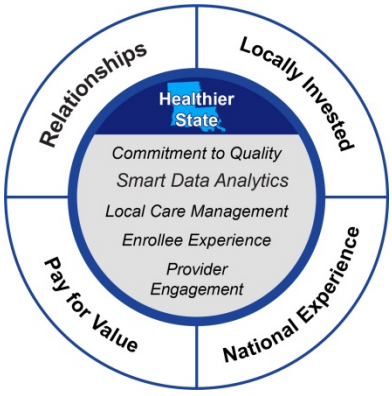
2.10.1 Executive Summary

The Proposer should provide an executive summary, which demonstrates its understanding of LDH's vision for…

"Helping enrollees live healthier lives" is not just our mission; our enrollees are at the core of everything we do. We put our enrollees first in many ways, not just through our care management model and approach, but in how we address social determinants of health, integrate medical and behavioral health and in how we approach value-based payments. ***We align this mission with Louisiana Department of Health's (LDH's) vision to work with all stakeholders in the Medicaid system — enrollees, providers, community-based organizations and other health plans — to reach the Triple Aim of better health and better care while successfully lowering costs.***

We are proud to submit our proposed solution for LDH's Louisiana Request for Proposal. LDH has shown commitment to establish principles to support high-quality care and promote health to Louisianans and the Medicaid Managed Care Program. We see LDH's transformative vision and we have worked side-by-side with LDH to pave a way to a healthier Louisiana for our enrollees and the communities in which they live. One of the ways in which we support LDH's mission is through our reinvestment of more than $5.6 million in recent years to make a difference in the lives of the enrollees we serve. We are especially proud to show our community support through our investments with Woman's Hospital Guiding Recovery and Creating Empowerment (GRACE) program, Louisiana Research Center "Taking Aim at Cancer" and Daughters of Charity Partners in Health program, to name a few. As you will see outlined below and throughout our RFP response, we continued with new investments that will make a difference in improving the lives of Louisianans.

Our tenure in Louisiana has provided us with a deep understanding of the needs of the population, and we are committed to applying our experience to helping LDH achieve the goals outlined in Section 1.3 of this RFP. The strategy medallion is one you will see throughout our response. This medallion highlights the specific ways we are committed to a Healthier Louisiana. While we will present many ways to align to LDH's vision, below are some highlights.



Improve Enrollee Health

We are enhancing our care management program by incorporating innovative and enrollee-focused resources to continue protecting and promoting health among Louisiana's most vulnerable populations.

- ***Hospital Care Transitions Program (HCT):*** Our new direct embedded HCT program helps an enrollee's move to their next level of care easier and their hospital discharge go as smoothly as possible. In December 2018, we placed four HCT coordinators within Our Lady of the Lake Regional Medical Center in Baton Rouge and the Louisiana Children's Medical Center (LCMC) Health University Medical Center in New Orleans to reach high-risk enrollees pre-discharge and provide specialized supports to address each enrollee's post-discharge needs. We support the HCT coordinators with an RN, a clinical pharmacist who addresses medication gaps and issues, and a licensed social worker with behavioral health expertise who addresses behavioral health concerns. In 2019, we plan to place a perinatal HCT coordinator in Louisiana Woman's Healthcare clinic affiliated with Woman's Hospital in Baton Rouge. The HCT coordinator will address the prenatal needs of inpatient high-risk women to ensure the best health outcomes for mother and baby and address social determinants of health needs.

- ***Improving the Health of Pregnant Women with Opioid Use Disorder (OUD)***: Pregnant women who have OUD are more likely to have a high-risk pregnancy and face disparately higher rates of maternal and infant mortality. In August 2018, we provided a $1.2 million grant to Baton Rouge Woman's Hospital to implement its GRACE program. By partnering with GRACE at Baton Rouge Woman's Hospital, an area with a proportionally high rate of infant mortality, we have been able to overcome health disparities and reduce the effects of substance use disorder (SUD)/OUD on pregnant women and their newborns.

Population Health Approach to Maximize Enrollee Health

Our population health efforts are bidirectional, being both informed by and informing our work across the state. Not only do we use our data aggregation and analysis tools to inform our population health approach, but we also use population health principles to inform our work across the organization.

- ***Social Determinants of Health (SDOH):*** We recognize the importance of population health management in identifying and addressing the social, behavioral, medical and functional needs of our enrollees to improve their health outcomes and reduce health disparities. We know our enrollees face unique challenges, such as food insecurity; unsafe or unstable housing; lack of transportation; unemployment and financial instability. Our population health approach takes into account these SDOH that often impede our enrollees from receiving care.

Figure 1. We received the Community Champions award at the LHC Housing Conference on April 3, 2019.

- ***Supportive Housing:*** Access to safe and affordable housing, along with supports necessary to thrive there is a most basic health-related resource need. We are committed to addressing housing in Louisiana through the work of our Permanent Supportive Housing (PSH) liaison who has supported over 50 enrollees in housing and ***our new housing navigator.*** In 2018, we worked with Louisiana Housing Corporation (LHC) and LDH to develop strategies to continue reducing homelessness and supporting individuals in housing, including offering bridge financing at no interest to LHC to support their HUD $11.5 million Continuum of Care PSH grant.
- ***Partners in Health with Daughters of Charity:*** We further develop SDOH interventions through ***our Partners in Health program*** launched in April 2018 with Daughters of Charity. Through a $2.5 million grant, we supported the hiring and training of 15 Daughters of Charity community health workers (CHWs) who assess at-risk individuals, identify social barriers, and refer and connect enrollees to appropriate community programs and resources. In 2018, CHWs at Daughters of Charity reached 8,234 unique individuals, encompassing both our enrollee and non-enrollee population. Of those individuals, 5,195 completed referrals to receive medical, dental and behavioral health services through Daughters of Charity health centers.

Figure 2: Care fellowship team at Daughters of Charity with UnitedHealthcare employees

Advance Evidence-based Practices and High-value Care

We use a systematic approach to seek and evaluate promising and evidence-informed practices. We have adopted multiple evidence-based practices within our current service

delivery array and we are committed to expand to include additional best practices and clinical practice guidelines to meet the needs of Medicaid Managed Care Program populations. Some of the innovations we bring to advancing evidence-based practices include:

- ***Hotspotting*** is the strategic use of data to identify enrollees with complex needs. Typically, these individuals have high utilization of services and social and behavioral complexities. Using our Hotspotting Tool, we can identify enrollees who are most likely to benefit from our CHW approach — a direct, evidence-based, in the community approach to service delivery. CHWs engage enrollees directly in place-based interventions, whether it is at the hospital bedside, at a homeless shelter or another location.
- ***Parent Child Interaction Therapy (PCIT)*** is an evidence-based, specialized behavior management identified by LDH as needed to strengthen the network of available therapeutic services for children, adolescents and their families in Louisiana. We were the first managed care organization in Louisiana to offer MCO-sponsored PCIT training. We helped the LSU Center from Evidence to Practice and MCO Healthy Blue identify potential provider candidates to receive PCIT training and shared information regarding potential expansion locations in the state.

Support Innovation and Continuous Quality Improvement

Our culture of innovation is driven by our mission to help people live healthier lives, and emphasizes continuous exploration and testing of new ideas, while collaborating with diverse partners to develop a simpler, more intelligent and cost-effective health care system for everyone.

- ***Dedication to Quality Improvement:*** Over the past 5 years, we have achieved year-over-year improvement in our HEDIS, CAHPS and overall NCQA scores. Our goal of reaching an 'Excellent' NCQA score is well within reach.
- ***NextHealth Technologies (NextHealth):*** In 2019, we are partnering with ***NextHealth to implement its artificial intelligence platform***, which predicts opportunities to address risk and prescribes personalized actions to improve outcomes for enrollee sub-populations. NextHealth offers powerful, subtle suggestions that alter behavior without harsh consequences and provide subtle cues to each sub-population to make the right choice desirable.
- ***Ready Responders:*** Ready Responders is a network of trained, licensed and fully insured EMTs, paramedics and nurses who visit high-risk enrollees with inappropriate ED utilization to help divert them from the ED. Since its launch in July 2018, our preliminary results show a ***25% decrease in ED PMPM costs and a 38% decrease in inpatient PMPM costs*** among enrollees engaged in the program, driven by decreased utilization.

Decrease Fragmentation and Increase Integration

Over the past decade, the integration of behavioral health and general medical services has improved patient outcomes, reduced stigma related to mental health and reduced health care costs. We decrease fragmentation and increase integration in the following ways:

- ***Medical/Behavioral Health Integration:*** Our integrated care team model facilitates a comprehensive approach to assessing our enrollees' physical health, behavioral health and SDOH, such as housing and employment, for linkage to community resources.

- ***Cross-functional Opioid and Substance Use Disorder (OUD/SUD) Strategy:*** Our pharmacy and utilization management (UM) teams collaborate to identify enrollees at potential risk of SUD/OUD and our provider relations team has expanded our available medication-assisted treatment (MAT) network. We train our case management teams to offer specialized care that promotes recovery, such as referrals to GRACE and ACER for pregnant women with SUD/OUD.
- ***Integration With Utilization Management:*** Our UM activities support our population health program by providing objective and systematic monitoring and evaluation of enrollee care and services. Inputs from our UM program provide critical evidence about health care patterns and practices and provide information that shapes our population health programs. For example, using UM data analysis, our team is able to identify patterns of high ED use and deploy programs, such as *UHC Doctor Chat* and *Ready Responders* to support sub-populations with high utilization.

Ensure Enrollees Ready Access to Care

We evaluate our network through the eyes of enrollees and confirm they are able to receive the right care from their preferred provider in the right location at the right time.

Telehealth Solutions: Our strategy is to expand our delivery of care to underserved Louisiana Medicaid enrollees through three modes of telehealth access: direct to enrollee, enrollee to specialist through the PCP, and doctor to doctor. ***From 2017 to 2018, we have seen a 34% increase in telehealth claims received***. Telehealth adoption is critical to provide access to specialties currently in short supply. We are committed to advancing telehealth options and continuous improvement with incentives and offerings to further the continuum and adoption.

Reduce Complexity and Administrative Burden for Providers and Enrollees

We continuously monitor our program, conduct surveys, and review complaints or direct feedback from providers and enrollees regarding burdensome or unnecessary policies and processes. As we learned in 2017, while we have focused processes to drive positive results, we always have room for improvement. We worked closely with providers along with LDH to improve and make systematic and meaningful changes to enhance the overall experience by removing complexity for providers and LDH. We made many improvements and supported efforts to find common MCO policies. We remain committed to help be the MCO of choice with providers.

Provider Scorecards: For value-based payment (VBP) programs to work, providers need timely and easy to understand reporting. We have engaged significantly with our provider community to become trusted partners to reward them for their great work. This comes with continuous outreach, education and support. For example, when we see that a provider is not achieving their targeted improvement metrics, we modify our support and identify solutions to address their challenges. We provide each participating provider with scorecards showing trends in rates relative to baselines and targets for clinical quality measures, utilization metrics and total cost of care, depending upon contracted parameters. Outreach is conducted via in-person meetings, webinars, lunch and learn sessions, and email. ***In fact, LDH adopted our provider scorecard template as the standard format across MCOs.***

Align Financial Incentives and Build Shared Capacity

Demonstrating a ***culture of innovation and continuous quality improvement***, UnitedHealthcare has continued to evolve our approach to VBP programs for Louisiana's Medicaid Managed Care providers in support of the "triple aim" over the last seven years.

Louisiana Children's Medical Center: In 2019, we furthered our commitment to helping Louisiana providers move along the Health Care Payment Learning and Action Network Alternative Payment Model (APM) continuum, receiving a letter of intent from LCMC to begin participating in fully clinical integrated population health data sharing. This engagement will allow LCMC to use data sharing to learn case management and build the foundation for a capitation model that we plan to launch by 2021. The outcomes of our successful collaboration with LCMC will continue to guide our strategic plan for the state, as outlined in Section 2.10.12.3. While we focus our 3-year strategy on our VBP programs, we remain committed to moving up the APM continuum. We are excited about our first major step toward achieving our first Level 4 APM agreement.

Minimize Wasteful Spending, Abuse and Fraud

Since 2012, UnitedHealthcare has safeguarded Louisiana's Medicaid funds, ensuring they are used efficiently and judiciously to provide enrollees with the care they need to improve their health and wellbeing in alignment with the Triple aim. We have exceeded LDH referral goals and ***achieved $1 million in recoveries since 2015***. Examples of best practices include screening tips prior to assignment to SIU, re-routing non-fraud cases to our Waste and Error Team and enabling our SIU to refer cases to LDH independently.

We are committed to improving access to care, improving the overall quality of care, and creating efficiencies within the health care system in Louisiana. We understand how the integration of benefits and operational structures can benefit the health care system and fundamentally improve convenience and satisfaction of the system's stakeholders. We provide local commitment by building community in Louisiana; and we are committed to high satisfaction, better quality and lower cost. We look forward to continuing the journey we have begun together, helping people live healthier lives.

2.10.2 Organizational Experience

2.10.2.1 Proposer Experience

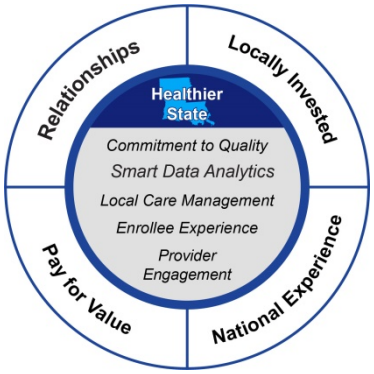
2.10.2.1.1 The Proposer should provide a brief summary of the organizational history of the Proposer and its…

Organizational History/Volume and States of Medicaid Business

UnitedHealthcare is proud of our 7-year partnership with the citizens of Louisiana and the Louisiana Department of Health (LDH). As of February 2019, we serve more than 442,000 Louisiana enrollees and are the largest organically grown managed care organization (MCO) in Louisiana. Through our commitment to enrollee health, strong brand recognition and local community partnerships, we are the ***enrollees' MCO of choice*** for the past 7 years, with the highest ***proactive choice rate.*** UnitedHealthcare has provided Medicaid managed care services for 44 years and we serve more than 6 million enrollees in 25 states in government-sponsored programs for low income and medically needy populations. These states include Arizona, California, Colorado, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Michigan, Missouri, Mississippi, Nebraska, Nevada, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, Washington and Wisconsin.

Organizational Goals

We base our organizational goals on our core values of ***Integrity, Compassion, Relationships, Innovation and Performance.*** Our core values translate to: honoring our commitments and never compromising our ethics; walking in the shoes of the people we serve and those with whom we work; building trust through collaboration; inventing the future and learning from the past; and demonstrating excellence in everything we do. These values are the overarching basis of how we serve the people of Louisiana by connecting them to better health, one person at a time. This approach aligns with LDH's vision for the future of Medicaid Managed Care as outlined in their white paper "*Paving the Way to a Healthier Louisiana: Advancing Medicaid Managed Care."*



- ***Advancing Evidence-based Practices:*** We are enhancing evidence-based practices and improving discharge planning with new processes to embed behavioral health, physical health and pharmacy staff in hospitals to improve access and care.
- ***Population Health:*** We are addressing social determinants of health (SDOH) in our programs and solutions to serve Medicaid enrollees better, particularly those experiencing homelessness, poor nutrition, unemployment and other factors that negatively affect health and well-being.
- ***Reducing Complexity and Administrative Burden for Providers:*** We are supporting providers through a combination of data, analytics, and targeted consulting — reducing complexity and easing administrative burden to ensure they succeed. For example, we have worked hard to remove barriers identified in early 2017 and are committed to continuous quality improvement. We engage and work with LDH on common policies and systems to improve the overall provider experience.

- ***Aligning Financial Incentives:*** We are actively working with LDH to transform payment incentives to encourage population-based care, as evidenced by our joint focus on LDH's vision on value-based payment (VBP). Our shared vision has helped transform our VBP to drive quality scores and increased provider incentive payouts year over year, ultimately resulting in better care and access for our enrollees.
- ***Commitment to the Louisiana Community and Health:*** We are strengthening local programs in Louisiana. For example, we invested more than $5.6 million in community initiatives since 2015, including Daughters of Charity Partners in Health program, Woman's Hospital Guiding Recovery and Creating Empowerment (GRACE) program, Louisiana Research Center "Taking Aim at Cancer" and Baton Rouge Area Foundation – Flood Relief.

Relevance of Medicaid Managed Care to our Mission

At UnitedHealthcare, our mission — ***to help people live healthier lives and to help the health care system work better for everyone*** — drives and guides us to meet the needs of our enrollees. At the core is a commitment to person-centeredness, which focuses on the enrollee's expressed needs, goals, desired outcomes, preferences and choices. We empower enrollees using person-centered principles that support our care management programs, processes, tools and approach to working with our enrollees. We are committed to our partnership with the LDH and the relationships that allow us to deliver seamless and appropriate care to our enrollees to achieve the goals of the Triple Aim; better health, better care and lower costs.

2.10.2.1.2 It is preferred, though not mandatory, that Proposers meet the following qualifications prior to the…

2.10.2.1.2.1 Have a minimum of seven (7) years of experience in providing health care services for a Medicaid…

UnitedHealthcare has more than 7 years of experience providing health care services in Louisiana; we first contracted with LDH in 2012. Nationally, we have spent 44 years providing health care services for Medicaid managed care programs.

2.10.2.1.2.2 Have, within the last twelve (12) months, been engaged in a contract or awarded a new contract as a

Within the last 12 months, UnitedHealthcare has engaged in or been awarded new contracts in 25 states. Some of the contracts we were awarded with Medicaid populations equal to or greater than that of Louisiana in the past 12 months include:

- ***Arizona:*** Our recent contract execution date for the Arizona Complete Care program started October 2018 and runs through September 2021, serving more than 371,000 enrollees out of 1.7 million Medicaid eligible individuals as of December 2018. We serve TANF, children with special health care needs and ABD populations in Arizona. This new integrated system will join physical and behavioral health services.
- ***North Carolina:*** Our recent contract execution date for the North Carolina Health Choices Program will start November 2019 and continue in a phased implementation to 2022. We anticipate serving more than 360,000 enrollees out of 2 million Medicaid eligible individuals by November 2019; we will serve TANF, CHIP, ABD and non-dual LTSS populations in North Carolina. North Carolina's program design seeks to advance high-value care, improve population health, engage and support providers.
- ***Washington:*** Our recent contract execution date for the Washington Fully Integrated Managed Care program started July 2018 and runs through December 2019 (annual renewal). Serving more than 208,000 enrollees out of 1.8 million Medicaid-eligible individuals as of December 2018; we serve TANF, CHIP, Expansion and ABD populations in Washington. We provide the full continuum of physical health and behavioral health.

2.10.2.2 Staff Experience and Organizational Structure

2.10.2.2.1 For each individual appointed to a key personnel role, the individual's name, résumé, key personnel…

We select key personnel after an extensive review of UnitedHealthcare resources and national Medicaid and managed health care experts. Our resulting leadership team are experts in the management of large health care delivery enterprises including leadership in managed care systems, Medicaid program and operations. When recruiting, we first consider Louisiana residents that have qualified experience in our roles. We have provided the names of the individuals, their resumes, the key personnel role they fill and their role in the governance and operating structure herein.

Scott Waulters, Interim Chief Executive Officer

Scott Waulters has full binding authority and autonomy over the operational management of the Medicaid program and remains fully accountable to the Department for every aspect of program administration. Mr. Waulters reports to UnitedHealthcare's regional Medicaid CEO.

Karl Lirette, Chief Operating Officer

Karl Lirette reports to Mr. Waulters and is responsible for the operations business unit, which includes grievance and appeals, claims administration, enrollee services, call centers, provider services, information services and encounter data. Mr. Lirette has oversight of Dental Benefit Providers, MARCH Vision, National MedTrans and our Hudson Veteran subcontractors.

Dr. Julie Morial, Chief Medical Officer

Dr. Julie Morial reports to Mr. Waulters as part of our operating structure. Dr. Morial is responsible for the clinical business unit, which includes medical management, case management and quality management. She has oversight of CareCore and Optum Health Care Solutions.

Dr. Jose Calderon-Abbo, Behavioral Health Medical Officer

Dr. Jose Calderon reports to Dr. Morial as part of our operating structure. Dr. Calderon is responsible for the behavioral health business unit, which includes behavioral health services. He has oversight of United Behavioral Health.

Tatyana Kotlovskiy, Interim Chief Financial Officer

Tatyana Kotlovskiy reports to Mr. Waulters as part of our operating structure. Ms. Kotlovskiy is responsible for the financial business unit, which includes budgeting and forecasting, accounting system management, financial reporting and audit management.

Shana Bush, Interim Pharmacy Director

Shana Bush reports to Mr. Waulters as part of our operating structure. Ms. Bush is responsible for the pharmacy business unit, with oversight of OptumRx.

Larry Smith, Contract Compliance Officer

Larry Smith reports to Mr. Waulters and our Board of Directors. He is responsible for implementing the UnitedHealthcare compliance business unit, which includes program integrity; contract compliance; and fraud, waste and abuse. He oversees OptumInsight.

SCOTT WAULTERS, INTERIM CHIEF EXECUTIVE OFFICER

Professional Experience

Company:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana**
Title:	Interim Chief Executive Officer (CEO)
Time Frame:	February 2019 – Present
Role and Responsibilities:	▪ Provides executive oversight and leadership for UnitedHealthcare to meet the needs of our enrollees and achieve contractual compliance ▪ Develops, translates and executes strategies or functional/operational objectives for UnitedHealthcare ▪ Provides leadership to and is accountable for the performance and results through multiple layers of management and senior level professional staff ▪ Confirms appropriate prioritization of initiatives and good personnel management ▪ Develops policies and procedures for operational processes to verify optimization and compliance with established standards and regulations ▪ Effectively develops strategic goals and turns those goals into specific operating and business plans that are executed at UnitedHealthcare ▪ Validates regulatory compliance ▪ Reviews medical expense drivers and creates plans to reduce waste and maximize the affordability of our programs

Company:	**UnitedHealthcare Community & State – Nationwide**
Title:	Executive Network Sponsor – all states
Time Frame:	June 2018 – February 2019
Role and Responsibilities:	▪ Conducted market reviews and network strategy for multiple states across UnitedHealthcare Community & State

Company:	**UnitedHealthcare Community & State – Edison, New Jersey**
Title:	Chief Operating Officer – myConnections
Time Frame:	February 2017 – June 2018
Role and Responsibilities:	▪ Led all startup and growth strategies focused on the social determinants of health and operations across multiple states and services lines ▪ Operationalized a flexible and scalable housing and social service solution for enrollees identified as persistent, frequent utilizers of health care services ▪ Instrumental in new strategic partnerships to develop, test and scale new models of care for enrollees with complex health, behavioral and social needs

Company:	**UnitedHealthcare Community Plan of New Jersey – Edison, New Jersey**
Title:	President/Chief Executive Officer
Time Frame:	September 2010 – February 2017
Role and Responsibilities:	▪ Led a team of over 250 direct associates serving 730,000 members with revenues in excess of $3.5 billion ▪ Operated a strong performing, NCQA Commendable organization that consistently met its fiduciary responsibilities to its customers ▪ Managed New Jersey product expansion and organic growth from 264,000 to 500,000 enrollees ▪ Implemented premium rate advocacy plan and legislative rounds with key appointed state leaders ▪ Specialized in risk management, affordability and network management

Education/Licensure/Credentials

- Bachelor of Arts – Industrial and Organizational Psychology, California University of Pennsylvania

Awards and Recognitions

- Named 2015 UnitedHealthcare Cultural Values Award winner for Performance
- Received 2014 Innovation Leadership Award
- Named 2013 UnitedHealthcare Cultural Values Award winner for Compassion
- Named 2013 New Jersey Humanitarian of the Year

KARL LIRETTE – CHIEF OPERATING OFFICER

Professional Experience

Company:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana**
Title:	Chief Operating Officer (COO)
Time Frame:	May 2013 – Present
Role and Responsibilities:	▪ Manages over $1 billion in medical expenses and oversees 400+ employees ▪ Completed UnitedHealthcare Executive Training Program 2016, Stanford University ▪ Manages marketing, network and operations teams for UnitedHealthcare ▪ Led Louisiana implementation team for Medicaid expansion and served as guest panelist for LDH Medicaid expansion tour and Media Day with UnitedHealthcare CEOs ▪ Louisiana "Core Team" leader for writing 2015 Louisiana Medicaid RFP, first place score out of five MCOs ▪ Managed build-out of new Baton Rouge facility, staffing/training of 300+ FTEs in 2015 ▪ Created and rolled out statewide provider quality value-based contracting model ▪ Responsible for go-live implementation of 2015 full-risk RFP and 2015 behavioral health carve-in ▪ Leads quarterly business reviews with LDH and Louisiana plan monthly town halls ▪ Built strong relationship with State's third-party payer, mitigating payment issues ▪ Redesigned provider service model to handle full end-to-end issues and complaints ▪ Executive sponsor for local employee engagement team ▪ Emergency plan coordinator for UnitedHealthcare with State Medicaid program

Company:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana**
Title:	Chief Financial Officer
Time Frame:	December 2011-April 2013
Role and Responsibilities:	▪ Successfully led team through first year startup, assisted with PCP network build ▪ Led build-out of newly created gain share financial model with LDH along with Mercer for "Bayou Health" program ▪ Active on go-live team resulting in first place State enrollment at 30% out of five plans

	▪ Led team creating onboarding and training documents ▪ Recipient of 2012 inaugural UnitedHealthcare Community & State President's Culture Award – Performance
Company:	**The Shaw Group – Baton Rouge, Louisiana**
Title:	Controller – Air Quality Systems (AQCS)/Natural Gas – Fossil Power Division/Senior Finance Manager
Time Frame:	April 2007 – December 2011
Role and Responsibilities:	▪ Financial lead on over $2.5 billion on six active projects, five domestic and one international ▪ Financial lead on Shaw's most financially successful project of $1.2 billion ▪ Created quarterly internal financial position papers for various complex project issues on revenue recognition or other significant financial issues
Company:	**McKesson Specialty Pharmacy Services – New Orleans, Louisiana**
Title:	Controller (McKesson Specialty/BioTech Pharmacy)
Time Frame:	November 2000 – April 2007
Role and Responsibilities:	▪ Successfully coordinated build-out of backup Specialty Pharmacy in Pittsburgh, PA ▪ Managed the financial and systems integration of VitaRx to McKesson, SAP ▪ Led the design and implementation of a new SAP/Business Warehouse inventory/profitability system enabling measurement of profit margin by product line ▪ Instilled and reorganized processes enabling revenue growth from $35 million to $250 million ▪ Redesigned medical billing processes that led to decreased days sales outstanding (DSO) from 120 to 24 days ▪ Created annual strategic plans and budgets for specialty pharmacy ($250 million)

Education/Licensure/Credentials

- UnitedHealthcare Executive Development Program
- Bachelor of Science – Accounting, University of New Orleans

Professional and Community Affiliations

- Current Advisory Board member with NextHealth National Executive Advisory Council
- Current Panel member of LDH Independent Review Panel
- Current Commissioner for St. Charles Parish Housing Authority Board
- Current Board member, Ormond Civic Association, Community Board

- Completed 2017 Baton Rouge Leadership Academy with Baton Rouge Business Report
- Recipient of 2012 inaugural UnitedHealthcare President's Culture Award – Performance
- Recipient of 2006 McKesson National FinanceRx ICARE Award

JULIE MORIAL, M.D., MPH, FACP – CHIEF MEDICAL OFFICER

Professional Experience

Company:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana**
Title:	Chief Medical Officer
Time Frame:	November 2017 – Present
Role and Responsibilities:	▪ Drives strategy and clinical value focused on quality, affordability and service while ensuring the voice of Louisiana's enrollees and providers. Focuses on the effective use of data to drive transformation. ▪ Works in concert with UnitedHealthcare and United Clinical Services (UCS) clinical operations and national affordability teams to ensure total medical PMPM performance targets and value-based risk sharing purchasing. Activities include Joint Operations Committee (JOC), data sharing, health care affordability initiatives and ensuring appropriate levels of inpatient/outpatient and ED utilization. ▪ Delivers clinical excellence. Assists with HEDIS® data collection process, CAHPS® improvement while driving UnitedHealthcare accreditation activities and quality rating initiatives for the local CMS plan. Assists in the implementation of value-based and risk-sharing purchasing models with the integration of these models across quality, evidence-based guidelines of care, utilization and strategic goals. ▪ Uses and maintains strong working knowledge of all government mandates and provisions for the local UnitedHealthcare health plan to ensure compliance and engagement of all stakeholders across the health care spectrum. ▪ Leads transformation of health system through clinical interface and communication with care providers and UnitedHealthcare network management. ▪ Creates strategies and relationships that drive Triple Aim for patient-centered medical home access, quality and affordability. ▪ Identifies new opportunities by participating in regional and local Medical Cost Operating Teams (MCOTs), national MCOT and JOCs. Oversees performance of United Behavioral Health including behavioral health and medical care integration and OptumHealth.

Company:	**Peoples Health – Baton Rouge, Louisiana**
Title:	Corporate Market Medical Director
Time Frame:	May 2010 – October 2017
Role and Responsibilities:	▪ Served as market medical director for the Capital Region of Peoples Health, a Medicare Advantage MCO that provides patient-centered medical care to seniors and the dually-eligible population. Charged with building the infrastructure and relationships that inform and educate physicians across the Baton Rouge community about quality initiatives — and virtual navigation — related to chronic disease management,

	long-term acute care, care coordination, risk adjustment and adherence. ▪ Built system that ensured correct physician documentation, preventive measures and patient assessment. ▪ Implemented initiatives that took Star scores from poor performance (2.5) to excellent (4.0), while markedly improving Risk Scores to No. 1 performer (compared to seven other established markets) in the Peoples Health. ▪ Significantly improved overall financial performance through progressive cost containment efforts with physicians, physician practices and partner health care institutions. ▪ Established a face-to-face presence with membership, and on a business level that did not exist previously. Significantly improved collaboration and alignment and created impetus to deliver timely and appropriate care.
Company:	**Blue Cross Blue Shield (BCBS) of Louisiana – Baton Rouge, Louisiana**
Title:	Associate Medical Director/Medical Director
Time Frame:	June 2006 – April 2010
Role and Responsibilities:	▪ Grew disease management (DM) program from a group limited to diabetes and heart failure for a small segment of the population (2006) to highly successful, highly populated, whole person DM model focusing on a suite of conditions — COPD, asthma, coronary heart disease and diabetes ▪ Drove improved communication and collaboration across team, significantly improving return on investment for this fledgling organization created in parallel to company vision ▪ Recognized by the Federal Employee Program Director's office (2011) as a “best practice among the other 39 BCBS state plans” ▪ Collaborated with DM manager and analytics team to develop program evaluation measures that monitored clinical outcomes and program success ▪ Designed and launched enrollee assessments that allowed health coaches to capture demographic data to address health disparities and health literacy ▪ Facilitated hiring of nationally recognized physician, Dr. Villagra, to perform third-party clinical review of diabetes program, adding significant credibility to the program, especially for the physician community ▪ Led review and assessment of nine local and national DM vendors, leading to decision to offer an internal program rather than outsourcing — a highly efficient and effective decision

Education/Licensure/Credentials

- Doctor of Medicine, University of Pennsylvania
- Master of Public Health, University of California Berkeley
- Bachelor of Arts – Biological Sciences, Yale University

Professional and Community Affiliations

- Board Member, Louisiana Policy Institute for Children, 2016 – Present
- Board Member, National Diversity Advisory, Louisiana State University, 2011 – Present
- Chair Healthcare Outreach Committee, Smoking Cessation Trust for Louisiana, 2011 – Present
- Member, American College of Physicians 1990 – Present
- Member, Board of Directors, Cancer Services of Greater Baton Rouge, Executive Committee, 2010 – 2016
- Member, American Society of General Internal Medicine 2003-2006
- Professional Awards:
  - Healthcare Hero Award, New Orleans CityBusiness, May 2018
  - *The American Health Strategy and Quality Institute*, The Right Track Quality in Care Award, October 2015
  - Ursuline Academy Ursuline Update, *Alumnae Spotlight*, August 2008
- Disease Management Awards:
  - *Annual Forum of Healthcare Effectiveness* 2005 Statewide Public Hospital and Ambulatory Centers Initiatives, Medical Center of Louisiana, New Orleans
    - First Place-*Cancer Strategy*: Cancer Screening Clinical Improvement
    - Third Place-*Cancer Strategy*: Cancer Screening Clinical Excellence
    - Second Place-*Congestive Heart Failure Strategy Group*: CHF Clinical Improvement
    - Third Place-*HIV Strategy Group*: Clinical Improvement

JOSE CALDERON-ABBO, M.D. – BEHAVIORAL HEALTH MEDICAL DIRECTOR

Professional Experience

Company:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana**
Title:	Behavioral Health Medical Director
Time Frame:	March 2018 – Present
Role and Responsibilities:	▪ Provides oversight to and direction of the behavioral health programs at UnitedHealthcare ▪ Interacts directly with psychiatrists, behavioral health providers and other clinical professionals who consult on various processes and programs ▪ Expands and manages development and implementation of evidence-based treatments and medical expense initiatives and will advise leadership on health care system improvement opportunities ▪ Maintains the clinical integrity of the program, including timely peer reviews, appeals and consultations with providers and other community-based clinicians, including general practitioners ▪ Works collaboratively with the medical director, clinical, network and quality staff

Company:	**University Medical Center of Louisiana – New Orleans, Louisiana**
Title:	Associate Medical Director, Co-occurring Disorders Program
Time Frame:	August 2015 – February 2018
Role and Responsibilities:	▪ Oversaw program development, clinical and quality integrity of the co-occurring disorders unit at University Medical Center ▪ Served as liaison to the Louisiana State University School of Medicine teaching and supervising medical students, residents in training and other health-allied professionals ▪ Participated in hospitals quality improvement, compliance and other administrative functions

Company:	**University Hospital Calhoun Campus – New Orleans, Louisiana**
Title:	Medical Director, Co-occurring Unit Interim
Time Frame:	2009 – July 2015
Role and Responsibilities:	▪ Oversaw program development, clinical and quality integrity of the co-occurring disorders unit at University Medical Center ▪ Served as liaison to the LSU School of Medicine teaching and supervising medical students, residents in training and other health-allied professionals

	▪ Participated in hospitals quality improvement, compliance and other administrative functions

Education/Licensure/Credentials

- Professional certification, Center for Mind-Body Medicine, Washington, D.C.
- Addiction Medicine fellow, American Society of Addiction Medicine
- Present Fellow, American Board of Psychiatry and Neurology
- Adult Psychiatry residency, Sinai Hospital, Wayne State University
- Internal Medicine Transitional Internship, Sinai Hospital, Wayne State University
- Medical Diploma, National Autonomous University of Mexico
- Active unrestricted medical license, Louisiana M.D.14816R
- Inactive unrestricted medical license, Michigan

Professional and Community Affiliations

- American Society of Addiction Medicine
- Member of American Academy of Actuaries, 2014 – Present
- Member of the Board, Anti-defamation League South Region, starting August 2019
- Climate Change Psychiatry Alliance
- Host: Whole Body Mental Health podcast on iTunes, and community radio show at 102.3 FM New Orleans and *whivfm.org*

TATYANA KOTLOVSKIY, INTERIM CHIEF FINANCIAL OFFICER

Professional Experience

Company:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana**
Title:	Interim Chief Financial Officer
Time Frame:	March 2019 – Present
Role and Responsibilities:	▪ Provides financial expertise to ensure that the health plan is operating effectively, with sound financial analysis, and with appropriate financial and operating controls ▪ Manages the day-to-day development of financial models and performance as it relates to the Medicaid managed care, goals and objectives ▪ Drives data analytics to cultivate and execute innovative solutions in concert with clinical and operational peers to achieve better care, better health, and lower costs for Louisiana's most vulnerable citizens ▪ Designs value-based Purchasing arrangements to reward and incent provider partners for improving access to care, focusing on population health concerns, and addressing disparities in health outcomes

Company:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana**
Title:	Director of Actuarial Services/Associate Director of Actuarial Services/Senior Actuarial Analyst
Time Frame:	February 2014 – March 2019 (Director of Actuarial Services) February 2013 – February 2014 (Associate Director of Actuarial Services) September 2011 – February 2013 (Senior Actuarial Analyst)
Role and Responsibilities:	▪ Partnered with Medicaid plans including Louisiana plan to drive health care quality and support strategic state priorities ▪ Ensured cohesion in the development and execution of the financial strategy in support of corporate objectives ▪ Reported directly to the chief actuary and provided executive and board level financial and strategic planning intelligence ▪ Supported Medicaid plans to provide a variety of functions, including pricing, financial forecasting and affordability initiatives ▪ Communicated with other teams providing guidance to accounting, regulatory and other functional groups ▪ Worked with state agencies to assess impact of program and policy changes and ensure soundness of capitation rates ▪ Provided oversight of complex actuarial issues related to analyzing and implementing changes that affect pricing and risk assumptions

Education/Credentials

- Bachelor of Science, Major: Mathematics, Minor: Economics, Specialization: Actuarial Science – The University of Minnesota

Professional Affiliations

- Society of Actuaries ASA designation, 2014 – Present
- Member of American Academy of Actuaries, 2014 – Present

SHANA BUSH, PHARM.D. – INTERIM PHARMACY DIRECTOR

Professional Experience

Company:	**UnitedHealthcare of Louisiana, Inc. – Metairie, Louisiana**
Title:	Interim Pharmacy Director
Time Frame:	April 2019 – Present
Roles and Responsibilities:	▪ Builds and maintains client relationships and serves as the primary point of contact for overall and day-to-day service locally ▪ Assists the health plan on all pharmacy-related activities including clinical program development and improving member satisfaction ▪ Understands and assures compliance with the state contract and the rules governing pharmacy (formulary/PDL, utilization management (UM), member communications) ▪ Creates and maintains state-specific policies ▪ Serves as the subject-matter-expert single point of contact for benefit and coding requirements and communicates to appropriate internal stakeholders for implementation ▪ Develops a strong working knowledge of health plan operations (compliance, finance, encounters, claims adjudications, networks, clinical, case management, HEDIS measures) ▪ Collaborates with internal partners to complete projects and to address ongoing pharmacy service needs of the plan ▪ Analyzes, reviews, forecasts, trends and presents information for operational and business planning ▪ Communicates pharmacy program changes with the assigned health plans key departments ▪ Supports short- and long-term operational/strategic business activities by maintaining operational information ▪ Attends State pharmacy meetings ▪ Submits timely and accurate pharmacy reports and deliverables ▪ Supports the assigned health plans' grievances department in the processing of grievances, appeals, fair hearings, as defined by the health plans' process to ensure a timely decision by the medical director ▪ Supports assigned health plans' health services, case management and behavioral health areas regarding targeted enrollees with specific pharmacy concerns

Company:	**UnitedHealthcare Network Pharmacy – Brentwood, Tennessee**
Title:	Regional Pharmacy Director
Time Frame:	January 2008 – April 2019
Roles and Responsibilities:	▪ Oversaw financial and utilization trend monitoring and management, State and regulatory interface

	■ Managed relationship and projects with the pharmacy benefit manager (PBM), key constituents with the State and within the health plan itself ■ Implemented clinical and UM programs and benefit designs ■ Supported DM initiatives and medical management via network physician interactions ■ Supported State audits and NCQA accreditation reviews ■ Interfaced with the P&T Committee ■ Provided drug information concerning medications and formulary updates with care management

Education/Licensure/Credentials

- Doctor of Pharmacy, Mercer University School of Pharmacy – Magna Cum Laude
- Bachelor of Science in Biology, University of Tennessee – Cum Laude

Community Affiliations

- Academy of Managed Care Pharmacy
- Tennessee Pharmacy Association
- Mississippi Pharmacy Association
- TennCare Pharmacy Advisory Committee

LARRY SMITH – CONTRACT COMPLIANCE OFFICER

Professional Experience

Company:	**UnitedHealthcare Community Plan – Baton Rouge, Louisiana**
Title:	Contract Compliance Officer
Time Frame:	April 2013 – Present
Role and Responsibilities:	▪ Implement and oversee the UnitedHealthcare Compliance Program ▪ Monitor fraud, waste and abuse compliance ▪ Monitor compliance to LDH contract requirements and federal and State regulations ▪ Act as principal point of contact between LDH business owners and UnitedHealthcare resources

Company:	**United Medical Healthcare – Hammond, LA**
Title:	Compliance Officer
Time Frame:	February 2008 – March 2013
Role and Responsibilities:	▪ Monitored compliance to corporate integrity agreement ▪ Provided education to staff on CMS and federal regulations for Medicare ▪ Defended denied claims up to the administrative law judge level

Company:	**Touro Infirmary – New Orleans, Louisiana**
Title:	Director, Touro At Home
Time Frame:	August 2001 – December 2007
Role and Responsibilities:	▪ Managed the operations of this home health unit of a major hospital in New Orleans, including staffing, business development, financial management and survey readiness

Education/Licensure/Credentials

- Bachelor of Arts – Liberal Arts, Loyola University
- Masters of Health Administration, College of St. Francis
- Certified in Healthcare Compliance

Professional and Community Affiliations

- Health Care Compliance Association since 2009

2.10.2.2.2 The following information about the Proposer's operating structure:

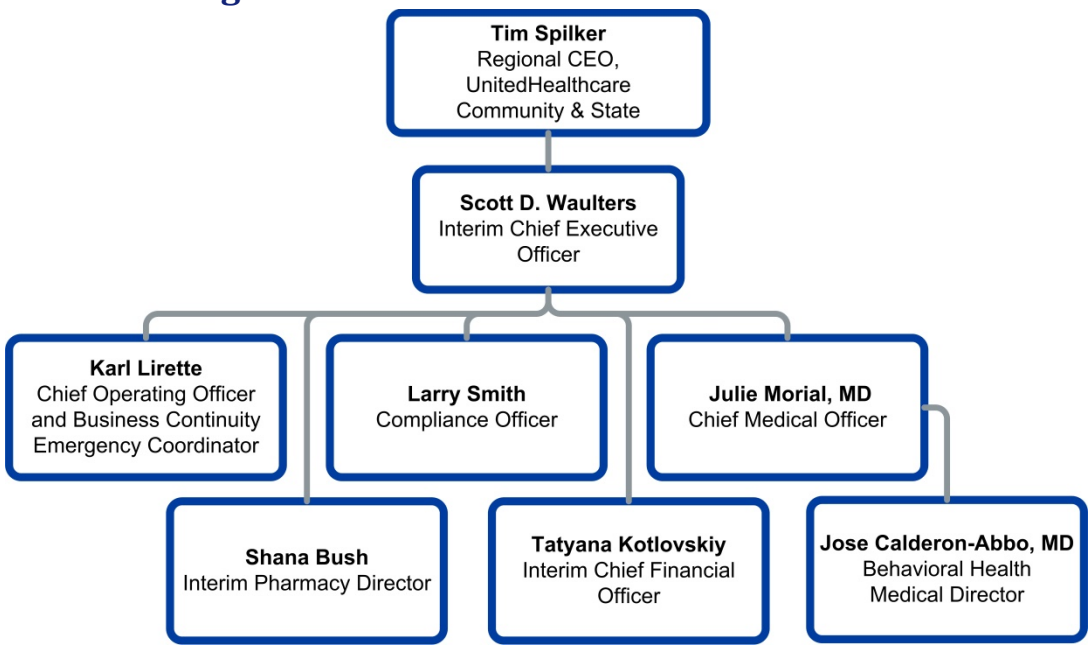
2.10.2.2.2.1 A description of the operating structure's leadership and how this leadership reports to and otherwise…

Our operating structure consists of a key personnel team who are accountable for the overall performance of the plan and all subcontractors and closely monitors enrollees' needs and health plan's issues. Our interim CEO, Scott Waulters, reports to Timothy Spilker, regional CEO, and holds quarterly business reviews to report on operational issues. He conducts key personnel and operations meetings on a daily, weekly and monthly basis and all-staff meetings quarterly. The key personnel team meeting reports on financial performance, medical management, membership, quality initiatives and health care affordability initiatives and creates the direction for the health plan at a strategic level. In addition, he is a member of UnitedHealthcare Community & State's national Medicaid leadership team comprising senior leaders and functional leads from across the organization. This national Medicaid leadership team serves as our governance structure; they review key deliverables for our state partners to share best practices and measure performance at least once a month. On a quarterly basis, Mr. Waulters leads executive reviews of Louisiana compliance metrics and performance results with national leadership. By leveraging many shared best practices, our local Louisiana team is able to bring innovations to LDH that have proven results in other states.

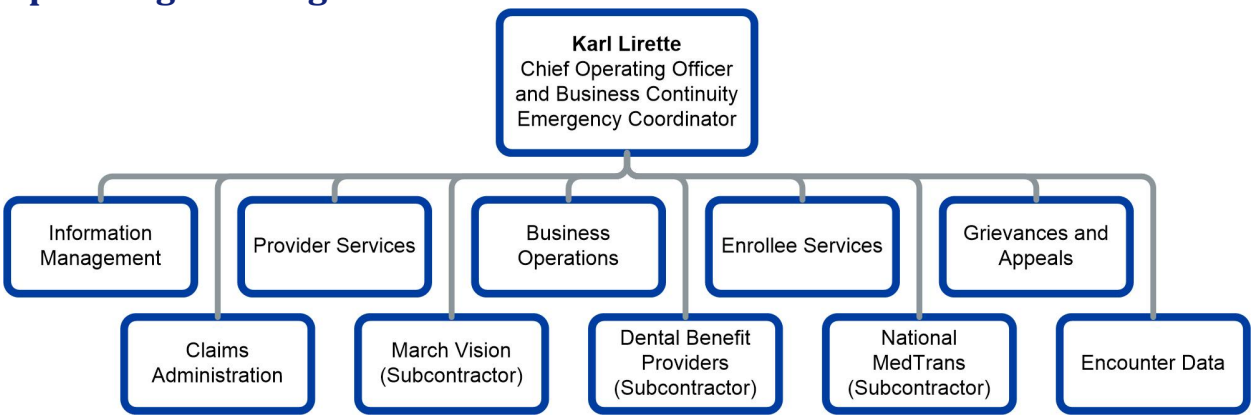
2.10.2.2.2.2 An organizational chart of the Proposer's operating structure, depicting the key teams or units…

These organizational charts show our leadership and functional teams supporting the Medicaid Managed Care program, including staff types, reporting relationships and key functional roles. Our organizational structure provides the framework for appropriate staffing levels and roles needed to administer the Medicaid Managed Care program successfully and coordinate the delivery of high quality, best-value health care services for enrollees and their families.

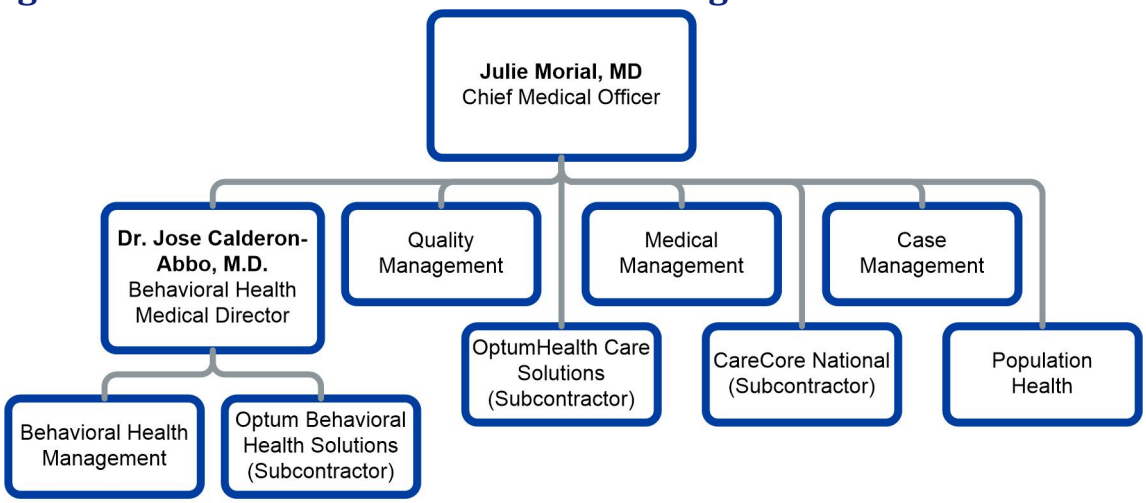
Key Personnel Organizational Chart



Operating Unit Organizational Chart

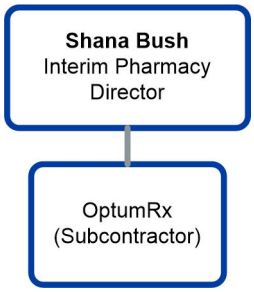


Integrated Clinical and Behavioral Health Organizational Chart

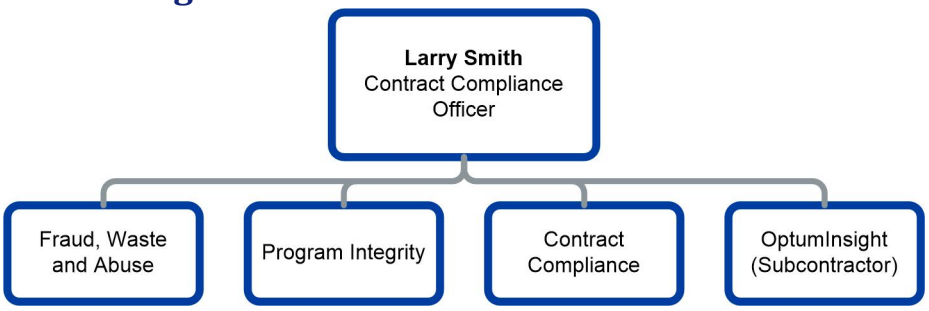


Financial Unit Organizational Chart

Pharmacy Unit Organizational Chart



Compliance Unit Organizational Chart



2.10.2.2.2.3 For each such team or unit, a brief description of the role the team or unit plays, the operating…

The team leads from each business unit, including senior leadership, operations, clinical, behavioral health, finance, pharmacy and compliance, participate in daily executive leadership meetings, which result in feedback that informs decisions for leadership. These meetings are in addition to individual business unit periodic meetings, as described herein.

Senior Leadership

Scott Waulters, our interim CEO, directs our key personnel leadership team in the strategic development, growth and operations of the Medicaid Managed Care Program. He participates in bi-weekly national CEO meetings to report the plan operations updates. The key personnel team is responsible for improving enrollee health; ensuring optimal operating performance of the health plan to meet the needs of its enrollees and providers; developing appropriate provider networks/contracts to deliver access to enrollees through a high-quality network; meeting contract and regulatory requirements; implementing contract changes;; and driving innovation. He holds quarterly business reviews with Louisiana key personnel and national executives to review all aspects of our program. Mr. Waulters provides key metrics and updates to our LDH performance review as required by the Model Contract Section 2.3.8.

Operations Unit

UnitedHealthcare's operations staff, led by COO, Karl Lirette, formulates business strategies and operational plans to ensure the optimal health plan performance. The unit is responsible for developing appropriate provider networks; ensuring ready access to care; reducing complexity and administrative burden; fulfilling contract and regulatory requirements; and achieving operating performance objectives. He works closely with Mr. Waulters to address strategic issues and chart the direction for the organization's future. He establishes operating metrics and daily, weekly and monthly scorecards to manage the ongoing operations that maintain contractual compliance. Mr. Lirette conducts weekly operational meetings, including all Medicaid plan leaders, and reports all operational concerns to the CEO. He conducts a monthly operational call with all functional leads under operations to report on key operational metrics. The report includes grievance and appeals, claims administration, enrollee services, provider services, call centers, information services and encounter data. In addition, he receives oversight report outs on Dental Benefit Providers, MARCH Vision, National MedTrans and our Hudson Veteran subcontractors. Mr. Lirette will provide key metrics and operational updates related to our LDH performance review as stated in our Model Contract Section 2.3.8.

Clinical Unit

Our clinical staff, led by Dr. Julie Morial, establishes and executes utilization, quality and case management strategies to meet and exceed LDH's goals and requirements. She advances evidence-based practices and population health. She provides medical oversight, expertise,

leadership and direction for the administration of the Medicaid Managed Care Program to deliver quality health care services as defined by LDH's contract and organizational standards. She oversees and directs health services and quality departments and serves as a liaison with LDH's medical leadership and other stakeholders. Dr. Calderon, Behavioral Health Medical Director, collaborates with Dr. Morial; together they ensure compliance with LDH Medicaid regulations, advance behavioral-medical integration, appropriate utilization of medical resources, and monitor quality of care and quality services. Our clinical personnel monitor and take action for continuous clinical quality improvement and patient safety. Dr. Morial is the head of the Quality Management Committee and is ultimately responsible for the implementation, coordination and integration of all quality management activities. She chairs the Provider Advisory and Healthcare Quality and Utilization Management Committee. Dr. Morial is responsible for providing clinical updates and key metrics related to our LDH performance review as stated in our Model Contract Section 2.3.8.

Behavioral Health Unit

Dr. Calderon collaborates with Dr. Morial and the pharmacy director to facilitate the integration of physical and behavioral health services for our Medicaid Managed Care enrollees. He oversees our quality improvement initiatives regarding the appropriate use of psychotropic medications and coordinates the day-to-day operations to achieve LDH's goals. Dr. Calderon leads and directs the development of appropriate risk management strategies in collaboration with LDH, other behavioral health staff, providers and stakeholders.

Finance Unit

Our finance team, led by Interim Chief Financial Officer Tatyana Kotlovskiy, oversees our financial operations, including standardization of items to measure and related tools and processes for encounter data, analysis and reporting. Ms. Kotlovskiy is responsible for collaborating with Mr. Waulters and our corporate financial team to establish a disciplined approach to financial performance management. She conducts medical economic analyses to support joint projects with clinical teams and cost management initiatives, including aligning financial incentives with providers. Ms. Kotlovskiy maintains the pro forma for the health plan and manages operational investment capital. She performs monthly trend analytics to evaluate unit and volume cost trends. She is also responsible for setting incurred but not reported and monthly financial closes. Managing state enrollee capitation and reconciliation and validating the timely completion and accuracy of all encounter submissions is a key part of her job. Ms. Kotlovskiy will participate in providing financial updates and key metrics related to our LDH performance review as stated in our Model Contract Section 2.3.8.

Pharmacy Unit

The pharmacy team, led by Interim Pharmacy Director Dr. Shana Bush, oversees all clinical and administrative pharmacy activities, including the proper provision of pharmaceutical services to enrollees. She also develops and maintains pharmacy practice standards, policies and procedures. She collaborates with Dr. Morial, Dr. Calderon and other UnitedHealthcare staff to ensure the integration of pharmacy data into UnitedHealthcare's management and quality improvement efforts in Louisiana. She provides pharmacy trend analysis and review to deliver multiple regulatory and ad hoc pharmacy reports. As the dedicated pharmacy resource for the Louisiana health plan, she is the direct contact person for Louisiana pharmacy providers and a resource for our Louisiana health plan and national clinical and pharmacy staff. Dr. Bush will participate in providing key metrics and pharmacy updates related to our LDH performance review as stated in our Model Contract Section 2.3.8.

Compliance Unit

Our Contract Compliance Officer Larry Smith collaborates with business leaders to promote the UnitedHealthcare Compliance Program, ensuring operational accountability and compliance with the contract. He serves as the point of contact for LDH and other regulatory agencies regarding compliance issues and regulatory audits. Mr. Smith reports to the Board of Directors and, with Mr. Waulters, co-chairs the Compliance Oversight Committee meetings. One of his main goals is to address ways to minimize wasteful spending, abuse and fraud. Mr. Smith oversees: fraud, waste and abuse program; compliance and ethics reporting; all regulatory audits; the risk assessment process; and verifies that compliance risks are proactively identified and addressed through prevention, detection, correction and monitoring strategies. He coordinates implementation of compliance training and education programs; development and implementation of appropriate corrective action; and with legal counsel, compliance investigations. In addition, he maintains compliance-related policies and procedures; verifies timely communication and education of the compliance program; works with operational leaders to validate understanding and communication regulatory contractual requirements; confirms appropriate delegated entity oversight; and verifies established processes and procedures meet regulatory and contract requirements, including a dedicated special investigations team, as stated in our Model Contract Section 2.3.8.

2.10.2.2.2.4 For each such team or unit, the number of full-time equivalents (FTEs) on the team or unit, a brief…

We outline, for each business unit, the number of FTEs in the unit, the typical qualifications or competencies of staff in the unit and the role of the unit lead. We have aligned our current staffing level to an estimated level of 472,283 members based upon current market share in combination with a signaled reduction in contract awards from five to four. We plan for staffing based upon enrollment increases or decreases the following ways:

- ***Workforce Planning:*** We use a standardized Workforce Management Projection Model that can accommodate membership changes and can project the number of FTE personnel required by functional area to support membership growth. For example, we have metrics and planning models for enrollee and provider call center, claims, appeals and disputes to calculate workforce projections. These models allow us to plan for the hiring, training and location of each required FTE, verifying we have the resources we need, when and where we need them.
- ***National Resources:*** We can deploy our national team to assist locally while we hire and train local staff. These national resources enable our local executives and staff to focus on the day-to-day activities to provide services and support to Medicaid Managed Care members. We have dedicated national leadership resources that we make available to support plan leaders at the local level in key roles such as medical director, pharmacy, behavioral health, health services director and operations director.

Senior Leadership Unit

- ***FTEs:*** There are seven FTEs in the senior leadership unit, inclusive of our CEO, chief operating officer, chief medical officer, behavioral health medical director, chief financial officer, pharmacy director and contract compliance officer.
- ***Description of Major Qualifications and Competencies:*** We list the qualifications of our senior leadership team later as unit leads under each major functional area.
- ***Description of Team Lead:*** Mr. Waulters provides overall direction, including strategic development, growth and operations of UnitedHealthcare to provide innovative care to our enrollees. He provides executive oversight and leadership to meet the needs of our enrollees and achieve contractual compliance.

Operations Unit

- ***FTEs:*** There are 459.6 FTEs in the operations unit (approx. 354 FTEs based on 375,000 enrollees).
- ***Description of Major Qualifications and Competencies:*** Staff in the operations unit have multiple years of experience in managed care plans and with providers relevant to their respective roles — grievances and appeals, claims administration, enrollee services, information management, encounter data and provider services.
- ***Description of Team Lead:*** Mr. Lirette is our operations unit lead and serves as the primary point-of-contact for all UnitedHealthcare operational issues. He is responsible for managing and administering multiple functions and general business operations. He manages daily staffing operations across multiple levels and departments in UnitedHealthcare to meet performance requirements. He is responsible for formulating sound business strategies and operational plans and is accountable for operational results.

Clinical Unit

- ***FTEs:*** There are 245.2 FTEs in the clinical unit (approx. 189 FTEs based on 375,000 enrollees).
- ***Description of Major Qualifications and Competencies:*** The key qualifications for this unit of personnel include clinical staff comprising RNs, LPNs and some non-clinical personnel. This staff has multiple years of experience in managed care plans and with providers in their respective roles: case management, quality management, SDOH and clinical transformation.
- ***Description of Team Lead:*** Dr. Morial is our clinical unit lead and is actively involved in all major clinical and quality management components of UnitedHealthcare's operations, including the integration of physical, behavioral and social health. She oversees clinical operations initiatives that focus on clinical excellence and performance improvement.

Behavioral Health Unit

- ***FTEs:*** There are 77.2 FTEs in the behavioral health unit (approx. 59 FTEs based on 375,000 enrollees).
- ***Description of Major Qualifications and Competencies:*** Our behavioral health team includes licensed behavioral health clinicians with experience serving the Medicaid population and assisting individuals with complex behavioral and emotional needs.
- ***Description of Team Lead:*** Dr. Calderon is the behavioral health medical lead and maintains the clinical integrity of behavioral health programs, including peer reviews, appeals and consultations with providers and other community-based clinicians, including general practitioners. He works collaboratively with clinical, network and quality staff and interacts directly with psychiatrists, prescribers, state officials and other clinical professionals who consult on various processes and programs.

Finance Unit

- ***FTEs:*** There are 4.5 FTEs in the finance unit (approx. 4.5 FTEs based on 375,000 enrollees).
- ***Description of Major Qualifications and Competencies:*** Staff in the financial unit have multiple years of experience in managed care plans and in the provider community relevant to budgeting and forecasting; accounting system management; financial reporting; and audit managment.

- ***Description of Team Lead:*** Tatyana Kotlovskiy is our finance unit lead and oversees all aspects for strategic financial planning, analysis and operations for UnitedHealthcare. She oversees the budget, accounting systems, financial reporting and audit activities.

Pharmacy Unit

- ***FTEs:*** There are 6.6 FTEs in the pharmacy unit (approx. 5 FTEs based on 375,000 enrollees).
- ***Description of Major Qualifications and Competencies:*** Staff in the pharmacy unit has experience in managed care pharmacy either in a health plan or PBM including experience with Medicaid; an understanding of state contract language; experience building and maintaining client relationships and networking; experience developing and implementing clinical programs to reduce trend or improve member experience; and the ability to develop tactical plans, drive performance and achieve targets.
- ***Description of Team Lead:*** Dr. Shana Bush is our pharmacy unit lead. She manages the contract requirements; creates and maintains state-specific policies; and conducts pharmacy benefit analysis to support the provision of clinically appropriate, high quality, cost-effective pharmaceutical care for our enrollees. She analyzes, reviews, forecasts, trends and presents information to leadership for operational and business planning.

Compliance Unit

- ***FTEs:*** There are 15.1 FTEs in the compliance unit (approx. 13 FTEs based on 375,000 enrollees).
- ***Description of Major Qualifications and Competencies:*** Staff in this unit have multiple years of experience in managed care plans and the provider community relevant to their respective roles — program integrity; compliance; and fraud, waste and abuse.
- ***Description of Team Lead:*** Mr. Smith is the compliance unit lead who oversees the UnitedHealthcare Compliance Program and serves as the primary point-of-contact for all UnitedHealthcare contract compliance issues. He provides oversight to the program integrity functions, including the special investigations unit (SIU) and payment integrity. He executes policies developed to prevent, detect and report fraud, waste and abuse to meet contract compliance. He manages the logistics of contract deliverables and ad hoc requests for information from LDH.

2.10.2.3 Material Subcontractors

Please refer to Attachment 2.10.2.3 Appendix F – Material Subcontractors including the executed agreement, for each of our material subcontractors that provide behavioral health, pharmacy, vision, transportation and dental services. These subcontractors are Dental Benefit Providers, MARCH Vision Group, National MedTrans, OptumRx and United Behavioral Health, respectively.

2.10.2.4 Proposer Reference Contact Information

2.10.2.4.1 The Proposer shall provide contact information (name, title, phone number and email) for the lead…

2.10.2.4.2 For each reference, the Proposer should provide a brief description of the types and numbers of …

The tables herein outline our contact information for the lead state-program manager, a brief description of the types and numbers of individuals served, our key responsibilities and any compliance actions taken by the State.

Louisiana

Medicaid Program: Acute Care (Medicaid) **Licensed Entity: UnitedHealthcare of Louisiana, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Jen Steele Director of Medicaid 337-233-9627 *jen.steele@la.gov*
Types of Individuals Served	**Number of Individuals Served**
ABD	27,996
Behavioral Health Only	26,310
Expansion	142,938
TANF**	245,719
Total	**442,963**

Key Responsibilities

This Medicaid program provides health care coverage throughout the state for traditional Medicaid beneficiaries, to include the chronically ill, ABD, Families and Children, LaHIPP, Expansion, Coordinated System of Care (CSOC) and TANF. Benefits include core benefits and services, such as audiology services, in-patient and out-patient hospital services, ambulatory surgical and ancillary medical services, laboratory and x-ray services, surgical dental services, diagnostic services, organ transplant, behavioral health medication management, EPSDT, emergency medical services, communicable disease services, durable medical equipment, prosthetics, orthotics and certain supplies, emergency dental, emergency and non-emergency medical transportation, home health and personal care services, hospice services, pregnancy-related services, nurse midwife services, pediatric and family nurse practitioner services, chiropractic services, rural health services, immunizations, end stage renal disease, optometrist services, pharmacy, podiatry, and rehabilitative and therapy services. The contract is integrated with behavioral health and transportation. The contract covers children and youth with medical complexity. As of Feb. 1, 2015, the health plan became a full risk plan.

- State-funded program for traditional Medicaid populations, such as ABD, Families and Children and TANF beneficiaries
- Available in all parishes
- Originated in 2015; current contract duration: Feb. 1, 2015 – Jan. 31, 2018 plus a 23-month extension from Feb. 1, 2018 – Dec. 31, 2019. Coordinated Care Network-Shared Savings contract (originated 2011) phased into this statewide Medicaid contract on Feb. 1, 2015.

***All Families and Children enrollees are included in TANF count.*

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Louisiana Inc.	Corrective Action Request	Apr 2016	Claims
UHC Community Plan of Louisiana Inc.	Corrective Action Request	May 2017	Prior Authorization; FWA-FWAE Operations; Network Operations; Outreach Activities; Member Materials; Care Management; Provider Experience; Network Management; Quality; High Level Oversight – Governance; Appeal & Grievance; Written Standards, Policies and Procedures
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	April 2016	Pharmacy Reimbursement
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Apr 2016	CEO Attendance at PI Meetings
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Jan 2017	Standing and Ad Hoc Reports
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Jan 2017	Standing and Ad Hoc Reports
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Feb 2017	Daily File Update
UHC Community Plan of Louisiana, Inc.	Fine	April 2017	Pharmacy Fees
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	May 2017	EQRO Audit; Multiple Functional Areas
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Aug 2017	TPL File Load (an email from Stacy Guidry)
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Nov 2017	Provider Directory
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Dec 2017	IT Connectivity
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Apr 2018	Prior Authorization
UHC Community Plan of Louisiana, Inc.	Fine	June 2018	Behavioral Health Access
UHC Community Plan of Louisiana, Inc.	Fine	June 2018	Provider Directory
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	July 2018	NEMT Claims Payment, Credentialing
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Aug 2018	Pharmacy Copays
UHC Community Plan of Louisiana, Inc.	Fine	Aug 2018	Subcontractor Oversight
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Oct 2018	Provider Directory
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Oct 2018	Recoupment of Retro-disenrollment
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Oct 2018	Standing and Ad Hoc Reports
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Oct 2018	Standing and Ad Hoc Repots
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Nov 2018	Claims Processing Turnaround Time
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Nov 2018	RFI Timeliness
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Nov 2018	Standing and Ad Hoc Reports
UHC Community Plan of Louisiana, Inc.	Fine	Dec 2018	Performance Measures
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Dec 2018	Inappropriate Claim Denial
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Jan 2019	NEMT Call Center
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Jan 2019	RFI Timeliness
UHC Community Plan of Louisiana, Inc.	Fine	Jan 2019	Provider Directory
UHC Community Plan of Louisiana, Inc.	Fine	Feb 2019	Claims Processing Turnaround Time
UHC Community Plan of Louisiana, Inc.	Corrective Action Request	Apr 2019	Mental Health Rehab Staff NPI Numbers

Arizona

Medicaid Program: AHCCCS Complete Care Integrated Services Licensed Entity: Arizona Physician's IPA, Inc. (APIPA)	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Jami Snyder Director of Medicaid 602-417-4111 *jami.snyder*@azahcccs.*gov*

Types of Individuals Served	Number of Individuals Served
ABD	40,922
CHIP	7,824
Expansion	89,246
TANF	233,302
Total	**371,294**

Key Responsibilities

This Medicaid program provides statewide coverage to low-income pregnant women, families, children; ABD SSI individuals; and uninsured children in families at other income levels through the KidsCare State Children's Health Insurance Program (SCHIP) program. Services cover Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical check-ups, occupational therapy, audiology, speech therapy, hospital clinic services — as appropriate, regular examinations, immunizations, child delivery and newborn care, substance use and behavioral health services, laboratory and X-ray services, including tests to prevent birth defects, expanded vision care, podiatry, asthmatic care, dental services and other specialty care benefits. The contract is integrated with transportation. The contract covers children and youth with some medical complexity. Most medically complex cases are covered with the inclusion of the Children's Rehabilitation Services.

- State-funded program for ABD, CHIP, Expansion and TANF beneficiaries
- Available in Gila, Maricopa, Pima and Pinal counties, excluding ZIP codes: 85542, 85192 and 85550
- Originated in 1982; current contract duration: Oct. 1, 2018 – Sept. 30, 2021 with two 2-year options to extend, not to exceed a total contracting period of 7 years
- Please note: On Oct. 1, 2018, the Children's Rehabilitative Services (CRS) contract integrated with the Acute Care/Uninsured Children contract, to create the newly formed AHCCCS Complete Care Integrated Services contract.

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Arizona	Corrective Action Request	May 2016	Care Management; Exclusions/Sanctions; Claims; Network Management; Provider Experience; Utilization Management
UHC Community Plan of Arizona	Fine	May 2016	Encounters
UHC Community Plan of Arizona	Fine	May 2016	Encounters
UHC Community Plan of Arizona	Fine	May 2016	Encounters
UHC Community Plan of Arizona	Fine	May 2016	Encounters
UHC Community Plan of Arizona	Corrective Action Request	Oct 2016	Claims; Utilization Management; Care Management; Encounters
UHC Community Plan of Arizona	Fine	Nov 2016	Encounters
UHC Community Plan of Arizona	Corrective Action Request	Jan 2017	Appeal & Grievance; Care Management
UHC Community Plan of Arizona	Corrective Action Request	May 2017	Network Operations; Provider Experience; Utilization Management; Quality; Credentialing/Recredentialing; Care Management

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Arizona	Corrective Action Request	May 2017	Claims; Provider Experience; Utilization Management; Credentialing/Recredentialing
UHC Community Plan of Arizona	Corrective Action Request	Jun 2017	Network Operations; Provider Experience; Utilization Management; Prior Authorization
UHC Community Plan of Arizona	Fine	Jul 2017	Encounters
UHC Community Plan of Arizona	Corrective Action Request	Sep 2017	Care Management; Provider Experience
UHC Community Plan of Arizona	Corrective Action Request	Sep 2017	Provider Experience; Call Center Member; Care Management
UHC Community Plan of Arizona	Fine	Nov 2017	Encounters
UHC Community Plan of Arizona	Corrective Action Request	Dec 2017	Claims
UHC Community Plan of Arizona	Fine	Mar 2018	Encounters
UHC Community Plan of Arizona	Fine	Mar 2018	Encounters
UHC Community Plan of Arizona	Corrective Action Request	Apr 2018	Quality
UHC Community Plan of Arizona	Fine	May 2018	Encounters
UHC Community Plan of Arizona	Fine	May 2018	Encounters
UHC Community Plan of Arizona	Corrective Action Request	May 2018	Quality
UHC Community Plan of Arizona	Corrective Action Request	May 2018	Quality
UHC Community Plan of Arizona	Corrective Action Request	May 2018	Quality
UHC Community Plan of Arizona	Corrective Action Request	Aug 2018	Quality
UHC Community Plan of Arizona	Fine	Oct 2018	Encounters
UHC Community Plan of Arizona	Corrective Action Request	Oct 2018	Provider Experience; Prior Authorization
UHC Community Plan of Arizona	Fine	Oct 2018	Encounters
UHC Community Plan of Arizona	Fine	Nov 2018	Encounters
UHC Community Plan of Arizona	Fine	Dec 2018	Quality
UHC Community Plan of Arizona	Fine	Dec 2018	Quality

California

Medicaid Program: Medi-Cal Managed Care – Geographic Expansion **Licensed Entity: UnitedHealthcare Community Plan of California, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Stephanie Issertell Contract Manager, Department of Health Care 916-633-0193 *stephanie.issertel@dhcs.ca.gov*
Types of Individuals Served	**Number of Individuals Served**
ABD	437
CHIP	2,263
Expansion	4,078
TANF	1,166
Total	**7,944**

Key Responsibilities

This Medicaid program provides health care coverage for eligible ABD, CHIP, expansion and TANF beneficiaries in California. Medically necessary services cover mild to moderate behavioral health, physical and vision care, and long-term services and supports in San Diego county. Other benefits include free health risk assessments (HRA), EPSDT screening and a Healthy First Steps Pregnancy Program — with member incentives for maintaining appropriate pre- and post-natal care and well-child immunization visits. The contract is integrated with behavioral health, transportation and LTSS (i.e., covers all LTSS in San Diego). The contract covers children under the age of 21 with specific high complexity diagnoses who enroll in the state's California Children's Services (CCS) program.

- State-funded program for ABD, CHIP, expansion and TANF beneficiaries

- Available in all counties, with LTSS in a select few
- Originated in 2017; current contract duration: Oct. 1, 2017 – Sept. 30, 2022

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of California	Corrective Action Request	Jul 2018	Network Management
UHC Community Plan of California	Corrective Action Request	Jul 2018	Prior Authorization; Appeal & Grievance
UHC Community Plan of California	Corrective Action Request	Dec 2018	Network Operations
UHC Community Plan of California	Corrective Action Request	Jan 2019	Claims; Finance; Appeal & Grievance

Colorado

Medicaid Program: Accountable Care Collaborative Program (ACC) and RMHP Prime and Child Health Plus (Prime/CHP)
Licensed Entity: Rocky Mountain Health Maintenance Organization, Inc.

Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Laurel Karabatsos Deputy Medicaid Director – Interim 303-866-3058 *laurel.karabatsos@hcpf.state.co.us*
Types of Individuals Served	**Number of Individuals Served**
ABD	6,454
CHIP	10,527
Expansion	19,570
TANF	9,637
ASO/BH	144,222
Total	**35,661 (RMHP – Prime)** **10,527 (CHIP+)** **144,222 (RAE/Health First Colorado)**

Key Responsibilities

The Rocky Mountain Health Plan (RMHP) – Prime and Child Health Plan Plus (CHP) contracts provide public low-cost health insurance for children and pregnant women. They offer benefits to those whose income is too high to qualify for Health First Colorado (Medicaid) program and do not earn enough to pay for private health insurance. Covered services include medical behavioral, vision and oral health care services, such as asthmatic care, audiology, hospital clinic services — as appropriate, immunizations, laboratory services, maternity care, medical checkups, newborn care, occupational therapy, pharmacy, regular examinations, speech therapy, X-ray services, vision care and other specialty care benefits.

The Rocky Mountain Health Plan (RMHP) – Health First Colorado (Medicaid) is part of a regional organization, and it helps enrollees residing in Western Colorado and Larimer county. It uses a network of Regional Accountable Entities (RAEs) to coordinate acute, primary and specialty care; pharmacy; and select behavioral health services to most Medicaid beneficiaries in the state. Medically necessary services are provided, to include clinic services, laboratory services, PCP and specialist services, radiology and prescription drugs. Populations covered include ABD, foster care, LTSS and TANF. All population types are enrolled mandatorily, including those receiving LTSS services. However, LTSS/HCBS services are carved out of the agreements and administered as a coordinate fee-for-service (FFS) wrap benefit under the Medicaid plans.

- State-funded programs for ABD, CHP, foster care, LTSS and TANF beneficiaries
- (Prime/CHP do not include foster care)
- Available in Western Colorado
- Recently, RMHP received an RFP award notice from the Colorado Department of Human Services, Office of Behavioral Health to operate a Crisis Services ASO in the 22 county Region 1 service area, effective July 1, 2019

▪ Originated in 1974; current contract duration: May 11, 2011 – June 2019. Acquired by UnitedHealthcare – March 2017. Contracts listed, including newly formed RAE contract – effective July 1, 2018 – June 30, 2019
Compliance Actions
Nothing Reported

Florida

Medicaid Program: Statewide Medicaid Managed Care (SMMC) **Licensed Entity: UnitedHealthcare of Florida, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Kimberly Turner Contract Manager and Program Analyst 850-412-4325 *sara.turner@ahca.myflorida.com*
Types of Individuals Served	**Number of Individuals Served**
ABD	37,405
LTSS	8,421
SSI	26,274
TANF	206,431
Total	**278,531**
Key Responsibilities	
This program provides health care coverage to LTSS, SSI and TANF and chronically ill Medicaid beneficiaries. Additional benefits include other expanded services (e.g., adult and children's dental, over-the-counter medications, personal hygiene items and circumcision). The elderly, chronically ill and disabled people living in community and nursing home environments are enrollees of this program — enabling those in the community to remain in the community, while avoiding nursing home placement. A wide range of community supports are provided, such as home health aide services, respite care, adult day care, personal assistance/care, housekeeping and chore services ▪ Medicaid; state-funded program for ABD, LTSS, SSI and TANF beneficiaries ▪ Available in 67 counties ▪ Originated in 2013; current contract duration: Jan. 1, 2019 – Dec. 31, 2023. Five programs (i.e., M* Plus: origination 1974; Florida Diversion: origination 1999; Frail Elderly: origination 1996; Medica: organization 2009 and CareFlorida: origination 2011) phased into the statewide SMMC from August to December 2013.	

Medicaid Program: Florida Healthy Kids **Licensed Entity: UnitedHealthcare of Florida, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Lindsay Lichti Deputy Director, Plan Management 850-224-5437 850-701-6105 (direct) *lichtil@healthykids.org*
Types of Individuals Served	**Number of Individuals Served**
CHIP	8,751
Total	**8,751**
Key Responsibilities	
This CHIP program provides health coverage to children in Florida, to include Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia. Its enrollees have access to a full range of CHIP health plan services. For example, services include primary, specialty, acute and behavioral care; disease and care management; maternity services and newborn care; outpatient and emergency health care access; home health and hospice; organ transplant services and comprehensive pharmacy benefits with low copays. Other programs include Healthy First Steps™ and Dr. Health E. Hound.	

- CHIP; state-funded program for CHIP beneficiaries
- Available in seven counties
- Originated in 1996; current contract duration: Oct. 1, 2015 – Sept. 14, 2017 with "evergreen" annual auto-renewals through Sept. 30, 2018, plus an amendment dated Oct. 1, 2018 – Dec. 31, 2019. This contract is in procurement status.

