths included:

- The utilization review process
- Clinical appropriateness of the utilization review decisions
- Assistance provided by care management staff in facilitating treatment coordination
- Ease of prior authorization process

- Timeliness of claims payment process
- Accuracy of claims payment process
- Ease of credentialing and recredentialing process
- Assistance provided by the provider service center or 1-800 provider help line
- Availability of disease management and health education programs for your members
- Care management programs provided for your members
- How would you rate [www.uhc.com](http://www.uhc.com)
- Care management program for your Medicare members.

Through the NQMOC our national clinical leadership works with each health plan to identify and implement improvement action(s) with national impact. In addition, each health plan's Provider Advisory Committee (PAC) and the Service Quality Improvement Subcommittee (SQIS) review their data, using year-over-year results and other plan data as benchmarks and identify actions for improvement specific to their provider network and membership needs. The SQIS may establish interdisciplinary work groups to partner with plan physician advisory committees to discover the most effective approaches to solving provider satisfaction issues. Annual survey results are also published in the provider newsletter and our provider relations representatives follow up with individual providers to assure satisfaction.

### **Provider Advisory Committee (PAC)**

The Provider Advisory Committee (PAC) performs peer review activities, including oversight of credentialing decisions decided by the National Credentialing Committee as well as review and disposition of concerns about quality of clinical care provided to member as requested by the Chief Medical Officer (CMO). The committee is responsible for evaluating and monitoring the quality, continuity, accessibility, and availability of the medical care rendered within our network. The CMO chairs the PAC and other senior leaders from the health plan attend the dinner portion of the meetings. While not the primary purpose of the PAC, the open dialogue with physicians from the community provides a treasure trove of feedback on provider issues, practice challenges and emerging trends.

### **Provider Advocates/Office Visits**

Provider Advocates assist providers with questions or problems, including issues with electronic claims submission and electronic claims. The field-based Advocates conduct provider visits and educate providers on electronic payments and statements, and the Advocates gather feedback from providers on practice issues and needs.

### **Provider Forums**

In addition to the individualized training we conduct at provider offices, we hold Provider Forums, which are half-day seminars led by the Provider Relations department with other UnitedHealthcare Community Plan department subject matter experts (Medical Management Director, EPSDT Coordinator, Behavioral Health Coordinator, Claims Educator, etc.) speaking on specific issues that affect provider practices, including electronic claims and electronic funds transfers. Office managers, billing representatives, clinical staff and other office staff from provider offices are invited to attend and provide input. Based upon the pre-registered list of attendees, our staff creates presentations specifically designed to meet the needs of the participants. Break out sessions are available. We expect to have at least two Provider Forums per year, with GSAs with higher membership concentrations having up to four.

### **Provider Feedback Examples**

#### **Maryland**

We take our provider feedback seriously and our local plans work to make changes that will support improvement in provider satisfaction. For example, the 2010 provider satisfaction survey results in Maryland identified customer service/provider relations overall and overall experience in obtaining prior

authorization for medications as two key drivers of provider satisfaction. In addition, provider complaints during CY 2010 regarding the UM process were driven by dissatisfaction with some aspect of the pharmacy process. These complaints comprised the majority of complaints during each quarterly complaint analysis. To understand better the problem(s) surrounding the formulary usage, the Maryland quality department performed a pharmacy survey during late 2009 into early 2010. The plan learned that approximately only 10 percent of the respondents utilize the formulary consistently and approximately 40.5 percent utilize the formulary some of the time. Thirty six percent of practitioners reported not using the formulary at all while 66.7 percent reported they sometimes prescribe medication that requires formulary override. These findings were identified as barriers for provider satisfaction and thought to explain why the formulary is problematic for the practitioner community. The health plan staff concluded that a large proportion of the prescriptions written were likely being denied due to needing a prior-authorization and the volume of denials may be associated with the practitioners' lack of formulary usage.

In addition to the above finding, many practitioners expressed the desire to receive a hard copy of the formulary. The health plan staff identified a mechanism to provide the formulary in supplemental formats in addition to electronic format on the practitioner portal. In addition, articles were placed in both the practitioner and member newsletter reminding both groups of the formulary. In the practitioner newsletter, practitioners were asked to submit their email addresses if they would prefer to receive the formulary via email on a periodic basis. 2010 Provider Satisfaction Survey results showed a 2 percent increase (24 percent) in providers' satisfaction with customer service/provider relations when compared with 2009 results (22 percent).

### **Arizona**

As a result of feedback obtained through provider and network monitoring, we initiated changes to our Arizona UnitedHealthcare Community Plan's Developmentally Disabled (DD) program therapy prioritization process. In 2010, our DD Program Coordinator identified a problem with therapy services referrals for DD members. Specifically, prior authorizations (PA) requests for habilitative PT, OT, speech and feeding therapies services were inappropriately being sent to us. These services are covered services, but researching and correcting the prior authorizations was very labor intensive. Calls were made to the parent or physician to confirm whether habilitative or rehabilitative services were required and to get the correct prior authorization issued. We determined the root cause was that providers did not understand the rule regarding which organization is responsible for providing and reimbursing habilitative versus rehabilitative services.

Our Arizona DD Program Coordinator created a DD Therapy Prioritization process for therapy services for DD children with special needs. For example, during a physician visit, the Parent of the child with special needs request a prescription for therapy that should go to the DD Support Coordinator or the physician identifies the member is in need of therapy. However, the prescription never reached the DD Support Coordinator and was sent to our PA department for processing. As a result of the change in process, all DD Therapy PA requests are now routed to DD Program Coordinator who contacts the DD State Support Coordinator to determine if the therapy request is current or if the DD member is on the DD Wait List and confirms that the DD Support Coordinator is aware of the PA request. Misrouted PA therapy request are immediately re-routed to the DD State Coordinator. This level of coordination between our plan and the State DD office has significantly reduced the number of misrouted PA requests and allows members to gain access to care more efficiently.

**J.6     *Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts. (All GSAs)***

Please see Attachment J.7 for our HEDIS results, in Excel format, for all or the measures specified below.

- *If you do not have results for a particular measure or year, provide the results that you do have.*
- *If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.*
- *If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).*
- *If you do not have HEDIS results for five states, provide the results that you do have.*
- *In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries.*

All requested information is provided in Attachment J.7.

***Provide results for the following HEDIS measures:***

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Comprehensive Diabetes Care- HgbA1C component*
- *Chlamydia Screening in Women*
- *Well-Child Visits in the 3,4,5,6 years of life*
- *Adolescent well-Care.*
- *Ambulatory Care - ER utilization*
- *Childhood Immunization status*
- *Breast Cancer Screening*
- *Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents*

The HEDIS document we have attached includes all Medicaid product lines for all states where we operate a Medicaid program.



## Section K: Member Materials (Section 11 of RFP)

### ***K.1 Describe proposed content for your member educational materials) and attach examples used with Medicaid or CHIP populations in other states. (All GSAs)***

Our Member communication materials will be developed to help ensure a seamless transition for Members who are entering Louisiana's CCN program from fee-for-service Medicaid. These materials include the UnitedHealthcare Community Plan member handbook, provider directory and other elements of the welcome kit, supplemented with health-related educational brochures developed by national organizations. Before using these educational materials, UnitedHealthcare Community Plan reviews the materials to ensure (1) services are covered by Louisiana, (2) the information is accurate and (3) the information is culturally sensitive.

Our member communications have been developed through years of experience producing and evaluating our member materials. Our member communications are regularly monitored for effectiveness. Cross-functional internal review takes place in Quality Management meetings. Feedback from the DHH and our members in Louisiana also will be evaluated in order to improve member materials especially so they resonate with the members in our Louisiana program.

UnitedHealthcare Community Plan has a comprehensive member education and outreach approach, which includes the following:

- Comprehensive Coverage of Topics of Interest to Members
- Written Member Materials
- Outreach Contacts for All Members.

These are described in the following sections.

#### Comprehensive Coverage of Topics of Interest to Members

Our educational materials and activities will include:

- Prenatal care
- Immunizations and preventive services
- AIDS and HIV
- Accessing network health services
- Leading causes of hospitalization
- Appropriate emergency room use
- Compliant, grievance and appeals processes
- Asthma and diabetes self-care
- Lifestyle choices and ways to promote good health
- Family planning
- Disease management services.

#### Written Member Materials

A core element of our member education effort is our cadre of written materials, many of which are designed to help members access care within a complex delivery system. These materials include the UnitedHealthcare Community Plan member handbook and other elements of the welcome kit, along with brochures on the following topics:


- |                       |                     |
|-----------------------|---------------------|
| ■ Adult Checkups      | ■ Diabetes Care     |
| ■ Child Immunizations | ■ Domestic Violence |

- Flu
- Lead Screening
- Nutrition
- Pregnancy/Newborns
- Special Needs Provider rights and responsibilities
- Asthma
- Cholesterol
- Dental Care
- Family Planning
- Heart and Blood Pressure
- Mammogram
- Pap Smears
- Smoking Cessation Services for people with visual impairments
- Annual birthday wish.

We are sensitive to the importance of ensuring that members have access to program information that they can easily understand. 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. Also, our materials are reviewed by focus groups to test their effectiveness. Written member materials are created in a minimum 12-point font (except ID cards), in an easily readable style.


UnitedHealthcare Community Plan is sensitive to the needs of people with disabilities and special health care needs as well as those who are socio-economically disadvantaged. As such written material will comply with the DHH “Person First” policy. Upon request, UnitedHealthcare Community Plan makes alternative formats available for members who have visual, hearing, speech, physical or developmental. We make translations into large print, Braille and voice recorded CD formats, upon request.


Before printing, materials requiring approval are submitted to the Board for review. Member materials are supplemented with health-related educational brochures developed by national organizations recognized by the Board. Before using these educational materials, UnitedHealthcare Community Health Plan reviews the materials to ensure (1) services are covered by the program, (2) the information is accurate and (3) the information is culturally sensitive.



<Address 1>  
<City>, LA <55555>

6/11






## Happy Birthday!

Things to do on your birthday...

**Make a wish.  
Blow out your candles.  
Celebrate.**

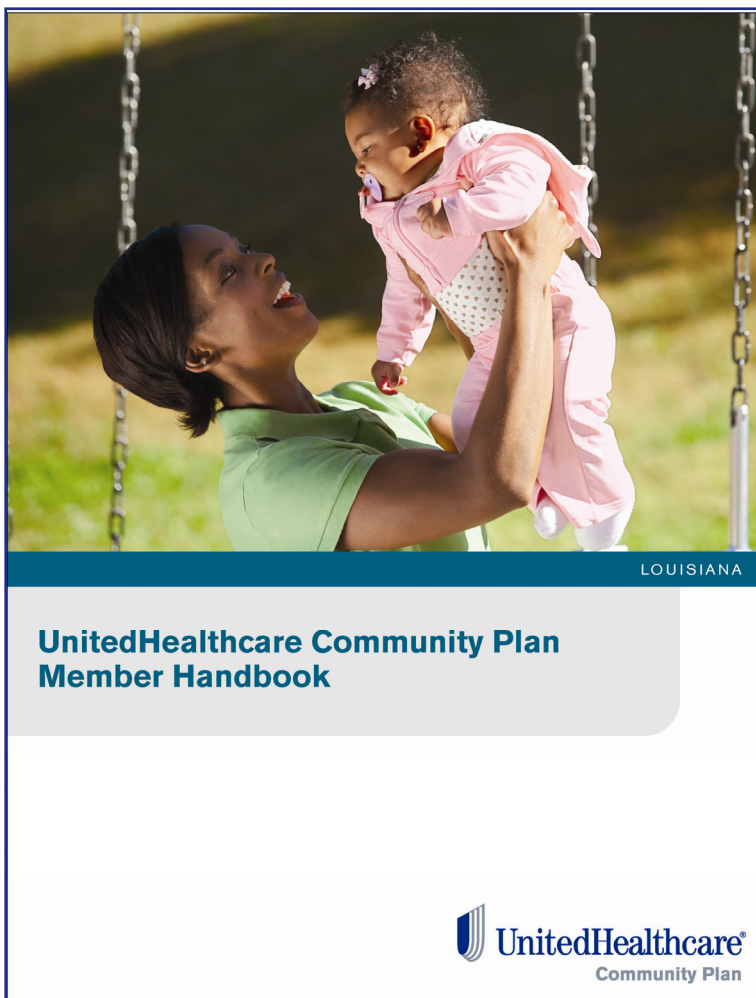


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## Member Handbook

UnitedHealthcare Community Plan's member handbook explains how to navigate our health plan and access the care Members need to remain healthy or treat a medical condition. Our member handbook adheres to the requirements in 42 CFR Section 438.10(f). We distribute the handbook to members within 10 business days of receiving member enrollment information and distribute revised handbooks when changes occur or upon request. Our member website prominently displays a link to our member handbook. UnitedHealthcare Community Plan's procedural information follows the current National Committee for Quality Assurance (NCQA) requirements. The member handbook will cover all of the sections required in the CCN including:

- Table of contents
- Managed care plan overview
- Covered benefits, amount duration and scope of coverage
- A complete description of covered services, including information about EPSDT services, health education and promotion programs, chronic care management, out of network family planning and behavioral health services
- Access to services, including PCP selection process, role of PCP as coordinator of services, appropriate utilization, how to make, change and cancel appointments, self-referral and referral requirements for non-participating providers, including prior authorization requirements
- How and where to access covered Medicaid services not covered under UnitedHealthcare Community Plan's benefit package (e.g. certain pharmacy cost sharing)
- Emergency, urgent, and after hours medical care access and utilization, including post stabilization care services and how to obtain emergency and non-emergency transportation
- Member Services description and contact information, including toll free number, TDD, fax, e-mail and mailing address
- NurseLine nurse triage toll-free hotline
- Complaint, grievance, appeal and fair hearing procedures
- Member's rights and responsibilities, including right to change providers, disenroll from UnitedHealthcare Community Plan, right to refuse treatment, right to a second opinion, all members rights and protections as specified in 42CFR Sections 438.100 and in the CCN program, responsibility to protect and not misuse ID cards, responsibility to report changes affecting Medicaid eligibility to DHH and responsibility for appropriate utilization of services
- How to access interpretation services



- Preventive health guidelines and preventive care
- Coordination of benefits and third-party liability, including Worker's Compensation claims and other insurance
- Advance directives
- How to use UnitedHealthcare Community Plan's Member ID card and DHH issued Medicaid card
- How to request information, including corporate operations and structure, PIPs, utilization review policies, and reporting marketing violations
- Enhanced benefits
- Date of last revision

### **Outreach Contacts for All Members**

UnitedHealthcare conducts at least six outreach contacts per year for all members under 21 years old and their parents/guardians and will conduct at least one additional contact per quarter to encourage them to make and keep screening appointments. The additional contact per quarter goes beyond minimum requirements for contacting members who are overdue for screening. The materials used for quarterly contacts may include calendar stickers, bookmarks and postcards. These materials are available online and, upon request, in alternative formats such as audiotape, large print and Spanish. When mail is undeliverable, we attempt to contact the member via automated phone messaging (see TeleVox, below), mail to the new address obtained from the post office or our UnitedHealthcare Community Plan staff go to the member's address. We document these attempts in our UTD. Welcome calls to all new members contain a message about UnitedHealthcare Community Plan services. When members call the Customer Service line, our hold message contains program information, with a prompt allowing members needing services to transfer directly to our Disease Management and UnitedHealthcare Community Plan staff. We mail each member an annual birthday screening reminder that offers transportation and scheduling help and tells the member how to contact us for help. The member website will contain content tailored to subpopulations such as African American, Asian and Latino members, and will allow members to log on and identify upcoming and missed services.

### **Provider Directory**

UnitedHealthcare Community Plan members will receive a provider directory in their New Member welcome kit that lists names, locations and telephone numbers of PCPs, specialists, hospitals and other providers. The directory also includes information on providers who are not currently accepting new patients and information on restrictions that could impact the enrollee's freedom of choice among network providers.

Provider directories are also available on our website. The directories are updated weekly and are searchable by provider name, location or specialty. Members can also call Member Services to request a copy. If our provider network changes, we will update and reprint directories and mail them to all members within the first quarter of each year.

Examples of our member materials from other states are included as Attachment K.1.

***K.2 Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6th) grade reading level requirement. (All GSAs)***

We ensure that all information is presented at a sixth-grade reading level using the Flesch-Kincaid Grade Level tool.

UnitedHealthcare Community Plan will produce written marketing and member education materials in English, Spanish and Vietnamese, including but not limited to member ID cards, clinical materials, member handbook and provider directory. Also, UnitedHealthcare Community Plan will translate written

marketing and member education materials including the member handbook when 200 or more members speak a common language within the GSA. Upon notice from DHH that the 200 member threshold has been reached, we will translate and make available these materials within 90 calendar days. We use a translation vendor, TransPerfect, for translation of materials. TransPerfect is a leader in global language and business services. It has EN 15038 certification and provides certificates of authenticity upon completion of each translation.

**K.3** *Describe your process for producing Member ID cards and information that will accompany the card. Include a layout of the card front and back. Explain how you will ensure that a Member receives a new Member ID Card whenever there has been a change in any of the information appearing on the Member ID Card. (All GSAs)*

## Member Identification Cards

UnitedHealthcare Community Plan commits to providing members with Member Identification (ID) cards within 10 days of receipt of enrollment data from DHH. Our streamlined process for the production and distribution of Member ID cards provides us with the opportunity to serve members in an expeditious manner and decrease interruption of service for members who are at high risk.

UnitedHealthcare Community Plan's core transaction system is COSMOS, a Windows-based managed care information system that provides eligibility, enrollment, claims processing and reporting capabilities to fulfill the Plan's information system requirements.


Upon receipt of the monthly enrollment report from the DHH, UnitedHealthcare Community Plan enrollment coordinators transfer member and provider data into COSMOS. Enrollment coordinators perform a quality check to verify members' selection of a Primary Care Provider (PCP). Members who have not indicated a medical home are assigned a PCP.

Enrollment coordinators transmit information to a Member ID file nightly so any changes in a member's information contained on the ID card are accurately reflected. The system automatically generates a new ID card when any change in a member's information affects the ID card. The data is encrypted and securely transmitted to the vendor. Because we use a vendor to produce ID cards, they are sent to members separately from the welcome packet. On days three and six following receipt of the 834 files from DHH, the vendor will produce and mail the ID card to the member via first class or priority mail. Members are instructed how to use the card. Member ID cards will closely mirror the ID cards UnitedHealthcare Community Plan issues to its commercial clients and will include:

- Member name and member identification number
- Members Date of Birth
- UnitedHealthcare Community Health Plan Address
- PCP's name, address and telephone number
- Name of the Benefit Plan
- Toll-free nurse triage telephone number and that the service is available 24 hours a day, 7 days a week
- Telephone number for Member services (if different)
- Telephone number for providers to verify eligibility
- Instructions on what to do in an emergency
- Toll free numbers for 24-hour Member Services, Provider Services and Prior Authorization and Reporting Medicaid Fraud (1.800.488.2917)

The following graphic represents a sample of our ID card and will be modified as needed to meet the requirements of the CCN:



 <b>UnitedHealthcare®</b>   Community Plan Health Plan (80840) 999-99999-99 <b>Member ID:</b> 999999999 <b>Member:</b> Subscriber Brown  <b>PCP Name:</b> Dr. Provider Brown <b>PCP Phone:</b> (999)999-9999 123 Main St. Anytown, US 12345  <b>DOB:</b> 99/99/9999  0501	In an emergency go to nearest emergency room or call 911. <small>Printed: 02/28/11</small>  This card does not guarantee coverage.  <b>For Members:</b> 999-999-9999 TTY 711 <b>Nurseline:</b> 999-999-9999 TTY 711  <b>For Providers:</b> www.uhccommunityplan.com 800-600-9007 <b>Medical Claims:</b> PO Box 8207, Kingston, NY, 12402 <b>Report fraud and abuse:</b> 999-999-9999
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**K.4** *Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated. (All GSAs)*

## Provider Directory Accuracy and Monitoring Activities

Our COSMOS claims payment system contains a unique provider record for each network provider. All provider data stored within our claims adjudication system is maintained centrally in an application called the National (Provider) Database (NDB). NDB is the source of truth for all of UnitedHealthcare Community Plan's provider data and is subject to rigorous audit and controls to ensure that the data presented for loading is accurately input into our systems. The provider data loading staff, National Database Management or NDM, employs independent auditing staff to review all records entered into NDB and reports their quality statistics on a monthly basis reflecting volumes, turnaround time, and defects per million opportunities.

Once the provider data is loaded into our source system, NDB, a fully integrated data interface, inputs the adds, changes and deletes into the COSMOS claims adjudication platform. This provider data feed is executed on a nightly basis and has passed rigorous testing to ensure accuracy of the provider loads. Upon entering the data into the source adjudication system, the Provider Directory extracts are created that provide the content for our online and paper provider directories. UnitedHealthcare Community Plan's online Provider Directory application is called Find a Doc and provides the capability for members and providers to access our network in real time via our website. The data within the Find a Doc application is updated in a real time basis and truly reflects the current provider network at that point of member or provider search. The application has the flexibility to display practitioners, provider groups and facilities in an easy and concise manner to alleviate complications for our member populations.

UnitedHealthcare Community Plan's paper Provider Directory process is currently executed using state of the art on demand printing and composition services through an outside vendor Standard Register. The process is built upon two secure external extracts— one order file containing member data and the other containing the provider network. The member extracts are generated each weekday as a byproduct of our 834 processing for new members as well as replacement orders being requested via our member services team. This external extract functions to tie the member to the appropriate directory to be generated and mailed in an on demand fulfillment process. This on demand capability allows for constant update of our directories to ensure that members are receiving accurate and timely provider data when a Provider Directory is mailed. More so, this allows our health plans to order directories per member need and not in bulk once or twice per year.

## Updating the Provider Directory

UnitedHealthcare Community Plan processes and sends a provider data extract weekly to our composition vendor Standard Register. Upon receipt of this data, each Friday Standard Register will compose a new directory using current and updated provider data by the Tuesday of the following week. Coupling this service with our daily member files allows any orders coming into Standard Register for print and fulfillment to utilize the most current Provider Directory version. These directories contain an indication to the membership that the content is current as of the date of last composition which is most likely less than one to two weeks old depending on timing. Overall, this process allows UnitedHealthcare Community Plan to update our provider directories weekly to ensure that we capture new providers to the network, changes in their demographic information, and those providers that no longer participate with the health plan.

On a quarterly basis each health plan will receive a revised copy of the Provider Directory for review and re-approval of the content, to include the provider data. In these quarterly review sessions our network support teams review the provider data for accuracy in the printed version and request the necessary updates of our provider data to ensure that accurate provider data is represented.

### ***K.5 Describe how you will fulfill Internet presence and Web site requirements, including:***

- ***Your procedures for up-dating information on the Web site; (All GSAs)***
- ***Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and***
- ***The procedures, tools and reports you will use to track all interactions and transactions conducted via the Web site activity including the timeliness of response and resolution of said interaction/transaction.***

The UnitedHealthcare Community Plan website is designed to inform potential members, current members and providers and features comprehensive content describing our programs, as well as provider and formulary look-up features. The URL is: <http://www.UHCCommunityPlan.com>. As a reflection of the dynamic nature of our state programs, UnitedHealthcare Community Plan web properties will always be changing. We want our web properties to play a prominent role in building the communities that are so vital to our business.

A content management system is built into the site that allows for quick updates to existing approved content. Our content manager collaborates with our marketing liaison and CCN subject matter experts to implement updates on the site to ensure the following are met:

- State and CMS marketing guidelines
- State and CMS enrollment guidelines
- State regulatory requirements
- Program accuracy and consistency

Adequate timeframes for state and federal approvals are built into the website design process.

## Member Website



Our member website contains orientation and educational materials, including information on member rights and responsibilities and provides a prominently displayed toll free customer service number, including a TDD number. We will also include contact information for the Louisiana enrollment broker, including a link to their website as well as contact information about Medicaid eligibility, including their toll free number and website link.

We include the following member materials on our Website:

- Member handbook in English and Spanish (for the CCN, we will add Vietnamese)
- Member Rights & Responsibilities (Included in member handbook)
- Health Information, including disease management and preventive services
- Drug Formulary
- Notice of Privacy Practices
- Provider Directory.

The Provider Directory offers search capabilities by provider address, county, ZIP code, provider name, provider gender and languages spoken. The directory will allow the member to view whether the provider is currently accepting new patients and the provider's facility or network affiliations. A user-friendly map is also provided. Members will also have the option to search providers by facility and group practice affiliations.

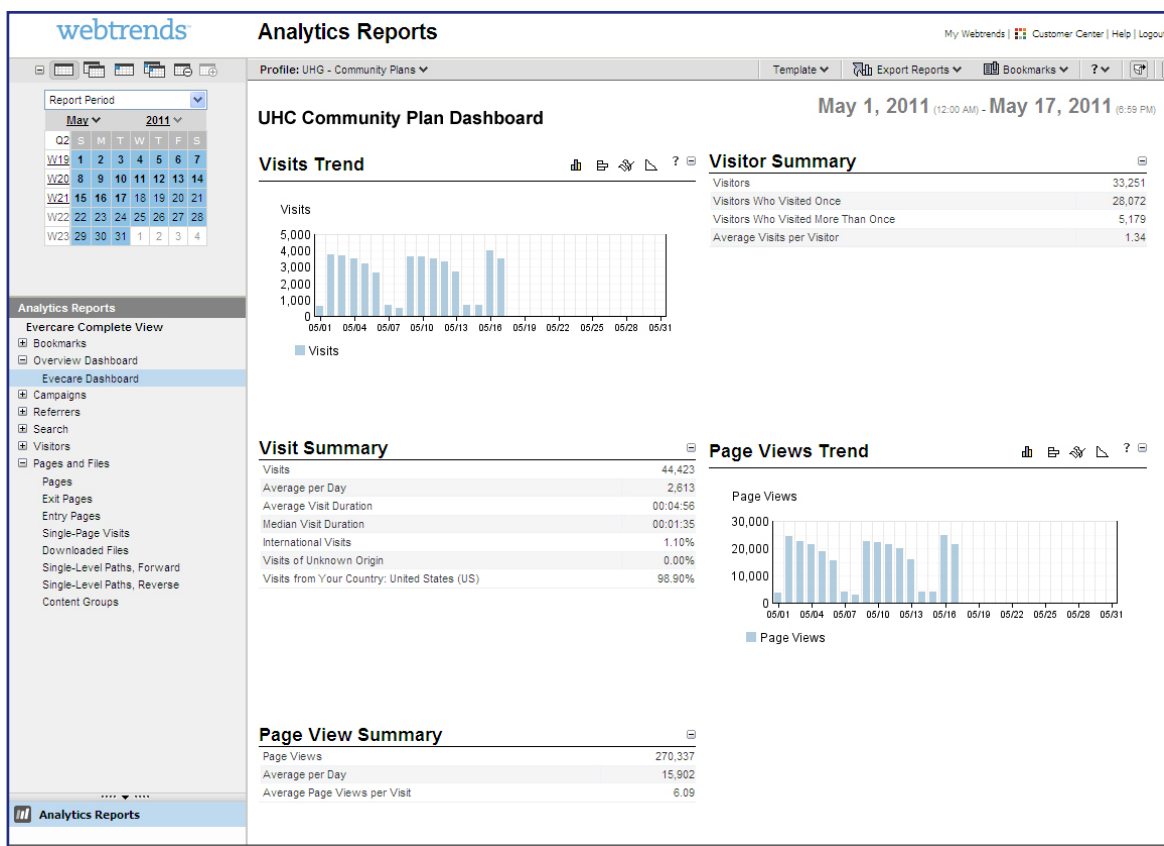
### Monitoring email Inquiries

UnitedHealthcare Community Plan has a general e-mail box that members can use to submit questions to us for customer care related inquiries. Members, providers and visitors to our website can send us e-mails by clicking on "Contact Us". The e-mail account is checked daily and responses are provided within a certain time frame depending on the situation, in some cases if an outreach call is needed versus responding by e-mail that will be completed as well. If the issue is out of scope for Customer Care, the

issue will be forwarded to certain contacts that the call center has been provided to handle the matter at hand. The Supervisor of our CRG (Customer Response Group) has oversight of the email account to help ensure timely response and handling of all issues received.

## Tracking Website Activity

UnitedHealthcare Community Plan uses Webtrends analytics to track all interactions and transactions conducted on our website. WebTrends is a highly sophisticated web analytics tool, and is one of the gold standards in the industry. By monitoring how all users — as well as specific clusters — navigate through our site, we can assess the importance and relevancy of the information and services our members need. The information we get from Webtrends enables us to analyze behavior patterns exhibited by various users and drives our overall website management strategy. We have real time access to website activity using this analytics tool and can track virtually all activity for any bit of information on our website. We can track direct traffic to any area of our site, the referring site, the number of times a specific document was downloaded and the number of hits by language spoken.



Examples of how we use Webtrends include the following:

- Using Webtrends usability testing and heat maps, we learned that the most important information for our members is whether their doctor is in our network; whether their drug is in our formulary and whether UnitedHealthcare Community Plan serves their area. Based on this information, we redesigned the architecture of our website to display those options more prominently.
- Our affiliate, Evercare, launched a re-designed hospice site. Comparing a snap shot of seven days, the new stand alone hospice site generated almost 7 times more traffic that the old hospice site.
- We know how many provider directories and summary of benefits are downloaded, both in English and Spanish, and the number of calls generated to our call center.

- We can measure the effectiveness of a targeted marketing campaign by analyzing the number of hits on specific areas of our website that pertain to the targeted market.

Our ability to perform usability testing and track the number of hits and where visitors go on our website, enable us to make changes that enhance our website and make it more user friendly. These website optimization activities offer our members, prospective members, providers and other interested parties the ability to easily retrieve the information they seek and provide the tools to assist them in making informed choices.



## Section L: Customer Service (Section 11 of RFP)

### ***L.1 Provide a narrative with details regarding your member services line including: (All GSAs)***

- ***Training of customer service staff (both initial and ongoing);***

Our commitment to our Members is exemplified by not only our highly capable Customer Care Call Center operations, but also by our commitment to reach out to all new members through our Welcome Calls. **We initiate these calls during the first month of membership and make multiple attempts at different times and days to make positive contact and educate our members regarding their benefits as well as complete an initial high-level health risk assessment. Our in-bound member services line is described below.**

### **Staff Training**

Dedicated staff in the Customer Care Call Center are thoroughly trained to handle a wide variety of questions. Our hiring strategies include an effort to find employees with understanding for the members, appreciation for their unique needs, passion for service and care for the members we serve. One strategy we have used is to employ individuals who were previous recipients of public assistance themselves, as they bring the ability to establish a particular rapport with our members. Our Member Service Representatives (MSR) are trained to handle a broad range of complex topics, with appreciation for privacy issues and sensitivity to people with disabilities and different cultural backgrounds. We provide MSRs with the knowledge and online resources to handle the majority of member and provider questions and needs.

In addition to in-depth telephone etiquette and systems training, our MSRs receive training on covered benefits, local health and social service resources, provider networks, handling calls in case of an emergency and cultural competency. We will provide training in the geography of all GSAs in which we hold a contract. Our MSRs currently use mapping search engines within COSMOS to locate and recommend providers who are within time/distance standards or other requested providers for our members.

New employees also are required to complete general compliance training via New Employee Orientation (NEO). This training includes, but is not limited to:

- Employee's individual responsibility for knowledge of and compliance with laws, regulations and policies
- Reporting violations or questionable conduct
- Fraud and abuse
- Legal consequences of non-compliance.

NEO training includes the Principles of Integrity and Compliance and information on the Compliance HelpLine, a 24-hour toll-free telephone line to report incidents of suspected non-compliance or other misconduct. New employees are required to acknowledge receipt of a copy of the "Principles of Integrity and Compliance" brochure and an agreement to review within 30 days.

Compliance training is required and is a condition of employment. Supervisors are responsible for ensuring that each employee reporting to them completes the applicable compliance training. Employees may obtain a copy of our Principles of Integrity and Compliance from our Website, or by calling the Compliance HelpLine to request a hard copy. Employees must complete our online Integrity and Compliance@Work training programs upon hire and at least annually thereafter. Completion of the training programs is documented and records are maintained by our human resources team.

MSRs have access to online tools, policies and procedures. These resources are written as step-by-step

processes to be easily understood and to provide consistent information.

New MSRs receive two phases of Customer Carr training during the first 14 weeks of employment. This training is designed to progressively move the individual from learning the basics of the CCN program and our health plan operations, to simulated interactions with members and testing, to ultimately interacting directly with members under direct supervision. Each topic is addressed through a variety of training vehicles, including reading, lecture, role-playing/simulations, and question-and-answer opportunities, with intermittent reviews to ensure that information are being retained. Once MSRs pass written evaluations, they are placed on the phone with supervisory monitoring to identify areas of retraining.

MSR training topics we cover by phase are shown in the following table:

<i>Customer Care Training Topics</i>	
<i>Phase I Training Topics</i>	<i>Phase II Training Topics</i>
<ul style="list-style-type: none"> <li>■ Our Customer Care philosophy and approach</li> <li>■ Introduction to the CCN Plan</li> <li>■ The role of the MSR as the member's first point of contact with the plan</li> <li>■ Integrity and compliance</li> <li>■ Plan structure, including medical management functions, claims functions, member service, and provider services</li> <li>■ Basic member service skills, including active listening, questioning, responses to look for and "flags" indicating the member may not understand materials</li> <li>■ Cultural Sensitivity</li> <li>■ Systems introduction (IT, telephone, and contact tracking system)</li> <li>■ Health plan and benefit explanation, including categories of eligibility</li> <li>■ Introduction to member materials, including their content, intent, and distribution</li> <li>■ Plan and the CCN's websites (accessing information and instructing members on their use)</li> </ul>	<ul style="list-style-type: none"> <li>■ Phase I review</li> <li>■ Introduction to other entities participating in the programs</li> <li>■ Member service process, policy, and procedure</li> <li>■ Frequently asked questions by members</li> <li>■ Recognizing issues that should be escalated or transferred to another department</li> <li>■ Appropriate documentation of calls via tracking systems, including complaints</li> <li>■ Using available tools, including on-line manuals, workflow diagrams, reference materials, mapping search engines and job aids</li> <li>■ Using the Language Line reference guide for involving interpreters when working with members with limited English proficiency</li> <li>■ Ongoing performance improvement efforts</li> <li>■ Claims system Introduction</li> </ul>

MSRs attend monthly team and department meetings to review new program developments and areas that have been identified through audits for group retraining. In addition, all MSRs receive annual retraining on mandatory topics such as cultural competency, privacy and integrity and compliance.

- ***Process for routing calls to appropriate persons, including escalation; The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);***

## Routing Calls

UnitedHealthcare MSRs will provide the following information and services to members:

- Assistance with the selection or change of a primary care provider in real time
- Member education on immunizations, preventive services, and the appropriate use of the emergency room

- Education on how to obtain services, including prior authorizations, referrals to participating specialists and assistance with scheduling appointments
- Information on UnitedHealthcare Community Plan's policies and procedures and covered services
- Explanation of the grievance and appeals process
- Documentation and resolution of member complaints and grievances
- Referral of members to care management as appropriate.

The Customer Care department is staffed by 55 trained professionals who are available to assist members and their families. All representatives receive training on program requirements including immunizations, preventive health services and the appropriate use of the emergency room.

UnitedHealthcare uses our Intelligent Desktop (IDT) application to record and track member inquiries. IDT interfaces with COSMOS, our claims processing platform, to check eligibility and claims information for addressing member inquiries and complaints. The IDT application has the following features and benefits:

- ***"User Friendly" Access for Member History:*** IDT streamlines the COSMOS claims and enrollment information from the Unisys mainframe by using screens that are user friendly and configured to match the MSR's workflows and information needs.
- ***Faster Call Response to Member Needs:*** Automates tracking of member inquiry information to lower telephone call processing time and eliminates rework. IDT documents the type of inquiries coming into a plan and their resolutions drive process improvement initiatives.
- ***Increases Ability to Assist More Members, More Quickly:*** Automates several repetitious forms increasing call representatives efficiency and productivity.
- ***Quick Access to Member Claims and Eligibility Information:*** Provides full COSMOS functionality with the added or improved capability of data aggregation, data lookup, and in some cases, data modification.
- ***Complete Documentation of Member Concerns:*** Ensures complete documentation and typing of complaint and grievances. The member history screen allows representatives to understand the entire situation of a member to expedite resolution of their issues or questions,

We have new features for our digitally recorded telephonic services including Text Search capability to identify emerging member call trends leading to improved first call resolution. Our enhanced system capability will allow all incoming member calls to trigger reminders for preventive and significant pending care services.

Sometimes a call cannot be handled by a MSR due to a member's request to speak to a supervisor, an immediate health care need, an unresolved issue resulting in repeat calls, urgency of an issue such as a member being sent to collections or the member is threatening legal action. If the MSR cannot service the member after repeated attempts, MSRs are instructed to follow an escalation procedure. The MSR will transfers calls to subject matter experts or their supervisors if they are not available. MSRs are instructed never to advise a member that a supervisor is not available. If a subject matter expert or their supervisor is not available, MSRs pursue senior managers or directors to handle the call.

- ***Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;***

## Members with Limited English Proficiency or Hearing Impaired

To communicate with and meet the needs of our non-English speaking members, our Customer Care staff includes bilingual representatives. In the event that no representative is fluent in a member's language, our Customer Care department has immediate access to interpreter services for 20 languages in 140

dialects through the AT&T language line (which is available via conference call). Customer Care can also be accessed through our TTY/TDD line which is available for hearing impaired members.

- ***Monitoring process for ensuring the quality and accuracy of information provided to members;***

## Monitoring for Quality and Accuracy

Qfiniti™ is the system UnitedHealthcare Community Plan uses to conduct daily call center monitoring activities. These activities include performing evaluations, playing recordings, performing record on demand (instant recording) and live monitoring. Supervisors access the Qfiniti™ system to review their team's quality evaluation details and scores. Recordings of calls are done 10 times per week for each MSR.

The evaluation includes the following components:

- ***Phone Technique:*** Using a professional greeting, applying hold courtesy skills, applying call control skills, following redirection procedures and using a professional closing at call end
- ***Building Trust:*** Identifying member's inquiry or problem, demonstrating full attention to member, delivering response with confidence, communicating clearly, and connecting with the member
- ***Accuracy and Completeness:*** Providing accurate and complete information to the member
- ***First Call Resolution:*** Assuring that call documentation matches the call content, routing/closing documentation correctly, making outbound call if necessary to resolve issue and sending out requested information
- ***Education:*** Leveraging member retention opportunities
- ***Policy Adherence:*** Verifying member identification, following HIPAA guidelines and internal policies, using internal terminology and proactively providing timeframes and phone number.

During the training period, newly hired MSRs are audited on five calls per day until he or she reaches an accuracy level of 98 percent over five consecutive audits. Once a MSR has completed the training period, he or she is audited on five random calls per month on the calls recorded in the Qfiniti™ system. Supervisors schedule monthly, hour long, coaching sessions to review quality results. The supervisors' business managers review 20 monitoring calls per week for each team. Monthly meetings are held with interdisciplinary health plan operations (member services, provider services and bilingual) to ensure that MSRs are handling calls appropriately.

- ***Monitoring process for ensuring adherence to performance standards;***

## Monitoring Process for Adherence to Performance Standards

UnitedHealthcare Community Plan is committed to being responsive to our members. We have implemented a call management program in order to monitor our Customer Care department response rate on a regular basis. We monitor the average speed of answer, the abandonment rate, hold time and average talk time of each incoming call. We are able to generate specialized reports to identify peak call times, average calls day/week/month, hours of use per day, assess the busiest times and days by number of calls and quantify representative productivity. Our performance standards vary depending on the state's requirements. In Louisiana, UnitedHealthcare Community Plan will use the performance standards as stated in the CCN-S RFP, that is 90 percent within 30 seconds or an automatic call pickup system, 1 percent busy signal, hold time of 3 minutes or less and abandon rate no more than 5 percent.

We are committed to meeting performance standards and consistently met or exceeded the performance requirements in 2009 for our program in Florida Healthy Kids program as shown below.

Performance Measure	Standard	FHK Results (2009 Average)
Abandonment Rate	< 5%	< 2.5%
Average Speed of Answer	30 seconds	23 seconds

- ***How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and***

## Interaction with Other Customer Service Lines

MSRs have reference materials that include a list of state services and community resources, such as Partner's for Healthy Babies, WIC, housing assistance and homeless shelters. The MSRs have the ability to transfer calls directly to external phone numbers.

- ***After hours procedures.***

UnitedHealthcare Community Plan's toll-free call center 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 information after our regular hours of operation

Our members have toll free access to our 24 hour NurseLine. The toll free number is prominently displayed on member ID cards, member handbook and other member education materials. Services available through the NurseLine include help for emergencies and information for all types of health and medical questions. Interpreter services and access to the National Relay Center are available to our nurses to assist with communication with our members who have limited English proficiency or who are hearing impaired.

***L.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate, if applicable. (All GSAs)***

Member hotline telephone reports are included as Attachment L.2.

***L.3 Describe the procedures a Member Services representative will follow to respond to the following situations: (All GSAs)***

- ***A member has received a bill for payment of covered services from a network provider or out-of-network provider;***

When a call is received from a member stating that they are being billed inappropriately, the MSR verifies the member's eligibility and date of service. If the date of service is less than 30 days, the MSR advises the member to contact the provider or to call back after 30 days from the date of service. If the MSR is appropriately trained to review a call, he or she launches the Claim Wizard in our Intelligent Desktop (IDT) application and locates the claim in question. If the MSR cannot handle claims review, the call is routed to the Customer Response Group (CRG).

If the claim is on file, and the member agrees with the billing, the call is documented in IDT and the MSR offers to resolve any additional questions and the call is ended. If the member does not agree with the billing, the call is routed to CRG.

For calls that are routed to CRG, the MSR advises the member that the provider will be contacted to resolve the issue. MSRs use suggested scripting such as: "A resolution specialist will contact the provider to resolve the issue. The resolution specialist will follow up with you when the issue has been resolved"



with the provider.” An offer is made to resolve any additional member questions and the call is documented in the IDT.

- ***A member is unable to reach her PCP after normal business hours;***

After informing the member of the opportunity to seek emergency services if needed, the MSR would discuss the circumstances prompting the call to our member service line and determine if the requirements of medical home availability 24/7 is not being met, if this is the case the MSR notes this as a Quality of Service Issue. The MSR documents the member’s attempt to contact her PCP, PCP name, and date of incident and refers the member to the CRG. The MSR advises the member that she can switch PCPs if she is dissatisfied with her care and also advises the member that the Nurseline is available toll free, 24/7.

- ***A Member is having difficulty scheduling an appointment for preventive care with her PCP; and***

Our Customer Service team will assist the member with making an appointment when the member advises the need for help or expresses frustration with making an appointment. The MSR will determine if the situation rises to the level of a Quality of Service issue. For example, if the member is seeking a preventive appointment with her PCP within an unreasonable timeframe, the issue may not be a Quality of Service issue. The MSR will educate the member on appointment availability standards. However, if an appointment is not available within the CCN’s required appointment availability standards, the MSR will refer the issue to the CRG for handling.

- ***A Member becomes ill while traveling outside of the GSA.***

If a member becomes ill while traveling outside the GSA, the MSR advises the member that the Nurse line is available 24 hours a day for assistance for members with a non life threatening emergency, however all life threatening emergencies will be covered while traveling outside the GSA. The MSR will provide the member with the Nurseline toll free number and will offer to transfer the member directly.

***L.4 Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. (All GSAs)***

Soon, one of every 10 persons living in the U.S. will belong to a “minority culture”. It is projected that by 2050 the current minority groups will comprise 50 percent of our population. We will be serving a much more culturally and linguistically diverse population and we will need to have a culturally proficient workforce to meet the challenges of these demographics.

In recognition of the unique and diverse needs of our member population, we work to identify and remediate disparities in our members’ care and outcomes. We strive to have our contacts with our members be sensitive, not only to their health care needs, but also to their cultures, races, ethnic backgrounds religions and disabilities. We provide interpreter services for our members who have limited English proficiency and use the National Relay Center for our members who are hearing impaired.

We are dedicated to continuously refining and updating our health care equity promotion strategy to improve member access to culturally sensitive Member Service Representatives, educational materials and medical care.

## Community Integration

UnitedHealthcare Community Plan builds, retains, and supports its membership by penetrating a core ethnic market within a specific area and establishes a presence there in order to better serve our members with diverse backgrounds.

We identify marketing representatives who speak the language, and are familiar with the area, to work in and engage the entire community from PCPs, faith-based organizations, community leaders and local politicians. We build out from our core zone until we are deeply rooted into a given target ethnic population.

To fully engage an entire community, UnitedHealthcare Community Plan opens store fronts to serve as “local hubs” in the community. These offices have a warm, friendly feel and are customer-service focused. Our members will often visit our storefront to ask questions, obtain information and drop off recertification materials. We staff these storefronts with not only sales and enrollment staff but also customer service staff who are trained to answer members’ questions. These offices ensure cultural sensitivity, increase our visibility in the specific markets, and provide a way for us to effectively communicate with our members from diverse backgrounds and cultures.

For example, in New York City we have a diverse membership with representation from many cultures, ethnic backgrounds and religions. To address these members’ needs, we established a storefront in Chinatown in Manhattan. This office offers in-language support and health care assistance by employees who speak many different dialects of Chinese and Korean. Also, we established an office in Coney Island, Brooklyn which primarily serves the Russian and Arabic community members. We offer in-language materials as well as in-language and in-person assistance and conduct a variety of educational events including:

- Pre-natal care for expectant mothers
- Role of the PCP and the importance of preventive care and childhood immunizations
- Healthy eating through our Food for Thought programs.