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Florida	Fine	Mar 2016	Auditing and Monitoring
UHC Community Plan of Florida	Fine	Apr 2016	Quality
UHC Community Plan of Florida	Fine	Apr 2016	Network Management
UHC Community Plan of Florida	Fine	Apr 2016	Care Management
UHC Community Plan of Florida	Fine	Apr 2016	Care Management
UHC Community Plan of Florida	Fine	May 2016	Prior Authorization
UHC Community Plan of Florida	Fine	May 2016	Vendor
UHC Community Plan of Florida	Fine	Jun 2016	Appeal & Grievance
UHC Community Plan of Florida	Fine	Jun 2016	Member Materials
UHC Community Plan of Florida	Corrective Action Request	Aug 2016	Quality
UHC Community Plan of Florida	Fine	Aug 2016	Prior Authorization
UHC Community Plan of Florida	Fine	Aug 2016	Appeal & Grievance
UHC Community Plan of Florida	Fine	Aug 2016	Quality
UHC Community Plan of Florida	Fine	Sep 2016	Member Materials
UHC Community Plan of Florida	Fine	Oct 2016	Vendor
UHC Community Plan of Florida	Fine	Oct 2016	Appeal & Grievance
UHC Community Plan of Florida	Fine	Oct 2016	Care Management
UHC Community Plan of Florida	Fine	Oct 2016	Outreach Activities
UHC Community Plan of Florida	Fine	Nov 2016	Utilization Management
UHC Community Plan of Florida	Fine	Nov 2016	Quality
UHC Community Plan of Florida	Fine	Nov 2016	Appeal & Grievance
UHC Community Plan of Florida	Fine	Nov 2016	Member Materials
UHC Community Plan of Florida	Fine	Nov 2016	Care Management
UHC Community Plan of Florida	Fine	Dec 2016	Appeal & Grievance
UHC Community Plan of Florida	Fine	Jan 2017	Vendor
UHC Community Plan of Florida	Fine	Jan 2017	Care Management
UHC Community Plan of Florida	Fine	Mar 2017	Prior Authorization
UHC Community Plan of Florida	Fine	May 2017	Vendor
UHC Community Plan of Florida	Fine	May 2017	Vendor
UHC Community Plan of Florida	Fine	Jul 2017	Prior Authorization
UHC Community Plan of Florida	Fine	Jul 2017	Claims
UHC Community Plan of Florida	Fine	Jul 2017	Vendor
UHC Community Plan of Florida	Fine	Jul 2017	Prior Authorization
UHC Community Plan of Florida	Fine	Oct 2017	Encounters
UHC Community Plan of Florida	Fine	Oct 2017	Claims
UHC Community Plan of Florida	Fine	Oct 2017	Network Operations
UHC Community Plan of Florida	Fine	Oct 2017	Vendor
UHC Community Plan of Florida	Fine	Nov 2017	Outreach Activities
UHC Community Plan of Florida	Fine	Nov 2017	Outreach Activities
UHC Community Plan of Florida	Fine	Nov 2017	Appeal & Grievance
UHC Community Plan of Florida	Fine	Nov 2017	Admin/Operations
UHC Community Plan of Florida	Fine	Dec 2017	Finance
UHC Community Plan of Florida	Fine	Dec 2017	Network Operations
UHC Community Plan of Florida	Fine	Dec 2017	Appeal & Grievance
UHC Community Plan of Florida	Fine	Dec 2017	Appeal & Grievance
UHC Community Plan of Florida	Fine	Dec 2017	Quality
UHC Community Plan of Florida	Fine	Dec 2017	Quality
UHC Community Plan of Florida	Fine	Jan 2018	Network Operations
UHC Community Plan of Florida	Fine	Jan 2018	Network Operations
UHC Community Plan of Florida	Fine	Jan 2018	Claims

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Florida	Fine	Jan 2018	Appeal & Grievance
UHC Community Plan of Florida	Fine	Jan 2018	Network Management
UHC Community Plan of Florida	Fine	Jan 2018	Appeal & Grievance
UHC Community Plan of Florida	Fine	Feb 2018	Care Management
UHC Community Plan of Florida	Fine	Feb 2018	Care Management
UHC Community Plan of Florida	Fine	Feb 2018	Network Management
UHC Community Plan of Florida	Fine	Feb 2018	Care Management
UHC Community Plan of Florida	Fine	Feb 2018	Claims
UHC Community Plan of Florida	Fine	Feb 2018	Care Management
UHC Community Plan of Florida	Corrective Action Request	Feb 2018	Quality
UHC Community Plan of Florida	Fine	Mar 2018	Credentialing/Recredentialing
UHC Community Plan of Florida	Fine	Mar 2018	Care Management
UHC Community Plan of Florida	Fine	Mar 2018	Vendor
UHC Community Plan of Florida	Fine	Mar 2018	Utilization Management
UHC Community Plan of Florida	Fine	Mar 2018	Network Operations
UHC Community Plan of Florida	Fine	Mar 2018	Appeal & Grievance
UHC Community Plan of Florida	Fine	Apr 2018	Quality
UHC Community Plan of Florida	Fine	Apr 2018	Provider Experience
UHC Community Plan of Florida	Fine	Apr 2018	Network Management
UHC Community Plan of Florida	Fine	Apr 2018	Care Management
UHC Community Plan of Florida	Fine	Apr 2018	Prior Authorization
UHC Community Plan of Florida	Fine	Apr 2018	Network Management
UHC Community Plan of Florida	Fine	Jun 2018	Care Management
UHC Community Plan of Florida	Fine	Jun 2018	Network Management
UHC Community Plan of Florida	Fine	Jun 2018	Network Management
UHC Community Plan of Florida	Fine	Jun 2018	Vendor
UHC Community Plan of Florida	Corrective Action Request	Sep 2018	Network Management; Provider Experience; FWA-FWAE Operations
UHC Community Plan of Florida	Fine	Sep 2018	Vendor
UHC Community Plan of Florida	Fine	Sep 2018	Billing and Enrollment
UHC Community Plan of Florida	Fine	Sep 2018	Claims
UHC Community Plan of Florida	Fine	Sep 2018	Claims
UHC Community Plan of Florida	Fine	Sep 2018	Appeal & Grievance
UHC Community Plan of Florida	Fine	Sep 2018	Claims
UHC Community Plan of Florida	Corrective Action Request	Sep 2018	Claims
UHC Community Plan of Florida	Fine	Nov 2018	Quality
UHC Community Plan of Florida	Fine	Nov 2018	Quality
UHC Community Plan of Florida	Fine	Nov 2018	Care Management
UHC Community Plan of Florida	Fine	Dec 2018	Care Management
UHC Community Plan of Florida	Fine	Feb 2019	Encounters
UHC Community Plan of Florida	Fine	Feb 2019	Appeal & Grievance
UHC Community Plan of Florida	Fine	Feb 2019	Vendor

Hawai'i

Medicaid Program: QUEST Integration **Licensed Entity: UnitedHealthcare Insurance Company**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Judy Mohr Peterson, PhD Med-QUEST Division Administrator 808-692-8050 *jmohrpeterson@medicaid.dhs.state.hi.us*

Medicaid Program: QUEST Integration Licensed Entity: UnitedHealthcare Insurance Company	
Types of Individuals Served	**Number of Individuals Served**
ABD including LTSS	20,365
CHIP	1,520
Expansion	15,889
TANF	10,665
Total	**48,439**

Key Responsibilities

This state-funded program (with Federal match) provides comprehensive medical, behavioral, LTSS, pharmacy coverage and other benefits throughout the state of Hawai'i. It combines the earlier separate programs: QUEST (non-ABD) and QExA (ABD including LTSS). Other benefits include medically necessary services, such as non-emergent medical transportation, personal care attendants, home delivered meals, home modifications, personal emergency response system and a 24-hour nurse line. The program covers all Medicaid eligible including those in long-term care (nursing home or alternative long term care setting), medically fragile children, and disabled individuals. Physical and behavioral health is provided using an integrated, member-centric approach. Behavioral health services for the serious mental illness (SMI) population are carved out to another program and DD/ID populations have certain services provided through the DDD program at the State of Hawai'i Dept. of Health.

- State-funded program for ABD, CHIP, expansion, other Medicaid categories and TANF beneficiaries
- Available on/in all islands/counties
- Originated in 2015; current contract duration: Jan. 1, 2015 – Dec. 31, 2017 with up to four 1-year extensions
- Two programs phased into QUEST Integration as of Jan. 1, 2015: QUEST (Medicaid) – 2012 and QUEST Expanded Access (QExA) – 2009

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Hawai'i	Corrective Action Request	Sep 2016	Appeal & Grievance; Network Operations; Member Materials
UHC Community Plan of Hawai'i	Corrective Action Request	Sep 2017	Credentialing/Recredentialing

Kansas

Medicaid Program: KanCare Managed Care 2.0 Licensed Entity: UnitedHealthcare of the Midwest, Inc.	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Position is vacant. The State is actively searching for a replacement.
Types of Individuals Served	**Number of Individuals Served**
ABD	15,910
CHIP	16,016
DD	2,319
LTSS	8,669
TANF	98,570
Total	**141,485**

Key Responsibilities

This Medicaid program provides health care coverage throughout the state for TANF, CHIP, ABD and LTC populations, to include multiple waiver populations (i.e., frail elderly, physically disabled and DD/ID).

Medicaid Program: KanCare Managed Care 2.0 Licensed Entity: UnitedHealthcare of the Midwest, Inc.
Services include medical, behavioral health, pharmacy, dental, vision and non-emergent transportation. Care managers (e.g., RNs, community outreach and behavioral health clinicians) deliver hands-on care management, including risk assessments and individualized plans of care with monitoring and oversight. Enrollment is mandatory enrollment for most populations. Enrollment is voluntary for Native Americans. The contract is integrated with behavioral health, transportation and LTSS. The contract covers children and youth with medical complexity, if they qualify financially or via the 1115 Waiver (LTSS), ▪ State-funded program for ABD, CHIP, LTC and TANF beneficiaries ▪ Available in all counties ▪ Originated in 2013; current contract duration: Jan. 1, 2019 – Dec. 31, 2021 with two 1-year extensions
Compliance Actions
Nothing Reported

Maryland

Medicaid Program: Medicaid, CHIP, Primary Adult Licensed Entity: UnitedHealthcare of the Mid-Atlantic, Inc.	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Dennis Schrader Chief Operating Officer and Medicaid Director Maryland Department of Health 410-767-4139 *dennis.schrader@maryland.gov*
Types of Individuals Served	**Number of Individuals Served**
Expansion	33,751
TANF including ABD, CHIP and SSI	112,965
Total	**146,716**

Key Responsibilities

This Medicaid program provides health care coverage throughout the state for the beneficiaries of Maryland's HealthChoice program. Services are provided for adults and children, and for children and youth with medical complexity; they include primary care and specialty physician care, prescription drugs, diagnostic services, inpatient services, home health, hospice, emergency services, OB/GYN care and eye exams for adults and children. Our adult value-added benefits include adult dental and vision care (e.g., exams, one pair of glasses every 2 years and one replacement pair, if needed within a 2-year period). Substance use treatment and transportation services are carved out of the HealthChoice program. These services are provided by the State's FFS program, and the health plan is contractually required to coordinate with the State's vendors.

- State-funded program for CHIP, expansion, SSI and TANF beneficiaries
- Available in all counties
- Originated in 1997; current contract duration: Jan. 1, 2019 – Dec. 31, 2019

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Maryland	Corrective Action Request	Jun 2016	Credentialing/Recredentialing; Prior Authorization; Quality; Utilization Management
UHC Community Plan of Maryland	Corrective Action Request	Nov 2016	Quality
UHC Community Plan of Maryland	Corrective Action Request	May 2017	Credentialing/Recredentialing; Vendor; Prior Authorization; Appeal & Grievance
UHC Community Plan of Maryland	Corrective Action Request	Dec 2017	Quality
UHC Community Plan of Maryland	Corrective Action Request	Mar 2018	Network Operations
UHC Community Plan of Maryland	Corrective Action Request	May 2018	Prior Authorization
UHC Community Plan of Maryland	Corrective Action Request	Jan 2019	Network Operations

Michigan

Medicaid Program: Michigan Medicaid Licensed Entity: UnitedHealthcare Community Plan, Inc.	
Name **Title:** **Phone:** **Email:**	Kathleen Stiffler Director of Medicaid 517.284.1129 *stifflerk@mi.gov*
Types of Individuals Served	**Number of Individuals Served**
ABD and MME	29,198
CRS/Children's Special Health Care Services (CSHCS)	2,987
Expansion	68,178
TANF including CHIP	147,907
Total	**248,270**

Key Responsibilities

This state-funded program provides comprehensive health care coverage in 65 counties throughout Michigan for ABD, CHIP Children's Special Health Care Services (CSHCS), expansion, MME and TANF beneficiaries. Services are those covered by Medicaid and other expanded services, emergency and urgent care, home health, hospice, inpatient hospital care, outpatient health care, podiatry, skilled nursing facilities, chiropractic services, outpatient health care, supplies — DME, prosthetic devices, diagnostics, diabetes — self-monitoring and training, and preventive care (e.g., screenings and blood tests). Medical appointment transportation is provided for an unlimited number of trips. Enrollees receive an enhanced vision benefit. It covers children and youth with medical complexity.

- State-funded program for ABD, CHIP Children's Special Health Care Services (CSHCS), expansion, MME and TANF beneficiaries
- Available in 65 counties
- Originated in 1996; current contract duration: Jan. 1, 2016 – Dec. 31, 2020. MI CHIP contract (originated 2010) phased into this statewide Medicaid contract on Jan. 1, 2016

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Michigan	Corrective Action Request	Sep 2016	Quality
UHC Community Plan of Michigan	Corrective Action Request	Nov 2016	Quality
UHC Community Plan of Michigan	Corrective Action Request	Mar 2017	Network Operations; FWA-FWAE Operations
UHC Community Plan of Michigan	Corrective Action Request	Apr 2018	Network Operations
UHC Community Plan of Michigan	Corrective Action Request	Oct 2018	FWA – FWA Operations/Network Operations

Mississippi

Medicaid Program: Mississippi CAN Licensed Entity: UnitedHealthcare of Mississippi, Inc.	
Name of Lead State Program Manager: **Title:** **Phone:** **Email**	Drew Snyder Executive Director 601-359-9562 *drew.snyder@medicaid.ms.gov*
Types of Individuals Served	**Number of Individuals Served**
ABD/SSI	27,685
TANF	153,173
Total	**180,858**

Key Responsibilities
This state-funded program provides statewide health care coverage throughout Mississippi for Medicaid beneficiaries, including the most vulnerable ABD/SSI and TANF enrollees of the Medicaid population. It features full Medicaid benefits and enhanced benefits beyond Medicaid FFS. These enhancements support a medical home model that connects enrollees with a primary care provider (PCP) and case managers to ensure enrollees receive the best and most appropriate level care, as and when needed. The contract is integrated with behavioral health and transportation. The contract covers children and youth with medical complexity. ▪ State-funded program for ABD/SSI and TANF beneficiaries ▪ Available in all counties ▪ Originated in 2011; current contract duration: July 1, 2014 – June 30, 2020 with two 1-year extensions

Medicaid Program: Mississippi CHIP Licensed Entity: UnitedHealthcare Insurance Company (UHIC)	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Drew Snyder Executive Director 601-359-9562 *drew.snyder@medicaid.ms.gov*
Types of Individuals Served	**Number of Individuals Served**
CHIP	26,927
Total	**26,927**

Key Responsibilities
This state-funded program provides high quality, accessible health care and customer service throughout the state of Mississippi for CHIP eligible populations. Medical coverage provides a broad range of services (e.g., inpatient and outpatient hospital care, rural health clinic [RHC] and federally qualified health center [FQHC] visits, laboratory and x-ray, behavioral health services, ambulance/medical transportation, pharmacy services, and vision and dental services). The program design connects enrollees with a primary care provider (PCP) and case managers to ensure enrollees receive appropriate levels of care. ▪ State-funded program for CHIP beneficiaries ▪ Available in all counties ▪ Originated in 2010; current contract duration: July 1, 2015 – June 30, 2018; includes a 1-year extension. Awarded a new CHIP contract with a 2019 start date, but implementation is delayed and currently pending from the State due to protest proceedings

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Mississippi	Fine	May 2016	Claims
UHC Community Plan of Mississippi	Corrective Action Request	May 2016	Provider Experience
UHC Community Plan of Mississippi	Corrective Action Request	Aug 2016	Quality
UHC Community Plan of Mississippi	Corrective Action Request	Jan 2017	Credentialing/Recredentialing; Network Operations; Member Materials; Care Management; Provider Experience; Appeal & Grievance; Quality
UHC Community Plan of Mississippi	Corrective Action Request	Jan 2017	Credentialing/Recredentialing; Provider Experience; Network Operations; Quality; Member Materials; Encounters; Appeal & Grievance; Care Management
UHC Community Plan of Mississippi	Corrective Action Request	Feb 2017	Claims; Prior Authorization
UHC Community Plan of Mississippi	Fine	May 2017	FWA – FWAE Operations
UHC Community Plan of Mississippi	Corrective Action Request	Oct 2017	Care Management
UHC Community Plan of Mississippi	Corrective Action Request	Dec 2017	Quality
UHC Community Plan of Mississippi	Corrective Action Request	Jan 2018	Claims
UHC Community Plan of Mississippi	Corrective Action Request	Mar 2018	Business Intelligence
UHC Community Plan of Mississippi	Corrective Action Request	Sep 2018	Encounters; Claims

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Mississippi	Corrective Action Request	Sep 2018	Encounters
UHC Community Plan of Mississippi	Corrective Action Request	Oct 2018	Credentialing/Recredentialing; Claims; Appeal & Grievance
UHC Community Plan of Mississippi	Corrective Action Request	Nov 2018	Network Operations
UHC Community Plan of Mississippi	Fine	Dec 2018	Claims
UHC Community Plan of Mississippi	Corrective Action Request	Jan 2019	Prior Authorization
UHC Community Plan of Mississippi	Fine	Jan 2019	Claims
UHC Community Plan of Mississippi	Fine	Feb 2019	Vendor

Missouri

Medicaid Program: Missouri's HealthNet (Medicaid) **Licensed Entity: UnitedHealthcare of the Midwest, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Bobbi Jo Garber Director of Medicaid 573-751-6522 *bobbi.j.garber@dss.mo.gov*
Types of Individuals Served	**Number of Individuals Served**
CHIP	7,184
Foster Care	9,152
TANF	144,105
Total	**160,441**

Key Responsibilities

This state-funded program provides statewide health care coverage throughout Missouri for CHIP, foster care and TANF enrollees of the Medicaid population. General types of services covered include medical, behavioral health, dental, vision and non-emergent transportation. Care managers (e.g., RNs, community outreach and behavioral health clinicians) deliver hands-on care management, including risk assessments and individualized plans of care with monitoring and oversight. Enrollment is mandatory for most populations. Enrollment is voluntary for Native Americans. The contract is integrated with behavioral health and transportation.

- State-funded program for CHIP, foster care and TANF beneficiaries
- Available in all counties
- Originated in 2017; current contract duration: May 1, 2017 – June 30, 2018; with four 1-year options to extend

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Missouri	Corrective Action Request	Jun 2018	Agents/Brokers; Marketing Materials

Nebraska

Medicaid Program: Nebraska's Heritage Health (Medicaid) **UnitedHealthcare of the Midlands, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Heather Leschinsky Deputy Director of Medicaid, HCBS and LTSS 402-471-9362 *heather.leschinsky@nebraska.gov*

Types of Individuals Served	Number of Individuals Served
ABD and Adults/Children with Disabilities	5,726
CHIP	12,766
Dual Eligible	7,754
I/DD	2,315
Katie Beckett	14
LTSS	4,582
Subsidized Adoption/Foster Care	1,952
TANF	49,190
Traumatic Brain Injury	19
Wards	1,460
Total	**81,274**

Key Responsibilities

The Nebraska Medicaid Managed Care Program, "Heritage Health," is an integrated statewide program that provides health care coverage for Medicaid eligible enrollees. Services include physical health, behavioral health, pharmacy and transplant benefits.

Services include inpatient and outpatient hospital services; ambulatory surgery service; ED; urgent care; clinical and anatomical laboratory services, radiology; FQHC and RHC services; Indian Health Services; EPSDT; physician services; home health care and private duty nursing services; rehabilitation; physical, occupational and speech therapy; DME and medical supplies; hearing aids and care; family planning; diabetic supplies; podiatry, chiropractic therapy, vision services; non-emergent ambulance transportation; ambulance services; skilled/rehabilitative and transitional nursing facility services; hospice services — except when provided in a nursing facility; and flu vaccinations.

- State-funded program for ABD, adults and children with disabilities, CHIP, dual-eligible, I/DD, Katie Beckett, subsidized adoption/foster care, TANF, traumatic brain injury and wards beneficiaries
- Available in all counties
- Originated in 1996; current contract duration: Jan. 1, 2017 – Dec. 31, 2021. This is a 5-year contract with two possible 1-year extensions split between three MCOs

Compliance Actions

Nothing Reported

Nevada

Medicaid Program: Health Plan of Nevada **Licensed Entity: Health Plan of Nevada, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Cody Phinney Deputy Administrator Department of Health and Human Services 775-687-3735 *cphinney@dhcfp.nv.gov*
Types of Individuals Served	**Number of Individuals Served**
CHIP	14,724
Expansion	103,079
TANF/CHAP	142,305
Total	**260,108**

Key Responsibilities

This state-funded program provides health care coverage throughout the state for Nevada's TANF, child health assurance program (CHAP) and CHIP enrollees. Available through an extensive, stable, provider

network, medically necessary services are targeted to enrollees' medical, behavioral and social needs, ensuring a consistent medical home and continuity of care. Services include a wide range of options, such as readily accessible obstetrical care, member incentive programs, EPSDT screenings, well-child care, immunizations, early prenatal/postpartum care, adult preventive care, behavioral health services, and programs to address social determinants of health, such as transitional and permanent housing. Our health education-wellness division offers bilingual instruction on pregnancy, asthma, cholesterol, diabetes, high blood pressure, weight management and smoking cessation. Other benefits include a 24-hour telephone nurse service, telemedicine access, extended-hour clinics, mobile medical services, supplemental non-emergency transportation and added non-covered medical benefits. The contract is integrated with behavioral health, social and transportation — to include myHousing and myRide, both of which are producing positive results in lowering the cost of medical care.

- State-funded program for CHAP, CHIP and TANF including expansion beneficiaries
- Available in two counties
- Originated in 1997; current contract duration: July 1, 2017 – June 30, 2021

Compliance Actions

Nothing Reported

New Jersey

Medicaid Program: New Jersey Medicaid **Licensed Entity: UnitedHealthcare of New Jersey, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Meghan Davey Director of Division of Medical Assistance and Health Services 609-588-2600 *megan.davey@dhs.state.nj.us*
Types of Individuals Served	**Number of Individuals Served**
CHIP	17,534
Duals	22,372
Expansion	130,793
LTSS	8,960
SSI	74,866
TANF including DD	231,849
Total	**486,374**

Key Responsibilities

This state-funded program provides health care coverage throughout the state of New Jersey for CHIP, DD, duals, expansion, LTSS, SSI and TANF beneficiaries. We offer a broad package of health services that cover medically necessary care, such as inpatient and outpatient hospital care, physician services, laboratory tests and x-rays, home health care and nursing facility care. The contract covers children and youth with medical complexity. Behavioral health benefits are integrated for individuals with LTSS and developmental disabilities.

- State-funded program (Medicaid) for CHIP, DD, duals, expansion, LTSS, SSI and TANF beneficiaries
- Available in all counties
- Originated in 1995; current contract duration: July 1, 2018 – June 30, 2019 (Bi-annual Renewal)

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of New Jersey	Fine	Mar 2016	Encounters
UHC Community Plan of New Jersey	Fine	Mar 2016	Encounters
UHC Community Plan of New Jersey	Fine	Mar 2016	Encounters

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of New Jersey	Corrective Action Request	Apr 2016	Network Management; Claims; Quality; Provider Experience; Care Management; Credentialing/Recredentialing; Appeal & Grievance; Prior Authorization; Security
UHC Community Plan of New Jersey	Corrective Action Request	Jun 2016	Network Management; Call Center Member; Member Materials; Prior Authorization
UHC Community Plan of New Jersey	Corrective Action Request	Oct 2016	Quality
UHC Community Plan of New Jersey	Fine	Oct 2016	Encounters
UHC Community Plan of New Jersey	Corrective Action Request	Oct 2016	Quality; Care Management; Utilization Management; Provider Experience
UHC Community Plan of New Jersey	Corrective Action Request	Nov 2016	Claims
UHC Community Plan of New Jersey	Corrective Action Request	Jan 2017	Care Management
UHC Community Plan of New Jersey	Corrective Action Request	Mar 2017	Care Management
UHC Community Plan of New Jersey	Corrective Action Request	Apr 2017	Network Management; Quality; Care Management; Appeal & Grievance
UHC Community Plan of New Jersey	Corrective Action Request	May 2017	Quality
UHC Community Plan of New Jersey	Corrective Action Request	Jun 2017	Care Management
UHC Community Plan of New Jersey	Fine	Jul 2017	Quality
UHC Community Plan of New Jersey	Fine	Dec 2017	Appeal & Grievance
UHC Community Plan of New Jersey	Corrective Action Request	Jan 2018	Care Management
UHC Community Plan of New Jersey	Corrective Action Request	Jan 2018	Encounters
UHC Community Plan of New Jersey	Corrective Action Request	Feb 2018	Prior Authorization
UHC Community Plan of New Jersey	Corrective Action Request	Mar 2018	Care Management
UHC Community Plan of New Jersey	Corrective Action Request	Mar 2018	Care Management
UHC Community Plan of New Jersey	Corrective Action Request	May 2018	Care Management
UHC Community Plan of New Jersey	Corrective Action Request	Jul 2018	Care Management; Network Management; Quality; Appeal & Grievance; Call Center Member; Credentialing/Recredentialing; Provider Experience; Utilization Management; Network Operations; Written Standards, Policies, and Procedures; Prior Authorization
UHC Community Plan of New Jersey	Corrective Action Request	Sep 2018	Care Management
UHC Community Plan of New Jersey	Corrective Action Request	Sep 2018	Quality; Care Management
UHC Community Plan of New Jersey	Corrective Action Request	Oct 2018	Provider Experience
UHC Community Plan of New Jersey	Corrective Action Request	Dec 2018	Care Management
UHC Community Plan of New Jersey	Corrective Action Request	Jan 2019	Network Operations
UHC Community Plan of New Jersey	Corrective Action Request	Feb 2019	Care Management

New York

Medicaid Program: New York Medicaid **Licensed Entity: UnitedHealthcare of New York, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Jonathan Bick Director – Division of Health Plan Contracting and Oversight 518-474-5515 *jonathan.bick@health.state.ny.us*

Types of Individuals Served	Number of Individuals Served
HARP	9,038
Expansion	40,722
SSI	17,236
TANF including ABD	425,287
Total	**492,283**

Key Responsibilities

This Medicaid health plan is available in the five boroughs of New York City and 43 additional counties in the state of New York. Medically necessary covered services are offered. Dental services are provided. Transportation services are available in some counties and carved out to State Department of Health (SDOH) in the remainder. The contract is integrated with behavioral health, transportation and LTSS. The contract covers children and youth with medical complexity.

- State-funded program (Medicaid) for ABD, SSI and TANF beneficiaries
- Available in five boroughs and 43 counties
- Originated in 2005; current contract duration: March 1, 2014 – Feb. 28, 2019
- Services being provided under informal extension pending execution of new contract

Medicaid Program: Child Health Plus
Licensed Entity: UnitedHealthcare of New York, Inc.

Name of Lead State Program Manager:	Gabrielle Armenia
Title:	Director – Child Health Plus Enrollment
Phone:	518-473-0566
Email:	*gabrielle.armenia@health.ny.gov*

Types of Individuals Served	Number of Individuals Served
Children and youth with medical complexity	52,730
Total	**52,730**

Key Responsibilities

This state-funded health plan is available in five boroughs of New York City, two boroughs in Long Island and 27 additional counties throughout the state of New York for children. Medically necessary services are provided, including dental and prescription coverage. The contract is integrated with behavioral health, transportation and LTSS. The contract covers children and youth with medical complexity.

- State-funded program for children
- Available in seven boroughs and 27 counties
- Originated in 1997; current contract duration: Jan. 1, 2016 – Sept. 30, 2019

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of New York	Corrective Action Request	Mar 2016	Network Management
UHC Community Plan of New York	Corrective Action Request	Apr 2016	Care Management; Network Management; Network Operations; Utilization Management; Credentialing/Recredentialing
UHC Community Plan of New York	Corrective Action Request	Apr 2016	Network Management
UHC Community Plan of New York	Corrective Action Request	May 2016	Claims
UHC Community Plan of New York	Corrective Action Request	May 2016	Care Management
UHC Community Plan of New York	Corrective Action Request	Jun 2016	Care Management
UHC Community Plan of New York	Corrective Action Request	Sep 2016	Finance/Accounting
UHC Community Plan of New York	Corrective Action Request	Sep 2016	Finance
UHC Community Plan of New York	Corrective Action Request	Oct 2016	Network Operations
UHC Community Plan of New York	Corrective Action Request	Oct 2016	Auditing and Monitoring
UHC Community Plan of New York	Corrective Action Request	Nov 2016	Network Management
UHC Community Plan of New York	Corrective Action Request	Dec 2016	Care Management

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of New York	Corrective Action Request	Jan 2017	High Level Oversight – Governance; Quality; Outreach Activities; Care Management; Appeal & Grievance; Billing and Enrollment
UHC Community Plan of New York	Corrective Action Request	Jan 2017	Network Management; Network Operations; Appeal & Grievance; Prior Authorization
UHC Community Plan of New York	Corrective Action Request	Feb 2017	Agents/Brokers; Network Operations; Claims; Utilization Management; Appeal & Grievance
UHC Community Plan of New York	Corrective Action Request	Feb 2017	Encounters
UHC Community Plan of New York	Corrective Action Request	May 2017	System
UHC Community Plan of New York	Corrective Action Request	Jul 2017	Network Management
UHC Community Plan of New York	Corrective Action Request	Jul 2017	Call Center Member
UHC Community Plan of New York	Corrective Action Request	Oct 2017	Care Management
UHC Community Plan of New York	Corrective Action Request	Oct 2017	Encounters
UHC Community Plan of New York	Corrective Action Request	Nov 2017	Network Operations
UHC Community Plan of New York	Corrective Action Request	Jan 2018	Prior Authorization
UHC Community Plan of New York	Corrective Action Request	Jan 2018	Care Management
UHC Community Plan of New York	Corrective Action Request	Feb 2018	Care Management
UHC Community Plan of New York	Corrective Action Request	Apr 2018	Member Materials
UHC Community Plan of New York	Corrective Action Request	May 2018	Network Management; Prior Authorization
UHC Community Plan of New York	Corrective Action Request	Jun 2018	Call Center Member
UHC Community Plan of New York	Corrective Action Request	Aug 2018	Call Center Member
UHC Community Plan of New York	Corrective Action Request	Aug 2018	Vendor
UHC Community Plan of New York	Corrective Action Request	Dec 2018	Network Management
UHC Community Plan of New York	Corrective Action Request	Mar 2019	Care Management

North Carolina

Medicaid Program: Prepaid Health Plan Services **Licensed Entity: UnitedHealthcare of North Carolina, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Sarah Gregosky, MSPH Deputy Director of Standard Plans – North Carolina Department of Health and Human Services 919-527-7027 *sarah.gregosky@dhhs.nc.gov*
Types of Individuals Served	**Number of Individuals Served Forecast for February 2020**
ABD	27,210
CHIP	55,997
LTSS	3,335
TANF	270,940
Total	**357,482**
Key Responsibilities	
This is a statewide Medicaid program, which works closely with the state to improve the overall health and well-being of North Carolinian Medicaid enrollees, both adults and children. The program provides whole-person, coordinated care, which addresses both medical needs and social supports and services, such as access to food, transportation, employment and housing. This includes preventive care, primary care, hospitalization, prescriptions and other health and wellness services, often at low or no cost. ▪ State-funded program (Medicaid) for ABD, CHIP, SSI and TANF beneficiaries	

▪ Available in all counties ▪ Originated in 2019; current contract duration: Nov. 1, 2019 – June 30, 2020 (Phase I) and Feb. 1 2020 – June 30, 2020 (Phase II) plus two additional 1-year periods from July 1 – June 30
Compliance Actions
Nothing Reported

Ohio

Medicaid Program: Covered Families/Children (CFC)/Aged, Blind or Disabled (ABD) **Licensed Entity: UnitedHealthcare Community Plan of Ohio, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Roxanne Richardson Interim Deputy Director Managed Care Department of Medicaid 614-752-2600 *roxanne.richardson@medicaid.ohio.gov*
Types of Individuals Served	**Number of Individuals Served**
ABD	22,584
Expansion	85,741
TANF including CHIP and Other Children	171,468
Total	**279,793** **(178,209 CFC/110,917 ABD)**

Key Responsibilities

This program provides health care coverage throughout Ohio for ABD, CHIP, expansion and TANF beneficiaries. The Medicaid program encompasses ABD, Ohio's Healthy Families eligibles (i.e., TANF-related Medicaid consumers), Ohio's Healthy Start eligibles (SCHIP consumers) — referred to as Covered Families and Children (CFC) and Medicaid expansion beneficiaries. It involves the delivery of all Medicaid-covered physical health services, including, for example, retail pharmacy, vision and dental, and behavioral health as of July 1, 2018, to eligible recipients. The program covers short-term nursing facility stays (<100 days) except in the case of the expansion population where the entire stay is covered. The contract is integrated with behavioral health and transportation. The contract covers both ABD children and Children in Custody (CIC) with a unique set of medical complexity.

- State-funded program (Medicaid) for ABD, CHIP, expansion and TANF beneficiaries
- Available in all counties
- Originated in 2005; current contract duration: July 1, 2018 – June 30, 2019 (Annual Renewal)

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Ohio	Fine	Apr 2016	Network Management
UHC Community Plan of Ohio	Corrective Action Request	Jun 2016	Care Management
UHC Community Plan of Ohio	Fine	Jul 2016	Network Management
UHC Community Plan of Ohio	Corrective Action Request	Sep 2016	Outreach Activities
UHC Community Plan of Ohio	Fine	Oct 2016	Network Management
UHC Community Plan of Ohio	Fine	Nov 2016	Quality
UHC Community Plan of Ohio	Fine	Jan 2017	Network Management
UHC Community Plan of Ohio	Fine	Feb 2017	Care Management
UHC Community Plan of Ohio	Fine	Feb 2017	Care Management
UHC Community Plan of Ohio	Corrective Action Request	Feb 2017	Care Management
UHC Community Plan of Ohio	Corrective Action Request	Mar 2017	Network Management
UHC Community Plan of Ohio	Fine	May 2017	Network Management
UHC Community Plan of Ohio	Corrective Action Request	Jun 2017	Network Operations
UHC Community Plan of Ohio	Corrective Action Request	Jun 2017	Encounters
UHC Community Plan of Ohio	Corrective Action Request	Jun 2017	Encounters
UHC Community Plan of Ohio	Fine	Aug 2017	Network Management

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Ohio	Corrective Action Request	Sep 2017	Network Management; Care Management; Utilization Management; Network Operations; Member Materials; Appeal & Grievance; Provider Experience; Quality; Prior Authorization
UHC Community Plan of Ohio	Fine	Sep 2017	Quality
UHC Community Plan of Ohio	Corrective Action Request	Oct 2017	Appeal & Grievance
UHC Community Plan of Ohio	Fine	Nov 2017	Network Management
UHC Community Plan of Ohio	Fine	Nov 2017	Network Management
UHC Community Plan of Ohio	Fine	Dec 2017	Quality
UHC Community Plan of Ohio	Fine	Feb 2018	Network Management
UHC Community Plan of Ohio	Fine	Mar 2018	Utilization Management
UHC Community Plan of Ohio	Corrective Action Request	May 2018	Network Operations
UHC Community Plan of Ohio	Fine	May 2018	Network Management
UHC Community Plan of Ohio	Fine	May 2018	Network Management
UHC Community Plan of Ohio	Fine	May 2018	Vendor
UHC Community Plan of Ohio	Corrective Action Request	May 2018	Vendor
UHC Community Plan of Ohio	Corrective Action Request	Jul 2018	Network Management
UHC Community Plan of Ohio	Fine	Sep 2018	Network Management
UHC Community Plan of Ohio	Fine	Oct 2018	Quality
UHC Community Plan of Ohio	Fine	Nov 2018	Network Management
UHC Community Plan of Ohio	Fine	Nov 2018	Network Management
UHC Community Plan of Ohio	Corrective Action Request	Dec 2018	Lines of Communication/Reporting Mechanisms; Utilization Management; Prior Authorization
UHC Community Plan of Ohio	Corrective Action Request	Jan 2019	Call Center Member
UHC Community Plan of Ohio	Corrective Action Request	Feb 2019	Prior Authorization
UHC Community Plan of Ohio	Fine	Feb 2019	Claims
UHC Community Plan of Ohio	Fine	Feb 2019	Network Management
UHC Community Plan of Ohio	Fine	Feb 2019	Network Management
UHC Community Plan of Ohio	Corrective Action Request	Feb 2019	Care Management; Claims
UHC Community Plan of Ohio	Fine	Mar 2019	Report Deliverable

Pennsylvania

Medicaid Program: UnitedHealthcare Community Plan for Kids **Licensed Entity: UnitedHealthcare of Pennsylvania, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Patricia Allan Executive Director Department of Human Services, Office of Children's Health Insurance Program (CHIP) 717-705-0542 *pmallan@pa.gov*
Types of Individuals Served	**Number of Individuals Served**
CHIP	36,268
Total	**36,268**
Key Responsibilities	
This is a state-funded program that provides health care coverage in 52 counties in the Commonwealth for CHIP beneficiaries. It provides free or low-cost health insurance to children under the age of 19 who meet eligibility requirements. Eligible children are enrolled and provided with all CHIP-covered inpatient, outpatient, diagnostic, pharmacy, dental, vision and mental health services. Services include immunizations; DME; well-child exams; laboratory and x-ray; hospital care; physical, occupational and speech therapy; case management for children with special needs; behavioral health care; vision care, including glasses, frames	

and contact lenses; tobacco cessation benefits; sports physicals and other specialty services. United Behavioral Health provides the behavioral services covered by the CHIP program. Emergency transportation is available also. CHIP enrollees with special needs may be transitioned to Medicaid depending on condition. Pennsylvania Medical Assistance provides extensive medical and mental health coverage for children with special needs that may not be available or may be limited through CHIP.

- State-funded program (Medicaid) for CHIP beneficiaries
- Available in 52 counties
- Originated in 1999; current contract duration: March 1, 2019 – Feb. 28, 2020

Medicaid Program: UnitedHealthcare Community Plan for Families **Licensed Entity: UnitedHealthcare of Pennsylvania, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Laurie Rock Director –Bureau of Managed Care Operations 717-772-6197 *lrock@pa.gov*

Types of Individuals Served	**Number of Individuals Served**
Expansion	74,475
TANF including ABD	147,378
Total	**221,853**

Key Responsibilities

This is a state-funded Medicaid program that provides health care coverage in 32 counties (i.e., Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bucks, Butler, Cambria, Chester, Cumberland, Dauphin, Delaware, Fayette, Franklin, Fulton, Greene, Huntingdon, Indiana, Lancaster, Lawrence, Lebanon, Lehigh, Montgomery, Northampton, Perry, Philadelphia, Somerset, Washington, Westmoreland and York) in the Commonwealth for disabled adult, Medicaid expansion and TANF beneficiaries. It covers unlimited visits to PCP; personal care available 24 hours a day, 7 days a week; ED care, when needed; immunizations; prescriptions and dental services; EPSDT screenings and treatment, vision exams and eyewear. Specialty care includes asthma care, cancer awareness, diabetes control and support, healthy heart programs, a well-mother/well-baby program, teenage pregnancy, AIDS, substance use prevention, smoking cessation and other community/health supports.

- State-funded health plan (Medicaid) for disabled adult, expansion and TANF beneficiaries
- Available in 32 counties
- Originated in 1989; current contract duration: Jan. 1, 2019 – Dec. 31, 2019 (Annual Renewal)

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Pennsylvania	Corrective Action Request	Apr 2017	Provider Experience; FWA – FWAE Operations
UHC Community Plan of Pennsylvania	Corrective Action Request	Nov 2016	Care Management
UHC Community Plan of Pennsylvania	Corrective Action Request	Jan 2017	Appeal & Grievance
UHC Community Plan of Pennsylvania	Corrective Action Request	Jan 2017	Network Operations
UHC Community Plan of Pennsylvania	Corrective Action Request	Apr 2018	Pharmacy
UHC Community Plan of Pennsylvania	Corrective Action Request	Apr 2018	Prior Authorization
UHC Community Plan of Pennsylvania	Corrective Action Request	Oct 2018	Prior Authorization

Rhode Island

Medicaid Program: RIte Care (CHIP/TANF) **Licensed Entity: UnitedHealthcare of New England, Inc.**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Patrick Tigue Medicaid Program Director 401-462-1965 *patrick.tigue@ohhs.ri.gov*

Types of Individuals Served	Number of Individuals Served
TANF including CHIP and CSHCN	54,192
Total	**54,192**

Key Responsibilities

This is a state-funded program that provides health care coverage throughout the state of Rhode Island for CHIP, CSHCN and TANF beneficiaries. It covers comprehensive member care for all Rhode Island Medicaid populations; medical and behavioral health, and pharmacy services are offered. RIte Care Medicaid child enrollees born after May 2000 are offered dental services by UnitedHealthcare Dental, which is a separate contract. The contract is integrated with behavioral health and provides preventive services similar to LTSS (e.g., minor modifications, personal care attendants and homemakers). The contract covers children and youth with medical complexity.

- State-funded program (Medicaid) for CHIP, CSHCN and TANF beneficiaries
- Available in all counties
- Originated in 1994; current contract duration: March 1, 2017 – June 30, 2022

Compliance Actions

Nothing Reported

Medicaid Program: Rhody Health Partners – Adult SSI
Licensed Entity: UnitedHealthcare of New England, Inc.

Name of Lead State Program Manager:	Patrick Tigue
Title:	Medicaid Program Director
Phone:	401-462-1965
Email:	*patrick.tigue@ohhs.ri.gov*

Types of Individuals Served	Number of Individuals Served
ABD including SSI	6,876
Total	**6,876**

Key Responsibilities

This is a state-funded program that provides health care coverage throughout the state of Rhode Island for ABD and SSI beneficiaries. It covers comprehensive member care for all Rhode Island Medicaid populations; medical and behavioral health, and pharmacy services are offered.

- State-funded program (Medicaid) for ABD and SSI beneficiaries
- Available in all counties
- Originated in 1994; current contract duration: March 1, 2017 – June 30, 2022

Compliance Actions

Nothing Reported

Medicaid Program: RIte Care – Expansion
Licensed Entity: UnitedHealthcare of New England, Inc.

Name of Lead State Program Manager:	Patrick Tigue
Title:	Medicaid Program Director
Phone:	401-462-1965
Email:	*patrick.tigue@ohhs.ri.gov*

Types of Individuals Served	Number of Individuals Served
Expansion	29,515
Total	**29,515**

Key Responsibilities

See description above for TANF population. This covers the Medicaid expansion being executed in the State of Rhode Island, currently. Medicaid Expansion was added as an amendment to the main Medicaid contract on Jan. 1, 2014.

- State-funded program for expansion beneficiaries
- Available in all counties
- Originated in 1994; current contract duration: March 1, 2017 – June 30, 2022

Compliance Actions

Nothing Reported

Tennessee

Medicaid Program: TennCare Licensed Entity: UnitedHealthcare Plan of the River Valley, Inc.	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Gabe Roberts Director of Medicaid 615-507-6444 *gabe.roberts@tn.gov*
Types of Individuals Served	**Number of Individuals Served**
LTSS	10,719
SSI	34,057
TANF including ABD	372,988
Total	**417,764**

Key Responsibilities

This is a state-funded program that provides health care coverage throughout the state of Tennessee for SSI, TANF and uninsured children beneficiaries. It provides services to all mandatory Medicaid eligibility groups and some categorically and medically needy voluntary groups, including children, pregnant women, the aged and individuals with disabilities. TennCare Standard includes children in these eligibility categories: uninsured, children under age 19 who are TennCare eligible and with family incomes less than 200% of the federal poverty level; who are TennCare eligible and meet "medically eligible" criteria (e.g., a health condition that makes the child uninsurable); and who are no longer eligible for TennCare Medicaid and are either uninsured or medically eligible. Services include, for example, inpatient hospital, physician, outpatient hospital, ambulance, physical therapy, nursing care, speech therapy, DME, home health care, hospice, hearing, vision, LTSS, behavioral health and non-emergency transportation. Pharmacy and dental services are provided but carved out. The contract is integrated with behavioral health, non-emergency medical transportation and LTSS (i.e., elderly, individuals with physical disabilities, individuals with intellectual/developmental disabilities in conjunction with Employment Community First (ECF), etc.). We provide care management and/or care coordination to infants, children, and adolescents, including those with complex needs or special needs. We provide support for preventive and wellness screenings for those under 21 years old in accordance with Bright Futures care recommendations.

- State-funded program (Medicaid) for ABD, SSI and TANF beneficiaries
- Available in all counties
- Originated in 1994; current contract duration: Jan. 1, 2014 – Dec. 31, 2017 with four 1-year extensions
- Jan. 1, 2014 – Three main region contracts (i.e., East: origination 1994; Middle Grand: origination 2006; and West: origination 2008) phased into this statewide TennCare Medicaid contract from January to December 2014

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Tennessee	Fine	Mar 2016	Claims
UHC Community Plan of Tennessee	Fine	Mar 2016	Claims
UHC Community Plan of Tennessee	Fine	Mar 2016	Care Management
UHC Community Plan of Tennessee	Corrective Action Request	Mar 2016	Encounters; Claims
UHC Community Plan of Tennessee	Fine	Mar 2016	Care Management
UHC Community Plan of Tennessee	Corrective Action Request	Mar 2016	Claims
UHC Community Plan of Tennessee	Fine	Mar 2016	Claims
UHC Community Plan of Tennessee	Fine	Mar 2016	Vendor
UHC Community Plan of Tennessee	Fine	Mar 2016	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Mar 2016	Credentialing/Recredentialing
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2016	Network Operations
UHC Community Plan of Tennessee	Fine	Apr 2016	Care Management
UHC Community Plan of Tennessee	Fine	Apr 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2016	Claims

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Tennessee	Fine	Apr 2016	Vendor
UHC Community Plan of Tennessee	Fine	Apr 2016	Care Management
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2016	Appeal & Grievance; Utilization Management; Credentialing/Recredentialing
UHC Community Plan of Tennessee	Fine	Apr 2016	Care Management
UHC Community Plan of Tennessee	Fine	May 2016	Vendor
UHC Community Plan of Tennessee	Fine	May 2016	Vendor
UHC Community Plan of Tennessee	Fine	May 2016	Vendor
UHC Community Plan of Tennessee	Fine	May 2016	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	May 2016	Claims
UHC Community Plan of Tennessee	Fine	Jun 2016	Care Management
UHC Community Plan of Tennessee	Fine	Jun 2016	Vendor
UHC Community Plan of Tennessee	Fine	Jun 2016	Network Operations
UHC Community Plan of Tennessee	Fine	Jul 2016	Appeal & Grievance
UHC Community Plan of Tennessee	Fine	Jul 2016	Appeal & Grievance
UHC Community Plan of Tennessee	Corrective Action Request	Jul 2016	Network Operations
UHC Community Plan of Tennessee	Fine	Jul 2016	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2016	Appeal & Grievance
UHC Community Plan of Tennessee	Fine	Aug 2016	Claims
UHC Community Plan of Tennessee	Fine	Aug 2016	Claims
UHC Community Plan of Tennessee	Fine	Aug 2016	Claims
UHC Community Plan of Tennessee	Fine	Aug 2016	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2016	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2016	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2016	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2016	Claims
UHC Community Plan of Tennessee	Fine	Aug 2016	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2016	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Aug 2016	Claims
UHC Community Plan of Tennessee	Fine	Aug 2016	Appeal & Grievance
UHC Community Plan of Tennessee	Fine	Aug 2016	Vendor
UHC Community Plan of Tennessee	Fine	Sep 2016	Network Operations
UHC Community Plan of Tennessee	Fine	Sep 2016	Vendor
UHC Community Plan of Tennessee	Fine	Sep 2016	Quality
UHC Community Plan of Tennessee	Fine	Sep 2016	Quality
UHC Community Plan of Tennessee	Fine	Sep 2016	Quality
UHC Community Plan of Tennessee	Corrective Action Request	Sep 2016	Quality
UHC Community Plan of Tennessee	Corrective Action Request	Sep 2016	Quality
UHC Community Plan of Tennessee	Corrective Action Request	Sep 2016	Quality
UHC Community Plan of Tennessee	Fine	Sep 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Sep 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Sep 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2016	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2016	Claims
UHC Community Plan of Tennessee	Fine	Nov 2016	Vendor
UHC Community Plan of Tennessee	Fine	Nov 2016	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2016	Quality
UHC Community Plan of Tennessee	Fine	Nov 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2016	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Dec 2016	Claims
UHC Community Plan of Tennessee	Fine	Dec 2016	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Dec 2016	Claims

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Tennessee	Corrective Action Request	Dec 2016	Quality
UHC Community Plan of Tennessee	Corrective Action Request	Dec 2016	Care Management
UHC Community Plan of Tennessee	Fine	Jan 2017	Care Management
UHC Community Plan of Tennessee	Fine	Jan 2017	Care Management
UHC Community Plan of Tennessee	Fine	Jan 2017	Vendor
UHC Community Plan of Tennessee	Fine	Jan 2017	Care Management
UHC Community Plan of Tennessee	Fine	Jan 2017	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Jan 2017	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Jan 2017	Claims
UHC Community Plan of Tennessee	Fine	Jan 2017	Vendor
UHC Community Plan of Tennessee	Fine	Feb 2017	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Feb 2017	Claims
UHC Community Plan of Tennessee	Fine	Feb 2017	Care Management
UHC Community Plan of Tennessee	Fine	Feb 2017	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Feb 2017	Quality
UHC Community Plan of Tennessee	Fine	Mar 2017	Vendor
UHC Community Plan of Tennessee	Fine	Mar 2017	Appeal & Grievance
UHC Community Plan of Tennessee	Corrective Action Request	Mar 2017	Claims
UHC Community Plan of Tennessee	Fine	Mar 2017	Claims
UHC Community Plan of Tennessee	Fine	Mar 2017	Vendor
UHC Community Plan of Tennessee	Fine	Mar 2017	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2017	Quality
UHC Community Plan of Tennessee	Fine	Apr 2017	Quality
UHC Community Plan of Tennessee	Fine	Apr 2017	Quality
UHC Community Plan of Tennessee	Fine	Apr 2017	Quality
UHC Community Plan of Tennessee	Fine	Apr 2017	Quality
UHC Community Plan of Tennessee	Fine	Apr 2017	Care Management
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2017	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2017	Encounters
UHC Community Plan of Tennessee	Fine	Apr 2017	Vendor
UHC Community Plan of Tennessee	Fine	Apr 2017	Vendor
UHC Community Plan of Tennessee	Fine	Apr 2017	Vendor
UHC Community Plan of Tennessee	Fine	May 2017	Claims
UHC Community Plan of Tennessee	Fine	May 2017	Claims
UHC Community Plan of Tennessee	Fine	May 2017	Claims
UHC Community Plan of Tennessee	Fine	May 2017	Vendor
UHC Community Plan of Tennessee	Fine	May 2017	Auditing and Monitoring
UHC Community Plan of Tennessee	Fine	May 2017	Care Management
UHC Community Plan of Tennessee	Corrective Action Request	May 2017	Encounters
UHC Community Plan of Tennessee	Fine	May 2017	Prior Authorization
UHC Community Plan of Tennessee	Fine	May 2017	Prior Authorization
UHC Community Plan of Tennessee	Fine	May 2017	Prior Authorization
UHC Community Plan of Tennessee	Fine	May 2017	Prior Authorization
UHC Community Plan of Tennessee	Corrective Action Request	May 2017	Written Standards, Policies and Procedures; FWA-FWAE Operations
UHC Community Plan of Tennessee	Fine	May 2017	Prior Authorization
UHC Community Plan of Tennessee	Corrective Action Request	May 2017	Credentialing/Recredentialing; Quality
UHC Community Plan of Tennessee	Fine	May 2017	Prior Authorization
UHC Community Plan of Tennessee	Fine	May 2017	Prior Authorization
UHC Community Plan of Tennessee	Corrective Action Request	May 2017	Encounters
UHC Community Plan of Tennessee	Corrective Action Request	May 2017	Encounters
UHC Community Plan of Tennessee	Fine	May 2017	Vendor
UHC Community Plan of Tennessee	Fine	May 2017	Vendor
UHC Community Plan of Tennessee	Fine	May 2017	Vendor
UHC Community Plan of Tennessee	Fine	May 2017	Vendor

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Tennessee	Fine	May 2017	Vendor
UHC Community Plan of Tennessee	Fine	May 2017	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Jun 2017	Network Operations
UHC Community Plan of Tennessee	Fine	Jun 2017	Network Operations
UHC Community Plan of Tennessee	Fine	Jun 2017	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Jul 2017	Network Operations
UHC Community Plan of Tennessee	Fine	Jul 2017	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Jul 2017	Claims
UHC Community Plan of Tennessee	Fine	Jul 2017	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Jul 2017	Encounters; Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Aug 2017	Quality
UHC Community Plan of Tennessee	Corrective Action Request	Aug 2017	Utilization Management
UHC Community Plan of Tennessee	Fine	Aug 2017	Quality
UHC Community Plan of Tennessee	Fine	Aug 2017	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2017	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2017	Vendor
UHC Community Plan of Tennessee	Fine	Aug 2017	Encounters
UHC Community Plan of Tennessee	Fine	Aug 2017	Vendor
UHC Community Plan of Tennessee	Fine	Sep 2017	Vendor
UHC Community Plan of Tennessee	Fine	Sep 2017	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Sep 2017	Claims; Network Operations
UHC Community Plan of Tennessee	Fine	Sep 2017	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Sep 2017	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2017	Network Operations
UHC Community Plan of Tennessee	Fine	Oct 2017	Vendor
UHC Community Plan of Tennessee	Fine	Oct 2017	Vendor
UHC Community Plan of Tennessee	Fine	Oct 2017	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2017	Claims
UHC Community Plan of Tennessee	Fine	Oct 2017	Vendor
UHC Community Plan of Tennessee	Fine	Nov 2017	Claims
UHC Community Plan of Tennessee	Fine	Nov 2017	Appeal & Grievance
UHC Community Plan of Tennessee	Fine	Nov 2017	Care Management
UHC Community Plan of Tennessee	Fine	Nov 2017	Vendor
UHC Community Plan of Tennessee	Fine	Nov 2017	Auditing and Monitoring
UHC Community Plan of Tennessee	Fine	Nov 2017	Vendor
UHC Community Plan of Tennessee	Fine	Nov 2017	Vendor
UHC Community Plan of Tennessee	Fine	Nov 2017	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2017	Claims
UHC Community Plan of Tennessee	Fine	Nov 2017	Claims
UHC Community Plan of Tennessee	Fine	Nov 2017	Claims
UHC Community Plan of Tennessee	Fine	Dec 2017	Network Operations
UHC Community Plan of Tennessee	Fine	Dec 2017	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Dec 2017	Claims
UHC Community Plan of Tennessee	Fine	Jan 2018	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Jan 2018	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Jan 2018	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Feb 2018	Claims
UHC Community Plan of Tennessee	Fine	Feb 2018	Claims
UHC Community Plan of Tennessee	Fine	Feb 2018	Claims
UHC Community Plan of Tennessee	Fine	Feb 2018	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Feb 2018	Claims
UHC Community Plan of Tennessee	Fine	Mar 2018	Claims
UHC Community Plan of Tennessee	Fine	Mar 2018	Claims
UHC Community Plan of Tennessee	Fine	Mar 2018	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Mar 2018	Provider Experience
UHC Community Plan of Tennessee	Corrective Action Request	Mar 2018	Provider Experience

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Tennessee	Corrective Action Request	Mar 2018	Provider Experience
UHC Community Plan of Tennessee	Corrective Action Request	Mar 2018	Claims
UHC Community Plan of Tennessee	Fine	Apr 2018	Claims
UHC Community Plan of Tennessee	Fine	Apr 2018	Business Intelligence
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2018	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2018	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Apr 2018	Quality
UHC Community Plan of Tennessee	Fine	Apr 2018	Claims
UHC Community Plan of Tennessee	Fine	Apr 2018	Vendor
UHC Community Plan of Tennessee	Fine	May 2018	Encounters
UHC Community Plan of Tennessee	Fine	May 2018	Encounters
UHC Community Plan of Tennessee	Fine	May 2018	Vendor
UHC Community Plan of Tennessee	Fine	May 2018	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	May 2018	Credentialing/Recredentialing
UHC Community Plan of Tennessee	Corrective Action Request	May 2018	Claims
UHC Community Plan of Tennessee	Fine	May 2018	Claims
UHC Community Plan of Tennessee	Fine	May 2018	Claims
UHC Community Plan of Tennessee	Fine	May 2018	Claims
UHC Community Plan of Tennessee	Fine	May 2018	Claims
UHC Community Plan of Tennessee	Fine	May 2018	Claims
UHC Community Plan of Tennessee	Fine	May 2018	Claims
UHC Community Plan of Tennessee	Fine	May 2018	Encounters
UHC Community Plan of Tennessee	Corrective Action Request	Jun 2018	Claims
UHC Community Plan of Tennessee	Fine	Jun 2018	Vendor
UHC Community Plan of Tennessee	Fine	Jul 2018	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Jul 2018	Network Operations
UHC Community Plan of Tennessee	Fine	Jul 2018	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Aug 2018	Network Management
UHC Community Plan of Tennessee	Corrective Action Request	Aug 2018	Care Management
UHC Community Plan of Tennessee	Fine	Aug 2018	Prior Authorization
UHC Community Plan of Tennessee	Corrective Action Request	Aug 2018	Claims
UHC Community Plan of Tennessee	Fine	Aug 2018	Vendor
UHC Community Plan of Tennessee	Fine	Sep 2018	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Sep 2018	Claims
UHC Community Plan of Tennessee	Fine	Sep 2018	Vendor
UHC Community Plan of Tennessee	Fine	Sep 2018	Claims
UHC Community Plan of Tennessee	Fine	Oct 2018	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2018	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2018	Claims
UHC Community Plan of Tennessee	Fine	Oct 2018	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2018	Network Management
UHC Community Plan of Tennessee	Corrective Action Request	Oct 2018	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2018	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2018	System
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2018	System
UHC Community Plan of Tennessee	Fine	Nov 2018	Network Management
UHC Community Plan of Tennessee	Fine	Nov 2018	Appeal & Grievance
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2018	Care Management
UHC Community Plan of Tennessee	Corrective Action Request	Nov 2018	Claims; Network Operations
UHC Community Plan of Tennessee	Fine	Dec 2018	Claims
UHC Community Plan of Tennessee	Fine	Dec 2018	Network Operations
UHC Community Plan of Tennessee	Corrective Action Request	Dec 2018	Claims
UHC Community Plan of Tennessee	Corrective Action Request	Jan 2019	Network Operations
UHC Community Plan of Tennessee	Fine	Jan 2019	Vendor
UHC Community Plan of Tennessee	Fine	Jan 2019	Claims
UHC Community Plan of Tennessee	Fine	Feb 2019	Vendor
UHC Community Plan of Tennessee	Corrective Action Request	Feb 2019	Claims

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Tennessee	Corrective Action Request	Feb 2019	Care Management
UHC Community Plan of Tennessee	Corrective Action Request	Feb 2019	Claims
UHC Community Plan of Tennessee	Fine	Mar 2019	Encounters
UHC Community Plan of Tennessee	Fine	Mar 2019	Encounters
UHC Community Plan of Tennessee	Fine	Mar 2019	Encounters
UHC Community Plan of Tennessee	Fine	Mar 2019	Network Operations
UHC Community Plan of Tennessee	Fine	Mar 2019	Vendor

Texas

Medicaid Program: Texas STAR **Licensed Entity: UnitedHealthcare Community Plan of Texas, LLC**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Stephanie Muth Director of Medicaid 512-707-6096 *stephanie.muth@hhsc.state.tx.us*
Types of Individuals Served	**Number of Individuals Served**
TANF	139,872
Total	**139,872**

Key Responsibilities

This Medicaid program provides health care coverage to Medicaid recipients in 44 counties throughout the state of Texas. Services cover EPSDT medical checkups, occupational therapy, audiology, speech therapy, case management for children with special needs, hospital clinic services — as appropriate, regular examinations, immunizations, child delivery and newborn care, substance use and behavioral health services, laboratory and X-ray services, including tests to prevent birth defects, expanded vision care, podiatry, asthmatic care, dental services and other specialty care benefits. The contract is integrated with behavioral health and transportation. The contract covers adults, children and youth.

- Medicaid; state-funded program for Temporary Assistance for Needy Families (TANF) beneficiaries
- Available in 44 counties
- Originated in 2006; current contract duration: Sept. 1, 2018 – Dec. 31, 2019

Medicaid Program: Texas CHIP **Licensed Entity: UnitedHealthcare Community Plan of Texas, LLC**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Stephanie Muth Director of Medicaid 512-707-6096 *stephanie.muth@hhsc.state.tx.us*
Types of Individuals Served	**Number of Individuals Served**
CHIP	10,554
Total	**10,554**

Key Responsibilities

This CHIP provides health care coverage to children in 34 counties throughout the state of Texas. Services include medical care for children; immunizations; DME; well-child exams; laboratory and X-ray; hospital care; physical, occupational and speech therapy; case management for children with special needs; behavioral health care; vision care, including glasses, frames and contact lenses; tobacco cessation benefits; sports physicals and other specialty services. A CHIP perinatal program is included in this coverage. The contract is integrated with behavioral health and transportation.

- CHIP; federally funded state program for CHIP beneficiaries
- Originated in 2007; current contract duration: Sept. 1, 2018 – Dec. 31, 2019

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Texas	Fine	Jun 2016	Encounters

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Texas	Corrective Action Request	Jul 2016	Encounters; Claims
UHC Community Plan of Texas	Fine	Jul 2016	Claims
UHC Community Plan of Texas	Corrective Action Request	Jul 2016	Care Management
UHC Community Plan of Texas	Corrective Action Request	Sep 2016	FWA – FWAE Operations
UHC Community Plan of Texas	Corrective Action Request	Sep 2016	Claims
UHC Community Plan of Texas	Fine	Sep 2016	Claims
UHC Community Plan of Texas	Fine	Jan 2017	Encounters
UHC Community Plan of Texas	Fine	Mar 2017	Reporting
UHC Community Plan of Texas	Corrective Action Request	Jul 2017	Encounters
UHC Community Plan of Texas	Fine	Jul 2017	Encounters
UHC Community Plan of Texas	Corrective Action Request	Jul 2017	Network Management
UHC Community Plan of Texas	Fine	Aug 2017	Appeal & Grievance
UHC Community Plan of Texas	Corrective Action Request	Nov 2017	Care Management
UHC Community Plan of Texas	Corrective Action Request	Nov 2017	Claims
UHC Community Plan of Texas	Fine	Nov 2017	Encounters
UHC Community Plan of Texas	Corrective Action Request	Jan 2018	Network Management
UHC Community Plan of Texas	Corrective Action Request	Feb 2018	Claims
UHC Community Plan of Texas	Corrective Action Request	Apr 2018	Network Management
UHC Community Plan of Texas	Corrective Action Request	Apr 2018	Network Management
UHC Community Plan of Texas	Fine	May 2018	Claims
UHC Community Plan of Texas	Corrective Action Request	Jun 2018	Vendor; Business Intelligence; Finance; Claims
UHC Community Plan of Texas	Corrective Action Request	Jun 2018	Network Management
UHC Community Plan of Texas	Corrective Action Request	Jun 2018	Response to Identified Issues; Appeal & Grievance; Credentialing/Recredentialing; Vendor; Utilization Management; Network Operations; Network Management
UHC Community Plan of Texas	Corrective Action Request	Aug 2018	Network Operations
UHC Community Plan of Texas	Corrective Action Request	Dec 2018	Network Management
UHC Community Plan of Texas	Corrective Action Request	Jan 2019	Network Management
UHC Community Plan of Texas	Corrective Action Request	Jan 2019	Care Management
UHC Community Plan of Texas	Fine	Feb 2019	Claims
UHC Community Plan of Texas	Corrective Action Request	Mar 2019	Network Management

Virginia

Medicaid Program: Medallion 3.0/4.0 – Medicaid **Licensed Entity: UnitedHealthcare Insurance Company**	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Karen Kimsey Chief Deputy 804-786-8099 *karen.kimsey@dmas.virginia.gov*
Types of Individuals Served	**Number of Individuals Served**
CHIP	8,103
TANF	64,339
Total	**72,442**

Key Responsibilities

This state-funded program provides statewide health care coverage throughout Virginia for CHIP and TANF enrollees. General types of services covered include medical, behavioral health, maternity care, pharmacy and transportation. The contract is integrated with behavioral health, transportation and pharmacy.

- State-funded program for CHIP and TANF beneficiaries
- Available in all counties

- Originated in 2005; Medallion 3.0 contract duration: Nov. 1, 2017 – Nov. 30, 2018 (Acquisition)/Medallion 4.0 current contract duration: Aug. 1, 2018 – June 30, 2019, with up to six successive 12-month renewal periods with rolling "go-live" period through Dec. 1, 2018

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Virginia	Fine	Feb 2018	Encounters
UHC Community Plan of Virginia	Corrective Action Request	Feb 2018	Encounters
UHC Community Plan of Virginia	Fine	Apr 2018	Claims
UHC Community Plan of Virginia	Corrective Action Request	Apr 2018	Claims
UHC Community Plan of Virginia	Fine	Jun 2018	Encounters
UHC Community Plan of Virginia	Fine	Sep 2018	Encounters
UHC Community Plan of Virginia	Fine	Nov 2018	Care Management
UHC Community Plan of Virginia	Fine	Dec 2018	Claims
UHC Community Plan of Virginia	Corrective Action Request	Dec 2018	Claims
UHC Community Plan of Virginia	Corrective Action Request	Feb 2019	Claims

Washington

Medicaid Program: Washington Apple Health
Licensed Entity: UnitedHealthcare of Washington, Inc.

Name of Lead State Program Manager: **Title:** **Phone:** **Email**	Mary Anne Lindeblad Director of Medicaid 360-725-1863 *maryanne.lindeblad@hca.wa.gov*

Types of Individuals Served	Number of Individuals Served
ABP	10,254
BD	1,728
CHIP	8,138
COPES	1,741
Expansion	92,470
TANF	93,896
Total	**208,227**

Key Responsibilities

This is a state-funded program that provides health care coverage throughout the state of Washington for ABP expansion, BD, CHIP, COPES and TANF beneficiaries. The program covers disease management, care and case management, customer service and benefit administration — to include physical, behavioral health and pharmacy benefit management; implementation of health homes; claims payment; network contracting; maintenance and reporting; quality improvement and oversight; contract compliance; credentialing; vendor oversight and program integrity functions. It covers those in the Community Options Program Entry System (COPES) for adults program. Personal care and case management services are available for eligible adults and children living in their own home, community-based residential facilities (adult family homes and assisted living) and skilled nursing facilities. Services are authorized by Home and Community Services, Division of Developmental Disabilities or Area Agencies on Aging. Eligible persons may be served through home and community-based waiver programs, such as COPES for adults, who require nursing home levels of care. Additional services provided by the waiver may include client training, skilled nursing, home-delivered meals, personal emergency response systems, home modification, specialized medical equipment, home health aides, transportation, adult day care, community transition services and nurse delegation.

- State-funded program (Medicaid) for ABP expansion, BD, CHIP, COPES, expansion and TANF beneficiaries
- Available in all counties
- Originated in 2012; Current Contract: July 1, 2018 – Dec. 31, 2019 (Annual Renewal)
- Healthy Options (originated 2012) rebranded by the State of Washington as "Apple Health" in January 2014

Medicaid Program: Washington Health Homes Licensed Entity: UnitedHealthcare of Washington, Inc.	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Stacey Bushaw Section Supervisor for Family Health Care Services 360-725-1829 *stacey.bushaw@hca.wa.gov*
Types of Individuals Served	**Number of Individuals Served**
Fee-for-Service (FFS)	182
Managed Care Organization (MCO)	8,098
Total	**8,280**

Key Responsibilities

Under Washington State's approach, this statewide Health Homes program provides a bridge to integrate care within existing health delivery systems. Authorized by Section 2703 of the federal Patient Protection and Affordable Care Act, the Managed FFS Demonstration model and Substitute Senate Bill 5394 from the 2011 legislative session, it places a designated Health Home provider at the center for directing "patient-centered care" for high-risk, high-cost beneficiaries in a specified, geographic coverage area. Each designated Health Home provider is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable ED visits. It offers timely post-discharge follow up and improves patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and LTSS. Each member has a care coordinator, who is embedded in a community-based setting to manage the full breath of beneficiary needs.

- State-funded program (Medicaid) for the FFS and MCO populations
- Available in all counties
- Originated in 2013; current contract duration: July 1, 2018 – Dec. 31, 2020; Washington Health Homes A, B and C phased into single statewide Washington Health Homes contract, as of July 1, 2016

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Washington	Corrective Action Request	Jun 2016	Care Management; Appeal & Grievance; Utilization Management
UHC Community Plan of Washington	Corrective Action Request	Mar 2017	Quality
UHC Community Plan of Washington	Corrective Action Request	Mar 2017	Quality
UHC Community Plan of Washington	Corrective Action Request	Jul 2017	Care Management; Prior Authorization; Appeal & Grievance; Encounters; Quality
UHC Community Plan of Washington	Corrective Action Request	Oct 2018	FWA – FWAE Operations; Care Management; Quality; Prior Authorization; Utilization Management; Pharmacy; Training and Education; Encounters

Wisconsin

Medicaid Program: BadgerCare Plus/Medicaid SSI Licensed Entity: UnitedHealthcare of Wisconsin, Inc.	
Name of Lead State Program Manager: **Title:** **Phone:** **Email:**	Jim Jones Director of Medicaid 608-266-5151 *gina.anderson@dhs.wisconsin.gov* Gina Anderson – Executive Assistant
Types of Individuals Served	**Number of Individuals Served**
ABD and SSI	18,666

FHP	31,925
TANF including CHIP	114,264
Total	**164,855**

Key Responsibilities

The "BadgerCare Plus Standard Health Plan" program provides quality health care to adults, parents or caretakers with household income at or below 100% of the Federal Poverty Level (FPL) and children and pregnant women with income at or below 300% of the FPL. This Medicaid fee-for-service program calls for copayments between $0.50 and $3.00 depending on the service. Copays are waived by the health plan for medical benefits, but they still apply for some services (e.g., vision benefits, etc.) within service area counties. Copayments apply for state carved out services like pharmacy, transportation, and chiropractic care and dental benefits administered by the state Medicaid program. Additional services not requiring copayments include case management services; crisis intervention services; community support program services; emergency services; family planning services, including sterilizations; HealthCheck; HealthCheck "other services"; home care services; hospice care services; immunizations; independent laboratory services; injections; services for ventilator-dependent enrollees; pregnancy-related services; preventive services with an A or B rating from the U.S. Preventive Services Task Force; school-based services; substance use day treatment services and surgical assistance.

The "Medicaid SSI" program provides the same benefits as Medicaid FFS (e.g., medical, dental, mental health/substance use, vision and prescription drug coverage) at no cost to enrollees through a care management model. SSI-related Medicaid enrollees receive coverage from Wisconsin Medicaid because of a disability determined by the Disability Determination Bureau. Enrollees meeting the following criteria are eligible to enroll in the program:

- Medicaid-eligible individuals living in a service area that has implemented an SSI managed care program
- Individuals ages 19 and older (e.g., individuals enrolled in Wisconsin Medicaid and SSI or receive SSI-related Medicaid)
- Special provisions, such as prescription drugs, are included for continuity of care purposes
- These programs are offered in 60 counties throughout the state of Wisconsin
- State-funded program (Medicaid) for SSI and childless adult beneficiaries — ABD, FHP and TANF including CHIP
- Available in all counties
- Originated in 1986 (BadgerCare Plus) and in 2005 (Medicaid SSI); current contract duration: Jan. 1, 2018 – Dec. 31, 2019

Compliance Actions

Health Plan	Type	Date Issued	Area of Non-compliance
UHC Community Plan of Wisconsin	Corrective Action Request	May 2017	Network Management
UHC Community Plan of Wisconsin	Corrective Action Request	Jan 2018	Coordination of Benefits

2.10.2.5 NCQA Accreditation

2.10.2.5.1 The Proposer should provide a copy of its certificate of accreditation by the National Committee for…

UnitedHealthcare initially achieved NCQA Accredited status (Standards Only) for its Medicaid program in 2014. This accreditation was valid from July 22, 2014, through July 22, 2017. In August 2016, we received ***Commendable*** status from NCQA, as evidenced in Attachment 2.10.2.5.1 NCQA Certificate of Accreditation. Our organization is committed to quality management and performance in every aspect of our business by anchoring quality standards to our corporate values of *Integrity, Compassion, Relationships, Innovation and Performance*. This commitment to quality aligns with LDH's vision for the future of Louisiana's Medicaid Managed Care program by supporting innovation and a culture of continuous quality improvement. Achieving NCQA accreditation is an indicator of the rigor of our continuous quality improvement, and is a responsibility we have to our enrollees. As a trusted steward of the Medicaid program, we are steadfast in our commitment to provide high-quality health care programs that set the standard for extraordinary performance while exceeding the expectations of our state partners.

UnitedHealthcare has more plans rated 4 stars and above by NCQA than any other national MCO

The process of achieving and maintaining NCQA accreditation provides us with an infrastructure of industry-recognized quality standards and an independent evaluation of plan performance against these standards. ***We have consistently achieved and maintained NCQA Accreditation for the Medicaid health plans we operate, including our Louisiana Medicaid plan.***

As illustrated in the following table, NCQA accredited UnitedHealthcare in Louisiana for the first time in July 2015. That accreditation was for 3 years with an annual rescoring of HEDIS and CAHPS. Based upon our August 2015 scores, those scores in conjunction with our Standards elevated us to Commendable status. Over the next 3 years, we saw continuous improvement in our Standards, HEDIS and CAHPS scores because of our commitment to quality improvement, maintaining our Commendable status.

We use the data collected from our annual CAHPS surveys to assess members' satisfaction with their PCPs, specialty care practitioners and the health plan overall, in addition to other health care components such as transportation and written member materials. Our CAHPS scores are now at 12.8 out of 13.

Year	Survey Type	Accreditation Status	Standards	HEDIS	CAHPS	Totals
July 2015	First (July 2014 – July 2017)	Accredited	48.8718	18.6357	12.4150	79.9225
August 2015	Annual Update	Accredited	48.8718	18.6357	12.4150	79.9225
August 2016	Annual Update	Commendable	48.8718	21.4970 ↑	12.1330	82.9890 ↑
July 2017	Renewal (July 2017 – July 2020)	Commendable	49.5420	21.4793 ↑	12.1330	83.1526 ↑
August 2017	Annual Update	Commendable	49.5420	23.1846	12.1911 ↑	84.9177 ↑
August 2018	Annual Update	Commendable	49.5420	23.6421 ↑	12.8267 ↑	86.0107 ↑

2.10.2.5.2 Where a Proposer utilizes a material subcontractor to provide behavioral health services, the Proposer…

Behavioral Health Accreditation

Our behavioral health subcontractor, United Behavioral Health, also maintains the accreditations from NCQA and URAC. They were awarded full NCQA Managed Behavioral Healthcare Accreditation through Jan. 18, 2021, and full URAC Health Utilization Management Accreditation through Feb. 1, 2020. We routinely monitor and audit subcontractors, including United Behavioral Health, for compliance with regulatory requirements, NCQA accreditation standards, as applicable, and for performance against established goals and quality standards. Where opportunities to collaborate on quality improvement activities exist, our quality team works directly with the subcontractor to develop interventions and monitor success, continuing to obtain feedback and recommendations throughout the process. Our quality team remains engaged, working with UnitedHealthcare leadership and the subcontractor to develop plans to improve enrollee outcomes and drive continuous quality improvement activities, as appropriate.

We have provided evidence of Managed Behavioral Healthcare Organizations accreditation as Attachment 2.10.2.5.2 Material Subcontractor NCQA Accreditation Certificate.

2.10.3 Enrollee Value-Added Benefits

2.10.3.2 The Proposer should identify whether it proposes to offer any of the following six (6) optional value…

2.10.3.3 For each selected value-added benefit, the Proposer should describe:

2.10.3.4 For each selected value-added benefit, the proposal should indicate the PMPM actuarial value of benefits…

2.10.3.5 The proposal should include a statement of commitment to provide the selected value-added benefits for…

In conformity with Section 2.5.5 and the LDH goal to align with the "Triple Aim" of better health, better care and lower costs to improve enrollee outcomes, we will offer a comprehensive package of value-added benefits.

LDH Program Goals: Ensuring ready access to care and improving enrollee health

Our value-added benefits represent an opportunity to increase health-related benefits and services and educational, preventive and outreach services. We design our value-added benefits to encourage enrollee engagement in targeted activities to build healthy behaviors and improve health outcomes.

UnitedHealthcare will offer the following value-added benefits:

- Dental Benefits for Adults
- Chiropractic Benefits and Mindfulness Exercises for Pain Management in Adults
- Medical Respite Services for Homeless Persons
- Newborn Male Circumcision
- Tobacco Cessation
- Vision Benefits for Adults

The following tables provide the detailed information on each of our value-added benefits. We include the PMPM actuarial value in each table and the required statement from our actuary, Interim Chief Financial Officer, Tatyana Kotlovskiy, who is a member of the American Academy of Actuaries, certifying the accuracy of the information as Attachment 2.10.3.4 Signed Actuarial Statement.

Dental Benefits for Adults

We recognize the importance of preventive and routine dental services to the overall health of our enrollees. People with low incomes have a disproportionately higher prevalence of dental disease and tooth loss related to lack of access to dental coverage and care. According to Kaiser Family Foundation, "oral health is a critical but often overlooked component of overall health and well-being." If not treated, oral disease can have serious secondary impacts, such as nutrition problems, chronic pain and heart disease. Poor oral health can also exacerbate chronic medical conditions such as diabetes and can lead to pregnancy complications.

Positive Dental Utilization Trend

We currently offer dental benefits to enrollees in Louisiana. Over the last 2 years, utilization increased:

- ***19%*** for preventive dental services
- ***5.9%*** for diagnostic services
- ***7.7% and 3.7% in 2017 and 2018,*** respectively, for restorative services

Dental Benefits for Adults	
Populations who may receive the benefit	Enrollees aged 21 years and older are eligible to receive this benefit.
Scope of benefit ▪ Descriptions, where applicable ▪ Comparison to Louisiana Medicaid ▪ Procedure codes	▪ **Description:** Our adult dental benefits include routine dental exams, x-rays, cleanings and fillings. The offerings of this benefit with in-network providers are limited to $500 per year for covered dental services. This benefit does not require prior authorization. ▪ **Comparison to Louisiana Medicaid coverage:** Louisiana Medicaid does not provide dental coverage for Medicaid-eligible adults. The promotion of oral health for children is a Medicaid Managed Care quality measure in Louisiana. We believe providing a similar benefit to adults supports enrollees to continue good oral health habits. Using a whole-person approach, our case managers promote the dental benefit to support wellness and preventive health care. Case managers will assist enrollees to access this benefit, understand coverage and encourage healthy outcomes through regular dental checkups. ▪ **Procedure codes:** D0120, D0140, D0150, D0210, D0220, D0230, D0270, D0272, D0273, D0274, D1110, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
Proposed copayments	$0
How the benefit will be provided to enrollees (including subcontractor details, if applicable)	Enrollees can access the benefit by visiting an in-network dental provider as provided through our subcontractor, Dental Benefit Providers, Inc. (DBP).
Oversight of the value-added benefit	Under the direction of our Chief Medical Officer Dr. Morial and Health Services Director Nicole Thibodeaux, our clinical team conducts oversight of this benefit through monthly reviews of enrollee-level utilization reports and crosswalks to case management referral reporting. We use this information to identify additional education needs of our case management staff as to the availability of the benefit. We do this to ensure enrollees who need the benefits have avenues to access them. In addition, we conduct Joint Operating Committee (JOC) meetings with DBP monthly and annually. During this call, we review compliance strategies and initiatives to support DBP's performance. This includes, but is not limited to: reviewing business performance overall; assessing key compliance/regulatory issues and risks; escalating issues; reviewing fraud, waste and abuse prevention efforts; discussing network adequacy, ensuring recent complaints and grievances are resolved, and monitoring benefit utilization.
[redacted]	[redacted]
Available for the 36-month term	Yes

Chiropractic Benefits and Mindfulness Exercises for Pain Management in Adults

Back pain is second only to headaches as the most common neurological ailment in the United States. In addition, the Centers for Disease Control and Prevention (CDC) identified increased prevalence of anxiety and depression in those suffering from chronic pain, which adversely

affects work, social, educational and other aspects of individuals' lives. We will work proactively to improve enrollee health and safety by providing non-opioid chronic pain management and treatment such as chiropractic visits and mindfulness exercises. Evidence-based medicine supports the use of chiropractic care to improve lower back pain. We also will include evidence-based mindfulness exercises, through our Live and Work Well resource to reduce chronic pain, manage stress and improve mental state for enrollees. In some cases, visits to the chiropractor can reduce or eliminate the need for pain medication, including opioids.

Chiropractic Benefits and Mindfulness Exercises for Pain Management in Adults	
Populations who may receive the benefit	Enrollees age 21 years and older are eligible to receive this benefit.
Scope of benefit Descriptions, where applicable Comparison to Louisiana Medicaid Procedure codes	▪ **Description:** We will provide 24 visits per calendar year to an in-network chiropractor. We also will provide access 24 hours a day, 7 days a week for enrollees to engage in mindfulness exercises from their home through our enrollee portal. This additional health benefit does not require a prior authorization. ▪ **Comparison to Louisiana Medicaid coverage:** Louisiana Medicaid does not provide coverage for chiropractic services. Chiropractic services can be a valuable part of an enrollee's pain-management treatment plan when used in conjunction with covered services such as physical therapy and behavioral health services. ▪ **Procedure codes:** 98940, 98941, 98942, 98943
Proposed copayments	$0
How the benefit will be provided to enrollees	Enrollees can access the benefit by visiting a chiropractor within our contracted network, and may be offered transportation support to access these services if needed
Oversight of the value-added benefit	Under the direction of Dr. Morial and Ms. Thibodeaux, our clinical team conducts oversight of this benefit through monthly reviews of enrollee-level utilization reports and crosswalks to case management referral reporting. We use this information to identify additional education needs of our case management staff as to the availability of the benefit. We do this to ensure enrollees who need the benefit have avenues to access them. We screen enrollees who use the benefit for case management if a referral or current case management is not already in place. In addition, enrollees can self-refer to receive chiropractic visits.
[redacted]	[redacted]
Available for the 36-month term	Yes

Medical Respite Services for Homeless Persons

UnitedHealthcare subscribes to the National Health Care for the Homeless definition of medical respite as acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. Short-term respite care allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and

National Success with Respite Programs

Our enrollees will benefit from our experience with the medical respite programs in Arizona, Nevada and Washington. For example, in Washington, ***total ED PMPM costs decreased by 45%*** for those enrollees who received medical respite as an alternative to the ED.

other supportive services. Our vision aligns to the National Health Care for the Homeless Medical Respite Standards and guides our engagement with partners and providers who share this same vision.

Medical Respite Services for Homeless Persons	
Populations who may receive the benefit	Enrollees in the New Orleans area who are homeless, as defined in 42 U.S.C. §254b
Scope of benefit ▪ Descriptions, where applicable ▪ Comparison to Louisiana Medicaid ▪ Procedure codes	▪ **Description:** Safe, high quality care and services including safe, temporary housing, post-acute clinical care, care coordination, wraparound support services, including housing/supportive housing, identification of community resources, social support, assistance with applications for SSI/SSDI, food stamps and other federal/state benefit programs. • Accessible accommodations: A bed (24 hours a day), on-site showering and laundry (facility or service), secure storage for belongings/medications and three meals a day • Staff (clinical/non-clinical): Care coordination services in addition to: 24-hour onsite staff and access to 24-hour on-call medical support (NurseLine for non-emergency medical inquiries) • Length of stay: Will be limited to the period necessary for complete medical recovery. Once the enrollee is medically stable, we will connect them to safe, affordable housing, linked to the health and community supports they need to stabilize and thrive in the community. As our experience with our partners increases, we also will consider opportunities for medical respite before surgery as appropriate. ▪ **Comparison to Louisiana Medicaid:** There are currently no formal medical respite programs in Louisiana; therefore, Louisiana Medicaid does not provide coverage. Instead, enrollees who are homeless with post-acute recovery needs may receive a higher level of care than necessary or be at greater risk for readmission or ED visits due to the inability to recuperate in an appropriate environment. Offering medical respite services allows enrollees who are otherwise homeless to have a stable environment in which we can establish a solid case management relationship. Enrollees will be able to get services in place to support timely healing. In addition to medical and behavioral health support, we will help find resources to address social determinants of health (SDOH). ▪ **Procedure Codes:** Based upon our experience in other states, we expect to use G9006, and we will confirm the appropriate code before implementation
Proposed copayments	$0

Medical Respite Services for Homeless Persons	
How the benefit will be provided to enrollees	We are in the process of identifying the most appropriate hospital facilities based upon admission/ED rates for enrollees who are homeless in New Orleans. Enrollees will access medical respite through discharge planning staff. We will develop clear protocols for identifying individuals who can be safely discharged to medical respite immediately upon release. We will select a community partner who has the appropriate space available to create a safe, effective medical respite program and whose vision aligns with the National Health Care for the Homeless Medical Respite Standards. Once established, we will make the program available to all Medicaid members who are homeless through our provider partner in New Orleans, regardless of their MCO.
Oversight of the value-added benefit	We have staffed a full-time housing partner, Felice Hill, who, in coordination with Dr. Julie Morial, will oversee the service. Dr. Morial and her clinical team will review utilization reports and reports on the economic impact of medical respite on utilization management collectively with medical respite partners and relevant providers on a quarterly basis, at a minimum.
[redacted]	[redacted]
Available for the 36-month term	Yes

Newborn Male Circumcision

According to the American Academy of Pediatrics, the "health benefits of newborn male circumcision outweigh the risks" as circumcision may help prevent urinary tract infections, penile cancer and transmission of some sexually transmitted infections, including HIV. Providing this benefit helps build enrollee trust in a health system that is sensitive to their personal and cultural priorities.

Newborn Male Circumcision Utilization
UnitedHealthcare offered this benefit to our enrollees under our current contract, with ***more than 17,000 newborn babies receiving this benefit in Louisiana since 2015***.

Newborn Male Circumcision	
Populations who may receive the benefit	Newborn males
Scope of benefit ▪ Descriptions, where applicable ▪ Comparison to Louisiana Medicaid ▪ Procedure codes	▪ **Description:** We will provide circumcisions for newborn males in the hospital or a physician's office. ▪ **Comparison to Louisiana Medicaid coverage:** Louisiana Medicaid does not provide coverage for circumcisions. We educate providers on this benefit through the *Provider Manual* so they can discuss with the mother, alongside covered pregnancy-related and EPSDT services. ▪ **Procedure codes:** 54150, 54160, 54161
Proposed copayments	$0
How the benefit will be provided to enrollees	Newborn male infants can receive circumcisions without a prior authorization if performed before discharge from a newborn nursery or in the physician's office within 30 days after birth. Our prior authorization staff will review all requests after 30 days of birth for medical necessity.

Newborn Male Circumcision	
Oversight of the value-added benefit	Dr. Morial and Ms. Thibodeaux, and our clinical team conducts oversight of this benefit through monthly claims and utilization reports at the enrollee level.
[redacted]	[redacted]
Available for the 36-month term	Yes

Tobacco Cessation

According to the CDC, "more people in the United States are addicted to nicotine than to any other drug." Using nicotine (smoking, smokeless tobacco, electronic cigarettes) increases the risk for serious health problems, many diseases and death. Per America's Health Rankings, Louisiana's adult smoking rate in 2018 was 23.1%. Quit With Us, Louisiana indicates that smoking kills 6,500 Louisianans each year.

Smoking during pregnancy can cause additional health problems, including premature birth, certain birth defects and infant death. According to the 2015 Louisiana Pregnancy Risk Assessment Monitoring System, 4.4% of women said they smoked the same amount or increased smoking during their pregnancy, and 11.8% kept smoking during the last 3 months of pregnancy.

Tobacco Cessation Success
Our Quit For Life® Program has proven successful for Medicaid enrollees:

- Average 6-month responder quit rate is 26%, more than quadrupling outcomes compared to when people try to quit on their own
- Satisfaction rate is 95% across Medicaid health plans

Tobacco Cessation	
Populations who may receive the benefit	Enrollees aged 18 years and older are eligible to receive this benefit.
Scope of benefit ▪ Descriptions, where applicable ▪ Comparison to Louisiana Medicaid ▪ Procedure codes	▪ **Description:** Enrollees will have access to the Quit For Life Program, the nation's leading tobacco cessation program. Enrollees will have access to five telephonic coaching calls (10 for those who are pregnant, including prenatal and postpartum), personalized, interactive text messaging, and anytime access to an interactive, mobile-friendly online website. ▪ **Comparison to Louisiana Medicaid:** Louisiana Medicaid covers tobacco cessation medications. The State also sponsors the Louisiana Tobacco Quitline (1-800-Quit). Promoting the use of evidence-based tobacco cessation treatments is a Medicaid Managed Care Quality measure in Louisiana. Promoting and providing an enhanced program will increase the success rate for our enrollees, with cumulative health and economic benefits for them. It also will benefit those around them who may have been exposed to secondhand smoke. ▪ **Procedure Codes:** 99406, 99407
Proposed copayments	$0
How the benefit will be provided to enrollees	Our case managers screen all enrollees for tobacco use using the SF-12 screening tool and individual Health Needs Assessment (HNA). Based upon the results from these screenings, case managers can provide information on and refer enrollees to the Quit For Life Program. In addition, enrollees will receive outreach from the Quit For Life Program for inclusion in the tobacco cessation program. Enrollees can also self-refer to the Quit For Life Program.

Tobacco Cessation	
Oversight of the value-added benefit	Our population health team, under the direction Dr. Morial, oversees this benefit through review of reports that track: participation, quit and satisfaction data, demographic information and self-referral. We use this information to identify additional education needs of our case management staff as to the availability of the benefit. We do this to ensure enrollees who need the benefit have avenues to access them. Through the SF-12 assessment, we will educate enrollees verbally on the availability of the Quit For Life Program. In addition, we will share the results of the SF-12 assessments with the Quit For Life Program so they can conduct outreach to those enrollees and make tobacco cessation reports available to LDH upon request.
[redacted]	[redacted]
Available for the 36-month term	Yes

Vision Benefits for Adults

According to the CDC, about 11 million Americans over age 12 need their vision corrected. Providing additional vision benefits to adult enrollees in Louisiana not only improves their overall quality of life and independence, but also enables early detection of other diseases like diabetes, multiple sclerosis and high blood pressure.

Vision Benefits for Adults	
Populations who may receive the benefit	Enrollees aged 21 years and older are eligible to receive this benefit.
Scope of benefit ▪ Descriptions, where applicable ▪ Comparison to Louisiana Medicaid ▪ Procedure codes	▪ **Description:** Vision services including one routine eye exam every year and $100 allowance for frames/lenses and a $105 allowance for contacts every year. ▪ **Comparison to Louisiana Medicaid coverage:** Louisiana Medicaid does not provide coverage for vision services or allowances for frames/lenses for Medicaid-eligible adults. Using a whole-person approach, our case managers promote the vision benefit to support wellness and preventive health care. Case managers will assist enrollees to access this benefit and encourage healthy outcomes. For diabetic enrollees, this benefit provides glasses and lenses in addition to existing coverage for eye exams available based upon diagnosis of diabetes. ▪ **Procedure codes:** V2020, V2025, 92002, 920049, 92014, 92012, 92015, S0620, S0621, H5200, H5201, H5202, H5203, H5210, H5211, H5212, H5213, H52201, H52202, H52203, H52209, H52211, H52212, H52213, H52219, H52221, H52222, H52223, H52229, H5231, H5232, H524, H52521, H52522, H52523, H52529, H52531, H52532, H52533, H52539, H526, H527, Z0100, Z0101
Proposed copayments	$0
How the benefit will be provided to enrollees	Enrollees can access the benefit by visiting an in-network vision provider as provided through our vision subcontractor, MARCH Vision.

Vision Benefits for Adults	
Oversight of the value-added benefit	We conduct monthly JOC meetings with MARCH Vision. During this call, we review compliance strategies and initiatives to support MARCH Vision's performance. This includes, but is not limited to, overall review of the business performance; assessment of key compliance/regulatory issues and risks; escalation of issues; review of fraud, waste and abuse prevention efforts; discuss network adequacy; ensure recent complaints and grievances are resolved; and monitor benefit utilization.
[redacted]	[redacted]
Available for the 36-month term	Yes

2.10.4 Population Health

2.10.4.1 Describe its understanding of, and experience with, improving population health for Medicaid…

We recognize the importance of population health management (PHM) in identifying and addressing the social, behavioral, medical and functional needs of our enrollees to improve their health outcomes and reduce health disparities. Medicaid enrollees are at increased risk of developing chronic illnesses and are more likely to require preventive health services in comparison with the general population. We know our enrollees face unique challenges, such as food insecurity, unsafe and unstable housing, lack of transportation, unemployment and financial instability. Our population health approach takes into account these social determinants of health (SDOH).

Our PHM approach is built upon the principles presented in the following table informs and guides our overall managed care program for enrollees across Louisiana. This approach supports LDH's vision for population health described in Appendix B, Section 2.6, Population Health and SDOH.

Principles of a Population Health Approach
Evaluating our entire enrollee population and engaging enrollees across the continuum
We establish baseline health-outcome measures using the performance measures specified in Attachment G, NCQA Quality Compass Benchmarks and utilization measures. We build upon external data sources, such as America's Health Rankings, NCQA Quality Compass Benchmarks and the LDH Office of Population Health (OPH) priorities to understand the challenges and context in Louisiana. A variety of tools including our health needs assessment (HNA), referral network, Hotspotting and HealthView Analytics Clinical Dashboard help us understand our enrollee population and identify subpopulations who may benefit from case management. We strive to provide programs and services that fit the unique situation of enrollees across the continuum.
Improving enrollee health status and supporting enrollees as they take an active role in managing their care through health promotion and disease prevention
We encourage enrollees to take action on their health using an array of health promotion and disease prevention tools provided through websites, mobile apps, texting programs and telephonic support. For instance, we offer live telephonic access to RNs who educate enrollees about conditions, such as diabetes and HIV/AIDS. RNs instruct enrollees on health care services through *NurseLine*, use clinical texting to engage expectant mothers, offer tobacco cessation, promote medication adherence and provide appointment reminders and mobile apps to help enrollees locate in-network and urgent care providers.
Using a data-driven approach to understand our enrollees' health risk, needs and circumstances
Our suite of advanced data analytics tools analyzes medical, behavioral and functional needs and the impact of SDOH on our enrollees' ability to access needed services. Our predictive modeling algorithms analyze demographics, medical, behavioral and pharmacy utilization and use more than 300 clinical rules to identify health risks and design programs that are appropriate to meet a subpopulation's needs. The next iteration of our data-driven approach incorporates ICD-10 codes that confirm SDOH needs and services are tracked while avoiding additional administrative work for providers.
Incorporating consideration of the SDOH
There is widespread recognition and evidence that SDOH are primary drivers for health outcomes, health care costs and quality. Our PHM program identifies social and economic barriers that stand in the way of enrollees meeting their health care goals. We incorporate SDOH into our PHM program as follows: ▪ Using data from enrollee screenings to identify barriers that may negatively impact our enrollees' ability to meet their goals and frequent SDOH barriers in specific populations and geographies ▪ Analyzing community capacity and quality to confirm population needs are being met ▪ Developing internal processes to connect individuals within populations to community-based organizations (CBOs) identified for these frequent barriers ▪ Investing in innovative best practices that build capacity, improve quality and reduce health care costs

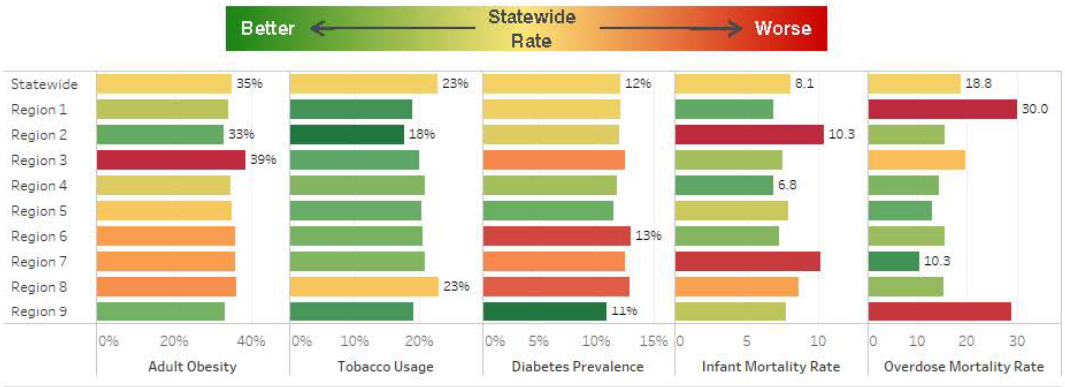
Principles of a Population Health Approach
Implementing targeted interventions for subpopulations experiencing health disparities
Using data from a variety of sources and advanced data analytics, we identify geographies within Louisiana and subpopulations of enrollees who experience health disparities. Armed with this information, we collaborate with a variety of CBOs and providers to develop interventions that help address those disparities. For example, our Northeast Healthy Teen Pregnancy grant targeted teen mothers, who have disproportionately high rates of pregnancy complications, premature births and low birth weight infants. We partnered with the Children's Coalition for Northeast Louisiana to develop and host highly attended school-based sessions in six schools. As of 2018, all of the mothers who had given birth had infants of healthy birth weight with an average of 7 pounds. Additionally, 98%of mothers stayed in school post-delivery, which indicates the program can also address inequity in educational achievement.
Addressing LDH's population health priorities
We have programs to address the LDH population health priorities in Appendix B, Section 2.6.1.1. For instance, to reduce infant mortality and maternal mortality and morbidity, we have implemented programs to identify enrollees who are pregnant and evaluate their pregnancy risk. We engage women with high-risk pregnancies in our Healthy First Steps (HFS) case management program. Through HFS Rewards, we educate all pregnant women about their developing baby and provide reminders and rewards for attending appointments during their pregnancy and the first 15 months postpartum. We continually evaluate the needs of this population and modify current or develop new programs to address them, such as our identification of low post-natal care rates among women with high-risk pregnancies in Baton Rouge. This identification led to our partnership with the Louisiana Women's Healthcare clinic in Baton Rouge where we **embedded a case manager** in the clinic to address prenatal needs of the enrollee during their OB visit.

2.10.4.1.1 Identifying baseline health outcome measures and targets for health improvement;

We choose baseline health-outcome measures from a variety of sources, including the quality performance measures specified in Attachment G and NCQA Quality Compass Benchmarks that allow us to examine quality improvement and benchmark performance through NCQA averages and percentiles. We monitor utilization rates; HEDIS-reported rates; and medical, behavioral, pharmacy and SDOH-related metrics to understand the population health status of our enrollees and areas for improvement. ***We currently track the measures required by LDH, including 45 of the 61 measures in Attachment G for the new contract.***

Using data from publicly available sources, we look at our communities and parishes through the lenses of health, social need and environmental conditions. We identify traditional core health measures, including tobacco use, adult obesity and diabetes prevalence rates. We build on this with data on key areas of concern in Louisiana, such as infant mortality rates and the devastating impact of opioids on our communities. We identify social and environmental measures to add context to the health and well-being of a local community or parish. In our experience, food insecurity, severe housing problems, unemployment, and free and reduced lunch rates provide clarity into the conditions our enrollees' families face in meeting their needs.

For example, using data from the CDC Diabetes Interactive Atlas, the Behavioral Risk Factor Surveillance System, CDC WONDER Mortality Data and data from the National Center for Health Statistics we analyzed adult obesity, tobacco use, diabetes prevalence, infant mortality and overdose mortality rates in Louisiana as presented in the figure.



	Adult Obesity	Tobacco Usage	Diabetes Prevalence	Infant Mortality Rate	Overdose Mortality Rate
Statewide	34.7%	22.8%	12.1%	8.1	18.8
Region 1	34.1%	18.9%	12.1%	6.9	30.0
Region 2	32.7%	17.7%	12.0%	10.3	15.6
Region 3	38.5%	19.9%	12.6%	7.5	19.7
Region 4	34.5%	20.8%	11.8%	6.8	14.3
Region 5	34.9%	20.3%	11.5%	7.9	12.9
Region 6	35.6%	20.6%	13.1%	7.2	15.5
Region 7	35.6%	20.8%	12.5%	10.1	10.3
Region 8	35.9%	23.1%	12.9%	8.6	15.3
Region 9	33.0%	19.1%	10.9%	7.8	29.0

*Percentages shown in chart identify the regions with the highest and lowest measures for the category. Statewide rate is noted at the top of the chart.

Figure 3. The analysis of baseline health outcomes provides insight into the needs of enrollee populations so we can design appropriate interventions. For example, the data show that Region 2 has the highest infant mortality rate (10.3%) in the state. Because we are embedding a case manager to provide support to pregnant women at Louisiana Woman's Healthcare clinic affiliated with Woman's Hospital in Baton Rouge (Region 2), our highest volume maternal provider in Louisiana.

Identifying Targets for Health Improvement

Using the named data sources and mechanisms to identify subpopulations within our enrollee population, we identify targets for health improvement, develop programs to address them and evaluate their effectiveness as presented in the figure.

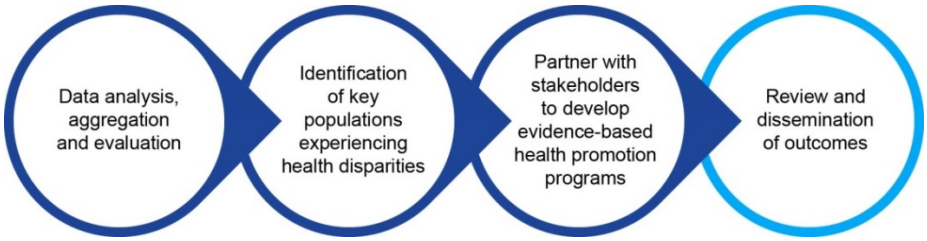


Figure 4. Our population health approach starts with the aggregation of data. We use internal and external data to prioritize the disparities faced by key sub-populations, which informs our implementation of programs in our enrollee communities.

Monitoring our Performance against HEDIS and NCQA and Utilization

Through our quality management (QM) program, we identify targets for improvement by reviewing low performing HEDIS measures, our performance against the NCQA Quality Compass percentiles and by monitoring utilization. For example, if our enrollees are performing poorly on a specific measure (e.g., eye exams for enrollees with diabetes), we take action to address this measure, such as calls to enrollees with gaps in care, educating PCPs, or developing targeted solutions. In this example, we have enhanced our value-added vision benefit to annual screenings — versus bi-annual — to improve compliance with diabetic retinal screens. We also track our performance against the Attachment G measures for which we have implemented a provider and enrollee incentive program, such as Measure 1. Well-Child Visits in

the First 15 Months of Life. We describe these provider and enrollee incentive programs in our response to RFP Section 2.10.4.1.4.

Comparison to State and National Rates and Subpopulations

We compare the health outcome measures of our enrollees to state and national rates and across subpopulations to identify targets by region, race/ethnicity and educational attainment. We use publically available data such as America's Health Rankings, the U.S. Census, Robert Wood Johnson Foundation, and analyses and data from OPH to understand the larger picture into which our enrollees fit. We evaluate public health measures in line with LDH priorities, which allow us to identify population health priorities and shape our responsive programs and partnerships.

We collaborate with Mom's Meals to provide two meals per day for 7-14 days delivered to the enrollee's place of recovery upon discharge. This program has been successful in helping reduce avoidable utilization in other states. In Wisconsin, total emergency room PMPM decreased by 35% for members after joining the program. Implemented in November 2018 in Louisiana, we are seeing positive indications of its effectiveness. Ninety-five % of enrollees engaged avoided readmission after discharge from an acute hospital setting.

Using a population health approach to address priority SDOH

Addressing SDOH is a vital component of improving population health. To support Louisiana's population health goals, we have developed a robust approach to collecting SDOH data through ICD-10 coding and other external data sources. Once identified, we are addressing the needs through strategic development of relationships with CBOs and our enrollee's communities to expand access to services. Our end-to-end model is informed by lessons learned as a Center for Medicare and Medicaid Innovation accountable community of health grantee and through multiple community-focused pilots.

2.10.4.1.2 Measuring population health status and identification of sub-populations within the population;

With our baseline measures established annually, we divide the population into subpopulations experiencing a disparate level of need. These subpopulations are based upon risk level, geographic area, access to care and common demographic factors, such as race/ethnicity, age and gender; for example, pregnant women and their infant children. Our suite of data analytics tools and strategies to measure population-health status helps us identify enrollee subpopulations with unique needs and provide targeted interventions accordingly. We stratify soon after enrollment and re-stratify on an ongoing basis.

Predictive modeling. Each month, we analyze our enrollees and identify subpopulations who may benefit from case management using algorithms to assess gender, age, other demographic variables, prior year total cost of care spending, acute inpatient admissions, ED visits, pharmacy, behavioral conditions and chronic conditions. The analysis applies more than 300 clinical rules to identify enrollees with gaps in care, condition-specific triggering events, high utilization, risk markers, substance use concerns and the impact of SDOH to their overall risk. ***Our predictive modeling algorithms have positive predictive validity of nearly 80%,*** allowing us to identify individuals and patterns among those individuals to proactively intervene.

Hotspotting. Hotspotting is a data-driven process to map geographical areas with the highest concentration of enrollees who use a disparate amount of medical, behavioral and social resources. Launched in June 2018, our proprietary Hotspotting tool provides the timely identification and engagement of enrollee subpopulations such as those with inappropriate utilization patterns, complex social, behavioral or medical needs and high costs within a defined region of Louisiana. Its dashboard provides a host of filters to segment enrollees by

demographics, SDOH, utilization, cost, diagnosis, risk factors and enrollment in case management. The tool provides heat maps and summary statistics that offer our clinical team an understanding of subpopulations that could benefit from additional community support.

HealthView Analytics/Next-generation behavioral economics. In 2017, we developed our HealthView Analytics Clinical Dashboard for identifying key metrics, such as avoidable ED use, ED use per 1,000, NICU admissions or enrollees who are pregnant, enrollees who have HIV and have opioid use disorder (OUD) at the parish or provider subpopulation. We then apply behavioral economics to influence human behavior for each subpopulation through customizing our communications to them, using tailored presentation of choice, framing messages and designing financial rewards. Proven behavioral economics principles point to new methods for facilitating, engaging and helping enrollees continue their healthy behaviors.

LDH Program Goal: Supporting innovation and a culture of continuous quality improvement in Louisiana

We are partnering with ***NextHealth Technologies to implement its artificial intelligence platform,*** which predicts opportunities to address risk and prescribes personalized actions to improve outcomes for enrollee subpopulations. NextHealth offers powerful, subtle suggestions that alter behavior without harsh consequences and provide subtle cues to each sub-population to make the right choice desirable.

2.10.4.1.3 Identifying key determinants of health outcomes and strategies for targeted interventions to reduce…

In 2018, nearly 50%of our enrollees responded in their HNA that they had some form of SDOH need.

We understand that access to care, socioeconomic status or education can influence the physical and mental health of individuals and the resiliency of communities. Our deep understanding of SDOH comes from both our field-based care teams who live in the communities we serve and publically available data, such as reports from LDH's Bureau of Minority Health Access and Promotions. We identify factors that impact health outcomes through a variety of data sources and analytic methods including demographic data, geography, our HNA, predictive modeling algorithms and our comprehensive assessment, which includes 33 questions that identify an enrollee's SDOH.

LDH Program Goal: Advancing health equity

To better understand a specific subpopulation's determinants of health, we are partnering with the Urban League of Louisiana (ULLA) to identify the factors that lead to poor birth outcomes. The ULLA conducted four listening sessions in Baton Rouge, New Orleans, Shreveport and Alexandria in early 2019 to assess women's access to and methods they use to access health care. In 2019, we are inviting community leaders, regulatory, political leaders and organizations, such as the March of Dimes, to two symposia in collaboration with the mayors of New Orleans and Baton Rouge to address the findings from our ULLA partnership. We plan to examine further indicators of health and well-being, including disease rates like diabetes and AIDS, and access to health insurance and health screenings.

Addressing Determinants of Health Disparities

In 2016, we developed our Louisiana Health Disparities Action Plan, which analyzed four areas against HEDIS performance measures, state goals and NCQA Quality Compass Benchmarks to determine specific gaps in care by urban and rural locations, member race, ethnicity, gender and age. We also considered those areas of priorities defined by LDH. We use tools, such as *Healthify,* to refer to resources available to each sub-population to address their needs. *Healthify* includes 3,929 Louisiana-based resources, including social support, financial support,

food and housing. Our community health workers (CHWs) work throughout the state to connect enrollees to community resources. Following are two examples of our work to identify and support subpopulations facing disparate outcomes due to key determinants of health.

Addressing High Maternal Morbidity and Mortality among African-Americans living in East Baton Rouge, Lafayette, Jefferson and Caddo

Analysis of baseline health outcomes provides insight into the needs of our enrollees so we can design interventions that address their needs. For example, we know Region 2 has the highest infant mortality rate in the state and our highest volume maternal provider, Woman's Hospital in Baton Rouge which has seen a 67% increase in babies being monitored for neonatal abstinence syndrome between 2013 and 2016. Women who are dealing with OUD/substance use disorder (SUD) are less likely to seek perinatal care due to the stigma, affecting their health and the health of their babies.

> We match our staffing to the demographics of the enrollees we serve to help promote trust and increase engagement with our enrollees. For example, all four of our HFS case managers in Region 2 are African American and three of the four case managers are of childbearing age and have children of their own.

As a result, we are expanding our Hospital Care Transitions (HCT) program, currently in place at Our Lady of the Lake Regional Medical Center and the LCMC Health University Medical Center, which facilitates a smooth hospital discharge to the enrollee's next level of care. In 2019, we will place a perinatal HCT coordinator in Louisiana Women's Healthcare clinic affiliated with Woman's Hospital in Baton Rouge. The HCT coordinator will address the prenatal needs of inpatient high-risk women to support at-term delivery and confirm continuity of care. This support includes addressing their SDOH and behavioral health concerns, collaborating with the HFS case management team to coordinate services and working with our neonatal resource services team to support a smooth transition for mother and infant after the NICU.

Addressing Access to Care Disparities in Rural Communities

Thirty-five of Louisiana's 64 parishes are considered rural and some parishes, such as St. Helena, have large rural populations. We know Louisiana's rural areas have lower rates of educational attainment, higher rates of poverty, unemployment, and complex chronic diseases and fewer and more isolated providers per capita. According to the 2018 America's Health Rankings, urban populations have higher average self-reported health status than their rural counterparts. These factors can lead to disparities among rural enrollees' access to care and related health outcomes. To address this disparity, we are implementing a telehealth suite that improves rural enrollee access to care by providing rural PCPs with access to specialty services via eConsult and providing enrollees access to services in their homes. Our solution includes:

- Connecting PCPs to specialists in over 120 specialties using RubiconMD (our specialist eConsultation partner)
- Using UHC Doctor Chat, a chat-first, virtual visit ED diversion program implemented in March 2019 where enrollees can use the app or web portal to communicate via secure chat, telephone or video with an RN or a physician who is licensed in Louisiana
- Educating enrollees about telehealth at NOELA Community Health Center, RKM Primary Care and Children's Hospital-LCMC
- Providing school-based telehealth in Plaquemines and Tangipahoa
- Providing access to behavioral health visits using a smartphone, computer or tablet to connect enrollees securely and privately to behavioral health providers

- Partnering with Genoa Healthcare (our specialized pharmacy partner embedded in behavioral health practices) to deliver behavioral health pharmacy services, such as medication adherence support, to enrollees with behavioral health needs
- Providing online cognitive behavioral therapy for prevalent behavioral health conditions and offering self-management tools, such as the Whole Health Tracker

2.10.4.1.4 How required components of this procurement and other Proposer developed initiatives are integrated…

Our PHM strategy is deeply integrated with several other key components of our managed care approach. Our population health efforts are bidirectional. Not only do we use our data aggregation and analytics tools to inform our population health approach, we also use population health principles to inform our work across the broader organization. Our population health improvement strategies extend into member-centered case management, disease management and health promotion activities. We build in technical and program capacity to meet both population and enrollee-specific needs. We also engage our provider relations team, enrollee helpline and staff throughout the enterprise and shape our community investments to meet our population health management targets. Examples of our integrated approach:

Our Louisiana leadership is committed to improving population health and shares this vision across the local staff. For example, our understanding of the disparities faced by enrollees with behavioral health needs led our chief medical officer to shape the algorithms that identify enrollees for case management to elevate those with behavioral health needs.

We provide our care teams with tools, reporting and predictive modeling that give them the ability to continually monitor every enrollee for indications that their health status, needs or circumstances have changed and to understand if the enrollee is part of a target sub-population. Our care teams and providers respond to changing enrollee health status, needs or circumstances and take action, such as discharge planning for enrollees in the hospital or engaging the enrollee in case management. Our integrated Case Management Teams connect enrollees to programs based upon their medical, behavioral or social sub-population status.

Addressing health disparities. To address disparate access to care in Louisiana, we connect PCPs to top specialists in more than 120 specialties through RubiconMD. Our *Behavioral Health Toolkit for Medical Providers* connects PCPs to free screening tools and information about the treatment of common behavioral health conditions. It helps PCPs link enrollees to treatment, includes clinical practice guidelines for behavioral health disorders and promotes the use of behavioral health screening tools, such as the PHQ-9 and the DAST-10 drug screener.

Integration with quality. In addition to using quality metrics promoted by LDH, NCQA and other thought leaders to provide insight on enrollee and population health outcomes and health status, we address those population health priorities through provider and enrollee quality incentives. Our value-based contracting strategy further aligns with our quality improvement and population health campaign. For example, recognizing that maternal/child health is an area of focus for LDH, we have developed enrollee and provider incentives to reduce infant mortality and maternal mortality and morbidity (LDH priorities 2.6.1.1.2 and 2.6.1.1.3) by promoting healthy perinatal activities related to HEDIS measures, as presented in the table.

Attachment G Measures Covered by a PCP Incentive or Enrollee Incentive Program and the State's Goal			
Attachment G Measure	**PCP**	**Enrollee**	**Goal**
1. Well-Child Visits in the First 15 Months of Life	Yes	Annual $20 Gift Card	62.06%
2. Well-Child Visits in Third, Fourth, Fifth and Sixth Years of Life	Yes	Annual $20 Gift Card	72.45%
3. Adolescent Well-Care Visits	Yes	Annual $20 Gift Card	50.12%
18. Prenatal and Postpartum Care: Timeliness of Prenatal Care	Yes	HFS Rewards	83.56%
21. Prenatal and Postpartum Care: Postpartum Care	Yes	HFS Rewards	64.38%

Integration with utilization management (UM). Our UM activities support our population health program by providing objective and systematic monitoring and evaluation of enrollee care and services. Inputs from UM provide critical evidence about health care patterns and practices and provide information that shapes our population health programs. Using UM data analysis, our team can identify patterns of high ED use and deploy programs, such as *UHC Doctor Chat*, *Ready Responders* and *NurseLine* education to support sub-populations with high utilization.

As an example of how our population health efforts are integrated with other efforts across the organization, we have developed a cross-functional OUD/SUD strategy. Our Behavioral Health Medical Director Dr. Jose Calderon-Abbo deploys targeted efforts based upon in-depth information and experience based upon his engagement with external stakeholders throughout Louisiana, including the HOPE Council and CBOs. Our Pharmacy and UM Teams collaborate to identify enrollees at risk of SUD/OUD and our Provider Relations Team has expanded our available medication-assisted treatment (MAT) network. We train our Case Management Teams to offer specialized care that promotes recovery, such as referrals to Woman's Hospital Guiding Recovery and Creating Empowerment (GRACE) and Addiction Counseling and Educational Resources for pregnant women with SUD/OUD. Our enrollee education and community grants promote prevention, treatment and community-level resiliency.

2.10.4.1.5 Other considerations the Proposer may seek to present.

We use integrated baseline health outcomes and SDOH data to set targets for key sub-populations and develop strategic partnerships to address disparities. We understand pregnant women who have OUD are more likely to have a high-risk pregnancy and face disparately higher rates of maternal and infant mortality. In August 2018, we provided a $1.2 million grant to Baton Rouge Woman's Hospital to implement its GRACE program, which is open to all Medicaid enrollees. By partnering with GRACE, we have been able to overcome health disparities and reduce the effects of SUD/OUD on pregnant women and their newborns by:

- Training direct care staff in non-judgmental communication and early detection of substance misuse to encourage accessing prenatal care
- Connecting newly identified enrollees with OUD to the Pregnancy Substance Misuse Case Management Program early in their pregnancies
- Providing enrollees with comprehensive case management services and connection to social resources outpatient recovery services, care planning and one-on-one support offered by providers trained in obstetrics and addictive disorders
- Continuing support for up to 6 weeks postpartum, with a warm handoff to community resources, including addiction recovery treatment centers and social services supports

LDH Program Goal: Improving enrollee health

Women enrolled in the GRACE program birthed infants who weighed on average 1.35 pounds more than the comparison group. Their gestational age at delivery was 5 days greater than the comparison group, and all GRACE deliveries as of March 2019 were at term compared to 50% preterm deliveries in a comparison group.

2.10.4.2 Describe what the Proposer will do to address population health in the first year of the Contract…

In the first year, we will continue to leverage investments we have already made in infrastructure, analytics, care management and the provider network. These items are key to addressing the overall health of the population and our communities. We continually evolve our strategic approach by evaluating internal and external data sources, establishing measures and targets for improvement and creating partnerships and solutions to address population health

disparities. We have developed a population health strategic plan to prepare for NCQA certification in 2020, and we will work with LDH to confirm that our Strategic Plan meets the expectations in Appendix B, Section 2.6.1.2 by March 2020. Here, we provide milestones and timelines that support our plans to address population health in year one of the contract.

Our Strategic Plan incorporates all of the elements required in Section 2.6 of the model contract, including the identification of key populations, health promotion and disease prevention programs; interventions to address SDOH and disparities; and working with enrollees, CBOs and state agencies. The table presents a representative portion of the high-level milestones and time frames to implement elements of population health in the first year of the contract.

Addressing Population Health in the First Year of the Contract	
Milestone	**Timeframe**
Record new baselines measures for population health based upon LDH priorities	Q3 & Q4 2019
Conduct a series of meetings with OPH around priorities such as HIV, HCV and syphilis	Q3 & Q4 2019
Establish target measures for population health strategy	Q4 2019
Hold internal brainstorming session across departments to confirm population health strategy	Q4 2019
Develop and refine population health strategy	Q1 2020
Submit population health strategy to LDH	March 2020
Meet regularly with Daughters of Charity to discuss the CHW program and SDOH data	Ongoing
Update population health SDOH data with new analyses	Q2 2020
Incorporate publically available data into new baselines	Q2 2020
Update population health baseline data for 2021 with 2020 results	Q4 2020
Provide updates to LDH on progress towards Population Health Strategic Plan goals	Ongoing

The table presents milestones and time frames to expand our programs to address two key LDH priorities, infant mortality and maternal morbidity and mortality in year one of the contract.

Infant and Maternal Population Health Programs in the First Year of the Contract	
Milestone	**Timeframe**
Evaluate and establish maternal/infant mortality baseline measures	Q4 2019
Develop and refine maternal/infant population health strategies	Q1 2020
Integrate OB provider support staff in high volume hospital	Q1 2020
Launch provider maternal episodes incentive to 40 OB provider groups	Q1 2020
ULLA Maternal Health Listening Sessions: Review data and develop work plan	Q1 2020
Host New Orleans symposium for maternal child health	Q2 2020
Educate providers on the launch of Tulane maternal psychosocial consultation grant and encourage participation	Q2 2020
Launch enhanced Healthy First Steps Rewards program	Q2 2020
Review data outcomes from GRACE at Woman's Hospital	Q2 2020
Evaluate Ready Responders Mahmee Program of home visits to maternal members and consider expansion opportunities	Q2 2020
Host Baton Rouge symposium for maternal child health	Q3 2020
Aggregate and create an action plan based upon the outcomes of the two symposia	Q4 2020
Mail Healthy First Steps educational material to pregnant members	Q1, 2, 3, 4 2020
Conduct live outreach calls to expecting moms to address concerns and promote wellness	Q1, 2, 3, 4 2020
Refer pregnant women with hypertension to Heart Safe Motherhood remote monitoring and care coordination program	Q1, 2, 3, 4 2020

Infant and Maternal Population Health Programs in the First Year of the Contract	
Assess and pay out incentives for provider-gap closure on prenatal and postpartum report	Q1, 2, 3, 4 2020
Offer Healthy First Steps High-Risk Case Management	Q1, 2, 3, 4 2020
Conduct home visits for our high-risk pregnant mothers	Q1, 2, 3, 4 2020

The table presents milestones and time frames to implement our ***Housing + Health Pilot program***, described in our response to RFP Section 2.10.4.3 to engage our enrollees who have the highest utilization and costs and who need housing and services assistance.

Housing + Health Pilot in the First Year of the Contract	
Milestone	**Timeframe**
Phase 1: Build Local Socio-clinical Infrastructure (90-120 Days) Build partner relationships, manage approvals and sign contracts; streamline housing procurement; and align trauma-informed clinical model.	Q3 2019
Phase 2: Begin Serving Members and Deploy Trauma-Informed Care Support enrollee identification, work with housing-health partners and benefit from external clinical partners. Build local direct care infrastructure, including confirming a supply of housing vouchers, developing nonprofit partnerships, aligning enrollee resources (e.g., SNAP) and engaging specialty care, behavioral, medical and social providers.	Q4 2019
Phase 3: Review Patient Outcomes: Discuss cases and provide leading and lagging metrics	Q1 2020
Phase 4: Expand Care: Establish PCP and hire, train and manage direct care staff	Q1 2020
Phase 5: Evaluate success, improve on experience and consider expansion	Q3 2020

2.10.4.3 Describe the Proposer's recent experience with utilizing data regarding social determinants of health…

As discussed in our response to RFP Sections 2.10.4.1 and 2.10.4.1.3, we fully integrate SDOH data into our population health approach using a variety of data channels, including publicly available sources, predictive modeling algorithms and our comprehensive assessment, which includes 33 questions that identify an enrollee's SDOH. We describe three programs, developed based upon SDOH data, to improve the health status of targeted populations in this section.

Solutions for Homeless and Housing-Insecure Enrollees

We know housing insecurity or homelessness significantly affects individuals' health utilization, access and costs. On average, enrollees experiencing homelessness have 22 times greater ED utilization and 17 times more significant total claims costs compared to average. Our analyses show that Orleans Parish has the highest concentration of individuals experiencing homelessness in Louisiana. These enrollees have complex needs and are the highest cost enrollees in Orleans with claims costs 42 times greater than the average.

Figure 5. On behalf of UnitedHealthcare, Felice Hill and her manager Brad Grudmeyer received the Community Champions award at the LHC Housing Conference on April 3, 2019.

Louisiana is recognized as a national leader in its efforts to support homeless individuals through its Permanent Supportive Housing (PSH) Program. We are committed to addressing housing in Louisiana through the work of our PSH liaison, who has supported over 50 enrollees in housing, and our **new housing partner, Felice Hill**. In 2018, we worked with Louisiana Housing Corporation (LHC) and LDH to develop strategies to continue reducing homelessness and supporting individuals in housing, including offering bridge financing at no interest to LHC to support the HUD $11.5 million Continuum of Care PSH grant.

We are implementing two new programs in 2020 in New Orleans to complement the State's work by identifying, engaging, and activating UnitedHealthcare enrollees who have the highest utilization and costs and who need housing and services assistance.

Medical Respite Program. Medical respite is short-term residential care that allows homeless individuals to rest in a safe environment while accessing medical care and other supportive services. Our planned program, to be offered as a value-added benefit (discussed in response to 2.10.3), provides medical respite that includes accessible accommodations, post-acute clinical care, care coordination and wrap around support services, such as applying for SSI/SSDI or food stamps. Accessible accommodations include a bed (24 hours a day), on-site showering, laundry, secure storage and three meals per day. We have begun to identify members in New Orleans who could benefit from medical respite — 113 members self-identified as homeless accounted for 20% of our total enrollee inpatient cost, and 22% of inpatient days.

Housing + Health Pilot. We have signed a Letter of Intent with Start Corporation to implement a Housing + Health Pilot, outlined in our response to 2.10.4.2. Start is licensed by LDH to provide community-based services, accredited by the Commission on Accreditation of Rehabilitation Facilities and certified as a Level 3 Patient Centered Medical Home (PCMH). We will apply their expertise with Housing First to develop 25 PSH units in locations throughout the state, including New Orleans, Shreveport and Baton Rouge. Through the pilot program:

- We engage the enrollee face-to-face in the ED or at the hospital when they are inpatient
- Working closely with our case management team, a housing specialist meets our enrollee and builds a meaningful relationship
- From discharge, the housing specialist helps our enrollee move into their home and offers basics, such as furniture and food
- Once transitioned, we support our enrollee using evidence-based practices, including harm reduction, trauma-informed physical-social-behavioral health care, positive psychology and interventions for adverse childhood experiences (ACEs)

> Our housing specialist helps enrollees develop a housing plan that outlines steps for achieving stable housing. She meets with enrollees to track and assess progress, identify barriers and troubleshoot solutions that help them establish goals and access PSH as soon as possible.

Addressing Diabetes through Healthy Living and Food Smart Families

We understand chronic diseases are an LDH population health priority. Through our state disease condition and disparities analysis, we found Regions 1, 3, 7 and 8 (including Orleans, St. Charles, St. Mary, Caddo, Tensas and West Carroll parishes) had the highest diabetes prevalence and high rates of food insecurity as measured by children receiving free/reduced lunch. For example, Tensas parish has a food insecurity rate of 26.1% and the highest statewide diabetes rate at 17.2%. To address these disparities, we partnered with the Louisiana 4-H Healthy Living and Food Smart Families programs.

Food Smart Families provides youth with nutrition, food budgeting and meal preparation programming, engages families through events and provides referrals to local hunger relief resources and ingredients for healthy dishes. The program is active in Orleans, Lafayette, St. Charles, East Baton Rouge and St. Mary parishes. Since 2012, UnitedHealthcare and LSU AgCenter have delivered 4-H Healthy Living programs to over 52,000 youth and families across Louisiana, including Tensas neighbor Franklin parish, supporting better diabetes management.

LDH Program Goal: Improving enrollee health

Among our expansion population with diabetes, ED utilization/1,000 enrollees decreased 9% between 2017 and 2018, and among TANF enrollees with diabetes, the decrease was 10% over the same period.

Partners in Health with Daughters of Charity

We are establishing a foundation to develop further SDOH interventions through ***our Partners in Health program*** launched in April 2018 with Daughters of Charity. Through a $2.5 million grant, we supported the hiring and training of 15 Daughters of Charity CHWs who assess at-risk individuals, identify social barriers, and refer and connect enrollees to appropriate community programs and resources. CHWs use the National Association of Community Health Center's PRAPARE assessment tool to understand social needs and barriers to care, such as housing status and stability and education. To connect individuals to resources, CHWs use the Aunt Bertha resource database and connect individuals to Daughters of Charity's health centers to address medical, dental and behavioral health needs. We will use the data from this program to understand how engaging with these resources affects an enrollee's health outcomes and develop partnerships to address SDOH gaps statewide.

Figure 6: Care fellowship team at Daughters of Charity with UnitedHealthcare employees

In 2018, CHWs at Daughters of Charity reached 8,234 unique individuals, encompassing both our enrollee and non-enrollee population. Of those individuals, 5,195 completed referrals to receive medical, dental, and behavioral health services. To address SDOH needs, 3,039 individuals received services through community-based organizations.

2.10.4.4 Describe the Proposer's approach to contracting with community-based organizations and OPH to…

Our partnerships with OPH and over 35 diverse CBOs in the past 3 years inform and strengthen our population health improvement strategies. Our contractual arrangement with OPH allows us to exchange specific data about our enrollees to improve access to preventive services, including recommended adult wellness visits and screenings for HIV and sexually transmitted diseases. Developing trust and alignment with CBOs who serve our enrollee communities is crucial to coordinating effective population-health improvement strategies; these successful partnerships do not always necessitate formal contracts. We apply local knowledge provided by our on-the-ground staff, including our Provider Network and Community Outreach Teams, to identify CBOs aligned with LDH's population health priorities. We understand each CBO partner's unique mission/vision, population served, capabilities and cultural expertise to develop locally relevant population-health improvement strategies informed by our national expertise.

Our $4.4 million investment in Louisiana CBOs over the past 7 years has helped us better understand and address our enrollees' population health needs while simultaneously building community resilience. To promote young children's healthy development and prevent ACEs — a shared priority with LDH — we partnered with the Childhood and Family Learning Foundation, Caddo Head Start, Christus School-Based Bullying P and sponsored "Booking It with Baby" with the Glenn "Big Baby" Davis Foundation. To prevent and promote management of chronic diseases — an LDH shared priority — we have worked with CBOs, such as the American Heart Association, Second Harvest Food Bank, Whole Kids Foundation and Fit for Life to coordinate solutions around unhealthy diet and physical inactivity for our enrollees in their communities.

2.10.4.5 [OPTIONAL] Respond to the following questions to be considered for piloting a Community Health…

2.10.4.5.1 Why is the Proposer interested in this opportunity?

Louisiana faces some of the most significant health challenges in the United States. As a partner to the State, it is incumbent upon us to help LDH **support innovation and a culture of continuous quality improvement** to address these challenges. Sharing LDH's vision, UnitedHealthcare is committed to advancing and supporting community-based initiatives to **improve enrollee health** outcomes for the residents of Louisiana.

Health care is local and encompasses more than clinical services. Without resources like healthy food, reliable transportation, stable housing or social connection, a person's health can be adversely affected. Left unaddressed, social determinants of health (SDOH) can lead to higher utilization and higher costs. . By focusing on delivering health care one person at a time where they live, we know we can meaningfully impact people's lives. We believe a population health approach confronting public health issues at the local level with community health workers (CHWs) will improve enrollee health outcomes and reduce health disparities in Louisiana.

We are excited to spearhead IMPaCT Louisiana, the demonstration pilot developed by Penn Center for Community Health Workers (PCCHW) and LDH. We look forward to helping LDH deploy an effective, evidence-based and financially sustainable CHW-first model that can be replicated statewide. Participating in IMPaCT Louisiana provides an opportunity to learn from and draw upon the important work already done by key stakeholders from LDH, PCCHW, and Center for Healthcare Value and Equity at the LSU Health Sciences Center (CHVE) in developing this evidence-based CHW initiative and implementing best practices in a deliberate, step-by-step action plan laid out in the *Blueprint.*

Aligned with LDH's vision, we believe in the efficacy of evidence-based, scalable CHW-first models. Drawing upon our organizational experience in deploying this strategic approach in other states will bring value to LDH as we invest in IMPaCT Louisiana to improve the lives and health of our enrollees.

Dr. Jeff Brenner, SVP of Clinical Redesign and the founder and CEO of the Camden Coalition of Heatlhcare Providers, leads our Clinical Redesign Team, a direct-care delivery unit focused on the deployment of community-based care models for our most complex Medicaid enrollees. Early results show that we can achieve improvement in the quality of care and reduce cost and utilization through the integration of physical health, behavioral health and social services delivered at home and in the community. CRT seeks to accelerate the development and expansion of these kinds of care models, using an integrated approach that addresses SDOH.

Outcomes for the myConnections Program in Arizona

Enrollee total cost of care declined 55% from $4,403 PMPM pre-engagement to $1,941 PMPM post-engagement. Enrollees' inpatient and ER utilization decreased dramatically, by up to 80%.

We are eager to move beyond pre/post analysis to comparison groups and to work with PCCHW and CHVE on the design and implementation of a randomized, controlled trial as part of IMPaCT Louisiana.

The evolution of our community-based, Housing is Health Care model started 3 years ago with the myConnections program. Informed and inspired by the NUKA Health System, a tribal-owned and managed system run by the South Central Foundation in Alaska, our myConnections model organizes resources in a community to address individuals' SDOH in an organized and intentional approach rather than as isolated experiences. This model supports communities and enrollees to improve health outcomes and develop self-sufficiency.

We understand community-based care models like myConnections, must be embraced by leadership from the top down to be successful and sustainable. For example, our leadership has trained at NUKA and they have been engaged in the transformation of our community-based care model from the beginning. For us, this local approach to health care is embedded in the DNA of our entire organization. We recognize this same leadership approach and commitment in LDH's vision, research and development of IMPaCT Louisiana.

The CHWs play an integral role in myConnections. We have recruited CHW generalists who are trained, equipped and familiar with community issues to solve for them. Using trauma-informed care, harm reduction, and motivational interviewing, our CHW generalists deepen relationships with enrollees by promoting their independence, wellness, recovery and resiliency. In multiple markets, myConnections provides housing for high cost, complex enrollees experiencing homelessness through a high fidelity, housing first model. Enrollees receive an apartment and wraparound services with a focus of supporting individuals to independence. CHWs provide patient-centered social support to address health inequities and real-life issues.

Implemented in Louisiana in 2018, our Hotspotting Tool identifies enrollees who would benefit from CHW engagement. Typically, these enrollees have high utilization of services as well as social and behavioral complexities. With Hotspotting, we can identify enrollees most likely to benefit from our CHW approach — a direct, evidence-based, in-the-community approach to service delivery. CHWs engage enrollees directly in place-based interventions, whether it is at the hospital bedside, at a homeless shelter or other location.

LDH Program Goal: Improve enrollee health

Further emphasizing our support and investment in community-based models and our belief in the importance of CHWs in improving population health is UnitedHealthcare's grant to the Daughters of Charity Health Centers in New Orleans for $1.5 million in 2018, followed by an additional $1 million in February 2019 for a total of $2.5 million in funding. Daughters of Charity used the initial grant to hire and train a team of 15 CHWs who assess at-risk individuals, identify social barriers and quickly link these vulnerable individuals to targeted interventions and resources within the community. CHWs at Daughters of Charity reached 8,234 unique individuals in 2018. Of these individuals, 5,195 completed referrals to receive medical, dental and behavioral health services through the health centers, and 3,039 completed referrals to receive services through community-based organizations, including referrals to address education, employment, food, housing, transportation, technology/internet and legal needs. In 2019, Daughters of Charity expects to reach 7,500 individuals using CHWs.

Drawing upon shared experience and a common vision to help Louisianans live healthier lives, we look forward to collaborating on IMPaCT Louisiana to connect enrollees to the most appropriate care in the most appropriate setting while reducing low-value care utilization.

2.10.4.5.2 How many CHWs does the Proposer currently employ? In what parts of the state?

In Louisiana, we currently employ 37 CHWs in parishes throughout all nine regions of the state.

We are committed to making incremental investments in the demonstration pilot beginning with six additional CHWs. This number is based upon a pilot of 600 enrollees (*Blueprint*) with a CHW/enrollee ratio of 1:100 as outlined in Appendix B, Model Contract, 2.6.3.2.5.

2.10.4.5.3 What is the Proposer's CHW/member ratio?

Our CHW to enrollee ratio for this pilot will be 1:100.

2.10.4.5.4 What are the main activities in which the Proposer's CHWs are currently engaged?

As trusted members of our field-based care teams, CHWs serve as a link between health and social services in the community — facilitating access to services and improving the quality and cultural competence of service delivery to enrollees. CHWs remove barriers to care by addressing SDOH and linking enrollees to the community and social resources needed to support healthy outcomes and reduce health disparities. Walking alongside our enrollees, CHWs help build individual and community capacity by increasing enrollee health knowledge and self-sufficiency through a range of activities, including outreach, community education, informal counseling, social support and advocacy. Specifically, our CHWs:

- Locate and engage difficult-to-reach enrollees and build trusted relationships
- Conduct in-person holistic assessments to understand enrollee needs, preferences and socioeconomic barriers
- Assess barriers to healthy living and accessing health care, including home visits
- Foster relationships with community organizations and link enrollees to social services (such as housing and AC/heating assistance) and surrounding support services
- Promote sustained, continuous enrollee/provider relationships
- Arrange appointments with medical and behavioral health providers and coordinate transportation as needed
- Outreach to enrollees when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care
- Provide health promotion, coaching and encouragement to enrollees in the self-management of chronic conditions while providing the tools and resources to do so
- Provide social support to help boost enrollee's morale and sense of self-worth
- Serve as a key knowledge source for services and information needed for enrollees to have healthier, more stable lives

2.10.4.5.5 How are the Proposer's CHWs currently trained? What are the minimum training requirements?

We embed the culture of trauma-informed care in the training and development of all frontline staff, including CHWs. Subject matter experts from our CRT provide training on evidence-based clinical care concepts, such as trauma-informed care and adverse childhood experiences (ACEs), while incorporating other principles like motivational interviewing, harm reduction, positive psychology and person-centered care. These training sessions broaden our knowledge base and help us create a trauma-informed environment to better understand, engage and support enrollees with complex socio-clinical needs.

As the enrollee's advocate in the community, CHWs are trained to identify needs and gaps and link enrollees to resources that promote, maintain, and/or improve health outcomes and reduce health disparities. CHWs are trained to locate and encourage engagement with social supports by working directly with the enrollee in their immediate community. CHWs also receive condition-specific training for a solid understanding of specific conditions supported through our models of care (e.g., heart failure, chronic kidney disease, sickle cell). Understanding common health problems, along with issues related to chronic illness and interventions, builds the foundation for meeting the tailored needs of our enrollees. Our goal is to provide culturally competent coordination of care with compassion and empathy while building trust and encouraging enrollees to obtain their short-term and long-term goals.

2.10.4.5.6 Does the Proposer have a process to ensure that its CHWs are trusted by the communities they serve?

Our process to facilitate trust between CHWs and the communities they serve begins with hiring CHWs who reside in local parishes, and share sociodemographic and cultural characteristics (e.g., income, race, education, language) with our enrollees. By working where they live, CHWs have a close understanding of the cultural and social fabric of their communities. With ties to their communities, CHWs bring personal knowledge of local needs, cultural competency and familiarity with social supports and resources, including local community-based organizations and faith-based groups.. Because of their firsthand knowledge of their communities, shared cultural/social experiences and ability to relate to enrollees personally, CHWs build trust, respect and understanding with enrollees. CHWs from local parishes are often aware of and can solve for social issues that others outside their communities might not see. Understanding community nuances and building trust through cultural competency allow CHWs to remove barriers and solve for social determinants of health, maximizing enrollee satisfaction, improving health outcomes and reducing health disparities.

2.10.4.5.7 What data does the Proposer collect to know if its CHW program(s) is (are) working?

We collect and use data in a number of ways to support the effectiveness of our CHW programs. CHWs gather data through health needs assessments (HNAs) and comprehensive assessments, and document enrollee interactions and updates to an enrollee's plan of care in CommunityCare, our clinical documentation platform.

LDH Program Goal: Support innovation and a culture of continuous quality improvement

UnitedHealthcare has partnered with NCQA and the National Association of Community Health Centers to implement diagnostic codes for services that target the SDOH. One of the key barriers to expanding access to nonmedical care for social needs is a lack of coding standardization. In response, we have started to roll out new ICD-10 codes that providers can use to document these needs.

Our newly announced collaboration with the American Medical Association (AMA) continues to build on these efforts. We are working with AMA to standardize how data is collected, processed and integrated for social and environmental factors contributing to an enrollee's well-being. UnitedHealthcare is also working with CMS and CDC to facilitate the nationwide adoption of ICD-10 codes.

In March, UnitedHealthcare received the 2019 Healthcare Innovation Award recognizing our work on SDOH and our initiatives to implement ICD-10 codes that track key social determinants of health indicators. UnitedHealthcare is the first health plan to receive this award.

We are also assisting Daughters of Charity in assessing the impact of their CHW interventions through ongoing data exchanges related to the adoption and expanded use of ICD-10 codes to identify social barriers to care. We use data capture and analysis to provide a monetary value for the services their CHWs helped to provide when linking individuals to targeted interventions and resources within the community. We integrate social and "non-traditional" data at scale, standardize it and value it — transforming disparate data elements into actionable information in clinical, enrollee experience and population analytics to help drive better health outcomes for our enrollees.

We have significant data capture and data analytic capabilities and look forward to collaborating with LDH, PCCHW and CHVE on ways to make the assessment of the CHW pilot program more robust by making this data available for tracking, measuring and evaluating outcomes and cost-savings for IMPaCT Louisiana.

2.10.4.5.8 How are the Proposer's CHWs or other care management staff integrated with providers?

As members of our field-based care teams and multidisciplinary Hotspotting teams, our CHWs are integrated with our case management programs, bridging community and clinic, to help our enrollees successfully navigate the health care system. They make important contributions to our care teams, establish and maintain trusting relationships with enrollees outside of a clinic environment and provide us with a deeper understanding of the communities we serve. We look forward to working with LDH and exploring ways to expand the integration of our CHWs with practice sites to foster relationships and better communication with their clinical teams as noted in the *Blueprint* (e.g., placing CHWs in one or two hospitals or clinics in the pilot's hotspot regions to create "clinical homes" or physical touchdown spaces for CHWs).

2.10.4.5.9 Who is the contact person for this application?

The contact person for this application is Scott Waulters, interim CEO, UnitedHealthcare of Louisiana, Inc.

2.10.4.5.10 Who is the lead team member who will oversee implementation?

Dr. Jeff Brenner and our CRT will oversee the implementation of LDH's IMPaCT Louisiana demonstration pilot. Our local physician leadership of Dr. Julie Morial, Chief Medical Officer and Dr. Jose Calderon-Abbo, Behavioral Health Medical Director will support Dr. Brenner.

2.10.5 Care Management

2.10.5.1 The Proposer should describe its anticipated approach to meeting the care management requirements of…

Implemented in 2015 in Louisiana, our comprehensive care management program meets every enrollee where they are on their health journey and connects them with programs, services and supports that help them live healthier lives and helps LDH achieve its goals and objectives. It aligns with Appendix B, Section 2.7, Care Management. Our program has reduced avoidable utilization, increased enrollee satisfaction and improved health outcomes.

LDH Program Goal: Improving enrollee health

We are committed to the Triple Aim of better care for our enrollees, better health for populations and lower costs. Comparing utilization from the 1-year period October 2016 through September 2017 to October 2017 through September 2018, our care management program has achieved the following:

- A **7.7% decrease** in total inpatient admissions per 1,000 across our TANF population
- A **5.3% decrease** in emergent emergency room visits for our non-expansion population
- A **4.7% decrease** in non-emergent emergency room visits for our non-expansion population

Our care management approach ***identifies*** each enrollee's unique situation, ***engages*** them with locally based care teams, ***supports*** enrollees and providers with programs tailored to their needs and to improve outcomes, and is continually ***evaluated*** to confirm its effectiveness.

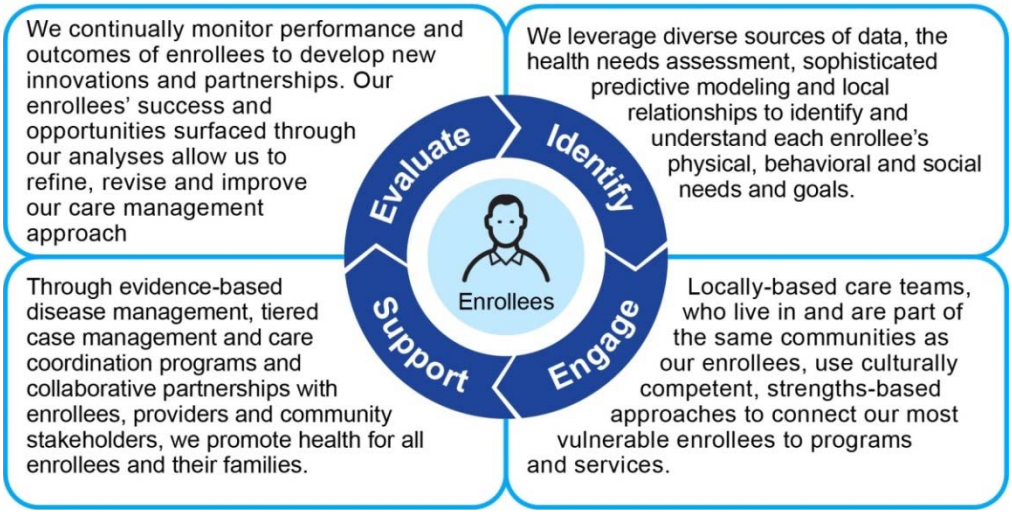


Figure 7. Our approach identifies enrollee needs, engages through locally based care teams, supports with programs tailored to enrollee needs and is continually evaluated for effectiveness.

We are enhancing our program by incorporating innovative, enrollee-focused resources to continue to protect and promote health among Louisiana's most vulnerable populations. These include next-generation tools to identify enrollee subpopulations such as HealthView Analytics, case management programs such as our Hospital Care Transition (HCT) program, strategic relationships with partners such as BehaveCare, housing resources, and resources that improve our enrollees' access to care, such as our UHC Doctor Chat telehealth solution.

LDH Program Goal: Ensuring enrollees ready access to care

To increase each enrollee's access to care and provide alternatives to ED use, we implemented **UHC Doctor Chat**, a chat-first, virtual visit ED diversion program in Louisiana in March 2019. Enrollees can use an app or web portal to communicate

via secure chat, telephone or video with an RN or physician licensed in Louisiana. For enrollees in case management, their case manager is alerted that they have used the tool, which prompts the case manager to follow up with the enrollee to address acute needs or close gaps in care.

2.10.5.1.1 The Proposer's process for ensuring that there is success in completing enrollee health needs…

In 2018, our MSAs made 168,000 phone calls and left 25,000 messages to reach our enrollees to conduct the HNA. Our efforts help us connect with and assess our enrollees within required time periods — in 2018, we completed nearly a third of HNAs within 5 days of enrollment.

Completing the new enrollee welcome call and HNA are critical to identifying enrollees who may benefit from case management and connecting them to resources as soon as possible. The welcome call is often our first live contact with an enrollee and the HNA is our opportunity to understand our enrollees in a personal way. We recognize that we are asking enrollees to share deeply personal information through the HNA, so we train our *Advocate4Me* member services advocates (MSAs) on enrollee-centered engagement strategies that build trust and confidence with every enrollee. Among enrollees reached telephonically, we have achieved ***monthly HNA completion rates as high as 94%***.

Local teams with knowledge of Louisiana develop our welcome call and HNA protocol. A national interdisciplinary committee confirms our HNA meets nationally recognized NCQA Population Health Management standards, includes evidence-based social determinants of health (SDOH) domains and achieves high levels of enrollee engagement. We bring to Louisiana experience and lessons learned from deploying comprehensive HNAs in 25 states that address behavioral health and SDOH. We look forward to partnering with LDH to develop an HNA to identify the needs of all enrollees.

We administer HNAs within the required time frames in Appendix B, Section 2.7.2, Health Needs Assessment using a variety of methods (print, web-based and telephonic). Within **14** days of enrollment, an *Advocate4Me* MSA makes at least 3 attempts to complete the new enrollee welcome call and HNA, calling at different times of the day and on different days of the week to maximize success. MSAs document each attempt in CommunityCare, our care management platform. To increase completion rates, we:

- ***Send a postcard*** letting enrollees know we are trying to reach them with directions to call us back
- ***Incentivize enrollees*** with a $10 gift card for completing their HNA within 90 days of enrollment
- ***Take advantage of every enrollee interaction*** to complete the HNA. For instance, when an enrollee calls *Advocate4Me* or *NurseLine,* our systems notify our staff when an enrollee needs an HNA, so they can work with the enrollee to complete it.
- ***Continuously monitor and improve our process*** through call audits and coaching, monthly call reporting, an assessment dashboard and internal performance metrics.

Since launching our HNA incentive in 2015, we have provided more than **$730,000 in incentives to 73,134 enrollees**, helping Louisiana achieve the #2 HNA completion rate across UnitedHealthcare's 25 Medicaid Managed Care plans.

Once we identify an enrollee who may benefit from case management, we make every effort to engage them and complete an HNA using our team of CHWs who live in the communities they serve and community partners, such as BehaveCare. We also leverage pharmacy data to identify the enrollee's most up-to-date contact information and hospital notification data to try reach and assess enrollees while they are in an inpatient setting.

LDH Program Goal: Ensuring enrollees ready access to care

We have signed a letter of intent with BehaveCare, which specializes in locating and engaging enrollees in New Orleans and Baton Rouge who are homeless or have limited resources, inconsistent support systems and higher use of emergency services. BehaveCare's community-based care specialists complete enrollee HNAs, conduct comprehensive assessments, provide Tier 3 case management services and facilitate in-home telemedicine visits to access primary, specialty and behavioral health providers.

2.10.5.1.2 How the Proposer will utilize predictive modeling, referrals and the HNA process to identify…

We use comprehensive data inputs, advanced analytics, clinical expertise and local knowledge to create a 360-degree view of our enrollees' and identify individuals who would benefit most from case management. Our identification and stratification tools identify enrollees who require intensive clinical intervention, such as those with special health care needs, high-risk pregnancy, unmanaged complex medical or behavioral conditions or acute social determinants, such as homelessness. As presented in the figure, our evidence-based process integrates HNA and predictive modeling results to understand ***every*** enrollee's needs and health risk; and how they might benefit from case management or other population health programs.

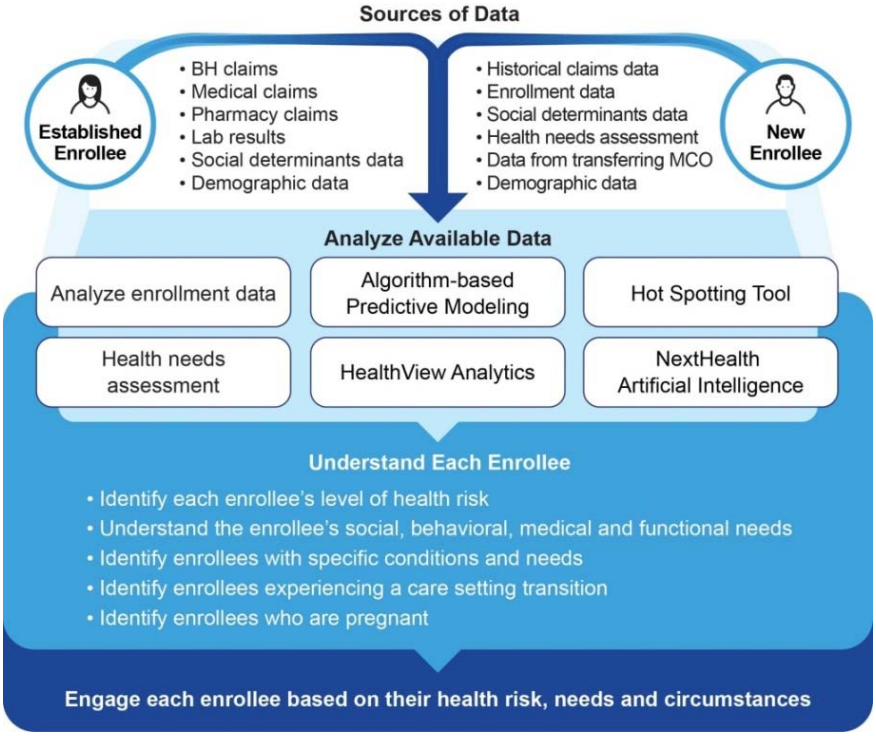


Figure 8. Understanding each enrollee. Our process incorporates an HNA for new enrollees and a monthly analysis of all enrollees using a variety of data sources and a suite of advanced analytics tools. It delivers a risk score for each enrollee and identifies case management needs and enrollees with special health care needs, specific conditions or who are experiencing a care setting transition.

Identifying Enrollees – Initial Health Needs Assessment

Our evidence-based pediatric and adult HNAs evaluate each enrollee's health and wellness and identify critical information, such as social, behavioral, medical and functional conditions and needs; PCP and provider relationships; existing treatment plans; current services, including over and underutilization of services; and barriers to accessing care. The HNA findings lead to immediate engagement of resources to meet the enrollee's needs. For instance, we refer enrollees with high-risk scores or special health care needs for a comprehensive assessment

and engagement in case management, and connect pregnant enrollees to a maternal support team to help them access prenatal care and programs, such as Healthy First Steps (HFS) and HFS Rewards.

When the HNA identifies an enrollee's behavioral health condition, it triggers additional assessments to understand their needs. For example, our adult HNA includes validated tools, such as the Alcohol Use Disorders Identification Test (AUDIT)-C to screen for risky drinking and the Patient Health Questionnaire (PHQ)-2 depression screener. Our pediatric HNA assesses trauma using the Child Stress Disorders Checklist-Screening Form, and depression using the PHQ-9.

Identifying members with special health care needs to engage them in case management is a crucial priority shared with LDH. In 2018, 37% of enrollees in case management were identified as having a special health care need through the HNA.

Identifying Enrollees — Referrals

We accept referrals from enrollees, families, providers, state agencies, such as the Office of Behavioral Health, and UnitedHealthcare departments, such as our *Advocate4Me* enrollee services center, per Appendix B, Section 2.7.5, Referral to Case Management. Our field-based staff and strong community partners, such as permanent supportive housing (PSH) providers, also identify enrollees for case management. Through our ***Shared Savings Value-based Payment (VBP) Provider Group program***, our provider-facing staff works with physician practices to identify enrollees in the hospital or who have visited the ED, have gaps in care or may require case management. Through ***VBP programs***, we incentivize providers for identifying enrollees who may benefit from case management. For instance, our ***Maternity VBP*** includes a ***Notification of Pregnancy (NOP)*** incentive, which identifies enrollees early in their pregnancy and connects them to our HFS program.

Helping an Enrollee with a High -Risk Pregnancy

Our enrollee, Jennifer, is a 44-year-old woman whose pregnancy had several risk factors, including two previous pre-term births, five previous miscarriages and advanced maternal age. We identified her high-risk pregnancy via the NOP and reached out to her to enroll her in HFS case management. After speaking with Jennifer, her OB-experienced RN case manager also referred her to our OB Homecare program to provide Jennifer with 17P to reduce her chance of pre-term birth. Jennifer's case manager worked with her OB Homecare RN to schedule weekly home visits. With support from these homecare visits and face-to-face assessments and pregnancy education from her case manager, Jennifer delivered her healthy baby at 37 weeks.

Identifying Enrollees – Predictive Modeling

Our predictive modeling process complies with the requirements in Appendix B, Section 2.7.3, Predictive Modeling. Each month, we use Impact Pro™, our predictive modeling tool, to analyze all enrollees and identify those who may benefit from case management. Our algorithms analyze gender, age, other demographic variables, prior year total cost of care spending, acute inpatient admissions, ED visits, pharmacy, behavioral conditions and total chronic conditions. The analysis applies more than 300 evidence-based clinical rules to identify enrollees with gaps in care, condition-specific triggering events, high utilization, risk markers, substance use concerns and the impact of social determinants to their overall risk. ***Our predictive modeling algorithms have positive predictive validity of nearly 80%.***

Identifying Enrollees – Our Hotspotting Tool

Hotspotting is a data-driven process to map geographical areas with the highest concentration of enrollees who have high needs and costs and who use a disproportionate quantity of health care services. Launched in June 2018, Hotspotting provides timely identification and

engagement of enrollee cohorts with high utilization patterns, complex social, behavioral or medical needs and high costs within a defined region of Louisiana. Our dashboard provides filters to segment enrollees by demographics, region, social determinants, utilization patterns, cost, diagnosis, risk factors and enrollment in case management and other programs. The tool provides heat maps that track utilization patterns across Louisiana. An individual enrollee view provides frontline staff with 12-months of historical utilization, cost and summary health statistics. The member summary, presented in the figure, is an example of information the tool provides on a select cohort of enrollees with specified characteristics.

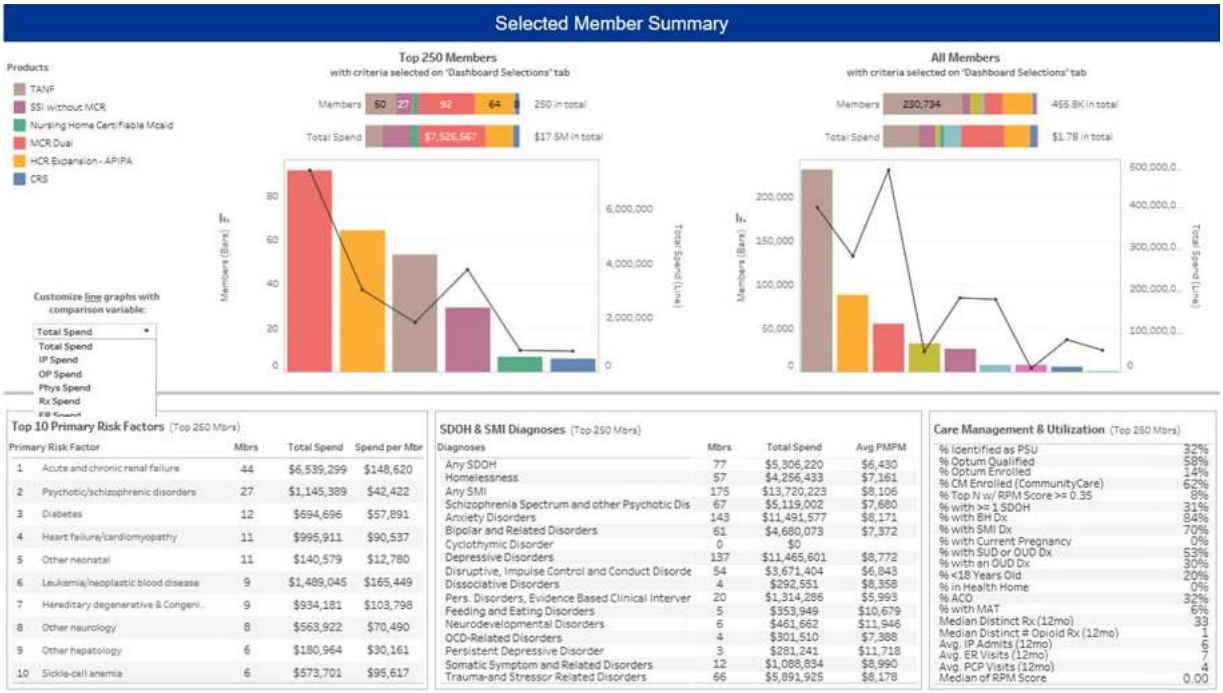


Figure 9. Member summary. This view summarizes statistics for cohorts of enrollees using filter criteria determined by the user. The view provides information such as the top 10 risk factors, SDOH and serious mental illness diagnoses and identifies care management utilization statistics within the cohort, such as the percentage of enrollees with an opioid prescription and average inpatient admissions.

LDH Program Goal: Improving enrollee health

Our Hotspotting Tool informed the creation of a specialized, field-based Hotspotting Team, which provides high-touch, trauma-informed Tier 3 case management. Engagement by our Hotspotting Team has resulted in a ***59% decrease in year-over-year PMPM inpatient costs*** driven by a decrease in admissions. ***ED utilization decreased 36%***, resulting in a ***38% year-over-year PMPM decrease in costs***.

2.10.5.1.3 How the Proposer will engage enrollees who may potentially benefit from case management in the…

Once we identify an enrollee who may benefit from case management, we make every effort to engage them using evidence-based strategies and to connect in a manner that is culturally relevant and appropriate to their circumstances. We know from experience that our population can be difficult to reach given Louisiana's unique geography and culturally diverse communities. Acknowledging that 35 of the 64 parishes in the state are considered rural, we locate our field-based care teams in every region of Louisiana and employ CHWs hired from the communities

where our enrollees live. In the Baton Rouge area (Region 2), where we have our largest cohort of enrollees, we staff nine CHWs who each have a deep understanding of the concerns and resources unique to their neighborhoods.

Our diverse and experienced teams of CHWs use their local knowledge and networks to outreach to an enrollee telephonically and in-person, traveling across their parish to visit an enrollee's last known address at least three times. If the enrollee is not home, the CHW leaves a door tag with contact information to encourage the enrollee to connect. ***In 2018, our team of CHWs across Louisiana completed more than 100,000 phone calls and 10,000 field visit attempts to engage enrollees in case management.*** We use a variety of methods to connect with and engage enrollees who may benefit from case management. For example, we:

- Send a letter to the enrollee to provide information about the availability of services that may support their needs and encourage the enrollee to contact us
- Benefit from local relationships, such as our partnership with BehaveCare
- Analyze LDH's historical claims data for new enrollees to identify recent providers and engage them to help us locate and engage the enrollee
- Conduct specialized outreach for pregnant enrollees through email and web-enabled maternity assessments and CHW seek-and-engage activities
- Analyze pharmacy data to identify refill dates and service locations. The CHW engages the enrollee's pharmacy to help us locate or conduct outreach to engage the enrollee
- Contact local homeless shelters or soup kitchens used by homeless enrollees or enrollees with a history of using community organizations to meet their needs
- Build relationships with housing resources, such as the Housing Authority of New Orleans, to help identify locations where we can find the enrollee
- Identify enrollee engagements with the health care system, such as an ED visit or a hospitalization. CHWs attempt to engage enrollees when they access services
- Build upon our relationships with State agencies, such as our behavioral health liaison dedicated to supporting the Louisiana Department of Education (LDOE), the Department of Children & Family Services (DCFS) and Office of Juvenile Justice (OJJ)
- Build upon our provider relationships, such as weekly meetings with Magellan who delivers Coordinated System of Care (CSoC) services to children and youth

Once we connect with the enrollee, a key component of our engagement is establishing trust and understanding the goals and capabilities of the enrollee, their family and other natural supports. We cross-train our case managers in physical and behavioral health and use staff members with shared knowledge and experience with enrollees, such as our peer support specialist. Through evidence-based approaches, such as motivational interviewing and trauma-informed care, our case managers actively listen to every enrollee and prioritize the enrollee's voice and choice in discussing the value and benefit of case management; and whether it is right for them. If the enrollee decides to participate in case management, we enroll them in a tier of case management aligned with their individual needs, as described next.