UnitedHealthcare Community Plan will replicate our community integration approach in Louisiana. We have found that this approach works well for us in other markets and offers quality service to our members from a variety of racial, religious and ethnic backgrounds. UnitedHealth Care Community Plan’s Vice President of Community Development, Charlisa Watson, has been working the last several months in Louisiana making contacts in the Latino, Hispanic, African American and Vietnamese communities, and with faith based organizations, in order to set the stage for our community integration efforts.

### **Cultural Competency Training**

UnitedHealthcare Community Plan, is committed to creating an environment in which attitudes, skills, behaviors and policies enable us to function effectively in cross-cultural situations. To assist our MSRs in meeting the needs of our members from diverse backgrounds, we provide an in-depth training module called, ***“Cultural Considerations: A Primer on Cultural Sensitivity.”***



Our training module is based on the recommended national standards developed by the Office of Minority Health’s Center for Linguistic and Cultural Competency in Health Care (CLCCHC).

### **Training Module Objectives**

- Define the meaning of Cultural and Linguistically Appropriate Services (CLAS).

- Identify the unique health-related beliefs of various cultures.
- Identify health care disparities among various cultures.
- How to interact with people of various cultures in a health care environment.

Our goal is to increase cultural awareness and sensitivity, leading to changes in clinical and administrative staff behavior and improved member-staff interactions. We strive to improve services and care so that positive health outcomes are realized.

### Cultural Variations

In our training module we provide information basic background facts, health and disease statistics, and general beliefs, especially those that may affect health care and MSR interactions for the following.

- Hispanic
- African-American
- Asian-American
- Middle Easterner
- Former Soviet Bloc
- Southeast Asian (i.e. Vietnamese).

For example, our MSRs learn:

- Hypertension is prevalent among African Americans and African American women are less likely to have a mammogram
- Diabetes is twice as prevalent among Hispanics as among the majority population
- The rates of cervical cancer incidence and mortality for Vietnamese-American women exceed those of any other minority or majority population in this country.
- Religion plays an important part in our members' lives.

Throughout the training, MSRs are coached to be “culturally open”, to cultivate a non-judgmental attitude of respect, interest and inquiry and to avoid stereotyping. Lastly, Member Service Supervisors conduct silent monitoring of calls to ensure the MSRs are following established policies and procedures on timeliness, professionalism, and cultural sensitivity, and that they are respectful in their interactions with members.

***L.5 Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services. (All GSAs)***

## Meeting Needs of Members with Limited English Proficiency

The primary language spoken by all UnitedHealthcare Community Plan members is captured during the enrollment process. Welcome calls are made to each newly enrolled member. During these calls, members are asked about their primary spoken language. The Member Services team has a designated representative that handles translation/interpretation requests. This representative tracks and logs all translation/interpretation calls and provides a report to Member Services management.

A provider's cultural competence, accessibility to the provider's premises and any special communication abilities are an integral part of UnitedHealthcare Community Plan's network development efforts. These requirements are detailed in the provider manual and ongoing communications with network providers. On all communications to members, communication specialists put all required language taglines at the bottom of each document. Another communication specialist and our communication manager review final drafts of all documents for assurance that we are compliant with all requirements. As a final review,

government relations representatives will review the documents to ensure all appropriate language taglines are included, before submitting the documents to the DHH for approval.

For the CCN program, written notices that will be sent to non-English speaking members will include a tag line in English, Spanish, and Vietnamese. Members will be directed to call the member call center to request assistance or materials in another language. The call center can provide assistance through foreign language speaking representatives or through the AT&T Language Line. We describe other UnitedHealthcare Community Plan services on behalf of non-English speaking members, including discerning provider site language capabilities, translation support and cultural competence.

### **Interpreter Services**

One of UnitedHealthcare Community Plan's fundamental objectives is to ensure our members and providers are able to overcome any language barriers that exist, so that basic health-related communication can occur. We achieve this objective by:

- ***Tracking provider language capabilities:*** We maintain data on our providers' language capabilities within our provider database.
- ***Maintaining electronic records of our members' primary language:*** This promotes effective communication with providers, call center staff, case managers and other outreach staff.
- ***Interpretation support:*** We provide interpreter support for members in any situation where the member and provider need support to communicate effectively. We offer 24/7 language line services, to members and providers via our Customer Care Call Center.
- ***Building partnerships with community agencies that provide interpretive services:*** The services that they provide include escorting members to the provider offices to assist with communicating effectively. This strategy worked very effectively with our Asian population in a recent mammogram campaign.

### **Meeting Needs of Members Who are Hearing Impaired**

We subscribe to services for the hearing impaired. These services address the needs of members who are deaf, hard of hearing, late-deafened or speech disabled. Through the National Relay Center, a member's message is relayed by a communication assistant, word-for-word to the hearing person on the other end of the line, in this case a UnitedHealthcare Community Plan MSR. In response, the communication assistant types what the MSR has said back to the member. By law, each conversation is handled with the strictest confidentiality.

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## Section M: Emergency Management Plan (Section 3 of RFP)

**M.1** *Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery: (All GSAs)*

### Continuity of Operations/Emergency Response Plan Overview

It is UnitedHealthcare Community Plan's policy that Business Continuity and Disaster Recovery Plans be developed, tested, and maintained to limit losses caused by disruptions to critical business operations and to enable efficient and effective recovery. The Enterprise Resiliency & Response Program includes processes and controls to protect the business of UnitedHealth Group, including UnitedHealthcare Community Plan; the life and safety of workforce members; and resources of the organization. UnitedHealthcare Community Plan has Business Continuity and Disaster Recovery Plans to ensure ongoing customer and provider services through any type of emergency situation. Over our 25-year history, we have maintained business continuity successfully through unscheduled natural disasters and other incidents.

To support our emergency response continuity of operations plan and to address pandemic preparedness and natural disaster recovery, we maintain policies and procedures based on the following:

- Employee training on preparedness, natural disaster, and recovery
- Identification of essential business functions and key employees to implement them
- Contingency plans for covering essential business functions should key employees be incapacitated or the primary workplace is unavailable
- Communication processes established for staff and suppliers should normal services be unavailable
- Continual monitoring for the potential of network disruption, so, whenever possible, the disruption can be averted or its impact minimized
- Adequate and timely care during periods of temporary network disruption for members, including health care facility closure(s) or loss of major provider(s)
- Post-disruption processes, including payment of claims, are addressed and operational, financial reconciliation, member reconciliation, and claims payment issues are minimized when the network returns to normal
- Testing to ensure plan preparedness.

Our Business Continuity/ Disaster Recovery (BC/DR) plans are in place and available for onsite review.

### Recovery Example: 2011 Spring Tornadoes and Flooding in the Southeast

The spring of 2011 was unusual in terms of the significant tornado activity seen in April, swiftly followed by significant flooding in the Mississippi delta. On April 27, 2011, a series of ~300 strong tornadoes moved from Texas through Kentucky, doing substantial damage to communities in Alabama, Georgia, Mississippi and Tennessee. UnitedHealthcare Community Plan health plan staff was ready. Through the ongoing outreach of health plan staff from member and provider services, health services, special care needs/associated dependencies groups, medical management teams and executive management recognized that effective, strategic communication was key.

For the high impact areas (e.g., Alabama & Mississippi, etc.), we simultaneously confirmed the health and status of our employees in the region, and implemented measures to ensure continuous communication and care continuity for members and providers. We implemented call-trees, and reached out to our high volume providers to identify their expected whereabouts during and after the storm. Systematically, our staff worked through the communication grid, contacting all persons on every level involved with care management.

Throughout the crisis, we worked with our provider network and supported our members to ensure continuity of care. We evaluated PCP network capacity in the geographic area, and communicated reassignments to providers and affected members. Our member outreach teams notified members and, as appropriate, family members to communicate prior authorization; provider transfer, if necessary; and other applicable instructions. We contacted those at-risk members with urgent/emergent and special needs, and arranged for care continuity, while collaborating with local Health Services agencies. We verified adequacy of transportation, access to medication and other key services (e.g., dialysis, etc.). Our case managers worked with providers and local pharmacies to ensure members did not experience any interruption in medication delivery.

Just 10 days after this devastating storm, while Emergency Response efforts were still underway in most states, we mobilized our UnitedHealthcare Community Plan resources once again to address the significant flooding issues in Tennessee, Mississippi and Louisiana. We proactively put measures in place for our members before the Morganza and Bonnet Carre Spillways were opened on May 14, 2011, and continued to monitor the status of our members, customers and providers once the river diversion efforts were underway.

Overall, UnitedHealthcare Community Plan was successful in meeting patient needs and understanding the impact to major physician practices. During and after these storms and flooding, we also maintained our compliance measures with the call center.

- ***Employee training;***

## **Employee Education and Training on Preparedness, Natural Disaster and Recovery**

All new recovery team members of UnitedHealthcare Community Plan are educated on the BCP, what it covers, and staff responsibilities and expectations; senior managers receive BCP training annually. In turn, they educate other established staff members, providing updated instruction and appropriate preparedness training. UnitedHealthcare Community Plan staff is well-trained and highly experienced in “pro-active” disaster recovery responses. UnitedHealthcare Community Plan recovery team members have multiple opportunities for training, to include:

- Business Continuity Emergency Management ULearn course
- Business Continuity Plan Development ULearn course
- Event Management ULearn course
- Business Continuity Emergency/Plan Development Change - Web-Ex Forums
- Structured Plan Walk Through
- Business Continuity Annual Exercise
- Event Management Team Site Lead Orientation.

- ***Identified essential business functions and key employees within your organization necessary to carry them out;***

## **Essential Business Functions and Key Employees within UnitedHealthcare Community Plan Necessary to Execute BCP**

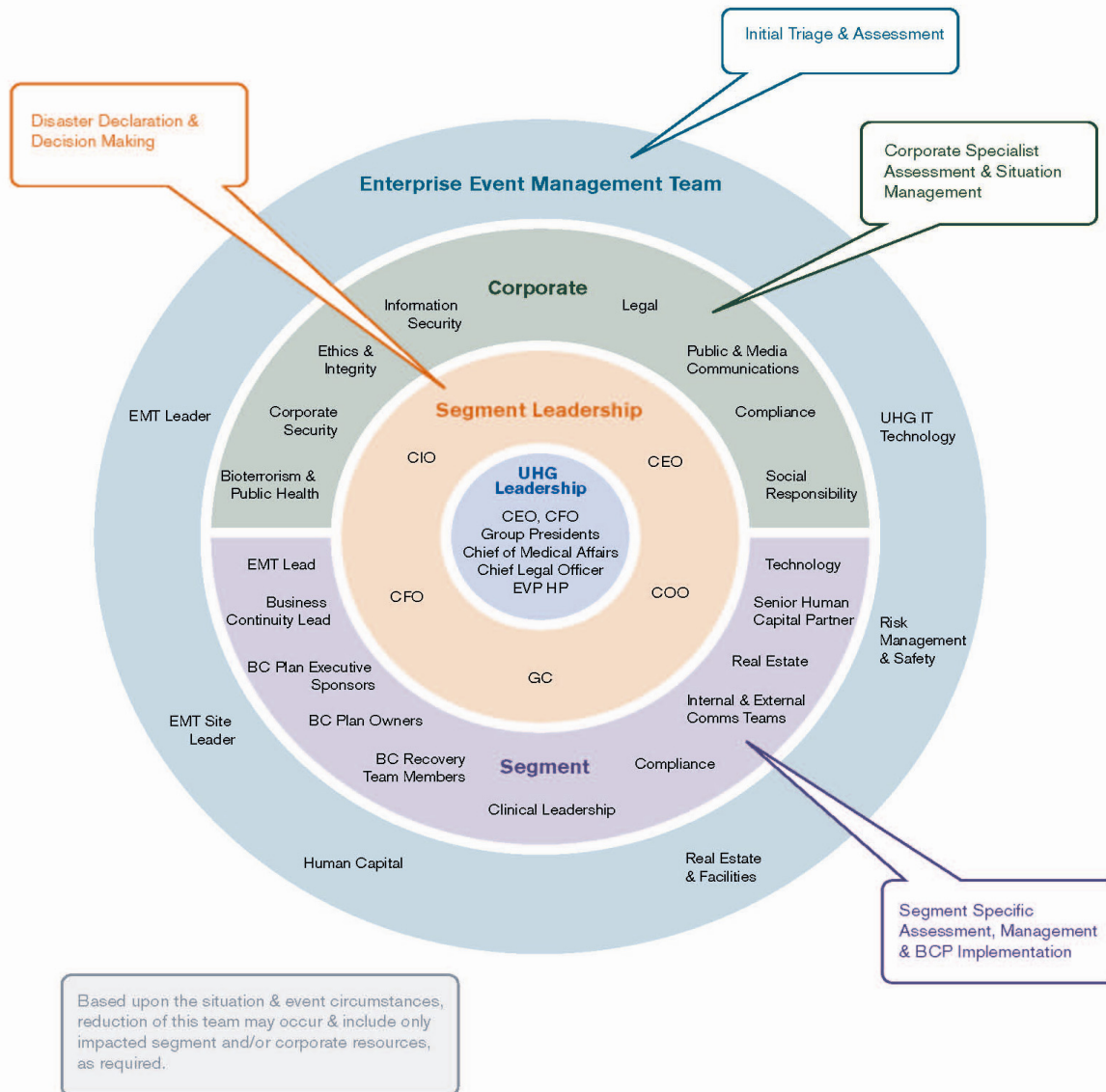
Effectively managing a crisis situation through to resolution requires a different decision-making process than is used for normal day-to-day business operations. Our Event Management Plan outlines the management organization (Event Management Team) and communication process to be used when facilitating a timely response to major events affecting our personnel, business operations or site locations, with the goal of avoiding or minimizing damage to the organization’s profitability, reputation or ability to operate. The Event Management Team reviews plans annually; ensuring technical assistance

is available to local teams. Our team works with our national call center that monitors all weather and disasters; they convene emergency calls with affected site and support leaders in potential event areas. The Event Management Team is responsible for managing the situation and making critical decisions to drive remediation and coordination with various internal and external stakeholders, as determined by the event type and short- and long-term impact on the organization. They also support execution on event management decisions and provide central coordination of communications, resources, personnel, issues, and other information through the notification and response phases of event management.

The Event Management Plan provides a structure that facilitates an effective response and recovery of a major event. It includes:

- Event Management Team and roles and responsibilities
- Event management process, including identification, escalation, notification and response channels
- Established standards and checklist for the Event Management Team, including, but not limited to: command center activation; damage assessment of people, information and property; risk management and safety; technology impact and response; and, employee, media and customer communications
- Disaster Declaration Standards.

## Business Continuity/Disaster Recovery Plan



- *Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;*

## Contingency Plans for Functions/Key Employees Due to Incapacitation/Unavailability of Primary Workplace

The Business Continuity Plans are part of the program designed to respond to disaster events, restore critical business function processes, and resume normal business function operations in a prioritized manner. Plans are used in conjunction with the Event Management and Disaster Recovery process. They focus on critical business functions and planning for worst-case scenarios, so we can react quickly and efficiently. These cover impacts from all types of disasters, both natural and man-made. The following are provided as planning recovery objectives:

- **Loss of Facility:** Complete interruption of facilities without access to its equipment, local data and content. The interruption may impact a single site or multiple sites in a geographic region. Recovery from anything less than complete interruption to be achieved by using appropriate portions of the Plan.
- **Loss of Critical Resources:** Complete interruption with 100 percent loss of personnel within the first 24 hours and 50 percent loss of personnel long-term. The interruption may impact a single site or multiple sites in a geographic area. Recovery from anything less than complete interruption to be achieved by using appropriate portions of the Plan.
- **Loss of Critical Systems:** Complete interruption or access of critical systems and data located at the various UnitedHealth Group Data Centers for an extended period of time. Recovery from anything less than complete interruption to be achieved by using appropriate portions of the Plan.
- **Loss of Critical Vendors:** Complete interruption in a service or supply provided by a third-party vendor(s). Recovery from anything less than complete interruption to be achieved by using appropriate portions of the plan.

Should our local offices become inaccessible or disabled, depending on specific circumstances, our affected staff would use other Louisiana offices connected to our internal network with full access to all systems, or staff would access our systems securely from their homes via our internal virtual private network (VPN). In certain cases, we would relocate functions to neighboring states (e.g., Alabama or Mississippi) to ensure continuity.

- *Communication with staff and suppliers when normal systems are unavailable;*

## Communication with Staff and Suppliers When Normal Systems are Unavailable

We maintain the following communication roles within the business continuity plans; Customer Communication Lead, Vendor Communication Lead, Segment Internal Communication Lead, Media Communication Lead, Regulatory Communication Lead. Individuals are assigned accountability for these roles and are responsible for developing communications for critical staff and suppliers regarding the impact and remediation efforts for the affected plan.

A variety of communication delivery methods are used including land line telephones, cell phones, 800 services, customer and provider portals, email and media communications. Plans include a call tree for contacting critical recovery team members and employees. Employees receive update to date information on the disaster and actions they should take on a company wide 800# and intranet site.

- *Specifically address your plans to ensure continuity of services to providers and members; and*

## Pandemic and Public Health Emergency Planning



As a health and well-being company, it is critical to plan for the impact of a public health emergency, including pandemics, on our customers, members, providers and our own operations. As the SARS experience of 2003 demonstrates, pandemics spread very quickly, and companies need to be vigilant and prepared. We predict a surge in need for our services, while potentially seeing a reduction in our ability to provide these services. Pre-planning is critical. Understanding what we need in advance, and being prepared to readily implement these actions, will help sustain our operations and minimize impact to our customers when a pandemic, or any other public health emergency, is upon us.

We use embedded planning for such public health emergencies in the Enterprise Resiliency & Response Program to ensure the availability of critical services for our customers. Individual Business Continuity Plans require planning for a loss of 50 percent of personnel, loss of facilities, critical vendors and disruptions to our technology, regardless of reason.

The Event Management Plan provides the command and control structure to ensure effective monitoring, communication and decision making during the emergency. IT Disaster Recovery Plans are in place to manage any impact to technology infrastructure and applications.

To assure our own internal planning and the information given to customers, physicians, enrollees and other stakeholders is current, complete and accurate; we collaborate actively with the Center for Infectious Disease and Policy (CIDRAP) at the University of Minnesota. We work with locally-based market medical dDirectors, who have established relationships with local health care providers, local medical societies, state medical licensure boards and state and local health departments. Our medical directors work in collaboration with public health agencies to help assure access to care in the event of a disaster. Relationships are well-established with other external stakeholders, including regulators and other government agencies, our customers/members and local community groups.

We work in collaboration with local and state health department officials to provide information on the availability of health services and adhere to the public health direction on prioritization efforts for the provision of such services. We use our communication vehicles to make information on provision and availability of services accessible to our members and members of the community.

We are committed to providing our customers with timely clinical information and will work with our customers to assure that benefit designs and their interpretation will facilitate socially and medically appropriate access to necessary clinical care, medical supplies, vaccines and pharmaceuticals. We will work with our customers to address and resolve unique issues that may arise during a crisis.

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- ***How your plan will be tested.***

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## **Plan Testing**

Business Continuity and Disaster Recovery Plans are tested at least annually through various techniques including tabletop (practical or simulated exercise), structured walk-through (functional), large or full-scale (live or real-life exercise) and emergency response. A formal test exercise report, identifying any gaps, issues or enhancements identified through testing, is published and monitored for remediation. When the remediation plan is complete, the plan is certified by the appropriate Executive Leadership. The certification process is monitored by the Program Steering Committee. In compliance with Section 16.4.3.6 of the RFP, we will not perform system maintenance, repair or upgrade activities to take place during hours that can compromise or prevent critical business operations, unless agreed to in advance by DHH.

Our business users participate in formal business continuity planning process where they identify and prioritize their business applications, ensuring their recovery in a timely fashion. Critical applications can be recovered using Disaster Recovery plans. The redundant IT disaster recovery systems capability is tested on an annual basis via a complete disaster recovery desktop walk through with the entire disaster

recovery (DR) team. Annual review of each DR plan takes place via a desktop walk through with each entire DR team assigned to the application plan. All of our data security controls, incl. our business continuity and disaster recovery safeguards and plans, are reviewed as part of annual Sarbanes Oxley (SOX) audits and regular SAS/70 Type II audits.

## Continually Monitoring System Functions

We use Hewlett Packard's OpenView enterprise software for the large-scale system and network management needed for UnitedHealthcare Community Plan's IT assets. OpenView detects and pre-empts any availability threatening failures. For example, OpenView places probes at the system level that send SMTP alerts to our engineers at preset thresholds to alert us prior to failure. This helps avoid situations where a disk drive becomes full, or process routines abort unexpectedly. We use our failure management processes and help desk service to identify and provide notification of issues with critical systems.

**M.2** *Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.*

- You have thirty thousand (30,000) or more CCN members residing in hurricane prone parishes. All three GSAs include coastal parish and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State assisted evacuations and self evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.*** (All GSAs)

UnitedHealthcare Community Plan's established procedures for handling emergency management situations include an initial assessment of the severity of the situation; prioritization of actions needed to resolve the immediate care needs of our members; development of an action plan, which includes assigning resources for implementation; implementation of action plan, including continuous monitoring; documenting successful interventions; and validation of successful intervention.

We minimize member and provider impact in a variety of ways. Our call centers, claims processing, clinical support, financial and banking operations are designed for resiliency and are positioned to continue to provide services to our members and providers. As a national company, we have geographically dispersed computing, customer service facilities and health care networks that can support and supplement the work of compromised localities.

In addition, our corporate Event Management Team monitors hurricane and typhoon activity on a daily basis, and is able to mobilize the appropriate planning and response resources quickly once the storm reaches hurricane status. Some hurricanes spawn very quickly, Hurricane Humberto in 2009 went from a storm to landfall in just 14 hours, fortunately with little damage as it made landfall between Texas and Louisiana. In cases where we do not have 72 hours to prepare, we will follow the steps outlined below in an accelerated manner.

## Day 1

### **72 Hours before Category 5 Hurricane landfall**

Our health plan CEO, Blaine Berguson, contacts the members of UnitedHealthcare Community Plan's Rapid Response Team. The Rapid Response Team includes our Chief Medical Officer (CMO), Mark Mahler MD, director of case management, director of member services, director of provider services, case management administrator, transportation coordinator and our compliance officer.

The Rapid Response Team convenes to discuss the immediate disaster situation and defines actions to be taken, resources to be deployed, and specific timeframes and touch points for monitoring. Our compliance officer is the designated point of contact to ensure all information and updates are captured and

communicated appropriately, both internally and externally.

Mr. Berguson confirms the health and status of our employees in the region and implements measures to ensure continuous communication and care continuity for members and providers.

Our Director of Member Services and Director of Provider Services collaborate to identify members affected, evaluate the PCP panel capacity within the geographic area, to communicate reassignment to members and providers.

Call trees are implemented to reach out to our high volume providers to determine their locations during and after the storm.

The Case Management Administrator and the CMO review case management and disease management files to identify members at most risk due to severity or fragility and provide the list to our member outreach teams. These members are priority contacts to determine if they need evacuation assistance and to arrange for care continuity

Our member outreach teams begin to notify our members to communicate prior authorization, provider transfer, if necessary, and other applicable instructions. National call center staff are deployed to assist in the outreach effort with the goal of reaching one third of our members Day 1.

Members who are on home based dialysis or hospice are identified and our care managers or home health nurses make home visits to ensure that adequate supplies are available, such as oxygen and generators should they not be evacuated. In the event these members are to be evacuated, appropriate sites are identified that will meet these members needs and the Transportation coordinator prepares to arrange transportation for these members as well as other members who have urgent health care needs.

Our Provider Advocates and Medical Directors work closely with the Louisiana State Medical Association to understand how clinics and hospitals are preparing for the storm, and to ensure that providers know how to contact us.

As the point person, our compliance officer provides DHH with details regarding service delivery to our members.

## **Day 2**

### **48 Hours before Category 5 Hurricane landfall**

The Rapid Response Team reconvenes for updates and to discuss next steps.

Member outreach teams continue to notify members. Two thirds of our members will be contacted by Day 2.

The volume of calls to our call center is monitored to ensure that standards are met.

The National Weather Service upgrades the Hurricane Watch to a Hurricane Warning.

Our Event Management Team convenes two separate calls:

- Appropriate changes for medical benefits to assist members preparing for the storm are discussed. Our medical benefits administration is modified removing prior authorization/notification requirements, allowing early replacement of durable medical equipment and easing restrictions on using out-of-network providers. Our standard practice is also to remove “fill too soon” edits for pharmacy but since pharmacy is carved out for the CCN, we offer assistance to DHH’s pharmacy benefits manager and help them in any way we can.
- Our internal operations and employee safety are examined. We ensure that we have sufficient staff at other locations ready to handle the calls, and we’re ready to continue operations without disruption

until the local operations are back to normal. We provide our employees sufficient time to prepare themselves and their families for the coming storm, and encourage them to take the opportunity to fill their gas tanks, ensure they have sufficient food & water on-hand for their families and pets, and ensure they have the 800 number readily available that we use to communicate critical information to our employees. One of the best ways we can serve our members is by having a staff that is ready to come back to work once the danger has passed.

We open our Optum Crisis Counseling line to all residents of the state to provide mental health support to those who may be anxious or fearful of the coming storm. The company's toll free line number, 800.342.6892, will be open 24 hours a day, 7 days a week for as long as necessary. The service is free of charge and open to anyone. Staffed by experienced master's-level behavioral health specialists from the company's OptumHealth business, the free help line offers assistance to callers seeking help in dealing with stress, anxiety and the grieving process. Callers may also receive referrals to community resources to help them with specific concerns, including financial and legal matters.

Our medical director and care managers begin to coordinate with facilities to track evacuated members. Discharge planning focuses on whether members can be returned to their homes, and if not, finding appropriate placements for them.

Our compliance officer provides a status report to DHH.

### **Day 3**

#### **24 Hours before Category 5 Hurricane landfall**

Rapid Response Team reconvenes for updates and to discuss next steps.

The Member outreach teams continue to notify members. All of our 30,000 members will have been contacted by Day 3.

UnitedHealthcare Community Plan on-site nurses are deployed in the local facilities to enable them to obtain hospital censuses for the health plan to input authorizations.

Our medical director and care managers continue to coordinate with facilities to track evacuated members. Discharge planning focuses on whether members can be returned to their homes, and if not, finding appropriate placements for them.

Our compliance officer provides a status report to DHH.

### **Day 4**

#### **Landfall**

As soon as it is safe to do after the storm has made landfall, our Real Estate Services team assesses the condition of our locations and our Rapid Response Team reaches out to members, providers and local government to determine what has been damaged and where the greatest needs exist.

The Event Management Team examines independent data sources to assess impact and needs, including FEMA National Situation Reports, Louisiana's Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP) information, and Louisiana Business Emergency Operations Center (LA BEOC) updates. Local news stations are also used as an additional source of information.

The Event Management Team holds daily calls after the hurricane has made landfall to share the situation assessment of the impact on the communities, health care services and our internal operations. This allows us to determine where additional support is most beneficial, which often isn't known until the full situation assessment done by local authorities is available.

We understand that many of our members can be vulnerable after a significant disaster, and we put their needs first, and will do what it takes to make things right for them.

Our medical director and care managers continue to coordinate with facilities to track evacuated members. Discharge planning focuses on whether members can be returned to their homes, and if not, finding appropriate placements for them.

Our compliance officer provides a status report to DHH.

## **Day 5 and Beyond**

The severity of the hurricane's impact on our communities and their ability to access health care is assessed. We continue to provide emergency medical benefit relief to our members, and we work collaboratively with our customers and providers to assess their impact of the storm.

We work with our members and providers to support their needs after a disaster –bringing grief & loss counselors on-site for their staff and ensuring specific health care needs are met. We are particularly concerned with our special needs patients, and our caring nurses proactively identify needs and ensure they are met.

We coordinate with local public health authorities to understand the need and determine the best way to use our resources.

UnitedHealth Group sponsored Children's Health Fund mobile vans are deployed to provide services to our members as well as at local American Red Cross shelters.

Our medical director and care managers continue to coordinate with facilities to track evacuated members. Discharge planning focuses on whether members can be returned to their homes, and if not, finding appropriate placements for them.

Our medical benefits administration that has been modified by removing prior authorization/notification requirements, allowing early replacement of durable medical equipment and easing restrictions on using out-of-network providers remains in place for 30 days, at which time we assess the need to extend this accommodation.

The Event Management Team continues to hold daily calls to share the situation assessment of the impact on the communities, health care services and our internal operations until the situation is returned to normal.

- ***Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage and power outages for 4 days or more in the Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.***

## **Provider and Member Call Center**

UnitedHealth Group, our parent organization, has developed an Enterprise Resiliency & Response Program that minimizes customer impact from disrupted service in a significant event or disaster, while aiding compliance to published regulatory guidelines. Our plans are developed to address all natural and man-made disasters (e.g., hurricanes, floods, fires, terrorism attacks, and disease pandemics). This business continuity plans focus on critical business functions and planning for the worst-case scenario so that we can react quickly and efficiently, adding value to our business and customers through effective risk reduction, compliance with industry, contractual or regulatory standards, and safeguarding of our operations and assets.

UnitedHealth Group leverages a number of technologies to reduce the probability of a disaster with the objective of resuming operation with limited to no disruption to stakeholders or data loss. An in-region strategy allows for a "system" of data centers to be deployed that are connected with very affordable and



yet high capacity, high availability networking.

UnitedHealth Group is committed to using state of the art technology. Providing excellent Customer Service remains a top priority for UnitedHealth Group. Receiving and resolving calls from clients is a large and critical part of our business. UnitedHealth Group has implemented a Virtual Contact Center that dynamically routes a million calls daily across 40+ contact centers and 20,000 service agents. If there is an event at a remote call center, incoming calls can be immediately rerouted to alternate call centers for processing and resolution, reducing any impact to our clients.

As a national organization, UnitedHealth Group Business Continuity strategies include leveraging resilient, or redundant, operations performed in geographically dispersed locations across the U.S. This strategy is supplemented by work at home (telecommuter) personnel, as well as abundant UnitedHealth Group locations which again span the U.S.

Assuming that our call centers are located in Baton Rouge, these would not be stand-alone facilities. Our call and claim operations are performed by trained staff from multiple geographically-dispersed locations, and our non-impacted locations are prepared to take on additional work. We will implement Advance Travel Teams. Individuals on these teams are equipped with laptops and are deployed to an alternate city in advance, to allow us to continue operations without disruption.

The Event Management Team assesses the situation daily with our members & customers and our own operations. Business Continuity plans are implemented to minimize impact to operations and a toll-free number is implemented to provide vital information to impacted employees.

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## Section N: Grievances (Section 12 of RFP)

**N.1** *Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance process, including your approach for meeting the general requirements and plan to:* *(All GSAs)*

- *Ensure that the Grievance System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;*

UnitedHealthcare Community Plan is committed to responding to member and provider concerns in order to resolve issues at the earliest opportunity. At every contact, we strive to be responsive and offer assistance to our members and providers in any way we can. We offer special assistance to our members who may need interpreter services or who are visually, developmentally or hearing impaired. To address issues that rise to the level of grievance or appeal, we offer help and guidance to our members and providers at every level of the grievance and appeals process. For example, all written materials sent to members and providers give simple instructions on how to access the next level of grievance or appeal. This commitment creates an environment in which we are viewed as a resource to our members and affords the opportunity to resolve issues with as little dissatisfaction as possible.

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### Policy and Procedures

UnitedHealthcare Community Plan maintains a structured grievance and appeals process, which includes access to a state fair hearing that affords members recourse for having their issues addressed in a professional, consistent and timely manner. Our approach is based on written policies and procedures that outline the grievance system process for members, subcontractors and non-contracted providers, defining their rights regarding any disputes they may have with UnitedHealthcare Community Plan. Our grievance system will comply with 42 CFR, Part 438, Subpart F and all applicable federal and state laws, regulations and policies. Prior to implementation, we will submit all policies and procedures relating to the grievance system to the DHH for approval.

We include information (including all related policies, procedures and time frames) regarding the grievance system in our provider manual, which is provided to all providers/subcontractors at the time we enter into a contract/agreement with the provider.

UnitedHealthcare Community Plan allocates appropriate numbers of qualified and trained personnel to establish, implement and maintain the necessary functions related to the grievance system's processes—including those related to timeliness. We designate a staff member as a "Grievance System Coordinator," and allocate appropriate numbers of qualified and trained personnel to establish, implement and maintain the necessary functions related to the grievance system's processes. Members, if they have any inquiry or complaint, are encouraged to call the toll-free number shown on their ID card. If the customer service representative is not able to answer the inquiry or resolve the complaint to the member's satisfaction over the phone, he/she will help the member prepare and submit a written complaint or grievance. This will include but is not limited to the provision of a toll-free telephone number, translation services, and a toll-free Telephone Typewriter (TTY)/Telecommunication Device for the Deaf (TDD) and interpreter capability.

We inform members of the program via the UnitedHealthcare Community Plan member handbook, member welcome call, member welcome packet and online through the UnitedHealthcare Community Plan Website. These member materials are developed in accordance with federal and state regulations regarding content, timing and translation of such information. Members are informed that grievance system information is available in prevalent non-English languages on request, how to obtain it, and via oral interpretation services in any language. For the Louisiana CCN, the information will also be provided in Spanish and Vietnamese. UnitedHealthcare Community Plan will translate member materials when 200

or more Members speak a common language within the GSA. Upon notice from DHH that the 200 member threshold has been reached, we will translate and make available these materials within 90 calendar days.

We inform providers of the member grievance and appeal process through the UnitedHealthcare Community Plan provider manual and the Provider portal on the UnitedHealthcare Community Plan Website. A grievance may be received by any department including Member Service, Care Management and Provider Relations.

- ***Ensure that individuals who make decisions on Grievances have the appropriate expertise and were not involved in any previous level of review; and***

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## **Ensuring Unbiased Review of Grievances and Appeals**

All grievances and appeals are investigated and resolved by UnitedHealthcare Community Plan staff. We ensure that individuals completing review of grievances and appeals were not involved in previous levels of review or decision making and are health care professionals with appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease. These health care professionals will be used in deciding the following:

- An appeal of a denial that is based on lack of medical necessity,
- A grievance regarding denial of expedited resolution of an appeal, and
- A grievance or appeal that involves clinical issues.

We may consult with or seek the participation of additional medical experts as part of the appeal resolution process with the member's consent.

- ***Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.***

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## **Expedited Process**

UnitedHealthcare Community Plan will expedite resolution of an appeal if, according to the information provided by the member or as indicated by a provider filing an appeal on the member's behalf, the standard resolution timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Under such circumstances, UnitedHealthcare Community Plan will resolve the expedited appeal within 72 hours, unless extended.

UnitedHealthcare Community Plan may request an extension of up to 14 days and will provide the member with a written notice of the extension and the reasons for the delay. UnitedHealthcare Community Plan will make every effort to contact the member and provide oral follow-up within 2 days with a written notice of denial of expedited resolution. If the expedited appeal request is denied, the appeal will be transferred to a 30-day standard appeal. This decision does not constitute an Action or require a Notice of Action. The member may file a grievance in response for denial of an expedited resolution.

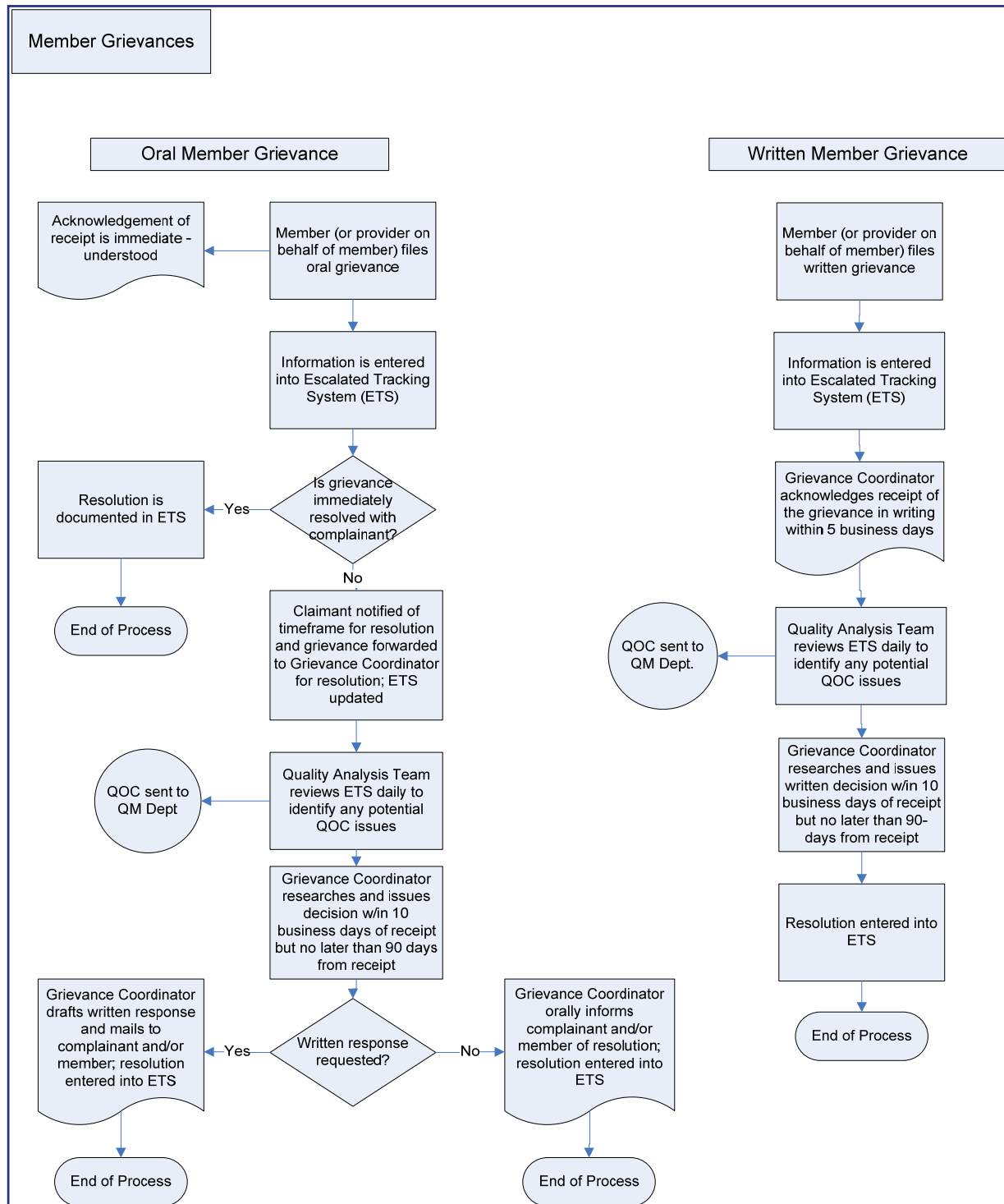
- ***Include in the description how data resulting from the grievance system will be used to improve your operational performance.***

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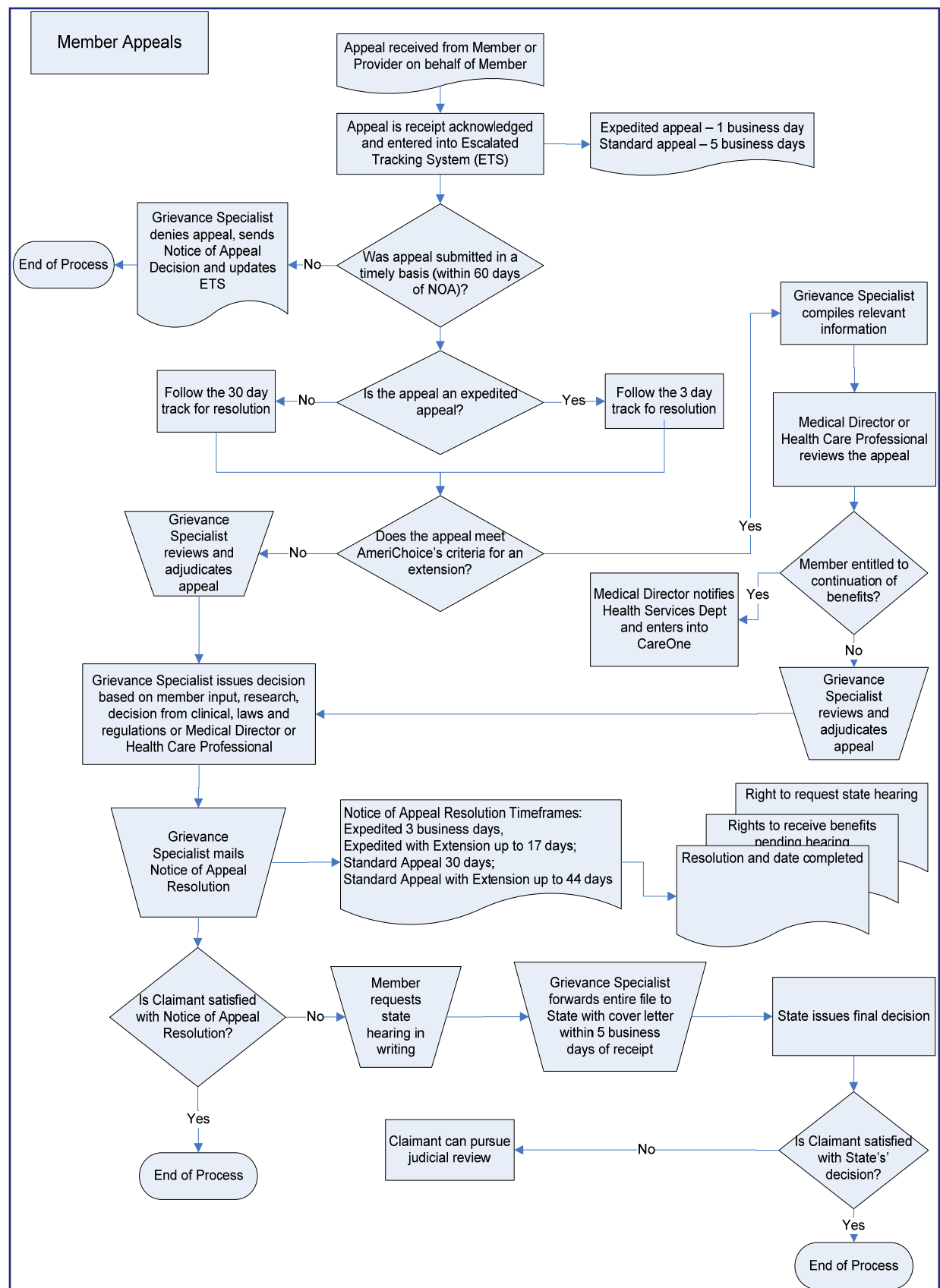
## **Improving Operational Performance**

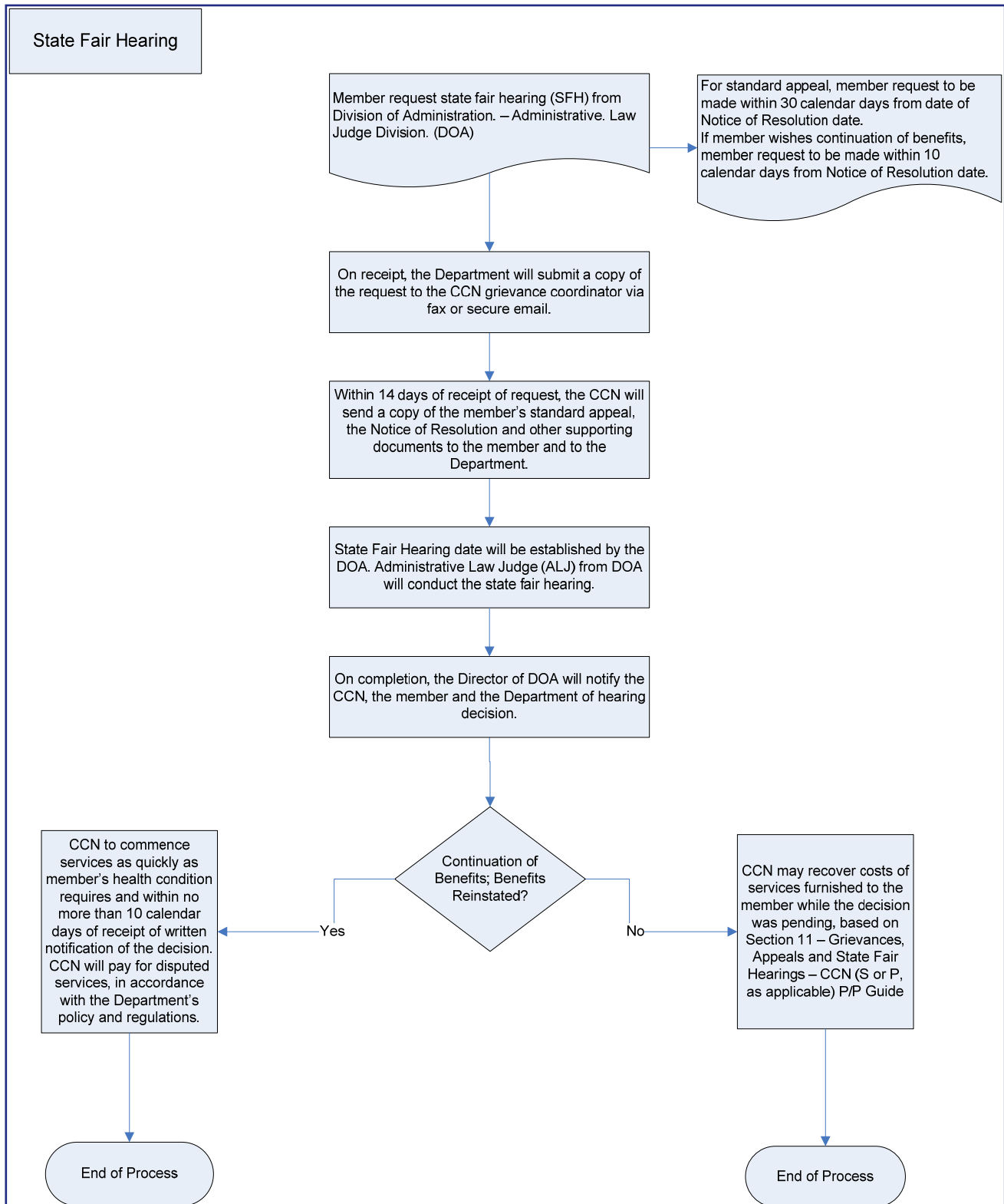
As part of the quality improvement process and to identify trends, we track grievances, appeals and state fair hearings via our Grievance Log. These trends are reported to the QAPI committee responsible for overall quality improvement to identify appropriate interventions, as necessary.

**Chart C. Member Grievances, Appeals and State Fair Hearing Process**









## **Member Grievances, Appeals and State Fair Hearing**

Upon enrollment, members receive written information that clearly explains the grievance system requirements.

The information includes pertinent policies and procedures and specific details on filing grievances, appeals and state fair hearings, to include:

- Definition of action: RFP Sect. 13.1 – Member Grievance and Appeals Procedures
- Definition of grievance: RFP Sect. 13.1.3– Member Grievance and Appeals Procedures
- Definition of appeal: RFP Sect. 13.1.2 – Member Grievance and Appeals Procedures
- The right to file grievances, appeals and claim disputes
- The requirements and timeframes for filing grievances, appeals and claim disputes
- The availability of assistance in the filing process
- The toll-free numbers that the member can use to file a grievance or appeal by phone
- Name and address of the grievance coordinator
- That members may use a personal representative during the grievance process
- That a provider may file an appeal on behalf of a member with the member's written consent.

### **Filing a Member Grievance**

Any member, his or her authorized representative or a provider acting on behalf of the member, with written permission from the member, may file a grievance with UnitedHealthcare Community Plan by calling toll-free into the Member Service call center or by mailing a grievance into our Regional Mail Operations office. A member, his or her authorized representative or a provider acting on behalf of a member with the member's written consent has 60 calendar days from the date of our notice of action or inaction to file a grievance or appeal. Welcome packet materials and the UnitedHealthcare Community Plan member handbook state that grievances should be filed directly with UnitedHealthcare Community Plan. These materials encourage the member to follow the grievance process appropriately. Members may file a grievance by calling Member Services or can submit one in writing. Verbal grievances are entered into the Escalation Tracking System (ETS)—our grievance database on the date of receipt and a case file created. Written grievances are date stamped, are entered into the database and a case file is created. We log and track member name/identification number; date grievance received/grievance acknowledgement; grievance description; staff assigned for disposition; disposition; disposition date; and member notification date. Other data captured includes but is not limited to date of resolution, description of resolution, and whether the grievance was determined valid.

If a member files a grievance orally, acknowledgement of receipt is understood. UnitedHealthcare Community Plan acknowledges receipt of written member grievances in writing, unless the member or provider requests an expedited resolution. The receipt of written member grievances is acknowledged in writing within 5 business days. We give members written notice of any action—not just service authorization actions—within the timeframes for each type of action. Acknowledgement letters are generated automatically via the ETS Client Letter Tool.

No punitive action will be taken against a provider who files a grievance on behalf of a member or supports a member's grievance.

### **Process for Resolving a Grievance**

Our Regional Mail Operations Office receives written grievances to address various issues; grievances and appeals are entered into the ETS. Our Member Service Call Center receives calls to address various issues, including member grievances. The majority of member grievances are resolved during the initial call to UnitedHealthcare Community Plan; however, cases requiring additional review, both written and

verbal, are entered into the ETS. Grievances requiring more research are extracted from the ETS through our Online Routing System (ORS) via a daily report generated by our Quality Management staff. The information is sorted to identify any potential quality of care issues. If a call/letter pertains to a potential quality of care issue, the member grievance is closed and forwarded to the Quality Management Department, where a quality of care investigation ensues, in accordance with all applicable quality management processes and procedures. If the call/letter pertains to a member appeal, it is routed to the Appeals and Claims Dispute Unit for handling.

The Grievance Coordinator conducts preliminary research to verify the appropriate path of the grievance. He or she researches and processes the grievance for resolution. If it is necessary to involve other departments, the Grievance Coordinator triages the grievance to the appropriate department and oversees the process until resolution is attained. The Grievance Coordinator will close the case file in ORS with all applicable data.

Members receive written notification of the grievance resolution within 10 business days or sooner; all grievances will be resolved within 30 calendar days of our original receipt of the grievance. Urgent and emergent grievances will be resolved within 24 hours of receipt. We acknowledge if the member requests or if we find a need for additional information that is in the best interests of the member, an extension of 14 days may be added to this timeline.

A notice of resolution will be mailed to the member within 2 days of resolution. The notice of resolution will comply with the requirements of the CCN.

### **Filing an Appeal**

UnitedHealthcare Community Plan will accept appeals in writing or verbally. A member or member's authorized representative, including their provider with written member consent may file an appeal on behalf of the member in response to the actions described above. The member has 60 days from the date of the Notice of Action to file an appeal. The timing and content of our Notice of Action complies with RFP Sect. 13.6.2 and 13.6.3 and meets the language and format requirements of 42 CFR §438.10(c) and (d) and RFP Section 12. UnitedHealthcare Community Plan date stamps appeals "received," enters the pertinent information into the grievance database, and creates an appeal case file to include available and relevant information associated with the appeal. The Appeals and Claims Dispute staff acknowledges the receipt of each member appeal in writing within 1 working day for expedited appeals and within 5 working days for standard appeals.

No punitive action is taken against a provider who supports a member's appeal or requests an expedited resolution.

### **Timelines for Resolving an Appeal**

Standard appeals, submitted by our members (or their authorized representatives) of the CCN, will follow the process, as noted in Section 13.5.2 –Member Grievance and Appeals Procedures in the CCN-S RFP. UnitedHealthcare Community Plan resolves appeals within 30 calendar days from the date of receipt of the appeal, unless an extension is in effect.

UnitedHealthcare Community Plan may extend the resolution timelines for either expedited or standard appeals on the request of the member or if UnitedHealthcare Community Plan needs additional information and the extra time needed to obtain the information is in the member's best interest. UnitedHealthcare Community Plan may request an extension of up to 14 days and will provide the member with a written notice of the extension and the reasons for the delay. UnitedHealthcare Community Plan will make every effort to contact the member and provide oral follow-up within 2 days with a written notice of denial of expedited resolution. If the expedited appeal request is denied, the appeal will be transferred to a 30-day standard appeal. This decision does not constitute an Action or require an NOA. The member may file a grievance in response to this decision.

## **Process for Resolving an Appeal**

After the appeal has been logged into our database for tracking purposes and the acknowledgement letter has been sent, the appeal is assigned to a Grievance Specialist. Our specialists have excellent communication skills, strong written and verbal skills, sound deductive reasoning skills and extensive knowledge of federal and state laws, regulations and policies. Member benefits continue until a decision is rendered if:

- The member files an appeal within 10 days of the postmark on the Notice of Action (NOA) or as described in the NOA; or
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or the appeal involves a denial and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service; or
- The services were ordered by an authorized provider; and the member requests a continuation of benefits.

UnitedHealthcare Community Plan provides each member or member's representative a reasonable opportunity to present evidence and allegations of fact or law in-person and in-writing. The member is informed of the limited time available in cases involving expedited resolution. Any information received during the resolution process is date stamped and incorporated into the case file. UnitedHealthcare Community Plan provides members an opportunity to examine the appeal file, including medical records and other documents considered by UnitedHealthcare Community Plan during the resolution process.

Unless the appeal involves a denial based on lack of medical necessity or otherwise involves clinical issues, the Grievance Specialist researches and adjudicates the appeal. For clinical appeals, the Grievance Specialist assembles relevant background information from UnitedHealthcare Community Plan's prior authorization and claims systems, obtains relevant clinical information, and forwards the matter to a Medical Director or other health care professional who has appropriate clinical expertise to review the matter. To render an appeal decision, the Medical Director or other health care professional must not have been involved in any decision-making or previous review surrounding the action or appeal. If the matter requires review by another UnitedHealthcare Community Plan department, the Grievance Specialist requests that a designated subject matter expert in the department address specific issues necessary to resolve the appeal. The Grievance Specialist may contact the member or the member's treating provider to obtain information necessary to resolve the appeal.

Upon completion of this process, the Grievance Specialist or designee provides verbal notice of UnitedHealthcare Community Plan's decision for an expedited resolution and issues a written Notice of Appeal Resolution for both expedited and standard resolutions. The Notice of Appeal Resolution contains the results of the resolution process, including the legal citations or authorities supporting the determination, along with the date it was completed. The Notice of Appeal Resolution will be in compliance with RFP Section 13.7 – "Resolution and Notification."

The Notice of Appeal Resolution is sent via certified mail within the applicable resolution timelines. UnitedHealthcare Community Plan will make reasonable efforts to provide oral notice to a member regarding an expedited resolution appeal.

## **State Fair Hearing**

For appeals not resolved wholly in favor of the member, the member will be notified of (1) the member's right to request a state fair hearing, once all CCN levels of appeals has been exhausted, to the Division of Administrative Law (including the requirement that the member must file the request for a hearing in writing within 30 calendar days from the date of the Notice of Appeal Resolution) and how to make the request; (2) how to request a state fair hearing; (4) the right to receive continued benefits pending the hearing and how to request continuation of benefits; and (5) information explaining that the member may



be held liable for the cost of benefits if the hearing decision upholds UnitedHealthcare Community Plan's decision. If the member wishes to have continuation of benefits during the state fair hearing, the hearing request must be made within 10 days.

We acknowledge on the DHH's receipt of the member's request for a state fair hearing that the DHH will submit a copy of the request to our grievance coordinator via fax or secure email. Within 14 days of receipt, we will send a copy of the member's standard appeal of our action; the contents of the standard appeal file—including research, medical records and other documents used to make our decision and a summary of the member's appeal; and a copy of the notice of resolution provided to the member and to the Department.

Parties to the state fair hearing include the CCN, the member and his/her representative.

We acknowledge that an administrative law judge (ALJ) at DOA shall conduct the state fair hearing. On completion, the Director of DOA will notify us, the member and the Department of the hearing decision.

We will adhere to the State of Louisiana's state laws, regulations and policies for continuation, discontinuation and reinstated status of member benefits.

For the State of Louisiana, our grievance and state fair hearing system will comply with applicable federal and state laws, regulations and policies, and will be modified as needed to meet the requirements of the DHH's CCN program.

### **Record Retention and Reporting**

A copy of grievance logs and records of disposition of appeals will be retained for 6 years. For any documents involving litigation, claim negotiation, audit or other action, the records will be retained until completion of the action and resolution of issues which arise from it or until the end of the regular 6 year period, whichever is later.

We will provide monthly reports in electronic format to the DHH in accordance with deadlines and conditions, as stated in the CCN-S RFP. The reports will minimally include: member's name and Medicaid number; summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. These reports with PHI redacted will be made publicly available for inspection.

We will promptly forward any adverse decisions to DHH for review/action upon request from DHH or our member.

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## Section O: Fraud & Abuse (Section 15 of RFP)

***O.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement. (All GSAs)***

UnitedHealthcare Community Plan is prepared to provide our program integrity plan for DHH's approval. Our company's operations are fully configured to meet the DHH's requirements related to preventing, detecting and deterring incidents of fraud, waste and abuse. Our parent organization, the UnitedHealth Group, has in place administrative procedures and management policies to ensure our compliance with all applicable federal and state standards. In fact, our program integrity efforts have already been developed and are in place for other state Medicaid programs.

Following is background on our program integrity operations. We stand ready to customize these policies, procedures and standards to the needs of DHH and will provide program integrity activities in accordance to DHH guidelines. This compliance plan will be submitted to DHH for review within 30 days from the date the contract is signed.

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### Fraud Detection Methods

This program applies to fraud, waste and abuse – principally perpetrated by health care providers, members and other external persons/entities (for example, pharmaceutical and medical device manufacturers).

UnitedHealthcare Community Plan is focused solely on the provision of health care services related to our public programs, including Medicare Advantage, Medicare Supplement, Medicare Part D, Medicaid, and various other federal and state health plans. While the fraud, waste and abuse public health programs can face overlap with that found in the private sector, the unique populations and services public programs provide result in distinct considerations. Through this program, we are committed to addressing the unique fraud, waste and abuse needs of its government plans and partners.

We use a variety of state-of-the-art data analytic tools to detect fraud through state-specific designed algorithms. These reports may be used to facilitate review of select claims before payment (prospective) or review of claims and provider practices post-payment (retrospective). Data analyses are effective in:

- Identifying Member card sharing to illegally obtain services for multiple individuals or identification theft
- Identifying aberrant provider billing behaviors
- Identifying potentially fraudulent or abusive billing schemes
- Monitoring the billing activity of sanctioned providers.

Because it has been estimated that providers commit 80 to 90 percent of health care fraud, waste and abuse, the focus is primarily on providers. This program applies to various types of health care providers, including principally:

- Hospitals and other inpatient/outpatient treatment facilities (e.g., rehabilitation, chemical dependency, etc.)
- Nursing home, assisted living, adult day care and hospice facilities
- Physicians, Osteopaths, Chiropractors, and Dentists

- Other health care professionals (e.g., nurses, physical and occupational therapists, psychologists, counselors, physician assistants, nurse practitioners, licensed practical nurses, personal care attendants, nutritionists)
- Medical laboratories and diagnostic centers
- Pharmacists
- Ambulance/medical transport/special transportation companies
- Interpretive service providers
- Durable medical equipment suppliers
- Medical billing companies.

### **Sources of Suspected or Potential Fraud, Waste and Abuse**

We learn of external fraud, waste and abuse from numerous sources, including principally:

- Electronic data mining of claims
- Internal and External tips and referrals
- UnitedHealthcare Community Plan's businesses/plans
- Federal/state regulators, including the U.S. Department of Health and Human Services Office of the Inspector General and the Department of Justice and state Attorneys General Offices and Medicaid Fraud Control Units
- Law enforcement tips
- Media/press and research/clipping services
- Professional anti-fraud associations (e.g., National Health Care Anti-Fraud Association, Special Investigation Resource and Intelligence System)
- Providers and plan Members
- Other health insurers.

### **Steps to be Taken if Fraud is Detected, Including DHH Notification**

We continually evaluate and measure the success of our program. We track on an ongoing basis various categories, including:

- **Retrospective Recoveries** – dollars recovered after claims have been paid
- **Prospective Savings** – claims denied prior to payment
- **Operational** – future savings from contract/process changes directly attributable to Program investigations.
- **Cost Avoidance** – Edits to prevent inappropriate payments

We also track matters where fraud, waste or abuse was substantiated and ensuring appropriate measures are taken to report and prevent future payments.

We track objective measures of the program's effectiveness and compare the effectiveness of our program with that of other fraud, waste and abuse programs through sources such as the National Health Care Anti-Fraud Association (NHCAA) Annual Anti-Fraud Management Survey.

We expect that affirmative retrospective monetary recoveries to decrease over time as preventive measures detect fraud, waste and abuse before claims are paid, provides better education of providers and members, and is successful in its battle against certain fraud, waste and abuse schemes and practices.

In addition to monitoring the success of our program in fraud, waste and abuse detection, prevention and recovery, we take corrective action when fraud, waste and abuse are discovered, including, for example, the following steps:

- Referring a matter to law enforcement officials for criminal prosecution
- Reporting providers to state professional licensing authorities
- Notifying and educating the offending provider or Member
- Advising our businesses and plans regarding possible changes in contract and or policy terms and procedures
- Creating and implementing new data mining queries/rules to identify the scheme at issue.

#### UnitedHealth Group's OIG/GSA Background Checks

As a longstanding contractor for various state Medicaid agencies, UnitedHealthcare Community Plan is well versed on the federal prohibitions related to affiliations with debarred individuals as set forth in 42 CFR 438.610. Like all UnitedHealth Group staff, each of the UnitedHealthcare Community Plan directors, officers, and other employees undergoes extensive background checks that are designed to identify issues of concern, including debarment by a federal agency.

UnitedHealthcare Community Plan is currently implementing new disclosure requirements for providers, as part of an enhancement to our credentialing process. These disclosure requirements will include data required by 42 CFR Part 455 and will address the debarment history for the UnitedHealthcare Community Plan contracted provider network. As to subcontractors or consultants, we require that each contract contain a signed copy of our Medicaid Regulatory Appendix. This appendix requires the disclosure of any and all persons that will render services so that we can compare the persons on this list to the appropriate excluded parties' databases in order to assure our compliance with this standard.

Within UnitedHealth Group, there is a significant amount of federal government business that is subject to these fraud and abuse requirements and associated prohibitions on the employment or payment to individuals "sanctioned." After evaluating how to promote compliance with these requirements, we concluded that instead of trying to determine which employees and contractors are subject to these laws, we would check:

- All employee applicants as a part of the standard background check
- All prospective contractors (including participating providers, contractor employees and owners) prior to entering into a contract
- All employees and contractors annually.

This decision was made in large part because it is virtually impossible to track who may be subject to the prohibition because of the ongoing changes within the organization. Someone employed or retained to perform non-government business can easily migrate into performing services for a government contract – sometimes without even knowing it. Consequently, we decided to check everyone. We comply with federal requirements to ensure that providers and employees do not appear on the Office of Inspector General (OIG) List of Excluded Individuals/Entities or the General Services Administration (GSA) Excluded Parties List of debarred contractors. UnitedHealth Group's Ethics and Integrity Office has been working with various parts of the organization to assure appropriate practices are in place to conduct initial and annual OIG/GSA background and conflict of interest checks of employees and contractors. At this time, we are conducting:

- OIG/GSA checks on all employee applicants
- An annual check of all then-current employees
- Checks of all new payees before they are entered into the Accounts Payable system
- An annual check of all then-current payees included in the Accounts Payable system.

UnitedHealthcare Group also performs OIG/GSA background checking practices for participating providers, including checking:



- Participating providers before enrollment
- Participating providers before paying claims
- All other vendors, suppliers and contractors at the time of the initial contract.

The OIG List of Excluded Individuals/Entities and GSA Excluded Parties List are public information available on the Internet. UnitedHealth Group's Ethics and Integrity Office licensed SanctionCheck.com from Compliance Concepts, Inc. to access this information. SanctionCheck.com is an easy-to-use web interface that allows us to perform individual and batch OIG/GSA checks through the Internet. We will include in this process searching the following websites monthly:

- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
- <http://exclusions.oig.hhs.gov/search.aspx>
- Health Care Integrity and Protection Data Bank (HIPDB)
- <http://www.npdb-hipdb/hrsa.gov/index.isp>
- Excluded Parties List Serve (EPLS)
- <http://www.EPLS.gov>.

### **Reporting and Interaction with DHH and Other Governmental Agencies**

UnitedHealthcare Community Plan will comply promptly with requests from the state agency or the Medicaid Fraud Control Unit (MFCU) for access to and copies of any records that we maintain. We understand that these requests could also include requests for computerized data that we store and for information on network and non-participating providers that the state agency is authorized to have access.

UnitedHealthcare Community Plan will cooperate fully in any investigation by regulatory and law enforcement agencies, or in any subsequent legal actions that may result from such investigations. UnitedHealthcare Community Plan also follow all applicable contractual and regulatory requirements concerning what actions are to be taken after filing a report.

UnitedHealthcare Community Plan always responds promptly to requests from the state agency or the Medicaid Fraud Control Unit (MFCU) for access to or copies of any UnitedHealthcare Community Plan records, computerized data that we maintain, or information kept by UnitedHealthcare Community Plan network providers to which the State agency is authorized to have access. We operate in full compliance with state and federal standards, policies, procedures, and regulations. As we do in other Medicaid states, UnitedHealthcare Community Plan agrees to meet, periodically, as requested, with DHH and MFCU to discuss fraud, abuse, neglect and overpayment issues.

Finally, UnitedHealthcare Community Plan will submit all required periodic reports concerning their fraud and abuse detection and prevention efforts. In many of our states, UnitedHealthcare Community Plan submits a report to the State on a quarterly basis concerning the cases under investigation by UnitedHealthcare Community Plan.

### **Suspension of Medicaid Payments Pending Investigation of Credible Allegations of Fraud**

In accordance with Section 6402(h)(2) of the Affordable Care Act of 2010 and upon approval and direction of the Department, UnitedHealthcare Community Plan will suspend payment for individual providers pending investigation of credible allegations of fraud.

## Section P: Claims Management (Section 14 of RFP)

**P.1 Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts. (All GSAs)**

Questions P1 and P2 reference the Electronic Claims Management Functionality Section and Adherence to Key Claims Management Standards sections; however, the CCN-S RFP does not contain such sections; therefore, for Question P1, we are responding to all of the following items in Section 14 as applicable and appropriate for the CCN-S model:

- 14.1. General Provisions
- 14.2. CCN Responsibilities-Service Authorization
- 14.3. FI Responsibilities-Service Authorization
- 14.4. FI Responsibilities-Prompt Payment
- 14.5. Claim Formats
- 14.6. Service Authorization Disputes
- 14.7. Remittance Advices and Related Functions
- 14.8. Payment Cycles
- 14.9. National Correct Coding Initiative
- 14.10. Self Audit Requirements.

### General Provisions (Section 14.1)

Our COSMOS system contains functionality covering enrollment, provider services, member services, benefits and claims processing. We can process and utilize all other reference files, including Provider Records/Profiles and Procedure Tables. Features of this integration require nightly feeds. We will tailor our application portfolio to the specific requirements unique to the Louisiana CCN plan. COSMOS has the flexibility that allows us to meet changing regulatory requirements without disrupting our claims processing flows. COSMOS system features include:

<b>COSMOS Features</b>	
■ Document management customized to meet the standards of DHH and its FI, inclusive of HIPAA transaction and code set compliance	■ Batch or online claims processing
	■ Claims inquiry by provider
■ High-volume system capabilities	■ Unlimited point-of-service functionality
■ Flexible claims processing rules and edits	■ Flexible benefit designs
■ Flexible provider networking and reimbursement	■ Real-time adjustments and voids
■ Multiple site processing	■ Selects claims for pre-payment quality review
■ Accepts inputs from paper, tape or electronic	■ System-wide navigation assistance
■ Free-text comments	■ Error tabling (all errors can be viewed at once)
■ User-defined rules for dollar/coverage amounts	■ Claims inquiry by member
■ Secured error override capability	■ Claims inquiry by service and service dates
■ Claims inquiry by partial claim number	■ Claims inquiry by process improvement projects

Our health information systems are fully compliant with HIPAA privacy and transaction and code set standards adaptable to updates in order to support CCN claims-related policy requirements as needed. Our HIPAA-compliant claims processing system is capable of cost-avoiding and processing claims in accordance with state and federal requirements. We support standard 820, 834, 835, 837, 270/271 and 277/278 file formats for all electronic transactions (EDI). To comply further with HIPAA privacy requirements, all applications use role-based access to ensure that staff only has access to reports and data to support their current role and function. Access is further controlled by using some of our best security practices: firewalls and physical separation of processing systems. Our systems provide information on areas including, but not limited to service utilization and claim disputes and appeals [42 CFR 438.242(a)].

Our core claims processing system is integrated with CareOne, our care/case/disease management system. We designed our CareOne application to coordinate the information flow among caregivers, case managers, members, and providers. CareOne includes assessment information, facilitates the development of a care plan, and includes ongoing monitoring and evaluation tools. Prior authorizations are also logged in CareOne and automatically shared with our claims processing system.

In accordance with the requirements set forth in this RFP, we agree to notify providers of the requirements that all claims be filed directly with us for services provided to CCN members and that any claims submitted directly to DHH's FI for a CCN member will be denied.

### **Provider Training on DHH Program Requirements Including Claims Functions**

UnitedHealthcare Community Plan understands the need to educate providers on the requirements of the CCN program, including claims submission and processing responsibilities. As part of our training, we will disseminate training and educational materials electronically and in hardcopy. We have summarized our training plan below and agree to document training efforts as required by DHH.

#### **Face-to-Face Education and Training**

- **Provider Claims Educator:** Our Provider Claims Educator will present at provider forums and be available to educate providers on appropriate claims requirements in their offices. The Provider Claims Educator reviews denial, call center, and adjustment trends to address issues with providers and provide education to help alleviate those issues. He/she develops and maintains internal educational materials for the call center, provider representatives, and claims staff to improve claims payment processes and also identifies claims that have paid incorrectly based on provider complaints and initiates claims repayment projects on their behalf.
- **New Provider Orientation:** UnitedHealthcare Community Plan invites all newly contracted providers and their office staff (including the office manager, billing manager, referral coordinator, nurses or medical assistants) to participate in orientation training conducted by our Provider Services staff located in Louisiana. Orientation training is scheduled to occur within 30 days of provider agreement effective date or anytime at the provider's request. The orientation sessions are extensive and include in-service, face-to-face training to communicate all applicable CCN and UnitedHealthcare Community Plan policies, procedures, rules, regulations, and expectations, including the encouragement of electronic claims submissions and assistance with electronic funds transfers. We also identify resources and appropriate methods of communication with us.
- **Provider Advocates/Office Visits:** Provider Advocates assist providers with questions or problems, including issues with electronic claims submission and electronic claims. The field-based Advocates conduct provider visits and educate providers on electronic payments and statements. The internal representative ensures that someone is always available to assist providers.

- **Provider Forums:** In addition to the individualized training we conduct at provider offices, we hold Provider Forums, which are half-day seminars led by the Provider Relations department with other UnitedHealthcare Community Plan department subject matter experts (Medical Management Director, EPSDT Coordinator, Behavioral Health Coordinator, Claims Educator, etc.) speaking on specific issues that affect provider practices, including electronic claims and electronic funds transfers. Office managers, billing representatives, clinical staff and other office staff from provider offices are invited to attend and provide input. Based upon the pre-registered list of attendees, our staff creates presentations specifically designed to meet the needs of the participants. Break out sessions are available. We expect to have at least two Provider Forums per year, with GSAs with higher membership concentrations having up to four.

### **Other Education and Training Resources**

- **Provider Newsletters:** Our Summer 2010 newsletter includes an article educating providers on electronic claims. We produce and distribute the Provider Newsletter to the network at least four times per year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, and information on electronic claims submissions and electronic funds transfer. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements.
- **Provider Administrative Guide:** We work with providers to make claim filing as straightforward and effortless as possible. We educate providers on our claims processing methods and direct them to a Website that provides additional information and training as described below. The Website and Provider Administrative Guide contain information pertaining to the process, working with paper versus electronic claims, and changing general demographic data. The Claims chapter of the Provider Administrative Guide provides detailed information covering EDI/electronic claims submission and electronic funds transfer (direct deposit). The Guide includes contact phone number to assist providers with questions.
- **Provider Portal:** Our provider portal is a significant mechanism we employ to assure providers submit claims data to us. Provider orientation includes a demonstration of the provider portal ([www.uhccommunityplan.com](http://www.uhccommunityplan.com)) covering each of the portal functionalities and includes hands-on computer training. The provider portal is integrated with our COSMOS transaction processing tables. This integration allows for instant error validation as data is input.

### **Electronic Claims Management (ECM) Functionality**

UnitedHealthcare Community Plan requires participating providers to submit claims on the appropriate claim form (UB04, HCFA 1500) as specified by DHH. We encourage providers to submit claims electronically to facilitate more expedient processing and we do not gain financially from a provider's use of electronic claims filing functionality. Providers may submit claims via paper forms. Currently, on average YTD, we receive approximately 85.75 percent of all claims electronically. Providers send paper claims to a designated post office box.

Upon receipt, paper claims are converted to electronic data via iDRS, our imaging and workflow system. The process involves scanning paper documents and attachments using optical character recognition, which prepopulates claims electronically. Data entry examiners verify the images by reviewing the scanned images against the pre-populated fields and correct any errors that exist. COSMOS assigns unique document control numbers (DCN) that permanently links images of the original claims to data in COSMOS. Electronic claims also receive a unique DCN upon loading into the system for tracking, logging and audit control purposes. All claims are stamped and tracked with their date of receipt to allow for real time status tracking.

All claims are worked in “first in, first out (FIFO)” order based on the date of receipt. Our Claims management team prepares pending claims reports on a daily basis to ensure that CCN claim examiners meet the requirements for claim turnaround time. On a daily basis, our Claims management team review on-line aging reports. Claim examiners research and work the identified claims ensuring claims are pre-processed within the timeframes stipulated by our contractual partners

### Identifying Excluded Providers

Upon receipt of completed credentialing applications and during the recredentialing process, credentialing specialists cross reference providers’ NPI and Medicaid ID numbers with the Office of Inspector General’s (OIG) List of Excluded Individuals/Entities (LEIE) and any available State databases to identify excluded providers. These lists are also cross referenced during our Credentialing team’s monthly monitoring process. As we identify excluded providers from the LEIE or any State sources they are given an adverse credentialing determination when identified during credentialing, or are terminated from our network when identified during the re-credentialing or monitoring processes.

Although identified excluded providers are not granted a contract with us, we still maintain a provider record on them. We flag their records as excluded providers. As claims are loaded into COSMOS for processing, any claim coming from a provider that is flagged as excluded is sent to our Special Investigations Unit (SIU) for manual review. SIU associates review these claims to confirm the excluded status of the submitting provider. If it is determined that the provider is excluded, we notify DHH as required in Section 15.1.6 of the RFP. When we determine that the provider is not excluded, the claim is sent back to the Claims team for processing.

## CCN Responsibilities-Service Authorization (Section 14.2)

UnitedHealthcare Community Plan agrees to the service authorization responsibilities in this section. Below is an overview of our service authorization process.

We agree to the following requirements without exception:

- To provide service authorization approval to providers using a unique authorization number as defined in the CCN-S Systems Companion Guide
- To confirm CCN membership as service authorization requests are submitted on the basis of the eligibility information provided by DHH
- To verify medical necessity as defined by DHH
- To identify date of receipt (the date we receives the claim)
- To provide on-line and phone based capabilities to providers for obtaining status information
- To obtain a submitter identification number from the FI prior to submitting claim
- To submit electronic claims received from providers to the FI within two (2) business days of receipt
- To submit paper claims to the FI in batch form within two (2) business days of receipt. The FI maintains claims billing information on the DHH Medicaid Website:  
[http://www.lamedicaid.com/provweb1/billing\\_information](http://www.lamedicaid.com/provweb1/billing_information).

### Service Authorization Overview

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 time frames:

- **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 10th 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 Medical Director 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 Community Plan'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. If there is, a case typically not deemed medically necessary, UnitedHealthcare Community Plan will reach out to DHH for consultation or approval. 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 Medical Director. 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 medical director 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 10 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.

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### **FI Responsibilities – Service Authorization (Section 14.3)**

The requirements in Section 14.3 apply to the FI and are not applicable to UnitedHealthcare Community Plan. We have restated the requirements below for confirmation.

#### **14.3. FI Responsibilities-Service Authorization**

- 14.3.1. Ensure MMIS verifies that a service is a covered service and is eligible for payment
- 14.3.2. Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a members eligibility span
- 14.3.3. Identify date of receipt; and
- 14.3.4. Provide Web-based claims status and inquiry capability.

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### **FI Responsibilities-Prompt Payment (Section 14.4)**

The requirements in Section 14.4 apply to the FI and are not applicable to UnitedHealthcare Community Plan; however, in our response below, we have addressed requirements that indirectly relate to our responsibilities.

UnitedHealthcare Community Plan understands the FI shall adhere to prompt payment requirements established under the American Recovery and Reinvestment Act of 2009. This ensures that 90 percent of clean claims for payment of services delivered to a member are paid to the provider within 30 calendar days of the receipt of such claims and process and if appropriate pay, within 90 calendar days, 99 percent of all provider claims for covered services delivered to a member. The 30 calendar days starts the date of claims receipt by the FI.

Therefore, we agree to adhere to DHH's two business day rule for clean electronic and paper claims and four-business day rule for clean claims requiring attachments. We acknowledge sanctions or monetary penalties may be applied for non-compliance with this rule.

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### **Claim Formats (Section 14.5)**

Our data warehouse, implemented in Oracle, utilizes standard industry practices for documented data dictionaries, extract/transfer/load (ETL) processing, and data quality assurance processes. We also use the HIPAA Gateway product by TriZetto which provides a common data dictionary, naming and format convention. To ease ad-hoc user reporting in the data warehouse, a series of internal data exchange data element names are translated into more end user friendly names that are cross referenced using data dictionaries. For all data interfaces, similar data elements have equivalent names across systems to accommodate interface maintenance and ongoing enhancements, and are formatted to allow the most flexibility for growth (for example, allowing where possible more spaces than is currently needed). This is similar to HIPAA's approach for name fields. Data types are also the same for similar elements. The frequency of updates/refreshes of similar data elements varies with the business purpose of the interface.

Our system complies with the following HIPAA-compliant standards for information exchange. We will not revise or modify the standardized forms or formats without approval from DHH. Should DHH present recommendations concerning claims processing that are consistent with industry norms, we will comply with said recommendations within 90 calendar days

Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance

- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 278 Utilization Review Inquiry/Response; and
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

We require providers to comply with standardized paper billing forms and formats, and all future updates for Professional claims (CMS 1500), Institutional claims (UB 04), and Louisiana's KM3 form for EPSDT/KidMed billing of paper claims. All electronic claims shall be submitted to DHH in the standard HIPAA transaction formats as specified above, specifically the ANSI X12N 837 Transaction formats (P - Professional, and I - Institutional). Unique authorization number will be submitted either on the paper claim or the electronic claim as service authorization was received.

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## **Service Authorization Disputes (Section 14.6)**

UnitedHealthcare Community Plan maintains a timely and organized process using policies and procedures to ensure prompt resolution of informal and formal complaints/grievances filed by members and providers. Our system includes a member grievance process, member and provider appeals processes that include access to the state's fair hearing process and a provider service authorization dispute process. We will file our formal procedure to DHH within 30 days of contract signatures. We allocate qualified and trained personnel to establish, implement and maintain this process.

### **Service Authorization Disputes Overview**

Our grievance and appeal system is HIPAA compliant and conforms to applicable federal and state laws, regulations and policies. On contract award and prior to implementation, this process will be approved by DHH. Upon enrollment, UnitedHealthcare Community Plan informs members and providers of our grievance and appeal procedures. Information includes:

- The right of members to file grievances and appeals and the right of providers to file appeals and claim disputes
- The requirements and timeframes for filing grievances, appeals and claim disputes
- The availability of assistance to members for informal/formal grievance and appeal filing
- That members may use an authorized representative during the grievance and appeal process
- That a provider may file an appeal on behalf of a member with the member's written consent
- Toll-free numbers for a member to file a grievance or appeal by phone
- Notice of appeal rights each time a covered service is denied, reduced, or terminated
- Notification of the member's right to appeal the decision to DHH after an official appeal to UnitedHealthcare Community Plan
- The right to a state fair hearing
- The method for obtaining a state fair hearing
- The rules that govern representation at the hearing
- Notice that, when timely filed, member requested benefits continue during appeal/state fair hearing request
- Notice that, if the final decision is adverse to the member, s/he may be required to pay for the costs of the service furnished.

We inform members of our grievance and appeal process via our member handbook, new member welcome packet and online through the UnitedHealthcare Community Plan Website. We inform members of the grievance and appeal process in prevalent non-English languages, via oral interpretation in any language and via TTY/TTD services. We provide members with forms, if requested, and assistance with filing grievances and appeals. Members may file grievances or appeals either verbally or in writing. UnitedHealthcare Community Plan informs providers of the member grievance and appeal process through the UnitedHealthcare Community Plan provider manual and the UnitedHealthcare Community Plan provider portal.

- **Notice of Action (Continuation of Benefits and Adverse):** CCN members are sent written notice of any change to their benefit status (e.g., continuation/adverse action) to inform them of their rights to appeal through UnitedHealthcare Community Plan and their right to access DHH's state fair hearing system. We send written notice of the decision to maintain, deny or reduce a service authorization request to providers. UnitedHealthcare Community Plan provides the initial Notice of Action no later than 14 calendar days from the date of the request for routine requests and no later than 3 working days for expedited requests. If UnitedHealthcare Community Plan does not make a decision in applicable timeframes, a decision is made on the date the timeframes expire. UnitedHealthcare Community Plan complies with advance notice requirements and timeframes for the Notice of Action.
- **Filing a Member Grievance:** Members or their authorized representative may file grievances with UnitedHealthcare Community Plan by calling our Member Services toll-free number or by mailing them to our Regional Mail Operations (RMO). Telephonic/verbal grievances are routed through the Online Routing System (ORS), technology that identifies call type and routes to other databases according to category. When the ORS identifies the call as a grievance, the information is logged into the system, and forwarded to a triage team who puts the information into the Escalation Tracking System (ETS), where a case file is created and populated. On receipt of a written grievance, appropriate personnel scan them into the ETS and create a case file. Per our Member Grievance policy, and on initial contact, we log and track various criteria (e.g., member name/identification number, date received, acknowledgement, description, staff assigned, disposition, etc.). We acknowledge receipt of each member grievance not later than 10 calendar days from initial receipt. Acknowledgement letters are generated automatically via the ETS Client Letter Tool.
- **Process for Resolving a Grievance:** Member Services receives calls 24 hours a day, 7 days a week to address various issues, including member grievances. All calls related to member grievances are recorded in the ORS. The majority of member complaints are resolved during the initial call and we maintain all data from all calls. If a complaint cannot be resolved, a grievance is forwarded to our Grievances & Appeals team on priority and set in queue via First-in/First-out (FIFO) for our resolving analysts to address. Resolving analysts are educated on grievance procedures, and member and provider rights. On notification of a grievance, our resolving analysts conduct preliminary research and verify the appropriate grievance path.
- **Filing an Appeal:** Members or their authorized representatives (including a provider acting on behalf of a member) may file an appeal in response to a Notice of Action. Members have 60 calendar days from the date of the Notice of Action to file an appeal in writing or verbally. The information is routed to the ETS, where a case file is created. An acknowledgement letter is generated within 10 calendar days for standard appeals. No punitive action is taken against a provider who supports a member's appeal or requests an expedited resolution.

### **Levels of Review and Timing**

We adapt our review and response times to meet HIPAA, federal, state and regulatory compliance. Within these parameters, we will adjust our services to meet DHH requirements.



<i>Level of Review</i>	<i>Standard</i>	<i>Expedited</i>
<b><i>Verbal Inquiry</i></b>	Addressed during initial phone call or close of next business day.	Addressed during initial phone call or close of next business day.
<b><i>Grievance: Acknowledgement Letter</i></b>	In 10 calendar days	N/A
<b><i>Grievance: Resolved</i></b>	As expeditiously as member's health condition allows no later than 30 calendar days	As expeditiously as member's health condition allows; no later than three working days
<b><i>Appeal: Acknowledgement Letter.</i></b>	In 10 calendar days	N/A
<b><i>Appeal: Resolved</i></b>	Not greater than 45 calendar days unless an extension is in effect	Written/verbal response in three working days (If denied member is notified of status change to regular appeal timeframes.)

### ***Expedited Review***

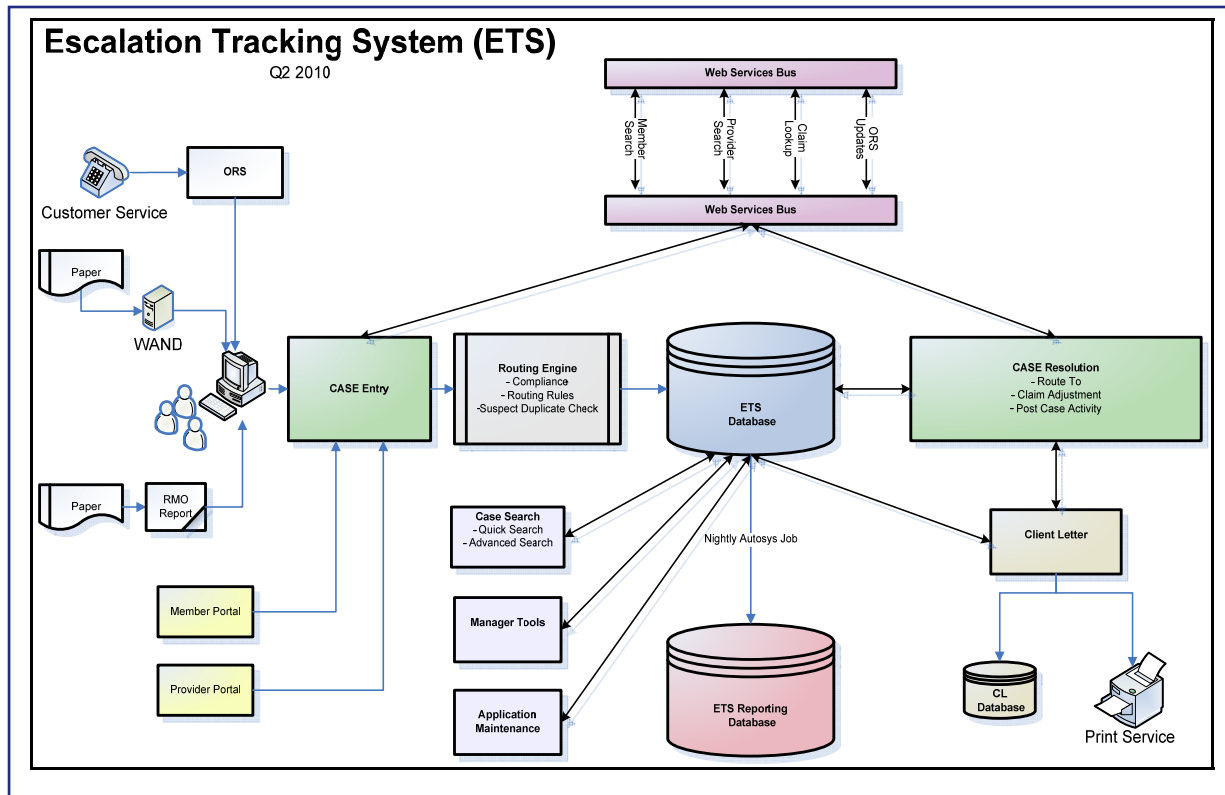
UnitedHealthcare Community Plan expedites resolution of an appeal if, according to the information provided by the member or the provider filing an appeal on the member's behalf, the standard resolution timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. Under these circumstances, UnitedHealthcare Community Plan resolves the expedited appeal in three working days. UnitedHealthcare Community Plan extends the resolution timelines for either expedited or standard appeals on the member's request or if UnitedHealthcare Community Plan needs additional information and time and it is in the member's best interest. UnitedHealthcare Community Plan may request an extension of up to 14 calendar days and provide the member with a written notice of the extension and the reason/s for the delay. UnitedHealthcare Community Plan contacts the member verbally, as expeditiously as possible, and provides written notice of expedited resolution denial in three working days.

If the request to expedite an appeal is denied, the appeal is transferred to a 45 calendar day standard appeal. Prompt oral notice is given and a written notice of the decision to not expedite the appeal is provided within two calendar days.

### **Tracking and Trending**

#### ***General Policies and Procedures***

UnitedHealthcare Community Plan has policies and procedures to describe the grievance system process and how it operates. These written directives cover our methods to receive, track, review and report all member inquiries, grievances and appeals. For high accuracy levels and optimum efficiency, we use a state-of-the-art technological tracking system (ETS) to maintain, record, and store all grievance and appeals activity, including policy mandated timeframes for member contact and resolution. We change our member grievance policies and procedures as requested by each state. Any procedures and changes will be submitted to DHH annually. UnitedHealthcare Community Plan Escalated Tracking System (ETS) — Our ETS allows us to capture, track, manage and monitor member and provider grievances and appeals. It is our imaging, scanning and workflow system.



Our ETS contains all information for each member's and provider's appeal or grievance case file. Original documentation is scanned in to and extracted from a centralized repository. Data entry staff review the scanned image and populate the database with appropriate information (e.g., case number, case type, patient information, received dates, etc.). Verbally received grievances and appeals are routed to staff, who populate ETS with grievance information. The member information is available to resolving analysts and managers who review cases and "push" them through the system driven by state mandated deadlines and using First-in/First-out (FIFO) methodology. When members call to query existing grievance/appeal status, we provide the most current information, educate the member on the process and steer him/her to the next appropriate level. Grievance and appeal status is available at any time. Compliance and regulatory conditions are built into the system, allowing for better "turn-around" time management; comprehensive reporting and analyses; effective operational workflow management and increased communication accuracy via our ETS Client Letter tool, a software application to generate state-specific notifications for members and providers in mandated timeframes. This system enhances practice and workflow. An all encompassing integrated database for information upload and retrieval, it is accessible via desktop technology; designed for many different functions within the grievance/appeals process; and available to many different levels of staff, based on need and HIPAA requirements.

### **Record Retention**

The ETS retains grievance and appeals records for five years. If any litigation, claim negotiation, audit or other action involving documents or records starts before the expiration of the five-year period, the records are retained until the action is complete and resolution attained, whichever is later.

### **Using Data to Drive Change in Policy and Procedure**

Reviews of any area of the grievance system to identify potential operation deficiencies trigger deliberate and prompt corrective action in affected areas. Corrective action may include additional education for UnitedHealthcare Community Plan staff or providers, or a change in our policies or procedures.

### ***Internal Auditing***

To ensure compliance in our grievance and appeal system, UnitedHealthcare Community Plan has an internal auditing team. The audit team conducts a monthly sampling of appeals, state fair hearings, and claims disputes, and audits the scanning, data entry and opening of mail. Audit tools encompass policies and procedures, and supports regulatory requirements. We maintain a formal process of addressing specialist audit errors, which we correct and track to completion. Audit results are reported on a monthly basis to executive management and discussed in team meetings. Audit findings identify trends and training needs, and improve our Grievance, Appeals and Claim Dispute processes. These are inserted into our policies and procedures, further driving continual improvement performance and assuring service quality. Some of our internal audit requirements include but are not limited to:

- Decision/resolution letters contain all required components
- Issues addressed appropriately
- Appropriate decisions made based on claim dispute and available research information
- Appropriate statute, rule, and policy applied in the resolution
- Completed file contains all documents
- All applicable timelines met; and
- Copies of acknowledgement and extension contained in the file.