2.10.5.1.4 How the Proposer will identify the appropriate tier of case management for an enrollee using objective…

Through our identification process, we determine each enrollee's appropriate tier of support and connect them to the right services, providers and resources that meet their needs and help them achieve their individualized goals. Our objective measures and criteria confirm every enrollee receives information, linkages and services consistent with their needs, as defined in Appendix B, Section 2.7.6, Tiered Case Management Based on Need.

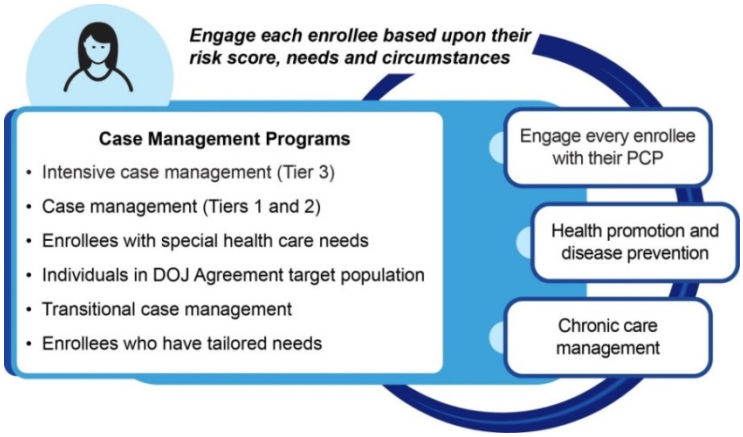


Figure 10. Based upon our understanding of each enrollee, we deliver a range of interventions across the care continuum. We connect every enrollee to a PCP and deliver programs that empower them as they take responsibility for managing their health. For at-risk enrollees, we implement case management programs aligned with their risk, circumstances and needs.

We identify all enrollees with special health care needs, comprehensively assess their needs and goals and offer ongoing support in an appropriate tier of case management per Appendix B, Section 2.7.4, Enrollees with Special Health Care Needs. The table summarizes our current objective measures and criteria to identify each enrollee's appropriate tier of case management. We will continue to assess and modify criteria in partnership with LDH to ensure we meet enrollees' changing needs and drive continuous improvement.

Objective Measures and Criteria for Placing Enrollees in Tiered and Transitional Case Management
Objective Measures and Criteria – Case Management (Low) (Tier 1)
Enrollees of rising risk who, without intervention, are at risk of becoming Tier 2 as determined by their predictive modeling risk score. They may have 1+ moderately managed or newly diagnosed chronic condition, and 0-1 social needs such as social isolation or transportation needs.
Objective Measures and Criteria – Case Management (Medium) (Tier 2)
Enrollees with a midrange predictive modeling risk score signifying an emerging risk for decompensation and increased utilization. These enrollees may have 1+ ambulatory diagnosis and/or comorbid mild-moderate behavioral health diagnoses, and 0-1 complex social needs, such as food insecurity. Tier 2 may include enrollees with special health care needs or transitioning from a nursing facility.
Objective Measures and Criteria – Intensive Case Management (High) (Tier 3)
Enrollees with the most significant physical, behavioral, functional and/or social needs and highest persistent utilization and spend, as measured by a high predictive modeling risk score or as identified through our Hotspotting Tool. This may include enrollees with special health care needs. These enrollees may have: ▪ 2+ unmanaged complex chronic conditions ▪ 1+ severe behavioral health diagnosis, such as schizophrenia, and/or co-occurring substance use disorder/opioid use disorder (SUD/OUD) ▪ 2+ complex social needs such as homelessness or former incarceration ▪ 2+ ED visits or inpatient stays in the previous 6 months ▪ High-risk pregnancy, such as SUD history or a history of preterm delivery or low birthweight infant ▪ Prior institutionalization or transition from a nursing facility
Objective Measures and Criteria – Transitional Case Management
▪ Enrollees who are transitioning to or from inpatient hospitals, nursing facilities, including the My Choice Louisiana population, psychiatric facilities, psychiatric residential treatment facilities, therapeutic group homes, permanent supportive housing, intermediate care facilities, residential SUD settings, and transitions out of incarceration.

Objective Measures and Criteria for Placing Enrollees in Tiered and Transitional Case Management
▪ Enrollees with a high readmission predictive modeling (RPM) risk score or high Readmission Screening Tool (RST) score. The RPM and RST are used for enrollees transitioning from an inpatient setting to a lower level of care. The tools incorporate the severity of the condition, diagnosis, medications, opportunities for health and other factors to determine risk level and eligibility for enrollment in transitional case management.

Supporting All Enrollees as They Take an Active Role in Their Care

We encourage enrollees to take action on their health using a variety of strategies and tactics to confirm the engagement with each enrollee is culturally relevant, appropriate for the enrollee's age and demographics and tailored to their health needs. We confirm every enrollee has a PCP and that the enrollee is engaged with their PCP. We refer enrollees for disease management or specialized programs, such as programs for pregnant women, including *Clinical Texting* and *HFS Rewards*. As presented in the table, we use a multimodal approach and an array of health promotion tools and resources to engage ***every*** enrollee and provide support tailored to each enrollee's circumstances. We know approximately 80% of our members have a smartphone and the other 20% have access to a similar device, so we engage enrollees through websites, mobile apps, texting programs and telephonic support.

Health Promotion and Disease Prevention Tools and Programs
Telephonic support:
▪ Our *Advocate4Me* enrollee services center responds to inquiries and promotes self-management including reminders about needed preventive care
▪ *NurseLine*, available 24 hours a day, 7 days a week, provides live telephonic access to RNs who educate enrollees about their conditions and how to use health care services
▪ *MyHealthLine* uses the Lifeline free smartphone to deliver *Clinical Texting* campaign texts and provide free calls to *Advocate4Me* and free texting with the care team
▪ *Behavioral Health Crisis hotline* supports enrollees and their families with behavioral health experiences
Texting, mobile apps and websites:
▪ *Clinical Texting* engages expectant mothers and new parents, adolescents and adults, enrollees with diabetes and smokers through programs, such as medication adherence and appointment reminders
▪ NextHealth's Urgent Care Locator will be able to send a text to enrollees listing nearby urgent care centers
▪ Mobile apps help enrollees locate in-network and urgent care providers, provide health benefits and coverage information and connect enrollees to *Advocate4Me* or *NurseLine*
▪ Available through our enrollee website, *myuhc.com*, our online health and wellness library provides education and tools to promote health awareness and prevention of health conditions
Newsletters and mailings:
▪ Enrollee newsletters and mailed material, such as birthday card reminders about preventive care
▪ Mailing condition-specific education materials for targeted conditions, such as cancer or asthma

Support Provided in Tiers 1-3 Case Management

If the enrollee agrees to participate in case management, an interdisciplinary, field-based care team provides care coordination to the enrollee. The team includes an RN, a licensed behavioral health advocate (BHA) and a CHW. We assign a care team that lives in the same community as the enrollee and has appropriate expertise to meet their needs. We are thoughtful in our initial care team assignment to confirm a compatible match, including considering cultural background, primary language, behavioral and/or physical health needs and

Figure 11. Multidisciplinary Care Team.

enrollee choice. We train case managers to help address the specific concerns enrollees face, such as person-centered care, recovery and resilience, trauma-informed care, crisis intervention, motivational interviewing, opioid use, medication-assisted treatment, advanced illness and grief and identifying readiness through stages of change.

LDH Program Goal: Improving enrollee health

Comparing the 1 year before engagement in case management to 1 year after, enrollees in case management have achieved*:

- A **40% decrease** in total inpatient hospital PMPM costs, driven by decreased utilization
- A **20% decrease** in total ED PMPM costs
- A **22% decrease** in total claims PMPM for enrollees engaged in our highest-risk case management program

**Additional cohort analyses planned to understand the impact of case management in context*

Each enrollee in case management has a primary case manager with expertise and training specific to their primary diagnosis. For example, an enrollee with primarily behavioral health needs is assigned a BHA case manager, and a woman with a high-risk pregnancy is assigned an OB-experienced RN.

LDH Program Goal: Reducing complexity and administrative burden for enrollees

To reduce complexity for enrollees in case management and help them navigate the health care system, we provide ***a primary case manager who can act as a single point of contact to coordinate care.*** The core of our model is the relationship between each enrollee and their case manager. The local presence and the expertise and experience of the case manager are critical to allowing the enrollee to develop a level of trust with the case manager coordinating their care. Establishing trust is the first step in helping the enrollee participate in and navigate the health care system.

Across all tiers of case management, our care teams and partners support enrollee health by confirming every enrollee receives the right care or support, at the right time, in the most appropriate setting, in the most efficient way. Our care teams collaborate with the enrollee and their multidisciplinary care team (MDT) to create a holistic plan of care, coordinate their social, behavioral and medical services and continually monitor their health status, as presented in the figure.

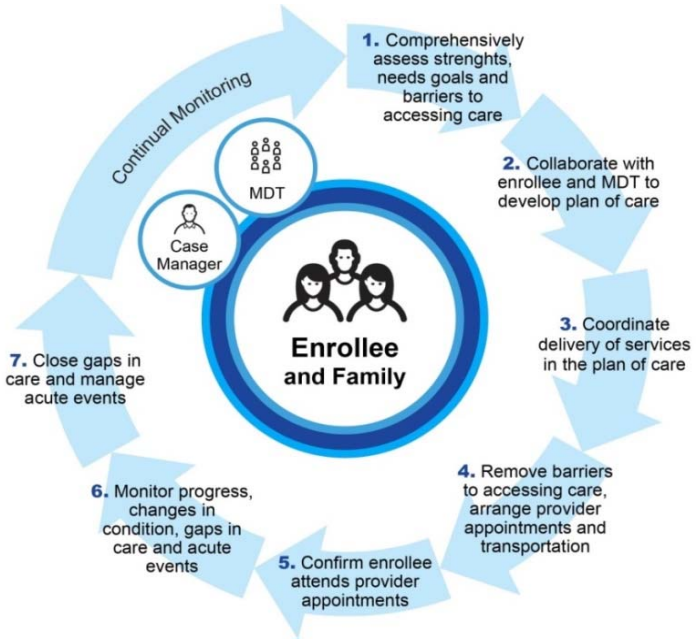


Figure 12. Case management process. Our field-based care teams coordinate the enrollee's care and continually monitor progress to confirm their needs are met and they are achieving their goals.

Our engagement of these enrollees aligns with the requirements in Appendix B, Section 2.7.6, Tiered Case Management Based on Need, such as in-person engagement and frequency of touch points. The table summarizes the supports provided in

each tier of case management, building in intensity and specialized expertise from Tier 1 to our highest need enrollees in Tier 3.

Supports for Enrollees Engaged in Tiered Case Management
Case Management (Low) (Tier 1)
▪ **In-person** comprehensive assessment and plan of care completed within **90** days of identification ▪ **Confirmation of PCP** or assistance finding a PCP ▪ **Disease management** education, mailers and program referral for identified chronic conditions ▪ Timely **appointment scheduling** and **transportation** arrangement to close gaps in care ▪ Access to telehealth or virtual visits ▪ Referral to state and local offices and programs, such as the Permanent Supportive Housing program, tobacco cessation and problem gambling ▪ Support in accessing eligible assistance such as SSI or WIC ▪ At least **quarterly** telephonic case management meetings with the enrollee ▪ Continual monitoring for care gaps and transitions using claims-based data and real-time admission, discharge and transfer (ADT) feeds ▪ Annual formal in-person reassessment and updates to the plan of care communicated to the enrollee's PCP
Case Management (Medium) (Tier 2)
Tier 2 includes Tier 1 supports plus the following: ▪ In-person comprehensive assessment and plan of care completed within **30** days of identification ▪ Identification of, and at least **quarterly** meetings with, an **MDT**, including the enrollee, the enrollee's family or authorized representative, the enrollee's PCP, behavioral health provider, specialist or pharmacist(s), CHW, BHA and RN, plus a peer support specialist, housing partner and/or state staff depending on need ▪ DME and pharmacy reviews for all medications and medication reconciliation ▪ At least **monthly in-person or telephonic** case management meetings with the enrollee ▪ **Quarterly** formal in-person reassessment and updates to the plan of care
Intensive Case Management (High) (Tier 3)
Tier 3 includes Tier 1 and 2 supports plus the following: ▪ **Daily or weekly** contact with the enrollee to close gaps in care within days or weeks of identification ▪ At least **monthly** in-person or telephonic MDT meetings based on the enrollee's care needs ▪ **Quarterly** formal **in-person** reassessment and updates to the plan of care ▪ **For our highest-acuity enrollees**, we engage them with our specially trained, interdisciplinary **Hotspotting Team** that provides high-touch, face-to-face Tier 3 case management for enrollees identified by our Hotspotting Tool

We look for every opportunity to apply the expertise of community partners and specialized teams to meet the needs of our enrollees. This includes coordination with provider-based resources to ensure collaboration and avoid duplication of services. Our personalized case management programs extend beyond minimum requirements and meet the specific needs of priority populations, as presented in the table.

Programs & Partnerships to Provide Tailored Case Management
Healthy First Steps (HFS) Maternity Program
Our comprehensive HFS maternity program provides support for pregnant enrollees and babies at every stage of the reproductive health cycle and at all risk levels, including: ▪ **HFS Rewards Program:** Provides education through a mobile-enabled website, clinical texting to remind pregnant enrollees and new moms about important prenatal, postpartum and well-child visits, and incentives for achieving important milestones throughout and 15 months after pregnancy. Nationally, those enrolled in HFS Rewards have a ***15% higher physician visit rate***. To continually improve the program, we use enrollee feedback to implement enhanced rewards based upon enrollee preferences. ▪ **HFS Case Management:** Specialized case management for high-risk pregnant enrollees and babies with an OB-experienced RN case manager, with case consults provided by a BHA for enrollees with SUD/OUD. The

Programs & Partnerships to Provide Tailored Case Management
HFS case manager provides support from identification through six weeks postpartum, and evaluates the enrollee's needs for ongoing Tier 1, 2 or 3 case management. ▪ **OB Homecare services** provide in-home supports, such as disease management, pre-term labor support and nausea and vomiting management for pregnant enrollees with these conditions ▪ **Neonatal Resource Services** provides utilization management and transitional case management for NICU infants for up to 15 months post-discharge ▪ **Coordination with the Woman's Hospital Guiding Recovery and Creating Empowerment (GRACE) program** through a unique partnership for pregnant enrollees in Baton Rouge struggling with OUD/SUD. GRACE provides compassionate Tier 1, 2, or 3 and transitional case management including education on and connection to MAT services, support for babies with neonatal abstinence syndrome (NAS), and linkages to community resources. ▪ In 2019, we will place a **perinatal Hospital Care Transition (HCT) coordinator** in Louisiana Woman's Healthcare Clinic affiliated with Woman's Hospital in Baton Rouge.
Specialty Program Case Management
Population: All enrollees and families caring for enrollees under age 21 who receive EPSDT personal care services, private duty nursing and pediatric daily health care **Tailored Support:** An RN case manager with specialized expertise provides Tier 3 case management to the enrollee and family through the life of the authorization(s), and transitional case management 30-60 days post service to deliver smooth transitions to other services or community-based programs dependent on enrollee and family needs.
Partnership with Children's Hospital Ventilator Assisted Care Program (VACP)
Population: All enrollees under 21 who are ventilator-dependent in their home. **Tailored Support:** We have contracted with Children's Hospital VACP to provide family and caregiver training before enrollee discharge, develop a plan for care in the home and community, coordinate outpatient care to help the family care for the enrollee at home and provide Tier 1, 2 or transitional case management, as needed. If the enrollee is also receiving Specialty Program Case Management, their case manager coordinates with VACP and assists with utilization management (UM) for specialized in-home services.
Partnership with BehaveCare
Population: Hard-to-reach enrollees in New Orleans and Baton Rouge who are experiencing homelessness or have limited resources, inconsistent support systems and higher use of emergency services **Tailored Support:** We are partnering with BehaveCare to expand our targeted Tier 3 outreach and support. BehaveCare's community-based care specialists provide case management services and facilitate in-home telemedicine visits to access primary, specialty and behavioral health providers.

LDH Program Goal: Supporting innovation and a culture of continuous quality improvement in Louisiana

Ready Responders is a network of trained, licensed and fully insured EMTs, paramedics and nurses who visit high-risk enrollees with inappropriate ED utilization to help divert them from the ED. During weekly in-home visits, neighborhood-based health care professionals connect enrollees via a telehealth consult to address their conditions, make a PCP or behavioral health appointment, provide transport vouchers to their providers, monitor prescription adherence, evaluate risk factors and answer questions. We are evaluating the effectiveness of the partnership since its launch in July 2018. Our preliminary results show a ***25% decrease in ED PMPM costs and a 38% decrease in inpatient PMPM costs*** among enrollees engaged in the program, driven by decreased utilization.

Transitioning Between Tiers of Case Management Intensity

For enrollees in case management, our goal is to implement customized enrollee interventions for as long as is required to keep or move them to lower risk levels. By engaging enrollees with an appropriate tier of case management and coordinating the delivery of services and supports

that meet their needs, enrollees will move to lower intensity tiers or graduate out of case management altogether. During regular touchpoints, continual monitoring of the enrollee's health status, reassessments and care plan updates, our case manager works with the enrollee and their MDT to look for indications the enrollee can move to a lower tier of case management. These include evidence that the drivers of the enrollee's utilization, such as homelessness, have been addressed; the enrollee is achieving the goals in their care plan; the enrollee is adhering to their treatment plans, such as taking their medications; and the enrollee is able to access resources (e.g., transportation or child care).

Support for Enrollees Experiencing Care Setting Transitions

Our transitional case management programs comply with Appendix B, Section 2.7.6.4 Transitional Case Management. They evaluate an enrollee's social, behavioral and medical needs and coordinate support services to arrange for safe and appropriate care from one care setting to another. Our programs include discharge planning for enrollees in the hospital and specialized transition planning for enrollees moving from a nursing facility to the community and justice-involved enrollees transitioning to the community.

Enrollees in the Hospital — Discharge Planning

Through discharge planning, we collaborate with the enrollee, the facility and their chosen planning team to develop a transitional plan of care to ensure progress made during the inpatient stay continues after discharge. Discharge planning helps confirm the enrollee remains safe when they transition home, such as reducing potential injury due to pharmacy errors, procedure complications or falls. The process includes medication reconciliation, patient education and self-management strategies, addressing any prior authorization needs, and connection for enrollees experiencing homelessness. It reduces readmissions by anticipating post-discharge issues, such as gaps in care or barriers to accessing care and identifying interventions to mitigate them, and following up with enrollees within 72 hours of discharge to ensure receipt of needed services. The discharge plan builds on the enrollee's strengths and identifies the services and supports that meet their needs and help them achieve their goals. The figure presents our discharge planning process.

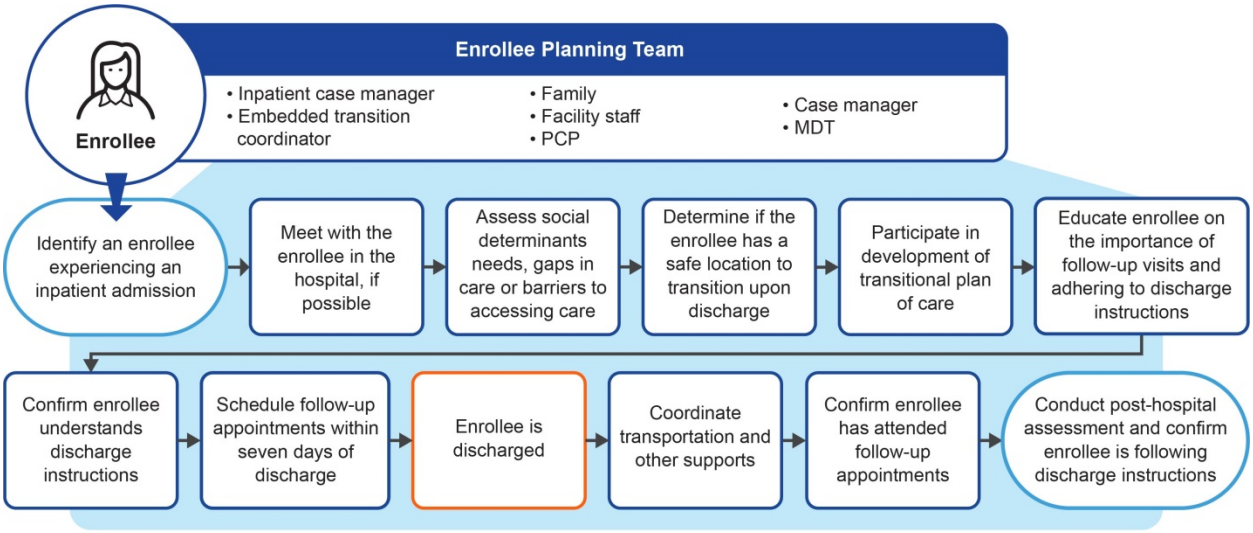


Figure 13. Discharge Planning. Discharge planning begins once we become aware of an enrollee's admission. During their inpatient stay, we comprehensively assess the enrollee's post-discharge needs and goals and support the development of a transition plan that deploys comprehensive services and supports to meet those needs and goals. The plan helps to prevent readmissions by anticipating post-discharge issues and implementing interventions to mitigate them.

LDH Program Goal: Improving enrollee health

Our HCT program helps enrollees transition safely out of a hospital setting to a lower level of care. **In December 2018, we placed four HCT coordinators within Our Lady of the Lake Regional Medical Center and the LCMC Health University Medical Center** to better reach high-risk enrollees pre-discharge and provide specialized supports to address each enrollee's physical, behavioral, pharmacy and social needs. We support HCT coordinators with an **RN**, a **pharmacist** who addresses medication gaps and issues, and a **licensed social worker** with behavioral health expertise who addresses behavioral health concerns. In 2019, we are **expanding this program** to address the unique needs of pregnant women in Baton Rouge by placing a **perinatal HCT coordinator** in Louisiana Woman's Healthcare Clinic affiliated with Woman's Hospital in Baton Rouge.

Enrollees Transitioning from a Nursing Facility to the Community

Our My Choice Louisiana liaison, an experienced BHA, coordinates with the State's My Choice Louisiana case manager to provide transitional case management support for enrollees transitioning from a nursing facility into a community-based setting.

Knowing that many individuals living in a nursing facility want to return to a community-based setting, we have implemented a comprehensive program to support enrollees transitioning through the My Choice Louisiana program. Through this program, we promote self-determination and self-direction through person-centered assessment and planning practices to support the enrollee's community integration goals. We assess their needs, strengths, goals and preferences, support the development of their transition plan, assure the continuity of the enrollee's care during transition and coordinate the delivery of an appropriate mix of services and supports to help the enrollee thrive in their new care setting. The figure provides an overview of our My Choice Louisiana process.

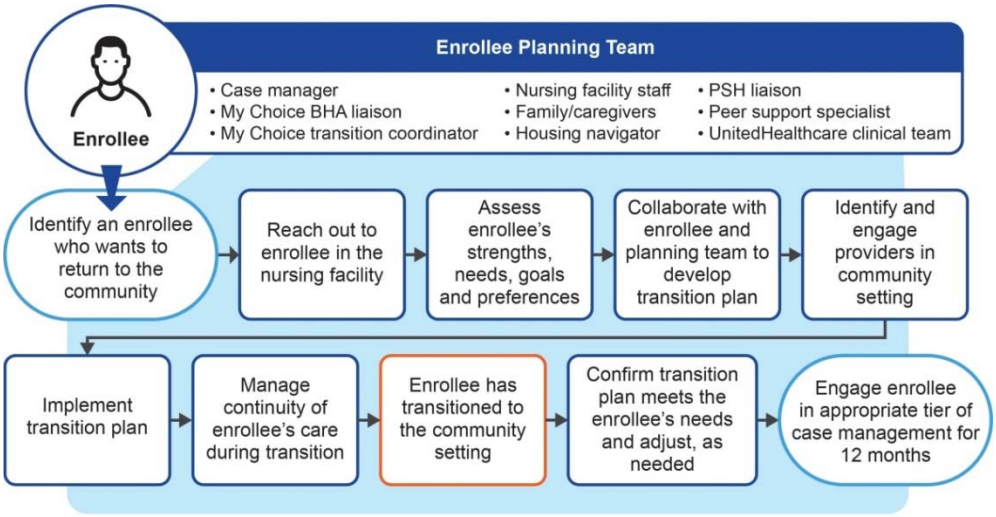


Figure 14. My Choice Louisiana process. We identify enrollees who desire to return to the community from an institutional setting, support the development of a person-centered transition plan, assure the continuity of the enrollee's care during transition, and identify and deliver an appropriate mix of services and supports to maintain the enrollee in their new care setting. After transition, we engage them in Tier 2 or Tier 3 of case management for 12 months to help the enrollee maintain community living.

Justice-involved Enrollees Transitioning to the Community

Justice-involved Louisianans are at increased risk of physical and complex behavioral health issues, including infectious diseases, co-occurring SUD and significant SDOH. Their return to the community post-release is frequently marked by high stress as they attempt to re-establish employment, housing and other relationships, often with limited financial resources and social

support. Community re-entry, therefore, presents a critical time to support these vulnerable enrollees in meeting their health care needs. Through our Department of Corrections Case Management Program, we support these enrollees with specialized transitional case management from a BHA or RN case manager with experience working with justice-involved enrollees. Through at least two telephonic pre-release visits, the case manager assesses physical, behavioral and social needs and confirms appropriate post-release care is in place, including community-based transition supports. To support successful reintegration into the community, the case manager follows up with the enrollee at least once post-release and provides ongoing Tier 2 or 3 case management depending on the enrollee's needs.

Process for Developing an Individual Plan of Care

In 2018, our case managers completed more than 30,000 case management meetings with enrollees and developed or updated more than 9,300 care plans.

Our care planning process, founded on principles of recovery and enrollee self-determination, encourages and empowers enrollees to lead the planning process and actively participate in all aspects of care planning. The enrollee's case manager, supported by the enrollee's chosen planning team, advocates for the enrollee to make meaningful decisions about their care and services. The case manager works with the enrollee to develop a plan of care that includes services and supports that meet their needs and preferences and help achieve their expressed goals and desired outcomes.

The plan of care is an integrated, person-centered, enrollee-driven, strengths-based plan. It highlights the enrollee's attributes that can serve as a foundation for achieving positive outcomes based upon their unique situation and needs. It is not static, but continually updated with the enrollee based upon changing needs and progress toward their goals. Our care planning process complies with Appendix B, Section 2.7.10, Individual Plan of Care, including face-to-face enrollee engagement, timeliness of the development of the initial plan of care, the frequency of required updates and the frequency of MDT care team meetings. We collaborate with the enrollee to update their plan of care when they show signs of deteriorating health, experience a change circumstances (e.g., loss of a caregiver) or an acute event, such as a hospitalization.

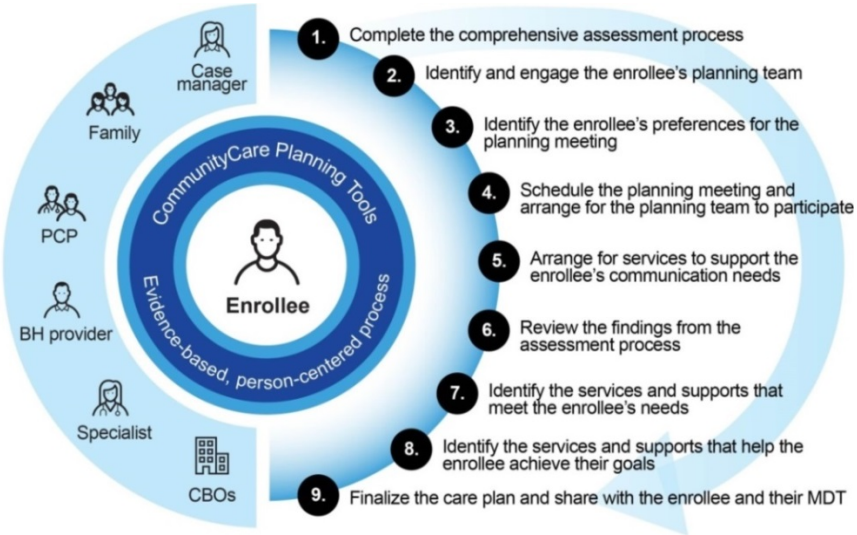


Figure 15. Care Planning Process. Using our care planning process, the case manager facilitates plan of care development. The plan of care includes social, behavioral health, medical and functional services and supports that meet the enrollee's needs and preferences and help the enrollee achieve their goals and desired outcomes.

2.10.5.1.5 How the Proposer will coordinate with providers and state staff that may provide case management…

We align our mission and program development closely with the vision and efforts of LDH and our provider partners. Our partnerships include clear operational workflows to confirm we align on details, such as the content of enrollee assessments or the frequency of touchpoints, which may be adjusted based upon enrollee or enrollee guardian preference. Our clinical team monitors enrollee outcomes and offers support to our partner case managers through case rounds and Joint Operating Committees (JOCs). We continue to evaluate and refine these partnerships to best meet our enrollees' preferences and match them with programs that are locally based and in line with enrollees' desires.

We have experience coordinating with provider and State staff in Louisiana. For example, we:

- ***Collaborate with Magellan Health*** to deliver CSoC services to our enrollees who choose to receive CSoC services. Magellan provides the behavioral health case management and we provide complementary medical case management. We identify UnitedHealthcare enrollees served by Magellan and coordinate with Magellan to manage the care of our enrollees through weekly meetings.
- ***Have an innovative relationship with LCMC Health*** to align financial incentives, share data and enhance coordinated clinical programs. To help LCMC take on case management responsibilities, we will share data including rosters of enrollees identified for case management through our predictive algorithms, claims data and HNA results. We will use JOC meetings to confirm care team coordination and share best practices.

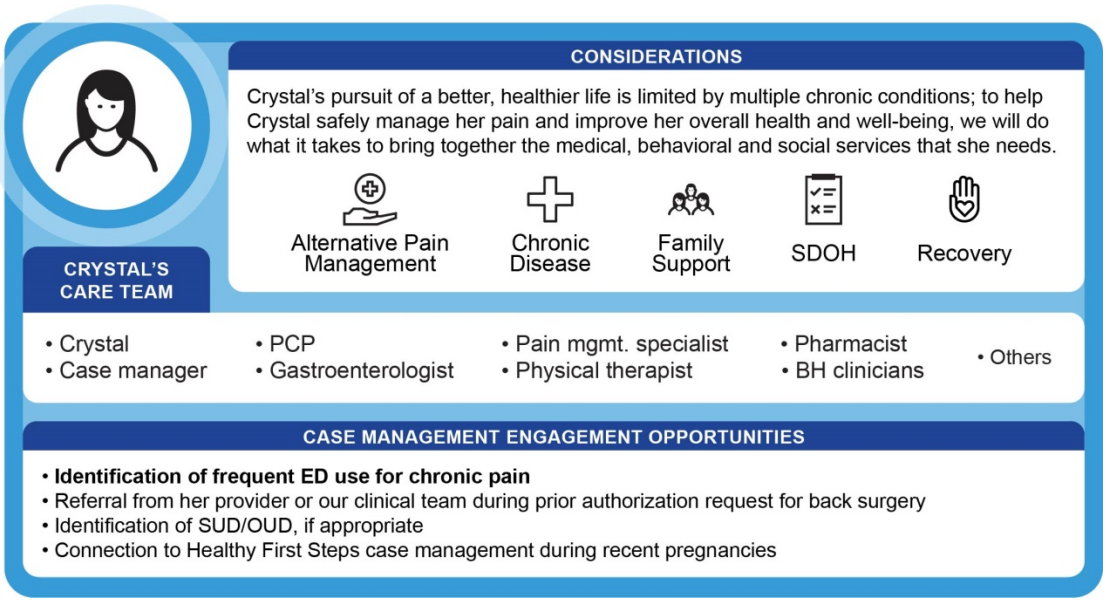
We coordinate with providers and State staff by exchanging enrollee data. Since 2014, we have been receiving data from approximately 75 participating hospitals through the Health Information Exchange. In 2018, the Louisiana MCOs along with LDH and Louisiana Hospital Association began discussions on a new system that would be designed to provide more robust ED information, readmission and inpatient data offered by Louisiana Health Information Network. This new technology will allow connected physicians and hospitals to share patient information and pull reports designed to help improve patient encounters and clinical outcomes. This initiative would significantly expand participation to most of the state's hospitals. We are currently in negotiations with the vendor to have a contract in place by the end of 2019. We share HNA information, care plans and gaps in care information with the enrollee's PCP and other members of the care team, as needed. This coordination helps simplify the enrollee's experience and prevents duplication of services.

We identify providers and state agencies through the assessment process. Through the HNA and the comprehensive assessment process, we work with our enrollees to identify their providers delivering services to them, State programs in which they are engaged, such as My Choice Louisiana, and their plans of care or treatment plans. Once identified, our case managers engage these providers and State agencies to develop the enrollee's plan of care and coordinate the integrated delivery of services and supports.

Dedicated staff to develop partnerships with providers and state agencies. We have dedicated staff that collaborate with State agencies, including our behavioral health liaison who supports LDOE, DCFS and OJJ; behavioral health liaison who serves as single point of contact liaison for judicial system; peer support/housing specialist, who serves as our PSH program liaison; behavioral health consumer and family organizations liaison; intellectual/developmental disability (I/DD) liaison to work with Office for Citizens with Developmental Disabilities staff; tribal liaison and My Choice Louisiana liaison who supports the My Choice Louisiana program.

2.10.6 Case Scenarios

2.10.6.1 Case 1



Like many of our enrollees in Louisiana, our enrollee, Crystal, is managing multiple chronic conditions and struggling with chronic pain, while faced with limited access to care in a rural area of St. Helena Parish. Along with our community partners, we must work together to reduce the likelihood that Crystal, and all our enrollees, will fall through the cracks and promote wellness and disease prevention. If we do not thoroughly understand Crystal's personal situation and connect her with the appropriate medical, behavioral and social services including high-touch case management, her ongoing chronic pain could affect her ability to care for herself and her family, keep a job and live a quality life as she defines it.

If Crystal was enrolled with us during one of her recent pregnancies, we would have engaged her in our Healthy First Steps (HFS) program, which offers pregnant enrollees education and incentives to access regular perinatal care. We also would have identified Crystal's pregnancies as high risk and engaged her in HFS case management. ***In Louisiana, HFS case management resulted in year-over-year reductions in low birth weight by 2%, C-section rate by 3% and premature birth rate by up to 9%.***

Becoming Aware of Crystal's Situation and Initial Engagement

As presented in the figure above, we use a variety of case-management engagement opportunities to become aware of Crystal's situation. Upon receipt of the request for back surgery, the utilization management (UM) team refers Crystal to case management. An RN from our clinical team (described below) immediately begins to engage Crystal and her PCP to understand her concerns and connect her to services and supports to improve her health and reduce the need for Crystal to visit the ED. The team reviews Crystal's follow-up care and realizes that we have no record of pain management therapy, and attempts to connect Crystal to appropriate pain management.

At this point, we become aware that Crystal's PCP has been providing her with pain management for years. Our medical director initiates a root cause analysis to understand why and how we did not become aware of her situation earlier. The analysis identifies the causes and the processes or tools that can be improved to confirm this does not happen to Crystal or

other enrollees moving forward. For instance, her PCP may be inappropriately coding for pain management treatment, our pharmacy data may not be reflective of Crystal's prescription filling patterns (e.g., she is paying cash for her prescriptions) or her PCP may be providing inappropriate treatments to meet Crystal's needs. The team also reviews pharmacy records to assess prescribing patterns that may be indicative of opioid misuse.

When Crystal's doctor requests prior authorization for her back surgery, our UM team reviews the request using evidence-based *MCG* criteria. We understand back surgery is not always the best course of action for pain relief and alternative forms of pain management can help Crystal avoid potentially difficult recovery from invasive surgery. Because the UM team determines the request for back surgery is not medically necessary until Crystal and her PCP have attempted non-invasive options to address her pain, our medical director contacts Crystal's PCP for a peer-to-peer discussion of pain management therapies Crystal can consider for her plan of care.

Specialists can be difficult to access in Louisiana's rural areas. **RubiconMD's** HIPAA-compliant **eConsult program** connects Crystal's PCP to top specialists in more than 120 specialties, including pain management and behavioral health to address the psychosocial aspects of and appropriate treatment for Crystal's chronic pain.

During peer-to-peer discussion with her PCP, our medical director obtains Crystal's pain management history, including medications she has used, and if she has attempted other forms of pain management, such as physical therapy (PT). Our medical director finds Crystal has not attempted PT to address her pain and calls her PCP to discuss options for Crystal to consider, such as referring her to St. Helena Parish Hospital's outpatient PT program, which is in our network. If transportation is a barrier to Crystal accessing services, our medical director suggests transportation services so she can access PT in St. Helena or neighboring parishes.

If no in-network providers can meet Crystal's needs, our medical director discusses with her PCP available out-of-network PT providers that Crystal can consider and can help her through a single case agreement. Our medical director and Crystal's PCP also discuss evidence-based alternatives for Crystal to evaluate for inclusion in her plan of care, such as our chiropractic value-added benefit, or mindfulness practices available to Crystal through our enrollee website, *myuhc.com*. Once reasonable options are explored, but have not mitigated Crystal's chronic pain, our medical director reviews whether she is an appropriate candidate for back surgery.

Connecting Crystal with a Case Manager

We train case managers to help enrollees like Crystal. Relevant trainings include addiction recovery, addressing ED utilization, crisis intervention, motivational interviewing, and identifying readiness through stages of change.

As discussed above, we identify Crystal as rising risk and enroll her in Tier 3 case management, based upon her multiple health issues, potential substance use, and recent ED use and pregnancies. An RN case manager is assigned to outreach to Crystal and begin enrolling her in case management. We support Crystal's case manager with a multidisciplinary care team, including a licensed behavioral health advocate (BHA) to address SUD, a community health worker (CHW) to address social needs, a pharmacist, our chief medical officer and our behavioral health medical director. Our BHA, RN and CHW live in or near Crystal's community, enhancing our ability to identify and coordinate services available to her.

Initial Engagement and Assessment of Crystal

Getting to know Crystal. Crystal and her case manager have a face-to-face visit to understand her goals for better health, identify her strengths and begin to develop a comprehensive plan of care. We know this initial meeting may touch on topics that are personal and uncomfortable,

which is why establishing a trusted relationship between Crystal and her case manager is so important. Crystal's relationship with her case manager becomes a safe haven where the two can discuss any of her needs. Crystal's case manager uses motivational interviewing to activate her interest, acts as a non-judgmental support, and provides insight into how our services can support her. Crystal shares her priorities, which include getting her pain under control and managing her conditions. Together, they explore the reasons for her recent pattern of ED visits.

Among enrollees enrolled in case management, total per member-per month emergency room costs decreased 20% from the year before they joined case management to a year following, driven by decreased ED utilization.

Assessing Crystal's needs and goals. To understand Crystal's needs, goals and preferences, her case manager uses shared decision-making tools, evidence-based practices, such as active listening, our Adult Core Comprehensive Assessment and assessments specific to Crystal's conditions, such as her diabetes. Understanding depression and anxiety are common for individuals dealing with chronic pain or recent pregnancies. Crystal is assessed for depression and anxiety using the PHQ-2/9 and GAD-2/7 screeners. She is also assessed for SUD/OUD with the DAST-10.

Crystal's case manager also assesses her social determinants needs using our Adult Core Comprehensive Assessment, which includes 33 questions related to social determinants of health, and our Access to Care assessment that identifies barriers that Crystal may face such as transportation or access to healthy foods, which may affect her diabetes and hypertension. Crystal may consider accessing the West St. Helena Food Pantry Dennis Mills, or attending monthly St. Helena 4-H meetings for education on nutrition. Crystal's case manager monitors environmental factors affecting Crystal's health, such as the condition of her home, and uses *Healthify* or local resources to identify and refer her to appropriate services.

Establishing Crystal's multidisciplinary care team (MDT). Crystal's case manager asks her for consent to contact her current and prior providers and request information, such as treatment plans. Crystal's providers may include her PCP, a pain management specialist, an endocrinologist, gastroenterologist and a physical therapist. Crystal identifies participants she wants on her MDT, including a spouse or partner, friends or family. The MDT has access to CommunityCare, our care management platform, which shares Crystal's plan of care, assessment results and other information, such as case notes with the MDT.

Screening and Treatment for Potential Substance Use Disorder

The challenges Crystal has been facing with Hepatitis C, frequent ED use and history of chronic pain, may be signs indicating drug misuse, so we assess her risk for or history of OUD/SUD to inform her care plan. To understand Crystal's experiences with pain management and SUD history, her case manager uses relationship-based communication techniques and evidence-based tools, such as the National Institute on Drug Abuse quick screen tool.

We are committed to addressing SUD in Louisiana. Our behavioral health medical director serves on the Advisory Council on Heroin and Opioid Prevention and Education (HOPE) and we are piloting a value-based payment model to expand access to high quality medication-assisted therapy (MAT) for enrollees with OUD.

In a review of her pharmacy history, her case manager determines if Crystal has exhibited behaviors that indicate she is at risk of OUD/SUD, such as visiting multiple prescribers and pharmacies to obtain controlled substances. Our network and quality teams monitor whether Crystal's doctor is an outlier in number of opioid prescriptions to confirm they are not enabling SUD. If screening indicates Crystal has OUD/SUD, her case manager connects her with evidence-based treatment, such as medication-assisted treatment (MAT), and

supports her recovery if she is already receiving treatment. Our medical director works with Crystal's providers to confirm her chronic pain treatment plan avoids the use of opioids and other controlled substances that could exacerbate her OUD/OUD.

If Crystal had been diagnosed with SUD/OUD during her pregnancy, we would have connected her to our perinatal SUD helpline, available 24 hours, 7 days a week. We engaged 650 pregnant women in SUD treatment in 2017-18 (27% engagement, exceeding statewide average), which demonstrates our commitment to these high-risk mothers and babies. We would have also referred Crystal to Addiction Counseling and Educational Resources' (ACER's) Slidell office offering MAT, care coordination, and individual and group counseling.

Developing Crystal's Plan of Care through Shared Decision-Making

Developing a plan of care is a collaborative process, taking place over the course of a series of planning meetings with Crystal, her case manager and her chosen MDT. Crystal's plan of care is dynamic and continually updated as she achieves goals, identifies new ones or as her needs change. During planning, Crystal reviews options and the team documents her choices in her plan of care. The table presents Crystal's goals, the expected outcome as she achieves her goals and the services and supports that may be effective in helping Crystal achieve her goals.

Crystal's Potential Goal	**Stated**	"I want to manage my pain safely."
	Measurable	Manage pain safely by avoiding opioid-based pain therapies and attempting alternative pain management in the next 90 days
Outcome	Crystal expresses experiencing a reduction in her perception of her pain, while pursuing opioid alternatives for pain management	
Interventions	▪ Connect Crystal with her preference in alternative pain management therapies/tools: St. Helena Parish Hospital's physical therapy and rehabilitation program ▪ If St. Helena Parish Hospital is not an option for Crystal, connect her to PT providers in Amite, Albany or Clinton ▪ Identify an out-of-network PT or chiropractic provider and establish a single case agreement to connect Crystal to care ▪ If transportation is a concern, connect her to transportation through our Friends and Family Program which compensates Crystal's friends or family for providing transportation or through a traditional transportation provider ▪ Explore alternatives to PT, such as chiropractic services. Our network includes chiropractors in Amite and Denham Springs, just across the St. Helena Parish line ▪ Connect Crystal to peer support and education in pain management skills through the American Chronic Pain Association ▪ Refer Crystal to a behavioral health therapist with expertise in treating the psychological aspects of chronic pain ▪ If Crystal is dealing with ongoing depression, anxiety or grief, connect her with local counseling (available in Greensburg, Roseland or Amite City) and support groups, such as a NAMI support group, or BetterHelp, which offers online access to licensed, accredited psychologists, family therapists, clinical social workers and counselors ▪ Educate Crystal on resources available to her through *myuhc.com*, such as mindfulness exercises, comprehensive mental health, and well-being information and assessments ▪ Support ED diversion by connecting her with urgent care, NurseLine and UHC Doctor Chat, which provides Crystal with access to immediate ED triage by an RN or an ED physician from home via secure chat, telephone or video If Crystal is dealing with SUD or OUD: ▪ Connect Crystal with a MAT provider and offer education and support on recovery, such as our Addiction Recovery Toolkit available online ▪ Share information on local narcotics anonymous groups, Warmline (a peer support helpline) and connect her to an OUD peer coach and arrange transportation	

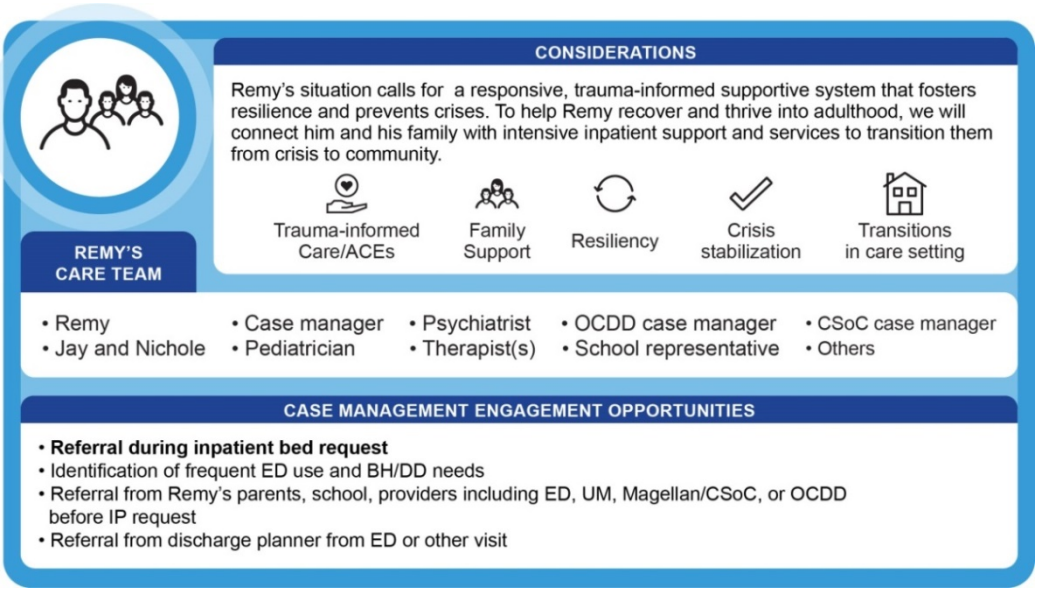
Crystal's Potential Goal	**Stated**	"I want to take care of myself and spend more time with my family."
	Measurable	Discover ways to integrate healthy behaviors and self-management tools for diabetes, hypertension and HCV into her family's daily life to reach the following goals: Reduce HbA1c by 1 percent in the next 90 days; reduce blood pressure to 130/70 in the next 30 days; approach physician to discuss HCV treatment options at next appointment
Outcome	Crystal reports an increase in the number of days she is exercising 20-30 minutes. She also reports discussing her HCV treatment options with her provider during scheduled follow-up appointment to manage her chronic conditions in a family-centered environment.	
Interventions	▪ Offer Rubicon MD's eConsult with access to specialty services to Crystal's providers to manage her chronic conditions and avoid traveling to multiple specialists ▪ Connect Crystal with Southeast Community Health Systems' education and counseling on nutrition to address her diabetes and hypertension needs ▪ Encourage Crystal to incorporate healthy eating, meal preparation and exercise habits as a family activity ▪ Connect Crystal to monthly Hepatitis C support group at Slidell Memorial Hospital ▪ Evaluate Crystal's Hepatitis C to determine if she meets the criteria for treatment and, if so, coordinate delivery of services with her PCP. Connect Crystal to the state's Hepatitis C subscription program (aka "Netflix Model") to obtain her medications. Our pharmacist offers education on adherence and discusses potential side effects and medication interactions as needed. ▪ Offer Crystal educational materials and resources, including Help4HEP Support Helpline, information from the American Diabetes Association and American Heart Association ▪ Encourage and support medication compliance, addressing any barriers (e.g., price, transportation) Crystal is facing in adhering to her prescribed medication regimen	
Crystal's Potential Goal	**Stated**	"If I get pregnant again, I want to have a normal pregnancy."
	Measurable	Define what family planning means to Crystal and have Crystal discuss her ideas with her OB/GYN at her next appointment
Outcome	Crystal feels confident about her reproductive choices and has the resources she needs to support those choices.	
Interventions	▪ Connect with family planning education and health-related social resources such as Healthy Start or an Office of Public Health (OPH) Reproductive Health Program ▪ Connect Crystal to the OPH clinic at St. Helena Parish hospital or the St. Helena Parish rural health clinic for education about pregnancy planning ▪ Engage Crystal with her PCP or OB/GYN to provide education about pregnancy spacing and the use of long-acting contraceptives, if she is interested ▪ Referral to family skills training program such as Positive Parenting Program (PPP), if Crystal has children in her family	

Ongoing Integrated Delivery of Crystal's Services and Supports

Across Louisiana, our enrollees with diabetes decreased ED use by 10% 2017 to 2018. The number of preventable hypertension hospital admissions decreased by 68% from 2016 to 2018.

Crystal's case manager checks in through monthly face-to-face visits to monitor Crystal's progress toward her plan of care goals. As Crystal is able to address her pain, potential SUD, and social barriers in line with her articulated goals, she gains confidence and feels empowered to better manage her diabetes, hypertension and HCV. Crystal's case manager continues to serve as her single point of contact for all of her MDT providers and confirms Crystal receives services to redirect her back on a path to a healthier and happier life.

2.10.6.2 Case 2



Our enrollee, Remy, has survived trauma that no child should ever experience. The extreme stress of repeated trauma, particularly at such a young and critical age, can have long-lasting effects. Trauma can overwhelm the developing brain's natural ability to cope, leading to greater perceived threat and changes to the body. These physiological responses may feel confusing, uncontrollable and frightening to Remy, making him less able to calm down. Without the appropriate support and skills to manage these intense experiences, children like Remy, particularly those with Autism Spectrum Disorder (ASD), often exhibit distressing and harmful behaviors. Remy's worsening symptoms are painful and overwhelming for any parent to manage, let alone Remy's parents, Jay and Nichole, whose mental health is declining and who are at risk for experiencing "secondary trauma."

Sadly, Remy's story is one that far too many families live through every day in Louisiana. In many parts of our state, rates of childhood PTSD are three times higher than the national average and inpatient bed shortages further exacerbate a dangerous situation. Many of these same challenges affect the lives of the nearly 60,000 Louisiana youth with behavioral health needs. For these children, we imagine a responsive, trauma-informed and supportive system that prevents the crises that Remy's family now faces. We strive to build that system with our community and state partners, based upon SAMHSA's Trauma-Informed Care core principles.

Coordinating in Crisis — Securing a Psychiatric Inpatient Bed for Remy

To help Remy recover and thrive, we need to act quickly to address his needs and get him the right care, at the right place. As soon as the ED submits an authorization request for an inpatient bed during Remy's second ED visit, our UM team engages the ED evaluator and Remy's Magellan Health Coordinated Services of Care (CSoC) case manager, if he is receiving CSoC services, to understand what setting would best suit Remy. The UM team also engages our Provider Advocate Team to educate the ED staff on the availability of community behavioral health resources as an alternative to discharging him home. Based upon Remy's worsening symptoms, the UM team confirms that psychiatric inpatient is the most appropriate setting for Remy. The team identifies and begins contacting providers with expertise meeting Remy's behavioral, physical and developmental needs, such as Children's Hospital, Lake Charles Memorial or Brentwood Hospital. If needed, the team locates and authorizes treatment in an available medical inpatient setting pending transfer to a psychiatric unit. The team may also

Building a Better System for Children like Remy
Louisiana has a shortage of crisis and inpatient services for youth. We will continue to work with LDH, providers and other MCOs to facilitate the creation of services for children like Remy. For example, we are actively working with provider partners, such as Oceans Healthcare to expand intensive outpatient program services. We are also approaching LCMC as they expand inpatient capacity for children and youth.

reach out to nearby out-of-network facilities to offer a single case agreement, including out-of-state providers if Remy is clinically authorized to cross state lines. Once our UM team locates an available psychiatric inpatient facility, they notify the ED to facilitate information exchange between facilities, confirm that Remy is stable for transfer and authorize safe transfer. The UM team refers Remy for enrollment in case management.

Assigning a case manager to work with Remy and his family. Given the acuity of Remy's symptoms, the complex presentation of multiple comorbidities, his recent ED visits and the referral from our UM team, our clinical team identifies Remy for Tier 3 case management and assigns him a licensed behavioral health advocate (BHA) to serve as Remy's case manager. We support the BHA with an RN to address Remy's medical needs.

Meeting Remy's parents and engaging Remy in case management. Remy's case manager makes every effort to meet Remy and his family in person in the ED to offer support as they await transfer. During the visit, Jay and Nichole, Remy's parents, may express frustration at the lack of support for their son and their own negative health care system experiences and may be resistant to the case manager's engagement. Remy's case manager uses active listening to understand Jay and Nichole's concerns and responds thoughtfully as to how they can help. His case manager explains how he will serve as a single point of contact to the family and helps Jay and Nichole understand the benefit of case management by sharing their experience with adverse childhood experiences (ACEs), crisis management and working with children like Remy. Remy's parents agree to enroll him in case management.

Remy's case manager coordinates his inpatient services with our UM staff and the ED team, confirms Jay and Nichole know the contact information of the facility and answers any questions they may have. Given Remy's history of trauma, we know that having trusted parental figures involved is essential to his success overcoming this crisis and future resiliency. If the inpatient setting is far from Remy's home, his case manager arranges supports for Remy's parents, which may include our covered benefit that provides travel and lodging for families, connection to a local Ronald McDonald House or coordinating transportation services.

We should have become aware of Remy's situation based upon his conditions and his first visit to the ED using the case-management engagement opportunities presented in the figure in the previous section, and immediately identified him as a candidate for case management. Our clinical team initiates a root cause analysis to understand why and how we did not become aware of Remy's situation earlier. The analysis identifies the processes or tools that can be improved to confirm this does not happen to Remy or other enrollees moving forward.

Supporting Remy and His Parents during His Inpatient Stay

Once Remy, Jay and Nichole have had time to settle and become safely established at his inpatient setting, Remy's case manager reaches out to discuss services and supports available to them. His case manager's priority is to advocate for Remy and his family to promote the best possible outcomes for Remy. Remy's inpatient stay is a crucial period for cultivating a stable relationship between Remy, his treatment team and the adults in his life, including his case manager. With the family's permission, Remy's case manager stays in close contact, making

regular telephonic or in-person visits to monitor progress, provide support in addressing their expressed goals and proactively prepare for Remy's discharge based upon the family's needs. Remy's case manager helps Remy's parents stay in contact with others involved in the family's life, such as calling his school to notify them of the hospitalization and next steps to address classes missed, tutoring or Individual Education Plan (IEP) support, and connecting the family with resources, such as respite care or personal care services in coordination with OCDD.

Advocating for Remy and his family. Remy's case manager collaborates with the inpatient facility to confirm Remy receives meaningful treatment within the standard of care and in alignment with best practices during his inpatient stay and from other providers involved in Remy's care. The goal is for Remy to be stabilized so he and his family can develop skills to allow him to return to and remain at home. Remy's case manager, our UM team and our Behavioral Health Medical Director, Dr. Jose Calderon-Abbo, monitor that Remy's treatment includes proper evaluation of co-occurring symptoms, self-injurious behaviors, psychopharmacology and evidence-based treatment, such as Dialectical Behavioral Therapy (DBT). They confirm Remy's plan has been developed in collaboration with Remy and his family and his progress is quantifiable. The UM team conducts concurrent review, monitors Remy's response to his treatment plan and works with the inpatient treatment team to authorize inpatient services and services upon discharge. Remy's case manager documents his assessments and case management-related documents in CommunityCare, our care management platform, which is available to the MDT.

Preparing for Remy's Discharge

Remy's case manager and our UM team collaborate with Remy, his family, his outpatient providers and the inpatient facility to determine the next best steps for Remy once he is stable. This includes developing a discharge plan and a crisis plan that allows Remy to safely transition to community life. The services in Remy's discharge plan build upon Remy's strengths, including a low to normal IQ, good language skills, a supportive family and OCDD involvement.

Understanding Remy and his family's needs for the transition. To identify the family's goals, reactions to trauma and social determinant needs, Remy's case manager uses evidence-based practices, such as motivational interviewing, and a variety of assessments. They include our Pediatric Core Comprehensive Assessment, Access to Care assessment, and behavioral health assessments, such as the Child Stress Disorders Checklist-Short Form, ACE Questionnaire and PHQ-9 depression screener. His case manager reviews safety assessments conducted by hospital staff and confirms Remy can safely return home, reporting any identified safety concerns to the appropriate authorities, such as Child Protective Services.

From 2017-2018, inpatient PMPM decreased **40%** for our adolescent enrollees with behavioral health needs like Remy's.

Identifying the best options for Remy's placement upon discharge. Remy may not be ready to return home immediately. If so, his next step may be to receive supportive care in a sub-acute or residential treatment facility. We work with the inpatient team and Remy's MDT to identify an appropriate step-down facility that provides family-centered care, such as Methodist Children's Home in Ruston or one of ***13 statewide therapeutic group homes and rehabilitation facilities*** for children and adolescents who may need a step wise approach to return to living at home. If Remy is stable enough to return home, his transition plan may include an appointment with a local Mental Health Rehabilitation agency, such as Family Solutions of Louisiana Inc. or connection to the local government entity in his community for lower-intensity interventions.

Coordinating CSoC services. Remy's case manager identifies whether Remy currently receives CSoC services, such as wraparound facilitation and parent support. If he is not already receiving them and Jay and Nichole are interested, Remy's case manager facilitates his referral to the program. If Remy already has a Magellan CSoC case manager, or once the referral is made, his case manager coordinates his medical and behavioral needs through weekly case rounds with Magellan. If the family decides to opt out of CSoC, his case manager engages Remy and his parents using the same evidence-based approach founded on CSoC's core values of individualized, collaborative home and community-based care.

Coordinating other behavioral health services. Remy will benefit from providers with experience caring for trauma survivors, such as one of the 425 behavioral health clinicians at 750 locations in our Louisiana network who specialize in child and adolescent trauma therapy. Remy's case manager confirms the supports Remy receives from OCDD, such as Children's Choice Waiver services. If needed, his case manager facilitates referral to one of the more than 300 Applied Behavior Analysis (ABA) therapists in our network, such as the Merakey Louisiana Shelly Hendrix Autism Center. Remy's services may also be delivered by one of several providers throughout Louisiana who we are training in Parent Child Interaction Therapy (PCIT).

> Enrollees engaged in behavioral health transitional case management have seen a **55% decrease** in inpatient PMPM and a **17% decrease** in ED PMPM when compared to the year before they enrolled in case management.

Establishing Remy's MDT. Remy's case manager works with Remy and his parents to bring together Remy's post-discharge MDT, which may include a pediatrician, a psychiatrist, therapist specialized in complex trauma, ABA therapist, his OCDD case manager, a school representative, his CSoC case manager, if applicable, and any other natural supports chosen by the family, such as a spiritual leader. Remy's MDT will meet monthly, as outlined in his plan of care.

Supporting Remy's discharge. Recognizing the transition from inpatient can be stressful and filled with both excitement and apprehension, Remy's case manager visits him and his family in person within 24 hours of discharge to confirm the delivery of services and supports in his discharge plan. For example, Remy's case manager confirms that Remy has a follow-up visit with his provider, who may be among the more than 700 behavioral and physical health providers we are incentivizing through our 7-day follow up after hospitalization (FUH) initiative.

Supporting Remy's Continued Growth after Discharge

Within 30 days of his enrollment in case management, Remy's case manager works with the family to begin developing an integrated, enrollee-driven and strengths-based plan of care to support Remy's continued and long-term health. The plan of care highlights Remy's attributes that can serve as a foundation for achieving positive outcomes based upon his unique situation and needs. During planning, Remy and his parents identify achievable short-term goals and his planning team presents services, supports and provider options for the family to consider to reach them. Examples are presented in the table. Remy's plan of care is dynamic and his care manager continues to update it as Remy achieves his goals and identifies new ones. For instance, as Remy approaches his teenage years, education about healthy sexual practices and preventing substance use will be crucial for Remy. We reassess Remy quarterly with face-to-face meetings to revise and update his plan of care.

Potential Goal for Remy	**Stated**	***Remy:*** "I don't want to go to the hospital anymore." ***Jay and Nichole:*** "Have a plan to keep Remy and all of us safe."
	Measurable	Create a crisis plan for Remy to prevent escalating crises and ED visits/hospitalizations for the next 60 days.

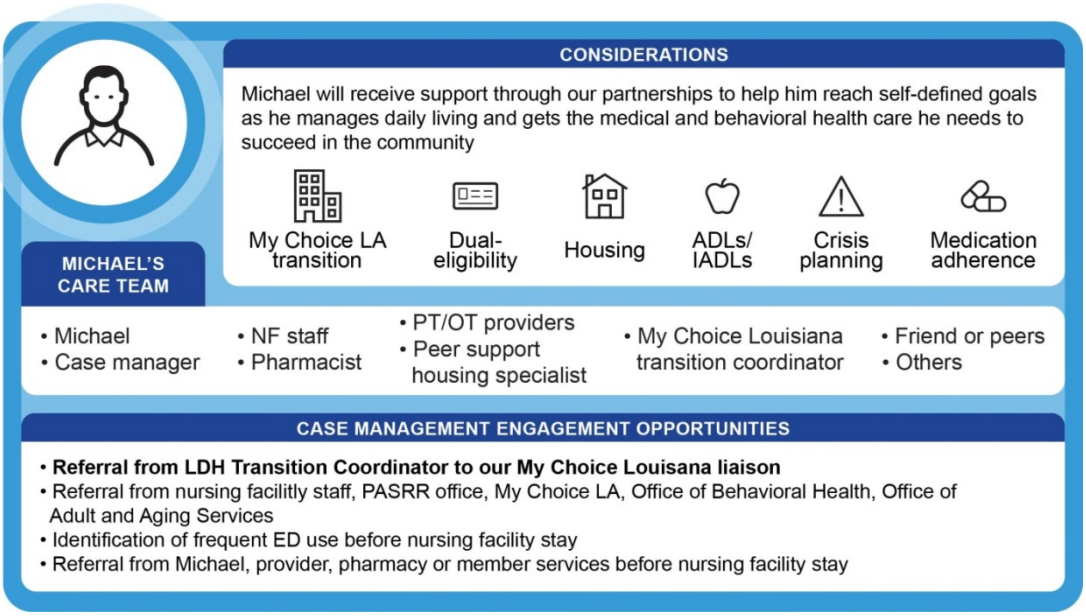
Outcome	Remy and his parents express confidence in knowing how to prevent and handle behavioral health crises.	
Suggested Interventions	▪ Crisis resources available 24 hours a day, 7 days a week, such as the Sexual Trauma Awareness & Response (STAR) Hotline, 211 or the behavioral health crisis text line and information accessible through *myuhc.com*, or from the LDH OBH crisis counselor or area human services district. Support ED diversion through connection with urgent care, NurseLine and *UHC Doctor Chat*, providing Remy's family with access to immediate ED triage by an RN via secure chat, telephone or video, with escalation to an ED physician if needed. ▪ Develop and practice coping, crisis management and communication skills learned through DBT, PCIT, or Youth Mental Health First Aid training provided by NAMI.	
Potential Goal for Remy	**Stated**	***Remy:*** "I want to go back to school, play with my friends and have fun." ***Jay and Nichole:*** "Empower Remy to be a regular kid and help us to be a healthy family."
	Measurable	Remy is able to stay in school with fewer missed days over the next 3 months and participate in activities that have meaning to him.
Outcome	Remy's parents describe feeling more stable and Remy spends more time with his friends and peers.	
Suggested Interventions	Connect Remy and his family to: ▪ PCIT, a 12- to 14-week family-centered treatment approach, to provide Jay and Nichole with effective skills for managing and improving Remy's behavior, and cultivate a strong relationship between Remy and his parents, or ▪ The Positive Parenting Program® (PPP), an evidence-based parenting and family support system designed to prevent and treat behavioral and emotional problems in children and teenagers ▪ Family peer support: We are the only MCO nationally approved to conduct "train the facilitator" training of peer support specialists in Seeking Safety group support for adults and youth who have experienced trauma ▪ Other parents who have children with special needs, such as Exceptional Lives or Family to Family meetings with parent peers who could help Jay and Nichole feel supported, discuss IEPs and school attendance, and connect them to relevant resources ▪ Supports, such as the Baton Rouge Children's Advocacy Center which provides children and families with guidance and trauma-focused clinical services	

Supporting Jay and Nichole. Caregiver well-being is paramount for Remy's recovery and resiliency. Fostering strong, responsive relationships between children with ACEs and their caregivers can buffer against the effects of toxic stress caused by early life trauma. Remy's case manager encourages Jay and Nichole to connect to their natural supports and refers them to services for their own mental health conditions and social needs. This includes helping to schedule services with their established provider or connecting them to community resources such as support groups or a credentialed family peer advocate. Remy's case manager can link Jay and Nichole to respite care services, if not already connected through OCDD waiver, available through Remy's area Human Services District Developmental Disabilities Services.

Achieving a Better Future for Remy

With Remy's parents' agreement, we continue to support Remy with Tier 3 case management and monitor post-discharge outcomes for at least 6 to 12 months to assess his integration back into the home, progress toward his goals and to prevent or provide support during future episodes while allowing Remy to remain at home. With the right supports and compassionate care in place for Remy and his family, we envision a future where Remy and his parents understand and are able to cope with Remy's triggers, where Remy feels safe and secure and has built meaningful relationships with his peers and the adults in his life, and where he can thrive into young adulthood.

2.10.6.3 Case 3



Like many seniors, our enrollee, Michael, planned to continue to live in the community as he aged. However, driven by worsening mental health, chronic pain and weakness, Michael was placed in a nursing facility, losing his apartment in the process. We understand that the best care for Michael and many of our other enrollees in My Choice Louisiana is not institutional but located in the community where they can sustain their independence, dignity, freedom of choice and be active in their communities. Michael may be feeling particularly overwhelmed at this moment — his excitement is accompanied by stress and apprehension.

> We have 1,246 members with serious mental illness (SMI) in case management today. Michael's case is very similar to one of our older enrollees with schizophrenic disorder, who was residing in a skilled nursing facility. We enrolled him in our case management program to support his transition home. Since returning to the community in October 2018, the enrollee has had no inpatient utilization and only one ED visit.

Michael is likely unsure of who to turn to for support, with multiple state administrators and nursing facility staff reaching out over the past few weeks. Without appropriate community supports, he is at increased risk for continued ED visits, stroke, debilitating pain, mental instability, heart attacks or further suicidal attempts, all of which will undermine his independence and confidence. Our goal is to support Michael through collaborative partnerships and help him reach his goals as he manages daily meals, finances, transportation, making friends, and getting the medical and behavioral care he needs to live the life he envisions.

Engaging Michael in Case Management

We identify that Michael requires assistance through the methods presented in the figure, such as referral from the My Choice Louisiana transition coordinator. Once we are aware of Michael, our clinical team evaluates his situation and refers him for engagement in our transitional case management program that supports enrollees transitioning through the My Choice Louisiana program. When we learn about Michael's situation, we challenge ourselves to think about how we could prevent this from occurring in the first place. Our clinical team initiates a root cause analysis to understand whether we identified and reached out to Michael for case management before his nursing facility stay and why and how we did not become aware of Michael's situation

earlier. The analysis identifies the causes and the processes or tools that can be improved to confirm this does not happen to Michael or other enrollees moving forward.

Due to his primarily behavioral health needs, we assign a licensed BHA case manager to Michael. His case manager has the appropriate experience and expertise to address Michael's needs, and is equipped with clinical skills including motivational interviewing to encourage treatment adherence, trauma-informed care, stages of change, cultural competency and crisis management. We support his case manager with a MDT, including an RN to address his medical needs, our peer support/housing specialist who serves as our permanent supportive housing (PSH) liaison, who helps identify and coordinate PSH options and waivers for which Michael may be eligible, and a CHW, who will help address Michael's social determinants needs.

Developing a Trusting Relationship with Michael

Michael and his case manager meet during a face-to-face visit at the nursing facility. His case manager recognizes that enrollees in Michael's situation may not be inclined to open up to new people, especially in the face of existing stigma around behavioral health. During this initial outreach, Michael's case manager explains their role and uses active listening to build rapport with Michael by asking him about himself, his experience at the nursing facility, his desire to transition into the community and other issues important to Michael, such as how he became estranged from his family.

> For enrollees with SMI, like Michael, we saw a year-over-year decrease of 11% in total avoidable emergency room PMPM costs after they were enrolled in case management. For enrollees with primary behavioral health needs, we saw a 33% reduction in inpatient admits between February 2018 and February 2019.

Michael shares that he desires to return to an apartment, preferably the one he was in before nursing home placement. His case manager explores Michael's concerns about a transition to the community and identifies services that can ameliorate his stresses. Recognizing Michael can decline case management, his case manager uses motivational interviewing and builds on the rapport they have begun to establish with Michael to explain the opportunities that case management can provide. Michael agrees to participate in case management. His case manager also meets with Michael's treatment team in the facility to identify and link key personnel to Michael's My Choice Louisiana transition coordinator.

Beginning to Understand Michael's Needs and Goals: Assessment

During their face-to-face, Michael's case manager conducts an HNA and uses comprehensive assessments to determine Michael's gaps in medical and behavioral care, functional capabilities, emotional well-being, mental health conditions and social determinant gaps. With Michael's permission, his case manager reviews Michael's history, including his prior ability to live independently, both what worked well and challenges that contributed to his ED visits. The case manager conducts a safety assessment to understand his suicide risk, particularly given his prior suicide attempts and the stress that this transition will likely create.

Michael's case manager uses additional resources to get a 360-degree perspective of his present situation and future goals. Michael's nursing facility shares information with Michael's case manager about his needs, functional status and treatment plans. His case manager delves into Michael's physical and behavioral concerns, understanding that his mental health conditions may be affecting his performance with activities of daily living (ADLs), instrumental ADLs (IADLs) and physical health. Michael's case manager collaborates with nursing facility staff to understand Michael's ability to perform ADLs, such as bathing, and his ability to perform IADLs, such as preparing meals. Michael's neuropathy is a concern for his quality of life and

affects his ability to live independently. His uncontrolled hypertension could cause serious complications; therefore, timely appointments with a PCP, neurologist and PT/occupational therapy (OT) are scheduled. Michael's case manager documents his assessments and case management-related documents in CommunityCare, our care management platform.

Understanding Michael's Medicare and waiver eligibility. We know Michael is dual eligible for Medicare and Medicaid and his case manager confirms whether Michael has enrolled in Medicare. If he has not enrolled (e.g., he may have only recently become eligible and is unsure of what to do next) his case manager connects Michael to the Senior Health Insurance Information Program (SHIIP) for one-on-one guidance on what plan might best fit his needs. Michael may have multiple options available to him, including Medicare Part A, Part B or Medicare Advantage, and SHIIP will help Michael choose the program that most appeals to him. Regardless of his Medicare choices, his case manager coordinates his services with those provided by his Medicare coordinators and providers. Based upon our understanding of Michael's situation, it is unlikely Michael is eligible for the Community Choices or Long-Term Services waivers, but his case manager refers Michael to the Medicaid Waiver department to determine his eligibility.

Michael's Multidisciplinary Transition Team and Transition Plan

Informed by Michael's priorities and assessments, his case manager convenes Michael's transitional MDT within 30 days of enrollment in case management to develop Michael's Transitional Treatment Plan. Michael's MDT includes Michael and people he chooses, such as, friends, peers, others who support him, such as a spiritual leader, and providers, including nursing facility staff. With Michael's agreement, his MDT includes an RN, CHW, pharmacist, our chief medical officer, our behavioral health medical director, his PT and OT providers, our peer support/housing specialist, and the My Choice Louisiana transition coordinator. The team engages in shared decision-making to help Michael develop a transition plan, coordinate among providers and develop a crisis plan.

The planning process prepares Michael for a transition from nursing facility to the community and brings together services he needs to be more independent, to receive care and address barriers to successful community living. Michael's case manager convenes a series of planning meetings with Michael and his transitional MDT to identify his strengths and skills (e.g., the ability to participate in transition planning), and services and supports for his transition plan. We emphasize the importance of Michael's self-determination, and encourage and empower him to lead and actively participate in all aspects of the planning process.

Avoiding Crisis

Michael's case manager provides information and framing to encourage him to be proactive in addressing behavioral health concerns before they become crises. In addition to building his relationship with his case manager and his local providers, Michael's crisis plan includes resources, such as our **behavioral health crisis line** and **UHC Doctor Chat**. Additionally, we are partnering with two crisis centers to provide services to enrollees like Michael that help prevent unnecessary ED use and inpatient admissions. The table presents Michael's goals and the interventions included to help Michael avoid crisis and the unnecessary use of the ED.

Michael's Potential Goal	**Stated**	"I want to stay out of hospitals and nursing homes."
	Measurable	Minimize Michael's ED visits to no more than one in the next 90 days by connecting him with behavioral health crisis services
Outcome	Michael expresses confidence in having a plan to deal with issues before they become emergencies	
Interventions	▪ Create a behavioral health crisis plan for Michael that includes the agreed-upon steps in	

	the face of a crisis and people to reach out in case of an emergency and/or when early warning signs appear. Supports include his behavioral health provider, his case manager, others, and use of our behavioral health crisis line in Louisiana. ▪ Connect Michael to regular behavioral health provider appointments, including cognitive behavioral therapy (CBT) or other evidence-based therapies, including one of the ***1,209 CBT clinicians in our network*** with locations throughout the state. ▪ Share resources such as *UHC Doctor Chat* which offers in home secure chat, telephone or video with an RN or an ED physician licensed in Louisiana. ▪ Offer to link Michael to a local Merakay behavioral health provider for peer support and treatment (locations in East Baton Rouge, Caddo, Calcasieu, Lafourche, Lafayette, Orleans, Rapides and Tangipahoa parishes).

Michael's New Home: Connecting Him to Supportive Housing

Through our national Housing First experience, we know that getting Michael into stable housing will be an essential foundation for the rest of his care. Our peer support/housing specialist evaluates available local community housing options through our network of partners and works with the My Choice Louisiana transition coordinator and the Louisiana PSH program to identify housing options for Michael. Michael's case manager arranges day visits for Michael to visit different housing options. If Michael has made significant improvement in functional performance and neuropathy, then his case manager collaboratively discusses housing options with Michael and his MDT. Otherwise, Michael may benefit from an assisted living facility or group home in the short term, with clearly established steps or goals he needs to take to get to an independent living situation.

To prepare Michael for living independently and the challenges he is likely to face, his peer support/housing specialist, case manager, nurses, PT and OT, and other community groups provide him with opportunities to learn ADL/IADL skills. His case manager helps identify needed skills, including a stress reduction class at a local community center or church or self-management skills for individuals with severe mental illness through NAMI's peer-to-peer program or a local provider. We also look to Michael's local **Council on Aging** for additional supports. His case manager instructs Michael in the use of non-emergency medical transportation with his behavioral health provider, and how to access public transportation or transportation for the elderly to support Michael's increased integration in his community. With Michael's goals articulated, his case manager and MDT facilitate connections to services/supports that will enable him to meet his goals, as presented in the table.

Michael's Potential Goal	**Stated**	"I want to live independently in an apartment on my own."
	Measurable	Michael transitions from the nursing facility in the next 2-3 months into a supportive housing setting
Outcome	Michael selects a setting that fits his preferences and provides him with the care he needs	
Interventions	▪ Connect Michael with community housing options and select one that best fits his needs ▪ Assess financial-medical benefits available to Michael including SSD, Medicaid or Social Security. Michael's case manager identifies existing benefits, helps determine his eligibility and helps Michael apply for benefits. ▪ Identify and help Michael select available community resources for transportation, food security, telephone and other social resource needs using *Healthify* and Aunt Bertha© and coordinate to wrap appropriate resources around Michael ▪ Encourage Michael to be socially involved, including Area Agency on Aging/Council on Aging senior centers in Michael's community, and identify community organizations such as faith-based groups that Michael might benefit from joining	

Michael's Potential Goal	**Stated**	"I want to feel good enough to do the things I want to each day."
	Measurable	Improve self-management strategies including increasing medication adherence to 5 out of 7 days
Outcome	Michael is able to meet the goals he sets each day because his chronic physical and behavioral health needs are better managed	
Interventions	▪ Address Michael's neuropathy and chronic pain by identifying and scheduling appointments for him with specialist providers including neurologists, PT and OT. ▪ Enhance **medication adherence** by connecting Michael to our pharmacy navigator: • Genoa, our behavioral health pharmacy partner, delivers medication management services through trained clinical pharmacists who assess and reconcile his medications, provide education, resolve drug therapy concerns and set goals in close communication with the clinical team. • Review options that facilitate adherence, such as long-acting antipsychotics. Our pharmacist reviews authorization criteria for long acting antipsychotics and works with Michael's behavioral health provider to offer education. ▪ Match Michael with a **peer support specialist** while at the nursing facility. UnitedHealthcare is contracting with NAMI St. Tammany and Local Governing Entities around the state to provide these peer supports to our enrollees.	

Managing Michael's Transition to Community Living

Michael's transition to his new home is expected to be a stressful time. His case manager and peer support/housing specialist visit Michael in the nursing facility several times a week in the time leading up to his transition date. One to 2 weeks before Michael's transition, his case manager conducts an in-home assessment to identify and confirm the delivery of services Michael may require, such as minor home modifications or specific PT or OT that may be needed for Michael to live in the community.

Michael's case manager checks on Michael within days of his nursing facility discharge to check on his transition. Michael and his case manager discuss changes to Michael's priorities, goals and preferences for care delivery, any care gaps or barriers to accessing care and social determinants needs. For example, his case manager offers Michael support if he would like a new medical provider closer to his apartment. Michael and his case manager develop a daily routine, and set and maintain measurable goals. Michael's case manager coaches Michael to confirm his routine includes self-care and caring for his living space, while managing his medical/behavioral care, finances, and social and leisure activities. We look forward to Michael learning not just to survive but also to thrive in his new surroundings.

Looking Forward

Over the next year, Michael starts to take on more IADLs and returns to his old routine. He now walks to the public library several days a week and attends regular wellness education programs at his local Council on Aging. Michael and his case manager meet monthly to discuss his plan of care and confirm progress with Michael and his providers. After 3 months in his new setting, Michael's case manager conducts an in-person formal reassessment, repeated quarterly or as needed when his needs and priorities change. The case manager updates his plan of care accordingly. Over the next 12 months, case management meetings taper off to a minimum monthly basis to confirm Michael maintains the support and resources he needs. At the 1-year anniversary of Michael's relocation, we evaluate how far he has come since he was first referred to our case management program. Michael may need ongoing case management, or may have progressed enough to live independently without this support. In either case, Michael's empowerment to lead a self-directed, healthy and meaningful life is a remarkable achievement, and we are humbled by the opportunity to accompany him along his journey.

2.10.7 Provider Network

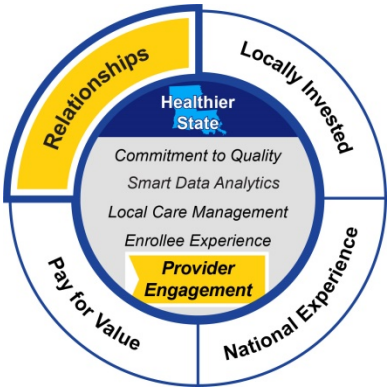
2.10.7.1 The Proposer shall provide an electronic list of all providers within its network, by provider type…

2.10.7.2 The Proposer should submit documentation that its provider network meets or exceeds the time, distance…

Please refer to Attachment 2.10.7.1 Provider Network Listing and Attachment 2.10.7.2 Provider Network Capacity Response, provided on flash drive.