When assessing grievances and appeals audit materials, we involve all appropriate departments. Team discussion rectifies issues; the results drive policy/procedure change to improve processes, outcomes and member satisfaction.

### ***External Auditing***

Grievance and Appeal Reporting to DHH — UnitedHealthcare Community Plan will submit a “mutually agreed upon” summary report of provider/recipient grievances, appeals and claim disputes; and a detailed log of recipient grievances and appeals and provider claim disputes in accordance with contract requirements to DHH by the 15th of each month after the end of each month. UnitedHealthcare Community Plan will provide a written report on informal and formal grievances to each client (e.g., DHH) as required. When UnitedHealthcare Community Plan files a “required” copy of any report regarding grievances system use with the Louisiana Department of Insurance, UnitedHealthcare Community Plan will submit the same to DHH in 30 calendar days.

### **Provider Claims Inquiries**

The UnitedHealthcare Community Plan Provider Service Team handles phone inquiries from providers through a centralized toll-free number and completes claims research projects. This unit is a first-level process that can resolve issues without using the formal provider claims dispute process. Claim information is also available online via our provider portal. Staff logs all inquiries in FIFO order.

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## **Remittance Advices and Related Functions (Section 14.7)**

UnitedHealthcare Community Plan understands the FI is responsible for providing us with an electronic status report indicating the disposition for every pre-processed claim for each claim type submitted by providers seeking payment. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim and with FI must assist providers in reconciliation of claims. If the claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

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## **Payment Cycles (14.8)**

UnitedHealthcare Community Plan recognizes the FI receives claims 24 hours per day 7 days per week. We agree that claims which are received on or before 10:00 a.m. each Thursday will be processed in that week's batch cycle, and the claim will be pre-processed on the subsequent Tuesday.

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## **National Correct Coding Initiative (14.9)**

UnitedHealthcare Community Plan has claims standards reflecting both CCN program standards and internally developed standards. The standards relate to financial accuracy, coding/data entry accuracy and timely turn-around. We also comply with Section 6507 of the Patient Protection and Affordable Care Act of 2010, regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative. Should DHH present recommendations concerning claims processing that are consistent with industry norms, we will comply with said recommendations within 90 calendar days

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## **Self Audit Requirements (14.10)**

UnitedHealthcare Community Plan agrees to meet a 99 percent submission rate of clean claims from providers and forwarded to the FI within two (2) business days. Clean paper claims requiring attachments that are authorized at the time of pre-processing are exempt from this standard. Clean paper claims requiring attachments will be submitted to the FI within four (4) business days of receipt from the provider.

We agree to time and date stamp all claims when received by the provider, whether received in paper or in electronic 837 format. We will provide the Julian date of receipt and date of submission to the FI.

We agree to submit pre-processed claims to the FI no later than two (2) business days of receipt of a claim from a provider. The CCN Internal Control Number (ICN) will reflect the Julian date that the claim was pre-processed. In compliance with the CCN-S Systems Companion Guide, the CCN ICN will be populated in loop 2300, MEDICAL RECORD NUMBER, REF02, data element 127. A reference identification qualifier value of EA will be used in REF01, data element 128.

We agree to create an audit report demonstrating the percent of claims submitted to the FI within two business days from date received from the provider upon request by DHH. In addition, we acknowledge complaints must be tracked and a performance penalty can be imposed if complaints from providers reporting delayed payments for correctly submitted clean claims can be substantiated.

## **Claims Quality Overview**

UnitedHealthcare Community Plan continuously monitors the pre-process to promote accurate and timely processing as well as to minimize the likelihood of adjusting already processed claims. Given the significant volume of claims processed by UnitedHealthcare Community Plan and the importance of the claims process for provider satisfaction and participation, we understand the vital nature of having a proactive, thorough approach for quality monitoring in our claims management process. As part of our effort to self-monitor, self-report and continuously improve our operations, we established a claims quality assurance program based on a set of quantifiable measures and multiple initiatives to monitor our claims processing operation and resolve deficiencies. We monitor measures through a combination of automated system-checks and manual assessments which drives quality improvement activities that include cross-functional efforts.

To ensure DHH's claims processing standards are met, UnitedHealthcare Community Plan will implement systems as well as proper staffing in order to exceed contract requirements.

The claim processing staffing models that are developed and implemented are specific to the CCN program and designed to ensure performance requirements are achieved. This is accomplished by

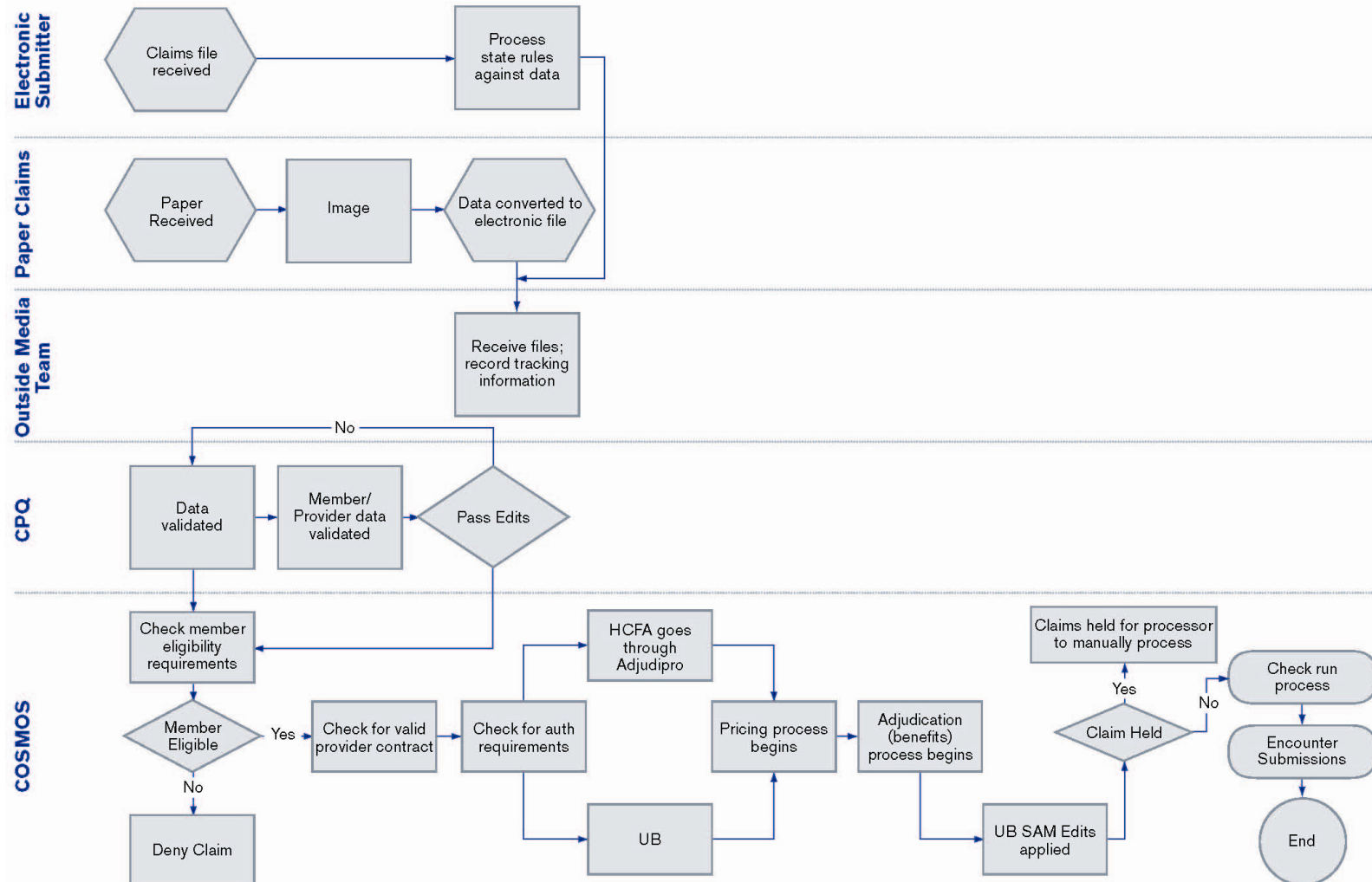
factoring the following components to determine the number of full-time employees needed to process claims:

- Projected members
- Contract rates
- Anticipated auto pre-processing percentage (depends on configuration outcomes)
- Productivity per hour

UnitedHealthcare Community Plan has built a solid foundation of exceeding the expectations of our state partners and we clearly have the resources, proven experience and expertise to implement a claims operation capable of meeting CCN RFP requirements. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.



## Claims High-Level Flow



## Monitoring/Measures to Ensure Standards

Prior to loading claims into COSMOS, the system applies automated edits to electronically submitted claims for formats and specific rules, such as invalid birth year or dollar amounts. Claims that do not pass these edits are returned to the provider. Paper claims are returned to providers only in cases where we are unable to identify the member. In this situation, we issue a letter to the provider, requesting that a copy of the member's ID card be submitted with the claim.

These "up front" measures, along with the process described above, ultimately ensure the completeness and accuracy of the weekly claims data submitted to the FI. We produce a variety of Crystal and Business Objects reports which are made available to our Operations and Claims management teams for review of claims for completeness and accuracy of claims data.

## Claims Accuracy Monitoring

The Claims team is responsible for ensuring that claims are pre-processed in a timely manner. This team uses a series of comprehensive management tools and reports to effectively monitor timeliness and efficiency. These reports are used to drive operational improvements to meet or exceed goals consistent with regulatory requirements. The inventory review provides insight into aging and volume of claims awaiting manual intervention.

To remain compliant with UnitedHealthcare Community Plan's internal turnaround time standards, we monitor aging for a consistent threshold of performance on a daily basis. Any drop in the metrics, below standard, requires a corrective action plan to get back to standard metric levels. A weekly review of our performance ensures consistent progress measurement and allows direction for internal resource sharing to support the volume. Results are shared monthly with the UnitedHealthcare Community Plan leadership team, providing discussion points for trending performance, potential obstacles, along with any additional remediation activities if necessary. We use the following reports to monitor performance:

- **Daily Inventory and Load Balancing Reports:** shows inventory of claims by type for monitoring of timeliness
- **Claims Pend Reports:** identifies claims delayed due to items such as missing pricing, manual processing, etc.
- **Daily EDI & Production Reports:** identifies incoming claims volume
- **Aging Reports:** shows the aging of claims for monitoring of timeliness
- **Weekly and Monthly Scorecard Metrics:** shows the state and internal metrics for monitoring
- **Quality Management Committee:** verifies that issues are being addressed and corrected.

***Cite at least three examples from similar contracts.***

Our expertise in executing successful claims platforms is based on our experience in providing Medicaid services to plans in 24 states and the District of Columbia. At this time, our other existing Medicaid lines of business processed on the COSMOS platform do not share the same performance metrics DHH has established related to turnaround time; however, we have provided Medicaid examples that most closely resemble CCN requirements.

## Rhode Island Medicaid Performance Results

Because of our integrated technical platform, including our COSMOS claim platform, we were able to exceed performance metrics expectations. This health plan has been serving members in Rhode Island since 1991, and presently provides services for over 45,000 members. Our performance results speak to our ability to exceed DHH's claims turnaround requirements for the CCN program.

<b><i>Rhode Island – UnitedHealthcare Community Plan Claims Performance Results</i></b>	
<b><i>Reporting Period</i></b>	<b><i>Result</i></b>
January 2010	99.8% within 30 calendar days
February 2010	99.6% within 30 calendar days
March 2010	99.7% within 30 calendar days
April 2010	99.7% within 30 calendar days
May 2010	98.8% within 30 calendar days
June 2010	99.9% within 30 calendar days
July 2010	99.6% within 30 calendar days
August 2010	100.0% within 30 calendar days
September 2010	99.4% within 30 calendar days
October 2010	99.7% within 30 calendar days
November 2010	99.7% within 30 calendar days
December 2010	99.8% within 30 calendar days
January 2011	98.5% within 30 calendar days
February 2011	99.6% within 30 calendar days
March 2011	100.0% within 30 calendar days
April 2011	100.0% within 30 calendar days

**Another key item to note is that** UnitedHealthcare® of New England's Medicaid health plan was ranked 26th among all Medicaid health plans in the country according to U.S. News & World Report/NCQA "America's Best Health Plans" 2010-2011. The study ranked the nation's commercial, Medicare, and Medicaid health plans based on access to care, overall member satisfaction, prevention, treatment and overall quality score. "America's Best Health Plans" is a trademark of *U.S. News & World Report*.

## **Connecticut Medicaid Performance Results**

UnitedHealthcare Community Plan currently provides Connecticut Medicaid program services and the table below details our claims turnaround performance metrics. UnitedHealthcare Community Plan has been serving the members in Connecticut since the third quarter of 2008, and presently provides services for over 53,000 members. We clearly have the resources, experience and expertise to successfully implement a claims system meeting DHH's needs.

<b><i>Connecticut – UnitedHealthcare Community Plan Claims Performance Results</i></b>	
<b><i>Reporting Period</i></b>	<b><i>Result</i></b>
January 2010	99.8% within 30 calendar days
February 2010	99.8% within 30 calendar days
March 2010	99.7% within 30 calendar days
April 2010	99.9% within 30 calendar days
May 2010	97.1% within 30 calendar days
June 2010	99.7% within 30 calendar days

<i>Connecticut – UnitedHealthcare Community Plan Claims Performance Results</i>	
<i>Reporting Period</i>	<i>Result</i>
July 2010	99.6% within 30 calendar days
August 2010	99.9% within 30 calendar days
September 2010	100.0% within 30 calendar days
October 2010	99.9% within 30 calendar days
November 2010	99.9% within 30 calendar days
December 2010	99.8% within 30 calendar days
January 2011	97.9% within 30 calendar days
February 2011	99.3% within 30 calendar days
March 2011	99.9% within 30 calendar days
April 2011	99.9% within 30 calendar days

## Mississippi CHIP Performance Results

The implementation of one of our newest plans, Mississippi CHIP (MS CHIP), in January 2010 demonstrates our experience in implementing a successful claims platform. It is not uncommon in new implementations for there to be confusion as to who is responsible for “owning” a process since there is no historical subject matter expert. By having effective leadership at the local level, solid processes and an effective work plan, we are able to overcome barriers that may have overwhelmed a less-experienced Medicaid provider.

As part of the implementation strategy, an IT project manager was assigned as a lead and served as a link to different functional areas (example, call center, claims, technology, etc.). Our hands-on involvement in local operations was a critical factor in the start-up of claims. Claims reporting and responsibilities are often confusing for a new health plan regardless of the training provided. We realized even if all went as planned, the complexity of MS CHIP claims would require additional support through the first quarter and we provided this support, which became a best practice for new start-ups.

For MS CHIP, our performance metrics **demonstrate our ability to go “above and beyond” minimum claims performance guarantee standards** as is the intent for the Louisiana CCN program.

<i>Mississippi CHIP – UnitedHealthcare Community Plan Claims Performance Results</i>		
<i>Timeframe</i>	<i>MS CHIP Performance Standard</i>	<i>Result</i>
Q1 2010	90% within 30 calendar days	98.13%
Q2 2010	90% within 30 calendar days	97.67%
Q3 2010	90% within 30 calendar days	93.71%
Q4 2010	90% within 30 calendar days	97.90%
Q1 2011	90% within 30 calendar days	95.66%

**P.2** *Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response: (All GSAs)*

## Claims Quality Review Overview

Our Claim Quality Review Program is our comprehensive review program that incorporates multiple audit reviews. It is designed to provide a consistent process for measuring the quality of claim processing, satisfy internal and external performance reporting requirements and facilitate continuous quality improvement and defect reduction. For the CCN-S, we will focus our efforts on our pre-processing activities of provider and member validation and authorization verification. However, we will work with the FI to support other initiatives on a mutually agreeable basis.

Our quality review programs are centrally managed and administered. The quality teams are staffed with dedicated quality review professionals who evaluate the performance of all customer groups/policies processed within the transaction centers. This dedicated staff also evaluates individual transaction specialists' performance.

UnitedHealthcare Community Plan is committed to continually improving the efficiency of our work processes and service. Our audit and quality control programs provide statistically reliable data, are aligned with industry norms and drive improvement to meet the needs of our customers as outlined below:

- Statistical Review (Office and Policy)
  - Test financial and procedural accuracy of claims processing
  - Provide statistically valid results
  - Satisfy internal and external reporting needs, including performance guarantees.

The Statistical Review is conducted by BPQM Quality Assurance on a monthly basis.

- Post Training Certification Review
  - Test financial and procedural accuracy of each trainee
  - Includes an expanded sample volume to quickly identify training gaps or training opportunities
  - Audits continue until processor meets minimum accuracy levels.

The Post Training Certification Review is conducted until certification is attained or requires performance management.

- High Dollar Reviews
  - Test financial and procedural accuracy of benefit payment of claims that have the greatest impact on financial results
  - >\$10,000 High Dollar Review.

The High Dollar Reviews will be conducted daily for all claims that exceed this paid threshold.

- Focus Audit Review/Data Mining
  - One time audit to examine transactions for specific problematic topics to identify error type sources.

The Focus Audit Review/Data Mining is conducted on an ad hoc basis.

- Individual Processor Review
  - Ongoing sample at the processor level to provide daily feedback and identify training opportunities



- Results are tied to individual performance programs (incentive, performance management, etc).

The Individual Processor Review is conducted on a continuous basis.

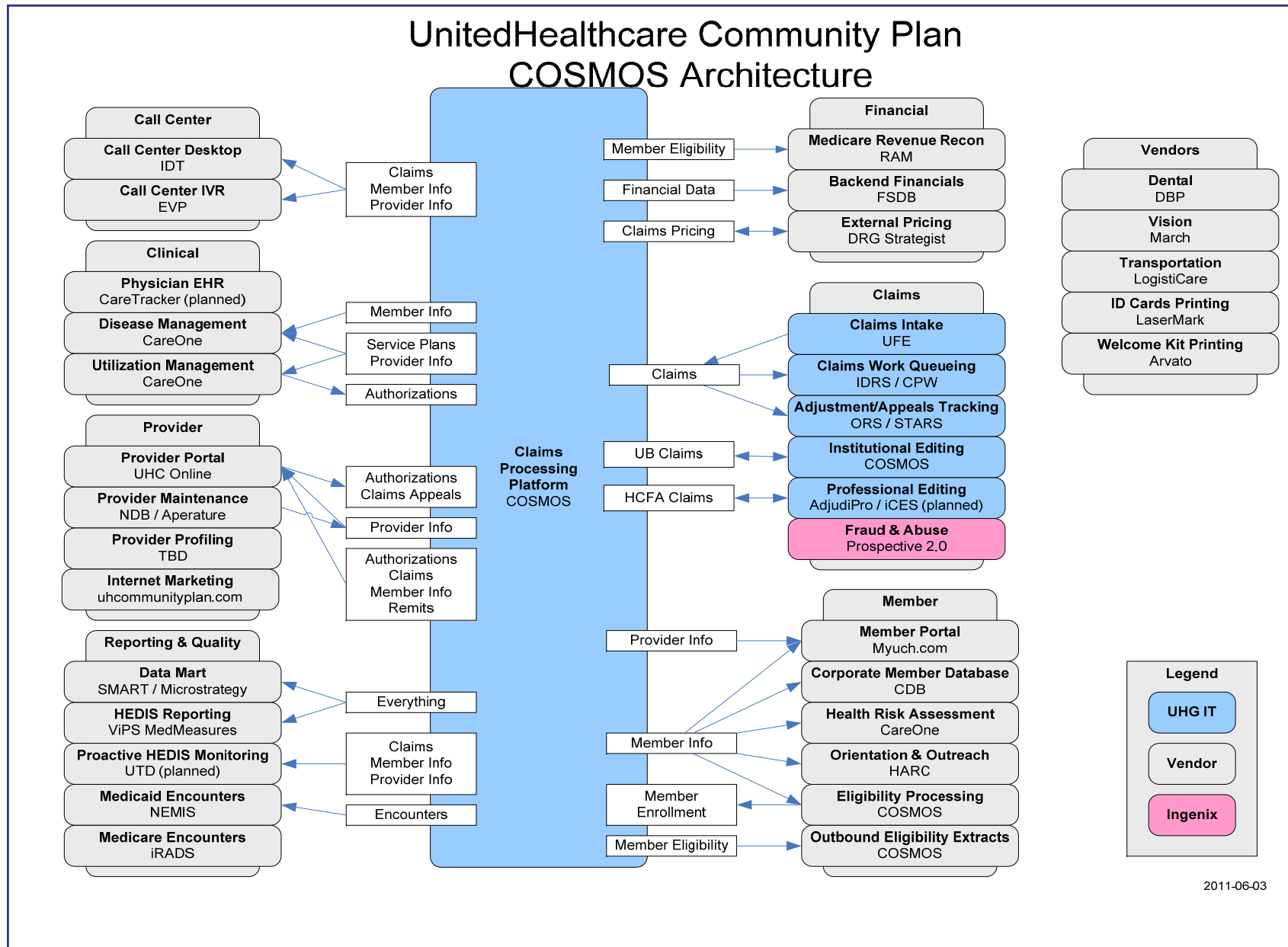
■ Auditor Validation Review

- Examines sub-sample of auditors work to ensure consistency in quality review procedures.

The Auditor Validation Review is conducted on a monthly basis.

**National Encounter Management Information System (NEMIS):** NEMIS, an advanced encounter submission system uses our proprietary, relational database design which is based on years of experience with encounter submission scenarios and supports rapid identification of problems with submitted encounters. This system serves as an additional audit checkpoint for our claims payment process. Specifically, the system ensures that our claims payments match state-specific coding and encounter requirements. NEMIS supports the tracking, correcting and reporting needed for remediation of identified problems.

Defects in submissions are logged and analyzed for identification of any systemic issues, allowing for the ongoing improvement in the quality of encounters submitted. Encounter adjustments, reconciliations, and post submission completeness reports provide detailed insight into the process with key checkpoints that ensure all transactions are balanced and reported. NEMIS completeness reports provide a systematic approach to data quality that further improves claims adjudication accuracy; all the way back to the source if necessary. NEMIS acts as an automated supervisor, reporting monitor, and data interface exclusively for the encounter submission process. NEMIS allows us to easily manage the entire “loop” of encounter submissions: from COSMOS claims processing through encounter submission and back. We find NEMIS to be of tremendous value in enhancing the quality of encounter data submitted, thus increasing our acceptance rate.



## Internal Audits

The UnitedHealthcare Community Plan internal audit is a continuous and comprehensive audit process performed by our Quality Management (QM) Department, which is separate and independent from Claims Operations, and therefore ensures the utmost integrity in the audit oversight process. All medical claims are included in our reports and audit processes. Audit personnel in our QM Department have broad experience in claims processing, possess strong analytical skills and work closely with the Claims Department to address any issues that may arise resulting from the audits. This collaboration enables UnitedHealthcare Community Plan to make corrections to the system as needed, and to provide the type of feedback and mentoring needed for examiners, in order to support performance improvement. The Claims Department monthly audit results consistently show that we will meet or exceed CCN standards.

## External Audits

Ernst & Young and Deloitte & Touche perform ongoing Sarbanes Oxley audits which include tests of our IT controls.

- *The process for auditing a sample of claims as described in Key Claims Management Standards Section;*

## Process for Auditing Sample Claims

UnitedHealthcare Community Plan will audit a random stratified sampling of all claims processed (both paid and denied), based on total dollars paid. Both auto adjudicated and manually processed claims are included in the review. Claims with higher paid dollars are audited more frequently. Claims are reviewed for financial and procedural accuracy.

The sample size is determined based on a 95 percent confidence level and an expected error rate of two percent of claim dollars submitted for payment. A fixed number of claims are randomly selected for review. Each week, 40 claims per division are sampled and audited. The number of claims selected per strata is based on the percent of paid dollars per strata.

- *The sampling methodology itself;*

## Sampling Methodology

The Smart Audit Master database (SAM) system divides all claims into 8 “buckets” called strata, depending on the total dollars paid. The dollar strata include:

<i>Strata</i>	<i>Total Dollars Paid</i>
1	<\$120
2	\$120 - \$330
3	\$330 - \$780
4	\$780 - \$1,700
5	\$1,700 - \$3,600
6	\$3,600 - \$10,000
7	\$10,000 - \$25,000
8	>\$25,000

- *Documentation of the results of these audits; and*

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## Documentation of Audit Results

Accuracy results are calculated within the audit database. Daily, weekly and monthly reports are real time.

- *The processes for implementing any necessary corrective actions resulting from an audit.*

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## Corrective Action

Monthly meetings occur with responsible business owners to determine corrective action and remediation projects. We utilize Quality's audit findings to drive continuous process improvement. This is done by using the tools of six sigma to perform statistical analysis to identify key drivers impacting claim accuracy. For each key driver identified, root cause analysis is performed and remediation activities specific to the identified root cause are designed and deployed to correct the identified defect. For accuracy issues that are determined to be caused by system or process defects, the Operations Management Support team has accountability for leading the research and remediation efforts. For those items that are determined to be caused by manual error the Claims team has accountability for leading the research and remediation efforts.

**P.3** *Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met. (All GSAs)*

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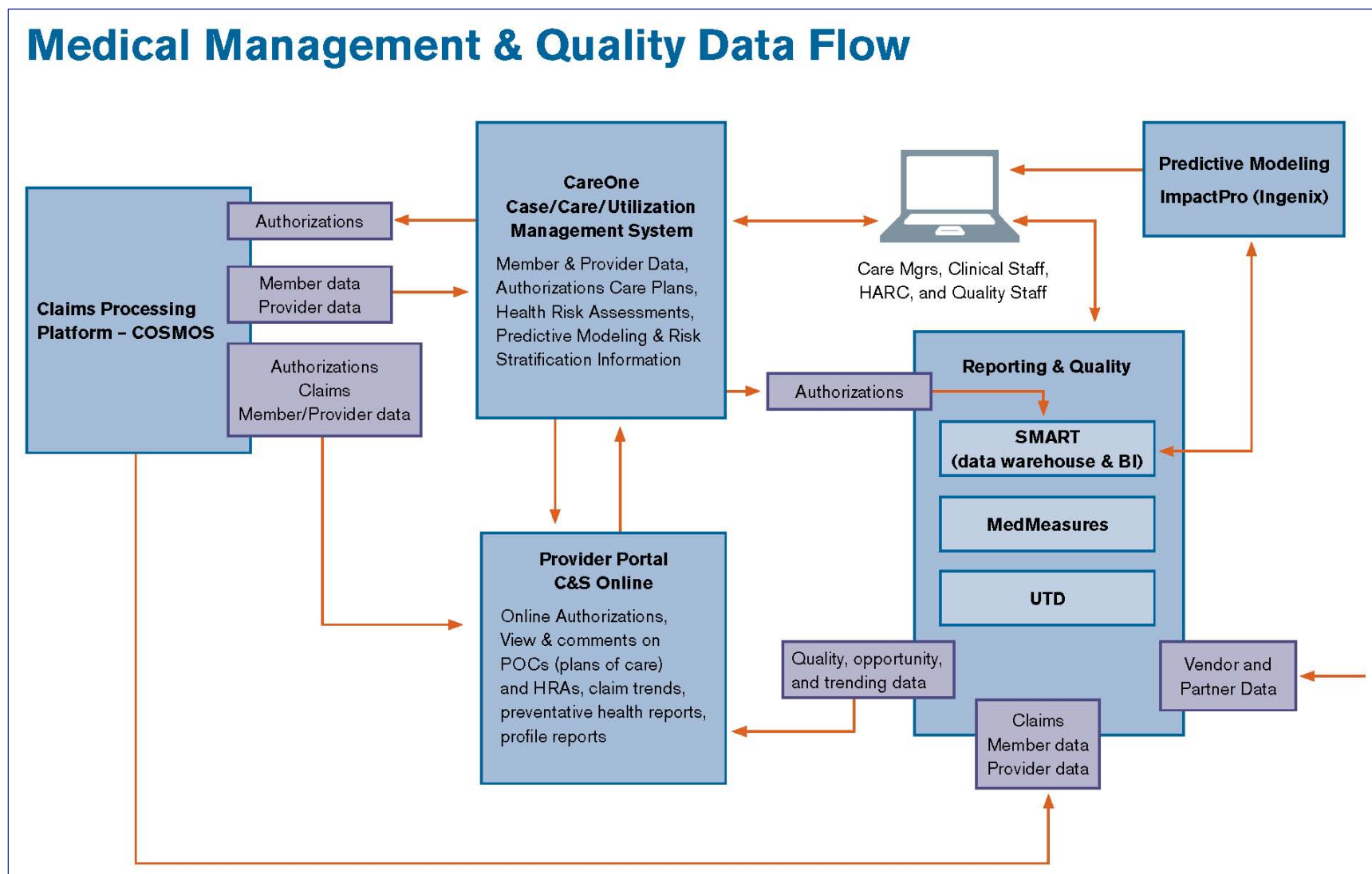
## Adherence to Service Authorization Procedures

UnitedHealthcare Community Plan's proprietary system, CareOne has functionality for tracking referral/utilization, prior authorizations, pre-certification and denial of services as well as reporting of the same.

UnitedHealthcare Community Plan can validate approval and denials of pre-certification, prior authorization and referral requests during adjudication of claims/encounters. Our claim system, COSMOS receives an interface twice daily containing the pre-certifications, prior authorizations and referrals from our CareOne system in order to either approve or deny a claim/encounter twice daily.

Denial of service is accomplished through the configuration of plan benefits in COSMOS. If a service is not covered or denied for any appropriate reason, COSMOS is configured to automatically deny the claims with the appropriate explanation. For example, if a precertification is required for a procedure and is not included with the claim, the claim will automatically be denied for payment.

The following flow diagram illustrates the coordination between our clinical system and claims processing and reporting.





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**Section Q: Information Systems (Section 13 of RFP)****Q.1 Describe your approach for implementing Management Information Systems in support of this RFP, including: (All GSAs)**

- **Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;**

As the nation's largest Medicaid health plan providing services to over 3.4 million members in 24 states and the District of Columbia, UnitedHealthcare Community Plan will continually bring to CCN members the benefit of knowledge, experience and evolving best practices from our technical, clinical, and operational efforts from the other states. Through our parent organization, UnitedHealth Group, we serve over 380,000 members in Louisiana, including:

- 37,255 UnitedHealthcare Medicare & Retirement members
- 344,250 UnitedHealthcare Employer & Individual members.

We offer DHH a comprehensive and highly integrated approach to meeting the needs of CCN members throughout the state of Louisiana. In addition to the scalability of our technical and operational resources, we also understand DHH's goal for the expansion of Electronic Health Records (EHR) in Louisiana. We support this goal by offering incentives to primary care providers who implement EHRs as detailed in our response.

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**System Capacity Assessment**

UnitedHealthcare Community Plan proposes to use the Comprehensive Online Software for Management and Operational Support COSMOS platform if selected to implement the CCN program. Because of the flexibility and design of COSMOS, the benefits configuration for the CCN plan will be added without the need for new or additional programming. Most of the preparation will be to ensure the needs assessment is complete, calling out any custom requirements – such as pre processing and submitting claims but not paying claims - and data or reporting needs, performing the actual configuration work to update components of our COSMOS system, and then applying our regimen of testing and quality assurance procedures. We maintain a claims processing system capable of complete and accurate claims pre-processing and submitting all pre-processed clean claims data to the FI via standard transaction formats (837I & P) within two (2) business days of receipt of the clean claim from the provider.

We will also engage DHH, its enrollment broker, MMIS vendor or FI at specific checkpoints during our COSMOS configuration and testing. For example, once test enrollment data has been loaded, we conduct random audits of our system on behalf of DHH or the enrollment broker to verify that various member enrollment scenarios have been executed to specification. UnitedHealthcare Community Plan will ensure completeness and accuracy of all data and exchanges via intensive unit, systems and end-to-end testing, as we do with all implementations.

Should DHH contract with a new FI during the Contract, we will comply with transitional requirements as necessary at no cost to DHH or its FI.

Michele Nelson, the project manager (PM) assigned to implement CCN on our COSMOS platform, will create a detailed project plan based on the results of the needs assessment process. The project plan will include specific tasks, start and end dates, dependencies on other tasks, and responsible team members performing the specific tasks. Ms. Nelson will follow our Project Management Organization's (PMO) established guidelines for project managing this effort, produce the necessary project tracking documents, including Sarbanes Oxley (SOX) compliant required documents and follow a stringent System Delivery Process (SDP) and Change Control Process. This documentation includes written systems process and

procedure manuals as required in Sections 13.12.1.1, 13.12.1.2, 13.12.1.3, 13.12.1.4, 13.12.1.5 and 13.12.1.6 of the RFP.

She will include DHH in project status calls and provide status updates at mutually agreed upon intervals. Ms. Nelson will support readiness reviews, go-live and post production activities until the program is in a steady-state, production mode, at which point our Operations & Maintenance group will monitor and support daily program activities.

The proposed transition plan includes the UnitedHealthcare Community Plan Command Center Model. The Command Center will be established prior to implementation and 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.

UnitedHealthcare Community Plan senior management team, as well as other key personnel, will assist Command Center staff to prevent service delays for new members and to ensure the project is on track and rapidly meets deadlines. A high level example of the MIS portion of the project plan for CCN includes:

ID	Task Name	Duration	Start	Finish
1	<b>Whole Project</b>	215 days	Fri 5/13/11	Thu 3/8/12
2	Discovery & Feasibility	89 days	Fri 5/13/11	Wed 9/14/11
3	Project Planning	50 days	Fri 5/13/11	Thu 7/21/11
13	Preliminary Requirements Analysis	30 days	Fri 7/22/11	Thu 9/1/11
31	Business Analysis	19 days	Fri 8/19/11	Wed 9/14/11
49	Recommendations	6 days	Thu 9/8/11	Thu 9/15/11
50	Core team meet to review and finalize project scope, conversion p	6 days	Thu 9/8/11	Thu 9/15/11
60	Business/System Requirements and Detail Design	32 days	Fri 9/9/11	Mon 10/24/11
61	Line of Business, Plan Codes, Group Codes	3 days	Fri 9/9/11	Tue 9/13/11
66	Vendor	8 days	Fri 9/9/11	Tue 9/20/11
80	Provider	9 days	Fri 9/9/11	Wed 9/21/11
99	PCP Auto-Assignment	8 days	Fri 9/9/11	Tue 9/20/11
108	Standard Fee Schedules	13 days	Fri 9/9/11	Tue 9/27/11
122	Professional Contracts	9 days	Fri 9/9/11	Wed 9/21/11
135	Institutional Contracts	22 days	Fri 9/9/11	Mon 10/10/11
149	Member Enrollment	16 days	Fri 9/9/11	Fri 9/30/11
170	Member TPL/COB	11 days	Fri 9/9/11	Fri 9/23/11
188	Care Management (CareOne)	9 days	Fri 9/9/11	Wed 9/21/11
209	Benefits	10 days	Fri 9/9/11	Thu 9/22/11
220	Claims	20 days	Fri 9/9/11	Thu 10/6/11
240	Finance	20 days	Fri 9/9/11	Thu 10/6/11
255	MACCESS Workflow Management	4 days	Mon 9/26/11	Thu 9/29/11
260	Code sets	5 days	Mon 9/26/11	Fri 9/30/11
264	Reports	21 days	Fri 9/9/11	Fri 10/7/11
273	Existing Interfaces Analysis and Design	32 days	Fri 9/9/11	Mon 10/24/11
335	Portal/Website (Provider/ member)	21 days	Fri 9/9/11	Fri 10/7/11
344	Development, Configuration and Set-Up	70 days	Tue 9/13/11	Mon 12/19/11
345	Validate Baseline configuration	20 days	Tue 9/13/11	Mon 10/10/11
351	Provider	45 days	Thu 9/15/11	Wed 11/16/11
358	Member Enrollment conversion	31 days	Tue 9/13/11	Tue 10/25/11
371	Benefits config and claims config	37 days	Fri 9/16/11	Mon 11/7/11
375	Finance	44 days	Tue 9/27/11	Fri 11/25/11
379	Interface development	48 days	Wed 9/14/11	Fri 11/18/11
429	APCP architecture systems set-up	39 days	Wed 10/26/11	Mon 12/19/11
478	Business Process additions/update	60 days	Wed 9/14/11	Tue 12/6/11
479	Create new/revised P&P and OI for business units	39 days	Wed 9/14/11	Mon 11/7/11
487	All users have Citrix access and logins/passwords	3 days	Wed 9/14/11	Fri 9/16/11
489	Reports Development	50 days	Wed 9/28/11	Tue 12/6/11
497	Training	27 days	Fri 10/28/11	Mon 12/5/11
498	Healthplans users	5 days	Fri 10/28/11	Thu 11/3/11
501	UAT testers	5 days	Fri 10/28/11	Thu 11/3/11
504	End users	22 days	Fri 11/4/11	Mon 12/5/11
507	Testing (end to end, parallel, packet, UAT)	111 days	Thu 10/6/11	Thu 3/8/12
508	end to end testing	27 days	Wed 12/14/11	Thu 1/19/12
517	Parallel testing prep	8 days	Fri 1/20/12	Tue 1/31/12
527	Parallel Testing	27 days	Wed 2/1/12	Thu 3/8/12
548	Facility packet testing/creation	88 days	Thu 10/6/11	Mon 2/6/12
560	UAT testing	35 days	Mon 12/19/11	Fri 2/3/12
580	Deployment for Go-Live	39 days	Tue 1/10/12	Fri 3/2/12
581	Production activation/load	24 days	Tue 1/10/12	Fri 2/10/12
582	Provider/Vendor/Covering Provider/Fee schedule connection	3 days	Tue 1/10/12	Thu 1/12/12
585	Member	14 days	Tue 1/24/12	Fri 2/10/12
590	Auths	14 days	Tue 1/24/12	Fri 2/10/12
595	Production turnover	39 days	Tue 1/10/12	Fri 3/2/12
599	Decision making process	11 days	Tue 1/10/12	Tue 1/24/12
607	Conduct go live decision meeting	13 days	Thu 1/12/12	Mon 1/30/12
608	Activate External interfaces	5 days	Tue 1/24/12	Mon 1/30/12
610	Go Live Activities for plan	1 day	Thu 1/12/12	Thu 1/12/12
614	Post Deployment	30 days	Fri 1/13/12	Thu 2/23/12

- ***Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;***

We will be able to significantly leverage the existing system configurations, data exchanges and interfaces already in place, as well as our extensive experience implementing Medicaid programs for 24 states and the District of Columbia. We will use the same disciplined software development process for the lifecycle of the configuration changes for the CCN program as we do for any software development project.

We configure our financial systems for new product codes. All key subsystems will follow formal software development and change control processes, as described above, to modify their systems to accommodate data extracts from COSMOS to support the CCN program. We configure benefits within COSMOS using a Plan Product code, with supporting Policy and Procedures (P&Ps). A test environment is created, with current production data if available otherwise with test data, for any configuration and testing work needed to be completed. Configuration is done and then a series of test scenarios are performed to ensure claims pre-process based on DHH's prescribed benefits and requirements.

We perform audits on all newly set up health plans. **In addition to a focused audit that is done at the transaction operations level for any new business, there are standard claims operations and transaction audits done for each claims examiner to ensure quality.** Additional audits will be performed periodically to ensure codes are set up per UnitedHealthcare Community Plan benefit determination and DHH program requirements. We also perform annual audits based on regulatory requirements. These audits include Sarbanes Oxley (SOX) and SAS70 audits.

We will produce a standard needs assessment documentation set that walks through the configuration options of COSMOS and defines the requirements of the CCN implementation in terms of those configuration options.

- ***System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and***

Our transaction systems receive, translate, edit, create and house data required for the day-to-day operations of the health plans we administer. These include our core transaction processing system, COSMOS, for enrollment, eligibility and claims administration; HIPAA Gateway and EDIFECs for electronic data interchanges with trading partners; CareOne for integrated physical care and disease/case management, prior authorizations, referrals and utilization management; and MACESS for member and provider inquiry management and correspondence as well as document imaging and associated workflow.

HIPAA Gateway receives eligibility data daily from DHH (or its enrollment broker); COSMOS receives eligibility data from HIPAA Gateway daily; CareOne sends pre-authorization data to COSMOS twice daily; COSMOS sends processed claims data to the data warehouse weekly; OPC monitors the processing of eligibility data by COSMOS continuously and sends Simple Mail Transfer Protocol (SMTP) status messages to the Service Desk as needed in real time, and so on. The bottom line is that each of these components in our technology platform are integrated and interoperate where they need to, but they are independent enough to allow rich functionality for the specialized functions they are designed to deliver.

A one-time data feed of historical claims data, at minimum 12 months worth, would be needed to perform initial predictive modeling and risk stratification on members assigned to us. We would set up for and load the historical claims data through our Integration Layer, used to edit and normalize data from multiple sources. The data would then be passed to our data warehouse (SMART), where all data for the program will ultimately reside for reporting and analytics purposes. The new historical claims data would be added to the monthly extract from SMART to OptumInsight, our sister segment, for ImpactPro

processing. Our care managers will be able to directly access the predictive modeling results, either from ImpactPro or from SMART, to help them with their care plans and management.

A one-time data feed of all active/open authorizations for members assigned to us would be needed to ensure a smooth transition of services for members, as well as for utilization management/history. Depending on the anticipated volume of active/open authorizations to be transitioned, we may either set up an interface program to automatically load them into our CareOne care management system or manually enter them – especially if the volume is expected to be low. The authorizations will flow from CareOne to COSMOS for claims pre-processing.

- ***Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.***

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## Eligibility/Enrollment Testing

Throughout our implementation experiences, we have found that enrollment and eligibility processes need to be focused on as the first key data exchange that should be specified, tested and deployed. There are two reasons for this. First, eligibility and enrollment testing is a necessary prerequisite to later claims submission, authorization, and pre-processing testing. The second factor is the need to “go live” with enrollment processing well before the actual plan “go live” date to allow for member communications, ID cards, outreach activities and clinical transition activities. We will perform multiple cycles of inbound eligibility (834/271U) testing before the actual CCN program effective date. This is true for the one-time and ongoing eligibility data feeds, and will therefore use the same process for set up, testing and deployment.

For enrollments, we use a standard 834 enrollment process. While we prefer using the standard HIPAA 834 transaction file format, we can accommodate other proprietary 834 file formats. Based on DHH’s preferences, we can map or convert the proprietary enrollment data to fit our standard enrollment data load process, and then load it into COSMOS, our core transaction processing system.

Testing that we employ includes:

- Testing of all inbound 834 Enrollment and 271U (unsolicited eligibility response) files
  - We automatically acknowledge these files upon receipt with the issuance of standard 997 Functional Acknowledgement transactions.

While UnitedHealthcare Community Plan’s management team will maintain frequent contact with DHH, its enrollment broker and other authorized representatives, key MIS staff members will be available to participate in calls and support DHH in data-related questions or issues. Our MIS team likes to have similar contacts at the state’s MIS department to maintain open communication regarding potential changes to data feeds, secure FTP questions/issues and other technical concerns.

Once CCN is in a production or a live mode we will continuously monitor enrollment data received and loaded in COSMOS through our standard enrollment process, error reports and dedicated resources. Discrepancies are reported and then worked/resolved by our dedicated enrollment coordinators.

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## Provider Network Testing

UnitedHealthcare Community Plan uses a multi-step process to carefully yet efficiently load and verify provider contract data according to specific business rules. This process starts with the receipt of an executed contract, credentialing application, which we use to verify demographic information (including the National Provider Identifier (NPI), I-9 form, Medicaid ID Number, etc.), confirmation that the provider application is complete and includes site survey results; validation that all credentialing documentation is complete; and final loading into National Database (NDB), our provider database.

When contracting providers, the first step of the process is for the provider to complete a credentialing



application. Our credentialing application requires providers provide specific data, including their NPI number, Medicaid ID number and their I-9 form. Upon receipt of credentialing applications, our National Credentialing Center (NCC) credentialing specialists review applications for completeness. Credentialing specialists telephone providers who submit incomplete applications to gather missing information. Upon receipt of all required application data, credentialing specialists enter data from the completed applications into our Universal Credentialing Datasource.

NCC staff members conduct primary source verification data provided via the credentialing applications. Data verified include, but are not limited to: validity of license, Medicaid Provider ID number, NPI number, education, board certification, sanctions, etc.

Once credentialed and contracted, all data contained in our credentialing system is loaded into our NDB (provider database) system. NDB is an IBM DB2 based system, housing information on all providers having contractual relationships with UnitedHealthcare Community Plan as well as other UnitedHealth Group affiliates. Provider data in NDB is electronically loaded and updated on a daily basis into COSMOS, our core transaction system. Our system tests all new contract data to ensure provider contracts are set to pay, or not pay as for CCN-S, according to the benefit design and eligibility and reimbursement policies. Once testing confirms provider contracts are set up in the system correctly, the contract is tagged as “claim ready”. We monitor the entire process to ensure that within 30 days of receiving completed and credentialed provider applications, contracting data is built in COSMOS correctly.

Our Network Management team conducts ongoing monitoring and updates to our contract files, such as:

- Fee schedule maintenance and updates
- Amendments to ensure regulatory compliance
- Fraud and abuse monitoring
- Routine reviews of data
- Unit cost management.

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## **Claims Testing**

We produce a standard needs assessment documentation set that walks through the configuration options of COSMOS and defines the requirements of the CCN implementation in terms of those configuration options. We ensure completeness and accuracy of all data and exchanges via intensive unit, systems and end-to-end testing, as we do with all implementations. With COSMOS, we will not need to implement new programming or other complex system to serve the new CCN business because of utilities integration. Most of the preparation will be to ensure the needs assessment is complete, calling out any custom requirements and data or reporting needs, performing the actual configuration work to update COSMOS, and then applying our regimen of testing and quality assurance procedures. We will also engage the DHH or its FI at specific checkpoints during our COSMOS configuration and testing.