2.10.8 Network Management

The Proposer should demonstrate how it will ensure timely access to culturally competent primary and specialty…



Our mission is to help people live healthier lives and to help make the health care system work better for everyone. To accomplish our mission in Louisiana, we work hard to evaluate our network through the eyes of enrollees and confirm they are able to receive the right care from their preferred provider in the right location at the right time. As we continue to evolve our network, we focus on sustaining an environment where enrollees feel comfortable in the care they receive no matter who they are or where they live. We recruit providers of all types and make sure they have tools that enable them to spend more time with their patients. We place extra focus on providers that serve particularly underserved populations (e.g., Native American communities, communities of color, communities with high poverty rates and enrollees experiencing homelessness).

We apply monitoring techniques (outlined in 2.10.8.5) and real-time insight from UnitedHealthcare staff, providers and enrollees to verify our enrollees have ***timely access to culturally competent care.*** Our local staff many of whom are native Louisianans, understand each region's unique culture and values. We are familiar with geographic distribution of ethnicities around the state (e.g., we make sure there enough Vietnamese-speaking providers and provider staff to serve New Orleans East area), and we provide staff sensitivity training on regional differences. For example, those familiar with the New Orleans area know it could be a hardship for an enrollee on the Westbank of New Orleans to travel across the Mississippi River to see a PCP on the Eastbank — regardless of actual distance.

When we identify a network gap, we actively address it through our Network Development Plan, outlined later. We employ innovative solutions like expansion of our telemedicine offering to make care available to enrollees regardless of geography. Where capacity is limited by closed panels or non-participating providers, we meaningfully incent providers through Value-based Payment (VBP) programs, like our PCP Gap Closure model, which directly and more timely pays providers who improve outcomes and close HEDIS care opportunities. These initiatives encourage providers to join our network, open their panels or expand office hours.

We continue to enhance our already deep provider relationships through local engagement and advisory groups — listening to, collaborating with, and actively supporting them by ***reducing complexity and administrative burden*** (e.g., based upon provider feedback, we added a feature to our provider service line to help PCPs locate and secure specialist appointments).

Through this combination of local experience, ongoing monitoring, innovation and collaboration, UnitedHealthcare continues to enhance and maintain a compliant provider network that drives health care in Louisiana toward the "Triple Aim" and meets all LDH requirements, including those outlined in Attachments A and D to the Model Contract.

2.10.8.1 Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.)

2.10.8.2 Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where…

2.10.8.3 Strategies (including a description of data sources utilized) for monitoring compliance with the provider…

Because Questions 2.10.8.1 through 2.10.8.3 are so closely related, our response addresses all requirements of these questions through a combined response with sections covering:

- Our approach to identifying network gaps
- Network compliance with Attachment D and known gaps
- Methods to remediate gaps by improving access, capacity and appointment availability

Approach to Identifying Network Gaps

Since 2012, when we partnered with LDH through a Shared Risk primary care management program, our ***culture of innovation and continuous improvement*** has informed our increasingly strategic and proactive network approach. We have a deep understanding of the state's geographic, clinical and cultural needs. This knowledge and experience guides our Network Management Team to employ focused recruitment to enhance our network year over year. Since moving to a Full Risk Managed Care Program in 2015, we have developed a full-service, comprehensive network that includes hospitals, primary and specialty care, behavioral health, and ancillary service providers. As demonstrated in the figure, our network has grown approximately 20% over the last 4 years to meet the individual needs of our enrollees.

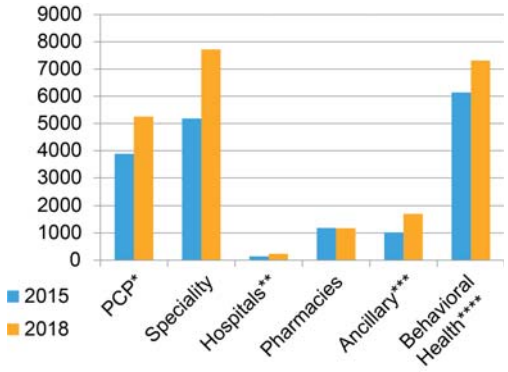


Figure 16. Network Growth from 2015 to 2018

Our Interdisciplinary Network Team composed of network management, provider relations, the Quality Management Committee (QMC) and clinical/case management meets at least monthly to identify and address potential network deficiencies. We coordinate an organization wide response to accessibility issues or provider trends identified through continuous monitoring, provider outreach and enrollee feedback.[1]

Engagement with Providers, Enrollees and Our Community

Through direct interaction with providers and enrollees, we are able to uncover actionable opportunities for network improvement in real-time that may not be visible purely through data. Examples of these types of engagement include:

- Our Enrollee Advisory Committee meets quarterly to foster feedback and open dialogue to assess enrollee satisfaction and remain responsive to enrollees' needs
- Reviews of provider performance by our provider advocates to identify utilization outliers and access to care issues
- Face-to-face meetings between our field-based shared savings specialists and providers engaged in our shared savings VBP model
- Partnership with local faith- and community-based organizations, such as Volunteers of America, Greater Baton Rouge, which helps identify community-specific network gaps and offers local providers' perspective on updates to our network operations

Additional sources of input include quality of service concerns via enrollee complaints and grievances, provider disputes, and enrollee and provider satisfaction surveys.

[1] *PCP includes FQHC/RHC, OB/GYNs and extenders; ** Hospitals include specialty, surgery centers and acute care facilities that provide BH; ***Ancillary includes HH, DME, vision, dental, PT, OT, ST and chiropractic; ****BH includes outpatient, individually credentialed clinicians, roster clinicians and group and residential IP facilities.

Continuous Network Monitoring

Our Interdisciplinary Network Team meets at least quarterly to assess network adequacy, and we use the following methods to help us prioritize and identify network gaps and opportunities for improvement. Through these meetings, we are able to identify specific provider recruitment opportunities and address the unique cultural, geographic and community-based needs of our enrollees.

Zelis Network 360® Tool: This tool provides a comprehensive analysis of network strength and identifies providers targeted for recruitment efforts by type, specialty and geography.

GeoAccess Reporting: We use GeoAccess mapping at least quarterly to evaluate the network for adequate coverage and compliance with LDH time and distance standards in Attachment D.

QMC Monitoring: Our QMC's activities include, but are not limited to, reviewing HEDIS data and network performance against access standards, recommending solutions for network expansion; monitoring improvement plans, enrollee satisfaction, provider cultural competency, peer comparison data, quality of care incidents and provider satisfaction; and conducting appointment and after-hours availability surveys.

Membership and Capacity Reports: We review quarterly enrollee-to-provider counts by specialty type and PCP capacity to confirm appropriate enrollee access and address any gaps.

Utilization Data: We employ utilization data as part of our annual business planning to identify and close network gaps. We review out-of-network prior authorization data by specialty type, location and program to help identify network needs.

Comprehensive Review of Appointment Availability

Timely access to care is essential for our enrollees and their families. Our monitoring and surveying approach confirms enrollees have access to a contracted provider to meet their health care needs. We monitor provider compliance with appointment availability requirements, wait time standards, and after-hours access requirements according to state-specific and NCQA accreditation requirements.

We use quarterly appointment and availability surveys, annual physical and behavioral provider satisfaction surveys, provider-level CAHPS surveys and enrollee satisfaction surveys to identify areas of improvement. We also employ a third-party vendor to conduct regular practitioner appointment access and availability survey calls to a random sample of PCPs, pediatricians, specialists, and behavioral health providers to determine compliance with contractual requirements. During the survey, the vendor solicits appointment availability for emergency, urgent, routine and preventive visits. When surveys indicate non-compliance, we conduct targeted training. Non-compliant providers receive additional outreach, face-to-face follow ups and, when necessary, we develop a corrective action plan. Continued noncompliance may result in termination. Compliance among PCPs and pediatricians in our network shows the most improvement year over year compared to other provider types. Nearly nine in 10 PCPs/pediatricians that were non-compliant in 2017 are now complaint in 2018. Our 2018 overall compliance rate for PCPs and pediatricians is 89.5%.

Survey results are presented to our internal Service Quality Improvement Subcommittee (SQIS), at least annually for review and to develop an action plan to improve overall scores. This committee is chaired by Chief Operating Officer, Karl Lirette, and is integrally involved in monitoring and providing feedback to the QMC for systemwide actions, if needed. For example, after reviewing the concerns for access and availability to behavioral health services, we initiated the expansion of our behavioral health virtual visits program to include more prescribers

(e.g., as of April 2019, we have added six MDs to our network). We have seen a steady increase of utilization and enrollee adoption of virtual visits with over 2,000 claimants in 2018 — up by over 1,000 units versus 2017.

Compliance with Attachment D and Existing Network Gaps

Current analysis shows we provide a comprehensive network of all provider types to meet the unique needs of Louisiana enrollees (based on LDH's Potential Enrollment file). However, as illustrated in the table, our data indicates the following access challenges for the provider types listed by LDH in RFP Section 2.10.8.3. Many of these gaps are due to known, statewide provider shortages in parishes (rural or otherwise) where our enrollees live. We are actively addressing these challenges. For enrollees with transportation needs, we provide transportation to and from appointments through our Non-Emergency Medical Transportation program for Medicaid covered services.

Provider Type	Existing Gap	Gap Closure Remediation
Adult Cardiologists	▪ Compliant with Attachment D	▪ Compliant with Attachment D
Pediatric Cardiologists	▪ There is a known provider shortage of pediatric cardiologists. This provider specialty is normally associated with large hospital systems.	▪ Telehealth expansion ▪ Contracting with large hospital systems in nearby parishes such as Lafayette and Alexandria; cross-border contracting ▪ Single-Case Agreements (SCA)
Dermatologists	▪ There are no dermatologists in Beauregard, Calcasieu and Cameron parishes. ▪ Enrollee standard access of care is in Lafayette parish	▪ Telehealth expansion ▪ Contracting with large hospital systems in nearby parishes such as Lafayette and Alexandria ▪ SCAs
Endocrinologists	▪ Known provider shortage in Caldwell, Catahoula, Concordia, East Carroll, Franklin, Grant, LaSalle, Madison, Morehouse, Sabine, Tensas, Vernon, West Carroll, Winn, Ouachita and Rapides parishes	▪ Seeking contracts with identified providers ▪ Telehealth expansion ▪ Currently contracted with large hospital system in the Shreveport area that offers this specialty ▪ Cross-border contracting ▪ SCAs
Adult Licensed Mental Health Specialists	▪ Compliant with Attachment D for rural areas of the state ▪ Known provider shortage in urban areas of the state	▪ Seeking contracts with identified providers ▪ Telehealth expansion ▪ SCAs ▪ Alternative providers available, including Licensed Professional Counselors (LPC), Licensed Marriage and Family Therapists (LMFT), and community-based providers
Pediatric Licensed Mental Health Specialists	▪ Known provider shortage across the state	▪ Telehealth expansion ▪ Exploring program to provide behavioral health consultation to PCPs ▪ SCAs ▪ Alternative providers available, including LPCs, LMFTs, and community-based providers

Provider Type	Existing Gap	Gap Closure Remediation
Adult Neurologists	▪ There are no neurologists located in Sabine Parish. Enrollees typically access care in Alexandria Parish.	▪ Telehealth expansion ▪ Currently contracted with large hospital system in the Shreveport and Alexandria areas that offer this provider specialty ▪ Cross-border contracting ▪ SCAs
Pediatric Neurologists	▪ Known provider shortage across the state ▪ We currently have providers contracted in the following parishes: Caddo, Calcasieu, East Baton Rouge, Jefferson, Lafayette, Orleans, Ouachita, Rapides, Saint Tammany, Tangipahoa, Rapides and Terrebonne	▪ Telehealth expansion ▪ Contracting with large health systems ▪ Cross-border contracting ▪ SCAs
Obstetricians/ Gynecologists	▪ Compliant with Attachment D	▪ Compliant with Attachment D
Pediatric Orthopedists	▪ Known provider shortage across the state ▪ Providers only located in Ascension, Caddo, Calcasieu, East Baton Rouge Franklin, Jefferson, Lafayette, Orleans, Ouachita, Rapides, Richland, St. Tammany and Vernon Parishes	▪ Currently contracted with large hospital system in the Shreveport and Alexandria areas that offer this specialty ▪ Cross-border contracting ▪ SCAs
Adult and Pediatric PCPs	▪ We currently have an adequate network of adult and pediatric physicians across the state to serve the potential Medicaid membership; however, there are known gaps within specific parishes in rural areas near the Texas, Mississippi and Arkansas borders	▪ Contracted with 90% of school based health clinics (SBHC) and all FQHCs ▪ PCP care in the home via Homedica partnership ▪ Telehealth partnership between UnitedHealthcare, Metropolitan Human Services District, Louisiana State University Department of Psychiatry, and Plaquemines Parish School Board (described later)
Adult Psychiatrists	▪ Compliant with Attachment D for rural areas of the state ▪ Known provider shortage in urban areas of the state	▪ Telehealth expansion, including six adult psychiatrists available via virtual visits ▪ Seeking contracts with identified providers ▪ SCAs ▪ Enrollees may also use other prescriber types (e.g., APRNs and PAs with prescription authority or medical psychologists)
Pediatric Psychiatrists	▪ Known provider shortage across the state	▪ Telehealth expansion ▪ Exploring program to provide behavioral health consultation to PCPs ▪ Seeking contracts with identified providers ▪ SCAs ▪ Enrollees may also use other prescriber

Provider Type	Existing Gap	Gap Closure Remediation
		types (e.g., APRNs and PAs with prescription authority or medical psychologists)
Pulmonologists (Adult and Pediatric)	▪ Known provider shortage across the state ▪ Providers are located in only 19 parishes; this provider specialty is normally associated with large hospital systems.	▪ Telehealth expansion ▪ Contracting with large hospital systems in nearby parishes such as Lafayette and Alexandria ▪ Cross-border contracting ▪ SCAs

Addressing Gaps in Access, Capacity and Appointment Availability

Here we outline our strategy for addressing network gaps by improving enrollee access, improving provider and network capacity, and improving appointment availability.

Improving Enrollee Access to Care

Given the geographic locations of enrollees and their need to access primary and specialty care, we have implemented the following solutions (e.g., telemedicine, home-based care and community partnerships) to bring the right care to enrollees at the right time and place. In addition to providing transportation for enrollees that require specialized care or extended travel (in state or out of state), we partner with the Ronald McDonald house charities for housing, and local hotels.

Expanding Access to Care through Telehealth

Telehealth is one of our most innovative strategies to provide enrollees with virtual access to behavioral health, substance use services, and primary and specialty care in the communities where enrollees live. These solutions not only address gaps in underserved areas, they enable enrollees to access care regardless of scheduling or transportation challenges.

Our strategy to deliver care to underserved Louisiana Medicaid enrollees through telehealth addresses three modes of access: direct to enrollee, enrollee to specialist through PCP, and doctor to doctor. ***From 2017 to 2018, we have seen a 34% increase in telehealth claims received.*** Today, as we continue to expand our telehealth programs, we are guided by a four-tier strategy for delivering high quality, accessible care to enrollees in Louisiana by focusing on providing access, capacity, innovation and quality.

As we look to further expand access for enrollees, we are exploring additional telehealth applications. We continue to identify PCPs statewide and FQHCs in rural parishes interested in expanding their capacity to serve as a host site for telemedicine services and we are leveraging our success in VBP programs to offer a telehealth hosting fee to attract providers to participate. We also will continue to build on our strong network of behavioral health providers, prescribers and specialty providers throughout Louisiana to deliver these services via mobile telehealth. Further, to facilitate the expansion of our telehealth programs, we have invested in training with our Louisiana health plan staff — conducting two sessions with 40 UnitedHealthcare employees — to help them better communicate options to both enrollees and providers.

The table provides an overview of our existing telehealth program, which has grown in 2019 to include four new programs. We also support NOELA and Children's Hospitals by promoting their ability to connect enrollees to specialist care through their PCP via Skype and smartphone.

Program	Implemented	Audience	Description
Virtual Visits	2015	Direct to Enrollee	Offers enrollees with behavioral health needs virtual visits via site-to-site connectivity and direct-to-enrollee connectivity
UHC Doctor Chat	2019	Direct to Enrollee	Helps patients statewide get the care they need when they need it. With the Dr. Chat app, patients can avoid the ED and receive on-demand care via computer or mobile device.
Lower Plaquemines (Virtual Visits Expansion)	2019	Direct to Enrollee	In partnership with Metropolitan Human Services District, LSU Department of Psychiatry, and Plaquemines Parish School board, this program expands behavioral health services to children and adolescents (regardless of MCO) in the underserved area of Lower Plaquemines Parish via telehealth
Host incentive program	2019	Enrollee to PCP to Specialist	We are in the process of partnering with Total Family Medical and Children's International to use a host fee to incentivize PCPs to use telehealth for specialist access while enrollees are visiting their PCP's office
RubiconMD	2019	Doctor to Doctor	PCPs have the ability to connect with specialists for same-day consultations, expanding PCPs' scope of care, including TeleMAT

Increasing Access through Community Providers/Partnerships and Care Extenders

We have strategically expanded our network and enrollee access to care by including community providers (e.g., FQHCs, SBHCs and Indian Health Care providers), care extenders (e.g., medical assistants, paramedics) and care through home visits and peer support. By allowing care extenders to operate in expanded roles and provide routine health care services, we can efficiently improve access for enrollees who may be experiencing access or availability challenges (e.g., high wait times, provider shortages, low PCP engagement). We engage provider organizations like the American College of Emergency Physicians, the Louisiana Academy of Family Physicians and other providers for guidance on preventive care and required health care screenings in accordance with HEDIS requirements.

To promote timely appointment access to behavioral health services and minimize non-emergency medical ER visits, we have implemented the following initiatives:

ExpressAccess Behavioral Health Network: While the industry standard (and our requirement) for a routine appointment is within 10 business days of request, ExpressAccess providers are contractually committed to offer an appointment within 5 business days. There are currently 60 ExpressAccess providers in Louisiana today—including rural parishes (e.g., four providers in Calcasieu, one MD and one MSW in Vermilion). Growing the ExpressAccess network is a priority to increase access for enrollees with behavioral health needs.

Ready Responders: We partner with Ready Responders to engage enrollees with high ED utilization in Orleans and Jefferson Parishes. Ready Responders offers a network of trained, licensed and fully insured physicians, EMTs, paramedics and nurses who visit the enrollee at home to conduct a medical assessment where a video telehealth physician consult may occur and treat the enrollee on the spot. This program has had a very successful ED diversion rate and a very positive overall enrollee engagement.

FQHCs: We value our strong FQHC relationships and support them in maximizing their capacity to increase access to care for enrollees. We have contracts with all 233 FQHC locations in the state and are currently partnering with several of them to expand access through telehealth.

These centers are critical to expanding access to enrollees in underserved areas, including Bienville, Bossier, Caddo, Caldwell, Claiborne, East Carroll, Franklin and Jackson parishes.

LDH Program Goal: Ensure enrollees ready access to care, including through non-traditional means

Investing $2.5 Million to Help Daughters of Charity Expand CHW Program

In 2018, through a $1.5 million grant from UnitedHealthcare, community health workers (CHW) at Daughters of Charity reached 8,234 unique individuals, encompassing both our enrollee and non-enrollee population. Of those individuals, 5,195 (63%) completed referrals to receive medical, dental and behavioral health services through the health centers, and 3,039 (37%) completed referrals to receive services through community-based organizations. Referrals to community-based organizations include referrals to address the education, employment, food, housing, transportation, technology/internet, and legal needs of underserved and uninsured individuals. With an additional $1 million grant disbursed in January 2019, Daughters of Charity expects that the CHWs will reach 7,500 additional people.

School-based Health Clinics: UnitedHealthcare has contracts with 90% of Louisiana's SBHCs, and we are in the contracting process with those remaining. Students and their families rely on SBHCs to meet their needs for a full range of age-appropriate health care services including primary medical care, mental health, dental health, substance use counseling, nutrition services and health education.

Home Visits via Homedica House Calls: UnitedHealthcare partners with Homedica House Calls to provide primary and palliative care to patients who have limited mobility, who find it difficult and taxing to travel to and from a physician's office. Nurse practitioners provide care under the direction of Board Certified internal medicine and palliative care physicians. The goal is to decrease hospital admissions and ED visits and improve the enrollee's experience.

Peer Support: Peer support is an important tool in enrollees' treatment and long-term recovery. Our peer support specialist, Denise Smith, offers unique services to Louisiana Medicaid enrollees and can have a significant positive impact on enrollees' engagement in care and self-perception. To encourage the use of peer support specialists within the provider network, we offer an alternative payment arrangement, provide peer support resources on our website and have sponsored community training specifically geared for these professionals.

Improving Network Capacity

When we identify opportunities to improve and enhance provider capacity and choice, we strategically recruit providers based upon the following; feedback received from PCPs regarding referral patterns for the needed specialties; benefit from existing contractual relationships with providers contracted with UnitedHealthcare's Medicare and Commercial lines of business; claims data received from nonparticipating providers and contracts with cross border providers. We also use internet searches and the State's licensing board to identify any newly licensed providers for recruitment. Once we identify providers, our Network Management Team engages them to discuss network participation and initiate the contracting and credentialing processes. In some cases, we may be required to enter into an SCA with an out-of-network or out-of-state provider to ensure enrollees have access to and receive the appropriate care. We further discuss recruitment strategies in our response to 2.10.8.4.

Improving Appointment Availability

In our efforts to achieve the appointment availability goals as outlined in Attachment D, we use our quarterly appointment availability surveys to assist in monitoring and identifying any opportunities for improvement. Provider compliance with timely appointment access measures

is essential to providing quality-driven, person-centered care. The goal of meeting the standards is to afford our enrollees timely access to care and promote improved health outcomes. Untimely access to care is a serious barrier and contributes to negative health outcomes. When our comprehensive appointment availability monitoring uncovers non-compliance with appointment availability or after-hours access to care, we take the following steps to address it:

- Our Provider Advocate Team contacts the provider, reviews the issue and educates them on the requirements and how they failed to meet them
- We send a follow-up letter to the provider clearly outlining the deficiencies and actions needed to meet the requirements, and notify them of a follow-up audit
- Our Provider Advocate Team meets in-person with persistently noncompliant providers to identify the source of the issue, deliver re-education and confirm steps are taken to address deficiencies (e.g., supplying written scripts to noncompliant network providers to confirm answering service or voicemail meets standards)
- In the rare instance that a provider is uncooperative and not making the necessary changes to meet access standards or coverage requirements, we refer them to the Credentialing Committee for a corrective action plan or possible termination

To improve enrollee access to care, UnitedHealthcare assists enrollees and providers in arranging appointments. Our member services advocates (MSA) assist enrollees in scheduling appointments with providers. For PCPs experiencing challenges in scheduling specialty appointments for enrollees, our provider service line offers assistance locating specialists.

2.10.8.4 Strategies for recruitment and retention efforts planned for each provider type, including quality and/or…

Recruiting, incenting and retaining high-quality providers is essential to sustaining an adequate network. ***Our ongoing recruitment and retention strategies begin with continuous monitoring of the network based upon LDH priority measures, access requirements and targeted recruitment.*** We are aware of the geographic, social, cultural and health-status issues Louisianans face and consider enrollee access in the context of these needs.

Recruitment

We are committed to complying with the Model Contract, including section 2.9.8.1.7, in managing our network. Our strategy focuses on targeted recruitment in geographic areas and provider types. We consider patient preferences, language barriers, cultural diversity, health disparities and disabilities. For example, with the addition of the Medicaid expansion population, the need for adult substance use services increased dramatically. We focused our recruitment efforts on providers that could serve these enrollees, increasing substance use residential facilities and medication assisted treatment (MAT) provider access by 17.2% since 2017.

We use quarterly GeoAccess reports to assist with identifying network gaps. We also collect ongoing feedback through community outreach, enrollee and provider call center interactions, provider relations feedback and care management activities to further inform the Network Management Team of any accessibility needs. Where there are known provider shortages — such as parishes along the Mississippi state border where there is a lack of endocrinologists, dermatologists, allergists and immunologists — we focus recruitment on cross-border providers, providers interested in offering or expanding telehealth services or large health systems. Our network team engages targeted providers to discuss participation and initiate the contracting and credentialing processes. Our strategy also includes recruiting providers that qualify as Veteran and Hudson initiative participants.

We also use quality data obtained through annual medical chart reviews to identify concentrations of enrollees experiencing conditions that require access to specialists and target recruitment to meet those needs. For example, our network includes over 300 applied behavior analysis providers for enrollees with autism spectrum disorders and we continually work to identify additional providers to meet this need. To enhance our local network, we also will use our national contracts to provide key ancillary services, including pharmacy, laboratory and other non-physician provider types that are able to provide services locally to enrollees.

Retention

Attracting and retaining high-quality providers committed to serving the Louisiana Medicaid population is essential to sustaining an effective network. Our success in retaining and incenting providers — as demonstrated by our 95% retention rate — is a reflection of our dedication to partnership, provider incentives, comprehensive education, and access to actionable data through technology. Through our 360° Provider Service Strategy, we employ these approaches to support a positive provider experience, reduce administrative burden, facilitate the best care to our enrollees, and engage providers as our trusted partners — all of which are critical to retention. Our strategy continues with responsiveness through our comprehensive provider support model and includes monitoring and tailored outreach to help providers achieve LDH priority measures and access requirements, education and streamlining data exchange.

Supporting Achievement of LDH Priority Measures and Access Requirements

We prioritize engagement with qualified Medicaid providers who promote culturally sensitive environments and embrace the role of the health care provider in minimizing disparities. We monitor their achievements in meeting LDH access and distance requirements outlined in Attachment D and LDH's priority quality metrics in Attachment G, including:

- Well-Child Visits (first 15 months)
- Well-Child Visits (years 3 - -6)
- Adolescent Well-Care Visits
- Adult Access to Preventive/Ambulatory Services
- Seven-Day Follow-Up after Behavioral Health Hospitalization
- Prenatal and Postpartum Care, Timeliness of Prenatal Care
- Prenatal and Postpartum Care: Postpartum Care
- Initiation of Injectable Progesterone for Preterm Birth Prevention
- Controlling High Blood Pressure
- Eye Exam (Retinal) Performed
- Percent of enrollees completing initial health needs assessment within 90 calendar days of enrollment

We employ the following approaches to monitor provider performance and right size our support to meet each provider's unique needs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Provides insight into enrollees' PCP experience (e.g., appointment availability, access, after-hours care and cultural competency).

HEDIS-reported Utilization Rates: Our provider support team uses monthly reviews of HEDIS rates and utilization metrics to educate and support providers in closing any gaps in care.

Inpatient and ER Utilization Rates: Available via in-person meetings and our online provider portal, these monthly reports give providers a scorecard of their aggregate rates to help guide them in achieving minimum standards, exceeding peers or meeting provider incentive agreements. The reports also include gaps-in-care data for enrollees assigned to the practice,

and relevant utilization patterns for each enrollee. We also monitor internal Louisiana Medicaid Managed Care utilization rates such as cost-per-enrollee, provider inpatient data and ER rates.

Provider Peer Comparison Reports: These annual reports show PCPs and specialists how their performance in select performance measures compares to their peers. Our provider-facing staff reviews utilization patterns with providers to help them improve performance.

Provider Profiling: Annual provider profiles for high-volume PCPs (i.e., providers serving 50 or more enrollees) verify that providers are complying with LDH requirements for access, provider responsibility and care management.

Fraud, Waste and Abuse (FWA) Review: We review results of data analytics and algorithms; referrals from enrollees, staff, the public and the provider communities; and a service verification program to uncover and investigate potential provider FWA.

The data obtained from these monitoring approaches illustrates the comprehensive support provided by our clinical staff, who work directly with PCP and OB/GYN providers to improve performance in clinical metrics. This team reviews performance data and suggests ways to improve a practice's results. Each participating practice receives scorecards showing trends relative to baselines and targets for clinical quality measures (including those listed previously).

Incenting Achievement of Quality Metrics through Value-based Payments

Our comprehensive suite of VBP models reflects our commitment to LDH's vision to help providers close gaps in care and improve quality outcomes in alignment with the state's priority measures. Our modular approach allows us to meet providers where they are in terms of affordability, quality improvement and operational sophistication. ***VBP arrangements also help address gaps in care by incenting measures tied to specialties where we have known shortages.*** For example, our Behavioral Health VBP model enables PCPs and behavioral health providers with the largest attributed enrollee base to receive incentives if an enrollee receives care from a behavioral health provider within 7 days of discharge. This facilitates integration and incentivizes behavioral health professionals to join and remain in network.

Provider Education and Support

Our 360° Provider Service Strategy supports a positive provider experience by pairing effective communication and collaboration with technology to enable improved performance, ease administrative burden, and promote quality care. Facets of the program include:

Provider-facing Technology: *UHCprovider.com* is our public web home for provider information, which includes connection to our secure provider portal, *Link*. *Link* provides administrative tools to simplify common clinical tasks. The My Practice Profile feature, implemented in December 2018, allows providers to view, update and attest to provider demographic data — making it easier for enrollees to find the right provider.

Provider Education and Training: Timely communication and education through provider-friendly tools found on *UHCprovider.com* and *Link are* essential to helping providers interact and transact with us and access free continuing education units on a variety of topics.

> "I wanted to write a note of thanks for the work [Provider Advocate, Julie Sutton] has done for us in the past year. Her expertise and insight has helped us raise the bar since I came to our hospital in January 2018. Thank you again for having such a capable, helpful and responsive person representing your company and helping us better take care of patients."

Provider Advocates: We assign our full-time, local provider advocates by parish. Advocates take a hands-on approach to help providers identify issues early through data analytics and targeted training. Advocates meet with providers face-to-face and online via webinar to answer questions, identify issues and work on the provider's behalf to reach resolutions. In addition to the provider advocates, our call centers, clinical team and local leadership team are all dedicated provider support.

Provider Expositions: We arrange biannual provider education expositions that focus on a broad range of topics that includes, refresher training on billing and claims issues, portal updates and the introduction of new programs or products. Our staff is available to provide a live demonstration of *Link* and answer questions during the exposition.

2.10.8.5 Strategies to ensure that its provider network is able to meet the multi-lingual, multi-cultural and

Our strategy for ensuring enrollees have access to providers competent in providing care to enrollees with limited language proficiency, diverse cultural and ethnic backgrounds and are ADA compliant includes customized education, network monitoring, strategic provider recruitment, and provider support and tools.

Network Monitoring/Recruitment for Cultural & Disability Competency

Provider network diversity facilitates improved access to quality care for Medicaid populations and promotes better patient-provider interactions. We design our network to meet enrollee needs, such as taking into consideration language fluency, understanding the values of different cultural groups, sexual orientation and gender identity, beliefs regarding healing, communication preferences and family dynamics. For example, we know that 2.3% of our enrollees speak Spanish (1.84%) or Vietnamese (0.39%) rather than English. Currently, 45% of our providers are bilingual. We also identify populations that are geographically centralized and then work to align network providers with the culturally specific needs of that population. For example, we make sure there is a sufficient number of Vietnamese-speaking providers and provider staff to serve the substantial Vietnamese population in the New Orleans East area.

Annually, we review multiple data points to assess the disability, cultural, ethnic, racial and linguistic needs of our enrollees. Data sources include 2010 U. S. Census data, CAHPS® 5.0H, Network Database reports on practitioner languages and race, American Community Survey Data Set (2014), UnitedHealthcare interpretation services utilization statistics, and physicians' languages to confirm our network aligns with the cultural needs of our enrollees. We also collect cultural and disability competency data during the credentialing process.

We have 535 attested behavioral health providers — including MDs, Ph.D.s, RNs and MSWs–across all 10 regions of the state to treat IDD patients.

In 2018, we were the first and only MCO to engage with Quality Interactions (QI) in their Compass Cultural Competency Survey for a sample of our network providers. Through the study, we discovered at least 60% of providers considered themselves skilled in working with culturally diverse enrollees. Providers also stated that they either had no training or had limited training within the past 3 years.

Training and Education

Louisiana Culture Training: Our chief operating officer and director of marketing and community outreach — both native Louisianans — developed required culture training to help all UnitedHealthcare staff understand everything from each region's unique heritage to how to pronounce common last names. This deep familiarity with the state's culture and values helps us pair our enrollees with the right providers in the right location at the right time.

Provider Education: We support provider understanding of cultural diversity and disability competency, through provider orientation and refresher training (e.g., provider expositions and town halls). We also provide educational materials, such as the *Care Provider Manual* and our *Practice Matters* newsletter, which includes articles such as *Support for Language Services* and *A Member's Right to Culturally Competent Care.* We also offer training via our provider portal, as well as professional, online continuing education and training related to caring for individuals with disabilities (live and recorded) through *UHC On Air*.

"Through Their Eyes" cultural competency training is required for all UnitedHealthcare staff — in support of the national culturally and linguistically appropriate services (CLAS) standards. This training helps us meet the individuals in our Louisiana Medicaid population where they are, calls on each of us to act with compassion, and helps us understand the unique needs of enrollees, providers and business partners. Current topics include medical interpreters, LGBTQ+ diversity and health literacy.

NAMI Training: In 2018, we contracted with the executive director of the National Alliance on Mental Illness (NAMI) in Louisiana to host two in person cultural competency trainings addressing Louisiana populations including Native Americans, Vietnamese, African American, and Creole. We offered continuing education units (CEUs) for these trainings.

Assistance with Translation and Interpretation

Real-time Interpreter Services are available for both providers and enrollees via bilingual provider phone representatives and our interpreter service, with more than 240 supported languages. We monitor the languages enrollees and providers request for interpretation services to tailor our support accordingly.

Communication Assistance: We offer provider support for enrollees who are deaf, hard-of-hearing or speech-impaired using TTY/TDD or a Telecommunications Relay Service (TRS).

Customized Materials: We offer customized materials for enrollees with limited English proficiency and who speak languages other than English or Spanish. Materials are also available in alternative formats for specific populations, including Braille, upon request (e.g., our Picture Recovery Workbook is available in Spanish).

Resources and Operational Requirements

Provider Data: Network providers are required to attest to having ADA-compliant offices. We list provider languages and accessibility in our provider directories so enrollees can easily identify practitioners who meet their needs.

CommunityCare Collaboration Platform enables network providers to view an enrollee's primary language preference.

I/DD Toolkit: To assist providers in serving enrollees experiencing intellectual or developmental disability (I/DD), we offer an I/DD tool kit. This toolkit includes resources for physical health and behavioral and mental health providers. It includes the following information: how to communicate effectively, management of behavioral crises, crisis prevention and psychotropic medication. We also offer free CEUs and resources on trauma-informed care and home and community-based services.

Cultural Competency Resource Guide was created and distributed at recent Louisiana provider expositions along with handouts on topics such as understanding ADA, and the Agency for Healthcare Research and Quality (AHRQ) health literacy universal precautions toolkit, We

also shared the cultural competency resource guide with our clinical practice consultants to share with PCPs during their office visits.

Liveandworkwell.com allows enrollees to search a community directory for providers that meet their unique needs, including those experienced in and sensitive to LGBTQ+ issues. We encourage providers to direct UnitedHealthcare enrollees to this site.

Ensure enrollees ready access to care with culturally competent providers

In 2018, we recognized Dr. Samuel Brown — a pediatrician in Kenner — with an award for cultural diversity. Dr. Brown serves a significant Spanish-speaking population and reinvested incentive dollars earned through his VBP contract to hire Spanish-speaking office staff. His dedication to delivering effective, culturally competent care for his patients exemplifies UnitedHealthcare's commitment to supporting and incenting providers dedicated to delivering the Triple Aim for Louisiana Medicaid enrollees.

2.10.8.6 Details regarding planned protocol for terminating network providers for no cause, including how to…

Our first priority is to offer the best possible provider network, ensuring ready access to high-quality care aligned with LDH's goals. Our network strategy focuses on recruitment, retention, monitoring and provider support. From time to time, we have to make decisions that may include terminating a provider for no cause. Our policy for provider termination for no cause complies with sections 2.9.8.3.6 through 2.9.8.3.10 of LDH's Model Contract, including:

- ***Timing of Termination for No Cause:*** Per Model Contract section 2.9.8.3.6, UnitedHealthcare will coordinate to ensure terminations for no cause coincide with annual open enrollment. On the rare occasion it would occur outside of open enrollment, we will comply with 2.9.8.3.6.1 through 2.9.8.3.6.4.
- ***Provider Notification of Termination:*** In compliance with the LDH requirements, we send provider notice of termination via mail within 1 day and via email within 15 days of the decision. Notification includes the reason for termination, effective date, provider's right to appeal and instructions for requesting an appeal. Appeal rights are consistent with federal and state regulatory requirements and NCQA standards.
- ***LDH Notification of Termination:*** Communication is critical in ensuring a seamless transition for impacted enrollees. UnitedHealthcare will notify LDH, its provider management contractor and other appropriate parties of terminations per Model Contract requirements 2.9.8.3.5, 2.9.8.3.6, 2.9.8.3.8 and 2.9.8.3.10. Per Model contract section 2.9.8.3.7, we will seek LDH approval if the terminated provider is located in a Health Professional Shortage Area.

Ensuring Uninterrupted Enrollee Care

Above all, UnitedHealthcare is committed to ensuring Louisiana Medicaid enrollees receive uninterrupted access to high-quality care, regardless of the natural ebbs and flows of provider contracts. We will sustain continuity of care and minimize the impact of the transition:

- In accordance with Model Contract Section 2.9.8.3.9, when a provider is terminated from the network, we notify affected enrollees in writing within 15 calendar days of provider notification and no less than 60 calendar days before the termination effective date.
- We employ our Provider Recommendation Engine (PRE) auto-assignment process to help locate available PCPs/providers for enrollees affected by a provider termination. The system tailors selection to the enrollee's needs, including provider specialty, enrollee sexual orientation or gender identity, enrollee age and gender, and whether the provider has open panels and meets specified distance requirements.

- For all other medical provider types, our Network Strategy and Provider Relations Teams assess available providers and assign the enrollee to the right qualified, contracted provider, taking into account criteria including time and distance, cultural and disability needs, and provider specialty.
- We notify enrollees of their medical provider assignment and, for both behavioral health and medical providers, advise them to call the enrollee services center should they wish to make another choice. We make sure enrollee services staff are aware of any large group termination and are available to assist enrollees in selecting a different provider.
- Member service advocates also assist enrollees with selecting a new PCP, using PRE and other resources, and they will help schedule an appointment with the new provider.

For enrollees who need assistance through the transition of care, an assigned care manager helps coordinate the plan of care with the new provider, the enrollee and any other identified care team enrollees and completes the transition. In the case of medical provider termination affecting enrollees in an ongoing course of treatment or with a special condition, we allow the enrollee to remain with their current provider for an additional 90 calendar days to facilitate continuity of care.

2.10.9 Provider Support

2.10.9.1 The Proposer should offer support to providers in a number of ways under the Contract to ensure that…

Our providers are our essential partners in improving health outcomes of our enrollees. In fact, we believe well-served providers are the fourth component of the State's Triple Aim because the provider experience is critical to improving the lives of enrollees and optimizing value for the State. Our provider support approach is founded on the voice of our providers and driven by innovation creating an industry-leading model. We understand LDH's vision and agree to comply with all requirements in Section 2.10.9 of the Model Contract.

Delivering Value-Added Supports to Providers

UnitedHealthcare will deliver value-added supports to our providers to expand access to care and reduce provider administrative burdens and costs.

We have clearly defined strategies to work with providers to collect their feedback and adjust processes to ease their administrative burden. We also use data to proactively identify issues and continuously improve processes. Using data and advanced analytics, we identify emerging trends and proactively outreach to providers to mitigate possible concerns. We also educate providers on the benefit of self-service tools and connectivity by moving providers from call-based inquiries/submissions to online or digital transactions.

Based upon feedback from providers, we know easy access to data allows them to improve their effectiveness and we know that leveraging known technology and resources reduces the burden of interacting with us. Knowing this, we expect to enhance Health Information Exchange (HIE) technology to allow connected providers and hospitals to share patient information and pull reports designed to help improve patient encounters and clinical outcomes. In addition to decreased manual work, exchanging clinical data can help close preventive care opportunities, support achievement of value-based quality of care metrics and support care coordination. To support the state's priorities, provider advocates (advocates) deliver education regarding opportunities to reduce the cost of processing claims, decrease prior authorization turn-around-times and other savings opportunities.

Processes to Effectively Manage Provider Relations/Communications

We know that supporting providers takes a multilevel approach designed to meet the needs and preferences of each provider. Our knowledge of Louisiana and our experience listening to providers helps us to understand their pain points and support opportunities. We know that there is variation in practice sophistication, patient characteristics, and technology infrastructure and availability for each provider. This understanding has resulted in the development of our provider engagement model designed to offer providers 360° service and support.

Provider 360° Service & Support: Our provider engagement model uses effective communication and collaboration with providers to improve and support the best care to our enrollees. By putting the provider experience at the center of our process, along with provider preferences related to electronic, face-to-face, phone support — we can address issues of importance to providers while leveraging resources and technology that improve their experience. For example, we have configured our MIS to operate in the same manner as LDH's system, helping to create an efficient, effective technology support that improves the provider experience. As show in the graphic, our Provider 360° Service and Support model includes:

Contracting Support: Our relationship with new providers begins with the provider contracting and credentialing onboarding process, which leads to a successful introduction to UnitedHealth Networks. We hold town hall meetings to welcome our providers, introduce our supporting

programs and tools, solicit ideas, and to provide a forum for any questions or concerns they may have. In addition, we begin education on the integrated care model, the level of support a new provider can expect from us; and what it means to be a participating provider in our networks.

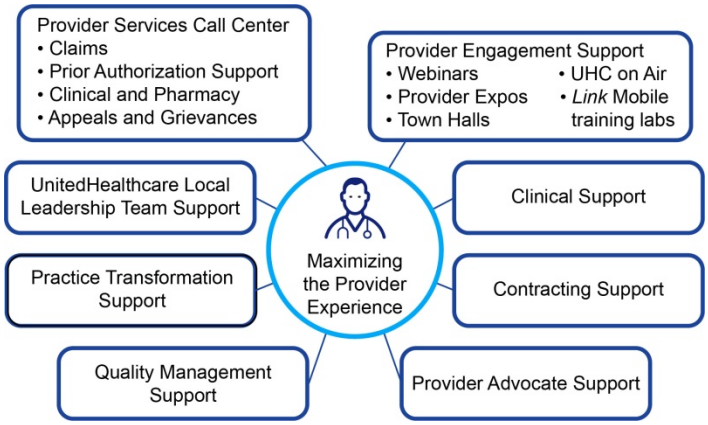


Figure 17. UnitedHealthcare's Provider 360° Service and Support model wraps around the provider to support their practice needs and maximize enrollee health outcomes.

Provider Advocate Support: By providing outreach and training for those providers reluctant or unable (e.g., lack of internet) to embrace *Link*, our secure provider portal, advocates play a critical role in increasing provider adoption of *Link* enhanced claims payment and prior authorization. Our advocates take a hands-on approach to provider education and issue identification. Through data analytics and targeted training, our advocates encourage providers to use technology to minimize unnecessary manual work and decrease provider costs associated with practice management activities.

Quality Management Support: In addition to receiving a value-based care incentive opportunity, we support providers with a clinical model that combines consulting, data and technology. This support helps drive the activities that will improve quality, reduce avoidable health care cost and subsequently trigger incentive payments within the shared saving payment model. Our provider-facing clinical staff shares performance data with providers through on-site visits and virtual support. They review performance on quality and incentive measure, gaps in care, utilization of services and suggest ways to improve their practice results.

Practice Transformation Support: The flexibility of our model allows us to meaningfully engage providers, informed by a provider's experience, resources and sophistication. We have used our Accountable Care Organization (ACO) program in Louisiana since 2013 and since then we have developed the flexibility to use "Non Traditional" ACO engagement models (<1,000 provider panel) with providers to design reimbursement structures that drive value for the provider. This value-based transformation model accommodates varying levels of, preparedness and willingness to enter into alternative payment arrangements. The supports we offer providers not participating in value-based payment (VBP) arrangements improve program performance and create a framework that facilitates their shift to VBP, supporting the State's broader goals.

Local Plan Leadership Support: Our plan leadership has relationships with providers throughout Louisiana. Engagement with providers occurs through attendance at Provider Expositions, Town Halls, or through our Joint Operating Committee (JOC), our Provider Advisory Committee (PAC) and for escalated issues as requested or needed.

Provider Services Call Center Support: Our Provider Services Call Center is available 24 hours a day, 7 days a week for medical and behavioral health support, prior authorization service support, claims inquiries or concerns and clinical and pharmacy support. On March 15, 2019, our provider phone representatives (PPRs) expanded their support to locate specialists for PCPs, confirm appointment times and provide specialist contact information and availability.

Clinical Support: Our provider-facing clinical staff, review performance on quality and incentive measures, gaps in care, utilization of services and recommendations to improve practice

results. Our clinical model combines consulting, data and technology in alignment with improved health and a provider shared saving payment model.

Our provider engagement model is aligned to provide information when providers need it, using a method they prefer to support their needs proactively. We ask providers for their feedback after every encounter (e.g., calls, visits and webinars) and use this information to support continuous program improvement and system efficiencies.

Timely Provider Payment and Support

We promote financial stability for our providers by offering claims and payment processes that are efficient, timely and convenient through *Link*, our secure provider portal, or through the provider's choice of clearinghouse. Our methods are flexible and effective including face-to-face claims support and weekly reviews of high volume claim denials through our Claims Provider Early Warning System (CP-EWS) tool to proactively analyze and identify trends. Our encounters rate of 97.85% exceeds current contract requirements and positions us to achieve the new contract requirements of 99%. Our claims support includes:

In the first 3 months of 2019, UnitedHealthcare paid 4,853,297 claims.

- 99.84% of those claims were paid within 15 business days
- 99.99% of those claims were paid within 30 business days

Pre-adjudicating Claims: *Smart Edits* are a pre-adjudicated claims editing capability we use to auto-detect claims with potential errors. Part of our electronic data exchange (EDI) workflow, *Smart Edits* delivers provider feedback within 24 hours of a claim submission. Using *Link*, providers can correct errors, reducing the complexity and provider concerns resulting from claims denials.

Link Computer Labs: Our Mobile *Link* computer labs allow our advocates to bring real-time on-site training opportunities to a facility or physician group. These interactive sessions introduce the provider to *Link*, its purpose, resources and functions. The sessions result in increased adoption to *Link* and the self-service model/tools. Since introducing in Q4 2018, we have introduced Mobile *Link* to Franciscan Missionaries of Our Lady Health System and St. Francis Health system with additional venues planned through 2019.

Implemented Activities and Approaches to Support Providers

We invest in people, processes and information sharing tools to serve providers quickly and efficiently. We add value to providers by bringing innovative solutions, meaningful data and information to reduce their administrative burdens, minimize complaints and to anticipate and address provider concerns proactively, using a systematic approach to resolution.

Minimizing Provider Complaints
We educate, train, communicate and build upon our relationships with Louisiana providers to promote understanding, minimize complaints and continually evaluate areas of our processes that create unnecessary administrative burdens for them. For example:
***PRISM*:** Through our Provider Relationship, Insight and Service Model (PRISM), we quickly resolve escalated issues for providers. PRISM is a single-point tracking and monitoring tool for our provider services staff. PRISM provides visibility into complex provider issues, enabling rapid response and resolution. As a single-point intake, PRISM streamlines and integrates information from claims, enrollment, clinical episodes of care and utilization history, and provides an all-inclusive picture of provider concerns, root cause analysis and resolution.
Geographically Assigned Advocates: Our Provider Relations Team, consisting of advocates assigned by region/parish and provider type, takes a hands-on approach to identify issues early. We communicate

Minimizing Provider Complaints
proactively and foster strong, positive relationships with providers. We have implemented a number of proactive monitoring initiatives (e.g., CP-EWS, claims payment timelines and utilization management notifications of denials) to determine issues/trends proactively. We recognize that it is essential for us to have a strong process in place to address provider complaints and disputes quickly and efficiently.
Complaint/Dispute Tracking: We maintain a process and a system for receiving, tracking and resolving all provider complaints and disputes. Our Provider Services Call Center is typically the "first contact" for intake, resolution and tracking of both in- and out-of-network provider complaints. We staff and train our PPRs to resolve issues on eligibility, prior authorization, and claim inquiries and other provider concerns. Provider Services Call Center staff is available 24 hours a day, 7 days a week. Please refer to Question 2.10.9.1.4 for additional detail.
Provider Satisfaction Survey Feedback: Through our commitment to continuous improvement, we ask providers for their feedback after every encounter (e.g., advocate visits, town halls, post-PPR call) and use this information to improve the provider experience. Please refer to Question 2.10.9.3.5 for further detail on the critical provider metrics and provider surveys used to measure provider satisfaction.

Minimizing Contracting Issues
We use internal and external resources to minimize provider burden with the application process, source verification and contract completion activities. We use the Council for Affordable Quality Healthcare's ProView, which is available to providers at no charge and streamlines the provider data collection administrative process for credentialing. This process reduces overall credentialing turnaround time, which eliminates duplication of application efforts among providers.
Contracting Accuracy: Our contract analysts use our PREDICT tool to perform quality checks on contracts prior to uploading contract details into our provider data systems. We implemented PREDICT in early 2017 to identify errors during provider contract data entry. We audit our provider contracts for accuracy through multiple processes, such as end-to-end review of claims to the contract, random sample audits and provider roster comparison to contract setup.
Timely Credentialing: We confirm PCP contracts are loaded accurately and timely into our system. We meet or exceed LDH's timely credentialing requirements and load at least 90% of executed provider contracts into our system within 30 days of Credentialing Committee approval. Advocates closely monitor the contracting process to quickly resolve issues that may arise.

Minimizing Prior Authorization Concerns
The Prior Authorization and Notification app is available on *Link* for providers to review requirements, submit requests, upload medical notes, check status and update cases for providers preferring self-service. When we identify providers who need assistance or have difficulties submitting requests for prior authorization, we engage them in a variety of ways:
Link Adoption and Training: Our secure provider portal, *Link*, helps reduce the provider's administrative burden when requesting service authorizations. Available to providers and facilities 24 hours a day, 7 days a week, it helps the provider submit all information required for a medical necessity review, provides access to our guidelines and review criteria and allows the provider to track the status of prior authorization requests.
***Provider Services Call Center Support*:** We combined our prior authorization intake and provider services to decrease administrative burden on our providers. Our PPRs can help providers determine what services require authorization and assist them with submitting an authorization request. This reduces provider burden by decreasing the number of calls needed and reduces the amount of paper forms required.
One-on-one Training: Staff educates providers about our prior authorization process and guidelines and criteria, during initial provider training and whenever UM protocols or criteria/guidelines change through our *Care Provider Manual*, on our secure *Link* provider portal, and in our newsletter, *Practice Matters*.

Minimizing Claims Concerns

As mentioned earlier in this response, prompt and accurate claims payment is a key concern among providers. In 2017, we significantly reduced the amount of claims rework and provider claims complaints with our CP-EWS team process. CP-EWS enables us to catch spikes in claims denial patterns and assist providers immediately if denials reveal the provider needs additional claim filing education.

2.10.9.1.1 Its process to determine adequate provider relations staffing coverage for the provider network;

We offer dedicated provider facing teams for each state. Each team knows what makes the provider unique and uses that knowledge to service specific provider needs. Staff members are trained to apply available resources to aid in all servicing needs. We determine provider type (e.g., hospital versus health system), complexity (e.g., FQHC/RHC), total medical spend and geography by parish when establishing service territories and staffing.

We determined our initial staffing coverage on our national provider relations staffing model based upon our 44 years of Medicaid and Medicare provider relations staffing experience and have continued to evaluate and enhance based upon the specific needs of Louisiana providers. Because of our PAC and JOC meetings, and in-person interactions with providers, we have fine-tuned this model for Louisiana provider support.

Our local Louisiana field-based provider relations team includes full-time staff — for both medical and behavioral health — with clearly defined systems for determining staffing coverage for the provider network. These activities result in an improved distribution of provider support by aligning our advocates to the top providers. Our advocates make contact with new providers a minimum of two times to provide education and support. We continue to monitor provider relations caseloads, provider outreach, workload and performance metrics through our workflow management software tool. Metrics and reporting provide immediate accountability, allowing rapid staff adjustments to meet appropriate staffing and changing provider needs.

We continue to support providers in their use of email and currently have full-time advocates who monitor the provider relations mailbox. Providers may submit a question, request an outreach or contact their provider advocate via email. We respond to email within 2 business days. Please refer to our response to Question 2.10.9.3.1 for additional provider relations staffing information.

2.10.9.1.2 Strategies to provide effective and timely communications with providers, including the development…

Our Provider 360° Service and Support model recognizes that effective communication and collaboration with our providers improves the provider experience, and supports the best care to our enrollees. We also understand that communication is not a “one size fits all” effort and we customize our approach to fit the needs of each provider. Our strategy is to use a broad continuum of approaches for education, communication, rapid response — we return calls within 24 hours — to provider questions, service and support to reduce administrative burden and build a positive experience for providers.

Provider Education Strategies

Our Provider Relations Team conveys information about LDH requirements, provides guidance regarding the tools available to providers to effectively meet these requirements and shares information better enabling providers to conduct business with UnitedHealthcare. We use

accessible, in-depth provider education to create seamless onboarding of new providers and ongoing education on new contract requirements. Newly contracted providers receive provider education using a combination of proven training techniques, including new provider onboarding/orientation webinars, site visits, town hall sessions, webinar presentations, educational mailings and telephone outreach. We engage new providers and communicate effectively with existing providers by:

Offering Provider Training Options: Our training is specific, comprehensive and multimodal. It combines electronic, face-to-face, written and web-based methods. For example, we have distributed educational toolkits that are subject-specific for providers to peruse in their own time. These include toolkits for diabetes care, OB kits related to health disparities initiatives and telehealth toolkits supporting behavioral health Virtual Visits.

Using Proven Training Techniques: The techniques we use align with industry-standard best practices, including on-site visits, town hall sessions, expos, webinar presentations, *UHC On Air*, educational mailings and telephone outreach.

Responding to Provider Requests: We are attuned to provider requests around improvement opportunities along with feedback from staff and professional associations. Through these mechanisms, we identify broad-based communication and training opportunities.

Provider Education Program

Our approach includes high-touch provider interactions via telephone, face-to-face, through provider town hall meetings or through virtual contact via WebEx. It is through our provider education program that we provide training on doing business with UnitedHealthcare and share Louisiana Medicaid managed care program requirements. The following outlines the variety of methods our Provider Relations Team uses to engage providers in timely and effective communication:

Onboarding: Our relationship with new providers begins with the provider contracting and credentialing process, which leads to a successful introduction to the UnitedHealth Network.

Initial Provider Training (Orientation Program): We have a well-developed provider orientation program that includes procedures for doing business with UnitedHealthcare and a provider introduction to the educational materials, mailings, online seminars, and on-site provider visits and group trainings. Our initial provider training covers a number of subjects such as accessing our online, self-service tools, prior authorizations, policies and protocols, claim reconsiderations and more. We encourage every new provider to complete UnitedHealthcare orientation within 30 days of the provider's contract effective date. Provider orientation is intended for providers newly contracted to UnitedHealthcare; providers new to a group; providers that have had a product added to their existing contract; and a practice that has had a line of business added (e.g., Medicaid, Medicare).

Continuing Provider Education: After initial training, local provider relations staff remains in frequent communication with our Louisiana contracted providers via phone calls, emails, blast faxes, town halls and in person visits. Proactively, provider-facing teams visit providers monthly/quarterly to assist with addressing key provider concerns and obtaining VBP incentives and gap closures. We communicate information to our providers via our quarterly provider newsletters developed specifically for our Louisiana providers, to update them on program changes, answer questions and provide applicable documents released by LDH.

Program Enhancement and Targeted Training: Critical components of any successful provider engagement model are receptivity to feedback, our own analysis of trends and iterative

improvement. Through staff feedback, trended claims data, associations and advisory councils, we identify training opportunities and specific providers for focused retraining. We send mailings to all providers on relevant training topics and update our training curriculum with the goal of further improving communication and information, especially on common issues such as changes in policies and procedures, billing and eligibility verification.

A description of our approach and training frequency for Louisiana providers includes:

Louisiana Provider Training Program	
Description of Educational Approach	**Frequency**
Onboarding/Orientation: Newly contracted providers. We provide a full UnitedHealthcare overview for Medicaid, Medicare and Commercial businesses.	Within 30 days of contract effective date
On-Site Visits: Frequent engagement to foster relationships, maximize performance, issue resolution, promote innovative tools/programs to support administrative and clinical efficiencies.	Quarterly, monthly or as needed by request
Teleconference: Topical in nature, associated with an outreach initiative or structured meeting. Providers receive monthly telephonic structured meeting.	Monthly and as needed/by request
Revenue Cycle Service and Education Centers: Mobile revenue cycle service centers allow providers the convenience of real-time investigation to root cause for revenue cycle concerns (e.g., claims, trends) or data integrity.	Ongoing education opportunity by request of provider/advocate
Link portal and UHCprovider.com Training Labs: Mobile *Link* computer labs allow providers to quickly adopt ease of use with *Link* training. Please refer to Question 2.10.9.1 for additional information.	By location based upon *Link* adoption rates, proactive scheduling
Town Halls: Multi-practice forum designed to educate on multiple or targeted topics at various locations throughout the state.	Monthly and ad hoc
Webinars: Multi-practice forum designed to educate on multiple topics. Can focus on specific agenda items (e.g., new protocol deployment, reference tools, online on-demand training modules.) We offer 30+ CEU credit classes.	Monthly and ad hoc
UHC On Air: Similar to "YouTube" making it accessible and relevant in today's constantly changing health care environment. Providers can contact us during or after *UHC On Air* trainings, making this an interactive exchange.	Available on demand 24 hours a day, 7 days a week
Provider Expositions: Educational event assembling multiple UnitedHealthcare business units, subcontractors and external partners in one venue to educate them on business policies and other useful information.	At minimum two times per state per year
Operational Meetings/JOCs: Operations meetings focus on operational performance and improvement strategies that ease administrative burdens.	Operations – Monthly JOCs – Quarterly

Our service strategy is comprehensive and all-inclusive. Staff members across functional departments, such as health services, quality management, provider relations, network management, community outreach and behavioral health use a high-touch approach to build and support provider relationships, provide accessibility to key provider information, proactively address common provider inquiries and increase awareness of programs and services.

Evaluating Education Effectiveness

To make sure our trainings are as effective as possible, we capture real-time feedback on our training—regardless of the type of training. This feedback loop includes evaluation forms for all in person training. Videos and training viewed include a post-presentation evaluation, and we survey participants at the end of every large group presentation and use that feedback to develop new and better content for future trainings of special interest to providers.

2.10.9.1.3 The processes that the Proposer will put in place to support providers with high claims denial rates; and

UnitedHealthcare has a dedicated Claims Team to monitor the adjudication and daily claims processing including monitoring high claims denial trends. The team monitors claim spikes and trends on a daily basis using a series of algorithms to identify extreme spikes in specific types of denials. When we identify a trend for a particular provider or provider group, further research is conducted by determining if the root cause is systemic or if it is a provider billing error. We then mobilize the Provider Relations Team and contact the provider to discuss the root cause, provide education on correcting the issue and offer additional resource tools. The team uses a number of resources to educate providers on successfully submitting claims and to keep them informed about denial trends. Finally, our CP-EWS is part of the mobilization of provider outreach offered to providers along with on-site coaching. Other tools and processes include:

Pre-adjudicating Claims: We use *Smart Edits, a* pre-adjudicated claims editing capability, to auto-detect claims with potential errors. Using Smart Edits, we can deliver feedback to a provider within 24 hours of a claim submission so they can proactively correct the error (through *Link*, our provider portal) and submit accurate, complete claims.

Provider Communications: We use webinars, town halls, newsletters and information in the Care Provider Manual and monthly Provider Network Bulletins to educate and build awareness on claims denials. Advocates also use the Field Aligned Support Team (FAST) as another touch point for educating providers quickly. The FAST team advocates analyze systemic and provider-specific alerts regarding claims processing to provide valuable information to providers.

Provider Group Claim Support: To support timely payment and comply with Act 710, we hold weekly meetings and review the top five providers in all specialties with 10% or higher claim denials. By analyzing the claims denial reasons, we can determine the necessary provider support through education or a face-to-face outreach.

Support by Type of Claim and Claim Alert: We hold weekly meetings to review denied claims by denial reason and type of claim. Our CP-EWS tool alerts us proactively to denial anomalies and high denial rates, which we review in our operational claims meeting with action planning designed to mitigate issues and support providers.

On-site Claims Event Model: If either the plan or the CP-EWS team identifies a significant outlier or high percent of denied claims, we visit the provider to review all claims and remediate to support timely payment. We also conduct a daily audit of OB/GYN claims to investigate high denial rate trends and to remediate as necessary to support the provider.

> "The Ochsner Managed Care Department would like to express our appreciation to our UnitedHealthcare Provider Advocates Rhonda Pena, Tiffany Bourgeois and Candy Williard for the **exceptional customer service and support** they provide to our team. Rhonda, Tiffany and Candy are always professional and a pleasure to work with. **They have been instrumental in facilitating resolution to our systemic issues**. We value the relationship and look forward to continuing our partnership."
>
> *–Jeff Mitchener, AVP of Payor Relations, Managed Care, Ochsner Health System*

2.10.9.1.4 The processes that the Proposer will put in place for evaluating and resolving provider disputes in a…

We have a tiered process in place for investigating and resolving provider disputes in a timely manner. This includes disputes related to the automatic assignment policy and individual enrollee assignment. Providers can file a complaint or dispute by phone, in writing or in person (with any UnitedHealthcare representative). Our provider dispute resolution process is a four level process to quick resolution. These levels include: 1) *Provider Services Call Center resolution,* 2) *PPR escalation*, 3) *first level claims dispute*, and, 4) *second level appeal.*

We prefer to resolve provider complaints and disputes through the Provider Services Call Center, which is open 24 hours a day, 7 days a week. Providers can share their concerns with a well-trained PPR who is able to resolve their dispute during the call. In the event the complaint cannot be resolved, the PPR will escalate the complaint and our escalation tracking software, which maintains, records and stores all provider dispute, grievance and appeals activity. It provides us with significant flexibility to provide reporting based upon multiple data elements, filters and sorting options. The PPR's escalation is designed to route the dispute to the appropriate specialist who will review and resolve the dispute within 30 calendar days. If the dispute is claims related, it will become a first level claims dispute. If the dispute is not resolved within 30 days (or to the provider's satisfaction), the provider may request a second-level appeal. This is a formal written or verbal path to resolve the concern within 30 days of receipt.

Auto-assignment Disputes: One of the types of complaints we receive are the result of auto assignment issues. Despite the reduction in these requests, if a provider calls to have an auto assigned enrollee moved due to geography, or family or the enrollee having a relationship with a different PCP, the PPR can move the enrollee effective next business day. If a provider wants enrollee moved for any other reason, we would advise the provider to put the request in writing (e.g., by mail). A provider specialist will review the request for removal or transfer considering both the provider and the enrollee's rights. If LDH approves the enrollee's removal/transfer, we call the enrollee to explain why the assistance was provided to select a new PCP. If the enrollee's removal/transfer is not approved, the provider advocate calls the PCP with an explanation. This may require that our Provider Relations Team contact a provider related to what it means to participate in the LA Medicaid program. However, the PCP is expected to continue to provide care to the enrollee.

2.10.9.2 The Proposer should describe how it will support the provider to improve quality and reduce costs…

Since 2012, UnitedHealthcare has continued to evolve our approach to VBP for Louisiana's Medicaid Managed Care providers in support of the Triple Aim — better care and improved health for enrollees, and lower costs. We recognize that true health care reform is multifaceted, and that strong, trusting payer/provider/community relationships are foundational for success. We realize a one-size-fits-all approach is ineffective — our modular suite of VBP models enables us to customize our approach with an operational infrastructure that supports providers based upon their readiness.

We continue to tailor our VBP programs for Louisiana providers, moving toward higher risk models that focus on LDH priorities to support innovation. [redacted]

2.10.9.2.1 Strategies to support primary care providers, including but not limited to investments in primary care…

Our goal is to incent both the provider and the enrollee *on the same measures* when possible. This alignment creates synergy — with both parties working toward the same goal based upon services given and received.

Infrastructure Investment: To support both LDH's Quality Strategy (Attachment G) and delivery system reform, we continue to build a foundation of relationships and infrastructure with providers to increase our solutions' effectiveness. Our innovative partnership with LCMC Health University Medical Center (New Orleans) and Our Lady of the Lake Regional Medical Center (Baton Rouge) provides both financial (e.g., value-based incentives) and programmatic support

(e.g., risk stratification, claims, assessment results) in the form of aligned financial incentives, shared data and enhanced coordinated clinical programs.

[redacted] Described in Question 2.10.9.2

Practice Coaching and Scorecards: Our provider-facing clinical staff, review performance on quality and incentive measure, gaps in care, utilization of services and suggest ways to improve their practice results. Our provider-facing staff meets with our provider groups — face to face — on a weekly/monthly/quarterly basis. The team reviews operational interventions, which allows for improved utilization and gap closures (suggestions on timing of scheduling appointments to accomplish gap closures, follow up for ED visits). We provide each participating practice with scorecards showing trending in rates relative to baselines and targets for clinical quality measures, utilization metrics and total cost of care, depending upon contracted parameters. During the current contract compliance to have common MCO scorecards and reports, LDH selected UnitedHealthcare reports as the model format among MCOs.

2.10.9.2.2 Strategies to support behavioral health and other specialty providers to participate in delivery system…

Our modular suite of VBP models enables us to customize our approach with providers based upon their readiness along the care continuum. We actively support and collaborate with providers through data, analytics and consulting to enable their success under the contract. If we see that a provider is not achieving their targeted improvement metrics, we work with them to modify our support process and to identify alternative solutions to address their challenges.

VBP Type	Description
Maternity VBP Bundle	Adds incentives for obstetrical and maternal fetal medicine providers to help them achieve better enrollee health outcomes in pregnancy care and to prevent preterm births. The bundle includes the *17P (Progesterone) incentive for OB* and the *Notification of Pregnancy (NOP)* incentive program.
Behavioral Health VBP Program	Initiative designed to decrease multiple inpatient admissions and ED utilization and meet or exceed the target threshold of 54.13%. This program uses the HEDIS Follow Up After Hospitalization (FUH) measure to incentivize providers to identify hospitalized enrollees and confirm they receive appropriate care after discharge. The program also encourages behavioral health providers and PCPs to collaborate on discharge follow up. PCPs and behavioral health providers receive credit for closing the same gap in care.
Opioid VBP Pilot	Includes a measure to identify and refer enrollees who may require medication-assisted therapy (MAT). Given the high overdose death rate in the Orleans and Jefferson Parishes, we initiated a partnership with Daughters of Charity to launch our OUD Quality MAT pilot (Q1 2019.) The OUD Quality MAT VBP includes a substantial monthly care management payment, in addition to targeted incentives for monthly MAT refills and a bonus for enrollees retained in treatment every 6 months.

2.10.9.2.3 Strategies to share provider performance data with providers in a timely, actionable manner.

When provider-facing clinical staff makes on-site visits to providers, they share performance data on quality and incentive measure, gaps in care, utilization of services and suggest ways to improve their practice results. Each participating practice receives practice scorecards showing trends relative to baselines and targets for clinical quality measures, utilization metrics and total cost of care, depending upon contracted parameters. We also educate providers on data available to them in our provider portal, *Link*, such as on-demand reporting on VBP measures (e.g., HEDIS) and comprehensive EPSDT services. Providers can also receive gap in care alerts through our CommunityCare platform, enrollee-level detail through our ClaimSphere HEDIS program and joint clinical action plans for more advanced TCoC models. Our Shared Savings providers can use the Integrated Patient Care Application (iPCA) online tool to collect a

360-degree view of enrollee care history of real-time clinical and administrative data and the ability to track enrollee cohorts for interventional care.

2.10.9.3 The Proposer should describe in detail its provider engagement model. Specifically, the Proposer should…

Through our engagement model, effective communication and collaboration with our providers not only improves the provider experience but is also the key to assuring the best care to our enrollees. Since program inception, we have continued to assess new strategy and deploy new methods to meet the needs of our providers. Using provider feedback, we identified key account providers where additional focus is required due to the complexity or size of the health system or FQHC. We developed service territories to promote 100% accountability to each provider across all 64 Louisiana parishes. Our new onboarding process, *UHC On Air*, and our secure provider portal, *Link,* are all innovations introduced in Louisiana to enhance provider engagement, improve communication and support the self-service needs of providers.

Our provider 360 service and support model facilitates issue resolution and dissemination of Louisiana health plan information. We engage care providers as our trusted partners through a strong service orientation and quality-based performance incentives. We support and reward providers committed to caring for complex populations, transforming care delivery and engaging in performance-based programs and reimbursement.

Provider Engagement Staff (2.10.9.3.1): To support and engage providers, we have a local team of provider relations specialists in medical and behavioral health that facilitate timely follow up and adequate support in compliance with Medicaid program requirements. Provider engagement staffs have daily oversight of provider outreach and education program development through our staff of advocates and provider-facing field-based staff. The majority of these individuals are locally based with statewide responsibilities.

Local Provider Field Representatives (2.10.9.3.2): Our advocates handle all lines of business in their daily outreach activities. They are assigned geographically by region/parish, and take a hands-on approach to the identification of issues early, communicate proactively and foster strong, positive relationships with providers. Additionally, we support providers through our provider-facing staffs with clinical and operational skillsets. They are local, field-based “feet on the street” experts who specialize in clinical, quality and transformation. All provider-facing staff are responsible for addressing provider issues and working toward solutions.

2.10.9.3.3 The mechanism to track interactions with providers (electronic, physical and telephonic);

As described in our response to **Question 2.10.9.1.2**, we log and track the status of provider services center calls, visits and other outreach using our workflow management software tool. All provider-facing and management staff have access, providing timely accountability. Senior field-based provider support staff use a workflow tool to track meetings and document their provider interactions including provider-facing events such as town halls, expos, on-site visits and webinars. We maintain regular meeting minutes from our Provider Advisory Committee (PAC) that are approved and reported to the Quality Management Committee (QMC). These minutes become a component of the quality improvement committee’s regular report to LDH.

Other provider interactions that we track include questions and requests to the Provider Relations Mailbox and calls to the Provider Services Call Center. Calls are recorded and tracked, including the use of a call reference number that is supplied to the provider after the call for prompt reference and follow up.

2.10.9.3.4 How the Proposer collects and analyzes utilization data and provider feedback, including complaints…

We collect and analyze HEDIS and gaps in care reporting (monthly) and provider satisfaction and CAHPS data (annually), along with feedback from our comprehensive provider education program. Our local quality staff collects HEDIS utilization data while a third-party vendor collects provider satisfaction data. Our Quality Management (QM) Team reviews and analyzes the root cause of member/provider complaints, identifies barriers, creates interventions and studies concerns identified through feedback and surveys. To close the loop on the quality of the interactions with members and providers, our Service Quality Improvement Subcommittee (SQIS) reviews results at least annually to develop an action plan to improve overall scores.

Our quality management program has oversight and responsibility for provider training initiatives based upon the results of provider feedback from trainings, surveys and complaints. We take the feedback verbatim and contact those providers that commented and make direct outreach to help resolve their issues and concerns. We use that feedback to develop a year-over-year plan to improve in those specific areas of concern. If we see a trend of low scores in customer service or contracting, we acknowledge that we have a deficiency then create a plan as an organization, address concerns, remove barriers, work to notify providers that we understand their concerns and inform the provider of our plans to correct the issue. We review written feedback from providers through the evaluation surveys we provide post-training or through the metrics described in the following table.

Type of Data	Description/Link to Training Needs
Healthview Analytics	Analytical tool used to identify concerns by parish, provider or enrollee. Enables identification of key geographic areas for critical health outcomes, concerns. In 2018, we were able to identify areas with the most ED overutilization by Geo and providers at LDH request during quarterly business review
Pharmacy	Prescribing patterns including review of generic versus brand name prescribing
HEDIS Utilization Rates	Monthly, we review HEDIS rates/utilization metrics monthly to address gaps in care concerns and plan interventions such as calls to enrollees to arrange appointments and transportation or reviewed with our providers to heighten their awareness
Provider Peer Comparison Reports	Annually, we share utilization rates with providers on select measures such as average cost per patient, ED utilization, hospital admissions, length of stay, high opioid prescribing and medication adherence. Providers can determine outliers to influence provider utilization patterns using provider communication and outreach
ED utilization rates	Monthly, we monitor utilization rates such as cost-per-enrollee, provider inpatient data and ED rates. This is a high-level review for developing trends in utilization and our quality outcome measures
VBP Scorecards	Monthly provider reports via in-person visits from clinical provider-facing staff. Provides a snapshot of their aggregate rates (e.g., a scorecard) to guide them in achieving minimum standards, exceeding peers or meeting provider incentive agreements through gaps in care data and relevant utilization patterns by enrollee
Inpatient Utilization Rates	Daily, PCPs receive reporting on their patients seen in ED, admitted or discharged from an inpatient stay. This enables the provider to be proactive in reaching out to the enrollee to ensure continuity and transition of care concerns are addressed

We review ***written feedback from providers*** through the evaluation surveys we provide after each training or through the metrics described in the following table (2.10.9.3.5.)

2.10.9.3.5 The metrics used to measure the overall satisfaction of network providers; and

Provider satisfaction and engagement are crucial components of providing care to our enrollees. Our approach to assessing and addressing provider satisfaction is to use multiple strategies —

large-scale surveys, provider-training evaluations, post-call and post-outreach provider feedback — to obtain feedback and employ progressive solutions to address and prevent concerns. These measurements, along with a deep understanding of the state's priorities, drive our specific actions and the way we implement changes to drive continuous quality improvement. In addition to these metrics, please refer to Question 2.10.9.4 for specific provider satisfaction results in the past 3 years.

Operational Area	Measured Metric
Provider Call Center	Call Abandonment Rate (Goal is <5%) Average Time to Answer (Goal is 90% answered in 30 seconds or less); Hold Time (Goal is 3 minutes or less)
Claims Processing	Time to Pay Clean Claims: Business Days, Calendar Days, Combined Calendar Day
Provider Complaints	Our Quality Management Leadership Team analyzes provider complaint data, identifies barriers and develops interventions and education via provider toolkits, provider communication/education or innovation.

2.10.9.3.6 The approach and frequency of provider training on MCO and Louisiana Medicaid managed care…

We have provided this information in our response to **Question 2.10.9.1.2.**

2.10.9.4 The Proposer should provide the results of any provider satisfaction survey reflecting its performance in…

We conduct annual large-scale assessments of provider satisfaction as part of our commitment to continuous quality improvement. Our surveys — which monitor provider satisfaction for medical/behavioral health providers, vision, behavioral health, dental and other provider types — include our Annual Provider Survey, LDH State Results Survey, the Behavioral Health Clinician Satisfaction Survey and the United Experience Survey (after provider services calls).

Survey Description and Provider Satisfaction Results in a 3-year Period			
Survey Name	**2016 (%)**	**2017 (%)**	**2018 (%)**
Annual Provider Satisfaction Survey	65	63	58
Annual **Behavioral Health** Clinician Satisfaction Survey	81	78	93
United Experience **Survey (UES)** Satisfaction/Quality Service	95.5/99.2	97.4/96.8	94.12/99.28

LDH State Survey Results

We have received the 2018 LDH survey results monitoring provider satisfaction for enrollment/onboarding/provider manual and printed materials (73%); provider education and training (59%); claims processing accuracy (73%); specialist access/network coordination of care (58%); customer service/provider relations relationship (72%); and utilization management timeliness (59%).

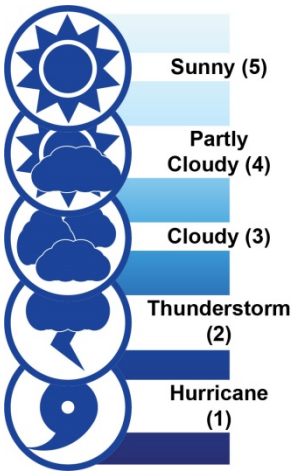
Lessons Learned

We take the results of our provider satisfaction surveys very seriously. Our Quality Management (QM) Team reviews and analyzes the root cause of provider issues, identifies barriers, creates interventions and studies outcomes of concerns identified through provider feedback and surveys. We monitor feedback data on an ongoing basis and respond through new programs, enhancements or even clinical education via our provider toolkits. In an effort to close the loop on the quality of the interactions with providers, we present survey results to our Service Quality Improvement Subcommittee (SQIS), at least annually for review and development of an action plan to improve overall scores.

Reviewing our 2018 Annual Provider Satisfaction Survey scores, we know this is not where we want to be. We were encouraged to see satisfaction scores in our annual survey improve in

several areas such as provider onboarding (from **72%** to **82%** between 2016 and 2018); and satisfaction with timeliness of claims processing increased from **70%** to **77%** from 2016 to 2018.

We know that there are many areas of growth in provider satisfaction during the contract term because of listening to the feedback of Louisiana providers. For example, after reviewing provider feedback from 2017, we introduced *UHC On Air* to provide an improved provider education and onboarding experience that addresses their need for information at their convenience; we added the *Link* Mobile Computing Labs to spur provider adoption of self-service thereby improving their ability to process timely claims and prior authorizations. Our original VBP program solicited many provider complaints about not attaining stated incentive goals. As a result, our new VBP provides incentive money for every gap in care closed and the feedback from providers has been positive. The following is an in-depth example of our commitment to the quality of our program in Louisiana and the additional efforts we have undertaken to put our values into action.



The Weather Report

We consider provider feedback an integral part of our quality improvement process to lead to the success of LDH's Medicaid Managed Care Program. Following the results of our provider satisfaction survey in 2017, we wanted to understand the results so we took a deep dive and developed a focused remediation process to resolve issues with key providers called "The Weather Report." The Weather Report was a direct survey that contained nine simple, focused questions on issues providers may have experienced and how we could improve. A leading question was how they would rate us on a scale of 1 to 5 based upon "The Weather" (e.g., with Hurricane=1; Sunny=5). The initial survey score provided an overall score of "Cloudy." The remediation efforts included:

- Identify 45 critical providers (physical and behavioral) and scheduled weekly meetings to obtain feedback to support identification of trends and root causes
- Engage and support of our leadership team
- Create an escalation team to resolve issues/provide ongoing support for 90 days
- Meeting with the LDH section chief and the provider relations manager to share remediation results; updated results moved our Weather score to "Partly Cloudy"

Louisiana Women's Healthcare (LWHA), provided an initial Weather Report score of "Hurricane." As part of their remediation, we provided an on-site claims specialist and an expanded claims team via WebEx to address their issues and provide additional training. The support continued with a claims supervisor meeting weekly with the providers weekly to address any issues. We also designated a nurse to work with LWHA to develop new specialist incentives. A post survey response from the CEO, confirmed the turnaround efforts resulted in a 4-point improvement to "Partly Cloudy" on The Weather Report.

From Hurricane to Partly Cloudy

Communications from the CEO for LWHA include:

Nov. 6, 2017: "…breakthroughs in administrative change, the working relationship is flowing smoothly and the trust is strong...issues have been coordinated."

"LWH has been at points of impasse with UHC-LCP...the improvements are such that we now appreciate the opportunity to work with you and your team, and look forward to continued coordination that improves the feasibility of LWH's participation in the Healthy Louisiana Plans."

March 26, 2019: "I think the operational turnaround you all have made over the past couple of years has really held in place."

2.10.10 Utilization Management

2.10.10.1 The Proposer should describe how it will satisfy the requirements for authorization of services set forth…

Our utilization management (UM) program accomplishes four core tasks, including identifying enrollees who may benefit from case management; confirming the appropriateness of care delivered to enrollees; confirming the effectiveness of our care management programs; and monitoring and addressing overutilization, underutilization and inappropriate utilization patterns. Our UM program meets NCQA standards. It features an integrated clinical, UM and quality management oversight structure and an interdisciplinary set of care management principles, policies and systematic processes and workflows that verify we are delivering positive outcomes in terms of member experience, outcomes and quality of life and the quality and cost of care.

Proposed Workflow from Initial Request to Final Disposition

Our service authorization processes meet the requirements in Appendix B, Section 2.12, Utilization Management, including the timeliness requirements in Appendix B, Section 2.12.9, Timing of Service Authorization Decisions. They include policies and procedures consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services. The figure presents our workflow from initial request to final disposition.

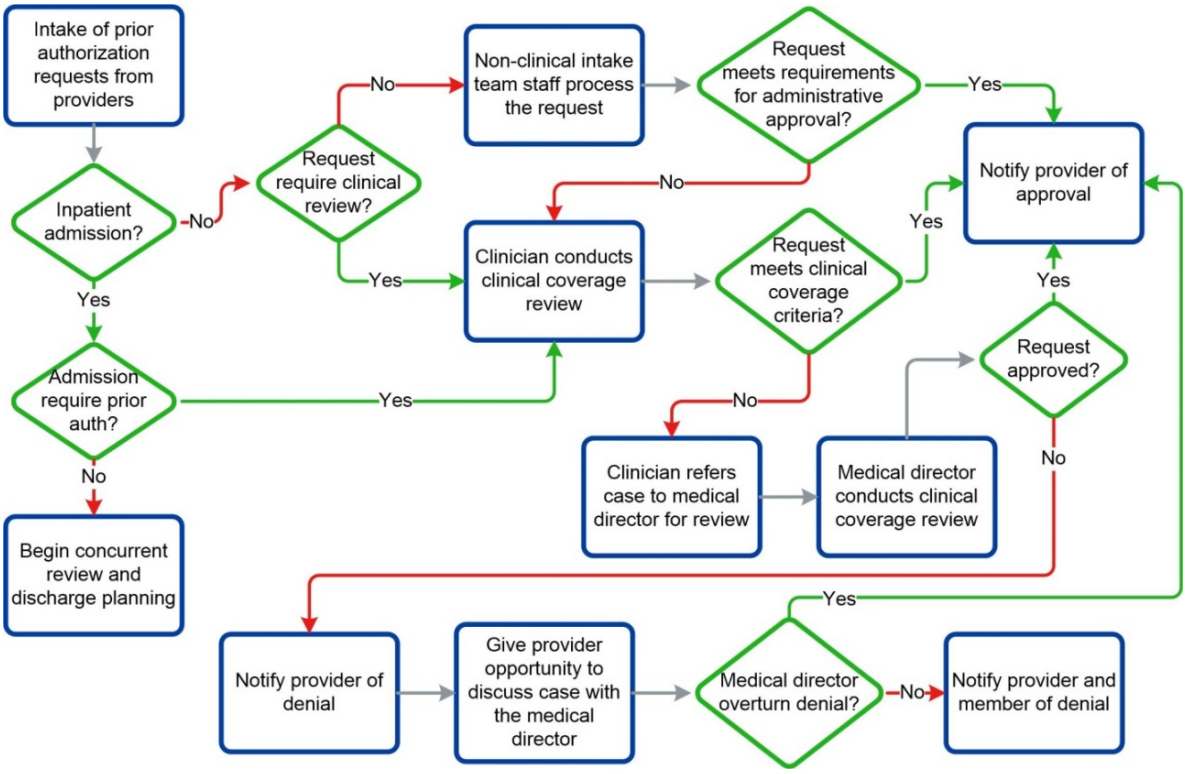


Figure 18. Prior authorization workflow from initial request to final disposition. Medical directors, nursing staff and other professional support teams work closely with providers to determine the medical necessity and appropriateness of care, avoid inappropriate use or duplication of services, and identify enrollees who may need to be engaged in disease management or care coordination or may need direction to their provider.

Intake. Providers may submit service authorization requests via phone or our secure *Link* provider portal. Enrollees and their representatives can request authorization of services by calling our *Advocate4Me* member services center. Intake staff compares the request to LDH's list of services that require clinical review. Requests that do not require clinical review can be administratively approved. If the request requires clinical review, the Intake Team builds a case

file by obtaining enrollee information, provider information, planned services and the network status of providers and submits the case for clinical review.

Determining medical necessity. Our UM program is integrated within medical and behavioral health fields and our process to determine medical necessity is consistent for all services and programs. While the process is the same, we make UM decisions using personnel, policies and guidelines specific to the service requested and the program benefits. A health care professional who has appropriate clinical expertise in treating the enrollee's condition determines the medical necessity and appropriateness of care. We determine medical necessity consistent with LDH's definition of medically necessary, in compliance with contractually covered services and based upon clinical practice guidelines; enrollee eligibility; state and federal mandates; enrollee's certificate of coverage, evidence of coverage or summary plan description; UnitedHealth Group medical policy; medical technology assessment information; and CMS National and Local Coverage Decisions.

In Louisiana in FY 2018, we received:

- 70,795 requests for standard service authorization. We completed 95.9% of these requests within 2 days, which exceeds the 80% requirement
- 1,775 requests for expedited authorization. We completed 100% of the expedited requests within 72-hour time frames.

Proposed Workflow for Expedited Authorizations

Our expedited prior authorization process complies with the requirements in Appendix B, Section 2.12.9.2, Expedited Service Authorization, including resolving the request within 72 hours of receipt. Once the provider makes a request for expedited prior authorization, we implement our expedited prior authorization process presented in the figure.

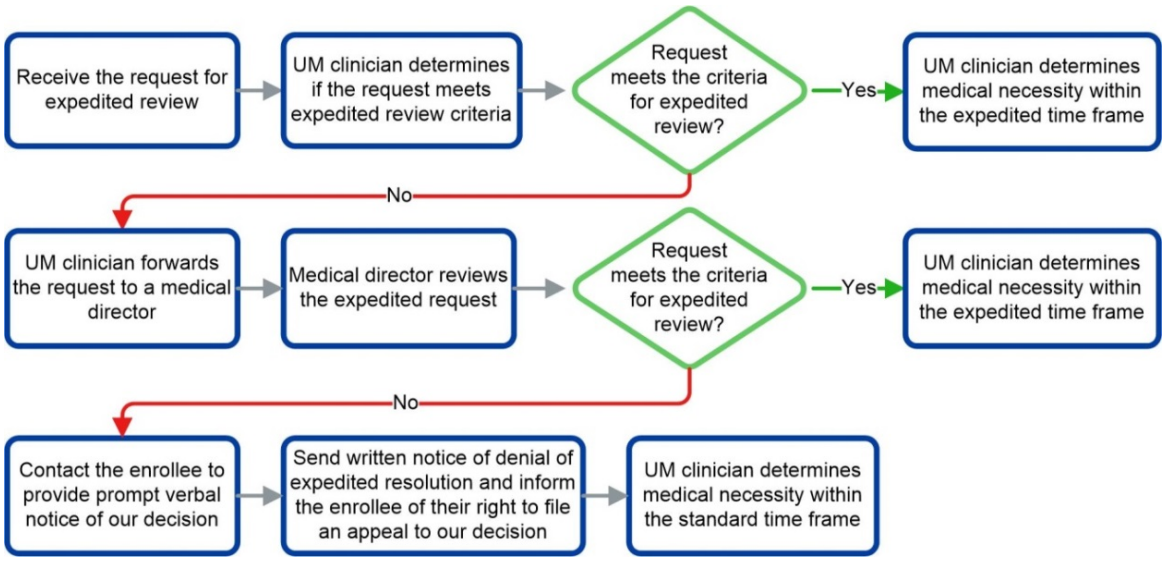


Figure 19. Expedited prior authorization process. A UM clinician determines if the request meets the criteria for expedited review. If it does not, a medical director reviews the request to determine if it meets the expedited review criteria and promptly inform the enrollee and process the request within standard time frames. If it does, we process the request within the expedited time frame.

Following the determination, we notify the provider as expeditiously as possible based upon the enrollee's health condition, but no later than 72 hours following receipt of the expedited authorization request. We may provide an extension of up to 14 calendar days if the enrollee or provider requests it or we justify the need to LDH and the delay is in the enrollee's best interest.

2.10.10.2 The Proposer should describe how it will satisfy the requirements for utilization management set forth…

2.10.10.2.1 The proposed criteria to use in its utilization management process and how such criteria will be…

Our evidence-based health care policies, clinical guidelines and review criteria standardize care management decisions regarding the most appropriate level and site of care needed to treat an enrollee's presenting issues, while providing the flexibility to address individual needs. Our policies, procedures and workflows for clinical coverage decisions are consistent with Louisiana's definition of medically necessary services. They promote quality of care and ensure adherence to standards of care, including clinical appropriateness, closing gaps in care, promoting recovery principles and promoting relapse/crisis prevention planning. Our guidelines and criteria comply with the requirements in Appendix B, Section 2.12.1.

Clinical and behavioral guidelines and criteria: We use evidence-based, nationally recognized *MCG* for physical health care services and internally developed behavioral health guidelines and criteria based upon published references from the American Psychological Association, the American Academy of Child and Adolescent Psychiatry and the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. We use American Society of Addiction Medicine criteria for substance use disorders. Our clinical leadership committees review our behavioral health guidelines at least annually. They include:

- ***Mental health conditions:*** 23-hour observation, crisis stabilization and assessment, day treatment, inpatient, intensive outpatient program, outpatient, partial hospital program and residential treatment center
- ***Substance use disorders (SUDs):*** 23-hour observation, crisis stabilization and assessment, detoxification (inpatient, outpatient and residential), intensive outpatient program, opioid treatment program, office-based opioid treatment, outpatient, partial hospital program and rehabilitation (inpatient and residential)
- ***Wraparound services:*** assertive community treatment, care management, peer services and supports for enrollee and family, psychosocial rehabilitation, respite care, sober living arrangement, supervised living arrangement and therapeutic foster care
- ***Other guidelines:*** telemental health and transcranial magnetic stimulation

Clinical practice guidelines: We have implemented clinical practice guidelines to inform UM decisions for conditions prevalent in the Medicaid Managed Care Program population, including the guidelines for the behavioral health conditions described in Appendix B, Section 2.12.1.4. Our guidelines cover conditions, such as ADHD, autism, diabetes, eating disorders, jaundice in the newborn, PTSD, sickle cell disease and neonatal service guidelines, such as neonatal abstinence syndrome.

Coverage determination guidelines: We follow the American Academy of Pediatrics Bright Futures recommendations in our preventive services coverage determination guidelines. Clinical coverage decisions are based upon eligibility of the enrollee; state and federal mandates; enrollee's certificate of coverage, evidence of coverage or summary plan description; UnitedHealth Group medical policy; medical technology assessment information; and CMS National Coverage Decisions and Local Coverage Decisions.

LDH Program Goals: Advancing evidence-based practices and ensuring enrollees ready access to care

Parent Child Interaction Therapy (PCIT) is an evidence-based, specialized behavior management identified by LDH as needed to strengthen the network of available therapeutic services for children, adolescents and their families in Louisiana. We were the first MCO in the state to offer MCO-sponsored PCIT training and will train 20 Louisiana

providers on PCIT initial certification and one provider to Level 1 certification. We helped the LSU Center from Evidence to Practice and MCO Healthy Blue to understand better which providers are candidates to receive PCIT training and shared information regarding potential expansion locations in the state. **We anticipate the availability of PCIT to expand by 12 more clinicians statewide by the end of 2019.**

How We Apply Our Proposed Criteria

A UM clinician determines if the service request requires prior authorization and, if so, processes it through our prior authorization process described in our response to Section 2.10.10.1. If a service authorization request requires clinical review and prior authorization, UM clinicians with the appropriate clinical experience review the request to determine medical necessity, verify the service request complies with level of care criteria and promotes alignment with clinical practice guidelines for the appropriateness of treatment (e.g., a request that could be considered experimental) and the appropriateness of the site of treatment (e.g., an inpatient request for services that can be delivered in an outpatient setting).

We verify the consistent application of medical necessity guidelines through annual inter-rater reliability (IRR) reviews of all licensed UM personnel. IRR reviews compare decisions among UM staff for uniform cases and then use statistical measures to assess consistency and identify potential sources of inconsistency. Upon completion of the assessment, management reviews the results and reports them to our Quality Management Committee for corrective actions. The process includes an evaluation of criteria application, guideline navigation, understanding of workplace policies and procedures and knowledge of regulatory agencies requiring compliance and timeliness guidelines.

We conducted staff MCG IRR testing in 2018 to establish the consistency of training and guideline application among clinical reviewers. The results of our assessment, for each MCG product, included:

- Inpatient and surgical care: 1,684 participants – 99% passed
- Ambulatory care: 1,084 participants – 98% passed
- Recovery facility care: 833 participants – 100% passed

2.10.10.2.2 The Proposer's process for monitoring and addressing high emergency room utilization;

Through our comprehensive UM monitoring program, we use a broad number of mechanisms to continually evaluate data at the population, parish, enrollee, provider and facility level to analyze the effectiveness of our care management programs. We compare our performance to nationally recognized standards (e.g., HEDIS) and evaluate trends, such as increasing use of the ED or inpatient utilization. Our Clinical Leadership Team uses these analyses to evaluate the ongoing effectiveness of our clinical programs, monitor utilization patterns and identify trends and opportunities for operational improvement.

Monitoring unnecessary ED utilization through advanced data analytics and reporting. Our Health Care Economics Team integrates and analyzes medical, behavioral and pharmacy claims, social determinants data and lab test results. They use data analytics and reporting tools to produce a suite of reports, dashboards and scorecards that help our Clinical Leadership Team monitor utilization. We use a variety of reports to monitor high utilization of the ED:

- ***Emergency Department Escalation Report*** identifies hospitals with the propensity to admit enrollees from their ED to observation or inpatient level of care compared to peer hospitals across Louisiana. We share this data with hospital partners during Joint Operating Committee meetings to discuss opportunities to reduce unnecessary care.

- ***Medical Experience Tracking Report (METR)*** helps our leadership team perform quarterly trend reviews that identifies outliers, trends and changes by broad category of service to determine areas of concern. The report helps us evaluate areas of concern through a deeper review of the data at the enrollee, procedure, provider and claim level. It analyzes how our hospitals perform compared to national and local benchmarks using metrics, such as admissions/1,000. Our ability to view this data in different cuts allows for the development of specific plans for performance remediation.
- ***Provider Peer Comparison Reports.*** Annually, we share with providers their utilization rates on select measures; and how they compare with their peers through Provider Peer Comparison Reports. Provider-facing staff uses this reporting to discuss utilization patterns with providers. Our Clinical Leadership Team also reviews the reporting to identify outliers and providers with unusual utilization patterns.

Monitoring unnecessary ED utilization through our HealthView Analytics Clinical Dashboard. In 2017, we developed our HealthView Analytics tool, a clinical dashboard for Hotspotting on key population-level metrics, such as avoidable ED use, NICU admissions, enrollees who are pregnant or have opioid use disorder. The tool allows us to identify key concerns by parish, provider or enrollee. For example, as presented in the figure, we used the tool to create an ED hospital dashboard for a key hospital in Lafourche Parish, which had a very high percentage of avoidable ED use. Using this, and other dashboards, in January 2018, we shared with hospital leadership detail on why the high ED use was occurring, such as the top diagnoses tied to those visits, so they could develop effective strategies to reduce it.

In a 2018, LDH quarterly business review, we were able to interactively share with LDH ED overutilization by region/parish, provider type and membership.

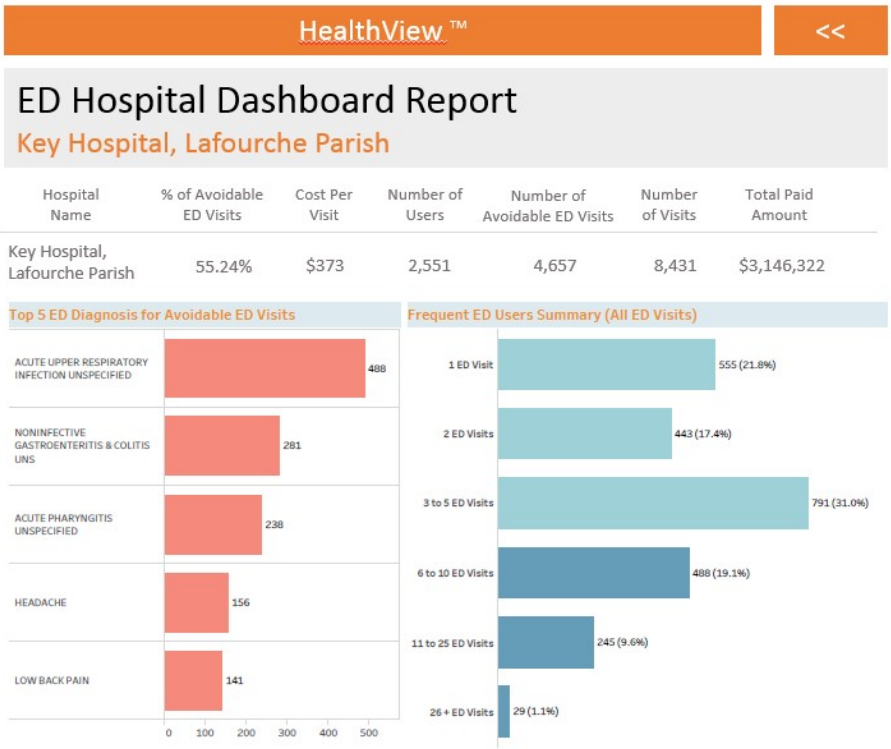


Figure 20. HealthView Analytics ED Hospital Dashboard. We used the dashboard to help a key hospital understand the causes of its high avoidable ED utilization, such as the top 5 diagnoses leading to avoidable ED visits or the enrollees with the highest avoidable ED utilization. Using this and other dashboards, we helped hospital leadership better target their reduction efforts.

Addressing High Emergency Department Utilization

Once we have identified high ED utilization, our Clinical Leadership Team uses a variety of methods to address it. They include:

- ***Developing corrective action plans (CAPs).*** We analyze the causes of the utilization variance and develop enrollee, provider or systemwide solutions to address them
- ***Identifying and engaging enrollees who may benefit from case management.*** Core to helping our enrollees appropriately access services is identifying those enrollees who may benefit from case management and engaging them in case management programs appropriate to their needs
- ***Identifying and engaging enrollees through Hotspotting.*** Our Hotspotting Tool provides the timely identification of enrollees who have inappropriate utilization patterns, complex social, behavioral or medical needs and high costs within a defined region of Louisiana. Once identified, we engage enrollees with our interdisciplinary Hotspotting Team, which provides Tier 3 case management
- ***Helping enrollees engage in healthy behaviors using behavioral economics.*** We are implementing technologies that help us identify enrollees whose behavior can be "nudged" and deliver interventions that will help enrollees make healthier choices
- ***Providing tools and programs to help enrollees appropriately access services***, such as providing in-home supports to address the needs of enrollees with inappropriate ED use, increasing enrollee access to care through telehealth and providing telephonic support to help enrollees use health care services appropriately

> Through our Shared Saving Provider Group program, our provider-facing staff works with physician practices to identify enrollees in the hospital, who have visited the ED using admission, discharge and transfer (ADT) feeds. Staff works with the practices to engage these enrollees to confirm they receive appropriate follow-up care to address the causes of their hospital or ED visit.

Developing Corrective Action Plans

When the Clinical Leadership Team identifies a utilization concern or a metric does not meet the established goal, the team identifies opportunities for improvement. The team recruits functional experts to analyze the data and develop an enrollee- or provider-specific plan to correct the variance and monitor ongoing performance. If our analysis identifies a systemic problem, we develop CAPs, such as education for case managers. If the issue is broad enough, we incorporate the change into our enrollee or *Care Provider Manual* and newsletters.

Identifying and Engaging Enrollees Who May Benefit from Case Management

Our evidence-based identification process integrates health needs assessment (HNA) results, referrals and predictive modeling analyses to understand ***every*** enrollee's circumstances and needs, their health risk score and how they might benefit from tiered case management. Our process identifies key drivers common to enrollees who require intensive clinical intervention, such as special health care needs, high-risk pregnancy, unmanaged multiple chronic and complex medical or behavioral health conditions, or low PCP engagement or acute social determinants, such as homelessness. Once identified, we engage enrollees in tiered case management programs, transitional case management or programs tailored to enrollees with unique needs, such as women experiencing high-risk pregnancy.

LDH Program Goal: Improving enrollee health

We have been successful in helping achieve the Triple Aim for our enrollees resulting in better care, better health and lower cost. Compared to the 1-year period

before engagement in case management, enrollees in case management have achieved a **40% year-over-year decrease** in total inpatient hospital PMPM cost and a **20% year-over-year decrease** in total ED PMPM driven by decreased utilization and a **22% year-over-year decrease** in total claims PMPM for enrollees engaged in our highest-risk case management program.

Identifying and Engaging Enrollees through Hotspotting

Launched in June 2018, our proprietary Hotspotting Tool provides the timely identification and engagement of cohorts of enrollees who have inappropriate utilization patterns, complex social, behavioral or medical needs and high costs within a defined region of Louisiana. Our Hotspotting dashboard provides a host of filters to segment enrollees by demographics, social determinants, utilization, cost, diagnosis, risk factors and enrollment in case management and other programs. An individual enrollee view provides a 12-month look back of utilization, cost and summary health care statistics. We engage enrollees identified by the tool with our interdisciplinary Hotspotting Team, which provides high-touch, low volume, in-person, local Tier 3 case management. The specially trained team includes RNs, licensed behavioral health advocates and community health workers.

LDH Program Goal: Improving enrollee health

We deliver each tier of case management through an array of customized services, unique programs and experienced teams, such as our field-based Hotspotting Team, which provides high-touch, trauma-informed Tier 3 case management. Engagement by our Hotspotting Team has resulted in a ***59% decrease in year-over-year PMPM inpatient costs*** driven by a decrease in admissions. ***ED utilization decreased 36%***, resulting in a ***38% year-over-year PMPM decrease in ED costs***.

Helping Enrollees Engage in Healthy Behaviors using Behavioral Economics

Behavioral economics recognizes human behavior can be influenced through the presentation of choice, framing of messages and design of financial rewards. Proven behavioral economics principles point to new methods for facilitating, engaging and helping enrollees embrace healthy behaviors. In 2019, we are enhancing our suite of enhanced data analytics tools by partnering with ***NextHealth Technologies to implement its artificial intelligence platform***. The cloud-based platform uses artificial intelligence and scientific methodologies to:

The NextHealth platform is driving material utilization improvement in Medicaid populations. Within 6 months of deploying its NextNudge™ platform, the average ED visit rate and costs had dropped by roughly 26% and 39%, respectively, among nudged compared to historical averages among the target populations.

- ***Know WHERE*** we want to focus to improve enrollee outcomes, reduce unnecessary utilization and drive down medical costs
- ***Know WHO*** to target by predicting which populations to target for the biggest impact
- ***Know WHAT*** programs to suggest by prescribing personalized enrollee-level “nudges” that change behavior and drive positive outcomes
- ***Know HOW WELL*** the programs are working by measuring and optimizing messaging, channels and outcomes, so limited resources deliver the biggest impact

The platform educates enrollees on alternative care settings using personalized phone calls, emails or texts and other methods, such as refrigerator magnets. It influences behavior by targeting enrollees with avoidable ED experiences and deploying personalized messages through the right channel to help drive lasting enrollee education and behavior change. For

example, ***NextHealth's urgent care or PCP locator*** texts local urgent care or PCP locations to enrollees based upon their location. NextHealth's analytics engine provides precise, ongoing measurement of campaign and overall program success. With the ability to proactively measure and optimize a program, we can rapidly understand what works and make changes to best serve our enrollees.

Providing Tools to Help Enrollees Appropriately Access Services

We provide enrollees with a suite of tools and programs that provide specialized, in-home supports to address the needs of enrollees with inappropriate ED use; help enrollees appropriately access health care services, such as NextHealth's urgent care locator; provide services to enrollees in their homes using telehealth; improve enrollee access to care by providing specialist eConsults to their PCPs; and telephonically help enrollees use health care services appropriately and understand their conditions.

LDH Program Goal: Supporting innovation and a culture of continuous quality improvement in Louisiana

Ready Responders is a network of trained, licensed and fully insured EMTs, paramedics and nurses who visit high-risk enrollees with inappropriate ED utilization to help divert them from the ED. During weekly in-home visits, neighborhood-based health care professionals connect enrollees via a telehealth consult to address their conditions, make a PCP or behavioral health appointment, provide transport vouchers to their providers, monitor prescription adherence, evaluate risk factors and answer questions. We are evaluating the effectiveness of the partnership since its launch in July 2018. Our preliminary results show a ***25% decrease in ED PMPM costs and a 38% decrease in inpatient PMPM costs*** among enrollees engaged in the program, driven by decreased utilization.

UHC Doctor Chat. To increase each enrollee's access to care and provide alternatives to ED use, we implemented UHC Doctor Chat, a chat-first, virtual visit ED diversion program in Louisiana in March 2019. Enrollees can use the UHC Doctor Chat app or web portal to communicate via secure chat, telephone or video with an RN or physician licensed in Louisiana.

Behavioral Health Virtual Visits connect enrollees to a virtual visit with a psychiatrist or therapist using secure video-conferencing via smartphone, tablet or computer. Clinicians can evaluate and treat general mental health conditions, provide therapy and prescribe medications.

We are partnering with ***RubiconMD*** to implement its eConsult service, which connects PCPs to top specialists in more than 120 specialties. Its HIPAA-compliant online platform empowers PCPs to easily request specialist input on a case and receive a specialist opinion within hours.

Advocate4Me and NurseLine. Our *Advocate4Me* Enrollee Services Center helps enrollees access services in an appropriate way, such as connecting them or finding an urgent care center. *NurseLine* provides live telephonic access to RNs 24 hours a day, 7 days a week who educate enrollees about their conditions and how to appropriately use health care services.

2.10.10.2.3 The Proposer's process for pre-admission screening and concurrent reviews;

Pre-admission screening for nursing facility admissions. When an enrollee is contemplating a move to a facility, we coordinate a pre-admission screening. If the enrollee is in case management, the enrollee's case manager works with them to identify facilities that meet their needs and preferences. Before placement, a qualified assessor performs a Level I PASRR to identify a serious mental illness or intellectual disability. The assessor submits the findings to the nursing facility. If the enrollee cannot be determined to have a serious mental illness or intellectual disability, the assessor also requests a Level II PASRR evaluation. If the enrollee is

in a nursing facility and determined to have a serious mental illness or intellectual disability, the Office of Behavioral Health (OBH) refers the enrollee to us for a Level II PASRR evaluation. We contract with Merakey to conduct these evaluations. Once we receive the findings, we send them to OBH for a determination of the appropriateness of a nursing facility admission or continued nursing facility stay. We complete an annual Level II PASRR evaluation of enrollees residing in a nursing facility to review the most appropriate setting for the enrollee's needs (in the community, a nursing facility or an acute care setting) and to determine the enrollee is receiving the services they need in these settings.

Inpatient admissions. Pre-admission screening and concurrent review promotes the continuity of the enrollee's care, confirms appropriate utilization, manages length of stay and facilitates collaboration among the UM clinician, case manager, inpatient facility and multidisciplinary team. We perform pre-admission screening and concurrent review for inpatient admissions and non-inpatient, high-intensity behavioral health services. We do not require prior authorization for emergencies. As presented in the figure, to perform pre-admission screening, a UM clinician determines if the admission requires prior authorization and, if so, processes it through our prior authorization process. Once the enrollee has been admitted, the Inpatient Case Management Team begins concurrent review to confirm the enrollee is receiving an appropriate level of care.

The team uses *MCG* criteria to help support the discharge planning process and evaluate an appropriate level of care for the enrollee upon discharge, such as to long-term acute care. When Level I PASRR screening is performed by a hospital discharge planner, if the enrollee has positive indicators of serious mental illness or intellectual disability and does not meet the conditions of a categorical determination, the hospital discharge planner can request a Level II.

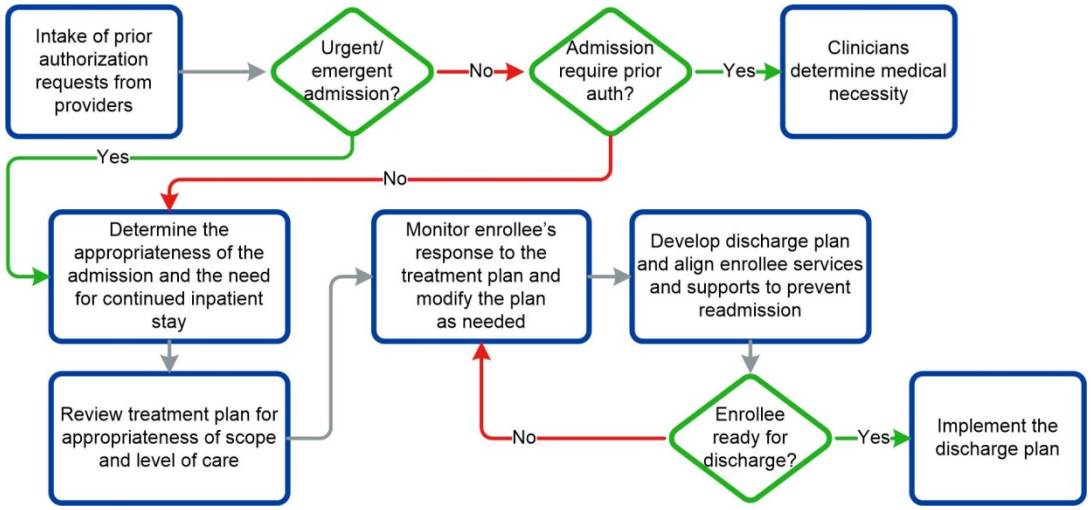


Figure 21. Inpatient pre-admission screening and concurrent review. Upon notification of a non-emergent inpatient admission, UM clinicians determine if the admission requires prior authorization. If so, they determine the appropriateness of the admission and the need for a continued inpatient stay. During the enrollee's inpatient stay, the UM clinician reviews the treatment plan for appropriateness and scope and the enrollee's response to the treatment plan and begins discharge planning.

2.10.10.2.4 How the Proposer complies with mental health parity requirements; and

We have long supported parity for mental health and addiction to help our enrollees live healthier lives. With behavioral health care available as an essential benefit, we improve outcomes by reaching additional people with prevention, wellness promotion, early intervention and treatment of mental health and substance use. We are an industry leader in confirming our financial and clinical models are compliant with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Final Rules for commercial group plans and Medicaid. Our internal MHPAEA compliance workgroup has conducted a thorough review of the impact of

MHPAEA to all key functions covering our benefits, clinical management processes and network contracting. We continue to support compliance for all plans subject to parity, including:

- Providing expert consultation and recommendations regarding compliance with MHPAEA as specified in the benefit plan
- Ensuring medical management techniques applied to mental health or SUD benefits are comparable to and applied no more stringently than the medical management techniques that are applied to medical and surgical benefits
- Ensuring that the criteria for medical necessity determinations for mental health or SUD benefits are available to any current or potential enrollee or contracting provider by making our level of care and coverage determination guidelines available to the public 24 hours a day, 7 days a week online
- Ensuring the plan benefits include a clear description of the behavioral levels of care and services covered
- Maintaining a clear and easily accessible process for filing appeals and complaints that complies with regulatory requirements, including NCQA and URAC accreditation
- Offering robust provider networks
- Monitoring the availability of providers and including an easy way for providers to note in our online directory that they are not accepting new patients
- Providing a clear reason to enrollees and providers for any denial of reimbursement or payment with respect to mental health or SUD benefits

We use detailed non-quantitative treatment limitation (NQTL) data collection tools that support the documentation of the quantitative testing required by parity (substantially all and predominant testing) and alignment of the NQTL applied to behavioral health benefits. UM staff validates individuals have transparent access to the necessary information to compare NQTLs of the medical/surgical benefits and behavioral health benefits under the plan. When applicable, we align with the plan's definition and use of medical necessity; fraud, waste and abuse program; exclusion of unproven services; network standards for provider admission and reimbursement; exclusions for failure to complete treatment; fail first requirements; formulary design for prescription drugs and restrictions based upon geographic location. This ensures that the processes used for mental health and SUD are comparable to and applied no more stringently than those applied to the medical/surgical benefits.

2.10.10.2.5 How the Proposer identifies and mitigates over-utilization, including any targeted categories.

We identify overutilization using the same methods to monitor and address high ED utilization. The table presents our targeted categories (e.g., ED utilization), the key populations affected by the targeted category, the tools we use to identify the overutilization in the targeted category and our strategy to mitigate the overutilization in each targeted category.

Key Population	Tool to Identify	Strategy to Mitigate
Targeted Category: ED Utilization		
All enrollees with high ED utilization	▪ HealthView Analytics ED dashboards ▪ Hotspotting ▪ ED Utilization Report from Orbit	▪ Developing CAPs ▪ Identifying and engaging enrollees who may benefit from case management ▪ Identifying and engaging enrollees through Hotspotting ▪ Helping enrollees engage in healthy behaviors using behavioral economics ▪ Providing tools and programs to help enrollees appropriately access services

Key Population	Tool to Identify	Strategy to Mitigate
Targeted Category: Pediatric Day Health Care (PDHC) Utilization (LDH Priority)		
Children with special health care needs currently receiving PDHC, extended home health (EHH), EPSDT personal care services (PCS)	▪ Reports on PDHC utilization ▪ Physical therapy, occupational therapy and speech therapy claims for PDHC enrollees ▪ EHH claims ▪ PCS claims	**PDHC:** ▪ Exploring Partnership with HeadStart and Early HeadStart to transition medically stable children younger than school age ▪ Case managers work with families who seek therapy services outside of the PDHC program **EHH:** ▪ Development and utilization of an EHH Acuity Tool that helps the case manager apply criteria to support the appropriate level of hours that have been requested **PCS:** ▪ We request the last well-check visit for the child from the PCP to support the need for hands-on care versus supervisory care ▪ We engage the PCP or pediatrician in pre-emptive peer-to-peer discussion, when needed **PDHC, EHH and PCS:** ▪ Our team of RNs collaborates with the MDT to coordinate the most appropriate level of care based upon the enrollee's unique circumstances
Targeted Category: Overuse of medications		
Members with or at risk of opioid use disorder (OUD)	Claims data and pharmacy reporting	Interventions, such as: ▪ Pharmacy and prescriber lock-in programs ▪ Pharmacy point-of-sale edits/reviews
Targeted Category: Unnecessary tests		
Certain providers' enrollees and enrollees with OUD/SUD	▪ Claims data – aberrant practice analysis ▪ Medical Experience Tracking Report (METR) review ▪ Payment integrity monitoring	Drug testing policy submitted to LDH for consideration based upon outlying physicians with extreme testing utilization patterns
Targeted Category: Readmissions		
All members	METR and claims, ADT feeds, Potentially Preventable Dashboard, Variant Day Analysis (VDA) and Hotspotting	▪ Follow up after hospitalization (FUH) VBP model (for behavioral health admissions) ▪ Hospital Care Transitions (HCT) program ▪ Transitional case management
Targeted Category: Inpatient utilization		
All members	METR and claims, ADT feeds, Hotspotting and VDA, Target Monitoring Report, Heads in Beds reporting	Tier 1-3 case management
Targeted Category: Physician services and outpatient		
All members	▪ Provider view – Network Optimization analysis ▪ METR and claims ▪ ADT feeds ▪ ED Utilization report for	CPCs and CTCs follow up for members who are being admitted, readmitted, have high ED use and high PCP use indicating likely poor management

Key Population	Tool to Identify	Strategy to Mitigate
	Clinical Transformation Consultants (CTCs) and Clinical Practice Consultants (CPCs)	
Targeted Category: Residential care use		
Members in skilled nursing facility/ custodial level of care	METR and claims, ADT feeds and VDA skilled nursing facility view	My Choice Louisiana transitional case management
Targeted Category: Back pain		
Members with back pain and high ED utilization	METR and claims and ADT feeds	▪ Tiers 1-3 case management ▪ Connect members to chiropractor visits, mindfulness, specialists and therapies
Targeted Category: Appropriate diagnosis and treatment of children with ADHD		
Children with ADHD	▪ HEDIS rates ▪ PCP knowledge and use of ADD/ADHD screening tool ▪ Diagnosis codes	Implemented an ADHD Performance Improvement Project (PIP) to address appropriate diagnosis and treatment of children with ADHD, following pattern of overutilization identified by Louisiana Bureau of Family Health

LDH Program Goal: Supporting innovation and a culture of continuous quality improvement in Louisiana

In 2017, we implemented an ADHD PIP to address appropriate diagnosis and treatment of children with ADHD, following a pattern of overutilization identified by Louisiana Bureau of Family Health. The quality of care for children with ADHD improved from 2017 to 2018. Using a validated screening instrument by the PCP and using the instrument in multiple settings increased by 20% and 18.33%, respectively. PCP care coordination almost doubled from 43.33% to 80%.

2.10.10.3 The Proposer should describe its historical experience with utilization management of comparable…

We implemented our UM program in Louisiana in 2012. Nationally, we have extensive experience performing UM functions in 25 state Medicaid programs, including integrated physical and behavioral UM programs in 22 states. This includes performing UM functions in 24 states that serve children, 24 states that serve enrollees receiving TANF and 22 states that serve ABD enrollees.

2.10.10.3.1 Challenges identified with high utilization and increasing medical trends;

Through our experience in Louisiana, we have learned that to address high utilization and increasing medical trend, we have to look at underlying drivers of high utilization. This includes evaluating traditional core health measures, such as tobacco use, adult obesity and diabetes prevalence rates, areas of concern, such as infant mortality rates and opioids, and the impact of social and environmental determinants. Two examples of challenges identified with high utilization and increasing medical trends include the following:

- ***Pregnant women with OUD.*** As noted in a July 2017 paper from Louisiana Health Secretary Dr. Rebekah Gee, the prevalence of infants born with Neonatal Abstinence Syndrome (NAS) prevalence quadrupled and the cost of care increased six-fold among Medicaid infants between 2003 and 2013. Woman's Hospital in Baton Rouge has seen a 67% increase in babies being monitored for NAS between 2013 and 2016. We also know Region 2 has the highest infant mortality rate (10.3%) in the state.

- ***Reducing inpatient readmissions.*** We look for collaborative partners in metropolitan areas where there were concerns about discharge planning and confirming enrollees are receiving the services needed in the community. Two of our larger providers in metropolitan areas include Our Lady of the Lake Regional Medical Center in Baton Rouge and the LCMC Health University Medical Center in New Orleans.

2.10.10.3.2 Initiatives undertaken to manage high utilization;

We use a variety of methods to monitor and manage high utilization. In this section, we describe two initiatives we have undertaken to provide supports to pregnant women with OUD and reduce inpatient readmissions by integrating HCT coordinators in three of our hospitals.

Reducing NICU utilization by focusing on OUD treatment for pregnant women. We understand that women who have OUD and are pregnant are more likely to have high-risk pregnancies, face disparately higher rates of maternal and infant mortality and experience unnecessary high utilization. In August 2018, we provided a $1.2 million grant to Baton Rouge Woman's Hospital to implement its GRACE program. The program is open to all Medicaid enrollees regardless of their MCO. By partnering with Woman's Hospital, an area with a proportionally high rate of infant mortality, we have been able to overcome health disparities and reduce the effects of SUD/OUD on pregnant women and their newborns by:

- Training direct care staff in non-judgmental communication and early detection of substance misuse to prevent avoidance of prenatal care
- Connecting newly identified enrollees with OUD to the Pregnancy Substance Misuse Case Management Program early in their pregnancies
- Providing enrollees with comprehensive case management services and connection to social resources outpatient recovery services, care planning and one-on-one support offered by providers trained in obstetrics and addictive disorders
- Continuing support for up to 6 weeks postpartum, with a warm handoff to community resources, including addiction recovery treatment centers and social services supports

LDH Program Goal: Improving enrollee health

Women enrolled in this high-touch case management program had infants who weighed an average 1.35 pounds more than the comparison group. Their estimated gestational age at delivery was 5 days greater than the comparison group (38.25 versus 37.5 weeks) and all GRACE deliveries were born at term as opposed to the comparison group where 50% of deliveries were preterm.

Reducing readmissions through our Hospital Care Transitions (HCT) Program. Our HCT program helps make an enrollee's move to their next level of care easier and their hospital discharge go as smoothly as possible. In December 2018, **we embedded four HCT coordinators** within Our Lady of the Lake Regional Medical Center in Baton Rouge and the LCMC Health University Medical Center in New Orleans to reach high-risk enrollees pre-discharge and provide specialized supports to address each enrollee's post-discharge needs. We support HCT coordinators with an RN, a clinical pharmacist who addresses medication issues and a licensed social worker with behavioral health expertise.

In 2019, we will **embed a perinatal HCT coordinator** in Louisiana Woman's Healthcare clinic affiliated with Woman's Hospital in Baton Rouge. The HCT coordinator will address the prenatal needs of inpatient high-risk women to confirm they deliver at term, support neonatal discharge planning, review social determinants needs and begin to address those issues, work with the Healthy First Steps Case Management Team to coordinate prenatal services to confirm the

continuity of the enrollee's care and work with the Neonatal Resource Services (NRS) Team to deliver a smooth transition for both the mother and an infant who has been in the NICU.

Building a Trusted Relationship to Help a Member

Luke, a 62-year-old enrollee, was admitted to Our Lady of the Lake Regional Medical Center in Baton Rouge in February 2019 with Osteomyelitis, requiring IV antibiotics. His medical history includes multiple comorbidities including a history of COPD, chronic tobacco use, diabetes, rheumatoid arthritis, hepatitis C, a history of multifocal discitis status post 6 weeks of treatment from October through December. Luke has been readmitted secondary to worsening back pain. The hospital discharge planner reached out to our HCT coordinator to help them plan for Luke's discharge as Luke would not speak to any of the facility discharge planners. Luke was angry and distrustful of everyone and was refusing to transition to assisted living level of care. Luke is a Vietnam Veteran and our HCT coordinator who is also a veteran, built on this shared experience to connect with Luke and build trust. The HCT coordinator worked with Luke to understand his needs and goals, located a long-term acute facility for Luke and gained his agreement to transition to the facility. Our HCT manager received calls from two facility case managers stating what a wonderful job the HCT coordinator is doing helping them with member transitions.

2.10.10.3.3 Initiatives to address use of low value care;

We have implemented programs and trainings to help providers deliver care that is appropriate to our enrollees and to connect enrollees to care in appropriate settings. Two examples include:

Meeting with providers to review quality outcomes and educate providers on clinical practice guidelines and HEDIS requirements. Our staff used a variety of tools and materials, such as our *HEDIS in a Box* toolkit, to identify their enrollees who have gaps in care and discuss ways we can help get these enrollees connected to preventive care. Provider-facing staff identifies enrollees with gaps in care through Patient Care Opportunity Reports.

Choosing Wisely provides evidence-based recommendations clinicians and enrollees can discuss, such as when tests and procedures may be appropriate and the process used for the recommendation. We have included *Choosing Wisely* principles in engagement of providers and enrollees and educated them on the five principles of the *Choosing Wisely* program. We have provided literature to PCPs and enrollees during provider expos, enrollee events and in-office provider signage.

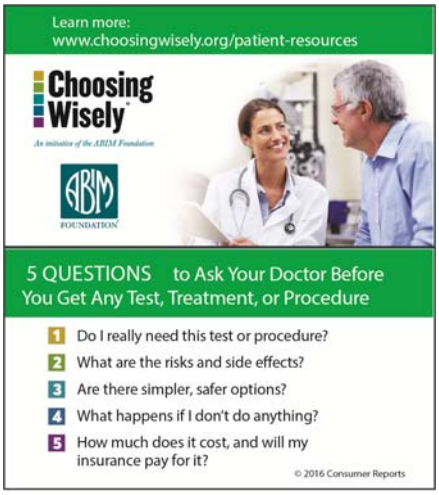


Figure 22. Choosing Wisely wallet card reminds enrollees to talk to their doctors about tests and treatments they really need to improve their health.

2.10.10.3.4 Initiatives to address long term stays of enrollees in the ER based on limited availability of mental…

Increasing the availability of mental health/substance use services. We are constantly working with providers to meet increasing standards of care and the needs of our enrollees due to the opioid crisis. We are working with LCMC to implement a mental health Intensive Outpatient Program (IOP) treatment facility. IOP is a structured therapeutic environment that provides treatment to enrollees while living at home and engaging in their personal lives. While not a covered benefit, we will provide IOP as a treatment option to our enrollees. We are in discussions with three other providers to bring their existing IOP facilities into our network.

Increasing access to Medication-Assisted Treatment (MAT). We recognize the need for a comprehensive approach to prevent, identify, treat and promote ongoing recovery for those with OUD. Aligned with the Heroin and Opioid Prevention and Education (HOPE) Council goals and the Louisiana Pew Charitable Trust Recommendation 2, which focused on expanding MAT capacity through care coordination and enhanced rates, we have developed a value-based payment (VBP) aimed at increasing access to high-quality MAT and supporting member retention in treatment. Given the high overdose death rate in the Orleans and Jefferson Parishes, in Q1 2019, we initiated a partnership with Daughters of Charity to launch our OUD Quality MAT pilot.

To reduce long-term stays of enrollees in the ED, we educate ED providers to call us as soon as the enrollee's need becomes apparent so that we can begin to coordinate services as soon as possible. When needed, we also identify out-of-network providers that can meet our enrollees' needs and execute a single case agreement to provide necessary services as quickly as possible.

We developed our program based upon the experiences and lessons learned in states that have successfully increased MAT capacity and treatment rates, such as Vermont and Virginia. Our Senior Medical Director, Dr. Katherine Neuhausen, led the successful Virginia Addiction and Treatment Services program as the former state Medicaid chief medical officer, and has provided valuable insight into the model development. Dr. Neuhausen will continue to work closely with Daughters of Charity as they build upon this VBP to scale up their capacity and provide comprehensive MAT services integrated with primary care, behavioral health, prenatal care, and Hepatitis C and HIV treatment for those with OUD.

Increasing the availability of MAT:

- Our Behavioral Health Medical Director, Dr. Jose Calderon-Abbo, provides education and discussion with providers regarding the expansion of MAT services at substance use centers
- We are working with Daughters of Charity to build a MAT program
- We are adding a MAT treatment induction code so we can pay the induction fee for providers to deliver the first dose of Suboxone and monitor the effect of the treatment

Providing crisis alternatives to the ED or hospital. We are partnering with two crisis centers to provide services to enrollees age 18 or older that help prevent unnecessary ED use and inpatient admissions. Safe Haven (operated by Start Corporation) will serve St. Tammany Parish and Compass Crisis Receiving Center (operated by Compass Health) will be located in Lafayette and will serve a 50-mile radius in the Acadiana region. We are partnering with Jefferson Parish Human Services Authority to connect our enrollees to its Living Room model, which provides a secure and welcoming environment that helps enrollees find solutions in times of crisis, avoiding automatic hospitalization or involuntary detention.

2.10.10.3.5 Initiatives undertaken to support providers with high prior authorization denial rates.

When providers need assistance or have difficulties submitting prior authorization requests, we engage them in a variety of ways. *Link* helps reduce the provider's administrative burden when authorizations. Available 24 hours a day, 7 days a week, it helps the provider submit all information required for a medical necessity review, provides access to our guidelines and review criteria, and allows the provider to track the status of prior authorization requests. Our provider-facing staff conducts one-on-one training sessions with providers, confirming they receive the education and support needed to follow the prior authorization process. Staff educates providers about our prior authorization process and our guidelines and criteria during initial provider training and whenever UM protocols or criteria change through our *Care Provider Manual*, on our secure *Link* provider portal, and in our provider newsletter, *Practice Matters*.

2.10.11 Quality

2.10.11.1 The Proposer should describe its organizational commitment to quality improvement and its overall…

We have contracted with LDH since 2012, and we understand the importance of the *Aims, Goals and Objectives* outlined in Attachment G. We are currently working with LDH to achieve these and to continue our upward trend in Attachment G quality measures. We agree to comply with all requirements in Section 2.10.11 of the Model Contract.

Organizational Commitment to Quality Improvement

Quality is fundamental to our culture. We embed systematic approaches to evaluate and improve quality through every level of our organization. These efforts engage the resources of our entire organization — both national and local — and improve service and health outcomes of enrollees.

Supporting Innovation and a Culture of Continuous Quality Improvement

Our quality interventions and strategies support LDH's *Aims, Goals and Objectives* while focusing on smarter spending — high-value, efficient care — through local care management and care delivery. The Quality Assessment and Performance Improvement (QAPI) program we create for the Medicaid Managed Care Program uses comprehensive population health analytics to identify trends, develop population-specific plans and apply individualized interventions, while monitoring the quality of care and service delivered in parishes statewide.

We weave our *Culture of Quality* into everything we do. Every UnitedHealthcare employee must attend a multiday culture retreat to learn how we put our quality and value at the center of our work. Our values of *Integrity, Compassion, Relationships, Innovation and Performance* inform and enhance our mission, to "*Help people live healthier lives and help make the health system work better for everyone*."

Quality Champions in Louisiana

To support our companywide culture of quality and drive innovation locally, Angela Olden, MA, BSN, RN, Population Health Director, and Deb Junot, BSN, RN, Quality Director, will continue to act as the quality champions for advancing and administering all Medicaid Managed Care Program requirements for the State. Ms. Olden and Ms. Junot are lifelong residents of Louisiana and have 40 years of combined managed care quality experience in the state.

Approach and Specific Strategies to Advance "Healthier Louisiana"

Our quality strategy for the Medicaid Managed Care Program verifies that our enrollees have access to, and use, an integrated program of primary and specialty health care based upon evidence-based clinical guidelines that foster better health, better care and lower cost. We support the LDH's *Aims, Goals and Objectives* by implementing provider incentive programs that support improved enrollee care and continuous quality improvement (CQI) initiatives.

Organizational Commitment to Support LDH Priorities and Innovation

Like quality, innovation is also part of the fabric of our company and woven into our efforts to align our quality improvement program with the LDH Quality Strategy. Some examples follow:

***Delivery System Reform*:** Listening to providers, we adapted our value-based contracting (VBP) model to meet providers where they are. In 2019, we moved to a [redacted]

Reducing Readmissions: To support LDH's goal of improved coordination and transition of care, we offer high-need enrollees support by providing home delivered meals after an acute inpatient hospital stay due to food insecurity/malnutrition. After a hospital discharge, Mom's Meals delivers 14 to 28 healthy meals appropriate to an enrollee's health condition to the enrollee's home. Since starting in November 2018, the innovative pilot program resulted in 95% of enrollees avoiding readmission after discharge from an acute hospital setting. We will evaluate this program at a future date for continued successful outcomes.

Innovative Care Coordination: Providing acute to post-acute transition services to enrollees is part of the evolution of the care continuum and supports LDH's goal to improve coordination of care. Our embedded Case Management Program in high-volume inpatient facilities addresses coordination of care — for medical, behavioral health and pharmacy (e.g., medication review and reconciliation) and the enrollee's needs related to social determinants of health (SDOH).

ED Diversion/Access to Care through UHC Doctor Chat: Enrollees can use the UHC Chat app or web portal to communicate via secure chat, telephone or video with an RN and M.D. if needed for care, 7 days a week (9 a.m. to 9 p.m.). We implemented UHC Doctor Chat, a chat-based, virtual visit ED diversion program in March 2019. The program addresses enrollees with CHF, COPD, sickle cell, chronic pain or asthma who have two or more ED visits in the past 12 months AND one non-emergent ED visit in the past 12 months.

Improved Member Health through Telehealth/Telemental Health: As we continue to focus on improved access for enrollees, we have several programs implemented and in development to support enrollees receiving and providers delivering accessible and integrated medical and behavioral healthcare. These programs connect the enrollee to the provider, the provider to other providers, and enrollees to specialists. Our expanded capabilities also address access to care issues with providers after hours to meet enrollee needs and improve chronic disease management and control.

Enrollee Education Partnerships to Drive HEDIS: We partnered with our vendor, MARCH Vision, on an initiative to close gaps in HEDIS eye exams by calling enrollees identified with diabetes that had not had their eye exams and scheduled them for services. The result was a **14.6% improvement** in our 2017 HEDIS diabetic eye utilization score.

2.10.11.2 The Proposer's approach should also include:

2.10.11.2.1 A description of the Proposer's assessment (using available data sources) of utilization rates and the…

The success of our performance strategy and the potential for improvement is guided by and in alignment with the Triple Aim and the broad aims of the LDH Quality Strategy — ***Better Care, Healthy People, Healthy Communities and Affordable Care***. Louisiana's Quality Strategy framework defines and drives our overall vision for advancing health outcomes and quality of care provided to Medicaid Managed Care Program enrollees.

We accomplish this by embedding the Louisiana Quality Strategy into our quality "trilogy documents" — which consist of the *Quality Improvement Program Description*, the *Quality Improvement Evaluation* and the *Quality Improvement Work Plan.* These documents articulate our Quality Strategy, driving overall plan performance while also recognizing areas where quality initiatives have the potential to drive additional improvement.

Tracking Potential for Improvement

We use data to track a variety of measures that provide insight into the effectiveness of our programs and the health outcomes of our enrollees. Our measures track reductions in unnecessary utilization, identify enrollees with gaps in care and provide indications that our

enrollees are receiving quality care that leads to improved enrollee outcomes, such as compliance with HEDIS measures. Our Quality Improvement (QI) Program describes the coordinated and collaborative activities and initiatives UnitedHealthcare provides to meet the needs of enrollees and to continuously improve service, medical and behavioral health care outcomes. We use several datasets and reports to assess utilization rates:

Inpatient Utilization Rates Report (Daily): Our PCPs receive a report on their patients that were seen in the ED, admitted or discharged from an inpatient stay. This allows the provider to proactively reach out to the enrollee to address continuity of care concerns.

ED Utilization Rates (Monthly): We aggregate and review utilization rates such as cost-per-enrollee, provider inpatient data and ED rates. This high-level view allows us to identify developing trends in utilization and quality outcome measures.

HEDIS-reported Utilization Rates Data (Monthly): We review HEDIS rates/utilization metrics across our entire enrollee population. We actively use this data to inform proactive approaches. For example, if our diabetic enrollees are having lower-than-recommended rates of eye exams, we take action, which could entail calls to enrollees with gaps in care or outreach to provider staff to heighten their awareness of enrollees that need these screenings. In both cases, this review provides both enrollees and providers with education on addressing these needs and eliminating gaps in care.

VBP Scorecards Reports (Monthly): Our scorecards illustrate to providers engaged in value-based contracting the measures where their enrollees have gaps in care. Our clinical provider-facing staff share these during monthly in-person visits. Scorecards allow the provider to focus on specific enrollees or measures to support both improved care and meet criteria to earn practice incentives. VBP scorecard data gives providers a snapshot of their aggregate rates to guide them in achieving minimum standards, outperforming peers or meeting provider incentive agreements. This information is also available through our online provider portal.

Provider Peer Comparison Reports (Annually): We share with providers their utilization rates on select measures; and how they compare with their peers. Medical plan leadership reviews this group-level data internally to determine outliers and to influence provider utilization patterns. For example, we use this data to identify the opioid/high-utilizer peer comparison rates. This allows the plan's clinical leadership to review the data, proactively monitor any potential abuse and formulate a plan to address outlier providers on this metric.

Physician MPIN	Physician Name	Physician Specialty	Physician Data	Peers Data	Comparison to Peers
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	33.00%	21.10%	56% higher
ABCDEF	ABCD EFGHIJ	INTERNAL MEDICINE	15.40%	21.10%	27% lower
ABCDEF	ABCD EFGHIJ	INTERNAL MEDICINE	59.10%	21.80%	2.7 times higher
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	14.30%	16.60%	14% lower
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	30.60%	16.90%	81% higher
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	64.70%	17.90%	3.6 times higher
ABCDEF	ABCD EFGHIJ	INTERNAL MEDICINE	5.00%	15.40%	67% lower
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	20.70%	15.40%	35% higher
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	4.50%	16.70%	73% lower
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	13.30%	16.10%	17% lower
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	53.80%	17.40%	3.1 times higher
ABCDEF	ABCD EFGHIJ	FAMILY PRACTICE	37.10%	19.00%	95% higher

Figure 23. Our Provider Peer Comparison Reports show utilization rates on select measures in comparison to their peers, highlighting PCP outliers to drive both provider education and overall plan performance.

Recognizing Potential for Improvement

The table to follow ("Key HEDIS Measures") represents a sample of key measures to drive efforts for a Healthier Louisiana. Monthly, we evaluate both incentive measures and monitor measures supported by additional interventions and provider/enrollee outreach and education. Our enhanced value-based incentives — added in 2018-2019 — along with member incentives targeted to populations identified as having health disparities, further enhance our

efforts. We continue to look for opportunities to continue to drive improvement in all measures and for all populations. The proposed new measures are inclusive of the expansion population and broaden our approach to encompass more adult population needs.

At the Department's request (Addendum 2), we have included four additional measures from Attachment G: #27, 35, 37 and 50. Of these four proposed measures, three have available baseline data at this time (e.g., 27, 35 and 50). In the past, we have not monitored Colorectal Cancer Screenings (#37) for the Medicaid population. The measure for Initiation and Engagement of Alcohol and other Drug Abuse or Dependence Treatment (#50) has a performance improvement project scheduled for 2019.

We have begun research to obtain baseline data on the remaining proposed measures available at this time. Once we finalize the measures in May 2019 for the 2020 contract, we will analyze and use this data to develop our quality improvement plan inclusive of integrated provider/member outreach and education for Attachment G to support all the efforts for *Better Care, Healthier People, Healthier Communities and Smarter Spending* for a Healthier Louisiana.

Health Plan Rates on Key HEDIS Measures (Attachment G)

ATT. G #	Attachment G. Measure	HEDIS 2018 Rate (%)	HEDIS 2017 Rate (%)	Improved from 2017 to 2018 (%)	Met State Benchmark 2018*		Included in Incentive Program?	
							PCP	Enrollee
1.	Well-Child Visits in the First 15 Months of Life	72.26	57.55	14.71	YES	62.06	YES	YES**
2.	Well-Child Visits in the Third, Fourth, Fifth, Sixth Years	68.86	68.19	0.67	NO	72.45	YES	YES*
3.	Adolescent Well-Care Visits	60.34	63.88	-3.54	YES	50.12	YES	YES*
4.	Adult Access to Preventive & Ambulatory Services	81.64	86.48	-4.84	YES	81.61	YES	NO
6.	Seven-day Follow-Up After Hospitalization for Behavioral Health (FUH)	26.58	42.13	-15.55	NO	43.94	YES	NO
18.	Prenatal and Postpartum Care: Timeliness of Prenatal Care	82.24	85.54	-3.3	NO	83.56	YES	YES
21.	Prenatal and Postpartum Care: Postpartum Care	64.48	64.84	-0.36	YES	64.38	YES	NO
22.	Initiation of Injectable Progesterone for Preterm Birth Prevention	18.06	18.01	0.05	NO	20.65	YES	NO
27.	Childhood immunization Status Combo #3±	71.29	73.72	-2.43	NO	71.58	NO	NO
35.	Cervical cancer screening±	57.66	62.76	-5.1	NO	58.44	NO	NO
37.	Colorectal cancer screening±	NA	NA	NA	NA	NA	NA	NA
42.	Controlling High Blood Pressure	NA	NA	6.32	NO	56.93	YES	NO
46.	Eye Exam (Retinal) Performed	55.23	50.12	14.6	YES	55.17	YES	NO
50.	Initiation and engagement of alcohol and other drug abuse or dependence treatment± *I=initiation E=engagement*	I-49.19	I-50.93	-1.74	YES	40.67	NO	NO
		E-16.74	E-14.44	2.30	YES	12.34	NO	NO

HEDIS Rates for 2019 not final. ** $20 Gift Card *$10 Gift Card*
± Four additional measures added by the Department in the response to the Q&A.

Emergency Department Utilization in Louisiana

Emergency Department (ED) utilization is a continuous improvement priority. In measurement year 2018, the plan ED utilization rate is — as of January 2019 — ***72.26%*** (currently waiting for claims lag). This was a decrease in ED utilization rate from ***78.36%*** in 2017. We accomplished this through several ED Diversion initiatives (described in Question 2.10.11.1) including telehealth initiatives and enrollee awareness and education — even during one of the nation's strongest flu seasons. With the innovative programs slated for 2020, we expect additional improvement on enrollee ED utilization.

2.10.11.2.2 A description of incentives that will be implemented for providers and enrollees to incentivize…

Since 2012, UnitedHealthcare has continued to evolve our approach to VBP for Louisiana's Medicaid Managed Care providers in support of the Triple Aim. Our goal is to incent both the provider and the enrollee *on the same measures* when possible. The table in our response to Question 2.10.11.2.1 illustrates the "crosswalk" between the enrollee and provider incentives measures for 2020.

This alignment creates synergy — when both parties are working toward the same goal based upon services given and received. We also have an incentive program for FUH (Attachment G, #6) for both medical and behavioral providers. This encourages coordination of care between PCPs and behavioral health providers. Our VBP programs help providers successfully progress along the Health Care Payment Learning and Action Network (HCP-LAN) continuum to achieve practice transformation, expand access to care and improve quality service delivery using a "right care in the right place at the right time" approach.

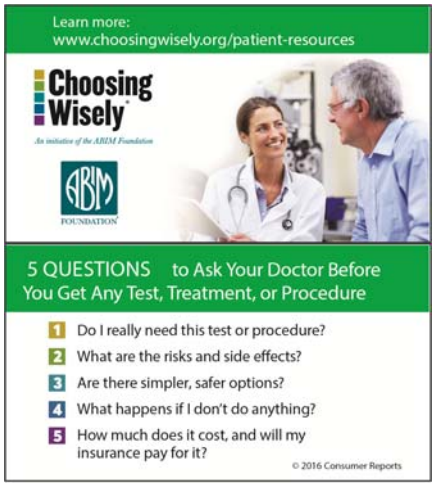


Figure 24. Choosing Wisely wallet card (also in Spanish) reminds enrollees to talk to their doctors about which tests and treatments they really need to improve their

Choosing Wisely

Choosing Wisely provides specific, evidence-based recommendations clinicians and enrollees can discuss, such as when tests and procedures (e.g., CT scans, antibiotics) may be appropriate and the process used for the recommendation. To support both enrollee and provider education in this effort, we have included *Choosing Wisely* principles for both provider and enrollees. We have educated providers and enrollees on the five principles of the *Choosing Wisely* program and we have provided literature to PCPs and enrollees during provider expos, enrollee events and in-office provider signage.

2.10.11.2.3 A description of evidence-based interventions and strategies that will be used to target super-utilizers…

Our strategy for targeting super-utilizers and reducing potentially preventable events (PPEs) begins with using data and analytics to identify super-utilizers. Our identification and stratification process generates a risk score and stratifies each enrollee according to predicted future utilization and cost. The algorithm incorporates medical, behavioral health and pharmacy claims, lab test results and other data. Our Impact Pro™ predictive modeling tool analyzes the data to deliver a prospective risk assessment for every enrollee and identify the clinical and utilization events affecting an enrollee's health risk. The process analyzes gender, age, other demographic variables, future inpatient risk and prior year total cost of care spending, acute inpatient admissions, ED visits, pharmacy, behavioral health and chronic conditions.

Our strategy also identifies enrollees with emerging risk who, without intervention, would likely become very high utilizers in the coming year. Our risk stratification engine uses multiple identification rules to identify enrollees with emerging risk, such as multiple medications, a behavioral health medication with no behavioral health provider, more than six behavioral health or medical providers and the presence of social risk factors.

- 41% of total WPC enrollees enrolled in the Super-Utilizer program
- Total inpatient hospital PMPM decreased by 43% year-over-year for members after joining the WPC – Super-Utilizer Case Management program, driven by decreased utilization
- Total ED PMPM decreased by 26% year-over-year for members after joining the WPC – Super-Utilizer program, driven by decreased utilization

We work with these enrollees to help manage the health concerns that are leading to very high utilization PPEs using the care management activities and resources discussed in the following section. At a minimum, enrollees identified with emerging risk will be assigned to Tier 2 case management and those who are identified as having persistent high utilization will be assigned to Tier 3 case management.

Other key elements of our strategy to target super-utilizers and reduce PPEs include:

Supporting participating PCPs and behavioral health practitioners to target follow up as indicated by their utilization patterns. These interventions include provider education, drill-down case review and potential further action depending on the results of the review. We work with providers to allow super-utilizers to get priority walk-in appointments and transportation to the PCP or urgent care by:

Identifying enrollees using advanced data analytics that support our algorithm-based blended identification and stratification process with emerging risk or persistent high utilization and allows us to assign these enrollees to an appropriate case management risk level (Level 2 or 3) and engage them in an appropriate intensity of case management.

Managing enrollee care through high-touch, high-engagement case management interventions delivered through field-based, integrated care teams, comprising an RN case manager, a licensed-behavioral health advocate and an enrollee advocate. The team collaborates to manage enrollee care and implement interventions that address the causes of the persistent high utilization. We target high utilizer enrollees with outreach calls and community health worker visits to address their specific needs (e.g., transportation, childcare, work schedules, access to care including scheduling PCP or specialist visits).

We send admissions, discharge and transfer) (ADT) data via the Health Information Exchange (HIE) to our providers on a daily basis. This enables appropriate follow-up engagement (e.g., schedule appointment within 7 days of discharge), reducing readmissions and other PPEs. We are finalizing an agreement with the Louisiana Health Information Network to expand our access to ADT feeds.

Monitoring enrollee health using technology that enables us to monitor in near-real time by aggregating data from various sources, such as claims data or ADT from hospitals, and presenting actionable information to the care team so it can engage enrollees with timely, targeted interventions and prevent an escalation of their utilization. ADT reports are also shared with the PCP and this communication allows the PCP to know about an enrollee's inpatient occurrence or an ED visit.

Meeting enrollee needs using an array of care management processes, services, supports and specialized programs for enrollees with persistent high utilization, such as peer supports, recovery response centers and tools that help enrollees actively manage their conditions.

Sharing member utilization reporting using high utilizer reports with the providers so they may concentrate their efforts on these enrollees to address their utilization patterns. We also place these enrollees in case management.

Conducting multidisciplinary continuum of care rounds and addressing enrollees with high utilization patterns.

Using Ready Responders, a network of trained, licensed and fully insured EMTs, paramedics and nurses who are connected via a proprietary mobile app to 911 systems, hospitals and payers.

Offering telehealth options to the enrollee to address access and after-hours concerns — with access to both medical and behavioral health providers – UHC Doctor Chat.

Using Hotspotting, the strategic use of data to identify enrollees with complex needs. Typically, these individuals have high utilization of services and social and behavioral complexities. Using our Hotspotting Tool, we can identify enrollees who are most likely to benefit from our community health worker (CHW) approach—a direct, evidence-based, in the community approach to service delivery.

2.10.11.3 The Proposer should describe how the Proposer's Medicaid managed care Quality Assessment and…

Quality and value are the shared responsibility of everyone on our team and our partners. Our goal is to deliver on Louisiana's three central aims *better care, better health* and *lower costs* while we support the state's Quality Strategy and corresponding goals and objectives related to improvements in clinical care (Attachment G.) The QAPI forms the foundation for how we drive quality improvement statewide and our organizational quality committee structure (Question 2.10.11.4.1) is the mechanism we use to engage the entire organization to meet state goals.

Annually: We formally evaluate and document our QAPI through a trilogy of documents that help us establish QAPI goals and objectives to drive health care utilization and improve the health status of covered populations. The trilogy documents that form the QAPI Program — the *QI Program Description,* the *QI Work Plan* and the *Quality Program Evaluation* — support an organization wide culture of CQI in Louisiana. Our Board of Directors approves all three documents and they are submitted to LDH for approval. The findings of our evaluation of the Quality program provide the plan with the foundation for the upcoming year quality strategies, which are addressed in the Quality Program Description and Work Plan.

QAPI Evaluation: The key mechanism for verifying adherence to LDH's Quality Strategy is our QAPI evaluation, through which we conduct an annual evaluation of the Quality Management program to assess the overall effectiveness of our quality processes in accordance with our state contract. The evaluation reviews all aspects of the Quality Management program and Quality Improvement Work Plan, focusing on whether the program has demonstrated improvements in the quality of health care service provided to enrollees.

Upon completion of the annual evaluation, the Quality Management Committee (described in Question 2.10.11.4.1) and the Board of Directors review and approve the annual evaluation. We use the results of the annual evaluation to develop and prioritize the next year's annual quality management program and Quality Improvement Work Plan.

Quarterly: The Quality Management Committee (QMC) reviews and evaluates the *QI Program Description, QI Work Plan* and the *QI Program Evaluation*. It is during the quarterly QMC review that we present the elements of the QAPI, obtain committee feedback and approval on all planned QI activities. We document activities, feedback and follow up in QMC meeting minutes. For additional information on the role of the QMC, please refer to Question 2.10.11.4.1.

Monthly: After QMC approval, our Quality Improvement Team reviews QAPI priorities in alignment with the LDH Quality Strategy and builds the QI Work Plan. The QI Work Plan is a living document and we revise it monthly as we continue to make progress on interventions and prioritize improvement opportunities. During this time, we also share our QI program goals and activities with enrollees through our *HealthTalk* newsletter, social media (e.g., Twitter @UHCPregnantCare) and through *SilverLink* live outreach calls. We complete QI Work Plan activities within the year.

Ongoing: Our quality team incorporates ongoing monitoring of critical quality indicators, formal performance improvement projects, ongoing application of rapid cycle improvement and the *Plan-Do-Study-Act* method along with analysis of gaps in care to identify specific improvement projects such as:

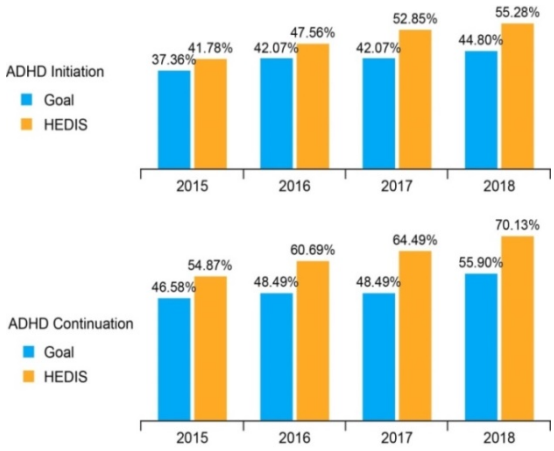


Figure 25. Three-year positive trends for ADHD, consistently exceeding HEDIS goals for the two-part measures.

Data-driven Example #1: ADHD Performance Improvement Project

Due to the prevalence of Louisiana youth who have ADHD diagnoses and medication prescriptions, LDH tasked the five MCOs to conduct a 3-year collaborative performance improvement project (PIP) on ADHD.

For the ADHD initiative, we analyzed gaps in care and found that providers needed additional education to address barriers. For example, during one clinical visit for ADHD measures (e.g., 30-day follow up once medication begins) our clinical support staff realized that a provider was scheduling the enrollee to return on the 29th or 30th day for follow up. This did not allow enough time to complete the follow up in the case of enrollees needing to reschedule appointment. We encouraged the provider to write a prescription for the medication for 10-14 days then schedule the follow-up appointment on the 21st day. This allowed room for rescheduling which still providing the opportunity to meet the VBP metric.

Data-driven Example #2: EPSDT

We also monitor our EPSDT scores and implement strategies to improve, and our outcomes demonstrate improvement. Along with our HEDIS/Performance Measure outcomes, our positive EPSDT screening ratio trends exemplify our commitment to our most vulnerable population.

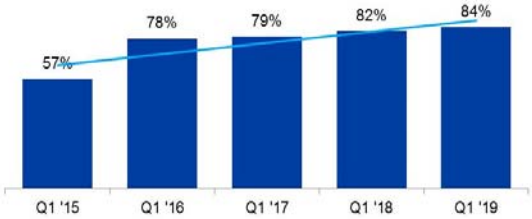


Figure 26. Our EPSDT Q1 total screening ratio is 84%, representing +4% above the Department's established goal of 80%.

The group with the lowest screening and participation ratios receives no incentive to participate, as the well-visit incentive stops at age 17. As noted last quarter, this may send a message to the older adolescents that a well visit is not important. A pattern of not maintaining a relationship with a PCP then follows into young adulthood. This is evidenced by 21- and 22-year-olds being

the least compliant for the HEDIS performance measure of Access to Care. Due to these findings, we continue to emphasize the importance of EPSDT/well visits to parents/guardians, via incentive programs, such as Baby Blocks through the first 15 months, and well visit gift cards for annual visits thereafter to try to build healthy habits early on. These benefits are noted in the *Enrollee Handbook*.

2.10.11.3.1 Analyzing gaps in delivery of services and gaps in quality of care, areas for improved management of…

Since 2015, we have had a Louisiana Health Disparities Plan to identify and reduce specific parish-based health disparities along with clinical priorities and action steps to address identified health disparities. We also use this action plan to assess and improve overall culturally appropriate programs, services and capabilities within the health plan.

To understand gaps in delivery of services and gaps in quality of care, we evaluated statewide population data using our HEDIS and Health Plan Manager (HPM) reports. HPM enables us to identify health care disparities annually associated with enrollee age, gender, race/ethnicity, language and geographic location, and to monitor and evaluate the effectiveness of the interventions using an age, gender, race/ethnicity, language and location filter. The HPM uses claims data to provide information on enrollee compliance based upon race and age, and even allows for a drilldown based upon compliance of select parishes.

An example of how we analyze gaps in delivery of services and care include the Louisiana Health Disparities Action Plan — an ongoing clinical priority. In the plan, we analyzed four parishes against HEDIS performance measures, State goals and NCQA Quality Compass Benchmarks to determine specific gaps in care by target locations (both urban and rural), enrollee ethnicity, gender and age. We also considered those areas of priorities defined by LDH.

Reducing Health Outcome Disparities by Parish

The following tables illustrate the clinical priorities and action steps for our focus across Louisiana to reduce the impact of health disparities based upon yearly analysis of the data in two of the four parishes analyzed. Our specific efforts to acknowledge and support the impact of culturally competent care and improved health outcomes in Louisiana are shown in four clinical areas inclusive of the expansion population.

Clinical Area #1: Adult Health (Attachment G #4)
Parish: East Baton Rouge, Lafayette, Jefferson, Caddo
Ethnicity: African-American
Gender/Demographics: Male and female, age 21+
Improvement Strategies & Action Planning (2018-2019): Local provider-facing staff outreach to PCPs with high numbers of non-compliant enrollees in targeted parishes. Reinforce HEDIS guidelines, Care Opportunity Reports, *Link* use. Reinforce enrollee and provider education during provider expos, Health Talk, enrollee welcome calls and VBP Adult Prevention Access measures.
Results: Percentage of Non-Compliance ▪ **East Baton Rouge:** Non-compliance improved from **16.24% (2016) to 16.05% in 2018.** ▪ **Caddo:** Non-compliance improved from **26.26% (2016) to 23.84% in 2018.**
Clinical Area #2: Women's Health (Attachment G #21)
Parish: East Baton Rouge, Lafayette, Jefferson, Caddo
Ethnicity: African-American
Gender/Demographics: Female, ages 16-35 years
Improvement Strategies & Action Planning (2018-2019): Local provider-facing staff outreach to OB providers with OB toolkit including Healthy First Steps (HFS). HFS now has one manager and four case managers in Louisiana. Connect *Reducing Premature Births* PIP outcomes to drive improvement, promote

Baby Blocks incentives program (e.g., eight incentives for pregnancy and postpartum.) Targeted live IVR calls to new mothers to determine postpartum visit status and appointment setting if needed. Use of social media through Twitter: @UHCPregnantCare (In Spanish: @UHCEmbarazada) and Text for Baby (English/Spanish). Use of "Baby Showers" program to educate pregnant mothers in geographical areas where we identified high pregnancy/low prenatal care.
Results: Percentage of Non-Compliance ▪ **East Baton Rouge:** Non-compliance improved from **51.50% (2016) to 37.46% in 2018.** ▪ **Caddo:** Non-compliance improved from **48.97% (2016) to 38.62% in 2018.**
Clinical Area #3: HbA1c Testing (Attachment G #46 Comprehensive Diabetes Care/CDC Measure)
Parish: East Baton Rouge, Lafayette, Jefferson, Caddo
Ethnicity: All races
Gender/Demographics: Female, all ages
Improvement Strategies & Action Planning (2018-2019): Locally based provider-facing staff continue to review opportunities for care for HbA1c measures. Updated Diabetes Toolkit, created by the quality team, and used exclusively in Louisiana with high volume providers. Practitioners with linked, diabetic patients, have CDC A1c as incentive measure on their VBP scorecard. Diabetic screening initiative noted in the *Member Handbook* and $50 voucher toward retail items for those who complete their HbA1c labs within 90 days of enrollment. In negotiations to collaborate with New Orleans East Hospital for their diabetic program affiliated with the Cleveland Clinic to generate positive outcomes.
Results: Percentage of Non-Compliance ▪ **East Baton Rouge:** Non-compliance improved from **26.23% (2016) to 23.01% in 2018.** ▪ **Caddo:** Non-compliance improved from **27.23% (2016) to 20.65% in 2018.**
Clinical Area #4: Diabetic Eye Exams (Attachment G #46)
Parish: East Baton Rouge, Lafayette, Jefferson, Caddo
Ethnicity: All races
Gender/Demographics: Female, all ages
Improvement Strategies & Action Planning (2018-2019): Targeted outreach to Lafayette, Jefferson and Caddo parishes, from MARCH Vision for Q4, with emphasis on female enrollees. UnitedHealthcare and MARCH Vision Automated Call Campaign conducted in June 2018 using a list of non-compliant Louisiana diabetic enrollees. Claims for 524 unique enrollees (some with multiple dates of service) were received as of October 2018. Importance of diabetic eye exams emphasized with culturally appropriate flyers addressed at provider expositions, reaching providers from all four targeted parishes.
Results: Percentage of Non-Compliance ▪ **East Baton Rouge:** Non-compliance improved from **61.30% (2016) to 52.84% in 2018.** ▪ **Caddo:** Non-compliance improved from **50.96% (2016) to 50.36% in 2018.**

We continue adjusting our efforts to achieve the desired health outcomes by potentially implementing initiatives such as Community Health Fairs, and providing continued engagement of CHW field staff from our enrollees' communities, and culturally tailored enrollee materials and resources.

We have a strong presence in the state with enrollees and their families and welcome the opportunity to enhance our efforts to offer programs and services that reflect an understanding and appreciation for the cultural diversity of enrollees and the community. This includes providing enrollee materials that are enrollee-centric, culturally inclusive and accessible to non-English-speaking enrollees.

2.10.11.3.2 Identifying underlying reasons for variations in the provision of care to enrollees; and

We identify the underlying reasons for variations in care based upon data analytics, culturally competent services delivery, analyzing enrollee outreach, and supporting and assessing a

provider's cultural competence working with enrollees. We also understand the impact of social determinants of health and health disparities in accounting for variation of care.

Reducing Variations in Care Provision

Our approach to improving member care is local and community-based. We build our programs focused on supporting our enrollees to achieve better health with an understanding of their communities, the cultural needs of enrollees, and provider network.

As an organization, we are committed to removing barriers to care for all enrollees. We recognize the critical importance of culturally appropriate and effective communication to improve the service experience for enrollees and to reduce/eliminate health disparities that result in variations in the provision of care. We use effective communication strategies to support enrollees. This includes assisting enrollees with limited English proficiency through our language interpretation services, assisting enrollees who are hearing or sight impaired using the 711 National Telecommunications Relay Service (TTY) line or using Braille or large print for member communications. For enrollees with cognitive deficits related to either disease states (e.g., Alzheimer's) or mental illness (e.g., depression, schizophrenia), our member services associates are trained to assist the member using empathetic listening and if necessary, engage the assistance of a CHW.

Based upon the feedback we have received from enrollees in Louisiana, culled from enrollee survey feedback, face-to-face community outreach and analysis of data, we find that transportation to appointments, childcare and taking time off from work are some of the major barriers that Louisiana enrollees face.

Reducing care outcomes variation is among the plan's goals. This is a phased process. As we implement care delivery/care continuum measures, the provider initially realizes significant cost of care reductions. As we perfect these measures over time, we can expect a reduction in variability and improved quality outcomes for our enrollees. This improvement includes access to care, ED utilization for non-engaged enrollees, inpatient and readmits, discharge planning, and high risk and non-engaged enrollee care coordination.

2.10.11.3.3 Implementing improvement strategies related to analytical findings pursuant to the two (2) functions…

To eliminate enrollee barriers to health, we use several methods to identify and mitigate issues:

Reminder Calls: By monitoring utilization rates and gaps in care, we initiate outreach to enrollees to remind them of appointments. Our customer service staff asks the member if there are any barriers to receiving care. They can then arrange their medical/behavioral appointment for the enrollee and arrange transportation during the call.