Our Claims team develops and implements front end edits to minimize inaccurate data, runs quality and data validity audits, trains claims processors, updates claims operating instructions, reviews root cause and develops solutions. These “up front” measures ultimately ensure the completeness and accuracy of the claims data submitted to the FI. Our transaction systems receive, translate, edit, create and house data required for the day-to-day operations of the health plans we administer. These include our core transaction processing system, COSMOS, for enrollment, eligibility and claims administration and HIPAA Gateway and EDIFICS for electronic data interchanges with trading partners.

Prior to loading claims into COSMOS, the system applies automated edits to electronically submitted claims for formats and specific rules, such as invalid birth year or dollar amounts. Once CCN is in a production or a live mode we will continuously monitor claims data received and loaded in COSMOS

through pre-processing edits, error reports and dedicated resources. These measures ensure the completeness and accuracy of the claims data submitted to the FI.

A one-time data feed of historical claims data (we are expecting DHH to provide claims history prior to 'go live' for our members) will enable initial predictive modeling and risk stratification on members assigned to us; and then ongoing monthly claims data to continue with the predictive modeling process. We would set up for and load the historical claims data through our Integration Layer, used to edit and normalize data from multiple sources. The data would then be passed to our data warehouse (SMART), where all data for the program will ultimately reside for reporting and analytics purposes. The historical claims data would be added to the monthly extract from SMART to OptumInsight, our sister segment, for ImpactPro processing. Our care managers will be able to directly access the predictive modeling results, either from ImpactPro or from SMART, to help them with their care plans and management.

Our internal audit process is continuous and comprehensive. All claims are included in our reports and audit processes and audit personnel have broad experience in claims processing, possess strong analytical skills and address any issues that may arise resulting from the audits. This collaboration enables UnitedHealthcare Community Plan to make corrections to the system as needed, and to provide the type of feedback and mentoring needed for examiners, in order to support performance improvement.

We produce a variety of Crystal and Business Objects reports which are made available to our Operations and Claims management teams for review of claims for completeness and accuracy of claims data.

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## Other System Testing

UnitedHealthcare Community Plan has an established Vendor Management team to assure all required data is received from our subcontractors as scheduled. The team employs validation edits and uses lag reports in this data collection and monitoring process. Once received, third-party data is further evaluated for accuracy and completeness through a stringent verification process that assures files are not duplicates and primary dates of service or claims post dates fall within expected ranges. Additional validation edits include: original input filenames, expected received date, actual received date, insert date, batch load ID, number of claim header and detail records, number of claims accepted and number of claims failing initial edits.

The team obtains corrections from our subcontractors, as needed, and ensures completion of reconciliation reports from our finance group and the subcontractor; all aforementioned groups collectively participate in the subcontractors' defect management program, too.

The Vendor Management Team either hosts or attends periodic, at times weekly, calls with our subcontractors to discuss outstanding issues and identified data trends, possible solutions to remediate or prevent problems, and process improvements on both ends.

- ***Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:***
  - ***Key activities and timeframes and***
  - ***Projected resource requirements from your organization for implementing information systems in support of this contract.***

We have provided our Information Systems implementation work plan, which captures key activities, timeframes and projected resource requirements, as Attachment P.1.

***Describe your historical data process including but not limited to: Number of years retained;***

- ***How the data is stored; and***
- ***How accessible it is.***

***The work plan should cover activities from contract award to the start date of operations.***

UnitedHealth Group Information Assets must be backed up on a regularly scheduled basis to ensure availability of Information Assets and limit data loss in the event of an outage. System and Information Owners are accountable for determining what assets are backed-up, per UnitedHealth Group's Classification Levels. Backups may include, but are not limited to:

- Master files
- Databases
- Transactions files
- System programs/utilities
- Application software
- Parameter settings
- System documentation.

UnitedHealth Group has two operational environments: distributed and mainframe.

- In the distributed environment, UnitedHealth Group has a backup policy of maintaining two copies of operational data at its secured technology centers. The primary copy is maintained on online disk storage in the same technology center where the business application resides to facilitate rapid access for operational recoveries and is not encrypted. The second copy is electronically transmitted via UnitedHealth Group's internal network and stored at a geographically dispersed UnitedHealth Group facility for risk management and disaster recovery purposes. In reference to the second copy UnitedHealth Group is the sole entity in the chain of custody for the data, and has opted to encrypt the data, at the time the media is written, for risk mitigation purposes. The data encryption occurs at the time the tape media is created using industry accepted encryption algorithms (256-Bit AES). The primary and secondary locations are not fixed entities and can change based on business demands and operational need, i.e. growth, expansion or disaster recovery.
- In the mainframe environment, UnitedHealth Group uses geographically dispersed mainframes for "Rapid Recovery" that use UnitedHealth Group's internally secured networks to transmit the backup data. In this situation, UnitedHealth Group maintains sole custody of all data with encryption of tape media at both primary and secondary locations.

In both the distributed and mainframe environments encryption of data on disk (at rest) is not employed at UnitedHealth Group. UnitedHealth Group continues to implement new solutions with advanced technologies to ensure there are additional levels of protection for our customer's data above the existing robust security infrastructure currently in place. The technology solutions currently available within the industry that would have the capacity to provide encryption for data at rest within UnitedHealth Group's current complex environment would be cost prohibitive and negatively impact operational performance. UnitedHealth Group continues to evaluate new and improved solutions that become available. Implementation of the appropriate encryption technology for data at rest must meet UnitedHealth Groups business objectives, risks, and data protection policies. UnitedHealth Group has implemented several mitigating controls to ensure data is protected, such as: in-sourcing of tape management facilities, implementing a Rapid Recovery solution to ensure data is protected and available should there be a situation requiring the recovery of data, onsite process for data eradication of disk drives that are replaced during maintenance, and data eradication on all decommissioned storage arrays to DOD standards prior to

leaving UnitedHealth Group controlled facilities, further mitigate the risk of exposure.

## Operational Backups

The Data Protection Infrastructure exists in all primary technology centers. The overall concept is to maintain a primary copy locally, with a second copy geographically dispersed offsite. Offsite copies are maintained within UnitedHealth Group owned facilities to reduce cost and business risks. Data is segregated by production/non-production and functional characteristics, i.e. Wintel, UNIX, Database, Archive. The process is managed by IBM's Tivoli Storage Manager (TSM) product.

UnitedHealth Group's Backup Strategy includes:

- Systems and databases are backed up daily
- The primary copy is held in virtual tape and off site copies are replicated before the next cycle begins
- Five versions of a file are retained for operational recovery
- Deleted files are kept in the system for 90 days
- Twenty-one versions of databases are kept for operational recovery, in addition to transaction logs

## Operational Backups – Primary vs Offsite Copy (Distributed and Mainframe Environments)

### Primary (onsite)

- **Virtual Tape Library:** System that emulates physical tape system and stores data on hard drives, which facilitates fast backup and restore time
- **Primary Use:** Operational Recovery of systems in place in case of data corruption or accidental deletion.

### Offsite

- Physical Tape Libraries located in UnitedHealth Group geographically dispersed location(s)
- Connection to backup server is across the UnitedHealth Group Wide Area Network, data is written to the alternate location, eliminating the need for third party offsite storage
- Primary use: Disaster Recovery of systems as defined by the Recovery Point Objective and the Recovery Time Objective (RPO and RTO) at an alternate site.

We will provide DHH a quarterly list of all back-up files stored at remote locations and the frequency with which these files are updated. In addition, we will comply with Section 13.9 of the RFP relative to off site storage and remote back-up).

## Retention/Preservation

UnitedHealth Group maintains strict data retention policies/standards, which address three business-driven retention requirements. These standards are maintained and managed by Enterprise Storage Services and Records Information Management and encompass the mainframe and distributed environments. A synopsis of these policies/standards is as follows:

- **Operational** – Backups that are used for file/database restoration resulting from a near term operational loss of data or Disaster Recovery (testing or actual) is retained for a period of 15 – 90 days.
- **Regulatory** – Records Information Management establishes the policies and standards for data retention necessary to meet regulatory requirements (SOX, HIPAA, Contracts, Financial, etc). **These retention periods range from 3 - 10 years depending on the content, risk, and regulatory requirements of the data.** We agree to produce, at our expense, legible hard-copy records upon the request of state or federal authorities, within 15 calendar days of the request.
- **Legal Holds** – This process is driven by UnitedHealth Group's Legal department. For data relevant to

litigation activities, UnitedHealth Group may be required to suspend destruction until the matter has been remediated. Issuance of a legal hold takes precedence over data retention policies and does not require business owner approval to implement.

Full backups are performed weekly with daily incrementals; however, applications may require more or less frequent backups determined by business need.

**Retention on full backups may be maintained for upwards of 12 cycles (for the monthly runs), 52 cycles (for the weekly), and 3 weeks of daily incremental updates, prior to recycling/rewriting over media.**

Data retention requirements are driven by Records Information Management Policies (RIMS) based on Governance requirements and drive retention periods (Preservation orders, SOX, HIPAA). These are separate from operational backups.

**Q.2 Describe the ability within your systems to meet (or exceed) each of the requirements in Section 16 of the RFP and the CCN-P Systems Companion Guide. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (All GSAs)**

## Compliance with Section 16 and Systems Companion Guide

UnitedHealthcare Community Plan has reviewed the reporting requirements in Section 16 of the CCN-S RFP and the CCN-S Systems Companion Guide and agrees to each and every item, including the generation of required reporting in the format and frequency as requested. We will be happy to submit sample reports upon request and have restated the required CCN reporting in the table below as confirmation of our compliance:

<i>CCN Required Reports</i>			
<i>Report File Name</i>	<i>Frequency</i>	<i>Format Location</i>	<i>Receiver</i>
Organizational Chart	Annually	N/A	DHH – Coordinated Care Section
Functional Organizational Chart	Annually	N/A	DHH – Coordinated Care Section
Network Provider and Subcontractor Registry and Spreadsheet	30 days after the Contract has been signed, and Monthly thereafter	Appendix X and Systems Companion Guide	DHH – Coordinated Care Section
Patient-Center Medical Home (PCMH) A. PCMH Implementation Plan B. B. NCQA PCPPCMH™ recognition report	During Readiness Review and Annually thereafter	TBD	DHH – Coordinated Care Section
PCP Care Management Fee Report	Quarterly	Systems Companion Guide	DHH – Coordinated Care Section
Provider Directory	Template due during Readiness Review	TBD	EB



<b>CCN Required Reports</b>			
<b>Report File Name</b>	<b>Frequency</b>	<b>Format Location</b>	<b>Receiver</b>
PCP Linkage File	Quarterly	Systems Companion Guide TBD	DHH – FI
Member Services A. Unsuccessful new member contacts B. Member Services Call Center	A. Monthly B. Monthly with an Annual Summary	TBD	DHH – Coordinated Care Section
Provider Call Center	Monthly with an Annual Summary	TBD	DHH – Coordinated Care Section
CCN Disenrollment Report	Quarterly	Appendix T	DHH – Coordinated Care Section
UM reports A. UM Committee Meeting minutes B. Medical Record Reviews	A. Within 5 working days of each meeting B. Quarterly with an Annual Summary	TBD	DHH – Coordinated Care Section
Fraud and Abuse Activity Report	Quarterly with an Annual Summary	TBD	DHH – Coordinated Care Section
CCMP A. Reports B. Predictive Modeling Specifications C. Program Evaluation	A. Quarterly with an Annual Summary B. Readiness review and Annually thereafter C. Annually	TBD	DHH – Coordinated Care Section
Model Attestation Letter	Attachment to all Reports	Appendix II	DHH – Coordinated Care Section
Service Authorization Requests Report	Upon Request by DHH	TBD	DHH – Coordinated Care Section
Form CMS 1513 Ownership and Control Interest Statement	With proposal and Annually, by October 1st , thereafter	N/A	DHH – Coordinated Care Section
Emergency Management Plan	30 days prior to proposed changes, Annual certification	N/A	DHH – Coordinated Care Section
Member Satisfaction Survey Report	Annually	Instrument and Survey Results	DHH – Coordinated Care Section
Provider Satisfaction Survey Report	Annually	Instrument and Survey Results	DHH – Coordinated Care Section
Network Provider Development and Management Plan	30 days after the Contract has been signed and Annually thereafter	TBD	DHH – Coordinated Care Section
Grievance, Appeal and Fair Hearing Log Report	Monthly, and Quarterly Summary	Appendix U	DHH – Coordinated Care Section
Grievance, Appeal and Fair Hearing Log -Redacted	Monthly, and Quarterly Summary	Appendix U	DHH – Coordinated Care Section

<b>CCN Required Reports</b>			
<b>Report File Name</b>	<b>Frequency</b>	<b>Format Location</b>	<b>Receiver</b>
Marketing Activities A. Marketing Plan B. Updates C. Annual Review	A. 30 days after the Contract has been signed B. Monthly C. Annually	Appendix T (TBDE)	DHH – Coordinated Care Section
Pre-processing Report	Daily	Systems Companion Guide	DHH – Coordinated Care Section
Financial Reporting	A. Annual Audited Financial Statement B. Four Quarterly Unaudited Financial Statements and Financial Reporting Guide C. Monthly if requested by DHH	Financial Reporting Companion Guide	DHH – Coordinated Care Section
Quality Assurance (QA) A. QAPI Program description and QAPI Plan B. Impact and effectiveness of QAPI program evaluation C. Performance Improvement Project descriptions D. Performance Improvement Projects Outcomes E. Early Warning System Performance Measures F. Level I and Level II Performance Measures G. PCP Profile Reports	During readiness review, and Annually thereafter A. 30 days from the date of the Contract and Annually thereafter B. Annually C. Within 3 months of execution of Contract and at the beginning of each Contract year thereafter D. Annually E. Monthly F. Annually and upon DHH request G. Quarterly with an Annual Summary	Quality Companion Guide TBE	DHH – Coordinated Care Section
System Refresh Plan	Annually	Systems Companion Guide TBD	DHH -Coordinated Care Section
Back-up File List	Quarterly	Systems Companion Guide TBD	DHH – Coordinated Care Section
Electronic Data Processing (EDP) Audit	Annually	TBD	DHH-Coordinated Care Section
Case Management Reports	Quarterly with an Annual Summary	TBD	DHH – Coordinated Care Section
Prior Authorization and Pre-Certification Summary	Annually	Systems Companion Guide TBD	DHH – Coordinated Care Section

<b>CCN Required Reports</b>			
<b>Report File Name</b>	<b>Frequency</b>	<b>Format Location</b>	<b>Receiver</b>
Telephone and Internet Activity Report	Monthly	TBD	DHH-Coordinated Care Section
Member Advisory Council Plan	Annually with Quarterly updates of meeting minutes and correspondence	N/A	DHH – Coordinated Care Section

**Q.3** *Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.* *(All GSAs)*

## Ensuring System Availability

UnitedHealthcare Community Plan’s technology approach consists of architecting our systems for scalability, monitoring and modeling existing and anticipated loads, budgeting for upgrades and deployment of additional capacity. UnitedHealthcare Community Plan engages a project manager (PM) for each new implementation. The PM serves as our facilitator and ensures that the customer is being heard, competing projects don’t interfere and all tasks are being delivered on time. COSMOS and its associated integrated computing environment comprise a distributed multi-tier architecture including several front-end processors and database servers designed to maximize availability and responsiveness.

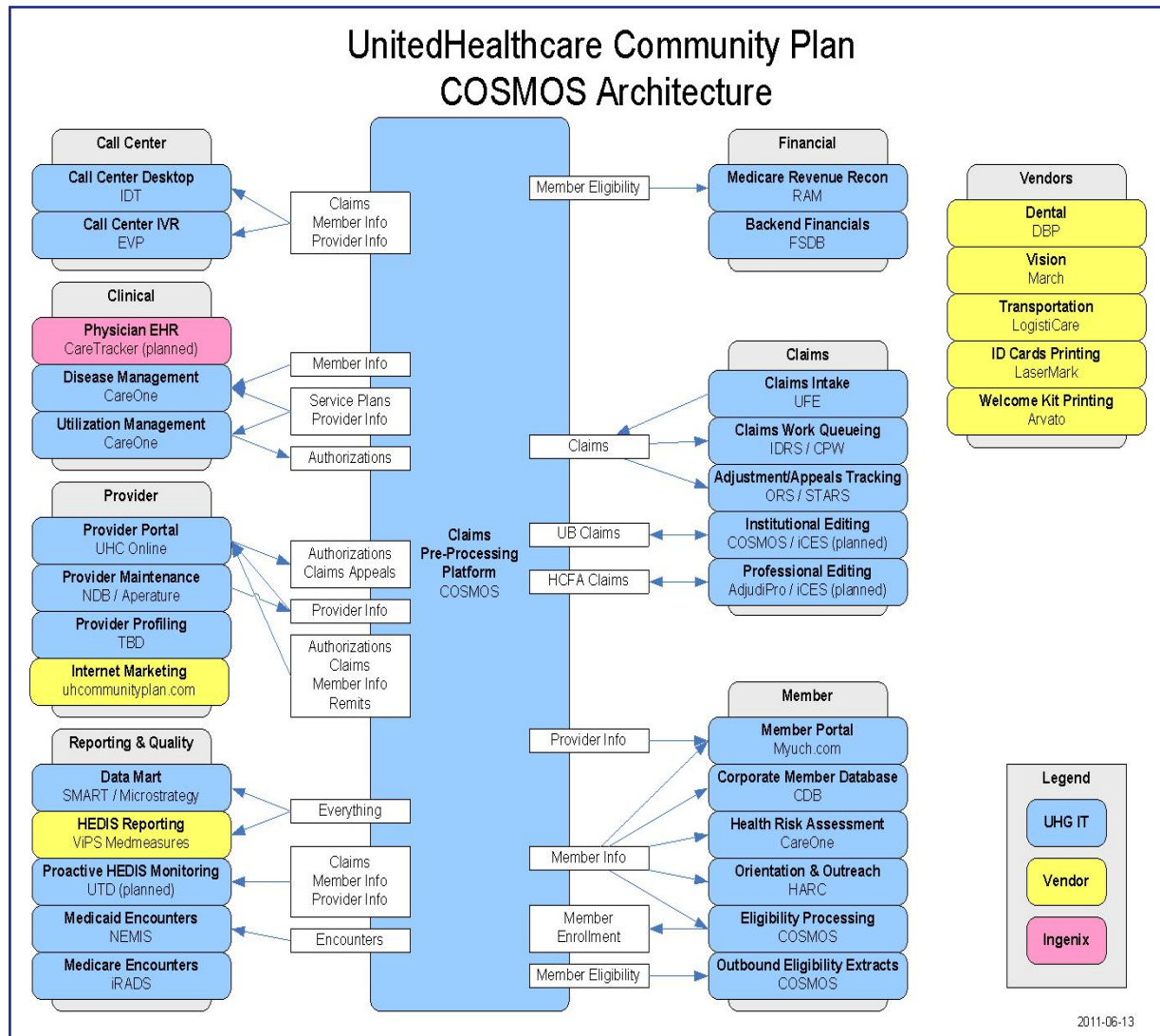
Our front-end Citrix servers perform online processing; the front-end Windows servers perform batch processing; and the database servers perform all Sybase database requests, whether from batch or on-line. We manage all processing through a combination of load balancing software and hardware that employs data replication technologies to maintain peak performance and maximum availability by allowing multiple paths for COSMOS to retrieve and store data. This architecture accommodates scalable expansion in two ways.

- The vertical option allows the addition of CPUs and disk storage to existing servers so that we can increase capacity of machines already in place without disruption to the servers or impact to production processing
- The horizontal option allows the addition of new front-end servers to increase the number of machine “footprints.”

Having the flexibility to add systems capacity in either manner allows us to quickly introduce routine upgrades, while giving us the latitude to plan for significant increases in computing needs without risk or material operational impact.

## Information Systems Architecture

The following diagram depicts each component of our COSMOS management information system and all other systems that interface with or support it.



This architecture also enables a level of fault tolerance through use of multiple servers and shared storage, allowing instant recovery from failures in these components. For example, in the event of a disk drive failure, our staff is able to continue working until the drives can be replaced with little to no disruption in operations, ensuring real time continuity. UnitedHealthcare Community Plan's critical systems, including COSMOS, iDRS (our document imaging system) and HIPAA Gateway are implemented with an R+1 (Redundant Plus 1) approach - meaning all hardware is replicated and in standby for seamless cut over with failover to secondary devices based on Service Level Agreement requirements for availability. We perform periodic load-testing of our systems to ensure maximum availability and responsiveness; using the Mercury LoadRunner tool set.

## Monitoring Tools and Testing

UnitedHealthcare Community Plan uses Hewlett Packard's OpenView software for large-scale system and network management to measure end-to-end performance of our systems, diagnose any bottlenecks

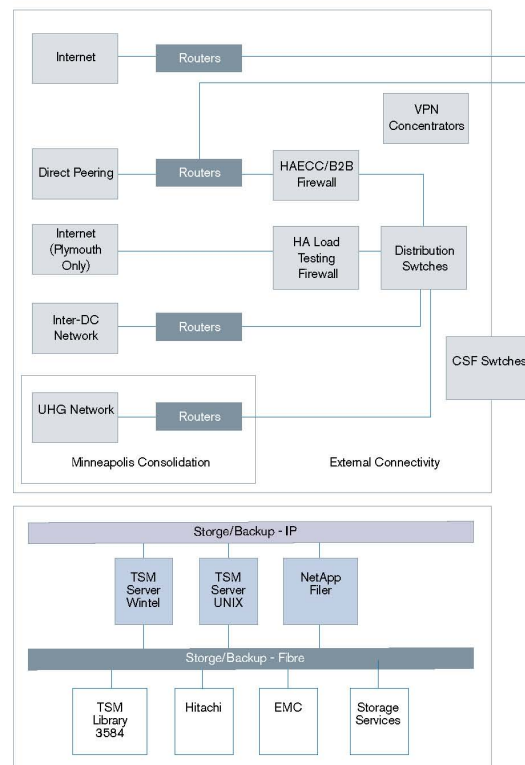
and adjust for better performance. OpenView allows us to innovatively detect and pre-empt any availability threatening failures. For example, OpenView places probes at the system level that send SMTP alerts to our engineers at preset thresholds to alert them prior to failure. This helps avoid situations where a disk drive becomes full or process routines abort unexpectedly. We use our failure management processes and help desk to identify and provide notification of issues with critical systems. We add capacity as utilization approaches predefined thresholds. We regularly stress test using Mercury LoadRunner across our applications and network, particularly in anticipation of upcoming business growth, and model the impact of such growth on the systems to determine how much additional systems capacity is needed.

## Telecommunication Availability

UnitedHealthcare Community Plan provides multiple paths from different carriers to connect our internal operations and connect to the internet. This allows for a high degree of communications redundancy, and virtually instantaneous recovery from a failure in the affected communication path. For voice communications, our AVAYA S 8720 telephone PBX is configured with hardware and software fault tolerance and is rated at over 99 percent reliability and redundancy. If there is a failure in the toll free 1-800 Customer Service line that routes into any of our locations, inbound calls are automatically routed to back-up locations.

## Telecommunications/Network Infrastructure

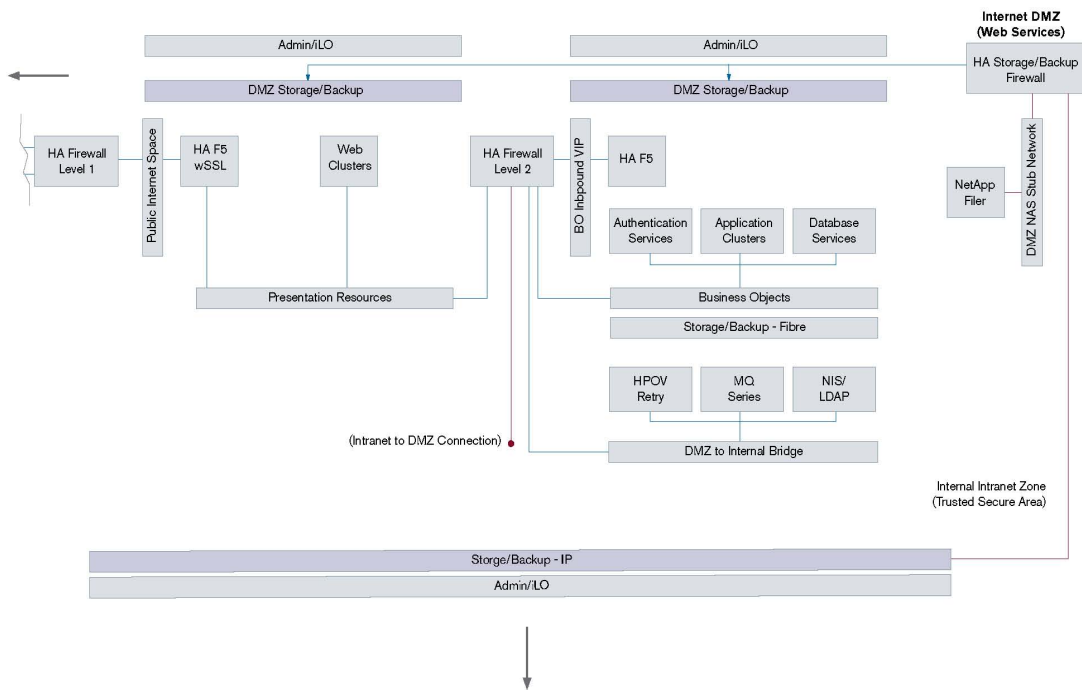
Part 1





## Telecommunications/Network Infrastructure

Part 2



## Legend

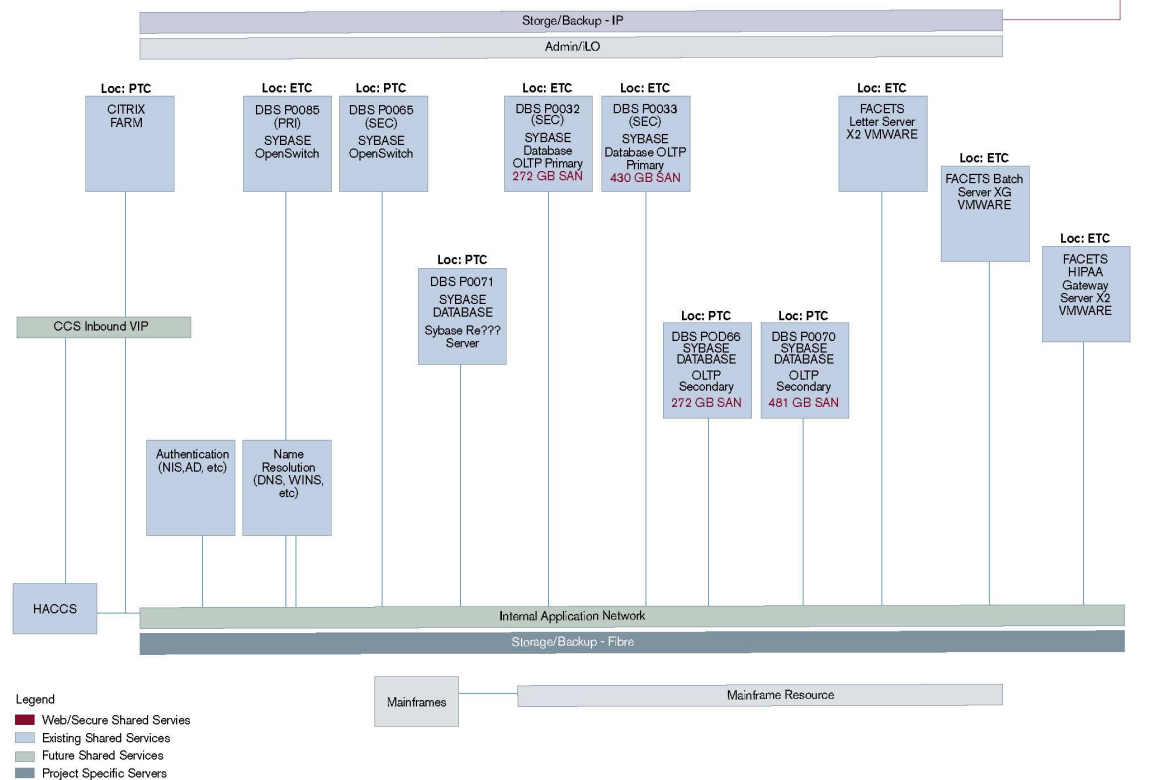
- Web/Secure Shared Services
- Existing Shared Services
- Future Shared Services
- Project Specific Servers

NOTE: Servers in the Web Services Domain all require static routes for their storage/backup interfaces

DESIGN NOTE: Additional SAN disk is required for new databases and the FACETS upgrade

## Telecommunications/Network Infrastructure

Part 3



## Capacity

UnitedHealthcare Community Plan routinely monitors our MIS' capacity to determine key thresholds of the hardware and software capacity that affects the performance of the COSMOS system. Through our parent organization UnitedHealth Group, we employ over 9,000 technology professionals in the United States who are responsible for computing hardware, software and communications. We have over six petabytes of storage (equivalent of 450 billion pages of text, enough to fill 20 million four-drawer filing cabinets). We have virtual contact center that dynamically routes a million calls daily across more than 40 contact centers and 20,000 service agents.

## Disaster Recovery

UnitedHealth Group's approach to disaster recovery is based on the two fundamentals: prevention and protection. A focus on balancing the combination of disaster prevention and protection results in reducing both the probability and impact of a disaster. The Enterprise Disaster Recovery Program first eliminates or reduces disaster recovery risk in critical areas, and then plans for the most probable disaster scenarios.

For many companies, disaster recovery means minimizing downtime as they try to restore systems and get them back online. UnitedHealth Group's strategy includes focusing on items that would assist in preventing a disaster from taking down systems in the first place. UnitedHealth Group has invested in creating an effective combination of people, process and technology that provides the fundamentals for a proven production method resulting in a stable, scalable environment for our applications to perform at operational excellence. This investment creates the "prevention" which is fundamental to the Enterprise Disaster Recovery Program. Prevention is the proactive remediation of known technology exposures. Prevention includes removing the "accidents just waiting to happen".

Completely avoiding a technology disaster is impossible. However, the Enterprise Disaster Recovery Program is based on anticipating and planning for the common types of disasters and designing solutions to address them. Disaster protection addresses recovery from the most probable disaster scenarios and a worst case "smoking hole" scenario.

Highlights of the disaster recovery protection components include:

- The UnitedHealth Group data centers can operate in a "lights out" mode for up to three days. If the data center continues to get fuel to run the generators, they are designed to run in this mode indefinitely.
- Operational backups are designed to use high performance disk-to-disk primary copy with physical offsite second copy tape
- Geographic high availability (GEO-HA) employs active-active or active-passive components located in two geographically separate data centers where either site can fully support the production application in the event of a disaster with little to no manual intervention
- Mainframe storage area network (SAN) replication "rapid recovery" employs full asynchronous data replication between the production host and the geographically dispersed hot standby disaster recovery host
- Distributed storage area network (SAN) replication system "rapid recovery" employs full asynchronous data replication of production storage pools and failover of production processing to geographically dispersed non-production processing
- Some distributed systems employ a hot internal solution with production to geographically separate non-production failover and tape data restore
- Vendor site recovery agreements with tape restore are purchased for less critical and less integrated applications
- Each critical application has a disaster recovery plan that is refreshed at least once each year and tested annually.

- Metrics in the form of key performance indicators are used to derive the “health” of the enterprise disaster recovery program.

The UnitedHealth Group Information Technology enterprise disaster recovery strategy involves identifying critical business processes and transitioning these critical applications, data, and supporting infrastructure to an alternate recovery location in a timely manner, thereby reducing the impact of a technology event to our critical business clients.

### Recovery Time Objective

A variety of recovery strategies are used which align to the defined criticality of the application. Business critical applications, as defined by the business impact analysis and subsequent business continuity plan, are given the highest priority and generally have a 72 hour or less recovery time objective. We also agree to comply with Section 13.7 regarding System Availability as well as Section 13.8 regarding Contingency Plans as required.

***Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to (a), or indicate whether these technologies and management strategies are already in place.***

UnitedHealthcare Community Plan has the necessary technology and management strategies in force and currently used in the administration of our other Medicaid plans. Because each Medicaid program is unique, we will make the necessary modifications to interfaces, configurations and reporting to accommodate the CCN requirements. Our IT implementation work plan, provided as Attachment Q1, includes a detailed assessment of the CCN program technology and management strategies as well as the timing for a successful implementation.

***Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.***

### Success in Action: Mississippi CHIP Operations and Technology

The implementation of our Mississippi CHIP (MS CHIP) plan in January 2010 demonstrates our success in executing a mix of technologies and management strategies described above. It is not uncommon in new implementations for there to be confusion as to who is responsible for “owning” a process since there is no historical subject matter expert. By having effective leadership at the local level, solid processes and an effective work plan, we are able to overcome barriers that may have overwhelmed a less-experienced Medicaid provider.

#### Operations

Gabe Moreno was assigned as the MS CHIP IT Project manager lead and served as a link to different functional areas (example, call center, claims, technology, etc.). Mr. Moreno’s hands-on involvement in local operations was a critical factor in the start-up of claims and the call center. He also identified key data requirements from other work streams that needed to communicate with call center operation.

*On December 31, 2009, as UnitedHealthcare began operations in Mississippi, we established eligibility interfaces with two state agencies. There were **zero discrepancies** noted in the file containing over 67,000 records. We had **achieved a perfect initial file transfer!***

Claims reporting and responsibilities are often confusing for a new health plan regardless of the training provided. We realized even if all went as planned, the complexity of MS CHIP claims and call center environments would require additional support through the first quarter and we provided this support, which became a best practice for new start-ups.

## Technology

The use of a single point-of-contact for technology-related issues was effective in the MS CHIP implementation. The Mississippi Department of Finance and Administration (DFA) was pleased with our technology interactions and we were able to successfully demonstrate readiness review. This process confirmed that business operations integrations should be tied closer to technology decisions and business requirements should drive the process.

We also employed our Personal Care Model (CareOne to Facets integration) for care/case management of high-risk members, which dramatically improved cost containment and quality of care outcomes for members. (This had not been previously done in the CHIP and CAN programs.) Obviously, it had a positive impact for all parties involved.

Our depth of implementation experience has taught us it is crucial to have a single owner managing technology interactions and reporting back to the health plan and we would follow a similar model in implementing the CCN program.

### **Q.4 Describe in detail:**

**(All GSAs)**

- ***How your key production systems are designed to interoperate. In your response address all of the following:***

## Orchestrating Interoperability

Interoperability between key systems, including sharing of data, is critical for successful data processing and ultimately to ensure program compliance. We have the processes, tools and systems in place and set up to fully support the various Medicaid programs we currently support in 24 states and the District of Columbia and are confident that we can successfully support the CCN program. .

UnitedHealthcare Community Plan categorizes our integrated and interoperable systems into three areas:

- Transaction oriented
- Information products (such as reports and data extracts)
- Monitoring.

All of our systems share data and interoperate via automated interfaces with a frequency of exchange that meets the needs of the particular business function supported. Our MIS landscape is composed of a well-integrated suite of applications, focused on serving key functions. At the center of the landscape is our Comprehensive Online Software for Management and Operational Support (COSMOS) platform.

Our COSMOS system contains functionality covering enrollment, provider services, benefits and claims processing. We can process and utilize all other reference files, including Provider Records/Profiles and Procedure Tables. Other MIS application suites are integrated with required data and transactions in one application suite being available, some in “real time”, to the other application suites. Some features of this integration require nightly feeds. We will tailor our application portfolio to the specific requirements unique to the Louisiana CCN plan.

COSMOS has the flexibility that allows us to meet changing regulatory requirements without disrupting our claims processing flows. COSMOS system features include:

<b>COSMOS Features</b>	
■ Document management standards that meet the needs of DHH and its FI, inclusive of HIPAA transaction and code set compliance	■ Batch or online claims processing
■ High-volume system capabilities	■ Unlimited point-of-service functionality



<b><i>COSMOS Features</i></b>	
■ Flexible claims processing rules and edits	■ Flexible benefit designs
■ Flexible provider networking and reimbursement	■ Real-time adjustments and voids
■ Multiple site processing	■ Selects claims for pre-payment quality review
■ Accepts inputs from paper, tape or electronic	■ System-wide navigation assistance
■ Free-text comments	■ Error tabling (all errors can be viewed at once)
■ User-defined rules for dollar/coverage amounts	■ Claims inquiry by member
■ Secured error override capability	■ Claims inquiry by service and service dates
■ Claims inquiry by partial claim number	■ Claims inquiry by process improvement projects
■ Claims inquiry by provider	

Our health information systems are fully compliant with HIPAA privacy and transaction and code set standards adaptable to updates in order to support CCN claims-related policy requirements as needed. We maintain a HIPAA-compliant claims processing system capable of processing claims in accordance with state and federal requirements. We support standard 820, 834, 835, 837, 270/271 and 277/278 file formats for all electronic transactions (EDI). To comply further with HIPAA privacy requirements, all applications use role-based access to ensure that staff only has access to reports and data to support their current role and function. Access is further controlled by using some of our best security practices: firewalls and physical separation of processing systems. Our systems provide information on areas including, but not limited to service utilization and claim disputes and appeals [42 CFR 438.242(a)].

Integrated with our core claims processing system is our care/case/disease management system, CareOne. We designed our CareOne application to coordinate the information flow among caregivers, case managers, members, and providers. CareOne includes assessment information, facilitates the development of a care plan, and includes ongoing monitoring and evaluation tools. Prior authorizations are also logged in CareOne and automatically (several times/day) shared with our core claims processing system to facilitate claims processing.

## **Disaster Recovery**

An important element in UnitedHealthcare Community Plan's MIS system is our disaster recovery plan. COSMOS resides on an IBM z/OS server platform running a DB2 database. Along with redundancy within the hardware itself, the server platform is configured with a second system backup should a failure occur on the first. This switchover takes place in approximately five minutes from detection of a failure event, minimizing the potential for data loss. The server platforms are scalable and run software that allows for the dynamic reallocation of system resources to different applications as necessary to support fluctuations in demand. As additional capacity is needed, more CPUs and more memory can be added to the server platform. This scalability enables us to add additional members, provider networks, reporting and care management transactions for Kentucky quickly and often without adversely affecting the platform or requiring downtime. Through more than 20 years of experience with the platform, we have developed a model that accurately forecasts capacity requirements based on membership and care management volume metrics.

UnitedHealthcare Community Plan's parent company, UnitedHealth Group, has a wholly owned network of data centers in the Minneapolis, Minnesota area to ensure ongoing business continuity from a core systems perspective, significantly mitigating the risks associated with data center-disabling events. These installations are Tier-3 data centers with fully redundant infrastructure. Backup mirrors of the production systems are located in a separate data center from production so full redundancy is available should a disaster strike one of the data centers.

In addition to its data center capabilities UnitedHealth Group has both Business Continuity Plans and Disaster Recovery Plans in place to provide backup services in the event of a disruption. Business continuity plans are part of UnitedHealth Group's overall Enterprise Resiliency & Response program designed and structured to respond to disaster events, restore critical business function processes, and resume normal business function operations in a prioritized manner. The plans focus on critical business functions and planning for the worst-case scenarios so that we can react quickly and efficiently. These worst-case scenarios cover impacts from all types of disasters, both natural and man-made. Various scenarios are provided as planning recovery objectives including loss of facilities, critical IT resources, critical systems and critical vendors.

For business functions that are deemed critical, we generally provide for near immediate failover of core IT services by leveraging geographically dispersed redundant operations and maintaining a recovery time objective of 72 hours or less. UnitedHealth Group's critical business functions include, but are not limited to, customer and provider call services, claims processing services, clinical and pharmaceutical services, banking operations, and core corporate functions. A variety of business continuity strategies are deployed depending on the business function, criticality ranking, and established recovery time objectives including but not limited to third party work group recovery contacts, teleworking, multiple shifts and staff sharing of computing and telephony resources.

Additionally all UnitedHealth Group Business Segments including UnitedHealthcare Community Plan must develop a disaster recovery plan for each critical business application or critical support system within its purview. The procedures for execution of such a capability are documented in a formal Disaster Recovery (DR) Plan, which is reviewed at a minimum on an annual basis and updated as necessary by the Segment Disaster Recovery Lead in conjunction with the Enterprise DR Services Coordinator. The objectives of the disaster recovery plan include, but are not restricted to:

- Reducing the critical impact that a catastrophic disruptive occurrence can have on a UnitedHealth Group business segment's critical business applications, its cash flow and its customers
- Enabling the transition of critical application functions to an alternate recovery facility
- Providing access for communicating information between the recovery facility and the customer point of entry
- Ensuring recovery of critical services to the affected business units, and providing critical services to customers during a survival-mode stabilization period, and
- Providing for time-phased restoration of critical business application processes and services after a disruption.

We will have a BC/DR plan for our Louisiana operation. We will file this BC/DR plan with UnitedHealth Group's corporate IT group and it will be audited by our internal and independent Compliance Department on an annual basis.

Our BC/DR plan will cover all of the information systems deemed "critical" based on a business impact assessment; these systems include the systems we will use for transaction processing, care management, data analytics and reporting such as COSMOS, CareOne and SMART. Our philosophy is that no unplanned downtime is acceptable; as such we prioritize our systems by business impact to our customers and our plans emphasize recovery of these systems first. In addition to COSMOS, CareOne and SMART, our call centers and email are all included in the highest level of criticality. Restoration processes for data are fully addressed, including how to recover from full or incremental backup.

We test our BC/DR plan annually by executing a complete disaster recovery "desktop exercise" with the entire DR team and through regular testing of our DR infrastructure to ensure that our systems can be recovered within 72 hours of practically any disaster scenario. Our BC/DR plan helps ensure that we can quickly recover our business operations. Our business users assist in the development of this plan by

participating in a formal exercise to identify and prioritize their business applications so they can be recovered in a timely fashion. UnitedHealth Group has purposely staffed distinct corporate level Departments that are solely responsible for the oversight and continued enhancement of our business continuity and disaster recovery plans and processes.

In the event that our local Louisiana office is inaccessible or disabled, depending on specific circumstances, our affected staff would use other local offices, which are connected to our internal network with full access to all systems, or would be able to access our systems securely from home via our Internal Virtual Private Network (VPN).

Our business continuity strategy will also include daily incremental backups of data files, application programs and the operating system at our datacenter in Minneapolis. Full system backups are performed on a weekly basis. On a daily basis, we will send backup tapes to an off-site storage facility. A bar-coding system is used to track tapes that are sent off-site, and the tape management system indicates the location of tapes at any point in time. The storage facility provides physical security and maintains a list of individuals authorized to access our tapes. Moreover, our backups are physically protected and stored at secure locations sufficiently distant from their production processing systems.

- ***How identical or closely related data elements in different systems are named, formatted and maintained:***
  - ***Are the data elements named consistently;***

## Common Syntax in Data Elements

The UnitedHealthcare Community Plan data warehouse, implemented in Oracle, utilizes standard industry practices for documented data dictionaries, extract/transfer/load (ETL) processing, and data quality assurance processes. We also use the HIPAA Gateway product by TriZetto which provides a common data dictionary, naming and format convention. To ease ad-hoc user reporting in the data warehouse, a series of internal data exchange data element names are translated into more end user friendly names that are cross referenced using data dictionaries. For all data interfaces, similar data elements have equivalent names across systems to accommodate interface maintenance and ongoing enhancements, and are formatted to allow the most flexibility for growth (for example, allowing where possible more spaces than is currently needed). This is similar to HIPAA's approach for name fields. Data types are also the same for similar elements. The frequency of updates/refreshes of similar data elements varies with the business purpose of the interface.

Our system complies with the following HIPAA-compliant standards for information exchange. We will not revise or modify the standardized forms or formats without approval from DHH. Batch transaction types include, but are not limited to, the following:

- ASC X12N 834 Benefit Enrollment and Maintenance
- ASC X12N 835 Claims Payment Remittance Advice Transaction
- ASC X12N 837I Institutional Claim/Encounter Transaction
- ASC X12N 837P Professional Claim/Encounter Transaction
- ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
- ASC X12N 276 Claims Status Inquiry
- ASC X12N 277 Claims Status Response
- ASC X12N 278 Utilization Review Inquiry/Response; and
- ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.

The MMIS will identify valid and invalid claims from our batch submissions and will reject and return any submission for immediate correction which contains fatal transaction format errors that prevent

processing, or that does not satisfy defined threshold error rates. We will use DHH provider billing manuals and become familiar with the claims data elements that must be included in claims submissions and agree to address any issues that prevent processing of a claim.

***– Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);***

Yes. Data elements are formatted similarly and in cases where there are differences, we have translation interfaces in place to map/normalize the data between systems.

***– Are the data elements updated/refreshed with the same frequency or in similar cycles; and***

Depending on the system and processes currently in place, the frequency and cycle of updates may vary. For example, eligibility data may be updated weekly or monthly whereas provider data may be updated daily. We will update the data elements in compliance with RFP or contract requirements.

***– Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.).***

Most data exchanges between key productions systems are automated and systematic, via interface programs. Production jobs are scheduled and triggered nightly to move data between systems and to update data within systems as needed.

***○ All exchanges of data between key production systems.***

***– How each data exchange is triggered: a manually initiated process, an automated process, etc.***

Most data exchanges between key productions systems are automated; however, there are instances where data exchanges are initiated manually. Examples include:

- Manual corrections to member eligibility data by the billing and enrollment team
- Manual adjustments to pended claims by our claims processing staff.

***– The frequency/periodicity of each data exchange: “real-time” (through a live point to-point interface or an interface “engine”), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.***

Data exchanges between our key systems typically occur nightly, based on scheduling per contractual requirements, and are automatically triggered per the pre-defined schedule. The frequency is dependent upon the data exchanges between different systems as well as contract requirements. UnitedHealthcare Community Plan will comply with CCN requirements in the frequency and timing of data exchanges.