UHC Doctor Chat: To facilitate access to care to meet enrollee needs, we implemented a chat-based, virtual visit ED diversion program in Louisiana in March 2019. The program addresses enrollees with CHF, COPD, sickle cell, chronic pain or asthma AND two or more ED visits in the past 12 months AND one non-emergent ED visit in the past 12 months, prioritized by their risk for experiencing an inpatient admission as identified by our Hotspotting Tool. Enrollees can also use the Chat app or web portal to communicate via secure chat, telephone or video with an RN and M.D. if needed for care, 7 days a week (9 a.m. to 9 p.m.).

Provider Cultural Competency Training: We understand the importance of providing culturally competent care. ***In fact, in August 2018, we conducted a provider survey focused on the cultural competency of our providers*** (e.g., PCPs, OB/GYNs, specialists and behavioral health). Seventy percent of providers agreed that unaddressed cultural issues (e.g., language barriers, low health literacy or mistrust) resulted in no-adherence, lower quality of care

or avoidable ED visits. As a result, our QMC created an action plan to revise the Cultural Competence provider website to include more training options. Many of the trainings include CEU credits to encourage provider engagement. We also distributed a summary of Cultural Competency resources at recent Provider Expos along with an Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit.

Our approach to quality management (QM)/QI consists of QI projects and studies, clinical practice guidelines, health promotion/health disparities initiatives, ongoing measurement and monitoring of key clinical and service indicators, continuity of care, health plan performance analysis and auditing, service coordination, educating enrollees and physicians, risk management and compliance with all external regulatory agencies and NCQA accreditation standards.

2.10.11.4 The Proposer should submit an overview of its proposed approach to Quality Management and Quality…

2.10.11.4.1 The Proposer's current QM/QI organizational plan description, goals, quality committees, and…

We use an integrated approach to our quality structure and oversight, incorporating physical health and behavioral health programs holistically to address care and service rendered across the health care continuum. Our documented quality committee structure delineates clear accountability and inclusive participation by leaders from all functional areas within our local health plan. These leaders are empowered to act to address opportunities to improve care and service. We consider our QM/QI program to be the foundation of our health plan. Our responsibility requires a vigorous and ongoing process to identify opportunities for improvement in care practices and in the processes that support our health care delivery system. Our QM/QI program organizational plan encompasses two primary operating committees and four subcommittees that oversee and drive quality excellence at every level of the Louisiana Medicaid Managed Care Program.

Organizational Plan Supporting the QM/QI Program

The QMC is the oversight, decision-making body that is accountable for the implementation, coordination and integration of all QI/QM activities specific to Louisiana. Our QMC includes both medical and behavioral health clinical staff and operational leaders who are committed to supporting a Medicaid managed care delivery system that meets the Department's *Aims, Goals and Objectives:*

- Advance evidence-based practices, high-value care and service excellence
- Support innovation and a culture of CQI in Louisiana
- Provide enrollees ready access to care, including through nontraditional means such as medical homes and telehealth
- Improve enrollee health
- Decrease fragmentation and increase integration across providers and care settings, particularly for enrollees with behavioral health needs
- Use a population health approach to maximize enrollee health, supported by health information technology, to advance health equity and address SDOH
- Reduce complexity and administrative burden for providers and enrollees
- Align financial incentives for plans and providers and building shared capacity to improve health care quality through data and collaboration
- Minimize wasteful spending, abuse and fraud

The Louisiana QMC analyzes and evaluates the result of QI activities, recommends policy decisions, verifies that providers and enrollees are involved in the QI program, institutes needed action and makes certain appropriate follow up occurs.

Quality Management Operating Committees	Description of Quality Committee and Oversight
Board of Directors	The Board has oversight of all QM functions and provides feedback and recommendations to the QMC. **Meeting Frequency:** Annual
Quality Management Committee (QMC)	Scott Waulters, interim CEO and Dr. Julie Morial, CMO are co-chairpersons of the QMC which meets at least quarterly. This decision-making body is ultimately responsible for the implementation, coordination and integration of all QM activities for the health plan inclusive of Board-delegated decisions. QMC membership includes a designated representative from each department that is a voting member. The QMC structure includes four subcommittees that oversee and drive quality. Each subcommittee chair is a member of the QMC to provide alignment between the subcommittees and the QMC's Quality Plan. In all committees and subcommittees, medical and behavioral health concerns are integrated. **Meeting Frequency:** Quarterly and ad hoc
Provider Advisory Committee (PAC)	Dr. Julie Morial is chairperson for the PAC. The PAC is a peer-review committee with local community and hospital-based clinicians that support our efforts to improve quality of care across the care continuum. The PAC is responsible for performing peer review activities and confirming final decisions by the National Credentialing Committee (NCC). The PAC is responsible for evaluating and monitoring the quality, continuity, accessibility, availability, utilization and network cost of health care. **Meeting Frequency:** Quarterly
Healthcare Quality and Utilization Management Committee(HQUM)	Dr. Morial is chairperson of the HQUM Committee. The committee meets at least quarterly and monitors clinical QM and utilization management (UM) activities, including a review of QM activities, progress on clinical performance measures and effectiveness of PIPs. The committee monitors overutilization and underutilization issues. **Meeting Frequency:** Quarterly
Service Quality Improvement Subcommittee (SQIS)	Karl Lirette, Chief Operating Officer and Dr. Morial, are co-chairpersons of the SQIS. The SQIS meets quarterly to monitor the quality of enrollee and provider services and our overall service performance levels. The SQIS oversees delegated service functions to monitor and support improved services to enrollees and providers. **Meeting Frequency:** Quarterly
Member Advisory Committee (MAC)	Brad Grundmeyer, Director Of Marketing & Community Outreach, is chairperson for the MAC. The MAC provides enrollee and family representatives the opportunity to discuss and direct feedback on our QM program and our support of the Quality Strategy by encouraging meaningful engagement with enrollees. Our goal is to drive actionable improvements to our delivery model through member feedback and engagement. Quality is a standing agenda item on the MAC and enrollee initiatives are discussed at this committee where enrollee input is sought. This committee reports to our QMC and enrollee input from this committee is a standing agenda item. The MAC reflects the diversity of our enrolled membership vis a vis race, gender, special populations and geographic areas. **Meeting Frequency:** Quarterly

2.10.11.4.2 A description and organizational chart of its proposed QM/QI program, including a list of the…

The QM/QI program objectively monitors, systematically evaluates and effectively improves the quality and safety of clinical care and quality of services provided to all enrollees in the health plan population. The graphic illustrates the QM committee structure.

To drive clinical and operational performance improvement, the Louisiana quality team incorporates ongoing monitoring of critical quality indicators, formal performance improvement projects, ongoing application of rapid cycle improvement and *Plan-Do-Study-Act* (PDSA) method and compliance with federal and state regulations and NCQA health plan accreditation standards.

Quality Management Staffing Resources

We provide health plan leadership, dedicated to a Culture of Quality. Every employee in our health plan is part of our overall quality strategy; several enrollees of the team have direct responsibility for day-to-day management of our quality initiatives. This includes interim CEO, Scott Waulters, co-chairperson of the QMC, who has administrative oversight of the Louisiana QAPI program.

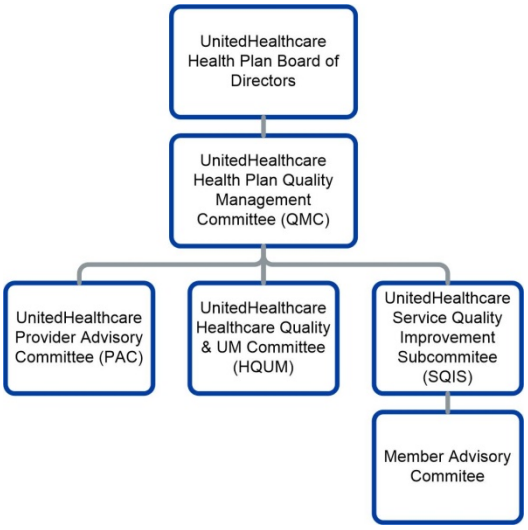


Figure 27. The Louisiana Medicaid Managed Care Program Quality Management organizational chart illustrating local oversight.

Staffing/# Staff	Description
Medical Directors (2) ▪ Chief Medical Officer ▪ Behavioral Health Medical Director	▪ **Dr. Morial** is a Louisiana licensed physician. Dr. Morial is chairperson of the PAC and is co-chairperson of the QMC as shown in the table. ▪ **Dr. Jose Calderon-Abbo** is a Louisiana licensed physician. He reports to Dr. Morial as part of our operating structure. Dr. Calderon is responsible for the behavioral health business unit and services. He has oversight of United Behavioral Health, our behavioral health services subcontractor.
▪ Provider-facing Staff (25)	Our provider-facing staff includes medical and behavioral clinical and non-clinical staff with expertise in utilization patterns, cost analysis, quality improvement process, reviewing provider performance, identifying gaps in care, tracking improvement in alignment with our value-based contracting and drive QM/QI program initiatives. As part of this staff, 12 individuals are responsible for QM: ▪ **Deb Junot Quality Management Director:** Responsible for the QM program implementation, development and strategy as it relates to our provider population and enrollee population. This position is responsible for the day-to-day operations of the program, which is inclusive of quality outcomes (HEDIS), enrollee surveys (CAHPS) PIPs as designated by the State. This position also represents the health plan at LDH state quality meetings and follows up on any State quality initiatives. ▪ **Quality Nurses:** RNs with expertise in patient safety and risk management work as part of our quality team to investigate quality of care, quality of service or critical incidents, refer and follow up on these issues with the Peer Review Committee and send patient safety trends to our PAC. ▪ **Quality Managers:** These clinicians and public health professionals closely monitor structure, process and outcomes measures over time and against our performance goals, conduct barrier analyses and implement programs to improve care and services rendered. ▪ **Quality Analysts:** Our quality analysts support our ongoing reporting needs, including verifying that our reported rates are reliable and valid and producing population health analyses to enable segmentation of enrollees based upon geography, demographics or social determinants.

2.10.11.4.3 The Proposer should demonstrate its capacity to participate in LDH's annual HEDIS performance…

We are privileged to have served Louisiana Medicaid recipients since 2012. Currently, we serve more than 442,000 Louisiana Medicaid Managed Care Program enrollees. As illustrated in the table, we have continuously improved our HEDIS and CAHPS scores, which demonstrate outcomes improvement year after year.

Year	Survey Type	Accreditation Status	Standards	HEDIS	CAHPS	Totals
July 2015	First (July 2014 – July 2017)	Accredited	48.8718	18.6357	12.4150	79.9225
August 2015	Annual Update	Accredited	48.8718	18.6357	12.4150	79.9225
August 2016	Annual Update	Commendable	48.8718	**21.4970** ↑	12.1330	**82.9890** ↑
July 2017	Renewal (July 2017 – July 2020)	Commendable	49.5420	**21.4793** ↑	12.1330	**83.1526** ↑
August 2017	Annual Update	Commendable	49.5420	**23.1846** ↑	**12.1911** ↑	**84.9177** ↑
August 2018	Annual Update	Commendable	49.5420	**23.6421** ↑	**12.8267** ↑	**86.0107** ↑

Availability of Resources

We are committed to providing the Louisiana Medicaid Managed Care Program with the resources required to continue improved outcomes and "Commendable" status as an NCQA-accredited health plan. To drive improved health outcomes we use data analytics from HEDIS, QOC, CAHPS, peer comparisons, Enrollee Gap Report, Enrollee Quality Gap Report, Utilization Report, Provider Network Accessibility/Availability Report, Provider After-Hours Report and the SDOH Report for the State. Please refer to our response to Question 2.10.11.4.2.

2.10.11.4.4 The Proposer should provide an example of a recent successful quality improvement activity; and

We conduct programs to improve the health of enrollees diagnosed with multiple or severe chronic conditions. The PIPs are a set of interventions affecting both the enrollee and practitioner that promote better care and service for enrollees who we monitor on an ongoing basis. We are committed to objectively and systematically monitoring and evaluating the quality and appropriateness of care and service provided to enrollees. To support this, PIP interventions are determined based upon the needs of the population and the State. They focus on identified clinical or non-clinical areas that specifically improve access to preventive services or health outcomes for vulnerable groups within the Medicaid population.

The table describes a recent PIP for *Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder.*

Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder
Due to the prevalence of Louisiana youth who have ADHD diagnoses and medication prescriptions, LDH tasked the five Medicaid MCOs to conduct a 3-year collaborative PIP on ADHD.
PIP Focus
To improve diagnosis and evaluation; pharmacologic and non-pharmacologic management; and care coordination. We noted evidence of improvement via intervention tracking measures and the HEDIS ADD two-part measure, "Follow-Up Care for Children Prescribed ADHD Medication." This measure was below the 95th percentile for all health plans at the start of the PIP in 2016. The third year of the PIP started July 1, 2018; the final report is slated for June 2019.
PIP Analysis
Four main interventions determined by LDH, along with the indicators for performance improvement. The

Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with Attention-Deficit Hyperactivity Disorder
foundation for our strategies was based upon results from the Integrated Practice Assessment Tool (IPAT) survey, HEDIS ADD scores and the PCP's chart reviews.
Barriers to Care
▪ Lack of PCP knowledge of assessment and intervention resources ▪ Lack of known trained practitioners in evidence-based treatments for children with ADHD ▪ Lack of PCP knowledge of the HEDIS ADHD performance measure
Care Interventions
▪ Provider-facing staff educate PCPs on resources such as the MCO sponsored American Academy of Pediatrics (AAP) ADHD Toolkit website, which includes Vanderbilt and other screening tools ▪ Parent Child Interaction Therapy classes sponsored by UnitedHealthcare to increase workforce capacity ▪ PCP education on the HEDIS ADD measure, Whole Person Care case management for children with special needs, the behavioral health provider search engine and other tools in our ADHD toolkit
Outcomes
As of the interim report in June 2018, examples of performance improvement indicators include: ▪ Validated ADHD screening instrument: **increase from 43.33% to 63.33%** ▪ Assessment of other behavioral health conditions/symptoms: **increase from 58.33% to 98.3%** ▪ PCP care coordination: **increase from 43.3% to 80%**

2.10.11.4.5 The Proposer should describe how it will identify quality improvement plans and projects to put in place, what potential topics may be, and how the Proposer will monitor the implementation and outcomes of the activity.

In alignment with the Louisiana's Quality Strategy, we have an ongoing program of PIPs that focus on clinical and non-clinical areas. They focus specifically on improvement of access to services or health outcomes for vulnerable groups within the Medicaid population. For each PIP, we establish QI work groups facilitated by our quality team and comprise subject matter experts and functional owners to oversee the PIP. When determining potential quality improvement topics, we consider the needs of the enrollee population such as health disparities, QI trends and ongoing cycles of outcomes data (e.g., HEDIS, CAHPS) along with Louisiana Quality Strategy priorities and requests. Potential topics under review include addressing improvements in our Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET) PIP and concentration on our Maternal Child outcomes and improvements. Using our process, we:

Collect Data: We collect and analyze data in alignment with the Department's Quality Strategy to use *specific, measurable, actionable, realistic and time-bound* (SMART) data clearly connected to state priorities. We review HEDIS data, utilization data, care management and disease management data, enrollee satisfaction surveys, CAHPS data and enrollee grievance data.

Review and Approve: We present the proposed PIPs to the applicable quality committee and for input and approval as part of our overall QAPI strategy to drive specific health outcomes.

Set Goals: We set valid, reliable indicators that accurately measure the theory of improvement for the PIP. We assess goals against specific baseline performance and evaluate against state or national benchmarks. Interim and final performance goals are established, and we track process metrics to verify that interventions are being implemented and progressing as planned.

Develop Interventions: After completing an analysis to identify barriers to meet performance goals, the PIP work group develops and implements interventions. The group selects interventions based upon our knowledge of the population and the effectiveness and appropriateness for the PIP population. The timing and intervention plan is also determined; the

number and percent of the population who actually receive the intervention; and, whether the intervention is conducted as expected or if issues arose that interfered with the implementation.

Analyze Changes: We conduct a quantitative analysis to determine if a rate change occurred in the original selected measurement, or if we have attained goals and benchmarks. We determine if changes are statistically significant or if they correlate to the timing of the intervention. Based upon the findings, we determine if the interventions should continue, be adjusted, or if new interventions should be developed.

Measure and Remeasure: The PIP work group monitors progress routinely, including regular re-measurement to determine if actions taken have resulted in meaningful improvement. A 3-year cycle is common, but may extend longer depending upon the topic, design and results.

Monitor Results: Interventions that result in improvement are standardized and monitored to foster sustained improvement.

Report Recommendations: We present final project reports and recommendations to the QMC and review our findings with our state partners and the External Quality Review Organization (EQRO) prior to closing and QIP activities. Additionally, we document QIPs in the format required by LDH and the EQRO and submit for regulatory review as required.

Interventions are evaluated and refined to achieve demonstrable improvement. At least annually, the appropriate QIP committee reviews the results of evaluations and recommendations.

2.10.11.5 The Proposer should submit a list of clinical practice guidelines relevant to the LDH Medicaid…

The following table provides LDH-specific clinical practice guidelines (CPGs). Please refer to Attachment 2.10.11.5-1 Sample Clinical Practice Guideline and Attachment 2.10.11.5-2 Sample Clinical Practice Guideline.

Clinical Practice Guidelines – Louisiana Medicaid Managed Care Program
▪ Guide to Clinical Preventive Services, 2014: Recommendations of the U.S. Preventive Services Task Force ▪ 2017 Recommendations for Preventive Pediatric Health Care ▪ Practice Guideline for the Treatment of Patients with Substance Use Disorders, second edition (2006); Major Depressive Disorder, Third Edition (2010); Schizophrenia, second edition (2004). In process of approval by Local and National PAC- April 2019 ▪ Guidelines for Perinatal Care, Eighth Edition ▪ 2008 Physical Activity Guidelines for Americans ▪ ASCCP Screening Guidelines for the Prevention and Early Detection of Cervical Cancer ▪ Primary Care Guidelines for the Management of Persons Infected with HIV: 2013 Update ▪ Treating Tobacco Use and Dependence: 2008 Update ▪ 2011 AHA/ACC Guidelines for Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease ▪ Effectiveness-based Guidelines for the Prevention of Cardiovascular Disease in Women 2011 Update: A Guideline from the American Heart Association ▪ 2014 Evidence-based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8) ▪ Standards of Medical Care in Diabetes – 2018 ▪ 2013 ACC/AHA Guideline for the Management of Heart Failure ▪ 2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure: An Update of the 2013 ACC/AHA ▪ 2007 National Asthma Education and Prevention Program Expert Panel Report 3 Guidelines for the Diagnosis and Management of Asthma

Clinical Practice Guidelines – Louisiana Medicaid Managed Care Program
▪ 2018 Global Strategy for the Diagnosis, Management and Prevention of COPD ▪ 2007 Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention Deficit Hyperactivity Disorder* ▪ 2011 AAP ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention-deficit Disorder in Children and Adolescents* ▪ 2011 Evidence-based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Degenerative Lumbar Spinal Stenosis ▪ Final Recommendation Statement ▪ ASCCP Screening Guidelines for the Prevention and Early Detection of Cervical Cancer ** Listed as a historical parameter*

2.10.11.5.1 The proposed process for developing and disseminating clinical practice guidelines to participating…

We adopt evidence-based CPGs, including *MCG*, which serve as the framework for clinical decisions and have proven to reduce variation in treatment resulting in optimized enrollee care and outcomes. We select CPGs from a variety of sources that address physical health and behavioral health and coordinate their development with other MCOs to avoid conflicting guidelines.

We select CPGs in consideration of our enrollees' needs and adopt them in consultation with providers and by review and approval from our integrated PAC and QMC committee enrollees. We use CPGs and best practices to select our value-based contracting quality measures. This drives improved quality and outcomes on value-based contracts and meets the individualized whole health needs of our enrollees in compliance with mental health and substance use disorder parity requirements.

The CPGs are available to providers and enrollees via our website; provider and enrollee newsletters; provider toolkits; our *Care Provider Manual* and *Enrollee Handbook*; prior authorization process and care management outreach; and initial and ongoing education. Our provider-facing staff disseminates CPGs in the course of medical record reviews, and as part of specific initiatives. For example, we incorporate the AAP 2011 CPG on ADHD into the ADHD PIP as mandated by LDH and the Island Peer Review Organization (IPRO), and is the basis for the AAP ADHD toolkit. UnitedHealthcare has collaborated with the Louisiana Chapter of the AAP, LDH and the other MCOs to co-sponsor access to the AAP ADHD Toolkit website for practitioners of any provider type. This allows all Louisiana children to benefit from proper care for ADHD disorders regardless of which practitioner or MCO provides their care.

2.10.11.5.2 How scientific evidence and the opinions of in-network and out-of-network experts and providers will…

As part of our national quality committees, our Medical Technology Assessment Committee (MTAC) and Clinical Policy & Operations Committees report to the National Medical Care Management Committee. MTAC meets at least 10 times each year to develop new policies in response to emerging technology or new treatments based upon scientific evidence. Additionally, we take the following actions to incorporate:

Expert Medical Practice: We adopt evidence-based CPGs, including MCG, and select CPGs from sources that address physical health and behavioral health. Our process for using and monitoring CPGs complies with NCQA requirements. Our CPGs align with the U.S. Department of Health & Human Services AHRQ. Our team of national physician experts reviews all new and existing CPGs at least annually. This includes:

Scientific Evidence/Expert Medical Practice CPG Resources
Disease management program guidelines from organizations, including the American Diabetes

Scientific Evidence/Expert Medical Practice CPG Resources
Association, Disease Management Association of America, American College of Obstetricians and Gynecologists (ACOG) and AHRQ
American Society of Addiction Medicine criteria for substance use disorder
Maternal child health guidelines based upon nationally accepted standards of care and key treatment elements as outlined by ACOG
CDC recommendations for screening of pregnant women infected with HIV/AIDS
Optum physical therapy guidelines
Behavioral health guidelines, which are internally developed and based upon published references from the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry and the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
HEDIS Technical Specifications
National Comprehensive Cancer Network guidelines for cancer
Guidelines for the diagnosis and management of asthma from the National Heart, Lung and Blood Institute
Numerous primary and subspecialty guidelines from national policies and standards, valid and reliable clinical evidence, and expert consensus in specific fields. For example, we follow the American Academy of Pediatrics Bright Futures recommendations for EPSDT screens

In-Network Expert/Providers: Our local PAC reviews, adopts and recommend guidelines to our National Committee to be inclusive of any local clinical practice.

Out-of-Network Experts/Providers: For our comprehensive preventive care guidelines, we have developed a Preventive Services Coverage Determination Guideline (CDG). The Preventive Services CDG is based upon guidance from the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), the Bright Futures Periodicity Schedule of the American Academy of Pediatrics and the Health Resources and Services Administration.

2.10.11.5.3 How the Proposer plans to evaluate providers' adherence to clinical practice standards and evidence…

Nationwide, we maintain processes for monitoring participating providers against established CPGs for acute, chronic and preventive care, and we use this same approach in Louisiana. This enables us to identify opportunities for reducing variation in practice patterns while supporting our participating providers by providing feedback concerning their practice. For example:

Provider Consultation: Upon implementation of new CPGs or changes to our currently adopted guidelines, we work with providers on our PAC to identify mechanisms to monitor implementation. These mechanisms include ad hoc, claims-based analyses of care rendered, or implementation of medical record review checks performed by our provider-facing staffs.

Provider Evaluation/Profiling: At least annually, we perform a formal evaluation of provider adherence to CPGs and present this evaluation report to our QMC, who makes recommendations for actions to improve adherence. Additionally, we profile the performance of our contracted health care providers to include overutilization and underutilization monitoring. We use this for quality of care monitoring and determining when a provider is not practicing in accordance with evidence-based clinical guidelines.

Provider/Practice Analyses: Ongoing, we produce provider- and practice-level analyses of clinical process and outcome indicators, primarily based upon HEDIS processes as HEDIS rates are based upon national CPGs. Monitoring this data gives us an opportunity to identify opportunities to assist our participating providers to improve tracking and outreach, resulting in

closed gaps in care that align with CPGs. In addition to any requirements outlined by our Louisiana regulatory partners, our process for using and monitoring clinical practice standards and guidelines complies with NCQA requirements. We review this process for appropriateness at least annually, and we communicate any changes promptly to our participating providers via our provider website.

Provider Interventions to Encourage Adherence

To ensure compliance with established and new clinical guidelines, we use:

HEDIS Outcomes Review: We review our outcomes data on a monthly basis and monitor the HEDIS utilization data results with our providers. The report demonstrates the gaps in the metrics and the enrollees to target to close gaps. We currently have a “per gap closed” VBP program for providers to incent quality outcomes.

Provider Education and Compliance Audit: We educate providers as we audit compliance through routine reporting and medical record reviews. Our provider-facing staff uses a variety of tools and materials included in our *Clinical Practice Consultant HEDIS Toolkit*, including gaps in care reports, when they meet with providers. At these meetings, the Clinical Practice Consultant reviews evidence-based quality performance guidelines for preventive and condition-specific care, reinforces appropriate coding and reviews documentation of care rendered.

Peer-to-Peer Consultation: We implement peer-to-peer consultation with providers when our clinical review processes indicate that a care plan may not adhere to established guidelines. In this process, the provider is educated on the guidelines and recommendations.

Provider Advisory Committee Review: If we identify a provider- or practice-specific pattern that leads to a concern that the provider is rendering care contrary to accepted guidelines and could potentially lead to adverse outcomes for our enrollees, our PAC reviews these findings for evaluation and action as needed not excluding termination of the provider.

2.10.11.5.4 The ongoing evaluation process for updating and revising the Proposer’s clinical practice guidelines…

We have adopted multiple evidence-based practices within our current service delivery model. We are committed to expanding our CPGs to include additional best practices and CPGs to meet the needs of the Louisiana Medicaid Managed Care Program populations. Throughout the development and adoption of CPGs and evidence-based practices, we discuss and review with our integrated PAC and the QMC for any recommendations and approval on an annual basis. Our national quality committees also work to develop new policies to address emerging technology or new treatments based upon scientific evidence.

We use a systematic approach to evaluate promising and evidence-informed practices. For example, we base our Transitional Care Management program upon the Coleman Model of Care Transitions. Our case managers use evidence-based motivational interviewing skills during care planning discussions with enrollees and their families. We use peer support services, evidence-based practice and care plan intervention for behavioral health recovery.

The Quality Department conducts medical records reviews on PCPs with 50 or more linked enrollees every 2 years. This review addresses CPG elements that the providers are required to perform. We report the results of these reviews to LDH on a quarterly basis and implement interventions with the providers when necessary. Additionally, we comply with all requirements related to fidelity monitoring for behavioral health CPGs (Model Contract 2.16.17.).

2.10.11.6 The Proposer should submit, as an attachment using the Quality Response Template provided in the…

Please refer to Attachment 2.10.11.6 NCQA Health Insurance Plan Ratings (2018-2019).

2.10.12 Value-Based Payment

The Proposer should propose a Value-Based Payment (VBP) Strategic Plan, including an implementation…

Demonstrating a ***culture of innovation and continuous quality improvement***, UnitedHealthcare has continued to evolve our approach to value-based payment (VBP) programs for Louisiana's Medicaid Managed Care providers in support of the Triple Aim over the last 7 years. Through participation in our VBP programs, providers overcome barriers to deliver better care to enrollees and move the needle on Louisiana's overall performance in critical health measures. To provide our enrollees the right care, at the right time, at the right place, we closely align our VBP strategy to our population health and care management strategies to help even the most vulnerable enrollees (e.g., high-risk maternal health enrollees) receive the care they need.

UnitedHealthcare's commitment to expanding VBP programs is evident in our growth in member months tied to providers engaged in VBP from 50% in 2017 to 91% in 2018.

The figure outlines our continuous development of VBP programs to meet LDH goals, and our strategic vision through 2020 and beyond. This, along with the programs discussed in 2.10.12.1 and our expansion plan in 2.10.12.3, is included in our VBP Strategic Plan, submitted to LDH annually. We will continue to abide by all State, federal and contractual requirements in the administration of VBP programs.

Through our experience across 25 states where we serve Medicaid enrollees, developing foundational payer-provider-community relationships and influencing behavior change over time is critical. As demonstrated in the figure, upon moving to a full risk plan in 2015, we added multi-level VBP arrangements for providers ready to truly drive change and improve outcomes for enrollees, based upon their size and level of sophistication.

From there, we continued to develop our offerings and engage providers — performing over 1,000 face-to-face visits in 2018 alone, to educate them about using our VBP programs.

Based upon feedback from providers, in 2018, we moved from rewarding quality on a PMPM basis to rewarding providers immediately as they close gaps. Further, though the standard national approach was to pay out incentives annually, UnitedHealthcare implemented quarterly incentive payouts in Louisiana. Providers welcomed this change, and we have already seen improvement in our quality scores. For the targeted measures in our [redacted], we closed an additional ***5,916 gaps in 2018 versus 2017*** (after normalization). In addition, 63% of group/measure combinations improved or maintained performance year over year for those targeted measures.

From 2017 to 2018, we saw a 34% increase in telehealth claims received. With the increase, we have begun implementing a telehealth hosting incentive for identified provider groups. We will reimburse host providers for coordination of the patient visit at their facility. We will continue to explore expansion in our telehealth programs, both VBP and non-VBP related, to support our providers as further outlined in the Network Management Section (2.10.8).

In 2019, we furthered our commitment to helping Louisiana providers move along the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) continuum, receiving a letter of intent from Louisiana Children's Medical Center (LCMC) to begin participating in population health data sharing. This engagement will allow LCMC to use data sharing to learn case management and build the foundation for a capitation model that we plan to launch in 2021. The outcomes of our successful collaboration with LCMC will continue to guide our strategic plan for the State, as outlined in Section 2.10.12.3. While our 3-year strategy focuses on our VBP programs, we are always willing to align or discuss alignment with multi-payer VBP models.

LDH Program Goal: Align financial incentives to meet providers where they are, improving health care quality through data and collaboration

Acting on Provider Feedback to Improve VBP Engagement

"[UnitedHealthcare] has been a great partner to work with on improving the health outcomes of our patients, and we look forward to advancing our relationship. The recent change [UnitedHealthcare] made to their [redacted] represents a preferred contracting model. The [redacted] is easy to understand, comprehensive, transparent and includes timely payments that are direct results of the quality care we are providing to our patients. – John Heaton, M.D., President of Clinical and Systems Operations, LCMC Health

2.10.12.1 The specific models and VBP arrangements the Proposer will implement to ensure that it meets the…

UnitedHealthcare has demonstrated success in, and continues to develop VBP programs that drive providers along the HCP-LAN APM continuum and has achieved LDH's vision for a healthier Louisiana. As outlined in 2.10.8.3, in 2019, we will continue to offer established programs such as our [redacted], 17-P, and Notice of Pregnancy models and expand our suite to include Hospital Performance Based Contracting, Behavioral Health, Opioid Use Disorder Quality Medication-Assisted Treatment, and Maternity Episodes programs. Beyond 2019, as outlined in our strategic plan, we will continue to push expansion into VBP for new specialties and advanced VBP models in alignment with state priorities.

We will continue to meet VBP requirements outlined in Section 2.17 of the Model Contract. Section 2.17.9 of the contract outlines LDH's preferred VBP arrangements over the next 3 years. Our current slate of programs already meets these criteria. [redacted]**. We also have preliminary CY2019 estimates. As we list each VBP**

model, we outline the expected and maximum payouts based upon CY2019. The annual estimated bonus payment could vary in future years depending on program design, provider feedback and LDH priorities.

We look forward to continued partnership with LDH as we expand our VBP footprint and programs in line with LDH priorities. In the following sections, we outline the VBP arrangements we have deployed, including APM category and targeted provider types. Through our provider support model, detailed in 2.10.12.4, we offer dedicated staff to support providers in reaching goals and intended outcomes, and provide data analytics and training sessions. We take provider feedback to heart and continue to evolve our VBP programs to align with provider needs and LDH priorities.

Performance-based Incentives (APM 2)

APM category 2 rewards many provider types with bonus payment opportunities, in addition to their fee-for-service (FFS) reimbursement, for delivering high-quality care in relation a set of HEDIS quality metrics defined by LDH in Attachment G. Providers can achieve bonuses by closing gaps in care and/or meeting and exceeding a targeted threshold of gap closure compliance rates. These incentives allow us to address specific and targeted quality measures through common incentive program methods, while offering VBP opportunities to a large volume of providers. This includes those in areas of the state with high rates of health disparities, such as East Baton Rouge, Orleans and Caddo parishes where health outcomes are consistently the lowest in the state for several quality metrics.

For many providers, this APM category serves as an entry point to a pay-for-quality environment, and we see this as a crucial engagement platform to build provider best practices that can mature into future VBP opportunities that entail greater risk at higher APM categories. Most of our performance-based incentives across all lines of business share common reporting platforms, bonus payment structure and field-based quality engagement resources. This reduces complexity for participating providers so they can focus less on administrative details of coordinating VBP programs and more on improving the quality of care delivered.

Notification of Pregnancy Incentive (HCP-LAN Category 2B)

- [redacted]
- [redacted]

This program rewards high-volume OB providers for submitting a notification of pregnancy (NOP) form to UnitedHealthcare to identify enrollees who are pregnant and who have pregnancy risk factors. When providers submit the NOP form, it triggers the enrollee's enrollment into case management where we can address prenatal risks. [redacted]. Since 2017, we have received over 11,000 NOP forms from providers to help us identify high risk and pregnant enrollees. [redacted] After program evaluation and feedback from the providers, we expanded it in 2019 to include our top 40 OB provider groups.

[redacted] (HCP-LAN Category 2C)

- [redacted]
- [redacted]

[redacted] It provides Medicaid enrollees with ready access to comprehensive wellness, prevention and care coordination services. [redacted]

[redacted]

Participating providers receive FFS reimbursement plus the opportunity to earn incentives for closing gaps in care. [redacted]

David Raines Community Health Center, an FQHC in Shreveport, was able to use incentive dollars earned through the [redacted] to add additional enrollee outreach staff. Outreach staff help close gaps in care by calling enrollees to schedule follow-up appointments — further improving the center's quality of care and outcomes for enrollees.

LDH Program Goal: Reduce complexity and administrative burden for providers

Increasing VBP participation through timely payment for improvement and user-friendly, actionable reporting

"[UnitedHealthcare] has been a great partner to work with to improve the health outcomes of our members. They have implemented the best and most comprehensive value-based incentive plan. The reports are easy to understand, and the program rewards the provider for incremental improvements, not just when we meet the target. This approach allows the providers to be awarded for any improvement in our members'/patients' outcomes." – Michael Griffin, President and CEO, Daughters of Charity

[redacted] (HCP-LAN Category 2C)

- [redacted]
- [redacted]

Implemented in Louisiana in January 2018, our [redacted] is one of the ways we work with specialists to facilitate access to comprehensive health, wellness, prevention and care coordination services for our enrollees. The program rewards qualifying OB specialist providers for closing care opportunities for certain HEDIS measures and improving birth outcomes. As part of the program, a provider can earn bonus payments for achieving or exceeding target scores for select performance measures in alignment with Attachment G. The bonus is in addition to the provider's compensation for rendering enrollee services.

We collect data through claims submission, reducing the administrative burden for providers and UnitedHealthcare. When earned, we send bonus payments to providers quarterly, as we do with our [redacted].

Behavioral Health Value-based Payment Model (HCP-LAN Category 2C)

- [redacted]
- [redacted]

Beginning in 2019, we incorporated the follow up after hospitalization for mental illness (FUH 7) HEDIS measure into our [redacted] This incentive ***facilitates integration across providers and improved care for enrollees*** by encouraging medical providers to help enrollees seek behavioral health care. It also encourages the medical provider to establish a relationship with behavioral health providers in their community so they can have a resource for future referrals. Through this incentive, PCPs work closely with behavioral health providers to coordinate vital mental health follow ups as soon as possible following a discharge. [redacted]. We believe incenting both medical and behavioral health providers with incentive dollars tied to the outcome of the same measure creates mutual incentive to collaborate following discharge. **We will continue to expand this new program based upon feedback from providers** and LDH priorities.

Opioid Use Disorder Quality Medication-Assisted Treatment Value-based Payment (HCP-LAN Category 2C)

- [redacted]
- [redacted]

We recognize the need for a comprehensive approach to prevent, identify, treat and promote ongoing recovery for those with opioid use disorder (OUD). Aligned with the Heroin and Opioid Prevention and Education (HOPE) Council goals and the Louisiana PEW Charitable Trust Recommendation 2, which focused on expanding medication-assisted treatment (MAT) capacity through care coordination and enhanced rates, we have developed a VBP program aimed at increasing access to high quality MAT and supporting enrollee retention in treatment. Given the high overdose death rate in the Orleans and Jefferson Parishes, in Q1 2019, we initiated a partnership with Daughters of Charity to launch our OUD Quality MAT pilot.

[redacted]

[redacted]

We look forward to partnering with additional high quality providers to expand our innovative OUD VBP pilots, and sharing the results of our pilots with LDH to inform the implementation of strategies to expand MAT services.

Hospital Performance Based Contracting Model (HCP-LAN Category 2C)

- [redacted]
- [redacted]

Our Hospital performance-based contracting (PBC) model is currently available for Louisiana's hospital systems. The primary objective of this model is to reward hospitals for improving the quality of care and the costs associated with that care. Quality and efficiency measures vary by hospital based upon the greatest areas of opportunity as determined from historical utilization and cost reporting. The quality measures that are available for inclusion are Hospital CAHPS (HCAHPS), Early Elective Delivery and Mortality Rate (for three conditions). [redacted]

17P (Progesterone) Incentive for OB Providers (HCP-LAN Category 2C)

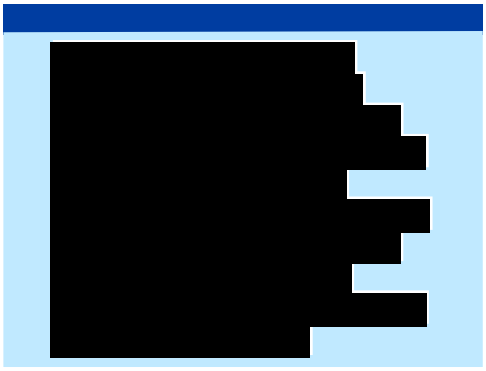
- [redacted]
- [redacted]

In January 2017, UnitedHealthcare implemented a 17-P pilot with Woman's Associates of Baton Rouge (Woman's) and Lane Medical to help high-volume OB providers lower preterm birth and align with LDH quality performance requirements. This pilot was well received by providers and in 2018, we expanded it to include our top 40 OB providers. They earn incentive payments for providing this service to our enrollees. We monitor performance through claims submission and pay the bonus quarterly, minimizing the administrative burden for providers.

Maternity Episodes (HCP-LAN Category 3a)

- [redacted]
- [redacted]

This episodic payment model has influenced the use of elective interventions (e.g., C-sections) and the use of appropriate support during labor and delivery, thereby driving a reduction in the likelihood of avoidable complications and readmissions — ultimately improving the total cost of perinatal care. In April 2019, UnitedHealthcare and Green Clinic OB physicians agreed to partner on an episode incentive program to improve maternal child outcomes.



To engage with our enrollees, we use our perinatal program, Healthy First Steps, which emphasizes enrollees' ongoing engagement with an OB provider, promotes attendance at regular visits and addresses any barriers to receiving care including assisting with setting and attending appointments. Further, beginning in May 2019, UnitedHealthcare is partnering with Louisiana Woman's Associates for Health to place a nurse in their practice. This position will address our Medicaid maternal needs and address any

barriers present for our enrollees (e.g., SDOH, behavioral health needs, appointments, referrals to our Healthy First Steps program, transportation or [redacted] needs).

Our OB case managers provide active monitoring and follow up to confirm ongoing compliance with visits for all enrollees, regardless of risks. We are initially implementing the episodes program as upside only with plans to incorporate downside risk in the future, and expand the program to include hospitals.

[redacted]

- [redacted]
- [redacted]

Shared Savings Programs (HCP-LAN Category 3a/b)

- [redacted]
- [redacted]

UnitedHealthcare's APM Category 3 programs provide financial incentives that supplement core FFS reimbursement in a way that drives a shift in mindset from volume of care to value of care. Nationally, these shared savings programs cover over 1.4 million Medicaid enrollees, account for over $4.5 billion in Medicaid spend, and 300 Medicaid shared savings providers spanning 19 states. Of those, 38% are in Louisiana.

> Louisiana providers in a shared savings program lowered their inpatient admit rate (per 1,000) by 26.8% between November 2016 and November 2018.

Our shared savings programs assist interested PCP practices to reach Patient Centered Medical Home (PCMH) recognition, drive higher quality of health and care, and seek to lower the cost of care by supporting a model focused on improving the lives and health of each enrollee. We encourage groups to have experience in the upside-only "total cost of care" shared savings model prior to taking on risk. If a group has maintained sufficient scale (i.e., meets LDH membership requirements); shown engagement in clinical transformation, process improvement, and care coordination; and generated some financial success under the terms of the shared savings agreement, we will consider them for a risk model. Outcomes influenced by this program include improve access to the PCP; reduce avoidable ED visits; reduce avoidable hospitalization; reduce avoidable readmission; more closely manage the most fragile of each engaged PCP's patients; and assure quality HEDIS measures are met.

In addition to receiving a value-based care incentive opportunity, we support our providers with a clinical model that combines consulting, data and technology. This support helps drive the activities that improve quality, reduce avoidable health care cost, and subsequently trigger incentive payments within the shared savings payment model. The support model is explained further in Question 2.10.12.4.

Accountable Care Shared Savings (ACSS-PMPM) Payment Model

Our most popular and preferred shared savings model is the Accountable Care Shared Savings (ACSS) payment model. [redacted]

Under our ACSS–PMPM program alone, we are engaged with over 65 PCP and PCMH practices across Louisiana. Through this collaboration, the shared savings program affects the lives of approximately 125,000 Louisiana Medicaid enrollees — approximately 28% of all UnitedHealthcare enrollees.

[redacted]

Capitation (HCP-LAN Category 4)

Level 4 VBP arrangements are the apex of the HCP-LAN APM continuum. One form of a Level 4 program is for groups to take full risk in the form of global capitation. The purpose of the capitation model is to support a comprehensive, population health approach by giving providers a monthly cash payment, along with timely clinical data to support proactive patient engagement and to optimally manage high-risk patients. We make capitation payments each month based upon the number of enrollees assigned to a provider group. The provider group, in turn, uses those funds to provide or arrange for the best possible care for each of their patients.

In April 2019, UnitedHealthcare and LCMC entered into a Letter of Intent to ultimately achieve a Level 4 approach to VBP and have already worked through the initial steps of the agreement.

We have agreed to a full clinically integrated network with LCMC for their physician-owned practices. [redacted]. With this direct, universal access to holistic information, LCMC can better serve their membership and learn care management. The final component is to enter into the final step of meeting a fully capitated level 4 APM agreement. We are excited with the tremendous relationship we have built with LCMC as we journey into our first Level 4 partnership in Louisiana. At this time, we cannot estimate the financial impact of this incentive as we do not have a final contract or set parameters.

LDH Program Goal: Align financial incentives for plans and providers and build shared capacity to improve health care quality through data and collaboration

"We strongly believe [UnitedHealthcare's] strategy aligns with our mission to improve the health of our patients. Because of our aligned goals, we are now entering into a Letter of Intent to fully integrate [UnitedHealthcare's] data with our systems and set the path for a more advanced risk sharing agreement. We look forward to a great partnership with UHC." – John Heaton, M.D., President of Clinical and System Operations for LCMC Health

2.10.12.2 The quantitative, measurable, clinical outcomes the Proposer seeks to improve through implementation…

We have developed our suite of VBP models to drive clinical outcomes that achieve measurable and quantitative results. Our APM approach directly aligns with the HCP-LAN APM Framework. Our continuum of programs rewards provider movement from traditional FFS arrangements (Category 1) to accountability and risk incentive models (Categories 3 and 4). All our VBP programs link quality to value through metrics aligned with the LDH's priorities outlined in Attachment G, as outlined in Section 2.10.11, Quality. We also place significant emphasis on the program's top utilization- and cost-driving conditions.

Providers on any VBP arrangement (including quality incentives) **averaged an MLR more than 17% lower** than providers not on a VBP program.

For all incentive programs, we incorporate State goals as our target measures. If there is no established State goal, then we refer to NCQA Quality Compass 50th, 75th or 90th percentile (selecting the next available percentile based upon current outcomes). We offer FFS plus reimbursement incentives for integrated care coordination for quality and value (APM Category 2), quality with shared savings/shared risk (APM Category 3), and capitated/quality and performance (APM Category 4) for ancillary providers. We also offer incentives for our providers to decrease enrollee ED use by offering after-hours or telehealth options.

Our suite of VBP offerings drives improved quality and health outcomes, as demonstrated here:

Accountable Care Shared Savings: This program targets providers committed to clinical integration and comprehensive population management. We set collaborative goals with participating providers and measure access to care, ED trends, admissions, readmissions and adverse event trends for their high-risk target populations, such as complex enrollees who are super-utilizers. As we mentioned previously, Louisiana providers in a shared savings program lowered their inpatient admit rate (per 1,000) by 26.8% between November 2016 and November 2018.

ACSS Program Success Example: Altus ACE Collaboration

Altus ACE in Texas has been a highly engaged, dynamic and innovative ACSS partner for the metro-Houston area since Jan. 1, 2017. Their four-pronged approach to closing health care gaps includes:

1) a proprietary risk stratification algorithm, 2) population health tools, 3) practitioner performance evaluation and 4) shared savings opportunities for network physicians. Collaborating with our shared savings specialist, Altus ACE consistently achieves monthly clinical integration metric goals. For example, they regularly exceed the established goal (85%) for quarterly PCP engagement with a high-risk cohort of individuals, as shown in the table.

METRIC	GOAL	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG
% high-risk cohort population seen in last 90 days	85%	98%	100%	98%	98%	100%	100%	93%	97%

[redacted]**:** This model focuses on closing gaps in care and improving quality outcomes. We make it easy for the provider to enroll in this program; our simplified approach accelerates our speed-to-market and APM membership growth. Our [redacted] is a population-health management program aimed at driving better health outcomes for our enrollees (children and adults). ***Membership in an APM Category 2 VBP has increased significantly because of this program — from 47,000 enrollees in 2017 to over 408,000 enrollees in 2018.*** Quality measures include the following key HEDIS improvement metrics aligned with Attachment G:

- ADHD Initiation, MY 2017: State goal is 44.8**; *our results are 55.26***
- Diabetic Eye Exam, MY 2017: State goal is 55.17, ***our results are 55.23, a 14.6% increase from the previous year***
- Well Child 15, MY 2017: State goal is 62.06, ***our results are 72.26***

Program outcome results during the first year include:

- After normalization, an additional 5,916 gaps were closed in 2018 versus 2017
- Sixty-three percent of group/measure combinations improved or maintained performance year over year for targeted measures
- [redacted]

Behavioral Health Programs: We currently have in place our Behavioral Health FUH VBP program, which focuses on coordination of care between PCPs and behavioral health providers. We will continue to evaluate and expand behavioral health VBP programs leveraging results in other Medicaid states where we have been successful in creating and managing behavioral health programs that work with providers to achieve measurable outcomes.

For example, we have an APM program deployed with Austin Travis County Integral Care, a central Texas community mental health center (CMHC). Our mutual goal is to reduce inpatient hospital care in a clinically appropriate manner. We evaluate the number of inpatient admissions over a 12-month period for all UnitedHealthcare enrollees treated by a CMHC. If inpatient admissions fall below the baseline measure, we agree to pay the CMHC a lump-sum bonus. These arrangements and the bonus payment serve as foundation for the CMHCs to fund their internal clinical integration activities and assist their progressive efforts in becoming a behavioral health, health home. Future iterations of the health home APM will include focus on the serious and persistent mental illness (SPMI) population, with attention to HEDIS measures of 7-day post-hospital follow up, enrollee engagement in clinic on a monthly basis, diabetes screening and reduction in adverse events.

OB Programs: Over the past year, we have focused on improving and expanding our maternal VBP programs (e.g., 17-P, [redacted], NOP and Maternity Episodes). These programs aim to prevent preterm birth, reduce infant mortality, and confirm maternal safety and appropriate care during childbirth and postpartum. The emphasis of these programs is maternal

health. Infants are included in our [redacted]

2.10.12.3 How the Proposer proposes to expand VBP arrangements over the initial years of the contract, and…

Our progress in VBP programs for Louisiana's Medicaid providers over the last 7 years has guided our approach to developing the strategic plan illustrated in the chart. This suite of programs — each of which is described in detail in Section 2.10.12.2 — will help our providers grow along the APM continuum over the next 3 years, steadily improving the efficiency and quality of care for our enrollees.

We acknowledge that Louisiana is America's least healthy state as defined in 2018 by America's Health Rankings. Our focus will continue to remain on improving the health of our enrollees. Our work to date and our strategic VBP expansion over the next 3 years will continue to improve enrollee health outcomes. ***LDH's 2018 Transparency Report ranked UnitedHealthcare first in five of eight pay for performance measures and first in 14 of 15 measures (per 2017 data).***

Through the strategic plan we have outlined here, we will continue to tailor our VBP programs for Louisiana providers, moving toward higher risk models and focusing on LDH priorities.

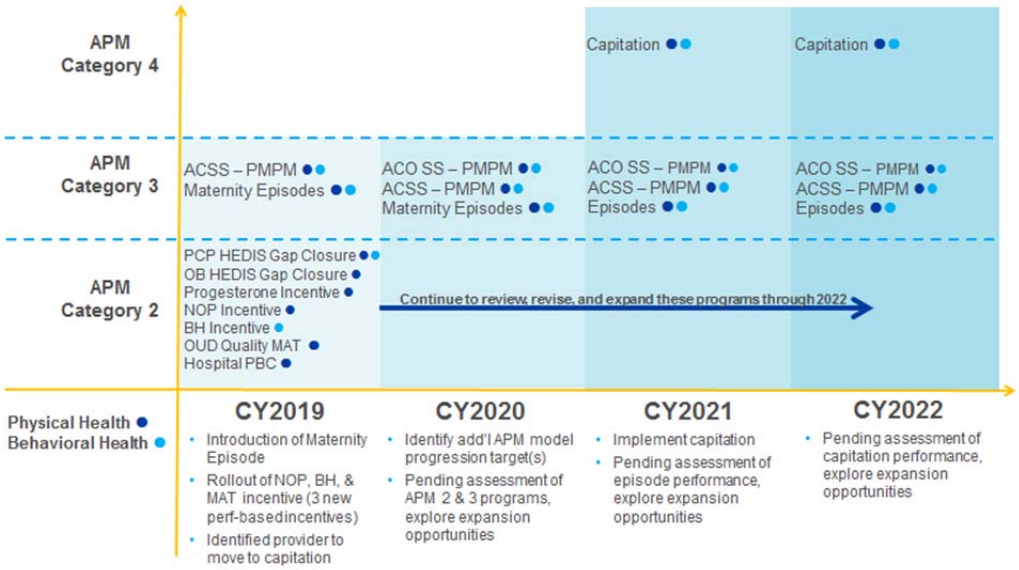


Figure 29. UnitedHealthcare Strategy for Expansion of Louisiana Medicaid Managed Care VBP Programs.

While our strategy encourages movement up the VBP risk continuum, we recognize that not all providers will be ready or able to take on episode-based reimbursement or capitation models. Therefore, we will continue offering our foundational VBP programs (APM Category 2) to those groups. This will confirm we meet LDH priorities and our enrollees receive high-quality care.

Each year we will apply the continuous quality improvement (CQI) process to apply the next evolution of VBP programs in the state. In 2019, we are continuing our flagship [redacted], which includes all provider groups with over 50 UnitedHealthcare enrollees. We also will continue our shared savings and [redacted]. Our 2018 pilots, 17-P and NOP, were well received and are being expanded to include the top 40 OB groups in 2019.

As outlined in our VBP strategic plan submitted to LDH on Aug. 15, 2018, we are on track to introduce Hospital PBC into the state in 2019. ***We have contracted with Woman's Hospital of Baton Rouge as the first practice in the state to have a Hospital PBC program.*** Lastly, we added three programs this year, Behavioral Health, OUD Quality MAT, Quality Care Incentive and Maternity Episodes. As outlined in Section 2.10.12.1, we will have already met many of the LDH's 2022 requirements by the end of CY2019.

In 2020, we will continue to move providers up the APM continuum. We are on track to implement at least one Accountable Care Organization (ACO) arrangement (as defined by LDH) by 2020. We will work with LDH to confirm our strategy and approach align with State priorities and that the targeted group(s) meets the ACO criteria. We will assess our 2019 programs (i.e., Behavioral Health, OUD Quality MAT and Maternity Episodes) based upon program effectiveness, provider feedback and alignment with LDH goals, to better understand expansion opportunities in 2020. We also will continue to partner with providers and LDH on any ongoing VBP programs, ensuring they are improving the health of our enrollees and that they continue to align with LDH priorities.

In 2021 and 2022, we plan to introduce capitation, the top of the VBP continuum, to at least one provider. To enable provider readiness to enter into full risk, we will offer the identified provider a shared savings or risk arrangement by 2021, furthering the development of total cost of care best practices and efficiencies prior to entering into a full risk arrangement. We will continue the CQI process on our VBP programs and work closely with our providers and LDH to focus on state priorities.

2.10.12.4 How the Proposer will support providers in successful delivery system reform through these payment…

To meet providers where they are on their VBP journey, we developed a set of modular incentive models that we can align with each provider's appetite for financial risk, level of integration and unique populations served. Before pairing providers with the appropriate shared risk program, we conduct an extensive review of their risk readiness that includes assessment of the provider's financial, structural and cultural capabilities necessary to succeed in a risk-sharing contract. Some examples of this review include:

- Verifying a provider has maintained sufficient scale to meet LDH membership requirements
- Confirming provider is engaged in clinical transformation, process improvement and care coordination
- Ensuring the provider has generated some financial success under the terms of the shared savings agreement

Next, we require the appropriate safeguards to be in place to facilitate success of the contract. This includes establishing requirements for provider stop loss and reinsurance, and establishing financial reserve requirements based upon the level of financial risk and the volume of services where risk is involved. Once they are engaged in VBP contracts, we provide tools and support to help providers succeed.

LDH Program Goal: Reduce complexity and administrative burden for providers

We are dedicated to supporting providers through a combination of data, analytics and targeted consulting — reducing complexity and easing administrative burden to help them succeed. We prepare benchmark and ongoing performance reports and monthly scorecards, provide enrollee-level detail through our ClaimSphere HEDIS program, develop joint clinical action plans for more advanced APM models, and conduct in-person provider visits for high-volume providers to review their data and discuss opportunities for improvement. ***In fact, LDH adopted our provider scorecard template as the standard format across MCOs.***

If we see that a provider is not achieving their targeted improvement metrics, we modify our support and identify alternative solutions to address their challenges. We provide each participating provider with scorecards showing trends in rates relative to baselines and targets for clinical quality measures, utilization metrics and total cost of care, depending upon contracted parameters. Outreach is conducted via in-person meetings, webinars, lunch and learn sessions, and email.

In addition to the IT support outlined in our response to Question 2.10.9.2, timely provider-facing reporting for our VBP programs includes the following platforms and processes, which will grow as our VBP solutions evolve to best serve Louisiana providers and achieve LDH priorities. To develop actionable quality strategies, each of these reports enable providers to roll up or drill down performance measurements at the shared savings practice, provider or enrollee levels — each applicable depending on the provider's needs. Our clinical provider-facing staff quality support teams work directly with providers to translate reporting into action plans. We also connect with our enrollees who are experiencing gaps in care to verify their assigned PCP, arrange for transportation if they need it, review the services they need, and connect them to their PCP to schedule an appointment. These tools, combined with our partnership, enable providers to understand the data we collect and employ it to improve performance.

[redacted]

Tools for Receiving/Sharing Data: To aggregate data and share it meaningfully with providers and LDH, we must first establish data connectivity as part of our VBP engagement plan through admission, discharge and transfer (ADT), structured data feeds and other methods.

Figure 30. In 2017, we created a large check campaign to share the success of our VBP program with providers.

[redacted]

As data is compiled via these tools, our data analytics and Health Care Economics Team uses the information to conduct aggregate and provider/enrollee level performance reporting based

upon quality and targeted criteria such as total cost of care readmissions, EPSDT compliance and other HEDIS measures. These analyses validate that providers submit accurate claims data, know their assigned panel and enrollees see their assigned PCPs. For example, one of our contracted providers approached us with a concern that they were closing gaps for certain HEDIS metrics, but were concerned they were not receiving the appropriate incentive payment. Through our research, we discovered the provider's claims clearinghouse was discarding the codes for the measure, meaning UnitedHealthcare was not receiving the correct data and the provider was not getting credit for the gap closure. The provider then instructed their clearinghouse to stop discarding the code. The claims clearinghouse modified their process, and the provider is now receiving their earned incentives.

Sharing Quality Measurements – Provider Support: We help providers improve performance, meet targets and build capacity so they can progress to more advanced total cost of care VBP models and practice maturity. To manage care effectively and lower costs, providers need to proactively engage their complex-needs patients, keep them out of the hospital and engage during post-discharge transitions. Our suite of online population health tools and reports allows providers to see enrollee activity across the continuum of care.

- [redacted]
- [redacted]
- [redacted]
- [redacted]

On-demand reporting on VBP/HEDIS measures and comprehensive EPSDT services is available in our provider portal, *Link*, and gap in care alerts are available via CommunityCare.

Upon request, we send files to providers via secure web transfer. We meet providers where they are in technical capability by providing data on their enrollees in a variety of formats — including raw data feeds for sophisticated providers with their own data and analytics tools, and reports and analytics platforms for providers looking for actionable recommendations and performance dashboards. For more advanced Total Cost of Care models, we partner to develop a joint clinical action plan targeting specific quality metrics and efficiency goals. Shared service providers receive both [redacted] and utilization operation reports (e.g., inpatient/ED admits, high utilizers).

We offer these additional reporting tools to our shared savings partners:

- ***Monthly Operations Report:*** Processed analytics provide actionable guidance for improving cost efficiency. This includes high-level trending and enrollee-specific opportunities. Guidance is primarily on ED, inpatient and pharmacy, lab and radiology.

- ***Performance Reporting:*** We provide reporting that updates the shared savings provider on where they stand against cost and quality targets in their incentive contract.
- ***Claims/Eligibility Data Sharing:*** Our Monthly Operations Report provides most shared savings providers with the information they need to support clinical transformation. Some shared savings providers have invested in advanced data analytics resources or capabilities, and request raw claims and eligibility data transfers from UnitedHealthcare.

For shared savings providers in Total Cost of Care models, our support is critical and surrounds the care provider, strengthening the provider/enrollee relationship.

Sharing Cost Measurements: We employ the following reporting tools and data analytics to track costs. Our consultants work with providers at all Joint Operating Committee (JOC) meetings to maximize their use of these tools.

- ***Real-Time Alerts:*** Pushed to providers through our provider portal, alerts on medical encounters signal opportunities for the provider to intervene and follow up with enrollees; alerts help manage cost drivers and manage transitions of care.
- ***Utilization Reports:*** In our JOC with providers, we share trend data on their paneled enrollees, including ED visits/1,000 and admissions/1,000. We show how they are trending, how they compare to peers and what the major drivers of change include, enabling providers to see the success of their approaches in advanced VBP models.
- ***Raw Claims Data:*** We deliver monthly raw claims data to several participating shared savings providers and we want to expand to additional shared savings providers when they are ready to receive and use the data. The data shows providers where utilization is occurring by services and by providers.

When educating our providers on our ADHD HEDIS measure, we discovered that providers schedule enrollees return visits on the 29th or 30th day. When the enrollee calls and needs to reschedule, this results in the enrollee falling out of compliance with the HEDIS requirements. When asked, providers stated they felt comfortable assessing that medication is working between 10-14 days of the initiation of the medication. We suggested providers take the following actions: 1) Write the ADHD prescription for 10-14 days of medication, and 2) schedule the return appointment to coincide with the prescription expiration date. ***This change resulted in an increase of 14.6 points in our HEDIS scores for this measure in 1 year.***

Reporting and Reconciling Payouts

As we have done in the past, we will continue to submit our VBP Strategic Plan (2.17.5) on time and as outlined by LDH. We continuously measure and monitor provider performance, utilization patterns and program costs to keep our VBP program aligned with the Department's goals. Correctly reconciling incentive payouts is critically important to providers and the overall success of any VBP program. Therefore, we apply industry-accepted accounting principles and practices to calculate and confirm accuracy of incentive payments. In Louisiana, we will continue to conduct annual payment reconciliations, to ***reduce administrative burden*** and the risk for calculation errors. Providers will have the right to dispute should they have any discrepancies with our results. Our health care economics specialist, who is a member of the Shared Savings Core Team and has financial management oversight and qualifications, performs initial calculations. The specialist then shares the data with internal stakeholders, and our network or plan leadership staff presents the findings to the appropriate shared saving leadership responsible for contract management to audit and confirm payout accuracy.

2.10.13 Claims Management and Systems and Technical Requirements

2.10.13.1 The Proposer should demonstrate its understanding of the Louisiana Medicaid program, applicable state…

LDH Program Goal: Reduce Complexity and Administrative Burden for Providers and Enrollees

We understand the requirements and the passion behind the Louisiana Medicaid program and comply with all requirements in Section 2.18 and 2.19 of the Model Contract, which focus on reducing complexity and administrative burden, meaningful provider engagement and enhanced claims processing standards. We offer the state a Louisiana-specific platform for claims adjudication that, over time, has evolved into a system that supports the accurate and efficient flow of data, and plays an essential role in achieving LDH's guiding principles of *Better Care, Better Health and Lower Costs.*

From Feb. 1, 2012 through Jan. 31, 2015, UnitedHealthcare participated in Louisiana Medicaid as a Shared Savings Plan. During this 3-year collaboration with LDH, we pre-processed provider claims, and batched them to the state's Fiscal Intermediary via HIPAA 837 encounter files for payment consideration. If our 837 files were not perfect, our providers were not paid. We learned every detail of the State claims processing system to ensure our encounters were accepted and our provider's claims were paid.

Our high encounter rates of 97.98% (March 2019) demonstrate that our MIS is configured to meet LDH requirements. We are exceeding the current requirement of 95% and are in a well positioned to achieve a 99% encounter rate under the Model Contract.

Upon winning the 2015 bid to continue serving Louisiana Medicaid, this time as a full-risk MCO, we used our 3 years of acquired knowledge to customize a claims processing system that emulates the State's so closely that we have been asked to assist other MCOs to attain the same levels of encounter acceptance. Our system not only addresses applicable administrative rules and statutes, but also removes administrative burdens to providers where Louisiana regulations allow. Through weekly internal meetings with our Claims, Configuration, Recoupments, Encounters and Provider Data Teams, we collaborated with LDH to continually evolve our system. As LDH's needs advanced, we were pushed to improve our ability to be operationally nimble and responsive to program changes and ultimately, to verify alignment of our Management Information System (MIS) and technology to the State's needs. For example:

Program Changes	Description
Reimbursement Policies	We incorporate LDH-specific administrative exceptions to our reimbursement policies to ensure compliance, including: ambulance, anesthesia, CLIA, drug testing, multiple procedure reductions, new patient visits, obstetric services, professional/technical and readmission policy
Advisor	As good stewards of state resources, we also advise LDH of industry-standard best practices to consider for Louisiana Medicaid to streamline claims and encounter processing, improve LDH data collection and reduce unneeded expenses
Drug Testing Policy Proposal	We presented an initial proposal and associated savings to LDH, then collaborated with all MCOs to present a coordinated proposal that would generate over $1 million in savings for UnitedHealthcare membership alone, while continuing to provide all necessary services to affected members. Proposal is currently pending LDH approval
CLIA Policy Proposal	In response to a negative LDH audit by the Louisiana Legislative Auditors (LLA), in an effort to make sure MCOs can provide LDH with the most comprehensive and positive CLIA-related claims data possible, UnitedHealthcare proposed an immediate change in the current LDH strategy that prohibits providers from including CLIA

Program Changes	Description
	identification numbers on claims. Proposed — allow MCOs to require CLIA identification numbers on claims. Result — MCOs can accurately deny inappropriately billed claims, and educate providers for future claim submissions. Ultimately, future LLA audits of LDH will find favorable, positive results.
CPT II Code Acceptance on Encounters	CPT IIs are supplemental tracking codes. While not reimbursable, they can: 1) reduce chart requests; 2) improve physician and MCO HEDIS performance; 3) improve health outcomes; and 4) eliminate unnecessary member mailings/reminders. Historically, encounters with CPT II codes were rejected. Since this data is valuable to providers, MCOs and the State, LDH accepted our proposal to accept CPT IIs on encounters. Additional benefit — increased MCO encounter acceptance rates.

2.10.13.2 The Proposer should describe in detail the Management Information System (MIS) it proposes to use in…

UnitedHealthcare's MIS is fully compliant with the requirements of the Model Contract.

Led by Susan Mieras, Health Plan Performance Director, and our dedicated Information Technology (IT) Support Team, consisting of approximately 63 IT professionals, we maintain a solution that integrates disparate technologies and data sources.

Systems Overview

At the center of our MIS architecture— is the Community Strategic Platform (CSP). Using the latest Oracle Exadata Database platform, CSP is our TriZetto Facets claims platform and includes interfaces that optimize the exchange of information to other key systems. The Oracle Exadata platform is the most advanced hardware for managing database loads, providing for the fastest in-memory databases with redundant hardware and fastest failure recovery times possible. With this hardware, we go from measuring time for recovery for system outages to measuring mean time between zero-outage component failures. The Exadata platform provides capability for zero planned downtime for hardware maintenance. CSP is co-resident on the Exadata platform with our SMART data warehouse and our NEMIS encounters reporting system, improving data freshness for reporting from a day, or weeks to as little as real time.

Using CSP, our IT team configures business rules such as claims payment of specific program services, authorization requirements, benefit limits and reporting requirements. Our system captures and reports multiple data elements critical to an effective enrollment process. It accommodates fee schedules, procedure and types of service coding. CSP validates data fields including edits to smooth the process for payment and operations. Our managed care information system applications work in concert with CSP to provide care coordination, encounter data submission capabilities, online provider and enrollee support solutions, and reporting and analytics capabilities. Our systems are fully interoperable and fluidly exchange information, allowing us to adapt to support current and future requirements.

We are dedicated to continuous improvement by investing in information systems — people, process and technology. Between now and the January 2020 go live, we are making significant investments in the platform underpinning our MIS to keep us on the leading edge of technology and capabilities. Here is a summary of planned infrastructure upgrades:

Systems	Planned Infrastructure Upgrades
Myuhc.com	In January 2019, we implemented upgrades to the digital experience for our enrollee portal, *myuhc.com*, offering easier navigation, increased personalization, dedicated health and wellness content, and many other enhancements. A significant new convenience feature is the ability for enrollees to easily change their PCP online. In 2018, we implemented enhancements to our online registration/login (HealthSafe ID™) and our Provider Search to offer a more robust enrollee experience. We conduct ongoing website usability testing and make

Systems	Planned Infrastructure Upgrades
	regular enhancements to improve the enrollee experience.
Mobile app	Mobile app for enrollees went live January 2019
Upgrades to Facets	To maintain support and compliance, we upgrade CSP twice a year to the most recent, leading-edge version of Facets. In 2019, we will upgrade CSP to Facets 5.6.
Eligibility Enrollment Management System (EEMS)	EEMS will go live in Q4 2019 providing greater flexibility for eligibility sources, improved speed to market for format changes, reduced maintenance costs and continued top of the line end-to-end cycle time for loading eligibility
ClaimSphere™	Cognizant's NCQA-certified HEDIS solution for prospective analytics helps us better and more quickly uncover the root cause for low HEDIS scores and take action. Care gap and performance reports from ClaimSphere HEDIS summarize quality of care delivered by providers and highlight any care disparities. Multiple standard reports and ad hoc analytics are available for follow-up action planning.
Clinical Platform	We currently use ICUE and CommunityCare, delivering clinician-facing web-based platforms that deliver an integrated experience to our enrollees and the health care communities that support them. Our clinicians can view an enrollee's entire engagement with UnitedHealthcare — past and present.
Link Portal	We continue to improve the provider experience by enhancing our provider portal, *Link*, a cloud-based platform that offers an array of native applications and a simplified way of doing business with UnitedHealthcare. This includes the My Practice Profile (MPP) application, which allows providers to initiate demographic updates online, and prompts them to attest to the accuracy of demographics every 90 days. In 2019, per the request of LDH, MPP will include an option for providers to trigger an accepting-new-patients indicator by location and product.

2.10.13.2.1 The length of time the Proposer has been utilizing the MIS proposed for the Contract; if for fewer than…

UnitedHealthcare has used our current MIS to support LDH since our transition to a full-risk MCO in February 2015. We maintain system scalability, stability and performance through a combination of load balancing software, advanced hardware and cloud and virtualization capabilities for our systems. A formal and auditable process, including structured submissions, required artifacts, scheduled review meetings, rigorous testing and approval dates, guides our change management processes. This allows us to implement high volumes of changes, while at the same time protecting the integrity and stability of our system environment. Additionally, we own and manage all of our data centers and rely on internal resources for recovery. We maintain formal disaster recovery plans for our critical technology and systems infrastructure and systems components supporting our most critical business functions. We review, assess and update our disaster recovery plans at least annually or more often as changes to systems occur. We continue to increase our footprint of virtualized servers and we have implemented a secure private cloud environment for applications such as our *Link* provider portal.

2.10.13.2.2 Hardware and system architecture specifications for all systems that would be used to support the…

Hardware and System Architecture Specifications

The following exhibit presents the components of our managed care information system and the relationship between these systems as are deployed in support of the State's Medicaid program. The system uses logging, journaling and audit tables to maintain a record of all transactions and data within each application. Our platforms actively store a minimum of 6 years of historical information including membership, eligibility and claims data for audit and reporting purposes and 10 years in archival systems. Our managed care information system comprises multiple systems strategically interfaced to support the delivery and management of integrated health care services. Categorized into main functional areas, the following table provides brief

descriptions of our main information systems. We have provided data and process flows for all key business processes within our response to **Question 2.10.13.2.4**

Information System	General Description/Functions Supported by System
1. Area: Clinical Information, Care Coordination, Utilization Management and Electronic Care Management Systems	
CommunityCare	
This tool enables care management and coordination, medication management and quality management by giving providers updated and shared access to patients' individual plan of care and supports alignment of clinical problems, goals and interventions. It provides electronic access for the care team, providers, specialists, caregivers and others. Containing claims information from CSP and authorization data from ICUE, CommunityCare includes our Population Registry and gives providers and care communities a comprehensive view of the services used by any given care population. Using the *enrollee view* within the Population Registry, providers have the clinical history of the whole person. CommunityCare: Provides automated notifications of care transitions; receives authorizations from ICUE for reference by the care team; supports DIRECT for secure clinical data exchange with providers and HIEs; supports import, parsing and attachment of C-CDA, ADT, LOINC and other standard format. **Hardware Configuration:** Web Tier: Vendor Hosted; App Tier: Vendor Hosted; Presentation: Vendor Hosted; Software: Vendor	
ICUE	
ICUE (Integrated Clinical User Experience) is our clinician-facing web-based clinical platform that delivers a coordinated, integrated experience to our enrollee and the health care communities that support them. ICUE features consolidated data, functions and user experience and serves as a single source of truth for clinical operations transactional data. System users have access to all of the categories of data they need, such as enrollee eligibility, benefits, provider information, claims data and clinical resources. **Hardware Configuration:** Web Tier: UNIX/IHS; App Tier: UNIX/WAS; Presentation: UNIX/Oracle; Software: Java	
ClaimSphere HEDIS	
ClaimSphere™ HEDIS is Cognizant's NCQA-certified HEDIS solution. It provides the foundation for medical quality management and improvement programs like provider profiling and gaps-in-care analysis. It performs detailed measure analysis with access to enrollee detail and information on specific enrollees qualified for each measure. Standard system views provide insight through analysis, gaps-in-care reporting, provider scorecards and drill down capabilities. We broadcast gaps in care via our secure provider and enrollee portals, mobile app, EDI eligibility transactions and CommunityCare.	
2. Area: Enrollee and Enrollment Data Management	
Consumer Database (CDB)	
CDB is a consolidated database of all UnitedHealthcare enrollees that serves as a "master index" of enrollees across all UnitedHealthcare systems. **Hardware Configuration:** Web Tier: UNIX/IHS; App Tier: UNIX/WAS; Presentation: UNIX/Mainframe; Software: Initiate (Vendor)	
CSP Customer Call Center – Member	
Supports enrollee services center operations in assisting enrollees with common inquiries (e.g., obtaining ID cards and searches for providers)	
Interactive Voice Response (IVR) System and Avaya Dialer	
Handles basic enrollee inquiries and directs incoming calls to the most appropriate enrollee services center professional. **Hardware Configuration:** Web Tier: Avaya (Vendor); App Tier: Avaya (Vendor); Presentation: Avaya (Vendor); Software: Avaya (Vendor)	
Provider Recommendation Engine (PRE)	
PRE is an intelligent rules engine that systematically matches enrollees who have not selected a PCP with "preferred" PCPs who have the highest quality scores and best outcomes, costs and location for enrollees. It also references historical enrollee, PCP, family PCP, and claims history to narrow its recommendation of "preferred" PCPs. PRE supports the State's "Patient Assignment Initiative," identifying enrollees who have not received services from their linked PCP, and transitioning them to the PCP who is actually serving them.	

Information System	General Description/Functions Supported by System
Hardware Configuration: Web Tier: Intel/Linux; App Tier: Intel/Linux; Presentation: Intel/Linux/Azure Pack SQL DB; Software: .NET	
Public Enrollee Portal (*uhccommunityplan.com*)	
UnitedHealthcare public web presence used for posting general information, handbooks and bulletins — common entry point for enrollees. The portal provides flexible search capability by type of provider, specialty, location and other criteria. **Hardware Configuration:** Web Tier: Intel/Linux; App Tier: Intel/Linux; Presentation: None; Software: Adobe (AEM)	
Secure Enrollee Portal (*myuhc.com*)	
Secure health and wellness information is available 24 hours a day, 7 days a week through our enrollee portal. Enrollees register for online access by setting up a secure HealthSafe ID™ and password. The personalized and easy-to-navigate digital experience allows enrollees to search for covered benefits, manage personal preferences, update contact information (including email addresses for facilitating contacts and information exchange), view/print and request ID cards, change their PCP and locate providers through a searchable *Provider Directory.* The portal also offers personalized health and wellness content such as seasonal reminders (i.e., flu shots), personalized care recommendations, links to plan programs (e.g., Healthy First Steps, transportation) and links to online resources, tools and community-based services. **Hardware Configuration:** Web Tier: Intel/Linux; App Tier: Intel/Linux; Presentation: None; Software: Adobe (AEM)	
Secure Enrollee Mobile app	
The free enrollee mobile app provides personalized care notifications, medication management capabilities, administrative transactions, access to local resources and connects users with a member services advocate	
3. Area: Provider Network Management and Credentialing	
CSP Customer Call Center – Provider	
Supports enrollee services center operations in assisting providers with common inquiries (e.g., verifying enrollee eligibility and verifying claims status)	
Interactive Voice Response (IVR) System	
Enterprise voice portal handles basic provider inquiries (e.g., enrollee eligibility/enrollment status and claims status) and directs incoming calls to the most appropriate provider services center professional. **Hardware Configuration:** Web Tier: n/A; App Tier: Wintel/ICM; Presentation: Unix/AIX/DB2; Software: Cisco/Java	
Network Database (NDB)	
NDB is our single enterprise repository for provider network management. **Hardware Configuration:** Web Tier: Unix/Mainframe; App Tier: Unix/Mainframe; Presentation: Unix/Mainframe DB2; Software: COBOL	
Link	
Secure provider portal providing a central access point where enrolled providers have access to eligibility and benefits, claims management, claims reconsiderations, enhanced online authorizations and gaps in care, and where they can update their practice profile including demographic and “accepting new patient” updates specific to the Louisiana Medicaid Managed Care Program. Additionally, providers can view and provide feedback on the health needs assessment and individual plans of care in CommunityCare. **Hardware Configuration:** Web Tier: Intel/Linux; App Tier: Intel/Linux; Presentation: UNIX/Oracle; Software: Java	
UHCprovider.com	
UHCprovider.com is UnitedHealthcare’s home for provider information. With access to *Link’s* self-service tools 24 hours a day, 7 days a week, current medical policies and the latest news bulletins, this site also has a library of resources to support administrative tasks including eligibility, claims and prior authorizations and notifications. *UHCprovider.com* includes a powerful internal search tool to help care providers locate the information they need quickly. The site also offers care providers the opportunity to submit feedback on their experience to help identify opportunities to improve or enhance how we work together. **Hardware Configuration:** Web Tier: Intel/Linux/Apache; App Tier: Intel/Linux/WAS; Presentation: n/a; Software: Java	

Information System	General Description/Functions Supported by System
4. Area: Claims Processing and Payment	
CSP	
CSP is an integrated managed care information system built on the TriZetto Facets platform, which meets all applicable state and federal laws and privacy regulations including, but not limited to, HIPAA. Functions include, core health-plan administration system's primary functions such as benefits, enrollment and disenrollment management, claims pricing, adjudication and payment. Comprehensive enrollee database, using Medicaid state ID numbers, including eligibility begin and end dates. Age-specific information and enrollment history. Enrollee TPL coverage, utilization and expenditure information. Integrated claim processing suite including claim edits, adjudication, COB processing, rules-based correction/adjustment, voiding and resubmission. Claim status data including incurred claims, processing status and payment timeliness data. Documents distribution of capitation payments. Generates explanation of benefits and remittance advice. Data for provider payment issuance purposes. **Hardware Configuration:** Web Tier: Intel/Linux; App Tier: Intel/Linux; Presentation: Exadata LINUX/Oracle; Software: Trizetto (Vendor)	
Optum Transaction Validation Manager (OTVM)	
Electronic data interchange (EDI) validation that enables us to test and certify HIPAA transaction sets and verify compliance with standards and regulations on inbound claims	
Escalation Tracking System (ETS)	
ETS facilitates administration, escalation management and processing of claim disputes, grievances and appeals. ETS: Manages, provides status, and tracks resolution on submitted grievances and appeals against policy-mandated time frames for enrollee contact and appeal or grievance resolution; generates reports related to the outcomes of grievances, complaints and appeals; provides flexibility to easily customize data elements according to State needs. Hardware Configuration: Web Tier: Wintel MS Visual Studio; App Tier: Wintel ASP.NET SSIS; Presentation: Wintel SQL Server; Software: ASP.NET	
Care Provider Early Warning System (CP-EWS)	
Tool that scans for unusual patterns in claims receipts, denials, rejections and cash paid at the state and provider level. CP-EWS allows immediate/on-time reaction to sudden changes in claim denial patterns, initiating immediate outreach to provider, notifying them of reason and remediation opportunities for incoming claim denials. Allows for proactive provider outreach in support of Act 710.	
MACESS	
MACESS is a workflow application that facilitates claim processing, including viewing of paper claims and supporting documentation in EDMS, and routing of claims to claim processors. **Hardware Configuration:** Web Tier: Wintel Sunguard; App Tier: Wintel ASP; Presentation: Wintel SQL SVR; Software: FSG (Vendor)	
Claims Rule Engine (CRE)	
Enables claim edits based upon configurable business rules that are quick to modify and deploy. Edits range from provider validation to CPT code-based rules.	
WebStrat	
WebStrat calculates reimbursement using diagnosis-related groups (DRGs) and ambulatory procedural classifications (APCs). Ready for future deployment. **Hardware Configuration:** Web Tier: Wintel/UNIX; App Tier: Wintel/NT UNIX WAS; Presentation: Wintel/SQL SVR Unix/Sybase; Software: .NET/Java	
5. Area: Information Reporting	
Strategic Management Analytic Reporting Tool (SMART)	
SMART is a comprehensive, integrated analytical data warehouse, using the latest Oracle Exadata Database platform that holds all Medicaid relevant information — including claims data (e.g., medical, pharmacy, vision and lab) and historical enrollee claims data from LDH, enrollee data, provider data, authorizations, external subcontractor data and predictive modeling information. SMART: Supports quality management, performance management and compliance reporting and ad hoc reporting on an "as needed" basis with turnaround times averaging less than 5 business days. Stores service-specific data that includes behavioral health, pharmacy, inpatient and outpatient services and includes consolidated patient census (common store of all patients receiving care). Consolidates relevant data for ClaimSphere EPSDT and HEDIS reporting and related analysis and monitoring.	

Information System	General Description/Functions Supported by System
Hardware Configuration: Web Tier: Unix/AIX; App Tier: Unix/AIX; Presentation: Exadata LINUX/Oracle; Software: Oracle	
Reporting Portal	
The reporting portal is an end-user interface to our custom Medicaid data warehouse, SMART. This feature has an option that can provide LDH staff access to actionable information including two types of reports: 1) contractual and "canned" reports that can be downloaded by the user, and 2) downloadable ad hoc reports that support utilization and trending inquiries	
6. Area: Financial, Capitation and Encounter Submission Management	
National Encounter Management Information System (NEMIS)	
NEMIS is our strategic, internally developed encounter data submission and reporting system that initiates submission of encounters, tracks responses, provides error correction and resubmission of Medicaid encounters to LDH in a format specified by the Medicaid Managed Care Program. **Hardware Configuration:** Web Tier: Intel/Linux; App Tier: Intel/Linux; Presentation: Intel/LINUX/DB2; Software: Java	
PeopleSoft	
Enterprise financial management solution containing several modules: general ledger, asset management, purchasing, accounts payable and accounts receivables, to provide a consolidated view of financial data. **Hardware:** Web Tier: Intel/Linux; App Tier: Intel/Linux; Presentation: Intel/Linux; Software: Axway	
7. Area: Information Technology Support	
B2B/External Customer Gateway (ECG)	
Suite of tools supports secure EDI transactions/file transfers between UnitedHealthcare and external parties	
ServiceNow	
Comprehensive tool that supports our UnitedHealthcare Support Center and information technology service management processes, including system monitoring and reporting of critical incidents	

Systems Used to Support the Contract

The CSP is the claims processing centerpiece of our information system. Our Louisiana Medicaid program platform is built on our CSP core transaction processing system, which provides eligibility, enrollment, claims processing, benefits configuration, capitation, reporting capabilities and the source data for our encounter submissions. CSP includes interfaces that optimize the transport of information to other key subsystems. These subsystems are fully interoperable and fluidly exchange information, allowing us to adapt to support current and future requirements. We present the following key features of our main information systems components and describe how they support the key organizational functions. They include:

System/Subsystem	Description (Correspond to Process Flows in Question 2.10.13.2.4)
Enrollment/Eligibility Subsystem	
We process daily/monthly electronic data transmissions from LDH (via Maximus) for Louisiana Medicaid enrollees, including additions, deletions and modifications to the program's enrollment. The enrollment processing establishes begin and end dates for enrollees under their current program eligibility category, while maintaining the integrity of information and feeding benefits and finance subsystems, among others.	
Claims Processing and Encounters (Subsystem)	
We capture the claim-received date and assign a unique claim number for all incoming claims. Data edits are applied to validate data is compliant, complete, accurate and appropriate under contract terms. Claims with invalid data points are rejected/denied, and those with valid data are adjudicated. Using our Escalation Tracking System (ETS), we store all grievance/appeals activity. As presented in the End-to-End Encounter Process Flow diagram (Question 2.10.13.2.4), we extract encounter data from our claims platform and load the data into NEMIS. We require claims files from all external vendors to submit encounter data to LDH. We maintain/review reports to reconcile financial fields of a claim with the financial fields of adjudicated encounters. The Encounter Team is responsible for running reports to confirm all data sent validating the	

System/Subsystem	Description (Correspond to Process Flows in Question 2.10.13.2.4)

claims system reconciles to the encounter submission reports and verifying the financial fields of a claim match the financial fields of adjudicated encounters.

Our CSP transaction processing system, which houses our claims data, serves as the main data source for encounter data extracts. CSP uniquely identifies claims submitted by the service provider based upon the submitted NPI and edits claims to make certain all data necessary to identify the pay-to-provider and process the claim to payment are present. CSP details a real-time history of actions taken on each claim. Based upon adjudicated claims data from CSP, we collect and format encounters data in HIPAA transaction formats and code sets through NEMIS, our encounter data submission and reporting system. NEMIS processes encounters across the breadth of our Medicaid businesses and initiates submission, tracks responses and provides error correction, reconciliation and resubmission of Medicaid encounters.

Customer Services

- **Telephone Management System/Member Services:** Call center technologies manage the flow of all incoming calls to provide timely responses to member inquiries. Automatic call distribution and IVR skill-based and priority call routing successfully link Louisiana Medicaid enrollees with member services advocates (MSAs) trained on the Louisiana program and ready to assist. Our innovative "natural language" capability recognizes more than 70,000 keywords and can categorize the call based upon the member's statement. Collectively, information accessed is used to connect the member with the most appropriate resource. The system also allows management staff to balance workload among MSRs on a real-time basis and facilitate the transfer of calls to other staff to address specific issues or concerns, as appropriate. All MSRs have desktop access to view information on each family member, including benefits, HEDIS gaps in care, provider information, claims and utilization. MSRs respond to LDH enrollee questions using relevant information, including any recent visits to the doctor or ED, interactions with our Care Management Team, and any recent family member calls.
- **Telephone Management System/Provider Services Call Center:** Our toll-free provider services call center responds quickly to provider inquiries. Provider phone representatives (PPRs), specifically trained in the Louisiana Medicaid Program, staff the call center. Each time a provider calls, they speak with a dedicated PPR thoroughly trained in provider processes and the expected caller needs. Our toll-free call center is open 24 hours a day, 7 days a week.

Utilization Management/Service Authorization

- **Utilization Management/Service Authorization:** Through our utilization management (UM) program, we gather quality measures, prior authorizations, clinical and claims data, and data from providers or subcontractors. We continuously monitor and manage overutilization/underutilization of services across our health plan using reporting, dashboards and scorecards developed from data gathered and analyzed by our SMART data warehouse. SMART links with and receives data from our clinical management system, ICUE, which provides an integrated, single solution for managing service authorizations for physical/behavioral health services. Providers can submit prior authorization requests for new or continuing medical/behavioral health services 24 hours a day, via telephone or through our secure provider portal. Providers can verify approvals, obtain real-time online verification of membership through the portal, view gaps in care using CommunityCare, *Link*, and within the provider's practice management system with 270/271 EDI integration.
- **Care Management/Care Coordination:** An interdisciplinary care management (CM) approach is central to our clinical model. We provide the tools to support the enrollee, PCP, case managers and the Care Coordination Team. CommunityCare, a CM collaboration platform, provides PCP information, enrollee Medicaid ID, a record of each service event, appointments, immunizations, a listing of the enrollee's durable medical equipment (DME) along with the ability to capture notes and store attachments. CommunityCare integrates evidence-based medicine gaps in care and hospital admission, discharge and transfer (ADT) messaging and allows providers to track interactions with enrollees such as post-ED discharge follow up and care opportunity outreach. Our UM system, the ICUE platform, is the system of record for medical service authorization data and coordination of behavioral health services. We use enrollee and authorization data based upon transactions processed in ICUE and passed back to CSP for claims management and CommunityCare for CM activities. Our care team uses ClaimSphere to identify gaps in care based upon EPSDT or HEDIS criteria for age, sex and frequency of services. We share these results

System/Subsystem	Description (Correspond to Process Flows in Question 2.10.13.2.4)
	in CommunityCare, so in addition to population wide queries based upon specific measures, CommunityCare enables viewing of individual enrollee's gaps in care. For example, during interaction with an enrollee, a case manager can view an enrollee's record to identify any gaps in care or other reminders.
Financial Systems (Subsystem)	
We configure CSP and the finance subsystems to facilitate prompt payment to providers. We send HIPAA compliant explanation of benefits (EOB). Our Finance and Management Information Systems Teams monitor reports through NEMIS and CSP to verify: 1) all data sent to LDH; 2) the CSP claims system reconciles to the encounter submission reports; and 3) the financial fields of claims match the financial fields of adjudicated encounters. We create general ledger transactions in CSP and integrate into our enterprise resource management application, PeopleSoft. All financial transactions are auditable according to generally accepted accounting principles (GAAP) and supported by Sarbanes-Oxley (SOX) and SSAE 16 controls.	

2.10.13.2.3 All proposed functions and data interfaces;

As demonstrated through our current participation in the Louisiana Medicaid Program, we are capable of supporting numerous types and levels of information processing and data exchange. We have provided data interfaces and process flows for all key business processes within our response to **Questions 2.10.13.2.2 and 2.10.13.2.4.**

2.10.13.2.4 Data and process flows for all key business processes; and

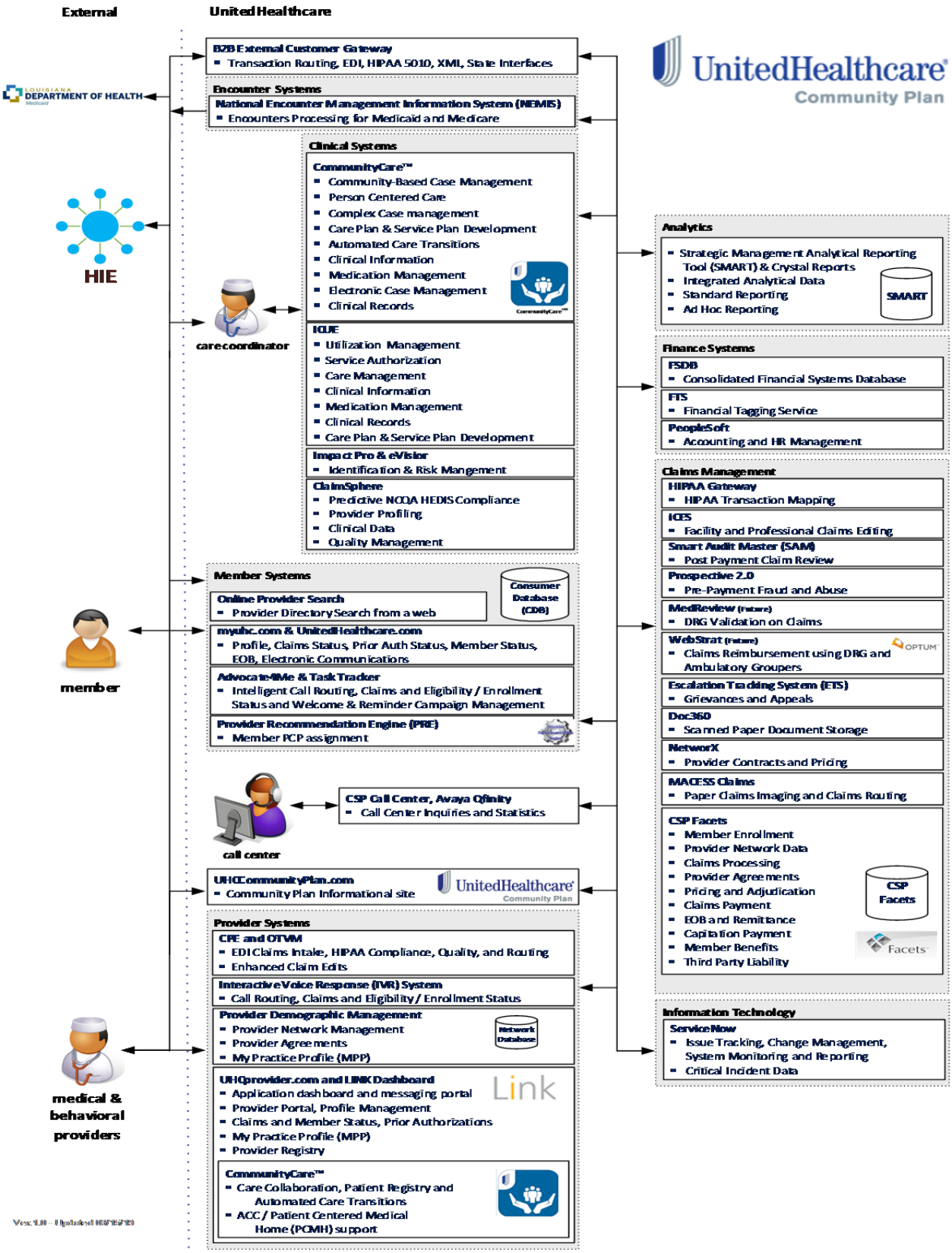


Figure 31. Architectural Diagram. Our Louisiana system is customized to meet state requirements. It is fully interoperable and fluidly exchange information, allowing us to support future needs.

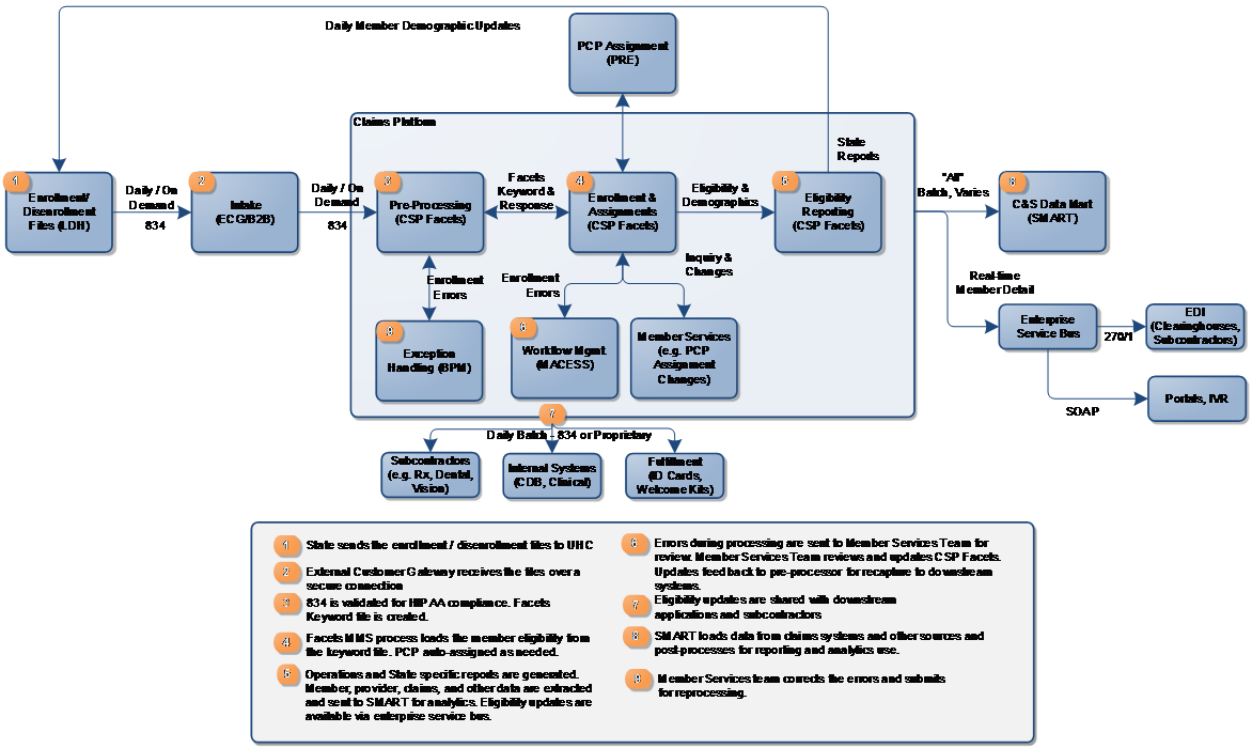


Figure 32. Enrollment/Eligibility Subsystem Flow. Our end-to-end enrollment flow validates inbound 834 files for HIPAA compliance, and loads the data into our CSP system.

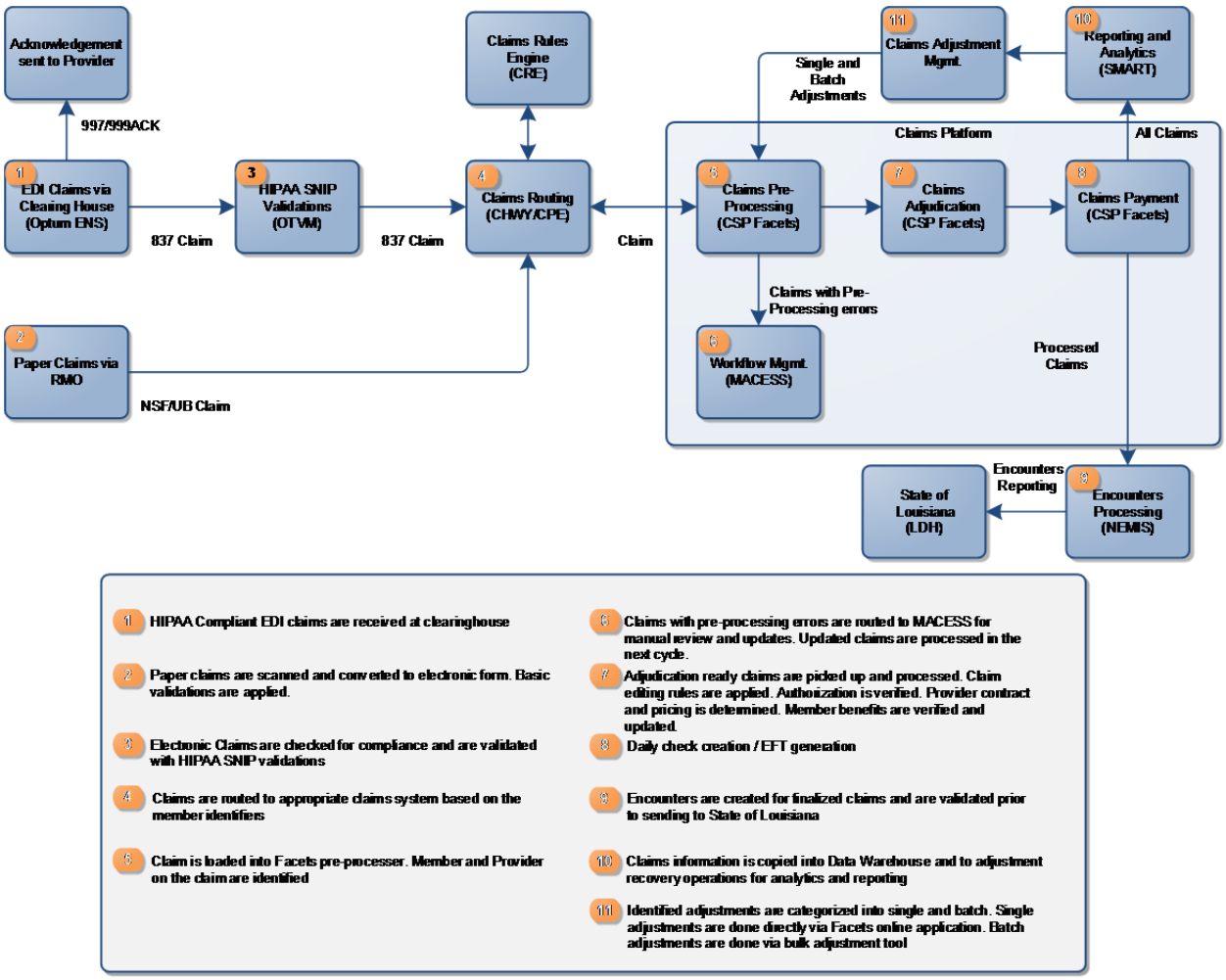


Figure 33. Claims Processing and Encounters. We receive via EDI, portal and paper, and load the data into CSP.

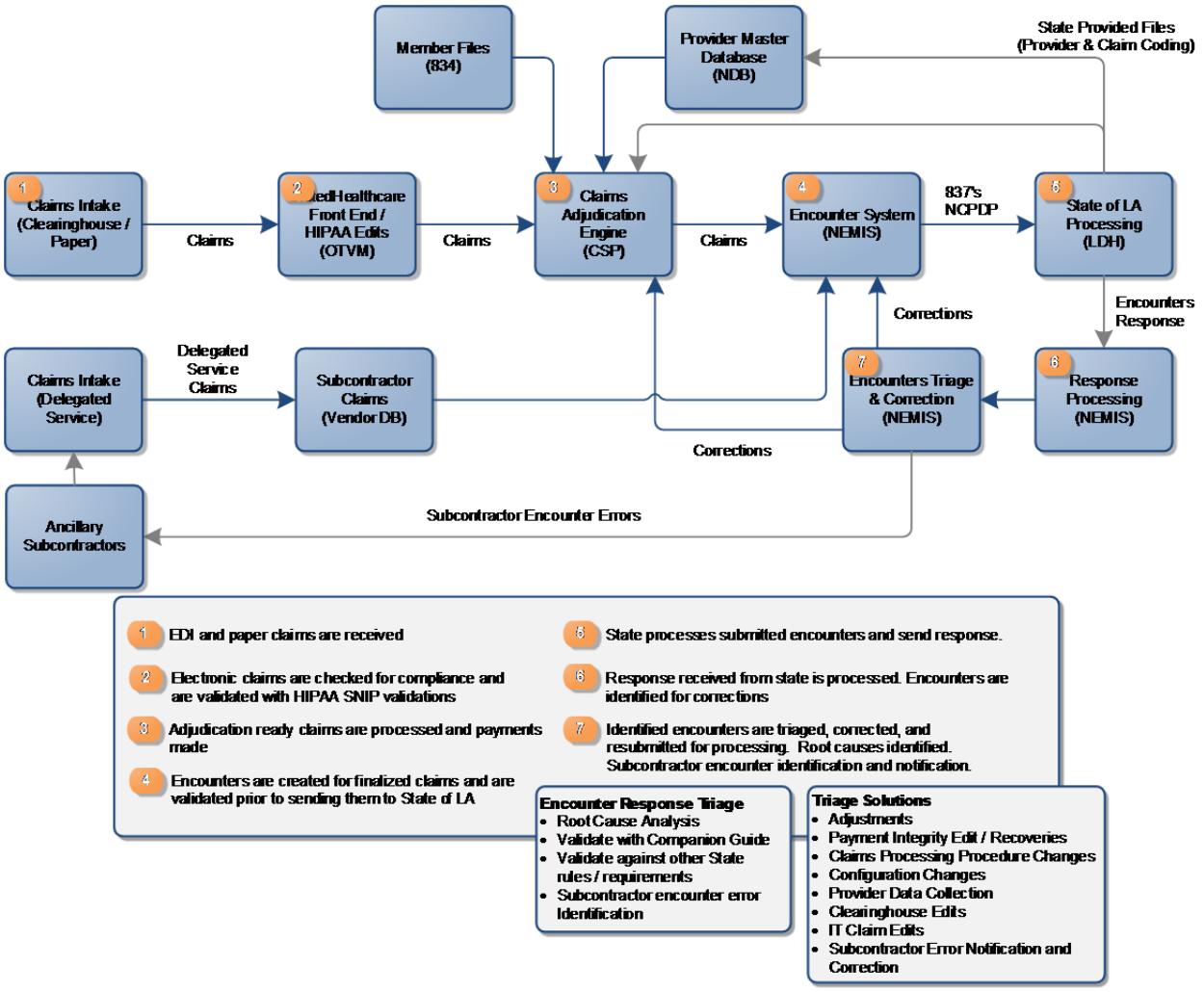


Figure 34. Encounters Flow. We gather encounter data from numerous sources and report this information using NEMIS.

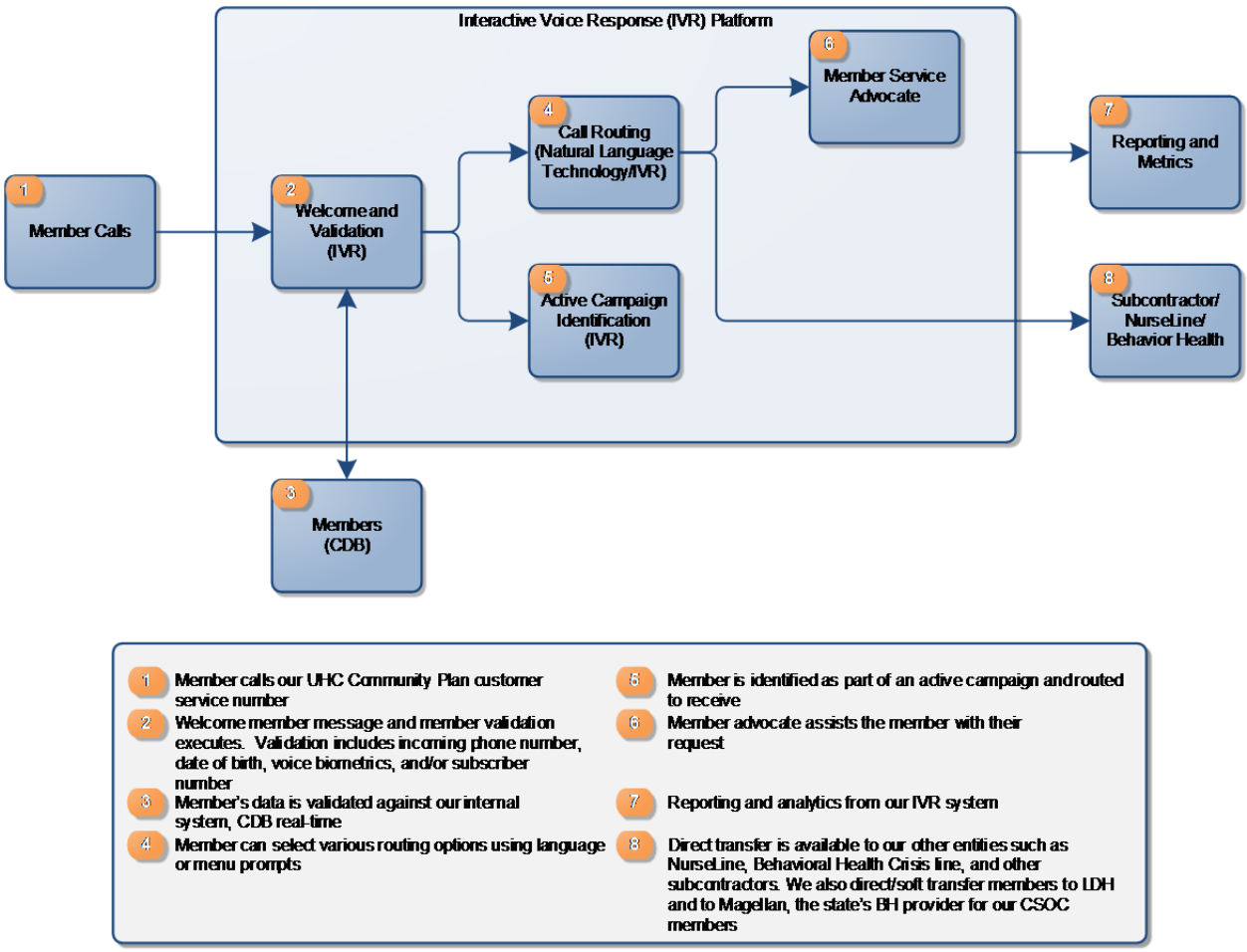


Figure 35. Telephone Management System (Enrollee). When an enrollee contacts our member services center, our interactive voice response (IVR) systems and intelligent routing technology identify the caller and route the call to the appropriate resource or self-service function.

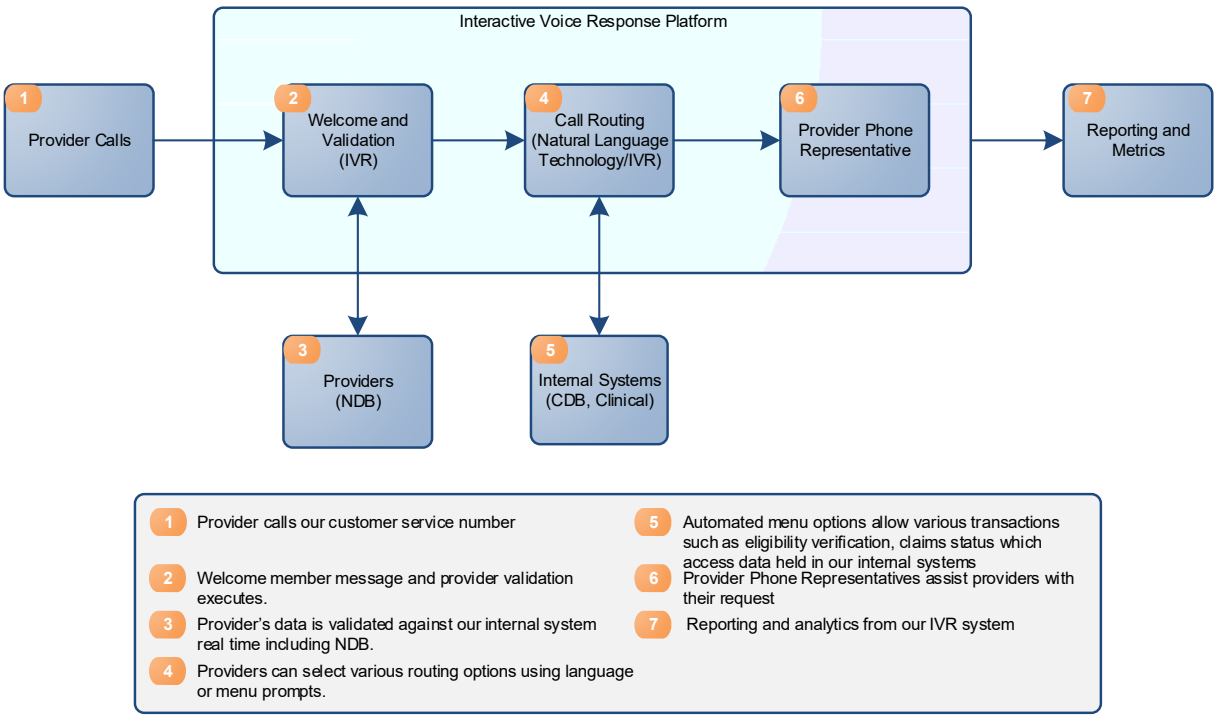


Figure 36. Telephone Management (Provider Services Call Center). Our provider call center is one of the "first stops" for providers to obtain information, education and resolve questions.

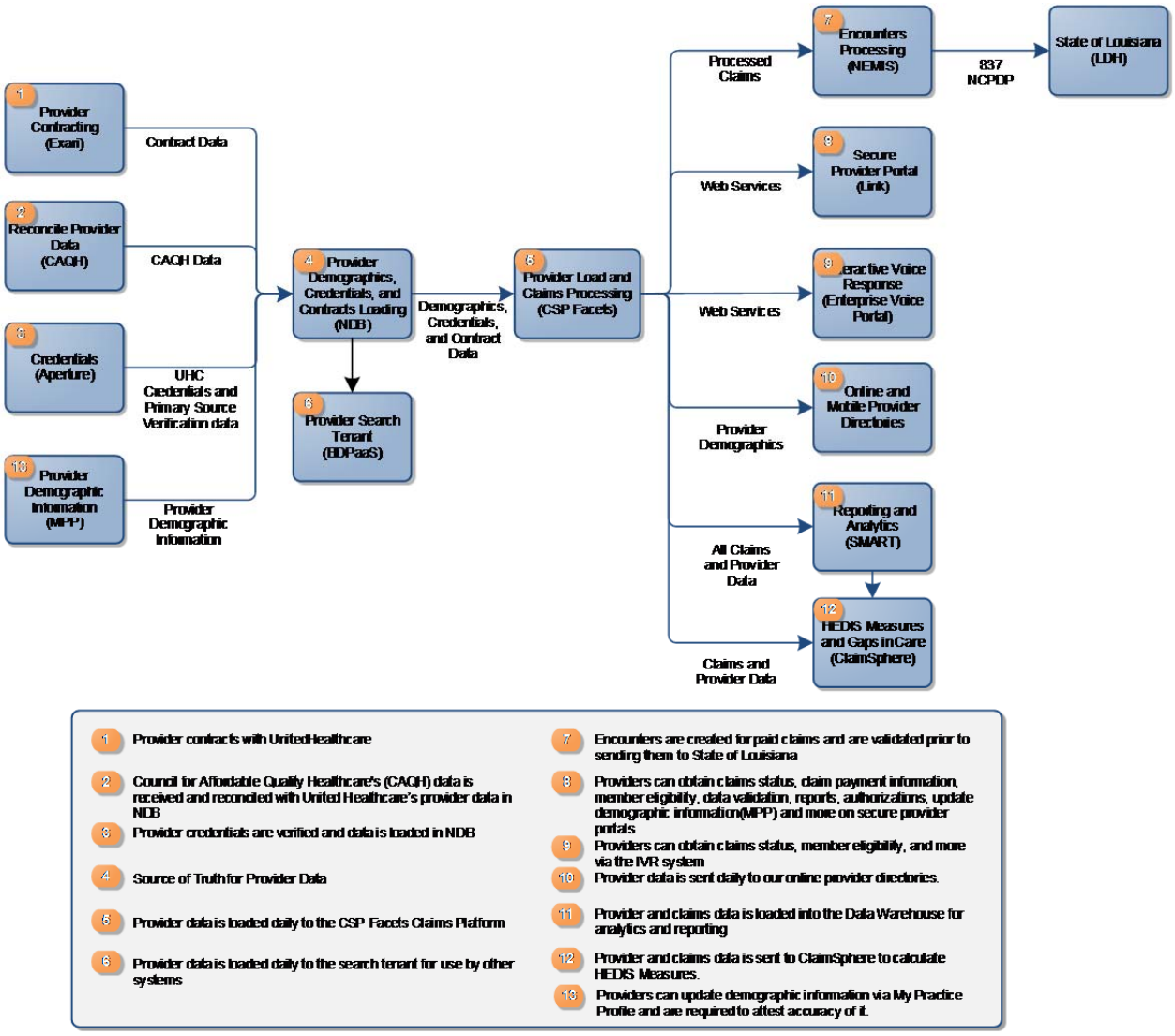


Figure 37. Provider Contracting Subsystem Flow. Our simplified credentialing process through CAQH supports data sharing and administrative simplification for providers.

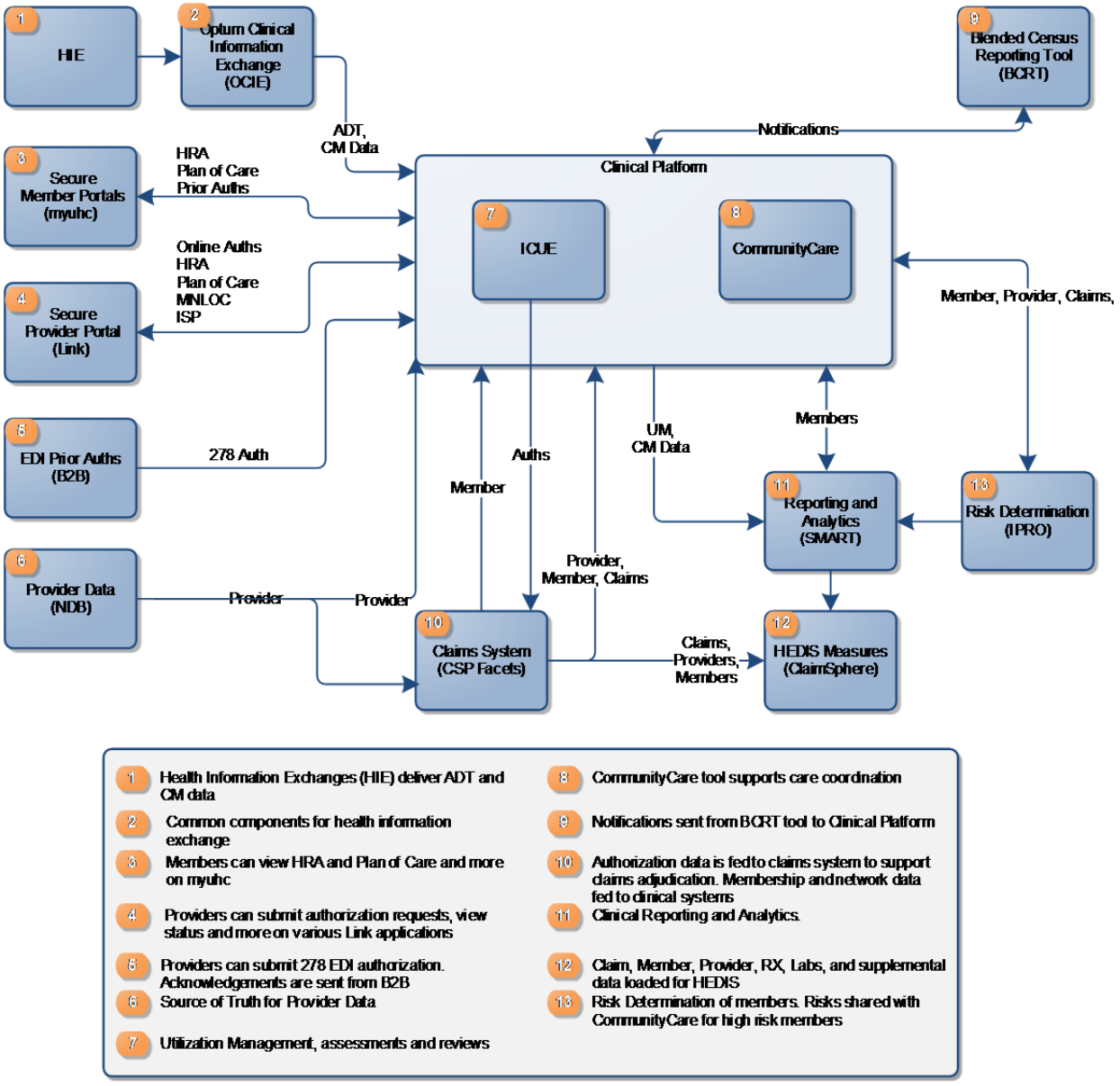


Figure 38. Utilization Management/Service Authorization/Care Management/Care Coordination Flow. Our UM/service authorization and care management process supports the state's HIT Roadmap and a coordinated system of care.

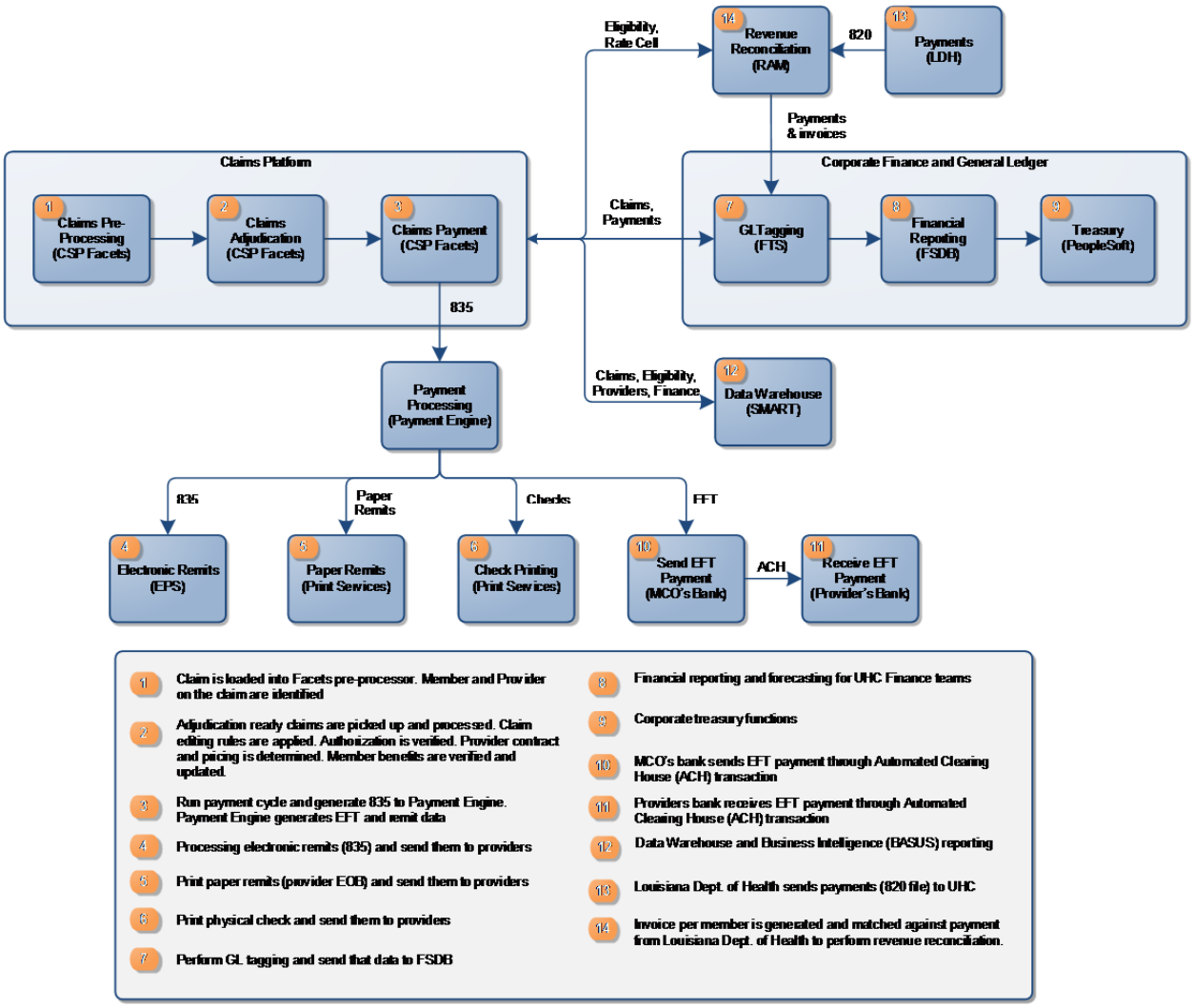


Figure 39. Finance Flow. This flowchart illustrates the claims payment process to enable prompt and timely payment to providers.

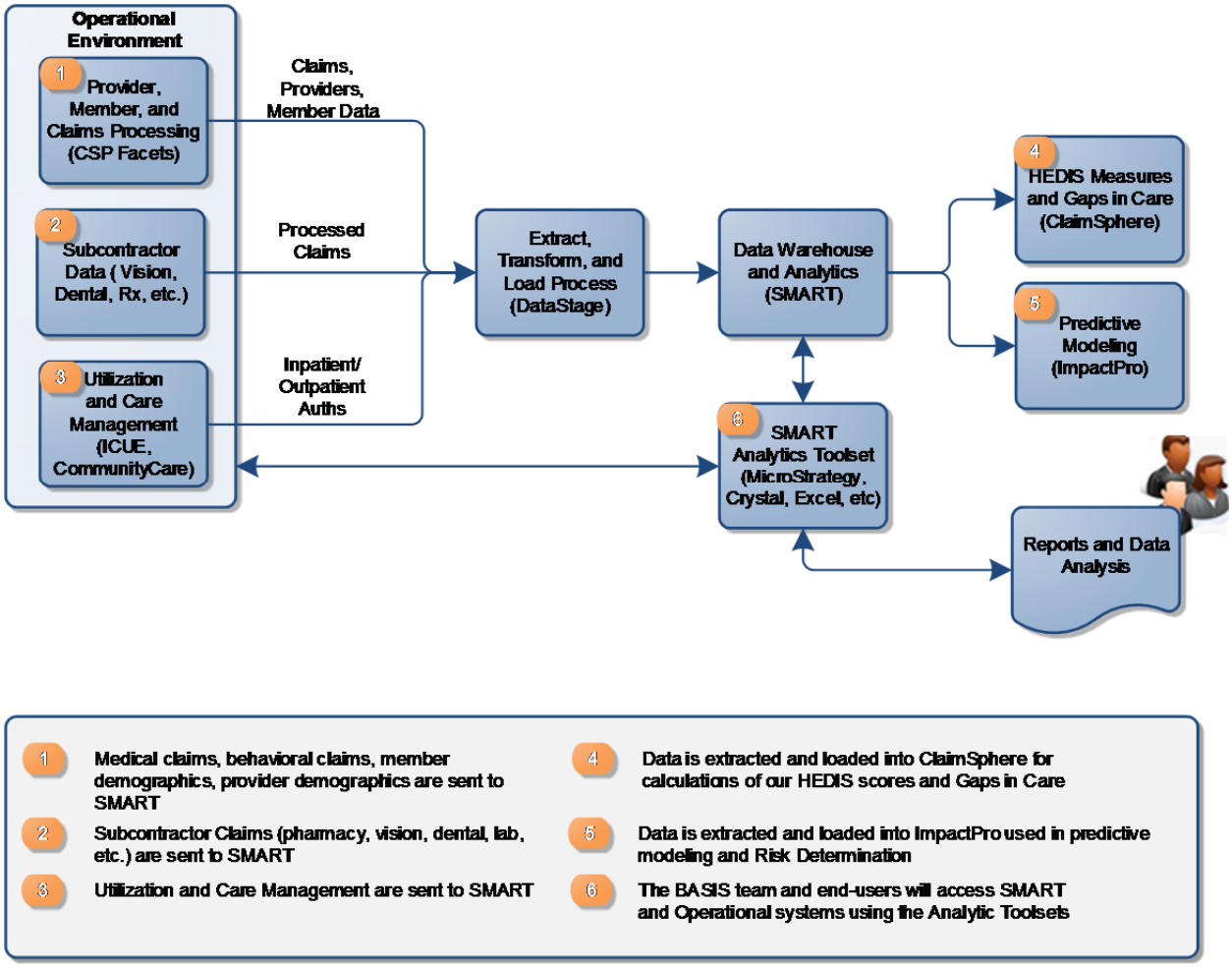


Figure 10: Reporting System Flow. Our integrated reporting and data analytics solution enables us to achieve maximum plan effectiveness and meet LDH's reporting requirements.

2.10.13.2.5 Proposed resources dedicated to Medicaid Management Information System (MMIS) exchanges.

The IT technical support for Louisiana is estimated to require 96,720 hours or 47 FTEs per year. This includes 20,800 hours or 10 FTEs to monitor infrastructure and technical operations and 66,560 hours or 32 FTEs to provide platform technical support. Six local IT staff will be dedicated to supporting the Louisiana program. Our dedicated information management and systems director has accountability for the technology supporting the Louisiana Medicaid Managed Care Program. The local IT staff dedicated to the Louisiana includes an Information management and systems director/chief information officer; IT systems analyst, operations support (four); IT systems analyst and HEDIS reporting manager.

In total, we anticipate the Louisiana Medicaid program to require 63 IT resources to support the program on an ongoing basis. This represents a small fraction of our overall IT support staff who can be accessed as needed to assist Louisiana Medicaid. UnitedHealth Group IT has more than 10,000 technology professionals across the United States. Following industry standards, our IT professionals are geographically dispersed to take advantage of the national labor pool and mitigate risks of localized disaster and weather events. We outline technical resources in the IT sections immediately above this section.

2.10.13.3 The Proposer should attest to the availability of the data elements required to produce required…

We have substantial experience aligning our system to meet LDH requirements including the data elements required to produce required management reports. In support of the Louisiana Medicaid program, we produce more than 80 weekly, monthly, quarterly and annual reports — plus ad hoc reports — on topics such as claims timeliness, encounter completeness, provider network, utilization rates, member roster, behavioral health, medical care coordination and overall Medicaid plan performance, including critical indicators and performance measures. A team of skilled analysts submits reports reflecting both data analysis and trending.

SMART, our robust, integrated reporting and data analytics solution enables us to achieve maximum plan effectiveness and meet LDH's reporting requirements. We integrate data into our data repositories from sources external to our core operations systems, including provider and encounter data from our vision and dental ancillary vendors, and pharmacy encounter data. We recently upgraded SMART to the latest Oracle Exadata Database platform, which brought noticeable performance benefits to reporting and analytics users. It also provides us with a future-ready data platform primed to enable timely, database decision-making across the business. Developing these composite data sets enables quality analysis such as HEDIS and others and supplements the medical management of enrollees.

2.10.13.4 The Proposer should describe in detail any system changes or enhancements that the Proposer is…

UnitedHealth Group upgrades and enhances its systems continuously. Comprehensive enhancements deploy on a monthly schedule or more frequently if possible, coordinated across platforms as needed. Every quarter, we deploy version upgrades to our CSP Facets platform, and we work closely with the product developer, Cognizant, to drive their roadmap for new systems features. We officially notify LDH of any significant updates per current contract requirements. We schedule change windows to avoid impact on enrollees, providers and other system users. The Change Management Team works with the system stakeholders and the Operations Team to determine release timing and change windows when there is no impact on system availability. If a change affects an enrollee or customer, we communicate through appropriate customer contacts and adhere to the LDH notification requirements.

2.10.13.4.1 Enrollment;

Eligibility Enrollment Management System (EEMS): Throughout 2019, we are rebuilding our enrollment module for CSP to provide greater flexibility for eligibility sources, improved speed to market for format changes, reduced maintenance costs and continued top-of-the-line end-to-end cycle time for loading eligibility.

2.10.13.4.2 Claims processing;

We implemented chatbots to automate some functions that our customer service personnel have to perform as part of their standard operating procedures. These chatbots automatically look up and populate the data or directions to screens for representatives when required. This automation improves the efficiency of our representatives in assisting our members/providers and accuracy of data entries during the calls. We are exploring opportunities to add chatbots to support our claims processers to improve the accuracy of data entries during claims correction.

2.10.13.4.3 Utilization Management/service authorization; or

We constantly upgrade our UM platform to support increased flexibility in requiring prior authorizations for services.

2.10.13.4.4 Care Management/disease management.

We actively use our resources to support Medicaid providers in practical and targeted ways to make progress toward meeting state and federal health information technology (HIT) and Health Information Exchange (HIE) requirements. UnitedHealthcare was the first MCO to execute and implement a contract with the Louisiana Health Information Exchange (LaHIE), and established hospital-specific data exchanges with facilities not actively participating with LaHIE to ensure we met our goal of providing comprehensive care management, and quality and efficiency of health care delivery, especially among smaller providers in outlying areas of the state. Work continues to partner with other Louisiana HIEs to develop relationships that increase enrollee data available to positively influence care management.

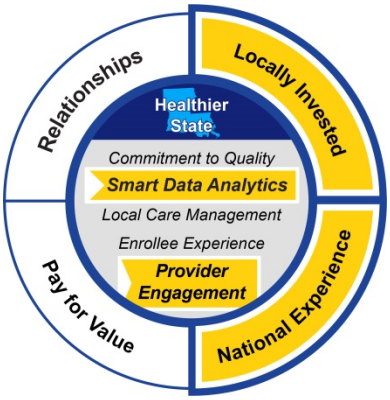
2.10.13.5 The Proposer should describe the capability and capacity of the Proposer's Information Technology (IT)

As shown in Question 2.10.13.2.2, our system architecture currently interfaces with LDH's system and that of its network providers and material subcontractors. These interfaces have been in place and operational since our 2012 Shared Savings program participation.

2.10.14 Program Integrity

2.10.14.1 The Proposer should describe its fraud, waste and abuse program and how it addresses the requirements…

UnitedHealthcare Fraud, Waste and Abuse Program Overview



Since 2012, UnitedHealthcare has been dedicated to safeguarding Louisiana's Medicaid funds, ensuring they are used efficiently and judiciously to provide enrollees with the care they need to improve their health and well-being in alignment with the Triple Aim. Once we became a full-risk plan in 2015, we expanded our Fraud, Waste and Abuse Program to include a robust Special Investigation Unit (SIU) and payment integrity functions. To expand our ability to combat fraud, waste, abuse and error, we combined advanced analytic capabilities, deep industry expertise and flexible infrastructure to help reveal unusual patterns that require further investigation and action.

Through ***innovation and continuous improvement***, LDH has recognized our best practices. We have exceeded LDH referral goals and achieved $1 million in recoveries since 2015. Examples of best practices include screening tips before assignment to SIU, re-routing non-fraud cases to our Waste and Error Team and enabling our SIU to independently refer cases to LDH.

From our parent company, UnitedHealth Group, to our employees, contractors and enrollees, we support a culture of compliance focused on ***minimizing wasteful spending, abuse and fraud***. Our Compliance Program is modeled on the seven elements of an effective compliance program, as outlined in 42 CFR §438.608(a)(1), and is compliant with all requirements of Model Contract Section 2.20. Supporting policies and procedures include our Fraud Waste and Abuse Prevention and Detection Plan, which we submit to LDH annually, as well as:

- UnitedHealth Group Code of Conduct
- UnitedHealthcare Government Programs Compliance Program
- UnitedHealth Group False Claims Act Compliance Policy
- UnitedHealthcare Compliance Investigations policy
- UnitedHealthcare Fraud, Waste, and Abuse policy
- Supplemental documentation to address federal and state-specific requirements

Since 2013, Larry Smith has served as our contract compliance officer and program integrity officer. He works in conjunction with our national and local SIU and payment integrity department, both of which are supported by our Legal Team. Mr. Smith co-chairs our local Compliance Oversight Committee with the health plan CEO to oversee the compliance program and confirm adherence with LDH requirements, policies and procedures. Further, Mr. Smith and the health plan's CEO or chief operation officer attend LDH Program Integrity (PI) and Louisiana Office of Inspector General's (OIG) Medicaid Fraud Control Unit (MFCU) meetings. During these PI/MFCU meetings, the Department's investigative units share schemes and case studies that influence our investigations. For example, behavioral health audits have been an area of focus for both the MFCU and UnitedHealthcare. In 2018, we reported 400 audits of behavioral health providers. At these PI/MFCU meetings, collaboration among investigators from all MCOs has led to more coordinated, effective provider audits and better data for PI/MFCU on cases the MCOs refer.

Prevention, Detection and Correction

A cornerstone of our Compliance Program, our Anti-Fraud, Waste and Abuse Program focuses on prevention, detection and correction activities undertaken to minimize or prevent overpayments due to fraud, waste or abuse. Through our operational model, appropriately titled Prevention, Detection and Correction, we further increase the effectiveness of our local compliance program by drawing upon our national team that spans 25 states where we serve Medicaid enrollees. Through information sharing with programs in other states, our national and state teams can uncover potential schemes, share information with other states, and bring in additional resources if needed to increase our ability to efficiently avoid or remediate fraud, waste and abuse in Louisiana. Additionally, we are pleased to have contributed to LDH's recent recognition by CMS for increasing referrals by 100% and tripling the number of tips received since LDH introduced its fraud referral form.

Figure 40. Key Features of UnitedHealthcare's Prevention, Detection and Correction Model

Several aspects of our prevention, detection and correction model are outlined in our response to Questions 2.10.14.1.1 through 2.10.14.1.5 where we address training and education, enrollee engagement, data analytics, high-risk claims and provider recoveries. The following are also critical aspects of our Fraud, Waste and Abuse Program.

Prevention

In accordance with Model Contract Section 2.3.1.4, to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program and/or any federal health care programs, all UnitedHealthcare employees undergo annual criminal background checks. We also perform required database searches on employees, entities, contract and contingent workers, and customers and business partners per all requirements of Model Contract Section 2.20.3.6. Further, our contracts with third parties contain language requiring them to screen their employees as required by applicable state and federal law. UnitedHealthcare checks the exclusion status of all contracted providers against the following lists:

- Health and Human Services (HHS) OIG List of Excluded Individuals/Entities (LEIE)
- General Services Administration Excluded Parties List Service
- GSA's System for Award Management (SAM)
- CMS's Medicare Exclusion Databank
- State Board of Examiners
- Social Security Administration Death Master File (SSADMF)
- National Plan and Provider Enumeration System (NPPES)
- U.S. Office of Foreign Assets Control (OFAC)
- Louisiana Adverse Actions List and all state licensing boards

When we discover any entity is excluded, suspended or debarred, we report them to LDH within 3 business days. This includes a director, partner or officer of the health plan, subcontractors, any consultants or employees with other arrangements to provide services material to the health plan and network providers.

When LDH informs us of a credible allegation of fraud against a provider, we immediately suspend payments according to 42 CFR §455.23, alerting network management and claims processors.

Detection

UnitedHealthcare employs an array of programs that combat fraud, waste and abuse both prospectively (before claims are paid) and retrospectively (after claims have been paid). We focus on being good stewards of state and federal dollars and are steadfast in our commitment to preventing FWA through programs and algorithms that identify problems arising from both intentional and uninformed practices. Our SIUs are critical to detection efforts. Our Louisiana-based SIU staff includes one investigator for every 50,000 enrollees and is supported by investigative teams throughout the company. To increase efficiency, our local SIU builds upon best practices of our national investigative teams, such as:

- Triaging all tips received to determine credibility before routing to the SIU or Waste and Error Team. The SIU investigates allegations of fraud, while the Waste and Error Team investigates non-fraud billing aberrations
- Streamlining the process by enabling SIU investigators to interact directly with LDH, including submitting referrals and notifications
- Performing pre-payment review by using algorithms to identify aberrant billing patterns that lead to referrals to the SIU
- Participation in the Healthcare Fraud Prevention Partnership and sharing awareness of industry trends

Through this collaboration between our national and local investigative staff, we received recognition from LDH for exceeding the Department's goal for SIU referrals and notices by 100% in state fiscal year (SFY) 2018.

We make it easy for employees, enrollees or providers to report suspicions of misconduct, including billing fraud or unethical activities. In addition to the ability to report tips to our compliance officer or management, we offer and provide education on the following methods for reporting of suspected fraud, waste or abuse. In compliance with the Model Contract, we are also implementing and will check weekly, a dedicated email account for employees, enrollees or providers to submit tips.

- UnitedHealthcare's Compliance & Ethics Help Center and FWA hotline (both available 24 hours a day, 7 days a week)
- HRdirect via toll-free number or our company's intranet site
- Online tip referral form
- Provider and enrollee portals
- Contact numbers for OIG/HHS
- Louisiana's FWA hotline

Correction

When FWA investigations reveal the need for corrective action, we may pursue actions, including, but not limited to, the following:

- Notifying and educating the offending provider or enrollee

- Creating and implementing new data mining queries/rules to detect if the scheme at issue is occurring with other providers
- Educating providers on possible changes in the contract and/or policy terms and procedures
- Issuing a corrective action plan to the provider
- Referring a provider to network management for appropriate disciplinary action
- Referring a provider to any other committees as necessary to remediate the issue (such as quality, contracting and credentialing)
- Reporting providers to state professional licensing authorities and medical boards
- Referring a matter to outside counsel for civil litigation
- Referring a matter to law enforcement officials or prosecutors for criminal prosecution

If a corrective action plan is issued, our compliance officer along with the business leaders of the affected functional area(s) monitor and evaluate the implementation of and progress made under the corrective action plan. They are also responsible for documenting that remediation activities are effective and address the concerns detailed in the corrective action plan.

When we identify providers who meet a threshold of claims denied through prepay record review, we provide them with a report describing the patterns of billing practices and encourage them to review it with one of our certified professional coders. We also employ one-on-one meetings and establish ongoing dialogue related to the identified coding issues. Prepay monitoring continues until the provider meets or exceeds the threshold of denied claims. This approach helps avoid the usual resource intensive pay and chase scenario.

All claims and encounters associated with fraud, waste and abuse are voided, and any money paid to excluded entities is returned to LDH within 30 days.

2.10.14.1.1 Any training programs that the Proposer uses to train employees, subcontractors, and providers on…

Knowledge is the first line of defense in safeguarding LDH's Medicaid dollars and preventing fraud, waste and abuse. Our educational content emphasizes to our employees, providers, subcontractors and enrollees that they are on the front lines in deterring and detecting Medicaid FWA and are obligated to report suspicions of unethical or illegal behavior.

Training for Employees and Subcontractors

Compliance training is required for all UnitedHealthcare employees, managers and directors, applicable company subcontractors, and those employees of other company segments who perform work on our behalf. In addition to new employee orientation, we provide mandatory annual and/or periodic employee compliance training, including, but not limited to:

- Code of Conduct, including Enforcement and Disciplinary Guidelines
- Privacy and Security
- Organizational Conflicts of Interest
- Identifying Fraud, Waste and Abuse
- Reporting suspected FWA, unethical conduct or non-compliance
- False Claims Act and Whistleblower Protection
- Contract compliance and FWA training, including:
  - Procedures for timely consistent notification, information exchange and collaboration with LDH

- Organizational chart including the program integrity officer and full-time program integrity investigators
- Effective lines of communication between compliance and employees

Our compliance officer conducts annual training on Louisiana-specific contract requirements, including those in Model Contract section 2.20.2.2.4.2. He also shares relevant publications from LDH throughout the year via email blasts (e.g., Health Plan Advisories, new legislation). Mandatory annual retraining requires an attestation and/or a passing test score. All compliance related trainings are completed within 30 days of hire and annually after that. Adherence is monitored by tracking training completion and notifying managers if employees do not complete training on time. Our compliance officer then follows up to verify training was completed.

Training for Providers

We offer initial and ongoing integrity and compliance training to providers through our secure provider website, *UHCprovider.com* (available 24 hours a day, 7 days a week). We also convey information about our FWA program in our *Care Provider Manual*, our provider newsletter, *Practice Matters*, and through targeted provider education letters. Our provider advocates also conduct in-person training to providers and their staff as needed.

We promote the American Board of Internal Medicine (ABIM) Foundation's ***Choosing Wisely*** campaign to providers. This program is aimed at avoiding overutilization of inappropriate services by providing specific, evidence-based recommendations clinicians and enrollees can discuss, such as when tests and procedures (e.g., CT scans, antibiotics) may be appropriate and the process used for the recommendation. Finally, providers have access to multiple venues for any questions and points of escalation. These venues include provider expositions, a provider hotline outside of the provider call center, grievances and appeals process, and provider advocates who address issues face-to-face.

Provider Awareness

Our provider awareness campaigns include proactive outreach to those providers with aberrant billing patterns in a collaborative, respectful manner to minimize provider tensions. The goal is to remediate identified behavior that could lead to a focused, potentially contentious audit in the future if not corrected or addressed. We perform this analysis without any payment delays and burdensome record requests. This approach allows us to influence billing practices through tailored provider engagement, including letters, outreach via phone and one-on-one meetings with the provider and a certified professional coder. The goal is to remediate identified behavior that could lead to a focused audit in the future. Providers receive a letter tailored to the claims experience from their practice and a report, which demonstrates the results of their billing compared to their peers. Providers are encouraged to contact us through their Provider Advocate to discuss the results in more detail. We monitor the provider's behavior for improvement and, if none is identified, we consider next steps such as outreach, audit, formal education or investigation. In 2018, we submitted letters to 360 Louisiana Medicaid providers spanning 22 prevention campaigns.

LDH Program Goal: Minimize Wasteful Spending, Abuse and Fraud

Targeted Provider Education through Practice Management

A specialized Practice Management Team of licensed clinicians conducts systematic reviews of provider practices to identify instances of atypical clinical patterns of behavior and determine if the behavior warrants intervention. They may make announced or unannounced on-site field audits. They conduct internal meetings with appropriate departments to inform them of the identified patterns and gather additional

information. The team then reviews aberrant claims billing patterns with the provider; provides education on clinical and billing guidelines; conducts clinical audits with potential performance improvement plans or network termination, or refers the case to the SIU if they identify prospective flag or recoupment opportunity. While this work typically leads to targeted education opportunities, practice specialists in Louisiana made 149 referrals to the SIU through this program in 2018.

Training for Delegated Entities

Delegated Entities are responsible for adhering to all compliance program elements outlined by federal regulations, and state regulations and UnitedHealthcare. These requirements are communicated via methods such as our Delegated Entity Oversight reference website and Annual Compliance Delegate Notice and Annual Attestation. Program elements include, but are not limited to, the following:

- Awareness of federal and state laws related to an effective compliance program, to safeguard against improper payments and utilization of services, and methods of reporting fraud, waste and abuse
- Code of Conduct upon hire and annually after that
- Document retention for 10 years from the date the activity is performed

2.10.14.1.2 How the Proposer engages enrollees in preventing fraud, waste and abuse;

Enrollees receive education upon enrollment, beginning with their welcome newsletter, which includes descriptions of fraud, waste and abuse, and instructions on how to report it. Their ID cards for the health plan and pharmacy include a telephone number to report tips. Additional education is provided through the *Enrollee Handbook* including definitions of FWA, how to identify FWA and examples, the enrollee's responsibility to prevent FWA and the various avenues available to report FWA. Enrollees receive additional education through the Getting Started Guide, *HealthTalk* newsletter, behavioral health support website (*liveandworkwell.com*) and enrollee mobile application.

Materials are designed to encourage appropriate and cost-effective use of health care, including the importance of the PCP, prior authorizations, emergency care, annual checkups, value-added services, non-covered services and more. Our compliance officer also presents on topics related to fraud, waste and abuse prevention at our Member Advisory Committee meetings. Enrollees are also able to review claims through our enrollee website, *myuhc.com* and contact us if they observe evidence of fraud, waste or abuse.

To educate enrollees and help limit overutilization of inappropriate services, we also offer the ABIM Foundation's ***Choosing Wisely*** campaign via literature provided during enrollee events and in-office provider signage. The campaign encourages enrollees to ask questions like:

- Do I really need this test or procedure?
- What are the risks and side effects?
- Are there simpler, safer options?
- What happens if I don't do anything?
- How much does it cost, and will my insurance pay for it?

Per the Code of Federal Regulations (42 CFR §455.20, Recipient Verification Procedure), states must have a method of verifying whether or not services billed by providers were received. UnitedHealthcare uses this requirement as an opportunity to engage enrollees to identify and report any suspicious activity. Any potential inconsistencies identified by the enrollees are further reviewed, investigated and reported, if warranted, within 3 days of notice that services were not received.

2.10.14.1.3 The data analytic algorithms that the Proposer will use for purposes of fraud prevention and detection;

One of the most efficient methods of detecting fraud, waste and abuse is predictive modeling and electronic data analysis. These tools identify aberrant and excessive billing practices and trends, inappropriate treatment, fictitious and unqualified providers, and fictitious and ineligible enrollees.

We apply automated claim edits based upon correct coding, industry standards for HIPAA, state and federal regulations, UnitedHealthcare reimbursement, medical and drug policies and specialty programs to validate accurate claim payment and confirm consistent enrollee and provider experiences. Programs used to identify potential FWA include, but are not limited to:

Diagnosis to Drug Match (DX/Rx): Data analytics confirms a “drug to diagnosis” match along with age edits to confirm medication use is appropriate. This program supports the identification of high-risk behavior by identifying fraudulent schemes such as securing controlled substances and other high-cost supplies for unlawful distribution.

Coordination of Benefits Smart Utility: This program matches eligibility information from participating payers across the nation and supplies the results back to the payers on a weekly basis. This information is used to set flags on the adjudication platform.

Algorithm/Data Mining: UnitedHealthcare can identify evidence of overlapping coverage through a variety of information resources including eligibility data, enrollee communications, claims and prior authorization data.

Prior Authorization: We work closely with health care practitioners and providers to determine the medical necessity and appropriateness of care, avoid inappropriate use or duplication of services, and identify enrollees who may benefit from care coordination. We also require prior authorization for services at risk for fraud (e.g., durable medical equipment or controlled substances).

Machine Learning: We use innovative machine learning, a type of computational science sometimes referred to as artificial intelligence, to uncover unusual behavior amongst providers. This science incorporates numerous technologies that actively create algorithms as data is analyzed and then can make predictions when presented with new data sets. Neural networks, clustering, network analysis and graph theory are a few technologies that comprise our collection of machine learning techniques.

Natural Language Processing (NLP): Another type of artificial intelligence, NLP enables a computer program to understand human language as it is spoken or written. With NLP, computers can read text, hear speech and interpret a tremendous amount of unstructured data (e.g., electronic health records, medical records, claims data and call center conversations) and place it into a usable structure. Using this data that would not be available without NLP, UnitedHealthcare can more efficiently extract trends and identify root cause issues to combat FWA. We use NLP to make sure we prioritize leads with allegation details that include fraud trend key words. We also employ NLP to identify trends in the examination of fraud referrals from external sources like OIG, DOJ and news articles to identify subject areas of concern.

Lock-in Program: In collaboration with LDH, we provide an administrative lock-in program that acknowledges the potential harm to an enrollee who misuses high-risk prescription medication, including controlled substances like opioids and medications that could be misused with opioids, and allows us to limit an enrollee to one pharmacy but does not limit access to emergency services. We retrospectively identify enrollees who are misusing and potentially committing fraud or abuse in two primary ways: reported tips from enrollees, providers or our employees

and data analytics. During 2018, the Lock-in Program averaged 200 to 250 enrollees.

To investigate reported tips or unusual data patterns, we review an enrollee's medical claims, such as ED visits or multiple prescribers, to identify potential drug-seeking behavior. Once the lock-in assignment occurs, we perform annual utilization reviews of the enrollee's paid pharmacy and health care services to determine if the enrollee meets the criteria for an extended lock-in. When enrollees are affirmatively identified for lock-in programs and when an enrollee in lock-in transfers to fee-for-service (FFS) or another health plan, we notify LDH immediately (or at a frequency determined by LDH). We also apply the lock-in program when notified of enrollees who transferred from the FFS benefit and were in the FFS lock-in program.

Pharmacy Drug Utilization Review (DUR) Program: The DUR program identifies high-risk, dangerous enrollee utilization patterns or gaps in care, looks at prescribing trends outside of evidence-based guidelines for educational opportunities, and looks to alert pharmacies of medication related issues they may not be aware of due to an enrollee's use of multiple pharmacies. This program helps detect potential high-risk activity.

Pre-Payment Flags When we believe a provider has engaged in fraud, waste or abuse, a prospective "flag" can be placed on provider payments. Flags are useful in preventing payments to providers until we validate their billing patterns and create opportunities for provider education or investigate billing practices, thus reducing administrative costs.

Prospective Payment Program: As required in the Model Contract, we have a software tool that includes provider peer-to-peer profiling, claim-centric editing, and predictive modeling tools that uncover previously undetected aberrant behaviors. We can apply these software tools to the plan's daily claim stream to identify fraud and abuse before the claim is paid. Both Provider- and Claim-centric prepayment flags help identify "complex" cases for review.

Aberrant Billing Patterns (ABP): We maintain libraries of ABPs that include queries and algorithms designed to identify suspected FWA based upon known or suspected schemes and practices. These ABPs include general queries and criteria applicable to all health plan claims and those tailored to common FWA schemes.

Claims Edits: A clinical edit system that analyzes physician health care claims based upon business rules, which automate reimbursement policy and industry standard coding practices. Our systems support health care reform mandates, including National Correct Coding Initiative (NCCI) bundling, medically unlikely event (MUE) and health care acquired conditions. This system helps identify claims for "automated" reviews. 2.10.14.1.4 Methods the Proposer will use to identify high-risk claims and its definition of "high-risk claims"; and

UnitedHealthcare's methods to identify high-risk claims range from individual monitoring of providers to innovative software for automated data risk scoring. Many of the algorithms, described earlier are used to identify the defined high-risk claims (e.g., durable medical equipment, home health aides, inappropriate use of medication or high-cost supplies for unlawful distribution). These methods include, but are not limited to, pre-pay analytic edits, aberrant billing patterns, data mining and machine learning.

The schemes used in health care fraud, waste and abuse prevention are continually evolving. UnitedHealthcare's definition of high-risk claims evolves with these changes. We keep apprised of industry trends through participation in national organizations like the National Health Care Anti-Fraud Association and the annual HHS OIG report, which lists convictions and recoveries by various categories and our own claims analysis. We share this information with investigative sources, including the MFCU, in Louisiana and other states.

LDH Program Goal: Minimizing Wasteful Spending, Abuse and Fraud

UnitedHealthcare used high-risk claims analysis to identify freestanding pathology laboratories with excessive utilization rates for unnecessary drug tests. Enrollees with uncomplicated alcohol use disorder, for example, were being tested for other substances like antidepressants and antipsychotics. UnitedHealthcare's Behavioral Health Medical Director, Dr. Jose Calderon, analyzed the data and presented his findings to LDH and the other MCOs. This data analysis led to a collaboration between LDH and UnitedHealthcare to create and implement a new statewide policy to control drug testing and establish a reimbursement code for bundling multiple tests. This innovative policy, planned to go live in the summer of 2019, will help drive the Triple Aim of better care, better health and lower costs.

2.10.14.1.5 The Proposer's experience with provider recovery collection.

While we are aggressive in our pursuit of resolving overpayments, we recognize that, at times, it may be complicated or difficult for providers. We work with them to determine the most equitable manner possible for a successful resolution. We have a dedicated team that oversees retrospective recovery activities and handles all actions necessary to enable recovery of overpayments, which we base upon an established recovery process that includes:

- Use of our Overpayment, Detection and Recovery (ODAR) platform to process the affected claims. Our team loads suspect claims to ODAR to confirm that no other take-backs were affected by that particular claim. They then send them through ODAR for financial processing. Investigators then produce the demand letters.
- The health plan is notified of the recovery opportunity. Approval is required to proceed with the process, and if approved, overpayment demand letters are sent to providers. In most cases, the turnaround time for provider response is 30 days.
- Providers are entitled to file an appeal following state and LDH guidelines and published in our *Care Provider Manual*.

Through this process, UnitedHealthcare has recovered $1 million since we became a full-risk plan in Louisiana in 2015. Through its FWA program, in 2018 alone, UnitedHealthcare recovered $653,346 in overpayments, resulting from over 1,200 provider investigations and audits. These include work performed by both our SIU and Waste and Error Teams. Noted as a best practice by LDH, our Triage Team refers all non-fraud cases to our Waste and Error Team, rather than SIU. This step in the process helps focus SIU resources more efficiently and effectively.

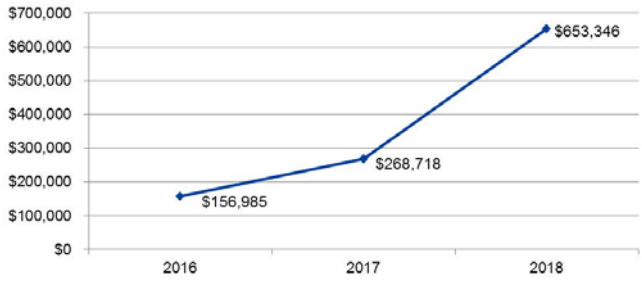


Figure 41. Louisiana FWA Recoveries

As demonstrated by the graph, our recoveries in 2018 increased by 40% from the previous year. In part, this success is due to the maturation of audits, but a significant factor in increasing recoveries is the teamwork among investigators and our Negotiations Team. Together, investigators and negotiators work with providers to reach workable settlements. This maximizes recoveries and minimizes the need for litigation while allowing providers to maintain their business activities. In 2019 and beyond, we expect this year-over-year increase in recoveries to continue.

2.10.14.2 The Proposer should provide a detailed description of its capability to produce the required reports…

Since 2015, UnitedHealthcare has worked closely with the LDH Program Integrity Team to submit timely reports and, in some cases, to help refine the format and process of those reports. Recently, we submitted innovative recommendations for improving the standing report on FWA activities to make it easier for all MCOs to prepare the report and for LDH to access the data. We will continue to provide LDH with all reports required under by the Model Contract, including the following.

Ad Hoc Reports of FWA Incidents Involving Individuals or Entities

In compliance with the Model Contract, we report any FWA incident or notice concerning individuals or entities within 3 business days. Additionally, we report all credible allegations to LDH Program Integrity utilizing its Fraud or Notification referral forms. We immediately report provider fraud and abuse or enrollee fraud to LDH and local law enforcement, and notify LDH immediately in the event we are contacted by any investigative authority. We check all required exclusion databases monthly. We also check all state licensing boards and report, within 3 business days, individuals or entities with sanctions in any state or line of business to LDH if there is Louisiana Medicaid exposure

We will continue to report on overpayments from LDH to UnitedHealthcare, FWA in the administration of the Louisiana Medicaid program (within 5 business days), and FWA identified through the medical and pharmacy utilization management program. We also will begin reporting, upon receipt, any disclosure by a provider of overpayments in excess of $25,000 in accordance with all Model Contract requirements.

Standing Reports of FWA Activities

Continued submission of these reports includes our monthly reports on tips audits, , and exclusion database review attestation; quarterly FWA audits and activities (becoming monthly) and verification of services; and annual reports of recoveries and overpayments and the FWA compliance program plan. We also will continue to provide monthly reports on unsolicited provider refunds and begin reporting upon receipt disclosure by a provider of overpayments in excess of $25,000 in accordance with the Model Contract.

For both Ad Hoc and Standing reports, UnitedHealthcare uses its proprietary reporting software and databases and keeps detailed tracking logs to support required reporting. Our reporting software, such as Serena Business Manager and DETECTS, track and monitor tips, including those reported through the Recipient Verification of Services process. Another proprietary database, ODAR, is used to track and reconcile payments to claims including reporting on unsolicited provider refunds. Our investigators also log and track their cases and associated investigatory processes. This data, combined with DETECTS and ODAR, forms the basis of our reports of tips, audits and FWA activities.

2.10.15 Veteran-Owned and Service-Connected Disabled Veteran-Owned Small Entrepreneurships (Veteran Initiative) and Louisiana Initiative for Small Entrepreneurships (Hudson Initiative) Programs Participation

2.10.15.1 Twelve percent (12%) of the total evaluation points in this RFP are reserved for Proposers who are…

2.10.15.2 If the Proposer is a certified Veterans Initiative or Hudson Initiative small entrepreneurship, the…

2.10.15.3 If the Proposer is not a certified small entrepreneurship, but has engaged one (1) or more Veterans…

2.10.15.4 If multiple Veterans Initiative or Hudson Initiative subcontractors will be used, the above required…

2.10.15.5 For additional information, see Appendix G, Veteran and Hudson Initiatives.

Our Commitment to Economic Development

As one of Louisiana's largest contractors in the Medicaid Managed Care Program serving the needs of more than 442,000 enrollees, we are committed to supporting LDH's efforts to increase state purchasing and contracting opportunities available to certified Louisiana-based small entrepreneurships under the Louisiana Veteran and Hudson Small Entrepreneurship Initiatives ("Certified Businesses"). By strengthening the diverse business community, we contribute to the overall economic growth and expansion of the nation's most rapidly expanding market segments. Delivering high quality services to the residents of Louisiana by using locally owned businesses has deepened our footprint and commitment to the communities we serve.

We have identified 67 medical and administrative subcontracting opportunities with certified business entities. We also will encourage our commercial and Medicare Advantage (People's Health) lines of business in Louisiana to contract with Veteran/Hudson businesses, which is additional and separate above our Medicaid certified commitment in this bid. We have a strong history of using Veteran's/Hudson entities over the past 5 years, spending over $20 million with previous and current certified businesses. We plan to remain committed to these partners and expand over the next 3-year commitment.

[redacted]. By engaging with these certified businesses upon contract award, we will ensure that certified Louisiana-based businesses deliver services related to the Medicaid Managed Care Program when possible. These services include, but are not limited to:

- Care transitions
- Home health care
- Pediatric day health center
- Retail pharmacy
- Durable medical equipment (DME)
- Rehabilitation
- Non-emergency medical transportation (NEMT)
- Wound care management
- Wellness
- Physical therapy/occupational therapy
- Marketing/Advertising
- Printing
- Recruiting/staffing

[redacted]

Continually Expanding Opportunities for Certified Louisiana Small Entrepreneurships

Our commitment to using certified businesses does not end with the list in this response. We are committed to not only using businesses LDH identifies through the Department of Economic Development, we will make every effort to replace active subcontractors, certified and non-certified, with certified businesses and monitor spend with this vendor population proactively. In addition, as part of our One United approach, we are encouraging our commercial and People's Health lines of business to consider using these vendors as well. This again would be above and separate from our certified Medicaid offer.

[redacted]

[redacted]

UnitedHealth Group's Supplier Diversity Program

Veteran Employees
UnitedHealth Group was named a 2019 Military Friendly Employer by Viqtory, a veteran-owned business that connects the military community to civilian opportunity.

In support of Louisiana's Veteran and Hudson Small Entrepreneurship Initiatives, we will build upon the successful experience of our parent company, UnitedHealth Group, to actively seek and partner with local businesses certified in the following classifications: small business, minority-business enterprise, women-owned business enterprise and veteran-owned business enterprise. We actively seek to partner with diverse suppliers that reflect the multicultural states we serve. We provide diverse businesses opportunities to compete for discretionary spend associated with third-party contracts and order fulfillment with our corporation. In 2018, UnitedHealth Group spent over $1.14 billion with small and diverse suppliers and providers across the enterprise.

Our sourcing teams actively work to identify opportunities for minority, women-owned and veteran-owned and other historically underutilized businesses. We also work with state and local government agencies, minority business groups and advocacy organizations to identify sourcing opportunities for diverse suppliers where possible.

We are corporate members of the National Minority Supplier Development Council (NMSDC) and the Women Business Enterprise National Council (WBENC). We also support NMSDC and WBENC regional affiliate councils throughout the United States.