***• As part of your response, provide diagrams that illustrate:***

- *point-to-point interfaces,*
- *information flows,*
- *internal controls and*

## Point-to-Point Interfaces, Information Flows and Internal Controls Diagram

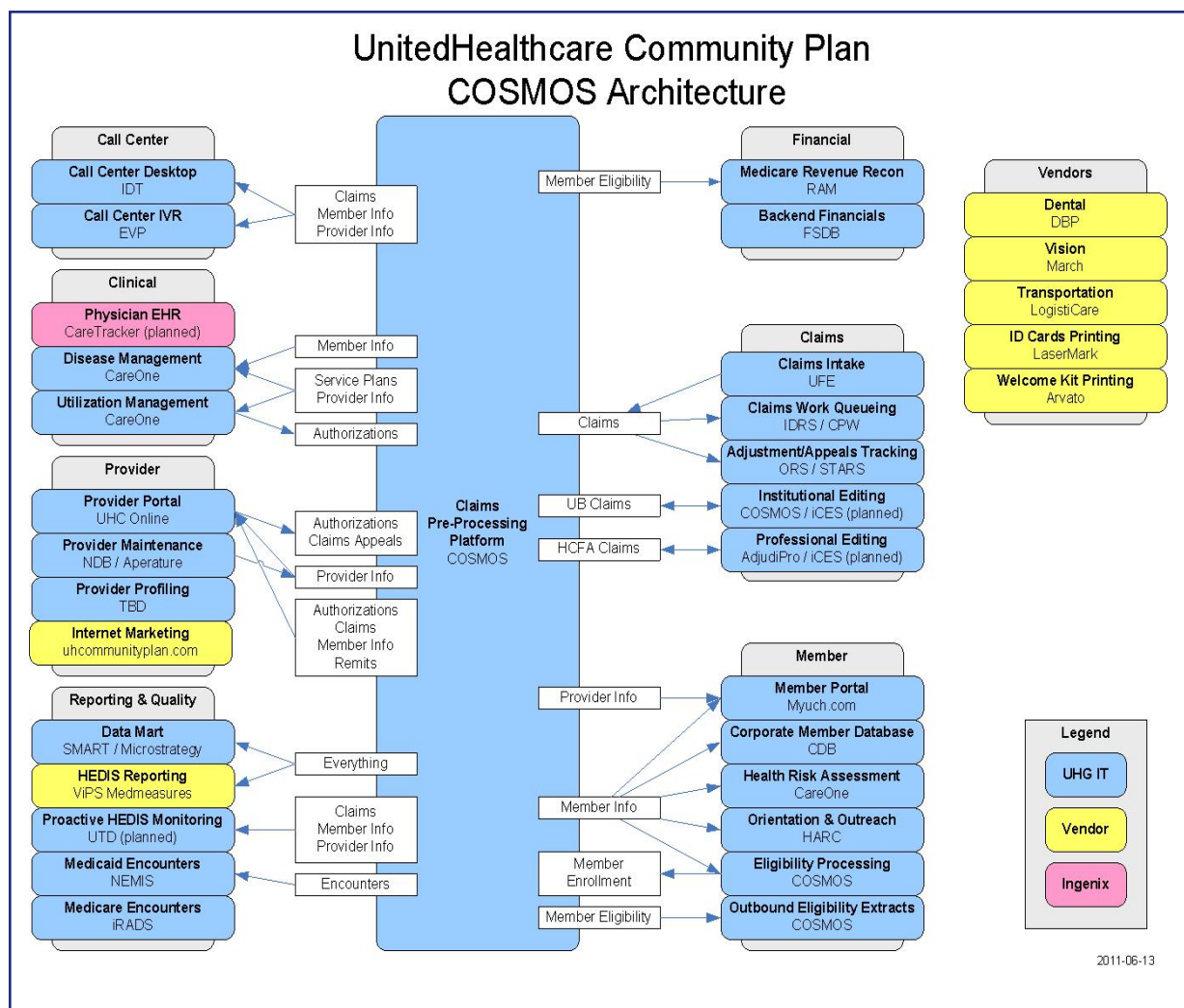
UnitedHealthcare Community Plan’s technology approach consists of architecting our systems for scalability, monitoring and modeling existing and anticipated loads, budgeting for upgrades and deployment of additional capacity. UnitedHealthcare Community Plan engages a project manager (PM) for each new implementation. The PM serves as our facilitator and ensures that the customer is being

heard, competing projects don't interfere and all tasks are being delivered on time. COSMOS and its associated integrated computing environment comprise a distributed multi-tier architecture including several front-end processors and database servers designed to maximize availability and responsiveness.

Our front-end Citrix servers perform online processing; the front-end Windows servers perform batch processing; and the database servers perform all Sybase database requests, whether from batch or on-line. We manage all processing through a combination of load balancing software and hardware that employs data replication technologies to maintain peak performance and maximum availability by allowing multiple paths for COSMOS to retrieve and store data. This architecture accommodates scalable expansion in two ways.

- The vertical option allows the addition of CPUs and disk storage to existing servers so that we can increase capacity of machines already in place without disruption to the servers or impact to production processing
- The horizontal option allows the addition of new front-end servers to increase the number of machine "footprints."

Having the flexibility to add systems capacity in either manner allows us to quickly introduce routine upgrades, while giving us the latitude to plan for significant increases in computing needs without risk or material operational impact.

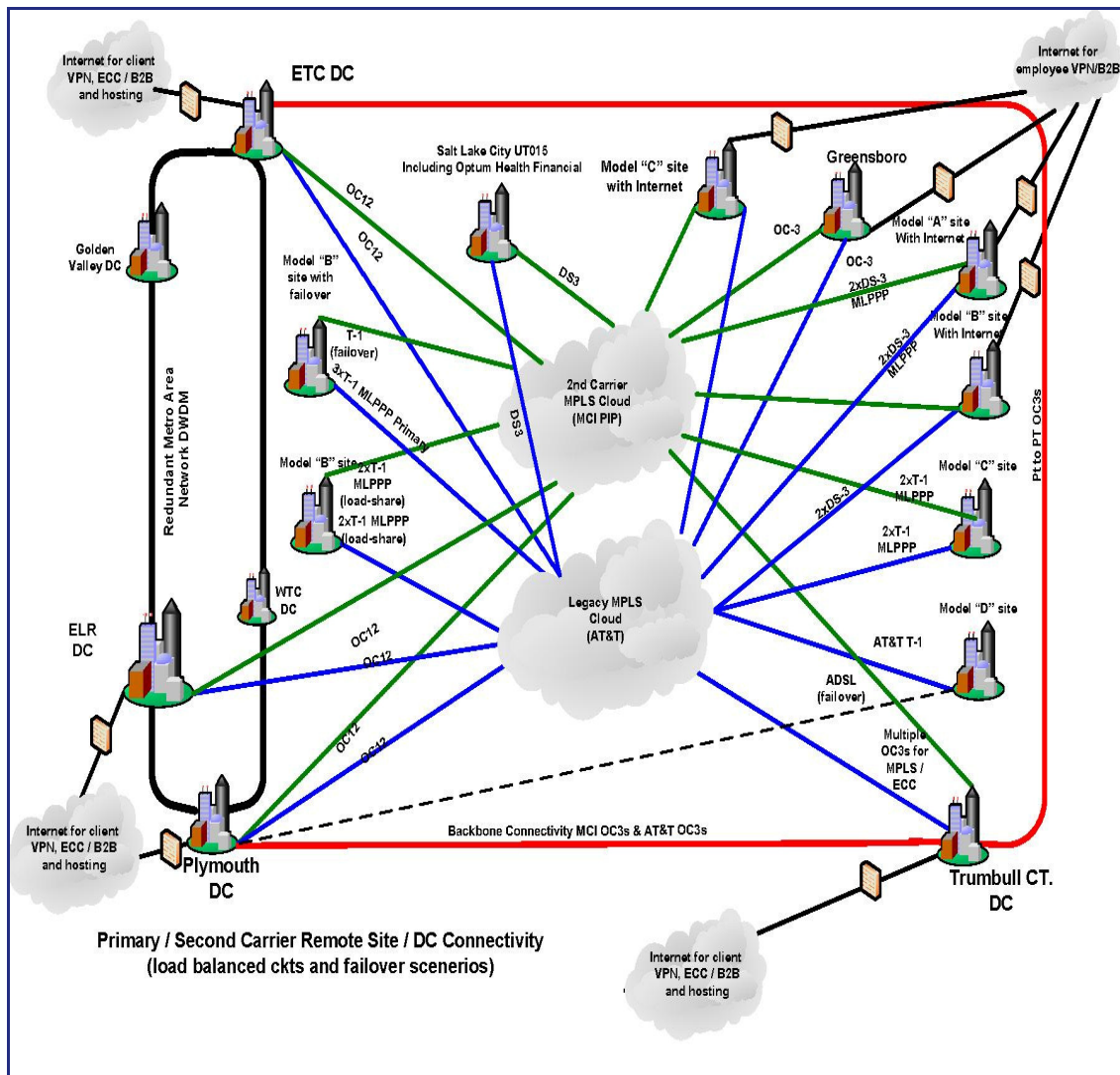




This architecture also enables a level of fault tolerance through use of multiple servers and shared storage, allowing instant recovery from failures in these components. For example, in the event of a disk drive failure, our staff is able to continue working until the drives can be replaced with little to no disruption in operations, ensuring real time continuity. UnitedHealthcare Community Plan's critical systems, including COSMOS, iDRS (our document imaging, workflow, and call tracking system) and HIPAA Gateway are implemented with an R+1 (Redundant Plus 1) approach - meaning all hardware is replicated and in standby for seamless cut over with failover to secondary devices based on Service Level Agreement requirements for availability. We perform periodic load-testing of our systems to ensure maximum availability and responsiveness; using the Mercury LoadRunner tool set. The following diagram depicts each component of our COSMOS management information system, including point-to-point interfaces, information flows, internal controls and all other systems that interface with or support it.

- *the networking arrangement (AKA "network diagram") associated with the information systems profiled.*

*These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.*



**Q.5** *Describe your ability to provide and store service/prior authorization data in accordance with the requirements in this RFP. In your response:* (All GSAs)

- *Explain whether and how your systems meet (or exceed) each of these requirements.*

## Providing and Storing Service/Prior Authorization Data

Our CareOne application is a comprehensive, integrated care management software application that provides tools to better understand and address our members' medical, behavioral, and social needs, and is designed to facilitate the information flow among caregivers, case managers, members, and providers. CareOne includes basic and comprehensive assessments while case managers can enter responses and print automated assessment summaries. CareOne also assists case managers in developing care plans and includes tools for ongoing monitoring and evaluation. CareOne includes a comprehensive depression screening assessment.

We link CareOne to our administrative platform, COSMOS, twice daily, to authorize services automatically for claims processing purposes based on the member's plan of care. The CareOne system is the foundation for both the assessment and care planning processes. CareOne includes assessment information, facilitates the development of a care plan, and includes ongoing monitoring and evaluation tools. CareOne includes behavioral health screening and assessment data. This is an important tool for promoting integration of somatic and behavioral health services. Through our secure online portal, our providers can access CareOne and submit medical prior authorization requests and check on the status of the authorization.

The care plan serves as the roadmap for each member's support team. Through the care plan, the case manager documents the member's goals, objectives, and desired outcomes, needed services and service parameters, and both formal supports and informal resources that could enhance care for the member. The case manager works to meet the needs of the member by accessing all possible resources for assistance by reaching out to community-based providers, physicians, and all those involved to facilitate a holistic approach to the management of the member's identified needs. The member is the center of the team and the case manager makes sure that the evolving plan is understood by and agreeable to the member each step of the way. CareOne features include:

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

A one-time data feed of all active/open authorizations for members assigned to us would be needed to ensure a smooth transition of services for members, as well as for utilization management/history. Depending on the anticipated volume of active/open authorizations to be transitioned, we may either set up an interface program to automatically load them into our CareOne care management system or manually enter them – especially if the volume is expected to be low. The authorizations will flow from CareOne to COSMOS for claims pre-processing.

- *Cite at least three currently-live instances where you are successfully providing service/prior authorization functions in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. Explain how previous or current experience will apply to the Louisiana Medicaid CCN Program.*

## Service/Prior Authorization Examples

UnitedHealthcare Community Plan's proprietary system, CareOne, has functionality for tracking referral/utilization, prior authorizations, pre-certification and denial of services as well as reporting of the same. The state partners below successfully use CareOne and COSMOS to provide service/prior

authorization functions in similar formats and standards as those proposed for the CCN program:

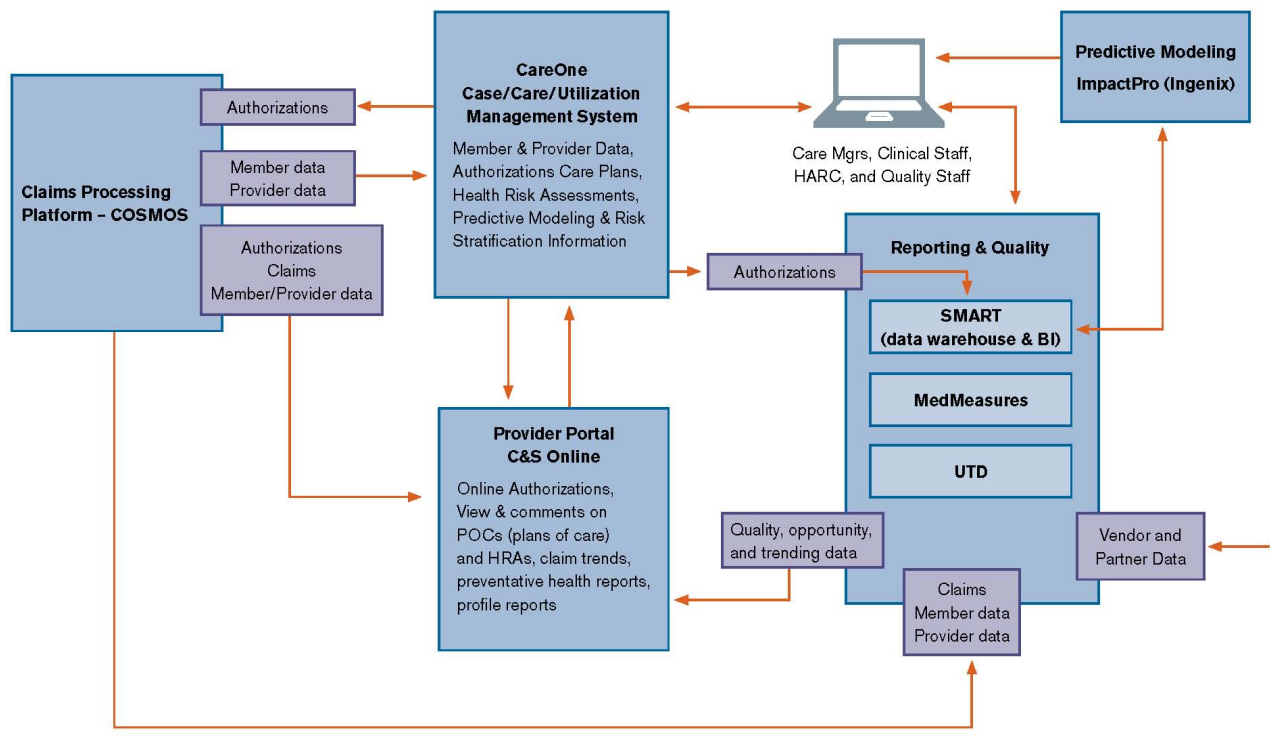
- Florida Healthy Kids plan
- Texas Long Term Care program
- Connecticut Medicaid program
- Hawaii Long Term Care Plan.

Our claim system, COSMOS receives an interface twice daily containing the pre-certifications, prior authorizations and referrals from our CareOne system in order to either approve or deny a claim twice daily. We are able to provide an electronic data file containing information on all Medicaid providers for service authorization and analysis purposes.

Denial of service is accomplished through the configuration of plan benefits in COSMOS. If a service is not covered or denied for any appropriate reason, COSMOS is configured to automatically deny the claims with the appropriate explanation.

All plans on COSMOS share authorization data between CareOne and COSMOS as illustrated in the following diagram.

## Medical Management & Quality Data Flow



- ***If you are not able at present to meet a particular requirement contained in the RFP, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (4) Identify challenges and “lessons learned” from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.***

UnitedHealthcare Community Plan is able to fully meet the service authorization requirements of the RFP; therefore, this item is not applicable.

***Q.6 Describe your ability to receive, process, and update eligibility/enrollment, provider data, and claims data to and from the Department and its agents; in accordance with the requirements in Section 14. In your response: (All GSAs)***

- ***Explain whether and how your systems meet (or exceed) each of these requirements.***

## Eligibility/Enrollment

Our transaction systems receive, translate, edit, create and house data required for the day-to-day operations of the health plans we administer. These include our core transaction processing system, COSMOS, for enrollment, eligibility and claims administration and HIPAA Gateway and EDIFICS for electronic data interchanges with trading partners. Updates from the DHH will be processed within one working day.

Throughout our implementation experiences, we have found that enrollment and eligibility processes need to be focused on as the first key data exchange that should be specified, tested and deployed. There are two reasons for this. First, eligibility and enrollment testing is a necessary prerequisite to later claims submission, authorization, and pre-processing testing. The second factor is the need to “go live” with enrollment processing well before the actual plan “go live” date to allow for member communications, ID cards, outreach activities and clinical transition activities. We will perform multiple cycles of inbound eligibility (834/271U) testing before the actual CCN program effective date.

Once CCN is in a production or a live mode we will continuously monitor enrollment data received and loaded in COSMOS through our standard enrollment process, error reports and dedicated resources. Discrepancies are reported and then worked/resolved by our dedicated enrollment coordinators.

In addition, we agree to meet the requirements as specified in Section 13.4 (Eligibility and Enrollment Data Exchange) of the RFP.

## Provider Network Testing

UnitedHealthcare Community Plan uses a multi-step process to carefully yet efficiently load and verify provider contract data according to specific State business rules. This process starts with the receipt of an executed contract, credentialing application, which we use to verify demographic information (including the National Provider Identifier (NPI), I-9 form, Medicaid ID Number, etc.), confirmation that the provider application is complete and includes site survey results; validation that all credentialing documentation is complete; and final loading into our National Database (NDB).

When contracting providers, the first step of the process is for the provider to complete a credentialing application. Our credentialing application requires providers provide specific data, including their NPI number, Medicaid ID number and their I-9 form. Upon receipt of credentialing applications, our National Credentialing Center (NCC) credentialing specialists review applications for completeness. Credentialing specialists telephone providers who submit incomplete applications to gather missing information. Upon receipt of all required application data, credentialing specialists enter data from the completed applications into our Universal Credentialing Datasource.

NCC staff members conduct primary source verification data provided via the credentialing applications. Data verified include, but are not limited to: validity of license, Medicaid Provider ID number, NPI number, education, board certification, sanctions, etc.

Once credentialed and contracted, all data contained in our credentialing system is loaded into our NDB (provider database). NDB is an IBM DB2 based system, housing information on all providers having contractual relationships with UnitedHealthcare Community Plan as well as other UnitedHealth Group affiliates. Provider data in the NDB is electronically loaded and updated on a daily basis into COSMOS, our core transaction system. Once testing confirms provider contracts are set up in the system correctly, the contract is tagged as “claim ready”. We monitor the entire process to ensure that within 30 days of receiving completed and credentialed provider applications, contracting data is built in COSMOS correctly.

Our Network Management team conducts ongoing monitoring and updates to our contract files, such as:

- Amendments to ensure regulatory compliance
- Fraud and abuse monitoring
- Routine reviews of data
- Unit cost management.

In addition, we agree to meet the requirements as detailed in Section 13.5.1.1, 13.5.1.2, 13.5.2, 13.5.2.1, 13.5.2.2, 13.5.2.3 and 13.5.2.4 of the RFP relative to the Provider File requirements.

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## **Claims Data**

Our health information systems are fully compliant with HIPAA privacy and transaction and code set standards adaptable to updates in order to support CCN claims-related policy requirements as needed. Our HIPAA-compliant claims processing system is capable of cost-avoiding and pre-processing claims in accordance with state and federal requirements. We support standard 820, 834, 835, 837, 270/271 and 277/278 file formats for all electronic transactions (EDI). To comply further with HIPAA privacy requirements, all applications use role-based access to ensure that staff only has access to reports and data to support their current role and function. Access is further controlled by using some of our best security practices: firewalls and physical separation of processing systems.

Our core claims processing system is integrated with CareOne, our care/case/disease management system. We designed our CareOne application to coordinate the information flow among caregivers, case managers, members, and providers. CareOne includes assessment information, facilitates the development of a care plan, and includes ongoing monitoring and evaluation tools. Prior authorizations are also logged in CareOne and automatically shared with our claims processing system.

Prior to loading claims into COSMOS, the system applies automated edits to electronically submitted claims for formats and specific rules, such as invalid birth year or dollar amounts. These measures ensure the completeness and accuracy of the claims data submitted to the FI. Our internal audit process is continuous and comprehensive. All claims are included in our reports and audit processes and audit personnel have broad experience in claims processing, possess strong analytical skills and address any issues that may arise resulting from the audits. This collaboration enables UnitedHealthcare Community Plan to make corrections to the system as needed, and to provide the type of feedback and mentoring needed for examiners, in order to support performance improvement.

A one-time data feed of historical claims data, at minimum 12 months worth, would be needed to perform initial predictive modeling and risk stratification on members assigned to us; and then ongoing monthly claims data to continue with the predictive modeling process. We would set up for and load the historical claims data through our Integration Layer, used to edit and normalize data from multiple sources. The data would then be passed to our data warehouse (SMART), where all data for the program will



ultimately reside for reporting and analytics purposes. The historical claims data would be added to the monthly extract from SMART to OptumInsight, our sister segment, for ImpactPro processing. Our care managers will be able to directly access the predictive modeling results, either from ImpactPro or from SMART, to help them with their care plans and management.

We produce a variety of Crystal and Business Objects reports which are made available to our Operations and Claims management teams for review of claims for completeness and accuracy of claims data.

- ***Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Section 14. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.***

### Three Examples of Success in Receiving/Processing/Updating Eligibility/Enrollment Data

The table below reflects three current Medicaid partners where we are successfully receiving, processing and updating eligibility/enrollment data similar to DHH standards and specifications.

<i>Current Load Rates of Eligibility/Enrollment Data from State 834 Files</i>		
<i>MS CHIP</i>	<i>Tennessee</i>	<i>Florida</i>
100%	98.39%	95.57%

For all three state partners, we receive, process and update daily, weekly or monthly enrollment files submitted by our client or the designated enrollment broker. Upon receipt of the eligibility/enrollment files, we update our system within 24 hours, as also required by DHH. For error/records requiring cleanup (manual intervention), our turn around to correct such errors/records is currently over 99 percent, well within the compliance requirements. We work with our state partners to transmit data records, including member address and telephone changes in the manner prescribed by them and are able to uniquely identify a distinct Medicaid member across multiple populations within our systems. For all three state partners shown in the above table, as well as for all of our Medicaid programs, we identify potential duplicate records for a single member and resolve the duplication, upon confirmation by the state partner, such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

- ***If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.***

UnitedHealthcare Community Plan is able to meet all the eligibility/enrollment requirements in Section 14 of the RFP; therefore, this item is not applicable.

- ***Identify challenges and “lessons learned” from implementation in other states and describe how you will apply these lessons to this contract.***

Throughout our implementation experiences, we have found that enrollment and eligibility processes need to be focused on as the first key data exchange that should be specified, tested and deployed. There are two reasons for this. First, eligibility and enrollment testing is a necessary prerequisite to later claims submission, authorization, and pre-processing testing. The second factor is the need to “go live” with enrollment processing well before the actual plan “go live” date to allow for member communications, ID cards, outreach activities and clinical transition activities. All of this preparatory experience is directly applicable to the CCN program. As we did for recent implementations, including Mississippi CHIP,

Mississippi CAN and Tennessee Medicaid programs, we **will perform several cycles of inbound eligibility (834/271U) testing before the start dates.**

This type of testing has produced successful past implementations resulting in early validation of the SFTP file transfer process, our system configuration, the membership load process, and ensuring sufficient capacity for initial file loads. This early emphasis on enrollment and eligibility in the implementation enables UnitedHealthcare Community Plan and DHH to review individual membership enrollment prior to production implementation.

***Q.7 Describe the ability within your systems to meet (or exceed) each of the requirements in Section 13 - System and Technical Requirements. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement. (All GSAs)***

## Compliance with Section 13 Requirements

UnitedHealthcare Community Plan will comply with the RFP requirements as specified in the table below. The table summarizes our compliance to each of the RFP requirements in Section 13: Systems and Technical Requirements. The *Response Details* column indicates the section of the response that provides details that addresses each specific requirement. For requirements needing additional clarification or discussion, we have submitted a *Clarification* statement in the *Requirement Description* column for your review.

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
<b>13 System and Technical Requirements</b>			
	The CCN shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts provider claims, verifies eligibility, validates prior authorization, pre-processes, and submits claims data to DHH's FI that complies with DHH and federal reporting requirements. The CCN shall ensure that its System meets the requirements of this RFP and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.	Fully meet/exceed requirement	Q1, Q4, Q5, Q11
	The System shall have and maintain capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within DHH specified timeframes, in response to changes in the Contract requirements. The CCN shall provide service authorization for all services that require service authorization. The System shall have the capacity to pre-process all claims and submit claims for payment on a fee-for-service basis to the FI.	Fully meet/exceed requirement	Q1
	The CCN shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.	Fully meet/exceed requirement	Q15
	The CCN shall submit pre-processed claims data to the FI in either an 837 electronic format or a paper claim, whichever was originally submitted by the billing provider.	Fully meet/exceed requirement	Q1, Q11
	Where deemed necessary by DHH, for the CCN's Web presence to be incorporated to any degree to DHH's web presence/portal; the CCN shall conform to all applicable state standards for website structure, coding, and presentation	Fully meet/exceed requirement	Q9, Q11
<b>13.1. Data and Document Management Requirements</b>			
13.1.1.	Adherence to Standards The System shall conform and adhere to the data and document management standards of the FI including standard transaction code sets.	Fully meet/exceed requirement	Q4
13.1.2	Confidentiality, Privacy, and Security The CCN shall comply with all applicable state and federal confidentiality requirements, including, but not limited to, the provisions of the HIPAA standards for data and document management, security, and privacy.	Fully meet/exceed requirement	Q1, Q9, Q15

<i>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</i>			
<i>Section</i>	<i>Requirement Description</i>	<i>Meet/Exceed DHH Requirement</i>	<i>Response Details</i>
13.1.3.	<p>System Accessibility</p> <p>The CCN's application systems foundation should employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is important that the application system support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.</p>	Fully meet/exceed requirement	Q11
13.1.4.	<p>Data and Document Relationship</p> <p>The System shall house indexed electronic images of documents to be used by members and providers to transact with the CCN and that are reposed in appropriate database(s) and document management systems (i.e., Master Patient Index) as to maintain the logical relationships to certain key data such as member identification, service authorization numbers, provider identification numbers and claim identification numbers. The CCN shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, such as interactions with a particular member about a reported problem.</p>	Fully meet/exceed requirement	Q11
13.1.5.	<p>The CCN shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents. The CCN shall provide DHH online retrieval and access to documents and files for six (6) years in live systems, for audit and reporting purposes, and 10 years in archival systems. Services which have a once in a life-time indicator (i.e., appendix removal, hysterectomy, etc.) are denoted on DHH's procedure formulary file and claims shall remain in the CCNs current/active claims history that is used in claims editing and are not to be archived or purged.</p> <p>Online access to claims pre-processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The CCN shall provide 48-hour turnaround or better on requests for access to information that is up to 6 years old and 72-hour turnaround or better on requests for access to information in machine-readable form that is between 6 to 10 years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.</p>	Fully meet/exceed requirement	Q1, Q11
13.1.6.	<p>All information, whether data or documentation, and reports that contain or reference information involving or arising out of this RFP is owned by DHH. The CCN is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter</p>	Fully meet/exceed requirement	Q16

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
	shall be final.		
<b>13.2. System and Data Integration Requirements</b>			
13.2.1.	<p>Adherence to Standards for Data Exchange</p> <p>The System shall be able to transmit, receive, and process data in HIPAA-compliant or DHH specific formats and/or methods, including but not limited to, secure File Transfer Protocol (FTP) over a secure connection, such as a Virtual Provider Network (VPN), during the on-site Readiness Review. Data elements and file format requirements may be found in the CCN-S Systems Companion Guide. The CCN shall maintain desktop workstation hardware and software compatible with current DHH standards as follows:</p> <ul style="list-style-type: none"> <li>■ Desktop Workstation Hardware: <ul style="list-style-type: none"> <li>– IBM-compatible PC using at least a Dual Core Processor (2.66 GHz, 6 MB cache, 1333 MHz FSB);</li> <li>– At least 4 GB (gigabytes) of RAM;</li> <li>– At least 250 GB HDD;</li> <li>– 256 MB discrete video memory;</li> <li>– A color monitor or LCD capable of at least 800x640 screen resolution;</li> <li>– A DVD +/-RW and CD-ROM drive capable of reading and writing to both media; and</li> <li>– 1 gigabyte Ethernet card.</li> </ul> </li> </ul> <p><b>Clarification:</b> UnitedHealthcare Community Plan provides every employee and contractor a standard, fully supported computer imaged with a standard user productivity suite along with shared printing, copying, faxing and scanning devices. As part of our overall data security program and strategy, some functionality is limited for some users based upon actual position requirements.</p> <p>UnitedHealthcare Community Plan partners with vendors to offer products to meet the needs of our businesses. We offer full service support and management of UnitedHealthcare Community Plan standard hardware including purchasing/leasing, installation and set-up, asset management and full technical support</p>	Fully meet/exceed requirement	-
	<ul style="list-style-type: none"> <li>■ Desktop Workstation Software: <ul style="list-style-type: none"> <li>– Operating system should be Microsoft Windows XP SP2 or later;</li> </ul> </li> </ul>	Fully meet/exceed requirement	-



<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
	<ul style="list-style-type: none"> <li>– Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts;</li> <li>– An e-mail application that is compatible with Microsoft Outlook;</li> <li>– An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 document standards;</li> <li>– Each workstation should have access to the Internet;</li> <li>– A desktop compression/encryption application that is compatible with WinZIP v11.0;</li> <li>– Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered; and</li> <li>– All workstations, laptops and portable communication devices shall be installed with full disk encryption software.</li> <li>– The CCN shall comply with DHH’s Electronic Claims Data Interchange (eCDI) annual certification of electronically submitted claims.</li> </ul> <p><b><u>Clarification:</u></b> UnitedHealthcare Community Plan provides every employee and contractor a standard, fully supported computer. All UnitedHealthcare Community Plan computers are imaged with a standard user productivity suite, which includes the Microsoft operating system, Microsoft Office Suite (Word, Excel, Access, PowerPoint and Publisher), Adobe Reader, Visio Viewer, e-mail client, enterprise calendaring and Internet Explorer.</p> <p>UnitedHealthcare Community Plan partners with Insight Software to offer a full-range of third-party applications to meet the needs of our business.</p> <p>UnitedHealthcare Community Plan offers a standardized Microsoft Outlook/Exchange environment that supports individual and group e-mail accounts, distribution lists and dual use groups, although some functionality is limited based upon the needs of the position. This standard approach enables UnitedHealthcare Community Plan to achieve efficiencies and productivity improvements.</p> <p>UnitedHealth Group offers a standardized Microsoft Outlook/Exchange environment that supports individual and group e-mail accounts, distribution lists and dual use groups. Office Communicator Instant Messaging is also available upon approval.</p>	<b><u>Clarification</u></b>	

<i>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</i>			
<i>Section</i>	<i>Requirement Description</i>	<i>Meet/Exceed DHH Requirement</i>	<i>Response Details</i>
13.2.2.	<p>HIPAA Compliance</p> <p>All HIPAA-conforming exchanges of data between DHH and the CCN are subject to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The Contract with the DHH is inclusive of the HIPAA Business Associate Agreement to this RFP (see Appendix C).</p>	Fully meet/exceed requirement	Q1, Q9, Q15
13.2.3.	<p>Connectivity and Interoperability</p> <p>All applications, operating software, middleware, and networking hardware and software shall be interoperable with DHH's systems as needed and shall conform to applicable standards and specifications set forth by DHH. The System shall have the capability to transmit and receive claims data to and from the FI's system as required for the appropriate submission of claims data.</p> <p><b><u>Clarification:</u></b> While our internal systems are fully interoperable as outlined in our response, we are unsure of the specific needs of DHH's systems to interoperate with our systems. If this is referring to extracts and file formats or two-way communication and data sharing, then we fully meet and satisfy this requirement. If this is referring to direct system-to-system interoperability, then we need to understand this requirement as we do not permit external systems direct access to our internal network and systems due to security and/or privacy issues</p> <p>The CCN shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the CCN's span of control.</p> <p>The CCN shall maintain computer hardware and software that provides the following established capabilities:</p> <ul style="list-style-type: none"> <li>■ Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs).</li> <li>■ Establish internet connection(s) so that all appropriate workstation PCs are able to access the Internet.</li> <li>■ Establish appropriate hardware firewalls, routers, and other security measures so that the CCN computer network is not able to be breached by an external entity.</li> <li>■ Establish appropriate back-up processes that ensure the backup, archival, and ready retrieval of network server data and desktop workstation data.</li> <li>■ Ensure that network hardware is protected from electrical surges, power fluctuations, and power</li> </ul>	<p>Fully meet/exceed requirement</p> <p><b><i>Clarification</i></b></p> <p>Fully meet/exceed requirement</p> <p>Fully meet/exceed requirement</p>	<p>Q4</p> <p>Q4</p> <p>Q1, Q3, Q4</p>

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
	<p>outages by using the appropriate uninterruptible power system (UPS) and surge protection devices.</p> <ul style="list-style-type: none"> <li>■ The CCN shall establish independent generator back-up power capable of supplying necessary power for four (4) days.</li> </ul> <p>If a system update or change is necessary, the CCN shall draft appropriate revisions for the documentation or manuals for DHH review and approval and submit to DHH 30 days prior to implementation of the revision. Documentation revisions shall be accomplished electronically and shall be made available for DHH review in an easily accessible, near real-time method. Printed manual revisions shall occur within 10 business days of the actual revision.</p> <p><b>Clarification:</b> Our tested and fully functional COSMOS operating system serves multiple state customers. As such, we maintain a core operating system that leverages best practices from multiple states and yet provide for customization to meet state specific requirements. If a minor system update or change is implemented, we will draft revisions to the appropriate documentation/manuals as required which will be available to DHH upon request. If a major system update is required, we will notify DHH in advance to assure seamless continuity with DHH and other trading partners.</p> <p>The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services. DHH's current MMIS contract expires December 31, 2010. DHH may exercise its right to extend all or part of a five (5) year extension to its current FI. DHH shall require the CCN to comply with transitional requirements as necessary, at no cost to DHH or its FI, should DHH contract with a new FI during the Contract.</p>	<p>Fully meet/exceed requirement</p> <p><b>Clarification</b></p> <p>Fully meet/exceed requirement</p>	<p>Q1</p> <p>Q1, Q6, Q9</p>
13.2.4.	<p>Program Integrity (Fraud and Abuse)</p> <p>The System shall be capable of generating files in prescribed formats for uploading to the FI's system that is used specifically for program integrity and compliance purposes. The CCN shall allow DHH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by DHH or the Louisiana Attorney General's Office direct access to its system(s).</p> <p><b>Clarification:</b> Our team would like to understand DHH objectives with this request and we would work diligently to develop a mutually agreeable access solution. Due to security and system data integrity concerns, full, unsupervised access to systems is problematic; however, we will create a custom 'data</p>	<p>Fully meet/exceed requirement</p> <p><b>Clarification</b></p>	Q10

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
	extract' on a regular basis for use by DHH and specific to the CCN program which can be loaded to DHH's system to generate internal reporting. In addition, we provide ad hoc reporting on request as needed.		
<b>13.3.</b>	<b>Pre-Processed Claims Data Submission</b> The System is required to conform to current HIPAA standard code sets. The CCN shall submit all pre-processed clean claims data to the FI via standard transaction formats within two (2) business days of receipt of the clean claim from the provider. Information required which supports claims data reporting and submission is defined in the CCN-S Systems Companion Guide.	Fully meet/exceed requirement	Q1, Q11
13.3.1. The System shall, at a minimum, be capable of meeting the requirements listed below:			
13.3.1.1.	All claims shall be submitted either on paper or electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 Transaction formats (P - Professional, and I - Institutional), and depending upon how the original claim was submitted to the CCN. Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.	Fully meet/exceed requirement	Q1, Q11
13.3.1.2.	The CCN shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.	Fully meet/exceed requirement	Q1, Q11, Q15
13.3.1.3.	In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and CPT Category II codes are mandatory, aiding the CCN and DHH to measure quality performance.	Fully meet/exceed requirement	Q11
13.3.1.4.	The CCN shall provide the FI with complete and accurate claims data for all levels of healthcare services.	Fully meet/exceed requirement	Q1, Q11
13.3.2.	MMIS identifies valid and invalid claims from a batch submission by the CCN. Any submission, which contains fatal transaction format errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the CCN for immediate correction.	Fully meet/exceed requirement	Q4
13.3.3.	The CCN shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in claims submissions. Due to the need for timely filing of data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of a claim.	Fully meet/exceed requirement	Q4
<b>13.4. Eligibility and Enrollment Data Exchange</b>			
13.4.1. The CCN shall:			
13.4.1.1.	Receive, process and update enrollment files sent daily by the Enrollment Broker;	Fully meet/exceed requirement	Q1, Q4, Q6

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
13.4.1.2.	Update its eligibility and enrollment databases within 24 hours of receipt of said files;	Fully meet/exceed requirement	Q1, Q4, Q6
13.4.1.3.	Transmit to DHH, in the formats and methods specified in the HIPAA guide or as otherwise specified by DHH, member address changes, telephone number changes;	Fully meet/exceed requirement	Q1, Q4, Q6
13.4.1.4.	Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control; and	Fully meet/exceed requirement	Q1, Q4, Q6
13.4.1.5.	Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.	Fully meet/exceed requirement	Q1, Q4, Q6
<b>13.5.</b>	<b>Provider File</b> At the onset of this Contract and periodically as changes are necessary, DHH shall publish a Medicaid provider list at <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> which includes provider types, specialty, and sub-specialty codes. The CCN shall utilize these codes within their provider file record. The objective is to coordinate the provider file records of the CCN with the same provider type, specialty and sub-specialty codes as those used by DHH and the Enrollment Broker.	Fully meet/exceed requirement	Q6
13.5.1. The CCN shall:			
13.5.1.1.	Have the ability to electronically receive, process and update the provider information within their network in a database so that the Enrollment Broker is able to electronically access and identify available PCPs for member linkage.  <b>Clarification:</b> Our relationships with 24 other state Medicaid programs do not include open-ended access, as apparently requested above. However, we would want to understand DHH objectives and discern ways to meet those objectives while preserving the integrity and security of our operating systems.	Fully meet/exceed requirement  <b>Clarification</b>	-
13.5.1.2.	Have the ability to create an electronic data file containing information on all Medicaid providers for service authorization and analysis purposes.	Fully meet/exceed requirement	Q1, Q5, Q8, Q11
13.5.2.	Provider file should include, at a minimum, the following functionality:	Fully meet/exceed requirement	Q1, Q6
13.5.2.1.	Linkages of individual providers to groups;	Fully meet/exceed requirement	Q1, Q6



<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
13.5.2.2.	Provider office hours;	Fully meet/exceed requirement	Q1, Q6
13.5.2.3.	PCP capacity; and	Fully meet/exceed requirement	Q1, Q6
13.5.2.4.	Provider languages spoken.	Fully meet/exceed requirement	Q1, Q6
<b>13.6. System, Information Security and Access Management</b>			
13.6.1. The System shall:			
13.6.1.1.	Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:	Fully meet/exceed requirement	Q16
13.6.1.1.1.	Restrict access to information on a —least privilege basis, such as users permitted inquiry privileges only, will not be permitted to modify information;	Fully meet/exceed requirement	Q16
13.6.1.1.2.	Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by DHH and the CCN; and	Fully meet/exceed requirement	Q16
13.6.1.1.3.	Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.	Fully meet/exceed requirement	Q16
13.6.1.2.	Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.	Fully meet/exceed requirement	Q10
13.6.1.3.	Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the CCN and DHH.	Fully meet/exceed requirement	Q1, Q9, Q16
13.6.1.4.	Ensure that audit trails be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:	Fully meet/exceed requirement	Q1, Q4, Q8, Q9, Q11, Q15, Q16
13.6.1.4.1.	Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;	Fully meet/exceed requirement	Q4

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
13.6.1.4.2.	Have the date and identification —stamp displayed on any on-line inquiry;	Fully meet/exceed requirement	Q4
13.6.1.4.3.	Have the ability to trace data from the final place of recording back to its source data file and/or document;	Fully meet/exceed requirement	Q4
13.6.1.4.4.	Be supported by listings, transaction reports, update reports, transaction logs, or error logs;	Fully meet/exceed requirement	Q4
13.6.1.4.5.	Facilitate auditing of individual records as well as batch audits; and	Fully meet/exceed requirement	Q1, Q4, Q8, Q9, Q11, Q15, Q16
13.6.1.4.6.	Be maintained online for no less than 6 years; additional history shall be retained for no less than 10 years and shall be provide 48) hour turnaround or better on request for access to information in machine readable form, that is between 6 to 10 years old.	Fully meet/exceed requirement	Q1, Q4, Q8, Q9, Q11, Q15, Q16
13.6.1.5.	Have inherent functionality that prevents the alteration of finalized records;	Fully meet/exceed requirement	Q11
13.6.1.6.	Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CCN shall provide DHH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;	Fully meet/exceed requirement	M1, Q4, Q8, Q16
13.6.1.7.	Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;	Fully meet/exceed requirement	M1, Q4
13.6.1.8.	Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;	Fully meet/exceed requirement	M1, Q4
13.6.1.9.	Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CCN and or its contractor's span of control. This includes, but is not limited to, any provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access;	Fully meet/exceed requirement	Q3, Q8
13.6.1.10.	Ensure that remote access users of its System can only access said System through two-factor user authentication such as Virtual Private Network (VPN), which must be prior approved by DHH during the on-site Readiness Review; and	Fully meet/exceed requirement	Q1, Q3, Q16

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
13.6.1.11.	Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. At a minimum, the CCN shall conduct a security risk assessment and communicate the results in an information security plan provided the on-site Readiness Review. The risk assessment shall also be available to appropriate federal agencies.	Fully meet/exceed requirement	Q9
<b>13.7. System Availability</b>			
13.7.1. The CCN shall:			
13.7.1.1.	Ensure that critical member and provider Internet and/or telephone-based IVR functions and information functions are available to the applicable System users 24 hours a day, 7 days a week except during periods of scheduled System unavailability agreed upon by DHH and the CCN. Unavailability caused by events outside of the CCN's span of control is outside of the scope of this requirement;	Fully meet/exceed requirement	Q11
13.7.1.2.	Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;	Fully meet/exceed requirement	Q11
13.7.1.3.	Ensure that the systems and processes within its span of control associated with its data exchanges with the FI and/or Enrollment Broker are available and operational;	Fully meet/exceed requirement	Q1, Q3, Q4
13.7.1.4.	Ensure that in the event of a declared major failure or disaster, the CCN core eligibility/enrollment and claims processing systems shall be back on line within 72 hours of the failure or disaster occurrence;	Fully meet/exceed requirement	Q3
13.7.1.5.	The CCN shall notify applicable DHH staff via phone, fax and/or electronic mail within 60 minutes upon discovery of a problem within or outside of the CCN's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the CCN and DHH. In its notification, the CCN shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes;	Fully meet/exceed requirement	Q3
13.7.1.6.	The CCN shall notify applicable DHH staff via phone, fax, or electronic mail within 15 minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;	Fully meet/exceed requirement	Q10
13.7.1.7.	Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail;	Fully meet/exceed requirement	Q3

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
13.7.1.8.	Resolve and implement system restoration within 60 minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the CCN's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the CCN's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability;	Fully meet/exceed requirement	Q3
13.7.1.9.	Cumulative System unavailability caused by systems and/or IS infrastructure technologies within the CCN's span of control shall not exceed twelve (12) hours during any continuous 20 business day period;	Fully meet/exceed requirement	Q3
13.7.1.10.	Within five (5) business days of the occurrence of a problem with system availability, the CCN shall provide DHH with full written documentation that includes a corrective action plan describing how the CCN will prevent the problem from reoccurring; and	Fully meet/exceed requirement	Q3
13.7.1.11.	Not be responsible for the availability and performance of systems and IS infrastructure technologies outside of the CCN's span of control.	Fully meet/exceed requirement	Q3
<b>13.8.</b>	<b>Contingency Plan</b> The CCN, regardless of the architecture of its System, shall develop and be continually ready to invoke a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters. Contingency plans include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.	Fully meet/exceed requirement	M1, Q1, Q3
13.8.1.	The CCN shall have a Contingency Plan that will be reviewed and approved by DHH during the Readiness Review. Minimum requirements of the Contingency Plan are defined below.	Fully meet/exceed requirement	M1, Q1, Q3
13.8.1.1.	At a minimum, the Contingency Plan shall address the following scenarios: The central computer installation and resident software are destroyed or damaged; The system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage; System interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity	Fully meet/exceed requirement	Q3, M1

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
	of data maintained in a live or archival system; System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system, but does prevent access to the System, such as it causes unscheduled System unavailability; and The Plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.		
13.8.2.	The CCN shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to DHH that it can restore System functions.	Fully meet/exceed requirement	Q3, M1
13.8.3.	In the event the CCN fails to demonstrate through these tests that it can restore System functions, the CCN shall be required to submit a corrective action plan to DHH describing how the failure shall be resolved within 10 business days of the conclusion of the test.	Fully meet/exceed requirement	Q3, M1
<b>13.9. Off Site Storage and Remote Back-up</b>			
13.9.1	The CCN shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.	Fully meet/exceed requirement	Q1
13.9.2.	The data back-up policy and procedures shall include, but not be limited to:	Fully meet/exceed requirement	Q1
13.9.2.1.	Descriptions of the controls for back-up processing, including how frequently back-ups occur;	Fully meet/exceed requirement	Q1
13.9.2.2.	Documented back-up procedures;	Fully meet/exceed requirement	Q1
13.9.2.3.	The location of data that has been backed up (off-site and on-site, as applicable);	Fully meet/exceed requirement	Q1
13.9.2.4.	The policies and procedures of such off-site location including compliance with HIPAA security rules;	Fully meet/exceed requirement	Q1
13.9.2.5.	The contractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within 15 calendar days of the request;	Fully meet/exceed requirement	Q1
13.9.2.6.	Identification and description of what is being backed up as part of the back-up plan; and	Fully meet/exceed requirement	Q1
13.9.2.7.	Any change in back-up procedures in relation to the CCN technology changes.	Fully meet/exceed requirement	Q1
13.9.3.	DHH shall be provided with a quarterly list of all back-up files stored at remote locations and the frequency with which these files are updated.	Fully meet/exceed requirement	Q1



<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
<b>13.10. System User and Technical Support Requirements</b>			
13.10.1.	<p>The CCN shall provide Systems Help Desk services to Providers, DHH, the FI, and Enrollment Broker staff that have direct access to the CCN System.</p> <p><b>Clarification:</b> Out IT team would like to understand this request; our Help Desk operates 24/7 but we would propose to make necessary data access available through a custom data extract uploaded to DHH system for DHH use.</p>	<p>Fully meet/exceed requirement</p> <p><b>Clarification</b></p>	-
13.10.2. The Systems Help Desk shall:			
13.10.2.1.	<p>Be available via local and toll-free telephone service, and via e-mail from 7a.m. to 7p.m., Central Time, Monday through Friday, with the exception of DHH designated holidays. Upon request by DHH, the CCN shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;</p> <p><b>Clarification:</b> Out IT team would like to understand this request; our Help Desk operates 24/7 but we would propose to make necessary data access available through a custom data extract uploaded to DHH system for DHH use.</p>	<p>Fully meet/exceed requirement</p> <p><b>Clarification</b></p>	-
13.10.2.2.	<p>Answer questions regarding the CCN System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH staff;</p> <p><b>Clarification:</b> Out IT team would like to understand this request; our Help Desk operates 24/7 but we would propose to make necessary data access available through a custom data extract uploaded to DHH system for DHH use.</p>	<p>Fully meet/exceed requirement</p> <p><b>Clarification</b></p>	-
13.10.2.3.	<p>Ensure individuals who place calls after hours are able to leave a message. The CCN staff shall respond to messages left between the hours of 7:00 p.m. and 7:00 a.m. by noon the next business day;</p>	Fully meet/exceed requirement	-
13.10.2.4.	<p>Ensure recurring problems not specific to System unavailability identified by the System Help Desk shall be documented and reported to CCN management within one (1) business day of recognition so that deficiencies are promptly corrected; and</p>	Fully meet/exceed requirement	-

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
13.10.2.5.	Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.	Fully meet/exceed requirement	Q8
<b>13.11. System Testing and Change Management Requirements</b>			
13.11.1.	The CCN shall notify DHH staff of the following changes to System within its span of control within at least 90 calendar days of the projected date of the change:	Fully meet/exceed requirement	Q8
13.11.1.1.	Major changes, upgrades, modification, conversions or updates to application or operating software associated with the following core production System: <ul style="list-style-type: none"> <li>■ Claims pre-processing;</li> <li>■ Medicaid recipient eligibility verification processing;</li> <li>■ Service authorization management; and</li> <li>■ Provider file and data management.</li> </ul>	Fully meet/exceed requirement	Q8
13.11.1.2.	The CCN shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes: <ul style="list-style-type: none"> <li>■ Within five (5) calendar days of receiving notification from DHH, the CCN shall respond in writing to notices of system problems.</li> <li>■ Within 15 calendar days, the correction shall be made or a requirements analysis and specifications document will be due.</li> <li>■ The CCN shall correct the deficiency by an effective date to be determined by DHH.</li> <li>■ The CCN System shall have a system-inherent mechanism for recording any change to a software module or subsystem.</li> <li>■ The CCN shall put in place procedures and measures for safeguarding against unauthorized modification to the CCN System.</li> </ul>	Fully meet/exceed requirement	Q8
13.11.1.3.	Valid Timeframe for System Changes Unless otherwise agreed to in advance by DHH as part of the activities described above, the CCN shall not schedule System unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.	Fully meet/exceed requirement	M1
13.11.1.4.	Testing The CCN shall work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing by DHH and/or its FI of the CCN System during the onsite	Fully meet/exceeds requirement	Q1, Q9

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
	<p>Readiness Review.</p> <p><b>Clarification:</b> Since the COSMOS operating system serves multiple state customers are obligated to protect the data from those states. Therefore, we would want to understand this request further but based upon our experience with implementations we are confident we can meet DHH requirements as we have with TN, MS, FL, and WI in past 12 months</p>	<b>Clarification</b>	
<b>13.12. Information Systems Documentation Requirements</b>			
13.12.1. The CCN shall:			
13.12.1.1.	Ensure that written System process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems;	Fully meet/exceed requirement	Q1
13.12.1.2.	Develop, prepare, publish/print, maintain, produce, and distribute to DHH distinct System design and management manuals, user manuals and quick reference guides, and any updates;	Fully meet/exceed requirement	Q1
13.12.1.3.	Ensure the System user manuals contain information about, and instruction for, using applicable System functions and accessing applicable system data;	Fully meet/exceed requirement	Q1
13.12.1.4.	Ensure when a System change is subject to DHH prior written approval, the CCN and or its contractor will submit revision to the appropriate manuals before implementing said System changes;	Fully meet/exceed requirement	Q1
13.12.1.5.	<p>Ensure all aforementioned manuals and reference guides be available in printed form and/or on-line; and</p> <p><b>Clarification:</b> Our manual and reference Guides are available to employees and will be made available to DHH upon request; we would prefer a mutually agreeable solution that could include use of a SharePoint site and to protect proprietary software and systems documentation</p>	<p>Fully meets/exceeds requirement</p> <p><b>Clarification</b></p>	Q1
13.12.1.6.	Update the electronic version of these manuals immediately, and updates to printed versions will occur within 10) business days of the update taking effect.	Fully meet/exceed requirement	Q1
<b>13.13.</b>	<p><b>System Function Reporting Requirements</b></p> <p>The CCN shall provide systems-based capabilities, such as ad-hoc tools, that enable designated DHH, FI or other DHH authorized staff or contractors, and designated Louisiana Attorney General Office staff, on a secure and read-only basis, query access to data that can be used in ad hoc reports.</p>	Fully meet/exceed requirement	-

<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
	<b>Clarification:</b> Our team would like to understand DHH objectives with this request and we would work diligently to develop a mutually agreeable access solution. Due to security and system data integrity concerns, full, unsupervised access to systems is problematic; however, we will create a custom ‘data extract on a regular basis for use by DHH and specific to the CCN program which can be loaded to DHH’s system to generate internal reporting. In addition, we provide ad hoc reporting on request as needed.		
<b>13.14.</b>	<b>Electronic Messaging</b> The CCN shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with DHH. This e-mail system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office and any subsequent upgrades as adopted. As needed, the CCN shall be able to communicate with DHH over a secure VPN. The CCN shall comply with national standards for submitting protected public health information (PHI) electronically and shall set up a secure emailing system that is password protected for both sending and receiving any personal health information.	Fully meet/exceed requirement	Q4, Q10, Q16
<b>13.15.</b>	<b>Address Standardization</b> The CCN System shall utilize mailing address standards in accordance with the United States Postal Service.	Fully meet/exceed requirement	Self-explanatory
<b>13.16.</b>	<b>Electronic Medical Records</b> At such time that DHH requires, the CCN shall participate and cooperate with DHH to implement, within a reasonable timeframe, a secure, web accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).	Fully meet/exceed requirement	Q15
<b>13.17.</b>	<b>Statewide Health Information Exchange</b> At such time that DHH requires, the CCN shall participate in statewide efforts to incorporate all hospital, physician, and other provider information into a statewide health information exchange.	Fully meet/exceed requirement	Q15
<b>13.18.</b>	<b>HIPAA-Based Formatting Standards</b> The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following: ASC X12N 834 Benefit Enrollment and Maintenance; ASC X12N 835 Claims Payment Remittance Advice Transaction;	Fully meet/exceed requirement	Q1, Q4

<i>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</i>			
<i>Section</i>	<i>Requirement Description</i>	<i>Meet/Exceed DHH Requirement</i>	<i>Response Details</i>
	<p>ASC X12N 837I Institutional Claim/Encounter Transaction;                      ASC X12N 837P Professional Claim/Encounter Transaction;                      ASC X12N 278 Utilization Review Inquiry and Response; and                      ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.                      Transaction types are subject to change and the CCN shall comply with applicable federal and HIPAA standards and regulations as they occur.</p>		
<b>13.19.</b>	<p><b><i>Audit Requirements</i></b></p> <p>The CCN shall ensure that their System facilitates the auditing of individual claims. Adequate audit trails shall be provided throughout the System. To facilitate claims auditing, the CCN shall ensure that the System follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) Audit and Account Guide, The Auditor's Study and Evaluation of Internal Control in EDP Systems.</p> <p>The CCN shall maintain and adhere to an internal EDP Policy and Procedures manual, available for DHH review upon request, which at a minimum shall contain and assure all accessible screens used throughout the system adhere to the same Graphical User Interface (GUI) standards, and that all programmers shall adhere to the highest industry standards for coding, testing, executing and documenting all system activities. The manual is subject to yearly audit, by both state and independent auditors.</p>	<p>Fully meet/exceed requirement</p> <p>Fully meet/exceed requirement</p>	<p>Q1</p> <p>Q10</p>
13.19.1.	<p><b>State Audit</b></p> <p>The CCN shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The CCN shall provide information necessary to assist the state auditor in processing or utilizing the files.</p> <p>If the auditor's findings point to discrepancies or errors, the CCN shall provide a written corrective action plan to DHH within 10 business days of receipt of the audit report.</p> <p>At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the CCN's EDP manual.</p>	Fully meet/exceed requirement	Q9
13.19.2. Independent Audit			



<b>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</b>			
<b>Section</b>	<b>Requirement Description</b>	<b>Meet/Exceed DHH Requirement</b>	<b>Response Details</b>
13.19.2.1.	<p>The CCN shall be required to subcontract with an independent firm, subject to the written approval of DHH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's System application. The independent firm shall:</p> <ul style="list-style-type: none"> <li>■ Perform limited scope EDP audits on an ongoing and annual basis using DHH's audit program specifications at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the Contract is in force with DHH and at the conclusion of the Contract; and</li> <li>■ Perform a comprehensive audit on an annual basis to determine the CCN's compliance with the obligations specified in this RFP.</li> </ul>	Fully meet/exceed requirement	Q9
13.19.2.2.	The auditing firm shall deliver to the CCN and to DHH a report of findings and recommendations within 30 calendar days of the close of each audit. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews.	Fully meet/exceed requirement	Q9
13.19.2.3.	DHH shall use the findings and recommendations of each report as part of its monitoring process.	Fully meet/exceed requirement	Q9
13.19.2.4.	The CCN shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within 10 business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the independent auditing firm. These findings are reviewed by DHH and shall become a part of the CCN's EDP manual.	Fully meet/exceed requirement	Q9
13.19.2.5.	Audits shall include a scope necessary to fully comply with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations (SAS-70 Report).	Fully meet/exceed requirement	Q9
<b>13.20.</b>	<p><b>Systems Refresh Plan</b></p> <p>The CCN shall provide to DHH an annual System Refresh Plan. The plan shall outline how Systems within the CCN's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.</p> <p>The systems refresh plan shall also indicate how the CCN will insure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are</p>	Fully meet/exceed requirement	Q9

<i>Scope of Work Compliance Summary - System and Technical Requirements (§ 13)</i>			
<i>Section</i>	<i>Requirement Description</i>	<i>Meet/Exceed DHH Requirement</i>	<i>Response Details</i>
	always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the System component.		

**Q.8** *Describe your information systems change management and version control processes. In your description address your production control operations. (All GSAs)*

## Change Management Overview

System Delivery Process (SDP) is the formal and structured process we use to build and make changes to any process used to receive, load and process data from CCN and to supply CCN with data extracts, including enrollment files. SDP is our disciplined approach for development and change management and it contains test controls for validity and accuracy. We developed SDP according to industry best practices from the Software Engineering Institute (SEI) and the Institute of Electrical and Electronics Engineers (IEEE). SDP consists of six phases, within which each include review steps, approval steps and required approvals. To ensure all required processes are followed and required documentation is created, we conduct internal and SOX compliant reviews between phases. A summary of these phases, and a few key activities/deliverables within each phase, are.

- **Define**
  - Translate business information into a formal project
    - Impact Analysis, including high level requirements and resources needed
    - Existing system/product documentation (identify scope of changes).
- **Plan**
  - Create comprehensive project documents and plans for project review/approval
    - Business Requirements Document (BRD)
    - Test Cases and Measurement Criteria.
- **Implement**
  - **Design**
    - Develop detailed systems and process designs to satisfy requirements
      - SDP Deployment (project) Plan
      - System Design and System Test Conditions
      - Prepare environments (development, test, production, etc.).
  - **Build**
    - Develop and test system changes to ensure all requirements are satisfied
      - User Acceptance Test (UAT) documentation
      - Updated SDP Deployment Plan
      - System/Changes installed and tested.
  - **Deploy**
    - Move the system/changes and all associated processes to production
      - MIS Change Ticket with backout plan
      - Completed system testing.
- **Close (Control)**
  - Measure and report results and close project (in steady state)
    - Support Plan implemented
    - All documents finalized/archived
    - Feedback, lessons learned and closure meeting.

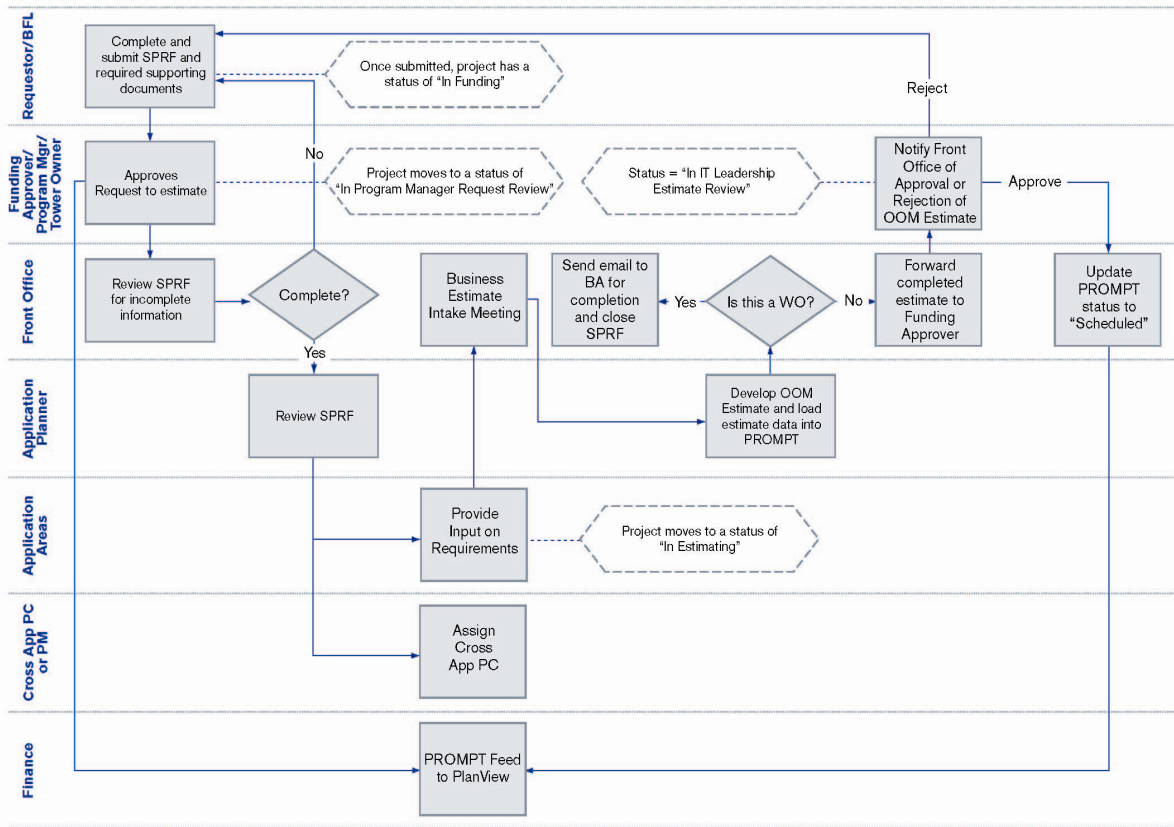
To further support the System Delivery Process and ensure standardization UnitedHealthcare Community Plan follows the formal UnitedHealth Group Change Management process. Change Management is the MIS Service Management process that ensures standardized methods and procedures are used for efficient and prompt handling of all changes. The process minimizes the impact of change-related incidents upon service quality and improves the day-to-day operations of the organization. The process also ensures a smooth implementation of new health plan programs without impacting existing programs on the same technology platform. High impacting changes, like implementing a new plan/program, core software version upgrades or HIPAA code upgrades (e.g. 4010 to 5010, ICD9 to ICD10), must be reviewed and approved by the Change Advisory Board (CAB). The CAB is comprised of representatives from all key workgroups who can assess change impacts and ensure funding and resources are available and scheduled to develop and implement the changes.

Like our SDP, the UnitedHealth Group Change Management methodology is outlined by a formal and auditable process, including structured submissions, required artifacts, scheduled review meetings and approval dates. This allows us to implement high volumes of changes to benefit our businesses and business partners, while at the same time protecting the integrity and stability of our environment. It allows us to manage our changing environment with discipline and urgency while mitigating the risk to the critical services we provide.

A variety of needs drive software changes, which may include reasons such as defects, change controls, innovations, projects, or implementations. Initiation of requested changes can begin at the front-line staff level, such as claims processors or care managers, or at the executive level of our information systems and technology team. However, regardless of how or where the change request originates, all changes follow a pre-defined approval process depending on the type of change requested. This formal UnitedHealth Group project initiation, or intake, process (outlined and depicted below) is another example and layer of standardization and control we employ for our change management discipline.

- Defects are opened in hp OpenView service desk (HPSD), a tool used to report and record issues, escalation and documentation of said issues, by any staff person who uncovers a system anomaly. All defects are automatically assigned to an appointed “Functional Area Expert,” who reviews and approves the work to be done. The functional area expert closes the HPSD ticket after triaging, and opens a Test Director ID for the defect to be fixed, tested, and deployed into Production.
- Project request, system enhancements and system implementations are reviewed and approved by the senior managers of the health plan and submitted into intake. Once the project is approved, it is assigned a project number and manager for tracking, estimation, approval by capital committee and scheduled with assigned resources to support successful completion. A given project may have several sub projects depending on the complexity and systems impacted. All intake is handled through our corporate Prompt Request Online Management Planning Tracking (PROMPT) tool. The development and delivery is tracked and managed through our enterprise tool, Planview.

## PROMPT Intake Process Diagram



## DHH Compliance Requirements

UnitedHealthcare Community Plan will notify DHH staff of the following major changes, upgrades, modification or updates to application or operating software associated with our core production system at least 90 calendar days prior to the projected date of the change, as feasible, in compliance with Section 13.11.1.1 of the RFP:

- Claims pre-processing
- Medicaid recipient eligibility verification processing
- Service authorization management
- Provider file and data management.

We also agree to respond to DHH notification of system problems (not resulting in unavailability) according to the following timeframes in compliance with Section 13.11.1.2 of the RFP:

- Within five (5) calendar days of receiving notification from DHH, we will respond in writing to notices of system problems
- Within 15 calendar days, the correction will be made or a requirements analysis and specifications document will be due



- UnitedHealthcare Community Plan will correct the deficiency by an effective date to be determined by DHH
- Our systems have a system-inherent mechanism for recording any change to a software module or subsystem
- We have place procedures and measures for safeguarding against unauthorized modification to our systems.

**Q9** *Describe your approach to demonstrating the readiness of your Management Information systems to DHH prior to the start date of operations. At a minimum your description must address: (All GSAs)*

## Information Systems Readiness Approach

In executing our implementation responsibilities, the principles that drive our efforts include:

- **Accountability:** While any transition necessarily must be collaborative between DHH and the other relevant CCN contractors and the state's Fiscal Intermediary (FI) in particular, UnitedHealthcare Community Plan understands its responsibility in the successful and timely achievement of all key transition milestones, deliverables and outcomes. We will work quickly and comprehensively with DHH to activate communication protocols, meeting schedules and agendas, standard and ad hoc reports to provide transparency and full disclosure of our transition progress.
- **No negative impact on members and providers:** The impact of the transition on members and providers will be the principal factor that motivates our planning, resource allocation and executive oversight processes. Our goal is to maintain existing member/provider medical relationships, nurture continuity of care and minimize the extent to which members are confused or worried about a transition to a new health plan.
- **Flexibility:** Every scenario in a transition can never be fully anticipated or planned for. Our management and executive teams are experienced and seasoned and this will enable our implementation and ongoing operations team to quickly and deftly adjust to any unanticipated events or challenges.
- **Discipline:** While we are flexible, the transition schedule is a fundamental marker of success and a driver of all planning and resource allocation discussions and decisions. The executive steering committee will provide the necessary internal authority to assure that sufficient resources are available at each stage of the transition.

The transition major activities center on the following deliverables or major processes:

- **Contract Start-up and Planning:** We will work with DHH early in the transition to establish project management and reporting standards, communication protocols, key points of contact, standing meetings and ratify or adjust the transition schedule. Once these mutual expectations and understandings are confirmed, we will finalize our Transition & Implementation Plan, subject to DHH review and approval. Among other things, this plan documents the content and format of all contract deliverables, project management procedures (including steps or processes that require DHH involvement) and transition reporting requirements and deadlines.
- **Implementation Schedule:** The Project Management Team, using Microsoft Project, documents and tracks key activities, milestones, deadlines, responsible parties and project dependencies. Substantive revisions to the schedule only occur in consultation with DHH. The management team and the Executive Steering Committee consider slippages in the schedule to be an "early warning sign" that prompts immediate and focused action.
- **Staffing and Organization:** The final composition of our management team, including those positions meeting the DHH definition of "key personnel," will be finalized before the contract's

effective date. Additionally, recruitment and training of new front-line staff will be a high priority, especially bilingual staff given the significant number of Creole and Spanish-speaking members.

- **Network Development:** While our proposed network begins from a strong position that provides significant access across the GSA coverage areas, ongoing development efforts will continue during the transition and throughout the contract. At no point will we consider our network “finished” or “complete,” because our outreach to unsigned providers who can improve access continues as a perpetually incomplete deliverable. During the transition, our particular focus will be on any providers that can ensure continuity of care for current members who have selected UnitedHealthcare Community Plan or are being defaulted to us through the process outlined in the Scope of Work. We will update DHH on our progress at least monthly using a format and reporting approach that is established during the contract start-up and planning phase.
- **Readiness Reviews:** We have a long tradition of assuring the integrity and reliability of major transitions through readiness reviews that are scaled to the technical and operational specifications of each contract. We understand the expectations and requirements around the organizational, financial, system and operations readiness reviews and we will be prepared to offer DHH the necessary tools, audit reports and findings (including any SAS70 audits conducted in the past three years), management personnel, business process documentation, testing protocols and corrective action templates.
- **System readiness, testing and data transfer.** We will align our hardware, software, network and communications (call center) systems and intend to test them for additional capacity, the addition of the providers that will serve the three GSAs and the new members being added to our plan. Our testing will include the following subsystems: enrollment/eligibility; provider; claims; financial; utilization management; and quality improvement. For the systems that depend on data exchanges with third parties, such as the administrative contractor or EQRO, we will also validate those interfaces through the production, exchange and loading of test files in a secure, HIPAA-compliant environment. Once the initial default enrollment list is finalized, we test the import of those members into a staging area of our system and validate the integrity of the data before loading them prior to operational start-up.
- **Our systems comply with recognized industry standards governing security of state and federal automated data processing systems and information processing.** As a minimum, we will conduct a security risk assessment and communicate the results in an information security plan provided no later than 15 calendar days after the Contract award. The risk assessment shall also be made available to appropriate federal agencies.
- **HIPAA Compliance:** We will provide documentation to verify HIPAA compliance relative to our systems, data interfaces and exchanges, facility security, employee training and quality assurance relative to any employee who handles protected information.
- **Corrective Action Plan(s):** If any aspects of our readiness review or testing efforts reveal deficiencies, we will produce a corrective action plan for DHH unless the deficiency is cured within 10 calendar days of its identification or notification by DHH.
- **Assurance of readiness.** Prior to the start of operations (date to be determined by DHH), UnitedHealthcare Community Plan provides assurance of system and operational readiness in a format to be determined through consultation with DHH. This certification of final readiness addresses hiring and training of all staff, MIS systems and interfaces operational and at the necessary level of capacity, distribution of the Provider Administrative Guide, finalization of written materials and Website content and provider training. If DHH deems our Web presence be incorporated in any degree to DHH’s Web presence/portal; we will conform to all applicable state standards for Website structure, coding, and presentation.

UnitedHealthcare Community Plan will also create internal documents and processes to align DHH expectations with operations as follows:

- **Communication Plan:** Specifies how UnitedHealthcare Community Plan communicates in writing and through ad hoc and regularly scheduled meetings and teleconferences with DHH, FI, other CHIP contractors and any relevant external parties.
- **Transition Risk Management Plan:** This document (which is constantly updated during the transition by all functional leads) identifies, assesses and poses risk mitigation, transference, or avoidance strategies in relation to events or externalities that may result in schedule delays, performance problems, infrastructure breakdowns, or other adverse effects.
- **Quality Assurance Plan:** Establishing quality-oriented operational benchmarks and monitoring our compliance with them, is fundamental to our management philosophy. We employ a toolbox that includes standard operating procedures for every major operational function (both during the transition and throughout the contract's operational phase), internal compliance audits, dedicated quality assurance staff and a rigorous training regimen that meaningfully links job descriptions to the benchmarks.

We also agree to the auditing requirements as specified in Section 13.19.1 (State Audits) and Section 13.19.2 (Independent Audits).

- **Issues Management:** UnitedHealthcare Community Plan has a structured approach for addressing and resolving problems in their early stages. Issues are documented by the responsible functional lead and are resolved through the appropriate application of the necessary resources (human, technological, financial, or administrative).
- **System Refresh Plan:** We will provide an annual Systems Refresh Plan as detailed in Section 13.20 of the RFP. The plan will outline how our systems are systematically assessed to determine the need to modify, upgrade or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

The plan will also indicate how we ensure that the version or release level of all of our system components (application software, operating hardware, operating software) are formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM or SDF for support.

We will also complete the required Information Systems Capabilities Assessment (ISCA) provided by DHH, which will be completed and returned to DHH no later than 30 days from the contract date.

- ***provider contract loads and associated business rules;***

## **Provider Contract Loads and Associated Business Rules**

UnitedHealthcare Community Plan is able to maintain provider agreements in order to achieve accurate processing for services as appropriate for the CCN-S program. Business rules are written for each agreement. Provider data from the NDB is electronically loaded and updated on a daily basis into COSMOS, our core transaction system.

- ***eligibility/enrollment data loads and associated business rules; and***

## **Eligibility/Enrollment Data Loads and Associated Business Rules**

Throughout our implementation experiences, we have found that enrollment and eligibility processes need to be focused on as the first key data exchange that should be specified, tested and deployed. There are two reasons for this. First, eligibility and enrollment testing is a necessary prerequisite to later claims submission, authorization, and pre-processing testing. The second factor is the need to “go live” with enrollment processing well before the actual plan “go live” date to allow for member communications, ID cards, outreach activities and clinical transition activities. We will perform multiple cycles of inbound

eligibility (834/271U) testing before the actual CCN program effective date.

Once CCN is in a production or a live mode we will continuously monitor enrollment data received and loaded in COSMOS through our standard enrollment process, error reports and dedicated resources. Discrepancies are reported and then worked/resolved by our dedicated enrollment coordinators.

- ***claims processing and adjudication logic.***

## Claims Pre-Processing Logic

COSMOS uses front-end edits to validate claims data to ensure proper adjudication. Additionally, COSMOS supports enrollment, eligibility, claim validation and processing, and reporting functions. The COSMOS system is versatile and flexible, providing UnitedHealthcare Community Plan with the capability to configure business rules. The system's numerous edits enforce appropriate coding to enhance inappropriate cost avoidance. In addition, the system is configured to capture and report data elements critical to supporting effective enrollment, accurate claims adjudication and utilization management processes.

***Q.10 Describe your reporting and data analytic capabilities including: (All GSAs)***

- ***generation and provision to DHH of the management reports prescribed in the RFP;***

## Required Management Reporting

UnitedHealthcare Community Plan has various proprietary tools and databases to support our data analytic needs for UnitedHealthcare Community Plan's Louisiana operations and our Quality Assessment and Performance Improvement functions. Through these existing tools and databases, UnitedHealthcare Community Plan has the capacity to support DHH's analysis function requirements.

Our Strategic Management Analytic Reporting Tool (SMART) is the core of our analytics environment, serving as both a data warehouse and a data analytics platform. From a data warehouse perspective, SMART is a multi-dimensional relational database that serves as a central repository for all of our Medicaid data. Some of the key items included within SMART are provider demographics, member demographics, claims header and line level details as well as authorizations and case management. In addition to consolidating all of the member related data into a common location, SMART enhances the core data in several areas. One of the key enhancements for trend analytics is the assignment of claims units and dollars to a four level service category definition. This allows us to track changes in several metrics like per member per month (PMPM), days/1000, visits/1000, etc., in quarter over quarter and year over year time periods, and at a service level that is actionable. These same trends can be sliced by Provider and Geography, etc., to drill into what might be driving a trend variation. The SMART data is also enhanced with several Industry definitions for analyzing data including 3M's All Patient Refined Diagnosis Related Groups (APR-DRG) grouper and Agency for Healthcare Research and Quality (AHRQ) diagnosis categories. SMART also leverages our ImpactPro tool that disease categorizes and risk stratifies all of our members based on their claims history. Member insight, as well as the ImpactPro identified 'gaps-in-care', are leveraged for both prioritizing member outreach and measuring outcomes of clinical programs. The SMART data warehouse contains all of UnitedHealthcare Community Plan's business, allowing national trend comparisons and better opportunity identification for program improvements.

From a data analytics perspective, the key business metrics are pre-defined on reports and dashboards and delivered to an internal Website on a regularly scheduled basis from the data warehouse. If any areas are identified within the scheduled reports that need further analysis, SMART contains a graphical user interface, Microstrategy, which allows detailed analysis using the same metrics and dimensions. This analysis tool is flexible and can start at the high-level trends and drill-down within hierarchies (service category, geography, etc.), and drill-through to claims line level detail. The SMART user-interface also

allows custom building any required analysis using data within the SMART data warehouse. This functionality is used to perform root cause analysis on trend variations from forecast. This self-service functionality is also used to do research on potential medical intervention programs, claim billing trends and possible fraud, waste and abuse situations.

Examples of pre-defined key business metrics include:

- **UM Scorecard** - authorization based inpatient trends days/1000, admits/1000, readmissions, etc.
- **Health Care Trend Analytic** - claim based utilization trends (Inpatient, Outpatient, Physician, Prescriptions), identifying significant variations period over period, utilizes category of service logic
- **Top 1 percent Members** - Ensure top risk stratified members are in outreach programs
- **Variant Day Analysis** - Trends Inpatient claims by Provider, Diagnosis Related Groups (DRG) to identify outliers in average length of stay for DRG's
- **Evaluation and Management (E&M) Trends** - Identifies outliers in E&M utilization and billing with Provider Specialty
- **Healthplan Performance Dashboard** - Dashboard of key metrics (membership, PMPM, Inpatient/Outpatient/Physician utilization)
- **Members without Visit** - Identifies members without visits to direct follow-up with PCP.

Examples of research and analysis include:

- Key metric reports identify a particular provider's unit cost increase has exceeded a threshold - Using SMART, we can drill into claim detail in pre and post time periods for the provider to identify changes in billing, pricing or utilization driving the cost increase and determine if any corrective action is required
- Clinical is considering implementing a new program (ER Diversion, Radiology authorization, etc.) - Using SMART, we can research the members that could be impacted by the program by diagnosis, procedure, risk score, etc., apply potential program criteria and determine if the program could be impactful to members.

UnitedHealthcare Community Plan also has the following tools to support our analysis functions for DHH:

### **ImpactPro™**

ImpactPro™ is our state-of-the-art analytical tool for predictive modeling and risk stratification. Using information readily available from medical claims, laboratory results as well as member enrollment files, ImpactPro uses a variety of algorithms and models to predict which patients are at greatest risk for severe health care 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 are just as useful in discovering existing members who may need care management services.

### **MedMeasures™ by VIPS®**

UnitedHealthcare Community Plan uses ViPS® 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. Through this we have the flexibility



to create measurement reports for analysis and reporting. This gives us the ability to review data at the member or provider level and generate reports based on various data components. Data from the MedMeasures system can create “scorecards,” which can display such things as performance measures for start and stop dates for specific interventions.

### **Universal Tracking Database (UTD)**

Our Universal Tracking Database (UTD) is an internally designed/custom relational database that accommodates multiple data inputs and has a Web-style interface. Through UTD, we can identify over and under-utilization of preventive health services. This includes identifying member compliance with receiving preventative health services based on EPSDT or HEDIS criteria for their age and sex, and the frequency with which members receive these services.

### **CareOne**

CareOne is our clinical care management solution that integrates seamlessly with our core operating system. This proprietary, integrated clinical system includes basic and comprehensive supplemental assessments (for example, health and functional assessments), facilitates the development of integrated care plans, and includes ongoing monitoring and evaluation tools. CareOne includes embedded protocols that identify key areas that should be addressed in specific care plans. CareOne helps with analysis functions through Operational Data Store (ODS) reports. These reports are used by internal clinicians and case managers to manage and prioritize daily activities and production. Business analysts use ODS to facilitate better business decisions. These reports provide insight into critical data about consumer populations and the health care communities that serve them.

### **IDT Intelligent Desk Top**

Intelligent Desk Top (IDT) is the call-center application for UnitedHealthcare Community Plan. Our member service representatives use IDT to help respond to questions from members or providers about claims, eligibility, provider searches, provider directories, ID card ordering, and PCP updates. The IDT application is integrated with the COSMOS database using real-time services. This allows member service representatives to view all claims for a member or provider and it provides the desired claim level detail. IDT provides us with the ability to track and log calls. Any issue that can not be resolved at the initial call are recorded and tracked in the Online Routing System (ORS). Once in ORS, these records serve as call history and can be routed to other areas within UnitedHealthcare Community Plan for resolution. We use our IDT Intelligent Desktop to create reports and analyze data about calls, including turnaround time for problem resolution, and identify areas for improvement.

### **Provider Portal**

Through our provider portal, providers can access provider performance measure results, and obtain information on members who are over or under-using services. As an example, the provider portal can include current lists of members who can benefit from care opportunities for each of a provider’s P4V “Pay for Value” physician incentive program measures.

### **Call Management System**

UnitedHealthcare Community Plan uses our Call Management System (CMS) reporting tool for real time and historical reporting on items like agent state, skill performance and call center metrics. It also reports on things like average speed to answer, hold time and abandon time.

Through these tools and databases UnitedHealthcare has exceptional capacity to produce reports and perform analysis to support informed decision-making for managed care activities, operations, and to support DHH’s efforts at affecting quality and cost.



## Resources

Our UnitedHealthcare Community Plan leadership team will have access to and support from a dedicated team for the various technical, financial and reporting needs, ultimately to support standard and ad hoc reporting needs of DHH and to satisfy our contractual agreement. Our UnitedHealthcare Reporting Team is dedicated to support our Louisiana health plans' reporting needs.

- *generation and provision to the State of reports on request;*

## On-Request and Ad-Hoc Reporting Capabilities

UnitedHealthcare Community Plan's Reporting team supports many standard and ad-hoc reporting needs, using our National Queue (NQ) report request application, the data warehouse/data repository, HEDIS reports and the BO/Crystal Reports suite of tools. UnitedHealthcare Community Plan's CCN management team will be able to request new standard and ad hoc reports through the NQ. They are then able to securely access standard, pre-defined and ad hoc reports through the Reporting Portal. They can also modify variables to some reports and run them on demand to satisfy new or one-time reporting needs. Some pre-defined reports have been established to provide general statistics, while others are specific to the individual health plans. Security, inherent in the Reporting Portal, ensures managers and internal teams only have access to the reports and data to support their current role and function.

Reports will be provided to DHH via Secure FTP (SFTP) or secure email, depending on DHH requirements and the nature of the data within the reports. Examples of types of ad-hoc reports that we currently provide to other Medicaid plans include:

- Claim adjustments by reason codes
- Claims by pre-processing date
- Daily adjusted claims
- Maternity claims
- Special pended claims
- Check posting of pended claims
- Procedure code verification
- 1099 miscellaneous report
- High dollar claims report.

## Other Reports

In addition to the availability of ad-hoc reports, standard reports required or needed by DHH may include, but are not limited to:

- Quarterly reports to the Division summarizing formal grievances and informal complaints and resolutions
- Quarterly reports on claims processing submission
- Copies of reports submitted to the Louisiana Department of Insurance
- HEDIS reports
- Reports and data generated by a subcontractor
- Enrollee satisfaction surveys and focused studies
- Results of annual study of clinical guidelines
- Monthly management report, summarizing our experience in areas such as, but not limited to:
  - Member enrollment statistics and trends
  - Utilization statistics and trends

- Claims processing statistics
  - Call center statistics
  - Provider network
  - Prior authorization
  - Member grievance
  - Quality and outcome measures
  - Pilots/initiatives
  - Key staffing updates
  - Recent successes
  - Issues and challenges or
  - Corrective action updates, if applicable.
- Quarterly and annual financial reports and statements, as required by DHH, the DOI and state of Louisiana, including reports that will allow DHH to assess our claims reserves and overall financial soundness
  - Notices of legal action
  - Monthly enrollment reports
  - EPSDT reports, per the EPSDT periodicity schedule
  - Monthly member ID cards reports; such as the date and the number of identification cards mailed to new members enrolled each month, and number of returned I.D. cards
  - Quarterly reports for each individual FQHC and RHC, which details claims processed during that respective quarter; Monthly summary report of all provider and recipient inquires, grievances and appeals and a monthly detailed log of all recipient grievances and appeals and all provider grievances and appeals made on behalf of a recipient
  - Semi-annual (internal) review (audit) report detailing completed activities and corrective actions, corrective actions which are recommended or in progress, and the results of all clinical, administrative and Enrollee satisfaction surveys conducted during the immediately preceding year.

Other types of standard reports we could create for DHH include, but are not limited to:

- Demographic analysis
- Enrollment trends
- Utilization analysis
- Financial analysis
- Medicaid compliance reporting
- Normative benchmarking
- Fraud and abuse.

- *the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an ad-hoc basis; and*

Due to security issues, DHH will not have direct access to our systems; however, we can extract data needed by DHH and specific to the CCN program from our SMART database, which can be loaded to DHH's system to generate internal reporting. We are open to discussing this option as a solution. In addition, we provide ad hoc reporting on request as needed.

- *Reporting back to providers within the network.*

## Provider Profile Reporting

To deliver quality care to our members, UnitedHealthcare Community Plan 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.

## Other Provider Communications

UnitedHealthcare Community Plan understands and values the importance of a strong, collaborative provider network. Our communication strategy is designed to proactively target providers, create awareness of the program and help providers collaborate with UnitedHealthcare Community Plan and our members. We go beyond basic communication strategies, such as telephonic outreach and mailings, and utilize many other meaningful facets of interaction such as the internet, face-to-face office visits and large forums. Our communication strategy includes mechanisms that inform, educate and advocate providers when working within the scope of the program including but not limited to.

- Routine Care Management Consultations
- Provider Account Management (PAM) Program
- Joint Operating Committee Meetings
- DHH Requested Meetings
- Provider Portal
- Peer Review
- General Office Visits
- Provider Forums
- Provider Administrative Guide
- Provider Newsletters and Fax Blasts

- Targeted Communications
  - Health Alerts
  - Trend Reports
  - Telephonic Outreach
  - Video Conference
  - Electronic Alerts.

**Q.11** *Provide a detailed profile of the key information systems within your span of control.  
(All GSAs)*

## Key Information Systems Supporting the CCN Program

UnitedHealthcare Community Plan has invested in providing an integrated solution that not only meets the needs of CCN claims pre-processing, but has positioned us to better manage costs and to increase provider satisfaction with access to enhanced reports, member information and claims information through internet portals. Our system employs various database technologies including Oracle relational data models and database architecture and fully supports query access using Structured Query Language (SQL). Per Section 13.2.3 of the RFP, we will not be responsible for the availability and performance of systems and IT infrastructure technologies outside our span of control.

UnitedHealthcare Community Plan has invested in providing an integrated solution that not only meets the needs of claims pre-processing, but also has positioned us to manage costs and to increase provider satisfaction with access to enhanced reports, member information and claims information through internet portals. The following table describes the various functionalities of our hardware and software components:

<i>UnitedHealthcare Community Plan's Management Information System and Subsystems</i>	
<i>Claims Processing and Management</i>	<i>Functionality</i>
COSMOS - Comprehensive Online Software for Management and Operational Support	Our medical claims processing engine and core transactions system; general and institutional claims editing, enrollment and eligibility data
COSMOS Interface Engine	Used to load data to COSMOS and share data between our internal systems. Also used to electronically link all member, provider and claims from/to our electronic partners, outbound eligibility extracts
AdjudiPro (CCI Editing)	COSMOS professional claims editing (CCI – Correct Coding). It has the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required. In addition, it has the ability to use HCPCS Level II and CPT Category II codes to measure quality performance.
iDRS - Intranet Document Retrieval System/CPW	Claims workflow/queuing and imaging
ORS - Adjustment Request Tracking	Tracking tool for claim adjustments requested; ensures accountability for claims research
CDB - Corporate Member Database	UnitedHealthcare Community Plan centralized member database
Escalation Tracking System (ETS)	Grievance and appeals logging and tracking
FSDB - Finance Systems Data Base and RPS-Reserve Processing System, Backend Financials	Used to manage financial transactions to our GL and reserving process

<b>UnitedHealthcare Community Plan's Management Information System and Subsystems</b>	
NDB - National Provider Database/Aperature	IBM DB2-based system, housing information on all providers having contractual relationships including credentialing
Revenue Access Manager (RAM)	Member capitation processing reconciliation engine
SMART/Microstrategy	Data mart for reporting and analytics; enables access for ad hoc reporting
<b>Medical Management and Quality Management</b>	<b>Functionality</b>
CareOne	Our utilization management, prior authorization, care management, and support system
CareTracker (optional for providers)	Physician Electronic Health Record and practice management
ImpactPro	A multi-dimensional, episode-based predictive modeling tool. ImpactPro™ compiles information from multiple sources including claims and laboratory data, and uses it to predict future risk for intensive care services.
ViPS MedMeasures	Our system for HEDIS measuring/reporting and quality management efforts, including provider profiling and member outreach
Universal Tracking Database (UTD)	A system for proactively monitoring HEDIS compliance and alerting providers, members and staff to care opportunities that will improve UnitedHealthcare Community Plan HEDIS scores.
<b>Member and Provider Service</b>	<b>Functionality</b>
IDT - Intelligent Desk Top	A call center integrated desktop centralizing access to several systems at the fingertips of our member and provider services representatives. IDT accelerates our ability to answer calls precisely and quickly, and enables us to track phone calls and allows the routing of issues to individuals responsible for resolution
Provider Portal -	An internet-based, self-service portal for providers to check membership eligibility, submit claims, and check claims status, and quality measures
Public Website – <a href="http://www.uhccommunityplan.com">www.uhccommunityplan.com</a>	Available to all members and prospective members. Includes network information and provider look-up, benefit information, commonly used forms, member handbook, and contact phone numbers and emails.
Member Website - <a href="http://www.myuhc.com">www.myuhc.com</a>	This is a secure portal, available for members only. Members have access to all information on the public Website, plus members can securely check eligibility, download images of ID cards, complete online Health Risk Assessments, and receive information and health reminders specific to the member's health status.
EFT - Electronic Funds Transfer	Electronic funds transfer and funds management
IVR - Interactive Voice Response System (Enterprise Voice Portal)	Providers can telephonically check claims status, member eligibility and privacy practices, route through to the various call centers for credentialing status, and request demographic changes and prior authorizations.  UnitedHealthcare Community Plan is developing initiatives to

**UnitedHealthcare Community Plan's Management Information System and Subsystems**

enhance IVR by instituting caller validation and developing IVR routing and language to route targeted members for targeted campaigns.

## Detailed Profile of Key Information Systems

UnitedHealthcare Community Plan has the required critical technical interfaces and subsystems in place as prescribed by the DHH. We have extensive experience interfacing our systems and providing data in the structure and format for state Medicaid programs, including inherent functionality that prevents the alteration of finalized records. We are successfully doing this in 24 states, including states, like Louisiana, that also have an MMIS vendor. We have extensive experience interfacing our systems with MMIS vendors' systems. The critical subsystems that we have in place for these interfaces include:

- **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 the DHH or its enrollment broker as the official enrollment record, and immediately report any inconsistencies to the DHH 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.
- **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.
- **Claims Processing Subsystem:** We maintain a claims processing system capable of complete and accurate claims pre-processing and submitting all pre-processed clean claims data to the FI via standard transaction formats (837I & P) within two (2) business days of receipt of the clean claim from the provider.
- **Reference Files:** Our system maintains reference file information, including pricing files, diagnosis and procedure/NDC codes, and edit/audit criteria, edit dispositions and reimbursement parameters/modifiers. Our system also has the ability to accept reference files from DHH if necessary.
- **Provider Subsystem:** The COSMOS system allows for accepting and maintaining physician and hospital networks, and health care provider information to support claims pre-processing, utilization/quality processing, financial processing and report functions. Our National Provider Database (NDB) maintains information on all providers who have a contractual relationship with



UnitedHealthcare Community Plan as well as other UnitedHealth Group affiliates. Provider data in our NDB is electronically loaded and updated daily into COSMOS, our core transaction system. Our system tests all new contract data to ensure provider contracts are set to process according to the benefit design and eligibility policies.

- **Provider Portal:** Our provider portal, [www.uhconline.com](http://www.uhconline.com), provides links for our providers to submit claims online and interfaced with our COSMOS transaction system to provide real-time claim status. Other links include formulary, performance measure results, prior authorization criteria and evidence-based guidelines. Our systems are able to transmit provider enrollment information to DHH.
- **Member Portal:** Our Member portal, [www.myuhc.com](http://www.myuhc.com) is available through a link on [www.uhccommunityplan.com](http://www.uhccommunityplan.com). This portal is available only to members. Through this portal, members can check eligibility, download images of ID cards, complete online Health Risk Assessments, and receive information and health reminders specific to the member's health status. Members also have access to information like the member handbook, complaints and grievance process information, benefit and coverage descriptions, community resources tool, provider directory search, and contact information.
- **Claims and Authorization Matching:** We monitor the utilization of services and concurrently track the financial impact of the medical services provided to UnitedHealthcare Community Plan members. We track the decisions in COSMOS as it checks if authorizations for specific services exist before processing claims using system referral processing. This functionality can be tailored to the service authorization requirements used for Louisiana. Furthermore, the system has the capability to view prior authorizations and preadmission certifications such as:
  - Automatic search of the authorization file from claims for potential matching authorizations and automatic linking when there is an unambiguous match
  - Automatic application of benefits depending on whether a claim is authorized
  - Flexible criteria and logic for determining a matching authorization
  - Automatic rules for waiving the requirement for an authorization depending on user-defined characteristics of the claim, such as the provider's specialty, service, diagnosis and Louisiana state requirements
  - Automatic matching of authorization to member information to allow for accurate benefit management by eligibility category; our authorization system for UnitedHealthcare Community Plan links to the member benefits to prevent authorization of non-covered services without a manual override.
- **Reporting Subsystem:** We use our Strategic Management Analytic Reporting Tool (SMART) as the custom data warehouse for reporting and data analytics. The SMART environment integrates claims care delivery data organized in a fashion to support a variety of data mining and analysis applications. We feed data to this data warehouse out of the transaction systems at various intervals from a variety of internal systems, including our claims processing system COSMOS and our CareOne medical management platform. SMART enables us to perform sophisticated analysis without affecting our transaction databases. Within SMART, we can perform data-intensive analysis such as medical cost trending to pinpoint issues with member care. Our management information systems enable us to be fully prepared to meet the data element and format requirements to produce all Louisiana -required management reports.
- **Case Management System:** Our CareOne application is a comprehensive, integrated care management software application that provides tools to better understand and address our members' medical, behavioral, and social needs, and is designed to facilitate the information flow among caregivers, case managers, members, and providers. CareOne includes basic and comprehensive assessments where case managers can enter responses and print automated assessment summaries.

CareOne also assists case managers in developing care plans and includes tools for ongoing monitoring and evaluation.

We link CareOne to our administrative platform, COSMOS, twice daily to authorize services automatically for claims processing purposes based on the member's plan of care. Through our secure online portal, our providers can access CareOne and submit medical prior authorization requests and check on the status of the authorization.

The 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 includes behavioral health screening and assessment data. As an example, CareOne includes a comprehensive depression screening assessment. This is an important tool for promoting integration of somatic and behavioral health services.

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

- Creating and maintaining Plans of Care (POCs)
- Maintaining Health Risk Assessments (HRAs)
- Standard and ad hoc reporting
- Managing prior authorizations
- Care/case management, and
- Utilization management.
- **MedMeasures by ViPS:** Developed by ViPS (a division of General Dynamics), MedMeasures is an NCQA-certified application designed specifically to facilitate the HEDIS reporting, compliance and accreditation process. With MedMeasures we are able to create compliant systematic samples, prepare documentation needed for NCQA audits and – as it relates to reporting – aggregate the data required to produce reports on critical HEDIS measures. MedMeasures helps ensure that the calculation of HEDIS metrics is handled consistently and accurately and that it is auditable for reporting purposes. Data from MedMeasures are also compiled into performance measure “scorecards”. Additionally, the system’s enhanced measure analysis feature provides access to member detail – information on specific members qualified for each measure. Finally, MedMeasures offers the capability to conduct provider profiling based on HEDIS quality metrics.
- **ImpactPro®:** ImpactPro is our proprietary, evidenced-based predictive modeling and care management analytics solution that is based on simple, yet core principles. ImpactPro enables us to analyze clinical, risk, and administrative profile information. Our Medical Management team uses ImpactPro to support our comprehensive utilization and disease management programs. Care managers use ImpactPro to easily identify, profile and stratify plan members into actionable groups based on one of the industry’s leading predictive modeling systems. ImpactPro helps care managers determine which members are in need of a specialized intervention program and which intervention programs will have the most impact on the quality of members’ health. Using the member’s medical history experience, ImpactPro identifies members at future risk for decay in their health status separating, for example, a non compliant diabetic that is actionable from a high cost auto accident representing a one time event. In addition, the system allows our clinicians to identify missed care opportunities where members are not receiving care in line with clinical best practices.
- **Universal Tracking Database (UTD):** A key element of our quality management and improvement effort is our internally developed Universal Tracking Database (UTD). Understanding the importance of HEDIS and other care-related metrics, we created UTD to facilitate member and provider outreach for gaps in preventive care. The unique ability of UTD is that it performs weekly measurement of

quality scores based on ongoing claims submissions to monitor clinical indicators and identify areas for improvement prior to the HEDIS reporting timeframe. We use this information to proactively reach out to members and increase the amount of preventive care delivered for our members.

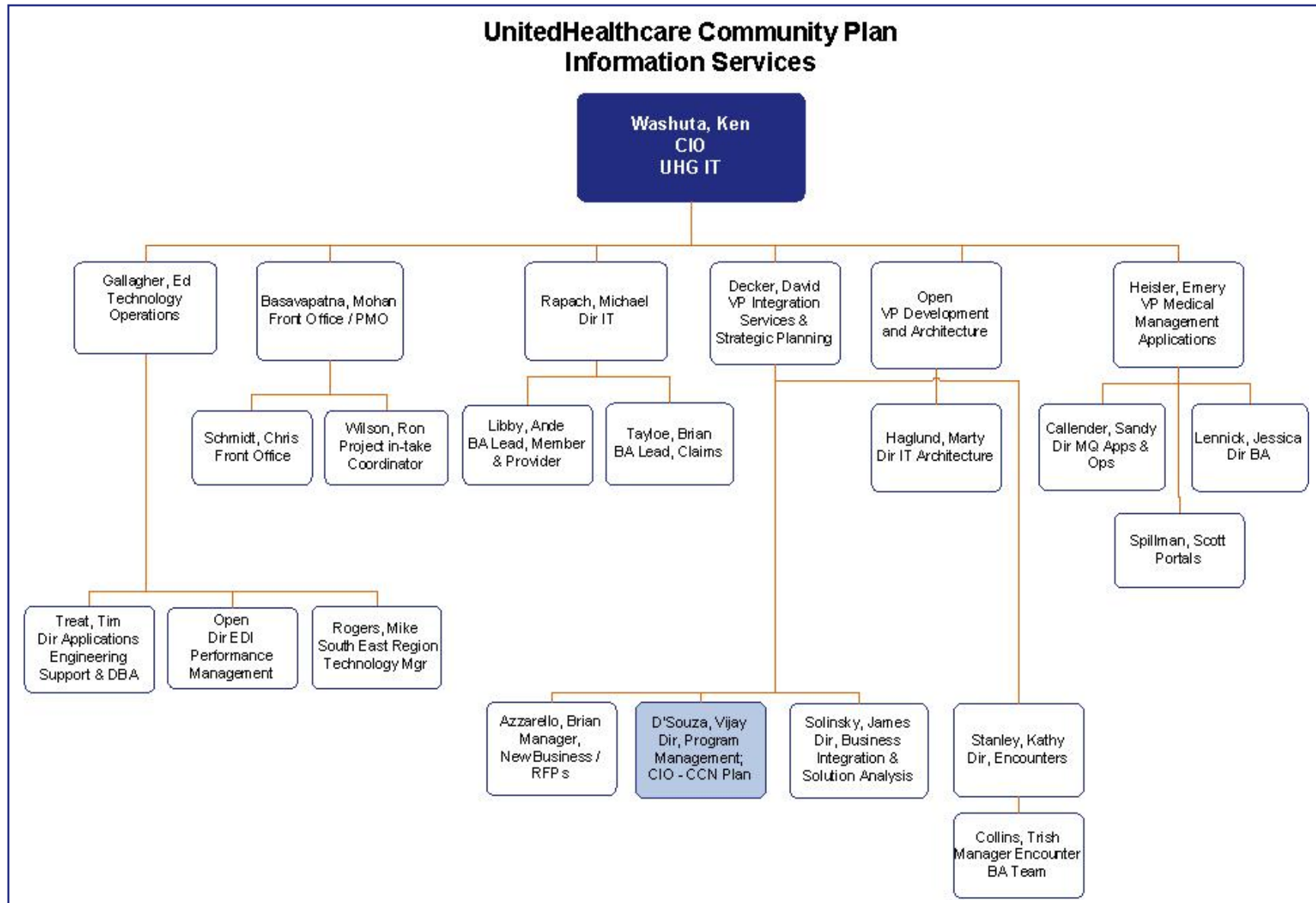
***Q.12 Provide a profile of your current and proposed Information Systems (IS) organization.  
(All GSAs)***

## **Information Services Organization**

UnitedHealth Group IT is a comprehensive, large scale information technology services organization, developing and enabling solutions to support the UnitedHealth Group mission and health services/benefits businesses. **Through deployment and ongoing support we will have between 100 and 120 IT professionals supporting the LA CCN program.** Within our IT team, we have dedicated resources to ensure the business needs are aligned with those of DHH and that a proven technology solution is in place to support our staff functions.

UnitedHealth Group IT manages, maintains and extends the applications and tools that power our enterprise. In addition to critical internal business applications, these tools power **more than 750 million claims for more than 70 million members.** From integrated health and financial products and real time claims processing to health and wellness systems such as eSync, UnitedHealth Group IT delivers technology solutions to enhance the performance of the health system and improve the overall health and well-being of the people we serve and their communities.

Vijay D'Souza will serve as the UnitedHealthcare Community Plan chief information officer (CIO) for the CNN program. Mr. D'Souza has over 15 years of continual growth in software analysis, design, quality assurance and implementation. He is part of our Office of the CIO directly supporting our Community and State Health Plans and will focus on the guidelines of the CCN program as well as the needs of its members and providers. As a technology executive, he has led several key IT initiatives within UnitedHealthcare Community & State and is accomplished in delivering configurable solutions impacting process, people and technology, under tight project schedules.



Above is an organizational chart of our current and proposed structure.

**Q.13** *Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers. (All GSAs)*

## Promoting and Advancing Electronic Claims Submissions and Electronic Funds Transfers

UnitedHealthcare Community Plan recognizes the importance of supporting providers with electronic claims submissions and electronic funds transfer. Our Performance Management team is charged with increasing the percentage of EDI claims for all of the platforms

We work with our providers to assist with electronic claims submissions and payments. Each month, we identify the highest users of paper claims submissions and follows up individually with these providers for additional training and support. Some providers, typically smaller practices, still choose to use paper claims because of its practicality for their particular needs and this is one of the challenges in this effort. The Performance Management staff works closely with these providers to encourage billing through our on-line claim portal, [www.uhccommunityplan.com](http://www.uhccommunityplan.com).

As a result of our training, education and outreach efforts, UnitedHealthcare Community Plan's EDI rate has trended upward the past several years. The table below summarizes our EDI claims rates from 2008 through 2011 YTD.

<i>UnitedHealthcare Community Plan EDI Rates: 2008 – 2011 YTD</i>			
<i>2008</i>	<i>2009</i>	<i>2010</i>	<i>2011 (Monthly Average)</i>
75.4%	80.3%	84.1%	87.15%

## Electronic Payments and Statement Support and Training

### Face-to-Face Education and Training

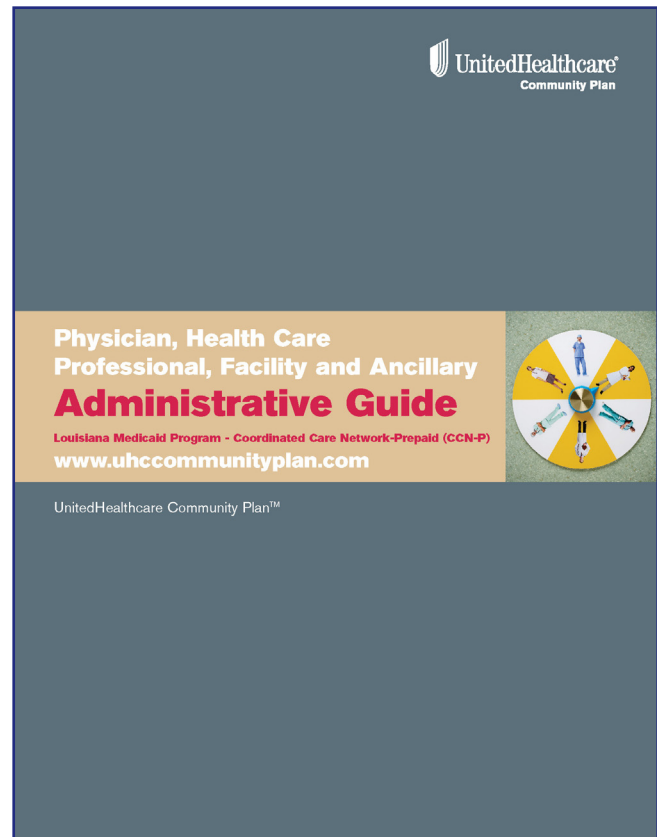
- **New Provider Orientation:** UnitedHealthcare Community Plan invites all newly contracted providers and their office staff (including the office manager, billing manager, referral coordinator, nurses or medical assistants) to participate in orientation training conducted by our Provider Services staff located in Louisiana. Orientation training is scheduled to occur within 30 days of provider agreement effective date or anytime at the provider's request. The orientation sessions are extensive and include in-service, face-to-face training to communicate all applicable CCN and UnitedHealthcare Community Plan policies, procedures, rules, regulations, and expectations, including the encouragement of electronic claims submissions and assistance with electronic funds transfers. We also identify resources and appropriate methods of communication with us.
- **Provider Advocates/ Office Visits:** Provider Advocates assist providers with questions or problems, including issues with electronic claims submission and electronic claims payment. The field-based Advocates conduct provider visits and educate providers on electronic payments and statements. The internal representative ensures that someone is always available to assist providers.
- **Provider Forums:** In addition to the individualized training we conduct at provider offices, we hold Provider Forums, which are half-day seminars led by the Provider Relations department with other UnitedHealthcare Community Plan department subject matter experts (Medical Management Director, EPSDT Coordinator, Behavioral Health Coordinator, Claims Educator, etc.) speaking on specific issues that affect provider practices, including electronic claims and electronic funds transfers. Office managers, billing representatives, clinical staff and other office staff from provider offices are invited to attend and provide input. Based upon the pre-registered list of attendees, our staff creates presentations specifically designed to meet the needs of the participants. Break out sessions are available. We expect to have at least two Provider Forums per year, with GSAs with higher membership concentrations having up to four.



- **Provider Claims Educator:** Our Provider Claims Educator will present at provider forums and be available to educate providers on appropriate claims requirements in their offices. The Provider Claims Educator reviews denial, call center, and adjustment trends to address issues with providers and provide education to help alleviate those issues. He/she develops and maintains internal educational materials for the call center, provider representatives, and claims staff to improve claims payment processes and identifies claims that have paid incorrectly based on provider complaints and initiates claims repayment projects on their behalf.

### **Other Education and Training Resources**

- **Provider Newsletters:** Our Summer 2010 newsletter includes an article educating providers on electronic claims. We produce and distribute the Provider Newsletter to the network at least four times per year. The newsletters contain program updates, claims guidelines, information regarding policies and procedures, cultural competency and linguistics information, clinical practice guidelines, and information on electronic claims submissions and electronic funds transfer. The newsletters also include notifications regarding changes in laws, regulations and subcontract requirements.
- **Provider Administrative Guide:** We work with providers to make claim filing as straightforward and effortless as possible. We educate providers on our claims processing methods and direct them to a Website that provides additional information and training as described below. The Website and Provider Administrative Guide contain information pertaining to the process, working with paper versus electronic claims, and changing general demographic data. The Claims chapter of the Provider Administrative Guide provides detailed information covering EDI/electronic claims submission and electronic funds transfer (direct deposit). The Guide includes contact phone number to assist providers with questions.
- **Provider Portal:** Our provider portal is a significant mechanism we employ to assure providers submit claims data to us. Provider orientation includes a demonstration of the provider portal ([www.uhonline.com](http://www.uhonline.com)) covering each of the portal functionalities and includes hands-on computer training. The provider portal is integrated with our COSMOS transaction processing tables. This integration allows for instant error validation while data is input.



**Q.14** *Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used. (All GSAs)*

## **Years of IT Organization and Software Support**

Our internal IT team supports UnitedHealthcare Community Plan and our parent IT organization further supports us. UnitedHealthcare Community Plan's core processing platform, COSMOS, was developed in November of 1990 on a Unisys platform. As of 2009, we are on the platform and associated applications



of IBM technology; hosted within the UnitedHealth Group IT Data Center and managed by our local and national IT staff.

Our focus is simple:

- Commitment to quality
- Dedication to the customer experience
- Drive for efficiency.

UnitedHealth Group IT manages to a Managed Services environment, hosting many applications from each of its operating businesses within its secured data centers facilities. For purposes of this arrangement, UnitedHealth Group hosts the claims, provider portal and care management applications. UnitedHealth Group supports a shared managed services environment in which various systems and applications share the same hardware. CNN data will reside in databases along with other customers' data. Each customer's data is logically separated from other customers' data by the assignment of a unique ID to each customer.

UnitedHealthcare Community Plan information system architecture contains several software solutions to meet the functional needs of serving our members, providers and the DHH Administration. We have taken a systems integration stance to implement best-in-breed technologies, including building systems internally and collaborating with vendors for other applications. To supplement industry-leading technologies like COSMOS, we have also developed targeted technologies that enhance our ability to work with Medicaid members and providers. All of the software identified in the table that follows is currently supported by internal resources and have been in place for at least five years or more.

We have internal maintenance agreements for all of our applications, infrastructure and to support individual users for computer and other technical issues. Our 24-hour helpdesk is available to report all issues, and established performance standards are in place to ensure continuous and smooth operations and expedient problem resolution. Issues are tracked to completion and are measured against the established performance standards to ensure compliance. Additionally, only 2 of the 18 software programs listed rely on external resources for support: MedMeasures by ViPS and iDRS developed by Imaging Solutions.

Software/ Application	Years Supported	Systems Maintenance	Contact Person	Contact Information
Claims Processing and Management				
COSMOS & COSMOS Interface Engine	20	Internal	Vijay D'souza	<a href="mailto:vijay_dsouza@uhc.com">vijay_dsouza@uhc.com</a> UnitedHealthcare Community Plan 7600 North 16 <sup>th</sup> Street Suite 230 Phoenix, AZ 85020
AdjudiPro	16	Internal		
UFE	20	Internal		
iDRS	13	External		
ORS	6	Internal		
CDB	5	Internal		
STARS	2	Internal		
FSDB & RPS	11	Internal		
NDB/Aperature	5	Internal		
RAM	2	Internal		
SMART/ Microstrategy	8	Internal		
iCES 4.X/CH Clearinghouse (planned)	3	Internal		
Prospective 2.0 by OptumInsight	1+	Internal		
Medical Management and Quality Management				
CareOne	11	Internal	Vijay D'souza	<a href="mailto:vijay_dsouza@uhc.com">vijay_dsouza@uhc.com</a> UnitedHealthcare Community Plan 7600 North 16th Street Suite 230 Phoenix, AZ 85020
CareTracker by OptumInsight (Optional for Providers)	N/A	Internal		
ImpactPro by OptumInsight	4	Internal		
Provider Issue Tracker	2+	Internal		
ViPS MedMeasures	6	External		
Member and Provider Service				
IDT	6	Internal	Vijay D'souza	<a href="mailto:vijay_dsouza@uhc.com">vijay_dsouza@uhc.com</a> UnitedHealthcare Community Plan 7600 North 16th Street Suite 230 Phoenix, AZ 85020
UnitedHealthcare Online Provider Portal	8	Internal		
EFT Transfer	10	Internal		
Member Website	15	Internal		
IVR/EVP	5+	Internal		

**Notes:**

- All software/applications were developed and are supported via UnitedHealthcare Community Plan/UnitedHealth Group IT with the exception of iDRS, which was developed by Imaging Solutions vendor, and MedMeasures, which was developed by ViPS.
- All software/applications versions are considered proprietary versions.

**Q.15 Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. (All GSAs)**

## Supporting Meaningful Use of EHR and Other Federal Mandates

In addition to our local expertise in health plan management and technology, UnitedHealthcare Community Plan has access to national resources that we rely on to support our efforts to comply with HIPAA regulations. Our Chief Information Officer (CIO), Vijay D'Souza, works through these resources to continually verify our compliance with HIPAA and other mandates, and ensures that our information systems and processing are adaptable to future requirements, innovations and adoption of best practices. Our core systems continue to be HIPAA compliant, and are ready to support initiatives such as EHR.

### Meaningful Use Guarantee

The federal government has stipulated that eligible physicians must achieve 'meaningful use' of the EMR in order to qualify for stimulus funds totaling almost \$64,000. In our experience, many EMR solutions promise meaningful use, but few guarantee that their solution will enable physicians to achieve it in their practice. The risk, of course, is the loss of stimulus dollars to the provider as well as the cost of the EMR to the practice.

Given the risks, especially for smaller practices, it was important for UnitedHealth Community to partner with an EMR vendor that could stand behind its product. OptumInsight CareTracker offers this simple guarantee to our providers: Our EMR will enable you to achieve meaningful use or you don't have to pay for it. Again, UnitedHealth Community understands that our providers are taking a substantial financial risk in adopting EMR; therefore we have chosen to encourage EMR adoption in Louisiana by minimizing their risk with this meaningful use guarantee.

### OptumInsight CareTracker EMR – Summary Page

**Member Information**  
Chart # 1000000000  
DOB: 10/1/1950  
Gender: M Age: 58

**Emergent Information**

**Summary View** Report Date: 10/3/2008

**INGENIX CareTracker** Filter by: All Since last visit Past 6 month Past Year Custom

**Summary View**

**ALLERGIES**

**Medication Allergies:** No Medication Allergies Recorded  
**Non-medication Allergies:** No Non-Medication Allergies Recorded

**DIAGNOSES**

Code	Description	Prognosis
I10	Hypertension	Not Documented
E10	Diabetes mellitus	Not Documented
I69	Unspecified cerebrovascular disease	Not Documented

**MEDICATIONS**

Medication	Dose	Frequency
Aspirin 81 mg Tab	1.00	QD
AVANDAMET 2 mg-500 mg Tab	1.00	BID
Hydrochlorothiazide 25 mg Tab	1.00	BID
Hyczar 50 mg-12.5 mg Tab	1.00	QD
Levothyroxine	1.00	QD

**OUTPATIENT NOTIFICATIONS**

**ASSESSMENT HISTORY**

Date	Assessment Name	Assessed By
8/26/2008	Community Assessment	Garcia Vivian
9/26/2008	2008	Garcia Vivian
7/14/2008	Community Assessment	Lee Alice
4/4/2008	Community Assessment	Lee Alice

## Health Information Exchange (HIE)

As we develop E-Health initiatives and approach implementation, our Information Systems and Technology team works closely with our government compliance staff to review current and potential mandates, which allows for seamless strides towards compliant E-Health solutions. This occurs as part of our software change management process, during which business analysts and plan executives consider HIPAA and other regulations when considering changes, enhancements and upgrades. UnitedHealthcare Community Plan's change management process is governed by our Software Change Management Policy and Procedure, and undergoes annual internal audit and Sarbanes-Oxley (SOX) reviews.

The rigor and success of this change management approach is evidenced by the multiple innovations that UnitedHealthcare Community Plan has implemented in recent years. Electronic data exchange and communication are core elements of each of these initiatives, which were implemented to reduce provider administrative burden and enhance our efficiency. As part of our continuous development process and our commitment to aligning with CCN goals, UnitedHealthcare Community Plan, in conjunction with our internal partners (OptumInsight/Axolotl), is ready to work with DHH on evaluating and potentially implementing programs below to interface with a global online interchange consistent with DHH's health information exchange (HIE) strategy to include such items as

- Online provider quality scores
- Health Risk Assessments
- Electronic payment and remittance
- Evidence based medicine
- Risk stratification tool
- Online panel rosters and eligibility
- Disease management protocols
- EHR Incentive Program Support
- Online Prior Authorizations
- Electronic claims submission/adjustments.

## Encouraging Electronic Medical Records Usage

UnitedHealthcare Community Plan envisions Electronic Health Record (EHR) and Electronic Health Information Exchange (e-HIE) as a key to make health care more accessible and improve continuity of care in the near future. Our efforts in this respect will be led by our Chief Information Officer, Vijay D'Souza. We will work with DHH to coordinate a strategy that supports the goals of DHH's EHR incentive program including:

- Enhancing care coordination and patient safety
- Reducing paperwork and improving efficiencies
- Facilitating information sharing across providers, payers, and state lines; and
- Enabling communication of health information to authorized users through state Health Information Exchanges (HIEs) and the National Health Information Network (NHIN).

### 2010 Technology Innovation Award Winner (OptumInsight)

*U.S. Department of Health and Human Services for its Connect software for exchanging electronic medical records.*

UnitedHealthcare Community Plan is committed to promoting provider adoption and usage of electronic medical record (EMR) technologies to all providers, with particular focus on those less able to afford the typically high upfront costs. As a result of this commitment, we will provide interest free loans to any participating primary care providers (PCPs) in Louisiana who meet the criteria and qualify for the CMS **Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs** and who purchase the OptumHealth Insight CareTracker EMR solution. These loans would be repayable from the incentive funds received under the CMS program.

To that end, UnitedHealthcare Community Plan has aligned with OptumHealth Insight, also a UnitedHealth Group company, to help ensure that all Medicaid providers in our network have the knowledge and means to adopt an affordable and effective EMR solution that will allow them to qualify for stimulus funds. The solution – OptumHealth Insight CareTracker EHR – was selected this year by the American Medical Association for consideration by their members and is fully CCHITTM 2011-certified. It is a highly affordable and simple to deploy solution that transforms physician workflow with minimal disruption.

UnitedHealthcare Community and OptumHealth Insight have come together to invest in a provider EMR program that will enable EMR adoption by any of our participating primary care providers. We will meet with work groups or committees to coordinate activities and develop system strategies that actively reinforce the health care reform initiative as requested by DHH. Elements of this program include, but are not limited to:

- Provider educational programs and materials about stimulus, meaningful use rules, and EMR technologies, including white papers, case studies, and primers on EMR adoption, and more
- Consultative support delivered by our team of physician advocates
- A guarantee from OptumHealth Insight that their EMR will enable our providers to achieve meaningful use, or they won't have to pay for the EMR
- Special zero percent financing for OptumHealth Insight CareTracker EHR, underwritten by OptumHealth Bank, so physicians can postpone paying for the EMR until they have received their federal stimulus funds

We strongly believe that the widespread adoption of EMR by providers will help achieve several objectives important to our organization and to Medicaid enrollees in the state of Louisiana:

- Improve patient care outcomes for Medicaid enrollees
- Slow the rising costs of care
- Help eliminate system fraud, waste and abuse.

### ***Describe your plans to utilizing ICD-10 and 5010.***

## **ICD-10 and 5010 Compliance**

We prioritize HIPAA compliance and continually monitor CMS regulations to ensure that we comply with regulatory mandates. At present, we are compliant with HIPAA version 4010A, and are actively updating to version 5010 and the development of ICD10 coding so that we will be prepared and compliant on the respective effective dates. To date, we have updated and implemented some interfaces and the core COSMOS platform to be compliant with 5010 and will have the remaining interfaces compliant well before the required date of January 1, 2012. We will be ready to test with DHH as part of the 5010 readiness review. We stay HIPAA compliant and have already started QA work for new x12 5010 EDI standards for Jan. 1, 2012 compliance and have started analysis for ICD-10 codes for Oct. 1, 2013 compliance. Lastly, we provide our members with a privacy notice as required by HIPAA.

UnitedHealth Group has completed the Committee on Operating Rules for Information Exchange(R) (CORE(R)) Phase I and II testing process. This process certifies that

### **Transitioning to HIPAA 5010 and ICD-10**

The federal government mandated that all covered entities (including providers, clearinghouses and health plans) must transition to the latest version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards and code sets. Click here for more information about the transition.

\* Jan. 1, 2012: The 5010 version of the electronic transactions standards will replace the current 4010 version.

\* Oct. 1, 2013: The International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM), the current code set for reporting diagnosis, will be replaced by ICD-10-CM.

Release Date: 2011-05-12



UnitedHealth Group can deliver more efficient and predictable patient-eligibility and claims-verification information to doctors, hospitals, physician offices and other care Providers, according to operating rules developed by CORE. The 5010 data transactions include patient eligibility/verification and claim status. This is a milestone in the company's efforts to streamline patient-eligibility and claims status transactions, so that care providers can spend less time on administrative functions and more time treating patients.

***Q.16 Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet. (All GSAs)***

UnitedHealthcare Community Plan manages and supports a robust Information Security Program. Its protocols are based on industry best practices, all applicable regulatory obligations, and customer considerations. Policies and standards are used to manage the specific requirements and basic premise of general computing, audit, and security controls.

DHH retains ownership of all information, whether data or documentation/reports containing references to such information involving or arising out of a resulting contract. UnitedHealthcare Community Plan will not share or publish DHH's information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.

The preventative controls implemented to secure customer's data include the following physical, personnel, procedural, and technical controls:

- Standard baseline configurations, which satisfy UnitedHealth Group security requirements
- Mandatory on-going security-related training for all employees
- Access control mechanisms designed to enforce 'least privilege' access to resources and data
- Access to resources granted on a 'need to access' basis, based on the user's assigned duties
- Regular access/entitlement reviews to ensure users have only the minimum required level of access
- Physical controls for sensitive areas, i.e. datacenters, user processing areas, etc.
- Appropriate contingency policies and procedures for responding to occurrences that could damage systems that contain PHI.

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## **Confidentiality: Privacy and Security Program Overview**

UnitedHealth Group seeks to retain the trust and respect of our customers and the public in the handling of private information, including health, financial, and other personal information in the conduct of our health and well-being enterprises. We are all responsible for ensuring the confidentiality and privacy of protected health information and other personal information used and maintained in our businesses. Privacy and confidentiality are core values at UnitedHealth Group.

UnitedHealth Group businesses and employees have a responsibility to observe the policies, procedures, and operational guidelines developed to protect individually identifiable health, financial, and other personal information.

The UnitedHealth Group Privacy and Security Program is designed to promote compliance with UnitedHealth Group's mission and various federal and state privacy regulations, including HIPAA, GLBA, and more stringent state privacy requirements. It is structured into two major components: The first is to provide employees with various training and resources to support their day-to-day compliance activities. Second, through various monitoring and control tools, it seeks to ensure employees are actually complying with existing processes and promotes ongoing compliance through a proactive change management approach. UnitedHealth Group privacy and compliance teams are responsible for the oversight of this program.



## UnitedHealth Group Privacy and Compliance Teams

UnitedHealth Group has designated individuals responsible for overseeing its Privacy and Security Program, including a privacy officer and security officer. In addition, each UnitedHealth Group business, in cooperation with the privacy and security officer, is responsible for:

- Promoting awareness of HIPAA, ARRA, state privacy and other privacy and security requirements throughout the company
- Developing and implementing privacy and security education and training programs in conjunction with our overall Integrity and Compliance Program
- Participating in the activities and decisions across cross-functional workgroups in assessing the privacy and security requirements, conducting gap-analyses, developing policies, recommending compliance action plans, reporting, and tracking privacy complaints, and monitoring ongoing compliance.

## Privacy Training and Resources

All UnitedHealth Group employees are required to be trained on privacy and security, to include their responsibilities of safeguarding the confidentiality of private information. Training is offered through corporate Integrity and Compliance training (Privacy Overview and Information Security modules) and through business training programs. In addition, various resources, including Policies and Procedures and the Privacy Office, are available to employees to provide guidance and address issues to support ongoing compliance with privacy and security requirements.

## Policies and Procedures

Each UnitedHealth Group business is responsible for analyzing its business practices to support compliance with privacy and security regulations. UnitedHealth Group policies and procedures are documented to provide for consistency across the organization, and also serve as a reference tool for the employee. UnitedHealth Group Compliance and business areas provide training to all employees, as necessary and appropriate for employees to carry out their job function in accordance with these policies and procedures. At a high level, UnitedHealth Group policies and procedures address the following privacy and security requirements, as applicable:

- |                       |                     |
|-----------------------|---------------------|
| ■ Use & Disclosure    | ■ Individual Rights |
| ■ Business Associates | ■ Privacy Notice    |
| ■ Plan Sponsors       | ■ Complaints        |
| ■ Authorizations      | ■ Safeguards.       |

As well, prior to releasing any information, the caller must be properly identified and authenticated by providing his/her name, consumer ID # or address, and date of birth, and if applicable their relationship to the member and that they have permission to speak on behalf of the member. Protected Health Information is only provided to individuals calling about themselves, parents about minor children under age 18, or to individuals with a valid authorization. Sensitive information is only provided to individuals calling about themselves, parents about minor children under age 12, or individuals with a valid authorization.

## Individual Rights

The Privacy Rule defines the specific rights that are afforded to individuals. These rights, as outlined in the regulations, include the right to notice of privacy practices for PHI, confidential communications (including such measures as delivery of PHI to an alternative address; or in an alternative format; or withholding PHI from a parent or guardian consistent with applicable state law), request restriction of uses and disclosures, access PHI, request amendment of PHI and request accounting of disclosures. These specific rights, as well as how UnitedHealth Group addresses each of these rights, are described below in more detail.

***The Right to Notice of Privacy Practices for Protected Health Information***

For those UnitedHealth Group companies designated as Covered Entities, individuals have a right to receive a notice of how UnitedHealth Group handles and safeguards PHI and the uses and disclosures that may be made as we conduct payment and health plan operations, and of the rights that are afforded to individuals by applicable privacy laws. By law, employers' group health plans are required to provide notice of their privacy practices to individuals covered under their health plan. The action that UnitedHealth Group takes depends on whether employer benefit plans are fully insured by the company or are administered by the company on a self insured basis. For our fully insured customers, unless agreed otherwise, individuals receive a Notice of Privacy Practices. Self insured customers are responsible for providing their own privacy notice to their employee beneficiaries.

***The Right to Request Confidential Communications***

Individuals have the right to request confidential communications, including such measures as delivery of PHI to a separate address or withholding of PHI from a parent or guardian consistent with applicable state law. UnitedHealth Group allows individuals to request confidential handling of their claims. Such restrictions can be arranged on the phone with a Customer Care Professional (CCP) and will generally apply to information communicated through EOBs, CCPs, and myuhc.com. When future calls are received on this individual, the CCP will not disclose information unless the individual has granted this authority. In order for an individual to remove their restriction, they must make a request of the company in writing.

***The Right to Request Restriction of Uses and Disclosures***

Individuals have the right to request restrictions on the use and disclosure of their PHI for treatment, payment or health care operations. However, health plans, including group health plans, are not required to grant such requests. Since these particular types of uses and disclosures are necessary for routine health plan functions, UnitedHealth Group does not routinely accommodate these restrictions since restrictions would significantly impact the effectiveness and quality of our service.

***The Right to Access PHI***

Under the Privacy Rule, individuals have a right to access their health information records. We are required to maintain this information in a "designated record set" (DRS) and to provide these records to individuals upon request, with very few exceptions. Individuals can exercise this right by contacting the toll-free Customer Care number on their ID card. A CCP will send a request form to the individual that will be used to verify the identity of the requestor and provide written authorization.

***The Right to Request Amendment of PHI***

The Privacy Rule establishes the right to correct or amend PHI that is inaccurate or incomplete. UnitedHealth Group handles corrections of PHI according to currently established procedures. In the majority of cases, we direct the individual to the originator of the information, such as the employer if there are changes to demographic information, or to the provider if there are changes to diagnosis information.

***The Right to Request Accounting of Certain Types of Disclosures***

Upon request, covered entities must provide individuals with an accounting of certain disclosures of PHI. Disclosures made in the course of normal health care operations are exempt from this HIPAA accounting requirement. Similar to the process for access requests, the CCP provides a request form to the individual that verifies the identity of the requestor. Upon receipt of the completed request an accounting of disclosures report is mailed to the requestor.

## **Monitoring and Controls**

### **Quality Program**

- Operations Quality: The Operations Quality team reviews telephone calls taken by Customer Care Professionals and claims processed to ensure adherence to policies and procedures. Feedback is provided to these representatives and their progress is tracked. Their supervisors are responsible for addressing any performance issues.
- Departmental Quality: Similar to the Operations Quality team that monitors Customer Care and Transaction Operations, there are individuals within the various functional teams that monitor their representatives' adherence to policies and procedures.

### **Access Control and Secure Transmission**

In accordance with our Risk Management approach to security implementation, numerous policies, procedures, and technical controls have been selected to manage access to systems and information. Work at Home (WAH) users are required to connect to UnitedHealth Group systems via a secure Virtual Private Network (VPN) which ensures all data is encrypted and not susceptible to interception. Secure Transmission Standards have also been selected and corresponding controls have been implemented to ensure the confidentiality, integrity and availability of electronic PHI transmitted via public networks. We restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences. Industry standard Intrusion Detection Systems are in place to enable the detection and response to information technology system intrusion events. Controls utilize appropriate encryption and authentication or equivalent means to protect the transmitted information.

### **Complaint Monitoring**

Privacy complaints are reported to privacy or security leads. High-risk and sensitive complaints are reported immediately. A structured incident management process ensures that all appropriate stakeholders and officials are notified of the matter in question and provides for a consistent resolution process and disciplinary response. Matters that require reporting to authorities are handled as required by applicable law.

The privacy or security leads review complaints to ensure they are handled properly, that corrective action plans are in place, and that appropriate sanctions are applied. Feedback is provided to the business area that is the subject of the complaint, as well as the business area handling the complaint. Reports of inappropriate disclosures are reported to the applicable Account Director (AD) or Strategic Account Executive (SAE) who is responsible for reporting these issues to our customers.

### **Project Review**

The compliance teams are an integral part of reviewing new and existing initiatives (including technology enhancements) to promote privacy and security compliance with regulatory requirements. As issues are identified, they provide consultative expertise, guidance to business partners and promote compliance with laws and regulations.

### **Business Associates**

UnitedHealth Group has Business Associate Agreements that meet HIPAA privacy and security requirements in place with subcontractor/vendor business associates that have access to protected health information (PHI).

### **Regulatory Analysis**

With new innovations in technology and service methods, come many changes and challenges to managing the privacy and security environment. The compliance teams are charged with evaluating and interpreting new and proposed privacy and security legislation and regulation. They provide consultative expertise, guidance to business partners and promote compliance with laws and regulations. In addition,

they answer questions and inquiries from business areas and satisfy requests for research related to specific privacy and security legislation/regulations. The compliance teams are integral whenever there is a change to privacy and security policies or procedures, and they assist the impacted business units in implementing such changes.

To ensure the appropriate attention is given to new legislation and regulations and changes in existing statutory and regulatory requirements that govern the business, UnitedHealth Group has an internal Compliance and Regulatory Affairs Organization that consists of Regional Regulatory Affairs and National Compliance Operations. The process through which legislative and regulatory changes are identified and implemented is robust and may include:

- Review and analysis of the legislation and its impact on the business'
- Communication to the business, with training and education, as appropriate
- Creation and execution of a plan to implement the regulatory requirements
- As appropriate, development of self-monitoring metrics that are reported back to compliance
- As needed, retrospective assessment by compliance to validate full implementation and sustained compliance
- As needed, oversight and management of action plans.

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## **External Customer Gateway (ECG) Overview**

ECG services provides a secured and security-compliant electronic transport mechanism for UnitedHealth Group internal entities and external business customers to exchange data files on demand or scheduled through integration with Job Automation & Control services. ECG also supports all UnitedHealth Group business segments currently on the UnitedHealth Group network with over 3,000 external business entities. ECG services include:

- Secured transport and non-repudiation of file transfers between UnitedHealth Group and external business partners/customers
- Job Automation & Control scheduling of file transfer pulls/pushes based on predetermined business calendar or integration with internal job controlled applications
- Custom file naming translation between internal and external entities
- Activity/audit reporting and UnitedHealth Group IT security compliance
- Integration with any wintel, distributed, or mainframe system reachable within the UnitedHealth Group network
- Time and cost savings:
  - Enhances productivity by eliminating manual tasks needed to deliver data.
  - Speeds up the report delivery process and the receipt of files.
  - Provides customers with electronic copies of reports for easy integration into key presentations, databases, or other applications.
  - Eliminates faxing reports, floppy diskettes, tapes, & expensive third party networks.
  - Allows for automated file transfer of data so the transfers occur on a regular schedule. This is useful for transferring a variety of data (Claims, Eligibility, Enrollment Reports, etc).

UnitedHealth Group's External Customer Gateway (ECG) utilizes the following transport methods:

- SFTP
- HTTPS
- FTP (file encryption required) (exception required)
- PESIT

- FTP w/SSL (coming soon on the Axway environment)
- Encryption & Repudiation used: McAfee eBusiness PGP.

### **External Customer Gateway Policies**

The following policies apply to ECG file transfers:

- FTP is the standard for file transfers within UnitedHealth Group's network to external customers
- Track:
  - Successful transfer of all files in a directory
  - Unsuccessful transfer of files
  - Size of files transferred
  - File names
- No transfer of files on an ad hoc basis. Ad hoc transfers are only for customers currently using ECG services. Files to be transferred may be put into the proper directory and transferred at the scheduled time.
- Exchanges and manages PGP Keys for business groups using ECG encryption services
- Tests encryption and de-encryption of files when using ECG encryption services
- Three weeks prior to any planned outages we will post the change on our Website. One week prior to the change, we will send you an e-mail notifying you of the change
- The ECG environment is available 365 days. No daily maintenance window.

## Section R: Added Value to Louisiana

**R.1** *The “value added” from Provider Incentive Payments will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor.*

*See Appendix HH for instructions for completing the Provider Incentive Payments for Provider Incentives and Enhanced Payments.*

*The completed template (Attachment FF) and all additional documentation and calculations shall be accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.*  
*(All GSAs)*

Our completed Appendix FF is included as an attachment and our accompanying statement from the preparing actuary is included as Attachment R.1.

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## Gain Sharing Program

UnitedHealthcare Community Plan is committed to working with our physicians to improve the health and quality of life of our Members by reducing inappropriate utilization of services, admissions and readmissions and to sharing a portion of savings resulting from those reductions. We achieve this through 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.

Model elements include multi-disciplinary care coordination and shared savings opportunities aligned with performance against quality and efficiency metrics.

Our gain sharing program will focus around a patient-centered, physician-driven model that has proven successful in other state Medicaid programs using a dedicated care management team.

This model engages the patient and their support system in their care which we believe is essential to ensure better health care, better health and reduce costs. It uses integrated data systems, electronic medical records (EMR), data analytic and decision support tools to ensure patient encounters with physicians provide a targeted clinical strategy. This comprehensive approach begins with the patients' first visit and includes proactive visits based on evidence based medical criteria.

We will engage in active Provider practice support and contracting to address reimbursement, and relevant health outcomes based on DHH performance metrics as well as those we consider important such as Emergency room utilization rates, medical or surgical hospital admission rates as well as readmission rates. These measures can also include an improved patient experience, better overall health outcomes, reduced reliance on intrusive or disruptive emergency services and a reduction in duplicative costs and expenses in diagnostic services.

## Quality Metrics

Our incentive model will include the five Performance Incentive Measures identified by DHH and is subject to DHH approval. This specific criteria may change based on the State's or UnitedHealthcare Community Plan's priorities.



**Proposed Structure for Payout**

- Only primary care providers serving as a patient centered medical home will be eligible for gain share payments
- Provider pool is determined by
  - Members who select or are assigned to PCPs affiliated with a health system, hospital, physician group or individual PCPs with 500 or more members
- Only providers in the top 33 percent of eligible providers, as determined by measurement to the performance standards specified in the UnitedHealthcare Community Plan Pay for Value program and meeting the applicable incentive performance measures used by DHH in the CCN program, will qualify for the gain share payment
- Provider must be a contracted provider and have an open panel at the payment date
- Provider pools would share
  - 10 percent of shared saving PMPM between \$0 and \$4 PMPM
  - 25 percent of shared saving PMPM between \$4 and \$6 PMPM
  - 50 percent of shared saving PMPM >\$6 PMPM
- Prior period losses must be earned back before current period gain would be owed or paid
- Provider pool is determined by the members who select or are assigned to PCPs affiliated with a health system, hospital, physician group or individual PCPs with 500 or more members
- Provider must be a contracted provider and have an open panel at the payment date
- Measurement period will be for the same period used by DHH in calculating the plan's shared savings amount
- Shared savings will be paid 15 days after receipt of the shared savings payment from DHH
- The allocation of pool amounts among eligible physicians will be based on a formula determined by members of the UnitedHealthcare Community Plan's Louisiana Physicians Advisory Committee